AN EXPLORATORY STUDY OF BLACK FEMALE CLINICIANS’ EXPERIENCES IN THERAPY WITH BLACK MALE ADOLESCENTS

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ERICA NICOLE STEWART

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APPROVED:

Nancy Boyd-Franklin, Ph.D. (Chair)

Karen Riggs-Skean, Psy.D.

DEAN:

Francine Conway, Ph.D.
BLACK FEMALE CLINICIANS’ EXPERIENCES IN THERAPY

Abstract

Black male adolescents in America have experienced many challenges in recent years specific to their race and gender, particularly with regard to education, e.g., disproportionality in rates of school punishment and the achievement gap, as well as mass incarceration, racial profiling, and police shootings. Despite the serious nature of these realities, it is important to note that the literature has devoted little attention to issues facing clinicians, particularly Black female clinicians, working with this population. To add to the limited literature on same-race therapeutic dyads, this qualitative study explored Black female clinicians’ experiences treating Black male adolescents. Ten clinicians who had worked with Black male adolescents were interviewed. A qualitative research design analysis of their interviews was conducted using a Grounded Theory methodology (Corbin & Strauss, 2014). Key themes related to the treatment of Black male adolescents by Black female clinicians emerged, including (a) the importance of the therapeutic alliance and building rapport, such as showing curiosity about the adolescent’s interests and exhibiting a genuine, non-punitive therapeutic style; (b) emotional reactions of Black male adolescents toward Black female clinicians, including positive and negative emotions and maternal, sister, and aunt transferences toward the clinician; (c) emotional reactions of Black female clinicians toward Black male adolescents, including feelings of maternal countertransference, protectiveness, worry, and urgency about the clients’ risk factors; (d) challenges in treating Black male adolescents; (e) differences related to treatment settings; (f) differences between working with Black male adolescents and other adolescent populations, including Black females; and (g) supervision and training implications when treating Black male adolescents. Implications for future research indicated the need for additional qualitative and
quantitative studies examining same-racial and cross-racial therapeutic dyads in the treatment of this population. Implications for clinicians and training suggested the need to attend to cultural considerations within the therapeutic dyad and in the supervisory relationship, the need to hire a diverse staff, the salience of a clinician’s “use of self” when treating Black male adolescents, and the value of consultation with other Black female clinicians.
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And we know that all things work together for good to them that love God, to them who are called according to his purpose (Romans 8:28). First, giving all praise and honor to my Lord and savior Jesus Christ; without His grace and favor I would not be afforded this opportunity. Through every valley, He has illuminated my path, ordering my steps towards the mountaintop for His purpose.

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Chapter I: Statement of the Problem

While the Black community has worked to overcome the psychological, ecological, sociological, and economic challenges inherent in over 400 years of systemic oppression, this legacy has been found to have an especially devastating impact on Black male adolescents. Research has shown that this population is at an increased risk for low academic achievement (Boykin & Noguera, 2011; Gregory, Skiba, & Noguera, 2010; Harper, Terry, & Twiggs, 2009); harsher disciplinary practices in school settings (Hirschfield, 2008; Noguera, 2003; Skiba, Michael, Nardo, & Peterson, 2002); incarceration (Alexander, 2012; NAACP, 2019; Roberts, 2003); racial profiling (Alexander, 2012; Meeks, 2010); and death by homicide (Boyd-Franklin, Franklin, & Toussaint, 2000; Langley & Sugarmann, 2018; U.S. Department of Justice, 1994).

Given the serious nature of these circumstances, the treatment of Black clients (Boyd-Franklin, 2003; Harrell & Rowe, 2014), Black families (Boyd-Franklin, 2003), and Black male adolescents (Boyd-Franklin & Bry, 2019; Boyd-Franklin et al, 2000; Harper et al., 2009; Jackson-Gilfort, Liddle, Tejeda, & Dakof, 2001; Smith, 2006), has received some attention in the literature in recent years. However, little literature exists on the treatment of Black male adolescents by clinicians of the same race and even less exploring treatment of this population by Black female clinicians. The current study explored this dyadic relationship in therapy.

This study explored the various risk factors identified in the literature as impacting the lives of many Black male adolescents, such as: (a) race, racism, and discrimination; (b) stereotypes and stereotype threat; (c) academic challenges, e.g., disproportionality of rates of school punishment, and the achievement gap; (d) risk factors related to the legal system, e.g., early labeling in school related to perceived
behavioral issues, the school-to-prison pipeline, mass incarceration, criminalization, and the impact of community violence and gangs.

In addition, although the current research was not conducted from an exclusively psychoanalytic or psychodynamic approach, it drew from certain psychodynamic concepts (e.g., transference, countertransference) in order that the Black female clinician-Black male adolescent therapeutic dyad might be better understood. As all of the participants had been trained in the psychodynamic theoretical orientation to treatment, they were familiar with these concepts; however, they did not necessarily adhere to this modality in treating their Black male adolescent clients. Therefore, an overview of transference, countertransference, and maternal transference and countertransference have been discussed in the review of the literature.

There has been some exploration of therapists working with clients from a range of different backgrounds (Boyd-Franklin, 2003, McGoldrick, Giordano, & Garcia-Preto, 2005); however, most of the research and literature on Black clients has focused on issues surrounding cross-racial treatment for African American clients, particularly those experienced by clinicians who are White or members of ethnic groups other than African American. As discussed above, very little literature exists exploring same-race dyads in therapy, particularly the experiences of Black female clinicians treating Black male adolescents. Thus, the current study sought to address this gap in the literature, focusing on the research questions that follow.

**Research Questions**

1. What methods are utilized to join, connect, or build rapport with Black male adolescents?
2. What challenges are encountered in therapy with Black male adolescents?
3. What emotions and transference reactions are experienced by the adolescent toward the clinician in therapy?

4. What emotions and countertransference reactions are experienced by the clinician toward the adolescent in therapy?

5. Is maternal countertransference experienced by the clinician toward the adolescent in the Black female clinician-Black male adolescent therapeutic dyad?

6. Are the emotions or reactions experienced by the Black female clinician in therapy with Black female adolescents different from those experienced in therapy with Black male adolescents?

7. Are the emotions or reactions experienced by Black female clinicians in therapy with adolescents from other racial or ethnic backgrounds different from those experienced in therapy with Black male adolescents?

8. How are these issues addressed in supervision and training?
Chapter II: Review of the Literature

Introduction

The review of the literature addresses three primary issues experienced by Black female clinicians working with Black male adolescents in therapy. First, clinicians must understand the challenges Black male adolescents face in order to provide effective treatment for this population. The risk factors affecting many Black male adolescents include: (a) race, racism, and discrimination; (b) pejorative stereotypes; (c) the achievement gap; (d) the school-to-prison pipeline; (e) the effects of criminalization and mass incarceration; (f) the impact of racial profiling; and (g) negative interactions with law enforcement that may involve police brutality and, at the extreme, police shootings. This stark reality has led to omnipresent fears for the safety of Black male adolescents among parents and other adults in the Black community, including Black female clinicians. It is important to note, however, that despite the prevalence of the risk factors listed above, therapists should not assume that each applies to every Black male adolescent.

The second part of this review explored the literature on the treatment of Black clients, families, and Black male adolescents. As discussed above, much of the literature on this topic emphasizes cross-racial (White therapist-Black patient) dyads. The current investigation is one of the few research studies that have explored a same-race dyad.

The current study incorporated some concepts derived from a psychodynamic theoretical orientation (e.g., transference and countertransference). Therefore, the third part of the review of the literature provides a brief discussion of psychoanalytic and psychodynamic treatment topics particularly relevant to this study of Black female
clinicians’ experiences treating Black male adolescents, including the issues of transference, countertransference and maternal transference and countertransference.

**Risk Factors Affecting Many Black Male Adolescents**

**Race, racism, and discrimination.** From birth until death, racism and discrimination continue to permeate American society and infiltrate every part of the lives of African American families and Black male adolescents. There are many ways in which racism and discrimination affect African Americans in their self-perceptions (e.g., self-esteem, cultural and racial identity), their relationships with one another (e.g., gender roles, dating, marriage, raising children) and with society (Boyd-Franklin, 2003; Jones, 1997). The insidious and unrelenting nature of racism and discrimination, however, may be difficult to explain to those who have never experienced those forces.

The multigenerational experiences of racism and oppression date back to the enslavement of Africans in America and are woven into the fabric of the country. This history, along with the rich cultural heritage of African Americans, provide many in the African American community, including Black male adolescents, with a unique perspective (Boyd-Franklin, 2003; Boyd-Franklin & Bry, 2019; Jones, 1997; Spielberg, 2014; Wong & Schwira, 2014).

The impact of slavery survives currently in the form of institutional racism, a system in which African Americans confront diminished educational opportunities, discriminatory financial and housing practices, inequities in healthcare, and a biased criminal justice system (Boyd-Franklin, 2003; Jones, 1997; Spielberg, 2014). The cumulative effect of institutional racism across generations and each individual’s lifespan perpetuates the disadvantaged status of many African Americans in the United States.
Expressions of bias that are more covert than institutional racism are common occurrences in the everyday lives of many African Americans (Sue, 2010b). These experiences, characterized as “subtle, stunning, often automatic, and non-verbal exchanges which are ‘put-downs’” (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978, p. 66), were termed microaggressions by Chester Pierce, an African American psychiatrist. Although the specific language used in a microaggression may appear somewhat benign, microaggressions contain underlying messages that convey insensitivity and disrespect to a salient aspect of one’s cultural identity (Okosi, 2018; Sue, 2010a), such as “you do not belong,” “you are intellectually inferior,” “you are not trustworthy,” and “you are abnormal,” among others (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Esquilin, 2007).

Microaggressions may be committed unconsciously by well-intentioned people (Spielberg, 2014). Perpetrators often express naiveté or defensiveness, or may attempt to rationalize and validate their behavior when the potential bias is called to their attention (Goldstein, 2008; Okosi, 2018; Spielberg, 2014; Sue, 2010b). This response leaves victims with self-doubt—uncertain as to whether they were insulted due to race. Common incidents of microaggressions experienced by many young Black males include being followed by security officers despite wearing professional attire, feeling fear from White people while riding on the elevator (Spielberg, 2014), or being told with surprise that they are “articulate” when speaking standard American English (Okosi, 2018).

These commonplace incidents, often experienced by Black male adolescents as well as others in the African American community, frequently result in race-related stress that may cause negative psychological outcomes, including depression, decreased life satisfaction, low self-esteem, rage, anxiety, paranoia, and helplessness, in addition to
negative physical health consequences (Okosi, 2018; Sue, 2010b; Sue, Nadal, Capodilupo, Lin, Torino, & Rivera, 2008).

**Stereotypes.** Johnson (2006) encapsulated the intense negativity characterizing societal views of African American men: “Much of the discourse that pertains to [them] has tended to portray them as unintelligent, drug addicted, violent sexual predators who are incarcerated and unemployable” (p. 187). The prevalence of such stereotypical images further ingrain a problematic view of Black male adolescents, leaving little room for nuance. The media often reaffirms the narrative that Black male adolescents are violent (Boyd-Franklin & Bry, 2019). When criminality is used as a euphemism for young Black males (Alexander, 2012; Welch, 2007), fear of this group within other populations occurs, and dangerous situations borne out of that fear become a predictable and tragic consequence. These stereotypic categorizations have caused many African American parents to worry about their sons’ safety at appallingly early ages, i.e., when they are only 5 or 6 years old (Boyd-Franklin & Bry, 2019).

The school system is a microcosm of society. Thus, administrators, teachers, and students each bring with them their cultural identities, values, and biases, both explicit and implicit. Bates and Glick (2013) found that teachers’ evaluations of students’ externalizing behaviors tended to be consistent with stereotypes typically associated with specific racial and ethnic groups, confirming that Black students were more likely to be rated as exhibiting externalizing or problematic behaviors in school. Such findings shed light on the labeling of Black male adolescents as hyperactive, aggressive, and/or conduct-disordered in disproportionate numbers (Boyd-Franklin & Bry, 2019). Conversely, Bates and Glick (2013) demonstrated that when teachers and students were
of the same racial or ethnic group, there was less correlation between student ratings and stereotypes.

**Stereotype threat.** Stereotype threat occurs when individuals perceive others as viewing them negatively which may cause them to adapt their behavior to conform to the stereotype. In their investigation of the effect of stereotype threat on academic achievement, Steele and Aronson (1995) found that African American students demonstrated their vulnerability to the pervasive negative stereotypes about their groups’ intellectual ability by their depressed performance on standardized tests as compared to White students. The prevalence of low expectations for Black male adolescents’ success in school may act as a self-fulfilling prophecy if their response to this stereotype is to lower their academic engagement and performance (Perry, Steele, & Hilliard, 2004; Steele, 2003).

In another study, Cohen, Garcia, Apfel, and Master (2006) explored the effectiveness of a social-psychological intervention on the academic performance of Black males. Prior to the intervention, students’ fears about confirming race-based negative stereotypes affected their achievement in writing. When given a reaffirming task, however, their grades improved significantly.

**Disproportionality in the schools and the achievement gap.** Black male adolescents are often disproportionately impacted by achievement gaps in the school system. According to Carter and Welner (2013): “One in five African American students will fail a grade in elementary or secondary school, compared to the overall rate of one in ten” (p. 2). Research has documented that Asian and White students consistently score higher on achievement tests than those from other racial/ethnic groups, e.g., Black, Latino, and American Indians (Gregory, Hafen, Ruzek, Mikami, Allen, & Pianta, 2016;
Gregory & Weinstein, 2004; U.S. Department of Education, National Center for Education Statistics, 2003). A number of factors, such as poverty, educational disadvantages, and higher rates of suspensions, may contribute to the discrepancy.

Community and family risk factors and deficient school conditions in low-income areas may often exacerbate the impact of poverty on student performance (McLoyd, 1998). Ladson-Billings (2006) contended that the disparity in academic achievement between Black and White students had its roots in the historic lack of equity of educational opportunities resulting in an “education debt.” These injustices continue as a systematic effort to prevent those living in urban communities from being afforded the same educational opportunities that children in more affluent districts receive. Poor students of color have an increased likelihood of attending schools with inferior resources and facilities (Kozol, 2005), high teacher turnover, and a lower percentage of high quality teachers (Darling-Hammond, 2004; Noguera, 2012; Ronfeldt, Loeb, & Wyckoff, 2013). The national failure to invest in teachers—the most important in-school resource—and to ensure that high-quality teachers are distributed in an equitable manner, further promotes the opportunity gap for African American students (Carter & Welner, 2013).

In most schools and districts, minorities (especially Blacks and Latinos), males, and low-achieving students are also most likely to be suspended, expelled, or removed from the classroom for punishment (Gregory et al., 2010). In a study investigating the impact of suspensions, Arcia (2006) found even one suspension, and the consequent missed instructional time, to be linked to negative outcomes (e.g., increased disengagement and escalated rule breaking), and to promote a cycle of academic failure, which, unfortunately for many Black youth, can result in prison.
School-to-prison pipeline. Edelman (2014) contended that poor children of color, denied equity and subject to all of the other racial and economic injustices that persist, are vulnerable to a “cradle to prison pipeline” because “the most dangerous place for a child to grow up in America is at the intersection of poverty and race” (p. 1). Students targeted for punishment in school are often smaller versions of the adults likely to be targeted for incarceration by society due to their race, gender, and socioeconomic status (Singer, 1996).

Given their common emphasis on order and control, researchers have compared urban schools with prisons (Alexander, 2012; Edelman, 2014; Noguera, 2003; Wacquant, 2001). When schools view social control as the most effective means to achieve their primary objective of educating youth, even an awareness of disproportionality and demographic biases towards punishment may not dissuade them from pursuing this strategy. This is consistent with the literature. Noguera (2003) asserted that schools’ fixation with behavior management and social control supersedes all other goals with the consequence that the neediest and most disadvantaged students are the ones most likely to receive punishment. For example, recent reports revealed that 33.8% of Black males with disabilities had been suspended from high schools across the United States during the 2011-2012 academic year (Losen, Hodson, Keith, Morrison, & Belway, 2015).

In addition, administrators and teachers who focus on the problematic behavior of the student without a regard to the context in which it occurs may be sacrificing an opportunity to ameliorate the problematic behavior. Such students may be fully aware of the rules and the subsequent consequences for breaking them but, foreseeing only the bleakest of futures, are unmotivated to change. According to Noguera (2003):
As they internalize the labels that have been affixed to them, and as they begin to realize that the trajectory their education has placed them on is leading to nowhere, many simply lose the incentive to adhere to school norms. (p. 343)

This negative pattern may ultimately lead to Black male adolescents’ encounters with law enforcement and the criminal justice system, i.e., the school to prison pipeline (Gregory, Skiba, & Noguera, 2010). For example, an African American prisoner in a maximum security facility described how the environment at his inner-city high school virtually guaranteed his current circumstances:

That school was run more like a prison than a high school. It don’t have to be nothing illegal about it. But you’re getting arrested. No regard for if a college going to accept you with this record. No regard for none of that, because you’re not expected to leave this school and go to college. You’re not expected to do anything. (Hirschfield, 2008, p. 79)

**Criminalization in schools.** In response to increasing rates of juvenile violence occurring in the community as well as within the schools during the 1990s, schools adopted “zero tolerance” policies (Burns & Crawford, 1999). This led to the criminalization of discipline within the school system. Hirschfield (2008) studied this phenomenon and posited three distinct but connected factors. First, schools replaced allowing teachers and other school officials to have the autonomy to decide on appropriate sanctions for disciplinary infractions with uniform procedures adapted from the juvenile justice system (Feld, 1999). Due to this substitution of discretion with strict guidelines that mandated exclusionary punishment, a second trend emerged: increased suspensions and expulsions. Hirschfield (2008) argued that expanded school exclusion practices alone—irrespective of adherence to a penal code or the discretionary power of
authorities—were emblematic of criminalization. As is the case with the criminal justice system, African American and other youth of color received punishments disproportionately harsher than their non-minority peers for the same behavior.

Finally, with “zero tolerance” policies governing the schools, criminal justice tools and personnel became increasingly implemented within the schools. In addition to security guards, many schools employ police officers. Techniques and technological devices emulating law enforcement encounters that occur outside of schools in the larger society, e.g., bag searches, personal searches, metal detectors, and video cameras, operated to define students as criminal suspects (Hirschfield, 2008), especially given their disproportionate presence in schools with significant African American populations. For example, DeVoe, Peter, Noonan, Snyder, and Baum (2005) found that the probability of metal detectors in schools is positively related to the prevalence of minority students. Additionally, urban schools contain more gates, walls, and barricades than schools in other areas (Gottfredson, Gottfredson, Czeh, Cantor, Crosse, & Hantman, 2000), indicating a tendency to brand students in urban districts as criminals based on racial and socioeconomic demographics. The three factors identified by Hirschfield (2008), i.e., moving away from teachers’ ability to have discretion with discipline in the classroom, instituting strict penal codes, and importing law enforcement practices and personnel, have acted to transform many urban schools into preparatory and facsimile prisons.

**Mass incarceration and criminalization.** Mass incarceration. Surveys have indicated that White youth are more likely to engage in drug use (Miech, Johnston, O’Malley, Bachman, & Schulenberg, 2016) and drug crime than Black adolescents and other people of color (Johnston, O’Malley, Bachman, & Schulenberg, 2007; Snyder & Sickmund, 2006); however, the prison population does not reflect these data. As stated by
Roberts (2003): “On any given day, nearly one-third of Black men in their twenties are under the supervision of the criminal justice system—either behind bars, on probation, or on parole” (p. 1272). As startling as the above figure is, it does not take into account the greater number of Black men whose involvement with the legal system falls short of conviction, e.g., men who are stopped and questioned, arrested, and/or charged with a crime. In addition, although crime rates have remained level, there has been a 500% increase in the number of inmates in jails and prisons over the last 40 years. The above statistics are counter-intuitive, given: (a) the increasing evidence that mass incarceration is an ineffective method of achieving public safety, (b) prison overcrowding, and (c) the financial burden mass imprisonment imposes on states (The Sentencing Project, 2017). One is left to wonder how and why this happened.

According to Alexander (2012), the “War on Drugs” was a form of social control instituted by the Reagan administration during the 1980s to oppress people of color, particularly Black men, through mass incarceration. Alexander (2012) described mass incarceration as a “racial caste system,” comparable to slavery and Jim Crow, whereby “a stigmatized racial group [is] locked into an inferior position by law and custom” (p. 12). For many Black male adolescents and those from other ethnic minority groups, an early involvement with the juvenile justice system, as discussed above, may lead to incarceration in their young adult years. This supports Alexander’s (2012) view of mass incarceration as the post-Civil Rights era incarnation of a racial caste system, with the same underlying purpose as its predecessors: the social control of Blacks.

Although mass incarceration has a deleterious effect on society as a whole, no one has borne the brunt of the racial caste system more than African American youth.
In Chicago (as in other cities across the United States), young Black men are more likely to go to prison than to college. As of June 2001, there were nearly 20,000 more Black men in the Illinois state prison system than enrolled in the state’s public universities….To put the crisis in even sharper focus, consider this: just 992 Black men received a bachelor’s degree from Illinois state universities in 1999, while roughly 7,000 Black men were released from the state prison system the following year just for drug offenses. (Alexander, 2012, p. 190)

Rather than spending this stage of their lives as scholars like their non-minority counterparts, these young Black men are branded felons and are effectively segregated from, and subordinated in, mainstream society through an intricate, systematic network of laws, regulations, and expectations. No longer can they vote or serve on a jury. They typically have difficulty gaining employment, housing, and public assistance—a situation paralleling the experience of many Blacks as second-class citizens during the Jim Crow era (Alexander, 2012).

**Criminalization in America.** Current laws may prohibit the discrimination against Black people, and some may believe that the legal system’s mandate of colorblindness is uniformly practiced, however, Alexander (2012) has argued that although the meaning of being Black in America has changed throughout the course of American history, the stigmatization remains:

Slavery defined what it meant to be Black (a slave), and Jim Crow defined what it meant to be Black (a second-class citizen). Today mass incarceration defines the meaning of Blackness in America: Black people, especially Black men, are criminals. (p. 197)
To illustrate the crucial point that criminality is linked to a *racial* stigma, Alexander (2012) pointed out that asking individuals about “White crime” would likely provoke reactions of laughter because the concept of the “White criminal” lacks social meaning and therefore does not resonate. When a White person commits a criminal act, he or she is seen as an individual actor; however, when a person of color, especially a Black man, engages in criminal behavior, such person is not viewed as an individual because of America’s transformed definition of Blackness (Alexander, 2012). Thus, race is ever-present when America considers criminality.

Media outlets have promoted the conception of criminality defining Blackness. Research has examined the disproportionate representation of Black males as criminals and White males portrayed in a positive manner, as defenders, or the “good guy” in news programming (Dixon, 2007; Entman, 1990, 1992). Previous research dating back to the 1970s and 1980s has suggested that a community’s conception of order and justice may be shaped by how news reports cover crime (Gans, 1979; Hackett, 1984).

Wing (2014) addressed the shocking nature of the narratives crafted by media outlets that often treat Black victims of violence more disparagingly than Whites who are alleged to have committed crimes, including murder. The media tends to demonize Blacks (e.g., “tangles with the law; suspended 3 times; shot before”), imply that Black victims are at fault for their death (e.g., “carrying pump air rifle, killed Marine out of fear for children’s safety”), or appear indifferent to them. Contrastingly, Whites are painted in a sympathetic light through the use of positive descriptions (e.g., “brilliant; soft-spoken, polite, gentleman; or outstanding student”), or with headlines that express disbelief for the alleged criminal act. Despite the unacceptability of expressing explicitly racist views
in an America that promotes itself as being a colorblind society, bias or judgment towards criminals is considered allowable (Alexander, 2012).

**Racial profiling.** Throughout history, African Americans have been viewed by some Whites as having predispositions towards criminal behavior and are therefore stereotyped as criminals (Drummond, 1990; Kennedy, 1997; Mauer, 1999). This is ironic given the fact that Whites commit the highest percentage of crime in America (Welch, 2007). The stereotypical, yet erroneous, perception that young Black men overwhelmingly commit crime persists and may have been a factor in the widespread implementation of the controversial law enforcement practice of *racial profiling*.

Racial profiling often occurs when Black males are targeted by the police, frequently while driving, stopped for minor traffic violations, or no violation at all, and then searched in the hopes that evidence of criminal activity will be discovered (Alexander, 2012). While this practice is at best a consequence of inaccurate and biased data (Welch, 2007) and, at worst, a technique to advance the social control of Blacks through mass incarceration, it continues to be utilized by law enforcement. In a racial profiling situation, a Black male, unaware of his right to refuse, but nonetheless often aware of the lack of probable cause for the search, will frequently be intimidated into consenting to the search. This is especially true when police officers have their hands on their revolvers at the time.

**Shootings of Black males.** Black men have been the victims of violence since the inception of this country—a reality well known in the Black community, but often unfamiliar to the rest of the American public until the numerous cases of high profile shootings of young Black men and adolescents by police officers brought the issue of police brutality to light.
In 1999, Amadou Diallo, an unarmed 22-year old man who had recently emigrated from West Africa, was shot 41 times by four plainclothes police officers. Mr. Diallo’s body was littered with 19 of the 41 bullets the police officers discharged from their weapons (Cooper, 1999). The four officers were acquitted at trial (Fritsch, 2000), and one officer, Kenneth Boss, was recently promoted to sergeant (Parascandola, Marcius, & McShane, 2015), sending the tragic message that even an extreme example of engaging in police brutality against a young Black man will not hinder career advancement for White law enforcement officers.

During the last ten years, the number of such incidents has risen, along with outrage over the killing of unarmed Black men and Black male adolescents by law enforcement. Despite protests by Black Lives Matter and other groups, officers have been acquitted in the shooting deaths of Jordan Edwards (age 15), Michael Brown (age 18), Terence Crutcher (age 43), and many others. These verdicts have lent substance to a narrative that officers who assert that they feared for their lives will not be held accountable for the deaths of unarmed Black males. This will continue to be the case until a counter-narrative emerges and officers are convicted for killing Black men and Black male adolescents.

**Community violence.** The impact of violence on Black male adolescents and their communities is analogous to that of trauma, jeopardizing health and safety (Boyd-Franklin & Bry, 2019; Jenkins, Wang, & Turner, 2009; Smith, 2015; Smith & Patton, 2016). Research has demonstrated that the exposure to violence experienced by urban adolescents is comparable to that of growing up in war zones overseas (Bell & Jenkins, 1991; Garbarino, 1995, 1999). Statistically, Black male adolescents have higher rates of
homicides, both as victims and perpetrators, than their White peers across different regions in the United States (Fox & Swatt, 2008).

In an investigation of the frequency and developmental timing of homicides that young Black men between 18 to 24 were exposed to in Baltimore, Smith (2015) found that subjects experienced an average of three homicides of loved ones, mainly male peers, across their lifespan. These deaths began in early childhood, increased during the primary school and adolescent years, then continued into emerging adulthood. Experiencing such tragic losses established a persistent threat to health and wellness throughout development. It is no wonder that many Black male adolescents are acutely aware of their own mortality. Boyd-Franklin and Bry (2019) described conducting an exercise with adolescents that asked them what their dream was for their future. One youth’s response to this “I have a dream” inquiry embodied the tragic sense of morbidity omnipresent among many in this population. He had no dream for the future because he was “convinced that he would be killed before he turned 25” (Boyd-Franklin & Bry, 2019, p. 46).

**Gang violence.** Given the constant threat to their survival, Black youth may attempt to seek protection by joining gangs or affiliating themselves with groups of other at-risk adolescents (Boyd-Franklin & Bry, 2019; Thornberry & Krohn, 2003). In addition to protection, some adolescents may desire the “prestige” conveyed by gang membership in their neighborhood (Boyd-Franklin & Bry, 2019). Other adolescents do not make a conscious decision to join a gang, but may choose peers engaging in delinquent activities which may evolve into gang membership (Esbensen, Peterson, Taylor, & Freng, 2009).

Adolescents with gang-involved family members may demonstrate a multi-generational pattern of gang involvement (Boyd-Franklin & Bry, 2019), as they are often
more likely to join gangs as a result of familial influences (Gilman, Hill, Hawkins, Howell, & Kosterman, 2014) Younger siblings or cousins of gang members may be gradually introduced to gang involvement when they are recruited to participate in gang activities that may be performed by males of their age, such as acting as “lookouts” during a robbery, or as “runners” transporting drugs for dealers. A family connection may also offer a youth protection without actual involvement through the practice of being “blessed in.” However, having family members who are gang-involved may endanger individuals in the family who have no affiliation with the gang as it “may increase the risk of gang retaliation against the family. In some inner-city communities, when incidents or ‘beefs’ occur between rival gangs, family members may be targeted and injured as a message to a gang member” (Boyd-Franklin & Bry, 2019, p. 109).

**Fears of African American Parents Raising Black Male Adolescents**

In their discussion of the parenting challenges African Americans face in raising sons, Boyd-Franklin et al. (2000) cited the necessity of preparing them for encounters with racism, prejudice, and discrimination. Both African American psychologists and parents of sons, Drs. Boyd-Franklin and Franklin offer a theoretical as well as a personal perspective. They stressed that the greatest fear of African American parents was ensuring their sons’ “basic survival” in a threatening, violent world. Boyd-Franklin (2003) has indicated that these fears are evident across different socioeconomic levels in African American families that are poor, middle class, and even upper middle class. They are also evident in Black parents raising sons in urban and suburban communities.

Many African American parents of sons find themselves in a dilemma unique among American parents. Their task involves not only raising their sons to be good, upstanding, contributing members of society (a goal often universally shared by parents),
but accomplishing this while living with the constant fear that their son’s existence could be threatened due to their race and gender. One African American mother-to-be expressed this situation poignantly:

It’s a boy….My heart was simultaneously filled with so much joy and frozen with so much terror. You see, the beautiful baby then growing inside me—my innocent, impossibly adorable, bright, promising, curly-haired brown-skinned boy—would become a “Black man.” (Maltais, para. 2)

Boyd-Franklin et al. (2000) noted that the threat of violence was that much more perilous because it could originate from multiple sources, e.g., crime in the Black community, mistaken identity, drug-related incidents, gang activity, racial profiling, police brutality, and police shootings, among others.

Another concern of African American parents arises from the messages society imparts to Black male adolescents that they are inferior, worthless, and criminal. Given the repeated nature of these communications, their underlying ideology can be easily internalized if it is not combatted within the home, school, and community. The narrative that America is the land of opportunity may also be harmful to Black male adolescents who fail to succeed. Not understanding the institutions created to marginalize them, they may feel that they deserved this outcome (M. Warrell, personal communication, July 30, 2015). Therefore, it is crucial that Black parents foster a positive racial identity and self-esteem through affirmative family messages and racial socialization. Verbal expressions of love and pride in Black sons as well as sharing both familial and cultural historical events can engender the desired racial identity development (Boyd-Franklin et al., 2000).

With respect to education, reflecting patterns in the criminal justice system, the intensification of school punishment (e.g., suspension and expulsion) is borne
disproportionately by minority students, particularly Black and Latino males, despite the lack of evidence that such minority students exhibit significant behavioral differences from their non-minority peers (Brooks, Schiraldi, & Ziedenberg, 1999; Gregory et al., 2010; Skiba et al., 2002). Finally, the Black community is well aware of the fewer resources, less qualified staff, and overcrowded classrooms that characterize urban schools (Warren, 2005).

Those who work in close relationship with Black male adolescents, e.g. teachers, counselors, or therapists, may experience similar fears for them as their parents. For example, in an investigation of teacher-student relationships, Gaines (2017) found that the African American teachers, being members of the Black community, expressed some of the same fears for their Black male students as described by Black parents. In addition to shared fears, adults working with Black male adolescents may also share parents’ hopes that these youth succeed and thus make efforts to promote positive outcomes. Research has confirmed that a high quality teacher-student relationship is an effective predictor for student success (Gaines, 2017). Although the influence of educators has been addressed in the literature, no such attention has been accorded to Black clinicians’ experiences treating young Black men and their fears for them.

**The Treatment of African American Patients in Therapy**

**Treatment of Black patients and families in therapy.** African Americans often have a healthy cultural suspicion of therapy, in part arising from a knowledge of the history of dishonesty and abuse perpetrated by the medical community through experimentation with this population, e.g., Tuskegee Syphilis Experiment. In addition, a strong religious/spiritual orientation in some African Americans may cause them to view therapy as inconsistent with their beliefs (Boyd-Franklin, 2003). Therefore, establishing
trust and a strong therapeutic alliance are essential when working with Black patients and families. The clinician’s use of self, self-disclosure, and role flexibility are essential elements in this process (Boyd-Franklin, 2003; Harrell & Rowe, 2014). It is also important that in addition to differential diagnostic assessment, clinicians view African American patients through the lens of their culture. “Treatment should be informed by examining how the intersection of person, culture, and context, and the congruence (or incongruence) between them, contribute to the African American client’s internally experienced and externally expressed distress” (Harrell & Rowe, 2014, p. 7).

Extended family relationships have been identified by scholars and researchers as an important strength of African Americans (Billingsley, 1992; Boyd-Franklin, 2003; Hill, 1999; McAdoo, 1981, 1996, 2002). Among the ways this manifests is through “reciprocity,” or helping one another by exchanging support, goods, and services (Boyd-Franklin, 2003). Understanding the power dynamics, boundaries, and family roles are key in family work. In order for the clinician to get an accurate assessment of the family dynamics, the clinician will need to ask questions. For example, in some Black families, extended family members, such as a grandmother or aunt, may help the parents with childcare. In other African American families, the mother and father may be absent from their children’s lives due to drug or alcohol use, incarceration, financial constraints, location, death, or other issues, in which case extended family members may be the primary caregiver for the children and adolescents.

Asking questions about the family constellation will allow a clinician to construct a genogram. This graphic representation of a family tree can provide vital psychological, medical, and relational information (Boyd-Franklin, 2003), and is indicated when working with individual clients, including Black male adolescents, and families. It is
important to note that many Black families tend to be enmeshed, having very close relationships with frequent interaction and reciprocity (Boyd-Franklin, 2003; Hill, 1999; Minuchin, 1974). However, some Black families are more disengaged, functioning more independently of one another. In her book *Black Families in Therapy*, Boyd-Franklin (2003) discussed the importance of utilizing a multisystems approach in treating Black clients and families. A multisystems, multicultural perspective often allows clinicians to more accurately address the particular needs of African American patients and families.

**Treatment of Black male adolescent patients in therapy.** The constant messages that young Black men are bombarded with from media sources and society about who they are often have a significant negative impact on their psychological functioning and thus their behavior. Many Black male adolescents are referred to treatment because of behavioral problems, likely reinforcing the persistent negative stereotypes they often encounter. Black male adolescents often experience stigmatization associated with vulnerability. The response of masking their true feelings may be particularly salient for them and one factor contributing to the resistance with which many Black men approach therapy (Franklin, 1999, 2004).

According to Boyd-Franklin et al. (2000), many Black male adolescents initially refuse to attend therapy. Parents should not let this response discourage them. Allowing the adolescent to participate in the process of clinician selection was recommended as a method by which adolescents might be more inclined to agree to undergo treatment. This might be facilitated by parents presenting the adolescent with a number of pre-screened clinicians and giving the adolescent the opportunity to choose the clinician with whom he is most comfortable.
Therapeutic engagement is very important when treating Black male adolescents. Jackson-Gilfort et al. (2001) found that discussing research-derived, culturally-driven themes (e.g., respect, anger/rage, alienation, the journey toward manhood) can improve therapeutic engagement with Black male adolescents, and thus facilitate a stronger therapeutic alliance. This finding confirmed earlier research demonstrating that culturally relevant content (masculinity, anger, respect) can be influential and beneficial in therapy with this population (Davis, 1999; Rasheed & Rasheed, 1999).

Using well-timed humor may also be beneficial in building rapport as many adolescent males employ humor to create closeness (Kiselica, 2003). This technique may also alleviate some of the misgivings Black male adolescents have about treatment, as it indicates the flexibility and “realness” of therapy and the therapist.

Franklin (1999) asserted that Black men in America suffer from an *Invisibility Syndrome*, defined as “an inner struggle with the feeling that one’s talents, abilities, personality, and worth are not valued or even recognized because of prejudice and racism” (p. 761). Often feeling the need to portray a masculine image, Black male adolescents may adopt a “cool pose,” as it has been termed, signifying “behaviors, scripts, physical posturing, impression management, and carefully crafted performances that deliver a single, critical message: pride, strength, and control” (Majors & Billson, 1992, p. 4). Certain elements in the therapeutic process, particularly self-disclosure and expressions of vulnerability, would be counter to this code of behavior for many Black male adolescents and Black men (Franklin, 1992, 2004).

In his work with Black men in therapeutic support groups, Franklin (1999) noted that a critical part of self-efficacy was for African American men to feel successful in “their efforts to buffer everyday hassles of racism” indicating increased self-confidence
and trust (p. 788). Black male adolescents encounter many of the same discriminatory racial situations, thus empowering Black male adolescents is important to their overcoming negative societal perceptions, bolstering their self-esteem, and improving how they approach life. Strength-based therapy, or therapeutic approaches that identify and build on a person’s strengths and talents instead of centering on psychopathology, has been demonstrated to foster positive identity, socialization, and development (Stevenson, Cameron, Herrero-Taylor, & Davis, 2002), and thus may be extremely useful in working with Black male adolescents (Boyd-Franklin, 2003; Boyd-Franklin & Bry, 2019; Harper et al., 2009; Smith, 2006).

In addition to focusing on strengths, Kiselica (2003) recommended that clinicians avoid the pitfall of asking adolescents a lot of questions as this may be perceived as intrusive and cause the adolescent to shut down. Considering the adolescent’s drive for autonomy and control (Eccles et al., 1993), coupled with the life realities that many adolescents face, it is important to ensure that the adolescent feels listened to and heard because this may be the only place he experiences this feeling of respect for his opinions.

An ability to view the youth from a multisystem’s perspective, and identify positive nuclear family members, extended family members, prosocial adolescent peers, school personnel, church members, and community members who can provide additional support, is important (Boyd-Franklin, 2003; Boyd-Franklin & Bry, 2019). Such individuals can provide collateral information as well as help to reinforce the work that is being done in therapy.

**Supervision and Training for Clinicians Working With Black Patients**

Supervision is not a static process. The emphasis on skill building early in training is consistent with a more directive approach by the supervisor. As the supervisee
progresses, the supervisor becomes more flexible, empowering the supervisee to take more risks with increased confidence (Boyd-Franklin & Bry, 2019). Just as it is important for supervisors to discuss their supervisory style with supervisees, it is important to acknowledge and foster the development of the supervisee’s own therapeutic style.

It is essential to remember that African Americans are heterogeneous with a broad range of racial identification, attitudes, and experiences (Franklin, Carter, & Grace, 1993; Hunt, 1987). Supervision may be very important in addressing certain issues that may emerge when African American clinicians treat Black adolescent males and their families. Racial identity plays an important factor in therapy for the Black clinician-Black patient dyad (Hunt, 1987). Shared experiences of societal stress and cultural familiarity can greatly influence the therapeutic process within the context of how the clinician understands and manages his or her own racial identity. Openly discussing racial identity in supervision can help to detect (a) overidentification, (b) prematurely solving problems, (c) moralization (preacher/teacher style to raise the consciousness of the Black patient), and (d) rescuing (wallowing in patient’s emotional content to assuage guilt for the clinician’s upward mobility) (Hunt, 1987).

Supervisors working with Black female clinicians are advised to encourage the supervisee’s “use of self” in working with Black male adolescents and families. Other methods of establishing therapeutic rapport that may be helpful include: (a) identifying common experiences; (b) normalizing the patient’s apprehension about entering therapy; and (c) the use of cultural references, as long as they are comfortable and real for the therapist (Boyd-Franklin, 2003).

In the first supervisory meeting, the supervisees should be encouraged to discuss their past clinical experiences, perceived strengths, areas for additional growth (Boyd-
Franklin & Bry, 2019), and goals for the clinical training year. It is also helpful to explore the supervisee’s experience in working with African American patients, and particularly with Black male adolescents. Processing complex multicultural issues with Black male adolescent clients and their families is often difficult, and effective supervision can be of significant value to the supervisee. In addition to cultural competence, it is important that the supervisor be comfortable discussing multicultural issues (Boyd-Franklin & Bry, 2019). A supervisor’s apparent discomfort is likely to increase the supervisee’s anxiety in addressing these issues with African American clients. In addition, a supervisor’s discomfort may cause the supervisee to have doubts about the supervisor’s knowledge of cultural issues.

Supervision also provides the opportunity to process culturally-derived reactions, and develop therapeutic strategies to work with these reactions in therapy to benefit the patient (Hunt, 1987). Additionally, discussing transference and countertransference and a non-judgmental exploration of the ways in which the therapist might improve a session will foster professional and personal growth as well as benefit both the clinician and the client.

The literature has suggested that supervisors might help build a supervisee’s competency through case discussions after the supervisor has witnessed the session by being present in the room, behind a one-way mirror, or through the use of technology, e.g., audiotape or videotape (Boyd-Franklin & Bry, 2019; Hunt 1987). Recording sessions may trigger feelings of healthy cultural suspicion towards therapy among some African American clients (Boyd-Franklin, 2003) and ensuring that clients are comfortable with recorded sessions is essential. Therefore it is important that clinicians not raise the issue of recording sessions prematurely but wait until they have established therapeutic
rapport with African American clients, including adolescents. Therapists working in clinics may also be subject to the pressure of clinic regulations or policies on taping client sessions. This issue should be discussed with clinic directors or supervisors in the context of cultural competency in working with African American patients in the first session. Giving clinicians permission to wait until a therapeutic alliance has been created with a Black patient, particularly an adolescent, before they raise the issue of taping, may increase the likelihood of a positive therapeutic outcome (Boyd-Franklin, 2003).

As with clients, some supervisees may also be very uncomfortable with the idea of observation during a session; however, others may value the opportunity to self-reflect on the session with a supervisor as this discussion can illuminate previously unidentified issues with the supervisee, the patient, or the treatment process that may be missed in the moment. Scheduling regular case conferences in which all staff members, including administrators, supervisors, and supervisees, meet to discuss particularly challenging clinical cases, such as those presented by Black male adolescents, has been shown to be very useful in (a) assisting in professional development; (b) helping to prevent staff burnout; and (c) allowing clinicians of varying levels of experience the opportunity to learn from one another, thereby demonstrating that each person may have something valuable to contribute to the discussion (Boyd-Franklin, 2003; Boyd-Franklin & Bry, 2019).

Although clinical work is often gratifying, it can also be very challenging, particularly when treating Black male adolescents and extended families, due to race-related issues and other traumatic experiences (Boyd-Franklin, 2003; Boyd-Franklin & Bry, 2019; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Given the taxing nature of the work, and the high caseloads experienced by many clinicians, “self-
care,” frequently discussed in the mental health field as a means to avoid compassion fatigue or burnout, is very important for clinicians (Boyd-Franklin, 2003; Dass-Brailsford, 2007).

In addition, diversifying staff is critical to training clinicians to work with African American patients (Garner, 2003; Gordon, 1993). Not only will the presence of many African American professionals on staff facilitate non-minority staff members to embrace multiculturalism and be open to learning about other cultures and countertransference issues, it will provide both Black and non-Black professionals with the opportunity to consult and receive varied clinical opinions for the treatment of their Black patients, while also emphasizing the heterogeneity of Black people. Garner (2003) warned, however, that organizations be aware that recruiting Black staff should not result in the expectation that “the Black staff members…take on board all of the issues to do with ethnic minorities,” as this would amount to “tokenism” and “thereby set…them up to fail” (p. 512).

**Psychoanalytic/Psychodynamic Concepts Relevant to This Study**

Although this dissertation was not constructed from a psychoanalytic/psychodynamic theoretical orientation, the psychoanalytic concepts of transference, countertransference, and maternal transference and countertransference were particularly useful in understanding some of the important emotional reactions within the Black female clinician-Black male adolescent therapeutic dyad. These concepts are discussed in detail in order to provide the framework for the comments of clinicians (see Chapter IV below) and the exploration of these concepts in the discussion (see Chapter V below). It should be noted that the participants in this study were not necessarily providing
psychoanalytic or psychodynamic therapy; however, they had all received training in this theoretical orientation and they were familiar with the concepts discussed below.

**Transference.** Within psychoanalytic or psychodynamic therapy, the therapist utilizes transference and countertransference within the therapeutic relationship to inform the treatment. The concept of transference, introduced and developed by Sigmund Freud (1916-1917/1944), holds that patients’ strong feelings existing prior to therapy would manifest and be transferred onto the therapist during the analytic process. Originally viewing transference as a form of resistance and the “greatest threat” to successful therapy, Freud’s theory evolved and he then saw it as a phenomenon intimately bound up with the nature of the patient’s life experiences. Subsequent scholars, notably Bibring-Lehner, Klein, and Kernberg, offered additional insight into the concept of transference. For example, in 1936 Bibring-Lehner suggested that the id (i.e., that the part of the psyche that works to satisfy basic urges, needs, and desires) drives the patient towards childhood influences and repressed and unfulfilled wishes. In this fashion, the patient’s transference can be a function of much earlier experiences that are currently associated with qualities of the therapist (e.g., female therapist eliciting mother transference). Klein (1952) asserted that transference is a consequence of the earliest introjection of objects, typically the mother. Kernberg (1987) joined both the structural/drive and object relations’ theories of transference claiming that it presents as affect either expressed by drive impulses or through internalized objects relations, thus necessitating the simultaneous analysis of both drive and object relations transferences and the conflicts between them during therapy.

Those earlier conceptualizations of transference have more recently begun to be superceded by the relational psychodynamic model wherein a clinician’s understanding
of any individual patient’s transference process will provide the clinician with a unique lens into the patient’s early experience, current interpersonal functioning, and potential psychopathology. Insight gained as to projections or distortions based on the previous history and the needs of the patient (Chodrow; 1999, Jordan, 1992) provide insight that can be used, when therapeutically appropriate, to help the patient understand certain affect and cyclical patterns that may be detrimental to the patient’s wellbeing. “For patients to be able to rethink their automatic ways of understanding other people, they first need to see them as ideas that have derived from their particular lived experience” (McWilliams, 2004, p. 95).

McWilliams (2004) anticipated that patients might be dubious about explorations of transference in the therapy and possibly attribute this to a clinician’s neurotic need for affirmation or validation. To prevent such possibility, McWilliams (2004) suggested explaining to patients the reasons why an examination of transference might be beneficial to the patient’s treatment. She found that most patients considered her explanation to make sense, and even patients who presented at the borderline level of functioning were often able to absorb her rationale for working with the transference.

Frattaroli (2001) provided an excellent example of how a clinician might approach working with transference in psychotherapy after a patient inquired as to the meaning of her realization that her strong reaction to him mirrored previous reactions to male authority figures:

“We don’t really know what it means yet, but it does make sense that sooner or later you would develop the same sort of problems with me that you’ve had with other important men in your life. That’s what’s called transference. Whatever problem people come into analysis to talk about, they end up repeating the
problem in their relationship with the analyst. And that’s actually good, because when we’re experiencing the problem together, it puts us in a much better position to understand it than if we simply talked about how you’ve experienced it in the past.” (p. 188)

This brief intervention was valuable to the treatment on several levels: (a) the clinician’s explanation of the patient’s transference towards him interprets the meaning behind her reaction; and (b) it taught her about transference in a manner that could be transformative in that she gained knowledge about her interpersonal patterns without judgment, thus reducing any shame that may be associated with the disturbing feelings she has (McWilliams, 2004).

**Countertransference.** Like transference, countertransference was initially thought to be problematic in therapy, jeopardizing the therapeutic progress (Freud, 1910; Racker, 1982). Although Freud had not written extensively on this subject, he articulated his view in a 1910 article: “No psychoanalyst goes farther than his own complexes and resistances permit, and we consequently require that he shall begin his activity with self-analysis and continually carry it deeper while he is making his own observations on his patients” (Freud, 1910, pp. 141-142). According to Hersey (2001), a clinician’s experience of significant people in his or her past exerts an influence on how the patient is experienced, thus distorting what is attended to by the clinician. Gabbard (2001) summed up this process succinctly: “countertransference could be conceptualized as the analyst’s transference to the patient” (p. 984).

In the classical view of countertransference—epitomized by Freud—only rigorous self-analysis or a return to analysis to address unfinished work regarding unconscious conflicts could eradicate this impediment to treatment (Hersey, 2001). Other analysts
have differed in their assessment. Ferenczi (1919), whose more positive view of countertransference was consistent with his conceptualization of a “two person” psychology that offered information essential to understanding the patient, was not appreciated in his time; however, his views are more consistent with how contemporary scholars conceptualize countertransference. He believed that since many patients tended to sense a clinician’s subjective reactions, there was therapeutic value in a clinician being forthcoming. In this reciprocal process, “the analyst could learn about himself in a useful manner from the patient, and… the patient could benefit from understanding how the analyst’s psychology influenced the treatment” (Hersey, 2001, p.7).

Heimann (1950) conceptualized countertransference to include all feelings experienced by the clinician toward a patient. Lacking awareness, countertransference reactions may be suppressed but not avoided, and will affect patient behavior as it will prompt the patient to relive past experiences in the therapy. Thus, clinicians must pay close attention to all of their feelings during sessions (Racker, 1957).

Sullivan exerted a significant influence on the shift within the psychoanalytic field toward two-person psychologies and how countertransference was viewed (Hersey, 2001). He emphasized the fluidity of an individual’s personality and the context in which interactions between people occur. According to Mitchell (1995):

Sullivan regarded the basic unit of mind as an interactive field rather than as a bounded individual. Different people evoke different responses in each other; a person does not have a static “personality” that is carried around and displayed across all interpersonal situations. (p. 244)
Greenberg (1995) built upon the work of Sullivan, stressing the mutuality inherent in the therapeutic relationship, terming his concept of countertransference the *interactive matrix*:

The interactive matrix is shaped, from moment to moment in every treatment, by the personal characteristic of the analysand and of the analyst. These include the beliefs, commitments, hopes, fears, needs, and wishes of both participants. It is only within the context of the interactive matrix that the events of the analysis acquire their meaning. (p. 1)

Greenberg’s view of countertransference as constant rather than episodic alerts clinicians to the importance of continued vigilance—clinicians who conclude that they definitively understand their part in the dyad’s interaction are likely to be in trouble (Safran & Muran, 2000).

Although consensus among contemporary writers may exist that the therapist’s emotions are important, the interactive field, rather than the origin of emotion in either the therapist or the patient, is considered the essential part of the therapy (Hersey, 2001). Renik (1993) viewed an emphasis on a clinician’s emotions to be extraneous to the therapeutic process because analytic treatment involves an interaction between the subjectivities of the analyst and patient, thus relegating attempts to determine the genesis of each emotion irrelevant. Along with Renik, Safran and Muran (2000) suggested that the nature of the interaction—involving two subjectivities—would preclude the clinician from judging what is truly occurring in the dyad: “The complexity of organismic wholes makes it difficult to pinpoint singular antecedent-consequent reactions” (Altman & Rogoff, 1987, p. 173). This is consistent with the view of two-person theorists who assert countertransference is co-created. Despite Renik’s conceptualization of
countertransference with respect to technique, he concurred with Ferenczi’s assessment that patients can frequently read their analyst’s reactions, thus often making it more beneficial to bring the reaction into the room and explore the patient’s response to it, rather than attempt to conceal it.

In according attention to both the importance of theory and the realities inherent in clinical practice, Wachtel (2002) suggested that the one-person versus two-person debate between competing theories of countertransference had created a stark demarcation in a situation in which nuance may have been indicated:

In the clinical realm, very few instances of “pure” one-person or two-person approaches are evident upon close inspection. The debate today, one might say only partly in jest, is between one-and-a-quarter person models and one-and-three quarter person models. That is, most clinicians who fall into what is usually depicted as the “one person” camp are not pure examples of such a conceptualization. They do take into account, to at least some degree, the impediments to achieving anything approaching “objective” knowledge of the patient and the ways in which the clinical material that “emerges” is influenced by the analyst in a host of ways. But when it comes to figure and ground, the “one-person” aspect of their thinking become figure and the “two person” aspect ground. Similarly, proponents of “two-person” models, notwithstanding their appreciation of the powerful and pervasive ways the material is shaped by their own presence and participation, nonetheless almost inevitably construct an understanding of “the patient” that guides their perceptions and their interventions. Here, too, the nature of their theoretical commitments is reflected in
what is likely to be figure and what ground, but both figure and ground can be discerned. (p. 216)

Wachtel acknowledged that clinicians have unique individual perspectives as a result of their knowledge, training, and history that should not be excluded in their entirety from any theoretical concept of countertransference (Hersey, 2001).

Gabbard (2001) searched for common ground on this issue, noting “a myriad of theoretical perspectives have begun to converge around the view that countertransference is partly determined by the therapist’s preexisting internal object world and partly influenced by feelings induced by the patient” (p. 983). He described how feelings emanating from the patient get evoked in the clinician, e.g., through projective identification. When feelings projected onto the clinician cause the clinician to respond, the manner of response may often be one the patient cannot tolerate. In addition, Jacobs (1986) introduced the occurrence of countertransference enactments to explain the interplay between transference and countertransference that occur outside of one’s consciousness, including nonverbal behavior. Chused (1991) described enactments as occurring “when an attempt to actualize a transference fantasy elicits a transference reaction” (p. 629).

Recognizing an enactment occurring when performing therapy can be challenging in the moment. Supervision is often helpful to tease apart the clinician’s feelings about the patient from what is happening in the room. Levenson’s (1995) formulation regarding countertransference consisted, in part, of identifying the patient’s “cyclical maladaptive patterns.” In this brief relational treatment model, the clinician is asked to note: “How are you feeling in the room with this patient? What are you pulled to do or not do?” (p. 51). The answers to those two important questions, along with the clinical interview, can
provide data sufficient to construct a narrative of how a patient’s interpersonal style impacts his or her symptoms, behaviors, relationships, and self-esteem (Hersey, 2001). Therefore, a discussion with supervisors and peers in supervision concerning the clinician’s responses to the questions can act to both illuminate the particular dynamics present in the patient’s life and highlight the clinician’s internalized objects.

It is often useful to view videotaped therapy sessions during training and supervision (Levenson & Strupp, 1999; Safran & Muran, 2000), as discussed above. Not only does this offer the clinician the opportunity for a more objective position, but it also allows for the direct observation of enactments, which can then be processed with others. Moreover, other viewers may experience their own countertransference reactions to the patient, e.g., feeling subtly devalued, and provide valuable feedback to the clinician that “may help the therapist become more aware of similar feelings of her own” (Safran & Muran, 2000, p. 217).

It is common for patients to sense clinicians’ reactions to them, as discussed above. Therefore, before disclosing countertransference to the patient, it is important to be mindful of the intention behind the disclosure and how it will benefit the patient and the therapy, taking into account the strength of the therapeutic relationship and the patient’s psychology.

**Maternal transference/countertransference.** Maternal transference/countertransference is a co-created process that occurs within the therapeutic relationship when a patient pulls for a maternal reaction from the therapist, and an altruistic therapist—feeling pulled—responds to this need in a process that simulates the mother-infant relationship. Just as a mother would track her infant, the therapist is attuned to the patient, making moment-to-moment adjustments that enable the therapist to stay in sync
with the patient (Beebe & Lachmann, 2002; Tronick, 1989, 1996). Mutual mirroring, such as gazing and vocalization, is critical to foster this synchrony and bonding in therapy (Kafka, 2008).

It is common knowledge that many patients come to love their clinicians, a situation illustrative of transference; however, the reverse—the clinician’s love toward the patient (e.g., countertransference)—is rarely discussed in the psychoanalytic literature, although the love clinicians have toward their patients is powerful in treatment and has been acknowledged by McWilliams (2004) as the main therapeutic agent. In a personal communication with McWilliams, Nicole Moore, a psychiatrist in the U.S. Air Force, eloquently articulated the mutuality and healing nature of love in the therapeutic relationship:

I don’t like myself when I can’t find something to love in a patient. I look for it. Often I can find something in the person’s history that stirs my genuine compassion; I can love the child who went through that and hold an image of that child in my heart. I think when patients see the love reflected back at them, they start to believe they are lovable after all, and they start to get better. (August 20, 2003)

Natterson (2003), an analyst, discussed the role of love in therapy, and described psychotherapy as a mutually loving process through which the actualization of love, in addition to self-actualization in the patient, proceeds through the stages of desire, belief, and hope. When therapy facilitates a nurturing, holding environment that allows a person to become his or her true self, this feeling of loving care can be transformative.

Specifically considering maternal transference (i.e., when the patient views or responds to the therapist as a maternal figure), and maternal countertransference (i.e.,
when the clinician’s love toward the patient is experienced as maternal), Bergmann (1987) cited the genesis of the patient’s love for the clinician in the clinician being “both similar to (by being in a caregiver role) and different from the childhood caregiver” (McWilliams, 2004).

Patients may or may not have experienced “good enough mothering” (Winnicott, 1952) from their childhood caregiver, and these early experiences are recreated in the therapeutic dyad. Nevertheless, with some patients, as they seek to undo past negative experiences with early objects by selecting clinicians that differ from internalized ones, and despite the clinician’s efforts not to fail the patient like the childhood caregivers, the dyad finds itself caught in repetitive enactments. Even in these circumstances, the clinician’s love can be experienced by the patient through processing these repetitions. Although the patient may feel hurt reminiscent of his or her childhood pain, the clinician, unlike early childhood caregivers, tolerates the patient’s suffering and offers a new experience with compassion and interpretation to distinguish the past hurts from the current reenactments (McWilliams, 2004).

Although limited literature exists regarding maternal transference and countertransference, no studies have been undertaken with respect to maternal transference and countertransference in the Black female clinician-Black male adolescent therapeutic dyad. One aspect of this study will explore the question as to whether Black female therapists experience maternal countertransference reactions in therapy with Black male adolescents.
Chapter III: Methodology

A qualitative analysis, in the form of semi-structured interviews, was utilized in this current study to identify the common experiences of Black female clinicians treating Black male adolescents in therapy. Through a Grounded Theory (Corbin & Strauss, 2014) data analysis, such common experiences were found and themes emerged that could provide the groundwork for future research investigating the Black female clinician-Black male adolescent dyad.

Participants

The current study utilized a network sample of 10 clinicians who identified as Black or African American females and had conducted psychotherapy with Black male adolescents. Participants included five clinical psychologists (50%), four school psychologists (40%), and one school psychologist-in-training (10%). Although this study was conceptualized from a psychodynamic and multicultural lens, participants’ theoretical orientations varied to include five integrationists (50%), drawing from various combinations of psychodynamic, attachment, systems, interpersonal therapy (IPT), emotionally focused therapy (EFT), cognitive behavioral therapy (CBT), client-centered, Rogerian, strength-based, and behavioral approaches; four cognitive behaviorists (40%); and one psychodynamic clinician (10%). It is noteworthy that although clinicians practiced in a range of theoretical orientations and treatment modalities, they had all received training in psychoanalytic/psychodynamic therapy and were familiar with the terminology. Their experiences working with Black male adolescents ranged from one year to thirteen years. Their practices consisted of individual therapy, group therapy, and assessment. The number of Black male adolescents treated by participants ranged from
five to 400. For the purposes of this study, therapeutic dyads were defined as consisting of a Black female clinician and a Black male adolescent patient.

**Procedures**

Network sampling was utilized to recruit participants. The principal investigator contacted known Black female clinicians by phone or email to screen for eligibility, inquiring as to whether the clinician conducted therapy with Black male adolescents, and treatment duration of at least 6 months. If the inclusion criteria were met, the investigator provided information regarding the purpose and the procedure for the study (see Appendix A). Although participants saw adolescents in a variety of settings, including clinics, community clinics, college counseling centers, and school-based mental health settings, schools and juvenile justice and/or correctional facilities were the two settings in which participants primarily conducted their work with Black male adolescents.

Ten participants were interviewed for this study. Individuals interested in participating in the study were offered in-person or phone interviews with the investigator. Four participants (40%) participated in an in-person interview, and six participants (60%) participated in a phone interview. The location for in-person interviews included the participant’s work office, the participant’s home office, and the investigator’s home. For phone interviews, both the participants and the investigator selected private locations for the interview. The duration of interviews ranged from a minimum of 45 to a maximum of 74 minutes.

Prior to the start of in-person interviews, participants were asked to read, review, and sign an informed consent agreement (see Appendix A) and an audio/video consent agreement (see Appendix B). For phone interviews, electronic versions of the informed consent agreement and an audio/video consent agreement were emailed to each
participant in the form of a Microsoft Word document file. Participants were instructed to provide an electronic signature for both consent agreements and return the files via email attachment to the investigator. Additionally, participants were informed that the results would be made available, upon request, when the study was completed.

All interviews were audio recorded so that participants’ responses could be transcribed for data analysis. The investigator also took notes via computer in the event of issues with the audio recording. After the data was collected and analyzed, as discussed below, a Grounded Theory methodology (Corbin & Strauss, 2014) was utilized to obtain and synthesize themes. Further, quotes and case examples from individual interviews were utilized to illustrate strategies for forming positive therapist-patient relationships, as well as case illustrations.

**Informed consent agreement.** The informed consent agreement (see Appendix A) explained the purpose and procedures for participation, risk and benefits of the study, confidentiality and limits to confidentiality, and provided contact information for all individuals affiliated with the study. The informed consent agreement explained that the study was completely voluntary and that interviewees had the right to decline participation at any time during the interview process. The informed consent agreement also asked for consent to audio and/or video record the interview (see Appendix B). The participants were informed that they could decline audiotaping of the interviews with no penalty.

**Measures**

At the start of the interview, the participant was informed that if, at any time, she wished to discontinue the interview, she could do so without penalty and would be thanked for her participation. If given permission, the interview was audiotaped.
Participants were informed that the interviewer would also take notes in order to ensure accuracy in reporting responses. An open-ended interview, consisting of 19 primary questions and 35 follow-up questions, was used as the main instrument of this study (see Appendix C). The questions within the open-ended interview were grouped and divided into different themes in order to help the investigator with future data analysis. The themes included: (a) participant’s demographics (e.g., number of years practicing psychotherapy, professional degree obtained, theoretical orientation, experience working with Black male adolescents, most common type of referrals and diagnoses treated for Black male populations versus other populations, and parental status); (b) treatment; (c) transference and countertransference; and (d) supervision and training. The length of each interview ranged from 45 to 74 minutes. A concluding prompt allowed participants the opportunity to ask questions and address any related issues that were not covered in the structured interview questions. Finally, each participant was informed that she could contact the researcher if she had any concerns or questions about the study, and all participants were then thanked for their participation in the interview.

Treatment of Data

The informed consent agreements have been kept in a locked storage file cabinet at the home of the principal investigator. Background data received from the demographic section of the interview was used to categorize participants based on number of years practicing psychotherapy, professional degree obtained, theoretical orientation, experience working with Black male adolescents, most common referrals for Black male adolescents versus other populations, most common diagnoses treated for Black male adolescents versus other populations, and parental status. The principal investigator knew a participant’s personal identity and/or contact information; however, a
participant’s identity was removed from the records and was not associated with the data. The principal investigator created pseudonyms and a code key in order to maintain each participant’s confidentiality.

Hard copies of interview data and audio recordings were stored in a secure location (locked file cabinet) in the principal investigator’s home. Once the data was transcribed, the information was transferred into a password-protected computer database at the principal investigator’s residence. Three years after the completion of the study, all documents with identifying information will be shredded, and the principal investigator will erase any audio and video recordings after publication.

**Data Analysis**

The data collected from interviews was analyzed using a modified Grounded Theory approach (Corbin & Strauss, 2014). Unlike quantitative methods of analysis utilizing statistical measures to interpret findings, in the qualitative method, hypotheses are formulated from the data collected in the interviews. The modified grounded theory approach was utilized to examine the relational themes present in the Black female clinician-Black male adolescent therapeutic dyad and to generate hypotheses based on the data. Grounded theory methodology consisted of three stages: open coding, axial coding, and selective coding. The process of open coding utilized the raw data from the interviews in their entirety and categorized similar words, phrases, and concepts together. This stage concluded when emerging new categories could no longer be identified. The process of axial coding consisted of identifying relationships between the categories that emerged via open coding. Finally, the process of selective coding involved generating central themes based on the interview responses and coding procedures. For the current study, the principal investigator first grouped the responses from the interviews by
specific concepts. Refined categories were developed from these concepts, and core themes were identified from the raw data of the interviews.
Chapter IV: Results

The results of this study exploring Black female clinicians’ experiences of working with Black male adolescents in therapy reflect their responses to semi-structured interview questions and are presented in six major sections, including: (a) therapeutic alliance and building rapport with Black male adolescents; (b) Black male adolescents’ transference reactions toward Black female clinicians; (c) Black female clinicians’ countertransference in therapy with Black male adolescents; (d) Black female clinicians’ other emotional reactions when working with Black male adolescents; (e) challenges encountered in therapy with Black male adolescents; and (f) supervision and training in the treatment of Black male adolescents.

**Forming the Therapeutic Alliance with Black Male Adolescents**

Participants were asked a series of questions about the Black female clinician-Black male adolescent therapeutic alliance with a focus on building rapport, transference, and countertransference. In addition, participants were asked to consider if their reactions are similar or different when working with adolescents from other backgrounds.

**Building rapport with Black male adolescents.** Methods used to join, connect, or build rapport with Black male adolescents. When participants were asked to describe the methods used to join, connect or build therapeutic rapport with Black male adolescents, six participants (60%) discussed the importance of showing curiosity about the adolescent’s interests. A number of interests were identified, most of which were entertainment-related, including music, television, video games, and anime; sports; places to hang out; where adolescents are from; and sneakers. Four (40%) participants responded that music was significant in joining with many Black male adolescents. One
clinician’s response also stressed the importance of “being real,” as discussed above, in the joining process:

I do think that music comes in more with Black male adolescents….Not to generalize, and obviously not all Black males are into hip hop music, but it just feels like [with] a lot of the ones that I’ve met, and maybe [it’s] just the population that I’ve worked with, music has been a good common ground, and I love listening to hip hop music. So it feels genuine to me. I’m not pretending to be something that I’m not….. I think [music has] been something that’s worked across the board.

Four participants (40%) cited sports as another common interest for many Black male adolescents. It was not necessary for the clinician to have extensive or current knowledge about sports to be able to connect with the youth, as being attentive and displaying a willingness to learn was effective in fostering a connection. One clinician did not let her lack of expertise dissuade her from engaging with the adolescent:

You have to connect there first. And even if you don’t know, ’cause I don’t know everything about sports. I don’t know the names of players anymore. I might start with…“Who is your favorite team?” or…“Tell me about who is playing now,” and let them give me that kind of stuff first.

Three participants (30%) identified discussing where an adolescent is from or places he enjoys “hanging out” as helpful in building rapport. One clinician noted how questions related to where the adolescent is from enabled a smooth transition into more serious subjects, e.g., discussing the reason for referral. She stated:

I know most of my inner city kids and my Philly kids….I would say…“Where are you from?...What part of Philly?” ’Cause people in Philly like talking about being
from Philly, and where you are from in Philly….We go there and talk about the neighborhood first, and then lead into…whoever referred [you, and I ask], “Do you know why you are here?”

Four participants (40%) discussed the use of games and/or activities to join, connect, or build rapport when working with Black male adolescents. Examples of activities included video games, board games, cards, sports, worksheets, and collages. One clinician found the use of games and activities to be an effective strategy:

“Sometimes just talking, words, [were not] enough. Most of the time, there had to be some kind of game or activity to get them to open up a little bit more, whether that was board games, card games, or action sports.”

Client-centered therapy was mentioned as a way to join with their patients because Black male adolescents may “shut down” when clinicians focus on their agenda and ignore the needs of the adolescent. Two participants (20%), acknowledging the challenge of establishing rapport with this population, reported changing the pace of the session. One stated:

I slowed down…how I would go about asking questions and getting history…to not feel like I was pushing too fast or…prying…because the trust took longer to build. And there was more of a focus…on talking about their life, and the things they enjoy, and the things that are fun for them, or…letting them…just come in and vent about what they needed to vent about, instead of…following more of an agenda [in] what we were talking about. To have it start to feel like more of a collaborative kind of space or environment where, if they needed, they can talk about whatever they wanted to talk about, and it wasn’t going anywhere else.
Many Black male adolescents have experienced negative encounters with the school and criminal justice systems. A few participants reported providing psychoeducation about therapy, and dispelling misconceptions about mental health treatment (e.g., confidentiality), were effective in building rapport so that clinicians were able to distinguish themselves from the systems in which they worked, and from being seen as authority figures. Participants also identified personal attributes or therapeutic style that facilitated building rapport with Black male adolescents, including being non-judgmental (five, or 50%), genuine (three, or 30%), relaxed (two, or 20%), and open (two, or 20%).

**Different methods used to join, connect, or build rapport with Black male adolescents.** Five participants (50%) stated they use methods to connect with Black male adolescents that are different from those used when treating other populations. One clinician discussed the importance of using humor with her group of Black male adolescents: “We use a lot of humor, which I think was helpful [in] building rapport….We would talk about sports, or things that our students liked, and then also crack jokes with them.” The clinician was also mindful of the need to rein in the group at times:

If they…maybe…were being a little disruptive, I’d [say], “Okay now,” and…joke with them about it….That was a way to not only build a rapport, but I think they [got the message], “Okay, I get it, Ms. [K]. I’ll calm down.” They were able to focus on what we had to focus on in group that day.

Another clinician, a school psychologist, articulated the importance of “reframing what therapy or counseling is” in order to create a safe environment that did not feel punitive:
When a Black adolescent male gets sent to me, he thinks that he’s in trouble, or [he’s told] that there’s something wrong with [him] and that [he] need[s] to see me. Repairing the harm that was done, and reframing the whole relationship, [I try to convey that] it’s not something that you have to do as a punishment to see me, but something that can be a victory. I think that takes some time.

This clinician, as with other participants, mentioned the power discussing an adolescent’s interest could have in his opening up:

I just had a student who the entire year didn’t really talk to me as much because [his] teacher sent him to [counseling likely] because…he was doing something that she didn’t agree with. At the end of the year, he joined with me [in a discussion of] computers and engineering. Just that one conversation…lasted about two hours. He actually mentioned in that conversation that he goes to see a therapist and does not talk to the therapist because he does not believe in therapy. He does not believe there’s anything wrong with him. However, he sat with me, the school psychologist, because he did not believe that he was talking to a therapist.

Two participants (20%) stated that they use the same method to build rapport across populations, but found that they connect most easily with Black male adolescents due to similar interests. One explained:

I think [my method is] universal to all patients. I try to be interested in what they’re interested in, but I think that maybe it’s easier with Black males, and females too, to some degree, because I’m probably already knowledgeable about what they’re interested in, so it [is] easier to talk about those things, as opposed to some other kids. There are teenagers that I worked with [who] may be interested
in something that I have no idea about, whereas [Black adolescents are] listening to rap music. I listen to rap music.

Another point of connection between the African American clinician and Black adolescents derives from a shared background:

Teenagers [who] are in the same city where I grew up [talk] about hanging out in [the] projects, or whatever….I grew up knowing those areas, or had friends [who] used to live in those areas, so there’s a level of understanding. I think that helps to build rapport.

Case example. One clinician provided a case example, involving forming rapport with an adolescent who was underperforming in school, illustrative of several points articulated by the participants:

I think that I try to…build rapport by…showing genuine interest in getting to know kids, and getting to know their story. There is a sense of relatability…feeling I can relate to them. I know that all Black people are not the same. We all have different experiences, and that also depends on cultural differences that exist between Blacks across the diaspora….I don’t want to make any assumptions about people, but I think it sort of helps enhance the work I do when they see another Black face in the room, a Black clinician. People have commented on it, because it’s something they aren’t used to seeing….I think that helps to build rapport, right there, that sense of familiarity and maybe some cultural overlap….

I like to get to know people, get to know more about their story. Usually, in the first few sessions, I spend a lot of time doing activities and playing games….One Black male patient…was referred to me for school refusal behavior….He’s 16 years old and in ninth grade,…under credit, over age….He
wasn’t going to school. He didn’t want to go to school. So they referred him for counseling.

Now he know[s] he should have been going to school. I don’t think he was coming to me for me to say, “You know, you should be in school”….I didn’t think that was the best use of our time together. [For] the first few sessions, [the] kid didn’t want to talk to me at all, so I had to work really hard to build rapport with him. And I remember us just sitting down and listening to music together….He shared with me who his favorite rapper was,…some guy I never heard of, some underground rapper from Brooklyn, and I [asked], “What’s his name? Let’s look him up on YouTube. What’s your favorite song by him?” And the music was a little bit rough. I’m [thinking], “Oh God, I hope a supervisor doesn’t walk by and hear this song playing.”

But…it’s about meeting…client[s] where they’re at. If this is what he wanted to listen to, and I think it surprised him that I was willing to listen to him with no judgment….“Oh this guy’s kind of dope. Do you know him? He’s from Brooklyn? Do you ever see him perform?”…After a couple questions, he started to open up and talk to me a little bit more….

I’m interested in [finding out] the things that they’re interested in [and] how…I [can] connect to that. For some people, that might be using music. [For other] kids, maybe it’s not about music, it could be whatever other thing that they’re interested in. I have kids who are into anime or video games and [I figure out] some way to get that foot in the door, and connect with them.

**Black male adolescents’ transference reactions toward Black female clinicians.** A broad range of transference reactions were identified through participant
Six participants (60%) stated that they have experienced maternal transference from Black male adolescent patients which one participant attributed to her assertiveness or “pushing” the adolescent: “I’ve definitely had a Black male call me Mom before….In certain situations,…where there is an issue, probably where I have pushed a little bit too much,…Black males probably interpret me more as a mother than a therapist.” Other participants attributed maternal transference to (a) the clinician’s having a maternal quality, and (b) being seen as an authority figure.

Two participants (20%) cited sisterly transference. One clinician remarked, “I’ve been told…that I’m like a big sister from younger clients, and…one of the guys in a [college psychotherapy support group] used to say I was like his sister.” Two participants (20%) discussed Black male adolescents experiencing an aunt transference toward them. One clinician commented, “Usually I think I strike the aunt vibe,…the cool aunt, the one you could talk to about whatever.” Two participants (20%) identified experiences of flirtatious behavior by Black male adolescents. One clinician elaborated: I’m a younger female….I was 25 when I started working in an alternative middle school. [One] challenge is Black male adolescents thinking that they can…talk to me, or just think…about how I look, [and then] possibly wanting to see me as a therapist because they thought I was attractive.

Another clinician responded:

I think sometimes the older ones…can be kind of fresh….It’s not challenging for me to have to draw boundaries [that clients] are not going to be fresh or flirty….I’m younger. I’m getting older, but….they may think, “Oh…I can seduce my teacher,” type of thing. I feel like sometimes with the older ones it tries to peek its head out a little bit.
Black female clinicians’ countertransference reactions when working with Black male adolescents. *Maternal countertransference.* All 10 participants (100%) expressed experiencing maternal countertransference when working with Black male adolescents. Five common factors identified by participants for the development of maternal countertransference in the Black female clinician-Black male adolescent therapeutic dyad included: (a) a pull for the maternal countertransference from the adolescent (three participants, or 30%), (b) the clinician’s maternal nature (three participants, or 30%), (c) relatedness/common experience (two participants, or 20%), (d) poor parenting (two participants, or 20%), and (e) the age of adolescent (three participants, or 30%). It should be noted that there was overlap when participants cited more than one of the five factors as contributing to their experience of maternal countertransference.

Of the three participants who responded that Black male adolescents pulled for a maternal countertransference, one attributed this to adolescents possibly seeing her as a parental figure because she and their parents were contemporaries: “For some it may have been because my age was similar to their parents’ and so they treated me almost in that way, and I responded in that way. It’s usually the younger ones.” Another clinician replied:

> I just I felt like it was a[n unmet] need,…like maybe not all children get that consistency of a person who protects them. A person [who] is going to continuously care and try to provide….If at the moment I could provide that, then that’s what I try to do.

Of the three participants (30%) who noted that they had a maternal nature, one clinician commented that her role as a therapist and a parent’s role both involved
“caretaking” which may have explained her countertransference as a result of her
“maternal instincts”: “I have been labeled, or described, as maternal by my friends….I
think there’s just a part of me that’s just maternal, whether or not it’s in enactment or
countertransference….Black boys bring that out more easily, I guess.”

Two participants (20%) discussed relatedness, or common experience similar to
their Black male adolescent patients, as a contributing factor for maternal
countertransference. One clinician remarked about how hearing from her Black male
adolescent clients about their negative experiences caused her to think of the Black men
closest to her undergoing the same tribulations and the dilemma she would then
experience in focusing solely on the client:

[I have] a lot of fear, hearing stories of things that they experienced, and then
imagining that for [the] Black men in my life,…having those worries,
and…having to deal with that….Seeing…what it would be like if [the people
important to me] were going through these same kind of things that my clients
were going through, and separating that out so that I could stay…present with
what was actually coming from the client, and how they were understanding their
experience, and how they were viewing it, and trying to see it their way, and not
through…my own lens….There [were] a lot of struggles with that at different
points. I have a younger brother, and then I have my son, and all of those things
impact each other.

Another clinician stated:

When I think of being maternal, I think of that supportive figure who is very
warm, and wants to…comfort a child or an adolescent. [I’m] reminded of my own
family, or family members, and feel...a caring connection towards them in that way.

Two participants (20%) identified poor parenting as a factor. One clinician who worked in the school system related her empathy for the abused and overburdened adolescents she worked with:

My reactions to parenting and discipline [come] from a really maternal place. It’s much stronger, I think, than it would’ve been in the past. A lot of it has had to do with hearing stories of parents not being there. Parents belittling them, criticizing them for struggling in different ways. Parents, in my definition, abusing them in the context of discipline. Seeing them come in tired. Seeing them come in sad, seeing them come in overwhelmed, or seeing them worried about their family. And I remember a client coming and talking about barely functioning himself, and talking about all these things he needed to do for his family, and for his mom, and for his older brother, and having to just be there for everything, and no one’s there for him. And so that would kick up just kind of all of that for me.

A clinician who works for the Department of Corrections had a comparable reaction of empathy, but also saw the necessity of educating her clients about social skills that they hadn’t been exposed to in their homes:

I do see them as kids who need to be re-parented. [Because I] know attachment theory and the importance of parenting in the development of a child’s life, I tend to display that nurturing side to me, at times, when I’m dealing with them. Plus a lot of them come...from one-parent households, with the mother being the primary caretaker. So they’re already used to dealing with women, and have certain expectations of how they should be treated by a woman. And sometimes,
many times, that needs to be changed. So I feel a responsibility in providing that experience for them while they’re here.

Three participants (30%) noted that the age of the Black male adolescent contributed to differences in feelings of maternal countertransference. These clinicians tended to feel an increase in nurturance, soothing, and a pull to correct behavior with younger adolescents that they didn’t experience with older adolescents. One clinician related her struggle with limits and boundaries, trying to supply what the adolescents weren’t getting at home, but understanding the need to suppress those impulses when they were inconsistent with her professional role:

I’d kind of want to pull up their pants [when they were hanging down too low]. I wanted to give them hugs. I had to bring in some lotion because this kid’s hands were ashy all the time. [I’d talk] to [the younger ones] about their hygiene….These were seventh and eighth graders….What is that? 12 and 13 years old? I had to try really hard to turn that off [when working] in the jail, because…technically [although] I could be old enough to be these guys’ mothers,…I don’t see myself in a mother role with them,…but I see myself doing more motherly things. [I] say things that aren’t therapist-like, that are more…mother-like….I found myself once actually pull[ing] up [a] kid’s pants while he’s walking past me, and I had to stop myself. I’m [saying to myself], “I can’t do that”….That wasn’t a therapist thing to do. Therapists don’t go around pulling up people’s pants, but I felt like I’d been working with this kid for a year….It was second nature….He was like, “Wait, what are you doing?” [My reaction was], “Oh, sorry”….Instinct.
Differences in Black female clinicians’ maternal countertransference when working with Black male adolescents versus other adolescents. Participants were asked to compare aspects of their therapeutic experience working with Black male adolescents with their experiences working with other populations. Regarding maternal countertransference, participants were asked if the experience was consistent across the adolescent population to include other races, ethnicities, and female patients. Four participants (40%) noted a difference in maternal countertransference between Black male adolescents and adolescents from other backgrounds, which they attributed to stronger maternal countertransference and shared experience. Two participants (20%) stated they felt an increased intensity with both Black male and female adolescents. Four participants (40%) replied that there was no difference in maternal countertransference based on the adolescent’s background. One clinician stated that “usually when I feel like there’s a need, I just try to fulfill that need.”

Sibling countertransference. Three participants (30%) noted a sibling countertransference when working with Black male adolescents. One clinician found “engaging in a tit-for-tat conflict approach” reminiscent of siblings and considered that she “would get sucked into those cycles most consistently.”

Countertransference reactions when working with Black female adolescents. Of the 10 participants that were surveyed, eight worked with Black female adolescents as well as Black male adolescents. Six of those participants (75%) stated they had the same or similar countertransference reactions when working with both populations. In addressing this comparison, one clinician replied:

I would honestly say that [Black female adolescents] are pretty similar….I’ve had females who…will call me auntie. That’s what they feel comfortable doing, and
I’ll allow them to do that. Same, similar types of transference and interactions with Black female adolescents.

Another clinician described her countertransference reaction as “similar” because she felt “this way about working with Black clients just generally.” Two participants (25%) stated that countertransference was present when working with Black female adolescents, but not to the same degree as with Black male adolescents, which one attributed to being the mother of a Black son:

[Countertransference exists with Black females, although] not the same level of intensity as far as the connection….I’m not sure if it’s because [I’m a mother of] a Black male [child],…. and I have a sense of responsibility for them as Black males….Now that I see a young Black male in front of me,…that’s what it is….And when I noticed it, it was almost a good realization for me.

Another clinician who has worked with both male and female adolescents in Corrections spoke to the intersection of gender and setting in which the Black males’ reaction to therapy seemed to be rooted in stigma, unlike the Black females who didn’t seem to have a negative association with therapy, but rather saw the process in a positive light:

When I was working with [females] in the Department of Corrections,…I was never fearful of them. Not that I was fearful of the Black guys….I’m more cautious because I am a female. I’m on the unit where there’s just one officer to however many guys are there. Whereas when you go into the female unit, they’re just so happy to have therapy, and to have somebody to talk to. Females I find are much more approachable and amenable to therapy. The Black guys [approach therapy as meaning], “You think I’m crazy?” “You think something’s wrong with me?” [They’re] very protective of themselves.
Black female clinicians’ other emotional reactions when working with Black male adolescents. When participants were asked about their emotional reactions when working with Black male adolescents, a broad range of emotions was expressed, including (a) happiness/joy (seven, or 70%), (b) anger (four, or 40%), (c) empathy (three, or 30%), (d) excitement (three, or 30%), (e) fear (three, or 30%), and (f) hopelessness (two, or 20%). Participants also noted feelings of curiosity, pride, compassion, and gratitude. Through the semi-structured interviews, certain responses best captured the felt experience of Black female clinicians when working with Black male adolescents. For example, two participants (20%) articulated feelings of frustration. One clinician’s work with Black male adolescents in prison left her feeling a sense that there was little she could do to surmount the forces of systemic oppression and her clients’ apparent indifference to the trajectory of their lives:

I would have to say the majority [of emotions] for me [arise from my feeling that] it’s very frustrating working in a jail….I look at the bigger picture, and I look at the whole jail system as a moneymaking system, and I realize that the kids don’t realize that they’re pawns in a bigger game. And some don’t take their time here seriously. It frustrates me knowing that I’m limited in what I can do, and that they more than likely [will] end up back in the system, not only as adolescents but eventually as adults. And that somebody else is benefiting from this life that’s being ruined, and it’s really based on their own lack of knowledge, their own ignorance, and lack of support. [I’m] surrounded by frustration because of what I feel I’m unable to do for them, and what they’re unable to do for themselves.
Five participants (50%) expressed sadness about the societal context in which Black male adolescents live, and the clinicians’ inability to control or change how the world perceives and treats them. One clinician responded:

[I feel] some sadness because [of how my work has] highlighted to me…the injustices that still exist, and how these kinds of systemic issues and institutional issues that have existed in our history all sort of circled down to children and people…coming of age. It makes me sad that that [it] is still happening.

Another clinician contrasted the environment which she had created for her clients with what they often faced elsewhere:

I can’t control what happens outside of the [clinician] role….We have this time together, and I can create this safe space, and be there to be your cheerleader and support you in so many ways, but that’s only in our 30 or 45 minutes together. And after that you go out in the world that maybe always isn’t so kind to you. And…that can be a little bit sad.

Three participants (30%) spoke about a sense of urgency, feeling compelled to provide their patients with the skills and insight necessary to thrive in society, but fearful that they wouldn’t have enough time to accomplish their goal. One clinician expressed the pressure she felt:

You don’t want anything else terrible to happen, more than what they’ve already experienced, so you’re trying everything. You want to teach them everything, you want to process everything, so that they’re just able to go out there and be able to handle things better than when they came into your office. You’re never able to get there, because there’s always so much [to do] in one session. But…it all goes
back to that sense of urgency that you feel to do something, or help them see something, or help them have some kind of insight.

Two participants (20%) commented that their sense of urgency emanated from considerations of race when working with Black male adolescents. One clinician responded:

That sense of urgency, not that I don’t feel it [with White clients]. I always want my patients to get better as quickly as they can. But I don’t think it may be as strong with my White clients in particular. There’s not the same societal pressure that there is on my clients of color….I know that if they get angry in public, the police are not going to shoot them [while] there’s potential for that to happen [with Black clients].

Another clinician commented about the divergent origin of her sense of urgency with clients—ascribing it with Black male adolescents to the tenuous nature of their safety in the world, and with other clients to how her competency might be questioned if positive outcomes were not demonstrated quickly:

The sense of urgency that I feel about my Black boys is…more of a protective thing….I just don’t want them to…make any mistakes because there’s no room for mistakes [for] a Black boy. With my other patients, if I feel a sense of urgency, then it’s usually because I feel like people are [judging] me, like, “What are you doing with this patient? Why are they not progressing?” [Urgency with those clients arises mostly from] my own insecurity about how good of a therapist I am, because I guess I don’t really worry about them functioning in the world the same way I do my Black boys.
Despite the adversity many Black male adolescents experience, three participants (30%) felt hopeful in their work. One clinician even described herself as “very hopeful” at times “because [Black male adolescents] just seem just so resilient…despite all these things that were going on, all the difficulties that they were experiencing at school.”

**Differences in Black female clinicians’ other emotional reactions when working with Black male adolescents versus other adolescent populations.**

Participants were asked if the emotions they experienced when working with Black male adolescents were consistent across the adolescent population to include other races, ethnicities, and female patients. Eight participants (80%) cited having a broader range and/or more intense emotions when working with Black male adolescents. One clinician described a unique intensity when working with Black male adolescents:

> The degree of the intensity…was probably higher than it typically is for me. That degree of range of emotions is not present in those ways for every single person that I’ve work[ed] with, but I felt like it was much more present for…every one of the clients that I was working with when I was working with the group [of Black adolescents] and the [Black] students that I saw that year.

One participant stated that her emotional experience was influenced by the job setting in which she worked (children’s hospital versus correctional facility). Another participant replied that she experienced the same emotions for different populations (e.g., happiness and sadness), but the reasons for the emotions differed based on population.

**Worry about Black male adolescents.** Participants were asked if they worry about their Black male adolescent patients. All 10 participants (100%) responded that they worry and provided the rationale for their answer. Four participants (40%) replied
that they worry about their Black male adolescents’ survival. One clinician explained that her worry was exacerbated by her clients’ dangerous behaviors:

I definitely worried about them quite a lot, actually. A couple of students…were involved in…violent things going on at the school itself. They were involved in…violence in the community. They talked about…having to have guns on them at different points, getting stopped by the police, dealing with drugs and stuff like that. And so I had a lot of worries [like], “Are you gonna be here next week or not?”

Eight participants (80%) cited worry about their patients interfacing with the criminal justice system, including police involvement, incarceration, and/or re-offence. One clinician expressed her confidence in her clients but concerns with their vulnerability:

I was so worried. Not because [I thought], “Oh they’re going to make bad decisions,” or anything like that. I was just worried about the situations that they would be put in, and…the impact of racism. Honestly, my biggest concern was…any interface with police or law enforcement. I was always very concerned about how that would shake down or how that would go….I definitely worried a lot about them, and how they were doing, and how they were managing the world.

Participants identified environmental factors as major causes of worry including family (30%) and community (40%). One clinician expressed her concern that the mandate to report certain conditions in a client’s home to social services would further endanger him:

[W]ith the group, there was worry about [the] kind of home environment, and…“What are you going home to?” And we had to do a…report because of
what one student reported in group, and [my thoughts are], “How was that gonna impact him? Is he gonna get hurt worse? Is he gonna get in more trouble?”

Two participants (20%) who worked in correctional facilities spoke to their concerns about the challenges their Black male adolescent clients face in overcoming their environment upon release:

I definitely do [worry], particularly because I realize that when they leave here,…they go on back to the same families; they’re going back to the same environment, communities; [the] same situations basically that created their behavior in the first place. So I just worry that the little bit I am able to do isn’t enough, isn’t going to be enough to help them stay out of trouble,…change who they are, and really see a different way of life.

Another clinician questioned whether the work she did with Black male adolescents could serve as a protective factor when they were released:

I wonder what the outcome of treatment [will be] for those who I saw in the correctional facility when they go back home….Are they prepared when they go back home? Did I give them as many tools as I can in therapy and treatment to prepare them to be able to challenge the negativity, or to challenge what has been compromising their situations? And some of them will outright say, “This is what I have to do to survive”….So I worry about [whether] they’re gonna use their critical thinking, or if they’re gonna be influenced by peer[s]. I don’t know when they get into that environment, I’m not sure how they’re gonna go about making better decisions. If they will. Will they get caught back in the trap, and things like that?…That environmental piece is pretty big for me. When I think of where we’re
discharging them back to, and where they’re going back to, I’m just [thinking],

“That environment just wasn’t conducive to you growing.”

Two participants (20%) cited worry about how Black male adolescents are perceived by society. In their responses, some referred to their work with other Black male populations (older and younger) that was relevant to their work with Black male adolescents. One participant articulated how a young African American adult male’s rage at the prejudice and bias he encounters has engendered thoughts of violence but left him with no outlet, other than the clinician, in which to express those feelings without the possibility of facing severe consequences:

Given the climate that we live in, in this country, there really is no room for mistakes out here, which is unfortunate. I had a young Black male, he’s a little older, he’s 21, so post-adolescence, or young adulthood, emerging adulthood, talk to me about…the rage that he has towards people because of...all the trauma that he experienced growing up….When I told him that I wasn’t scared of his anger, you would think that I had just given him a million dollars. He was just so thankful, and so relieved that I wasn’t frightened by him, because that’s the experience that he has walking around on a day-to-day basis. People are…scared of him just because of the color of his skin. For him to be able to sit there and tell me how he thinks about harming people, murdering people, and giving him the space to do that, and not be scared by it, he was grateful for it, but I know that had he said that to anybody else [he would have been seen as dangerous]. He was actually pretty aware of it too, because he told me. When he was first admitted…on the in-patient unit [of] the hospital, he was having these homicidal thoughts, and he said, “I wasn’t going to say that to anybody.” Can you imagine
what they would have done to me, if I would have said anything, so I kept it to myself.

Three participants (30%) stated concern regarding the school system and that perceptions of Black male adolescents can influence how the administration and staff interpret and respond to an adolescent’s school performance and behavior, which may result in overclassification, harsher punishments, and lower achievement. One clinician stated the importance of school engagement because, “It all starts there, the school-to-prison pipeline….How they’re going to be treated in school, those day-to-day interactions, [is] going to determine their trajectory.”

**Case example of worry.** One clinician gave a case example involving a Black male child who was barely old enough to attend school, but whose behavior elicited attention from staff. The clinician envisioned a tragic fate for him as the consequences for nonconformance to behavioral standards become far more severe as Black males get older. The clinician indicated that despite the age differences between this child and a client population of Black male adolescents, her reactions of fear, worry, and concern do not diverge:

I’m scared for the [Black boys I work with]. There’s a lot of stuff going on in this world that part of me [understands] that it feels good, but I’m still worried about what’s going to happen to them. I can’t stop worrying….Sometimes I have a conversation with parents…about kids’ behavioral problems, even if I don’t think they’re so out of control. But…look at this world that we live in, there’s very little tolerance for Black males to begin with, let alone those who don’t conform to certain rules….It’s scary for parents, and I…feel like I’m with them on that.
[T]his kid,…he was five actually, I [had been] working with him over the past year. He was all over the place, he walked into the school, everybody [knew] who he [was]. And the concern that you’re already having [for a] kid [who is] five….Now he’s got this trauma factor going on….How long is it going to be before the cops have got this kid in a chokehold? Now everybody’s chasing him around the school,… “No stop,” “Don’t do this,” and “Don’t do that.” And there’s a certain cuteness there, but pretty soon he’s not going to be afforded that same level of cuteness or anything. And the consequences are going to be more severe. And I feel like that’s always something that’s out there.

I talk…with the families, how…we’re concerned about these kids because if the school is complaining about them, imagine how it’s going to be for them as they get older, as they get bigger, as they look more manly. What then is going to be the response? Not just from people in the schools, but people outside of the schools, because this kid doesn’t know how to sit down in his seat, or because he might be a little bit more high stress.

This case highlights the harsh reality of the labeling that many Black boys face in the school system, i.e., being identified as a “problem child” when they are only 5 years old. It further illustrates how early the worry begins for African American parents and for Black female clinicians in their work with Black male clients. The clinician’s fear is evident as she considers her patient’s trajectory. She worries that the low tolerance for how his behavior is perceived will eventually lead to interfacing with law enforcement as he approaches his adolescent years.

Worry about Black female adolescents. Seven of the eight participants (87.5%) who worked with Black female adolescents stated that they worried about this
population. Three participants (30%) noted that they worry more about Black males than other populations, including Black female adolescents. Although similarities existed regarding worry about both Black male and female adolescents, including issues of survival, incarceration, and perception, one major distinction regarding worry with Black female adolescents was their greater vulnerability to unsafe situations. Four participants (40%) articulated safety concerns such as objectification, molestation, and rape. One clinician responded, “I worry more about them getting involved [in] schemes, or people taking advantage of them,…because they do a lot of Internet surfing….I’ve worried about [that] with my Black female clients,…especially those [who] experienced trauma.” Another clinician replied:

I do feel like young women of color are objectified and hyper-sexualized….Hip hop definitely perpetuates a lot of these stereotypes….Sometimes [with the] young girls that I’ve worked with, [there’s] an issue of them basically being used by men and boys.

**Protectiveness toward Black male adolescents.** Many participants brought up feeling protective toward their Black male adolescent patients prior to the specific research question about this quality. When asked, all 10 participants (100%) affirmed protectiveness. Reasons provided for protectiveness had been cited by participants as answers to previous questions concerning maternal countertransference and worry. These included systemic issues and racism toward Black males in America (60%), relatedness/common experience (30%), parenting (20%), and societal judgment or misperception of Black male adolescents (20%). One clinician who worked in corrections provided a compelling example of connecting with an adolescent because she, unlike all
of the other staff members to whom he had been referred at the facility, did not prejudge him based on reports of his negative actions:

I noticed that a lot of the staff members were…judging him based on his behaviors. And I kept hearing people talking,… “He did this and this!”…They eventually referred him to me, and when I was speaking with him I [expressed], “Oh, I see now why you’re very suspicious.” [He was] suspicious because a lot of people were seeing him because of his behavior, [but none may have taken] the chance to sit down with him, talk to him, understand who he is, and that he is not defined by his behavior.

And it…frustrate[s] me a little bit when I hear other people who don’t know someone…prejudging, judging them. I’m just [thinking], “Do you even know who you’re talking about? You’re looking at a rap sheet, or looking at what things he’s done, and already making your own conclusions about this young man”….I don’t like [it] when people are very presumptuous in what they think about [young Black males, tending to] judge someone based on [his] behavior.

*Differences in protectiveness when working with Black male adolescents versus other adolescent populations.* When participants were asked if the protectiveness they experienced when working with Black male adolescents was consistent across the adolescent population to include other races, ethnicities, and female patients, eight participants (80%) replied they felt more protective of Black male adolescents. One clinician’s response indicated that her feelings of protectiveness extended to all adolescents, but was especially significant for Black youth:

Working with adolescents in general, for me, really pulls for…feeling very protective, but the intensity for it was definitely different for my Black male
adolescents, for sure. I think the level at which I thought they might be misunderstood or actually harmed…was more intense…than [for] other groups.

Two participants (20%) responded they did not feel more protective of Black male adolescents than other adolescents. One clinician stated the importance of knowing the context in which behavior occurs and offering this insight to all populations:

[I do not feel] different[ly]. I’m consistent pretty much with everybody. I’m not a fan of suspensions. I feel like everybody goes through things in life. A lot of people don’t know [if] you didn’t eat yesterday. A lot of people don’t know that maybe your house burned down, or you had a traumatic event happen, because kids don’t want to really tell [staff] that. If I can come to the table and I can share that there are some things that you don’t know about this child and you should give them a little grace, I’m going to advocate for them.

**Challenges Clinicians Encountered in Therapy with Black Male Adolescents**

When participants were asked about challenges experienced when working with Black male adolescents, four main themes emerged: (a) therapeutic challenges, (b) systemic challenges, (c) developmental challenges, and (d) processing trauma.

**Therapeutic challenges.** Four participants (40%) cited building rapport as a significant challenge with Black male adolescents and, similarly, two participants (20%) cited establishing trust. Three participants (30%) mentioned “buy-in” to therapy as an issue. Due to behavioral problems, many Black male adolescents are mandated to therapy by a court or their school. This presents a challenge for clinicians as they attempt to establish rapport, trust, and “buy-in” to therapy because the system has, in effect, removed the adolescent’s sense of agency. Clinicians are not then viewed as a safe
person, but rather as being part of the system to which they belong. One clinician described this dilemma:

Establishment of trust is harder. It’s always been harder…dealing with a behavioral population primarily that [is] either mandated to come to counseling, even though they don’t really want to be there, or who have so many negative experiences with the school and the administrators that they view you as one of them as well.

**Systemic challenges.** Three participants (30%) noted the patient’s family as a systemic factor in making therapy more difficult. Parental and/or sibling conflict, parental enabling or reinforcement of maladaptive behavior, financial strain, parentification of the adolescent, and fatherlessness were provided as reasons. One clinician who works in corrections elaborated on how some families of adolescents might promote the continuation of negative behavior:

> Sometimes parents make it difficult to work with their kid. You can see why a kid is lying, getting away with stuff, because either Mom is telling them to, or Mom is allowing it….We have to really try and engage the families, which we don’t get a chance to do much here, and educate the families on how their parenting style is contributing to their child’s behavior. And when the parent doesn’t want to hear it, it makes it difficult for us to work with the kid, or expect the kid to be any different….Believe it or not, we get a lot of kids…in here that are really kind of spoiled. They’re used to getting their way, and Mama’s just kind of babying them when she needs to be setting limits.

Two participants (20%) cited the school system as particularly challenging when working with Black male adolescents. Issues of falling behind and academic failure,
adolescents’ negative perceptions of their ability and hopelessness, and the need for clinicians to advocate for their patients were stated as presenting obstacles when working in schools. Two participants (20%) identified the adolescent’s community, e.g., a high crime neighborhood, as a major systemic challenge. Gang involvement was also mentioned as a concern. One clinician who works in corrections addressed how continued gang involvement might be seen as less risky for some adolescents than pursuing the positive agenda encouraged by clinicians:

One of the major issues that we have here is competing with gangs—the gang lifestyle, the gang mentality—because that’s [an] influence…that they have to compete with and that [has] lasting effects…when they leave here. So we can tell a kid to stop hanging out with so and so, or he needs to be doing this, going to school, doing that, but when the leader of a gang is telling them to do [the] opposite, you know, “Take this gun,” “Do this,” “Go fight this person,” their safety is first and primary. And so they tend to operate in more of a survival mode than feeling like they can relax and really focus on change….I see them in an environment that isn’t conducive to change sometimes. Actually, it can be detrimental to them to change certain aspects of who they are [and] their behavior.

Three participants (30%) discussed the challenge of working with multiple systems. One participant articulated the difficulty inherent in agreeing to what is in the best interest of the adolescent when multiple individuals and organizations are represented in the decision making process:

[When] working with teenagers, there’s never a time when you’re working [with] just a teenager. You work with the parents, you work with the school, you work with whatever other agency they’re involved in, whether that’s [child protective
services], or whatever….The challenge [with possibly] so many different people at the table [is] getting everyone to…be on the [same] page and understand what…is…going on with this person, or the patient; getting everyone to see that there’s more than just what they’re seeing on the surface; getting everyone to understand that there are a specific set of challenges particularly for African American boys…and I think that’s the hardest part, given their race [and often] the context [in which] they grow up.

**Developmental challenges.** Two participants (20%) noted working with an adolescent population as particularly difficult due to the developmental stage. Adolescents’ unwillingness to change and individual characteristics were provided as therapeutic obstacles. One clinician also mentioned an attitude common to many adolescents: they “think they know it all.”

**Trauma.** Four participants (40%) cited difficulty working with Black male adolescents due to complex trauma histories. One clinician’s statement captures how the primacy of the symptom, i.e., behavioral issues, rather than addressing the cause—trauma—is harmful in treatment with Black male adolescents:

> When it comes to Black men, fatherlessness is an important issue [as is] talk about parenting styles….Oppression, and the effects of oppression [are] important to talk about. And there definitely needs to be more training on trauma,…identifying [it], and not misdiagnosing it as something else, and how to treat it.

**Supervision and Training When Working With Black Male Adolescents**

**Role as a supervisee.** Participants cited the race of their supervisors as a factor in whether diversity was addressed in supervision. Six participants (60%) responded that
Black female clinicians attended to cultural issues. One clinician commented on the discrepancy:

Overall, with my White supervisors, [diversity was not discussed] unless I brought it up, for the most part. I can think of maybe one [White female supervisor who was] more in tune with these types of things…With my Black supervisors, it was…par for the course. [We] talk[ed] about it all the time.

Four participants (40%) indicated that their non-Black supervisors did not address diversity unless it was brought into the room by the participant. One clinician stated, “Mostly when my supervisors have been Black women,…it gets brought up by my supervisor as opposed to me.” Another clinician commented that her White supervisors set a poor example of respecting diversity, an example which she is committed not to follow:

My supervisors have all been White folks, and I didn’t really get to…where I am clinically because of the supervision I received. I pretty much got it on my own, which is one reason why I particularly make an effort to be there for both Black and White interns that I supervise, to make sure that they get the understanding that I have now, that I didn’t have when I was at their level.

Two participants (20%) cited the type of job or setting as a factor in discussing diversity. One replied that in her current position of providing “mobile therapy…we don’t really address things like that.” In previous positions, she’s “had supervision or supervisors who have touched on it and others who have not,” and thinks “the nature of the job” in mobile therapy may influence the subject matter discussed in supervision: “We don’t really get there.”
Role as a supervisor. Four of the five participants (80%) who have supervised others reported addressing issues of diversity with their supervisees. One clinician articulated her experience with a White supervisee who was successful at joining with a group of Black male adolescents because of her approach to them:

I was supervising a group of young Black males and I felt like she also had that experience, as a White woman—it wasn’t even a racial thing—[of] feeling…very protective of them. And I think…that was a very interesting dynamic, to supervise someone who didn’t feel like [she] may have been equipped to do that. And when I saw that she did make an impact, I…reassur[ed] her that it didn’t have anything to do with [race]. You just have to listen to these boys. You have to validate their experiences. That’s all they want….And I think that’s what gives a lot of [White clinicians] comfort, [that they] don’t [have to] be so self-conscious about [their] race during those things….And…she connected with them because she realized what the struggles were, but that people kept judging them and just seeing them for what their behaviors were. So I think it came up with me supervising because [her identity as a White woman] was like the elephant in the room. [When] we discussed that level of connection, [whether] she could connect,…she found out that she could because they weren’t basing it off of what race she was, they were basing it off of the fact that she really looked like she cared, and she showed them that she cared about them.

One clinician (10%) identified the particular situation at her job—supervising very experienced staff—as a reason she does not discuss cultural factors or emotions often, although she expresses misgivings about having overlooked this issue:
With my supervisees, I [probably] don’t address [diversity] enough. Usually our supervision consists of documentation and notes and caseloads, and stuff like that. We don’t really talk about feelings….We don’t really spend the time on reflecting on how our clients are affecting us or…my supervisees. So, I can definitely do a better job with that. But I find that most of the individuals I supervise have…more experience than me [even though] I’m their supervisor. [For] the first probably six, seven months, they were telling me the ropes, and I’ve been there for almost two years. I think I take for granted that they’ve experienced almost everything at this point.

**Issues to consider in supervision and training when working with Black male adolescents.** When asked what issues should be addressed in supervision and training when working with Black male adolescents, two participants (20%) and four participants (40%) cited processing transference and countertransference, respectively. Paying attention to over-identification with the patient and clinician’s biases were points for consideration. Three participants (30%) mentioned diversity with a focus on Black male adolescents. Three participants (30%) identified diagnosis and case conceptualization. One clinician articulated the importance of culturally competent diagnoses and conceptualizations of Black male adolescents to avoid stereotyping:

The ways that Black male clients are treated, the way they are conceptualized, the diagnoses that are being considered [are issues that should be addressed]. How what they are presenting…is understood in the context of everyone else…needs to be considered too, because aggression is typical….It’s unfortunate that this has been the common presentation for them, because…the stereotype is that Black males are aggressive. The pieces about them feeling vulnerable, the pieces about
them having been abused, and not knowing what other ways to express their feelings,…their cultural influences, and client presentations [need to be considered]. If you just look at them the same way you look at everyone else you’ll miss what the underlying issue is for them.

One clinician spoke to the conflict she had processing situations which evoked divided loyalties for her, in this instance between a post-adolescent Black male client who has had negative experiences with others in her organization and the system in which she works:

I had a Black male adult patient who had some negative interactions with other people in the institution where I [worked]. And [even though] I brought this up with my supervisor,…we didn’t really process it and explore what that was like for me. [As] the therapist, another Black person hearing this man share his experience with this White doctor at this institution,…it was a tough position for me to be in because I was inclined to align myself with [the patient and say], “Yeah, that’s messed up, I can’t believe this happened to you.” But at the same time I also felt an allegiance to the institution and my coworker.

[W]hen patients bring stuff into the room about some of their experiences, how do you as a therapist deal with that, and how do you address it, and what it brings up for you? For me it brought up [a] similar experience that I might have had that I was able to understand, and probably that’s why I could better relate to him. But it would have been nice to…explore that a little bit more.

[Many of] these young Black boys…have had negative interactions. Often times I hear people complain about the school guard [who] said something mean to them, or treated them a certain way. How do you handle that?...You’re sort of
torn….You’re working with these other systems that the kids are involved in, [and] you want to have positive relationships with them,…whether it be the teacher or the school guard or whatever, but then you also want to validate this [patient’s] experience.

Participants also noted building rapport, skills, and what is not explicitly stated in therapy as important issues to address in supervision and training.

**How to address issues in supervision and training when working with Black male adolescents.** When asked about methods to address issues in supervision and training when working with Black male adolescents, four participants (40%) discussed the importance of creating a safe space to talk. Without fear of judgment, supervisees want to be able to share what is occurring in the therapeutic dyad and express any countertransference reactions, biases, or errors made in session. Three participants (30%) stated watching video recordings or listening to audiotape of sessions as beneficial. Other methods described included culturally-informed training, maintaining a diverse staff, consultation, and resources. One participant who works in corrections considered that there “are a lot of different ways that it can be addressed”:

[H]ow we do [training] here is we have…conversations…on a regular basis. We’ll have case conferences, we’ll…look at documentaries that talk about various things with regards to Black men. I’ve shown interns documentaries on the Crips and the Bloods. I’ve shown them documentaries on rap music, the messages that it sends. I’ve shown them several different types of documentaries to educate them on the history of Black men in America. [I’ve recommended that they] read certain books, like Michelle Alexander’s book. We’ve had conversations about [that].
Chapter V: Discussion

Themes

In this exploratory study of the Black female clinician-Black male adolescent therapeutic dyad, participants were asked questions related to the treatment of Black male adolescents, emotional reactions in therapy, differences when working with other adolescent populations, and supervision and training. The present chapter explores themes which emerged from the data, including: (a) building rapport with Black male adolescents, (b) emotional reactions of Black male adolescents toward Black female clinicians, (c) emotional reactions of Black female clinicians toward Black male adolescents, (d) challenges in working with Black male adolescents, (e) experiences working in different treatment settings, (f) differences in working with Black female adolescents and other adolescent populations, and (g) supervision and training when working with Black male adolescents. Limitations of the current study and implications for future research, clinicians, supervision, and training are also discussed.

Therapeutic alliance and building rapport with Black male adolescents.

Research has shown that the therapeutic alliance is consistently associated with the effectiveness of treatment (Orlinsky, Rønnestad, & Willutzki, 2004). The findings of this study confirmed the research, as participants noted how crucial building rapport was to successful treatment with Black male adolescents. Black female clinicians articulated very clear strategies for building rapport with Black male adolescents. Primarily, clinicians identified showing curiosity about the adolescent’s interests, including sports, music, television, places to hang out, where an adolescent is from, video games, anime, and sneakers. This technique of being curious allows an adolescent to open up without
feeling exposed, reduces defensiveness and resistance, and can re-establish a connection if the therapeutic alliance has been ruptured.

Adolescents often enjoy being active, and several of the participants in this study found that engaging in activities with the Black male adolescent, e.g., video games, board games, cards, sports, worksheets, collages, etc., was very helpful in joining with them. Clinicians engaging in activities with patients serves as a bridge in which to build rapport—the patient feels more comfortable and may slowly begin to become less guarded. The adolescent’s conceptualization of traditional therapy (i.e., the clinician asking questions designed to elicit a client’s innermost thoughts), which may have a negative connotation, and may seem particularly unappealing to male adolescents, shifts away to what is happening in the room as the therapeutic rapport is established.

Client-centered therapy and “slowing things down” were cited by participants as ways to build rapport. Their comments were consistent with the literature indicating that following the patient’s lead and paying attention to cues are critical in joining with male adolescents (Kiselica, 2003). Clinicians may feel pressured to uncover certain information in a session; however, asking questions prior to establishing trust is likely futile, and adhering to an agenda without flexibility could lead to mistrust and the adolescent may shut down—a situation which may be irreparable. Participants emphasized the value of simply listening, as many Black male adolescents do not feel heard. Therefore, avoiding the pitfall of asking too many questions is key to prevent feelings of intrusiveness (Kiselica, 2003).

Personal attributes and therapeutic style also affect a clinician’s ability to establish rapport. Black male adolescents had a positive response to Black female clinicians who exhibited a genuine, open, and relaxed approach. Orlinsky et al. (2004)
found personal traits (e.g., friendliness, assertiveness), along with other “extrinsic” characteristics (e.g., race, gender, age, class, etc.) to influence the quality and dynamic of the therapeutic relationship.

Many of the participants noted utilizing various methods to connect with their Black male adolescent patients, one of which was humor. This is consistent with the literature. Kiselica (2003) asserted: “many young men use humor as a vehicle to achieve intimacy” (p. 1227), and many young Black males relate through humor. Other participants noted that “cracking jokes” can reduce tension and resistance by showing a willingness to connect in a manner familiar to adolescents. It should be noted, however, that humor is subjective. Clinicians should watch for cues from the adolescent to ensure that the humor is being well received before continuing this method of joining.

Adolescents do not frequently come to therapy voluntarily. Some of the participants discussed working in settings, e.g., schools and prisons, where adolescents are mandated to attend therapy as a result of perceived negative behavior, and thus view therapy as punitive. To ameliorate this situation, participants who worked in schools and prisons mentioned the helpfulness of reframing therapy so that it would no longer carry the connotation of being punitive, but would be associated with an environment in which to feel safe. In the absence of such reframing, getting the adolescents to “buy in” to the therapeutic process is extremely challenging. School psychologists are often linked to the staff member who referred the adolescent, associating therapy as a punishment. Participants working in schools and corrections discussed the importance of distinguishing therapy itself from the system in which therapy was mandated in order for the adolescent to benefit from therapy. Thus, reframing therapy and utilizing the aforementioned methods are essential to building rapport.
The methods clinicians utilized to build rapport with Black male adolescents were also found to be effective across populations by a few clinicians; however, these clinicians experienced joining to come more naturally with Black male youth.

**Emotional reactions of Black male adolescents toward Black female clinicians.** Black female clinicians identified a number of ways in which their Black male adolescent clients responded to them. Several clinicians indicated that they experienced a sense of respect from their patients, which they considered to be likely the result of the respect with which they treat the youth as mutual respect is not a situation that Black male adolescents often encounter in society. Some of these clinicians identified respect as developing as a result of listening to the adolescent’s story without judgment. When clinicians are authentic, caring, and flexible, adolescents tend to open up, engage, and feel more comfortable and connected. This increase in connectedness may lead the adolescent to feel relieved, take advice, and fear disappointing his clinician, which were also identified as emotional reactions in therapy.

Some participants discussed a range of negative emotions or reactions as well. Black male adolescents frequently experience feelings of anger, confusion, or apprehension when beginning therapy. The adolescent may be unaware of the reason for referral or, as discussed above, believe he is being punished for negative behavior. Frustration, mistrust, and resistance may occur due to: (a) a lack of agency, (b) stigmatized views of therapy, and (c) perceived negative associations between the institution and the clinician.

A few participants volunteered the observation that there appeared to be a difference between how Black male adolescents react towards them versus their White
colleagues that manifested in “vibes”; contrasts in respect; and trying to “get over” on White clinicians.

**Flirtatious behavior by the adolescent.** During adolescence, hormones increase and identity development occurs. Adolescents may develop “crushes” or intimate feelings for clinicians, and express these feelings both directly and indirectly. Participants noted overt expressions which they described as being “fresh or flirty,” and Black male adolescents attempting to work with them based on their appearance and age. Clinicians discussed establishing firm boundaries in therapy during the development of the therapeutic relationship while also modeling structure and intimacy without sexuality for the adolescent.

**Transference.** For this study, transference is defined as an attempt by the patient to revive or re-enact real or fantasized significant memories and situations from early childhood in the therapeutic relationship. The Black female clinicians interviewed identified maternal, sister, and aunt transferences by their Black male adolescent patients.

**Maternal transference.** Maternal transference was the main transference reaction cited by participants. Reasons provided for this type of re-enactment were participants: (a) possessing a maternal quality, (b) being viewed as an authority figure by the adolescent, or (c) “pushing” the adolescent to make positive changes in his life. Same-race dyadic therapeutic research is sparse, but Gaines (2017), in a study exploring urban public high school teachers’ experiences, found that some Black female teachers working with African American male students similarly described students demonstrating maternal feelings towards them. One participant remarked on the situation faced by some African American female teachers—African American male students may fail to view them as professionals, but rather as family members: “As a[n African American] female
educator working with African-American males you have to be careful, because
you...you are mommy, auntie to them” (Gaines, 2017, p. 48).

*Sister and aunt transferences.* The family is very significant within Black culture; however, roles can shift, boundaries may be more porous, and extended family members tend to play an essential part in a child’s upbringing (Boyd-Franklin, 2003). The love from extended family is one of the “greatest strengths and resources” in Black families (Boyd-Franklin et al., 2000, p. 16). Extended family often incorporates individuals who are not biological relatives, including church members and community members, who love children, “adopt” them into their family, and play a key role in raising young Black males (Warfield & Marion, 1985; Boyd-Franklin et al., 2000).

Although an adolescent’s relationship with a family member can be positive or negative, participants cited positive transferences by their patients when describing these re-enactments. Whether it was the personality, gender, an attribute, or age of the clinician, participants recalled being told by adolescents that they felt like they were seen as a big sister, or were affectionately called “auntie.”

**Emotional reactions of Black female clinicians toward Black male adolescents.** The current investigation identified a broad range of emotions experienced by Black female clinicians working with Black male adolescents, many of which were related to how society perceives and treats Black male adolescents. The participants expressed their desire to impart all of the wisdom, knowledge, and skills they possessed to their patients, but were often left feeling dissatisfied and questioning whether they had done enough. Participants’ emotions became more pronounced due to their inability to effect change on a large scale to benefit or protect the Black male adolescents. This amalgam of negative emotions due to systemic issues, when coupled with a Black male
adolescent’s failure to understand the seriousness of the external factors they face, led to feelings of sadness, frustration, anger, fear, urgency, and hopelessness in some of the participants.

Participants expressed their worry for their Black male adolescent patients, citing (a) fear for their survival; (b) concern regarding interfacing with the criminal justice system, including police involvement; (c) incarceration, and/or re-offence; (d) environmental factors, such as family and community; and (e) negative perceptions by society. Boyd-Franklin et al. (2000) and Boyd-Franklin and Bry (2019) described Black parents experiencing similar worries in raising their Black sons, including survival, gang involvement, incarceration, academic achievement, and stereotypes.

Despite the negative reactions participants had to the overwhelming adversity faced by Black male adolescents, a broad range of positive emotions were experienced by the clinicians in these dyadic pairs, most notably joy and happiness. Additional positive emotions identified by participants included pride, excitement, empathy, compassion, and gratitude. Furthermore, some clinicians, impressed by the resilience and tenacity exhibited by their Black male adolescent patients, felt hopefulness for them and hopeful in their work.

**Countertransference reactions of Black female clinicians toward Black male adolescents.** *Maternal countertransference.* Black female clinicians’ countertransference reactions when working with young Black males in therapy have not been documented in the literature, as discussed above. The results of this investigation strongly emphasized the maternal countertransference Black female clinicians experienced toward their Black male adolescent patients. Participants discussed relatedness and common experience as a contributing factor for maternal reactions. They
considered their own fathers, brothers, nephews, cousins, and sons encountering systemic racism and discrimination, which intensified their maternal instincts toward their Black male adolescent patients. Some participants described their Black male adolescent patients pulling for a maternal countertransference, likely as a consequence of maternal transference. Clinicians cited similar age to an adolescent’s parents and the adolescent’s need for maternal nurturance as factors for co-occurring maternal transference and countertransference. A factor identified as engendering maternal countertransference was poor parenting. When children are struggling because of their home environment, the clinician’s awareness of needs not being met may heighten maternal feelings. Harsh discipline, verbal abuse, neglect, fatherlessness, or parentification pulled for increased nurturing feelings in the participants.

The age of the patient was also a factor in maternal reactions, with younger adolescents being more likely to be nurtured, soothed, and corrected than older adolescents. During the adolescent stage of development, autonomy increases with age. Mothering, in turn, adjusts as the adolescent becomes more independent. In this manner, clinicians’ may moderate their reactions as the clients approached early adulthood.

Maternal nature also contributed to maternal countertransference. Clinicians noted the caretaking nature of their profession, and being in a caretaking role may lend itself to mothering. Moreover, some clinicians mentioned their maternal nature in therapy as instinctual and representative of their personality.

**Protectiveness.** Like maternal countertransference, all participants experienced protectiveness when working with Black male adolescents. Similar reasons were provided for protectiveness as had been mentioned for maternal countertransference and worry, including systemic issues and racism toward Black males in America;
relatedness/common experience; parenting; and societal judgment toward, or
misperception of, Black male adolescents. Throughout their interviews, participants
provided multiple examples of their patients being judged and misunderstood by school
administration and faculty, correctional staff, family members, and society, eliciting a
protective reaction from the clinician. Black female clinicians have struggled to succeed
in the same societal environment of racism and discrimination confronting Black male
adolescent patients. Often, this common experience can benefit the therapy, facilitating
rapport or advocacy where other clinicians may struggle or ignore specific multicultural
issues. Unfortunately, Black clinicians may find themselves as “protectors of the race,”
which could cloud judgment and the therapeutic process (Hunt, 1987, p. 117).
Irrespective of proficiency, clinicians should consult with other clinicians and supervisors
continuously to maintain objectivity, as it is easy to lose perspective when working in this
field.

Challenges in working with Black male adolescents. In discussing challenges
in the treatment of Black male adolescents, four major themes emerged: (a) therapeutic
challenges, (b) systemic challenges, (c) developmental challenges, and (d) processing
trauma.

Therapeutic challenges. The participants described building rapport and
establishing trust as particularly difficult with the Black male adolescents who had been
mandated to attend therapy, as discussed above. Showing genuine interest in them can
help to overcome these challenges and supersede the common misperception, sometimes
verbalized by Black male adolescents, that the only reason the clinician is working with
the adolescent is because he or she is getting paid to do it (Harvey, 2005, p. 243). This
study further showed that “buy in” to therapy was also a challenge when working with
Black male adolescents. Using the methods described above, along with displays of genuine concern and joy in working with them, can increase their sense of agency and thus facilitate connection.

The view towards psychotherapy held by many African American males, endorsing stigma, may be an unspoken barrier to therapeutic alliance development (Brown, 2003; Carrington, 2004). Faced with greater life stressors such as racism and discrimination, yet affirming the stigmatization of help-seeking behaviors which they may often view as intended for weak or White people (Boyd-Franklin, 2003), Black male adolescents may see no viable alternative for them other than externalizing their feelings through aggressive behaviors. Despite externalization being a focus of some Black male adolescents’ behavior, the participants indicated that these young men were able to be vulnerable with their Black female clinicians, opening up to them and expressing softer emotions, like sadness, once rapport was established. Young Black men are caught in the intersectionality of race and gender. “Many African American men believe they cannot be helped absent an appreciation of what it means to be Black and a male in this society” (Franklin, 1999).

**Systemic challenges.** Participants identified family, school, community, and working with multiple systems as challenges they have encountered in therapy with Black male adolescents. Therapy does not occur in isolation—systems affect both the clinician and the adolescent, and, consequently the therapy.

**Family system.** Regarding the family system, clinicians cited the following factors as impacting therapy: (a) parental and/or sibling conflict, (b) parental enabling or reinforcement of maladaptive behaviors, (c) financial strain, (d) parentification of the adolescent, and (e) fatherlessness. Participants elaborated on family systems’ challenges
stating that some of their adolescents come from “chaotic” environments without stability and safety. Further, participants noted that some parents enabled and reinforced maladaptive behaviors that led to poor school performance, school discipline, and incarceration. Parents may be unaware of the degree to which their own positive and negative actions shape their children’s behavior. For example, parents may claim a desire to stem their child’s aggressive behavior, but may have themselves demonstrated that “power and control of others is achieved most effectively through physical force” (Hale-Benson, 1985), and parents serve as powerful models for their children’s behavior.

Many Black male adolescents come from single female-headed households, a situation which may give rise to certain challenges, including (a) transference-countertransference reactions, (b) parentification, (c) financial difficulties, and (d) identity issues if no Black male role model exists. Many participants noted their Black male adolescent clients exhibiting maternal transference, as discussed above. How the patient feels about his own mother is likely to be enacted in therapy. Therefore, the closeness or distance; emotions such as joy, frustration, anger; or a longing for nurturance and protection in therapy may mirror what an adolescent feels toward his own mother. Some clinicians commented on the importance of re-parenting their patients who had insecure attachments with their mothers, or experienced repeated negative interactions, including harsh discipline, criticism, or neglect from Black women, and thus these therapists attempted to provide a corrective emotional experience for them.

Growing up in a single female-headed household often leads to increased responsibilities and certain expectations that others who are raised in two-parent households typically do not face. Boyd-Franklin et al. (2000) discussed how family roles shift when an adult male is absent from the home. Some mothers may view their son as
“the man of the house” or use other descriptors including “best friend,” “confidant,” or “only joy” (p. 31). This can confuse family roles as the son may function as a child in one instance and be elevated to adult status in the next.

The financial strain experienced by some Black male adolescent patients was also mentioned by several participants as therapeutically challenging. For example, patients have attended therapy hungry and have reported to clinicians their family’s expectations that they, as young as they were, financially contribute to the family’s support. Clinicians recounted the negative impact on school performance and mental health as their patients self-reported and exhibited tiredness, worry, overwhelm and sadness.

With respect to identity development, Black male adolescents develop their ideas of manhood from parents, other adult men, peers, media, and how Black men are treated in society (Boyd-Franklin et al., 2000, p. 125). Systemic issues, such as racism, interfacing with law enforcement, and the school-to-prison pipeline, were cited by participants as giving rise to concerns regarding Black male identity development.

School system. The school system presents a unique set of challenges when working with Black male adolescents. Many young Black males attend schools suggestive of prisons, with crowded classrooms, taught by under-trained and under-paid teachers, in an environment in which control is prioritized (Wacquant, 2001). As discussed above (see Chapter II), the school-to-prison pipeline—described by Noguera (2003) as educational systems that “frequently punish the students who have the greatest academic, social, economic, and emotional needs” by enforcing “zero-tolerance” policies leading to suspensions and expulsions from schools (p. 341)—is a reality that threatens the life trajectory of many Black male adolescents and those from other marginalized groups (e.g., Latinos and low achievers). When these youth are removed from learning
opportunities, they have increasing idle time to reinforce negative behavior. Adolescents’ poor academic performance and failure, their negative perceptions of their ability, feelings of hopelessness, and the resulting need for clinicians to advocate for their patients present obstacles for clinicians working in schools.

*Developmental challenges.* Adolescence is a transitional stage during which identity development, physiological changes, school transitions, cognitive development, social role re-definition, and the emergence of sexuality occur (Eccles et al., 1993). Many adolescents may feel disoriented and confused by such rapid change within these multiple dimensions. In the current study, some adolescents’ unwillingness to change and individual characteristics were discussed as therapeutic obstacles. Consistent with the literature affirming “adolescents’ desires for autonomy and control” (Eccles et al., 1993, p. 97), one clinician referenced the “know it all” attitude exhibited by some of her Black male adolescent patients.

*Trauma.* Several participants commented on the complex trauma histories of their patients. When referrals in schools and correctional facilities were based on behavioral concerns, other aspects of an adolescent’s life, such as family stressors; physical, emotional, or sexual abuse; significant loss; or multicultural concerns, were typically not considered. A failure to acknowledge sociopolitical realities (i.e., circumstances having a disproportionate and adverse effect on particular populations as a result of bias or negative stereotyping) is part of a larger societal problem to which clinicians are not immune. Thus, as some participants noted, when clinicians focus solely on behavioral issues, they miss the importance that complex trauma factors into diagnosing, conceptualizing, and treating Black male adolescents. Therefore, it is imperative not only to discuss diversity, but clinicians must also “increase their efforts to become more
knowledgeable and less judgmental about cultural differences, while confronting the prejudices inherent in the profession” (Douglas, 1993, abstract).

**Experiences working in different treatment settings.** Clinicians interviewed for this study worked in clinics, hospitals, community clinics, correctional facilities, schools and school-based mental health programs. Although many of the participants’ responses to interview questions were consistent across settings (e.g., challenges with establishing rapport, endorsed feelings of maternal transference and protectiveness, similar methods of joining, and worry about Black male adolescents), other responses were a function of the specific setting in which the participants treated their Black male adolescent patients.

**School system.** Clinicians who work in schools discussed the challenges working with multisystems, such as school staff; the adolescent’s family; and child protective services, such as the Division of Child Protection and Permanency (DCP&P). Coordination of care is important for the success of the adolescent; however, each system may have its own goals and strategies for the adolescent’s development. Thus, getting all involved to have a unified set of goals can prove difficult. In addition to coordination, consistency among the systems in reinforcing the skills taught by the clinicians, such as assertiveness, communication techniques, and anger management, is important. Therapeutic setbacks may occur when skills taught in therapy are not reinforced by other systems, e.g., teachers and family members, in the adolescent’s life.

School clinicians noted the importance of advocacy for the Black male adolescents, particularly when they have been penalized or classified by staff although another resolution might have been more beneficial. For example, a frequently imposed consequence for behavioral infraction in school is suspension. One clinician noted how allowing adolescents to be free to roam the street might be counterproductive, as it might
promote risky behaviors, such as drug abuse and gang involvement, rather than foster positive adolescent development into adulthood. Clinicians elaborated on witnessing Black male adolescents acting out due to trauma such as not having enough to eat, physical abuse, worrying about family and finances, gang recruitment and involvement, and witnessing violence in the home or community. Some participants mentioned being excluded from meetings at schools in which their clients were discussed and needing to invite themselves so that the adolescent would have a voice in the room. When they are present at such meetings, clinicians can often provide a more complete picture of the events that may be causing the unwanted behavior and help to develop a comprehensive plan to assist their client.

**Corrections.** Clinicians in schools and corrections (e.g., juvenile detention facilities and prisons) both commented on the significance of getting to know the adolescent before focusing on the behavioral issue that resulted in the referral. Participants who worked in prisons noted the rush to judgment based on the underlying crime committed. They objected very strongly to the negative perceptions and assertions made about Black male adolescents by other staff members, such as self-harm was used as a manipulation versus a manifestation of a mental health issue, or that the adolescent would never be released. These pejorative beliefs increased the protectiveness participants felt for Black male adolescents versus adolescents of other populations.

Common themes also included feeling limited and not being able to do enough for their Black male adolescent patients. Feelings of sadness, anger, and frustration with a criminal justice system built on the mass incarceration of Black males (Alexander, 2012) was discussed by some of the participants. For this reason, providing culturally competent therapy is critical. This is consistent with the literature stressing the “urgent
need for innovative, ethnic-appropriate interventions to improve effective delivery of services to Black men” (Franklin, 1999, p. 786).

**Differences in working with Black female adolescents and other adolescent populations.** This study compared aspects of clinicians’ therapeutic experience with other adolescent populations in addition to its focus on the Black female clinician-Black male adolescent dyad. Slightly more than half of the participants noted a difference in maternal countertransference when working with Black male adolescent patients versus those of other races or ethnicities. Within this group, most participants mentioned having stronger maternal countertransference and shared experience when working with Black male adolescents; however, a few participants identified an increase in this form of countertransference toward both Black male and female adolescents. Some clinicians felt no difference in maternal countertransference across populations, which they attributed to their maternal nature or fulfilling a maternal need of the adolescent.

Most participants cited having a broader range of, and/or more intense, emotions when working with Black male adolescents versus other adolescent populations. Interestingly, the majority of clinicians felt more protective of their Black male adolescent patients. It appears that for these Black female clinicians, maternal countertransference and protectiveness are qualitatively different in their work with Black male adolescents. An increase in fear about survival, interfacing with law enforcement, over-classification, school failure, and harsher punishments led them to feel pulled to protect, and sometimes advocate for, Black male adolescents to ensure their fair treatment and continued survival.

Participants expressed worry about both Black male and female adolescents. The causes for worry were similar for both genders: survival, incarceration, and perception;
however, several participants noted that they have an increased concern for Black males than other adolescent populations including Black females. One key distinction between Black male and Black female adolescents was participants’ concern for the females’ safety. Some participants discussed concerns about their Black female adolescent patients being raped, molested, or objectified citing the Internet and social media as mediums for placing these young women at risk. As technology advances adolescents are also bombarded with stereotypical images objectifying females which can have detrimental effects. Townsend, Neilands, Thomas, & Jackson (2010) stated that critical analysis of societal messaging is essential for Black female adolescents. If this does not occur, results indicated that a strong identity may not be enough to reduce sexual risk. Thus, participants have reasonable concerns about their Black female adolescent patients “being used” by boys or, in some cases, men.

**Supervision and training when working with Black male adolescents.**

Culturally competent therapy ensures that patients receive treatment that honors and respects all aspects of their identity. In supervision, the supervisor should be mindful of the transference and countertransference reactions that arise due to the patient’s and supervisee’s backgrounds, as well as the different dynamics (e.g., parallel process) that may occur within the supervisory relationship due to the supervisor’s background. Attending to these dynamics is important in the treatment of the Black male adolescent, essential in clinical development of the supervisee, and key in the process of the supervisory relationship.

**Role as a supervisee.** In this study, the race of supervisor was closely correlated with whether racial and other multicultural issues were addressed in supervision. Participants indicated that Black supervisors regularly discussed the race of the client,
whereas most non-Black supervisors did not attend to diversity issues unless prompted by the supervisee. This difference may be attributed to the supervisor’s cultural competence, comfort discussing race, multiculturalism, privilege, implicit biases, or training on diversity.

**Role as a supervisor.** The majority of the participants in this study who have provided supervision process racial and other multicultural issues with their supervisees. Many participants process transference and countertransference reactions even when their theoretical orientation was not psychoanalytic or psychodynamic, and they do not use psychodynamic terminology in supervision. From a supervisor’s perspective, discussions concerning the patient’s and supervisee’s background and history are conducted to ensure they understand the dynamics occurring in therapy. Paying attention to what is happening in the room can inform diagnosis, case conceptualization, and treatment.

Despite most participants having addressed diversity in roles both as the supervisor and the supervisee, a few noted that the setting may influence whether cultural or racial issues are discussed. The culture at one job setting may value diversity in which processing issues within a multicultural framework is expected; and the culture at another setting may prioritize other factors, e.g., attrition rates, documentation, and safety considerations, that crowd out discussions of cultural issues. The latter is may be the case with some correctional facilities.

**Issues to consider in supervision and training when working with Black male adolescents.** It is clear that Black male adolescents present with a specific set of challenges. A wide range of issues were suggested to ensure competent supervision and training when working with this population, including the need for discussion of
(a) transference and countertransference, (b) diagnosis, (c) case conceptualizations, and (d) diversity issues specifically focused on young Black males.

Participants emphasized the importance of creating a therapeutic approach that feels real and “relatable”, which required training in how to work with the therapeutic, systemic, developmental, and trauma-related challenges faced by Black male adolescents. Countering the societal demonization of Black males could be facilitated through the education of staff and supervisees as to the context for mass incarceration, fatherlessness, and externalized behavior. Case conferences, videotapes of therapy sessions, documentaries, and literature were suggested as helpful ways in which this information may be imparted. Gordon (1993) highlighted the importance of hiring diverse staff, as a homogenous group can lend itself to exclusion despite intention. Diverse representation gives the opportunity to consult with others, fostering knowledge in the service of the clinicians and their patients.

While acknowledging the need for evaluation, participants in this study emphasized that supervision should be a safe place free from judgment where a supervisee can be honest about therapeutic experiences and what informs them. When supervisees feel safe with their supervisor, they are more inclined to engage in difficult discussions, such as those surrounding race and cultural competence, thereby promoting clinical development and benefitting patients. Countertransference reactions, related to over-identification with Black male adolescents, privilege, and biases, should be approached by supervisors with openness in the context of the supervisee’s cultural background and experiences. In addition to culturally-informed training, further factors identified as being helpful in the supervisee’s advancement of working with Black male adolescents included: (a) conceptualizing cases with multicultural considerations,
(b) modeling how to manage countertransference reactions, (c) providing empathic reflections regarding therapeutic experiences, and (d) watching video recordings or listening to audiotapes of sessions.

**Limitations of the Current Study**

The qualitative research methodology utilized in this study yielded comprehensive accounts of Black female clinicians’ experiences in therapy with Black male adolescents. Several limitations, however, should be considered in interpreting, utilizing, and applying the results obtained. Factors impacting the generalizability of the results included a small sample size and a non-random sample. With regard to sample size, participants consisted of 10 Black female clinicians derived from a networked sample affiliated with academic institutions or current employment in two northeastern states with significant urban population centers. Geography and professional affiliation may have impacted the results obtained, and may not be generalizable to the larger population of Black female clinician-Black male adolescent dyads. Additionally, because this was a qualitative study, a random sample or control group was not utilized, further impacting the generalizability of the results. It would also be helpful to broaden the sample to include clinicians working in a wider range of clinical settings. In addition, one must consider the possibility of investigator bias given that the researcher is a Black woman, who conducted the interviews, and analyzed the data.

As a qualitative study, hypotheses generated are exploratory in nature. Data analyzed and theories developed may not necessarily be used to support or challenge research conducted by others in this area of inquiry. As this study specifically examined the experiences of Black female clinicians working with Black male adolescents, the results may not be generalizable to either: (a) non-Black male adolescent patients;
(b) non-Black female clinicians working with Black male adolescents; or (c) any other race, ethnicity or gender combinations.

**Implications**

**Implications for future research.** Several implications for future qualitative and quantitative research that will build upon this study’s exploration of relational dynamics within same-race ethnic dyads are suggested. Given the limited research on same-race therapeutic dyads, this study is an important first step in adding to the literature on this subject and, more specifically, the Black female clinician-Black male adolescent therapeutic dyad. As this is the initial study examining such dyad using a qualitative analysis, replication of this study and its findings are warranted. Quantitative analyses testing the theories obtained from the data would be helpful to determine the generalizability of the results. Further, replication of the current study would also serve to reduce potential investigator bias, as discussed above, arising from her identity as a Black female clinician interested in exploring the sociopolitical and familial factors that may impact the therapeutic relationship with Black patients. Employing a diverse research team throughout the research process could moderate partiality. In addition, future studies may include a larger sample size, variability in geographic location, and additional settings to increase generalizability.

As this study focused on the cross-gender Black female clinician-Black male adolescent therapeutic relationship, future studies examining the same-gender Black female clinician-Black female adolescent dyad would add to the literature. Understanding the methods Black female clinicians use to join with Black female adolescents, transference and countertransference reactions when working with this particular population, as well as the training and supervision provided, are important areas for
future study. Comparing data obtained in this current study to results in a study of a Black female clinician-Black female adolescent dyad would illuminate similarities and differences in how the dynamics of race and gender interact in the Black female clinician-Black adolescent therapeutic relationship. It would also be important to investigate the experiences of same gender-same race Black male clinicians working with Black male adolescents in therapy.

Although some research has been conducted on cross-racial dyads (Thompson & Jenal, 1994; Thompson, Worthington & Atkinson, 1994; Zhan & Burkard, 2008), additional research is needed. Studying how race impacts treatment and the therapeutic relationship can reduce therapeutic ruptures and help clinicians engage patients with cultural sensitivity. As this current study examined the effects of the US sociopolitical landscape on the Black female clinician-Black male adolescent dyad, a worthy area for future research could explore the dynamics that emerge in treatment dyads of other racial compositions. For example, further study of Gordic’s (2014) finding that “dynamics of power and privilege permeate White therapist’s treatment of African American clients” (p. 188) is indicated.

Further, exploring whether White clinicians and those from other cultural and racial backgrounds experience maternal countertransference in cross racial therapy with Black male adolescents and the reasons for these reactions could further inform similarities and differences in unconscious motivations and affective responses experienced by clinicians of different racial groups, and address how to work with these emotions in training and supervision.

In addition, the Black female clinicians interviewed in this current study discussed a range of training and supervision techniques they have either experienced, utilized, or
recommend to be implemented. Future research could address the efficacy of different training and supervision techniques to improve treatment with Black male adolescents.

**Implications for clinicians.** The current study offers a number of implications for Black female clinicians working with Black male adolescent patients. In *Black Families in Therapy*, Boyd-Franklin (2003) described the “the therapist’s use of self and the values, perceptions, and cultural similarities and differences that have an impact on our personal frame of reference and on our work as therapists” (p. 177). Self-disclosure and use of cultural references when appropriate can be very helpful, as well as being true to oneself, which is most important (Boyd-Franklin, 2003). Similarly, in this current study, Black female clinicians’ relatedness/common experience and genuineness helped to build rapport and increase trust with Black male adolescents. Therefore, Black female clinicians should be encouraged to use their own cultural knowledge and experiences in therapy with Black male adolescents to improve treatment outcomes.

The current study also indicates the importance of consulting with other Black female clinicians. Far too often, a Black female clinician may be the only ethnic minority voice in the room. This can present challenges in trying to navigate systemic, clinical, and personal concerns. Thus, building a network of Black female clinicians offers a unique support system to encourage, educate, and empower an upward trajectory both professionally and personally.

**Implications for supervision and hiring a diverse staff.** With regard to supervision, this current study found that attending to transference-countertransference reactions in the therapeutic relationship, with considerations for the dynamics between the clinician’s and the patient’s cultural background and experiences, are key. Further, being mindful of the supervisor’s background and experiences in the supervisory
relationship and in the therapy is important to take into account. “Since Blacks are a heterogeneous group, racial attitudes may range from being extraneous to being extremely important” (Hunt, 1987, p. 116). This spectrum, ranging from disconnectedness to overidentification based on salience of racial identity, is valuable to understand within each dyad as it may impact therapy or clinical development.

Hiring diverse staff is another critical point when working with Black male adolescents. Garner (2003) argued that awareness is essential for offering culturally sensitive psychotherapy. Organizations providing psychotherapy may feel having a diverse client population is enough; however, Black female and male clinicians may provide different, important perspectives which may be unavailable when an organization is monolithic. Employing diverse staff positively impacts not only the organization, but the patient population as well. “The factor of shared race often eases the transition into treatment” (Boyd-Franklin, 2003, p. 186), and can reduce suspicion and guardedness. In addition, Black patients often ask to work with Black clinicians. With few or no Black clinicians on staff, organizations may have difficulty with Black referrals and retention (Garner, 2003).

**Implications for training.** This current study also illuminated the need for psychology training programs to hire more Black male and female professors, supervisors, and trainers to offer experiential and clinical expertise in race and cultural issues. When institutions lack diverse staff, students may be required to travel far distances to meet with qualified Black psychotherapists and supervisors with such expertise (Garner, 2003). Furthermore, Black trainees typically feel increased comfort discussing multicultural issues with other Black professionals due to a shared cultural understanding. This increased openness and realness can benefit the Black male
adolescent client; otherwise overidentification, moralization, and rescuing the patient is more likely to occur (Hunt, 1987). Exploring the trainee’s racial identity and working through cultural ideas, perceptions, and values based on that racial identity can deepen the therapy and advance cultural proficiency. In addition, as Blacks are a heterogeneous group, hiring many Black professionals allows trainees to be exposed to the diversity within the Black diaspora, offering a rich experience reflective of the Black population in the United States.

**Conclusion**

In summary, this study sought to elucidate the therapeutic experiences of Black female clinicians working with Black male adolescent clients. The areas of focus included: (a) treatment with Black male adolescents; (b) emotions experienced in the therapeutic dyad including transference and countertransference reactions; (c) comparisons to other adolescent groups; (d) differences in settings; and (e) supervision and training regarding Black male adolescents. Although some participants’ responses were consistent with the literature on Black male adolescents, the current study is likely the only study to explore the Black female clinician-Black male adolescent dyad to date, revealing a continued need for same-race ethnic research.

Throughout the study, participants highlighted the significance of understanding the challenges Black male adolescents face in the United States. With this in mind, building rapport was discussed, with client-centered and active therapeutic approaches utilized, such as (a) curiosity about adolescent interests, (b) engaging in activities, (c) listening without an agenda, (d) reframing therapy as non-punitive, and (e) humor. The interplay between gender and race in the therapeutic relationship was explored as various transference and countertransference reactions emerged in this therapeutic dyad.
BLACK FEMALE CLINICIANS’ EXPERIENCES IN THERAPY

Both maternal transference and countertransference were identified likely indicating a mutual co-occurring process. Protectiveness, urgency, and worry were cited as emotions experienced by Black female clinicians in response to the survival threat, risk of incarceration, gang involvement, school failure, and environmental concerns faced by their Black male adolescent patients. While certain relational dynamics and emotions appeared consistent across adolescent populations, some participants endorsed increased intensity and broader affect signifying a unique experience in therapy with Black male adolescents. Considering the real threats to survival, freedom, and upward mobility faced by young Black males, it is imperative that additional research is conducted to uncover innovative ways to administer quality mental health services, followed by implementation of the results of this research. Moreover, this study demonstrated the need for psychology programs to hire more Black male and female professors, supervisors, and trainers to educate trainees on multicultural issues and, more specifically, on the impact of institutional racism and bias, therapeutic challenges, and relational dynamics encountered when working with the Black male adolescent population.
References


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Wing, N. (2014). *When the media treats white suspects and killers better than Black victims*. The Huffington Post.


Appendix A: Informed Consent Agreement

Study Title: An exploratory study of black female clinicians’ experiences in therapy with black male adolescents

Invitation to Participate: You are invited to participate in a research study that is being conducted by principal investigator Erica Stewart, Psy.M, M.S, an advanced doctoral candidate in the Clinical Psychology Psy.D. program at the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University. Before you agree to participate in this study, you should know enough about it to make an informed decision. If you have any questions, ask the investigator. You should be satisfied with the answers before you agree to be in the study.

Purpose: The purpose of this study is to explore the therapeutic relationship between black female clinicians’ and their black male adolescent patients. Using a psychodynamic and multicultural lens, this study will examine if any specific relational themes emerge in this therapeutic dyad by looking at the following areas: therapeutic strategies, emotions in the therapeutic relationship, and training/supervision.

Participants: This study will use a network sample of approximately 10-20 black female clinicians who have worked with one or more black male adolescent for at least 6 months. You will only be considered for participation in this study if you return a signed consent form. There is a cap on the number of participants, as this is a small study, so the acceptance into the study is on a first come, first serve basis. That is, the first twenty participants who return their signed consent form will be offered the opportunity to participate in the study.

Procedure: If you participate in the study, you will be interviewed individually during a designated time at an agreed upon location. It is expected that the interview will take 60-120 minutes to complete. However, the length may vary greatly depending on the depth of the answers provided. With the investigator, you will discuss your experiences conducting therapy with black male adolescents including successful and unsuccessful treatments, emotions evoked when working with black male adolescents vs. other populations, and issues that have come up in supervision and training in working with this population. You may refuse to answer any questions with which you are not comfortable. If you indicate at any time that you want to stop the interview, you will be thanked for your participation and will be free to go home.

Risk/Benefit: There are minimal risks associated with your consent and participation in this research study. Talking about particular cases may create discomfort for some participants. Again, you can indicate that you would like to stop the interview at any time. Participation in this study may not benefit you directly; however you will play a major role in helping additional researchers, clinicians, and others to better understand the therapeutic relationship between black female clinicians and black male adolescent patients.

Compensation: There will be no compensation for your participation in this research study.
**Cost:** There will be no cost to you for participating in this research study.

**Confidentiality:** This research is confidential. We are asking your permission to allow me to audiotape/videotape the interview as part of the research study. If the interviews are video-recorded, recordings will include full facial features. Your name will not be attached to any of the recordings. The research records will include some information about you. This information will be stored in such a manner that some linkage between your identity and the response in the research exists. Some of the information collected about you includes: your name, age, ethnicity, and education history. Also, you will be asked to talk about patients as part of this interview. You will not be asked to disclose any confidential information about patients. Please refrain from providing identifying information. Any information that you provide which may be used to identify the patient will be removed from the transcript. Names of people and places will be replaced with pseudonyms.

Please note that we will keep information confidential by limiting individual’s access to the research data and keeping it in a secure location in the investigator’s residence. Hard copies of interview data and audiotapes will be stored in a locked filing cabinet and no one other than the investigator will have access to this information. Transcriptions will be stored on password protected computer database. In addition, you will be given an identification code and a pseudonym in which only the investigator will have access to the code key. The research team and the Institutional Review Board at Rutgers University are the only parties that will be allowed to see the data, except as may be required by law.

If a report of this study is published, or the results are presented at a professional conference, your information will be disguised to not have any identifiable information. All study data will be kept for at least three years after completion of the research, all documents with identifying information will be shredded, audio and video tapes will be erased, and any computer files will be erased by the researcher at this time.

If you have any questions or concerns about the research, you may contact me, **Erica Stewart**, at (908) 705-5474 or email me at enstewart802@gmail.com. You can also contact my dissertation faculty chairperson, **Dr. Nancy Boyd-Franklin**, at (917) 608-8894 or email boydfrank@aol.com.

If you have any questions about your rights as a research participant, you may contact the IRB Administrator at Rutgers University at:

- Rutgers University, the State University of New Jersey
- Institutional Review Board for the Protection of Human Participants
- Office of Research and Sponsored Programs
- 3 Rutgers Plaza
- New Brunswick, NJ 08901-8559
- Tel: 848-932-0150
- Email: humansubjects@orsp.rutgers.edu

I have read and understood the contents of this consent form and have received a copy of it for my files. By signing below, I consent to participate in this research project.
Appendix B: Consent to Audiotape and/or Videotape

You have already agreed to participate in a research study entitled: An exploratory study of black female clinicians’ experiences in therapy with black male adolescents, conducted by Erica Stewart, Psy.M. We are asking your permission to allow me to audiotape/videotape the interview as part of the research study. This procedure is optional; you do not have to agree to be recorded in order to participate in the main part of the study.

The recordings will be transcribed to ensure the authenticity of your responses, which is important for data analysis to ensure that information from the research study has been recorded accurately. This analysis includes reviewing the transcripts to discover common themes, similarities and differences across all participants.

The recordings will include the responses that you provide throughout the interview. Please avoid mentioning names of individuals or any identifying information of clients. Any names of people or places which are disclosed will be replaced with pseudonyms. If the interviews are video-recorded, recordings will include full facial features. We will not attach your name to any of the recordings. Instead, you will be given an identification code and a pseudonym. Only the researcher will have access to the code in a password secured database.

The investigator will keep this information confidential by limiting access to the research data. The recordings will be stored on a password protected computer and any hard copies of transcriptions will be stored in locked filing cabinet in a secure location. This information will be permanently erased and destroyed three years after the study ends.

Your signature on this form grants the investigator named above permission to record you as described above during participation in the above-referenced study. The investigator will not use the recording(s) for any other reason than that/those stated in the consent form without your written permission.

Participant (Print) ________________________________

Participant Signature ____________________________ Date _________________

Investigator Signature ___________________________ Date _________________
Appendix C: Semi-Structured Interview

Demographic Information

1. How many years have you been a practicing clinician?
2. What professional degree did you obtain (e.g., psychologist, social worker, etc.)?
3. What is your theoretical orientation? How would you label or describe the therapy you perform (e.g., psychodynamic, cognitive behavioral therapy, family systems, or other)?
4. How long have you been specifically working with black male adolescents?
5. Approximately how many black male adolescents have you worked with?
   a. What are the common reasons for referrals for black male adolescents on your caseload? Do these referrals differ from referrals of other adolescents (e.g., ethnicities, gender)?
6. What are the most common diagnoses for black males on your caseload?
   a. Do these diagnoses differ from diagnoses of other adolescents (e.g., ethnicities, gender)?
7. Do you have any children? If so, do you have a son?

Treatment

8. When you think about your black male adolescent patients, what ages come to mind?
9. In your experience, how is your therapy with black male adolescents similar or different to your work with other populations (e.g., gender, ages, races, ethnicities)?
10. Can you describe the methods you have used to join, connect or build therapeutic rapport with black male adolescents?
    a. Do you use any different methods to connect with black male adolescent patients? Please give some examples.
11. Have you had any experiences when you felt like you were successful in therapy with a black male adolescent?
    a. If yes, can you provide a case example?
    b. What thoughts did you have about the patient and the therapy?
    c. What feelings did you have about the patient and the therapy?
    d. Is this a typical reaction for you when you have a positive experience other with patients? What about with patients from other ethnic and racial backgrounds?
       i. What was similar about the experience?
       ii. What was different?
12. Have you had any experiences when you felt like you were not successful in therapy with a black male adolescent?
    a. If yes, can you provide a case example?
    b. What thoughts did you have about the patient and the therapy?
    c. What feelings did you have about the patient and the therapy?
d. Is this a typical reaction for you when you have a negative experience with other patients? What about with patients from other ethnic and racial backgrounds?
   i. What was similar about the experience?
   ii. What was different?

13. What challenges, if any, have you experienced when working with black male adolescents?

14. Do you worry about your black male adolescent patients?
   a. Do you have similar worries about black female adolescent patients?

Maternal Transference and Countertransference

15. Considering your work with black male adolescents, what emotions have been evoked?
   a. Are your reactions or emotions different with young black males verses those who are older? What ages?
   b. Are these emotions consistent with how you feel toward your work with other populations?
   c. How would you describe the different reactions or emotions that black male adolescents have had toward you as a clinician?
   d. What were the types of transference you have encountered from these patients toward you?
   e. How would you describe the different reactions or emotions that you have experienced toward your black male adolescent patients?
   f. What were the types of countertransference reactions you experienced with different black male adolescent patients?
   g. Are your reactions to black female adolescents different?
   h. Have you had the experience of feeling protective toward your black male adolescent patients?
      i. If yes, what do you think are some of the reasons why you have felt protective of them?
      ii. Is this different from the ways you have felt protective toward adolescent patients of other ethnic/racial backgrounds or adolescent female patients?
      iii. Can you give me a case example of a time when you felt protective toward a black male adolescent?
   i. Have you had the experience of feeling “maternal” toward black male adolescents?
      i. If yes, what do you think are some of the reasons why you have felt “maternal” toward them?
      ii. Is this different from the ways you have felt toward adolescent patients of other ethnic/racial backgrounds or adolescent female patients?
      iii. Can you give me a case example of a time when you felt “maternal” toward a black male adolescent?
Supervision

16. Have any of these issues been addressed by your supervisors or in your supervision of others?
17. Do you feel that any of these issues should be addressed in supervision or training?
   a. If yes, what issues?
   b. How would you address them in supervision or training?

Conclusion

18. Is there anything that has not been discussed that you would like to share with me?
19. What has been your experience of participating in this interview?

Closing Prompt

Thank you for participating in my study and sharing your experiences with me!