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# Barriers and Facilitators BIPOC Clients Encounter in Receiving Mental Health Services

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FLORIDA STATE UNIVERSITY

COLLEGE OF EDUCATION, HEALTH, AND HUMAN SCIENCES

# BARRIERS AND FACILITATORS BIPOC CLIENTS ENCOUNTER IN RECEIVING MENTAL HEALTH SERVICES

By

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A Dissertation submitted to the
Department of Human Development and Family Science
in partial fulfillment of the
requirements for the degree of
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Sapna Srivastava defended this dissertation on October 16, 2023.

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# ABSTRACT

Black, Indigenous, and people of color (BIPOC) have historically had lower return rates for psychotherapy and a higher likelihood to discontinue therapy as compared to non-Hispanic White clients. Given that premature discontinuation of psychotherapy treatment has been linked with lower rates of mental health symptom improvement, understanding factors that contribute to BIPOC client continuation and discontinuation of psychotherapy services can help mental health care clinicians improve therapy continuation rates for BIPOC clients. Existing literature has remained unclear, and results are conflicting in identifying factors that contribute to BIPOC clients continuing therapy and factors that contributed to discontinuing therapy. Much of the existing literature has focused on clinician perspectives of factors contributing to BIPOC client continuation and discontinuation, and with wide variety among BIPOC client samples, understanding broader consensus was difficult. Therefore, it was important to understand diverse BIPOC client perspectives on factors that contributed to BIPOC client continuation and discontinuation of therapy services in the U.S.

The purpose of this study was to understand, from BIPOC client experiences and perspectives, what factors contribute to continuation and discontinuation of BIPOC therapy services. Participants included 25 BIPOC-identifying individuals with current and/or previous therapy experience. Using a qualitative constructivist grounded theory methodology, participants were asked their perspectives on factors that contributed to continuation and/or discontinuation of therapy services in their experience. Results for continuation factors and discontinuation factors largely mirrored one another. Based on participant perspectives, factors such as quality of services, clinician clinical skills, clinician integration of culture, client-clinician matching, and external factors played a role in some form in both the continuation and discontinuation of

BIPOC client therapy services. Findings provide implications for clinical utilization and future research considerations to increase the continuation of therapy services for BIPOC clients, with hopes of improving the quality of mental health care services for BIPOC individuals in the U.S.

# CHAPTER 1

# INTRODUCTION

Black, Indigenous, and people of color (BIPOC) clients who have obtained mental health services have lower return rates (Arnow et al., 2007; Takeuchi et al., 1995; Wang, 2007) and a higher propensity to dropout of treatment, particularly when compared to non-Hispanic White individuals (Miranda et al., 2015; Schwarzbaum, 2004; Sue at el., 1978). This implies that BIPOC clients have encountered barriers during and/or after receiving mental health care services that hindered them from continuing treatment. As BIPOC clients have been shown to need mental health care as much as their White counterparts (General, 2001), hinderance to continuation of mental health care can result in ongoing, unaddressed mental health and relational issues for BIPOC communities as a whole. As such, it is important to better understand BIPOC client perspectives on what constitutes barriers and facilitators to mental health care continuation.

## Background

Black, Indigenous, and people of color (BIPOC) individuals have had lower rates of initial mental health service seeking, higher dropout rates (Miranda et al., 2015; Schwarzbaum, 2004; Sue et al., 1978), and lower return rates for therapy services (Arnow et al., 2007; Joiner et al., 2022; Takeuchi et al., 1995; Wang, 2007) compared to non-Hispanic White individuals (Cachelin & Streigel-Moore, 2006; General, 2001; Joiner et al., 2022). As compared to clients who completed treatment, clients who terminated mental health services prematurely were less likely to have improved (Pekarik, 1986; Prinz & Miller, 1994; Saatsi et al., 2007; Westmacott et al., 2010), and would presumably still be in need of mental health services (Kazdin et al., 1994). Since mental health services, such as marriage and

family therapy, have been shown to be effective in improving client outcomes (Shaddish et al., 1993), understanding barriers and facilitators BIPOC clients experienced in receiving mental health services is an initial step towards understanding how clinicians in the mental health care system could contribute to decreasing mental health service discontinuation rates and increasing continuation rates for BIPOC clients.

Extant research regarding barriers and facilitators to mental health care continuation for BIPOC clients showed overlap and remained unclear regarding what role these factors have played in high rates of service discontinuation as compared to White clients. Existing studies suggested that barriers to BIPOC client continuation of mental health care services included factors such as client-therapist ethnic-racial mismatch, lack of family support, stigma, and lack of therapist cultural knowledge. Similarly, while research on facilitators has remained limited, existing studies have suggested that facilitators to BIPOC client continuation of mental health care services included considerations such as client-therapist ethnic-racial match, client-therapist factors, family involvement, and clinician cultural competency. While factors constituting both barriers and facilitators to BIPOC client continuation of mental health care appeared similar, contradictions remained within the literature, creating confusion around what factors BIPOC clients believed were most relevant.

Overall, research pertaining to factors regarding mental health care continuation specifically for BIPOC clients has remained limited. Across available research, great diversity has existed between the various client samples focused upon (e.g., BIPOC LGB young adults, immigrant clients in Italy and the UK, adolescent males in a substance use recovery program, etc.), which has created difficulty in understanding what issues may be common among BIPOC client interactions with clinicians. A better understanding of potentially common issues that have

impacted continuation of mental health care services for BIPOC clients in the U.S., regardless of presenting problem, can provide clinics and clinicians with a starting point for understanding and addressing mental health care disparities. Additionally, among the existing literature, the focus remained heavily on clinician perspectives rather than client perspectives of barriers and/or facilitators to mental health care continuation. Focusing predominantly on the views of clinicians, who already hold more power than clients within therapeutic settings (Zur, 2014), provided the more privileged perspective of clinician-client interactions. Research amplifying BIPOC client perspectives on barriers and facilitators to mental health care continuation remains necessary in understanding the high rates of mental health care service discontinuation for BIPOC clients.

## Research Purpose

The purpose of this study was to give voice to Black, Indigenous, and people of color (BIPOC) clients' perspectives in understanding what prevents and contributes to the decision to continue mental health services. In further understanding BIPOC client perspectives, this study aims to understand factors that mental health clinics and clinicians can use in efforts to increase continuation and decrease dropout rates for BIPOC clients. A family systems theoretical framework (Bowen, 1966) guided semi-structured interviews conducted using a constructivist grounded theory methodological approach (Charmaz, 2014). In gaining a greater theoretical understanding of BIPOC client perspectives of barriers and facilitators to continuation and discontinuation of mental health treatment, client feedback can be used as an entry point for further research and implementation in decreasing the disparity in mental health care utilization and continuation for BIPOC clients and families in the U.S.

## Research Questions

The research questions guiding this study were:

(1) What are barriers and facilitating factors that contribute to BIPOC clients' continuation of mental health services?

(2) What are barriers and facilitating factors BIPOC clients encounter that contribute to discontinuation of mental health services?

### Definitions

This section defines frequent terms used for the purposes of this dissertation study. While much of the existing literature tended to use terms such as "dropout," "premature dropout," "attrition," "termination," and "unilateral termination" to describe the process in which the client no longer continues services, these terms tend to reflect the perspective of the clinician more so than the client. As this study focused on the client's perspective, such phrases will be encompassed in the term *discontinuation*. Similarly, terms such as "retention," "treatment participation," and "engagement" are terms often used in the literature to describe the process of clients continuing and remaining active in mental health services. Since the terms used in the literature emphasize the clinician's perspective, for the purposes of this study focused on the client's perspective, such phrases will be encompassed in the term *continuation*. Further, for the purposes of this study, the term *barrier* will be utilized to mean an obstacle or factor preventing BIPOC clients from continuing mental health services. As the opposite, the term *facilitator* will be used to depict any factor that aids in the continuation of mental health services. Additionally, in conducting the study, the term *therapy* was used with participants as a short-hand and more colloquial term for "psychotherapy" and "mental health services," thus the term was also utilized throughout the writing of this dissertation. Lastly, the term "therapist" was the more normalized

and accessible term for “psychotherapist,” or “mental health care provider,” therefore the term therapist was used with participants. However, to remain inclusive of all types and licensures of mental health care providers, the term *clinician* was used throughout the writing of this dissertation to refer to professionals who provide mental health care services.

# CHAPTER 2

# LITERATURE REVIEW

The purpose of this study was to understand the barriers and facilitators Black, Indigenous, and people of color (BIPOC) clients encounter when receiving mental health care services that impact their decision to continue or discontinue services. In this chapter, family systems theory (Bowen, 1966) will be utilized as a guiding theoretical framework. Next, an examination of existing literature regarding barriers, as well as facilitators, to BIPOC clients continuing mental health care will be presented. Lastly, an analysis of the limitations within the existing literature will be provided, emphasizing gaps the current study proposes to address.

## Theoretical Framework

In grounded theory research, the type of qualitative approach proposed for this dissertation, findings are intended to facilitate theorizing and theory (LaRossa, 2005) and an anticipated outcome of this study is a framework for better understanding barriers and facilitators to mental health care. Particularly because most research on Black, Indigenous, and people of color (BIPOC) clients' utilization of mental health services is atheoretical, a grounded theory approach stands to make an important contribution to the literature. That said, theory importantly guides research and, as such, family systems theory is described as a way of understanding client-therapist dynamics related to mental health care utilization.

### Family Systems Theory

Family Systems Theory (Bowen, 1966) is an approach to understanding the dynamics and functioning of systems by applying General System Theory (GST; von Bertalanffy, 1968). GST incorporates tenants from physics to use mechanistic models in explaining and understanding, on a microlevel via Family Systems Theory, how individuals interact and operate

within their day-to-day systems (Whitechurch & Constantine, 1993). The organization of systems is considered to be in layers based on complexity and breadth, and identified by the terms of subsystem, system, and suprasystem (Whitechurch & Constantine, 1993). A subsystem is considered a smaller part of a system, while both are considered to be encompassed by suprasystems. For example, the system between client and therapist can be looked at as a subsystem of the system of access to mental health care, which could be considered in the suprasystem of BIPOC individuals' access to resources. Within the client-clinician subsystem, clinicians are known to have greater hierarchy in their positions of power. This position of higher clinician hierarchy is also isomorphic—or a replicated process—within the extant literature on barriers and facilitators of BIPOC clients continuing therapy in which research participants are more frequently the clinicians (Choi & Gonzalez, 2005; Griffiths & Tarricone, 2017; Singer & Tummala-Narra, 2013; Untanu & Dempsey, 2018), rather than the clients (Chang & Yoon, 2011; Moore et al., 2020, Takeuchi et al., 1995).

The discrepancy in BIPOC mental health care continuation rates can be considered a feedback loop that is being maintained by predominantly negative feedback. The concept of feedback loops is heavily influenced by cybernetics and is considered a closed 'circuit' in which information is circled throughout the loop and ultimately fed back into the circuit, helping the system to regulate its own behavior (Whitechurch & Constantine, 1993). Feedback loops receive different types of feedback, positive and negative, which help the system regulate differently. Positive and negative refer not to the delineation of 'good' as positive, and 'bad' as negative, but to the relationship between the feedback and the structure of the loop (Constantine, 1986).

It is known that the overall homeostasis, or balanced state, of the suprasystem of BIPOC communities and the utilization of the mental health care system remains one where high rates of BIPOC client discontinuation of mental health services are normal. As such, we know barriers BIPOC clients encounter when receiving mental health care services act as negative feedback, meaning these barriers help maintain homeostasis of high rates of BIPOC client discontinuation of mental health services. For example, due to historically privileged access to resources such as education, there is a higher representation of White clinicians in the profession, than therapists of color. Given many BIPOC populations' historic distrust of White communities, health care providers, and mental/health care systems as a whole, much of the extant literature acknowledged the frequent differences in ethnic-racial background between client and therapist as a likely boundary serving as a barrier to continuation of services for BIPOC clients (Burkett, 2017; Chang & Yoon, 2011; Choi & Gonzalez, 2005). Thus, it is possible that the ongoing ethnic-racial differences within a majority of client-clinician dyads serves as negative feedback within the existing system. The existing system, in turn, results in consistently higher rates of BIPOC mental health service discontinuation.

Additionally, facilitators BIPOC clients encounter that contribute to continuation of mental health care services act as positive feedback to the existing homeostasis of high rates of discontinuation, and can help move the system towards creating a new state of equilibrium. In this new state of equilibrium, BIPOC clients could have similar or higher continuation rates of mental health care as compared to White clients. For example, it is possible that family support and involvement within mental health services may act as positive feedback within the feedback loop, thereby potentially increasing therapy engagement and continuation for BIPOC clients. The positive feedback of family support may also directly counteract existing negative feedback

loops, such as mental health care stigma, and may thus disrupt the existing equilibrium of high BIPOC client discontinuation rates. Thus, if negative feedback, such as mental health stigma, can be identified and decreased while identifying and increasing positive feedback, such as family involvement, a new homeostasis of increased rates of BIPOC mental health care continuation may be created and maintained.

## Barriers and Facilitating Factors Contributing to BIPOC Continuation of Mental Health Care

Research also documented some key factors that promoted Black, Indigenous, and people of color (BIPOC) continuation of mental health care. Within the extant literature, factors that contributed to BIPOC client continuation of therapy included ethnic-racial matching between the client and clinician, involvement of family, and higher levels of clinician cultural competency.

### Client-Clinician Ethnic-Racial Matching

Some studies indicated that ethnic-racial match between client and clinician appears to be related to increased continuation of mental health services (Choi & Gonzalez, 2005; Joiner et al., 2022; Takeuchi et al., 1995). In one quantitative study looking at a large sample of clients ($n$ = 2,076) from a community clinic in Florida, analyses indicated lower rates of post-intake continuation of therapy services for Black clients, who comprised 10% of the total sample, much lower than the estimated 23% of Black community members impacted by mental health issues with the county (Joiner et al., 2022). However, for Black clients who did continue therapy services, there was a significant association between higher continuation rates and being matched with a clinician of the same ethnic-racial background. In one qualitative study, clinician participants perceived that many of the elderly participants of Black and Latino racial-ethnic background frequently inquired whether or not the clinician they were recommended to meet with was of a similar ethnic-racial background (Choi & Gonzalez, 2005). The participants noted

that these elderly clients seemed pleasantly surprised when finding the clinician was of similar ethnic-racial background, as compared to the reluctance encountered upon hearing their clinician was of a different racial-ethnic background. When Chang and Yoon (2011) asked BIPOC participants—who had worked with White clinicians—to imagine how it would have felt to work with a clinician of the same ethnic-racial background, fifteen of the twenty-three participants believed ethnic-racial match with a clinician would foster a more satisfactory therapeutic experience. Similarly, a quantitative study noted that 'ethnic-specific' clinics in which a large number of BIPOC clients are seen likely had higher therapy continuation rates for BIPOC clients due to ethnic-racial match between client and clinician (Takeuchi et al., 1995). However, ethnic-racial match was not a factor specifically assessed in relation to mental health care continuation rates at 'ethnic-specific' clinics within this study and therefore was a connection made by the authors as a likely explanation of their results.

While some research indicated ethnic-racial match as a factor contributing to BIPOC client continuation of mental health services, there were other studies indicating ethnic-racial match may not impact continuation of services. In fact, one study suggested that client-therapist ethnic-racial matching might itself be a barrier to continuation. When Chang and Yoon (2011) asked BIPOC clients who had worked with a White therapist, to imagine what it would be like to work with a therapist of a similar racial-ethnic background, nine of the 23 participants imagined ethnic-racial matching with their clinician to pose a barrier in the therapeutic process. Participants feared that ethnic-racial match with their clinician could result in discrimination or stigma against their presenting issues due to commonly held cultural beliefs, or were concerned about clinician overidentifying with the client. Moreover, seven of the 23 participants noted racial-ethnic mismatch as being a component of the therapeutic process helpful in developing a

positive relationship between client and clinician, and feel they would have experienced discomfort in seeing a clinician within their own racial-ethnic group. Additionally, many participants viewed certain therapeutic characteristics or skill sets as more important than racial-ethnic match entirely, such as being compassionate, non-judgmental, caring, and being open to discussing difficult topics (Chang & Yoon, 2011). The mixed value assigned to the role of client-clinician ethnic-racial match for BIPOC clients and continuation of mental health services warrants additional research understanding BIPOC client views on racial-ethnic match between clinician and client.

**Client-Therapist Factors**

Research has shown that factors attributable specifically to the clinician and the relationship developed between BIPOC client and clinician can contribute to continuation of mental health care services (Cordaro et al., 2012; Fox et al., 2017). One qualitative study looking at factors contributing to immigrant client perspectives on completion of evidence-based treatment found that participants felt more aligned with the clinician when the clinician exhibited empathy, professionalism, flexibility, sensitivity, reliability, and cultivated a positive working relationship (Fox et al., 2017). Participants shared these clinician qualities made them feel more secure and at ease, contributing to their continued therapeutic work.

A quantitative study found that clinician warmth and friendliness, working alliance goals, and patient participation predicted intervention completion (Cordaro et al., 2012). However, this study focused specifically on predictors of program completion and dropout with adolescent males enrolled in a brief substance abuse intervention. The sample, which included 58 participants total, consisted primarily of minority adolescents between ages of 14 to 19 years ($M$ = 16.32), with 74.1% Hispanic-White participants ($n$ = 43), 17.2% African American participants

($n = 2$), and 3.4% Hispanic-Black participants ($n = 2$). The study used the Vanderbilt Psychotherapy Process Scale – Short (VPPS-S; Smith et al., 2003) to assess therapeutic alliance and client involvement, and the Working Alliance Inventory-Short (WAI-S; Horvath & Greenberg, 1989) to assess working alliance between client and clinician. Independent raters utilized audio and video of therapy sessions to code with each scale. Lastly, participants were categorized as either completing treatment, or having terminated if the client did not return after the first or second therapy session. Participants who completed treatment were compared to participants who terminated treatment. Clinician warmth and friendliness, working alliance goals, and client participation were found as significant predictors of completion status, using descriptive discriminant function analysis, and were confirmed using logistic regression analyses. However, the demographic characteristics for the comparison groups were limited, and shared variance for all measures may have been inflated due to using identical raters for the WAI-S and VPPS-S. In addition, though ethnic-racially diverse, the sample consisted specifically of adolescent males presenting for substance abuse treatment, and it is unclear if the results would hold among a sample of clients of varying ages and presenting problems.

While some client-clinician factors are shown to impact BIPOC client continuation of services, other research suggests client-clinician factors do not ultimately contribute to BIPOC client continuation of mental health services. A quantitative study comparing treatment continuation rates for a nationally representative sample presenting with depression, found that all races and ethnicities were likely to continue treatment when prescribed medication and receiving care from a specialized mental health provider (e.g., a psychiatrist, psychologist, therapist, counselor, etc.) rather than a health care professional who does not specialize in mental health (Fortuna et al., 2010). However, after adjusting for demographic characteristics and

clinical factors such as co-occurring psychiatric disorders, African American participants, who consisted of 81 of the 564 total sample, were significantly more likely to discontinue treatment when compared to non-Latino White participants. The result of higher rates of discontinuation for African American participants held true even though over 70% of African American participants received care from a mental health specialist, which was a facilitator for treatment continuation for the rest of the sample. The conflicting results around the ultimate value of client-clinician factors, as well as the various presenting problems within the samples create ambiguity around the role of client-clinician factors with regards to therapy continuation across racial-ethnic background, regardless of client presenting problem.

**Family Involvement**

Much of the extant research showed participants working with the older adult population shared that understanding the family system, cultural context, and roles of family members of the older adult in treatment, helped in managing expectations, garnering buy in from gatekeeping family members, and getting the family system involved (Choi & Gonzalez, 2005). Similarly, four of the 14 participants working as mental health clinicians with immigrants and refugees in Italy noted that establishing positive relationships with all family members and gathering family support were helpful (Griffith & Terricone, 2017). However, the four participants who reported on benefits of family support in clinical work with immigrants represented only approximately a third of the total participants of the study, leaving the consensus unclear around the role of family involvement in clinical engagement with immigrant and refugee clients. One systematic review synthesis on barriers and facilitators to Black youth and family treatment engagement noted two studies that discussed the role of parents in youth treatment engagement (Planey et al., 2017). These studies indicated that mother’s beliefs and experiences around mental health care

and engagement in her own care, serve as a mediator for child treatment engagement. However, a limitation of this study remains that the focus landed primarily on youth participants. Additionally, the systematic review synthesis was not a primary data collected study and therefore is limited in the context provided for various trends. Another study with Black and Latino LGB participants indicated that family members often served as support in seeking mental health services, as well as staying engaged in continuing services (Moore et al., 2020). This study conducted qualitative interviews with 38 participants who identified as LGB as well as Black or Latino, to understand barriers and facilitators to engagement factors in mental health services. However, while many indicated the benefit received from family support of therapy services, others noted the benefit in autonomy from the family in seeking mental health services, particularly when the family exhibits anti-LGB attitudes. Given the mixed beliefs around the role of family involvement in the continuation of mental health services, the extant literature can benefit from further understanding the impact of family involvement in the continuation of BIPOC client mental health care.

**Clinician Cultural Competency**

Within the extant research, many studies called for additional cultural competency for clinicians (Choi & Gonzalez, 2005; Untanu & Dempsey, 2018), yet few have been able to detail what constitutes cultural competency, particularly from the client perspective (Fox et al., 2017). While certain studies cited an increase in cultural competency as a factor that would contribute as a facilitator for continued BIPOC mental health care service use, not all outlined what increased cultural competency could look like (Choi & Gonzalez, 2005). Another study noted both ambiguity as well as attempted steps towards culturally competent care (Untanu & Dempsey, 2018). In this study, clinicians in the UK noted not receiving adequate training on how

to serve BIPOC clients (Untanu & Dempsey, 2018). Yet these clinicians provided specific ways in which they were competently and culturally intervening, such as understanding the individual within the context of their culture, approaching racial-ethnic related topics with openness, suspending preconceived notions and assumptions, remaining aware of differences within minority groups, and focusing on understanding meaning and impact of cultural norms from the client's perspective. Yet another study in the UK (Fox et al., 2017) succeeded at understanding perceived cultural competencies from the perspective immigrant clients who have completed evidence-based treatment within the previous twelve months. Immigrant participants felt their therapist engaged them in treatment by taking a culturally sensitive approach and understanding them from a cultural perspective, respecting any cultural differences, and considering the role of culture in difficulties (Fox et al., 2017). However, while this study had its strengths, it also had its limitations. This study included only immigrant clients born outside of the UK who completed treatment. The study therefore failed to include clients who refused or discontinued treatment, thereby missing the opportunity to capture barriers to treatment that may co-exist. Additionally, the sample excluded UK-born BIPOC clients, and therefore neglected to understand BIPOC clients' experiences as a whole. Lastly, the study limited its focus to one specific modality of treatment. Thus, research is still needed to understand BIPOC client perceptions of what constitutes clinician cultural competency.

## Barriers and Facilitating Factors Contributing to BIPOC Discontinuation of Mental Health Care

Extant research has established various factors within the therapeutic process that contribute to Black, Indigenous, and people of color (BIPOC) clients' discontinuation of mental health services (e.g., Chang & Yoon, 2011; Choi & Gonzalez, 2005; Griffiths & Terricone, 2017). These factors somewhat mirror barriers and facilitators contributing to BIPOC client

continuation of therapy, and include ethnic-racial mismatch between client and clinician, lack of family support, stigma, and clinician lack of cultural knowledge.

**Client-Clinician Ethnic-Racial Mismatch**

Studies have indicated that, according to clinicians, ethnic-racial mismatches between BIPOC clients and their clinician posed a barrier to continuing treatment (Choi & Gonzalez, 2005; Griffiths & Terricone, 2017). Although studied less frequently than clinicians' perspectives, one study compared client perspectives along with independent raters (Cheng et al., 2023), and another known study focused specifically on the clients' perspectives of the significance of client-clinician ethnic-racial background differences (Chang & Yoon, 2011). The researchers conducted semi-structured interviews with 23 BIPOC clients who had been in treatment with a White clinician within the last three years. Nineteen of the 23 participants perceived ethnic-racial mismatch between client and clinician to be a significant barrier to the therapeutic relationship. These participants believed that a White clinician could not understand their experience as a person of color, and thus frequently refrained from discussing particular racial/cultural topics with White clinicians. However, 16 participants also noted that the ethnic-racial mismatch between the client and clinician had a minimal impact on the therapeutic relationship. All 16 of these participants indicated having a satisfactory experience with their ethnic-racially mismatched clinician. Moreover, when participants in this study were invited to imagine what their experiences might have been had they seen a clinician with similar racial-ethnic background, nine believed client- clinician racial-ethnic match would create challenges within the therapeutic relationship.

Another study used both client self-report surveys and independent rater reports to explore the relationship between client-clinician ethnic-racial matching, client-therapist working

alliance, and length of psychotherapy treatment (Cheng et al., 2023). The study found that ethnic-racially matched client-therapist dyads who had been working together for three months or more were rated higher in working alliance by the independent raters, but the same result was not supported by the client self-report surveys on working alliance. Through statistical analysis, the study found that length of continuation of treatment was significantly associated with high working alliance in ethnic-racially matched client-therapist dyads. However, length of treatment continuation was not a predictor of working alliance, and there was little difference in length of treatment between ethnic-racially matched client-therapist dyads and ethnic-racially unmatched client-therapist dyads. Thus, it appeared that to outside observers, there were higher rates of alliance in racial-ethnically matched clients and therapists, but there was minimal impact on length of treatment continuation. Additionally, client-reports of working alliance with clinician differed from outside observers, and did not support the resulting positive relationship between alliance and ethnic-racial match with clinicians, thus bringing the association between independent outsider rated high alliance in matched client-therapist dyads and longer treatment continuation length into question.

Another study looking at immigrant client perceptions of Multisystemic Therapy (MST) treatment completion in the UK, found that while one immigrant participant noted it was helpful having a clinician who was also a BIPOC individual, the remaining six immigrant participants did not believe it made a difference that their clinician was of the ethnic-racial majority (Fox et al., 2017). The participants' main concern as a client was that their background, culture, and feelings be taken into account in a professional manner by the clinician. Another quantitative study looking at client satisfaction with services found no difference in likelihood of client satisfaction between ethnic-racially mismatched client-clinician dyads and those that are ethnic-

racially matched (Murphey et al., 2004). In other words, clients were equally likely to be satisfied with services across differences and similarities in racial background with clinician. Additionally, male clients with a clinician of similar racial backgrounds were more likely to report that both the client and therapist agreed to end treatment together. On the other hand, male clients with a clinician of different racial backgrounds were more likely to indicate that the therapist was the sole decision-maker in ending treatment. The authors speculated that this could be because this particular group of male clients wanted to remain in therapy longer, but the clinician deemed they had made sufficient progress. Or, more troublingly, it is possible that in these instances, BIPOC male clients were not consulted with prior to discontinuing mental health services. Given the mixed findings between client- clinician ethnic-racial mismatch, client satisfaction, and implications for treatment discontinuation, more research is needed to understand client perspectives regarding whether ethnic-racial client-clinician match in plays a role in BIPOC client continuation of mental health services.

**Lack of Family Support**

Two studies, both collected using mental health provider interviews, noted that a lack of client family support for mental health care services posed a barrier for clients continuing care (Choi & Gonzalez, 2005; Griffiths & Terricone, 2017). A study conducted by Choi and Gonzalez (2005) focused specifically on the care of older adult BIPOC individuals with interviews conducted with 18 mental health providers, 13 of whom were White. Within this study, clinicians indicated resistance to mental health care services shown by the adult children of the elderly client to be a barrier to continuation of services. The authors described various reasons for the adult child resistance, including guilt and shame for parents seeking outside help, community members finding out, or being unaware or in denial of parent’s mental decline. The

other study, by Griffiths and Terricone (2017), involved interviews with mental health clinicians in Italy on their experiences providing services to immigrants and refugee clients. Ten of the 14 clinician participants discussed difficulties in providing care to immigrant and refugee clients due to client's lack of family support. Eight of these participants noted that the clients' families lived outside of Italy. However, although clinicians' perspectives were included, it is unclear how the participants viewed the role of family support in the continuation of therapeutic services.

**Stigma**

BIPOC client perceptions of mental health and treatment have also served as a barrier to continuation of services (Choi & Gonzalez, 2005; Griffiths & Terricone, 2017). Clinicians working with BIPOC older adult clients reported that misunderstandings or lack of awareness around mental illness contributed to the shame and stigma often felt when receiving treatment, frequently leading to client discontinuation of services (Choi & Gonzalez, 2005). Clinicians shared that clients frequently became fearful of being labeled as "crazy." Additionally, clinicians reported their own assumption that clients eventually tended to encounter discomfort in the process of therapy, particularly when confronting emotions, and would tend to discontinue therapy in response. In the study conducted with Italian mental health workers, all 14 participants acknowledged that immigrant and refugee client perceptions of mental health and mental health clinicians frequently caused challenges in establishing a relationship with clients (Griffiths & Terricone, 2017).

Alternatively, another study indicated that African American participants were more likely to believe that mental health professionals could help with easing the suffering of mental illness issues, as compared to White participants (Anglin et al., 2008). In this mixed-methods study, a nationally representative sample of White and African American participants presenting

with major depressive disorder or schizophrenia were assessed on perceived potential helpfulness of professional mental health services, and perceived likelihood that mental health issues would resolve on their own. Interestingly, African American participants not only believed that mental health services were likely to help, but these participants had an even stronger belief that mental illness issues were likely to be resolved naturally. Thus, the researchers speculated that under-utilization of mental health care by African American populations may be less to do with stigma regarding mental health services, and more to do with the belief that things would likely resolve naturally. The differing perspectives on the role of stigma in continuation of mental health services and the lack of BIPOC client perspectives, indicate a need for greater understanding of clients' views of stigma towards mental health care in relation to discontinuing services.

**Clinician Lack of Cultural Knowledge**

Research focusing on the perspectives clinicians indicates a lack of cultural knowledge as a likely barrier to BIPOC client mental health care continuation (Griffiths & Terricone, 2017; Untanu & Dempsey, 2018). Two studies conducted in Europe had clinician participants who acknowledged their own lack of cultural training and knowledge as a barrier to providing quality care to clients (Griffiths & Terricone, 2017; Untanu & Dempsey, 2018). Nine of the 14 clinician participants in Italy and all of the clinicians sampled in the UK discussed being uneducated in how mental health care is perceived within specific cultural contexts. Thus, these participants felt they were not well equipped to provide services to the BIPOC populations with which they worked (Griffiths & Terricone, 2017; Untanu & Dempsey, 2018).

A quantitative study conducted with client participants in the U.S. found lack of perceived clinician cultural competence to be associated with high rates of client mental health

care discontinuation for female sexual minority clients (Anderson et al., 2019). Within this study, the Client Cultural Competency Inventory (CCCI) – Respect subscale (Switzer et al., 1998) was used to measure participant's perceptions of their mental health care clinician's cultural competency. The three-item scale included assessment around clinician respect of "beliefs, customs, and the way things are done in my family", clinician making "negative judgements about [the client] and ways in which [they] were different" from the clinician, and clinician use of understandable, everyday language (Switzer et al., 1998). However, this study remains limited in that qualifications of what constituted as culturally competent only included the items provided on the scale assessed from the perspective of a predominantly White/European American sample of 83.1% of the 278 participants. Therefore, future research is needed around Black, Indigenous, and people of color (BIPOC) client perceptions on what constitutes clinician culturally competent care, and its influence on mental health care continuation.

## Limitations of Extant Research

While researchers have examined both barriers and facilitators of Black, Indigenous, and people of color (BIPOC) client continuation of mental health services, many limitations within the literature remain. First, the studied populations, while certainly BIPOC, vary widely across backgrounds and focus on specific segments within populations (e.g., immigrant and refugee clients in Italy; geriatric BIPOC clients; BIPOC adolescent males dealing with substance abuse, etc.) that may not be generalizable to other populations. Secondly, little to no theoretical conceptualization is provided in the extant literature. Third, a few of the studies were conducted outside of the U.S., therefore the systemic nature of mental health care outlined within those studies may or may not necessarily apply to the system of mental health care established in the United States, which is the area of focus for this study. Fourth, the large overlap in presenting

themes among both barriers and facilitators in the literature creates confusion, implying facilitators predominantly as the opposite of barriers and vice-versa. Greater understanding of the full scope of each barrier and facilitator to treatment continuation remains necessary. Lastly, many studies focus primarily on the clinician perspective, with little to no integration of client perspective. Those studies that do incorporate client perspectives, are either limited to very specific populations (e.g., immigrant clients in the UK, BIPOC LGB young adults, BIPOC clients working specifically with White therapists, etc.) or primarily do so through the use of tests, assessments, and batteries. Qualitative methodologies, on the other hand, pose opportunities for rich data collection to gain depth of understanding around and organic perspectives on contextual factors that may more fully explain trends found by quantitative studies (Creswell, 1998; Glaser & Strauss, 1967). Thus, to be able to truly understand barriers and facilitators to continuation of BIPOC client services, it is necessary to conduct exploratory, qualitative research from the perspective of the client. Therefore, within the current study, the BIPOC client perspective was put at the forefront of understanding barriers and facilitators to continuation of therapy services.

Findings from this study have the potential to address the limitations existing within the reviewed literature by creating a theoretical framework based on BIPOC client perspectives on barriers and facilitators to continuing mental health services in the United States. By understanding both barriers and facilitators to mental health service continuation from a diverse BIPOC client perspective, this study elicited greater clarity around ways in which mental health clinics and clinicians can limit barriers and enhance facilitators to providing mental health care to BIPOC populations. Results from this study further delineate ways in which mental health clinicians contribute to increasing rates of mental health care service continuation for BIPOC

clients. Additionally, this study serves as a springboard from which BIPOC client perspectives can inform future research directions aimed at understanding important barriers and facilitators to mental health care continuation in greater depth.

# CHAPTER 3

# METHODS

The purpose of this study was to understand, from the clients' perspectives, what Black, Indigenous, and people of color (BIPOC) clients encountered as barriers and facilitators to mental health care continuation. This chapter begins by outlining the research questions and providing rationale for the chosen methodology. Next, an overview is provided of constructivist grounded theory methodology. Then, details are delineated around study sample, recruitment, and data collection. Lastly, specific data analysis components of constructivist grounded theory methodology are described.

## Research Questions

This study aimed to answer the following questions: 1) What are barriers and facilitating factors that contribute to BIPOC clients' continuation of mental health services? And 2) What are the barriers and facilitating factors BIPOC clients encounter that contribute to discontinuation of mental health services?

## Qualitative Methods

Extant research in understanding barriers and facilitators to mental health care continuation for Black, Indigenous, and people of color (BIPOC) clients is widespread amongst various BIPOC populations and simultaneously narrow within the segments of these various populations, with a lack of general understanding of the factors that contribute to continuation or pre-mature termination of mental health services. In addition, the extant literature remains largely atheoretical. For this reason, a grounded theory methodological approach was used to understand factors playing a role in BIPOC clients' decisions to continue or discontinue mental health care.

## Grounded Theory

Grounded theory methodology is a unique qualitative approach that serves as an inductive process for using observations within data collection as a basis for generating a theoretical approach (Creswell, 1998). Grounded theory methodology was initially established collaboratively by Glaser and Strauss in 1967, who eventually deviated from one another due to their differing beliefs in how grounded theory should be approached. Glaser took a stance with the researcher as a neutral, removed third-party collecting data, with codified methods and an empirical format echoing that of more quantitative methods (Charmaz, 2014). Alternatively, Strauss acknowledged that the researcher is unable to remain free of bias and can utilize their subjective perspectives within the emergent processes of grounded theory. Constructivist grounded theory emerged from the combination of Strauss and Glaser's early collaborative work, growing into an alternative approach accounting for multiple social realities that are co-constructed through meaningful interactions between people (Charmaz, 2014).

Constructivist grounded theorists view the previous knowledge and experiences of the researcher as a tool in co-constructing theoretical perspectives, while also emphasizing the necessity to account for researcher "position, privileges, perspective, and interactions" as part of the research reality constructions (Charmaz, 2014, p. 13). Emphasis remains on the emergence of information from data in conjunction with researcher reflexivity to inform theoretical categories. Constructivist grounded theory remains an iterative process using constant comparative analysis. Constant comparative analysis incorporates cycling between the interviews, transcribing, and analyzing data to further hone and narrow the questions asked in future interviews (Glaser & Strauss, 1967). Within the constant comparative process, codes created from initial data continue to be compared to ongoing data collected to confirm that the developed codes continue capturing

developments within the data. Constructivist grounded theory data analysis consists of initial coding, focused coding, and saturation, with focus remaining on property emergence from the data. (Charmaz, 2014).

The constructivist grounded theory methodological approach best suited this study for a number of reasons. The absence of theoretical frameworks amongst extant literature looking at barriers and facilitators of BIPOC client mental health care continuation remains a limitation of existing knowledge. Thus, a grounded theory approach can help bridge this gap in creating an initial theoretical framework helping to explain and address high BIPOC mental health discontinuation rates. Last, constructivist grounded theory is noted as being particularly beneficial in social justice related projects and addressing social issues (Charmaz, 2014). Though earlier iterations of grounded theory emphasized that data analysis be done without the presence of pre-conceived ideas (Glaser, 1978), Charmaz (2014) recognizes both the importance of keeping an open mind and that the researcher approaches the data with prior skills and ideas. Thus, the integration of reflexivity on how the researcher's past influences their interactions with the data, made constructivist grounded theory a strong approach for this study in various ways. Since the researcher is both a mental health care clinician and an academic, and interviewed client participants who were unlikely to be either of those things, it was important for the researcher to remain reflexive and aware of the likely presence of power and privilege as she interacted with both participants and the data. Additionally, the researcher is also an BIPOC individual who is also a client engaged in mental health care services. Thus, the unique emphasis of reflexivity in the constructivist grounded theory approach remained a strong methodological fit for the study.

## Participants

### Sample Criteria

The inclusion criteria for the sample were that participants had to be at least 18 years of age, identify as Black, Indigenous, and people of color (BIPOC), and/or as an ethnic minority in the United States, be proficient in English, and be currently involved in voluntary, outpatient mental health care services and/or have terminated outpatient mental health care services within the last four years. While existing studies excluded participants who have terminated mental health services more than 12 months prior (Anderson et al., 2019; Chang & Yoon, 2011; Fox et al., 2017), this resulted in either smaller sample sizes (Fox et al., 2017), a homogenous sample of predominantly White/European American participants (Anderson et al., 2019), or having benefitted from the opportunity to include participants from a larger data set (Chang & Yoon, 2011). Thus, maintaining an inclusion criteria for participants who had terminated services within the last four years allowed opportunities for higher terminated client recruitment, which was arguably the more challenging group of participants to recruit (Anderson et al., 2019).

### Sample Size and Recruitment

The researcher recruited 25 eligible participants until saturation was reached. Saturation is the process in which data are collected until data are completely captured within the existing codes, and no new theoretical categories emerge (Charmaz, 2014). Research on the process of saturation has found that, depending on the scope of inquiry, saturation could be reached with as few as 12 participants (Guest et al., 2006). Given that this study examined two facets—barriers and facilitators—from participants' perspectives, aiming for a minimum of 24 participants doubled the average number of participants upon which saturation could be reached in studies of average scope. Since the target sample was presumably difficult to access, a snowball sampling

method was utilized as part of recruitment (Atkinson & Flint, 2001). In a study testing recruitment of hard-to-reach populations, social media platforms, such as Facebook, were shown to have advantages in increasing geographical scope of sample, therefore broadening representativeness of the sample (Baltar & Brunet, 2012). Thus, the researcher recruited through social media sites including Facebook and Instagram, to conduct video interviews through the secure, HIPAA compliant Zoom web-conference platform. Additionally, this study received grant funding support of $800 from the Graduate School Spring Dissertation Award at Florida State University. Award funding was utilized towards participant compensation to aid in recruitment of BIPOC client participants, an often difficult to access population (Anderson et al., 2019). Eligible participants who fully completed both the demographics survey and interview process were compensated with a $15 gift card.

Participants were recruited via virtual flyers posted on social media (e.g., Facebook, Instagram, etc.) and recruitment continued using a snowball sampling method, which asked for participant referrals from various initial participants (Atkinson & Flint, 2001). Participants were asked to contact the researcher via email if interested in participating, or complete the demographic survey using the provided link and QR code. After completing the demographic survey, eligible participants were contacted to schedule a recorded Zoom interview.

## Data Collection

Informed consent and demographic information was obtained and semi-structured, in-depth 20-100 minute interviews were conducted with participants. These interviews focused on the client's perceptions of their mental health care experiences, what helped them continue to engage in mental health services, and what contributed to them terminating mental health services. Those who were still continuing mental health services were asked, hypothetically,

what would have contributed to them no longer continuing services. Similarly, those who terminated mental health services were asked, hypothetically, what would have contributed to them continuing services. Interviews were conducted online via recorded FSU Zoom, a secure and HIPAA Compliant version of the video-conference software.

**Demographic Characteristics**

In addition to including the informed consent, the demographic characteristics survey was distributed via Qualtrics, prior to the interview. The demographic survey included the following variables: age; gender identity; sexual orientation; income level; highest education received; religious/spiritual identification; race; ethnicity; immigrant generation (e.g., first generation American, etc.); whether they were attending therapy sessions previously, currently, or both; format(s) of therapy sessions (e.g., in-person, teletherapy, and/or phone sessions); approximate number of therapy sessions attended; approximately how long since the participant last had psychotherapy services with (each) clinician; and any known information the participant was able to provide on the therapist(s) they had seen (e.g., including race/ethnicity, clinician field/licensure type, if licensed or working to obtain full licensure, etc.).

Data were collected from a total of 25 participants. Participants ranged in age from 20 to 48 years old (average = 31.3 years). Of the participants, 36% ($n$ = 9) were men and 64% ($n$ = 16) were woman. Of the sample, 68% ($n$ = 17) self-identified as Black, 20% ($n$ = 5) self-identified as Asian, 8% ($n$ = 2) self-identified as multiracial, and 4% ($n$ = 1) identified as White. Participants self-reported how they identify ethnically, with 36% ($n$ = 9) identifying as African, 28% ($n$ = 7) identifying as African American, 8% ($n$ = 2) identifying as Caribbean, 8% ($n$ = 2) identifying as Latin, 8% ($n$ = 2) identifying as Indian, 8% ($n$ = 2) identifying as Chinese, and 4% ($n$ = 1) identifying as Filipino. In the sample, 80% ($n$ = 20) had a graduate level degree, while 20% ($n$ =

5) reported having a college degree. Current annual household income within the sample ranged from between $20,000 to over $150,000, where 32% (*n* = 8) earned between $20,000-$59,000 annually, 40% (*n* = 10) earned between $60,000-$89,000 annually, and 28% (*n* = 7) earned $90,000 or above annually. Participants fell into three categories of psychotherapy experience, with 52% (*n* =13) participating based on past therapy experience, 44% (*n* = 11) participating based on both past and current therapy experiences, and 4% (*n* = 1) participating based on current therapy experience. A summary of participants' demographic characteristics is provided in Table 1 below.

*Table 1. Participant Demographic Characteristics*

| Name | Gender Identity | Race | Ethnicity | Age | Therapy Experience |
|---|---|---|---|---|---|
| Kenneth | Man | Black | African | 29-31 | Past |
| Tonya | Woman | Black | African American | 35-37 | Past & Current |
| Nate | Man | Black | African American | 35-37 | Past & Current |
| David | Man | Black | African | 35-37 | Past & Current |
| Brandon | Man | Black | African American | 41-43 | Past |
| Ethan | Man | Black | Caribbean | 32-34 | Past & Current |
| Tim | Man | Black | African | 44-46 | Past & Current |
| Vicky | Woman | Black | African | 26-28 | Past |
| Boris | Man | Black | African | 29-31 | Current |
| Gavin | Man | Black | African | 23-25 | Past |
| Kendra | Woman | Black | African American | 32-34 | Past |
| Cassandra | Woman | Black | African | 26-28 | Past |
| Nandini | Woman | Asian | Indian | 29-31 | Past & Current |
| Tina | Woman | Black | African | 26-28 | Past |
| Denelle | Woman | Black | African American | 29-31 | Past |
| Victor | Man | Asian | Chinese | 29-31 | Past |
| Rain | Woman | Black | African | 29-31 | Past |
| Laurena | Woman | White | Latin | 20-22 | Past & Current |
| Elizabeth | Woman | Black | African American | 32-34 | Past |
| Tulsi | Woman | Asian | Indian | 32-34 | Past |
| Danica | Woman | Asian | Filipino | 29-31 | Past |
| Nia | Woman | Asian | Chinese | 23-25 | Past & Current |
| Kadeisha | Woman | Black | African American | 23-25 | Past & Current |
| Valencia | Woman | Multiracial | Caribbean | 47-49 | Past & Current |
| Kamilla | Woman | Multiracial | Latin | 23-25 | Past & Current |

In conducting participant interviews, the researcher used a semi-structured interview guide. A semi-structured interview guide allowed both a focused line of questioning for the researcher and for the participant to be the expert on the subject, infusing their own organic perspective within the openness of the questions (Leech, 2002). Grand tour questions are a type of question utilized in semi-structured interviews to help participants provide more concreteness within a broad question (Leech, 2002). Semi-structured interviews with grand-tour questions were appropriate for the current constructivist grounded theory study in that it allowed

participants space to provide their perspectives, while providing some structure around what to address. See appendix B, C, and D for sample semi-structured interview questions utilized.

## Constructivist Grounded Theory

As previously outlined, constructivist grounded theory data analysis process involves initial coding, focused coding, and saturation (Charmaz, 2014).

### Initial Coding

Coding is the process of naming data that "simultaneously categorizes, summarizes, and accounts for each piece of data" (Charmaz, 2014, p. 111). Initial coding is the beginning process of interacting with the data in which the researcher sticks closely with the data and remains open to what the data relays. Within the process of initial coding, the researcher interacted with interview transcripts line-by-line, adding labels to segments of transcripts that grounded within the data. This meant that initial codes frequently used the participants' words within the naming process and reflected data as actions. For example, when a participant described an interaction with their mental health clinician in which they were given tips and resources to help with their main issue, the resulting initial coding name was "received tips for coping."

### Focused Coding

The focused coding process began after the initial coding process. Focused coding involves using the most significant or frequent initial codes to continue sifting, synthesizing, and analyzing sizable amounts of data (Charmaz, 2014). The goal of focused coding is to assess the strength of the initial codes used in capturing emerging concepts within the data. Thus, focused codes tend to be more conceptual in nature, to better capture data in larger units. For example, a focused code of "coping tools" was used to capture additional instances in which client participants received intervention tools and tips from their mental health care clinician.

Additionally, within the focused coding process, axial coding can be utilized to create subcategories that link together concepts to form the broader focused codes (Strauss & Corbin, 1998). For instance, “gained tools, resources, and insight” was an axial code used to capture focused codes such as “coping tools”, as well as “enlightening and insightful”, and “provided resources”. However, a difference to axial coding within a constructivist grounded theory approach is that these codes continued to be emergent from the data, rather than a formal, procedural application as within Strauss and Corbin’s initial approach (Charmaz, 2014).

**Saturation**

Saturation becomes the sign at which data collection is no longer necessary, as no new theoretical insights nor novel components of the core theoretical categories emerge (Charmaz, 2014). It must be clarified that saturation is not reached after the same patterns continuously emerge in the data, but only after there are no additional properties of the similar patterns to glean from the data (Glaser, 2001). Thus, theoretical saturation occurs when both there is no emergence of new insights and when existing theoretical categories capture the entirety of data collected. Given the specificity of saturation to each study and research inquiry, it becomes difficult for researchers conducting grounded theory to anticipate the sample size needed to attain theoretical saturation (Bryman & Becker, 2012).

After the results were established, the researcher conducted member checks in order to help establish trustworthiness within the data. That is, the results were provided to select participants to assess their agreement with, or suggestions for how representative the results felt of the perspective they shared. The researcher conducted six member checks, four who fell into the ‘past’ category having terminated therapy within the past four years, and two who fell into

the ‘both’ category of both having terminated therapy within the past four years and being actively engaged in therapy at the time of participation.

This study aimed to understand BIPOC client perspectives on mental health care continuation using a grounded theory methodological approach. The constructivist grounded theory approach fit the research questions by adding to the theoretical frameworks lacking in the existing literature and emphasized reflexivity in researcher interactions with participants and the data. Participants were at least 18 years old, and were either currently receiving mental health care, previously discontinued mental health care services within the last four years, or both. A total of 25 participants were recruited through social media platforms and interviewed online via FSU Zoom. Data were analyzed consistent with a constructivist grounded theory approach using initial coding, focused coding, and saturation.

# CHAPTER 4

# RESULTS

The purpose of the current study was to understand, from a BIPOC client perspective, what barriers and facilitating factors contribute to BIPOC client continuation and discontinuation of psychotherapy services. Semi-structured interviews were conducted with participants who identify as BIPOC and who had either previously been in therapy, were currently in therapy, or both. The results of the interviews are described in this chapter.

## Research Question 1: What are barriers and facilitating factors that contribute to BIPOC clients' continuation of mental health services?

Through axial coding, five primary themes were identified as factors that contributed to BIPOC clients' continuation of psychotherapy services: (1) *Takeaways*, (2) *Integrating culture*, (3) *Similarities with clinician*, (4) *Clinical skills*, and (5) *Better than alternatives*. Within each theme, subthemes further expand on participants' perspectives on what helped in continuing mental health services. The theme *takeaways* included three subthemes of (a) *positive and helpful sessions*, (b) *noticing progress*, (c) *insight, tools, and resources*. The second theme, *integrating culture*, included three subthemes of (a) *multidimensional individuals*, (b) *cultural sensitivity*, and (c) *BIPOC specific experiences*. The third theme, *similarities with clinician*, was comprised of the two subthemes (a) *identity overlap*, and (b) *similarities increase connection and understanding*. For the fourth theme of *clinical skills*, the three subthemes involved were (a) *genuine care*, (b) *prioritizing needs and safety*, and (c) *feedback opportunities*. The fifth and final theme of *better than* alternatives was comprised of two subthemes: (a) *ongoing need*, and (b) *avoiding restarting*. The themes and subthemes helped illuminate BIPOC client perspectives and preferences that helped in continuing therapy based on their experiences within mental health services.

### Theme 1: Takeaways

The first theme of gaining *takeaways* as a factor that helped BIPOC client participants continue therapy services was further detailed as experiencing *positive and helpful sessions*, *noticing progress*, and gaining *insight, tools, and resources*.

**Positive and helpful sessions.** Multiple participants reported having an overall positive therapeutic experience, many sharing an overall sense of satisfaction with services. Kadeisha said, “I don't know if I had any negatives. I always felt very satisfied with the way things were going and how sessions went.” Others shared that the sessions were helpful in being heard, in convenience, in managing the issues they were dealing with, and having gotten what they had hoped for out of the experience. Another participant (Kendra) shared, “It was helpful to have the same space to process and feel like I was getting what I needed.” Some relayed that the overall experience was positive and helpful, even if the experience still fell short of their overall hopes and expectations for the sessions. Elizabeth discussed this being true of her experience, “I believe it was positive. I learned a few things about myself with her, but I don't feel it was as transformational [as a prior therapy experience].” Participants, such as Elizabeth, valued having a positive experience with some takeaways, even if they had experienced more transcendent therapy experiences previously.

**Noticing progress.** Making noticeable progress was a takeaway that helped participants continue therapy. Some discussed the benefit of tangible changes resulting from therapy and felt encouraged and hopeful in seeing their progress, including instances in which physical manifestations of therapeutic work in their home served as reminders of the positive impact of current therapy sessions. Others shared that making progress in multiple areas of life was steady,

constant, and felt able to resolve issues cropping up across multiple areas. Danica shared her experience of this:

> I think one of the things that kept me going was the fact that every other aspect of my life, I felt like we knocked it out, like work-life balance, career, all of the other anxieties I have, all those kind of smaller issues, we were able to talk through and address, and, it's not like it was a checkbox, but it was like that stuff was able to resolve, and I was able to apply the different things I learned much quicker, and it felt like it was just constant, you know, I just felt like I was progressing.

Participants, such as Danica, were able to notice progress, changes, and/or resolution in various areas of their life that made continuing therapy sessions feel encouraging.

A few participants also described an appreciation and desire for therapists to challenge them, particularly in a way that was still empathic, but helped them to grow. Denelle described this as a particular takeaway from her sessions:

> She would challenge me…like expanding my thinking essentially, expanding my ability to express things I guess at a deeper level. Really challenged me to pinpoint exactly how I felt about certain things, which was a pretty big challenge for me. So, I really liked that about her. And she was really very validating…but she balanced that really well with getting me to think about my involvement in certain situations, and how I might be contributing to certain cycles and things like that. So validating and challenging is a good way to put it.

Participants also expressed appreciation in feeling their therapist was interested in contributing to their growth and process of change. Nia is one such participant, who shared:

> [Being challenged by clinician] actually, feels great and like refreshing. This is what I want, because I ‘wanna change. I'm not doing therapy just to have a person sitting across the room be like, “Yeah, I heard you. That must be hard.” That's not what I'm looking for, and I think [my therapist is] not like that. I can see that she wants to see me change. And, yeah, I think that's really important.

As Nia shared above, she values good listening and being validated and understood, but reiterated that she desired more than validation from sessions and appreciated when the therapist participated in sessions in ways that supported creating change.

**Insight, tools, and resources.** Participants shared an appreciation for increased insight and awareness gained through therapy sessions. Gaining more insight that leads to growth and “feeling enlightened” was something that was valued and kept participants invested in continuing therapy services. Danica exemplified valuing enlightenment when she said:

> So, I think that's why I went as long as I did, because, even within those first three months, it was like again, kind of feeling like I'm having these epiphanies and realizations and feeling like I have this new level of awareness.

Participants discussed appreciating when the therapeutic process supports them in gaining new insight to help them get closer to where they want to be, what they want to do, and who they want to become. The process of getting to their desired point for participants can involve gaining new perspectives and helpful tools from their sessions and clinicians.

Participants also shared valuing gaining tips and tools for coping with the issue(s) of focus during sessions. Some discussed receiving exercises and coping mechanisms to deal with issues such as anxiety and trauma responses. This was supported by Victor’s experience:

> So, my main reason for therapy for that time was to kind of cope with some anxiety and some stress, and the therapist focused a lot on the kind of the behavioral part of it. And gave me a lot of like tips, for like relaxation, and how to cope with like anxiety and stress.

Participants shared feeling supported and appreciating concrete usable takeaways that could help with the issues brought up during sessions.

Participants also indicated that receiving tasks or homework to engage in between sessions was helpful in deepening and applying the gains they experienced during session. Participants shared how homework gave them more to engage in and therefore retain from what was discussed during sessions. Some participants also highlighted how they valued their therapist's ability to share and provide resources that the client could utilize as helpful to them. These resources could be in the form of handouts, groups to join, or apps to try. Victor shared: "I do remember him sharing several other resources I can connect to. Oh, and also, he gave me some like relaxation app that I could download and use, and I think I did try it, and it was helpful." Participants also expressed valuing not only receiving thoughtful and relevant recommendations, but when therapists also followed up with the participant to see how the experience of the recommendation went for them. Kadeisha shared:

> And then another thing that they did well, that was a positive, they would ask me like just 'kinda check in with me. If they would recommend something, and maybe this is common practice, but they would just, you know, 'how did that work, or how did that feel?'

She went on to share that she had experienced these helpful recommendations in multiple therapy experiences and appreciated it each time.

**Theme 2: Integrating Culture**

The theme of integrating culture includes participants sharing a preference of being acknowledged as *multidimensional individuals*, discussions being addressed with *cultural sensitivity*, and with the ability and space given to address *BIPOC specific experiences*.

**Multidimensional individuals.** Participants discussed the expansive nature of their identities and how certain components of identity are just one part of the picture. There was a preference among participants for not only marginalized components of identity to be acknowledged, but also the full spectrum of human identity to be acknowledged beyond those identities that are historically marginalized. Tonya outlined this:

> I would say, even though I have this identity of being Black and being a woman, I have all these other identities, and so I don't necessarily think it's helpful to just pigeonhole people into these really specific aspects of other identity. For example, if I come in as a Black woman to therapy, then you think, okay, "*Black* woman. Black *woman,*" like doing the emphasis on one of these two as opposed to seeing me as a fully-fledged spectrum of a human.

She goes on to share that any narrowing down of her experience to being Black, being a woman, or being a Black woman can be unhelpful and limiting of her experience and humanity.

Participants also emphasized the need to allow BIPOC clients to be the expert on their own stressors and experiences. Because those with BIPOC identities experience so many additional factors and stressors, whether the therapist is BIPOC or not, it is important to allow the client to be the one to determine their needs and desires for processing when it comes to their experiences in a BIPOC body. Elizabeth shares:

> …Whether it's COVID-19 disparities, whether it's the murders of Black bodies in the last few years, I'm sure they may not understand if they're not person of color, they may not understand what that feels like and what microaggressions feel like in the workplace, and about how to provide support with that.

One way in which participants discussed therapists could support BIPOC clients is by honoring their unique perspectives and impacts from their experiences as a BIPOC individual. Similarly, participants discussed the need for acknowledging the individual nuance in each client's experience within their cultural contexts, particularly when considering treatment options. Rather than utilizing a more formulaic treatment based solely on the presenting problem, addressing the individual context and needs of each client specifically is preferred. Nia said this:

> But at the end of the day, they are individuals, and they all come in with very different experiences, and I think you just have to really think about what is the best for that person and you have to meet them where they are.

Meeting clients where they are is one way in which many participants believe therapists can better acknowledge the nuances in clients' individual experiences.

**Cultural sensitivity.** Participants spoke about the importance of acknowledging intersectional identities and subsequent experiences, being able to understand clients' cultural experiences and references without much explanation, and regardless of identity, taking the time to understand the full historical context of the clients. For instance, Tonya expressed:

> I would encourage these mental health professionals or the mental health field to take the time to understand the history and the current context of these different communities who you're offering services to, and that includes not just how these communities have engaged with mental health services, or like the very narrow understanding of these

communities and how they intersect with this profession or the services, but then also their historical context, their cultural context, the struggles they've experienced collectively. And then also some of the more individual kinds of issues that have come up in these communities.

She relayed an example she heard on a podcast in which the Black woman host learned, from her White woman therapist, about origins of intergenerational trauma stemming from the interactions between slave owners and enslaved ancestors. This example was shared as the perceived gold standard for being culturally informed, grounded, sensitive, and competent as a therapist, regardless of your identity.

Additionally other participants expressed a preference for therapists being upfront in naming their level of comfort or discomfort in working with BIPOC clients in a culturally sensitive way. Some BIPOC clients noted that they can sense discomfort from therapists who may be overthinking their words and actions in session. By overtly acknowledging their level of discomfort or comfort, therapists would help in creating a safer and more culturally sensitive space, rather than covertly conducting sessions from a place of discomfort and possibly doing harm as a result. Kayla shared:

> I think for whatever reason, I could just tell when they have not had experience. I think I'm able to notice it because I do it myself. When I'm not in my comfort zone. It's just like, 'Oh, like am I saying the right thing?' Or just over analyzing things. Like, 'it's okay.' So, I guess to kind of make this concrete, which is difficult for me to do, but I think just acknowledging that if something is a weak spot for you.

Being upfront in acknowledging areas of cultural growth and/or discomfort can help in fostering more trust and safety during the session.

Another form of cultural sensitivity noted by participants is consistently integrating and weaving conversations around systemic and BIPOC experiences throughout the course of sessions. Rather than the topic of BIPOC experiences being one component that's discussed once and never brought up again, instead is something that's consistently interwoven throughout sessions, particularly when the client touches on it. Victor discussed this when saying:

> I think it's the like the ongoing conversations and the awareness of like systemic issues and, you know, what it means to be BIPOC living in United States, and I think I would like the therapists, and I mean I would like myself to have that as an ongoing conversation, not just like the first session you talk about it, and then like you just put it aside and never bring it up again. And I think it needs to be an ongoing conversation, and I think, as a therapist myself, and as a client, I think that really matters, because, again, I see it as a lot of mental health issues are related to those contextual factors and your identity. And that's the way that I see and I think that's how I experience it.

Acknowledging the contextual factors related to identity, while perhaps not focusing solely on it, but incorporating it throughout sessions so that it is consistently acknowledged was a preference for many participants. Some shared that there is a hope and expectation that space will be made to be able to discuss identity as well as intersections of identity, and the impact that has on what is being brought up in session. Some participants also highlighted the preference of their clinician being overtly social-justice oriented and anti-racist and bringing those stances into therapeutic work with BIPOC clients.

**BIPOC specific experiences.** Participants acknowledged an appreciation for clinicians who were able to address BIPOC specific experiences well. This involves being able to address, process through, and unpack experiences that are specific to BIPOC individuals in a way that is helpful, empathetic, and natural. Danica says:

> I know that she just did a good job of… I don't know if I made this up... but I just know, she did well with me, just really addressing the fact that I was like the child of immigrants. So, I don't know if she herself was first or second generation, or what, but she did a really good job with that, and again, I don't know if she ever actually said that she was, but it just felt like she was able to address that really well!

Participants also valued and recommended seeing a social-justice oriented therapist who works with and can discuss BIPOC client experiences. Seeing a clinician experienced in working with BIPOC clients would involve being able to discuss their racial and ethnic experiences with their therapist during their sessions. Victor shared:

> So, at the end, I hope everyone can find themselves a therapist who can talk about their racial experience, ethnic experience. And I think, as a client, maybe when you look up therapists, do you pay attention to are they orienting themselves to be socially-just, are they very explicitly talking about working with BIPOC clients, those are some things to pay attention to when they find a therapist.

The ultimate hope was to be able to have open discussions about race, ethnicity, and identity with clinicians, which can involve intentionality in choosing the clinician initially.

There was also a preference among participants for clinicians to understand additional stressors, trauma, and complexities with identity that BIPOC clients' experiences. According to participants, it would be ideal for clinicians to understand how much day-to-day stress BIPOC

people in the US experience, and how baseline stress levels can often be higher as a result. Participants indicated that clinicians should understand and acknowledge stress can often be compounded as a result of navigating life in a BIPOC body. Nia shared:

> Like, well, I have trauma. Right, like this, just like being a person of color, living in the United States, you inherently have trouble, and you inherently are consumed by who you are and your identity in this society all the time. And I feel like you have to get that, like you need to understand now that is what your client is going through.

Participants described a hypervigilance that tends to occur on a daily basis that they want to be assured a clinician they work with can understand, honor, and integrate it into therapeutic work.

Participants also shared a preference for the clinician to initiate conversations around cultural differences and name it when it may be playing a role in session interactions. Naming differences between clients and clinicians includes racial differences, as well as ethnic differences. One participant, Kendra, shared her appreciation for her therapist acknowledging the "heterogeneity within Blackness" by acknowledging that she, the therapist, is African, while Kendra is African American. Kendra discussed:

> But then we talked, I don't know if it was that conversation or later, about her being African, you know, like, like being an African immigrant, and me being African American, and how like if, if I felt like there was some disconnect in her understanding me, which I'm like, there's a tiny bit but it wasn't—but even the fact that we had that conversation. Like we're still Black, but we have different experiences.

Participants appreciated the clinician being the one to bring up conversations about differences between them and the client, including and especially cultural, racial, and ethnic differences, even if there is overlap between client and therapist in any of those areas.

### Theme 3: Similarities with Clinician

Within this theme, participants discussed a preference for some form of *identity overlap* with clinicians, and feeling that experiencing *similarities increase[d] connection and understanding* in their interactions with clinicians during sessions.

**Identity overlap.** Participants expressed interest in clinicians with shared components of identity, be it race, ethnicity, gender, or age. Many participants, particularly female participants, expressed a strong preference for a woman clinician at minimum, one (Elizabeth) even expressed that not having a woman clinician was a "dealbreaker". Others had more specific preferences in their clinician's identities, preferring specifically shared identities (e.g., a Black woman clinician), but being open to seeing a woman of color clinician as well. Kendra shared this specifically: "Actually, I reached out to an Asian woman. A woman of color, I preferred a Black woman…". Other participants, after experiences with clinicians in which there was little to no overlap in their identities, were very particular about wanting a clinician with multiple intersections of shared identities. Tonya felt this way in saying, "I was looking for a Black woman, as I mentioned, because I wanted to work with someone who I felt like shared my identities or several of my identities." There was a strong preference for a clinician who not only shared multiple intersections of identities, but also life experiences.

**Similarities increase connection and understanding.** Participants shared that having similarities in common with their clinicians—be it in age, gender identity, race, ethnicity, and/or life experiences—positively impacted the safety, comfort, openness, understanding and connection they felt they share with their therapist. As an example, Elizabeth acknowledged the benefit of having a clinician of the same race: "For me, it was good that we were the same race. I

felt that connection, so it felt like a safe space." Participants valued the ease and relief of seeing a clinician who understands their cultural norms. Tulsi shared her experience:

> …Going to someone South Asian immediately brought me a sense of comfort and then on top of it was someone who actually understands like basic cultural norms that come up in the South Asian culture. And so that was the experience that I was just like, 'cool, I am not 'gonna go to someone who just doesn't understand that ever again.'

Participants also indicated that having some level of a shared experience or identity with their therapist allowed certain topics to be more easily open to discussion and connection. Victor indicated:

> I think knowing that he was Hispanic, I think I did feel like, 'oh, maybe since I also speak a different language,' I think at that time was like, 'Oh, I could share more about my experience,' I think, knowing that he has that background.

Having some identities or experiences in common with clinicians created an added sense of safety, comfort, connection, and depth to sessions for participants.

Participants also discussed gaining helpful perspectives from clinicians who shared their similar personal experiences. Elizabeth discussed really appreciating connecting with her clinician on both being first generation in immigrant families in the U.S. She shared:

> …The things that I was sharing with him he was able to find clarity based upon his own family dynamic, things that had happened with his sister and what worked and what didn't work, and he gave very tangible advice that I still use to this day and when I'm not talking to some of my family members.

One thing noted in learning from similar life experiences from clinicians was that participants appreciated that clinicians seemed able to share relevant information without switching the conversation around to be about the clinician's experience over the client's experience.

Other participants indicated appreciating having multiple layers of similarities both in identities and experiences with their clinician(s). Kadeisha exemplified this in sharing:

> In each of my individual experiences they were Black women in graduate programs, so they had graduate school experience, so they were able to understand on a different level what I was going through being in [a southern state]. So that really made the experience.

Resoundingly, having commonalities with clinicians and the benefits they experienced from that, was a theme that came up frequently among participants as a factor that has positively influenced their therapy experience, and contributed to continuing sessions.

**Theme Four: Clinical Skills**

Participants discussed the actions they encountered with clinicians that they preferred and helped in deciding to continue sessions. Participants shared experiencing *genuine care* from clinicians that helped them feel human, expressed valuing when clinicians *prioritized their needs and safety* within sessions and remained flexible in valuing what they as the client preferred. Participants also shared the benefits of clinician-initiated *feedback opportunities* in which they had the opportunity to provide feedback, but not the onus of initiating that conversation.

**Genuine care.** The subtheme of genuine care arose in many ways, including in feeling genuine care and empathy from their clinician, not in an obligatory way, but in a way in which the client can sense the clinician genuinely means it. Nia shared:

> She was just really so personable, and she really made me feel like she cared for me as a person, and she cared for who I am. That was really important. I think, very helpful.

Participants also shared feeling genuine care when clinicians prompted clients to engage in self-care and kept accountability in doing so. Additionally, participants noted feeling cared for when clinicians tracked topics during session in which they circled back, made connections to, and further processed in subsequent sessions. Another way in which clients shared feeling genuine care and empathy from clinicians was being able to laugh together genuinely, in a way that was a give and take. Tonya shared this process from her experience:

> I think [I've felt the therapist's genuine care from] also the elements around those specific moments, like, so we've taken the time to build rapport. There are moments where we're able to laugh together. It's very important to me to be able to laugh with my therapist, because even if I'm expressing something negative that's happened to me, I will say it in a humorous way, as a form of processing, or whatever.

Participants also widely acknowledged feeling genuine care from their therapist from a sense of feeling heard, feeling their clinician was kind-hearted, patient, warm, encouraging, personable, accessible, and caring. Participants shared that they felt those qualities from instances such as the clinician checking in with client and their emotional state prior to ending session, and allowing plenty of time and space for any stronger emotional responses, without making it feel like a big deal.

**Prioritizing needs and safety.** Participants discussed an overarching theme of clinicians prioritizing what they, the client, needed and preferred to share and discuss over the course of sessions. Participants shared an emphasis on appreciating the clinician allowing them to share components of their lives at their own pace, rather than feeling forced to share, and working alongside each other over the course of sessions. Tonya further shared the example how her current therapist set the tone for allowing her to share at her pace from the first session:

> I was told, 'I will find out the things that are important to you, and important to your life story over the course of these sessions as we go on, so there's no need to tell me anything that you don't want to tell me, both now and in the future. So, you're open to just share whatever you want to share.'

Another participant (Elizabeth) shared her experience with her clinician: "And she wasn't pushy for anything it's just more so… 'what's going on? How do you want to share?' So, she felt very inviting." A commonality among participants' experiences was the clinician staying open to what the client wanted to share and when.

Participants also discussed how their clinicians created a safe space during sessions for them as clients to feel open and vulnerable in sharing. Participants described safety fostered by building rapport with their clinician over time contributed to feeling safe in being open and vulnerable, as well being given the option to share vulnerable topics at the client's pace and comfort level. Tonya shared that she was given the option on whether or not she wanted to go into a sensitive topic, and upon declining the first time, shared: "The second time it came up I was like, 'well, I might as well talk about it, cause it's 'gonna keep coming up, and I feel comfortable enough with her to go into that vulnerable aspect'." Being given the option of being allowed to share only when she was ready supported Tonya in eventually feeling safe to be vulnerable during session. Additional ways in which participants discussed clinicians made clients feel comfortable and safe in being vulnerable and sharing included being reassured of session privacy, feeling able to be open, and feeling as though the clinician is fully open to hearing all that the client has to share. Kendra shared ways in which she felt her clinician made sessions a safe space: "I think the transparency and then the non-defensiveness, and also the curiosity into my experience was really helpful in making it a safe space." Participants shared

feeling their needs and safety would be prioritized if clinicians could meet them where they are and allow clients to express themselves freely and without judgment. Nia reiterated clinicians being open to participants in sharing her perspective: “But I think at the end of the day realize that it is a human sitting in front of you, right? Just let them be who they are.” Clinicians meeting clients where they are and as they are had been felt by participants as a way in which clinicians would prioritize both client needs and safety simultaneously.

**Feedback opportunities.** Many participants expressed appreciation for and wished that clinicians would initiate soliciting client feedback about how sessions are going. For Tonya, this was a tool that their clinician implemented more after the participant expressed having a negative reaction during and proceeding a previous session. However, she wished seeking feedback had been a consistent process during sessions:

> I think that if there was a more structured approach in our sessions, that I knew he was going to check in on a regular basis, so I would have those opportunities to bring something up, if something had happened that I could talk about or share with him, that would have been helpful.

Tonya reflected that the uncomfortable process of bringing up negative feedback to her clinician would have been easier if she knew there was a built-in structure in which she would be asked for her feedback. Similarly, Kadeisha shared having experiences in which her feedback on sessions was requested at least twice from the clinicians she saw. Kadeisha shared how being asked for her feedback impacted her perception of sessions:

> I guess it let me know, and again [asking for feedback is] probably just a part of their job, but just letting me know that they were actually hearing me, validating me, and like

trying to help me find solutions. So just like very proactive and, you know, action oriented. They were there for support.

Clinicians initiating seeking feedback on sessions from their clients adds to the safety and support that participants experienced or wish they had experienced.

**Theme 5: Better Than Alternatives**

Another factor participants shared plays a role in continuing therapy is that continuing is better than the alternatives of stopping or having a gap in care. Participants discussed continuing due having an *ongoing need* for services, as well as *avoiding restarting* therapy services with an unknown new therapist.

**Ongoing need.** Another trend that participants shared was continuing therapy due to ongoing need, for a variety of reasons. Dealing with a variety of ongoing external stressors contributed to an ongoing need for Nia, who shared:

> Family life has been like shit lately… a lot of external factors in my life that have been like—work also has been crazy. I would go through the week thinking, I'm 'gonna have so much I need to talk to my therapist about. Yeah, so definitely like, I feel like a lot has happened lately.

Some participants felt they still had more to process with their clinician, but felt as though they had to choose between quality of services or being able to afford to continue. Danica, shared that there were still significant experiences from her past that she still needed to process, stating: "Yeah, even though I felt good day to day that aspect of my life again, still haven't fully processed [prior trauma] and still trying to cope with it, I guess." Others still felt satisfied with services, and recognized their ongoing need for therapy, thus felt it easy to continue sessions. Kadeisha said: "I was happy with the services that I was receiving, and I knew I was at a place

where I really needed it so that 'kinda helped me keep going. So, it helped." The need for additional services, whether the services were satisfactory or not, played a role in participants continuing therapy.

**Avoiding restarting.** For some participants, they noted struggling with not being entirely satisfied with the therapy services they were receiving, but knowing the process of finding a new clinician and starting over is exhausting. Nia discussed the exhaustion of the idea of starting over:

> …Going through the same thing, having to unpack your life story again and again like, knowing that you still need help, but you'll have to go through this process another time, you know, it would make me wonder, 'okay, maybe I should actually stay with the therapist?'

These participants were weighing the options and considering whether or not it would be worthwhile to start over with another clinician whose quality would also be unknown. Victor shared his experience:

> Knowing that it would be hard to find a new [therapist] like if I discontinue, I have to go through the whole process and I don't know who or what the next person is going to be like. So, for me, even though I thought 'oh, it could be better,' but it's like is it worth me discontinuing and re-starting the process?

Participants discussed that even though they would feel unsure about the quality of services at times, the uncertainty of if a new experience would be any better and the labor of starting from all over again with a new therapist, helped them decide to continue therapy services.

Participants shared factors that helped them in continuing therapy included gaining takeaways from sessions like noticing progress, clinicians integrating culture and being able to

acknowledge client multidimensionality, having similarities in identities and life experiences with clinicians, clinician's skills such as creating safety and showing care, and recognizing continuing is better than the alternative of not having services or restarting with a new clinician. From participants' perspectives, these factors played a role their decision to continue therapy.

### Research Question 2: What are barriers and facilitating factors BIPOC clients encounter that contribute to discontinuation of mental health services?

Alongside inquiring after factors that contributed to continuing therapy, this study also identified BIPOC clients' perspectives on factors that contributed to discontinuing therapy. Five themes were discussed by participants, including (1) *unsatisfactory services*, (2) *disconnection*, (3) *clinician mismatch*, (4) *inaccessibility of services*, and (5) *well and connected enough*. Each of these themes is further comprised of subthemes that further illuminate ways in which each factor contributed to discontinuing therapy.

Within the theme of *unsatisfactory services* were subthemes of (a) *low quality services*, and (b) *stagnant sessions*. The second theme of *disconnection* was further broken down into the three subthemes of (a) *clinician disconnect*, (b) *clinician-cultural disconnect*, and (c) *(virtual) format disconnect*. The third theme of *clinician mismatch* is comprised of three subthemes of (a) *missing desired overlap*, (b) *lacking preferred fit*, and (c) *limitations to matching*. The fourth theme, *inaccessibility of services*, included three subthemes of (a) *scheduling difficulties*, (b) *monetary expense*, (c) *clinician unable to continue*. The fifth theme, *well and connected enough*, includes two subthemes: (a) *better enough* and (b) *enough resources*. Each of these themes and subthemes are detailed further in this section.

### Theme 1: Unsatisfactory Services

Participants shared feeling more inclined to discontinue services when they were unsatisfactory. Participants described services as unsatisfactory when they were of *low quality* and unhelpful and having experienced *sessions stagnating*.

**Low quality services.** Participants agreed that effectiveness of therapy services was one of the key factors in deciding to continue or discontinue therapy sessions. David shared: "How well I do from therapy matters. If I am not feeling better, what is the point [of continuing]?" Participants shared a lack of impact from therapy services on symptoms and wellbeing made them question if sessions were even working and as a result, if sessions were worthwhile continuing. Additionally, low quality services made it easy to decide to stop therapy, particularly if there was concern of sessions doing further harm or damage. One participant (Kendra) noted: "It was probably better [to have stopped couple's therapy]." She goes on to share that she felt that couple's therapy sessions were lacking a systemic approach, saying: "It just felt hypervigilant, and not systemic, hyper-focused and not systemic." Some participants shared concern about the competence of some of the clinicians they had encountered, with more specific concerns around proper assessment, and failing to take in the fuller context and picture of the presenting problems. Additional participant concerns around quality of services included feeling defensive in interactions with their therapists, wishing better and more thought-provoking questions were being asked, and wishing the therapist took a more active role in intervening over allowing client to largely self-process. Some participants expressed no longer looking forward to therapy sessions anymore, which was supported by Tulsi's experience: "I think I just kind of avoided going in…'cause it was just like I just didn't 'wanna deal with it at that point." Participants expressed a sense of wanting to avoid sessions, even if they had previously enjoyed

therapy experiences. Participants also shared feeling they were no longer getting as much out of sessions.

**Stagnant sessions.** Participants expressed wanting more from sessions, which included more benefit in the form of added perspective, frequent challenging, and more thought-provoking and exploratory questions. Participants shared that when they no longer felt they were growing and progressing from sessions is when they considered discontinuing sessions. Tonya said: “[Sessions were not supporting] …getting a grip on how I can move forward as a person, or how it could reflect internally and improve my internal self.” There was a lack of movement in the direction that the participant had hoped sessions would go in towards supporting growth and progress. This experience was supported by Brandon, who said: “I was not learning or anything like that. Nothing different. So I did not want to move forward any longer.” A lack of growth and progress from sessions factored into the decision to discontinue therapy for many participants.

Similarly, participants also shared experiencing sessions plateauing or feeling stuck. Participants shared feeling as though momentum was lost, sessions felt redundant and repetitive, and that nothing new was stemming from sessions. This was supported by Danica’s experience:

> [I decided to discontinue because] …also I felt like we were hitting… I felt like we were plateauing a little bit. I couldn't get past this certain issue of this one memory that we had tried…all these things, and it just felt like we couldn't get past it.

She shared that this was a frustrating experience and though she and the therapist took a lot of time, it was a difficult process made more challenging by the lack of forward momentum. Similarly, Nia shared feeling stuck in sessions: “I felt like I'm just ‘gonna go in there, I'm ‘gonna tell him the same thing I've been telling him. He will tell me the same thing that he’s been telling

me about." Nia shared the feeling of redundancy, being stuck, and the lack of progress was tied to no longer looking forward to sessions and ultimately part of the decision to discontinue.

**Theme 2: Disconnection**

Experiencing disconnection at a variety of levels is another factor that participants shared played a role in discontinuing therapy services. Participants expressed experiencing *clinician disconnect* in which it felt as though clinicians were not picking up nor understanding what clients were *expressing* and experiencing. Participants shared experiencing *clinician-cultural disconnect* in which participants felt cultural burdens such as leading and educating around topics of culture. Lastly, participants experienced *(virtual) format disconnect* in which participants expressed difficulty feeling a connection with their clinician via teletherapy.

**Clinician disconnect.** Many participants shared feeling some sort of disconnect with their clinician. Participants shared instances in which the clinician seemed unable to pick up on the client's emotions, possibly made more challenging via a teletherapy format in some instances. Participants also discussed experiences in which the clinicians took up a lot of space sharing their own thoughts, or as Elizabeth put it, "had a tendency to be long-winded and very prescriptive." Participants shared that clinicians taking up much of the space in sessions left them feeling like there was little room to share their own thoughts and feelings.

Others shared seeing clinicians in a university counseling setting in which the clinician was not always tracking well with the participant, not always picking up on emotions, what the client's needs were, nor reflecting back accurately. Additionally, participants shared their experience that clinicians in university settings often seemed rushed, and even felt as if the session(s) were being rushed as well, sometimes resulting in the participant feeling invalidated

and questioning if their needs were significant enough to warrant services. Feeling rushed is reflected in Nia's experience:

> …So that therapist is through my school's counseling service. I understand that they have a huge client base, they need to give their resources to those who need it the most, but like a lot of times I feel like he just, he tries to get me out of there.

Participants also shared instances in which clinicians missed the meaning of what the participant was sharing, such as for Tonya: "…then there'd be other sessions where I felt like, 'Okay. He completely missed what I was trying to say there.'" Further, there were instances in which the participants did not feel the clinician was trying or making an effort to understand and track what they were sharing, as relayed in Nia's experience: "And you're not trying. Yeah, you're not trying to understand. You're not trying to really understand me and my experience. It's definitely the vibe that I got towards the end." Participants felt there was a disconnect from clinicians in their tracking, leaving enough space for, and picking up on client emotion, feeling rushed—particularly in university settings, and feeling as though the clinicians were making an effort to understand the participants' experience.

**Clinician-culture disconnect.** Participants discussed feeling a disconnect from the clinician and topics related to culture and identity. Participants shared feeling a burden of being the one to initiate conversations around the topic of culture and identity, and that the preference would be if the clinician initiated cultural and broader contextual conversations. This is mapped Victor's in experience:

> I don't think I presented it at the beginning as like, 'this is our like the reason why I was in therapy', but you know it's more like I wish that the therapist would have initiated that

> conversation and then and bring it up, and then so that I don't, you know, I don't have to take the lead of talking about it.

Participants also shared the burdens of correcting, explaining, and educating their clinician. Participants relayed their experience that a lack of understanding from their clinician tended to happen so frequently that it was exhausting and required too much patience to continuously correct the clinician. Participants discussed instances of being in the position of having to educate and give additional context to their clinician around experiences specific to the participant's identities, that would not be required with clinicians of similar identities. This was reflected by Tonya's experience: "There were instances in which I would have to provide cultural information that I think I wouldn't have to provide if this was someone who shared my race and ethnicity or my gender." Tulsi expressed a similar sentiment and experience around feeling obligated to explain her cultural background to a clinician:

> I think it's that I shouldn't have to explain as much…It's like I kind of feel like I have to explain my culture or explain my background, and…that might work for some people, but for me, I explained my culture on a consistent basis. I don't need to do that to a therapist too.

Participants felt the onus of cultural context should be less on the client, and more so the responsibility of the clinician. Additionally, a lack of information from the clinician on their own culture and identities added to the burden participants felt in discussing issues of identity. Participants discussed the preference and importance of knowing information such as the clinician's cultural and ethnic background, as well as gender identity and sexual orientation. Participants shared that knowing this information directly from the clinician adds a sense of

safety and openness in discussing topics related to their own identities. Victor reiterated the value of knowing a clinician's background and identities:

> I think it will give me permission to talk about it more if my therapist is like, 'Oh, this is my identity' because sometimes when I kind of talk about my problem and talk about my identity, I don't know if the therapist is knowledgeable in that area? Or are they comfortable talking about those things?

Participants shared experiencing a cultural disconnect from clinicians by being the ones to initiate conversations around culture and identity, often having to correct and educate clinicians around the participant's own cultural experiences, and knowing little on the clinician's background and identities.

**(Virtual) format disconnect.** Participants described experiences with teletherapy as unhelpful, ineffective, disconnected, and unsupportive. Teletherapy was described to be a barrier to continuing therapy in many cases, and made it easier to discontinue. Participants described the process of connecting with clinicians via teletherapy to be more difficult, even if they had been seeing the clinician in person prior to beginning teletherapy. Elizabeth experienced such a disconnect, and shared:

> I would say it was better when it was in-person, when I was going in-person. But once it shifted to online, it just felt that the therapist was more cold, I couldn't really connect as well with her. And so, I didn't really get much out of it. So, from there I just I stopped the sessions in their entirety.

She shared that teletherapy also added to the "virtual fatigue" that she was already experiencing as a result of the pandemic, and thus made it easy to discontinue therapy altogether at that point. Participants also discussed feeling unsupported and unable to achieve the same level of intimacy

as experienced within in-person sessions, and felt sessions were also less effective. Many participants still tried to continue via teletherapy for as long as they could, such as Danica, who shared:

> When I did the teletherapy, one of the reasons I only did it for the three months is I just don't feel like it was the same, like I didn't have that same connection. It just didn't feel as effective.

Participants still acknowledged the benefits of teletherapy on paper, such as making more sessions and wider variety of clinicians available, but expressed wishing the quality of teletherapy services would improve.

**Theme 3: Clinician Mismatch**

Participants shared mismatch with their clinician contributed to discontinuation of services. By therapist mismatch, participants expressed feeling their clinician was *missing desired overlap* in identity that would be ideal. Participants shared clinicians were *lacking preferred fit* in areas such as life experience and race/ethnicity, often due in part to *limitations to matching* and ability for client participants to find a clinician who meets their preferences.

**Missing desired overlap.** Participants shared a desire for specific overlap in identity with the clinician(s) they saw for therapy. Participants, particularly participants who were women, expressed not feeling fully comfortable with male therapists and relating better to therapists who were women. Woman participants expressed a fear of being judged which they said stopped them from opening up fully during sessions with male therapists. Nia shared her discomfort with a therapist of the opposite gender: “I think the gender is definitely a barrier, I think for me. I just didn't feel as safe, honestly like sharing a lot of my thoughts.” She shared that she learned from her experience with a male therapist that she connects better with therapists who are women, and

realized in hindsight that she should always request a woman therapist in the future. Participants further noted a preference for clinicians who overlapped with them in multiple identity intersections, such as gender orientation and race. Additionally, participants shared sometimes experiencing a disconnect when working with clinicians who did not have overlapping identities. Kadeisha explained her experience working with clinicians who were not women of color:

> But even just talking with clinicians who are not women of color. I think they were just kinda like – ‘cause they don't understand, you know the depth of experiences. So I feel like I have to over explain like, “No, I'm okay, this is just the way that I talk.” So it was, I don't know how to put words to it, but I think just being able to connect in a way that it can’t be taught.

She shared that prior experiences with clinicians who were not women of color made her certain that she wanted to work with women clinicians who shared her ethnic-racial background.

**Lacking preferred fit.** Participants discussed recognizing instances in which their clinician was not a great fit for their needs and preferences. Participants shared experiences of lacking fit with their clinician around issues of identity. One participant (Tonya) shared also experiencing a life event in which made her lack of fit with her current clinician additionally concrete:

> …after that experience I made the decision that I no longer wanted to see a White man for therapy, especially to talk about [woman specific issues] because I knew I needed to process that. So, I wanted to see a female therapist.

In Tonya’s case, her need that would be better suited by a new therapist became greater than any support she might have received in the existing sessions with her White male therapist. Participants additionally shared instances in which the clinicians’ approach to therapy was not

helpful and did not meet the needs of the participant. Danica shared her an experience that has since resulted in her actively preferring to see a clinician of color:

> I mean, I've been wanting to go back and been struggling to find a new therapist, because I think [having shared experiences with therapists] something that I've realized is important, because even the thought… so when I did that brief teletherapy was with a White woman, and it did feel much more, I don't know, formulaic or something.

Having uncomfortable therapeutic experiences with clinicians with whom fit was lacking, as well as positive experiences with clinicians who were a good fit, helped participants gain clarity around clinician preferences. Additionally, participants discussed that in some instances, when working with a clinician that overlaps in identity with the participant was not a possibility, it was a barrier in motivation to continue sessions, or continue pursuing sessions. Kadeisha shared such an experience when her existing clinician was leaving the clinic:

> She did let me know that I could reapply [for therapy services at the university center] and they'll switch me to another therapist. But I was 'kinda like, not really motivated. Because she was one of two Black women at the center and the other Black woman leads our group and also has a full caseload. And so I was like, 'If I'm not 'gonna get her, which I probably will not, she's 'gonna be super booked, I'm just not 'gonna reapply.'

In instances such as Kadeisha's, a lack of access to clinicians of the preferred fit was a deterrent to continuing therapy sessions.

**Limitations to matching.** Participants shared instances in which they experienced limitations around accessing their preferred clinician match. Participants shared having to see a therapist who did not meet their preferences due to lack of availability with preferred clinician matches. Participants acknowledged an overall difficulty in accessing clinicians of similar

backgrounds. Additionally, participants who used group clinics and/or third-party services to find a clinician discussed they were often given limited options on factors around preference for clinicians, if given any options at all. Participants also shared difficulty finding clinicians of similar backgrounds due to geographic location. Nia shared: “I'll tell you this. I am in [a predominantly White southern state]. There is no way in hell I could find… like an Asian clinician…in my area!” Participants described how limitations in accessing a preferred clinician match resulted in scheduling with clinicians who were unlikely to be the best fit. One participant (Tonya) shared: “I guess because I was sort of settling with the [therapist] I ultimately chose.” Participants, such as Tonya, shared experiencing a disconnect with the clinician who was not ultimately a good fit, which contributed to ultimately discontinuing services. Participants experienced limitations in finding their preferred clinician fit due to lack of access to clinicians with preferred backgrounds. Clinicians with preferred backgrounds were difficult for participants to access due to lack of availability, as well as lack of options presented or availability geographically. Given the preference participants shared around having a preferred fit with their clinician, often involving overlaps in identity, limitations to accessing clinicians who may be the preferred match could contribute to issues ultimately leading to discontinuation.

**Theme 4: Inaccessibility of Services**

Another factor that participants discussed as contributing to discontinuing sessions was being unable to continue accessing services. Participants shared logistical scenarios that became barriers, such as *scheduling difficulties*, the *monetary expense* of sessions, and *clinicians being unable to continue* sessions—typically due to moving or leaving a clinic.

**Scheduling difficulties.** Participants discussed how scheduling was an issue in a variety of ways that contributed to discontinuing services. Participants shared that in some instances it was difficult to align schedules with the clinicians, particularly when needing to reschedule or if there was a need for more intensive services. One participant (Danica) experienced difficulty aligning her schedule with her that of her clinician:

> Yeah, we really needed, I think, multiple long sessions, and that, scheduling wise was really difficult, because she also worked limited hours. And again, she was really popular. Part of the reason, I contributed to that, giving her two or three clients. But that was something I'm talking about with my other friends who are seeing her, that was the hardest part is not having that flexibility because she is so stacked, so trying to reschedule and do things was always kind of difficult.

Participants shared understanding that many good clinicians were going to have busy and booked out schedules, but shared that it felt unfortunate in instances when they felt unable to get the support they desired. Participants also acknowledged it was difficult to make time for therapy when stressors piled up and was difficult to make time for yourself. Particularly when participants' own schedules got busier, participants shared it was easier to trail off on services. One participant (Victor) mentioned: "I think it was the end of the year, and that limited the sessions." Even hypothetically, participants currently in therapy mentioned an anticipated increased likelihood of ending sessions if/when they became inconvenient with their schedule. Participants also acknowledged the extra time and commitment that often goes into attending in-person session, and how in-person sessions may not always be logistically accessible given factors like needing to take time off of work, transportation, traffic, etc. Scheduling difficulties can include difficulty aligning schedules with clinician, difficulty making time among stressors

and/or increased business, and additional scheduling logistics involved—particularly with in-person sessions.

**Monetary expense.** Participants acknowledged the expense of sessions was frequently a barrier to sessions. Participants noted that increases in cost of sessions resulted in an increased likelihood of discontinuing services. One participant (Kendra) shared an experience of increased pricing: "…even her sliding scale rate was too much for me to afford. That was, you know, [after her] transition to full time private practice." Participants currently in therapy noted that hypothetically, if pricing of sessions were to change, that would be a reason they would likely discontinue therapy. Participants additionally noted costs being too high, often in relation to what they were getting out of sessions. Participants shared some combination of sessions not working out and being expensive, often due to paying out of pocket. One participant (Danica) shared: "[Discontinued] Given the fact that 'I don't feel like I'm getting the full utility for the price point'." Participants also discussed the cost of sessions sometimes getting in the way of ability to fully utilize sessions. Tonya discussed an instance of limiting services due to cost: "…it was also expensive in the first place, so we could only meet like once a month, anyway. So, I already felt like I wasn't giving enough time with that therapist." Participants shared that monetary expenses of therapy can influence the decision to discontinue therapy if and when there were increases in session fees, if costs of sessions were too high as compared to benefits, and if cost was also a barrier to fully utilizing sessions.

**Clinician unable to continue.** Participants discussed experiencing their clinician being unable to continue services as a reason for which sessions were discontinued. A common occurrence participants discussed was being unable to continue with their clinician because at least one party moved. This was true even in instances of telehealth as either the therapist or the

participant moved across states. One participant (Kendra) shared: “So was also like a logistical thing. I moved to [another state], and she's not licensed in [that state].” Another participant (Nia) experienced her therapist moving: “My first therapist…if I could keep her, I would have, but she had to move out of the state so she couldn't practice anymore in the state that I was residing in.” Participants currently in therapy also shared expectations that one of the hypothetical reasons they would stop sessions with their current clinician is if either party had to move states and were no longer able to work together. Additionally, participants shared experiences of their clinician leaving the clinic or practice and no longer being able to work together. One participant (Kadeisha) shared her disappointment at her clinician leaving: “I guess I'm just so sad that she graduated cause I was like, ‘I feel like we were just getting to something here’.” Participants experienced discontinuation of sessions as a result of the clinician no longer being able to move forward due to one party moving, or the clinician leaving the practice or clinic.

**Theme 5: Well and Connected Enough**

Participants shared that another factor in discontinuing sessions in their experience was feeling able and *better enough* with *enough resources* to be fine without therapy. Typically, some form of progress had been made such that participants felt able continue without individual sessions.

**Better enough.** Participants also shared discontinuing due to feeling better enough. Participants discussed feeling that they had experienced enough growth and were at a better place to feel okay stopping sessions. Participants discussed that while there may still be things that they would like to continue or maintain processing, they felt they had made enough progress and gained enough tools and coping mechanisms to be fine without sessions. One participant (Victor) shared:

> I think it was reaching to the end of the semester, and I think that's…and I think at that point my anxiety was better. I think I was able to manage that a little better. So I think, after kind of consulting the therapist and given that I don't think that we had many like therapy sessions left, so we just decided to discontinue. And I think he did offer, if I needed it, more sessions the next semester I could reach back out, and I didn't feel the need to the next semester, so I just discontinued it.

Participants, such as Victor, felt they had achieved enough relief that they were able to end sessions, and did not feel the need to return. This is supported by Danica's experience:

> I felt like generally I had had so much growth that I didn't need to keep going. And then the fact that the pandemic had started I was like, 'You know what? It's fine, I feel like I'm…weirdly enough, this is as positive mentally as I've ever been, and I don't feel like I need this therapy right now'.

Participants recognized the progress they had made and how much better they were feeling as contributors to feeling fine discontinuing therapy. Participants currently in therapy also recognized that, hypothetically, getting to a point of being in a good space or of life going really well, would likely result in a decision to discontinue therapy. Participants discussed experiencing feeling well enough to discontinue therapy, often having experienced enough growth, relief, and increase in ability to cope.

**Enough resources.** Participants also shared having other resources and connections helped them feel able to discontinue therapy. Participants shared being able to lean on friends and family members, groups, having developed self-care routines, and using other methods of coping to lean on as a replacement for individual therapy. Elizabeth shared that the resources and connections were more helpful to her at the time than virtual sessions were:

> And I found for myself that the more I poured myself into exercise, or talking to family and friends, I felt just as supported than having a therapist. So I think that was a big factor of me just discontinuing services altogether.

Others shared that though they would have still liked to continue therapy, they felt able to lean on other resources and connections to make up for no longer having the outlet of individual therapy. Kadeisha shared her transition into discontinuing individual therapy:

> …So that was kind of hard at first, but I just 'kinda had to get proactive and try to find other outlets and find community in other places, and just amp up things that I do on my own. So I don't have that time with [individual therapy], but I can go to group [therapy]. Or if I can't make group, I'll just amp up my journaling for the week.

Participants, such as Kadisha, were able to be intentional about developing routines and support systems that were supportive in place of individual therapy sessions. Participants shared feeling able to utilize a variety of sources of coping as well as connections and forms of community to maintain their wellbeing and move forward without individual therapy sessions.

The results of this study provided BIPOC client perspectives on factors that contributed to the continuation as well as discontinuation of psychotherapy services, many of which were opposite sides of the same coin. Factors that participants shared helped in continuation of therapy services included components such as gaining takeaways from sessions, the clinician's integration of culture during sessions, having some similarities with their clinician's identities, clinician skills such as prioritizing client needs, and recognition that continuing therapy was better than the unknown alternatives—including starting over with a new clinician. BIPOC client participants shared their perspectives on factors that contributed to discontinuing therapy services such as unsatisfactory services including feeling stagnant in progress, disconnection on

various levels such as between clinician and cultural components, mismatch with therapists including missing a desired overlap in identities, inaccessibility of services such as clinicians being unable to continue, and participants feeling well and connected enough such that they had enough resources and supports to lean on instead of therapy. Understanding BIPOC client perspectives illuminates a deeper understanding of the factors that contributed to continuation and discontinuation of psychotherapy services in a diverse sample of BIPOC client participants.

# CHAPTER 5

# DISCUSSION

## Overview

The purpose of this study was to understand, from a BIPOC client perspective, what were barriers and facilitating factors to continuing and discontinuing psychotherapy services. Across all BIPOC communities, there have been low initiation rates and high discontinuation rates for therapy (Miranda et al., 2015; Schwarzbaum, 2004). Within the existing literature there have been a lack of clarity regarding what factors contribute to continuation and discontinuation of therapy for BIPOC clients. Additionally, there is little in the extant literature that integrates the first-hand perspectives of diverse, adult BIPOC clients in the U.S. as a basis for understanding broader factors that contribute to the continuation and discontinuation of therapy, let alone using a theoretical basis. Thus, the current study aimed to prioritize BIPOC client perspectives to formulate an understanding around factors that contribute to BIPOC client continuation and discontinuation of therapy.

To accomplish this, the researcher conducted semi-structured interviews with BIPOC participants who were either currently and/or had previously been in therapy. The researcher utilized a constructivist grounded theory methodology (Charmaz, 2014) to analyze semi-structured interviews. Existing literature presents limited information on the perspective of BIPOC clients on what contributes to continuing or discontinuing sessions, often focused on narrow topics. This study aimed to address this gap by interviewing BIPOC participants who were currently and/or had previously been clients in therapy. The following chapter will discuss the results of the current study, the grounded theory and resulting implications, the strengths and limitations of this study, and future directions.

**Research Question 1: What are barriers and facilitating factors that contribute to BIPOC clients' continuation of mental health services?**

Within the results of this study, participants discussed their perspectives and experiences with factors that contributed to continuing therapy services. From BIPOC client participant perspectives, factors that contributed to continuing therapy included: takeaways gained from therapy sessions, when the clinician integrated culture in session, similarities in identities and experiences with clinician, when clinicians utilized helpful clinical skills such as prioritizing client needs, and acknowledgement that continuing therapy was better than the alternatives of stopping sessions or starting over with another clinician.

**Theme 1: Takeaways.** Participants appeared to continue sessions from which they gained takeaways. Whether participants felt sessions were positive and helpful, noticed the progress they had made, gained insight, tools, and resources—participants desired acquiring value from sessions. Participants valued that sessions were positive, even if they were not the best services they had ever received. Experiencing sessions as positive and helpful appeared to act as a baseline for the minimum that clients expected to experience in considering continuing sessions. Participants appeared to be experiencing the benefits of having dedicated space to process during their sessions. Participants seemed to value having a space dedicated to just their concerns. Existing literature on client preferences of psychotherapy outcomes, benefits, and progress is limited (De Smet et al., 2020), and BIPOC client perspectives and preferences on therapy benefits is minimal. The current study adds to the existing literature by highlighting BIPOC client perspectives and preferences that support the continuation of therapy services for BIPOC clients.

Participants appeared to highly value noticing their progression within and outside or sessions, and shared feeling easily encouraged in recognizing their progress, and hopeful of

achieving more—indicating an interest in continuing sessions at least as long as progress continued. Participants also reflected a high interest in being challenged and made to think during sessions, in addition to being validated. However, participants did also note that clinicians finding a balance in how they challenged during sessions was ideal. Participants indicated a preference for clinicians who could gently challenge, while also validating and empathizing throughout, even doing both at the same time when possible.

Participants shared appreciating the insight that they received during sessions and movement towards greater self-awareness or even as one participant called it: “actualization.” Participants discussed feeling more enlightened by new perspectives and, as another participant put it having “epiphanies and realizations.” Participants also valued receiving tools to help with issues they were dealing with such a trauma responses, anxiety, and stress. Clients also noted valuing when clinicians not only worked to provide additional relevant resources, but also followed up with the participant afterwards to see if they had utilized it and what their experience was in trying the suggestion. Additionally, receiving homework or related tasks to engage in post-session appeared to help participants in deepening the takeaways they received during sessions. The value placed on components that lead to progress implies high levels of client motivation and participation, which the existing literature has indicated as one factor that can contribute to predicting completion of sessions (Cordaro et al., 2012).

**Theme 2: Integrating culture.** Participants shared preferences around having the full spectrum of their humanity identified and unique nuances of their individual context acknowledged, having treatment tailored to their specific individual needs rather than plugging in a treatment plan that feels “formulaic”, and allowing participants space to be the expert on their own experiences and stressors. Participants’ preference for clinicians acknowledging their

unique context as well as their multidimensional identities as BIPOC individuals is congruent with components of the existing literature (Untanu & Dempsey, 2018). The existing literature identifies clinician perspective-based culturally-relevant interventions such as acknowledging BIPOC clients in the context of their culture, and recognizing differences within specific BIPOC communities (Untanu & Dempsey, 2018), which map on to the BIPOC client-perspective results from the current study—particularly around BIPOC client participants' desire to be recognized as multidimensional individuals, along with a desire for clinicians to address BIPOC specific experiences. The results from the current study yielded contributions to the extant literature by beginning to identify and integrate BIPOC client perspectives and preferences in what constitutes helpful cultural-related approaches and interventions: individualized treatment based on unique and cultural-specific contexts, and recognition of the multidimensional facets of BIPOC individual identities.

Participants preferred for clinicians to acknowledge the multifaceted humanity of BIPOC clients, avoiding the focus of sessions solely narrowing on the client's marginalized identities—unless that is the client's preference—while also making the topic consistently present and available over the course of sessions as well. Participants appreciated clinicians falling somewhere in the middle of the spectrum, integrating both recognition of BIPOC clients as multidimensional individuals and more than just their marginalized identities, as well as being able to acknowledge the role those identities play in their experience as relevant to what the client is bringing into session.

Given the lack of literature around BIPOC client perspectives on helpful components of culturally sensitive clinical care, hearing BIPOC client participants share aspects of culturally sensitive care that have been of value in their experience and perspective can contribute to the

extant literature. By understanding BIPOC client perspectives on what is viewed as helpful components of cultural competency the results of the current study contributes to extent literature by offering a starting point of exploration of client-perspective based culturally sensitive interventions that can support helpful continuation of therapy services.

**Theme 3: Similarities with clinician.** Participants relayed a preference for clinicians that share some form of identity, ideally to relate to experiences in navigating the world in some form. Participants seemed to feel that having similarities with their clinician improved ease and safety in sharing, increased ability to connect with the clinician more authentically, and feeling understood. Participant preference for some form of matching with clinician identities is supported, at least in part, by the existing literature (Chang & Yoon, 2011; Choi & Gonzalez, 2005; Joiner et al., 2022; Takeuchi et al., 1995), while contrasting with one study in which BIPOC client participants did not necessarily indicate perceiving a significantly high alliance with clinicians of similar race-ethnicity (Cheng et al., 2023). Understanding BIPOC client preferences for some level of clinician matching, and the underlying reason of having increased connection and safety, helps in understanding a possible facilitator around not only client-clinician matching, but also an emphasis on the client feeling understood and safe in sharing their experiences, including their BIPOC-related identities.

Additionally, given the conflicting understanding of the value of client-therapist identity matching, this study contributes to the extant literature in understanding from BIPOC clients what is valuable about having identity overlaps with their clinician, such as feeling safer, connected, supported, and understood. While these components may come more easily in client-clinician pairings in which there is at least some identity overlap, it is worth further research to understand if BIPOC clients continue to value identity overlap and clinician matching as highly,

if the components of connection, understanding, and safety are present, regardless of clinician identity overlap.

**Theme 4: Clinical skills.** Participants expressed appreciation for feeling genuine care, empathy, warmth, and personalness from their clinician. Participants shared sensing and valuing when the clinician's care was from an authentic place and not out of a sense of obligation. Participant preferences around experiencing genuine care from clinicians algined with existing literature outlining higher alliance with clinicians who exhibit warmth, empathy, and sensitivity (Fox et al., 2017), as well as factors of clinician friendliness and a positive working relationship contributing to predicted client completion status (Cordaro et al., 2012). Existing literature shows clinician factors of care, warmth, empathy, authenticity, and connection as playing a large role in the therapeutic relationship and thus, commonly understood to support client continuation of therapy (Norcross, 2010). The results of the current study support existing literature, while also contributing BIPOC clients' perspective that caring clinician factors have been of value in BIPOC client therapeutic experiences.

Participants also shared a preference for having a collaborative relationship with their clinician, in which the clinician and client worked alongside one another towards the client's goals. The collaborative dynamic between the clinician and client included clients feeling invited to share at their own pace, meeting the client where they are, and allowing the therapeutic process to be what the client needs. Safety was also a key component participants indicated as important and appeared to be built through the collaborative and authentic approach of clinicians. Participants shared feeling safety in the efforts taken to build rapport—including rapport-building around shared humor. By fostering a collaborative relationship with BIPOC clients, it seems clinicians also tended to develop rapport and a sense of safety that helped participants feel

more open in sharing. Increased client sharing allowed possibility for more progress and thus in increased likelihood for continuation of sessions.

Existing literature emphasizes the role gathering client feedback plays on increasing rapport and quality of therapy services (Miller et al., 2010; Orlinsky et al., 2004). When feedback was solicited from participants, it made them feel aligned with clinicians, such as in one participant's experience of being asked for feedback: "[It let] me know that they were actually hearing me, validating me, and like trying to help me find solutions." Increased opportunities to gather client feedback provided a clear way to understand what changes can be made, or what can be continued, what works for the client, and created more opportunities for—and ideally decreasing barriers to—client continuation of therapy.

**Theme 5: Better than alternatives.** Participants discussed continuing services due to ongoing stressors, needing support, having more to process, avoiding a lag in mental health care, and avoiding having to restart from scratch with another clinician. Client perspectives on reasons for continuing therapy are not largely represented in existing literature, let alone with a focus on BIPOC client experiences. The results from this study contribute to the literature around BIPOC client perspectives on the needs of BIPOC clients who may be seeking to continue therapy services. Participants' ongoing need for services typically seemed to trump instances in which the services were below satisfaction. Participants appeared to feel that less satisfactory services were still better than the alternative of no therapy services and/or the alternative of starting sessions all over again with a new clinician. The ongoing need for services and avoiding restarting with a new therapist are certainly primary reasons for BIPOC clients to continue sessions.

Based on the perspectives of the BIPOC client participants in this study, BIPOC clients were more inclined to continue therapy services when they: perceived progress and gained greater awareness; when clinicians integrated both BIPOC individual multidimensionality and acknowledged the impact of oppressed identities; experienced connection and understanding from clinicians with similar identities; when clinician prioritized client needs, safety, care and feedback; and when the alternatives seemed worse. The current study contributes to existing literature—which has been focused on very specific segments of BIPOC client samples (Chang & Yoon, 2011; Choi & Gonzalez, 2005; Cordaro et al., 2012; Takeuchi et al., 1995; Untanu & Dempsey, 2018), as well as broader non-BIPOC specific client samples (De Smet et al., 2020)—by confirming alignments in diverse BIPOC client perspectives on factors that contribute to continuation of therapy. Additionally, the current study contributes to the limited understanding in existing literature around client perspectives and preferences on factors that contribute to continuation of therapy, let alone understanding of BIPOC client perspectives and preferences.

**Research Question 2: What are barriers and facilitating factors BIPOC clients encounter that contribute to discontinuation of mental health services?**

Participants described factors that, in their experience, contributed to their decision to discontinue therapy services. Factors that played a role in participants' discontinuation of therapy involved services that were unsatisfactory, experiencing some form(s) of disconnection with the clinician, feeling a mismatch of identities and experiences with their clinician, lacking ongoing access to therapy services, and feeling well connected enough to discontinue therapy services.

**Theme 1: Unsatisfactory services.** Participants shared experiencing low quality services which involved sessions that felt ineffective, lacked competence and systemic approaches, felt defensive with the clinician, lacking the level of involvement and processing desired, and no longer looking forward to therapy. Participants also shared they felt a lack of growth,

progression, and benefit from sessions, and felt stuck in the therapeutic process. As one participant shared: “I feel like I stopped growing in my sessions. That's why I ended up deciding that I wanted a different therapist.” Participants feeling dissatisfied with the quality of services and therefore discontinuing services maps onto existing literature (Khazaie et al., 2016).

Just as participants valued growth and progress in sessions, a lack of such takeaways seemed to leave participants unsatisfied with sessions. A perceived lack of therapeutic progress and feeling unsatisfied with services has been shown to increase rates of discontinuation in the literature with a sample including both White and BIPOC clients (Acosta, 1980), and is mirrored within a fully BIPOC client sample in the current study. Feelings of dissatisfaction and stagnation within therapy services contributed to further consideration of discontinuing therapy services among BIPOC client participants in this study.

**Theme 2: Disconnection.** Some participants experienced a disconnection from their clinician, a disconnection between clinician and culture, and a disconnection due to format of sessions. Participants experienced disconnect from their clinician feeling as though the clinician was not tracking with them, was missing the participant’s meaning, misunderstanding, not hearing, rushing and invalidating, and even taking up processing space during sessions. Participants acknowledged in some cases that the clinician not tracking or reading emotions well could be to do with either the telehealth format, or with the clinician being a beginner. However, the participant still seemed to be left with a lack of validation. Participants also shared in certain instances in which they did not feel understood, may have been related to cultural differences, for instance in having a White man clinician. However, one participant shared feeling as though the clinician was not trying to understand her experience: “And you're not trying. Yeah, you're not trying to understand. You're not trying to really understand me and my experience. It’s

definitely the vibe that I got towards the end." Participants also described feeling that the university counseling system may have had an impact on some clinicians seen within those settings, as far as clinical decisions and approach go, with an underlying sense of often feeling sessions were rushed in some way. Additionally, participants expressed instances of feeling as though clinicians went on a diatribe in which they were more directive, and left little room for the client to express themselves and share what was authentic to them in that moment.

**Theme 3: Therapist mismatch.** Participants discussed experiencing therapist mismatches in areas such as gender and race, as well as aspects of clinicians not being their preferred fit in having different life experiences, and in session and treatment structure. Additionally, participants discussed some limitations to seeing a clinician who would be a good match, such as access, availability, limited options provided by clinics, and limitations of geographic area. Participants shared that lacking some form of overlap in identity and/or experience with their clinician resulted in feeling uncomfortable, for example with clinicians of the opposite gender, as well as feeling a disconnect with clinicians who were not, for example, also women of color. Participants shared concerns around safety and comfort in fully sharing thoughts, or feeling as though the clinician did not fully understand them nor connect. Some participants decided to forgo continuing sessions at the same clinic unless a clinician who matched their preferences became available. Thus, instances in which there is a missing overlap or preferred fit can be a contributing factor towards discontinuing sessions. The current study results of client-therapist ethnic-racial mismatch relating to discontinuation of therapy aligns with some of the existing literature (Chang & Yoon, 2011; Choi & Gonzalez, 2005; Griffiths & Terricone, 2017). However, the current study results indicated that, in addition to client-therapist ethnic-racial mismatch, a lack of match in gender identity or certain identity-related life

experiences also played a role in participants considering or ultimately deciding to discontinue therapy services.

**Theme 4: Inaccessibility of services.** Participants expressed being unable to continue therapy related to scheduling difficulties, monetary expenses, and because the clinician was unable to continue. Participants discussed scheduling issues related to having difficulty adjusting their schedule with the clinician's limited availability, having difficulty making time for therapy amidst stressors, and logistically affording to attend in-person sessions. Additionally, participants discussed leaning towards discontinuing sessions due to financial concerns including being unable to afford increases in session pricing and having difficulty justifying the cost of sessions with the benefit(s) being received. Participants tended to express regret of no longer being able to work with their clinician after their clinician moved. All of these factors limited availability to sessions and were largely external and largely uncontrollable by the participant. The external barriers to continuation reported by the BIPOC client participants in the current study map onto common barriers to continuing therapy as reported in non-BIPOC specific populations (Roe et al., 2006; Springer & Bedi, 2021) as well as in some BIPOC samples outside of the U.S. (Khazaie et al., 2016). On a broader level, changes to help increase access to therapy would likely be more systemic in nature, for example, policy changes to support increased monetary and insurance coverage of therapy, or larger streamlined coordination of national licensures and board monitoring such that cross-state therapy can become more accessible across licensures.

**Theme 5: Well and connected enough.** Participants shared feeling as though they had experienced enough growth, progress and felt better enough to discontinue sessions. Participants shared feeling enough relief, having enough coping mechanisms, felt able to process their own experiences individually or with other supports on a daily basis, and feeling comfortable enough

in their existing progress. Circumstances around ending sessions seemed to be a combination of reasons, such as finances also becoming tighter, but regardless, participants shared feeling well enough to discontinue sessions, often crediting that progress to the sessions themselves. Additionally, participants talked about gaining enough resources and connections to utilize rather than going to therapy. Participants discussed feeling they could lean on other connections, use coping and self-care mechanisms such as exercise and journaling, and having mindfulness routines established. The current study results indicate the tangible benefits BIPOC clients recognized receiving from therapy, including reaching one of the ultimate therapeutic goals of clients feeling 'good enough' to function without regular therapy sessions, and thus, discontinue. Existing literature used quantitative surveys to gather results from non-BIPOC specific client samples indicating feeling satisfied and positive impacts from therapy were reasons for termination (Roe et al., 2006). However, the current study obtained this result from direct qualitative interviews with an entirely BIPOC client sample. The factor of feeling well enough is unique in that while feeling good enough is a reason participants did discontinue therapy, participants shared largely feeling good enough after continuing therapy for a sufficient length to receive enough benefit and/or resources to feel stable and level enough to function without the ongoing support of therapy.

Factors that participants shared contributed to discontinuation in their experience and perspective included: services that were unsatisfactory and no longer showed progress; disconnection from the clinician at multiple levels, including culturally; mismatch with the clinician in areas of preferred fit; services being inaccessible whether due to finances, scheduling, or clinician ability to continue; and participant clients feeling better enough to discontinue services. The results of the current study largely map onto existing literature on

reasons for discontinuing therapy in non-BIPOC specific samples (Acosta, 1980; Roe et al., 2006; Springer & Bedi, 2021), as well as some very specific BIPOC samples (Chang & Yoon, 2011; Choi & Gonzalez, 2005; Griffiths & Terricone, 2017; Khazaie et al., 2016). However, the current study adds to the existing literature in understanding reasons for therapy discontinuation first-hand from a diverse BIPOC sample in the U.S.

While there was a conflicting dichotomy and lack of clarity found in the extant literature between factors that contributed to therapy continuation and factors that contributed to therapy discontinuation, the results from both research questions of this study largely harmoniously mirrored each other in the various factors that contributed to discontinuation and continuation of psychotherapy services.

**Toward a Grounded Theory: Common Factors**

As a field, we have learned about common factors to support client retention and creation of change in working with clients (Wampold, 2010). This valuable piece of work that has helped clinicians understand how best to support clients, support higher rates of client continuation, and help create change, was developed as a meta-analysis looking at many studies. The studies utilized in the meta-analysis were conducted largely in the 1970s-2000s, a time during which there was largely limited representation of BIPOC individuals within psychotherapy services, let alone psychological research and publications (Bailey et al., 2002; Roberts et al., 2020; Staples & Mirande, 1980). Given the limited updates to the common factors and subsequent minimal integration of culturally based common factors (Wampold, 2015), the results of this study can be used to begin supporting the addition of similar common factors specifically for BIPOC clients, based on the experiences and perspectives of BIPOC clients. Such common factors include clinician factors, cultural factors, session factors, and outside factors.

**Clinician factors.** Participants shared valuing feeling genuine care and a prioritization of safety with clinicians. Participants expressed feeling cared for as human beings—rather than solely as clients—by their clinicians. Clinicians are encouraged to be genuine in expressing care to clients, particularly when reflecting and validating. Additionally, genuine care appeared to be fostered through rapport building in which both the clinician and client related authentically as well as used humor. Clinicians can create safety with clients both by consistently building rapport, as well as utilizing a collaborative approach in allowing clients to share and disclose entirely at their pace and comfort, meeting the client where they are, and structuring sessions around the specific needs of the client.

Clinicians are also encouraged to create and initiate more opportunities for clients to provide authentic feedback about the therapeutic approach and sessions. In order to do so, clinicians must first ensure that they can be a safe space for clients to share any potential negative feedback. Clinicians would benefit from regulating their responses and ensuring they can receive feedback constructively. Additionally, it seems that creating structure and some form of consistency in offering clients opportunities for feedback may increase the likelihood of clients sharing feedback on changes they would prefer, rather than occasional or sporadic opportunities to provide feedback—albeit better than none. Increasing opportunities for client feedback is also an opportunity for clinicians to even the power dynamic that exists within client-therapist relationships, which is often amplified in cases where the clinician holds additionally privileged identities. Decreasing the power dynamic between clinician and client helps empower the client and encourages client autonomy over their therapeutic treatment. Gathering feedback from clients is also a direct way of addressing any client concerns, dissatisfaction, hesitation, or

even appreciation. Utilizing client feedback can easily contribute to continuation of session for BIPOC clients.

Participants in the current study also valued feeling a sense of connection with their clinician. Participants felt this sense of connection came easily in having shared experiences and/or identities with clinicians. Yet ultimately, the connection that participants felt with clinicians of shared identities came from feeling understood, validated, safe, and connected with the clinician. Clinicians can increase a sense of connection with BIPOC clients by ensuring they are tracking with the client, validating and staying present in sessions, and prioritizing making space for the client to share their thoughts, emotions, and perspectives. If/when clinician shares their own experience, participants found it helpful when clinicians did so in a way that was relevant to their concerns and remained centered on and relevant to what the client is dealing with. Additionally, given the disconnect participants felt from clinicians when using teletherapy, clinicians may better maintain a connection with clients via telehealth by making additional efforts to be warm, emotive, personable, and empathic such that their genuine presence is still felt across the computer screen as much as possible.

**Cultural factors.** Participants shared valuing being recognized as multidimensional individuals, when clinicians made the effort to be culturally sensitive in their therapeutic interactions, and initiated, addressed, and integrated opportunities to acknowledge and process BIPOC and identity experiences. Participants expressed importance of being recognized in the full spectrum of their humanity, rather than being boxed into their most marginalized identity(/ies). Additionally, participants appreciated clinician-initiated opportunities and integration of conversations around BIPOC identity and experiences. Given participants preferred both acknowledgement of the multidimensionality of their humanity and identity, as

well as integrating conversations around experiences of identity and related systemic and contextual factors, clinicians would benefit from working to strike a balance in addressing topics related to marginalized identities, offering opportunities to discuss contextual topics, and following the preference of the client in what is the ultimate focus of sessions.

Additionally, participants shared ways in which clinicians can exhibit cultural sensitivity. Participants emphasized the ability of clinicians to be familiar with the systemic and historical contexts, not just as it relates to the field of mental health care, but also on a broader historical basis. Clinicians are encouraged to do their own work to understand cultural components and contexts such that the burden does not lie predominantly with the client to educate on more than their own experiences during sessions. Additionally, clinicians acknowledging their comfort level, or lack thereof, in addressing culture- and race-related components in therapy can also be one way of acknowledging the role of culture and opening up collaboration with the client in weaving identity-related components. Another way in which clinicians can integrate cultural sensitivity includes tailoring treatment to meet the specific needs of the client within their unique (cultural and systemic) contexts. When constructing and implementing treatment plans for clients, closely consider the role that the client's unique contextual factors play and how that can be integrated to the plan. Therapists should consider doing as much as possible to tailor treatment to the human and their broader needs, as well as the symptoms and dynamics they may be bringing in.

**Session factors.** Given that participants highly valued the takeaways they got from sessions, and felt less enthused with sessions in the absence of said takeaways, clinicians would benefit from supporting BIPOC clients in gaining insight, self-awareness, and making progress towards their goals. Additionally, clinicians could support continuation of services by helping

clients to recognize their progress and taking time to highlight progress and changes as they become apparent during sessions.

**Outside factors.** Factors outside of the control of clients and even clinicians play a role in clients' ability to access psychotherapy services. Such factors include monetary barriers, as well as geographic barriers when one or both parties move, especially across state lines, in which case many licensures do not permit even teletherapy across states. Additionally, making the process of starting therapy over again with a new therapist easier can help clients feel like they have more options should the services they are currently receiving be less than satisfactory. For clinicians, helping to make the therapeutic process more accessible financially could include joining health insurance panels to be able to accept health insurance. However, this does not come without its share of barriers itself for interested clinicians, from an often tedious documentation and paperwork process, lag time in receiving payment, lack of guarantees of approval of payment, and caps on amount of payment receivable (Knapp & VandeCreek, 1993). Thus, shifts on a policy level will be beneficial in easing some of the processes involving insurance panels and access to psychotherapy services, both for clients as well as for clinicians.

## Strengths, Limitations, and Future Directions

To properly understand how to best utilize the results yielded, it is helpful to understand the strengths and limitations of this study. One major limitation of the extant literature is the lack of studies focusing on BIPOC client perspectives, and instead focusing more predominantly on clinician perspectives. Thus, one primary strength of the current study is that it focused directly on the reported perspectives of BIPOC clients. All participants in this study identified as BIPOC and were either currently in therapy, had received therapy services within the last four years, or a combination of both. There were also a few participants ($n$ = 7) who were not only BIPOC

clients, but were also clinicians themselves. Thus, given the scope of the current study, multiple perspectives were gathered as part of the data, but all were BIPOC individuals who had received therapy services.

Additionally, another limitation of the existing literature is a lack of clarity around what constitutes barriers and facilitators to the continuation or discontinuation of psychotherapy services for BIPOC clients, from the perspective of BIPOC clients. Thus, another strength of the current study is yielding results that can serve more concretely as a basis for understanding, from BIPOC client perspectives and experiences, what factors have been experienced in each continuing and/or discontinuing therapy services.

One limitation to the current study was a lack of intersectional representation within the sample, particularly of BIPOC individuals who also identify as part of the LGBTQIA+ community. The limited number of participants who also identified (openly) as part of the LGBTQIA+ community shared components of the data which did not necessarily contain enough overlap that the codes that rose as themes, but such perspectives would be worth exploring further with a more representative sample.

Future directions for research include continuing to conducting similar studies with larger and more intentional sampling to increase representation in sample, continue to assess relevance of factors across BIPOC communities and assess for more. Additionally, eventual community specific studies would be beneficial to understand what continuation and discontinuation factors may be specific to certain within group communities. More intersectionally representative samples, including BIPOC clients who also identify as part of the LGBTQIA+ community would also be beneficial to further research to further understand the role of intersectionality with factors contributing to continuation and discontinuation of therapy. Similarly, additional studies

can be done with support for including or even primarily focusing on experiences of non-English speaking BIPOC clients. Additionally, studies can be conducted to better understand barriers and facilitators to continuing and discontinuing therapy for BIPOC client experiences in relational therapy experiences, such as couple and family therapy. Understanding the dynamics of having multiple related parties present can further benefit understanding ways clinicians can increase BIPOC clients' continuation and decrease discontinuation of relational therapy. Lastly, future studies can use mixed- and quantitative methods to continue to build on the current results and utilize larger samples to test and clarify common factors for therapeutic change specific to BIPOC clients.

**Conclusion**

The purpose of this study was to understand, from BIPOC client perspectives, what factors contribute to continuation of psychotherapy services, and what factors contributed to the discontinuation of psychotherapy services. A qualitative constructivist grounded theory approach was used in identifying five themes illuminating factors that contributed to BIPOC client continuation of therapy services and five themes captured factors that contributed to discontinuation of therapy services. Factors that contributed to BIPOC client participants' continuation of therapy included takeaways received from sessions, clinician integration of culture, similarities with clinician, clinical skills of the clinician, and that continuing was better than the alternatives. Factors that contributed to BIPOC client participants' discontinuation of therapy included receiving unsatisfactory services, experiencing levels of disconnect with clinician, feeling there was a mismatch with the clinician, an inaccessibility to ongoing therapy services, and clients feeling well and connected enough to discontinue therapy. The study adds to existing literature by qualitatively centering the experiences and perspectives of a diverse sample

of BIPOC client participants in the U.S. on factors that help in continuing and discontinuing therapy. Study findings and the resulting grounded theory can help to inform clinical services and future research directions to continue supporting the quality of psychotherapeutic services for BIPOC clients.

# APPENDIX A

# IRB APPROVAL

FLORIDA STATE UNIVERSITY OFFICE *of the* VICE PRESIDENT *for* RESEARCH

APPROVAL

Dear Sapna Srivastava:
On 5/10/2023, the IRB reviewed the following submission:

| Type of Review: | Expedited<br>(6) Voice, video, digital, or image recordings; (7)(a) Behavioral research |
|---|---|
| Title: | Barriers and Facilitators Ethnic-Racial Minority Clients Encounter in Receiving Psychotherapy Services |
| Investigator: Sapna Srivastava | |
| Submission ID: MOD00003481 | |
| Study ID: STUDY00000243 | |
| Funding: None | |
| IND, IDE, or HDE: None | |
| Documents Reviewed: | None |

The IRB approved the modification, effective from 5/10/2023.

Other Information:

You are advised that any change or revision to the protocol for this project must, through a study modification, be reviewed and approved by the IRB prior to implementation of the proposed modification(s).

Federal regulations require that the Principal Investigator promptly report, through a Report of New Information, any incident involving, for example, the following: a new or increased risk or safety issue; harm experienced by a study participant; non-compliance with federal regulations or the determinations of the IRB; audits, monitoring reports or

inspections by study sponsors, monitors or federal agencies; breach of confidentiality; complaint of a study participant; etc.) (see the Investigator Manual (HRP-103), which can be found in RAMP IRB, under the IRB, Library and General tabs).

In conducting this protocol, you are required to follow the requirements listed in the Investigator Manual (HRP-103).

FSU IRB standard operating procedures (HRP-090) require that investigators use only the most current IRB-approved (i.e., "stamped") version of consent, assent and parental permission forms as well as other materials given to research participants or used for study purposes, and that are applicable to the specific study and study activity. IRB- approved materials for this study are located in the study's RAMP IRB workspace; to find your IRB-approved materials, first navigate through the IRB and Submissions in the top row, then under Submissions, navigate to the table below and click the Active tab and search for this study by study ID or study Name. Second, select this study by clicking on the study Name. Once in this study's workspace, navigate to the Resource tabs located under the workflow diagram and click the "Documents" tab; there, in the Study or Site Related Documents section, locate the IRB-approved materials by category (e.g., Consent Form, IRB Protocol, Recruitment Materials), and for study activities use only the most current IRB-approved version listed in the "Final" column.

Note that in accordance with applicable federal law and FSU policy, all approved or cleared studies are subject to post-IRB approval monitoring throughout a study's life cycle. Studies are subject to random as well as other assessments (audits) to ensure on- going protection of study participants and adherence to applicable law, ethics, policy and the IRB-approved/cleared study protocol. For additional information about this monitoring, refer to the FSU IRB's HRP-059 Standard Operating Procedure (SOP) – Post Approval Compliance Monitoring, available in RAMP IRB, under the IRB, Library and Standard Operating Procedures tabs.

When you complete your study, the study must be closed in RAMP IRB; see our RAMP IRB-Related FAQ #4. If you leave FSU, you must either close your study or (if the study is to remain on-going at FSU) modify your study to designate another FSU researcher as the study's principal investigator (PI); see our General FAQ #10.

Sincerely,

Office for Human Subjects Protection (OHSP)
Florida State University Office of Research
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Tallahassee, FL 32306-2742
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## APPENDIX B

## DISCONTINUED SERVICES SEMI-STRUCTURED INTERVIEW GUIDE

Grand tour questions:

Sessions Logistics:
Started sessions?:
Ended Sessions?:
Total # of sessions?
Structure of sessions (individ., couple, etc.):
Format of sessions (in-person, telehealth, etc.):

1. Tell me about your overall therapy experience.
    a. Prompters:
        i. What were positive aspects?
            1. For example, of your last session?
        ii. What were negative aspects?
            1. For example, of your last session?

2. Tell me about your experience with your therapist.
    a. Prompters:
        i. How much input did you have in choosing your clinician?
        ii. What were any qualities and factors you had been looking for when trying to find a clinician?
            1. Did factors such as age, gender, race, ethnicity play a role in your search?
            2. What was the gender, race, and ethnicity of your clinician?
        iii. What were positive aspects?
            1. For example, of your last session?
        iv. What were negative aspects?
            1. For example, of your last session?
        v. How would you describe your clinician's style (collaborative in getting your feedback, directive in giving advice or telling what to do, etc.)?
            1. How did your clinician's style fit with you?
            2. What communication, if any, did you have with your clinician about their style and your needs/preferences?

3. Tell me about what contributed to your decision to discontinue therapy.
    a. Prompters:
        i. What most contributed to your decision to stop therapy?
            1. For example, in your last session?
        ii. What has been most difficult about stopping therapy?

4. Did outside circumstances impact your decision to stop therapy?

a. Prompters:
    i. What role, if any, did Covid-19 play in your decision to stop therapy?

5. Tell me about what had helped you continue therapy for as long as you did?
    a. Prompters:
        i. What made it easiest to continue therapy?
            1. For example, in your last session?
            2. For example, in your initial session(s)?
        ii. What was most difficult about continuing therapy?
            1. For example, in your last session?
            2. For example, in your initial session(s)?

6. Tell me about what could have led to your decision to keep going to therapy?
    a. Prompters:
            1. For example, in your last session?
            2. For example, in your initial session(s)?
        i. What other potential therapist/clinic related factors would have contributed to your decision to continue therapy?

7. If clinician: How has being a clinician (or clinician in training) impacted your therapy experience, if at all?
    a. Expectations? Observations? Insights? Positively? Negatively?

8. If clinician: What, from your experience as both a client and a clinician, do you believe are some of the barriers leading to BIPOC clients to discontinue therapy?

9. If clinician: What, from your experience as both a client and a clinician, do you believe are some of the most significant facilitators to BIPOC clients continuing therapy?

10. What else, if anything, would you want mental health professionals or the mental health field to know about how to best serve BIPOC clients??
    a. What else, if anything, would you want mental health professionals or the mental health field to know about how to best serve clients generally??

11. What would you share with BIPOC folks who are considering therapy, starting therapy, or are currently in therapy?

# APPENDIX C

## CONTINUING SERVICES SEMI-STRUCTURED INTERVIEW GUIDE

Grand tour questions:

Sessions Logistics:
Started sessions?:
Total # of sessions (thus far)?:
Structure of sessions (individ., couple, etc.):
Format of sessions (in-person, telehealth, etc.):

1. Tell me about your overall therapy experience.
    a. Prompters:
        i. What have been positive aspects?
            1. For example, of your most recent session?
        ii. What have been negative aspects?
            1. For example, of your most recent session?

2. Tell me about your experience with your therapist.
    a. Prompters:
        i. How much input did you have in choosing your clinician?
        ii. What were any qualities and factors you had been looking for when trying to find a clinician?
            1. Did factors such as age, gender, race, ethnicity play a role in your search?
            2. What was the gender, race, and ethnicity of your clinician?
        iii. What have been positive aspects?
            1. For example, of your most recent session?
        iv. What have been negative aspects?
            1. For example, of your most recent session?
        v. How would you describe your clinician's style (collaborative in getting your feedback, directive in giving advice or telling what to do, etc.)?
            1. How did your clinician's style fit with you?
            2. What communication, if any, did you have with your clinician about their style and your needs/preferences?

3. Tell me about what has contributed to your continuing therapy.
    a. Prompters:
        i. What has helped continue therapy most?
            1. For example, in your most recent session?
        ii. What has been most difficult about continuing therapy?
            1. For example, in your most recent session?
            2. For example, in your initial session(s)?
        iii. What outside circumstances, if any, impacted your decision to continue therapy?

1. What role, if any, has Covid-19 played in your decision to continue therapy?

4. What outside circumstances, if any, impacted your decision to seek therapy?
   a. Prompters:
      i. What role, if any, did Covid-19 play in your decision to seek therapy?

5. Tell me about what could cause you to stop going to therapy?
   a. Prompters:
      i. What in your most recent session could have potentially happened that would contribute to your discontinuing therapy?
      ii. What other potential therapist/clinic related factors would contribute to your decision to stop therapy?
      iii. What, if any, apprehensions did you have prior to this therapy experience?
         1. If any of those apprehensions had come to fruition, how would that have impacted your therapy experience?

6. If clinician: How has being a clinician (or clinician in training) impacted your therapy experience, if at all?
   a. Expectations? Positively? Negatively?

7. If clinician: What, from your experience as both a client and a clinician, do you believe are some of the barriers leading to BIPOC clients to discontinue therapy?

8. If clinician: What, from your experience as both a client and a clinician, do you believe are some of the most significant facilitators to BIPOC clients continuing therapy?

9. What else, if anything, would you want mental health professionals and/or the mental health field to know about how to best serve BIPOC clients from your perspective??
   a. What else, if anything, would you want mental health professionals or the mental health field to know about how to best serve clients generally??

10. What would you share with BIPOC folks who are considering therapy, starting therapy, or are currently in therapy?

# APPENDIX D

# DISCONTINUED AND CONTINUING SERVICES SEMI-STRUCTURED INTERVIEW GUIDE

Grand tour questions:

Sessions Logistics:
Started sessions?:
Ended Sessions?:
Total # of sessions?
Structure of sessions (individ., couple, etc.):
Format of sessions (in-person, telehealth, etc.):

1. Tell me about your overall previous therapy experience (within the past two years).
    a. Prompters:
        i. What were positive aspects?
        ii. What were negative aspects?

2. Tell me about your experience with your previous therapist.
    a. Prompters:
        i. How much input did you have in choosing your clinician?
        ii. What were any qualities and factors you had been looking for when trying to find a clinician?
            1. Did factors such as age, gender, race, ethnicity play a role in your search?
            2. What was the gender, race, and ethnicity of your clinician?
        iii. What were positive aspects?
        iv. What were negative aspects?
        v. How would you describe your clinician's style (collaborative in getting your feedback, directive in giving advice or telling what to do, etc.)?
            1. How did your clinician's style fit with you?
            2. What communication, if any, did you have with your clinician about their style and your needs/preferences

3. Tell me about what made you stop going to therapy.
    a. Prompters:
        i. What most contributed to your decision to stop therapy?
        ii. What has been most difficult about stopping therapy?

4. Did outside circumstances impacted your decision to stop therapy?
    a. Prompters:
        i. What role, if any, did Covid-19 play in your decision to stop therapy?

5. Tell me about what had helped you continue therapy for as long as you did?
    a. Prompters:

i. What made it easiest to continue therapy?
ii. What was most difficult about continuing therapy?

6. Tell me about what could have led to your decision to keep going to therapy?
   a. Prompters:
      i. What other potential therapist/clinic related factors would have contributed to your decision to continue therapy?

Sessions Logistics:
Started sessions?:
Total # of sessions (thus far)?:
Structure of sessions (individ., couple, etc.):
Format of sessions (in-person, telehealth, etc.):

7. Tell me about your overall current therapy experience.
   a. Prompters:
      i. What have been positive aspects?
      ii. What have been negative aspects?
   b. What of your sessions were required by forces outside of yourself?
   c. How much input did you have in choosing your clinician?

8. Tell me about your experience with your current therapist.
   a. Prompters:
      i. How much input did you have in choosing your clinician?
      ii. What were any qualities and factors you had been looking for when trying to find a clinician?
      iii. What have been positive aspects?
      iv. What have been negative aspects?
      v. How would you describe your clinician's style (collaborative in getting your feedback, directive in giving advice or telling what to do, etc.)?
         1. How did your clinician's style fit with you?
         2. What communication, if any, did you have with your clinician about their style and your needs/preferences

9. Tell me about what has contributed to your continuing therapy.
   a. Prompters:
      i. What has helped continue therapy most?
      ii. What has been most difficult about continuing therapy?
      iii. What outside circumstances, if any, impacted your decision to continue therapy?

10. What outside circumstances, if any, impacted your decision to seek therapy?
    a. Prompters:
       i. What role, if any, did Covid-19 play in your decision to seek therapy?

11. Tell me about what could cause you to stop going to therapy?
    a. Prompters: What other potential therapist/clinic related factors would contribute to your decision to stop therapy?

12. How has being a clinician (or clinician in training) impacted your therapy experience, if at all?
    a. Expectations? Positively? Negatively?

13. If clinician: What, from your experience as both a client and a clinician, do you believe are some of the barriers leading to BIPOC clients to discontinue therapy?

14. If clinician: What, from your experience as both a client and a clinician, do you believe are some of the most significant facilitators to BIPOC clients continuing therapy?

15. What else, if anything, would you want mental health professionals or the mental health field to know about how to best serve BIPOC clients??
    a. What else, if anything, would you want mental health professionals or the mental health field to know about how to best serve clients generally??

16. What would you share with BIPOC folks who are considering therapy, starting therapy, or are currently in therapy?

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