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Exploring the Cognitive Process and Complexity of Diverse Patient Conceptualization: A Mixed Methods Study

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EXPLORING THE COGNITIVE PROCESS AND COMPLEXITY OF DIVERSE PATIENT CONCEPTUALIZATION: A MIXED METHODS STUDY

by

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ABSTRACT
EXPLORING THE COGNITIVE PROCESS AND COMPLEXITY OF
DIVERSE PATIENT CONCEPTUALIZATION: A MIXED METHODS STUDY

Michelle P. Toigo, M.S.

Marquette University, 2019

In an era when culture is valued in therapy, the field has increasingly emphasized therapist competence in working with diverse clients and reducing mental health disparities (Bernal, Jimenez-Chafey, & Rodriguez, 2009). While there are multiple aspects of multicultural competence (e.g., choosing assessments with appropriate norming groups, consulting with members of the client's culture, culturally sensitive therapy practices), case conceptualization is believed to be a crucial competence to providing effective services to clients who are racial or ethnic minorities (Hill, Vereen, McNeal, & Stotesbury, 2013). These skills allow the therapist to integrate client culture into their understanding of the client and may help improve treatment outcomes (Ridley & Kelly, 2007). Despite the potential importance of multicultural case conceptualization skills, there has been little empirical research to date on these skills. The present study sought to examine the content and quality of multicultural case conceptualizations and how the training experiences of trainees influenced the development of their multicultural conceptualization skills. A mixed methods approach was used to gain qualitative and quantitative insight into the nature of multicultural client conceptualizations among trainees, with a primary emphasis on qualitative methodology. Eleven trainees engaged in a think-aloud task through which they created a multicultural case conceptualization of a diverse client with whom they had worked in therapy. Additionally, trainees were interviewed regarding their experiences learning multicultural case conceptualization skills. Foremost, trainees described several topics related to the clients racial or ethnic background and discussed why they believed the client's culture was pertinent to that particular case. Further, trainees described both facilitative and challenging experiences as they learned multicultural case conceptualization skills. Limitations and implications for training and research are discussed. The study concludes with an exploration of future research directions to address gaps in the literature on multicultural case conceptualization skills.

PREFACE

I selected this topic for a few reasons. First, I am interested in how therapists form an understanding of their clients and, particularly, those clients who are culturally different from themselves. My own experiences as a bicultural individual have instilled in me the belief that what is normative and healthy is not so clear and the boundaries we draw around these terms may not allow for differences between cultures. In my experiences as a bicultural therapist, I have found that having the mental flexibility necessary to conceptualize a client in a way that appropriately honors the various aspects of their identity and life experience is quite a challenging skill. For this reason, I am interested in how we as therapists come to understand those clients who are different from us and how, in all the complexity of real-world practice, we engage in these case conceptualization skills. Second, the relatively limited prior research in this area made it an appropriate topic for further study. My hope is that this research has provided a better understanding of the content trainees include in multicultural case conceptualizations and what characterizes their experiences when learning case conceptualization skills.

ACKNOWLEDGMENTS

Michelle P. Toigo, M.S.

There is a lot in life that I do not understand, and I have found that adage about "the more you know, the less you know" to be true for me. Perhaps trumping them all is how I have ended up with this brilliant, hilarious, beautiful community that has this endless faith in me. I am certain that this community fills my life with color and vitality and gives me faith in the world around me. To my family, friends, supervisors, patients…for each of you, I am constantly grateful. To call out a few…

To Drs. Alan Burkard, Jennifer Cook, and Lisa Edwards, my dissertation committee, thank you for sticking with me through this long process and allowing me to study a complex topic in a way that hasn't been done before. To my dissertation chair, Dr. Alan Burkard, you have supported me in countless ways beginning during my time as a master's student and through my PhD. And to Dr. Terry Young who acted as my supervisor, professor, and mentor for many years, you ignited my passion for this field with your own, helped me develop a method for grounding my work in science, and demonstrate such humanity in the way you treat your patients. Lessons such as "we are not the mental health police" are always on the forefront of my mind. As I told you all after the defense, this work is what I feel I am meant to do and you all got me there. Thank you.

To my husband, Ross, with whom I have gone through this entire experience. You somehow manage to make me believe I can be more in my career than I ever would have

imagined and still keep me compassionate towards myself, reminding me that life is about so much more than my work. You have encouraged decisions over the past decade of our life together that have enabled my career to take flight but have not been in the best interest of the career that you have worked so hard for. And somehow you have made me laugh the whole way and take life less seriously. You have done all this with a grace and kindness that has allowed me to be a wife, mother, partner, researcher, and clinician, all at the same time. I will never be able to put into words how lucky I got when you knocked on my door almost a decade ago and how much you transform each phase of our life together. You will always be my best decision.

To my daughter, Leilah, your goofy spirit and constant light in my life has provided me with so much more meaning and laughter than I would have ever thought possible. I am so lucky and grateful for each and every moment of this beautiful life with you… the early mornings, the falls and tears as you toddle around the house, the giggles and funny faces that match my own… each of those ordinary, magnificent moments that I never take for granted. As you grow into a toddler and I grow into an early career psychologist, I find myself hoping for a kinder, more compassionate world for you to journey through. I hope to teach you that actively engaging in what this world has to offer and reaching for the light is far more meaningful than living safely on autopilot. Thanks for your constant sunshine this past year kiddo.

To my siblings, Massoud, Zack, and Natalie, you clowns are my closest friends, the people who have the most blind faith in me, and the place I always feel at home. Thank you for every time you helped me to recognize my own potential and for doing so with the Dumb and Dumber brand of humor that keeps me from taking it all so seriously.

In particular, to my eldest brother and leader of our pack, you have consistently and quietly pushed us each along with the belief that, with a little grit, we can quite literally do whatever we want. This has always provided a foundation for me during times of wavering confidence. To my parents for teaching me to be attuned to others' suffering at such an early age and creating a core belief that our relationships are so much more important than anything else. You taught me how to view this world with engagement and joy, embracing what life has to offer while looking out for the welfare of others. I don't know how many people can say that about their upbringing.

Finally, to each of my patients. I am called in to see you when you have gone through something life changing. I am so often overcome by what you are dealt. Meeting you in this place in your life, I have been stunned countless times by the grace so many of you exude while facing things that terrify us all. You redefine for me constantly what strength looks like and how beautiful life can be when so much of what we take for granted is swept away. I am endlessly grateful to each of you for letting me walk through the dark with you.

To all my best friends, extended family, and those others who make up the fabric of my life, thank you for caring about what I do, being patient with the time my work has required, and giving me inspiration by living your own lives so well.

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CHAPTER 1: INTRODUCTION

In an age of globalization and cross-cultural interaction, the field of psychology has increasingly valued addressing the needs of a diverse community of clients. For instance, professional organizations and accrediting bodies including the American Art Therapy Association (2007), the American Counseling Association (2014), the American Psychological Association (2010), and the National Association of Social Workers (2001) has demonstrated this value. Each of these professional organizations have integrated multicultural competencies into their accreditation standards and practice guidelines. It seems quite evident that a broad range of helping professionals have recognized a critical need to respond effectively to culture and diversity with regard to the mental health treatment of individuals of racial or ethnic minority backgrounds.

This emphasis on integrating multicultural competencies into the mental health profession is even more necessary due to the demographic shifts of the United States (US; National Center for Health Statistics, 2004). The US is predicted to become increasingly culturally diverse over the next thirty years which will shift the cultural background of those seeking therapy. By 2050, the percentage of individuals who are racial or ethnic minorities in the U.S. is projected to reach approximately 50% of the national population (National Center for Health Statistics, 2004). Such a change indicates that therapists will most likely work with clients of various racial or ethnic backgrounds. For instance, a 2015 survey of psychology health service providers conducted by the American Psychological Association indicated that over 40% of the psychologists surveyed worked with individuals who identified as racial or ethnic minorities on a frequent or very frequent basis. Furthermore, this report concludes that consistent

increases in diverse client populations necessitates a more complex, comprehensive understanding of such populations and how to provide competent treatment that is culturally responsive (APA, 2015).

In addition to the increase of diversity in the U.S. population, multicultural counseling competence is critical to address the poor therapeutic outcomes found in research for clients who are racial and ethnic minorities. Consider that individuals who are racial or ethnic minorities delay seeking treatment, terminate early from treatment, are diagnosed with higher levels of psychopathology, and experience treatment outcomes that are not as successful as individuals who belong to the racial or ethnic majority (Bernal, Jimenez-Chafey, & Rodriguez, 2009). For example, African American men are more frequently diagnosed with Schizophrenia and other psychotic disorders and experience less reduction in symptoms following treatment than individuals of the racial or ethnic majority (Tegnerowicz, 2018). Such outcome disparities indicate that mental health professionals need to understand and address those factors that influence this phenomenon (Tegnerowicz, 2018). Many researchers have asserted that multicultural counseling competence may be necessary to address disparities in mental health outcomes (Burkard & Knox, 2004; Fuertes & Brobst, 2002; Sue, Arredondo, & McDavis, 1992; Tao, Owen, Pace, & Imel, 2015).

Relatedly, researchers have also found strong associations between multicultural counseling competence and treatment outcomes for individuals who are racial or ethnic minorities. For example, client-rated multicultural competence was strongly associated with therapeutic alliance, client satisfaction, general counseling competencies, and session depth (Tao et al., 2015). Additionally, multicultural competencies were found to

have a moderate relationship with symptom remission following treatment (Tao et al.,

2015). Similarly, Griner and Smith's (2006) meta-analysis showed that culturally-adapted

interventions designed for specific racial or ethnic groups were four times more effective

than universal interventions that were not adapted to the client's racial or ethnic

background. These collective findings from these meta-analyses suggest that culturally

competent treatment significantly increases treatment efficacy in multiple domains when

working with individuals of minority racial or ethnic backgrounds (Griner & Smith,

2006; Tao et al., 2015).

Multicultural Case Conceptualization

While there are multiple aspects of multicultural competence (e.g. choosing

assessments with appropriate norming groups, consulting with members of the client's

culture, culturally sensitive therapy practices), case conceptualization is believed to be a

crucial competence to providing effective services to clients who are racial or ethnic

minorities (Hill et al., 2013). The importance of multicultural case conceptualization

skills can be found in literature including professional organization standards, therapist

educators, and theorists. For instance, multicultural competence in case conceptualization

is emerging in practice guidelines and training materials for mental health practitioners.

Multicultural conceptualization is identified as one of ten guidelines important to the

2017 APA multicultural standards identified in the *Multicultural Guidelines: An*

Ecological Approach to Context, Identity, and Intersectionality. In this document, the

Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century stated:

Guideline 2: Psychologists aspire to recognize and understand that, as cultural

beings, they hold attitudes and beliefs that can influence their perceptions of and

interactions with others as well as their clinical and empirical conceptualizations.

As such, psychologists strive to move beyond conceptualizations rooted in

categorical assumptions, biases, and/or formulations based on limited knowledge

about individuals and communities… Exposure to the literature on practices in

mental health, case conceptualization, and treatment in different cultures is

preparation for the central practice task of grasping what the world may look like

from the vantage point of student-clients, as well as their extended families,

neighborhood friends, and peers (p.4).

Also, recent revisions of counseling textbooks such as *Clinical Mental Health*

Counseling: Fundamentals of Applied Practice (Sheperis & Sheperis, 2015) and

Counseling Theory: Guiding Effective Practice (Parsons & Zhang, 2014) describe

multicultural conceptualization as crucial for educators to attend to when developing

trainee case conceptualization skills. Additionally, theorists Hansen et al. (2000) created a

list of 12 minimal multicultural competencies for practice. They asserted that the ability

to recognize cases in which clinical issues involve cultural dimensions, to integrate

culture into hypotheses related to clients, and to develop accurate clinical

conceptualizations is critical to culturally competent care. Overall, there appears to be a

general consensus among professional organizations, educators, and theorists that

multicultural conceptualization is a central skill critical to multicultural competence.

Rationale for the Study

Few researchers have empirically explored multicultural conceptualization skills,

although multicultural conceptualization has been called out as potentially important

multicultural competency (Hansen et al., 2000; Lee & Tracey, 2008; Lee et al., 2013;

Neufeldt et al., 2006). More specifically, research has not explored the content that comprises a multicultural conceptualization or what influences this area of skill development. Research that informs our understanding of the process of multicultural case conceptualization and those factors that influence the development of this skill may provide guidance in training future clinicians, and perhaps help to close the gap in service for racially and ethnically diverse clients (Lee & Tracey, 2008; Lee et al., 2013; Neufeldt et al., 2006).

Purpose of the Study

The purpose of this study is to explore the content and quality of trainees' conceptualizations of a client who is of a differing racial or ethnic background from themselves. Trainees were chosen as a focus of this study because they are actively learning about, practicing, and refining their counseling skills in coursework and while under supervision. Specifically, trainees are developing their level of multicultural counseling competence and multicultural skills in accordance with recommendations provided by the professional organizations and accrediting bodies governing their field of practice. Therefore, trainees are at a critical point of professional development and are likely working to develop multicultural case conceptualization skills. This study examines the content and quality of multicultural case conceptualizations and how the training experiences of trainees influenced the development of their multicultural conceptualization skills. A mixed methods approach was used to gain qualitative and quantitative insight into the nature of multicultural client conceptualizations among trainees, with a primary emphasis on qualitative methodology.

Research Questions

This study explores the cognitive process and complexity through which trainees create conceptualizations of clients who are of a differing racial or ethnic background from themselves. The research questions guiding this study are: (1) What content do trainees use in developing a case conceptualization of clients that are racially or ethnically diverse? (2) What factors influenced the inclusion of race or ethnicity into the trainees' case conceptualization? (3) What is the quality of the multicultural case conceptualizations by trainees? (4) How has training influenced trainees' development of multicultural client conceptualizations?

Definition of Terms

Essential terms to define at the outset of the study are multiculturalism, multicultural competence, multicultural case conceptualization, quality of conceptualization, and trainee. These definitions provide clarity for the remainder of the study.

Multiculturalism. Though there are several definitions of the term, in this study, *multiculturalism* is defined as an individual's race or ethnicity. Erikkson and Abernethy (2014) explained that diversity considerations within psychology began with a focus on the ways that racial differences create deficits in mental wellness. The focus then expanded beyond race and ethnicity, recognizing the intersection of cultural identities such as gender, sexual orientation, socioeconomic status, immigration status, age, religious and spiritual identity, and physical ability (Erikkson & Abernethy, 2014). As such, the definition of multicultural has shifted across time periods. This shifting definition has complicated multicultural research and lacks specificity regarding

treatment efficacy and competence when working with "multicultural individuals."

Limiting multiculturalism to race and ethnicity is intended to narrow the focus of the

study and to better understand two important facets of multicultural conceptualization.

Excluding other multicultural factors (e.g. gender, ability) is not meant to indicate these

factors are less important or do not need to be included in future research on case

conceptualization.

      Multicultural counseling competence. Therapist counseling competence has

been defined as "the ability to engage in actions or create conditions that maximize the

optimal development of client and client systems" (Sue & Torino, 2005, p. 8).

Multicultural counseling competence is an expansion of this concept of general therapist

competence and pertains to work with clients of minority racial or ethnic background.

Specifically, multicultural counseling competence is most commonly identified as having

three components addressing awareness, knowledge, and skills (Sue et al., 1992).

Awareness is comprised of explicit and implicit worldviews, biases, constructs, and

stereotypes. Sue and Sue (2013) have suggested that awareness is a critical component of

multicultural competence, as counselors must become aware of their worldviews in order

to understand how their views may influence the therapeutic context. Knowledge is

information acquired about the worldviews of culturally different clients (Hill et al.,

2013). Knowledge is often attained through methods commonly used in didactic courses

including the use of multicultural handbooks, research, and lectures (Roysicar et al.,

2010). The therapist must learn to integrate knowledge of cultural groups with knowledge

of counseling theories to provide culturally competent treatment (Sue & Sue, 2013).

Finally, the skills component are the interventions and strategies the therapist uses to

apply cultural knowledge to work more effectively with a given client (Sue, Arredondo, & McDavis, 1992). In their foundation work titled *Multicultural Counseling Competencies and Standards: A Call to the Profession*, Sue, Arredondo, and McDavis (1992) explained that "a culturally skilled counselor is one who is in the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different clients (Sue, Arredondo, & McDavis, 1992). Such skills may include choosing and administering appropriate interventions, building rapport, and the ability to engage in social justice work (Sue & Sue, 2008). This three-part definition informs much of the research upon which this study was built (e.g., Butler, 2003; Cary & Marques, 2007; Inman & Kreider, 2013; Roysircar, Dobbins, & Malloy, 2010; Suthakaran, 2011; Ter Maat, 2011).

Multicultural case conceptualization. Multicultural case conceptualization ability is the extent to which a therapist identifies, integrates, and examines the influence of cultural, contextual, personal, and sociopolitical factors in the etiology and treatment of the individual (American Psychological Association, 2010; Constantine, 2001; Ladany Inman, Constantine, & Hofheinz, 1997; Sue, 2003). This definition of multicultural case conceptualization extends beyond the general case conceptualization skillset in a few ways. Broadly, general case conceptualization is a method of understanding a client's presenting issues and planning treatment which integrates multiple sources of client information. General case conceptualization is the ability to synthesize a large amount of complex information such as cognitive, behavioral, emotional, and interpersonal factors, into an overall understanding of the client's behavior, level of functioning, and psychological life (Lee & Tracey, 2008). Multicultural case conceptualization skills are

distinct from general case conceptualization skills in that they pertain to the specific ability to recognize salient cultural factors in clients' presenting concerns and requires the clinician to integrate this information in client conceptualization and treatment planning (Constantine, 2001).

It may be important to note here that case conceptualization is often used interchangeably with the term *case formulation* in the literature. There is an important difference between case conceptualization and formulation. Shea et al. (2010) specifically noted that case formulation emphasizes how culture shapes clients' personal experience and their expression of mental health issues, while case conceptualization focuses on the therapist's consideration of dynamics in the therapeutic relationship and between the client and their environment. Therefore, case formulation emphasizes the client's experience and presentation, whereas case conceptualization focuses on the therapists' process of understanding and treating the client. In this study, multicultural case conceptualization is the primary focus. Relevant literature on case formulation is included in the literature review (e.g., Eells, 2015) for comprehensiveness, as many authors use the terms interchangeably.

Quality of conceptualization. Quality of conceptualization is typically studied by assessing the level of trainee cognitive complexity. In fact, Welfare (2007) contended that the primary goal of therapist training is the development of therapist cognitive complexity with the goal of improving the quality of conceptualization skills.

Cognitive complexity is defined as the level of differentiation and integration in an individual's cognitive system (Crockett, 1965; Welfare, 2007). Differentiation is defined as the number of available constructs in an individual's cognitive system in a

certain domain. For example, the therapist may understand their client as spiritual, struggling with depression, and being from an African American ethnic background (Crockett, 1965; Welfare, 2007). In this simplified example, three different constructs, spirituality, depression, and ethnicity, form the therapist's conceptualization of the client. Integration is defined as the ability to recognize relationships among cognitive constructs regarding a particular domain (Crockett, 1965; Welfare, 2007). In the aforementioned example, the therapist may conceptualize the client's spiritual system as being a major component of their African American ethnic background which could perhaps be a strength in managing their depression.

As previously indicated, therapist conceptualization quality is often defined as the number of different constructs and the extent to which these constructs are integrated together. Therefore, a higher level of cognitive complexity, or differentiation and integration, is associated with higher quality of client conceptualization (Ladany et al. 1997; Welfare, 2007).

Trainee. *Trainee* is used to refer to the participant group in this study. Trainees include second year master's clinical mental health students and first year Licensed Professional Counselors In-Training. These trainees were combined into one participant group because all had recently experienced training in multicultural competence and were seeing clients under the supervision of a licensed clinician. Additionally, all participants were working with clients who were of a different race or ethnicity than themselves. Therefore, this participant group was at an appropriate point in their training to provide information on the content and quality of multicultural conceptualizations and discuss their training experience with these skills.

Overview of Study Methods

In this study, mixed methods were utilized with a qualitative emphasis. Specifically, the study is an embedded design (Creswell & Plano Clark, 2011), and quantitative findings are intended to support or affirm qualitative data. Interviews consisted of a think-aloud procedure in which participants vocalized their thought processes leading to the creation of a client conceptualization. Following the think-aloud procedure, a semi-structured protocol guided participant interviews. The semi-structured interview was comprised of two components. First, the trainee was asked questions pertaining to the integration of race and ethnicity into the conceptualization created during the think-aloud portion of the interview. Second, trainees were asked questions regarding their training on multicultural case conceptualization skills.

Overview of Data Analysis

The content of the think-aloud interview procedure and the semi-structured interview were analyzed using Consensual Qualitative Research (CQR; Hill, 2012). CQR is a method through which interview content can be qualitatively analyzed resulting in themes that are representative of the sample of trainees' experiences. In addition to CQR, the research team used the content from the think-aloud procedure to complete the Counselor Cognitions Questionnaire (CCQ; Welfare, 2007). The assessment provides a quantitative measure of the complexity (level of differentiation and integration) of the trainees' client conceptualization. The CCQ (Welfare, 2007) was used as an embedded quantitative measure and was analyzed using established scoring criteria.

CHAPTER 2: LITERATURE REVIEW

This chapter begins with a review of general case conceptualization literature which will address an overview of conceptualization models, research on treatment outcomes, and influential therapist factors associated with case conceptualization. A review of the literature on general case conceptualization is intended to provide context for understanding multicultural case conceptualization skills. A primary shortcoming of the literature on case conceptualization is the lack of focus on multicultural issues. For this reason, the second section of this review provides a rationale for the importance of integrating multiculturalism into case conceptualization. The third section of this review will provide an analysis of literature and research on multicultural case conceptualization including conceptual literature and research findings. In the final section, a critical analysis of research methodology specific to multicultural case conceptualization is offered and study methods are briefly reviewed.

General Case Conceptualization

Case conceptualization has long been recognized as important to counseling and psychotherapy as an essential skill which guides therapist decision-making regarding treatment (Eells, 2007). Importantly, these skills allow the therapist to cognitively organize large amounts of complex information that directly effects treatment (Easden & Fletcher, 2018). Case conceptualization guides therapist decision-making by linking the presenting concerns with causal factors (Eells, 2007). Therefore, case conceptualization is an important skill which the therapist can use to form their understanding of the client (Easden & Fletcher, 2018).

While case conceptualization is an important clinical skill, there is limited empirical research in the area and even less on multicultural case conceptualization. This section provides an overview of the case conceptualization literature and research to provide context for understanding multicultural case conceptualization skill development.

Case Conceptualization Model Overview

This section on general case conceptualization begins with an overview of conceptualization models. Conceptualization models are briefly described by theoretical orientation to explore foundational differences between the various approaches. Subsequently, common procedural steps which are consistent across approaches are described.

Theoretical approaches. Conceptualization models have generally aligned with three primary theoretical approaches including psychoanalysis, cognitive-behavioral, and humanistic theory. More recently, integrative models, such as the biopsychosocial model, have sought to provide a unified approach to conceptualization (Engel 1977; Sperry & Sperry, 2012).

Models of conceptualization derived from psychoanalytic theory emphasize interpersonal and developmental factors in conceptualizing clients (Eells, 2007). Psychodynamic conceptualization developed on the principle that people are motivated to connect with one another (Horiwitz & Eells, 2007; Luborsky & Barrett, 2007). Specifically, the therapist may consider how the client conceptualizes themselves and others and how that understanding shapes their relationships. In addition to the interpersonal emphasis, developmental factors pertaining to early life experiences are emphasized by therapists using this approach. These early life experiences form the

foundation for how that client understands themselves and their environment (Horiwitz & Eells, 2007). An example integrating both developmental and interpersonal themes from a psychodynamic conceptualization approach is a client who has depression and few close relationships. That client may hold the self-perception that they are unworthy of intimacy, stemming from negative messages they had received from their parents as a child. A psychodynamic approach to conceptualization would consider how these childhood messages formed the client's maladaptive view of themselves in relation to others. Based on this conceptualization, treatment interventions may focus on improving interpersonal relationships and decreasing depression.

In contrast to the psychoanalytic approach, therapists using cognitive-behavioral therapy (CBT) frameworks conceptualize how the client learns from their environment and whether the client's behaviors reflect maladaptive or adaptive psychological functioning (Nezu, Nezu, & Cos, 2007). Therapists decide how adaptive psychological functioning and behavior is based on whether a behavior is effective in the client's environment. For example, for a client who has anxiety regarding declining grades in school, avoids studying, and instead engages in recreational activities resulting in further decline in grades, a therapist using a cognitive-behavioral approach would conceptualize this aspect of their functioning as maladaptive. Declining grades may lead to anxiety, avoidant behaviors, and perhaps negative thoughts regarding that client's intellect. As in this example, most CBT approaches focus on the client's presenting concerns and do not emphasize client strengths. Alternately, one CBT conceptualization model which does focus on client strengths in addition to thoughts, emotions, and behaviors is the "Case Conceptualization Crucible" (Kuyken et al., 2009). This approach emphasizes the

consideration of client strengths when conceptualizing the client. Overall, therapists adhering to a CBT approach conceptualize how their client manages problems and what emotions and thoughts are associated with the client's presenting concerns (Nezu, Nezu, & Cos, 2007).

Distinct from a cognitive-behavioral perspective, humanistic approaches to conceptualization emphasize the client as being constantly in a state of flux and striving to achieve mental wellness within their environment (Eells, 2007; Greenberg & Goldman, 2007). Humanistic models emphasize how the individual has adapted to meet changing environmental demands. Individuals who are successful in meeting these changing demands demonstrate periods of struggle, followed by resolution of concerns reflecting flexibility to meet environmental demands. Alternately, individuals who are unsuccessful are rigid in approaching changing environmental demands and may experience prolonged periods of distress and pain as they are unable to adapt to challenges (Greenberg & Goldman, 2007). For example, a client on an inpatient unit who is overwhelmed by stress and experiencing suicidal thoughts caring for an aging parent may reach out to other family for help in caring for the parent. This response may be conceptualized as an adaptive solution from a humanistic approach and could result in resolution of the problem. That client may also decide he needs to care for his aging parent on his own and continue to experience overwhelming stress and suicidal thoughts. This response is considered maladaptive and may result in a continuous cycle of ongoing suicidal thoughts secondary to stress.

In contrast to the aforementioned approaches which adhere to a single theoretical school, the biopsychosocial model is an integrative conceptualization framework

developed by George Engel (1977). The model was specifically created in an attempt to incorporate a systems approach for providers in medical settings (Engel, 1977). Conceptualizations using this approach are comprised of three component parts including biological, psychological, and sociocultural functioning. For example, an individual with depression and several medical issues may be conceptualized from a biopsychosocial perspective using the following client information. Biological considerations may include the client's genetic history of depression and changes in neurological functioning due to medications he has recently started taking to treat chronic pain concerns. Psychologically, this client may perceive himself to be dependent on others which contributes to his depression. Further, the client may feel hopeless in managing his medical issues and the recent change in physical functioning might leave him fearful regarding his future capacity to care for himself. Socially, the client may have a close relationship with his husband and several close friends from a support group whom he feels he can trust. Concurrently, his medical problems and depression have caused him to isolate himself and he worries that lifelong friends are now distant.

The above approaches provide a guiding framework for therapists to consider which factors to include in conceptualization. While these theoretical models may provide a foundation for case conceptualization, the above approaches do not emphasize or address how multicultural concerns are integrated into the formulation. This lack of multicultural integration is problematic and could result in discriminatory mental health treatment (Ridley & Kelly, 2007). For example, a client may struggle within their environment if affected by oppression, discrimination, or inequitable resources. The aforementioned approaches do not account for these effects on clients and this client may

be perceived by the therapist as unable to meet environmental demands and

psychologically maladjusted. This conceptualization of the client neglects the client's

multicultural experiences and identity, potentially resulting in inaccurate perceptions of

the etiology of client concerns or the selection of ineffective treatment interventions. As

such, best practice in conceptualization suggests that therapists consider multicultural

factors within conceptualization, regardless of theoretical approach, to increase accuracy

of conceptualizations.

  Common processes in conceptualization. Regardless of theoretical perspective,

conceptualization approaches often universally follow three main steps. These steps

include (a) identifying relevant clinical information, (b) connecting and interpreting

gathered client data, and (c) applying the formulation to a client case (Eells, 2007). As

such, the therapist initially observes and describes relevant clinical information. Most

approaches to conceptualization include an open-ended clinical interview, in addition to

interviewing family informants and psychological testing (Eells, 2007). While several

guidelines exist outlining factors to integrate into a conceptualization, Berman (1997),

Prochaska (1995) and Needleman (1999) each offer examples of these guidelines.

Berman (1997) addressed multiple contextual components in his list of elements to

include in a case conceptualization. These elements included (a) how age-appropriate the

client's behaviors are, (b) how the client's abilities and values affect the treatment, (c) the

role peers, caregivers, and adults have on the client, (d) how sexual orientation, gender,

or cultural background affect treatment, (e) the client's medical history, religion,

socioeconomic status, education, and history of abuse, and (f) sources of strength. In

another perspective, Prochaska (1995) created a list of factors which should be included

in case conceptualization. These factors included (a) client symptoms and situational problems, (b) maladaptive cognitions, (c) current interpersonal conflicts, (d) family and systems conflicts, and (e) intrapersonal conflicts. In another model, Needleman (1999) described five elements which should comprise a case conceptualization. These components include the client's (a) cognitive, affective, and behavioral responses to triggering events, (b) beliefs that determine those responses, (c) circumstances that initiate the client's maladaptive responses, (d) environment's response to the client's behavior, and (e) learning history that contributes to the client's vulnerability. Though these examples are far from inclusive of all data gathering frameworks in conceptualization, this sampling of conceptualization models provide a snapshot for client factors that are typically emphasized. Overall, models include inter- and intrapersonal characteristics and seldom emphasize contextual factors, such as clinical setting or client cultural background.

Second, the therapist infers, interprets or organizes gathered client information. As such, the therapist conceptually moves from description, diagnosis, and listing client characteristics to addressing how these factors fit together to cause or maintain the problem. This second step is the key to what differentiates the various theoretical approaches (Eells, 2007). For instance, psychoanalytic theory hypotheses focus on how the client's past relationships may influence their current interpersonal functioning. In CBT hypotheses, the therapist formulates how the client's thoughts, emotions, and behaviors influence the presenting concerns. In humanistic theory hypotheses, the therapist conceptualizes how effectively the client can flexibly meet changing environmental demands. Overall, in this second step, the therapist's focus when creating

a hypothesis regarding the etiology of client concerns is guided by their theoretical school. This hypothesis serves as a representation of the client.

Third, the therapist applies the conceptualization to a client case by developing treatment goals and strategies based on this client understanding. In this sense, therapists use the conceptualization to choose treatment interventions the therapist believes may be most effective for that client. Additionally, the therapist may share their conceptualization and proposed treatment plan with the client for feedback. This client feedback can then be used to modify the conceptualization and further inform treatment. Importantly, this step is ongoing and includes revisions to the conceptualization as new information emerges or when treatment does not progress (Eells, 2007). This step of continuous refinement of the conceptualization is universally included in all approaches, yet tends to be overlooked in practice, particularly by trainees (Eells, 2007). Specifically, compared to expert therapists, trainees are more likely to continue to apply the same case conceptualization, unaltered, to a given client regardless of treatment progress (Eells, 2015).

Amongst these common steps to case conceptualization, there is little inclusion of the client's culture. In the data gathering step, the frameworks do not guide the therapist to include cultural considerations when gathering salient client information. For instance, there is limited consideration of cultural strengths, how the client's cultural background may inform their treatment goals, and how the client's racial or ethnic background influences their close relationships. Therefore, in the subsequent interpretation phase during which the data is meaningfully integrated, the therapist does not include cultural considerations into the client conceptualization. The lack of cultural integration is further

compounded in the final phase for culture is not accounted for or integrated in treatment planning. This lack of cultural consideration may lead to misdiagnosis and ineffective treatment (Ridley & Kelly, 2007). Since novice therapists are less likely to adjust their early conceptualizations once formed, conceivably they may not adjust to account for multicultural influences even if these factors are later discussed in therapy (Eells, 2015).

Comparing Expert and Trainee Conceptualizations

Research suggests experience level of the therapist appears to have a strong connection to case conceptualization abilities (Eells, et al., 2011). As context for this section, theorists and researchers have defined expert therapists as mental health providers with ten or more years of practice (Eells et al., 2011). Experienced therapists were defined as those with less than 10 years of experience. Novice therapists were defined as those who were practicing but not yet licensed.

In early theoretical work on conceptualization, Sakai and Nasserbakht (1997) contended that expertise in conceptualization is characterized by three factors. Foremost, clinical experience was theorized as necessary to increase case conceptualization skill level. Additionally, cognitive changes were theorized to occur as the therapist gains clinical experience. Furthermore, these changes result in a greater ability to identify salient client characteristics and to integrate these characteristics into a meaningful representation of the client. Lastly, therapists were theorized to focus on qualitatively different aspects of the client with gained experience, such as the client's strengths, transference and countertransference factors, and emotional reactions the client elicits in the therapist. In sum, clinical experience may be necessary to promote the cognitive changes among therapists that appear to result in higher quality case conceptualizations.

There is very limited empirical research in this area and, consequently, Eells and her colleagues explored how expert and novice therapist's case conceptualizations differed to better understand the effect of clinical experience on the content of case conceptualization. In the only study in this area, Eells et al. (2011) compared quality case conceptualizations by expert and novice therapists and found several significant differences. Foremost, expert quality case conceptualizations were more comprehensive in the domains of global, psychological, social, and occupational functioning than those with less experience. Specifically, expert formulations contained more descriptive, diagnostic, inferential, and treatment planning information and focused more on symptoms, relationship history, psychological mechanisms, and on the need for further evaluation. Expert therapists also made far more connections between types of client information including, symptoms or problems, predisposing experiences, events, traumas, stressors, psychological mechanisms, biological mechanisms, and social and cultural mechanisms. Importantly, expert-level therapists were more likely to provide a comprehensive and integrated perspective of the client that made sense of the interconnections among salient client characteristics. Additionally, expert quality case conceptualizations included a higher number of sources of client strengths and identification of potential therapy interfering events than novice therapists. In sum, novice clinicians offered case conceptualizations that were less sophisticated and integrated than those developed by experts.

Influence of Case Conceptualization on Treatment Outcomes

In addition to research on the effect of clinical experience, there are also a few studies that explore the relationship between treatment outcomes and case

conceptualization skills. For example, Crits-Christoph and Luborsky (1998) explored treatment outcomes that resulted from psychodynamic case conceptualization approaches. They studied the Core Conflictual Relationship Theme model, a psychodynamic approach to conceptualization that emphasizes object relations and interpersonal dynamics. In a sample of 43 clients, therapists based their interventions on two psychodynamic themes they used to conceptualize their clients. Therapists conceptualized who the client would like to be in that core conflictual relationship and the client's response from others from an object relations perspective. Conceptualizations which included these psychodynamic themes to understand the client's presenting problems had a moderately strong correlation with that client's treatment outcome. Specifically, clients whose therapists included these psychodynamic themes in conceptualization displayed a decrease from the beginning to the end of therapy in the percentage of interpersonal problems present in that conflictual relationship.

A more recent investigation examined the association between case conceptualization ability and therapeutic outcomes among therapists using a cognitive-behavioral approach with clients suffering from depression. Cognitive-behavioral perspectives emphasize the association between a client's thoughts, feelings, and behaviors and how these factors contribute to the presenting concern (Eells, 2007). In this study, a conceptualization rating scale was used to evaluate case conceptualization quality across 12 domains considered most relevant to case conceptualization such as automatic thoughts, core beliefs, client strengths, and compensatory strategies for 28 clients receiving CBT for depression. They found that higher quality case conceptualization was positively associated with improved client depression as assessed

by the Beck Depression Inventory-II (Easden & Fletcher, 2018). After accounting for variables which typically impact depression improvement, such as number of therapy sessions, comorbid personality disorders, and symptom severity, therapist competence in case conceptualization was found to explain a significant portion of the variance in improvement of depression symptoms. Alternately, lower quality client case conceptualizations were associated with less of a decrease in client depression scores.

Collectively, these two investigations suggest case conceptualization skills impact subsequent treatment outcomes. Though sparse, the empirical research to date has provided evidence that therapist competence in case conceptualization is positively associated with treatment outcomes.

Variables that Effect Case Conceptualization Quality

In addition to the influence of case conceptualization on treatment outcome, research has also found an association between case conceptualization and two areas of individual difference among therapists. These factors may differ by therapist and contribute to varying degree of multicultural case conceptualization skills. In particular, therapist cognitive influences and clinical training were found to be positively associated with case conceptualization skills.

Therapist cognitive influences. A few therapist cognitive factors have been found to influence the level of case conceptualization skills including cognitive complexity and psychological mindedness. The therapist's level of cognitive complexity is comprised of two cognitive abilities that have been found to influence case conceptualization skills, differentiation and integration (Crockett, 1965; Welfare, 2007). Differentiation is the number of identified characteristics that influences the client.

Examples of such client characteristics may include client emotions, automatic thoughts, behaviors, core beliefs, gender, racial background, and presenting concerns. Integration is how well the therapist can make associations between these client characteristics. For example, the therapist may conceptualize how the client's racial background and gender influences their core beliefs or how a client's emotions and behaviors contribute to the presenting concern. The therapist's level of differentiation and integration, referred to as their cognitive complexity, is believed to have a significant influence on the therapist's ability to create client conceptualizations. As such, therapists, identify many relevant client factors (i.e., differentiation), and then those client factors are meaningfully integrated with one another (i.e., integration) to formulate the conceptualization of the client's experience (Ladany et al., 1997; Lee & Tracey, 2008; Welfare & Borders, 2010).

Theoretically, cognitive complexity is believed to influence the quality of clinicians' case conceptualizations (Welfare & Borders 2010). Cognitive complexity level pertains to one's ability to mentally consider and manipulate complex, ambiguous information. Pertaining specifically to case conceptualization, cognitive complexity level increases the therapist's ability to cognitively hold many different client characteristics and integrate these factors together in a way that is meaningful. Indeed, the extent to which therapists can identify salient client characteristics (differentiation) and integrate these characteristics into an overall understanding of the client (integration) is typically how conceptualization quality has been operationalized in the extant literature (Ladany et al., 1997; Lee & Tracey, 2008; Welfare & Borders, 2010).

A few researchers have examined cognitive complexity and the association with case conceptualization. For instance, Granello (2010) found that high cognitive

complexity is positively associated with self-reported empathy and depth of client

conceptualization. This finding suggests that there is an association between cognitive

complexity level and those abilities which underlie case conceptualization skills.

Additionally, another study found that counselors with high cognitive complexity

produced less biased and stereotyped conceptualizations than counselors with lower

cognitive complexity (Ladany, Marotta, & Muse-Burke, 2001). Therapists with high

cognitive complexity produced conceptualizations with more detailed information

regarding the client's experience rather than assuming a client's diagnosis or the

presenting concern provided sufficient information. Overall, a higher level of cognitive

complexity is suggested to result in higher quality of client conceptualizations (Ladany et

al., 1997; Welfare & Borders, 2010).

Beyond the specific cognitive complexity ability, a secondcognitive influence

appears to be the level of therapist psychological mindedness. Psychological mindedness

is an individual's inclination or personal ability to see associations among thoughts,

feelings, and actions, with the goal of learning the meaning of experiences and cause of

behaviors (Hartley et al., 2016). These abilities appear important to case

conceptualization for psychological mindedness requires cognitive flexibility and

hypothesis forming based on characteristics which may not be directly observable, such

as feelings or thoughts (Hartley et al., 2016). As such, psychological mindedness appears

to be at the heart of case conceptualization abilities.

Hartley et al. (2016) explored factors associated with case formulation skills in

clinical practice, including psychological mindedness. Specifically, Hartely et al. (2016)

tested the predictive ability of therapist psychological mindedness, attachment style, and

burnout on quality of staff case conceptualizations for clients experiencing psychosis. In a multiple regression analysis, they found that psychological mindedness was the only predictor of case formulation skill. The study provides evidence of the importance of therapist psychological mindedness for case conceptualization. Notably, psychological mindedness and cognitive complexity may both rely on similar underlying characteristics, such as the therapist's cognitive flexibility and ability to see relationships.

Therapist training. In addition to therapist cognitive influences, a diversity of training experiences is believed to promote the development of case conceptualization skills. For instance, didactic methods of training may include course instruction, readings, workshops, and research. Additionally, clinical experience is a component of training which may include working with and learning from supervisors, colleagues, and clients. These methods of training are suggested to promote proficiency in case conceptualization (Eells, 2007; Lee & Tracey, 2008) however, the literature on therapist training provides little empirically-based guidance on improving conceptualization skills. Indeed, Eells (2007) indicated that an important area of future research pertains to how case conceptualization skills are effectively taught to therapists in training. While there is a need for further study, the limited research has focused on two areas including the association between case conceptualization skills and amount of clinical training, and the influence of targeted training opportunities on these skills.

Amount of training. The influence of clinical training was first studied by Lee and Tracey (2008) who explored the association between trainee general case conceptualization skills and the number of clinical courses. They found that trainees with more than one semester of clinical training coursework, such as a practicum or internship

class, exhibited significantly higher quality of case conceptualization ability in comparison to trainees with only one practicum or internship course. Therefore, conceptualizations produced by trainees with more clinical coursework displayed a higher number of client characteristics (differentiation) and showed more thorough integration of characteristics as assessed by trained raters.

A few studies have sought to expand this research on the influence of clinical training by exploring the effect of clinical experience on case conceptualization skills. Specifically, research has compared novice therapists (i.e., master's degree counselors-in-training) to those with more experience (i.e., post-master's degree counselors) and found a significant association between level of clinical experience and case conceptualization skills. For example, Welfare and Borders (2010) examined the association between the level of trainees' differentiation and integration abilities and level of clinical experience. They found that clinical experience working with clients was significantly associated with trainee ability to identify salient client characteristics (differentiation), but not their ability to integrate these characteristics into a holistic representation (integration). Trainees may have more readily developed differentiation than integration skills because integration is a complex cognitive skill which is challenging for trainees and seldom a focus of training (Tate & Amatea, 2010; Welfare & Borders, 2010). Therefore, integration skills may be more challenging for trainees to develop than differentiation skills resulting in quicker development of differentiation skills. Further, trainee development of differentiation skills prior to integration skills may reflect a normative developmental process such that trainees typically gain experience identifying salient

client characteristics before learning to meaningfully integrate these characteristics with one another.

A construct related to amount of clinical training is therapist experience level. Though therapists with more clinical experience do not necessarily have more clinical training, one aspect of training which has been found to improve case conceptualization skills is degree of clinical experience (Lee & Tracey, 2008), therefore, a closer examination of the influence of clinical experience on case conceptualization skills is warranted. For instance, Eells et al. (2011) conducted a study with 65 cognitive-behavioral or psychodynamic therapists classified as experts, experienced, or novice who generated think-aloud conceptualizations based on a vignette. Transcripts were content coded and conceptualization content was analyzed to explore the conceptualization process at each of these experience levels. They found numerous differences based on experience level, such as how comprehensive the conceptualizations were and to what degree client characteristics were presented in an integrated manner. Perhaps a prerequisite for integrating client characteristics in a meaningful manner may be a strong foundation in differentiation skills. Overall, these findings suggest that clinical training in the form of coursework and clinical experience positively influences the development of case conceptualization skills, and several studies have suggested that, specifically, the experiential component of training promotes these skills (Eells et al., 2011; Lee & Tracey, 2008).

Targeted experiential trainings. Beyond the level of therapist training, several studies have assessed the impact of experiential targeted trainings on case conceptualization skill development. In particular, several trainings have used simulated

clients and provided instruction on case conceptualization to increase case conceptualization skills. For instance, one study by Osborn et al. (2004) retrospectively analyzed course effectiveness for a class that used a simulated multidisciplinary team meeting to increase case conceptualization skills. As a component of an advanced counseling skills graduate course, trainees met with a simulated client four times. The course instructor observed the interactions with the client via a live feed. After each meeting the trainees engaged in individual supervision with the instructor to process the interactions, conceptualize the client, and explore treatment options. They found that trainees were more able to discuss the use of a theoretical approach with the assigned client and infuse this theory throughout the case conceptualization when comparing conceptualization skills from the beginning to end of the course. Following the course, trainees were asked whether the method of teaching was helpful in increasing case conceptualization skills and 47% responded that the method was helpful. As a study limitation, there is little information regarding instructor feedback to improve case conceptualization skills which detracts from the replicability of the study. Despite these limitations, this study provides an example of how case conceptualization skills may be improved using a targeted course format with a simulated therapy component.

In a study which used technology to provide consistent feedback to trainees, videotapes of simulated clients and a computerized program were used to target case conceptualization skills (Caspar et al., 2004). Specifically, they focused on increasing similarity between expert and novice level case conceptualizations. In this computerized method, 32 trainees were split into a control group and a training group. The 16 participants in the training group engaged in four one-hour training sessions. Participants

watched videotapes of hypothetical clients engaged in an intake session. After the session, participants entered all material they thought was relevant to the case into a computer program. Their responses were compared to expert responses to the same hypothetical client. Participants received feedback from the computer program indicating what percentage of the client data the participant entered into the computer was consistent with the expert conceptualization. The participant then had the opportunity to change their client conceptualization and received feedback from the computer program a second time. They found that there was a significant increase in the conceptualization content in comparing the first and last training session of the group receiving feedback in comparison to the control group who did not receive feedback. This study provides evidence that the number of client characteristics included in the conceptualization may be increased through direct feedback.

Role plays were used as another training method in a study to target case conceptualization skills (Little et al., 2005). In this study, researchers used a training model targeting differentiation and integration of client characteristics to produce comprehensive case conceptualizations. They found that trainees who were given specialized skills training, with an emphasis on role-play and feedback from classmates and the instructor, developed higher levels of conceptualization complexity than those who did not receive the skills training. Though the use of role-play to improve case conceptualization skills was an extension of prior research in this area, role plays may not accurately reflect the case conceptualization process which takes place with actual clients.

One study sought to address the limitations posed by role plays by using actual clients to create conceptualizations following a targeted workshop. Kendjelic and Eells (2007) compared case conceptualizations written by therapists with clinical experience ranging from one month to 20 years. While 20 participants engaged in a two-hour training session in case conceptualization, 23 therapists were part of a control group and did not receive case conceptualization training. The workshop addressed the importance of case conceptualization as a core therapist competency and broke down conceptualization into a framework to help trainees conceptualize the client's overall adaptive or maladaptive patterns. Additionally, the training provided education to participants regarding how the quality of case conceptualizations improved when multiple facets of the client's life are integrated into a coherent representation. Next, each participant wrote two to three conceptualizations based on intake interviews at a university-based mental health clinic. Overall, the conceptualizations produced by those therapists who had engaged in the training program were more comprehensive, contained more client information, and the client information was more meaningfully integrated than those who had not received training. Additionally, the conceptualizations following the training were more likely to address precipitants, predisposing factors, and inferred causes of the individual's presenting concerns. Effect sizes suggested that the average therapist in the training group produced a more comprehensive formulation than 86% of those in the control group. Importantly, this is one of few studies which used actual, rather than simulated, clients to evaluate the quality of conceptualization. Although this provides evidence that, regardless of degree of experience, a short training exercise increased conceptualization skills, the study lacks specificity in targeting trainee

development. In summation, both traditional forms of clinical training such as didactic coursework and clinical experience, and targeted trainings using clients have been found to increase case conceptualization skills (Caspar et al., 2004; Osborn et al., 2004; Welfare & Borders, 2010).

Summary. Overall, constructs suggested to have a significant association with general case conceptualization skills include therapist cognitive influences and clinical training. In particular, cognitive factors, including the level of cognitive complexity and psychological mindedness, have been found to be positively associated with case conceptualization skills (Hartley et al., 2016; Ladany et al., 1997; Welfare, 2007). As such, opportunities to develop these abilities through training opportunities may be particularly important. Additionally, clinical training in the form of classwork, clinical experience, and targeted case conceptualization training opportunities have been found to increase case conceptualization skills (Caspar et al., 2004; Osborn et al., 2004; Welfare & Borders, 2010). Perhaps these training opportunities serve to increase the conceptualization skills by increasing trainees' cognitive abilities in this domain. While a number of methods were found to be helpful to improving conceptualization abilities, findings clearly indicate that immediate feedback played an important role (Caspar et al., 2004; Little et al., 2005; Osborn et al.; 2004). Though this prior research informs potential influences on therapist case conceptualization ability, there is limited case conceptualization research which addresses multicultural issues.

Limits of Case Conceptualization Literature

Overall there are several issues within the scant empirical research on general case conceptualization skills, one of which is the lack of research on how therapists

conduct case conceptualizations in real-world practice (Easden & Fletcher, 2018; Kuyken et al., 2009). For example, Osborn et al. (2004) and Lee and Tracey (2008) used analogue research designs to evaluate trainee case conceptualization skills. This analogue design used pseudo clients presented through vignettes, which may not reflect case conceptualizations created based on actual clients. This limitation calls for research designs which assess case conceptualization skills using actual therapy clients as real clients may more accurately reflect the complexity of clinical practice than hypothetical vignettes.

Beyond methodology, multicultural concerns have not been well integrated in case conceptualization models. For instance, theoretical models of conceptualization do not address the integration of multicultural client characteristics as an area of focus when conceptualizing the client. For many clients, cultural background may be a salient concern and, because these models do not encourage multicultural considerations, culture is likely to be neglected in conceptualization and treatment (Falicov, 1998). For instance, a foreign exchange student who experiences consistent discrimination based on their race and feels isolated and depressed in the United States may possibly be conceptualized as interpersonally maladjusted if culture is neglected. Indeed, from a humanistic approach to conceptualization, one's adjustment to environmental challenges is a primary consideration in how psychologically healthy one is conceptualized to be. Further, the conceptualization may result in treatment focused on facilitating social skill development. Therefore, this conceptualization neglects culture as a major factor which contributes to the etiology of concerns. Overall, the consideration of multicultural factors in

conceptualization is an important, and often neglected, component of case conceptualization.

Multicultural Counseling Competence

Integrating client multicultural factors into case conceptualization is believed to be a part of culturally competent therapy practice (Bernal et al., 2009; Bray, 2010; Tegnerowicz, 2018). The following section includes a discussion of the influence of multicultural counseling competence on client treatment outcomes. Given these treatment outcomes, the section then includes a rationale for the importance of multicultural case conceptualization skills as one component of multiculturally competent practice. The section concludes with a brief discussion regarding the lack of specificity in research on multicultural counseling competence and potential consequences of this issue.

Influence on Treatment Outcomes

Multiculturally competent practice may positively influence treatment outcomes, an important area given that inadequate mental health treatment for racial and ethnic minorities is a widespread concern (Bernal et al., 2009; Tegnerowicz, 2018). This inadequate treatment results in mental health disparities, despite the heightened attention multicultural issues have received in research, training, and ethical codes over the past 30 years (Bray, 2010; Heppner, Casas, Carter, & Stone, 2000; Ridley, 2005). In fact, more than a half century of research highlights the pervasiveness of racism in the mental health system (Ridley, 2005). Additionally, mental health services provided to individuals of racial or ethnic minority background has been found to be less effective than those provided to White clients (Tao et al., 2015). Overall, despite these mental health disparities, there continues to be a lack of attention to cultural issues in therapy practice.

The widespread lack of attention to cultural factors that pervades the field of psychology is detrimental to practice and results in ineffective treatment to clients who are racial or ethnic minorities (Eells, 2007; Ridley & Kelly, 2007). Specifically, there is a lack of attention to the influence of acculturation, racial identity, and immigration on the client, the therapist, and the setting in which they meet. This lack of attention characterizes many therapists' practice despite the clinician belief that they are practicing in a multiculturally competent manner. Indeed, findings from an early empirical study indicate that many therapists who claim to consider culture when working with clients cannot articulate how they do so, particularly in considering client assimilation and acculturation (Ramirez, Wassef, Paniagua, & Linskey, 1996). Notably, the lack of attention to important multicultural issues increases the risk of over-pathologizing or under-pathologizing clients based on the therapist's misunderstanding of culture (Ridley & Kelly, 2007). When therapists do not account for cultural influences in therapy, miscommunication, misunderstanding, and mistreatment often occur. Indeed, therapists who ignore or minimize culture may overlook the realities of their clients' lives, their own lives, and the counseling context in which the therapy is embedded. Ridley and Kelly (2007) contended that these cultural oversights guarantee biased perceptions of clients' circumstances, inaccurate case conceptualizations, misdiagnoses, and potentially ineffective treatment interventions. To address racism in the mental health system and disparities in service, many have focused on increasing multicultural counseling competence (American Psychological Association, 2010; Bray, 2010; Sue et al., 1992).

Practicing with multicultural counseling competence may have a positive influence on client treatment outcomes. For example, client-rated multicultural

competence was strongly associated with therapeutic alliance, client satisfaction, general counseling competencies, and session depth (Tao et al., 2015). Additionally, multicultural competencies were found to have a moderate relationship with symptom remission following treatment (Tao et al., 2015). Similarly, Griner and Smith's (2006) meta-analysis showed that culturally-adapted interventions designed for specific racial or ethnic groups were four times more effective than universal interventions that were not adapted to the client's racial or ethnic background. The collective findings from these meta-analyses suggest that culturally competent treatment significantly increases treatment efficacy in multiple domains when working with individuals of minority racial or ethnic backgrounds (Griner & Smith, 2006; Tao et al., 2015). As such, focus on multicultural counseling competence is of primary importance and appears to directly influence therapy outcomes. While research findings have indicated that multicultural counseling competence positively influences treatment outcomes, the majority of literature has pertained to multicultural awareness and knowledge development and neglected inquiry into multicultural skills (Ponterotto, Rieger, Berrett, & Sparks, 1994; Priester, Jones, Jackson-Bailey, Jana-Masri, Jordan, & Metz, 2008; Ridley & Kelly, 2007).

Case Conceptualization Integrating Culture

While there are multiple skills within multicultural competence important to clinical practice (e.g. choosing assessments with appropriate norming groups, consulting with members of the client's culture, culturally sensitive therapy practices), multicultural competence in case conceptualization is believed to be crucial to providing effective services to clients who are racial or ethnic minorities (Hill et al., 2013). As such,

competency in case conceptualization includes accounting for cultural influences, sociocultural context, effect of discrimination and oppression, client racial identity, and sources of cultural support and strength. The integration of these cultural influences into case conceptualization reflects a cultural perspective. This cultural perspective is important when working with diverse clients because the conceptualization serves as a hypothesis regarding that client and guides treatment planning (Eells, 2007). For instance, an individual's racial or ethnic background is often salient to that person's identity and may influence the efficacy of mental health treatment. Therefore, failing to address these aspects of the client when forming a conceptualization results in an inaccurate understanding of that client and, perhaps, less effective treatment interventions. These less effective treatment interventions may contribute to the mental health disparities which comprise the current mental health care system today (Leong & Lee, 2006; Ridley & Kelly, 2007).

Based on the potential importance of integrating culture into conceptualization, multicultural case conceptualization is emerging in practice guidelines and training materials for mental health practitioners. For example, multicultural case conceptualization is included as one of ten guidelines in the 2017 APA multicultural standards titled *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*. Also, recent revisions of counseling textbooks such as *Clinical Mental Health Counseling: Fundamentals of Applied Practice* (Sheperis & Sheperis, 2015) and *Counseling Theory: Guiding Effective Practice* (Parsons & Zhang, 2014) describe multicultural conceptualization as crucial for educators to attend to when developing trainee case conceptualization skills. Overall, multicultural case

conceptualization has been emphasized as a crucial multicultural skill contributing to multicultural counseling competence.

Despite the importance of integrating culture into case conceptualization, conceptualization models and empirical research have not kept pace with the assertation of the importance of multicultural competence in case conceptualization. Importantly, clinician inattention to culture in case conceptualization may reflect the current lack of conceptualization models which guide the therapist to do so. Additionally, general approaches to case conceptualization are used to universally conceptualize clients of all cultural backgrounds and these models do not make adaptations or provide guidance on how to integrate culture into client conceptualizations (Eells, 2007; Levenson & Strupp, 2007; Messer & Wolitzky, 2007). Specifically, the models do not direct clinicians to gather cultural information from the client during intake or provide guidance on how culture may be integrated with other client characteristics (Eells, 2007). Perhaps clinicians do not include cultural issues in case conceptualizations when models of case conceptualization do not integrate, address, or value the importance of culture in the conceptualization process.

Additionally, the empirical association between self-report multicultural competence and multicultural case conceptualization skills are unclear. For example, Ladany et al. (1997) explored the association between trainee multicultural case conceptualization ability and self-reported multicultural counseling competence. They found no correlation between self-reported multicultural counseling competence and multicultural case conceptualization skills. This indicates a need for further research exploring the empirical association between multicultural counseling competence and

multicultural case conceptualization skills. In summation, though multicultural case conceptualization skills are purported to be a critical skill contributing to multicultural counseling competence (Bray, 2010), theoretical and empirical literature does not reflect this importance.

Need for Multicultural Specificity

Beyond concerns regarding lack of clinician attention to client multiculturalism, the sparse literature in this area lacks specificity. Foremost, there is little research focusing on the development of individual multicultural skills, such as multicultural case conceptualization. Indeed, much of the didactic training and literature on multicultural competence has focused on multicultural awareness and knowledge and has neglected trainee skill development (Ponterotto et al., 1994; Priester et al., 2008). The lack of research on the development of specific multicultural skills results in little guidance to therapist educators for the development of these skills. The lack of attention and specificity regarding multicultural skills is problematic because there is little information regarding how therapists develop these skills and how well therapists are performing these skills in practice (Eells, 2015).

Additionally, the multicultural counseling competence literature lacks specificity regarding the cultural groups included by the term *multicultural*. Indeed, the term has been used to capture competent care in working with clients with many aspects of individual variation including gender, age, sex, religion, ability level, race, ethnicity, income, and others. Notably, competence working with one of these groups does not necessarily indicate competence working with a client whose identity is comprised of a different component of multiculturalism. The lack of specificity becomes problematic

because the use of the term multiculturalism to denote these various cultural groups provides little guidance on how to work with any one of these distinct groups in a culturally competent manner (Lee, Sheridan, & Rosen, 2013). For example, a therapist may be competent in working with individuals of racial or ethnic minority background yet hold limited competence in working in other areas of diversity, such as with individuals who are LGBTQ. Overall, the literature on multicultural counseling competence is discussed in global terms and specificity regarding multicultural skills and specific cultural groups may promote trainee development to practice in a multiculturally competent manner.

Summary. Multicultural counseling competence is an important aspect of trainee development with multicultural case conceptualization skills being one critical aspect of overall competence (Sue et al., 1992). Indeed, the sparse empirical research suggests that multicultural counseling competence positively influences client treatment outcomes (Tao et al., 2015). Furthermore, there is little research on specific multicultural skills and how they may influence treatment. Beyond the generally positive influence of multicultural counseling competence on treatment outcomes, the literature has focused broadly on the concept of competence and provides little guidance on how to develop the skills that may be necessary to be a culturally competent therapist. This has resulted in little guidance for therapists and therapist educators on how to develop multicultural counseling competence and perform the specific multicultural skills used when working with diverse clients (Hill et al., 2013). One such multicultural skill is multicultural case conceptualization.

Multicultural Case Conceptualization

A primary gap in the general case conceptualization literature is the lack of focus

on multicultural issues (Engel, 1997; Greenberg & Goldman, 2007; Kuyken et al., 2009).

Multicultural case conceptualization models have sought to address this gap in the

literature and provide guidance on how to engage in multicultural case conceptualization

skills (Leong & Lee, 2006; Ridley & Kelly, 2007). Multicultural case conceptualization

has been defined as the extent to which a therapist identifies, integrates, and examines the

influence of cultural, contextual, personal, and sociopolitical factors in the etiology and

treatment of the individual (American Psychological Association, 2010; Constantine,

2001; Ladany et al. 1997; Sue, 2003). While the current literature and research on

multicultural case conceptualization is limited, some multicultural case conceptualization

models have emerged. Additionally, there is some limited research regarding the content

of multicultural case conceptualizations, the influence of therapist training, and the

impact of therapist racial attitudes and personality on multicultural case conceptualization

skills.

Multicultural Case Conceptualization Models

While there are several general case conceptualization frameworks discussed at

the outset of this chapter, there are few frameworks for the systematic integration of

multicultural client information into case conceptualization. Of the limited models that do

exist, the Cultural Accommodation Model (CAM; Leong & Lee, 2006) provides a

framework to conceptualize general and multicultural client information while the

Multicultural Assessment Procedure (MAP; Ridley & Kelly, 2007) is a systemic,

comprehensive approach to multicultural conceptualization. Each of these models are briefly discussed below.

The CAM (Leong & Lee, 2006) is intended to help therapists recognize the culturally relevant factors that distinguish that client on both group and individual dimensions. Specifically, the model is comprised of three types of client information which are integrated together to form the client conceptualization. Initially, the clinician focuses on universal aspects of the client identity that pertain to all individuals regardless of their cultural background. An example may be the experience of negative emotions as all individuals experience instances of sadness or frustration at times. Next, the clinician addresses those aspects of the client which pertain to their membership in a specific cultural group. For example, whether a client's cultural group tends to be individualistic (emphasizing the needs of the individual) or collectivistic (prioritizing the needs of the group) may be a source of information to include in the group component of the conceptualization. If a foreign exchange student is from a collectivistic culture and adheres to these cultural values, they may prioritize earning money for their family. Alternately, students from individualistic culture may prioritize pursuing a career that is in line with their own personal interests. Finally, the therapist considers those aspects of the client that are unique. This aspect of client information pertains to the phenomenological experience of that client. For instance, an individual's experience during a trauma flashback may be unique to that individual. One individual may experience symptoms of hypervigilance, while another individual may experience flashbacks to the traumatic event. After collecting these three types of information, the therapist integrates this client information together to create a conceptualization. Beyond

describing these three types of client sources of information, the model does not provide a systematized structure regarding steps to the multicultural case conceptualization process.

As an alternative model, the MAP framework (Ridley & Kelly, 2007) seeks to offer a systematic and comprehensive approach to guide multicultural case conceptualization that includes concrete steps for the conceptualization process. An assumption that underlies MAP is that culture is always pertinent to psychological assessment and case conceptualization and that therapists should consider how, rather than if, culture is relevant to understanding the client (Ridley & Kelly, 2007). The assumption that culture is always relevant encourages the therapist to consistently integrate cultural considerations in client conceptualization by proceeding through four phases.

The first phase, identify cultural data, involves gathering clinical data through multiple data collection methods. Data is gathered through the clinical interview and therapists are encouraged to start by asking their clients to describe and clarify their cultural background (Scott & Borodovsky, 1990). In the second phase, the therapist interprets cultural data by organizing and interpreting cultural information to arrive at a working hypothesis. The therapist differentiates cultural from idiosyncratic information by asking their clients about their personal meanings and experiences and comparing them with cultural norms. When these experiences overlap with established norms, a hypothesis may be made that cultural norms apply. Further, therapists should use the available research to determine base rate information for cultural data regarding psychological disorders, comorbid conditions, medical conditions that manifest

psychological symptoms, and suicide rates by cultural group (Ridley et al., 1998). Additionally, the therapist should differentiate between dispositional stressors and environmental stressors such as inequitable resources or discriminatory work environments (Ridley & Kelly, 2007). In the third phase, the therapist incorporates cultural data by integrating clinical information with other relevant data to test the conceptualization working hypothesis. For example, the therapist may rule-out medical explanations of the client's presenting concerns or integrate psychological testing. The final phase entails reaching a sound assessment decision. In this phase, the therapist continues to alter the conceptualization based on treatment progress and emergence of new client information (Ridley & Kelly, 2007).

While the CAM and MAP models provide guidance on the inclusion of culture in case conceptualization, no research has been conducted on the efficacy or effectiveness of these models. The sparse research that is available addresses conceptualization content, the influence of conceptualization training on skill level, and the influence of therapist attitudes and personality on skill level. This research is intended to explore what therapists include in a multicultural case conceptualization and factors that influence the level of multicultural case conceptualization skills.

Multicultural Case Conceptualization Content

Two studies have explored the content of trainee's multicultural case conceptualizations to gain a better understanding of what cultural aspects of cases are integrated into conceptualization. For example, Neufeldt et al. (2006) interviewed 17 trainees after they watched two five-minute videotapes of simulated clients. One simulated client was a young, Chinese American female college student and the second

simulated client was a European American retired male who was 60 years old. Participants answered several questions regarding their conceptualization of the simulated clients and factors to consider in treatment. Foremost, they found that trainees were three times more likely to discuss considerations of diversity when referencing the Chinese American case than the European American case. For the Chinese American case, a few trainees described the potential effect of acculturative stress on mental health, recognized that the client may not align with values generally accepted by their racial group, and conceptualized how the client's life goals varied from that of her racially-similar parents or peers. In terms of cultural assets for this case, trainees discussed their supervisor and their own prior experience with diverse populations as beneficial to the multicultural case conceptualization process. Interestingly, while minority trainees identified their own race as a cultural asset to themselves, Neufeldt et al. (2006) noted that no trainees in the sample explored how client cultural background could be a source of strength. Overall, they found that the extent to which client culture was integrated into the case conceptualization varied widely amongst trainees. In summation, a few trainees discussed themes specific to conceptualizing the Chinese American student, such as their own cultural assets in working with this client, acculturative stress, and the degree to which the client held cultural beliefs that were consistent with racially-similar others. Alternately, trainees did not explore cultural strengths for either case or diversity considerations in the European American case. This may indicate that, while trainees were able to make some inferences regarding the role of culture in the Chinese American student's life, they may not attend to cultural strengths or diversity considerations in Whites.

A more recent study by Lee, Sheridan, and Rosen (2013) sought to expand Neufeldt et al.'s (2006) research by using three client vignettes in which salience of race was varied. For instance, the explicit vignette included an Indian female client whose presenting concern was that her cultural values conflicted with her desire to leave her abusive husband. The implicit vignette included an African American male whose peer made derogatory comments toward the hypothetical client. A final vignette was included in which culture was not mentioned in a case centered on an Asian American family. Participants watched all videos which were randomly shown such that each case scenario had equivalent chances to be shown to the participant first, second, or third. Participants then provided written responses to three questions designed to assess general and multicultural conceptualization skills. Foremost, trainees integrated client race into the case conceptualization only when issues pertaining to client culture was highly explicit in the presenting concern. Trainees also focused on multicultural content discussing several themes related to the client's culture including client class, gender, or racial and ethnic background. Specifically, participants discussed both benefits and experiences of discrimination due to being part of a minority cultural group. Finally, trainees discussed how they believed culturally-relevant clinical interventions may be effective but reflected feeling a lack of cultural competence to engage in these techniques. Overall, culture was not addressed unless explicitly identified as the presenting concern.

In summary, the limited research in this area suggests that trainees vary in the extent to which they attend to culture within their conceptualizations. One determinant suggests that trainees may only include culture with their case conceptualization when culture is an explicit presenting concern expressed by the client (Lee et al., 2013;

Neufeldt et al., 2006). The lack of attention to culture may be a concern, for clients may not initiate discussions regarding their culture if they are unaware that the topic could be of therapeutic focus. When trainees do attend to culture in case conceptualization, they appear to neglect individual cultural variation such as the degree to which clients adhere to various cultural values and may make assumptions regarding the beliefs and values of clients based on their race (Neufeldt et al., 2006). Therefore, trainees may not explore the unique experiences with and expressions of their clients' racial or ethnic background.

Multicultural Case Conceptualization Training

One factor which has been suggested to influence the inclusion of multicultural content in case conceptualization is multicultural training (Constantine, 2001). Multicultural training methods may consist of workshops, courses, clinical experience, supervision, and readings which target development of multicultural case conceptualization skills. Research on multicultural case conceptualization training has centered on two primary themes. These themes include barriers to training which limit the development of conceptualization skills and empirical findings which support the notion that training significantly impacts multicultural case conceptualization skills (Constantine, 2001; Constantine & Gushue, 2003; Neville et al., 2006).

Barriers to training. There are several barriers to training that make improving multicultural case conceptualization skills a challenge. Foremost, prior research examining case conceptualization quality has indicated that trainees appear to be inattentive to cultural factors in conceptualization (Ladany et al., 1997; Lee et al., 2013; Schomburg & Prieto, 2011). For example, Ladany et al. (1997) explored the association between supervisee multicultural case conceptualization ability, self-reported

multicultural competence, and supervisee racial identity. To evaluate conceptualization

quality, they developed a Multicultural Case Conceptualization Coding System which

indicates the degree to which race was integrated into the case conceptualization. Ladany

et al. (1997) found that supervisees were predominantly unaware of racial factors in their

conceptualization, however, supervisor instruction to attend to racial aspects of the client

significantly improved multicultural case conceptualization quality. Indeed, many have

suggested that multicultural supervision may be one way therapists gain an awareness

that the client's race or ethnicity is important in a particular case (Ancis & Ladany, 2010;

Bernard & Goodyear, 2009; Brown & Landrum-Brown, 1995; Carney & Kahn, 1984;

Cary & Marques, 2007; Dressel et al., 2007; Falender et al., 2014; Fukayama, 1994;

Remington & DeCosta, 1989). In a study which expanded the use of the Multicultural

Case Conceptualization Coding System (Ladany et al., 1997), Schomburg and Prieto

(2011) explored the relationship between self-reported multicultural counseling

competence score and multicultural case conceptualization skills in couples' therapy.

Similar to the Ladany et al. (1997) findings, regardless of self-reported multicultural

competency, trainees were inattentive to racial factors in their case conceptualization

responses to vignettes involving African American and European American clients.

Findings from this study indicate that self-reported multicultural competence was

unrelated to multicultural case conceptualization ability and trainees lacked an attendance

to racial factors in conceptualization. Similarly, Lee et al. (2013) found trainees did not

attend to culture unless culture was made explicit in the presenting concern reflecting a

lack of awareness of when culture is salient to the client. Overall, unless trainees are

explicitly instructed by their supervisor to attend to client culture, it appears they often

may not integrate culture when conceptualizing a case.

In addition to a lack of attending to culture, trainees appear to struggle applying

cultural knowledge to create multicultural case conceptualizations in real-world practice

(Eells, 2015; Ridley & Kelly, 2007). Trainees may experience this struggle because skill

development, such as multicultural case conceptualization skills, is often not the focus of

didactic coursework (Binder, 1993; Eells, 2015). Indeed, when exploring the content of

multicultural coursework, 33% of syllabi include class presentations on specific cultural

groups or issues, while only 11% of syllabi include multicultural case conceptualization

skills (Priester et al., 2008). This finding indicates that many trainees do not have the

opportunity to practice multicultural case conceptualization skills. The lack of attention to

multicultural skills may be problematic because there appears to be a difference between

knowledge regarding various cultural groups and how that cultural knowledge is

integrated with other client characteristics using multicultural case conceptualization

skills (Binder, 1993; Eells, 2015). For instance, a trainee may have learned that

individuals who are Indian may have a more fluid time orientation than White

individuals; however, trainees may fail to recognize this cultural norm when working

with an Indian client. This client may consequently be conceptualized as resistant or

devaluing of therapy when he/she/they are late to appointments. This example highlights

how trainees may consider themselves knowledgeable regarding diverse cultures, and yet

struggle to apply that knowledge and conceptualize clients in a way that accurately

integrates that client's culture within the conceptualization (Binder, 1993; Eells, 2015;

Ladany et al., 1997). Notably, these barriers to training may be confounded with several

developmental issues trainees frequently encounter at this stage of their professional development.

Complicating these barriers to training, conceptual and empirical work have explored several developmental differences between trainees and experienced therapists which may contribute to the challenge improving these skills through training. Foremost, literature suggests that trainees tend to broadly integrate the client's racial or ethnic background and struggle to perceive variation in cultural values between members of diverse racial groups (Falicov, 1998; Neufedt et al., 2006). For example, while one student client from Saudi Arabia may adhere to collectivist values prioritizing their family's needs over their own, a different student from a collectivistic background may not adhere to these beliefs and may embrace a more individualistic identity. As such, trainees tend to assume members of diverse racial groups have similar cultural beliefs to one another (Falicov, 1998; Neufedt et al., 2006). In contrast, more experienced clinicians tend to explore the extent to which clients adhere to cultural values. Falicov (1998) hypothesized that these differences in conceptualization result in trainees being more likely than experienced therapists to over-pathologize the role of race or ethnicity for individuals of minority status. Neufeldt et al. (2006) found some evidence supporting this perspective for trainees that regardless of client racial background, trainees assumed homogeneity within the culture. Overall, trainees appear to experience difficulty conceptualizing the nuanced role of culture for individual clients. This may result in either broad assumptions based on culture, or inattentiveness to the client's racial or ethnic background in conceptualization. In summation, research findings have indicated that trainee conceptualizations are marked by an overall inattentiveness to cultural

factors, difficulty applying cultural information to the individual client, and a tendency to homogenize the client with others of their cultural group (Ladany et al., 1997; Lee et al., 2013; Neufeldt et al., 2006; Schomburg & Prieto, 2011).

Effectiveness of training. In addition to examining barriers to training, research has also focused on the effectiveness of training to improve multicultural case conceptualization skills. Prior investigations have explored the influence of training on multicultural case conceptualization skills including multicultural coursework and clinical experience (Constantine, 2001; Constantine & Gushue, 2003; Neville et al., 2006).

A few studies have examined the influence of completed multicultural courses on trainee multicultural case conceptualization skills. In a study examining multicultural case conceptualization quality, Constantine (2001) explored the association between multicultural training and multicultural case conceptualization ability among trainees with varying level of multicultural training. She found that participants who had engaged in a multicultural course displayed higher multicultural conceptualization skills than those who had not engaged in a multicultural course (Constantine, 2001). Similarly, Constantine and Gushue (2003) explored multicultural training and multicultural case conceptualization quality among school counselors. They found that participants who engaged in a multicultural training course produced conceptualizations characterized by a higher level of cultural differentiation and integration than those trainees who had not engaged in multicultural coursework. Findings from these studies suggest that trainee engagement in a multicultural course was positively associated with multicultural case conceptualization skills. The studies were limited in that they did not explore the

association between multicultural clinical experience and multicultural case conceptualization skills.

A few studies extended this research on the influence of training by examining whether the combination of multicultural courses and clinical experience working with racial and ethnic minorities influenced multicultural case conceptualization skills. For instance, Weatherford and Spokane (2013) explored the association between trainee multicultural case conceptualization complexity, personality disposition, and multicultural training. They expected that multicultural case conceptualization complexity would have a positive association with multicultural training and openness-to-experience and a negative association with social dominance, right-wing authoritarianism, and universal orientation. They found that higher multicultural training including a combination of multicultural coursework and multicultural clinical experience was positively associated with more complex multicultural case conceptualizations when compared to those with less multicultural training. In another study, Lee and Tracey (2008) explored the general and multicultural conceptualization skills of 91 psychotherapy trainees across three client vignettes. Trainees with more clinical experience and multicultural coursework were found to produce multicultural case conceptualizations with higher differentiation and integration than those with less clinical experience and multicultural coursework

These collective findings suggest there are several barriers to training which may challenge development of multicultural case conceptualization skills. To address these barriers, research findings suggest that more multicultural coursework and clinical experience working with diverse clients may promote development of these skills. While

the findings suggest that training may be important to consider in multicultural case conceptualization research, trainee attitudes and personality may also influence multicultural case conceptualization skills.

Influence of Attitudes and Personality

While much of the research has focused on the influence of training, additional research suggests that some characteristics of the therapist may influence multicultural case conceptualization skills. Two general categories of factors appear to be associated with multicultural case conceptualization skills. Foremost, findings are somewhat conflicting regarding the relationship between multicultural case conceptualization and therapist racial attitudes. Additionally, other research findings have supported the connection between multicultural case conceptualization and therapist personality differences.

Attitudes regarding racial influence. Several theoretical models for understanding individual's racial beliefs may have implications for multicultural case conceptualization. For example, Janet Helms (1992) created the Racial Identity Model which is comprised of six stages that describe the extent to which one believes that race is impactful on an individual's life. Therapists with more advanced racial identity may be more likely to include factors relevant to the client's race or ethnicity in their multicultural case conceptualizations than clients with less advanced racial identity statuses.

An individual with a low stage of racial identity may be conceptualized as holding a color-blind racial ideology. Color-blindness occurs when individuals "deny, distort, and minimize the existence of race and racism" (Neville et al., 2006, p. 2). Therapists who

hold to a color-blind ideology may be less likely to include relevant racial or ethnic factors in multicultural case conceptualizations because they may be less aware of the impact of race on the individual's life. Alternately, those who are more aware of the influence of race may adhere to less of a color-blind ideology and hold a greater appreciation for individual differences. For instance, a therapist who does not believe race has an impact on one's life may be less likely to consider the impact of discrimination and marginalization on an African American client's level of depression than a therapist who believes that race influences mental health. Indeed, color-blindness is an aspect of individual difference which has been suggested to influence therapists general counseling competence (Burkard, Edwards, & Adams, 2015), and, quite possibly, multicultural case conceptualization skills

In one of the first studies to explore the role of therapist racial identity on case conceptualization, Ladany et al. (1997) explored the association between multicultural case conceptualization ability and racial identity status among trainees. They found that racial identity status was not significantly related to multicultural case conceptualization ability. Further, supervisor instruction to focus on culture was the only significant predictor of multicultural case conceptualization ability, suggesting that supervision may be an important influence on these skills.

A later study expanded this understanding of trainee racial identity and supervision by exploring racial identity of supervision dyads and trainee multicultural case conceptualization ability (Constantine, Warren, & Miville, 2005). They explored supervisory dyads consisting of White supervisors and supervisees and examined whether higher racial identity stage was associated with higher multicultural counseling

competence self-report score and better-quality multicultural case conceptualization skills. In the study, multicultural case conceptualization quality was assessed by the Ladany et al. (1997) coding system which evaluates conceptualization differentiation and integration. Constantine et al. (2005) found that racial identity statuses of trainees and supervisors was associated with multicultural case conceptualization skills. Specifically, supervisees in supervision dyads in which the supervisor had a higher racial identity status than the supervisee reported higher self-perceived multicultural counseling competence and obtained higher multicultural case conceptualization ratings than did their counterparts in supervision dyads in which both supervisor and supervisee reported lower racial identity statuses. This finding indicates that supervisor racial identity status may promote multicultural skills in supervisee, regardless of supervisee racial identity status. Further, those supervisees who were engaged in a supervision relationship in which both they and their supervisor had advanced racial identity tended to produce higher quality multicultural case conceptualizations.

The conflicting findings from Ladany et al. (1997) and Constantine et al. (2005) suggests that the influence of racial identity on multicultural case conceptualization skills may depend on the supervisor's racial identity. Supervisor racial identity may have an influence on whether cultural factors are included in supervision sessions, thereby influencing supervisee multicultural case conceptualization skills. Perhaps the supervisor's power in the supervision relationship may determine whether racial and ethnic content is included in supervision sessions. An additional hypothesis is that racial identity measures do not accurately measure the construct of racial identity which may cause confounding results in the empirical literature (Burkard & Knox, 2004).

In a study which examined racial attitudes more broadly, Constantine and Gushue (2003) examined whether school counselors' ethnic tolerance attitudes and racism attitudes were associated with multicultural case conceptualization ability. They found that ethnic tolerance attitudes were positively associated with multicultural case conceptualization ability such that school counselors with higher ethnic tolerance scores created higher quality multicultural case conceptualizations than those with lower ethnic tolerance scores. Consistently, school counselors with higher racist attitudes produced lower quality multicultural case conceptualizations than those with lower racist attitudes. Overall, counselors with higher ethnic tolerance attitudes may be better able to identify and integrate salient cultural information into the multicultural case conceptualization. Alternately, counselors with racist attitudes may be less aware of cultural issues and, therefore, less likely to integrate culture into case conceptualizations.

Racist attitudes and racial identity status may share a common underlying factor of one's belief that racial background has an impact on an individual's experiences. Similarly, color-blind ideology may share this same underlying factor and reflect the belief that race is not an impactful aspect of one's life and, therefore, should not be integrated into case conceptualizations. This belief may be negatively associated with complexity of multicultural case conceptualizations. For example, in a sample of 51 trainees, color-blind racial ideology was negatively associated with complexity of multicultural case conceptualizations (Neville et al., 2006). Specifically, higher differentiation and integration scores on a client conceptualization were found to be associated with lower levels of color-blindness compared to those who self-reported a higher color-blind ideology. The influence of color-blindness on multicultural case

conceptualization complexity was consistent when controlling for social desirability and multicultural coursework training (Neville et al., 2006). This finding indicates that color-blindness may have an impact on multicultural case conceptualization skills that is beyond the influence of didactic training.

Overall, findings are somewhat conflicting regarding the relationship between multicultural case conceptualization and therapist racial attitudes (Constantine et al., 2005; Constantine & Gushue, 2003; Neville et al., 2006; Schomberg & Prieto, 2011). Consistent with other literature that has examined the direct influence of attitudes on multicultural skills, Burkard and Knox (2004) found that racial identity results may be influenced by the quality of racial identity measurement. Overall, these findings suggest that therapist racial attitudes may be one important factor to consider when helping trainees' developt multicultural case conceptualization skills. Therapists who hold the belief that race does not impact an individual's experiences may encounter difficulty understanding how a client's race or ethnicity may be salient to their mental health and struggle to develop multicultural case conceptualization skills.

Therapist personality differences. In addition to racial attitudes, personality factors including therapist level of empathy and openness-to-experience have also been found to be associated with multicultural case conceptualization skills. Therapist personality factors are important to consider in multicultural case conceptualization research because personality influences all aspects of the therapeutic process, including the development of multicultural skills (Weatherford & Spokane, 2013). Despite the potential impact that personality may have on multicultural case conceptualization

ability, there are relatively few studies which explore how personality influences these skills.

A few studies have explored the association between empathy and multicultural case conceptualization skills. In one study, Constantine (2001) explored the association between cognitive empathy, affective empathy, and trainee multicultural case conceptualization ability. Cognitive empathy refers to the therapist's ability to intellectually assume the perspective of their client, while affective empathy refers to mirroring the client's emotions with the same emotion. Constantine (2001) found that affective empathy attitudes contributed significant variance to multicultural case conceptualization ability including conceptualization of the etiology of client concerns and conceptualization of effective treatments. Cognitive empathy contributed significant variance only to the conceptualization of effective treatments. Therefore, trainees' attunement to their diverse clients' emotional life was associated with their ability to conceptualize the cause and most effective treatment of their clients' presenting concerns. A cognitive understanding of the client contributed to treatment planning only. Conversely, Singh (2010) explored the relationship between multicultural case conceptualization performance and empathy in trainees and found no significant association. These conflicting findings may be due to differences in how empathy and multicultural case conceptualization was measured in each of these studies. Constantine (2001) measured empathy using affective and cognitive components and multicultural case conceptualization using etiology and treatment components. Alternately, Singh (2010) used a broad measure of empathy and multicultural case conceptualization ability which may have resulted in the lack of association between empathy and these skills.

Overall, results from these studies are unclear and further research must be conducted to more fully understand the association between empathy and multicultural case conceptualization.

Beyond therapist empathy, Weatherford and Spokane (2013) explored the association between multicultural case conceptualization ability and several personality traits. In particular, they explored the association between trainee multicultural case conceptualization complexity and openness-to-experience, social dominance, right-wing authoritarianism, and universal orientation. They hypothesized that therapists who were more open to new experiences or people would have higher multicultural case conceptualization skills than those who were intolerant or rigid in their approach to unfamiliar experiences or people. Additionally, they hypothesized that there would be a negative association between multicultural case conceptualization and social dominance, right-wing authoritarianism, and universal orientation. Openness-to-experience (i.e., extent to which individuals approach unfamiliar experiences or people with tolerance and flexibility) was found to have the only significant association with multicultural case conceptualization ability. These therapists displayed greater multicultural case conceptualization skills, demonstrated by higher differentiation and integration, than those who self-reported a less tolerant approach to the unfamiliar.

Overall, the research regarding therapist personality traits on multicultural case conceptualizations is sparse. Findings regarding the influence of empathy are mixed and one study suggests an association with therapist openness-to-experience.

Multicultural Case Conceptualization Summary. Multicultural case conceptualization skills are difficult for novice therapists to develop and there is little

focus in the extant literature on development of these skills among trainees and clinicians (Eells, 2015; Ridley & Kelly, 2007). Despite the lack of research in this area, findings have indicated that trainees tend to be inattentive to culture, experience difficulty applying cultural information to the individual client, and tend to make assumptions regarding client culture rather than exploring cultural identity with the individual client (Ladany et al., 1997; Lee et al., 2013; Neufeldt et al., 2006; Schomburg & Prieto, 2011). To improve multicultural case conceptualization skills, clinical training and direction from the supervisor has generally been found to be beneficial, however, there is little information regarding what about training is most helpful. Finally, there appears to be an association between racial attitudes and personality traits with multicultural case conceptualization skills, though research is far from conclusive.

Noteworthy among the literature is the lack of research that has explored the content included in multicultural case conceptualizations. Though models exist which provide guidance on client information to include in multicultural case conceptualizations (i.e. MAP; Ridley & Kelly, 2007), few researchers have explored the content that is included in practice. Additionally, there is a lack of information on how trainees learn to conceptualize clients. Though prior research has indicated that clinical experience and multicultural coursework are positively associated with multicultural case conceptualization skills (Constantine, 2001; Constantine & Gushue, 2003; Lee & Tracey, 2008; Weatherford & Spokane, 2013), there is little research on what about these training experiences is most helpful in developing these skills. Further, there is a paucity of research on challenges trainees encounter when learning to conceptualize diverse clients.

Overall, the sparse empirical research on this important topic has several methodological concerns which inform the literature on multicultural case conceptualization.

Methodological Concerns

This section provides a brief review of methodological issues in multicultural case conceptualization research including the use of hypothetical vignettes to measure conceptualization skills and lack of existing measurement tools for multicultural case conceptualization. Beyond the measurement of specific multicultural skills, such as multicultural case conceptualization, tools for measuring multicultural counseling competence may be inadequate for reasons discussed in the subsequent section. In addition to prior research on methodological concerns, the section includes a discussion of gaps in the literature that future research may address. The chapter concludes with a brief overview of the study methods.

Prior Research

A primary limitation of research evaluating quality of conceptualization concerns the use of an analogue design to evaluate the conceptualization skills used to understand actual clients (i.e., Singh 2010; Weatherford & Spokane, 2013). In exploring multicultural case conceptualization ability, Weatherford and Spokane (2013) indicated that hypothetical vignettes likely do not capture all aspects of multicultural conceptualizations in a real-life context which may be more complex than what these vignettes can afford (Singh, 2010; Weatherford & Spokane, 2013). For example, in real-world practice, the therapist may contend with cultural attitudes reflected by those in power in their specific clinical setting, time constraints of practice, and power differentials between themselves and those who evaluate their performance. While these

factors may influence a trainee's confidence in and ability to integrate multicultural content in client conceptualization, these influences may not be accounted for in case vignettes. Similar gaps in the research exist in the general case conceptualization and formulation literature. In fact, Hartley et al. (2016) explored factors associated with general case formulation skills and noted the inherent limitation of vignettes to represent the complexity of real-life clients as vignettes do not capture setting variables such as time constraints or therapeutic relationship variables such as countertransference. Though several researchers have discussed the use of vignettes as a potential limitation in their study (Hartley et al., 2016; Singh, 2010; Weatherford & Spokane, 2013), there is little empirical research using the therapist's actual clients to assess conceptualization quality. Therefore, a gap exists in the research understanding trainee multicultural case conceptualization skills in use with actual clients.

Beyond use of analogue research methods, measurement of case conceptualization quality is also an area of concern in research. Though several tools including the Content Analytic Procedure (Ladany et al., 1997) and the CCQ (Welfare, 2007) have been adapted to include a multicultural component, this was not the original intent of these measures. A tool that measures multicultural case conceptualization skills would be of benefit to studying and improving these skills.

Relatedly, a measurement issue in the multicultural competence literature is the use of self-report tools of multicultural counseling competence. These tools have been suggested to evaluate therapist self-efficacy rather than actual competence (Ladany et al., 1997; Ridley & Kelly, 2003; Singh, 2010). Indeed, multiple studies show little association between quality of multicultural case conceptualization and self-reported

multicultural competence scores (Ladany et al., 1997; Schomburg and Prieto, 2011).

Notably, these constructs are seemingly theoretically related raising questions regarding

the lack of empirical association. The first hallmark study in which this finding emerged

was Ladany et al. (1997) which explored multicultural case conceptualization ability and

self-reported multicultural competence. They found no association between the related

constructs of multicultural case conceptualization and multicultural competence. This

finding has since been replicated by other researchers (i.e., Schomburg and Prieto, 2011).

The difference between self-report measures and actual counseling skill levels suggests

that self-report measures may evaluate self-perceived ability to engage competent

multicultural work rather than performance (Ridley & Kelly, 2003). Indeed, Ridley and

Kelly (2007) have hypothesized that many therapists who self-report conceptualizing

cases from a multicultural perspective are largely inattentive to multicultural concerns in

actual practice. This suggests that methods for evaluating therapist skill level beyond

self-report may assess therapist competence with more accuracy than self-report

measures.

To address these concerns with the ability of self-report measures to evaluate

therapist skill level, researchers may need to explore use of alterative research methods.

Qualitative research might be particularly suited for multicultural case conceptualization

research, because these methods would allow for a phenomenological understanding of

what trainees' experience as they develop multicultural case conceptualization skills. For

instance, gaining a better understanding of those aspects of training that are helpful and

unhelpful in learning skills and of trainees' experience when developing these skills from

a qualitative research perspective may inform training on multicultural case
conceptualization skills.

Current Study

Therapist development of general case conceptualization skills are important to
understand, because therapist conceptualization skills have been linked to client treatment
outcomes such as depression symptoms (Easden & Fletcher, 2018). Despite the purported
importance (Eells, 2015; Ridley & Kelly, 2007), trainees struggle to master the
complexity of case conceptualization skills. Trainees may struggle to develop these skills
because the conceptualization process is complex and requires the ability to identify
which client characteristics are most salient to understanding that person. Beyond
identification of these salient characteristics, the therapist must meaningfully integrate
these components of the client's identity into a representation of the client that will shape
treatment. Clinical training may target improvement in this area; however, there are few
measures to assess case conceptualization quality and little understanding of what
trainees' experience as they develop these complex skills (Ladany et al., 1997; Welfare,
2007).

While there is little empirical research on general case conceptualization, there is
even less information specific to trainee integration of client race or ethnicity into case
conceptualization. Indeed, multiculturalism is seldom emphasized in case
conceptualization models and empirical research (Eells, 2007; Ladany et al., 1997; Ridley
& Kelly, 2007). Further study is needed in this area because therapists will increasingly
work with racial or ethnic minority clients in the coming years (National Center for
Health Statistics, 2004). The increasing proportion of diverse clients and lack of attention

to client culture in practice can lead to misunderstanding, miscommunication, and ineffective case conceptualizations (Ridley & Kelly, 2007). Overall, the lack of research targeting multicultural case conceptualization skills provides preprofessional educators with little guidance on how to improve these important skills. In fact, beyond the evidence that trainees struggle in this area, there is little information regarding how therapists conceptualize diverse clients when engaging in clinical work and what factors are facilitative and challenging as they develop multicultural case conceptualization skills.

The present study seeks to address this gap in the literature using a mixed methods framework. Mixed methods are a form of research combining qualitative and quantitative techniques. A primary advantage of using mixed methods is that data sources can be triangulated to more fully understand research findings. The use of multiple data sources is beneficial when exploring a topic with little existing research or inconsistent findings because results from one data source can be used to inform findings from a second data source. The specific mixed methods framework chosen for the present study is an embedded design in which Consensual Qualitative Research (CQR; Hill, 2012) is emphasized and quantitative results are integrated to better understand the qualitative findings.

As part of the CQR (Hill, 2012) semi-structured interview, participants engaged in a think-aloud conceptualization task to explore the content of a multicultural client conceptualization. The purpose of think-aloud procedures was to better understand the thought processes which underly cognitive tasks. In a think-aloud procedure, participants concurrently verbalized all task-relevant thoughts (Ericcson & Simon, 1993; Fox et al.,

2011). A primary benefit in the use of think-aloud procedures is the ability to explore cognitive processes which are often difficult to empirically examine. Therapy skills, and specifically case conceptualization skills, are internal and cognitive which makes empirical study difficult. Indeed, the lack of research on conceptualization skills has been suggested to stem from the challenge in empirically examining cognitive skills (Eells, 2015). Think-aloud procedures provide a method beyond self-report through which the researcher can explore these cognitive skills. For this reason, a think-aloud procedure, as one component of the semi-structured interview, was used to explore content of case conceptualizations.

Overall, the methods chosen for this study were intended to address several gaps in the literature. Foremost, this investigation is one of few studies which explores multicultural case conceptualization skills through the trainees' personal experiences. This qualitative approach provided information regarding what factors challenged and facilitated multicultural case conceptualization skills to inform trainee education in this area. Additionally, the study explored content included in an actual multicultural client conceptualization. Prior studies have used analogue research designs rather than actual therapy clients. As such, the overuse of analogue designs is a primary gap in the extant literature the present study addressed (Eells et al., 2011; Neufeldt et al., 2006; Lee, Sheridan, & Rosen, 2013). Finally, the inclusion of a case conceptualization measure allowed for comparison of current study participates to a normed sample to better understand the quality of participants' conceptualization.

Conclusion

Multiculturalism is not well incorporated into case conceptualization despite the noted importance of cultural factors in providing services to an increasingly culturally diverse client population (APA, 2015; National Center for Health Statistics, 2004). Indeed, when empirically examining the integration of client race or ethnicity into case conceptualization, there is a consistent lack of integration of multicultural information into case conceptualization unless the supervisor instructs the trainee to attend to culture or the client's cultural background is explicitly stated to be the presenting concern (Lee & Tracey, 2008; Lee et al., 2013). This lack of attention to client multicultural identities may be connected to the challenge's trainees encounter integrating multicultural concepts into case conceptualization (Eells, 2007). As trainees struggle to make meaning of the client's culture in the context of a multitude of other client characteristics, trainees at this developmental level tend to over-pathologize the client and fail to explore and conceptualize how this client does and does not reflect values associated with their cultural group (Falicov 1998; Eells, 2015; Lee et al., 2013; Ridley & Kelly, 2007). For this reason, research specifically exploring these skills and what factors facilitate and challenge development in this area is an important step toward improving training on multicultural case conceptualization.

CHAPTER 3: METHODS

This study explores the cognitive process and complexity through which early career trainees create conceptualizations of clients who are racially different from themselves. Guiding this study are the following research questions: (1) What content do trainees include when developing conceptualizations of clients that are racially or ethnically diverse? (2) What factors influenced the inclusion of race or ethnicity into the trainees' client conceptualization? (3) What is the quality of the multicultural conceptualizations by trainees? (4) How has training influenced trainees' development of multicultural client conceptualizations? In this chapter, I will describe the participants (referred to as *trainees*), measures, procedures, and data analysis used in this study. This study follows a mixed methods approach.

Mixed methods research is particularly suited to conceptualization research for two reasons. First, the use of mixed methods research allows for qualitative and quantitative analysis by collecting data in the form of both words and numbers (Creswell & Plano Clark, 2011). The dual emphasis characteristic of mixed methods makes it possible to explore conceptualization content and the influences on this skill qualitatively and gather quantitative data regarding conceptualization quality. A second reason for using mixed methods research is that the limitations of a qualitative research approach can be offset by the use of a quantitative measure to provide a more thorough understanding of the research topic (Creswell & Plano Clark, 2011). The quantitative data provided a measure of conceptualization quality and the qualitative data provided information regarding the content of the conceptualizations. A primary criticism of literature on multicultural case conceptualization is that researchers have either attended

to frequency counts of how many client characteristics are mentioned in a conceptualization (i.e., Ladany et al., 1997) or analyzed the content of the conceptualization without providing any measure of conceptualization quality (i.e. Neufeldt et al., 2006). Therefore, the use of multiple data analysis methods provided a check on the team's interpretation of the data and a more thorough understanding of how trainees conceptualize diverse clients. Multicultural client conceptualization is a complicated, internal process and mixed methods was an appropriate fit for providing triangulated, comprehensive findings.

Participants

Early career professionals including master's-level interns and first year post-master's Licensed Professional Counselors-In Training (LPC-IT) were selected as the population of focus for this study. This population was chosen as a focus for this study because therapists at this point in training are developing and practicing clinical skills with clients and are not yet practicing independently. The principal investigator attended a master's level therapy skills course to distribute information regarding study participation, demographic forms, and informed consent. Interested students completed the informed consent and demographic forms and submitted these to the principal investigator. Ten potential trainees were recruited through this class and eight met inclusion criteria. Two trainees were excluded from this study because they were not actively working with clients at the time of data collection.

Additionally, LPC-IT's who had graduated from the university in which the research was taking place in the previous year were sent a recruitment email. Three LPC-IT's who expressed interest in participating in the study contacted the principal

investigator by email. The principal investigator sent a demographic form and informed consent to the three interested trainees. All three met aforementioned inclusion criteria.

Eleven early-career trainees were recruited as participants. All trainees in the sample received their graduate training through the Clinical Mental Health program at a private, mid-size university in Wisconsin. Eight trainees were currently enrolled in internship and completing their second-year training in Clinical Mental Health Counseling. Three trainees were first-year Licensed Professional Counselors-In Training who had completed their Clinical Mental Health Counseling training in the previous year. All trainees were fluent English speakers. Nine trainees identified as female and two trainees identified as male. Nine trainees identified as non-Hispanic White or Caucasian racial background. Two trainees identified as Asian. Trainee ages ranged from 23 to 30 with a mean of 25.36 *(SD= 2.06)*.

Mental health settings in which the trainees' practiced therapy included inpatient psychiatric settings, college counseling centers, in-home, and on-site outpatient clinics, community centers, and addictions clinics. All trainees were currently engaging in at least one hour a week of supervision. Trainees indicated that the percentage of multicultural clients seen in their current setting ranged from 10% to 95% with a mean of 49.77% *(SD=34.90%)*. Total supervisors to date ranged from one to seven supervisors over the course of their training. Eight trainees had not worked with a supervisor of color and 3 trainees had worked with one supervisor of color.

Trainees were asked several questions pertaining to their current site training and beliefs regarding multiculturalism in mental health conceptualization and treatment. Trainees were instructed:

Below are a number of statements regarding the importance of multiculturalism in

counseling. Please read each one and indicate the extent to which you agree with

each statement using the following Likert-type rating scale (0: not at all, 5: very

much).

First, trainees were asked, "How frequently does your current or most recent internship or

mental health work setting emphasize multicultural issues in counseling/treatment?"

Trainee responses ranged from one to five with a mean of 3.18 (*SD=1.08*). Second,

trainees were asked, "To what extent do you feel it is important to include multicultural

information into the case conceptualization of the case?" Trainee responses ranged from

three to five with a mean of 4.55 (*SD=0.69*). Lastly, trainees were asked, "How

frequently have your training experiences in your current or most recent internship or

work site emphasized the importance of multicultural issues in client case

conceptualization?" Trainee responses ranged from one to five with a mean of 3.36

(*SD=1.29*).

During the interview, trainees were asked to describe their current clinical setting to

provide context for the conceptualization (see Appendix D). Five trainees described

working with child and adolescent clients on presenting concerns of attention deficit

hyperactivity disorder, oppositional defiant disorder, and externalizing behavior such as

tantrums and aggression. Six trainees described working with adult clients. Six trainees

described working with adult clients who have depression and eight trainees described

working with clients who have anxiety. Six trainees described trauma history as a

component of the presenting concern. Two trainees mentioned working primarily with

racially and ethnically diverse clients and three trainees described working with clients of

middle or lower socioeconomic status. Five trainees worked in a group setting and six trainees provided individual therapy.

Research Team

Three graduate students enrolled in a doctoral program in counseling psychology served as the primary data analysis team. The principal investigator has been a member of several CQR teams. The primary investigator completed ten of eleven interviews. A second team member completed one interview in order to gain experience as a CQR interviewer. All three team members engaged in all levels of data analysis. The principal investigator identifies as a biracial female. A second team member identifies as gender non-conforming and of European American descent. The third team member identifies as male and of European American descent.

The auditor is a 59-year-old male of European American descent. He is a professor of counseling psychology and experienced CQR researcher who has multiple CQR publications (e.g., Burkard et al., 2014; Knox et al., 2011). The auditor worked independently of the team. The auditor reviewed and approved the protocol, informed consent, and demographic form prior to data collection. During data analysis, first the auditor reviewed the domain list and changes were made to domain list titles based on auditor feedback. Second, the auditor was sent core ideas for each case and provided feedback. Third, the auditor reviewed the cross-analysis for each domain and provided feedback. Finally, a results table was compiled, and the auditor reviewed the table for consistency. After feedback was provided by the auditor at each of these points in data analysis, the team met to discuss the feedback and make revisions.

Training. Team members engaged in several CQR training practices prior to conducting data analysis. In accordance with recommendations set by Hill et al. (2005), team members were instructed to read several articles providing an overview of CQR including Hill et al. (1997) and Hill et al. (2005). Additionally, team members read exemplar studies including Hill et al. (2005), Knox, Hess, Williams, and Hill (2003), and Ladany et al. (1997). Further, in accordance with Thompson et al. (2012), the CQR analysis process was described and discussed in detail with examples from previous studies, and team members practiced reaching consensual agreements using previous examples provided by the auditor.

Lastly, team members were enrolled in a qualitative methodology course during which they had the opportunity to ask the instructor for guidance in CQR. The instructor had extensive experience in CQR, was trained by Dr. Hill, the author of CQR, and provided guidance regarding best practice in the method. These training procedures helped ensure all members of the research team felt comfortable actively engaging in the data analysis process.

Biases. Identification of biases is an important feature of CQR which was incorporated at multiple time points in this study. Biases are beliefs and preconceived ideas about the phenomenon of interest which may shape the way in which the data is analyzed. Exploration and open disclosure of potential biases is critical, because team members carry their biases into the data analysis process. Therefore, team member biases can influence the way in which the collected data are interpreted (Hill et al., 2005). Although qualitative researchers make every attempt to stay as close to the data as possible, it is acknowledged as impossible to entirely remove the researcher's own

subjective interpretation of the data. To address these concerns, biases and expectations were addressed openly and at multiple time points in the data analysis process as a team in order to explore how they may influence the data analysis process.

Team members discussed their biases prior to data collection, prior to data analysis, after finalizing the domain list, after finalizing core ideas, and once cross-analysis had been completed. In the first research meeting, the principal investigator shared her own biases to provide a model for this type of exploration for the other team members and create a space for vulnerability and honesty in communicating biases. Members were then instructed to think about their own biases and return to the next team meeting for a fuller discussion. Time was allowed for members to explore their biases in order to encourage depth of thought in considering the multitude of factors which influence one's worldview.

During discussions of biases, a few themes emerged that the team monitored during the data analysis. Primary themes that emerged among team members included how personal multicultural identities may shape worldview, that trainees were unlikely to integrate race/ethnicity into their overall understanding of the client, and the importance of supervision on the development of conceptualization skills. Additionally, the principal investigator was biased in her expectations of what components of the client identity would emerge during the conceptualization process based on her review of the literature. Members of the research team are referred to as the principal investigator and team member one and two.

First, a common bias shared by team members was the influence of their own identities on the data analysis process. The principal investigator expressed holding the

bias that her own experience as a bicultural individual may make her harsh during this process which she felt could influence her lens during data analysis. Team member one expressed a similar bias in that she believes in the importance of intersectionality and the integration of multiple components of the client's identity based on her own experience as a White, queer individual in the counseling profession. Team member two discussed his awareness of his own level of privilege as a White, heterosexual, cisgender male creates a tendency to defer on multicultural issues to those from non-dominant backgrounds and identities feeling his opinion on diversity may be less valuable.

A common theme among team members sources of bias included the expectation that trainees would not integrate differing aspects of the client's identity. In the formulation literature, this is described as the level of "integration" of the formulation (Eells, 2015). All three team members expressed their assumption that novice therapists would almost certainly mention the client's race/ethnicity but fail to integrate this information into their understanding of the client.

The importance of supervision in the development of conceptualization skills also emerged as a common expectation among team members. Based on her own experiences learning conceptualization skills and on the literature review, the principal investigator held the belief that supervision is primary in learning to effectively conceptualize clients. Consistently, team members one and two described the importance of supervision in developing conceptualization skills. The principal investigator and team member two both shared their own negative experiences with early supervisors when attempting to integrate race and ethnicity into client conceptualization. The principal investigator and

team member two both felt this may color their judgements of trainees' early supervision experiences.

A primary bias held by the principal investigator was that she had explored the conceptualization literature and held biases based on her perception and analysis of the literature. She expressed the belief that categories would emerge during the qualitative data analysis which would reflect the components of conceptualization in the existing theoretical and empirical literature base such as perceived client beliefs or references to the therapy relationship. Further, the CCQ (Welfare, 2007) used in this study is divided into distinct subcomponents of the client's identity including cognitive, emotional, spiritual/values, or behavioral client characteristics. Therefore, the principal investigator expected that the client characteristics trainees discussed in their conceptualization would match these CCQ subcomponents. These pre-conceived categories expected to emerge served as a primary bias because CQR is inductive and categories are intended to emerge through the qualitative data analysis process. In order to reduce the influence of this bias, literature regarding components of conceptualization was not discussed as a team until the conclusion of CQR data analysis to limit this bias and maintain the inductive foundation of CQR.

Measures

The data collection tools used in this study included a short demographic form and the CCQ (Welfare, 2007). A semi-structured qualitative interview including a think-aloud procedure and several semi-structured questions were used in data collection.

Demographic form. Trainees completed a short demographic form (see Appendix B). The form provided the research team with background information

regarding potential trainees. The demographic form included general information

regarding trainee race/ethnicity, age, sex, and training background. Additionally, the form

included information regarding internship or work setting, percentage of multicultural

clients, supervision, and the level of emphasis on multicultural conceptualization skills

involving race/ethnicity. The form instructed trainees to identify a client whom they wish

to describe during the interview.

Several screening questions were included on the demographic form in order to

identify trainees who did not meet inclusion criteria. First, the respondent indicated

whether they have worked with a client who is of a minority race or ethnicity or who is of

a differing racial or ethnic background than themselves. Second, the respondent indicated

whether they were fluent in English. This inclusion criterion is a requirement of the CCQ

measure used in this study (Welfare & Borders, 2010). Third, respondents indicated

whether they were receiving one hour or more supervision per week.

In addition to these inclusion criteria, the form included several questions

regarding the trainees' multicultural beliefs and training experiences. Specifically,

questions pertained to supervision and perceived importance of multiculturalism when

conceptualizing clients.

Interview protocol. Trainees completed telephone interviews regarding client

conceptualization. The principal investigator piloted the protocol before arriving at a final

version of the protocol (see Appendix D).

Piloting the protocol. Prior to data collection, the principal investigator completed

two pilot interviews and the interview protocol was adjusted. In accordance with

recommendations provided by Hill et al. (2005) these pilot interviews served several

purposes. First, piloting allowed the team to revise questions that were unclear to the potential trainee. Second, piloting provided information about data that were likely to be collected from the questions. Lastly, the piloting process allowed the principal investigator an opportunity to practice the protocol questions in a realistic, interview-like setting (Hill et al., 2005). Pilot interviews took place with Licensed Professional Counselors' who were no longer in supervision and would therefore not be eligible to participate in this study.

The protocol was adjusted based on pilot interviews to include a warm-up question regarding challenges encountered during training. During pilot interviews, the warm-up questions asked the trainee to describe their clinical setting and clients. These questions encouraged the trainee to begin thinking about their clinical work; however, the content gathered was superficial in nature and the think-aloud procedure required the trainee to be vulnerable and actively engage with a difficult skill. I added a question regarding challenges in training to encourage the trainee think critically about their development as a therapist and establish rapport early in the interview. One goal of the CQR protocol is developing rapport with the participant (Burkard et al., 2012). As the trainee's skill level was being assessed in this procedure, building rapport at the beginning of the interview and lending support was critical.

Final protocol. The final protocol included warm-up questions, a think-aloud procedure, several semi-structured interview questions, and final concluding thoughts regarding the development of conceptualization skills. First, the interview consisted of three opening questions to develop rapport and help the trainee reflect on their clinical work. The trainee was asked to describe her/his/their current site, the clients with which

they work, and the challenges they have faced in coursework and clinical work. The third

question regarding the challenges was added after the pilot interviews to encourage

trainees to reflect more deeply on their development and to validate trainees'

vulnerability.

Second, trainees completed the think-aloud client conceptualization procedure.

Trainees were introduced to the think-aloud procedure and instructed to practice the

think-aloud procedure with a short five-minute activity in which they described a good

friend to the extent that a stranger would feel as if they had a comprehensive

understanding of the friend. This training procedure is borrowed from the Role Category

Questionnaire (RCQ; Crockett, 1965). The exercise provided a warm-up for

conceptualization without requiring counseling-specific skills or content. Following the

practice exercise, trainees were asked to conceptualize a client with whom they have

worked who is of a minority racial/ethnic background and/or is of a different racial/ethnic

background than the trainee. Respondents were asked to describe any and all sources of

information they believed were salient in order to achieve a full understanding of the

client. Trainees were informed that the goal of the procedure is to follow the process they

work through when conceptualizing clients, eventually arriving at a holistic

understanding of the client. Trainees were asked to go into as much detail as possible. No

time limit was placed on the think-aloud procedure.

After the think-aloud procedure, trainees completed a semi-structured interview.

In the first component, trainees were instructed to answer three questions regarding the

think-aloud conceptualization case (see Appendix D). Trainees were asked how they

decided whether their client's race or ethnicity was an important component of their

conceptualization and how their clinical site facilitated or hindered their conceptualization of this client.

In the second component of the semi-structured interview protocol, trainees answered questions that related to their development of conceptualization skills in working with clients who are racial or ethnic minorities. Trainees were asked how they learned to conceptualize clients and what was most challenging and helpful in developing multicultural conceptualization skills.

The interview concluded with two final questions. First, the trainee was asked if they had any questions or concluding thoughts regarding the topic of multicultural client conceptualization or the interview. Second, trainees were asked about their experiences with and reactions to the interview to allow a space for debriefing.

Counselor cognitions questionnaire (CCQ). The CCQ (Welfare, 2007) is a brief measure assessing the quality of client conceptualizations. This measure uses a client conceptualization to assess the quality of the conceptualization. As discussed in chapter 1, conceptualization quality is defined as the complexity of the conceptualization (Welfare, 2007). Complexity is comprised of the level of differentiation (number of different ideas) and integration (connection between these ideas) the counselor applies when conceptualizing a client (Welfare, 2007).

CCQ development and validation. In an initial CCQ pilot study of 17 master's and doctoral students, administration time of 15 minutes was established and directions for the completion of the form were clarified. As a result, directions were added to "describe a client as fully as you can by writing words or phrases that explain their defining characteristics" (Welfare & Border, 2010, p. 8). Additionally, trainees rated

whether each characteristic was positive, negative, or neutral. Lastly, directions were added to, "Think about your interactions with them and any attributes or characteristics which you might use to describe them" (Welfare & Borders, 2010, p. 8).

An early validation study of 34 master's and doctoral students from the Council for Accreditation of Counseling and Related Programs found that differentiation scores ranged from 8 to 50 with a mean of 22 (*SD=8.72*). Integration scores ranged from 6 to 15 with a mean of 10.42 (*SD=2.39*). There was a positive correlation between differentiation and integration scores (r (31) =.48, *p=.005*). Welfare & Borders (2010) suggested these results indicate scores of cognitive complexity are related but not sufficiently explained by either differentiation or integration scores alone. Inter-rater reliability was strong for both differentiation and integration (.99, .95) (Welfare & Borders, 2010).

In a larger study of 120 master's and doctoral level students, differentiation ranged from 6 to 72 with a mean of 22.03 (*SD=10.39*) and integration scores ranged from 0 to 22 with a mean of 9.88 (*SD=3.78*). A positive correlation between differentiation and integration was found (r (117) = .64, *p<.001*). Trainees who had completed their master's training also scored significantly higher than trainees which provided evidence of construct validity because research shows that experience increases integrative complexity (Ancis & Syzmanski, 2001). Integrative complexity scores in the CCQ (Welfare, 2007) were unrelated to scores on the RCQ (Crockett, 1965), which provided evidence of discriminant validity. Welfare and Borders (2010) suggested that this finding indicated counseling-specific domain specificity for the CCQ (Welfare & Borders, 2010). Lastly, the CCQ inter-rater reliabilities in studies of psychometric properties were .99, .96, and .95 which indicates strong reliability (Welfare & Borders, 2010). Therefore,

sufficient psychometric properties have been established for the CCQ to be administered as a measure of cognitive complexity in this study.

Administration. Typical administration procedure for the CCQ (Welfare, 2007) is as follows. Trainees describe their client as fully as they can using words or phrases. They are told to describe the client to the extent that a stranger feels as if they would know them. They then indicate whether the characteristic is positive, negative, or neutral and rate the importance of the characteristic in conceptualizing this client. The proportion of positive and negative client characteristics is associated with a score for integration because higher quality conceptualizations include both negative, neutral, and positive characteristics about the client (Welfare & Borders, 2010). The list of words or phrases are then compiled into categories. For the purposes of this study, the research team completed the form based on the think-aloud client conceptualization content and then the completed form was sent to trainees for and changes or adjustments. All trainees confirmed that the data on the completed CCQ form accurately represented their client conceptualization. The decision to alter the administration procedure in this study was made in collaboration with Laura Welfare, the author of the measure (L. Welfare, personal communication, June 20, 2017). Administration took place following the interview and research team members completed the questionnaire based on the trainee's responses. The completed assessment was then sent to trainees for confirmation that the questionnaire accurately reflected their client conceptualization.

Scoring. Team members used the conceptualization created by the trainee to sort the content into distinct characteristics with a positive, negative, or neutral valence. After the content of the conceptualization was captured on the first form, the content was sorted

into categories and the number of content themes that relate to each category was listed. These measures provided an assessment of the number of categories as well as the number of items in each category. There is no restriction on the number of different characteristics or the connection between these characteristics that a trainee may include. There is no maximum or minimum on this measure in an effort to be inclusive of all ranges of conceptualization complexity levels (Welfare & Borders, 2010). The CCQ scoring manual provides detailed instruction on scoring the protocol (Welfare, 2007).

   Training. The rater training manual includes the full protocol, sample scoring, and training and administration procedures to guide the use of the measure. The CCQ administration and scoring manual provides three training samples through which raters learn how to score the responses. Welfare and Borders (2007) have suggested that raters-in-training should achieve an initial .90 inter-rater reliability with all three sample scores in order to use the CCQ proficiently. Additionally, at least two raters should score each response sheet to ensure inter-rater reliability (Welfare & Borders, 2007). In accordance with Welfare and Borders (2007), these training recommendations were followed in this study. After each transcript was independently reviewed by team members one and two, interrater reliability was calculated. The inter-rater reliability for the CCQ differentiation and integration scores was calculated to determine if the CCQ could be scored consistently. All eleven trainees each received a score on differentiation and integration. During independent scoring, team member one and two differed by one point on the integration score of one trainee. The discrepancy was discussed as a team and a decision was made regarding integration score for that trainee. An inter-rater reliability of .95 was found indicating high inter-rater reliability.

Differentiation. Differentiation, the number of constructs a trainee identifies when conceptualizing a client, was created by totaling the number of client characteristics included in the conceptualization. Characteristics regarding a client belief, mannerism, quality, trait, tendency, behavior, thought, feeling motivation, fear, or concern were awarded one point each (Welfare & Borders, 2007). Gender and age are considered to be basic demographic information and were, therefore, not scored; however, demographic characteristics which reflect the trainee's understanding of the client were awarded one point (Welfare & Borders, 2010). An example of this would be the characteristic "mature 16-year-old" as this statement reflects some understanding of the client rather than simply their age. When trainees included two characteristics which were seemingly synonyms, such as "direct" and "blunt," these were both awarded points as this reflects distinct constructs in the trainee's thought process (Welfare & Borders, 2007). Phrases which contained multiple constructs were awarded points based on the number of constructs included. For example, "limited support from family and limited support from friends" earned two points based on the scoring criteria. If an adjective was used to describe a word, such as "overly kind," this was awarded one point as the phrase represents one distinct idea (Welfare & Borders, 2007). Single characteristics written as a phrase, such as "unwilling to change" were awarded one point. Points were summed, and descriptive statistics are included in the results section.

Integration. Integration describes how constructs are connected to form an overall understanding of the client. First, integration points were awarded based on the characteristics listed. In the scoring protocol for the CCQ, a balance of positive and negative characteristics (no more than 80% of one valence) awards one point in

integration (Welfare & Borders, 2007). Neutral valence characteristics were not counted in this percentage. One point was awarded for including at least one characteristic in the following areas: cognitive, spiritual, emotional, contextual, and behavioral. Listing a characteristic of the counseling relationship, such as "cooperative" also earned one point.

Second, integration points were awarded based on the categorizations. For example, one point was awarded for every unique category listed that included more than one characteristic. Additionally, a point was awarded for each list of categories that included a characteristic that reflects awareness of the counseling relationship (Welfare & Borders, 2007).

Procedures

In the following section, I provide a discussion of the study procedures. First, data collection procedures are described including informed consent, interview procedures, and the administration of the CCQ. Finally, the data analysis procedures are examined including the mixed methods design and CQR.

Data collection procedures. Data was collected in three phases. In the first stage of data collection, trainees completed the demographic form and informed consent. These forms were returned to the researcher and trainees who met inclusion criteria were contacted to set up an interview. Those who did not meet inclusion criteria were thanked for their interest in the study. In the second stage of data collection, interviews were conducted and transcribed. The transcripts were sent to trainees to ensure they were comfortable with the content they provided during the interview. Lastly, the client conceptualizations were scored using the CCQ (Welfare, 2007). These completed CCQ forms contained the interview data provided by trainees and were sent to trainees to

confirm that the content accurately captured their client conceptualization. All trainees responded that they believed their client conceptualization was accurately recorded on the CCQ form (Welfare, 2007).

Informed consent. An informed consent form was sent with a recruitment email and demographic form to all trainees prior to interviews. The consent form described the purpose of the study and time involved in participation. Additionally, the form included benefits and risks of participation and confidentiality information. Space was provided for the signatures of trainees and the principal investigator. The consent form is included in Appendix A.

Interview process and transcription. Trainees were provided with the interview protocol in advance of the interview. This decision was made in accordance with recommendations provided by Burkard et al. (2012). Providing trainees with the interview questions for review prior to the interview ensured trainees had experienced the topic under investigation, served as informed consent so trainees were entirely aware of what would be asked of them, and allowed time for trainees to think and reflect on protocol questions (Burkard et al., 2012).

The principal investigator conducted ten of eleven interviews. A research team member completed one interview based on their own personal investment in CQR training. One interview was completed in-person rather than by telephone due to trainee telephone issues. Length of interviews ranged from 45 minutes to 90 minutes.

During the client conceptualization think-aloud task, the trainee was not interrupted by the interviewer. Researchers have asserted that asking participants to think out loud by verbalizing and vocalizing spontaneous inner speech does not alter or disrupt

the participant's natural thought process unless the participant's thoughts are interrupted by the interviewer (Fox et al., 2011). As discussed previously, requesting explanations or elaborations changes the response of trainees, rendering the procedure less valid. Therefore, the principal investigator made every effort not to disrupt the thought process.

Technical considerations regarding interviews included recording procedures and interview transcription. Audio-recording was used in this study and all audio-recording equipment was tested before use. Additionally, the researcher took notes throughout the interview in order to ask follow-up questions and maintain a secondary record of trainee responses. No visual recording devices were used. Nine of eleven trainee interviews were transcribed by the principal investigator. Each of the two research team members completed one interview transcription. Team members listened to the audio-recording and transcribed all interview content. Transcribed content was sent to trainees and all trainees verified the accuracy of the transcription.

Institutional Review Board. Midway through data collection, the IRB was consulted for a change to the inclusion criteria. The original inclusion criteria stated the trainee was to conceptualize a client who was (1) of a different race or ethnicity than the trainee *and* (2) who was of a minority racial or ethnic background. As nine of the 11 trainees were of majority racial background, conceptualizing a client who was of a minority racial or ethnic background *and* a background different from themselves were one and the same. One trainee was of a minority ethnic background and chose a Caucasian client. Therefore, the client was of a differing ethnic background than the trainee but did not meet this second inclusion criteria of being of a minority racial or ethnic background. The trainees misunderstood the inclusion criteria on the informed

consent and protocol and described choosing this client for her conceptualization based on the impact of cross-racial differences between the client and trainee. As a result, the inclusion criteria were altered and trainees conceptualized a client who was (1) of a different race or ethnicity than the trainee *or* (2) who was of a minority racial or ethnic background.

Inclusion criteria were changed to accommodate this interview for several reasons. First, as the original inclusion criteria were easier to meet for trainees who were of a majority racial/ethnic background, the original criteria inadvertently made it more difficult for trainees of racial/ethnic minority backgrounds to participate. Second, the client's race did not emerge until half way through the think-aloud procedure. Therefore, the trainee could not have been asked to identify a new client at this point in the interview and would not have been included in data analysis. Therefore, in consulting with the auditor and the IRB, the inclusion criteria were changed to conceptualize a client who is of a differing racial ethnic background than themselves and/or a client of minority racial or ethnic background.

Data analysis procedures. This study follows a mixed methods design with emphasis on the qualitative portion of results. Qualitative data analysis was conducted using CQR procedures (Hill et al., 2005). Quantitative data was analyzed using the Statistical Package for Social Sciences (SPSS) software.

Mixed methods. The study used a mixed method design with emphasis on the qualitative portion of the data. The CCQ, a quantitative measure, was embedded to provide information regarding the quality of the conceptualizations created by trainees during the interview. The conceptualization generated by the think-aloud procedure and

the data from the semi-structured interview were analyzed using CQR (Hill et al., 2005;

Hill et al., 1997). Research team members then analyzed the conceptualization using the

CCQ (Welfare, 2007). The research team completed the form based on the think-aloud

client conceptualization content. The completed assessment was then sent to trainees for

confirmation that the questionnaire accurately reflected their client conceptualization. All

trainees confirmed that the data on the completed CCQ form accurately represented their

client conceptualization.

A fixed mixed methods design was used, such that the process and procedures

were preplanned rather than emerging during data collection. Additionally, the study used

an embedded design (Creswell & Plano Clark, 2011). In this design,

qualitative data was the focus and quantitative data was intended to better understand the

qualitative findings. The point of interface, also known as the stage of integration, refers

to the point at which quantitative and qualitative strands of research were mixed

(Creswell & Plano Clark, 2011). The point of interface used in this study was at the data

analysis phase. Results from the CCQ were embedded within the interview results during

data analysis. I now briefly discuss the qualitative data analysis process.

CQR. The interview, including the think-aloud procedure and the semi-structured

interview questions, was analyzed using CQR (Hill et al., 2005). The think-aloud content

provided information regarding the most influential factors which emerged during the

data analysis. The semi-structured questions sought to elaborate the client

conceptualization and provide information regarding influences on multicultural

conceptualization skills. The team adhered closely to guidelines provided by Hill et al.

(2005) and Thompson et al. (2012) for the data analysis procedures. The CQR data analysis process is divided into three phases, which are outlined below.

Domaining the transcripts. In CQR, the domain list is created from the interview transcript to describe each individual trainee's experiences within distinct groups or clusters (Hill et al., 2005). This process included (1) developing a domain list for each case, (2) updating the domain list with new case transcripts, (3) assigning interview data into domains, and (4) developing a consensus version of interview data and core ideas within domains for each case.

In this study, the research team developed a list of domains by reviewing the transcripts from each interview (Hill et al., 2005). During team meetings, members came to consensus by adding, deleting, or combining domains until a domain list was created that all members agreed upon. Once the domain list was finalized, team members independently read through the list and assigned raw data from the transcripts to each domain (Hill et al., 2005). Included in the "other" domain was information that was deemed important but did not fit into any existing domains in the list (Thompson et al., 2012).

After researchers had independently domained the data for a transcript, the team met to discuss how they divided the raw data from the interview transcripts into the various domains. The team discussed any differences regarding how interview data was divided into the domains until consensus was reached. The team made changes to each domained case as needed until a consensus version was created. The final domained transcript included the domain titles followed by the raw data that fitted within each domain. In accordance with recommendations set by Hill et al. (2005, we continued

changing the domain list until the list stabilized. The list stabilized following the domaining process of the third case transcript.

The team attended to the amount of data that was double or triple-coded to ensure that domain titles were distinct from one another and the same interview content did not fit within several domains. For example, if content is "double-coded," or fit into the same two domains, these domains were combined as this signaled that the domains did not represent distinct content. Further, we double coded information sparingly which provided the team with an indication that the domains were unique (Thompson et al., 2012). No information was triple-coded. Following the creation of a final domain list, the core ideas then served as a summary of what each trainee said, in their own words, in each domain (Thompson et al., 2012).

Core ideas. After all cases were domained, core ideas were developed for each case. Core ideas can be conceptualized as a concise summary of trainees' words within each domain (Thompson et al., 2012). The core ideas served as summaries of the content of each domain for each case. Core ideas were briefer than the raw data and the team sought to eliminate trivial details (Thompson et al., 2012). Additionally, core ideas remained as close to the data as possible as there is a tendency to jump to a higher level of abstraction than what is warranted by the data (Hill et al., 2005). The *coring process* condensed the trainee's words into a format that was concise, clear, and comparable across cases (Hill et al., 2005).

Several steps characterized the coring process. First, the interview data in each domain was written to yield concise and clear wording that the team agreed accurately reflected the words of the trainee. Second, each case was sent to the auditor for feedback.

Third, auditor feedback was discussed during team meetings. Changes were made by using the raw data to resolve discrepancies as a team. Fourth, a final version of each case was created (Thompson et al., 2012).

Cross-analysis. Cross-analysis is the final phase of CQR data analysis and is characterized by a description of the themes that emerged across trainees (Hill et al., 2005; Ladany, Thompson, & Hill, 2012). Additionally, cross-analysis includes the proportions of trainees who endorsed each theme (Hill et al., 2005). The proportions allow for transferability of findings to a more general population and provide information of how representative each theme was of the overall sample (Hill et al., 2005).

The cross-analysis process consisted of several steps. First, a team member created a document which organized core ideas from all trainee cases within each domain. Second, this document was used to create categories within each overarching domain based on the cored down interview data. Team members independently created categories which they felt reflected the cored data within each domain. Third, the team then met to discuss categories and arrive at a consensus for each domain. These categories were sent to the auditor to provide feedback. Fourth, the team integrated this feedback and created a final version of categories within each domain. Categories were assigned frequencies as follows: (a) *general* pertained to all or all but one trainee endorsing a response, (b) *typical* pertained to more than half of the trainees endorsing a response, and (c) *variant* pertained to half or less of the trainees endorsing a response (Ladany et al., 2012).

CCQ. First, the principal investigator used the transcript from the think-aloud client conceptualization procedure to complete the CCQ form (see Appendix C; Welfare,

2007). In this phase, the principal investigator used only the client conceptualization content from the interview transcript to write each client characteristic discussed during the conceptualization. The principal investigator then sorted the characteristics into themes on the third page of the CCQ form. Team member one and two then checked the completed forms based on the transcripts and any potential changes to the form were discussed as a group.

Second, completed CCQ forms and typed transcripts of the interview content were sent to trainees by email for verification that the form accurately reflected the content of their client. All trainees responded to this email confirming that the form and transcript were correct.

Third, after trainees verified the content of the form, two team meetings were held to provide training on CCQ scoring to assess conceptualization quality. The team completed CCQ scoring training practices as outlined by Welfare (2007).

Fourth, team member one and two scored the completed CCQ forms. First, a differentiation total was created which summed the number of distinct constructs. Second, integration scores were calculated following the scoring protocol set in Welfare (2007). When scoring the protocol, raters classified each construct as one of four types of descriptors including cognitive, emotional, spiritual/values, or behavioral. As more complex conceptualizations include a variety of types of characteristics, trainees earned a point for each type of descriptor used (Welfare & Borders, 2010). Additionally, because awareness of the counseling relationship is an important marker of conceptualization quality (Ancis & Syzmanski, 2001; Welfare & Borders, 2010), scores increased when trainees included client descriptors for characteristics that mention the counseling

relationship (Welfare & Borders, 2010). Raters also assessed valence of characteristics

because client conceptualizations should include discordant information such that the

client is not perceived to have all positive or all negative traits (Welfare & Borders,

2010). Raters classified each construct as positive, negative, or neutral. They then

calculated the balance of positive and negative characteristics and awarded one point if

less than 80% of the characteristics were of one valence (Welfare & Borders, 2010).

Lastly, raters totaled the number of unique categories listed by the trainee as a marker of

conceptualization quality (Welfare & Borders, 2010).

CHAPTER 4: RESULTS

The results of this study are presented in two major sections. First, CQR (Hill et al., 2005) findings related to the think-aloud conceptualization procedure are provided in Table 1. During the conceptualization procedure, trainees conceptualized a client who was of a different racial or ethnic background than themselves. Results from the conceptualization were quantitatively analyzed using a measure of conceptualization quality (CCQ; Welfare, 2007). In the second section of the results, trainees explored how they learned to conceptualize clients and what factors challenged and facilitated this learning process. CQR (Hill et al, 2005) findings from the second section of results are included in Table 2. Categories are labeled with the following frequency descriptors based on 11 cases total: *General* = 10-11 cases, *Typical* = 5-9 cases, *Variant* = 2-4 cases. Categories that emerged in only one case were moved to an "other" category. "Other" results are not described in this manuscript.

Multicultural Conceptualization

Trainees engaged in an open case conceptualization of a client who was racially or ethnically different from themselves. The conceptualization content was quantitatively and qualitatively analyzed and results are enumerated in the following section.

Prior to discussing quantitative results is a brief presentation of client background and presenting concern to provide client contextual information. First, trainees briefly described several demographic components of the client background. Five trainees worked with child clients and six trainees worked with adult clients. All 11 trainees reported the client's race during the client conceptualization which included clients who were African American, Native American, Indian, Mexican American, Saudi, and

Caucasian. Five trainees stated the client's gender including three males, one female, and one trans female-male. Four trainees mentioned the client's socioeconomic status which included two clients of low, one of middle, and one of high socioeconomic status. Three trainees discussed the client's religion which included Muslim, Hindu, and Christian. Finally, all trainees described specific mental health diagnosis or situational stressors. Six clients were reported to have externalizing behaviors (i.e. ADHD, tantrums), five had depression and/or suicidal ideation, and five had anxiety concerns. Five clients were reported to have academic stress as their primary presenting concern.

Quantitative measurement of conceptualization quality. Content of the think-aloud procedure was assessed using the CCQ (Welfare & Borders, 2010). The below section includes individual trainee scores, descriptive statistics from this study and the norming group, and the correlation among variables.

Inter-rater reliability. Inter-rater reliability for differentiation and integration scores compared to the norming sample are provided in Table 1. Each of the 11 CCQ forms was scored by the two trained raters. The inter-rater reliability for differentiation total was significant at .99 and for integration was 1.00. These very high inter-rater reliabilities suggest the two raters scored the responses consistently. Inter-rater reliability in this study was consistent with that demonstrated in the norming study.

Table 1
Inter-rater Reliability

	Differentiation	Integration
Present Study	.99	1.00
Norming Study	.99	0.95

Individual scores. The CCQ (Welfare & Borders, 2010) provides two subscales used to assess the quality of a case conceptualization. Differentiation, the number of

client characteristics, and Integration, the association between these characteristics.

Information regarding each trainee's individual scores is presented in Table 2.

Table 2
Conceptualization Performance by Individual Case

Case Number	Differentiation Score	Integration Score
Case 1	46	14
Case 2	19	8
Case 3	39	14
Case 4	18	14
Case 5	34	17
Case 6	43	15
Case 7	33	10
Case 8	49	14
Case 9	36	14
Case 10	43	13
Case 11	18	8

Descriptive statistics. Descriptive statistics for the sample of trainees is provided

in Table 3. The mean differentiation score for this sample of trainees was 34.36

(SD=11.34) with a range between 18.00 and 49.00. The mean integration score for this

sample of trainees was 12.82 *(SD= 2.89)* with a range between 8.00 and 17.00.

Descriptive statistics for the trainee sample scored at a higher level than the

masters-level trainee sample on which this study was normed. For the norming group of

master's level psychology trainees, the mean differentiation score was 22.00 *(SD= 8.72)*

with a range between 8.00 and 50.00. Therefore, 72% of trainees in this sample scored

above the mean of the norming group on differentiation. The mean integration score for

the mater's-level trainee norming group was 10.*42 (SD= 2.39)* with a range of 6.00-

15.00. Consistently, 72% of trainees in this sample scored above the mean of the norming

group on integration. Overall, the mean differentiation score in this study was

approximately one standard deviation above that of the master's-level trainee norming

group. Consistently, the mean integration score in this study was approximately one

standard deviation above that of the master's-level trainee norming group.

Table 3

Descriptive Statistics for Study Sample

	Mean	Standard Deviation	Range
Differentiation	34.36	11.34	18.00-49.00
Integration	12.818	02.89	08.00-17.00

Table 4

Descriptive Statistics for Master's Norming Group

	Mean	Standard Deviation	Range
Differentiation	22.00	8.72	8.00-50.00
Integration	10.42	2.39	6.00-15.00

Pearson correlation coefficient. Pearson correlation coefficient is displayed in

Table 5. The two variables, differentiation and integration, displayed a moderate, positive

correlation, $r(11) = .59$, $p < .10$. This finding suggests that differentiation and integration

scores are positively associated such that trainees who scored higher on differentiation

also tended to score higher on integration.

Table 5

Correlation of Differentiation and Integration Scores

	Correlation	Descriptor
Pearson's Correlation Coefficient	0.5913	Moderate positive correlation

Topics related to race or ethnicity. Several topics related to the client's race or

ethnicity were included in the trainees' conceptualization. The following section

describes those topics trainees included in their multicultural client conceptualizations.

Table 6

Interview: Domains, Categories, and Frequencies for Think-Aloud Client Conceptualization

Domains	Categories for Client Conceptualization	Frequencies
Topics related to race or ethnicity	Race of client was identified	General
	Cultural expectations of client's family influences presenting concern	Typical
	Influence of Acculturation	Variant
	Discrimination experienced by the client based on their culture	Variant
	Client appeared to not identity with their phenotype	Variant
	Strengths or benefits associated with client's race or ethnicity	Variant
Reason race or ethnicity was important to include in the client conceptualization	Trainee recognized the importance of client's race or ethnicity to understanding the presenting concern	Typical
	Client identified and discussed the relevance of race or ethnicity to the presenting concern	Typical

*Eleven total cases. General=10-11, Typical=5-9, Variant=2-4

Generally, the race of the client was identified as a demographic marker. For example, one trainee began her conceptualization by stating, "Client is a 26-year-old student from Saudi Arabia." Trainees' included race as an aspect of demographic information typically within the first minute of the conceptualization in conjunction with the client's age, gender, and diagnosis.

Typically, trainees discussed how the cultural expectations of the client's family influenced their presenting concern. For example, one trainee working with a Mexican-American client explained:

The big thing that we discussed the second time we met was how he [the client] felt a lot of cultural pressure to keep his stress to himself and said that, from a young age, his dad told him that boys don't cry particularly in their culture.

A second trainee working with an African American child client on aggressive behavior explained, "I found in working with some of the African American families that play fighting is just a normal male bonding experience … People have their perspective and experiences in their culture and what they know which is completely valid."

Trainees variantly described the influence of acculturation as an aspect of the client's race or ethnicity in their conceptualization. One trainee described how her Saudi client thinks to himself, "I work in the United States. It doesn't mean I need to give up every aspect of my traditions or keep the old aspect of every tradition" as he navigated whether to engage in an arranged marriage. A second trainee stated:

> She's talking about being a Mexican American individual and how she grew up with these family values and these rules that she's expected to take on. But the conflicting piece of how that intersects with her education and her values and her dating and all these different spheres.

The trainee goes on to discuss how her client struggled to find her place among what "millennial American women might be doing but that perhaps for her culture are deemed inappropriate."

Variantly, trainees' described incidents of discrimination experienced by the client. One trainee discussed the discrimination experienced by their client and described an incident in which the client experienced a *microassault* (Sue & Sue, 2013) in college classes. The trainee stated:

> A student in her [client's] class who was a White male was telling her during her presentation that all immigrants should speak English. He actually used the term American and he said all immigrants should speak American … This professor

had let this microaggression happen in front of his eyes in the classroom and then

had done nothing to stop it until these two were at each other's throats. Just letting

this White male student be like, oh, immigrants shouldn't be here or build a wall,

send them back, speak American.

The trainee hypothesized that this incident led to the development of her client's

depression.

In a variant category, two trainees discussed how the client did not identify with

their phenotype. For instance, one trainee expressed:

We had some concerns with her understanding her cultural identity because she

didn't, it didn't appear that she wanted to be Black. Her parents are White. And so

she was having a hard time in school fitting in and trying to find friends. She

would only hang out with peers who were White. She never wanted to do her hair

and her parents had talked to her a lot about her history and her ethnic

background.

Finally, trainees variantly described the strengths or benefits associated with the

client's race or ethnicity. For example, one trainee discussed how their client was

conscientious and the family's cultural values helped the client to keep therapy

appointments. A second trainee discussed the importance of their client's racial

background to receive a monthly stipend. The trainee explained:

She [the client] is currently part of a Native American tribe and receives a

monthly stipend which has allowed her to stay in the middle class even in her

youth and helped her to support her children because she's not currently married.

Importance of race or ethnicity. Beyond the racial or ethnic topics trainees

decided to include, trainees described how they made the decision that the client's

cultural background was pertinent to understanding the case. In this section, domains and

categories were identified based on trainees' conceptualization of a client. Two domains

emerged which included the importance of race or ethnicity when conceptualizing the

client and topics related to race or ethnicity.

Trainees discussed how they knew the client's race or ethnicity was important to

include in their client conceptualization. A category which typically emerged among

trainees was the trainee recognizing the importance of racial or ethnic background for

understanding the presenting concern without the client explicitly telling them that race

or ethnicity was a salient aspect of their life. For example, one trainee described how the

client had to "blend two different cultures" as an African American child living with a

White adoptive family. The trainee believed this blending of cultures led the client to

experience confusion. A second trainee articulately described her experience navigating

the association between her Indian client's ethnic background and their presenting

concerns. She stated:

> Expectation wise, I knew that every culture has different expectations for
>
> children…How kids are raised in different cultures can be very different….I
>
> didn't want what we think of in the Western, United States culture of how children
>
> function normally to override what they still thought was normal child
>
> behavior…And so it was difficult because it was always a line for me between
>
> trying to figure out our treatment model and it's values in the United States. I
>
> want to benefit them and help them with their concerns with what we know can

be effective. But I also don't want that to undermine what they still think is appropriate.

A second category which typically emerged was the client identifying the relevance of race or ethnicity to their presenting concern. These trainees expressed how they knew race or ethnicity was important to include in the conceptualization because the client explicitly initiated a discussion of their race or ethnicity during therapy. One trainee worked with a student from Saudi Arabia and felt the client's racial or ethnic background was important because "the client himself brought up these issues related to family and cultural traditions." A second trainee described an incident in group that informed her that the client's racial background was important to her. This incident was never integrated into treatment. The trainee described co-facilitating a group therapy session in which the group members and facilitators were Caucasian with the exception of one African American group member.

> We're trying to do a group and she just kind of yelled, 'You guys are White. You will never understand me. You're just white girls.' And she made a couple of comments to, not just us, but other people in the group room about being a different race or things like that.

Training in Conceptualization

Following the multicultural client conceptualization procedure, trainees completed a semi-structured interview regarding multicultural case conceptualization skill development. The results of this interview are provided in Table 7. Trainees responded to questions regarding general challenges during training. Trainees then discussed overall program training in multicultural case conceptualization skills and the

influence of training at clinical sites where the trainee practiced therapy on developing

multicultural conceptualization skills.

Table 7

Interview: Domains, Categories, and Frequencies for Training

Domains	Categories	Frequencies
Challenges During Training	Recognizes a lack of clinical skills to work effectively in therapy	Typical
	Struggles to address cultural differences between trainee and client	Variant
	Struggles to address some clinical needs of clients	Variant
	Some external circumstances influenced clinical work	Typical
	High workload and time management	Variant
	Classroom instruction was not consistent with clinical practice	Variant
	Agency did not attend to clients' culture	Variant
Learning to Conceptualize Clients	How trainee learned to conceptualize clients	
	Opportunities to practice conceptualization skills were provided in practicum and internship class	Typical
	Conceptualization skills were taught throughout the master's training curriculum	Typical
	Trainees learned conceptualization using theoretical models taught by course instructors	Typical
	Internship supervisors supported learning about conceptualization	Variant
Learning to conceptualize multicultural clients	How trainee learned multicultural conceptualization skills	
	Multicultural class increased trainee's awareness of or ability to address culture with clients	Typical
	Multicultural issues integrated by instructors throughout the training program	Typical
	Trainee was able to actively engage multicultural conceptualization during internship	Typical
	Factors that facilitate development of multicultural conceptualization skills	
	Master's training emphasized an integration of culture	General
	Engaging client about culture encouraged integration of culture into conceptualization	Typical
	Factors that challenge development of multicultural conceptualization skills	

	Feared pathologizing or making assumptions based on clients' culture	Typical
	Trainee struggled to understand various client expressions of culture	Typical
	Training program did not prepare trainee to address culture in conceptualization	Variant
Current Clinical Training Experiences	Factors that facilitate multicultural conceptualization	
	Colleagues are supportive and engaged regarding culture	Typical
	Supervisor actively engaged supervisee in integrating culture	Variant
	Supervisor supported integration of culture when trainee initiated the conversation in supervision	Variant
	Culturally informed intake forms promoted attention to culture	Variant
	Factors that challenge multicultural conceptualization	
	Trainees question colleague competency	Typical
	Colleagues and site do not actively address culture	Typical
	Supervision	Variant
	Barriers to addressing culture with clients	Variant
	Client is not ready to discuss racial and ethnic identity when they are unstable	Variant
	No hindrances	Variant

*Eleven total cases. General=10-11, Typical=5-9, Variant=2-4

Challenges during training. This initial section addresses challenges encountered during training. Two primary categories and several subcategories emerged. This domain provides context for the nature of the training site and for the development of conceptualization skills.

A typical challenge trainees described was a lack of clinical skills to work effectively in therapy. This category spanned from trainees feeling unable to navigate difficult conversations and recognize trauma reactions to learning treatment protocols and managing "personal insecurities." For instance, one trainee stated, "I don't feel like I have very useful tools to actually help the student." Another trainee expressed "trying to navigate through my own emotions as a person and as a learning counselor" was a

significant challenge. Two subcategories emerged that further elaborate this lack of clinical skills to effectively provide therapy. A variant subcategory emerged in which trainees described difficulty understanding cultural differences between the trainee and client. For instance, one trainee stated, "I'm White and come from a middle class background….being able to at least try to understand where they are coming from" was challenging during training. Another trainee discussed difficulty understanding the experience of culturally different clients and discussed the most significant challenge for her was, "When I first started, just some of the cultural differences between me and my clients… you know admitting I don't really understand what that's like." A second subcategory that variantly emerged was the trainee struggling to address the clinical needs of clients. One trainee expressed clients often need more intensive, long-term care than what he is able to offer "making it tough to make progress." Similarly, one trainee expressed, "there are so many different ability levels. Some of the kids have learning difficulties, some have IEPs in school, some don't. So there's a lot going on between all the children and making sure their needs are being met."

A second typical category regarding challenges trainees encountered in training was the extent to which external circumstances influenced clinical work. All data within this domain was subsumed under three variant subcategories. First, trainees variantly expressed a high workload and considered time management to be a significant challenge in training. For example, one trainee expressed, "sometimes I wish that I was taking three classes at once instead of four and it was a three-year program instead of two just to be more prepared and dive into things more deeply." A second trainee expressed the high workload during graduate training created a lack of time to fully conceptualize each

client. Second, trainees variantly expressed that classroom instruction was not consistent with clinical practice. For example, one trainee expressed interest in trying techniques learned in class and feeling disappointed when the techniques "weren't really able to be applied in our [clinical] setting." A second trainee described struggling during internship "because in many ways the training I received in my master's program was very much treating the symptoms and not looking at the context so much." In a third variant category, trainees discussed working within an agency that does not attend to clients' culture. For example, one trainee stated that their internship site did not take culture into account and tended to "over-pathologize" certain kinds of behavior and expect all clients to "excel the same way." Similarly, another trainee stated that, at their internship site, "there wasn't a very conscious effort to bring culture into assessment."

Learning to conceptualize clients. Trainees initially shared how they learned conceptualization skills during their graduate programs. This discussion was the sole portion of the interview that pertained to general client conceptualization rather than multicultural conceptualization skills. Three typical and one variant category emerged in this domain.

In a first category, trainees typically described that practicing conceptualization skills in practicum and internship class was beneficial. One trainee stated, "I think we've had a lot of practice in practicum and internship classes, especially giving case presentations." A second trainee stated:

Our practicum experience was when we were first asked to conceptualize clients. That was the first time that we had really talked about it and practiced it. I think practice was the main thing that helped with being able to conceptualize clients.

Second, trainees typically expressed how using theoretical models as a guide was helpful when learning conceptualization skills. Trainees used a variety of models including cognitive-behavioral, biopsychosocial, and multicultural models. One trainee expressed, "from a theories standpoint, it helps you to be a little bit more focused and gives you direction." Another trainee stated "I think for myself, from a theories approach, it is important to conceptualize clients from counseling theories. We are encouraged to use one or two theories to conceptualize clients."

In a third category, trainees typically expressed that coursework was helpful when developing conceptualization skills. Trainees referred to courses such as introduction to counseling, multicultural counseling, foundations of clinical mental health counseling, and ethics. One trainee described learning multicultural case conceptualization skills and stated, "I think it's an ongoing process throughout the program."

In a final variant category, trainees indicated that internship supervisors were most helpful facilitating the development of multicultural conceptualization skills. For instance, one trainee stated:

> My supervisor is great at letting me think out loud and conceptualize, while also helping me with feedback and their own thoughts and feelings related to the conceptualization. I feel like I have a strong relationship there, where I have been able to develop conceptualization skills.

Learning to conceptualize multicultural clients. Trainees discussed how they learned multicultural conceptualization skills. Three categories were identified in this domain.

Trainees typically described that their multicultural class increased their awareness of or ability to address culture with clients. One trainee stated, "Because of multicultural counseling class, I have a general or bigger picture about what it's like to work with diverse groups from diverse populations and know some general struggles and common strengths and general cultural traditions." A second trainee stated "I think our multicultural class helped a lot integrating culture into clients and how you use them [conceptualizations] as a counselor."

Typically, trainees described that their overall training program increased multicultural conceptualization skills. This category spanned from trainees discussing an increase in awareness through their instructors' integration of multiculturalism throughout academic curriculum, to being taught models of multicultural identity during the first semester of graduate training, to practicum instructors encouraging trainees to navigate multicultural issues with clients. For instance, one trainee stated:

> Our instructors emphasized a lot of self-awareness and to reflect on our own biases and stereotypes and also multicultural awareness. Even though we don't always know exactly how to conceptualize these multicultural factors, I think I have this awareness to try to notice the cultural differences between my clients and I.

A second trainee expressed:

> I don't think there has been a single course I have sat in on or participated in where multicultural aspects were not brought up in some form in counseling or the counseling relationship. So I feel like I have received a lot of support there and a lot of direction in the ability to look for resources and find resources.

Trainees typically discussed learning multicultural conceptualization skills at their clinical site. For example, one trainee stated "I learned to conceptualize clients on-site, while reading patient charts." A second trainee expressed how they have the freedom to discuss conceptualization on-site with a "diverse group of practitioners."

Facilitating factors. Trainees discussed factors that facilitated their development of multicultural conceptualization skills. Three categories emerged in this domain.

Generally, trainees described their master's training as having an emphasis on integrating culture into conceptualization. One trainee expressed "I think that overall what was most helpful is the amount of exposure I have had both on-site and in coursework." Another trainee discussed how their multicultural course instructor pushed students to "expand our conceptualization to incorporate more of that culture."

Trainees typically expressed that directly engaging the client during counseling about culture facilitated their development of multicultural conceptualization skills. One trainee expressed "not dancing around" multicultural factors and issues and being "super comfortable just addressing them" is important, because she believes her client would not have initiated a conversation regarding cultural concerns on their own. A second trainee stated:

> I talk about points of their culture that are important to them…And I like to put that all out front so that it doesn't feel like if it comes up as something important, they'd feel the need to hide it or not talk about it or think that I won't understand.

Challenging factors. Trainees explored factors that challenged their development of multicultural conceptualization skills. Three categories emerged in this domain.

Trainees typically expressed a primary challenge they experienced in developing multicultural conceptualization skills was their fear of pathologizing or making assumptions about a client's culture. One trainee described "I think being careful to not stereotype… … walking the line between like not pathologizing that culture, but also helping the client work through problems that might be happening within that culture." A second trainee stated:

There are similarities between people within one culture but then everyone has individual differences so trying to be aware of those similarities that exist and those norms and also not stereotyping. Trying to find that balance of being cognizant of cultures but then being cognizant of individual differences.

A second typical challenge trainees encountered in developing multicultural conceptualization skills was understanding the various client expressions of culture. For example, one trainee stated "culture is such a pervasive thing in everything we do. The more I think about it the more I just go, like, how can I even fully address this?" A second trainee described the challenge he experienced when first learning multicultural case conceptualization skills. He stated:

I guess I didn't have an understanding of even what goes into the term multiculturalism. How many aspects of life and the individual that points to and that encompasses and just how important it is in seeing the client as a whole rather than just saying my client came in, they have a substance use issue. Having this multicultural foundation and conceptualization has really given me the ability to see and treat my clients.

Variantly, trainees expressed the training program did not prepare them to address culture in conceptualization. One trainee described that, in her master's training:

We had a lot of didactic training in terms of multicultural work. There weren't that many strategies. I don't think it was embedded in the system for it to be practical when I was working as a clinician at my internship site.

Current clinical training experiences. Trainees discussed current experiences working as a supervised therapist as they developed multicultural conceptualization skills. First, trainees discussed factors that facilitated multicultural conceptualization during their clinical experiences. Second, trainees explored factors that challenge multicultural conceptualization during their clinical experiences.

Factors that facilitate multicultural conceptualization. Four categories emerged related to factors that facilitated the development of multicultural conceptualization skills. Typically, trainees expressed that colleagues were supportive and engaged regarding culture. One trainee stated "they [current colleagues] are very much more culturally aware and culturally sensitive than at the other clinics I have worked at." Similarly, other trainees described instances in which colleagues encouraged the trainee to include culture when conceptualizing clients of minority racial or ethnic background.

In a variant category, trainees expressed that their supervisor during their clinical experiences actively engaged the trainee on integration of culture into multicultural conceptualization.

The first supervisor I had would challenge us and have us read cases and present conceptualizations to her... She was very multiculturally competent and fairly

aware… If we weren't tending to some of the racial views or dancing around them she would always call them [racial aspects of case] out.

Another trainee stated "one of my supervisors…one of the discussions I had with him was very fruitful and he really helped me go deeper" when conceptualizing a client of minority racial or ethnic background. As such, these trainees described active facilitation of multicultural conceptualization skills.

A variant category that emerged among other trainees was their supervisors' passive support of multicultural conceptualization when the trainee initiated the conversation. For example, when asked how their site facilitated multicultural conceptualization skills, one trainee responded that their supervisor "has not gotten in the way" of multicultural conceptualization. A second trainee initiated a discussion of race in conceptualizing a client and their supervisor "agreed" with their conceptualization.

Variantly, trainees indicated that culturally informed intake forms promoted attention to culture. One trainee expressed that their site's intake forms encouraged her to make her "practice more inclusive, accepting, and affirming." Others simply noted the intake form used during their clinical experiences allowed a space for cultural considerations. These trainees expressed that the inclusion of culture on the intake forms promoted trainee attention to their client's race or ethnicity.

Factors that challenge multicultural conceptualization. Trainees explored site factors that challenged the development of multicultural conceptualization skills. Six categories emerged in this domain.

Typically, trainees questioned the competency of their colleagues' multicultural conceptualization skills. For instance, one trainee expressed that he had never seen his

supervisor address the topic of culture with a client. A second trainee described instances in which she sought help when working with a client of a differing racial background and found they could not "consult or help as much" since, they too, were unfamiliar with working with clients of that minority racial or ethnic background.

A second typical category which challenged multicultural conceptualization during clinical experiences was colleagues' not actively addressing culture. One trainee expressed that the therapists at her site vary in whether they would discuss racial or ethnic issues in counseling. Another trainee expressed that issues concerning "race, religious background, and belief systems are not brought up on-site at all." One trainee who shadowed group therapy expressed "I know there have been people who have made a comment that was racist or things like that in a group room…when people have just said ignorant things, but there is never really a deep discussion."

In a variant category, trainees expressed how poor supervision has challenged their ability to develop multicultural conceptualization skills. For instance, one trainee described a lack of feedback and direction in supervision and stated "my site is reluctant to bring up issues of multicultural content or things that are pertinent to race or religious background, or different types of belief systems, things of that nature."

In a variant category, trainees expressed that the client is not ready to discuss race and ethnicity when their mental health is unstable. For instance, one trainee discussed how "we did see a bit of progress and then her safety was becoming more of a risk factor and it [the client's race] wasn't as focused on." A second trainee stated "I can understand that [the client's race or ethnicity] doesn't take priority if the kid is saying they're suicidal."

Variantly, trainees described barriers to addressing culture with their clients. For instance, one trainee stated "the vast majority of our clients are White, and that might be something of a barrier because I don't have so much experience working with students from different racial or ethnic backgrounds." When asked what challenges her conceptualization of clients who are racially or ethnically dissimilar from herself, a second trainee expressed "to say I completely understand my client and their situation would be invalidating and ignorant and incorrect … I don't think you can ever gain full understanding of your client."

Trainees variantly discussed how there were no hindrances during their clinical experiences when developing multicultural case conceptualization skills. When asked what site factors challenged his development of multicultural conceptualization skills, one trainee stated "I have not been able to come up with anything that I think has hindered my ability to do this [multicultural conceptualization]."

Illustrative Example of Multicultural Client Conceptualization

In this section is an illustrative example of a multicultural client conceptualization and experiences developing these skills. The illustrative example described below reflects several common themes representative of the sample of trainees' both in the client conceptualization and trainee experiences learning multicultural conceptualization skills. The completed CCQ (Welfare, 2007) which was completed based on the think-aloud client conceptualization is included as Appendix E. To maintain trainee confidentiality, slight changes have been made to demographic information of the trainee, the client, and to the conceptualization itself. The trainee has been assigned a pseudonym.

Peter is a 24-year-old, Caucasian male completing his master's training in Clinical Mental Health Counseling. He works with students in a counseling center providing brief therapy. Peter reports that 10 to 15% of his clients are "multicultural." He indicates his internship site places a moderate emphasis on multiculturalism and the integration of multiculturalism in conceptualizations. He believes multiculturalism is very important to integrate in client conceptualizations.

Multicultural client conceptualization. The client Peter conceptualized was a first-generation college student from a Mexican-American background. The client presented with "academic stress and personal stress related to grades, financial issues, and having no time for self-care." Peter's integration of the client's racial or ethnic background into his conceptualization of the client was that "from a young age his dad told him that boys don't cry in their culture…he doesn't really identify with that value or agree with that value but still felt this pressure to conform to it." This cultural tension between hiding and expressing stress was primary to Peter's conceptualization of the client. The client was seen once for therapy due to failing grades. Had therapy continued, Peter stated "we would have focused on how to separate his own expectations of himself from his parent's expectations."

Peter explained that he knew culture was important to this client because the client explicitly discussed the tension surrounding his cultural values during their first session. Peter described that his client "identified pretty directly the cultural value that had been imposed on him from a young age that he didn't necessarily share but still felt pressure to conform to." Therefore, the client identified how his ethnic background and cultural values were part of his presenting concern.

Peter's conceptualization quality was assessed using the CCQ (Welfare, 2007). In his conceptualization, Peter scored 33 on differentiation *(M= 34.36, SD= 11.34*) and 10 on integration *(M= 12.82, SD= 2.89).* Therefore, Peter scored in the average for differentiation and his integration score was one standard deviation below the mean. These scores indicate that Peter identified an average number of client characteristics in his conceptualization when compared to other trainees. The extent to which Peter discussed different types of client information (i.e. cognitive, emotional, behavioral) and the degree to which he included both positive and negative characteristics regarding his client, and whether he included characteristics which reflected the counseling relationship comprised his integration score was one standard deviation lower in comparison to this sample of trainees. Therefore, despite Peter's inclusion of an average number of client characteristics, the conceptualization was somewhat less integrative than most trainees in the sample.

Interview. Peter described several training experiences that were representative of the sample of trainees in this study. Two primary challenges in his training pertained to external factors. For instance, he described how clients often need more intensive treatment than what can be managed in the brief therapy model at his setting. He also indicated feeling overwhelmed by the workload, stating that time management was a challenge in his training experience.

Peter discussed his experiences learning multicultural conceptualization skills which were representative of the sample of trainees in this study. Peter explained that "practicum and internship classes and especially giving case presentations and writing a paper or summary to go along with it" were how he learned general conceptualization

skills. He described learning multicultural conceptualization skills in particular through "the multicultural class and small dialogues group."

He discussed several factors that facilitated and challenged his development of multicultural case conceptualization skills in his training as a Clinical Mental Health Counselor. The primary influence that facilitated Peter's development of multicultural conceptualization skills was the "emphasis on broaching" of certain faculty members. He described how one professor in particular consistently emphasized the importance of initiating conversations regarding the client and therapist's racial or ethnic background when engaging in cross-racial therapy. Similar to the majority of trainees, a challenge Peter explain in the development of multicultural case conceptualization skills was "being careful to not stereotype…and not pathologizing that culture."

At his clinical site, Peter noted supervision as being a factor which both facilitated and challenged his development of multicultural case conceptualization skills. During supervision, Peter stated that he was not limited in what he decided to discuss as being relevant to client treatment which he believes was facilitative of multicultural conceptualization skills. He described "having the freedom to focus on whatever seems important to me with the people I worked with. I don't know if I would say it necessarily actively facilitated that [multicultural conceptualization], but he [the supervisor] didn't get in the way of it either." On the other hand, he described a lack of focus on multiculturalism during supervision. Peter explained that he never observed his supervisor addressing culture in therapy. This lack of focus on multiculturalism in supervision hindered his ability to learn multicultural conceptualization skills. Therefore, although Peter had the freedom in supervision to discuss the content he felt was relevant

to the case, his supervisor did not initiate discussions of culture in supervision or in the

therapy sessions that Peter had observed. Peter expressed that his supervisor's lack of

initiative in attending to culture challenged his ability to develop these skills.

CHAPTER 5: DISCUSSION

While trainees in this study displayed a range of case conceptualization skills, as a group the quality of their skills was generally greater than that displayed by the original master's norming group (Welfare & Borders, 2010). Specifically, the number of differentiated client characteristics included in the client conceptualization and the integration among these characteristics was greater than that of the norming group. When addressing client culture, trainees included various aspects of the client's race or ethnicity but were limited in the scope of the multicultural issues they addressed. Trainees decided to integrate these various topics regarding the client's race or ethnicity into their conceptualization for mixed reasons, including recognizing the importance of the client's culture to understanding their presenting concern and the client having identified the relevance of their culture. In regard to acquiring these skills, trainees discussed the importance of various didactic and onsite training experiences. These and other findings are discussed below. The chapter concludes with a discussion of study limitations, implications for training, and future research directions.

Multicultural Case Conceptualization

Trainees in the present study displayed significantly higher conceptualization complexity than participants in the norming sample (Welfare & Borders, 2010) including both conceptualization differentiation and integration. Specifically, trainees in this sample identified a somewhat greater number of client characteristics (e.g., client thoughts, important relationships, stressors) and displayed more conceptual integration of these characteristics than the norming group. It is possible that differences in scores were due to strong graduate training on case conceptualization skills, as training has been well-

documented to increase these skills (Duys & Hedstrom, 2000; Kendjelic, 1998; Osborn et al., 2004; Caspar et al., 2004; Little et al., 2005). While graduate training may have resulted in this difference, little information regarding training of the norming sample was offered, therefore it is difficult to determine whether specific aspects of graduate training may have influenced the differences in case conceptualization scores displayed by the two groups. Notably, trainees' higher case conceptualization quality may have restricted the range of their answers and represented higher development in case conceptualization skills than for those trainees who perform at a lower level. Therefore, the high complexity of the case conceptualizations produced by this sample of trainees may have influenced challenges trainees identified in training and impacted how they learned case conceptualization skills. Alternately, the differences in scores between the current study trainees and that of the norming group may have been influenced by the method of administration. Briefly, the differences in measure administration of the open conceptualization may have resulted in current trainees earning higher scores than the format used by the norming group who completed the written form independently. This potential influence is discussed further in the limitations section of this chapter.

While trainees identified a number of topics related to race and ethnicity in their conceptualizations, they most often focused on identifying the race of the client and the influence of family cultural expectations on the presenting concern. Trainees may have focused on race because it was visible and easily identified. Similarly, they focused on the cultural expectations of family because clients actively discussed this concern. In both instances, these aspects of culture were easily identifiable and there was little inference needed to integrate these factors into the conceptualization. This is consistent with

research by Jones and Welfare (2016) that found participants are more comfortable broaching easily identifiable cultural factors than they are with cultural factors that are less easily identifiable. These recognizable aspects of the client may be a common starting point for trainees which helps to organize pertinent, easily recognized information before exploring and connecting client variables in more depth (Eells, 2011). Additionally, prior research has suggested that trainees typically conceptualize how a client's cultural values compares to family and peers of the same racial or ethnic background when conceptualizing a diverse client (Neufeldt et al., 2006). These aspects of the client may have been more easily integrated into conceptualization because they were visible and readily discussed in therapy resulting in these categories being more frequently integrated into conceptualization in this, and other, studies (Eells, 2011; Neufeldt et al., 2006).

While not as common, trainees also discussed less identifiable topics related to the client's race or ethnicity including acculturation stress, experiences of discrimination, client lack of identification with racial phenotype, and strengths or benefits as a result of the client's culture. In comparison to racial identification and family cultural values, these topics necessitated the trainee make inference regarding the impact of their race or ethnicity based on material the client presented in session. Indeed, prior investigations have suggested that trainees with a greater awareness of the impact of race on the client's life may include factors related to the client's racial or ethnic background beyond those which were visible or made explicit by the client and specifically mention discrimination and acculturation as two such variables (Constantine & Gushue, 2003; Constantine, Warren, & Miville, 2005; Neville et al., 2006; Schomberg & Prieto, 2011). Alternately,

these concerns may have been less prevalent among the clients, resulting in the themes being discussed by fewer trainees. Though the result from the current study and other studies have found that few trainees discuss these topics in conceptualization (Eells et al., 2011; Neufeldt et al., 2006; Sakai & Nasserbakht, 1997), the inclusion of these themes is recommended (Kuyken et al., 2009; Ridley & Kelly, 2007). Overall, trainees in the current study displayed high case conceptualization complexity and included various topics related to the client's race or ethnicity into their conceptualizations.

Trainees discussed mixed reasons for how they decided that racial or ethnic factors were important to include when conceptualizing a particular client. Several trainees recognized the importance of the client's race or ethnicity to the presenting concern, while other trainees indicated that clients directly discussed the relevance of race or ethnicity to their presenting concern. These findings suggest that some trainees actively sought the opportunity to integrate race or ethnicity in conceptualization by their own volition, while others appeared to wait until the client directed the focus. Those trainees who actively sought out racial or ethnic client information may have had higher racial awareness, allowing them to more easily recognize that client race or ethnicity was an important factor (Constantine & Gushue, 2003; Neville et al., 2006). Additionally, these trainees may have discussed this client with a supervisor who has higher racial awareness, a quality of supervision which has been found to increase supervisee multicultural case conceptualization quality (Constantine et al., 2005; Ladany et al., 1997). Overall, the trainee or supervisor belief that one's race or ethnicity is impactful may have resulted in varying propensity of trainees to themselves recognize the importance of race or ethnicity in understanding their client.

Alternately, several trainees described knowing that the client's race or ethnicity was salient because the client initiated this discussion during therapy. Perhaps trainees preferred the client introduce multicultural considerations within therapy to avoid introducing a topic that they perceived to be potentially off-putting or damaging to the relationship (Jones & Welfare, 2016). Additionally, trainees whose clients identified culture as salient may have understood that race and ethnicity is an important factor in conceptualization but struggled to recognize when the client's race or ethnicity should be considered. This is a trainee struggle that is supported by the literature (Binder, 1993; Eells, 2007; Eells, 2015; Ridley & Kelly, 2007). Indeed, in prior investigations, trainees were found to integrate racial or ethnic factors into their conceptualization only when culture was described as the specific presenting concern by the client (Lee et al., 2013; Schomburg & Prieto, 2011), suggesting a gap between knowing culture is important and having an awareness that culture is salient for a specific client. Following the open conceptualization procedure, trainees described their training experiences in learning these case conceptualization skills.

Training in Conceptualization

The following sections explore trainees' experiences learning both general and multicultural case conceptualization skills. Trainees were queried about general challenges during their training experiences and how they learned to conceptualize clients, which was intended to provide some context for their overall training experiences for case conceptualization. Next, specific training experiences related to the integration of multicultural issues in case conceptualization were explored, focusing on how trainees

learned these skills, factors that influenced the development of these skills, and current onsite training experiences.

Challenges during training. While discussing their overall training challenges, many trainees recognized their own lack of clinical skills to work effectively as a therapist. As an example, trainees struggled to address cultural differences between themselves and the client, a finding also noted in a prior investigation (Lee et al., 2013). Trainees felt the cultural differences between themselves and their clients influenced the quality of their clinical work, and they felt challenged in understanding and relating to their minority clients. Additionally, participants struggled to meet the diverse clinical needs of clients, a challenge which many trainees find to be quite complex (Bernard & Goodyear, 2014; Eells, 2007). These findings appear to reflect some trainee self-awareness in reflecting on their abilities, particularly around cultural differences and clinical needs. As is described in developmental theories of counselor development, this may reflect they are beginning to see the complexity of practice and becoming more aware of this complexity (Stoltenberg & McNeill, 2011).

In addition to recognizing their lack of clinical skills, trainees also recognized that external factors also directly influenced their clinical work. For instance, a few trainees described how the high workload and time management difficulties as a graduate student were a primary challenge as a therapist trainee. Therapists at this novice level have multiple training demands amongst which they must balance their time including clinical experience with supervision, didactic coursework, research requirements, and supplementary workshops or readings (Eells, 2007). As such, trainees can struggle to manage several competing demands on time (Eells (2007). As another influence, a few

trainees perceived classroom instruction to be inconsistent with clinical practice, which may speak to the difference between learning about therapy through coursework and providing therapy in real-world clinical practice (Binder, 1993; Eells, 2015). For instance, one participant discussed how she was interested in practicing specific interventions learned in class; however, her site provided manualized behavioral therapies on a short-term basis and she did not have the time or resources onsite to integrate techniques of interest. The inconsistency between coursework and clinical practice may be associated with the practical limitations on time described by a few trainees. Alternately, this inconsistency may reflect the challenge trainees' encounter in flexibly applying knowledge to real-world practice. Finally, a few trainees perceived that cultural considerations and multicultural competence was not emphasized at their clinical site which they felt limited their growth as a therapist. Trainees believed this lack of emphasis on multiculturalism was reflected in the cultural practices of the agency, a factor which has been suggested to influence the development of multicultural skills (Hill, 1991; Ridley & Kelly, 2007).

Learning to conceptualize clients. Beyond general training challenges, trainees discussed numerous ways through which they learned to conceptualize clients during graduate coursework. Several trainees discussed how the opportunity to practice these skills in practicum and internship classes was helpful, a finding that is consistent with training recommendations for general case conceptualization skills (Eells, 2015). Courses such as practicum and internship class are an ideal setting for practicing skills because these classes provide a safe space where trainees can be vulnerable in practicing their conceptualization skills, learning from other trainees' conceptualizations, and receiving

feedback from peers and the course instructor. Prior research also found case conceptualization skills increase with each incremental semester of practicum or internship course experience (Lee & Tracey, 2008), supporting the notion that trainees case conceptualization skills benefit from these courses.

Beyond practicum and internship courses specifically focusing on applied therapy skills, trainees described learning conceptualization skills using theoretical models taught by course instructors including biopsychosocial, cognitive-behavioral, and multicultural models. As participants had limited clinical experience, these theoretical models may have provided a useful structure to begin practicing this complex cognitive skill (Eells, 2007). Indeed, Kuyken et al. (2009) has suggested that using theoretical models to guide case conceptualization serves as a valuable lens through which to understand the client's presenting concerns. While prior investigations have found that trainees use cognitive-behavioral or multicultural models as guides for case conceptualization (Lee et al., 2013), the use of a biopsychosocial approach was more frequently mentioned by the trainees and may reflect their specific training program. Additionally, many of the trainees were in medical sites and these findings may reflect integrative care settings (Bray, 2010; Engels, 1977).

Additionally, findings reflect that trainees learned general case conceptualization skills throughout the training curriculum, specifically in ethics, foundations of clinical practice, and introduction to counseling courses. These foundational courses may provide information regarding theoretical models, that offers structure for developing general case conceptualization skills. While this finding seems to make sense, researchers have suggested that complex clinical skills, like case conceptualization, are typically not a

focus of didactic training curriculum which is often to the detriment of clinical practice and therapist counseling competence (Binder, 1993; Eells, 2007). Perhaps the trainees in this study attended graduate programs in which the curriculum was designed with an integrative emphasis and a focus on applicability and case conceptualization skills, though the results do not offer explicit clarity. Additionally, trainees may be reflecting on the knowledge gained through these foundational courses to inform their general case conceptualization skills. Case conceptualization skills require knowledge about what client characteristics are most impactful and how facets of a client's life, such as their relationships and thoughts, influence one another. Trainees may have gained this important information necessary to the conceptualization process in their foundational coursework.

In addition to the academic setting, a few trainees discussed how internship supervisors supported learning about conceptualization. Supervision is believed to be a primary training modality through which novice therapists refine skills such as case conceptualization (Bernard & Goodyear, 2014; Falender et al., 2014). In fact, researchers have supported this perspective and found that clinical experience under supervision influences the development of case conceptualization skills (Lee & Tracey, 2008). Perhaps these trainees received supervision that was focused on case conceptualization skills and, specifically, the ability to identify salient client characteristics and integrate these characteristics to form a meaningful representation of the client. Though this type of focus on conceptualization skills is not common in clinical supervision (Constantine & Sue, 2007), this may have had an influence on the case conceptualization skills of these

trainees. Overall, findings reflect that trainees learned general case conceptualization through training including didactic coursework and internship.

   Learning to conceptualize multicultural clients. In addition to their general training in case conceptualization, trainees had several experiences that supported their overall learning of multicultural case conceptualization skills. First, the majority of participants described the importance of coursework dedicated specifically to multiculturalism. Trainees discussed how the multicultural counseling course allowed them a time specifically dedicated to learning about cultures that are different from their own and how to adapt clinical practice based on the client's culture. Prior research has also found that multicultural coursework is significantly associated with multicultural case conceptualization skill development (Gushue & Constantine, 2003; Lee & Tracey, 2008; Weatherford & Spokane, 2013). For instance, Gushue and Constantine (2001) found that trainees who had taken a multicultural course had more complex multicultural conceptualizations than those who had not and similarly, Lee and Tracey (2008) found that those trainees who completed two or more multicultural courses had more complex conceptualizations than those with less multicultural coursework. Additionally, Edwards, Burkard, Adams, and Newcomb (2017) found that participants who had taken graduate courses with multicultural-related content described increased sensitivity to the role of culture and privilege, had a higher level of knowledge about multiculturalism and counseling, and had further explored their own worldviews, cultural identities, and biases as a result of this coursework. Overall, these findings support the notion that multicultural coursework positively influences multicultural case conceptualization skills.

Similar to training in general case conceptualization, trainees described learning multicultural case conceptualization throughout their training curriculum. Specifically, trainees described an emphasis on developing cultural self-awareness, reflecting on biases and stereotypes, and integrating multicultural issues throughout training curricula, particularly internship courses. Given that both general and multicultural case conceptualization were integrated throughout the program, it is possible that multiculturalism was fully integrated into education on case conceptualizations. These current findings are contrary to prior work, which has suggested that multiculturalism is not well-integrated throughout training curriculum (Ridley & Kelly, 2007). Perhaps the emphasis by accreditation and professional organizations on multicultural issues has resulted in training curricula marked by multicultural integration. Alternately, this finding may be specific to the graduate program these trainees attended which may have focused on integration of multiculturalism throughout curriculum.

Most trainees felt that they learned these skills by actively engaging multicultural case conceptualization during internship. Specifically, trainees described the importance of creating multicultural case conceptualizations in their clinical experiences and refining these conceptualizations through discussions with other clinicians and supervisors. One reason internship may be critical to learning multicultural case conceptualization skills is that the internship is the setting where participants often gain experience working with clients of diverse racial or ethnic backgrounds, and as such the initial place where they learn to reconcile the implications of clients' reported experiences into their clinical thinking. Prior research suggests that clinical experience has helped improve multicultural case conceptualization skills (Lee & Tracey, 2008). Overall, academic and

onsite training appear to be influential in learning multicultural case conceptualization skills.

Facilitating factors. Beyond describing how trainees learned these skills, participants highlighted two factors which were most facilitative of their multicultural case conceptualization skill development. Foremost, all trainees felt their master's training overall emphasized an integration of culture. Importantly, multicultural aspects of the client and trainee impacts every part of the therapeutic relationship, from rapport building to choosing effective treatment interventions to termination, therefore, multiculturalism should be integrated throughout training curricula (Constantine, 2001; Ridley & Kelly, 2007). This consistent integration of multiculturalism throughout training curricula has been suggested to support multicultural case conceptualization skill development (Ridley & Kelly, 2007; Sue et al., 1992). Perhaps the trainee learns that multiculturalism is relevant throughout the therapeutic process when instruction is integrated throughout training curriculum. Alternately, when trainees learn about diverse cultures in one distinct course, the integration of multiculturism in practice reflects this distinction and trainees lack the awareness of how to apply multicultural skills in tandem with other clinical skills (Neufeldt et al., 2006). Findings from the present study support the notion that integration of multiculturalism throughout training is an important facilitative factor to improve multicultural case conceptualization skills.

In addition to integration of culture in training, most trainees felt the development of multicultural case conceptualization skills were facilitated by engaging in conversations with their clients regarding race or ethnicity. Trainees described how engaging in open discussions with clients regarding how their race or ethnicity impacts

other important aspects of their mental health helped the trainee to refine their conceptualizations. This finding is consistent with research findings that have indicated that clinical experience significantly impacts multicultural case conceptualization skills (Weatherford & Spokane, 2013).

Challenging factors. While trainees identified a few factors that were particularly facilitative of their multicultural case conceptualization skills, participants also discussed a few influences which challenged their development of these skills. Foremost, many trainees were concerned about pathologizing or making assumptions about clients' culture. This fear may be well-founded as prior research has suggested that trainees are more likely than experienced therapists to over-pathologize the role of race or ethnicity for individuals of minority status (Falicov, 1998; Neufeldt et al., 2006). These trainees worried that they would integrate the client's culture into the conceptualization in a way that was not true to that client's experience and was based on their stereotypes rather than on the client's actual multicultural identity. Trainees may have also feared the reactions of supervisors or anticipated feeling embarrassed if they lacked the ability to effectively integrate culture into conceptualization. Alternately, this fear may reflect positive development in that trainees are considering the consequences of their own lack of multicultural understanding and feeling challenged in contending with the implications of their conceptualizations. Though current literature supports the notion that over pathologizing clients is typical of trainees (Falicov, 1998; Neufeldt et al., 2006), researchers have remained silent on how this concern may be addressed to improve multicultural case conceptualization skills.

Additionally, many trainees struggled to understand the various expressions of client culture and felt overwhelmed with how overwhelming culture is to fully conceptualize. Specifically, trainees spoke to the multitude of characteristics which comprise one's multicultural identity and how these characteristics can impact every part of that client's life and the therapeutic relationship and process. This challenge in choosing what multicultural aspects of the client are important to consider and then integrating these characteristics within therapy reflects similar skills needed to create a meaningful and accurate case conceptualization (Binder, 1993; Falicov, 1998; Neufeldt et al., 2006). Though the research has described this as a common challenge (Binder, 1993; Falicov, 1998; Neufeldt et al., 2006), there is currently no research which addresses how trainee educators may address this challenge with trainees.

Indeed, a few trainees in the study believed their program did not prepare them to address culture in their conceptualizations. Counselor educators may struggle to design curriculum which addresses the complexity of the client's culture within a classroom setting that is similar to what trainees' experience in the field. Indeed, for this reason, there has been a small number of studies that use simulated client actors to mirror the complexity of field practice within an academic setting, all of which have reported a significant increase in general case conceptualization skills (Caspar et al., 2004; Kendjelic & Eells, 2007; Little et al., 2005; Osborn et al., 2004). While this literature supports the notion that case conceptualization may be influenced by using simulated clients within a classroom setting, prior studies have lacked focus on client culture and research is needed to extend this finding to multicultural case conceptualization skills specifically.

Current clinical training experiences. In addition to their overall graduate training experiences, participants also provided further information regarding their current training in multicultural case conceptualization. Specifically, trainees described experiences in their current clinical setting which facilitated and challenged their multicultural case conceptualization skill development in practice.

Factors that facilitate multicultural conceptualization. Foremost, participants noted the importance of colleagues who were supportive and engaged with them in addressing culture. Specifically, trainees described having colleagues who were culturally informed and open to discussions regarding culture. Perhaps trainees need both formal and informal supports to effectively improve the integration of multicultural issues in clinical practice. Informal supports may help trainees learn to apply multicultural knowledge when working with individual clients. While research has suggested that the clinical setting (Hill, 1991) and multicultural supervision (Pope-Davis et al., 2000; Vereen et al., 2008) are impactful factors in developing these skills, the limited research in this area has not examined the influence of colleagues on skill development.

Relatedly, some trainees also noted the importance of their supervisors actively engaging them in integrating culture into their clinical work or supporting their active work on multicultural concerns during supervision. Though several trainees felt supervision facilitated these skills, participants described a slight difference in their facilitative experiences with multicultural supervision. Specifically, while a few trainees felt their supervisor supported the integration of culture when the trainee initiated this discussion during supervision, others described their supervisors' active engagement with and initiation of conversations regarding culture. This nuanced difference in facilitative

supervision experiences is important to highlight, because some suggest that supervisors are responsible for initiating cultural discussions as the individual in power (Gatmon et al., 2011; Gloria, 2008), yet trainees varied in whether they described themselves or the supervisor initiating these conversations. Indeed, prior research has found that supervisors' active engagement with multiculturalism and challenging the supervisee to question their assumptions about the client's background is an important aspect of assessing client multicultural factors (Edwards et al., 2017). Despite the importance of supervisors' initiation of this topic, prior research has found that when supervision relationships do include content related to race or ethnicity, supervisors are less likely to initiate these conversations (Gatmon et al., 2001). Overall, colleagues, and particularly the supervisor, actively addressing culture was facilitative for many trainees in developing multicultural case conceptualization skills.

Beyond the influence of colleagues and supervisors, some participants noted their clinical sites used culturally-informed intake forms that promoted their attention to culture early in therapy. Perhaps culturally inclusive intake forms provided the trainee with the time and structure through which to begin discussing racial and ethnic identity with the client and explore how the client's culture impacts their life. Engaging in cultural conversations from the beginning of the relationship may help normalize culture for clients as a regular and important part of therapy and open the door for these discussions as therapy progresses (Ridley & Kelly, 2007). Perhaps while trainees felt that offering an open invitation to discuss multicultural considerations during intake was important, they felt uncomfortable in broaching the topic with clients (Jones & Welfare, 2016). Culturally informed intake forms appear to be one way of initiating cultural

conversations with the client during the intake session, a practice which is supported by prior work in this area (Gatmon et al., 2001; Ridley & Kelly, 2007). Additionally, the presence of race on the form may convey a value of the agency which promotes trainee attention to client race during the intake session.

Factors that challenge multicultural conceptualization. In addition to facilitative factors, trainees discussed several challenges to their multicultural case conceptualization skills during their clinical experience. Foremost, many trainees spoke to the overall culture of the organization, highlighting the importance of clinical setting in which the trainee is embedded when developing multicultural skills (Hill, 1991). Specifically, some trainees questioned the cultural competency of colleagues and felt that their clinical site did not actively address culture. Perhaps the colleagues and site lack of attention to culture resulted in trainees questioning the competency of their colleagues. Trainees may have felt embedded in a system of care that did not encourage the consideration of the client's culture and felt challenged in integrating culture into conceptualization as prior research has suggested that novice mental health providers feel little power in the organization to initiate discussions of multicultural issues (Gatmon et al., 2001; Gloria, 2008). Trainees may have lacked confidence to integrate culture into conceptualization as individuals in the organization with less experience and power.

In addition to the general cultural competency of colleagues, a few trainees specifically highlighted their supervisors' as the primary challenge in learning to integrate the client's race or ethnicity into conceptualization. Trainees who had never seen their supervisor discuss race with a client felt challenged in doing so themselves. Perhaps supervisors' limited competency to engage in facilitative multicultural

supervision resulted in a lack of cultural conversations in supervision and left trainees with little direction on how to apply cultural knowledge learned in coursework to their individual clients. Indeed, poor quality multicultural supervision marked by a lack of racial or ethnic awareness and tendency to overlook cultural issues has been found to negatively impact the supervision relationship, trainees, and clients of minority racial or ethnic backgrounds (Constantine & Sue, 2007; Dressel et al., 2007; Edwards et al., 2017).

Beyond challenges associated with colleagues and supervisors during clinical experiences, a few trainees discussed client factors which challenged the development of multicultural case conceptualization skills. In particular, a few trainees felt that clients are not ready to discuss racial and ethnic identity when they are unstable. These few trainees appeared to believe that treating acute an need, such as suicidality, is distinct from cultural considerations and that acute needs take precedent over culture. The tendency to approach multicultural aspects of the client as distinct from other salient client characteristics is an issue in therapy practice (Eells, 2007; Neufeldt et al., 2006; Ridley & Kelly, 2007). Other trainees noted that there were specific barriers to addressing culture with clients, such as working in a group setting. These trainees felt that the group context created a barrier to addressing culture with clients, preventing them from exploring culture. The setting in which therapy takes place appears to have an influence on the development of multicultural case conceptualization skills, though there is little empirical literature in this area to provide clarity.

Despite these difficulties, a few trainees did not note any challenges encountered when engaging in clinical experience. These trainees described having had clinical settings in which culture was not encouraged in the past and feeling grateful that their

current clinical site was culturally informed and engaged with multicultural issues.

Indeed, receiving strong multicultural supervision at a clinical site which encourages

multicultural dialogue is suggested to be facilitative of multicultural case

conceptualization skills (Eells, 2007; Ridley & Kelly, 2007). Overall, findings indicate

that clinical setting, colleagues, supervisors, and clients can be both facilitative and

challenging influences on multicultural case conceptualization skill development.

Study Limitations

Though the aforementioned findings contribute to the scarce empirical research in

this area, there are several limitations inherent in the study which must be discussed

before considering how these findings impact future research and practice. For instance,

participants were provided with the interview protocol in accordance with CQR

recommendations provided by Hill et al. (2005). This procedure is inconsistent with

recommendations for think-aloud procedures (Ericsson & Simon, 1993). Providing the

protocol in advance allowed the participant time to consider their responses and ensured

the participant had engaged in cross-cultural therapy which is an important CQR

guideline (Hill et al., 2005). In typical think-aloud methodology, participants would

ideally have not been introduced to the conceptualization task prior to the procedure.

Therefore, providing trainees the opportunity to review the protocol in advance may have

increased conceptualization performance as measured by the CCQ (Welfare, 2007).

As a second administration limitation, the administration technique for the CCQ

(Welfare, 2007), is a departure from that used in prior studies. In the few studies which

have used the CCQ to assess conceptualization quality, participants filled out the CCQ

form (Welfare & Borders, 2010; Welfare, Nolan, & Vari, 2016). In collaboration with

Laura Welfare, the author of the measure, the decision was made to use the think-aloud

content to populate the form and send the completed forms to trainees to assess the accuracy of the conceptualization from the trainee perspective (L. Welfare, personal communication, June 20, 2017). Consequently, there is no comparative study which uses the trainees' actual clients as stimuli to assess multicultural case conceptualization using a think-aloud task. Therefore, results comparing CCQ scores in the present study with CCQ scores in prior research should be considered with caution based on the differences on administration. Specifically, the aforementioned finding that the sample of trainees in this study tended to include more client characteristics in their conceptualization and create more integrative conceptualizations overall may be due to these differences in administration.

A second adaptation to the CCQ (Welfare, 2007) was the inclusion of multicultural client characteristics. The CCQ (Welfare, 2007) measure was designed to evaluate general, rather than multicultural, case conceptualization. Laura Welfare, the creator of the CCQ, proposed that the CCQ can be used to evaluate inclusion of any type of client information into conceptualization, including multicultural content (L. Welfare, personal communication, June 20, 2017). While the CCQ (Welfare, 2007) provided a validated tool for assessing case conceptualization quality, there are no tools designed specifically to assess multicultural conceptualization skills which is a primary gap in the literature (Ridley & Kelly, 2007).

Beyond administration differences, trainees had mixed motivation for participation in this study. Most trainees were second-year master's-level therapists who received class credit for participating in this study while the remainder of trainees were Licensed Professional Counselors In-Training who volunteered for the study based on

their own interest in multiculturalism. Therefore, the motivation of the two groups of trainees who comprised this sample was different suggesting a lack of homogeneity in the sample. Despite this potential lack of homogeneity, there were no primary differences in conceptualization quality and content or experiences learning case conceptualization skills based on whether trainees were second year master's students or LPC-IT's.

Alternately, one way in which the sample was highly homogenous is that all participants were current or former master's students in a Clinical Mental Health Counseling master's program from the same institution. This may have affected the range of training experiences participants as the quality of conceptualization training may have been unique to trainees from this institution. The study needs to be replicated with a wider sample in the future to investigate whether results regarding training experiences in multicultural case conceptualization were specific to the training program in which participants were embedded or may pertain to master's level therapists more widely.

Finally, the sample of trainees produced case conceptualizations that were of a high quality. Therefore, experiences these trainees discussed in learning case conceptualization skills and factors that were most facilitative and challenging in developing these skills may not reflect the experiences of those trainees who produce conceptualizations of low complexity. Replicating this study with a broader sample of trainees may capture those training experiences for both those who excel in producing high quality case conceptualizations as well as those who struggle in this area.

Implications

Despite the aforementioned limitations, results of the present study yield a number of implications across several areas of training and research. Implications for training and future research are enumerated in the sections below.

Training. Foremost, findings from the study indicate multiculturalism and case conceptualization skills training be further integrated within training curriculum. Most trainees spoke to the importance of learning case conceptualization skills and multiculturalism throughout the training curriculum to refine multicultural skills as one of several therapist competencies. It may be important to note that prior research suggests this integration is not typical of academic curricula (Lee et al., 2013; Ridley & Kelly, 2007), though it seemed to be apparent for the trainees in this study. Findings from this study support the incorporation of case conceptualization skills and multiculturalism throughout training, as is recommended in guidelines for psychology practice (American Counseling Association, 2014; American Psychological Association, 2015) and by those who have studied multicultural case conceptualization skill development (Constantine, 2001; Eells, 2007; Ridley & Kelly, 2007;).

In addition to academic training, the present study supports the notion that clinical experience working with an organization and supervisor that encourages and models cultural competence is essential to developing trainee multicultural case conceptualization skills. Colleagues and supervisors attending to culture is important because the degree to which trainees perceived others to be emphasizing culture facilitated or challenged their own integration of race or ethnicity into multicultural client conceptualizations. Therefore, findings from this study suggest that participants may have

benefited from working with a skilled supervisor in learning how to apply didactic coursework to the specific client population and integrate culture into conceptualization (Bernard & Goodyear, 2014). Overall, findings support the recommendation that supervisors and colleagues model and practice multicultural client conceptualization skills with trainees to support trainee multicultural client conceptualization skill development (Ancis & Ladany, 2010; Bernard & Goodyear, 2009; Constantine & Gloria, 1999; Hill, 1991; Ridley & Kelly, 2007).

Future research. Beyond training implications, several areas of future research would inform trainee development in this important topic. Foremost, further study on the impact of multicultural case conceptualization skills on treatment outcomes is an area of continuing empirical study. Though research findings have indicated that multicultural case conceptualization skills improve treatment outcomes (i.e., Easden & Fletcher, 2018), the literature in this area is sparse. Further research on the impact and accuracy of case conceptualizations would encourage the emphasis of these skills in therapist training programs.

Additionally, this study could be replicated with aspects of multiculturalism beyond race and ethnicity. As discussed in chapter one, the principal investigator limited the scope of multiculturalism to race and ethnicity to increase the specificity of the research. Replicating this study having therapists conceptualize clients of diverse gender identities, religious and spiritual orientations, ability levels, and numerous other aspects of individual variation would promote specificity regarding research on trainee multicultural case conceptualization skills.

An additional area of future research which would promote specificity is the creation of measurement tools designed to evaluate multicultural case conceptualization skills. Conceptualization measures such as the CCQ (Welfare, 2007) have been adapted to include multicultural information; however, these tools were not specifically designed to assess multicultural case conceptualization and lack the ability to capture nuanced multicultural information. The creation of these tools is essential to facilitate trainee multicultural case conceptualization skills.

Further, research may explore the differences in training and conceptualization experiences by examining differences across levels of training or experience. For example, researchers could examine differences between master's and doctoral level trainees' conceptualization content and experiences learning these skills. Examining differences based on the experience level of trainees would inform how the quantity of training impacts those content areas which are included in conceptualization and whether experiences learning these skills differ between groups. Though the present study included second year master's students and first year LPC-IT's, there were no differences which emerged between the groups in terms of training experiences and conceptualization content themes and quality. Therefore, replicating this stud by examining differences across levels of training which are theorized to be vastly different in terms of therapy skills would shed light on the impact of experience on skill development.

Additionally, future researchers may explore the application of conceptualization in treatment. There is sparse literature regarding how case conceptualizations impact treatment decisions and outcomes. Gaining a better understanding of how case

conceptualization skills influence treatment outcomes would provide a clear rationale for the focus on these skills during training and may guide which content themes could potentially lead to the best treatment outcomes for diverse patients.

Further, the use of multicultural case conceptualization as a measure of multicultural counseling competence may be addressed in future research. Several recent multicultural case conceptualization studies (i.e.,Bromely, 2004; Lee & Tracey, 2008; Lee et al., 2013; Neufeldt et al., 2006) have used multicultural conceptualization skills to measure overall multicultural counseling competence, despite the fact that conceptualization is just one aspect of competence. Examples of other skills within multicultural competence include choosing assessments with appropriate norming groups, intake interviewing, adapting evidence-based practices, and developing culturally sensitive therapy practices (Hill et al., 2013; Sue & Sue, 1992). Multicultural case conceptualization skills may have underlying influences, such as cognitive complexity level (Welfare & Borders, 2010), which may not pertain to other aspects of multicultural competency (i.e., knowledge acquisition regarding various cultural groups). Further research should be specific in what aspect of multicultural counseling competence is studied.

Beyond research promoting multicultural specificity, innovative research methods through which to explore constructs which are difficult to assess, such as multicultural case conceptualization, is an opportunity for continuing growth. The think-aloud procedure in the present study used actual therapy clients rather than hypothetical vignettes or self-report tools in an effort to more closely reflect the process therapists go through when creating multicultural case conceptualizations in practice. Though the use

of a think-aloud procedure has limitations, this is one option for future research to continue to improve applicability of research to practice on multicultural case conceptualization skills. Thus far, medical research using simulated clients has led the pursuit of applicable research (Osborn, Dean, and Petruzzi, 2004). Psychology can follow this trend by continuing to improve accuracy of therapist competency measurement by using innovative research designs.

Conclusion

Multicultural case conceptualization skills are an important area to focus both clinically and empirically. These skills are a crucial aspect of therapist competence which allows the clinician to make meaning of the data they are learning about a client. Notably, there are many types of data therapists could consider in conceptualizing a client and just of a few examples of these include multicultural client characteristics, thought patterns, social relationships, biological predispositions, and environmental stressors. Not only is it a difficult challenge to identify all the sources of client information which may be salient to a particular person, but these characteristics must then be integrated together in a way that effectively informs treatment and reflects a holistic understanding of the client. In this sense, when conceptualizing a client, the sum may be greater than its parts. The meaning the therapist makes out of these different sources of client information acts as a bridge between assessment and intervention and contributes to therapist competency and clinical judgement. Overall, multicultural case conceptualization skills are a complex, challenging, and important aspect of therapist competency.

These skills are made all the more important by the age of globalization and cross-cultural interaction that characterizes the field of psychology today. From the

standpoint of treatment outcomes, research findings have consistently indicated that racial and ethnic minorities delay seeking treatment, terminate early from treatment, are diagnosed with higher levels of psychopathology, and experience treatment outcomes that are not as successful as individuals who belong to the racial or ethnic majority (Bernal, Jimenez-Chafey, & Rodriguez, 2009; Tegnerowicz, 2018). To address these disparities, multicultural case conceptualization skills and, more broadly, multicultural counseling competence, has been suggested to have a positive influence (Burkard & Knox, 2004; Fuertes & Brobst, 2002; Ridley & Kelly, 2007; Sue, Arredondo, & McDavis, 1992; Tao et al., 2015; Weatherford & Spokane, 2013). Therefore, multicultural case conceptualizations skills should be considered as an important part of addressing mental health disparities and improving treatment outcomes for diverse clients.

Beyond mental health outcomes, to not consider culture in mental health practice is to neglect a large part of what motivates clients, makes them unique, and influences their life and experiences. The role of the mental health provider is to understand and provide treatment to clients who typically engage in therapy because they are suffering and struggling. In order to competently treat clients in a manner that honors their experiences and struggles, an accurate perception of who they are and what influences their life is critical.

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Appendix A

Informed Consent

Marquette University Agreement of Consent for Research Participants

Project Title: Exploring the Cognitive Process and Complexity of Diverse Patient Conceptualization: A Mixed Methods Study

Project Director: Michelle Toigo, MS

Principle Investigator Address/Phone: Michelle Toigo, MS

Doctoral Student

Marquette University

Milwaukee, WI 53201

(651) 895-7785

When I sign this statement, I am giving consent to the following basic considerations:

I understand clearly that the purpose of this research study titled, "Exploring the Cognitive Process and Influence of Supervision on the Complexity of Diverse Patient Conceptualization: A Mixed Methods Study" is to examine the skill of multicultural case conceptualization. I understand that the study takes place in one audiotape phone interview, ranging from one to one and a half hours. I understand that I will be sent a record of my conceptualization to check for accuracy following the phone interview. I understand that I will have the opportunity to addend my responses should I feel they do not accurately reflect the interview. I also understand that there will be up to 16 participants in this study.

I understand that the interviews involve the creation of a patient conceptualization as well as a discussion regarding the influence of supervision on conceptualization skills (see enclosed interview protocol). I understand that I will also be asked to complete a brief demographic form.

I understand that all information I reveal in this study will be kept confidential. I will not reveal identifying information of the patient I have chosen at any time. All of my data will be assigned an arbitrary code number rather than using my name or other information that could identify me as an individual. When the results of the study are published, I will not be identified by name. I understand that the data will be destroyed by

shredding paper documents and deleting electronic files three years after the completion of the study.

I understand that the risks associated with participation in this study are minimal, but may include some minor discomfort when creating a patient conceptualization and talking about previous supervision experiences. I also understand that the only benefit to participation in this study is the opportunity to work through this conceptualization process out loud which may provide me with greater clarity and insight regarding my own internal process. I understand that participating in this study is completely voluntary and that I may stop participating in the study at any time without penalty. I understand that my decision to participate or not to participate in this study will not impact my relationship with Marquette University in any way. I understand that all data collected prior to my terminating participation in the study will be destroyed.

I understand that I will be audiotaped during the interview portion of the study. The tapes will later be transcribed and destroyed (i.e., erased) after three years. For confidentiality purposes, my name will not be recorded.

All of my questions about this study have been answered to my satisfaction. I understand that if I later have additional questions concerning this project, I can contact Michelle Toigo, MS at (651) 895-7785 or michelle.ghaffari-nikou@marquette.edu. Additional information about my rights as a research participant can be obtained from Marquette University's Office of Research Compliance at 414/288-1479.

I HAVE HAD THE OPPORTUNITY TO READ THIS CONSENT FORM, ASK QUESTIONS ABOUT THE RESEARCH PROJECT AND I AM PREPARED TO PARTICIPATE IN THIS PROJECT.

_____   _____
            Participant's Signature   Date

_____
            Participant's Printed Name

_____   _____
            Researcher's Signature   Date

Appendix B
Demographic Form

Code Number (to be completed by researcher): _____

Age: _____

Sex: _____

Race/Ethnicity:_____

Are you a fluent English Speaker? ____ yes   ____ no

Please list the type of program you are currently enrolled in or recently completed (e.g., Clinical Psychology, Counseling Psychology, Clinical Mental Health Counseling):
_____

I am currently enrolled in an internship experience: ____ yes   ____ no

I recently completed an internship experience: ____ yes   ____ no

I am currently a Licensed Professional Counselor-In Training in supervision: ____ yes ____ no

Have you worked with a client who is of a minority racial/ethnic background and is of a differing racial/ethnic background than yourself? ____ yes   ____ no

Please list the type of training are currently completing or completed (e.g. master's internship, doctoral internship): _____

Please identify the type of internship or mental health work setting you are currently completing or recently completed (e.g., college counseling center, hospital):_____

Please list the percentage of multicultural clients you have seen in your current or most recent internship or mental health work experience: _____

Please indicate the total number of supervisors with whom you have worked during your training and post-degree work experiences: _____

To the best of your knowledge, based on all past internship and post-degree training experiences, how many supervisors of color have you worked with during clinical supervision? _____

Likert Questions

Below are a number of statements regarding the importance of multiculturalism in counseling. Please read each one and indicate the extent to which you agree with each statement using the following Likert-type rating scale (0: not at all, 5: very much).

How frequently does your current or most recent internship or mental health work setting emphasize multicultural issues in counseling/treatment.

0   1   2   3   4   5

To what extent do you feel it is important to include multicultural information into the case conceptualization of a client?

0   1   2   3   4   5

How frequently have your training experiences in your current or most recent internship or work site emphasized the importance of multicultural issues in client case conceptualization.

0   1   2   3   4   5

Thank you for completing this demographic form. Prior to the interview, please think about a client with whom you have worked who is of a differing racial/ethnic background than yourself. Please do not include any identifying information of the client you have chosen on this, or other, research materials.

Appendix C
Counselor Cognitions Questionnaire

This questionnaire is designed to explore how counselors describe their clients.

Please list two clients whom you know well. Use only an initial or symbol to represent each of them.

1. A client with whom you believe you were ***effective***:_____

2. A client with whom you believe you were ***less effective***:_____

Spend a few moments thinking about these clients and comparing and contrasting them. Think about your interactions with them and any attributes or characteristics which you might use to describe them.

In the first column on each page, describe the client as fully as you can by writing ***words or phrases*** that explain their defining characteristics. Do not simply put those characteristics that distinguish them from each other; rather, include all that come to mind. Describe each of them completely so that a stranger would be able to determine the kind of people they are from your description only. You do not have to use all of the space provided.

In the second column, indicate if the characteristic you listed is ***mostly positive*** (+) or ***mostly negative*** (-) in your impression of the client. If the characteristic is ***neutral***, leave column two blank.

Counselor Cognitions Questionnaire (page 2)

1. A client with whom you believe you were
*effective***:**_____

	Characteristic	**+/-**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
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24		
25		

Counselor Cognitions Questionnaire (page 3)

2. A client with whom you believe you were ***less effective***:_____

	Characteristic	**+/-**
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
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25		

Counselor Cognitions Questionnaire (page 4)

Now review the characteristics you listed for each client. Consider if any of them group together or fit into categories. If so, write a *label that describes the category* and write the *numbers of the characteristics* that explain or fit within that category. You may use each characteristic in more than one category. You do not have to use all of the space provided.

1. A client with whom you believe you were *effective*:_____

Category Label	Characteristics (e.g., #2 and #7 or #1 - 4)

2. A client with whom you believe you were *less effective*:_____

Category Label	Characteristics (e.g., #2 and #7 or #1 - 4)

Appendix D
Interview Protocol

The focus of this study is to examine the nature of multicultural case conceptualization. Multicultural case conceptualization ability is the extent to which a therapist identifies, integrates, and examines the influence of cultural, contextual, personal, and sociopolitical factors in both the etiology and treatment of the individual (American Psychological Association, 2010; Constantine, 2001; Ladany et al., 1997*;* Sue, 2003). Multicultural case conceptualization skills are distinct from general case conceptualization skills in that they pertain to the specific ability to recognize salient cultural factors in clients' presenting concerns and utilize this information in client conceptualization and treatment planning (Constantine, 2001). In this interview, you will initially conceptualize a client who is culturally different from yourself. After conceptualizing a client case, I will ask you several questions regarding your conceptualization and how you learned these skills. Do you have any questions before we start?

Interview Protocol Ideas

1. Warm-Up
    a. Tell me about your work at the current or most recent internship or work setting.
    b. Tell me about the client concerns with which you work on in your internship or current mental health work experience.
    c. What are some of the challenges you have faced in your training in coursework or clinical work?
2. Think aloud procedure
    a. As it is different for people to think out loud and walk through their cognitive process with someone else, we will begin by practicing for a few minutes with a short exercise, just to get you used to this method. The purpose of this section is to gain a greater understanding of the step-by-step, cognitive process you work through in creating conceptualizations. Keep in mind that the goal of this portion of the interview is to create a well-formed, comprehensive conceptualization that you feel represents the person. Think about a close relationship you have with a good friend. Think about your interactions with them and any attributes or characteristics which you might use to describe them. I want you to say everything you are thinking, bringing forth all those factors or aspects of the friend that you need to consider in developing your conceptualization of the person. Pretend you are alone in a room, talking to yourself and thinking out loud about the conceptualization. Do not explain your

thoughts but simply say what you are thinking and I will ask questions if I need further clarification. If you are silent for a time period longer than (10 seconds), I will prompt you to continue to verbalize what you are thinking. Describe the friend as fully as you can.

b. In this section of the interview, I ask you to recall a client with whom you have recently ended or are nearing the end of counseling who is of a different racial/ethnic background than you. Please do not include any identifying information of the client. The purpose of this section is to gain a greater understanding of the step-by-step, cognitive process you work through in creating client conceptualizations. Keep in mind that the goal of this portion of the interview is to create a well-formed, comprehensive conceptualization that you feel represents your client. Try to be as true to how you typically work through on site and arrive at a conceptualization the client you have identified for this study. I want you to say everything you are thinking, bringing forth all those factors or aspects of the case that you need to consider in developing your conceptualization of the client. Pretend you are alone in a room, talking to yourself and thinking out loud about the conceptualization. Do not explain your thoughts but simply say what you are thinking and I will ask questions if I need further clarification. If you are silent for a time period longer than (10 seconds), I will prompt you to continue to verbalize what you are thinking. As such, I want to think-aloud and verbalize your thinking process.

c. Do you have a client you would like to discuss?

d. I want you to go ahead and talk through in detail your thought process of understanding this client. Begin with your first encounter and talk through the information you are gathering, both explicit and implicit, and how you go about the process of forming a conceptual understanding of this client. Just like before, I will encourage you to think aloud and verbalize how you are arriving at the conceptualization of the client you identified to discuss. Try to go in as much detail as possible. Do you have any questions before we start?

3. Open-ended target questions
    a. For the following questions, I would like you discuss the immediate case conceptualization you just described.
        i. It sounds like you made connections between several categories of information regarding the client including _____. Can you talk about what you saw and how that informs your understanding of the client and how one category connects to another?
        ii. In working with this client, how did you decide whether it was important to include race/ethnicity into your conceptualization of the client?

      iii. How did the clinical site you are currently working facilitate your ability to integrate racial/ethnic factors into the conceptualization of the client?

      iv. In working with this client, how did the internship or work site in which you are currently working hinder your ability to integrate racial/ethnic factors into the conceptualization of the client?

  b. When answering the following questions, I would like you to consider all of your past educational and training experiences and how they may have influenced your multicultural case conceptualization skills.

      i. Tell me a little bit about how you learned to conceptualize clients?

      ii. What in your training experiences influenced your development of overall multicultural case conceptualization skills?

      iii. What is most challenging about developing multicultural conceptualization skills?

      iv. What was most helpful in developing multicultural conceptualization skills?

4. Closing Questions

  a. Any other thoughts or questions?

Counselor Cognitions Questionnaire: Single Client Form

This questionnaire is designed to explore how counselors describe their clients.

Please list a client whom you know well. Use only an initial or symbol to represent him or her.

<div align="center">Client: Case XXX</div>

Spend a few moments thinking about this client and comparing and contrasting him or her with other clients. Think about your interactions with this client and any attributes or characteristics which you might use to describe him or her.

In the first column, describe the client as fully as you can by writing ***words or phrases*** that explain his or her defining characteristics. Do not simply put those characteristics that distinguish this client from other clients; rather, include all that come to mind. Describe the client completely so that a stranger would be able to determine the kind of person he or she is from your description only. You do not have to use all of the space provided.

In the second column, indicate if the characteristic you listed is ***mostly positive*** (+) or ***mostly negative*** (-) in your impression of the client. If the characteristic is ***neutral***, leave column two blank.

In the third column, indicate the ***importance*** of the characteristic to your overall impression of the client. A score of 1 = not at all important while 5 = extremely important.

Counselor Cognitions Questionnaire (page 2)

	Characteristic	+/-
1	First year college student (context)	
2	First generation college student (context)	
3	Mexican American (context)	
4	Came here through Daca (context)	
5	Academic stress (emotional)	-
6	Personal stress re grades (emotional)	-
7	No time for self-care (behavioral)	-
8	Lives with biological parents and 2 siblings (context)	
9	Outside of school C does homework, takes care of sibling's child, and works (behavioral)	
10	Possible dyslexia causes homework to take a long time (behavioral)	
11	Slept four hours per night (behavioral)	-
12	Gained weight as a result of not having time to exercise (beh)	-
13	Worried about not getting good enough grades to stay in school (cog)	-
14	Worried parents would pull him from school if he failed math (cog)	-
15	Panic symptoms during math (emotional)	-
16	Heart rate increase (behavioral)	-
17	Shortness of breath (behavioral)	-
18	Dizzy (behavioral)	-
19	Depersonalization (behavioral)	-
20	Worried panic would interfere with success (cognitive)	-
21	Avoided class because anxious and behind (behavioral)	-
22	Tried various self-care practices (behavioral)	+
23	Too anxious to meditate (emotional)	-
24	No outlet to discuss stresses (context)	-

25	Cultural pressure to keep stress to himself (context)	
26	Dad told him boys in his culture don't cry (context)	
27	C doesn't agree with cultural value of not showing stress (context)	
28	Pressure to not show stress so family wouldn't think he was weak (emotional)	-
29	Didn't want girlfriend to think he wasn't masculine bc he was showing stress (cognitive)	
30	Therapy was a powerful experience because client didn't have anyone else (context)	
31	Stopped working together after second session because of grades (behavioral)	-
32	Planned to attend four year school with friend but grades weren't good enough (context)	-
33	Worried low grades wouldn't allow him to transfer (behavioral)	-

Counselor Cognitions Questionnaire (page 3)

Now review the characteristics you listed. Consider if any of them group together or fit into categories. If so, write a *label that describes the category* and write the *numbers of the characteristics* that explain or fit within that category. You may use each characteristic in more than one category. You do not have to use all of the space provided.

Category Label	Characteristics (e.g., #2 and #7 or #1 - 4)
Mexican American and showing stress	3, 4, 2, 6, 27, 28, 29
Panic related to math	15, 16, 17, 18, 19, 20, 21, 10
No time for Self-Care	22, 23, 24, 7, 12
Grades	6, 13, 14, 5, 32, 33, 34
No outlet to discuss stress	31, 30, 26, 27, 28, 29, 25
Context outside of school	9, 11, 8