Are counselling psychology training courses developing multicultural competencies in their trainees? Comparing cultural competency in health care and counselling psychology trainees.

Doctoral Portfolio in Counselling Psychology

By

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I declare that this thesis has been composed solely by myself and that it has not been submitted, in whole or in part, for any other degree or professional qualification. Except where states otherwise by reference or acknowledgment, the work presented is entirely my own.

Umesh Joshi

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Abstract

The need for professionals to develop multicultural awareness, knowledge and skills has been recognised in literature and mental health practitioner programmes since the early 1970s. Despite the professional growth of the Doctorate in Counselling Psychology (DCoP), recent research still suggests that cultural competency skills must be further emphasised and developed in training courses. Following an integrative philosophical model, this study adopts a mixed methods approach including interviews and cross-sectional surveys to explore how cultural competency skills are facilitated in DCoP training or acquired by professionals compared to biomedical trainees and professionals. Interviews were conducted with the DCoP course directors, while the Lie scale (Eysenck, 1976) measuring social desirability and the Healthcare Provider Cultural Competence Instrument (HPCCI) (Schwarz, Witte, Sellers, Luzadis, Weiner, Domingo-Snyder, 2015) measuring level of cultural competency skills, were administered to the DCoP and biomedical groups. I hypothesised that the DCoP trainees will score significantly higher on cultural competency compared to trainees from other training programmes and this proved not significant. The results have implications for further developments of cultural competencies in counselling psychology and biomedical training courses.

Chapter 1: Literature Review

1.1. Search Strategy and Databases Used

Electronic databases used in identifying relevant literature include: PsychINFO, PsycARTICLES, PsycBOOKS. Proquest Nursing and Allied Health Source (Nursing Journals), PUBMed, Google Scholar, EBSCO host databases; including; Academic Search Complete, British Education Index, Child Development & Adolescent Studies, CINAHL Plus, Education Abstracts, Education Research Complete, Humanities International Complete, MEDLINE, Psychology and Behavioral Sciences Collection, SocINDEX. The keyword search terms used include cultural competency, cultural competency training, culture and counselling, culture counselling psychology, cultural competency counselling psychology, cultural competency medicine, cultural competency nursing, cultural competency pharmacy, cultural competency cognitive behavioural therapy (CBT), cultural competency psychodynamic, cultural competency humanistic, environmental racism, model minority, hate crim statistics Brexit. Further to this, outcomes of searches were further refined to manage large and unmanageable search results by using limits in searches, to ensure peer reviewed, full text articles were shown. Relevant literature was selected for inclusion in the review by ensuring the literature selected presented information and data relevant to the research question and hypotheses studied in this work. References within key articles were also used to search for literature relevant to the study.

1.2. Culture: A complex word

Culture may be defined as an "integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group" (Cross, Bazron, Dennis & Isaacs, 1989, P. 7). More specifically and particular to an individuals' experience of culture, this research accepts Marsella and Kameoka's (1989)

definition: “Culture is shared learned behaviour that is transmitted from one generation to another for purposes of human adjustment, adaptation, and growth. Culture has both internal and external referents. External referents include artefacts, roles, and institutions. Internal referents include attitudes, values, beliefs, expectations, epistemologies, and consciousness.” (p. 233). By broadly defining culture to include demographic, status (educational, social, economic etc.), affiliation variables and ethnographic variables – the construct “multicultural” becomes generic to all counselling relationships (Pedersen, 1997). Narrow definitions of culture may be limited to multiculturalism; to what might more appropriately be called multi-ethnic or multinational relationships with groups who share sociocultural heritage. Sociocultural heritage may refer to one’s history, ancestry and religion. Whilst these are important factors in the overall contribution to one’s culture, they are not inclusive of the broadly defined contexts contributing to the individuals’ overall cultural differences, which directly inform and are informed by their experiences (Pedersen, 1997). Cultural factors are representative of group affiliations held by individuals, including age, gender, ethnicity, physical and mental ability, sexual orientation, religion, language and social class (Collins & Arthur, 2010). Therefore, healthcare professionals must consider that those from the same ethnic background may have cultural differences between them. Not all Caucasian people have the same experience (Pedersen, 1997). Neither do all black, Asian, LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer) or all those who are handicapped. No particular group is unified in its perspective, and therefore healthcare professionals must consider that a broad definition of culture is particularly important in preparing healthcare professionals to deal with the complex differences among clients from every cultural group (Pedersen, 1997).

To effectively explore the notion of culture, Eells (2007) identified 5 key features of culture. The first is an acknowledgment that culture permeates all realms of the human experience, and

therefore practitioners must work to uncover and integrate a broad range of data throughout the helping process. The second is that culture has internal and external dimensions. Eells uses the example of an Arab male who presents with depressive symptoms after losing his job. The clients' external cultural referent is that Arab men must provide for their family. The internal referent is the feeling of shame for not fulfilling this role. External aspects of ones' psychological presentations are often more obvious than the internal (Ridley, Li & Hill, 1998). Third, culture comprises within-group differences from those with similar cultural backgrounds. In consideration of these variations, clinicians must expect to encounter those who embrace values, beliefs, attitudes and behaviours which deviate from their supposed cultural norm. Thus, the fourth feature of culture comprises these idiosyncrasies. The fifth feature of culture is its inclusive nature. Ridley et al. (1998) consider the term culture as being applied to a group with shared learned behaviour for the purposes of growth, adaptation and adjustment – cultures include groups defined by a variety of characteristics (race, sexual orientation, religion etc.). The focus at this level is on between-group or intercultural differences (Ho, 1995).

Collins and Arthur (2010) acknowledge the 5 key features identified by Eells (2007) through the contribution of their own research on cultural factors and add to Eells's definitions by including "Personal identity factors", "Contextual factors" and "Universal factors". Personal identity factors incorporate Eells' (2007) fourth feature which encompasses idiosyncratic experiences, as well as genetic make-up, developmental paths and socialisation. Collins and Arthur (2010) expand on this by including education, work experience and marital status. Contextual factors refer to historical, social, political, environmental or economic contexts in which individuals live. These factors have a significant impact on personal experiences, worldview and values. The contribution of these factors further broadens the notion of culture,

confronting the reader to acknowledge the breadth of influences on the development of ones' conceptualisation of culture to be completely individual to that of another person, despite whether they come from similar groups (ethnicity, religion, gender etc.) or not. Being confronted with such research encourages us to explore the practical applications of cultural competencies in counselling psychology.

1.3. Approaches to Working Cross Culturally: Core Paradigms

1.3.1. Psychodynamic Approach

Details of the "talking cure" were first recorded for publication in Germany between 1880 – 1882, whilst physician Dr Josef Breuer was working with his 21-year-old patient: Anna O (Launer, 2005). In 1880s Germany, within Anna's own cultural world, her 'mad' behaviour was one of few permissible forms of protest. Women were often oppressed by their family and social circumstances (Launer, 2005). It appears that through this experience, Breuer had developed a new medium for his time, one in which he listened to affect a treatment and establish a diagnosis. It was from this work that "Studies on Hysteria" was first published by Breuer and Freud (Freud & Breuer, 1895). During the editor's introduction to the republication of *Studies on Hysteria*, Strachey states that the book is usually regarded as the starting point for psycho-analysis (Strachey, Breuer, & Freud, 1955). This starting point focussed on psycho-analysis with 5 cases presenting with symptoms relating to hysteria. The five cases focussed on: 1. Anna (age 21) "markedly intelligent" and "looked after a number of poor people" (p.21). 2. Emmy (age 40) "revealed an unusual degree of education and intelligence" (p. 49). 3. Lucy (age 30) an Englishwoman living as a governess. 4. Katrina (age 18) "a daughter or relative of the landlady's" (p. 125) at the refuge in which Freud rested and 5. Elisabeth (age 24) whose

parents owned an estate in Hungary. Whilst varied in age, these 5 cases present similar demographics: women of white, middle-class heritage. They were psychoanalysed by white, middle-class men.

From a psychodynamic perspective, culture may be viewed not only as an anthropological construct pertaining to group membership but also as a psychological construct which impacts psychological development and intrapsychic development. Within any culture, dominant values and behaviours are transmitted to young children through enculturation. This process is defined as internalised culture (Ho, 1995). Further, Ho's definition of internalised culture captures the cultural influences which operate within the individual, shaping (not determining) the formation of their personality and various aspects of their psychological functioning. This intrapsychic expression strengthens the need to consider within-group variations as individuals respond to normative cultural patterns in different ways (Wheeler, 2006). Further, Wheeler (2006) acknowledges the complexity of culture, operating both in intrapsychic functioning and in interpersonal encounters. Hence, providing challenges for counsellors using cultural competency skills in attempting to untangle the client's cultural world and identity. The intercultural differences in people's core values give much possibility to misunderstanding and interpersonal conflict. It is acknowledged that counselling itself is a culture specific activity, which was developed within the norms of western industrialised society (Wheeler, 2006). The philosophical assumptions underlying western ideology include beliefs in individual autonomy, scientific methods and the Protestant work ethic (Tuckwell, 2002). These beliefs vary significantly when compared to collective, holistic and spiritual values held in African and Asian worldviews (Tuckwell, 2002). For effective psychotherapy across cultures (cultural competency), individual techniques from therapists must provide form and structure to working with different clinical problems, discuss diverse content and use it in

varied settings and with people of assorted cultural backgrounds (Jacob & Kuruvilla, 2012). Yet, the heterogeneity within cultures, regions and populations requires therapists to understand local and individual reality (Jacob & Kuruvilla, 2012). Further, they state that therapists set out to match strategies for specific individuals and their distress and consider choosing the best treatment options from diverse therapeutic techniques (Jacob & Kuruvilla, 2012).

Wheeler and Izzard (1997), as two psychodynamic counselling course trainers, acknowledge that psychodynamic counselling has been criticised for being "inflexible, authoritarian, antiquated and unresponsive" (p. 401) to issues of modern-day society. Their article focussed on the integration of sexual orientation and race and culture in their curriculum, course philosophy and community. With acknowledgement of their research to consider psychodynamic and psychoanalytical literature on psychodynamic perspectives on homosexuality, race and culture, their research also provides consideration for how their psychodynamic counselling training course aims to facilitate cultural competency skills in trainees. Further, giving the current research the scope to consider how their approach may be applicable to psychodynamic teachings of homosexuality, race and culture in counselling psychology doctoral courses and developing cultural competence in accordance to this.

Regarding homosexuality, psychodynamic approaches have perpetuated the belief that only heterosexuals can reach emotional maturity (Crouan, 1996). Classical theories ignore female homosexuality, referring exclusively to male homosexuality (Rohde-Dachser, 1992). Freud (1905) presupposed innate bisexuality, with object choice being resolved at the Oedipal phase of human development. Thus, development of homosexual "tendencies" are incorporated into certain traits (feminine traits in men, masculine in women) (Wheeler & Izzard, 1997). Classical

theory suggests that homosexual development in men consists of intense love and identification with the mother, which develops into choosing himself as her sexual object, to love himself and later another man. This implies a narcissistic object choice. This process of homosexual development involves, through feminine identification, to be sexually subjugated by the father. Female homosexuality is seen as regressive, as a result of the expected family relationship not occurring (Rohde-Dachser, 1992). Hence, female homosexuality is seen as more pathological than male homosexuality. Psychoanalysis can indicate the unconscious significance of homosexual orientation and/or homosexual behaviour for the maintenance of psychic balance (Rohde-Dachser, 1992). Learning these theories can develop trainees' cultural competency in working with clients who do not identify as heterosexual and consider the impact on their psyche if they are living in a cultural setting which does not allow for them to express their sexual orientation and behaviour.

With consideration of the literature regarding homosexuality from a psychoanalytic perspective, there is a need to reconsider traditional theories of sexual development (Wheeler & Izzard, 1997). Grey (1992) acknowledges that sexuality is heterogeneous, contrasting to traditional views of sexuality as monolithic. Another criticism is that it is not appropriate to infer a person's pathology from one 'symptom'. This would not be done with heterosexual people or those with mental health difficulties, so why with homosexuals? (Wheeler & Izzard, 1997). Further, one's sexuality is not a symptom (Wheeler & Izzard, 1997). Wheeler and Izzard state the need to develop and adopt a more curious stance towards all forms of sexuality in consideration of one's psychological equilibrium and acknowledge that there is no evidence of greater pathology among homosexuals compared to heterosexuals. In order to encourage their trainees to hold this stance of open curiosity, Wheeler and Izzard invited students to participate in guided fantasy or imaginative exercises to explore their own deeper issues. This would

include writing a letter to one's parents telling them that one is lesbian or gay. They noticed that students appeared inhibited in expressing non-politically correct views, which, they argued, can inhibit their learning. Though, how this learning would be conducted when teaching homosexual students. It may be helpful to ask them to acknowledge an awareness of transference and countertransference when engaging in a client session with a homosexual client, to consider how this impacts their relationship with the client. There is also a lack of acknowledgement of working directly with homosexual clients, a criticism of traditional literature. It is imperative for trainers to encourage trainees to consider the client's frame of reference to effectively adopt cultural competency skills in their practice. Friedman and Downey's (1993) comprehensive review of scientific literature concludes, 'Despite all reservations and qualification, the largely circumstantial evidence that a prenatal biological effect, probably hormonal, influences sexual orientation seems convincing to us' (Downey, 1993, p. 1179).

Considering race and culture, Barker (1992) told a story of a psychiatrist, who was asked by children in the Seychelles what he would do if he found a Guinea pig. He said he would keep it, look after it and feed it. The children gasped in shock, as they did not consider keeping the Guinea pig an option. To them, the Guinea pig belonged to the community and would be used by the wider group. Hence, survival of a community is seen as more important than that of an individual. Groups within the community may take care of problems individuals may experience (Lago & Thompson, 1996), as opposed to emphasis on individualism in the west. In training their students, Wheeler and Izzard (1997) explain that they consider it crucial for students to gain an understanding of how racism operates in organisations and for individuals; the awareness of the experience of ethnic minority people in a dominant white culture. They explain that it is advantageous to have students on the course from other cultures than the

majority culture, then making the majority students aware of others' experiences. Counsellors can learn about other cultures through social contact with others and through travel (Wheeler & Izzard, 1997). This would inform the development of their cultural competency skills. However, we must consider that whilst this is helpful for the majority culture students, as their learning continues, this would be where the minority students' learning stops. As minority students would be only sharing their experiences and their norms and may be subject to racial microaggressions through inadvertently teaching majority students. Although through this experience, the minority students may learn of the microaggressions and assumptions clients may express or hold of them. If race and racism are not specifically brought into focus, they can be easily avoided (Wheeler, 1996). The transference within the counselling relationship is considered of paramount importance. The relationship between a white counsellor and ethnic minority client, will be charged by history, and trainees must face their own racism and prejudice to recognise transference and counter transference accurately (Wheeler & Izzard, 1997). Further, Wheeler and Izzard (1997) refer to assessment and formulation, discussing that race and cultural differences can be considered alongside intra-psychic conflict, but cultures have expectations which cannot be ignored and should not be pathologised (Littlewood, 1992). Researchers have proposed that a client should be invited to talk about their cultural and historical influences in their current difficulties (Sue & Sue, 1990).

Issues of race and culture in psychodynamic counselling are not easy to address, yet a broader view of the client's internal and external world is necessary if psychodynamic psychology is to have an impact outside of a white middle-class context and deliver culturally competent therapy. Still it must be stated that there are limited resources (books, journals) that consider psychodynamic therapeutic practice regarding culture in a broader sense. They consider culture as synonymous with race and ethnicity and the demands of cultural differences on the

counsellor, but not necessarily how intervention may further facilitate and support working cross culturally with clients. Wheeler and Izzard (1997) have been used primarily in this section, as their journal article appears to be the only one which includes race, sexual orientation and training needs. Their research brings to the readers awareness that there can be enough integration to accommodate cultural difference whilst maintaining the essence of psychodynamic work. Their research also demonstrates that there is ability to consider culture from more than one perspective in research and training.

With consideration to working with diversity, including illness and disability, Segal (2006) states that the role of the psychodynamic practitioner when working with those who have illnesses or disabilities is to understand their position. Research papers have considered the individual differences in working with those who have physical illness or disabilities without attempting to generalise a single approach (Segal, 2006). Further research addressing the individual differences healthcare professionals may experience when working with illness or disability from a psychodynamic perspective is lacking. However, Bull and Farrell (2012) published a book which guides practitioners in working with those who present with a learning disability from an art therapy standpoint, which can be used by psychotherapists and art therapists. Farrell captures the main themes he came across working in the field of learning disabilities and developed a spider diagram depicting these themes:

Farrell's (2012): Common themes across working in learning disabilities

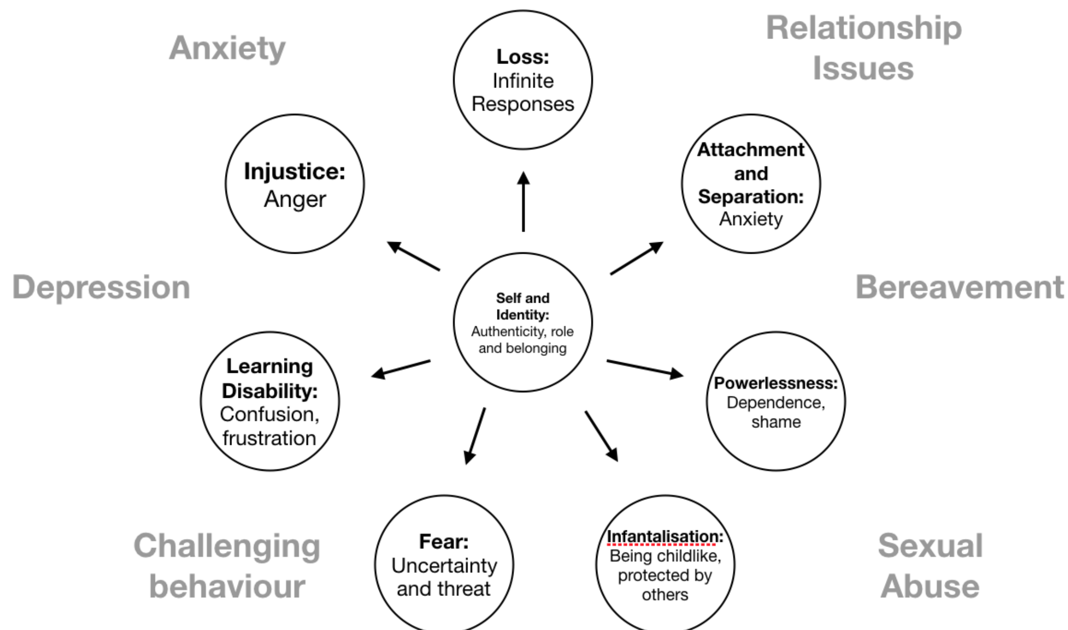

Figure 1. Common themes found in working with learning disabilities (Farrell, 2012, p. 4).

As is mentioned in the text, this was the first art therapy book exploring how to work with those who present with learning disabilities in 12 years. Green (2014) discussed using play therapy from a Jungian standpoint with children presenting with ADHD (Attention Deficit Hyperactivity Disorder) and autism in *The handbook of Jungian play therapy with children and adolescents*. Whilst these books may be a useful tool for psychotherapists, they are from an art therapy and play therapy standpoint and are not be applicable to all practitioners working within a psychodynamic framework. James and Stacey (2013) completed a systematic review of literature exploring effectiveness of psychodynamic interventions for people with learning disabilities. They found 13 relevant studies and found that papers offered some preliminary support for psychodynamic intervention with those who present with learning disabilities. The British Psychological Society (BPS) division of clinical psychology published a document in 2016 (edited by Nigel Beail) which includes information on how psychodynamic therapists can

work with those with intellectual disabilities. It seems in recent years there is growing research and support in working with those who have learning disabilities from a psychodynamic perspective.

1.3.2. Person-Centred Approach

Over a century later than Breuer's initial encounter in talking therapies, Carl Rogers developed his therapeutic practice approach: person-centred therapy (Gillon, 2007). Referring to the short biography written by Gillon (2007), Rogers' began his education in agriculture, moving on to study religion, graduating with a degree in history. From this, he went on to train as a Minister of Religion, before realising his profound interest in Psychology and eventually signing up to train in Clinical and Educational Psychology. Through his work with young people and parents, he first developed his understanding of the approach. After a conversation with the parent of a young person with whom he worked with, he learned that it is the client who knows what hurts, which directions to go, which problems are crucial and which experiences have been deeply buried. From this, he considered it better to rely upon the client for the direction of movement in the therapeutic process. His ideas were cemented firmly by American Psychology at the time (Gillon, 2007). Psychology was enormously popular in America during this period (the 1920s and 1930s), with psychologists working to improve family functioning and workplace performance (Leahey, 1991).

Considering the culture within which person-centred counselling was born, the cultural beliefs emanating from humanistic therapy's principles explained by Lago and Thompson (1996) are: theories are based on the idea of the individual and that individuals can change their own destiny. Humans are in a constant state of movement and "becoming" of themselves. There is

a requirement and perception that one must be active in one's life, not passive. The process of therapy is used to free the client of parental, family and societal expectations that have had perceived negative impact. The challenge is to live authentically as one's self, the concept of personal choice is valued, and parental and cultural values are open to be questioned. Hence, the emphasis is on the good nature of humanity, potentiality and wholeness (Feltham & Dryden, 1993). Person-centred therapy has been called abundance thinking, focussing on the future and positivity, rather than a preoccupation with pathology (Feltham & Dryden, 1993). Further, it is an inward experiment, cooperation, and stretching the client's boundaries (Feltham & Dryden, 1993).

Pedersen (1987) listed ten assumptions practitioners make in their work with clients, which appears to still be applicable today: 1. Assumptions regarding normal behaviour. 2. Emphasis on individualism. 3. Fragmentation by academic discipline. 4. A dependence on abstract words. 5. Overemphasis on independence. 6. Neglect of clients' support systems. 7. Dependence on linear thinking. 8. A focus on changing the individual, not the system. 9. Neglect of history. 10. Dangers of cultural encapsulation. Pedersen (1987) explores each of these assumptions with depth, yet we must consider why some practitioners continue to carry these assumptions despite having received therapeutic training. The core conditions expected in humanistic therapy consist of congruence, empathy and unconditional positive regard (UPR). Congruence within the therapeutic relationship indicates that the therapist will transparently experience their emotions (Gillon, 2007). Empathy consists of two parts: feeling and role-taking (Gladstein, 1983). Feeling, indicates feeling your clients' feelings in the moment with them, whilst role-taking implies putting oneself in the client's "shoes". Consequently, allowing the therapist to experience the feelings of the client. UPR is consistent acceptance for the client's expression of positive and negative feelings (Rogers, 1957). Yet, these conditions are not

sufficient in working with those from all cultural backgrounds. Be that different races, sexuality, ages. An Asian client, for example, may view the therapist as the expert or an authority figure (Rathod & Kingdon, 2009) and struggle to use the therapeutic space to delve deeper into themselves without significant facilitation and probing from the counsellor. Also, using a humanistic approach in which the client is encouraged to delve deeper into their own being, free of parental, family and societal expectations may be difficult for those who come from a culture which views the survival of their community as more important than that of the individual. This may lead to the therapist unconsciously engaging in Pedersen's 10 assumptions, which directly contradict the client's expectations and needs from a therapist providing culturally competent therapy. For trainees to develop awareness of both their own and others' deep cultural, racial and spiritual frameworks of being, thinking and living, Lago (2005) suggests they must: enhance their understanding of their own stereotypes, assumptions and judgement; they must be taught to appreciate very different psychological and cultural frameworks by which other people live; inform their own process of self-monitoring in relation to negative attitudes when conducting transcultural interviews and taught how to avoid imposing their own frame of reference upon clients. Lago (2005) also considers that assistance from skilled tutoring and competent clinical supervision is necessary.

1.3.3. Cognitive Behavioural Approach

Historically, cognitive behaviour modification therapy became visible in the early 1960s (Bannink, 2012; Kazdin, 1978). The roots of Cognitive Behaviour Therapy (CBT) can be traced back to the development of behaviour therapy in the 1920s (Bannink, 2012). It began as an approach which moved away from the disease model's conceptualisation of abnormal behaviours (Eysenck, 1959). The approach considers direct modification of observable

behaviours, rather than working with underlying "disease" factors which produce symptomatic behaviour (Pedersen, Draguns, Lonner & Trimble, 2008). Therefore, it is explained as a sociopsychological model which aims to alter behaviour through psychological principles (Ullmann & Krasner, 1965). Cognitive-behaviour therapy (CBT) uses the principles of the behavioural approach, whilst integrating thinking as a core component for change; evaluating validity of the client's thoughts and beliefs; assessing client expectations and predictions; and assessing the client's attributions for causes of events (Bannink, 2012). It must be acknowledged that the following research in this subsection, refers to the term culture as primarily synonymous to race, ethnicity and religion. This is due to the predominant focus and perspective held by research regarding culture from a CBT perspective.

CBT is the most widely recommended psychological therapy for mental health problems (Rathod & Kingdon, 2009). In the initial session, the therapist will explore with the client: when the problem began, how frequently the problem occurs, what tends to occur before the problem (antecedents), and the consequences of the problem (Pedersen et al, 1996). The therapist will also explore the client's thoughts during this experience and what the client will do to help alleviate their distress. These are standard questions in behaviour therapy (Spiegler & Guevremont, 1993). However, it must be acknowledged that each society has its own "idioms of distress" (Nichter, 1981) to communicate subjective discomfort publicly. College students in the U.S. have described their subjective distress as low self-esteem or subjective-discomfort (Ruiz & Casas, 1981). Among Chinese communities, distress is often conveyed via somatic complaints such as headaches and chest pains (Kleinman & Kleinman, 1985). Japanese people may associate depressive symptoms with environmental or somatic terms such as "rain" or "headache" (Tanaka-Matsumi & Marsella, 1976). Before beginning the process of change, an acknowledgement of potential barriers in therapy ought to be considered. Lack of

knowledge regarding the client's culture can create obstacles in the cognitive and behaviour change process, especially if explanations used to explain therapeutic change do not agree with cultural models (Rathod & Kingdon, 2009). In Chinese culture, one's sense of self-worth, identity and happiness is connected to and influenced by their relationship with others (Yip, 2005). Also, Asian cultures view professionals as authority figures, knowledgeable and to be respected (Rathod & Kingdon, 2009). Therefore, when one is delivering therapy to this client group, it can be helpful to use an instructive and educational style during the early developmental stages of the therapeutic relationship, for example, conveying metal health information and CBT via collaborative empiricism and guided discovery as therapy progresses (Williams, Koong & Haarhoff, 2006). This approach demonstrates an integration of cultural expectations in the intervention, whilst maintaining a collaborative CBT approach and demonstrating cultural competence.

Functional analysis (FA) can be used to yield a clear demonstration of variables which influence the client's presenting problem as it relates to their current life circumstances (Neef & Peterson, 2007). The first step in FA is Higginbothan, West and Forsyth's (1988) four procedures of negotiating the meaning of the client – therapist relationship with the cultural perspective of the client's presenting problem (to effectively provide culturally competent CBT). The first procedure, the client is asked to give their own perspective of the presenting problem. Second, the therapist discloses the explanation (therapeutic model) (Kleinman, 1980) that they would use to understand the problem. Third, the two frameworks are compared for similarities and conflicts. Finally, the client and therapist translate the explanatory model into language, which is mutually understood and accepted, so they can jointly set the content of therapy, target behaviour and outcome criteria. This model is based on that of Kleinman (1980), who emphasised the importance of assessing client views through the development of effective

therapy in different cultures. The second step in FA is to acknowledge the situations and person variables controlling the presenting problem. Further, this includes developing understanding of what happens immediately prior to the problematic behaviour/situation, if people are present during it and how they react to the client's experience. This can all inform the client's perceptions and self-statements, deemed to influence the occurrence of the target behaviour (Meichenbaum, 1977). In consideration of how people may react to the client's experience, research has evidenced differences in terms of cultural acceptance of what may be "abnormal" behaviour in one culture, compared to another. For example, visual or auditory hallucinations in the west are considered a sign of mental illness (Pedersen et al, 1997), yet among some Balinese and Hawaiian (Takeuchi et al., 1987) people, hallucinations may be considered an everyday experience of connecting with the spirit realm. FA allows the therapist to understand under which specific social circumstances hallucinations occur, and where, if culturally appropriate, can help the client re-establish environmental control over hallucinations, rather than reducing them with the use of drugs (Al-Issa, 1976). The third purpose of FA is to give the client and therapist plausible basis for negotiating treatment strategies to change target behaviours. This is agreed between the client and the therapist, making the success or failure of therapy readily transparent (Pedersen, 1997). Therapy effectiveness is evident through observable changes in behaviour, regardless of cultural context (Pedersen, 1997). To facilitate this process, self-regulation techniques can be drawn from Eastern religious experiences, such as meditation and yoga (Shapiro & Zifferblatt, 1976). Mindfulness from Buddhist teachings can be used in therapy to help clients as a protective and coping strategy (Mikulas, 1981). Hence, with inclusion of cultural perspectives, FA is a culturally competent model for delivering CBT.

However, it must be acknowledged that CBT does not traditionally focus on developmental history after the initial assessment, and for some clients this would be considered a limitation (Ghassemzadeh, 2007) and would require the therapy to be adapted in order to be successful (Rathod & Kingdon, 2009). For example, in some African Caribbean cultures where slavery, discrimination and racism have been important past and present experiences, a focus on these aspects may be necessary (Rathod, Kingdon, Phiri & Gobbi, 2009) for some clients. The task for the therapist is to consider the degree of acculturation of clients in multicultural settings, and where the client's beliefs lie on the spectrum between different cultures (Rathod, Kingdon, Phiri & Gobbi, 2009). Below is the diagram from the Rathod, Kingdon, Phiri and Gobbi paper: *Cognitive behaviour therapy across cultures* (Rathod, Kingdon, Phiri & Gobbi, 2010, p. 525):

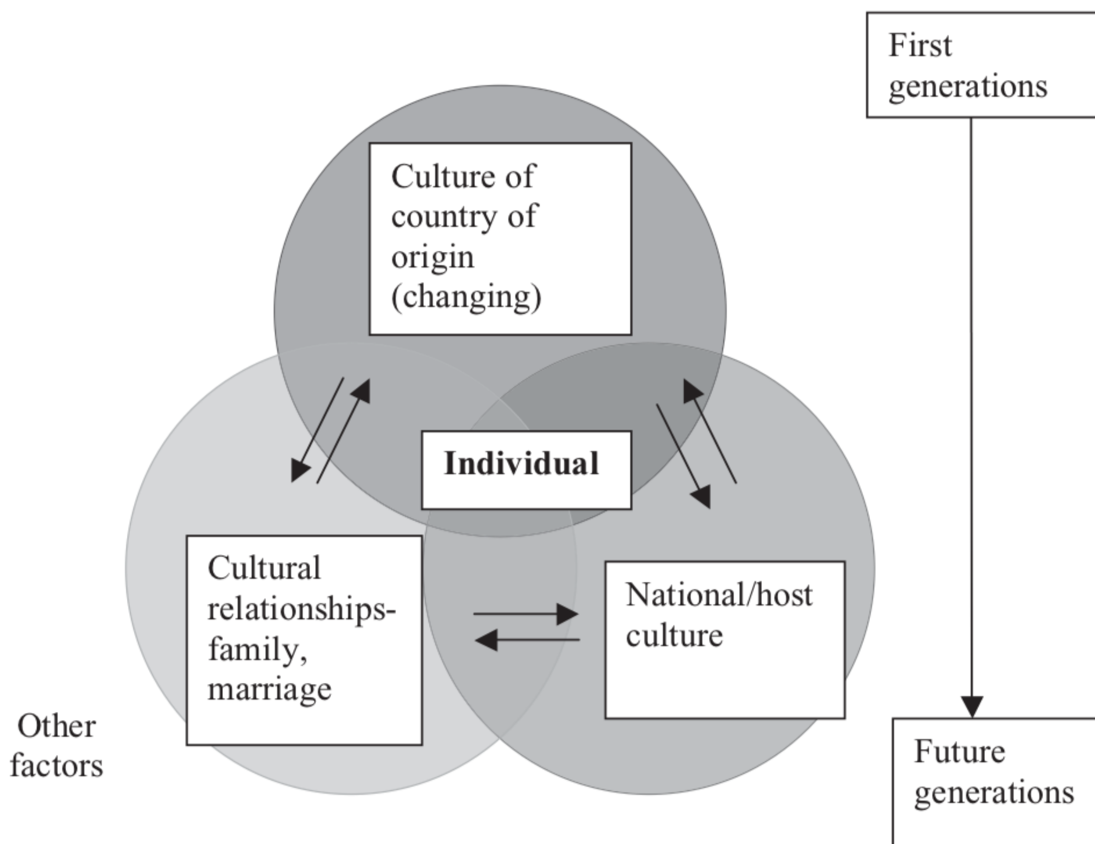

Figure 2. Assessment of Acculturation and Cultural Beliefs.

Figure 2 acknowledges that two or three cultures coexist for many clients. This diagram could be a useful tool in identifying the client's presenting problem from their perspective, and the perspective of their country of origin, host culture and cultural relationships. Literature regarding therapeutic intervention for many cultural groups has recommended adaptation of CBT as necessary and possible (Deffenbacher, 1988). Research has found that adapted techniques of CBT have been acceptable and successful with Pakistani (Chen, Nakano, Letzugu et al, 2007) and Chinese (Williams, Koong & Haarhoff, 2006) clients. Hence, cognitive therapy must be modified to fit the values and beliefs of the given culture, as distorted cognitions in one culture, may be functional and adaptive in another (Chung, 1996).

However, one criticism of the research presented in the Cognitive Behavioural Approach regarding culture, is that it views the term "culture" as race and ethnicity. Culture, as already established, is a term broad enough to be inclusive of sexuality, gender identity and age etc. In consideration of Rathod et al.'s (2009) model of Assessment of acculturation and cultural beliefs, how does one differentiate between cultural norms and maladaptive perceptions of cultural norms? Through talking to other people within the family or the client directly, we may be at risk of colluding with potentially maladaptive thoughts and behaviours held by the family system or the client without recognising this in our process with them. The acculturation assessment could also be adapted to be inclusive of all elements of the individual's cultural perspective, being inclusive of age, sexuality, gender, sex etc. These could and should be explored by the therapist with the client, to acknowledge how and where they fit into the client's views of how they associate with the different aspects of their identity. Having these elements explored or written in the "Other Factors" section may be beneficial in helping both therapist and client to be mindful and aware to explore these elements, which could easily be overlooked. The research thus far in consideration of CBT has acknowledged that behavioural

therapies have been a key component for change in mental health and have been received well in "developing societies" (Rahman, Malik, Sikander, Roberts & Creed, 2008). Yet, terminology such as "developing societies" suggest an ethnocentric perspective on said societies, and psychologists and fellow healthcare professionals must continue to be mindful of using terminology which undermines the "culture", i.e. race, country or society, itself. The papers used for considering CBT in cultural competencies and working cross-culturally appear to refer primarily to race and ethnicity and people's age and sex within and under those specific races and ethnicities. Hence, the research lacks the inclusivity of considering LGBTQ+, those lacking in physical/mental ability and socioeconomic status, in working cross-culturally.

Ross, Doctor, Dimito, Kuehl, & Armstrong (2007) conducted a study with LGBT people in which they considered whether talking about the experiences of oppression the LGBT community and individuals faced, helped to reduce their feelings of oppression. Their study demonstrated statistically significant reductions in symptoms of depression and significant increases in self-esteem, following the intervention. This work could be easily adapted and used with the acculturation assessment tool devised by Rathod, Kingdon, Phiri and Gobbi (2007). Hence, Craig, Austin, & Alessi (2013) considered gay affirmative CBT with Sexual Minority Youth (SMY) and offered recommendations for incorporating gay affirmative practices in traditional CBT. The term SMY refers to young people who are LGBT+ or have sexual contact with the same or both sexes. Yet, their conclusions suggest that further empirical research is required to demonstrate the effectiveness of CBT with SMY. Crameri, Barrett, Latham and Whyte (2015) refer to culture as LGBT+ and age and consider the development of culturally safe services for older LGBT+ service users. Cultural safety builds on cultural awareness and cultural sensitivity (Barrett, 2008). Cultural awareness involves education, and ensuring that one understands the histories impacting health, well-being and care needs

(Crameri, Barrett, Latham & Whyte, 2015). Cultural sensitivity expands awareness education to understanding of power imbalances, particularly between service providers and consumers. The notion of cultural safety builds on notions of awareness and sensitivity and is characterised by individual service providers reflecting their own values and beliefs in the services they provide (Crameri, Barrett, Latham & Whyte, 2015). Crameri, Barrett, Latham and Whyte (2015) conclude that achieving this depends on ongoing education and reflection and highlighting the importance of organisational leadership which guides staff on the delivery of culturally safe services. This sends a message to both staff and older LGBTQ+ people about an organisation's commitment to deliver culturally safe services. Cultural safety is equivalent to cultural competency.

1.4. Practical Application of Knowledge and Theory

1.4.1. Developing an Inclusive Therapeutic Approach

Essentially, all clients in need of psychological services come from diverse cultural backgrounds despite potentially perceived similarities of race, ethnicity, sex, age, sexuality and social class/status. Cooper (2009) acknowledges the essential values of counselling psychology. He acknowledges counselling psychology to be unique, as its tendencies are founded on philosophically orientated values and an explicit statement of principles (Goldstein, 2009). Further, counselling psychology is not solely grounded by values, as with all professions (Koehn, 1994), but those values form the application of our work. Essentially, the respect for our client's autonomy, trustworthiness and our commitment to maintaining confidentiality are not just products of our work, they are the essence of what we do (Cooper, 2009). Counselling psychology is 'ethics-in-action'. By considering a broad range of counselling psychology texts

(British Psychological Society Qualifications Office, 2008; Gillon, 2007; Orlans & Van Scoyoc, 2008; Wolfe, 1996), Cooper (2009) identifies 6 key principles of counselling psychology. These include:

1. Prioritising the client's subjective and intersubjective experience (versus the prioritisation of the therapist's observations, or objective measures).
2. Focussing on the facilitation of growth and actualisation of potential (versus the focus on treatment of pathology).
3. An orientation towards empowering clients (versus viewing empowerment as an adjunct to an absence of mental illness).
4. A commitment to a democratic, non-hierarchical client-therapist relationship (versus a stance of therapist-as-expert).
5. Appreciation of the client as a unique being (versus viewing the client as an instance of universal law).
6. An understanding of the client as a socially and relationally-embedded being, including an awareness that the client may be experiencing discrimination and prejudice (versus a wholly intrapsychic focus).

These principles are often associated with humanistic psychology, and counselling psychology is frequently defined as having a humanistic value base (Joseph, 2008; Olans & Van Scoyoc, 2008; Walsh & Frankland, 2009; Woolfe, 1996). This is evident if we consider the core values of humanistic psychology, and how they greatly overlap with those of counselling psychology. These include:

1. Human beings, as humans, supersede the sum of their parts and cannot be reduced to components.
2. Human beings have their existence in a uniquely human context, as well as in cosmic ecology.
3. Human beings are aware and aware of being aware – i.e. they are conscious. Human consciousness includes an awareness of oneself in the context of other people.
4. Human beings have some choice and with that, responsibility.
5. Human being are intentional, aim at goals, are aware that they cause future events, and seek meaning, value, and creativity (Journal of Humanistic Psychology, 2009).

Cooper (2007) extends his argument by stating that core ethical commitments underlying humanistic practices is ‘humanisation’: “a commitment to conceptualising, and engaging with people in a deeply valuing and respectful way” (p. 11). However, are these philosophies and intentions enough? How can one be truly valued in a respectful way if the practitioner is unable to facilitate the clients’ process, lacking the skills in understanding how to learn about and be inclusive of the clients’ cultural identities and stance?

Laungani (2004) demonstrated how the therapeutic relationship can breakdown between client and therapist due to the therapists’ misunderstandings of the clients’ cultural background. This example highlights how a lack of training in cultural competency skills in the therapist can lead to a breakdown in the therapeutic relationship. It was created and shared by Laungani in their paper: “Counselling and therapy in a multi-cultural setting” (2004), which explores attitudes towards the interpretation of words and metaphors across cultures. In this research, the use of metaphors in Indian culture is explored specifically, and how the use of metaphors in Indian culture differs from western culture. In short, Laungani explains that Indian culture derives its

use of metaphors and words from ancient religious stories, such as the Mahabharat (ancient religious text), which are told to children from a young age. The Mahabharat is something which is commonly used with shared understandings across the culture, with the use of words which have more than one translation, depending upon the context in which they are used. Laungani (2004) imitates a real therapist – client situation, which includes an Indian (Muslim) client and a white English (or American) therapist and how they respond to one another. This situation indicates that if a client expresses their selves according to their cultural metaphors and language, and the therapist is uneducated on their culture and therefore unaware of how to respond to such self-expression, it can lead to a breakdown in the therapeutic relationship. It is one explanation for why racial and ethnic minorities receive lower quality health care (Sue et al, 2009). The entire scenario has been quoted to provide the reader with an example of the difficulties those with profoundly different cultural backgrounds may experience in accessing services, which can truly cater to and be understanding of their needs. Through reading this example, allow us to consider if the practitioner is unintentionally oppressing the client:

“Client: Well. Doctor Sahib, what should I do? (He rings his hands in a gesture of despair and looks imploringly at the therapist.)

Therapist: (With a mask of neutrality over his expressionless face) What do you think you should do?

Client: (Rather peeved, even angry.) Every time I am asking you a question you are throwing the question back at me!

Therapist: Oh, am I?

Client: (Exasperated.) You have done it again! Look Doctor Sahib. You are the expert. I have come to you for help. If I knew how to help myself surely I would not come to see you.

Therapist: (Not in the least put out) Mr. Ahmed, it is really for you to decide what you should do. I cannot decide for you.

Client: (Acutely disturbed and even bewildered.) I understand. But I am not asking you to decide for me, Doctor. I am asking your opinion. I have come to you for help. I don't understand why you should not help me. You should be guiding me. Helping me. Showing me the way. I am like a Bedouin, lost in the sand dunes of Arabia. But you don't want to help me to decide what I should do.

Therapist: (Defensively) That is not quite true.

Client: When I go to see my GP, he tells me what I should do, what medicines I should take, how long for, and so on – and then leaves it to me to decide whether I will take them or not. But you don't even tell me what I should do! (Looks at the therapist.) If you were a brain surgeon, would you be asking me to perform my own operation?

Therapist: (In spite of himself) No, of course not!

Client: What's the difference? So if you were a brain surgeon you would perform brain surgery on me. You are a surgeon of the mind and yet you will not perform psychosurgery – which you can!

Therapist: (Reluctantly gets drawn into an argument) It is not my role to tell you what you should do, or even what you ought to do. My role, as I see it, is to interpret, or throw some light on your problems, to help you to see your problems.

Client: I am not asking you to tell me what my problems are. I know what my problems are! I am asking for advice, *how to overcome my problems*.

Therapist: (Remains silent)

Client: You know what I think, doctor. (Pointing his index finger to his forehead) It is fate. It is Allah's will. It is my kismet, my 'taqdeer'. What was to happen has happened. Who can fight against one's fate, against what is written! (Here he quotes the well-known couplet from the Persian poet Omar Khayyam (translated by Edward Fitzgerald)

The Moving Finger writes; and having writ,
Moves on: nor all thy Piety nor Wit,
Shall lure it back to cancel half a Line
Nor all thy Tears wash out a Word of it.

Therapist: (Totally at a loss as he hears the poem, which his client has recited in Persian: sits in embarrassed silence, unable to decide what he should say.)" (P. 199 – 200).

In this instance, Laungani acknowledges that without any specific knowledge of the client's presenting problems, there is a gulf between client and therapist. Both are locked in their private, cultural worlds. They are unable or unwilling to step out of them. Even the manner in

which they relate to one another reveals their cultural biases. Yet, referring to Cooper's (2009) key principles of counselling psychology and the humanistic core values, the therapist was presumably working with the client with these values underpinning their work and their intentions. However, their attempt at providing a humanistic container was not enough for the client in this instance. The client's voice is not being understood. The client is therefore, unintentionally oppressed by the therapist. The therapist did not possess nor demonstrate the cultural competency skills necessary to work with the client.

Wilk (2014) uses their research to consider that training in doctoral and master's programmes could integrate intercultural training. This would include learning about alternative interventions used in non-western cultures and considering how they can be utilised within a western framework, to benefit the client in their treatment (Wilk, 2014). Through learning different methods and approaches to use with diverse clients, we use problem-solving and communication as a positive learning opportunity within the client work. Thus, Wilk (2014) continues to suggest we must consider the use of a pluralistic approach in therapy, which ought to be informed by intercultural communication skills in training for therapists, allowing for collaboration on goals, tasks and methods of therapy with the client. This gives the therapist the opportunity to build strong therapeutic relationships with diverse clients from races, religions and sexual orientations which may differ from their own (Wilk, 2014). Roth (2001) states that many studies on intercultural communication focus on miscommunication and misunderstanding. Recent literature considering intercultural communication does not derive specifically from the field of psychology and is considered in the contexts of sociolinguistics (Piller, 2017; Hua, 2018). Hence, exploring notions of identity and cultural identity (Hua, 2018). With this in mind, it is imperative that psychology imbeds and explores outside of its own remits, recent literature developed by diverse researchers, to consider how this can be

imbedded in teaching and understanding of diversity on counselling psychology doctoral courses, to facilitate the development of a pluralistic therapeutic approach. If we fail to do this, cultural encapsulation can occur, in which the cultural assumptions of the therapist establish a standard of behaviour where the clients' culture and behaviours are judged, measured and interpreted and diagnosed from a western perspective (Nadirshaw, 2009). i.e. ethnocentrism. This process evidently occurs in Laungani's example (above).

The notion of pluralism is philosophically underlined as a doctrine that any substantial question admits a variety of plausible but mutually conflicting responses (Rescher, 1993). Further, all understanding is dependent on experience and it is inevitable that all humans will have a complex range of experiences (Cooper & McLeod, 2007). Rescher (1993) argues that the normal human condition is dissensus (widespread dissent) rather than consensus. Thus, the quest for consensus is ethically problematic and closes off from that which is most different and diverse in people. It is further viewed by Cooper and McLeod (2007) as not just an epistemological position, but an ethical and political commitment to respect, value and include "Otherness". They define the notion of otherness as others' worldviews, which includes counsellors, psychotherapists and clients. Cooper and McLeod (2007) introduced the pluralistic framework as an alternative the unitary models which dominate counselling psychology. Through this framework, they acknowledge that it is unlikely for one "right" therapeutic approach to be appropriate in all situations, and that different people are helped by different processes at different times. Thus, utilising concepts, strategies, and specific interventions from a range of therapeutic orientations. Instead of considering what a client needs, the pluralistic framework asks, "What do clients want?", giving the client more power to work on a specific issue or to work on their selves with no specific issue, using therapy to gain further insight into his or herself (Cooper & McLeod, 2007). As explained by Cooper and

McLeod (2015), the pluralistic approach consists of three pillars: *pluralism across orientations*, *pluralism across clients* and *pluralism across perspectives*. Pluralism across orientations refers to clinicians having an openness to considering contributing factors to clients' presenting factors and correspondingly, a variety of different ways of helping them. This approach challenges the "schoolism" which has been endemic in counselling and psychotherapy. Pluralism across clients recognises the diversity of clients and offering each client a tailored approach to counselling rather than one which is pre-determined. This pillar places emphasis on recognising and celebrating diversity across clients. Pluralism across perspectives means that both clinician and client have a decision in the therapeutic goal setting and therapeutic tasks and methods. Further encouraging shared decision making and feedback across clients and therapists. This approach is developing momentum and recognition in the field of counselling and psychotherapy. Integration and explanation of the developing approach can be useful in informing integrative practice through pluralistic means or vice versa. The model fits a counselling psychology framework as counselling psychology courses teach humanistic, CBT, Psychodynamic and systemic practices and may be useful to consider and place explicit reference to in training courses.

Taking pluralism further allows us to consider how this approach may be integrated into counselling psychology training, whilst developing cultural competency skills in trainees. It is pivotal to include counselling psychology's essential values and where they come from, to further emphasise that cultural competency skills ought to be a core component in counselling and counselling psychology. When we begin training, we must begin by being moulded into professionals who already think with inclusivity and an ability to work with people from vastly different cultural backgrounds to our own.

1.4.2. Formulation

A formulation can be explained as a summary of a client's difficulties, based on psychological theory, and informing the intervention (Johnstone, 2011). A method for exploring the client's difficulties is to consider and reflect upon their contextual factors. Collins and Arthur (2010) reflect on contextual factors, considering education, work experience and marital status on informing one's culture. There are theories which expand upon these aspects of culture such as Bronfenbrenner's bioecological theory of systems (1979, 1989, 2001, 2006, 2009), encouraging psychologists to understand the different systems which encompass the individual.

Bronfenbrenner's widely accepted theory explains the impact of different systems surrounding a child, which directly impact and influence their development (See Below: Figure 3). Their model starts by mapping where initial interactions occur and from a micro-level analysis, considers how we shape those around us and how we are concurrently being shaped (Kraus, 2008). It identifies that our development is concurrent with our environment and our relationships (Kraus, 2008). Therefore, directly informing the development of the cultural aspects stated by Colins and Arthur (2010). Working from the individual outwards, the model consists of 4 systems surrounding the individual: Microsystem, Mesosystem, Exosystem and Macrosystem. The notion of "Individual" in this theory refers to sex, age, health, and factors primarily associated with the general demographics of the person to whom the model is applied to. The Microsystem includes direct influences, such as school, family, peers, healthcare services, religious influence (e.g. church, temple). The Mesosystem is defined as comprising the relationships existing between two or more settings (Bronfenbrenner & Morris, 2006). It connects the structures within the microsystem, E.g. the family and the school, with peers and

family. The Exosystem is the wider system, which has the potential to have both indirect and direct impacts on shaping development, such as neighbours, mass media, social services and local politics. The Macrosystem consists of the attitudes and ideologies of culture surrounding the individual. Thus, informing their cultural values.

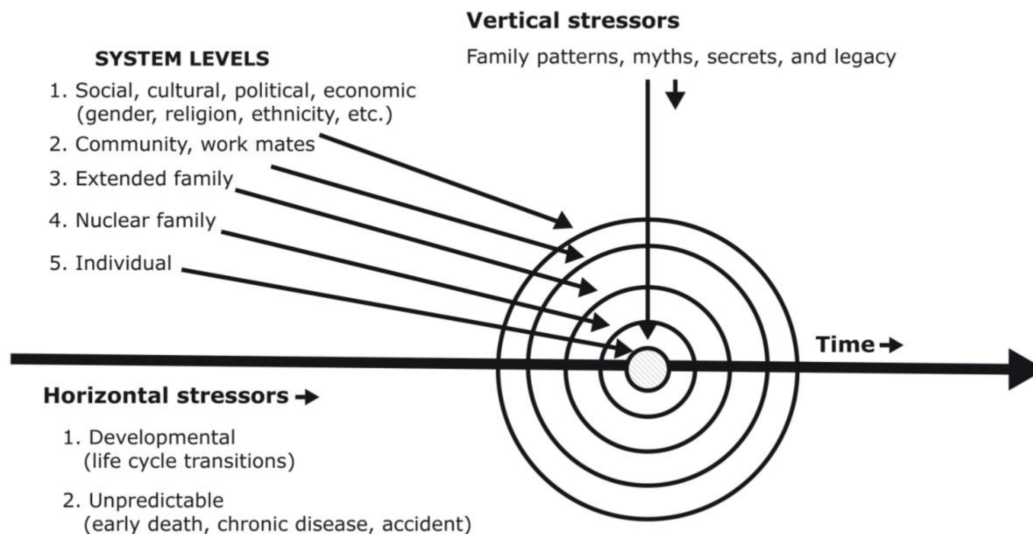

Figure 3. Bronfenbrenner's bioecological theory of systems.

The literature explains that the primary intention of this model is to inform developmental processes in young adults and children, rather than considering the impact of different levels of cultural context on the individual person. At the same time, this model may be used for the latter by practitioners and further inform an entire view of the client from an angle different or separate to the model of assessment used by individual practitioners or the services they may work for. In consideration of this argument, standardising the assessment protocol to avoid systematic judgements the clinician is unaware of is crucial (Lewis-Fernández & Díaz, 2002).

Thus, Lewis-Fernández & Díaz (2002) devised a cultural formulation method to assess cultural factors impacting the clinical encounter. They consider that a systematic approach in

diagnosing illness would help clinicians diagnose culturally patterned experiences of illness which are distinct from mainstream psychiatric diagnostic criteria. The intention of the model was to acknowledge and endorse the importance of narrative from an anthropological perspective whilst echoing the tradition of psychodynamic formulation (Lewis-Fernández, 1996). The results of the practical application of the model showed it was successfully used with patients from four US ethnic minorities (Lewis-Fernández & Díaz, 2002). This technique allows a reflexive stance on the clinician-client relationship, in which the practitioner can continuously shape their evaluation, including both the clinician's and the client's perception of their illness (Lewis-Fernández & Díaz, 2002).

The model refers to the "mini clinical ethnography" which refers to a list of anthropological assessments of cultural factors which may be imminently impactful on the clinical situation (Kleinman, 1988; Weiss, 1997). Fernández & Díaz's (2002) paper goes on to demonstrate case examples in which the cultural formulation method may be used. Whilst a useful formulation, the formulation itself comes from the stance of culture meaning ethnicity, race or heritage. Thus, excluding the broad notions which inform the definition of culture in this work. It is also a model which has been tried, tested and used in the United States only. Fernández and Díaz (2002) acknowledge that the model is useful in teaching clinicians how to elicit culturally relevant clinical material and also elicits them to the content of many different cultural perspectives. Unfortunately, the model's limitations appear to be missing in the actual paper, but suggests further research using the model to explore its application in improving client outcomes. Although there is acknowledgement that training courses ought to imbed the cultural formulation model in their programmes.

Whilst we can acknowledge this model to be vital in its contribution to the field's understanding of cultural awareness and competency skills, in itself it is too specific and focussed primarily on the notion of culture. Whilst we have discussed the breadth of the notion that is culture, I think the importance and value of this model would be for it to be imbedded in standard assessments, normalising cultural consideration.

1.5. Biomedical Colleagues

Having considered cultural competency through the lens of counselling psychology, this next section explores the notion of cultural competency and practice with biomedical professionals. Previous research on the development of cultural competency with nurses has included the development of *The Process of Cultural Competence in the Delivery of Healthcare Services* (Campinha-Bacote, 2002). This model refers to culture as meaning ethnicity and race. This model assumes: 1. Cultural competency is a process 2. Cultural competence consists of 5 constructs: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. 3. There is more variation within ethnic groups than across ethnic groups (intra-ethnic variation) 4. There is a relationship between cultural competence of healthcare providers and their ability to provide culturally responsive care. 5. Cultural competence is an essential component in rendering effective and culturally responsive services to culturally and ethnically diverse clients (Campinha-Bacote, 2002). Campinha-Bacote developed this model after her experience with nursing, medicine and then further interest in cultural competence in counselling. From this blend of experiences, she was able to formulate this model (Campinha-Bacote, 2002). See below an image of the model:

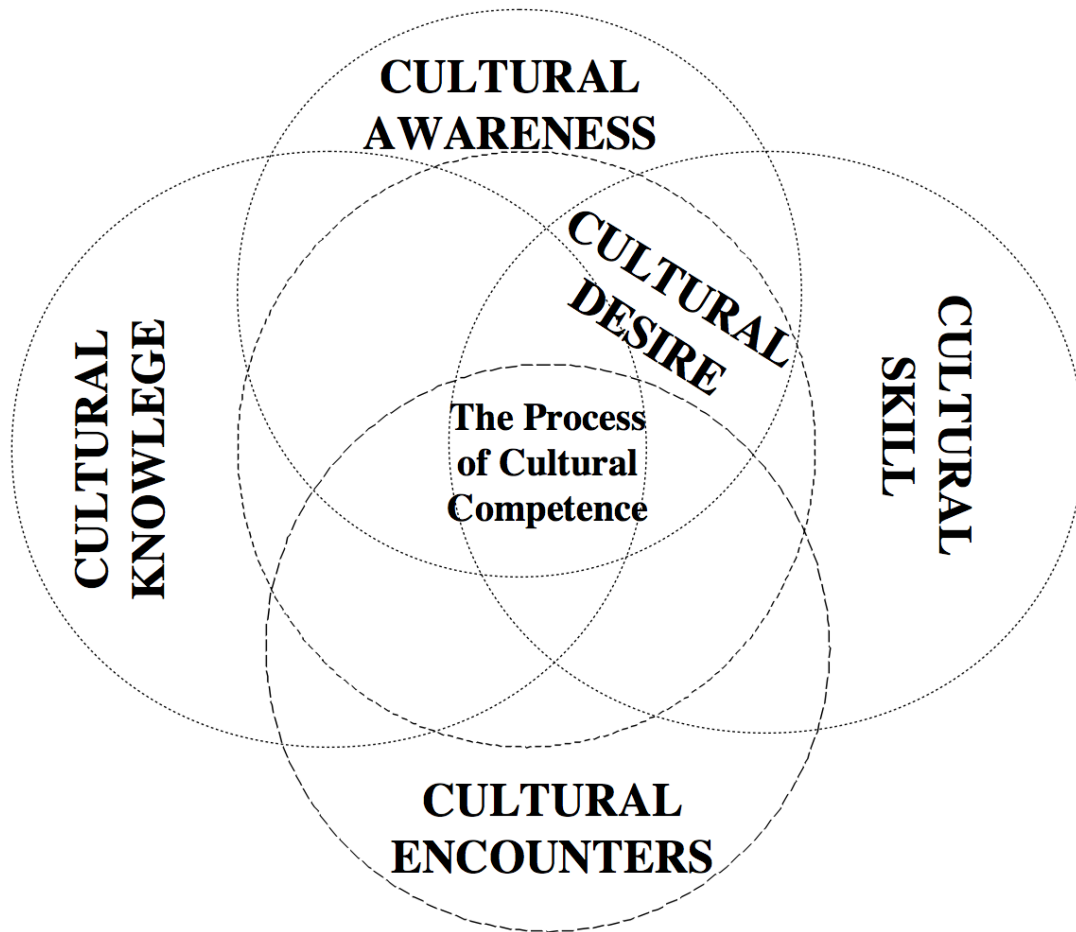

Figure 4. The Process of Cultural Competence (Campinha-Bacote, 2002).

To make sense of the model, I will explore each component in its meaning and then overall contribution. This information has all been derived from Campinha-Bacote's paper: *The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care* (2002).

1. Cultural awareness is the self-examination and in-depth exploration of one's own cultural and professional background and beliefs. Hence, recognising one's own prejudices. This will help healthcare professionals avoid engaging in cultural imposition. Cultural imposition is the tendency for an individual to impose their own beliefs, values and behaviours on another culture (Leininger, 1978).

2. Cultural knowledge is the process of seeking and obtaining an educational foundation regarding diverse cultural and ethnic groups.
3. Cultural skill is the ability to collaborate with clients; to understand their presenting problem and perform culturally based physical assessments. A cultural assessment is defined by Leininger (1978) as “systematic appraisal or examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the context of the people being served” (pp. 85-86).
4. Cultural encounter is the process of the healthcare provider engaging in cross cultural interactions with clients from diverse backgrounds.
5. Cultural desire is the motivation for the health care provider to want to engage in the process of becoming culturally aware, rather than having to.

Whilst this model provides a very useful model of explanation and expectations of healthcare professionals regarding their cultural competency skills, it fails to acknowledge how one in the healthcare field may obtain the expected skills. It appears to be dependent upon the individual healthcare professional, whilst presuming there will be support from healthcare organisations. The suggestions from the researcher advise that to further develop cultural competency skills within healthcare professionals, we must measure their levels of cultural competency. Long (2016) is still stating that there is a need for cultural competency training among nursing students. Research studies of nursing students who have worked abroad show increase in self-awareness, self-confidence and attitudinal changes in dealing with cultures different to their own (Foronda, 2010). It seems that whilst there is research to support the development of cultural competency skills in trainees and qualified professionals, the application of this appears to be varying and dissimilar across training courses and healthcare organisations.

Cultural competence has been introduced to the field of medicine as an important factor in addressing health disparities (Guzman, 2016). Although cultural structures and legacies are often reduced to stereotypical and superficial cultural differences and doctors continue their work without interrogating the roots of inequalities in health (Guzman, 2016). Hence, certain populations suffer health disparities and continue to receive poor quality care, as the medical profession avoid larger structural issues such as racism and economic inequality (Guzman, 2016). Cultural competency training is acknowledged as theoretically necessary to improve quality of care and reduce healthcare disparities among racial and ethnic minorities (Betancourt et al. 2003). There are four major strategies of cultural competency discussed by scholars (Guzman, 2016): 1) Increasing the effectiveness of communication between patient and provider (Perloff et al. 2006; Teal & Street, 2009); 2) recognising and reducing stereotyping and bias which can impact decision-making processes during medical encounters (Crandell et al. 2003); 3) associating the term cultural competency with the development of knowledge about diverse cultural understandings of health and illness which patients may hold (Juckett, 2005; Flores, 2000); 4) understanding the social detriments of the health model is critical in gaining compassion and working effectively (Seeleman, Surrmond & Stronks, 2009). Please see Figure 5 below, devised by Guzman (2016):

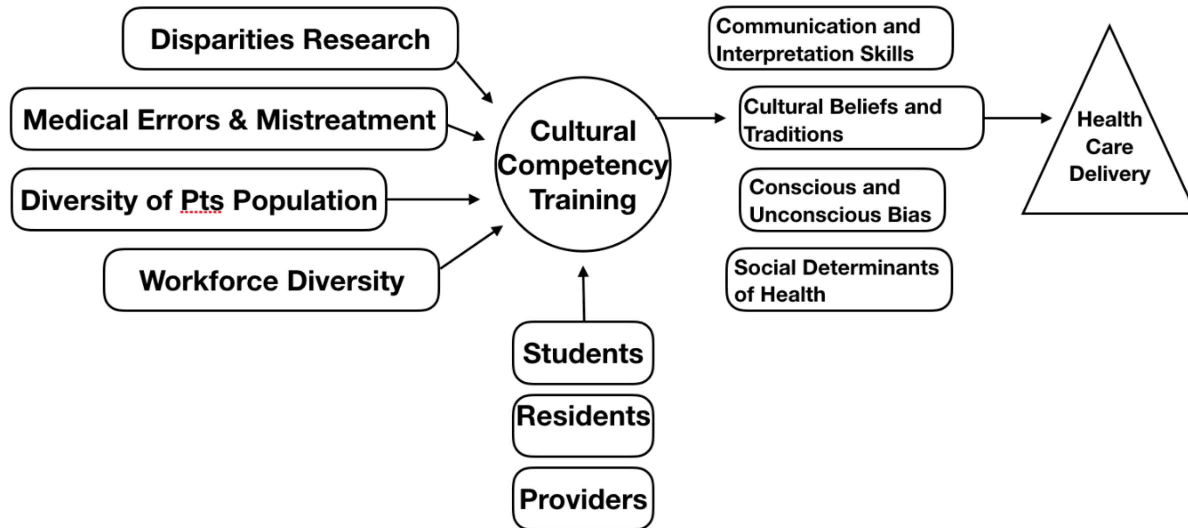

Figure 5. Cultural Competence Framework (Guzman, 2016).

Considering this model, the development of cultural competency skills is primarily concerned with research, diversity, the clinician's attitudes and skills (Seeleman, Suurmond & Stronks. 2009). Undergraduate medical school is the foundation on which healthcare professional training begins (Guzman, 2016). Yet, undergraduate medical trainings do not necessarily prepare future physicians to understand the cultural influences on a patient's perception of illness and how these perceptions can influence treatment and quality of care (Crandall et al, 2003). Developing these skills intends to change the providers of healthcare themselves rather than just educating them. Today, more efforts are placed into changing the socialisation of medical students through enhanced curriculums (Guzman, 2016). Knowledge and skills which have historically belonged to the social sciences (humanistic, psychosocial and ethical components) which are outside of the traditional biomedical model are now being emphasised (Guzman, 2016).

Boutin-Foster et al (2008) propose a framework which explores the customs, languages, and beliefs systems that are shared by physicians, thus defining medicine as a culture. Focussing

on physicians' culture can help to broaden student's concept of culture, sensitizing them to the importance of cultural competence (Boutin-Foster et al. 2008).

Alongside this, we ought to acknowledge some of the constraints to implementation of the development of cultural competency skills. Such as the crowded curriculum and gruelling workload medical students experience (Guzman, 2016). As well as this, we must consider how some students may think they are imbedding or using cultural competency skills but may be consciously or unconsciously abusing their power. Here is a piece titled "A hidden Curriculum" by a young doctor (Brooks, 2015):
"While practicing the medical interview, I was told that Latinos may say yes to all review of system complaints and that cultural competence meant minimizing some of their concerns. While studying for boards, I learned that the race of the patient was often a hint to his or her disease" ... "I watched a young white teenager receive extended opiates for a post–lumbar puncture headache because she looked like a good kid, yet witnessed scrub nurses make fun of a Latino gunshot survivor for crying out in pain. On another occasion, an attending explained that *some cultures* have lower thresholds for pain" ... "I doubt that these experiences are unique to the hospitals or the medical school at which I have thus far trained. I expect that they pervade health care systems throughout the country..." (Brooks 2015, p. 1909).

As is with Nursing, there is research to support the development of cultural competency skills in Medicine and Surgery trainees and qualified professionals, but the application of this appears to be varying and dissimilar across training courses and healthcare organisations.

Zweber (2002) used their research paper to encourage students to attend to their own cultural heritage and consider how one's culture can impact their healthcare choices, outcomes and

consider how to overcome cultural barriers, focussing on developing cultural competence in pharmaceutical care practice. They acknowledged that it is important to note that there are vast differences among the cultures and individuals within each racial/ethnic group. It appears Zweber's definition of cultural competency refers primarily to competency in working with those from racial and ethnic minorities in the west.

Hepler and Strand (1990) state that the pharmaceutical care model aims to improve the quality of life through drug therapy. To do this, it is essential to involve the patient, physician and pharmacist in decisions involving drug therapy (Zweber, 2002). The individual's description of quality of life is influenced by their culture and will impact their choices regarding drug therapy (Zweber, 2002). For example, a Muslim woman observing Ramadan may not be able to take erythromycin three times daily with food. Attempting this whilst fasting may lead to nausea and vomiting. (Zweber, 2002). There have also been instances in which individuals have suffered due a lack of cultural competency skills in healthcare professionals. The book, *The Spirit Catches You and You Fall Down*, shares the story of how advanced healthcare systems did not meet the needs of a Hmong child. The child presented with a seizure disorder, and due to language barriers and a lack of understanding, the child did not receive effective treatment and the family employed traditional remedies and treatment strategies which physicians were unaware of (Fadiman, 1997). Spector (1996) lists questions to better understand a patient's cultural heritage and its effects on health perceptions. Some of these questions include:

- "How do you keep yourself healthy?"
- "Who do you seek for help with minor health problems? Major health problems?"
- "Who makes healthcare decisions in your family?"

Acknowledging the social structure and the role of family members in patients from diverse cultures can help us to understand their health care choices. Having an awareness of and acknowledging how family members can strongly influence the healthcare decisions one makes can help healthcare professionals to prevent conflicts (Zweber, 2002). For example, in some Hispanic families, the grandmother will be responsible for making health care decisions, whereas in some Southeast Asian cultures, the oldest male in the family makes these decisions (Ethnic Medicine Information from Harborview Medical Center, 2018). Keeping these treatment choices in mind can keep professionals aware of home remedies patients may be using and the potential for harmful interactions between home remedies and prescribed western medication (Lavizzo-Mourey and Mackenzie, 1996; Lawson and McCauley, 1996; Moffic & Kinzie, 1996). Pharmacists may be less concerned with traditional remedies which do not use food or herbs, but they need to be acknowledged nonetheless as this can improve the pharmacist's overall understanding of the patient's healthcare (Zweber, 2002).

Hence, communication and the language used to communicate with patients is the first step to bridging the gap between communication barriers (Payer, 1988). Patients are often left confused or feeling as though they do not understand what the doctor or pharmacist has told them as they may communicate in specialised language (Zweber, 2002). Miscommunication may lead to diagnostic error (Lavizzo-Mourey & Mackenzie, 1996; Lawson & McCauley, 1996; Moffic & Kinzie, 1996). Nonverbal communication accounts for 55-95% of message communication (Spector, 1996; Tindall, Beardsley & Kimberlin, 1994). Being aware of how individuals from a variety of diverse cultures engage in eye contact, and their boundaries for personal space, contributes to the effectiveness of the service delivered by the pharmacist without holding prejudgement towards the patient and accommodating the patient's cultural perspective (Zweber, 2002).

Wheeler et al. (2012) conducted a qualitative study with 9 health professionals (including psychiatrists, pharmacists and nurses) and 3 mental health consumers to explore the role of pharmacists in mental health. They found that western medicine was viewed as "too narrow" (p.186) in its approach. Participants expressed issues which need to be considered when developing a prescribing and treatment plan, including the influence of cultural factors (Wheeler et al, 2012). Further, participants identified that by developing treatment partnership with the consumer through a collaborative model in a multi-disciplinary team and directly with consumers would improve care. A participant from this study stated, ""It's mysterious – the medicines I take. I think I take too many medicines but [doctors] are hesitant, I'd like to talk to pharmacists about that... doctors just say, 'take this and you'll get better,' I want a pharmacist to tell me more about my medicines" (Wheeler et al. 2012, p. 12).

Holmes, Williams and Ford (2016) reported on using a collaborative approach to embedding cultural competency into a Bachelor of Pharmacy curriculum. This was conducted in Australia at the University of Tasmania. Their aim was to work collaboratively with other courses within the health capacity to design, imbed and deliver cultural competence programmes in the undergraduate Pharmacy curriculum, suiting discipline specific needs. Staff from Pharmacy, Nursing, Medicine and Students and Education developed the Global Perspective Programme (GPP) based on four elements of cultural competency. These include: "1 Awareness of one's own world- view, 2 Attitude towards cultural differences, 3 Knowledge of different cultural practices and worldviews, 4 Skills, including communication skills" (Holmes et al. 2016, p. 27). The key features of the GPP programme were: "suitable for all students, domestic and international; core module in the first year of the course; core module embedded and assessed within an existing unit; a continuum of learning activities throughout the course; all learning

and assessment activities constructively aligned to intended learning outcomes; ongoing program development and improvement informed by student and staff evaluation." (p. 27). The GPP was imbedded into the first year of the Bachelor of Pharmacy and seven other courses in the Faculty of Health. This approach highlights the benefit of collaborating with staff from other disciplines to facilitate the development of cultural competency skills in students. The GPP will remain a core module in the Bachelor of Pharmacy at the University of Tasmania (Holmes et al. 2016). As is with Nursing and Medicine and Surgery, there is research to support the development of cultural competency skills in Pharmacy trainees and qualified professionals, but the application of this appears to be varying and dissimilar across training courses and healthcare organisations.

1.6. Historical implications on the development of culture

We can understand the history of slavery and how it relates to present day notions of culture and its development, through thinking about the notion of systemic racism. Feagin and Barnett (2004) define this as "racialized exploitation and subordination of Americans of color by white Americans" that "en- compasses the racial stereotyping, prejudices, and emotions of whites, as well as the discriminatory practices and racialized institutions gen- erated for the long-term domination of African Americans and other people of color." (Feagin & Narnett, 2004, p. 1100). The authors also argue that recent presidential administrations have failed to develop educational policies that remove the burdens placed on many children by an ineffective, and still segregated, educational system.

For example, an educational curriculum which, when looking at history, focusses on slavery only, and not the other advancements which were made in Africa, in which young black people

are only exposed to their history through the history of slavery. This also includes environmental racism, in which non-white people are disproportionately exposed to pollution (Pulido, 2000), impacted by historical and present-day residential segregation (Massey and Denton, 1993). Hence, after people were "freed" from slavery, certain provisions remained in which they were still underprivileged and not provided with as much opportunity to succeed. All of these aspects will then directly impact BME service users regarding the development of their mental health, their ability to emotionally regulate, their awareness or access to services and their engagement with a white therapist. Considering the notion of pre-transference (Alleyne, 2011), in which anticipation of working with a BME client may negatively impact a therapist's transference in the session, further impacting the client's engagement or feelings of safety in the session based on their experiences with white people previously.

Indian and Chinese cultures have also been mentioned in this literature review. With reference to the histories of these cultures, we can consider how this impacts the proposed notion of culture and some of the difficulties Asian minority groups may experience. Sinha and Kumar (2004) wrote the paper: *Methodology for understanding Indian culture*, which includes three essays exploring the complexity of Indian culture. They state that most of the methods in their paper were developed in the west and acknowledge that the paper reflects the evolving perspectives on Indian culture, which vary from starkly ethnocentric (with or without adaptions to fit the Indian context) to integrative and eclectic. Hence, the perspectives of Indian culture from a literature perspective is informed from a mostly western point of view. It is acknowledged that Indian culture is a highly complex one, with indigenous perspectives still holding a primary position encompassing (Dumont, 1980) and enfolding (Schulberg, 1968) other cultural traditions (Sinha & Kumar, 2004). Sinha and Kumar (2004) provide an insightful summary on the complexity of the Indian culture, specifically, Indian people. They state that

Indians are collectivists, but they also have a well-protected "secret self" that contains highly individualistic thoughts, feelings and fantasies (Roland, 1988), whilst striving to serve self interest and achieve individual distinctions. They possess both an independent and inter-dependent self (Markus & Kitayama 1991), in which the independent self is focussed on fulfilling personal goals and the interdependent self is focussed on fulfilling the expectations of others. Further, the "other" is highly evident in the consciousness of the interdependent self, which can lead to the preoccupation of fulfilling the expectations of others (Higgins, 1987). Further, Indian people place a premium on context sensitivity and balancing disposition. Contrary to westerners, they have a "radar-like" sensitivity to the specifications of a situation and the long-range implications of their response to it (Sinha & Kanungo, 1997). Public places such as a job evoke different norms and values to private settings, such as with the family. Whilst I acknowledge this summary to be predominantly based upon the literature presented by Sinha and Kumar (2004), their implications for future research state the importance of a multi-method, integrative approach which integrates ethics and emic. This summary is a reductive perspective, focusing primarily on the people of India. Hence, I think we must consider the impact these perspectives may have from an intergenerational point of view, on present day first, second or third generation Indian people living in the west, and the conflicts between what they are taught at home or when they visit the land of their heritage, by parents and families, and what they are taught by western society.

With consideration to the history of Chinese culture and the literature on Chinese people, (Nathan, 1993) comparatively discussed the experience of Chinese and Indian people. Tu (1998) stated that identity has been more of problem for Chinese than for Indian intellectuals. Schwartz (1982) identified distinctive features of Chinese civilisation, including ancestor worship, a religious quality to Chinese familial life, the theme of universal kingship, the

familial model of the Chinese socio-political order, the unity of ruling and teaching, the "primacy" and "sacred" quality of the political order, the faith that good order had been realized in the past, and a sense of total order. Nathan (1993) acknowledged that Chinese persons' networks are twice as large as Americans and they are more likely to associate with people of the same age and educational level. In explaining these differences, the researchers referred to the importance of the work unit in Chinese society, which dictates that most Chinese people have constant, intimate, and important relations with colleagues at work.

Whilst the histories of these cultures are vast, broad and their traditions pre-date the fixations and practices present in the western world, some of the research presented is mostly from the United States, indicating a need for further research of minority ethnic groups in the U.K. from a psychological perspective, when considering the notion of culture. Asian people as a collective group may be viewed as a model minority by majority ethnic people in the United Kingdom or the United States. The model minority stereotype is the notion that Asian people achieve universal and unparalleled academic and occupational success (Museus & Kiang, 2009). Whilst this myth has been mentioned as one reason for the invisibility of Asian people in higher education research, the absence of empirical knowledge prohibits learning about this group and helps perpetuate that stereotype, thereby forming a vicious cycle that can maintain ignorance and distorted perceptions of the realities that this population faces (Museus & Kiang, 2009). This myth can be viewed as harmless or a positive preconception, but it has also been associated with negative ramifications. For example, Asian-American studies scholars have noted that the myth has been strategically used by opponents of equal opportunity policies and programs to support the notion of meritocracy with evidence that racial discrimination does not exist or impede the educational and occupational process of racial/ethnic minorities (Suzuki, 2002). The model minority myth can also be associated with negative individual

consequences, in which individuals experience pressure to conform to this stereotype (Lewis, Chesler & Forman, 2000) and that this pressure can constitute a stressor that functions to impede students' willingness and desire to engage in the learning process (Museus, 2008). Considering the current narrative which is held to oppress minority groups is useful in considering the origins of populations, and how the development and segregation of races can be used in obvious and not-so-obvious means to oppress. Hence, it is our responsibility as Counselling Psychologists to consider the impact of the daily microaggressions and outward oppression people may be experiencing in their day-to-day life, and how we can work alongside people who present with diversity, as opposed to working with their presenting difficulty alone. Whilst acknowledging that race and ethnicity are not synonymous with culture, these histories have been referenced as they have been used in the literature, and also provide an insight into the nuances that may be unknown, misrepresented or ignored when working with those who have a frame of reference dissimilar to that of a western therapist. These aid the understanding of the proposed notion of culture by allowing us to consider the heritages of cultures therapists frequently come into contact with and must work with. Whilst providing an acknowledgement of their characteristics and histories and understanding that the literature defining these groups does not necessarily come from these groups themselves. Hence, their representation may not always be a true description of their lived experiences, stories and traumas. Though psychologists may have an understanding of some of the characteristics associated with these cultures, having further acknowledgement of the traumas these societies have experienced and how this may have impacted their development e.g. colonialism, we can think about how we can further work with diverse groups to learn from their perspective, and help them to understand themselves to facilitate wellbeing, whilst recognising the struggles they and their ancestors may have experienced and how this now relates to the notion of their perceived identity and mental health difficulties. Thinking about

the fundamental need for services to provide service users with a model of care which effectively meets their needs, developing an inclusive therapeutic approach can be informed by the necessary skills training for clinicians to integrate and learn to continue to integrate a pluralistic framework to their clinical practice.

Whilst the literature does not adequately make sense of the research question because the definitions of culture in the literature are mostly synonymous with race and ethnicity, it provides us with descriptive understandings of cultural heritages and norms, therefore informing some of the experiences of the people associated with the cultures explored. In the context of culture, recent and dated research provides context in a useful and insightful way. The older the research, the more context it provides in the development in the notion of culture and how on some level, this may impact first, second or third generation immigrants in the U.K.

Whilst a range of theoretical models are considered, particularly because of the modalities taught in Counselling Psychology doctoral training, as well as an overview of literature from a biomedical perspective, the research literature needs to implement the proposed notion of culture in this research in further understanding how effective cultural competency teachings can be taught. This ought to include continuous reference to intersectionality and challenging the thinking of both trainers and trainees to hold a critical perspective on the psychological/psychometric tests used with service users from diverse backgrounds (e.g. first-generation asylum seekers). Whilst counselling psychology imbeds a variety of modalities in its teaching to equip practitioners to be effective integrative practitioners, it shies away from the responsibility of knowing how to integrate effective teaching on cultural competency skills.

We ought to step away from needing to use the term cultural competency and refer simply to competency. As ability to engage service users from diverse backgrounds is a core competency.

1.7. Course Curricula and Skills Training

Literature on cultural competency training on U.K Counselling Psychology doctoral programmes is sparse. Some literature, such as (Cutts, 2013) explores multi-cultural counselling in U.K, stating that we need to move beyond the discussion of multi-cultural literature, to consider the concept of social justice. Moller (2011) drew on American literature to state that multi-cultural counselling may be a way forward for counselling psychology in the U.K. Unfortunately, it has been difficult to find literature on the current provision of training in cultural competence on U.K Counselling Psychology doctorate programmes. Hence, the present study is being undertaken as there is not enough literature from sources within the U.K which relate directly to the research question.

Course curricula can be obtained from some university websites, explaining the details of what is taught in each module, but this is not necessarily expanded upon or detailed enough to critique without verbal information from lecturers or course directors informing researchers of the intention of their course. The literature presented in this review regarding counselling psychology cultural competency training, focusses on the core paradigms as these paradigms are taught across the counselling psychology doctoral courses. Hence, the purposes of referring specifically to psychodynamic, humanistic and cognitive behavioural approaches under the subheading of "Approaches to Working Cross Culturally: Core Paradigms" is because these paradigms are taught on the counselling psychology doctoral programme, and provide us with necessary and insightful information regarding the literature in working through culturally competent means through each of the approaches taught on the doctorate. These paradigms

have been brought together in this research, to take a step towards inclusivity and taking the current literature in the direction of expanding on course curricula and skills training on doctoral programmes.

The themes identified from the literature pertaining to the definitions of culture is complex and varied and indicates acknowledgement that the word culture itself is not synonymous to race or ethnicity, as is suggested in some of the psychological literature which considers working with diversity. Some of the themes in the literature include, focussing on the individual, as well as being aware of local and individual realities (Jacob & Kuruvilla, 2012) of the people we work with. This was also present in the nursing literature, which considers that nursing staff who have worked abroad showed increased self-awareness, confidence and attitudinal changes when working with cultures different from their own (Foronda, 2010). Having empathy for the client and managing assumptions appeared consistent across both psychological and biomedical literature and teachings, with emphasis on a client centred approach. Again, acknowledging diversity and considering intersections and variations within groups was also present across both psychological and medical literature, thinking about the client/patient experience and how our own perspective, from either a therapeutic or biomedical perspective could negatively impact the client, whether that be with unhelpful information or misdiagnosis of physical ailment, which is often this case with diverse populations continuing to receive poor quality care (Guzman, 2016). Literature across both also considers the development of knowledge in working cross culturally (Wilk, 2014), as it is considered theoretically necessary across the literature, but the application of this appears to be varying and dissimilar across training courses and healthcare organisations. There is research to support the development of cultural competency skills via collaboration amongst courses and/or perspectives in both psychological and biomedical literature. It seems taking these perspectives forward may be a

new approach in developing consistency on how we learn, teach and practice inclusively and increase accessibility to services for diverse populations. The literature from a psychological standpoint appears to focus on self-awareness and thinking of the position of the other, whilst providing models to effectively collaborate. The literature from medical training also provides models to consider effective approaches to working cross-culturally but also provides more specific, straight-forward methods, such as the specific sets of questions to ask patients, as is suggested by Spector (1996).

The term cultural competency is spread across the literature but the language itself may be problematic. Practicing cultural competency in theory sounds ideal, and places emphasis on reflective practice and engagement with diversity. The idea of using a specific strategy to engage with a diverse client indicates that one is working through culturally competent means. However, it is imperative to consider that applying theory to practice is not as simple as theory may suggest, and to be able to integrate effective cultural competency, one must be able to identify competency to include cultural competency and apply the core skills of a psychologist or medical professional when working with populations which differ from their own. If being culturally competent is different in practice from theory, it is fair to speculate why this language is used and how it can be utilised as a part of core competencies as opposed to being considered an added benefit. We do not know how the term differs from the perspective of professionals compared to the perspective of a service user. The pitfalls within this help us to acknowledge the term as an academic term in which psychologists know how to talk about this concept and "do" this concept and do so in a way which satisfies colleagues and maintains a status quo regarding the use of language in literature. It is an academic sounding concept, which may not necessarily translate into being genuinely competent.

With consideration to the current social and political environment, Cavalli (2019) wrote a paper exploring the increase of hate crime since Brexit (following the EU referendum). They obtained statistics via police recorded crime (available quarterly) and the Crime Survey for England and Wales (CSEW). They reported that Racially or religiously motivated hate crime in Britain increased by 111.8% between 2011 and 2018. Following the EU referendum in May 2016, racially or religiously aggravated offences were 41% higher in July 2016 than July 2015. Hence, the impact of using language such as "cultural competency" with service users may maintain a barrier in their ability to access and understand the therapist, creating further division, since the term is used primarily for academic training purposes and in psychological literature. Trainers and trainees may limit their ability to truly understand the experience of the service user if they rely solely on psychological teachings regarding cultural competency. Instead, including this knowledge with current understandings of the political and social climate ought to develop their practice and understanding to be truly client centred.

1.8. Social Desirability

Having explored healthcare professionals' trainings on cultural competency skills, let us move toward considering social desirability (SD) bias within healthcare trainees and professionals. Much of the research conducted on human behaviour is derived from self-report measures (Peterson & Kerin, 1981). Unfortunately, this information can be distorted due to human tendency to present oneself in the best possible light (Fisher, 1993). Respondents are usually unwilling or unable to report accurately on sensitive topics for ego-defensive or impression management reasons. This resulted in data which is biased toward what participants perceive as acceptable (Maccoby & Maccoby, 1954). This phenomenon is called social desirability bias (Fisher, 1993). Whilst some social desirability responding (SDR) is likely to occur in all self-

ratings (Crowne & Marlow, 1964), it is likely to have particular potency in self-assessments when learning counselling skills (Lawson & Winkelman, 2003). As a result of participants' automatic and controlled self-presentation (Paulus, 1984; 1988), limitations of self-knowledge and an inadequate understanding of their skills, SDR can be magnified when participants are evaluating themselves on skills critical to success, especially for those in training and for which lecturers and training manuals identify good and bad skills and behaviours (Lawson & Winkelman, 2003). Lawson and Winkelman (2003) conducted a study on 44 tertiary students in Australia from relevant courses exploring self-report listening skills and socially desirable responding (SDR). Their analysis suggested the presence of strong SDR effect, to which they concluded that high self-endorsement in listening skills can reflect SDR, a lack of self-awareness, possession of good skills or a combination of these factors. Participating in the study as future professionals in the counselling field, students may have set aside their own biases due to their serious intent to develop these skills, or social desirability and real unawareness of level of skills could have influenced the overall results. Another study which considered social desirability in counselling students was conducted on 204 entering master's level counselling students comparing wellness to psychological distress and social desirability (Smith, Robinson & Young, 2007). Their research found a negative relationship between psychological distress and social desirability. Hence, informing the overall wellness of the group. This group consisted primarily of Caucasian females of similar age, lacking diversity in gender and ethnicity, and generalisability, but it informs the impact of social desirability scores on psychological distress in this particular group. McBride and Hays (2012) completed a study exploring participants' training and clinical experiences related to the geriatric population and understanding their self-reported cultural competency skills and ageist attitudes. The study found a statistically significant negative correlation between their attitudes of the geriatric population and self-reported multicultural counselling competency. McBride and Hays (2012)

acknowledged that SDR may have had an impact on participants' responses, and they tried to reduce this by ensuring anonymity and confidentiality of data for participants of the research study.

From a medical perspective of SDR, Merrill, Laux, Lorimor, Thornby, & Vallbona (1995) measured social desirability among senior medical students regarding their attitudes towards geriatric or hypochondriac patients, finding that students found it acceptable to dislike the hypochondriac patient but not the elderly person. Though, this study did not account for older people who present as hypochondriac patients and the cultural perspective of social acceptance to dislike a particular group. Social desirability scores were inversely related to Machiavellian scores, indicating that students with a Machiavellian response pattern viewed their role as a physician in a less idealised way (Merrill et al, 1995). Further, Van de Mortel (2008) conducted a review to examine how widely SD scales are used in nursing and health-related questionnaire-based research to determine the impact of SDR on outcomes. The review found 14,275 studies which used questionnaire-based research, of which 31 used an SD scale. Of those 31, 43% found that SDR influenced the results and a further 10% controlled for SDR when analysing the data. 45% of these studies were not influenced by SDR. This data suggests that a proportion of papers influenced by SDR could present flawed conclusions.

With consideration of the research on SD and SDR, it seems social desirability informs distress and biases in patient work. Yet, consideration for social desirability is usually used in research to consider its impact in association with other variables instead of the impact of social desirability bias in healthcare professionals' practice and the impact this may have on assessing competency accurately. If healthcare professionals are afraid of being seen as unknowing of particular competencies, social desirability bias may lead to unwarranted theoretical or

practical conclusions about attitudes, intentions and behaviours. If professionals or trainees fear acknowledging a lack of skills, this may lead to a diagnostic "trial and error" approach, which can be dangerous for patients and clients if healthcare professionals are unable to deliver a competent service.

1.9. Present Study

This study conducts a mixed-methods approach, in which 6 of the 13 Counselling Psychology course directors in the United Kingdom were interviewed and asked to consider how and if their training course is facilitating cultural competency skills in their trainees. Further, the quantitative element of this study gave questionnaires to final year trainees or recently qualified: counselling psychologists, nurses, and medicine and surgery professionals and pharmacists, to measure the cultural competencies of these healthcare professional groups. Further, the aim of this research is to reassert the notion of the word culture, being inclusive of more than one's race, religion and ethnicity, but to also consider Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Pansexual, Two-Spirit (LGBTQ+), sex, age, mental and physical ability. Through establishing a broad definition of culture, the researcher aims to explore how the main paradigms in counselling psychology facilitate a therapist's ability to work cross-culturally and how this process is, or could be further facilitated through a pluralistic approach, through the training of counselling psychologists and fellow biomedical healthcare professionals (Nursing, Medicine and Surgery and Pharmacy).

In consideration of the literature review, we can see that whilst there is literature supporting the use and integration of cultural competency skills in trainees and health care professionals, there appear to be gaps in the literature regarding consistency and advocacy. Wilk (2014)

suggests that training in doctorate and master's programmes could integrate intercultural training in western nations. Since the early 1970's literature and graduate programmes have been addressing the need to develop multicultural awareness, knowledge and skills. With Wilk (2014) still suggesting the development of education and training for counsellors and counselling psychologists, it seems an overdue but necessary step for counselling psychology's development as a profession in the UK. Beach et al (2005) have concluded that cultural competence training is a promising strategy for improving the knowledge, attitudes and skills of health professionals. Hence, the research question for the qualitative element of the study is: Are counselling psychology training courses developing multicultural competencies in their trainees?

The hypothesis for this research has been emanated from the literature, with considerable consideration of the core values and competencies of counselling psychology based upon reflective practice, research and working within the client's frame of reference. The research hypothesis for the Quantitative element of the study are:

1. The counselling psychology group will have a significantly higher level of cultural competency compared to biomedical group.
2. Counselling psychology group will have lower levels of social desirability than the biomedical group.

It has been hypothesised that the counselling psychology group will demonstrate higher cultural competency and lower social desirability than the biomedical group. This hypothesis is based on the literature review whereby the core competencies and values counselling psychologists are trained in make this group more likely to reflect critically on culture and to have self-awareness of social desirability.

The counselling psychology group consists of trainee and recently qualified (in the last 2 years) counselling psychologists and the biomedical group consists of trainees and recently qualified (in the last 2 years) biomedical professionals. Specifically, the quantitative element is focussing on the current level of cultural competency skills of trainee and recently qualified counselling psychologists, nurses, medicine and surgery and pharmacy professionals. In order to measure cultural competency skills, the participants will be given The Healthcare Provider Cultural Competence Instrument (HPCCI) (Schwarz, Witte, Sellers, Luzadis, Weiner, Domingo-Snyder, Page, 2015). Using this instrument will identify the cultural competencies of trainees from different disciplines, working or intending to work in their field. Considering current trainee cultural competency will allow us to consider the need to develop this further in healthcare courses and for those currently working in healthcare services. Approval to use the HPCCI has been given by Schwarz et al. via email. The Lie Scale (Eysenck, 1976) will be used to measure social desirability, as cultural competency is desirable for healthcare professionals. The Lie Scale will determine participant's honesty compared to their answers on the HPCCI. Then the scores between healthcare professionals will be compared to determine the cultural competency levels between professionals. This will determine whether healthcare professionals are working at similar levels of cultural competency and whether their current cultural competency skills need to be improved. Conducting the qualitative study prior to the quantitative study will give an awareness of the potential results in the cultural competency skills in trainee and recently qualified counselling psychologists. This will provide context for the quantitative research hypothesis and the questions in the HPCCI (Schwarz et al., 2015) and Lie Scale (Eysenck, 1976), but will not significantly influence the results of the quantitative phase of the research.

Chapter 2: Methodology

This chapter aims to explore the methodology adopted in this research. This study was conducted in two phases. Phase one is the qualitative phase, which is designed to provide perspective in understanding if cultural competency skills are being developed in trainees, how they are being developed and understanding the individual perspectives and experiences of counselling psychology course directors regarding cultural competency skills. Phase two is the quantitative phase, which aims to further explore evidence of current levels of cultural competency skills in healthcare and counselling psychology trainees/recently qualified professionals. By using mixed-methods, the qualitative phase was used to understand if and how cultural competency training is delivered and the quantitative phase to consider the effectiveness of this and directly inform the hypothesis for the quantitative study. This chapter will explore the evidence base of the methodologies used, consider their epistemological philosophical underpinnings, and provide rationale for the approaches and analyses used.

2.1. Quantitative and Qualitative Approaches

The term "methodology" refers to the procedures and processes involved in research. It explains my chosen method and how this is linked to the research hypothesis and questions (Ponterotto, 2005). The present study used mixed-methods methodology (mixed research is also a synonym; Johnson & Onwuegbuzie, 2007). The mixed research approach in this study includes qualitative and quantitative methodologies. Qualitative research covers a broad range of research methods including interviews, observation and textual analysis (Silverman, 2011). The data obtained from qualitative research is of words, rather than numbers and provides well-grounded, rich descriptions and explanations of processes from its participants (Miles & Huberman, 1994). Hence, with qualitative data, the researcher can see which events lead to which consequences and derive fruitful explanations (Miles & Huberman, 1994).

Quantitative research refers to methods which analyse numeric representations of the world through the use of instruments such as survey and questionnaire data, as well as biological and physiological data (Yoshikawa, Weisner, Kalil, & Way, 2008). Michell (1997) argues that quantitative science requires two stages which are *scientific* and *instrumental*. 1) The scientific stage – showing that the attribute being measured can be quantified and; 2) the instrumental stage – constructing instruments for numerically assessing significances. By establishing these two stages to conduct quantitative research, Michell (1997) explains the scientific step as investigating the hypothesis to ensure that it is attributable to quantitative research. Second, the instrumental task involves devising procedures to measure magnitudes of the attributes shown to be quantitative. Failure to conduct these two stages is considered "at best speculation and, at worst, a pretence at science" (p. 359, 1997).

2.2. Mixed methods: Epistemological and Ontological Differences

Johnson and Onwuegbuzie (2007) acknowledge that quantitative and qualitative researchers originally held opposing schools of thought regarding the intent and approach of psychological research. Quantitative purists' articulate assumptions that are consistent with positivist philosophy, believing that social observations should be treated in the same way that physical scientists treat physical phenomena (Johnson & Onwuegbuzie, 2007). They think that the observer ought to be separate from the subject(s) of observation, believing that social science inquiry should be objective (Johnson & Onwuegbuzie, 2007). Further, it is desirable for quantitative research to produce time- and context-free generalisations (Nagel, 1986). This purist perspective assumes that the researcher should eliminate biases, hold an emotionally detached and uninvolved relationship with the subjects of the study to test their stated hypothesis (Johnson & Onwuegbuzie, 2007).

Qualitative purists (also known as constructivists and interpretivists) reject positivism and proclaim constructivism, idealism, relativism, humanism, hermeneutics and postmodernism to be superior (Guba & Lincoln, 1989; Lincoln & Guba, 2000; Smith, 1983; 1984). Qualitative purists (e.g. Guba, 1990) assert that time and context-free generalisations are not possible, nor desirable, believing that multiple-constructed realities coexist (Johnson & Onwuegbuzie, 2007). Thus, it is difficult to fully differentiate cause and effect, as explanations are derived from what the qualitative data infers, as the knower and known cannot be separated because the subjective knower is the only source of their reality (Guba, 1990). With the constructionist perspective, meanings and experiences are socially constructed rather than inhering within individuals (Burr, 1995). This research attempts to theorise the socio-cultural contexts and structural conditions in which individual accounts are provided (Braun & Clarke, 2006). This clash between the two schools suggests that quantitative and qualitative methods should not be mixed.

A third research paradigm of Mixed Methods acknowledges that both quantitative and qualitative research are important and useful. It draws from the strengths of both paradigms individually to minimize the weaknesses of both in a single research format (Johnson & Onwuegbuzie, 2007). The idea of combining the strengths of both qualitative and quantitative methods was introduced by Cook and Reichardt (1979). The definition of mixed methods involves the integration of both research styles and their philosophical assumptions through intentional collection and analysis of data (Guetterman, 2017). The value of this approach is supported by research evidence. An empirical study was conducted with post-graduate students which found that mixed methods are perceived to be more rigorous, current and generate a deeper meaning for the research topic (McKim, 2017) compared to single research formats.

Five rationales for conducting mixed methods include (Greene, Caracelli & Graham, 1989): 1) complementarity – elaborating or enhancing the results of one method with results from the other; 2) initiation – seeking to understand contradiction or inconsistent results between the methods; 3) triangulation – seeking convergence or corroboration with different methods; 4) expansion – extending the breadth and scope of inquiry through different methods; and 5) development – using the results of one method to develop or inform the other (Greene et al., 1989). Mixed methods were utilised for the purposes of triangulation and expansion. By mixing methods, the research will provide the opportunity to gain a more complete understanding of research problems (Ivankova, Creswell & Plano Clark, 2007) and capture the complexity behind the development of cultural competency skills in training courses from the perspectives of those who represent the course (course directors) and the trainees who receive the course. These rationales were further evolved by Collins, Onwuegbuzie, and Sutton (2006), stating four reasons for using mixed methods: 1) participant enrichment – recruiting participants and for ensuring good sampling; 2) instrument fidelity – to develop instruments or to investigate their effectiveness; 3) treatment integrity – understanding treatment or programme fidelity issues and; 4) significance enhancement – supporting interpretation of findings. Considering these reasons and further enhancing my perspective with the rationale's provided by Collins, Onwuegbuzie and Sutton (2006), this research also aims to use the mixed methods approach for treatment integrity and significance enhancement. Treatment fidelity gives this research the opportunity to consider the fidelity of university courses in their development of cultural competency skills in trainees, as well as trainees' level of cultural competency skills. Significance enhancement allows the researcher to support the interpretations of findings by measuring cultural competency skills in the counselling psychology group and consider, in comparison, if and how course directors perceive their course as developing these skills in their trainees. By measuring the cultural competency skills of trainees and newly qualified

professionals from other healthcare disciplines, to consider the general cultural competency trainings of healthcare training courses.

2.3. Post-Positivist Research

Holding a post-positivist position has led to utilising a mixed-methods approach in this research. As explained by Johnson and Onwuegbuzie (2004), post-positivism holds the view that 1) the relativity of reason can vary across persons, 2) observation is not the perfect window into one's reality 3) it is possible for one theory to fit a single set of empirical data 4) the Duhem-Quine thesis; a hypothesis cannot be fully tested in isolation as various assumptions must be made to test the hypothesis and alternative explanations will continue to exist 5) acknowledging that as psychological researchers we only obtain probabilistic evidence and future research may not resemble our present findings 6) the social nature of research enterprise, acknowledging that researchers exists within their own communities which impact their beliefs, values and attitudes and 7) the value-ladenness of inquiry, which acknowledges that human beings can never be completely free of our values, which impact what we choose to research, what we see and how we interpret what we see.

2.4. Integration and Rational for adopted method

Integration can be understood as the combination of qualitative and quantitative methods within a given stage of inquiry (Creswell, Plano Clark, Gutmann & Hanson, 2003). It may emerge through the research questions, within data collection, data analysis or interpretation (Creswell, Plano Clark, Gutmann & Hanson, 2003). During these phases, it is possible to implement components of both qualitative and quantitative research (Creswell, Plano Clark,

Gutmann & Hanson, 2003). Within the present study, integration emerged through the research questions, data collection, analysis and interpretation. The research question for the qualitative data provided the study with a focus and intention, from which the quantitative phase would follow. The data collection of the qualitative data provided access to participants from the qualitative phase, to help recruit participants in the quantitative phase. The analysis helped to identify the answers to the qualitative research question and provide perspective for the quantitative phase. The integration in this research involves merging. The term merging refers to the integration of the quantitative and qualitative results together for analysis and comparison (Guetterman, 2017). Merging was used to acquire a complete understanding about the topic than the quantitative or the qualitative results alone would produce. Analysis of the data from the qualitative phase gave scope in understanding if cultural competency skills are being developed in trainees, how they are being developed and understanding the individual perspectives and experiences of counselling psychology course directors regarding cultural competency skills. The quantitative phase provided evidence of current levels of cultural competency skills in healthcare and counselling psychology trainees. By using mixed methods, the qualitative phase was utilised to understand if and how cultural competency training is delivered and the quantitative phase to consider the effectiveness of this.

2.5. Phase 1: Qualitative Study

2.5.1. Rationale for using Semi-Structured Interviews

"Phenomenology is the study of the structure, and the variations of structure, of the consciousness to which any thing, event or person appears" (Giorgi, 1975, p. 83). Specifically, phenomenology refers to an interest in understanding social phenomena from ones' own

perspective, through describing the world as it is experienced by participants, with the assumption that reality is what people perceive it to be (Brinkmann & Kvale, 2015).

An interview is an inter-change of perspectives between two people conversing about a theme of mutual interest (Brinkmann & Kvale, 2015). A semi-structured interview is guided by the schedule and interests of the researcher. This type of interview encourages the participant and researcher to establish rapport. The ordering of questions is lesser the priority, which gave the opportunity to probe interesting areas that arise; following the respondent's interests or concerns (Smith, 2003). Brinkmann and Kvale (2015) categorize the semi-structured qualitative interview into twelve aspects from a phenomenological standpoint. These include Life World, Meaning, Qualitative, Descriptive, Specificity, Deliberate Naiveté, Focus, Ambiguity, Change, Sensitivity, Interpersonal Situation and Positive Experience. The semi-structured qualitative interview for this research holds the phenomenological standpoint of Focus and Change. With Focus, the interviewer is focused on particular themes, but works neither in a directive or non-directly fashion (i.e. a semi-structured interview). Open questions focus on the topic of research, without the interviewer providing specific opinions about the themes in their research. Hence, it is up to the interviewer to bring forth the dimensions they consider important in the themes of the question. The description of Change is:

"In the course of an interview, subjects can change their descriptions of, and attitude toward, a theme. Subjects may themselves discover new aspects of the themes they are describing and suddenly see relations they had not been aware of earlier. The questioning can thus instigate processes of reflection where the meanings of themes described by subjects are no longer the same after the interview. An interview may be a learning process for the interviewee, as well as for the interviewer." (p. 34).

In using this description of Change, the participant can be encouraged to not only consider how their course contributes to the development of cultural competency skills in trainees, but also their own views and experiences on cultural competency, with the intention to broaden their own perspective on this subject matter whilst considering if and how their doctoral course facilitates this level of thinking and training within its trainees.

Through acknowledging and understanding the participant's area of expertise, semi-structured interview can be used to facilitate their process in answering the questions by giving them the autonomy to include any information which may have informed and developed their experience in how their course includes the development of cultural competency skills.

2.5.2. Rationale for using Thematic Analysis

Thematic analysis is a process to be used with qualitative information which allows for the translation and analysis of qualitative information (Boyatzis, 1998). Considering the developmental history of thematic analysis, it was inconsistently used during the 1970s (Clarke & Braun, 2014), but good specification and guidelines were developed and explained by Boyatzis (1998). The approach has been widely recognised since the publication of Braun and Clarke's paper: *Using thematic analysis in psychology* (2006). Boyatzis (1998) acknowledged that thematic analysis allows a researcher with a qualitative method to translate their observations by providing access to discoveries and insights which have been generated through communicative methods, of which the ideas and results have been disseminated. Acknowledging this evidence base, it is evident that using an interview to translate my observations through thematic analysis would be helpful. It is a robust, systematic framework for coding qualitative data (Clarke & Braun, 2014), and then that coding was used to identify

patterns across the data in relation to the research question. This is a recursive process, established through the recognition of recurring themes through the qualitative data (Braun & Clarke, 2006). Meanings are thematised (Holloway & Galvin, 2016) and then encoded (Boyatzis, 1998). It is required that thematic analysis is deliberate, reflective and thorough (Clarke & Braun, 2014), which provided the opportunity to present psychological qualitative research in a robust and sophisticated format, by focussing and presenting it in a way which is readily available to those who are not a part of academic communities (Clarke & Braun, 2014). The aim of this research is to relate to fellow academics and students in consideration and analysis of the development of cultural competency skills in counselling psychology doctoral courses and healthcare trainings.

This research refers primarily to the work of Braun & Clarke (2006; 2014) in providing the rationale for using thematic analysis, as they advocate and provide evidence for the effective procedure, expectations and outcomes of strong thematic analysis.

2.5.3. Limitations of Thematic Analysis

Braun & Clarke (2006) acknowledge that many of the limitations of thematic analysis depend more so on the researcher than they do the method itself. The limitations will then be considered in their 2006 paper when considering the limitations for this work. Poorly conducted analyses or an inappropriate research question can lead to poor research (Braun & Clarke, 2006). Further, whilst the flexibility of thematic analysis is one of its advantages, it can also be a disadvantage, as the approach may be potentially paralysing when deciding which aspects of the data to focus on. Also, if the method is not used in conjunction with another theoretical framework which anchors the claims made by the research, the research itself may be limited to mere description (Braun & Clarke, 2006). Braun and Clarke (2006) state that

simple thematic analysis does not allow the researcher to make claims regarding language use or the functionality of talk.

2.5.4. Consideration of other Methodologies

Other methods of analysis could have been suitable for this research. Narrative Analysis (NA) was a method considered, as it is concerned with stories that are told over time and how the stories are constructed, organised and presented, with consideration to societal discourse (Riessman, 2008). Whilst this analysis may have been useful in considering how participants understood their experiences over time, thematic analysis would give more understanding of the themes across interviews and how these themes form understanding for the development of cultural competency skills which is more in line with the research question, as opposed to the lived experiences of course directors.

Interpretive Phenomenological Analysis (IPA) was also considered for analysis of the data. The emphasis of IPA is to learn from the participants (Reid, Flowers & Larkin, 2005) and is concerned with a detailed examination of the participants lived experience, and how they make sense of this experience (Smith, 2011). Whilst this may provide a richer analysis of data compared to NA, this again focusses more so on the lived experiences of the participant (Reid, Flowers & Larkin, 2005), as opposed to thematic analysis in which the focus and emphasis is placed primarily upon the themes and patterns found across the dataset, which endeavours to tell an interpretative story (Braun & Clarke, 2006). It would distract from the themes which would provide an overall understanding of the development of cultural competency skills in counselling psychology doctoral courses. Whilst the lived experience of the participant is essential to consider, making this the focal point of the research would distract from its overall intention. As stated, 'IPA is hearing the voices of participants from across the sociocultural

spectrum' (Reid, Flowers & Larkin, p. 21, 2005). Had the participants of the qualitative research been the healthcare trainees, this mode of analysis may be deemed more appropriate than thematic analysis, as the emphasis would be on their lived experience of the course in reference to the development of their skillset.

2.5.5. Sample size and Sampling methods

There are 13 BPS accredited Counselling Psychology doctoral courses in the United Kingdom. Each course director was asked to participate directly via email, with information regarding the study. The participants required for the qualitative research are extremely specific, hence selective sampling was used to recruit participants. Selective sampling involves the researcher selecting participants according to the aims of the research (Coyne, 1997). Categories such as status, role or function in organisation serve as starting points (Coyne, 1997). The term selective sampling is similar to the term purposeful sampling, in which the researcher refers to information-rich participants from which the researcher can learn a great deal about the issues central to the research (Patton, 1990). Hence, selective sampling may also be understood as purposeful sampling (Coyne, 1997).

A maximum of 6 participants were decided upon for the qualitative phase with consideration of research suggestions. Research has suggested that doctoral research ought to contain 4 – 10 interviews, though the number of interviews is not indicative of depth and quality (Smith, Flowers & Larkin, 2009). Data saturation had been reached upon the completion and analysis of 6 interviews, hence no further interviews were required. It was evident that data saturation had occurred, as no new themes emerged from the process of analysis.

2.5.6. Participants

A total of 6 participants were recruited for interviews. This included 4 females and two males. 3 of the participants were from non-British backgrounds. All participants are Caucasian. Due to the small population size from which this participant group was obtained, in order to maintain participant anonymity, further details cannot be provided.

2.5.7. Materials

The materials for the qualitative element of the study included:

- An Information sheet (Appendix 1) – explaining the purpose of study, what participation in the study would include and the confidentiality of participant information and the participant's anonymity.
- Consent form (Appendix 2) – devised to ensure participants understood the meaning of their participation in the study.
- Letter (Appendix 3) – further informing participants of what their contribution to the study would mean and further explaining what they can expect from the study.
- Debrief Sheet (Appendix 4) – which provided the participant with a summary of how their participation has contributed to the study.
- 11 semi-structured interview questions were developed by the researcher and approved by the research supervisors (Appendix 5). The following sample demonstrates the questions asked during the interview: "Do you mind telling me the fundamental philosophy of this course?", "What should cultural competency training include?", "What is your opinion on Counselling Psychology doctoral trainees developing cultural competency skills?" The semi-structured approach was utilised by encouraging participants to develop and expand upon the points made during the

interview. Prompts usually included asking the participant to elaborate on their answer or asking them to elaborate on aspects of their responses which evoked curiosity, as contributing to and providing further perspective on the question asked and the overall research.

- The interview schedule was designed in collaboration with the thesis supervisor, with consideration of the philosophical position of the course, the course directors' experiences and hence, their opinions on trainees and training specific to cultural competency. This was considered as a useful schedule to further the information and insight gained from the literature review.
- Rigour checks were made by discussing interview questions with doctoral colleagues and teaching staff on the professional doctorate, to test coherence, comprehensibility and suitability of questions.
- A pilot study was not completed due to time limitations for the completion of the doctorate and the deadlines provided by the university for the completion of the thesis.

2.5.8. Procedure

The information sheet, Consent form and letter were attached to the initial email inviting the course director to participate. If potential participants responded with interest to participate, they were asked to send a completed consent form via email prior to the interview. An interview date and time was decided via email communication and this informed the interview schedule. Participants were given the option to engage face-to-face, via skype or telephone. All participants arranged to engage via skype. Once the time was agreed, a video call was made to the participant on the agreed date and time. After they answered the call, the researcher introduced themselves and confirmed the participants consent to engage in the interview, again confirming that the interview will be audio recorded with a Dictaphone. The number of

questions they will be asked was stated and the information in the information sheet was reiterated. Upon receiving verbal consent to continue with interview, participants were made aware when recording was about to begin. After clicking record, the semi-structured interview. Upon completion of the interview, the Dictaphone was stopped and participants were given the opportunity to ask any questions and sent the debrief sheet via skype. Interviews lasted between 20 minutes and 12 seconds and 1 hour and 4 minutes.

Interviews were then transcribed on Microsoft word. The interviews were listened to on a computer with headphones, and then stopped and started whilst data was typed. Interviews and recordings were kept in an encrypted, password protected file. No particular transcription notation was used when completing transcriptions. As is stated by Braun and Clarke (2006), "*As there is no one way to conduct thematic analysis, there is no one set of guidelines to follow when producing a transcript*" (p. 17). Although, they do state that the transcript is required to be a rigorous and thorough 'orthographic' transcript – a verbatim account of all verbal and non-verbal (e.g. coughs) utterances. This was ensured when transcripts were typed. Please see the Audit Trail in appendix 12 for details regarding the step-by-step analysis for this research.

2.5.9. Process of Analysis

As explained by Sutton and Austin (2015),

"*Coding refers to the identification of topics, issues, similarities, and differences that are revealed through the participants' narratives and interpreted by the researcher. This process enables the researcher to begin to understand the world from each participant's perspective.*" (p. 228).

To develop the themes, the coding process was used. During the coding process, each interview was read through and then each segment coded using NVivo. This is an electronic system, in which interviews can be imported and analysed. Any codes devised from previous interviews are remembered and remain in a list, to refer to, if these codes arise again. As interviews were read through and similar, the same or new codes were found in each interview, the process of devising themes from the codes had begun. Codes were organised onto an Excel document and 5 themes were developed. Each corresponding code was then placed under each theme and the suitability of each code to each corresponding theme was considered. Themes were renamed until the relationship between the codes within each theme and the relationship between each theme appeared accurately to the data obtained from the interviews. From this process, each theme was defined and labelled.

2.6. Phase 2: Quantitative Study

2.6.1. Rationale for using survey questionnaires

Quantitative research consists primarily of two distinct methodological research approaches; experimental and survey (Davis, 2007). Using survey research is a valuable method for gathering "information about the incidence and distribution of, and the relationships that exist between, variables in a pre-determined population" (Coughlan, Cronin & Ryan, 2009, p. 9). Self-administered questionnaires allow the researcher to survey large numbers of people from widespread geographical locations and sample them cost effectively (Polit & Beck, 2008). With acknowledgement of the evidence base supporting the use of surveys, surveys were considered the most efficient and practical method to collect data on levels of cultural competency skills. Using the internet to gather data online is becoming a more popular method

of choice (Granello & Wheaton, 2004) than collecting data in person. This may include collecting data via email or the world wide web (Stewart, 2003). The survey was also replicated online via the website qualtrics.com with the intention of attaining a larger sample size, producing generalizable results. The simplest method of using computers in survey research is by sending questionnaires via email or the email itself can be used to direct the potential respondent to a website from which the questionnaire can be accessed (Porter, 2004). This method provides cost effective access to a large sample and ease of data management (Granello & Wheaton, 2004; Umbach, 2004). Another advantage of collecting data online is faster turnaround time (Umbach, 2004). As is with this research, both paper and online formats of the surveys are used, giving the opportunity to reach larger samples of potential participants through face-to-face encounters as well as online. Whichever survey is used, they all share common steps and limitations (Coughlan, Cronin & Ryan, 2009). Upon formulating a research question which may include survey materials, one must identify the research problem and then attempt to determine which factors influence the construct under investigation (Hallberg, 2008). As is with this research, cultural competency skills are the primary construct under investigation in this research, whilst considering social desirability. However, Hinkin (1998) states that the difficulty in conducting research in organisations, such as universities, is assuring the accuracy of measurement of the constructs under examination (Barrett, 1972). A construct is representation of something which does not exist as an observable behaviour (Hinkin, 1998). Hence, the more abstract the construct, the more difficult it is to measure (Nunnally, 1976). As a result of this, it is crucial that the instruments used in the research adequately represent the constructs under examination. The surveys mentioned for this research include the “Lie Scale” (Eysenck & Eysenck, 1976) and the HPCCI (Schwarz et al, 2015). The HPCCI (Schwarz et al., 2015) was used to measure cultural competency skills and uses Likert type scales, which are the most frequently used in survey research (Cook, Hepsworth & Warr, 1981) and are

considered the most useful when researching behaviour (Kerlinger, 1986) and factor analysis (Hinkin, 1998). Further research has suggested coefficient alpha reliability with 5 point Likert scales (Lissits & Green, 1975). As this research is measuring the frequency of behaviour (the ability to apply cultural competency skills), it is important to accurately scale the response range to maximize the obtained variance on a measure (Harrison & McLaughlin, 1991). As is with the HPCCI (Schwarz et al., 2015) the inventory uses a minimum of 5 point and a maximum of 7-point Likert scales. The "Lie Scale" (Eysenck & Eysenck, 1976) measures social desirability as a tool to consider how one's desire to be socially desirable may directly impact upon their truthfulness when answering the HPCCI (Schwarz et al., 2015), as cultural competency skills are desirable for healthcare professionals. This scale consists of simple, "Yes" or "No" responses. Please see "Materials" section below for more information on each tool.

2.6.2. Sample size and Sampling methods

Previous research indicates that poor sample selection may lead to findings which are not generalizable (Coughlan, Cronin & Ryan, 2009). The sample size for the study was determined via the use of G*Power. The total sample size recommended by the programme was 158 participants in total. To recruit participants for the quantitative element of the study, course directors for training courses which fit into the inclusion criteria were emailed directly, to ask if they would be willing to circulate a link to the survey online via email to their cohort or have the researcher come to the university to distribute the survey prior to or immediately after a lecture.

Sampling using multiple probability techniques (Teddlie & Yu, 2007) were used in this research. Hence, cluster sampling was used, which occurs when the sampling unit is a group and not an individual (university courses), and the units of interest (the trainees) are selected and given the opportunity to partake. This also applied for the recently qualified professionals, by connecting with them via professional organisational groups; through websites; and social media.

2.6.3. Inclusion criteria

The inclusion criteria for participants to participate in the quantitative element of the study were as followed:

- Final year trainee on a health care professional training course
- Final year trainee still focussing on the research elements of their course but is no longer attending the university for lectures or further training
- Graduated within the past two years from a health care professional training course
- The courses identified included: Counselling Psychology Professional Doctorate, Nursing (Hons and Masters), Medicine and Surgery MBChB and Pharmacy (MPharm).
- These programmes were selected as the trainees on these courses proceed to work in real-life work settings where their clients or patients come from multicultural backgrounds. Hence, these groups were the most appropriate to provide information about cultural competency skills in healthcare training courses. This is measured directly through their level of cultural competency skills.

2.6.4. Participants

A total of 60 participants were recruited for the quantitative phase. 48 participants were female, 10 were male and 2 chose not to disclose or did not identify as such. Ages ranged between 24 – 55. 36 participants consisted of the counselling psychology group and 24 from the biomedical group.

2.6.5. Materials

The materials for the quantitative phase include:

- Information sheet (Appendix 6)
- Consent form (Appendix 7)
- Demographic information sheet (Appendix 8)
- Two self-report surveys; The Lie Scale (Eysenck & Eysenck, 1976) (Appendix 9) and the Healthcare Provider Cultural Competence Instrument (HPCCI) (Schwarz, Witte, Sellers, Luzadis, Weiner, Domingo-Snyder, Page, 2015) (Appendix 10).
- Debrief Sheet (Appendix 11)
- An online version of the survey included all of the above materials. The online version was created and distributed via qualtrics.com (a website to design and distribute questionnaire's and surveys).

The information sheet provided participants with an explanation of the purpose of the study, why they have been recruited, the confidentiality of their data and that they and the university from which they are participating will be anonymised. The consent form ensured that participants understood what was expected of them through their participation of the study. The Lie Scale (Eysenck & Eysenck, 1976) and the HPCCI (Schwarz, 2015) have been used in

conjunction with one another. The Lie Scale (Eysenck & Eysenck, 1976) may be used to eliminate subjects showing a desirability response set (Williams, 1969). For the purposes of this study, it was used to consider the truthfulness of participants, in how truthfully their responses to the Lie scale (Eysenck & Eysenck, 1976) may be reflected in their responses to the HPCCI (Schwarz, et al., 2015), as cultural competency may be viewed as a desirable trait for healthcare professionals in training. Questions in the Lie Scale (Eysenck & Eysenck, 1976) are answered with "Yes" or "No" responses. A sample of some of the questions in the Lie Scale (Eysenck & Eysenck, 1976) include: "Are all your habits good and desirable ones?", "Have you ever said anything bad or nasty about anyone?", "Have you ever been late for an appointment or work?".

The HPCCI (Schwarz et al., 2015) was used to measure cultural competency in trainees. Consent to use the questionnaire was obtained via email by Joshua Schwarz. The HPCCI (Schwarz et al., 2015) consists of 5 sub-scales which measure 1. Awareness and Sensitivity; 2. Behaviour; 3. Patient-Centered Communication; 4. Practice Orientation and; 5. Self-Assessment. Each question is answered on a Likert scale. Scales 1 and 2 use a 7-point Likert scale. Scales 3, 4 and 5 use a 5-point Likert scale. "Strongly Disagree" is represented by the lowest number in the Likert scale and "Strongly Agree" by the highest number on the scale, on Subscales 1, 4 and 5. Scale 2 uses the phrases "Never" for the lowest number on the scale and "Always" for the highest. Scale 3 uses "Never" on the lowest number on the scale and "Very Often" for the highest. To provide clarity on the Likert scale for each subscale and a sample of the questions in the HPCCI (Schwarz et al., 2015), see below a sample of one question from each subscale (in order of presentation in the inventory):

Scale 1: Awareness and Sensitivity

1. Race is the most important factor in determining a person's culture

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

Scale 2: Behavior

12. I include cultural assessment when I do client or family evaluations

Never 1 2 3 4 5 6 7 Always

Scale 3: Patient-Centered Communication

2. When there are a variety of treatment options, how often do you give the client and their family a choice when making a decision?

Never 1 2 3 4 5 Very Often

Scale 4: Practice Orientation

13. The health care provider is the one who should decide what gets talked about during a visit

Strongly Disagree 1 2 3 4 5 Strongly Agree

Scale 5: Self-Assessment

40. As a health care provider, I understand how to lower communication barriers with clients and their families

Strongly Disagree 1 2 3 4 5 Strongly Agree

Question 8 of scale 1 was modified from: "Language barriers are the only difficulties for recent immigrants to the United States" to "Language barriers are the only difficulties for recent

immigrants to the United Kingdom”. This change reflects that data is being collected from university courses based in the United Kingdom.

2.6.6. Procedure

Course directors were contacted from the mentioned courses directly via email to ask them to share the study with their final year cohort. In the initial email the course directors were emailed the materials of the study and sent a link to the online version of the surveys. They were made aware that their university will remain anonymous and participant names are only required to evidence their consent to participate in the study. If the director accepted the research as acceptable for their students to participate in, they chose to send an email to the appropriate cohort to ask them to participate in the study online, posted it onto the cohort’s university website or invite me into the beginning or end of a lecture to conduct the study. All universities and courses which participated in the study, distributed the survey online. All surveys were completed online, no physical copies of the survey were completed. A total of 8 courses disseminated the survey to their students.

2.7. Ethical Approval

Prior to the submission of ethical approval, it was imperative to ensure that the research demonstrated ethical suitability. As acknowledged by Coughlan, Cronin and Ryan (2009), researchers have an obligation to maintain the ethical rights of the participants in the study, primarily considering informed consent and confidentiality. Ethical approval was obtained from the university ethics panel.

The book *"Designing and Conducting Research in Education"* states that ethical issues include consent, harm, privacy and deception (Drew, Hardman & Hosp, 2007). These ethical issues were overcome by explicitly explaining the intentions of the research in the information sheet and obtaining direct consent via the consent form. The information sheet ensured participants had complete understanding of the purpose and method of the study (Best & Khan, 2006) and understood that their participation was entirely voluntary. Direct consent was obtained from the participants in this study, in which agreement was obtained directly from the participant (Drew et al, 2007) via the consent form. The notion of informed consent includes capacity, information and voluntariness. Capacity includes the ability to evaluate information received and make a choice based on this information. It was ensured participants were of able capacity via the inclusion criteria. Recruiting healthcare trainees/recently qualified professionals and course directors, each has the capacity to engage in higher education and hence the ability to make informed decisions regarding their consent.

There was no risk of moderate, severe or enduring physical, emotional, psychological harm or deception to the participants engaging in the study. In the information sheet that is sent to them, there is a summary of the discussion we are about to have to prepare them and give them information on the intentions of the interview. The debrief sheet was sent to clients at the end of study, and participants were then given time after to interview to be debriefed and discuss any concerns or queries they has regarding the interview. Participants were made aware of their rights to withdraw from the study on the information sheet and the consent form. They were informed that their data will be stored confidentially and their names and the university they represent will be anonymised.

Chapter 3: Results

3.1. Qualitative Phase

Braun & Clarke's (2006) version of thematic analysis was used to analyse the data. The six phases of analysis they described, which were utilised for the purposes of this work include: 1. *Familiarising yourself with your data* 2. *Generating initial codes* 3. *Searching for themes* 4. *Reviewing themes* 5. *Defining and naming themes* 6. *Producing the report*. The six phases will now be defined, as this is what I used for the process of analysis.

Phase 1: *Familiarising yourself with the data*; began with transcription of the verbal data. Transcription is described by Braun and Clarke as an interpretative act, where meanings are created, rather than simply being a mechanical one of putting spoken sounds on paper. Following transcription, the process of immersion began. Braun and Clarke (2006) state the importance of immersion and describe it as actively re-reading the data to search for meanings and patterns. The entire data set was read through once before coding began. During this time, ideas and identification of patterns were shaped. As suggested by Braun and Clarke (2006), notes were made during this phase and ideas marked for the purposes of coding.

Phase 2: *Generating initial codes* is described to begin once the researcher has familiarised themselves with the data. The data was then transferred from word documents to NVivo (a qualitative data analysis computer software package) for the purposes of coding. Codes identify a feature of the data which appears interesting to the analyst and can be assessed in a meaningful way regarding the phenomenon. By using coding as the initial step to organise the data into meaningful groups, the data was systematically worked through and repeated patterns

(themes) were identified. As computer software was used for the purposes of coding, coding was completed in the way which was described by Braun and Clarke (2006), which involves tagging and naming selections of text within each data item.

Phase 3: *Searching for themes*. After all the data had been coded, this phase involved sorting codes into potential themes and collating all the relevant coded data extracts within the identified themes. A visual, table format was used in Microsoft Excel (see Appendix 12) to facilitate this process, as is suggested by Braun and Clarke (2006). At this stage, the different themes were developed after analysis of the codes.

Phase 4: *Reviewing themes.* This phase involves two levels to reviewing and refining themes. Level one involved re-reading coded data for each theme to consider if they appear to form a coherent pattern. Level 2 considers what counts as an accurate representation of data by considering whether the thematic map reflects the meanings evident in the dataset as a whole. The dataset was re-read to consider whether the themes "work" in relation to the data set and to code any additional data which may have been missed in earlier phases of analysis. Once the thematic map worked in accurately representing the dataset, the next phase was started.

Phase 5: *Defining and naming themes*. Themes were then defined and refined, by identifying the essence of each theme and determining which aspects of the data the theme captures. This can be seen in the subsection of this thesis: Definitions and Labels for Selected Themes. By refining themes as is suggested, it was considered whether or not a theme contains any sub-themes. From this point, the names of the themes were determined and finalised.

Phase 6: *Producing the report*. The final report can be seen below. This phase involved providing a detailed account of the data, by exploring and explaining the analysis of each theme one-by-one, aiming to provide a concise, coherent, logical, non- repetitive, and interesting account of the story the data tell – within and across themes. This phase provides the evidence for themes within the data. By using vivid examples and extracts which capture the points demonstrated, an argument was formed in relation to the research question.

For further advice and detail on the six phases, please refer to Braun and Clarke's (2006) paper: "*Using thematic analysis in psychology*".

The thematic analysis conducted in this study was driven by theoretical and analytical interest. By searching for semantic themes, the "surface level" meanings were acknowledged and organised to show patterns and a summary of interpretation. Hence, theorising significant patterns and their broader meanings and implication whilst holding a post positivist (critical realist) epistemological position.

3.1.1. Definitions and Labels for Selected Themes

Theme 1. Cultural Competency. Explores the different elements of cultural competency discussed by the participants. This includes definitions of culture, but also understanding and developing cultural competency skills and awareness. Participants discussed their intentions in how cultural competency is imbedded on their course and their expectations for trainees.

Theme 2. Inadvertent Learning. Outlines the ways in which participants discussed using personal views and experiences to inform and develop cultural competency skills. They

referred to experiences of inadvertent learning, including exposure to cultural diversity, attitudes toward diversity, environmental influences and exposing oneself to difference. They acknowledged the influence of personal attitudes towards diversity and personal experiences.

Theme 3. Reflective Practice. This theme considers the core counselling skills imbedded in and used by practitioners to inform their daily practice, specifically in the context cultural competency. With consideration of using reflective practice, core skills and one's own philosophical position, participants inferred that clinicians ought to use their clinical responsibility in reference to their skills and experiences to effectively deliver culturally competent therapy.

Theme 4. Training. Focusses on the development of cultural competency skills through doctoral training, including lectures, placements, diversity in trainees and trainers and BPS expectations. Participants acknowledged the advantages and disadvantages of training courses both specific to their own course and general training within the field compared to their narrative of what necessary training is and should include.

Subtheme 1. Counselling Psychology's Development. Acknowledges the responsibility that counselling psychology holds as a profession, regarding the philosophy and development of the field, as well as diversity within the field. Further, considering differences in cultural competency training between courses and how cultural competency is assessed, to considering programme marketing and recruitment. Participants demonstrated similar views on their understanding of the historical development of counselling psychology and shared perspectives on how counselling psychology can develop itself as a field.

Please see Appendix 12 for a full table of themes and associated supporting evidence (extracts) from the interviews.

Whilst Theme 1 may not provide as much evidence as the other major themes, the content itself provides enough scope and perspective for it to stand as a main theme in relation to the following themes derived from the data.

In the following reports, please acknowledge that participants have been referred to as: P1, P2, P3, P4, P5, and P6. P is an abbreviation of Participant and the number corresponds to the interview. E.g.: P1 indicates the participant from interview 1.

3.1.2. Report of Theme 1: Cultural Competency

Participants described their understanding of cultural competency and how this can be defined. They often noted that culture is not limited, and often open to including sexuality, gender identity, race and ethnicity. P3 described his experience of acknowledging cultural competency as:

"I need to be sensitive to, I need to know something about how cultures might be different and how this might have an impact on my work." (p. 61)

In this extract the participant was considering his role as a counselling psychologist in effectively uncovering the role the client's culture plays in the differences between them. He acknowledges his role as a counselling psychologist as being sensitive to the impact cultures may have on the therapeutic work. P5 used the example of a white English man, who is born is this country and lived here his whole life and is gay being *"more open or comfortable with his sexuality rather than, let's say, someone who has also grown up in London but he's a*

second-generation Muslim man from Pakistan" in which their sexuality may be shunned by their culture. Participants considered the differences between client cultures on an interpersonal level; considering ethnicity, religion, societal and political context. This is echoed in research which states how the construct of multiculturalism becomes generic to the counselling relationships (Pedersen, 1997).

Participants used examples from their clinical experiences to demonstrate how their awareness of cultural differences led to the implementation of cultural competency skills in clinical practice. P3 goes on to explore an example of how this has manifested in his clinical experience with a gay client:

"I-I-I find myself saying things to clients like, you know, erm, you know you're talking about your experiences as a gay man in growing up and that's something that-that I really want to make sure that I, you know, really understand what that was like for you." (p. 64)

Participants demonstrated that it is important for them to be within the client's frame of reference and understand the impact of their internal working model, informed by culture, and how as the therapist can use this to work with the client's presenting issues. Acknowledging culture was described by participants as an integral part of the therapeutic relationship. Whether this was clients from similar or different cultural backgrounds, as discussed by P6:

"You're trying to understand what's going on within the the bigger picture, and therefore, erm making culture a phenomenon to be explored and investigated" (p. 137)
"Erm, same thing when it comes from from the same cultures, yeah?" (p. 137)

P2 mentions how she rationalises acknowledging culture and considering differences between client and therapist culture with clients: P: *"You tell me. Now feedback to me on how this is. What's this? And also sort of saying, hey! I'm aware of it. We come from different places. This is okay to talk about."* (p. 31) Participants directly acknowledged difference in their cultural background without hesitation or avoidance, to ensure the client feels comfortable discussing all elements of themselves in the therapeutic space. Which is echoed by P4: *"So I think actually working with people from diverse backgrounds, I've found that I'm-I'm real- I'm asking a lot of questions about, what is it like?"* (p. 95) By acknowledging the questions participants asked their clients through the examples they provided, it was evident that participants considered it important to discuss cultural difference with their client's directly, and their personal emphasis on engaging in cultural competency skills within their own practice gave scope to consider the emphasis they must place in their training programmes. Further, participants went on to share how the differences in client and therapist culture can manifest. P6 considered: *"For some people, it creates comfort to be within the same cultures. For others, it's something that that is not seen as as an advantage."* (p. 136) From their clinical experience, P6 is sharing that the differences in client and therapist culture can have differences in how the client responds to the therapist, viewing sameness or differences as an opportunity to feel heard and understood in a way they may not be able to otherwise. P5 shared how this has previously manifested for her, being of a different nationality: *"P: You know, I found that sometimes people because they felt that I wasn't English either, I: Mhm. P: that somehow helped them and they felt more comfortable with me."* (p. 114) Participants discussed how differences can be used within the therapeutic space. P3 shared his work with a gay client, whilst not identifying as gay himself: P3 *"So, in terms of er using, you know, working the transference, I: Mhm. P: er, me not being gay actually produces a lot of useful material because it may be that, let's say this client has*

had past experiences of feeling that his relationships with straight men have been very one dimensional or he's felt judged in some way or there's been some kind of emotional distance, I: Mhm. P: or er, you know, homophobia, even. I: Mhm. P: Erm, that-that that's something that's he's likely to be sensitised to I: Yeah. P: in his relationship with me." (p. 72)

By providing insight into his client's personal experience, P3 discusses that by using the differences in their culture, he is able to effectively challenge the internalised homophobia his client experiences, and how he will be sensitised to this in his relationship with P3. Hence, P3 is able to provide a narrative to the client which challenges the experiences his client has had with heterosexual men. This presents clients with the notion that their cultural identity and presenting problems are interlinked. Examples were used by participants, both real and fictional to describe how this may have or has manifest within a client. Hence, P2 acknowledged, *"that that effort is our kind of ethical and moral responsibility when we're dealing with the other."* (p. 28). Making the effort to develop understanding as to how to acknowledge the other, is our moral responsibility as practitioners. To understand what this diversity could include, P3 shared:

"P: People have lots of different ways of thinking and being. Er, you know, both in terms of their their culture, their identity, their gender, their religion, erm, you know there's a multiplicity of ways of being,
I: Mm. P: ways of thinking." (p. 56)

In itself, this showed that P3 considers different aspects of ones' identity as something which is a part of their culture and informs their culture, which directly influences their way of thinking. Truly acknowledging the other is a demonstration of cultural competency. This notion

was explored and shared by all participants. The development of *"respect of the otherness"* (p. 132) is *"very much there"* (p. 133) P6 shared. P5 also shared their notion of this including having some knowledge but also *"constantly be open to questioning."* (p. 108). P4 considered their idea of cultural competency including: *"to have that openness and to have that ability to, to really try to understand the person from their perspective as much as, some of the things that they might come up against."* (p. 103) The ability to be able to effectively demonstrate this in one's work was considered by participants. This included asking questions such as *"you tell me how this is for you?"* (P2, p. 31) and *"What, what do you mean? Can you tell me a bit more? What is the position of, say a father, within a family in India?"* (P6, p. 137). Hence, *"the practitioner should further research the individual's environment and what directly informs their beliefs"* (P6, p. 133). Further, cultural competence involves general understanding of the dimensions of culture and their impact on patient-provider interactions. (Schwarz et al., 2015)

The participants considered what a client focussed practitioner would do when working with diversity and how different skills can be implemented via our own research into specific cultures as well as how to explore these differences in the room with the client. They considered a combination of interpersonal therapeutic skills and personal knowledge and experiences to inform sound practice. This directly relates to the development of cultural competency skills. P5 shared during their clinical training, they researched into different cultures they worked with and this enriched their cultural competency, but they did not learn anything regarding the development of these skills from their course at the time:

"P: You know, erm that that was that kind of brought down my, no, enriched my cultural competency but nothing from the course." I: So you'd say you were very much responsible for your cultural competency training as a trainee? P: Yeah, yeah. I: And thereafter as well? P: Yeah." (p. 116 – 117)

Which informed that a lot of what they had learned and developed regarding their own knowledge and skills was due to their own initiative during the training and thereafter, which indicates that some courses did not place enough emphasis on the development of cultural competency skills historically. P4 emphasises the importance of cultural competency for trainees by stating that trainees *“need to have that competency to be able to work from, you know, whatever, we don't know who's going to walk through our door”* (P4, p. 102). All participants described having the skills of cultural competency as important. P3 shared: *“I think it's important that it has a clear presence in the programme”* (p. 77) and *“give it its own space”* (p. 79). P3 explored this notion further by deliberating:

“P: So I think, I think erm culture's a good word, cultural competency is a, is for me, firstly recognising that there are these multiplicities of culture P: that exist. And also there's a kind of erm, what's the word I'm looking for, a kind of er intersectionality. So we might belong to more than one culture. (p. 59) P: When I say that, it's not just clients, it's our colleagues erm you know, people we work with in teams. Diversity's about having the awareness of that culture exists I: Yeah. P: and what it means.” (p.60)

Further, this acknowledgement and definition of culture formed by P3 informs the complexity of the notion and how one may consider the notion when working with any or all clients and colleagues (the people around us). This was reiterated by P4: *“we try not to just focus on cultural aspects, we try and think about it in terms of diversity in general.”* (p. 102). Cultural competency appears to be a notion which course directors intend to imbed throughout their courses with the intention that this is rooted in trainee thinking throughout their journey as psychologists and is informed by their relationships with their peers and colleagues.

3.1.3. Report of Theme 2: Inadvertent Learning

This theme appeared throughout all of the interviews, as participants described their views on what inadvertent learning regarding cultures and cultural competency skills includes. Participants considered how they and how trainees can learn from their environmental experiences, including their cohort, their exposure to difference and diversity and consider their own views towards diversity. P1 considers personal experiences of acknowledging difference: *"P: So, I guess there's the... experiential aspect of it. By being around people who are from very different background, (p. 5) P: So I can hear certain words and phrases that erm say people who are second or third generation, Indian people use, (p. 12) P: And the similar things I've noticed with erm the people whose parents who came from Jamaica or somewhere else, (p. 13)"*

Here, he is exploring the nuances of language, and differences in how these subtleties influence acknowledgement of one's personal and cultural experiences. With acknowledgement of whether a person has immigrated from another country or if they are second generational and their parents have. Having this exposure influenced his own worldview. P2 expands on this notion by exploring their experiences of exposure to diversity: *"P: Both, kind of clinically, collegially, you know, erm, socially, everything, you know, erm, you know, kind of, just walking around, you know, the city and I'm thinking well, that that probably changes you know, unlike the way I probably was growing up in [state] where, you know, one of the things that predict of course fears and assumptions about the other is lack of, lack of, exposure to I: Yeah. P: you know, diversity. And so, you know, and so you have I think that really kind of being in a kind of environment where there it's harder to hold I: Mhm. P: stereotypic assumptions about people*

from backgrounds different to yourself." (p. 41) This reinforces that counsellors can learn about other cultures through social contact with others and through travel.

Further, P2 is considering how their social environment influences predictions and assumptions which one can develop. By being around diversity now, unlike her upbringing where she was surrounded by similar or likeminded cultures and norms, a diverse environment challenges the assumptions one may hold when existing within an environment when those assumptions are consistently challenged. The management of assumptions was echoed by participants throughout the interviews and is explored in further depth in the reflective practice theme report, as the notion directly links to how this is managed in the therapeutic setting. Here she inadvertently refers to the notion of enculturation and the process of internalised culture. Hence, the notion of diversity is more explicit due to more diversity in training cohorts. This notion of inadvertent learning, which was discussed by participants considered individual environmental influences, as well as aspects of exposure to diversity via cohort and social experience outside of the training experience, and how they merged for trainees. P4 shares this perspective by considering that trainees bring their own experiences of different cultures to the training and *"so, they're, everyone's learning from each other"* (p. 98). With P4 considering how trainees are learning from each other, it lends itself conveniently to the notion that inadvertent learning is beneficial considering the diversity of views and opinions of trainees working amongst each other and sharing their individual experience which informs clinical judgement, practice and development of theory, as is expanded on by P2: *"P: See, that's the thing. I think that you have to have, and of course it goes without saying that if you have a more multi-cultural trainee population and trainee cohort, now, questions and discussions around diversity are going to come up more because they will come up more, you know, from the trainees as well."* (p. 46)

P2 considers that more diversity within cohorts encourages the overall development of cultural competency discussions and questions, which will inform the future of how this is developed within counselling psychology, if the population itself develops as multicultural. This implies that diversity issues are not considered to a greater extent by courses if the cohort is not diverse, as issues to do with reflective practice and diversity would be less frequent without inadvertent learning from diverse cohorts.

With consideration of trainer diversity, P1 contributes to this notion of inadvertent learning for trainees by considering trainer diversity: *"P: Erm... interestingly, we don't actually have any, on on our main er teaching team, the four of us we don't actually have anybody who's white British. P: Erm, so I think at the minute we kind of, because we have such diverse backgrounds anyway it's it's kind of shown in everything we do. P: And feeds into the work and the lectures."* (p. 17 – 18). P1 contributes to the overall perspective found in interviews that staff diversity inadvertently but directly informs cultural competency within trainees, by being exposed to difference and diversity by the trainers, despite how cultural competency specifically may be structured and delivered on the course itself. This was shared by some participants in their interviews, with some considering the value of having a diverse academic team, and some acknowledging the disadvantages of having an academic team which lacks diversity.

Further limitations to inadvertent learning discussed by participants included training in an area or city which lacks cultural diversity (P2): *"P: Whereas if you're in an area of the U.K. that is much less diverse, you know, I dunno, I guess, most of the places where counselling psychology trainings are situation in the U.K. er, you know, there's a certain level of diversity. But let's say somebody's doing the independent route. I: Mhm. P: Let's say somebody's doing*

the qualification in counselling psychology and the reason that they're doing that is 'cause they might not have had access to a training programme. I: Yeah. P: Well, somewhere on the portfolio, on the independent route, they're gonna have to prove the competency around multicultural practice or multicultural awareness. So, they're gonna have to do some kind of essay or something, I'm just thinking, what if that person, you know, you know, you know is in a very different kind of environment where you can't have the kind of training experiences and stuff like that. (p. 42) P: Erm, and that relates to erm you know openness and engagement with different cultures and backgrounds. I think that's important. I don't think we should shy away from that. (p. 54)"

There is an elaboration on what the inadvertent learning theme has covered, with P2's perspective on how limited exposure to those from diverse backgrounds can limit them in their training experience and development of cultural competency skills. Reference 2 provides P2's view on how openness and engagement with different cultures and backgrounds is important and informs these skills.

3.1.4. Report of Theme 3: Reflective Practice

Further to the last extract of Theme 2, a common discussion amongst participants was the management of assumptions. This was one of the most used (4th most used) codes within the data-set across the six interviews. Participants viewed the management of one's own assumptions in clinical practice as pivotal in our clinical responsibility and reflective practice to deliver effective therapy overall but expanded upon the importance of this in working with diversity and providing effective culturally competent intervention. P1 reflects on his

perspective of helpful therapeutic intervention when considering others' experience and managing assumptions by questioning to understand the client's true experience:

"P: So when we do our sessions on ethics and respect for people, we're lookin' at, well the assumptions you make, P: You know, what do you assume about somebody on their walk through the door if they come through, regardless of their skin colour or culture or religion or anything else. P: and what it's like to be somebody from a particular background." (p. 4 – 5).

Here P1 was considering their true experience and the impact of how assumptions can impact others, hence, if clinicians remain respectful and ethical, we can effectively learn to understand how to be within the client's frame of reference. This will help the client to frame their understanding of what is considered "normal" behaviour for the client and emphasise their individualism. Participants considered, *"You know, what prejudices do I have"* (P5). This notion is expanded on by P2 by considering how the practitioner can manage their own assumptions:

"P: Well I think that erm, the fundamental thing which won't surprise you erm when I say this, given what I've said this far, er, the base line erm of cultural competency is the awareness that your perspective and your experience is is you know, is not either the only one to have or the normal one to have or the right one to have"(p. 27)

P2 describes the process of holding our own perspectives lightly as fundamental to be open and engaged in therapy. She describes cultural competency as embodying this fundamentality, to ensure the practitioner is not projecting their norms or ethnocentrism onto the client's experience. "*And I think that erm within that there's a fundamental kind of humility and awareness to hold your own kind of ideas and background experiences lightly because, you know, you can't really be open and engaged to everything out here, if you aren't also at the*

same time holding your own perspectives lightly" (P2, p. 24) "*and recognising them as your perspectives.*" (P2, p.24). Participants consistently discussed the crucial need to avoid cultural encapsulation by *"recognising your them as your perspectives"* (P2, p. 24), *"trying to bracket off our own assumptions"* (P4, p. 93) and *"the ability to, to stay with and not to be judgemental and to understand in as much open way as possible."* (P6, p. 138). P5 expressed their initially difficulties managing their assumptions due to their own experiences and lack of exposure to diversity:

"P: So, erm, it was erm it was very much a learning curve for me and I'm aware now, looking back at it, that I was very culturally unaware and potentially, I mean hopefully not, but potentially because I was very unaware of my assumptions and my prejudices, P: and erm therefore maybe I didn't pay so much attention to culture" (p. 113 – 114).

P5 is evidently considering the impact of her lack of cultural awareness due to her own experiences, leading to her making many assumptions during her interaction with clients. Only after exposure to difference and diversity was she able to effectively reflect upon the assumptions she had made during her work and how consciously developing this thinking enabled her to change her thinking. She went from a position of engaging in cultural encapsulation to changing her perspectives to pay attention to culture. This relates to P2's notion of a "*fundamental kind of humility*" (p. 24) in "*holding your own perspectives lightly*" (p. 24), to avoid the process of cultural encapsulation, which is a trap of privilege which counselling psychologists could easily fall into. Hence, relying on their core skills and perceiving them as sufficient in working with diversity.

In contrast, P3 considers managing assumptions when having some similarity in cultural background to a client:

"P: Very, very, very devout Christian and I'm Christian myself but he had very very, I mean his, it was interesting, his own kind of religious framework was so predominant in his mind I: Mhm. P: that erm I actually think it was part of his presenting issues, very obsessive P: client. Erm, but we did a very interesting piece of work where I tried to find points of convergence between the religious conceptual framework I: Mhm. P: he had." (p. 67)

P3 discusses how the client's presenting issues converged with his cultural values. By using his own cultural similarities to find similarities in how the client and himself practice their belief, to manage his own assumptions and enter the client's frame of reference.

Participants also considered the impact of managing assumptions within the context of training. Specifically referring to reflective practice. This notion in context of cultural competency and clinical responsibility in delivering effective therapy was the third most referred to theme throughout the interviews. P1 considered, *"But a lot of it is er to do with exploring your own unconscious biases"* (p. 7) and *"So although I'm trying, I may screw up."* (p. 15). Participants shared the perspective of learning the client's experience. P2 shared:

"P: to acknowledge the difference. To not to assume the difference will be a problem but to include it in the mix and I: Yeah. P: and not assume that it's not an issue for the client. To not assume it is an issue for the client. To not assume it's not an issue for you to be reflexive I: Mhm. P: to sort of think huh, you know, like what's coming up for me as I work for this client who's different" (p. 32).

With this extract P2 looked at the management of assumption in combination with reflective practice. She articulates her response by intertwining the two, acknowledging that to manage our own assumptions one must consider through their reflective practice their experience with the client and how this can impact the relationship. Reflective practice refers to the notion of

reflecting in action, in which a practitioner acknowledges the tacit processes of thinking, which accompany doing (Schon, 1983), which was explored by all participants in their work with diversity. The "doing" part of reflective practice is expanded on further by P3 in considering the reflective ability which should be instilled in trainees: *"P: Erm, but I think reflective, reflective skills are also key I: Mhm. P: across all those domains. That's something that would be central counselling psychologists bring. Er, they have a kind of, because there's an emphasis on personal development and relationships and being self-aware adds context, I think counselling psychologists as helping our trainees to do, whether they're working with a client or conducting research and thinking about their own relationship with their research topic or dealing with some kind of conflict or difficulty in a team they're working in. We're wanting our trainees to have, to bring a kind of certain reflective, erm, skill to I: Mm. P: their interventions."* (p. 57 – 58).

With this extract P3 is stating the importance of reflective skills being central to counselling psychologists. With the profession placing emphasis on personal development, relationships and self-awareness, this adds context to the notion of reflective practice in various aspects within the role of a counselling psychologist, including research and interventions. By giving examples of reflective practice via the questions one may ask themselves in their work with diversity, P3 implies that in order to be effective as a counselling psychologist in clinical practice, our responsibility is to be sensitive to the workings of another culture and how this may impact the work we deliver. Even if one is working with somebody from a similar cultural background, "*it doesn't mean that we're seeing the world in exactly the same way.*" (P6, p. 136), due to *"being very aware of the potential kind of nuances and dynamics that will exist between assumptions… of each other."* (P5, p. 108). P2 expands upon their own notions of reflective practice and also how this is imbedded into their course as a clinical responsibility

for trainees to demonstrate: *"P: Like really reflecting, working with, processing. There is your awareness, okay it's not enough to be aware. How are you responding to that awareness?"* (p. 50)

P2 conveys her own style of thinking in relation to her reflective practice as a clinician and as a trainer. She demonstrates the sorts of questions she reflects on and her consideration for the standards of proficiency. P2 echo's P3's view that reflective practice should be imbedded not only in reference to culture but also with *"everything else"* (p. 45). She states the importance of demonstrating this clinical skill through process reports, not just through awareness but how that awareness is influencing the therapeutic process. This is a measure which ensures that trainees are demonstrating their cultural competence to work reflexively with diversity. P5 also shared this perspective by discussing:

"P: er to think of themselves as different. To acknowledge differences between them
I: Mhm. P: and between them and their clients and them and other colleagues and so on. And that really really challenges and develops their reflective ability." (p. 105)

"P: So, feeling safe in being reflective within themselves and in the presence of others." (p. 106)

By encouraging trainees to acknowledge the differences between themselves and their colleagues, P5 reflects on the importance of feeling safe in being reflective within themselves and in the presence of others. By doing this, they are able to consider the nuances and dynamics which exist between assumptions of each other and comfortably reflect with clients in their clinical work. This ties into the notion of adapting one's clinical practice to meet the needs of the client, which was explored by P2 during the interview:

"P: I think that, erm, the skills that counselling psychology training is ought to really foster and their trainees has to do with that kind of openness and engagement and flexibility. That willingness to be flexible in all sorts of different modes of thinking and different modes of approaching things. And now whether that's approaching things clinically or whether that's approaching things in terms of research or kind of, you know, kind of appreciating the value of different types of knowledge and different types of, you know, kind of therapeutic activities or different kinds of contributions that psychology can make in the world. I think that erm, em we counselling psychology, if you take the kind of, the really pluralistic ethos as being part of it, that's a- that's a very kind of er pragmatic and helpful and flexible way of going out into the world 'cause you're sort of thinking okay, I wanna keep my ears open and listen and hear from you about what's workable in this situation. I mean I like to think of counselling psychology as being kind of a pragmatic in a good way because it's being focussed on what works, rather than being fixed on ideas about what is right." (p. 23 – 24).

Here P2 is sharing their perspective on the emphasis of reflective practice and clinical responsibility trainees ought to develop through the course of the doctorate and thereafter. By maintaining flexible and reflective clinical practice, trainees will be equipped in holding different modes of thinking and applying them in their contributions to practice and research. These contributions encourage the practitioner to maintain an approach which is "workable" whilst being based in psychological theory to contribute in a helpful way to what they are faced with in their professional practice. P2 implies that rigidity in one's perspective is unhelpful, as it may not always meet the needs of the situation. The aim being, that trainees are *"ready when they graduate"* (P1, p. 1) and *"employable"* (P1, p. 1). As P5 stated in their interview, *"we want our students to have to be integrated personally and professionally. And that comes with*

self-awareness, really." (p. 106). Other participants considered the effectiveness of adapting clinical practice and described the process as working with the awareness they have of cultural difference between them and the client. If one is not working with the awareness, *"That's not imbedding it in the practice"* (P1, p. 50). This is the most effective way of acknowledging the other in the room, "*that effort is our kind of ethical and moral responsibility when we're dealing with the other.*" (P2, p. 28). "Otherness" is defined as others' worldviews (Cooper & McLeod, 2007) and matches the way participants used the term "other". P4 acknowledges what the other consists of:

"P: So, we kind of see that you know, when a person comes into the therapy room I: Mhm. P: they bring their whole world with them." (p. 91)

"P: People have very different, you know complex relationships I: Yeah. P: with themselves, with other people, I: Mhm. P: with how they feel about the environment they live in, how they connect in a spiritual way erm, and so all of those things kind of come into play in the therapy room." (p. 92)

That otherness is a combination of everything that exists in that individual's world, including their relationships, environment and spirituality all impact the therapeutic alliance and how they present themselves in therapy, as the different components of the self that interact with one another within the client. How this can be facilitated by the therapist was explained by P6:

"P: But by stay with, I mean to be in a position I: Mhm. P: to have enough openness I: Yeah. P: so say that the clients' otherness I: Mhm. P: from a culture can exist. Can have space to exist without judgement." (p. 132)

She explains that to be able to effectively allow the client to experience all parts of themselves in the room, the therapist has to "stay with" the client and demonstrate the openness to allow

those aspects of personality and experience to manifest in the room for the client without judgment from the therapist. P5 explains what cultural competency skills can include:

"P: Erm, so it's about, cultural competency I think is really about having some knowledge but constantly be open to questioning, I: Mhm. P: wanting to learn more," (p. 108)

By remaining curious and open to questioning, the therapist is giving the client or the "other" the permission to openly discuss the parts of themselves they may not consider, may be ashamed to discuss or fear due to judgement.

The skills of reflective practice are regulated and reinforced by courses via placements and clinical supervision that trainees receive during their placements as shared by P4:

"P: Erm, but the thing is, is really, trying to bring in that, the cultural aspect into, into well certainly into the clinical supervision because I think erm, you know, students, we've got to be training students to be able to work with everyone." (p. 102)

"P: Erm, so I think it, you know, definitely bought in in erm in clinical supervision and then in the kinda of maybe a more theoretical way," (p. 102)

The emphasis in the above extract showcases P4's expectations of what clinical supervision ought to include for trainees. By bringing cultural aspects trainees are faced with to clinical supervision, ought to develop their skills to effectively work with a diverse client group from an evidence-based and theoretical perspective, informing reflective practice. The emphasis is for trainees to bring these aspects of their clinical practice to supervision and for this to be facilitated by supervisors who bring knowledge of theory and perspective. P3 expands upon the expectation of supervisors to develop these skills:

"P: So, we give our supervisors, the clinical supervisors in the placements, I: Mm. P: we ask them to evaluate trainees against various competencies." (p. 83)

"P: So, we get feedback from the supervisors I: Mm. P: that er you know, assessing how well they think that trainee's working in this area." (p. 84)

Supervisors are given competencies for trainees to fulfil during their placements. This is common with counselling psychology doctoral training courses, and P3 expects that with these evaluations, trainees are developing the skills they require to be culturally competent. P3 reflects upon his own experiences of supervision as being helpful in his work with diversity. With consideration to their experience and view of what clinical supervision ought to include, participants also reflected on their clinical experiences with diversity. Participants shared that they have all had experiences working with diversity and felt competent in their work. P2 explains this is particular detail:

"P: because I did my, even though I did my clinical psychology doctorate in the [location], I did my er my final two thousand hour internship in NHS, here. Er, 'cause I'd already moved here and so erm and that was in a erm highly diverse erm area erm near [location]. Erm, and erm I saw clients from a-a huge range of cultural backgrounds. When I moved into private practice, in a very central [location] location, was cha- you know, it was- it was quite different." (p. 39)

"P: Erm, I saw clients from a variety of backgrounds, still, but even if they were, they tended to be quite erm, gosh, I wouldn't see, I wouldn't see clients, the clients I saw were all incredibly socio-economically privileged." (p. 39)

In this extract P2 is elaborating on their experience of working with minority groups and that the completion of their training regarding their internship where they were based meant they

were exposed to a high level of diversity and a range of cultural backgrounds. This suggests that these experiences informed her process in the development of her cultural competency skills, and the shift between who can access psychology in the NHS compared to who can access psychological services privately. P3 also shared *"I have worked with people from different kind of religious, ethnic backgrounds and in terms of sexuality and so forth and age ranges."*(p. 65) which helps us understand their definition of culture is not limited to ethnicity or race as it is in some psychological literature regarding culture, and this appeared to be a shared understanding of culture across interviews. P5 also discussed *"I think I learnt quite a lot on the job during the training."* (p. 111). Generally, participants believed their placement and supervision experiences informed the development of their clinical practice and ability to work with diversity. As is shared by P3:

"P: You know, where, you know, er there's loads, I think lots of skills practice is important I: Mhm. P: to develop cultural competency. Roleplays and stuff like that." (p. 80)

"P: Er, and I did get to work with, in my placements, with people who came from a range of different backgrounds, er cultural backgrounds and I think the supervision that I had was very helpful erm, when I was working with clients from different kind of cultures." (p. 85)

This in turn appears to influence their perspective on what the development of cultural competency skills ought to include for trainees during their training experience as a catalyst to develop their reflective practice and clinical responsibility. This directly informed notions of professional development which were discussed throughout interviews as a means for understanding how these skills ought to be imbedded throughout practice during training and thereafter, transcending professional identity into personal development. P5 discussed this by considering:

"P: Er and also being very aware of their, still what it is that they need to learn because P: you know, I strongly believe that in this profession, if you feel like you don't have any more to learn, then or you know everything, then you're not really P: suited P: for it." (p. 106)

"P: A journey erm and it was the start of the journey and they need to keep evolving and they need to keep developing I: Mhm. P: and it's very important to be integrated, how they are as people I: Mhm. P: and how they are as professionals. So this is a real skill I: Mhm. P: that we want our students to have to be integrated personally and professionally. And that comes with self-awareness, really." (p. 106)

Through this consideration, we could consider their views on what professional development ought to involve and how maintaining an awareness of continual development on a personal and professional basis informs their self-awareness and personal and professional growth. The notion of professional development was considered across interviewees in their perception of what this includes and how this continues throughout one's career. P3 elaborated on this considering:

"P: And actually I think it's when you get into your independent practice after training, I: Mhm. P: hopefully if you've got a really good foundation, that's when you really start learning I think. Probably about cultural issues, in a different way." (p. 81)

In this segment P3 was expanding upon the notion of achieving ones *"ideal version"* (p. 81), doing *"good enough"* (p. 81) and that there is *"always room for improvement"* (p. 81). They described this as an *"interesting challenge"* (p. 81) and went on to explain this with the above extract. This extract describes and explains their view on what professional development is and

how a *"good foundation"* (p. 81) in training and experience can give one the necessary skills to learn and develop as a clinician in all of their skills, including cultural competency.

3.1.5. Report of Theme 4: Training

Cultural competency as a skill and expectation was discussed throughout all interviews and interweaves throughout the themes. Participants considered the expectations of the BPS and their expectations as training providers. They explored different elements of the training process and how this relates to the development of cultural competency skills. Starting with their views on the BPS' expectations on the development of cultural competency skills, participants appeared to have different perspectives on how this is portrayed to them as training providers. P3 discusses that the BPS have recently introduced new standards including cultural competency:

"P: Largely because erm the BPS have recently as you might know, they recently introduced, they changed the standard I: Mhm. P: er for counselling psychology training programmes. They've introduced new standards. Er, which includes a whole new section that relates to cultural competency. It was, they were there before but I think it's really positive that the BPS standards now have explicitly referred to and in more detail referred to I: Mm. P: these competencies." (p. 74)

During this extract, P3 was explaining the developments in the expectations the BPS has of training providers to include the development of cultural competency skills and more explicitly than previously. They convey excitement and enthusiasm for the changes in the BPS' expectations as this is something courses have to work towards conveying. Although P3 acknowledges that there is not a set way that courses are told to develop competencies, they

are given the freedom to develop this in their own way. They stated, *"They don't say this is this is this is the way you need to do it."* (p. 75). However, towards the end of the interview P3 acknowledges that there are a range of expectations that need to be covered and conveyed throughout the course. This could lead to inconsistencies between how much emphasis each course places on different aspects of the expectations the BPS has. P5 shares how they understand the BPS' expectations regarding the training process for cultural competency:

"P: I think that it's really really needed and really really lacking and in a way, in a way I feel that the BPS, the new standards in the Division of Counselling Psychology where they've said, not standards it's competencies, that er courses must erm involve some kind of training on difference and diversity, I: Mm. P: they've left it actually very very vague." (p. 120).
"P: Erm, so I think that somehow the [brief pause] the BPS what is expected in terms of cultural competence through the training and deepening all trainees you know with this module that we do." (p. 121)

P5 shows a different view of how expectations for the development of cultural competency training is explained. By describing the competencies as *"lacking"* (p. 120) and *"very very vague"* (p. 120). They believe that their course meets this criterion as they have a module on their course exploring cultural competency. This difference in views indicates differences in how course directors perceive the same given information and what each course directors' expectations are of the BPS and of the training they provide as course directors. Whilst it gives course directors less pressure to cover topics in a specific format if they are given the freedom to develop these skills and competencies in their own way, as mentioned, there are inconsistencies in the development of these skills across courses. Other participants believed that cultural competency being mentioned, despite its depth, meant this is something they have

to provide evidence for delivering in their training, *"you have to make sure that you are doing a good job of incorporating that into your training programme."* (P2, p. 43) and P6's view including:

"P: I I I think that generally speaking, when I think of the competencies of counselling psychology, this emphasis on erm otherness, plurality, social justice, cultural spirituality, has come the past ten years. I: Yeah. P: Erm and and has been, you know, very much promoted. Erm, it wasn't there as a competency, say in the standards, which positions a programme director to attend to it explicitly." (p. 134).

With this acknowledgement, we can consider course directors own motivations to prove their competencies in delivering culturally competent training. The training itself has changed over the past decade and is slowly moving to incorporate the development of cultural competency skills in trainees. P1 mentions that, *"diversity, cultural diversity, erm, and you know the person who wrote it, I know has this view that this isn't being done on courses."* (p. 4). This indicates that there is already the idea that courses are not doing enough to develop cultural competency. P2, P3 and P5 shared that their course has a specific module dedicated to cultural competency and working with diversity. P2 explained this:

"P: we have working with difference and diversity module erm, but then you know, it comes into the discussion, I would say, in most other erm, you know, kind of, modules across the programme in one way or another. For example, er, this er week er we were doing a erm er a lecture in our, we have a, a series of advanced counselling psychology workshops in third year and this term is measurement and evaluation. And we were talking about, erm, and working with intelligence testing and neuropsychological testing and particularly in the intelligence testing or the cognitive testing, kind of, week, we were talking about how tests are normed, on whom they're normed I: Mhm. P: and just thinking about the questions that get asked on the

[scale] and how your knowledge of the answers to those questions is going to be, you know, to some extent, culturally determined" (p. 34 – 35).

Whilst having a module specific for working with difference and diversity, P2 shared that these skills are imbedded throughout other modules on the course. By imbedding critical thinking in a way which includes difference and diversity, P2 explains how these skills are imbedded in other modules, to inform trainees' critical thinking to include diversity, even if the topic is not directly related to the notion of diversity. P4 and P6 have incorporated multicultural training into their existing modules. P6 stated:

"P: Yeah, so, we have created a unit I: Mhm P: er which is called erm counselling er psychology competencies. I: Mhm. P: So think of it as an umbrella. I: Yeah. P: Erm, another umbrella is theoretical models of therapy." (p. 140).

"P: Yeah? So in the umbrella of counselling psychology competencies, we're having seminars and workshops that are focussing on erm, one of these on on multicultural er training and and er theory and skills." (p. 140).

With this we have the understanding that whilst the core unit does not focus specifically on diversity, a significant element of the unit incorporates this into its teaching and expectations of the trainees. Participants shared that they tried to imbed critical thinking and acknowledgement for culture throughout their course. *"we try and bring cultural issues into other erm into other modules as well."* (P4, p. 102), *"Err, I guess at the moment we try to do it through, no matter what you teach, you try to imbed erm respect for people and a recognition of diversity into everything you do."* (P1, p. 17). All participants acknowledged improvements they could make regarding current training. P5 acknowledged that, *"it could be a lot more."* (p. 122). In reference to cultural competency training, as after the module in the first year of

training, the trainees' exposure to diversity *"is if they work in a diverse enough setting"* (P5, p. 121), later stating *"we don't really explicitly do anything else actually."* (p. 124). As is further stated by P1:

"You know, what do you assume about somebody on their walk through the door if they come through, regardless of their skin colour or culture or religion or anything else." (p. 5)

"... I don't know. It's a little bit like, how should an LGBT session be run." (p. 16).

With P1 acknowledging that whilst they may be imbedding cultural competency practice, there are no "hard and fast" rules about how this should be conducted, or the specific terminology used to portray effective cultural competency. As stated by P1 earlier in the interview: *"well actually we are doing it all, we just don't call it those words"* (p. 4). Further, this informs that reflective practice with the intent to work with diversity is present in the course and interviewed but is emphasised differently with consideration to the language used and the amount of time dedicated to cultural competency specifically. Other participants shared their view of current training to facilitate and encourage trainees to consider a client's *"whole context"* (P4, p. 91) and acknowledging that they want participants to understand the current expectations of the course,

"that they themselves think as different in relation to others and how this comes across in clinical practice and their professional setting and so on. And that really gets them to think." (P5, p. 121). Hence, encouraging practitioners to imbed the different aspects of core counselling skills to match the scenario they are encountered with in their clinical practice and professional environment. This reinforces that trainees have to acknowledge their role as psychologists both inside and outside of the therapy room. This topic was expanded upon by participants to consider how trainees can apply their training. P3 considered pluralism as

recognising *"that there isn't just one way of thinking about er good therapeutic or research practice"* (p. 56). He stated the intention for the development of skills as:

"P: Skills that you're developing that are not just about how to provide therapy but it's about how to er work well within a team, how to understand erm your role within the team, within the organisation, erm, and how to facilitate the practice within the team as well. So, erm, those are the kind of skills that we're trying to devel-develop in our trainees as well as being good clinicians, and good researchers." (p. 57).

By developing an open-minded perspective within trainees as to what safe and therapeutic practice can include, it gives them the ability to be flexible within the therapeutic space as well as in how they work within their team and organisation. The implication that trainees ought to develop the open-mindedness to effectively work with whatever they may encounter, in terms of client presentation and organisational work culture. i.e. a pluralistic framework. This was further emphasised by P1, stating that the *"reality of the workplace means you need to know a lot about other methods"* (p. 1) and ensuring that *"regardless of who you meet, you're attempting to maintain an open mind"* (p. 4).

This adaptability emphasises the skills P1 wants trainees to carry through and be able to match the demands of the workplace to be competent and demonstrate competence in their work and interactions with others through their techniques and the adaptations of their *"lingo"* (p. 3). This gave me the understanding that P1 considers the training course a means to facilitate open-mindedness in therapeutic approach and cultural competency skills. Other participants also considered their expectations for trainee development via the course of the training. All participants echoed the expectation that trainees ought to demonstrate competence in their practice. As quoted from P5: *"What we want is to have people who erm are skilled in working*

but are also very much aware of what is going on for them; very self aware." (p. 105). By considering self-awareness as something which has been mentioned and explored with different lenses through different themes, it seems to be co-current with overall maintenance of professional development and sound therapeutic practice with the consideration of what participants have shared. P6 expanded on this notion of effective practice by stating their expectations of trainees is to demonstrate *"initiative"* (p. 130) and *"the ability to work independently"* (p. 130). Hence, cultural competency being interweaved throughout their course. The notion of an open and flexible therapeutic approach which genuinely considers culture was discussed by P2 as to how this is imbedded in their course:

"P: Er, you know, if a research supervisor er er said you know, somebody says I'm doing IPA study so it needs to be really homogenous and so therefore I'm only going to er recruit erm white people you know, just in case, you know like I, you know, black people's experiences are different. We'd be like well hold on a second, is that meaningful homogeneity or I: Mm.

P: not meaningful homogeneity because IPA is all about homogeneity that counts with respect to the phenomenon in question." (p. 48).

"P: And so that's why it's gotta be imbedded, it's gotta be interwoven, I: Mhm P: you know, and it cannot be lip service." (p. 49).

This example provided me with the insight of how P2 facilitates trainees' critical thinking via conversational exchange and how the training is interwoven to ensure trainees are not simply reflective but are able to demonstrate meaningful considerations for the other from a research perspective. P2 shared how this would be assessed regarding assignments trainees submit, and gave the example of marking a process report but seeing that the trainee has not worked with the significant cultural difference between them and the client:

"P: Erm, and then thinking about, for example, reflections, process reflections and process reports. Every time a student does a process report, if the student is not talking about the potential or picking up on the potential impact or significance of differences or awareness of difference I: Mhm. (p. 35) P: in a case study or in a process report, we're gonna wonder why. I: Yeah. P: Especially when a really significant cultural difference has been named, has been acknowledged, but there's not been discussed or unpacked or otherwise referred to or
I: Yeah. P: reflected on in any way." (p. 36).

By encouraging trainees to reflect on their process by acknowledging culture, P2 is informing trainees of the importance of addressing difference directly to facilitate the therapeutic process, incorporating their difference instead of assuming the cultural difference and working with the presenting issue. As considered by P1: *"Err, I guess at the moment we try to do it through, no matter what you teach, you try to imbed erm respect for people and a recognition of diversity into everything you do."* (p. 17). The trainee experience is guided by the ethical stance and reflective process of the course directors in facilitating the development of knowledge and skills they deem necessary for all aspects of working as a counselling psychologist. By exploring cultural exposure during trainee placements, participants presume that trainees will encounter a variety of diversity during their placement process, as was stated by P3: *"clinical experiences that trainees get in their placements includes exposure to a variety of cultural backgrounds."* (p. 81). Placements and supervision have been mentioned in the reflective practice theme, but by including them in this theme, provides space to consider the effectiveness of placements informing the training process. Further, P3 considered that trainees *"would not go very far unless trainees are actually experiencing working with people from different cultural backgrounds"* (p. 82). P3 considers that mixing with diverse cultures through clinical practice is key to developing a successful career in counselling psychology. This is

reinforced by the course: *"we want you to tick box check all the different, the diversity of the placements that you're working in."* (p. 82). P4 shared that they believe cultural competency is developed through placements also, as they have trainees working across the world in their cohort and those in the U.K. are in "multicultural" settings. As is emphasised by P5 and seems to be true for all courses, *"So any training, any competency training that they get is if they work in a diverse enough setting"* (p. 121). Working in a diverse setting also applies to the diversity of the cohort and academic work and learning. Almost all participants discussed the usefulness of having a diverse cohort to inform inadvertent learning or direct learning of peers. P1 discussed the diversity of the cohorts on their course: *"P: our student group is so diverse."* (p. 5).

"P: there's people from every age group and background and" (p. 5).

"P: ethnicity and culture and religion. Everything, all in pretty much every year group." (p. 5).

With this acknowledgement, P1 is discussing the diversity of the cohorts in every year group. P2 elaborated on this further:

"P: that if you have a more multi-cultural trainee population and trainee cohort" (p. 46).

"P: There will be more people, you know, kind of who are, you know, noticing the difference that is there in that room. Like, if you have a completely homogenous, like here's a bunch of like British, you know, kind of caucasian women in a room. Like, it's not gonna occur to you as much I: Mm. P: to sort of talk about difference." (p. 47).

"P: Whereas if there's some men and there's some people from different backgrounds, different countries, then there'll be more part of a conversation." (p. 47).

From what P2 shared in this extract, allowed space to consider that if there is a diverse cohort, they are more likely to consider and discuss the impacts of the theory and practice they are learning on groups which embody their own diversity, versus groups which are extremely homogenous and the acknowledgement of that diversity is less likely to enter the conversation as their frame of reference will be of a similar world view and experience. P5 expanded on this notion further by reflecting:

"P: er and also hopefully by having a diverse enough student group, peer group, where they openly talk about their experiences either informally or in facilitated discussions I: Mhm.

P: in the class. And I think on our course we're quite fortunate in that we do have a diverse group of students. It's not just white middle class." (p. 122).

With this reflection, P5 is considering the benefits of having a diverse group which is able to discuss their experiences and learn from one another. The idea of counselling psychology cohorts consisting of white, middle class people is something which was also echoed by other participants. By having cohorts which are predominantly from the same ethnic and socio-economic background, the conversation is limited, again, to their experiences. P1 shared:

"Erm, but I know programmes in [area of England], you know, it's majority, you know, white women ages twenty seven." (p. 5)

"And on clin. psych. programmes in tends to be white women aged twenty seven." (p. 5)

With this acknowledgement, it seems course directors are aware of a general demographic of people who apply and work within the field of counselling psychology and predominate over its training programmes. This limitation is something which would hinder the development of cultural competency skills in the training process. The concerns regarding this are how the

course is delivered with consideration for cultural diversity via the teaching. As was emphasised by P1:

"P: Erm, having spoken to programme leads on other programmes and having done certain examining for other programmes, I: Mhm. P: er, I know it's, it's covered in a almost a white English way. I: Mhm, yeah. P: So, something a little bit imperial about it. I: Mm. P: Erm, it's almost like the guidelines are written for white English people to stop being so insensitive I: Yeah. P: and clumsy." (p. 15).

This indication infers that course content regarding cultural competency may be taught from an ethnocentric standpoint which could limit trainees from understanding and developing the ability to put themselves within the client's frame of reference. Research reinforces this notion, as stated by Arthur (1998, p. 90): "Counsellors are likely to exhibit ethnocentrism when their theoretical orientations are based in culturally specific values and when assessment and intervention strategies do not incorporate culturally relevant information regarding clients' worldviews.". All participants shared that cultural competency skills during their own training was limited, not emphasised and is focussed on much more in present training. *"But I think historically it probably wasn't doing a good enough job I: No. P: in terms of cultural competence."* (P3).

3.1.6. Report of Subtheme 1: Counselling Psychology's Development

With consideration to the wider aspect of training; the influence and development of counselling psychology on training courses; socio-political issues; wider society, this theme was derived from notions including the definition of cultural competency from course directors, trainer's cultural competency and differences in training between courses, whilst

considering Black Minority Ethnic (BME) counselling psychologists presently in the profession and their access to courses. With acknowledgement of how P2 understood cultural competency, they discussed how it is not so specifically defined:

"P: So, I think that sometimes cultural competence, often cultural competence is not what people think it is." (p. 45).

"P: It's-it's not in some sort encyclopaedia entry on I: Yeah P: here's a culture of a certain place. You know? Or certain people, you know." (p. 45).

"P: We don't have a module called multi-cultural therapy because we want it to be more broadly defined I: Yeah. P: than that." (p. 45 – 46)

"P: Th-th-that, you know, that difference and diversity occurs on all sorts of different levels." (p. 46).

Here, P2 demonstrates an acknowledgement of cultural competency, not so much as a "textbook" definition but the ability to broadly work across difference and diversity. Her understanding of this encourages the notion that a narrow view of cultural competency would be limiting and disable clinicians to effectively work with diversity if they remained stuck in a narrow view of only viewing a culture based on literature surrounding it, and acknowledge that culture occurs on "different levels". This notion of reflective practice and acknowledging ambiguity to work within clinical practice has been echoed throughout the different themes by all of the participants. P2 also referred to trainers' cultural competence and was the only participant to mention this so explicitly. It has been included in the analysis as it provides insight into how trainers' cultural competency is an important insight into the development of these skills in trainees and hence, the development of counselling psychology:

"So trainers have to be trained, to sort of say, okay, you're marking a process report, you're asked to comment on issues where how the trainee deals with power or difference or anything like that." (p. 48 – 49)
"P: You always, I have to make sure in terms of mentoring, you know, er my team in terms of marking standards and everything else, that they I: Yeah. P: attend to that all the time." (p. 49).

With this understanding, it is helpful to reflect on how P2 considers how she has had to train trainers to notice whether dynamics are effectively observed and worked with by trainees when they attempt to demonstrate their skills in their reports. This considers the cohesiveness of the team having a shared understanding and expectation of how the trainees should demonstrate their skills via verbal communication and training. This follows onto the notion of differences between cultural competency training which was observed in the interviews. P5 considers this by stating their own experience:
"P: And erm, I get the sense that, I mean I don't know about the course that you're attending, but I get the sense that the module that we do here, in year one, where we ask trainees a lot to talk and reflect and think about difference and diversity is one of the very few that does that. I: Mm. P: And the reason that I get that sense I: Mhm. P: is because we invite erm, people er to come and talk who are familiar with other courses I: Mm. P: in the U.K. and they all say to me, oh it's really good that you do that course. Oh, it would be good if other, this module it would be good if other courses did that." (p. 121).

By discussing that her course provides a module on difference and diversity and her direct conversations with guest lecturers suggesting that other courses should provide this within their curriculum, indicates that not all of the doctoral courses in counselling psychology provide a

module focussing on difference and diversity. With this consideration, trainees from different training institutions may develop similar reflective skills and practice, but this may not be as orientated toward difference and diversity for those who do not have this module as a core module on their training course. P1 acknowledges that their course does not have a specific module on difference and diversity, but this is embedded throughout the course *"it could probably do with it being formalised and being more articulate."* (P1, p. 17). He elaborated on how this is presently done on the course, *"no matter what you teach, you try to imbed erm respect for people and a recognition of diversity into everything you do."* (p. 17). When asked how the course integrates this, they shared, that they do not have anybody who is "white British" on the team and *"it's kind of shown in everything we do"* (p. 17). Whilst both approaches may be helpful in understanding and being able to reflect on how to effectively work with diversity, as mentioned by P1, this is not formalised. He goes on to share the differences between the independent route compared to attending a doctoral training course:

P: I guess, most of the places where counselling psychology trainings are situation in the U.K. er, you know, there's a certain level of diversity. But let's say somebody's doing the independent route. (p. 41) *I: Mhm. P: Let's say somebody's doing the qualification in counselling psychology and the reason that they're doing that is 'cause they might not have had access to a training programme. I: Yeah. P: Well, somewhere on the portfolio, on the independent route, they're gonna have to prove the competency around multicultural practice or multicultural awareness. So, they're gonna have to do some kind of essay or something, I'm just thinking, what if that person, you know, you know, you know is in a very different kind of environment where you can't have the kind of training experiences and stuff like that."* (p. 42).

Through this awareness, P1 considers the difference between the independent route and attending a course for somebody who may not have exposure to cultural diversity. This

suggests that even though the trainee in this instance may possess the skills to qualify as a counselling psychologist, they may not have the direct experience with diversity during their training which informs their competency as a qualified clinician. P5 acknowledges that *"different courses do it in a different way*" (p. 140). P2 considered from her experience that counselling psychology courses in the U.S. are more focussed on cultural competency than the U.K.:

"P: I think traditionally counselling psychology has been a profession in the U.K certainly, which is ironic because in the United States counselling psychology er that section is devoted to counselling psychology is probably much more focussed on multiculturalism and kind of thinking about multiculturalism than the U.K has historically been. So I think that the U.K counselling psychology is really trying to kind of move in that direction as well." (p. 34).

This gives some understanding into the inconsistencies between courses but does not explain why counselling psychology development in the U.K. does not place as much emphasis on cultural competency as courses in the U.S. P2 gives the understanding that this is still a developing concept within counselling psychology in the U.K. Further, P2 was the only participant to consider equal opportunities to access counselling psychology training. She considered:

"P: It's a difficult one that, because in terms of inclusivity and not just across in terms of culturally but also in terms of socioeconomically and also because counselling psychology courses are really expensive I: Mhm. P: and they have just a lot of limits on what the funding is and so, that's already kind of limiting in certain ways for various kinds of, you know, different socioeconomic backgrounds. There's certain just cannot access counselling psychology training I: Mm. P: which I really hate." (p. 33 – 34).

Inclusivity due to socioeconomic status informs the difficulty individuals may experience accessing the training and joining the profession. This in turn influences one's ability to contribute to the development of counselling psychology from a perspective other than that of people who are of a particular socioeconomic status. P2 expanded on what they are doing within their professional capacity to extend these opportunities to people from diverse backgrounds:

"P: So, the last erm higher education academy, webinar that I did was erm, er around er different ways of engaging in academia as related to kind of culture and backgrounds and whether, you know, kind of the students come from, you know, kind of a British er background or English speaking background versus from somewhere else. So, international students and trying to make sure er you are being maximally, kind of sensitive and questioning of kind of what works best for international students." (p. 38).

With consideration of the work P2 is undertaking around inclusivity, it seems she is taking the initiative she believes is necessary to consider how to recruit and be open to recruiting diverse students and making counselling psychology an accessible course to all people, even though the costs of the courses are still high. This relates to the notion of BME people becoming counselling psychologists and this was explored by P2 and how she has witnessed minority ethnic people developing their own identity within the profession:

"P: And you know, I'm aware of this because I was sat on the divisional committee a few years ago. That was the last meeting of the committee that I was at when somebody they were starting a sort of special group for black and minority ethnic counselling psychologists because they, you know, and the rational for doing that was like they really felt like they needed a sort of space to grow awareness for more black and minority ethnic people I: Mm.
P: in the division I: Mm. P: and sort of training and the profession." (p. 51).

Her experience indicated what she perceived as BME people feeling the need to shape and form their own identity as there was not enough recognition for their group within the profession and the need to do this in order to grow awareness for and develop training and the profession overall. With these groups coming into place "a few years ago" as an attempt to be heard by BME people within the profession, the development of counselling psychology in its inclusion of BME counselling psychologists is underdeveloped.

3.2. Triangulation of Phases

With consideration of the data and results from the qualitative phase, was helpful to consider the impact this may have on the quantitative phase in consideration of the hypothesis and the results produced. The implication that there are inconsistencies among courses in how culturally competency is developed within trainees, whilst each course is adamant that there is a focus on this, we must consider on whether there will be differences in the levels of culturally competency skills between counselling psychology and biomedical trainees.

3.3. Quantitative Phase

The purpose of this study was to measure the levels of cultural competency skills in biomedical healthcare trainees and professionals in comparison to counselling psychology trainees and professionals. This study also intended to test for a relationship between social desirability scores and cultural competency skills.

A Multivariate Analysis of Covariance (MANCOVA) was conducted to compare two groups, namely: final year trainees and recently qualified counselling psychology professionals and final year trainees and recently qualified biomedical professionals. These two groups were compared in a number of dependent variables (DV) which consisted of the subscales of the

HPCCI; 1. Awareness and sensitivity, 2. Behaviour, 3. Patient Centered Care, 4. Practice orientation and 5. Self-assessment. Social desirability, measured using the lie scale was used as a covariate, helping me to test whether social desirability was related to self-report scores in cultural competency.

Hypothesis one predicted: The counselling psychology group will have a significantly higher level of cultural competency compared to biomedical group.

Hypothesis two predicted: The counselling psychology group will have lower levels of social desirability than the biomedical group.

Thirty-six final year trainees and recently qualified counselling psychology professionals participated. Twenty-four trainees and recently qualified biomedical professionals participated.

The descriptive statistics ensured that the assumptions for the MANCOVA were not violated. The data for each DV for each sample are normally distributed. The standard deviations suggest that there is homogeneity in variance.

Table 1
Test of equality of covariance matrices

Box's M	24.904
F	1.496
df1	15
df2	9714.317
Sig.	0.097

Tests the null hypothesis that the observes covariance matrices of the dependent variables are equal across groups.

A key component in MANCOVA testing is to ensure equal variance-covariance matrices. Box's M tests the null hypothesis that the observed covariance matrices of the dependent

variables are equal across groups. To test for homogeneity of variance-covariance matrices, Table 1 indicates that the significance value of the test is greater than 0.05, suggesting that the assumptions are met, and homogeneity has been assumed.

Table 2
MANCOVA results table

MANOVA	Df	Wilks' Lambda	*f* Value	Sig.
Lie Scale	5, 53	.826	2.234	.064
Group	5, 53	.107	1.219	.313

MANCOVA results indicate that there was no significant combined effect of group on cultural competency skills (F (5, 53) = 1.22, p = 0.313, $p\eta^2$= .103). Social desirability approached significance as a predictor of cultural competency (F (5, 53) = 2.23, p = 0.064, $p\eta^2$= .174).

Table 3
Group 1 represents Counselling Psychology and Group 2 represents Biomedical.

Dependent Variables	Group	Mean	Std. Error
Awareness and sensitivity	1	62.768[a]	.930
	2	65.265[a]	1.145
Behaviour	1	83.152[a]	2.208
	2	83.438[a]	2.719
Patient Centered Care	1	12.600[a]	.316
	2	12.891[a]	.389
Practice Orientation	1	36.019[a]	.588
	2	35.555[a]	.724
Self Assessment	1	40.822[a]	.550
	2	40.392[a]	.677

a. Covariates appearing in the model are evaluated at the following values: Lie Scale = 6.4833.

Table 3 shows the mean scores for each group and how they pertain to the five DV's.

Table 4

Individual effects on each of the five cultural competency DVs for Group and the Lie Scale as covariate

	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Lie Scale						
Awareness and sensitivity	8.562	1, 57	8.562	.281	.598	.005
Behaviour	1385.466	1, 57	1385.466	8.073	.006	.124
Patient Centered care	16.151	1, 57	16.151	4.607	.036	.075
Practice Orientation	3.440	1, 57	3.440	.283	.597	.005
Self Assessment	71.147	1, 57	71.147	6.688	.012	.105
Group						
Awareness and sensitivity	85.06	1, 57	85.06	2.800	.100	.047
Behaviour	1.113	1, 57	1.113	.006	.936	.000
Patient Centered Care	1.151	1, 57	1.151	.328	.569	.006
Practice Orientation	2.924	1, 57	2.924	.240	.626	.004
Self Assessment	2.518	1, 57	2.518	.237	.628	.004

Table 4 shows no individual significant difference between groups on any of the individual dependent variables. Lie scale predicts behaviour, patient centered care and self-assessment.

Table 5

Correlations between the Lie Scale and HPCCI subscales

			1	2	3	4	5	6
1.	Lie Scale	Sig. (2-tailed)		.121	.363**	.295*	.057	.319*
2.	Awareness and sensitivity	Sig. (2-tailed)	.121		.425**	.066	.355**	.286*
3.	Behaviour	Sig. (2-tailed)	.363**	.425**		.408**	.410**	.509**
4.	Patient Centered Care	Sig. (2-tailed)	.295*	.066	.408**		.184	.482**
5.	Practice Orientation	Sig. (2-tailed)	.057	.355**	.410**	.184		.277*
6.	Self Assessment	Sig. (2-tailed)	.319*	.286*	.509**	.482**	.277*	

Note: N = 60. Sig. (2-tailed) **Correlation is significant at the 0.01 level (2-tailed). *Correlation is significant at the 0.05 level (2-tailed).

As shown in Table 4, the correlations confirm that social desirability (as measured by the Lie Scale) has significant positive relationships with behaviour, patient centred care and self-

assessment. They confirm the MANCOVA effects which highlighted significant effects with the same three cultural competency variables.

Table 6
Comparison of the groups on lie scale scores (means, standard deviations and standard errors).

	Group	N	Mean	Std. Deviation	Std. Error Mean
Lie Scale	CounsPsy	36	5.806	3.232	0.539
	BioMed	24	7.500	4.011	0.819

An independent groups *t*-test indicates that biomedical trainees and professionals scored higher on the lie scale than counselling psychology trainees and professionals (see means in Table 6) although this effect was not strong enough to reach significance (t = -1.805, df = 58, p = .076). This tentatively suggests that the biomedical group may be prone to altering their responses on self-report questionnaires to appear socially desirable.

Hypothesis one predicted: Counselling psychology doctoral trainees will have a significantly higher level of cultural competency compared to biomedical students. The null hypothesis had to be accepted in this instance as results did not produce significant outcomes regarding cultural competency skills in counselling psychologists or biomedical professionals.

Hypothesis two: Counselling psychology professionals will have lower levels of social desirability than biomedical professionals. Comparison of the groups on the Lie scale indicate that there is an effect approaching significance thus only providing tentative support for this hypothesis.

Whilst the results did not produce significant group effects, the scores in relation to social desirability verged on significance. Had a larger sample on data been collected, and had these

mean differences remained stable in a larger sample, biomedical professionals would have scored significantly higher on social desirability than counselling psychology professionals.

Chapter 4: Discussion

The aim of this mixed-methods research was to consider whether courses are developing cultural competency skills and compare levels of cultural competency between final year trainees from counselling psychology doctoral courses and a variety of biomedical courses. Interviews were conducted with course directors to explore if and how cultural competency is developed in counselling psychology doctoral courses and used surveys to measure levels of cultural competency and social desirability in healthcare professionals. To effectively acknowledge the rich and nuanced findings across the themes within the qualitative phase, this research has acknowledged each theme as a sub-heading for the discussion to build upon previous theory and literature, whilst critiquing the assertions of the work after providing an explanation of the results.

4.1. Explanation of Results

The results of the qualitative phase provided understanding in how current counselling psychology courses are developing cultural competency skills in their trainees. At the time of this research, there were thirteen counselling psychology courses within the U.K., of which six were interviewed. These interviews were used to provide insight into course directors' perspectives on current training programmes. 4 themes and one subtheme had been deducted from the interviews, namely: Cultural Competency, Inadvertent Learning, Reflective Practice, Training, Counselling Psychology's Development. Whilst separate and intertwined, the themes provided context as to what participants deemed most significant in their own experiences, their expectations of trainees and how they endeavour to develop cultural competency skills in trainees. Essentially, they deemed that core counselling skills *are* cultural competency skills but emphasis on culture by interweaving it and exploring it explicitly in association with different aspects of the course, ensure that it is within the trainees' frame of reference in reflection as they train and after they qualify.

In reference to their own experiences, course directors acknowledged that the development of cultural competency skills in trainees has developed significantly since they were training. Yet there are inconsistencies between courses and a lack of regulation as to how much emphasis each course must place on different aspects of the training. Whilst this may give course directors the freedom to effectively work and navigate the content they teach to trainees; each trainee may differ considerably regarding their emphasis on cultural competency. This could be considered inevitable, and even if, for example, it was compulsory for courses to provide a module on cultural competency skills, levels of cultural competency skills would still vary. All course directors shared that they imbed cultural competency skills throughout their course, whilst some have dedicated modules on their training, others have this as a part of current courses, and one stated they did not have anything specifically dedicated to cultural competency. Yet, all stated that they endeavoured to imbed this throughout their teaching and the trainees' learning. For example, questioning the cross-cultural validity of psychometric tools, demonstrating working with culture in process reports and considering the client's entire context in ones' work. Course directors discussed the value of having people who are not a part of the majority culture in Britain, which helps trainees on the course to learn from each other. This result lends support to Wheeler and Izzard (1997) who also described this as the benefit of counselling psychology trainings.

The relationship between the qualitative phase and the quantitative phase, whilst it was not direct, was to develop an understanding of current developments in the field of counselling psychology regarding the development of cultural competency skills in trainees. The qualitative phase framed the context for the hypotheses of the quantitative phase. The intention of the quantitative phase was to explore the cultural competency skills of biomedical and

counselling psychology trainees in their final year of training. Cultural competency is a key skill which ensures trainees have the initiative and intuition to explore the relevant cultural norms which will influence their treatment. Whilst the group comparisons were not significant, there were significant relationships between social desirability and cultural competency and a near-significant group effect on social desirability, tentatively suggesting that the counselling psychology group showed more truthfulness on self-report questionnaires than the biomedical group. Had there been more participants for this phase of the research, this may have proved significant. The results of the quantitative phase tentatively suggest that cultural competency is viewed as a desirable trait by the biomedical group. As stated earlier, the biomedical group scored higher on the lie scale than the counselling psychology group (see means in Table 6).

The lack of significance between the counselling psychology group and the biomedical group in their cultural competency scores indicates that counselling psychology and biomedical courses may not be doing enough to facilitate the development of cultural competency skills in trainees. Hence, giving further consideration to the development of these skills with references to previous research and with suggestions for future research. The discussion has been structured with reference to the themes developed through the qualitative data, providing me with the opportunity to consider the present study in direct relation to the literature review and the data obtained from this study.

4.1.1. Cultural Competency

With consideration to this theme and the literature surrounding the notion of cultural competency, as stated by Whiley and Davis (2007), there is little convergence between cultural competency skills and evidence-based practice, rather the adaptation of interventions to suit client needs. To some extent, this still appears to be present. Culture, as a notion, may be too

broad to account for individually. Whiley and Davis' (2007) paper focusses specifically on people of colour. Much of the present psychological literature does not account for culture as culture but uses culture as a synonym for race and ethnicity. Hence, culture is reduced to fragments: papers on race, disability, sexuality, gender appear to be separate or sometimes connected in one paper (e.g. south-Asian women accessing counselling). Throughout interviews and as is evidence in the extracts associated with this theme, participants acknowledged culture to be diverse, and referenced different aspects of culture when working with clients, including sexuality, race, gender and religion. This acknowledgement evidences the participants' views to not be as limited as the literature in their understanding and exploration of culture. Participants acknowledged that culture is a broad notion and inclusive of a variety of demographic details. This provides the insight that what the literature is presently reflecting, does not reflect the perspectives of practicing clinicians or lecturers in what the meaning of culture is. Further, encouraging the division of counselling psychology to push forward the narrative in all psychological literature which re-frames the notion of culture to be truly inclusive, diverse; multifaceted.

Other research has considered that defining any social group as a cultural group is too broad to be meaningful (Nuttall, Webber & Sanchez, 1996). Hence, broader applications of the concept may dilute the focus on longstanding issues of race and ethnic concerns and fail to provide adequate attention to racial issues (Sue & Sue, 1990; Ridley et al., 1994). Without courses drawing attention to issues faced by minority groups including discrimination and inequality, there are fears that the status quo may remain (Arthur, 1998). Alternatively, a more inclusive definition of multicultural counselling acknowledges the unequal treatment and discrimination experienced by diverse populations and is not limited to racial or ethnic differences (Arthur, 1998). Whilst participants did not limit their own perceptions of the meaning of culture,

counselling needs to design interventions from the worldview of the client and by having culture as a central construct in professional practice, it will be consumer-driven (Pedersen, 1995). P6 considered the importance of using culture as a phenomenon to be explored in therapy, whether they are from a similar or dissimilar culture to the client. This was echoed by other participants, in using the position of curiosity to understand and facilitate wellbeing, as opposed to working solely on the presenting problems through suggested treatment approaches. E.g. a course of CBT for depression. Whilst the treatment of depression via CBT depends on how the clinician delivering CBT includes cultural competency, one of the criticisms of CBT as noted in the literature is that there is not enough focus on developmental history and for some clients this would be considered a limitation (Ghassemzadeh, 2007) and would require the therapy to be adapted in order to be successful (Rathod & Kingdon, 2009). As mentioned in the literature review, in some African Caribbean cultures where slavery, discrimination and racism have been important past and present experiences, a focus on these aspects may be necessary (Rathod, Kingdon, Phiri & Gobbi, 2009) for some clients.

The data captured in this research differs from Pedersen's (1995) suggestion of culture being a central construct in professional practice. Each course delivers the notion of cultural competency training differently. Whilst some courses have a dedicated module, others attempted to consistently imbed the notion throughout their teachings. With this lack of consistency throughout courses, we will have different trainees and hence, qualified professionals, with completely differing notions on the importance and emphasis which needs to be placed on the focus of culture in the therapeutic relationship and in training trainees. With there being limited data on the implications of cultural competency in counselling psychology doctoral training courses, and with BPS recommendations being vague and non-directive, course directors implement teaching in a way in which feels appropriate given their

understanding of the notion, as opposed to being consistently inclusive in teaching and understanding of different models and tools used in working as a culturally competent psychologist. As was evident in the data, P3 viewing the introduction of cultural competency in the BPS recommendations as a positive shift, whereas P5 described this as *"actually very very vague"*.

Cultural competency is a buzz word (or phrase), a tick box exercise to state one has demonstrated their cultural competency and therefore is culturally competent. Not only is this unsafe, it is undermining of the needs of an ever-growing diverse population, with multiple intersections and needs. The need is for counselling psychology teaching to integrate cultural competency in training, to ensure it is not separated in teaching but effectively integrated to be a part of core competencies, and to avoid being separated into fragments. Hence, maybe it is time to step away from terminology such as "cultural competency" and integrate this notion into the same framework as competency. However, an alternative consideration is that having a separate module focussing on cultural competency or separating it from the same framework as competency, places emphasis for students to consciously engage in this notion in training by having a specific reference point within their training and lectures to facilitate their understanding and skillset.

4.1.2. Inadvertent Learning

Literature has stated the benefits of practitioners working abroad and with those from diverse populations, as well as surrounding themselves with diversity. Some of the benefits of learning from diverse cultures were discussed and stated in the cultural competency subsection above. P1 and P2 discussed the benefits of using personal time outside of placement and learning

environments to develop relationships and learn from the social perspective of diverse people. If people choose not to expose themselves to diversity, what can be included in course curricula which encourages trainees to not only engage in using interventions and methods of working which are inclusive, but ensure that their time on placement on the course is spent on developing their inadvertent learning? With this example, it is imperative to consider further developments required for trainees to engage in inadvertent learning based on their surroundings. It is advantageous to have students on training courses from cultures other than the majority culture, then making the majority students aware of others' experiences (Wheeler & Izzard, 1997). Counsellors can learn about other cultures through social contact with others and through travel (Wheeler & Izzard, 1997). This was echoed by participants, with P1, P2, P4 and P5 discussing the diversity of the cohort on their courses and how this facilitates the learning experience by exposing majority culture clients to minority culture students. As was discussed in the literature review, this is when the minority students learning stops and the majority culture students learning begins.

Fundamentally, the interpretation being made is that the data within this theme demonstrates the need for counselling psychology to be open to working with a diverse range of people, in order to effectively utilise skills development and being able to demonstrate this through clinical outcomes, assignments and discussions. There is not as much literature present on the benefits of inadvertent learning. This terminology is not specifically used in the literature. Alhejji & Garavan (2015) argue the need for future research to adopt multiple perspectives ensure better cross-fertilization of perspectives and make use of more sophisticated methodologies. Hence with consideration to the present literature and the findings of the qualitative data, it is imperative that courses consider the integration of working in diverse settings on placements, as not all cohorts will be diverse cohorts and those taking the

independent route to study the course will not necessarily have the same opportunities as those attending a university setting.

4.1.3. Reflective Practice

More recent literature considers these perspectives as integrated into core counselling skills, which echoes the perspectives of the participants in the qualitative phase. As stated by (Ragg, 2011) in their book *Developing Practice Competencies: A foundation for generalist practice*, the importance of self-awareness and to source insight into differences, involves being aware of one's own thoughts and feelings, to be better positioned in understanding the difference between themselves and others. This is considered particularly important when cultural or spiritual differences exist in the therapeutic relationship (Daniel, Roysircar, Ables & Boyd, 2004; Suyemoto, Liem, Kuhn, Mongillow & Yauriac, 2007; Yan, 2005; Wiggins, 2009; Ragg, 2011). This was echoed by participants in the qualitative phase, who placed emphasis on managing one's own assumptions and remaining within the frame of reference of the client to provide effective culturally competent therapy. Further to this, the notion of a pluralistic approach in counselling and psychotherapy which was initially devised by Cooper and McLeod (Cooper & Dryden, 2015) complements the idea of delivering effective client led, culturally competent practice.

Reflective practice, whilst fundamentally important to the practice of any counselling psychologist, is a safe paring of buzz words which allows psychologists to imply that they are sensitive to the needs of the client during the implementation of their practice. However, when considering the concept of the Johari Window (Luft & Ingham, 1961), which encourages practitioners to be self-aware in considering their own blind spots , we ought to think about the true implications to practice and how one can continue to develop their awareness whilst

continuing to implement intervention specific to the needs of a continually diverse client population.

Such as is with the counselling psychology doctorate, trainees are required to complete personal therapy as a core component to complete their doctorate. In implementing this, counselling psychology is ensuring the development of practitioners engaging in the developing of their reflective practice skills and working through their own difficulties, to cultivate effective clinical practitioners.

Research continues to demonstrate that the strength of the therapeutic relationship is important in determining the effectiveness of counselling and counselling psychology interventions (Flückiger, Del Re, Wampold, & Horvath, 2018; Galbraith, 2017). Amidst an overall focus of building cultural competencies to support a broader conceptualization of diversity, there is also an increased awareness and mandate to inform therapeutic approaches with Indigenous perspectives and ways of knowing (Fellner, John, & Cottell, 2016).

From the data from the qualitative phase, all participants discussed reflective practice in a way which aligns with the literature. The literature frames terms around reflective practice which make it easy to think that one is engaging in reflective practice based on how they discuss the notion or publish their considerations on it. However the actual practice of reflective practice is difficult to monitor specifically. When participants discussed their own experiences, they were able to consider that they only became aware of some of their own assumptions and prejudices once engaging in practice with diverse people (as was stated by P5). In reflection of reflective practice, P2 considered how having a pluralistic approach is helpful in considering what is workable given the clinical situation, being focussed on what works instead of fixed on

what is right. Whilst there was continual emphasis on wanting students to be able to embody this notion effectively, and how the use of supervision is fundamental in the reflective practice process, most participants stated they learned a lot whilst "on the job" and after training.

From one perspective, one could argue that the vast amount of previous literature is sufficient for the development of reflective practice skills in clinicians; despite the exposure they may experience to diversity and presentations which they are unfamiliar with. Although there is plenty of research on this notion, it is important to think about the data obtained in this research and how the development of effective reflective practice skills can be developed in a manner which is truly inclusive of key competencies whilst challenging enough to encourage practitioners to consistently remain in a position of openness, curiosity and fear of complacency in order to deliver effective interventions.

4.1.4. Training

Training of counselling psychologists with reference to the data indicates a lack of consistency across courses and a need for further scrutiny of how pluralistic training methods are implemented in training courses. Whilst this links to Counselling Psychology's development as a field, firstly we need to consider consistency.

Different modalities and training courses considered in the literature review provided different perspectives on training in cultural competency skills. It was evident from Wheeler and Izzard's (1997) perspective that teaching ought to include experiences of minority cultures, in order to help trainees to reflect of the impact of their interactions and have insight on the frame of reference of the clients they are working with. From a person-centred perspective, Lago

(2005) considers that practitioners enhance their understanding of their own stereotypes, assumptions and judgement; they must be taught to appreciate very different psychological and cultural frameworks by which other people live; inform their own process of self-monitoring in relation to negative attitudes when conducting transcultural interviews and taught how to avoid imposing their own frame of reference upon clients. Neef and Peterson (2007) acknowledge that from a cognitive behavioural perspective, functional analysis may be the most useful approach in working cross-culturally. With reference to the different modalities and their perspectives on working with diversity, we can see a diverse range of perspectives and approaches from the modalities taught on the counselling psychology doctorate.

With consideration to the data obtained from the interviews within this research, different participants discussed different ways in which their training involves cultural competency training. For example, P1 considered that they do the work to interweave cultural competency training throughout the training but do not use those words to describe it. P6 acknowledged that their course has module specific to working cross culturally and P2 and P4 stated that they have a module dedicated to this but also interweave this notion across other modules. Whilst P3 reflected on the importance of this exposure on placement. All participants considered the importance of training on placement in order to develop effective cross-cultural skills. Much like some of the research, there are different approaches and perspectives to working cross culturally in counselling psychology doctoral courses.

With the differences in training cultural competency skills across courses, as has been considered in the cultural competency sub-section, we ought to consider the impact of this on skills development in trainees. With inconsistencies in course deliveries of such an imperative

competency, we ought to consider the benefit of courses working together to develop a similar framework in how the notion is integrated in teaching.

Whilst the benefits of courses practicing differently allows potential students to pick a course which aligns most closely with their preferred method of learning and developing as a psychologist, it is important to consider that the development of cross-cultural skills should not be optional and ought to be taught through means which are consistent throughout courses. For example, working with homosexuality through a psychodynamic perspective was considered by P3, and is an important reflective process. However, this could easily be missed in training unless a homosexual individual raises this question during the training process. Hence, developing and renewing training regularly ought to be considered by course directors; working in unity to develop the profession with the same intention.

4.1.5. Counselling Psychology's Development

With consideration to the theme of counselling psychology's development, the literature review was used to consider the implications for further research and what is needed within the field of counselling psychology. As was discussed in the literature review, Wilk (2014) used their research to consider that training in doctoral and master's programmes could integrate intercultural training. This would include learning about alternative interventions used in non-western cultures and considering how they can be utilised within a western framework, to benefit the client in their treatment (Wilk, 2014).

Through learning different methods and approaches to use with diverse clients, we use problem-solving and communication as a positive learning opportunity within the client work. Thus, Wilk (2014) continues to suggest we must consider the use of a pluralistic approach in

therapy, which ought to be informed by intercultural communication skills in training for therapists, allowing for collaboration on goals, tasks and methods of therapy with the client. This gives the therapist the opportunity to build strong therapeutic relationships with diverse clients from races, religions and sexual orientations which may differ from their own (Wilk, 2014). P2 reflected on the notion of cultural competence and discussed that it is not what people consider it to be, acknowledging that there is no straightforward response to working with diversity but acknowledged it to be broadly defined. In order to match the expectations explained by Wilk (2014) for more inclusive cross-cultural working, P2 discussed the notion of training trainers. She was the only participant to consider this and provided an insightful perspective on training a lecturing team on the job, to work in a way which supports the appropriate development of trainees. Whilst every job, in some sense, provides a learning experience, P2 described the expectations she has for her staff and how she teaches this to them. This is an important factor in the development of counselling psychology, and how unity and the development of collegial working and perspectives ties into the fundamental development of effective cross-cultural teaching. Whilst this mode of working is fundamental, it may or may not be shared across courses and ought to be brought to light for the consideration of all counselling psychologists in practice, supervision and teaching roles.

With consideration to the literature, and the various sources of literature used in this study, the themes emerging indicate that different schools of thoughts from different disciplines are slowly emerging within counselling psychology in order to truly develop cultural competency skills. Thinking about how the literature exploring intercultural communication is predominantly explored in models and disciplines other than psychology, such as business, or sociology, we are heading in a direction in which we are able to embody these notions in order to effectively develop psychology to be suitable for all. Whilst psychology appears slow in its

transition to be inclusive, the emphasis of this research is to encapsulate these differing perspectives to push counselling psychology practice and research to a phase in its development ensuring it is up-to-speed and working towards a truly inclusive model.

With consideration to the data obtained from the interviews within this research, P2 considered the notion of mentoring trainers who teach on the doctoral courses in how to mark assignments with a similar frame of reference in consideration of culture. She also identified that guest lecturers have stated that it would be beneficial if other doctoral courses offered a module discussing cultural competency. Hence showcasing the awareness within the field that there are differences in training across courses. P1 reflected that this is imbedded in everything that is taught; a respect for people despite the kind of theory or practice being taught. The notion of inclusivity was also considered, not just in terms of ethnicity and diversity but considering this from a socioeconomic perspective, as the Counselling Psychology Doctoral course is expensive and limits the number of people who can apply to the course due to the finances required.

P2 discussed engaging in a webinar considering different ways of engaging academia to diverse backgrounds, considering what works best for international students. The black and minority ethnic (BME) division for counselling psychologists was also mentioned, as P2 shared that BME Counselling Psychologists stated the need for their own space and discussions around trainings.

With consideration to the literature and the data, it is evident that the data does not necessarily align with the literature. There are broader difficulties which need to be considered in the development of counselling psychology such as; the mentoring of trainers; engaging with diverse groups/international students to consider how academia can work for them;

accessibility to courses for people of diverse backgrounds and diverse socioeconomic backgrounds. It is our responsibility as professionals to consider how to overcome these issues.

4.1.6. Biomedical Literature and Data

The lack of significant research on undergraduate medical education calls for additional work (Guzman, 2016). As was mentioned by participants in this research, other research has stated for students to experience cultural immersion to raise their awareness, improve their ability to address cultural differences and learn to appreciate these differences and understand the core cultural issues which may impact any patient (Breedlove & Hedrick, 1998; Schneider & Levin, 1999; Champaneria & Axtell, 2004; Fortin & Barnett, 2004; Haider et al., 2011).

If we consider research implications for further development of cultural competency skills in reference to the biomedical group, Jeffrey's (2015) book *Teaching Cultural Competency in Nursing and Health Care* acknowledges that research in the area of teaching and learning cultural competency "has been limited" (P. 67). She acknowledges that developing cultural competency for diverse learners can be a daunting task and emphasises the use of the Cultural Competence and Confidence (CCC) model. The CCC model is used to acknowledge the multi-dimensional factors involved in learning cultural competency, promoting culturally congruent care and focusses specifically on learning to provide effective care. Jeffrey's consistently talks about establishing the framework, suggesting at the time of publication, it was a work in progress. Singleton (2017) completed a study in which she used the Transcultural Self-Efficacy Tool to measure cultural competency to students on the Doctor of Nursing Practice (DNP) degree. Results from the experiment showed a significant gain from pre- to post-measure in students overall transcultural efficacy and suggested that formal education and learning

experiences can increase cultural competency skills. Using research such as this for the foundation in the development of these skills in trainees may be useful in improving participant scores, such as those who participated in the quantitative phase of this study. Hence, provides further insight into how current training can learn from literature in order to improve cross-cultural skills.

Bentley, Jovanovic and Sharma (2008) completed a study in which they explored cultural diversity training for UK professionals via a nationwide cross-sectional survey. Their search strategy involved health professional courses for the 2006/7 year. Courses included: Undergraduate medicine, Postgraduate Medicine, Nursing, Physio-therapy, Occupational Therapy, Speech and Language Therapy and Pharmacy. They devised a questionnaire with an accompanying letter explaining the intent of their study. Their questionnaire included 11 questions, 8 of which were answered by ticking the most appropriate box. Examples of questions included:

- "Would you describe the ethnic and/or cultural makeup of your region as diverse?"
- "Do you offer your students educational programmes on ethnic/cultural diversity during their training? If no, are you anticipating establishing one next year?"
- "Is the offered programme optional or required"
- "Are the students formally assessed on the content of the programme, and is this via oral or written assessment?" (Bentley et al., 2008, P. 494)

Principles encouraging cultural awareness within training have been issues by other professional bodies, including pharmacy (General Medical Council and Postgraduate Medical Education and Training Board, 2005). UK regions in which ethnic minorities only account for a small percentage of the population are less likely to have healthcare schools which teach

cultural diversity training, than regions which have higher ethnic minority representations (Bentley et al., 2008). With educational institutes where cultural diversity training does exist, methods and amounts of teaching widely vary (Bentley et al. 2008). This suggests that ignorance to health-related cultural matters contributes to the inconsistencies in diversity training. Each institute offering cultural diversity training does so out of its own appreciation of cultural-specific healthcare needs, as opposed to guidelines from professional bodies (Bentley et al. 2008). Cultural competency training in major UK healthcare professionals is inadequate (Bentley et al. 2008). If programmes do not incorporate cultural diversity training in their courses, trainees will not acquire the skills necessary to deal with ethnic minority healthcare (Genao, Bussey-Jones, Brady, Branch, Corbie-Smith, 2003; Brach & Fraser, 2000; Loudon, Anderson, Gill & Greenfield, 1999). Yet 10 years later there still appear to be inconsistencies in the development of cultural competency skills of trainees. Boutin-Foster, Foster and Konopasek (2008) acknowledge that cultural competence education programmes have increased, yet the duration, setting and content across courses differ. Whilst the intention is the same; to increase knowledge, promote positive attitudes and teach appropriate skills regarding cultural competency, this still comes with its own challenges. Some of the challenges involve over-coming the learner's resistance to develop cultural competency, and the other is to avoid stereotyping and using language such as "other" to define those culturally different to ourselves (Boutin-Foster et al. 2008). The literature tends to understate the complex processes that are involved in developing culturally sensitive services that are able to accommodate the beliefs, values and traditions of ethnic or religious minority groups who seek to maintain a distinct sense of cultural "otherness" (McEvoy, Williamson, Kada, Frazer, Dhliwayo, & Gask, 2017). Otherness is a concept that has been defined in alternative ways by authors who adopt different paradigmatic positions. McEvoy et al. (2017) define the term otherness in an inter-subjective sense, as being an epistemic perception of separateness, which is located in

identified points of difference at an individual (self and other) or collective (us and them) level. The collective differences which may be perceived by individuals may include collective groups of people, e.g. ethnic origin, gender, sexual orientation. The differences at an individual level may include differences within these collective groups, hence, individual differences. E.g. intersectionality and variance in identity whilst seemingly belonging to a larger collective group.

Previous literature has stated that medical students already have a crowded curriculum and gruelling workload (Guzman, 2016) and space for the development of further reflective practice, specifically in relation to culture, may be limited. However, with reference to the literature and the data obtained from this study, it is imperative to acknowledge the literature which informs teaching and practice. The data showed that biomedical colleagues perceive cultural competency as a desirable skill and are more likely to skew their responses in order to seem competent. Whilst this data was not significant but approached significance, it is crucial to consider the importance placed on reflective practice skills in biomedical trainings and if and how the literature can inform teaching in a way which ensures professionals are developing skills out of necessity, instead of interest alone in cultural competency skills.

4.2. Strengths and Limitations

Although there have been many criticisms for implementing mixed methods in research (Doyle, Brady & Byrne, 2009), as previously discussed, the mixed methods approach has much to offer. Criticisms stem from the 'incompatability thesis', holding the view that quantitative and qualitative analyses cannot be mixed due to differences in their epistemological and ontological origins (Doyle, Brady & Byrne, 2009), a view firmly held and believed by methodological purists. Purists appear to believe strongly in the dichotomy of world views and

research methods (Creswell & Clark, 2007). Further, researchers have cautioned new researchers in accepting an uncritical view of mixed methods by overlooking the underlying assumptions between each paradigm (Sale, Lohfeld & Brazil, 2002). On the other hand, Onwuegbuzie (2002) acknowledges that positivist and non-positivist philosophies are on an epistemological continuum, in which mixed methods occupy the middle ground. Further, Howe (1988) disputes the incompatibility thesis and credits a pragmatic approach, encouraging researchers to continue with "what works". Others argue that pragmatism helps the researcher to adopt an approach most appropriate for answering the research question or questions (Doyle, Brady & Byrne, 2009). Yet some researchers argue that a pragmatic approach is inadequate (Martens, 2003), considering what may be compromised through taking such an approach. Tashakkori and Teddlie (2003) argue that a pragmatist approach considers the research question more important than the method or the paradigm underlying it. Though we must consider that the research question itself sets the tone of the research beneath it. The research question is reinforced and strengthened through the scientific validation of the methods and paradigms underlying it, yet they ultimately serve the purpose of validating a strong research question.

Researchers acknowledge that it may be difficult for a researcher to conduct mixed methods if the two methods are conducted concurrently (Johnson & Onwuegbuzie, 2004). Namely, the time dedicated to two methods as opposed to one, inevitably takes longer to complete. Hence, it can be difficult to complete a project with given deadlines considering the amount of time and resources required for both. Initially, it was difficult to recruit participants for both phases of the study. After gaining success in recruiting 6 participants for the qualitative phase, the desired number of participants for the quantitative phase was not achieved, which led to recruiting participants for this phase for eight months.

For the qualitative phase, all interviews were conducted via skype. In some instances, there may have been interruption of the connection, which in turn interrupted the interview and the flow of the interview. Asking participants to repeat themselves after this may have impacted the flow of the conversation and the details that they intended to share. Regarding the analysis, the flexibility of thematic analysis can be an advantage but also a disadvantage which potentially paralyses the researcher when they are deciding which aspects of the data to focus on (Braun & Clarke, 2006). This flexibility also led to further time dedicated to structuring and analysing the data.

For the quantitative phase, courses appeared sceptical in their responses or declined engagement completely when they became aware that this research was measuring levels of cultural competency skills. This made the recruitment process difficult and it took longer to reach a usable number of participants. The desired number of participants was not obtained due to this and due to time restrictions, and hence the analysis was conduct on the given group. There were also varying numbers of participants from each profession in the biomedical group. The intention for the research was to compare nursing, medicine and surgery and pharmacy students as individual groups. Unfortunately, these groups had to be collapsed into the "biomedical" group, due to the recruitment issues experienced. With consideration to the demographic details of the participants, the race and ethnicity of participants was not considered prior to and during data collection and may have been useful for the purposes of this research as another variable.

There was a struggle in finding research which focussed on the development of cultural competency skills in counselling psychology courses specifically; it was required to gather

previous research encompassing culture and teaching to formulate an effective literature review, as opposed to referring to existing research which encompasses these elements.

However, this research project is unique in its approach of having asked counselling psychology course directors directly to discuss the development of cultural competency skills to further our knowledge of what courses are currently teaching to develop these skills in trainees.

4.3. Suggestions for further research

One of the limitations reported in empirical research is biased participant sampling procedure which exclude ethnic minority groups from most studies whilst extrapolating findings to be applicable to the general population (Roth & Fonagy, 2005; Wilk, 2014). Cultural limitations and assumptions are overlooked consistently in North America and Great Britain, whom provide counselling services to diverse populations that might not be culturally responsive due to limited research investigating therapeutic efficacy with diverse populations specifically (Zane et al, 2004; Wilk, 2014). Hence, it could be useful to conduct further mixed methods research by interviewing service users from diverse backgrounds regarding the treatment they receive from counselling and healthcare services and giving questionnaires of cultural competency to service providers from the same services. This could provide further insight into levels of cultural competency in specific services versus the treatment diverse clients believe they are receiving. This research could provide understanding as to the needs of both service users and clinicians in terms of training and professional development. In this research, it would be imperative to ensure the confidentiality and anonymity of participants.

To maintain focus on the development of cultural competency skill in doctoral courses, further research could consider conducting a longitudinal study with counselling psychology trainees at the beginning, during and at the end of doctoral course, by using a tool such as the HPCCI to measure how these skills are developed throughout the doctoral process. This would provide evidence for how these skills have been developed through the course of the doctoral process. Whilst the limitations of this research could include changes to course structure, people leaving courses or declining participation after initial agreement. Also, participants becoming familiar with the tool may lead to inevitable changes in answers to demonstrate perceived progress which may not be truly indicative of their actual progress, in order to be perceived as increasing their cultural competency.

The BPS sets the standards and expectations and the course directors emphasise these expectations in varying degrees depending on the course and its format. Participants of the qualitative phase discussed meeting BPS expectations, and future research could interview BPS directors to consider what influences the development of course criteria for counselling psychology doctoral courses, with some emphasis on the development of cultural competency skills. This could provide course directors and counselling psychologists with some insight into how training development is informed.

4.4. Conclusion

Are cultural competency skills being developed by counselling psychology training courses? Yes. Is this consistent across courses? No. Overall, there is a development in cultural competency skills in trainees. However, this research has found that there are overall inconsistencies in emphasis across institutions. Courses are given expectations by the BPS but these expectations regarding cultural competency are not specific. Hence consistency is not

present, and this may be something we, as a profession, need to work towards in redefining culture and the development of cultural competency skills.

Critical Appraisal

Critical Appraisal

I have chosen to take a linear approach in writing this critical appraisal, with consideration of my development as researcher, practitioner and the application of my research to my practice. My personal and professional development coincide with my professional journal and will be considered throughout this piece of work.

Development as a Researcher

I started the Professional Doctorate in Counselling Psychology immediately after graduating from my undergraduate degree. Having acquired a 1st in my undergraduate dissertation which was my first research experience, I felt in good stead to meet the research competencies and expectations of the course. My undergraduate dissertation was my first experience of conducting quantitative psychological research and inspired to me explore research methods which may broaden my research perspectives and analytical skills. My undergraduate dissertation considered personality traits and participant motivation to seek psychological services and attitudes and stigma associated with this. It was a generic undergraduate study which referred to the Big Five Factors of Personality (Goldberg, 1999) and noted a positive relationship between agreeableness and attitudes towards counselling and a negative relationship between neuroticism and attitudes towards counselling. I was still developing my understanding for counselling psychology and where my passions lie within the field. During my final year degree during the counselling module, I completed an assignment exploring the current developments in counselling psychology. The assignment explored whether counselling in western countries facilitated client needs from non-western cultural backgrounds. Essentially, it explored cultural competency skills of practitioners and

practitioners developing a pluralistic approach in working with culturally diverse clients, referring primarily to Wilk's (2014) paper. Having already started my dissertation but completing this assignment alongside it, I was able to consider minority groups' access to mental health services and the development of cultural competency skills in counselling psychologists. This led to the development of my present research thesis which asks if counselling psychology doctoral programmes are developing cultural competency skills in trainees. Alongside this, comparing the levels of cultural competency skills in counselling psychology and biomedical trainees. This is a mixed-methods research project which uses qualitative and quantitative approaches. By using interviews, I am able to ask participants if and how their course develops cultural competency skills and use thematic analysis to interpret common themes and reasons of the development of cultural competency skills in trainees. The quantitative element

Having carried out the research thesis, I have been able to understand and develop my understanding of how to plan and present research whilst working collaboratively with my thesis supervisors on the overall project and aspects which I may struggle with. As we have to amend the thesis for submission to a journal, by searching for appropriate journals and considering their impact factors and their instructions for authors, I have been able to develop my insight into what the expectations are for researchers intending to submit their research and how to amend my research according to journal expectations. As I am personally interested in developing my career to include psychological research and working as a research associate. Developing these skills and experiences via the doctorate gives me further motivation and insight to work in research. I presume this would be a gateway to working in academia as I am interested in lecturing part-time later in my career, when I have more experience in various areas of counselling psychology, including clinical practice, supervision and research.

By conducting research throughout my undergraduate degree and then in the doctorate, I believe I learned from the journals themselves. By reading the journals I was consistently searching for and referencing, I was able to develop my knowledge of how to effectively develop and explain my position, reference research and present credible research.

Development as a Practitioner

Prior to starting the doctorate in counselling psychology, my clinical experience consisted of the volunteering I did at Victim Support (a charity providing emotional and logistical support to victims of crime) and Samaritans (a listening service which provides emotional support via telephone, email and face-to-face). Alongside this, I completed the qualification in counselling skills which developed my therapeutic practice via evidence-based practice, focussing on a humanistic approach (primarily referring to the humanistic works of Carl Rogers) and considering CBT and Psychodynamic approaches. The basis of my psychological and counselling knowledge stemmed from my undergraduate degree and from my academic experiences of learning and writing about therapeutic practitioners, including Rogers.

My work at victim support and Samaritans developed my ability to operate as a practitioner using the core conditions of therapy. The core conditions include empathy, unconditional positive regard (UPR) and congruence (Kirschenbaum & Jourdan, 2005). Empathy should be viewed as an interpersonal process that can involve emotional contagion, identification, and role taking (Gladstein, 1983). Further, by identifying the emotions of the other and role taking, one is able to help a client to feel understood. This may lead to helpful outcomes for some clients (Gladstein, 1983). UPR is consistent acceptance of the clients' positive and negative emotions (Rogers, 1957). As opposed to rejecting negative emotions and only accepting the

positive. We are able to relate to client's internal working models and consider how to facilitate wellness and psychological growth. Congruence is when one transparently experiences their emotions within the therapeutic relationship (Gillon, 2007). Modelling congruence can help the client to attend more closely to their own emotions (Gillon, 2007). By having an awareness of the core conditions prior to starting the doctorate, I was able to develop my ability to apply these conditions despite my work setting or environment. As is stated by Rogers (1957), these conditions operate independently of the therapeutic approach being used. Further, this allowed me to implement these conditions when learning about and implementing new modalities, including CBT, psychodynamic and systemic approaches.

In the beginning of the doctorate, we were introduced to further methods of humanistic therapy, including Gestalt therapy. Gestalt therapy is described as being focussing on events most significant to the client, focussing on the present moment, the obvious rather than interpretation and encouraging the development of self-support (Yontef, 1979). This method of humanistic therapy taught me to attend to the clients' needs in a different way. I was able to work with the present moment and acknowledge the clients' defences or incongruence in their responses through being present with them in that. During the early stages of the doctorate we were also trained in cognitive behavioural therapy (CBT). Dobson (2009) states that CBT consists of three concepts: 1. cognitive activity impacts behaviour 2. Cognitive activity can be monitored and altered. 3. Desires to change behaviour can be achieved through cognitive change. Initially I had a sceptical view of cognitive behavioural therapy, due to hearing rumours about ineffective practice from services providers who offer short-term CBT to service users. Although delving into the theory and learning about the intentions of the model, I was able to understand and implement these methods into my work. Hence, being able to deliver effective CBT and using this method in conjunction with the core conditions. Rather than placing the

entire emphasis on the client, the CBT approach acknowledges therapy as a collaborative process in which both the client and therapist bring their own knowledge and experience to the therapy; the client brings the knowledge and experience they have of their presenting problem and the therapist brings their knowledge and experience on effective problem-solving techniques (Westbrook, Kennerley & Kirk, 2007). This then shifted my initial judgements of CBT but also taught me to be open-minded towards any therapeutic modality I may encounter, as considered that there is something to be learned from every therapeutic model. Alongside learning these models, we have skills sessions. In these sessions, we were placed in groups of three, and took the role of therapist, client and observer. Sessions were video recorded and sometimes observed by members of staff. These sessions, whilst intense and intimidating initially, were a valuable opportunity to be observed receive feedback to develop our skills and therapeutic approach. Using skills sessions directly impacted my ability to effectively develop myself as a practitioner. Receiving feedback from peers and members of staff helped me to quickly develop insight into my presentation and the way in which I deliver therapy. It allowed me to further reflect on how I need to present in the room and nuances in my interaction which I may need to adjust or alter to meet the needs of the client. My peers and staff offered me positive feedback regarding my development as a practitioner through the skills sessions.

I consider myself to have a humanistic foundation, in my practice as a clinician and in how I operate in my personal life. Whilst classical humanism was developed by ancient Greek philosophers in the fifth century BCE, the most recent wave of humanism began in the 20th century as a response to behaviourism and psychotherapy aligning themselves closely with the medical model (Schneider, Pierson, & Bugental, 2014). Modern humanistic therapy was developed by Abraham Maslow (consider Heirachy of Needs), Carl Rogers and the notion of the core conditions and Frederick Perls development of Gestalt therapy. We learned about each

one of the theories associated with the named people and considered how we could further integrate them into our practice. Prior to the doctorate I had only been familiar with Rogers' notions and intentions for humanistic therapy. The doctoral module focussing on humanistic therapy gave me the opportunity to develop my skills as a counselling psychologist and include further humanistic theory and interventions to facilitate the well-being of people I worked with. I was fascinated and excited by the new methods I had learned and used them in my practice as a clinician. With consideration of the hierarchy of needs, I was able to consider the clients' current position in their life and where they may be in accordance to that theory and what their notions may be for the ideal self. With consideration of Gestalt methods, I have been able to use polarities in my work, encouraging clients to consider two extremes of one scenario and where they place themselves. Also, using the present moment to encourage the client to attend to the feelings and how that influences their ongoing dynamic and relationship with themselves and others. As is defined by Yontef (1979) gestalt therapy is described as vigilant contact with an event most significant to the client, focussing on the here and now, the obvious rather than interpretation, and encouraging the development of self-support. The empty-chair method is another which has been helpful in work with clients to help them bring closure (Paivio & Greenberg, 1995). This can be with those who are deceased or those who they may struggle to confront in their day-to-day life. Adapting and using this method consistently with Rogers' core conditions, I noticed an improvement in my practice and what I could offer to clients who may present with varying difficulties.

After learning about and building my humanistic roots, we learned about cognitive behavioural therapy (CBT). Prior to being taught this module, I had heard rumours of CBT being an ineffective therapeutic method and had reservations about what I would learn from the module and how likely I would be to adapt the approach into my practice. CBT is a collaborative

process, in which the therapist brings their clinical expertise and experiences and the client brings the experiences of their problem (Kennerly, Kirk & Westbrook, 2016). The therapist works with the client to develop positive thinking styles and coping skills (McLeod, 2009). After learning about core beliefs and methods of CBT formulation, I found myself intrigued by CBT and how I can integrate its interventions into my practice to become an integrative practitioner.

Learning about psychodynamic methods intrigued and inspired me. I did not know much about psychodynamic theory other than Freud's (1953) psychosexual stages of development (Oral, Anal, Phallic, Latent and Genital) which I had learned about during my time in 6th form. I had also developed some knowledge on psychodynamic formulation and theory in the final year of my undergraduate degree. Learning about psychodynamic theory gave me deeper scope into the dynamics of the therapeutic relationship; considering the notions of free association, transference, ego strength, client defensiveness and boundaries. Free association is viewed as a pathway to the unconscious (McGarth & Freud, 1986), in which the client is encouraged to talk freely, even when feeling reluctant to do so. In using free association in therapy, the therapist is aware of the consequences of their intermittent intervention of the clients' flow of thoughts (Gill, 1984). Transference is the notion in which a person unconsciously projects feelings and attitudes from a past relationship onto a person or situation in the present (Hughes & Kerr, 2000). Transference is viewed as an expression of resistance (Racker, 2018). These notions from psychodynamic teachings are what I notice most regularly in my practice with clients and inform my reflective practice when considering my intervention.

Application of Thesis Research to Clinical Practice

Completing this research has impacted my clinical practice in developing my confidence in asking clients about their cultural identity honestly and openly during the assessment process and also during therapy. If a client discusses a culturally norm in their life to which I have no understanding or knowledge (e.g. attending a specific church or temple), I'll openly ask the client what that experience involves and how it impacts them. This gives me the opportunity to remain within the client's frame of reference whilst acknowledging what contributes to their worldview and mental health.

By completing process reports as part of the assessment criteria in the doctorate, gave me the scope to develop my research knowledge and evidence-based practice.

My development as a researcher informs my process as to how I became interested in diversity issues in counselling psychology. Initially used as a topic for the purposes of an assignment, I found myself genuinely interested and intrigued by the topic. Being a cis gendered male, who is Indian in heritage, British by nationality and identifies as gay, I have always acknowledged myself to be an "outsider" as this was what I was told by the society I was surrounded by from an early age. Hence, my increased involvement in activism and interests in equality and social justice grew stronger the older I became and the more aware I became of my rights. I recognised that counselling psychology work is social justice work. Further, I became perplexed by what research suggested regarding those who do not fit western cultural norms; ethnic minorities are less likely to access mental health services.

Developing an understanding of this psychological research, and considering the present political climate, I wondered if counselling psychology was doing enough for minority groups. From the research I had read, it did not seem like enough. This fed into the sense of injustice I

have experienced from an early age, stemming from the outright discrimination I faced as child including racism, homophobia, and the microaggressions I regularly encounter.

With acknowledgement of my personal experiences and how this directly impacts my relationship to the research, I was able to learn more about the development of cultural competency skills and more specifically, what culture means for a client and how they experience their culture. By remaining in the clients' internal frame of reference (Gillon, 2007), gives me the empathy and ability to understand how they relate to themselves, their relationships and society. To understand different aspects which may be associated with the client's culture, I consider which elements of their culture which may be influenced by or influencing their presenting issues. For example, if a client has gender identity or sexuality issues, I would be likely to use the "Genderbread Person" (Appendix 13) to help them understand their gender identity, gender expression and sexual orientation. If I need further understanding of their religious background or experiences, I will usually openly ask the client how their face influences their day-to-day living and what their relationship is like with God, their religion, and those who believe and do not believe in the same religion as them. If they present with learning difficulties or disabilities, I am usually made aware of this prior to working one-to-one with the client and consider how I can adapt my approach to meet the needs of the client.

By managing my own assumptions and biases, I avoid colluding with my clients as well as judging them, by attempting to consistently remain within their frame and reference and consider how the client's cultural influences may be influencing their presenting problems and how we can work together to understand and validate their experience, whilst working to change the presenting issues.

Researching and considering cultural competency skills has also influenced me in developing an LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Pansexual, Two-Spirit) therapy group in my place of work. I work with children and young people with mental health difficulties in the National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS). We recently received feedback from transgender service users stating that they do not think the service meets their needs. This research also taught me that we need to listen and respond to service users' needs. Having personally acknowledged that there is a lack of LGBTQ+ specific services for adults and even fewer for young people with mental health issues, I thought creating the therapy group will give young people the opportunity to not feel isolated in how they identify in a heteronormative society whilst equipping them with the ability to effectively navigate the world with resources on managing their own anxieties, self-acceptance, improving their mental health and how to effectively communicate with others who misunderstand, misrepresent or repress them. To define heteronormativity Schilt and Westbrook (2009) referred to Kitzinger's (2005) definition by explaining it as "the suite of cultural, legal, and institutional practices that maintain normative assumptions that there are two and only two genders, that gender reflects biological sex, and that only sexual attraction between these "opposite" genders is natural or acceptable" (Schilt & Westbrook, 2009, P. 441).

The LGBTQ+ therapy group is currently undergoing formation. I have been given four months with weekly allocated time to research and develop the group. The group will be a 7-week programme. Week 1 will focus on psychoeducation and goal setting (considering what clients want from the group); week 2 considers the anxieties around personal expression, which considers anxieties around expressing one's sexual orientation or gender identity, how these

can be managed and how the law can protect us. Session 3 will focus on battling stereotypes, which considers culture and cultural expectations; specifically, religion, race and societal norms in different racial backgrounds and as well as different areas within the U.K. Session 4 focusses on self-acceptance, session 5 looks at accepting others whilst rejecting oppression, session 6 considers how to live authentically and session 7 will be a reflective session in which cliets consider their experience of the groups, their likes, dislikes and how close they feel they are to their original goal set in week one. Outcome measures will be used to consider the effectiveness of the group. The outcome measures used will include the Revised Children's Anxiety and Depression Scale (RCADS), Outcome Rating Scale (ORS) and Session Rating Scale (SRS). The RCADS is a 47-item questionnaire which measures different traits associated with depression and anxiety. Once the scores have been input into a computer system and correspond with the client's age, the system generates a graph detailing if and to what extent the client's depression and anxiety is of clinical significance. The ORS and SRS are used throughout CAMHS services. The ORS considers the present wellbeing of the client with consideration to their systems, including personal, interpersonal, social and overall wellbeing. The SRS considers the client's relationship with the therapist, in which the client rates how much they think the work has focussed on their goals, their rating of the therapeutic relationship. By using these tools to measure outcomes, I will be able to determine the effectiveness of the group, whilst encouraging group members to provide feedback in the final week, as to what they liked, disliked or thought was missing from the group.

Mental health services are not as easily available, accessible or effectively delivered to those from ethnic minorities (Sue, Zane, Hall |& Berger, 2009). By considering LGBTQ+ people of colour accessing mental health services being reduced further, by creating a group in a multicultural city in which young LGBTQ+ people can access the group who are within the

CAMHS service, gives further opportunity for psychoeducation and to reduce the statistics of suicide and mental health associated with LGBTQ+ youth. A study conducted in 2016 found that 58% of LGBT young people planned or attempted suicide (McDermott, Hughes & Rawlings, 2016). Being a member of the LGBTQ+ umbrella myself and considering the impact it has had on me and those I know who are also a part of the umbrella, I acknowledge with further negative media attention presently discussing gender identity that young people who struggle with these issues require a safe space to validate their identity, and tend to their mental health needs.

With consideration to my general practice, I encourage clients to explain parts of their cultural identity which I may not understand, hence I am able to remain within their frame of reference and consider the impact that their cultural norms are having on their mental health and well-being. For example, if a client believes in a religion of which I have no knowledge, I will ask the client to expand on their belief system, how this interlinks with their day-to-day living and consider whether their religion is a protective factor of their mental health or a maintaining factor. By remaining in an unbiased position when clients explore the cultural aspects of their identity, I have shifted from a position of anxiety to a position of openness and understanding. I previously had feelings of anxiety if a client explored aspects of their culture, of which I had no understanding or knowledge. My anxiety related to my fear of the client feeling misunderstood or invalidated by my lack of knowledge. With conducting this research, I have been able to see the benefit of maintaining a curious and open position when exploring cultural aspects with clients, as this seems to encourage their thinking and processing around the contribution the cultural elements of their life make to their identity and well-being, whilst teaching me about their position in relation to these elements.

My reflections on the doctoral experience as a whole are positive. The process informed by personal development through the theories I learned about, my reflective practice referring to these theories influenced and developed me as a person. The personal development group we had to attend every week throughout the course encouraged us to work together as a cohort. Personal development group allowed me to connect with my cohort on an emotional level whilst we encouraged and supported each other through the doctoral process.

Attending personal therapy as a mandatory part of the course influenced my professional development. I had two therapists prior to my current therapist, as I had to navigate different therapeutic relationships until I found a therapeutic relationship which met my needs. My first therapist did not listen to me. When I would talk to her about different presenting difficulties I was experiencing, I noticed she would often project her perspective of my problem onto me, as opposed to remaining with my internal frame of reference and understanding the feelings I was experiencing beneath what I discussed in therapy. She also made assumptions about my cultural differences and pointed this out in the session but without reason or direct enquiry. I made her aware of what did not work for me in the therapeutic relationship and she continued to respond inappropriately. I then stopped attending therapy with her after 3 sessions. The second therapist was humanistic in nature and we built rapport very quickly. Unfortunately, she was inconsistent in her boundaries: often arriving late to sessions (which were at her house) and having her husband bring cups of tea into the session. As one of our sessions was ending and I was leaving her house, she gave me a kiss on the cheek. I thought this was inappropriate and I did not want to engage in therapy with her any longer. After that I was recommended the therapist I work with at the moment. A colleague of mind had worked with her previously and recommended her to me. After going to therapy with her, I noticed that her boundaries are consistent, and I felt safe to bring anything I needed to, to therapy. I trust her more than my

previous therapists and feel contained and heard in sessions. I experienced some trauma in early childhood and this is something which she is helping me through.

I noticed during my experience on the doctorate that whilst cultural diversity is discussed in associated with some theories, or in critiquing the use of a psychometric tool with diverse cultures, I think there was not enough covered regarding cultural diversity in general. We had one lecture on the LGBTQ+ community, which was very helpful and informative, but I think it should be an integrated part of every course. We also had few lectures on working with children and young people. A lot of the skills I learned for working with children and young people were through supervision, conducting my own research and by working directly with children and young people. I was also the only male in my cohort. I reflected on the recruitment process for counselling psychology courses. Whilst I am grateful for the opportunity, I reflected upon why males are less likely to apply for the doctorate in counselling psychology. During my undergraduate degree, my peers were mostly female, too. There is a need for more male counselling psychologists in the field, as I am also the only male in my office at work. I find that having more men in the field may be beneficial in working with other men, boys and adolescent males, as in my own experience, I have had male clients disclose and share information with me which they may not have shared if they were working with a female counselling psychologist. The majority of my case load also consists of female clients. I wonder what it is about counselling psychology and therapy which leads to it being a female dominated profession. Is there a lack of awareness in society that it is okay for men to access services? I consider what the fear is and why people may be reluctant to access support, if they know how to access it. A lot of young people I work with are also white British. I do wonder if there is enough exposure to minority groups of mental health services which may be available to them. Essentially, having reflected upon counselling psychology being a profession dominated by

white middle class females, with services accessed mostly by white British females, I wonder whether the issue is exposure to courses and services and general education about mental health and different career paths within mental health. Psychology could be developed and integrated into core education, focussing primarily on understanding mental health diagnoses, conditions and presenting difficulties as well as providing insight into different career options within the field of psychology. Psychology has broad career opportunities and only until coming towards the end of my doctoral experiences, did I become aware of some of them. This experienced influenced my research development and lived experience of the course by reflecting openly with colleagues and supervisors to consider these differences and what may be influencing them.

Conclusion of Appraisal

I believe the thesis research I have conducted makes a valid contribution to the field of counselling psychology and provides scope for perspective on cultural competency in a variety of healthcare professions. Completing this research has given me the opportunity to develop my research skills in developing my understanding of how to complete research which may be worthy for submission to a credible journal. As a practitioner, I have been able to develop my reflective practice, consider my own cultural values and how these may impact my relationship with a client from a similar or different cultural background. I have been able to apply my understanding of the research to my clinical practice in openly listening to clients being client led, putting aside the anxieties I may have around asking about a client's experience with fear of offending and asking them questions openly and explaining why I am asking about cultural aspects of their life. I am also aware of different methods of formulation to include client issues and needs from a cultural perspective. Essentially, we are all from different cultural

backgrounds and the way each family and individual manage their cultural identity informs the way they navigate in the world.

References:

Al-Issa, I. (1976). Behavior therapy and hallucinations: A sociocultural approach. *Psychotherapy: Theory, Research & Practice*, *13*(2), 156.

Alleyne, A. (2011). 10 Overcoming racism, discrimination and oppression in psychotherapy. *The handbook of transcultural counselling and psychotherapy*, 117.

Arthur, N. (1998). Counsellor Education for Diversity: Where Do We Go from Here?. *Canadian Journal of Counselling*, *32*(1), 88-103.

Babbie E (1990) *Survey Research Methods* 2nd edn. Wadsworth Publishing Co, Belmont Ca

Bannink, F. (2012). *Practicing positive CBT: From reducing distress to building success*. John Wiley & Sons.

Barker, P. (1992) *Regeneration,* Harmondsworth: Penguin.

Barrett, C. (2008). My People. *A project exploring the experiences of gay, lesbian, bisexual, transgender and intersex seniors in aged-care services: Victoria: http://www. also. org. au. php5-1. dfw1-1. websitetestlink. com/research/seniors/untitled (accessed: 21 July 2017).*

Barrett, G. V. (1972). *New research models of the future for industrial and organizational psychology*. Personnel Psychology, 25, 1-17.

Beail, N. (2016, February). Psychological therapies and people who have intellectual disabilities. Retrieved January 19, 2019, from https://www1.bps.org.uk/system/files/Public files/id_therapies.pdf

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public health reports (Washington, D.C. : 1974)*, *118*(4), 293-302.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Park, E. R. (2005). Cultural competence and health care disparities: key perspectives and trends. *Health affairs*, *24*(2), 499-505.

Boutin-Foster, C., Foster, J. C., & Konopasek, L. (2008). Physician, know thyself: The professional culture of medicine as a framework for teaching cultural competence. *Academic Medicine*, *83*(1), 106-111.

Borders, L. D. (2014). Best practices in clinical supervision: Another step in delineating effective supervision practice. *American Journal of Psychotherapy*, *68*(2), 151-162.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. sage.

BP Sinha RN Kanungo, J. (1997). Context sensitivity and balancing in Indian organizational behaviour. *International journal of psychology*, *32*(2), 93-106.

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, *57*(1_suppl), 181-217.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Breedlove, C., & Hedrick, H. (1998). Encouraging Lifelong Professional Development Across the Medical Education Continuum: Call for Papers in Medical Education. *JAMA*, *280*(20), 1786-1786.

Briley, D. A., & Aaker, J. L. (2006). When does culture matter? Effects of personal knowledge on the correction of culture-based judgments. *Journal of Marketing Research*, *43*(3), 395-408.

Brinkmann, S., & Kvale, S. (2015). *InterViews: Learning the craft of qualitative research interviewing*. Los Angeles: Sage Publications.

British Psychological Society Qualifications Office. (2008). *Qualification in Counselling Psychology: Candidate Handbook*. Leicester: British Psychological Society.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by design and nature*. Harvard University Press.

Bronfenbrenner, U. (1989, April). The developing ecology of human development: Paradigm lost or paradigm regained. In *biennial meeting of the Society for Research in Child Development, Kansas City, MO*.

Bronfenbrenner, U. (2001). The Bioecological Theory of Human Development. *Making human beings human: Bioecological perspectives on human development* (pp. 3-15). Thousand Oaks, CA, Sage Publications Ltd.

Bronfenbrenner, U., & Morris, P. A. (2006). The bioecological model of human development. *Handbook of child psychology*.

Bronfenbrenner, U. (2009). *The Ecology of Human Development: Experiments by Nature and Design*. Cambridge, MA: Harvard University Press.

Brooks, K.C. (2015). “A Silent Curriculum.” JAMA 313(19):1909–10.

Bull, S., & O'Farrell, K. (Eds.). (2012). *Art Therapy and Learning Disabilities: "don't Guess My Happiness"*. Routledge.

Burr, V. (1995). *An introduction to social constructionism*. Florence, KY, US: Taylor & Frances/Routledge.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of transcultural nursing*, *13*(3), 181-184.

Cavalli, N. (2019). CSI 34: Did hate crime double after Brexit?. Retrieved April 18, 2020, from http://csi.nuff.ox.ac.uk/wp-content/uploads/2019/06/CSI34_hate-crime.pdf

Champaneria, M. C., & Axtell, S. (2004). Cultural competence training in US medical schools. *JAMA*, *291*(17), 2142-2142.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of counseling psychology*, *56*(4), 521-536.

Chen, J., Nakano, Y., Ietzugu, T., Ogawa, S., Funayama, T., Watanabe, N., & Furukawa, T. A. (2007). Group cognitive behavior therapy for Japanese patients with social anxiety disorder: preliminary outcomes and their predictors. *BMC psychiatry*, *7*(1), 69.

Chung, C. K. (1996). Adaptation of cognitive therapy to Korean culture. CME Syllabus & Proceedings Summary. In *149th Annual Meeting of APA* (p. p132).

Collins, K. M., Onwuegbuzie, A. J., & Sutton, I. L. (2006). A model incorporating the rationale and purpose for conducting mixed methods research in special education and beyond. *Learning disabilities: A contemporary journal*, *4*(1), 67-100.

Collins, S., & Arthur, N. (2010). Culture-infused counselling: A model for developing multicultural competence. *Counselling Psychology Quarterly*, *23*(2), 217-233.

Connor-Smith, J. K., & Weisz, J. R. (2003). Applying treatment outcome research in clinical practice: Techniques for adapting interventions to the real world. *Child and Adolescent Mental Health*, *8*(1), 3-10.

Constantine, M. G. (2001). Predictors of observer rating of multicultural counseling competence in Black, Latino and White American trainee. *Journal of Counseling Psychology*, 48, 456-462.

Cook, J. D., Hepworth, S. J., & Warr, P. B. (1981). The experience of work. San Diego: Academic Press.

Cook, T. D., & Reichardt, C. S. (1979). *Qualitative and quantitative methods in evaluation research* (Vol. 1). Sage Publications, Inc.

Cooper, M. (2007). Humanizing psychotherapy. *Journal of Contemporary Psychotherapy, 37*(1), 11-16.

Cooper, M. (2009). Welcoming the Other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review-British Psychological Society*, *24*(3/4).

Cooper, M., & Dryden, W. (Eds.). (2015). *The handbook of pluralistic counselling and psychotherapy*. Sage.

Cooper, M., & McLeod, J. (2007) *A pluralistic framework for counselling and psychotherapy:*

Implications for research. Counselling and Psychotherapy Research, 7 (3). pp. 135-143. ISSN 1473-3145

Coughlan, M., Cronin, P., & Ryan, F. (2009). Survey research: Process and limitations. *International Journal of Therapy & Rehabilitation*, *16*(1).

Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries?. *Journal of advanced nursing*, *26*(3), 623-630.

Craig, S. L., Austin, A., & Alessi, E. (2013). Gay affirmative cognitive behavioral therapy for sexual minority youth: A clinical adaptation. *Clinical Social Work Journal*, *41*(3), 258- 266.

Crameri, P., Barrett, C., Latham, J. R., & Whyte, C. (2015). It is more than sex and clothes: Culturally safe services for older lesbian, gay, bisexual, transgender and intersex people. *Australasian journal on ageing*, *34*, 21-25.

Crandall, S. J., George, G., Marion, G. S., & Davis, S. (2003). Applying theory to the design of cultural competency training for medical students: a case study. *Academic Medicine*, *78*(6), 588-594.

Creswell, J. W., & Clark, V. L. P. (2007). Designing and conducting mixed methods research: Wiley Online Library.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., Plano Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. *Handbook of mixed methods in social and behavioral research*, *209*, 240.

Cross, T., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). Toward a culturally competent system of care. *Washington, DC: Georgetown University Child Development Center*.

Crouan, M. (1996) 'Pushing against the wind: The recognition of Lesbians in counselling training', *Counselling,* 7(1): 36-9.

Crowne, D. P., & Marlowe, D. (1964). *The approval motive: Studies in evaluative dependence*. New York: Wiley.

Cutts, L. A. (2013). Considering a social justice agenda for counselling psychology in the UK. *Counselling Psychology Review*, *28*(2), 8-16.

Deffenbacher, J. L., Oetting, E. R., & DiGiuseppe, R. A. (2002). Principles of empirically supported interventions applied to anger management. *The Counseling Psychologist*, *30*(2), 262-280.

Dobson, K. S. (Ed.). (2009). *Handbook of cognitive-behavioral therapies*. Guilford Press.

Davis MB (2007) *Doing a Successful Research Project.* Palgrave, Houndmills

Dogra, N., Conning, S., Gill, P., Spencer, J., & Turner, M. (2005). Teaching of cultural diversity in medical schools in the United Kingdom and Republic of Ireland: cross sectional questionnaire survey. *Bmj, 330*(7488), 403-404. doi:10.1136/bmj.38338.661493.ae

Doyle, L., Brady, A. M., & Byrne, G. (2009). An overview of mixed methods research. *Journal of Research in Nursing*, *14*(2), 175-185.

Drew, C. J., Hardman, M., & Hosp, J. (2007). Ethical issues in conducting research. *http://www. sagepub. c-om/upm-data/26094_3. pdf*, *24*(05), 2014.

Dumont, L. (1980). *Homo hierarchicus: The caste system and its implications*. University of Chicago Press.

Eells, T. D. (2007). *Handbook of psychotherapy case formulation*. New York: Guilford.

Ethnic Medicine Information From Harborview Medical Center. Available at: http://www.ethnomed.org, accessed January 07, 2018.

Eysenck, H. J. (1959). Learning theory and behaviour therapy. *Journal of Mental Science, 105(438), 61-75*

Eysenck, H. J., & Eysenck, S. B. (1976). Manual of the eysenck personality inventory. San Diego, CA: Educational and Industrial Testing Service.

Fadiman, A. (1997). *The SPIRIT CATCHES YOU AND FALL DOWN*. Farrar, Straus and Giroux.

Feagin, J. R., & Barnett, B. M. (2004). Success and failure: How systemic racism trumped the Brown v. Board of Education decision. U. Ill. L. Rev., 1099.

Fellner, K., John, R., & Cottell, S. (2016). Counselling Indigenous peoples in a Canadian context. *Handbook of counselling and psychotherapy in Canada*, 123-148.

Feltham, C., & Dryden, W. (1993). *Dictionary of counselling* (p. 58). London: Whurr.

Fisher, R. J. (1993). Social desirability bias and the validity of indirect questioning. *Journal of consumer research*, *20*(2), 303-315.

Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. *The Journal of Pediatrics, 136*(1), 14-23.

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, *55*(4), 316.

Foronda, C. (2010). Associate Degree Nursing Students' Thoughts, Feelings, and Experiences of Short Study Abroad in a Low-Income Country. *Dissertations (2009-)*, 51.

Fortin, A. H., & Barnett, K. G. (2004). Medical School Curricula in Spirituality and Medicine. *JAMA: The Journal of the American Medical Association, 291*(23)

Freud, S. (1905) *Three Essays on the Theory of Sexuality, SE 7* .

Freud, S. (1953). Three essays on the theory of sexuality (1905). In *The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume VII (1901-1905): A Case of Hysteria, Three Essays on Sexuality and Other Works* (pp. 123-246).

Freud, S., & Breuer, J. (1895). Anna O. *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, *2*, 21-47.

Friedman, R.C. and Downey, J. (1993) 'Psychoanalysis, psychobiology and homosexuality', *Journal of the American Psycboanalytic Association,* 41(4): 1159-98.

Galbraith, V. (Ed.). (2017). *Counselling psychology*. Routledge.

Genao, I., Bussey-Jones, J., Brady, D., Branch, W. T., & Corbie-Smith, G. (2003). Building the case for cultural competence. *The American journal of the medical sciences*, *326*(3), 136-140.

General Medical Council and Postgraduate Medical Education and Training Board. (2005). *Principles of good medical education and training*. London: GMC, PMETB.

Gerrish K, Guillaume L (2006) Whither survey research? The challenge of undertaking postal surveys within the UK research governance framework. *Journal of Research in Nursing* **11**(6): 485–97

Ghassemzadeh, H. (2007). The Practice of Cognitive–Behavior Therapy In Roozbeh Hospital: Some Cultural and Clinical Implications Of Psychological Treatment In Iran. *American journal of psychotherapy*, *61*(1), 53-69.

Gill, M. M. (1984). Psychoanalysis and psychotherapy: A revision. *International Review of Psycho-Analysis*, *11*, 161-179.

Gillon, E. (2007). *Person-centred counselling psychology: An introduction*. Sage.

Gim, R. H., Atkinson, D. R., & Kim, S. J. (1991). Asian-American acculturation, counselor ethnicity and cultural sensitivity, and ratings of counselors. *Journal of Counseling Psychology*, *38*(1), 57.

Giorgi, A. (1975). An application of phenomenological method in psychology. *Duquesne studies in phenomenological psychology*, *2*, 82-103.

Gladstein, G. A. (1983). Understanding empathy: Integrating counseling, developmental, and social psychology perspectives. *Journal of counseling psychology*, *30*(4), 467.

Goldberg, L. R. (1999). A broad-bandwidth, public domain, personality inventory measuring the lower-level facets of several five-factor models. *Personality psychology in Europe*, *7*(1), 7-28.

Goldstein, R. (2009). The future of Counselling Psychology: A view from the inside. *Counselling Psychology Review, 24*(1), 35-37.

Granello DH, Wheaton JE (2004) Online data collection: Strategies for Research. *J Couns Dev* 82(4): 387–93

Green, E. J. (2014). *The handbook of Jungian play therapy with children and adolescents*. JHU Press.

Greene, JC, Caracelli, VJ, Graham, WF (1989) Toward a conceptual framework for mixed-method evaluation designs. Educ Eval Policy Anal 11: 255–274.

Grey, C.C. (1992) 'Psychoanalysis and the social construction of gender and sexuality (discussion)', International Forum of Psychoanalysis, 1: 74-8.

Guba, E. G. (1990). *The alternative paradigm dialog. In E. G. Guba (Ed.), The paradigm dialog* (pp. 17-27). Newbury Park, CA: Sage.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage

Guetterman, T. C. (2017). Designing a Rigorous Mixed Methods Research Study. *질적연구*, *18*(1), 1-16.

Guzman, C. V. (2016). A Discourse Analysis of "Cultural Competence" as Presented In the Journal of the American Medical Association. *Conference Papers -- American Sociological Association*, 1-36.

Haider, A. H., Sexton, J., Sriram, N., Cooper, L. A., Efron, D. T., Swoboda, S., & Lipsett, P. A. (2011). Association of unconscious race and social class bias with vignette-based clinical assessments by medical students. *Jama*, *306*(9), 942-951.

Hallberg IR (2008) Surveys. In: Watson R, McKenna H, Cowman S, Keady J eds. *Nursing Research: Design and Methods.* Elsevier, Edinburgh: 179–87

Halpern, D. F. (2013). *Thought and knowledge: An introduction to critical thinking*. Psychology Press.

Harrison, D. A., & McLaughlin, M. E. (1991). Exploring the cognitive processes underlying responses to self-report instruments: Effects of item content on work attitude measures. Proceedings of the 1991 Academy of Management annual meetings, 310-314.

Haverkamp, B. E., Morrow, S. L., & Ponterotto, J. G. (2005). A time and place for qualitative and mixed methods in counseling psychology research. *Journal of Counseling Psychology*, *52*(2), 123.

Helms, J. E. & Carter, R. T. (1991). Relationship of White and Black racial identity attitudes and demographic similarity to counselor preferences. Journal of Counseling Psychology, 38, 71-75

Hepler, C. D., & Strand, L. M. (1990). Opportunities and responsibilities in pharmaceutical care. Am J hosp pharm, 47(3), 533-543.

Higginbotham, H. N., West, S. G., & Forsyth, D. R. (1988). *Psychotherapy and behavior change: Social, cultural and methodological perspectives*. Pergamon Press.

Higgins, E. T. (1987). Self-discrepancy: a theory relating self and affect. *Psychological review*, *94*(3), 319.

Hinkin, T. R. (1998). A brief tutorial on the development of measures for use in survey questionnaires. *Organizational research methods*, *1*(1), 104-121.

Ho, D. Y. (1995). Internalized culture, culturocentrism, and transcendence. *The Counseling Psychologist*, *23*(1), 4-24.

Holloway, I., & Galvin, K. (2016). *Qualitative research in nursing and healthcare*. John Wiley & Sons.

Holmes, S., Williams, M., & Ford, V. (2016). A collaborative approach to embedding cultural competence into the Bachelor of Pharmacy curriculum. *Research in Social and Administrative Pharmacy*, *12*(5), e27-e28.

Howe, KR (1988) Against the quantitative-qualitative incompatibility thesis or dogmas die hard. Educ Res 17: 10–16.

Hua, Z. (2018). *Exploring intercultural communication: Language in action*. Routledge.

Hughes, P., & Kerr, I. (2000). Transference and countertransference in communication between doctor and patient. *Advances in Psychiatric Treatment*, *6*(1), 57-64.

Ivankova, N. V., Creswell, J. W., & Plano Clark, V. L. (2007). Foundations and approaches to mixed methods research. *First steps in research. Pretoria: Van Schaik*, 253-282.

Jacob, K. S., & Kuruvilla, A. (2012). Psychotherapy across cultures: the form–content dichotomy. *Clinical psychology & psychotherapy*, *19*(1), 91-95.

James, C. W., & Stacey, J. M. (2013). The effectiveness of psychodynamic interventions for people with learning disabilities: A systematic review. Tizard Learning Disability Review, 19(1), 17-24.

Jeffreys, M. R. (2015). *Teaching cultural competence in nursing and health care: Inquiry, action, and innovation*. Springer Publishing Company.

Johnson, RB, Onwuegbuzie, AJ (2004) Mixed methods research: a research paradigm whose time has come. Educ Res 33: 14–26.

Johnstone, L. C. (2011). *Psychological formulation: A radical perspective* (Doctoral dissertation, Middlesex University/Metanoia Institute).

Johnstone, L., Whomsley, S., Cole, S., & Oliver, N. (2011). Good practice guidelines on the use of psychological formulation. *Leicester: British Psychological Society*.

Joseph, S. (2008). Psychotherapy's inescapable assumptions about human nature. *Counselling Psychology Review, 23*(1), 34-40.

Juckett, G. (2005). Cross-cultural medicine. *American family physician*, *72*(11).

Katz, J.H. (1985)The socio-political nature of counseling, The Counseling Psycholo-gist, 13: 615-24.

Kazdin, A. E. (1978). Behavior therapy: Evolution and expansion. *The Counseling Psychologist*, *7*(3), 34-37.

Kennerley, H., Kirk, J., & Westbrook, D. (2016). *An introduction to cognitive behaviour therapy: Skills and applications*. Sage.

Kerlinger, F. (1986). Foundations of behavioral research (3rd ed.). New York: Holt, Rinehart & Winston.

Kim, E., & Kang, M. (2018). The effects of client–counselor racial matching on therapeutic outcome. *Asia Pacific Education Review*, *19*(1), 103-110.

Kirschenbaum, H., & Jourdan, A. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, Research, Practice, Training*, *42*(1), 37.

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry* (Vol. 3). Univ of California Press.

Kleinman A. (1988). *The Illness Narratives: Suffering, Healing, and the Human Condition.* New York, Basic Books.

Kleinman, A., & Kleinman, J. (1985). in Chinese Society among Culture, Depressive Experiences, and the Meanings of Pain. *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder*, *16*, 429.

Koehn, D. (1994). *The ground of professional ethics*. London: Routledge.

Kraus, K. L. (2008). *Lenses: Applying lifespan development theories in counseling*. Nelson Education.

Lago, C. (1996). *Race, culture and counselling*. McGraw-Hill International.

Lago, C. (2005). *Race, culture and counselling*. McGraw-Hill Education (UK).

Lago, C. (2006). Race, culture and counselling: The ongoing challenge. Maidenhead, UK.

Lago, C.O. & Thompson, J. (1996) *Race, Culture and Counselling,* Buckingham: Open University Press.

Launer, J. (2005). Anna O and the ‘talking cure’. Qjm, 98(6), 465-466.

Laungani, P. (2004). Counselling and therapy in a multi-cultural setting. *Counselling Psychology Quarterly*, *17*(2), 195-207.

Lavizzo-Mourey, R. J., & MacKenzie, E. (1996). Cultural competence--an essential hybrid for delivering high quality care in the 1990's and beyond. *Transactions of the American Clinical and Climatological Association*, *107*, 226.

Lawson, M., & Winkelman, C. (2003). The social desirability factor in the measurement of listening skills: a brief report. *Counselling Psychology Quarterly*, *16*(1), 43.

Leahey, T. H. (1991). *A history of modern psychology*. Upper Saddle River, NJ: Prentice Hall.

Leininger, M. (1978). *Transcultural nursing: Theories, research, and practice* (2nd ed.). New York: John Wiley.

Levinas, E. (2003). *Humanism of the Other* (N. Poller, Trans.). Chicago: University of Illinois.

Lewis, A. E., Chesler, M., & Forman, T. A. (2000). The impact of “colorblind" ideologies on students of color: Intergroup relations at a predominantly White university. *Journal of Negro Education*, 74-91.

Lewis-Fernández, R. (1996). Cultural formulation of psychiatric diagnosis. Culture, Medicine and Psychiatry 20:133–144.

Lewis-Fernández, R., & Díaz, N. (2002). The cultural formulation: a method for assessing cultural factors affecting the clinical encounter. *Psychiatric Quarterly*, *73*(4), 271-295.

Lincoln, Y. S., & Guba, E. G. (2000). The only generalization is: There is no generalization. *Case study method*, 27-44.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic controversies, contradictions, and emerging confluences, revisited. *The Sage handbook of qualitative research*, *4*, 97-128.

Lissitz, R. W., & Green, S. B. (1975). Effect of the number of scale points on reliability: A Monte Carlo approach. Journal of Applied Psychology, 60, 10-13.

Littlewood, R. (1992) in J. Kareem and R. Littlewood (1992) *Inter-cultural Therapy: Themes, Interpretations and Practices*, Oxford: Blackwell Scientific.

Long, T. (2016). INFLUENCE OF INTERNATIONAL SERVICE LEARNING ON NURSING STUDENTS'SELF EFFICACY TOWARDS CULTURAL COMPETENCE. *Journal of Cultural Diversity*, *23*(1).

Loudon, R. F., Anderson, P. M., Gill, P. S., & Greenfield, S. M. (1999). Educating medical students for work in culturally diverse societies. *Jama*, *282*(9), 875-880.

Luft, J., & Ingham, H. (1961). The johari window. *Human relations training news*, *5*(1), 6-7.

Maccoby, E. E., & Maccoby, N. (1954). The interview: A tool of social science. *Handbook of social psychology*, *1*, 449-487.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological review*, *98*(2), 224.

Marsella, A. J., & Kameoka, V. A. (1989). Ethnocultural issues in the assessment of psychopathology. In *Portions of this paper were presented at the workshop on" Depression and Suicide in Minorities," sponsored by the Division of Clinical Research, National Institute of Mental Health, Bethesda, Maryland, Dec 7–8, 1987.* Arlington, VA, US: American Psychiatric Association.

Massey, D. & N. Denton. (1993). *American Apartheid: Segregation and the Making of the Underclass*. Cambridge: Harvard University Press.

McBride, R. G., & Hays, D. G. (2012). Counselor demographics, ageist attitudes, and multicultural counseling competence among counselors and counselor trainees. *Adultspan Journal*, *11*(2), 77-88.

McCauley, R. N., & Lawson, E. T. (1996). Who owns' culture'? 1. *Method & Theory in the Study of Religion*, *8*(2), 171-190.

McDermott, E., Hughes, E., & Rawlings, V. (2016, June 30). Understanding lesbian, gay, bisexual and trans (LGBT) adolescents' suicide, self-harm and help-seeking behaviour. Retrieved December 04, 2018, from http://www.queerfutures.co.uk/wp-content/uploads/2016/06/Queer-Futures-Final-Report.pdf

McEvoy, P., Williamson, T., Kada, R., Frazer, D., Dhliwayo, C., & Gask, L. (2017). Improving access to mental health care in an Orthodox Jewish community: a critical reflection upon the accommodation of otherness. *BMC health services research*, *17*(1), 557.

McGrath, W. J., & Freud, S. (1986). *Freud's discovery of psychoanalysis: The politics of hysteria*. Cornell University Press.

McKenna H, Hasson F, Keeney S (2006) Surveys. In: Gerrish K, Lacey A eds. *The Research Process in Nursing* 5th edn. Blackwell Publishing, Oxford: 260–73

McKim, C. A. (2017). The value of mixed methods research: A mixed methods study. Journal of Mixed Methods Research, 11, 202-222. http://dx.doi.org/10.1177/1558689815607096

McLeod, B. D. (2009). Understanding why therapy allegiance is linked to clinical outcomes. *Clinical Psychology: Science and Practice*, *16*(1), 69-72.

Meichenbaum, D. (1977). Cognitive behaviour modification. *Cognitive Behaviour Therapy*, *6*(4), 185-192.

Merrill, J. M., Laux, L. F., Lorimor, R. J., Thornby, J. I., & Vallbona, C. (1995). Measuring social desirability among senior medical students. *Psychological reports*, *77*(3), 859-864.

Mertens, DM (2003) *Mixed methods and the politics of human research: the transformative-emancipatory perspective*. In: Tashakkori, A, Teddlie, C (eds), *Handbook of Mixed Methods in Social & Behavioral Research*. Thousand Oaks, CA: Sage. 135–164

Michell, J. (1997). Quantitative science and the definition of measurement in psychology. British Journal of Psychology, 88(3), 355-383.

Mikulas, W. L. (1981). Buddhism and behavior modification. *The Psychological Record*, *31*(3), 331-342.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. sage.

Moffic, H. S., & Kinzie, J. D. (1996). The history and future of cross-cultural psychiatric services. *Community Mental Health Journal*, *32*(6), 581-592.

Moller, N. (2011). The identity of counselling psychology in Britain is parochial, rigid and irrelevant but diversity offers a solution. *Counselling Psychology Review*, *26*(2), 8-16.

Museus, S. D. (2008). The model minority and the inferior minority myths: Understanding stereotypes and their implications for student learning. *About Campus*, *13*(3), 2-8.

Museus, S. D., & Kiang, P. N. (2009). Deconstructing the model minority myth and how it contributes to the invisible minority reality in higher education research. New Directions for Institutional Research, 2009(142), 5-15.

Nagel, T. (1986). *The view from nowhere*. New York: Oxford University Press

Nadirshaw, Z. (2009). *Race, culture and ethnicity in mental health care*. In R. Newell & K.

Nathan, A. J. (1993). Is Chinese culture distinctive? — a review article. The Journal of Asian Studies, 52(4), 923-936.

Neef, N. A., & Peterson, S. M. (2007). Functional behavior assessment. *Applied behavior analysis*, *2*.

Nichter, M. (1981). Idioms of distress: Alternatives in the expression of psychosocial distress: A case study from South India. *Culture, medicine and psychiatry*, *5*(4), 379-408.

Nunnally, J. C. (1976). Psychometric theory (2nd ed.). New York: McGraw-Hill.

Orlans, V., & Van Scoyoc, S. (2008). *A Short Introduction to Counselling Psychology*. London: Sage.

Orlinsky, D. E., Botermans, J. F., & Rønnestad, M. H. (2001). Towards an empirically grounded model of psychotherapy training: Four thousand therapists rate influences on their development. *Australian psychologist*, *36*(2), 139-148.

Onweugbuzie, AJ (2002) Why can't we all get along? Towards a framework for unifying research paradigms. Education 122: 518–530.

Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. *Journal of counseling psychology*, *58*(1), 1.

Paivio, S. C., & Greenberg, L. S. (1995). Resolving" unfinished business": Efficacy of experiential therapy using empty-chair dialogue. *Journal of Consulting and Clinical Psychology*, *63*(3), 419.

Patton M.Q. (1990) *Qualitative Evaluation and Research Methods*, 2nd edn. Sage, Newbury Park, California.

Paulus, D.L. (1984). Two-component models of socially desirable responding. Journal of Personality and Social Psychology, 46, 598–609.

Paulus, D.L. (1988) *Socially desirable responding: Some new solutions to old problems*. In A. Angleitner & J.S. Wiggins (Eds.), *Personality assessment via questionnaire*. New York: Academic Press.

Payer, L. (1988). Medicine and culture: varieties of treatment in the United States. *England, West Germany, and France*.

Pedersen, P. (1987). Ten frequent assumptions of cultural bias in counseling. *Journal of Multicultural Counseling and Development*, *15*(1), 16-24.

Pedersen, P. (1997). *Culture-centered counseling interventions: Striving for accuracy*. Sage.

Pedersen, P., Draguns, J., Lonner, W., & Trimble, J. (2008). *Counseling across cultures*. Thousand Oaks, CA: Sage Publications.

Perloff, R. M., Bonder, B., Ray, G. B., Ray, E. B., & Siminoff, L. A. (2006). Doctor-patient communication, cultural competence, and minority health: Theoretical and empirical perspectives. *American Behavioral Scientist*, *49*(6), 835-852.

Peterson, R. A., & Kerin, R. A. (1981). The quality of self-report data: review and synthesis. *Review of marketing*, 5-20.

Piller, I. (2017). *Intercultural communication: A critical introduction*. Edinburgh University Press.

Polit DF, Beck CT (2008) *Nursing Research: Generating and Assessing Evidence for Nursing Practice* 8th edn. Wolters Kluwer | Lippincott Williams & Wilkins, Philadelphia

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of counseling psychology*, *52*(2), 126.

Porter SR (2004a) Raising response rates: What works? *New Directions for Institutional Research* 2004 (121): 5–21

Pulido, L. (2000). Rethinking environmental racism: White privilege and urban development in Southern California. Annals of the Association of American Geographers, 90(1), 12-40.

Racker, H. (2018). *Transference and countertransference*. Routledge.

Rathod, S., & Kingdon, D. (2009). Cognitive behaviour therapy across cultures. Psychiatry, 8(9), 370-371.

Rathod, S., Phiri, P., Gobbi, M., & Kingdon, D. (2009). Developing Culturally Sensitive CBT for Psychosis in BME communities. In *Poster Presentation at Royal College of Psychiatrists Annual Meeting: Liverpool*.

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and cognitive psychotherapy*, *38*(5), 511-533.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. London: Sage.

Rescher, N. (1993). *Pluralism: Against the Demand for Consensus*. Oxford: Oxford University.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*, 20–23.

Ridley, C. R., Li, L. C., & Hill, C. L. (1998). Multicultural assessment: Reexamination, reconceptualization, and practical application. *The Counseling Psychologist*, *26*(6), 827-910.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications and theory*. London: Constable.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of consulting psychology*, *21*(2), 95.

Rohde-Dachser, C. (1992) ‘Male and female homosexuality’, *International Forum of Psychoanalysis,* 1: 67-73.

Roland, A. (1988). *In Search of Self in India and Japan: Towards a Cross-cultural Psychology.* Princ- eton, NJ: Princeton University Press.

Rønnestad, M. H., & Skovholt, T. M. (2003). The journey of the counselor and therapist: Research findings and perspectives on professional development. *Journal of career development*, *30*(1), 5-44.

Ross, L. E., Doctor, F., Dimito, A., Kuehl, D., & Armstrong, M. S. (2007). Can talking about oppression reduce depression? Modified CBT group treatment for LGBT people with depression. *Journal of Gay & Lesbian Social Services*, *19*(1), 1-15.

Roth, K. (2001). Material culture and intercultural communication. International Journal of Intercultural Relations, 25(5), 563-580.

Ruiz, R. A., & Casas, J. M. (1981). Culturally relevant and behavioristic counseling for Chicano college students. *Counseling across cultures*, 181-202.

Ryan, A. B. (2006). Post-positivist approaches to research. *Researching and Writing your Thesis: a guide for postgraduate students*, 12-26.

Sale, JEM, Lohfeld, & LH, Brazil, K (2002) Revisiting the quantitative-qualitative debate: implications for mixed- methods research. Qual Quant 36: 43–53.

Sandelowski, M (2001) Combining qualitative and quantitative sampling, data collection and analysis techniques in mixed method studies research. Nurs Health 23: 246–255.

Saunders, M., Lewis, P., & Thornhill, A. (2007). *Research Methods for Business Students* (4: e uppl.) Harlow: Pearson Education.

Schilt, K., & Westbrook, L. (2009). Doing Gender, Doing Heteronormativity: “Gender Normals,” Transgender People, and the Social Maintenance of Heterosexuality. *Gender & Society*, *23*(4), 440-464.

Schneider, J. S., & Levin, S. (1999). Uneasy partners: the lesbian and gay health care community and the AMA. *JAMA*, *282*(13), 1287-1288.

Schneider, K. J., Pierson, J. F., & Bugental, J. F. (Eds.). (2014). *The handbook of humanistic psychology: Theory, research, and practice*. Sage Publications.

Schon, D. (1983). *The Reflective Practitioner New York. NY: Harper & Collins*.

Schulberg, L. (1968). *Historic India, Great Ages of Man: A History of the World Culture Series.* Amsterdam: Time-Life International.

Schwartz, B. (1985). China’s Cultural Values. Occassional Paper No. 18. *Center for Asian Studies, Arizona State University, Tempe, Arizona*.

Seeleman, C., Suurmond, J., & Stronks, K. (2009). Cultural competence: a conceptual framework for teaching and learning. *Medical Education, 43*(3), 229-237.

Segal, J. (2006). Working psychodynamically with people with physical illness or disability. Psychodynamic Practice, 12(2), 127.

Shapiro, D. H., & Zifferblatt, S. M. (1976). Zen meditation and behavior self-control: Similarities, differences, and clinical applications. *American Psychologist*, *31*(7), 519.

Singleton, J. K. (2017). An enhanced cultural competence curriculum and changes in transcultural self-efficacy in doctor of nursing practice students. *Journal of Transcultural Nursing*, *28*(5), 516-522.

Sinha, J. B., & Kumar, R. (2004). Methodology for understanding Indian culture. *The Copenhagen Journal of Asian Studies*, *19*, 89-104.

Sinha, J. B. P. & R. N. Kanungo, R. N. (1997). 'Context Sensitivity and Balancing in Organizational Behaviour'. *International Journal of Psychology* 32: 93-105.

Smith, H. L., Robinson III, E. M., & Young, M. E. (2007). The relationship among wellness, psychological distress, and social desirability of entering master's-level counselor trainees. *Counselor Education and Supervision*, *47*(2), 96-109.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review, 5(1),* 9-27.

Smith, J. A. (2003). Validity and qualitative psychology. *Qualitative psychology: A practical guide to research methods*, 232-235.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Smith, J. K. (1983). Quantitative versus qualitative research: An attempt to clarify the issue. *Educational researcher*, *12*(3), 6-13.

Smith, J. K. (1984). The problem of criteria for judging interpretive inquiry. *Educational evaluation and policy analysis*, *6*(4), 379-391.

Spector, R.E. (1996). Cultural Diversity in Health and Illness, 4th ed., Appleton & Lange, Stamford CT pp. 1-2.

Spiegler, M. D., & Guevremont, D. C. (1993). *Contemporary behavior therapy* (2nd ed.). Belmont, CA, US: Thomson Brooks/Cole Publishing Co.

Stewart S (2003) Casting the net: Using the internet for survey research. *British Journal of Midwifery* **11**(9): 543–6

Strachey, J., Breuer, J., & Freud, S. (1955). *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, *Volume II* (1893-1895): *Studies on Hysteria. In The Standard Edition of the Complete Psychological Works of Sigmund Freud, Volume II* (1893-1895): *Studies on Hysteria.* Chicago

Sue, D. W. (1990). Culture-specific strategies in counseling: A conceptual framework. *Professional Psychology: Research and Practice*, *21*(6), 424.

Sue, D.W. and Sue, D. (1990) *Counseling the Culturally Different: Theory and Practice*, 2nd edn, New York: Wiley.

Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual review of psychology*, *60*, 525.

Sutton, J., & Austin, Z. (2015). Qualitative research: data collection, analysis, and management. *The Canadian journal of hospital pharmacy*, *68*(3), 226.

Suzuki, B. H. (2002). Revisiting the model minority stereotype: Implications for student affairs practice and higher education. *New directions for student services*, *2002*(97), 21-32.

Takeuchi, D., Higginbotham, N., Marsella, A., Gomes, K., Kwan, L., Jr., Ostrowski, B., Wight, K. (1987). Native Hawaiian mental health. In A. B. Robillard & A. J. Marsella (Eds.), *Contemporary issues in mental health research in the Pacific Islands*(pp. 149-176). Honolulu, HI, US: University of Hawaii Press.

Tanaka-Matsumi, J., & Marsella, A. J. (1976). Cross-cultural variations in the phenomenological experience of depression: I. Word association studies. *Journal of Cross-Cultural Psychology*, *7*(4), 379-396.

Tashakkori, A., & Teddlie, C. (2003). Issues and dilemmas in teaching research methods courses in social and behavioural sciences: US perspective. *International Journal of Social Research Methodology*, *6*(1), 61-77.

Teal, C. R., & Street, R. L. (2009). Critical elements of culturally competent communication in the medical encounter: a review and model. *Social science & medicine*, *68*(3), 533-543.

Teddlie, C., & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of mixed methods research*, *1*(1), 77-100.

Tindall, W. N., Beardsley, R. S., & Kimberlin, C. L. (Eds.). (1994). *Communication skills in pharmacy practice: a practical guide for students and practitioners*. Lippincott Williams & Wilkins.

Tu, W.-Ming. (1998). *The living tree: the changing meaning of being Chinese today.* Stanford (Calif.): Stanford University Press.

Tuckwell, G. (2002). *Racial identity, white counsellors and therapists*. Singapore: McGraw-Hill Education (Asia).

Ullmann, L. P., Krasner, L. (1965). *Case studies in behavior modification*. Holt, Rinehart and Winston.

Umbach PD (2004) Web surveys: Best Practice. *New Directions for Institutional Research* **121**: 23–38

Umbach PD (2005) Getting back to the basics of survey research. *New Directions for Institutional Research* **127**: 91–100

van Deurzen-Smith, E. (1990). Philosophical underpinnings of counselling psychology. *Counselling Psychology Review*, *5*(2), 8-12.

Van de Mortel, T. F. (2008). Faking it: social desirability response bias in self-report research. *Australian Journal of Advanced Nursing, The*, *25*(4), 40.

Walsh, Y., & Frankland, A. (2009). The next 10 years: Some reflections on earlier predictions for Counselling Psychology. *Counselling Psychology Review, 24*(1), 38-43.

Weiss M. (1997). Explanatory Model Interview Catalogue (EMIC): Framework for comparative study of illness. Transcultural Psychiatry 34:235–263.

Westbrook, D., Kennerley, H., & Kirk, J. (2007). Coping with Depression: Counseling and Psychological Service. *George Mason University*.

Wheeler, A., Crump, K., Lee, M., Li, L., Patel, A., Yang, R., & Jensen, M. (2012). Collaborative prescribing: A qualitative exploration of a role for pharmacists in mental health. *Research in Social and Administrative Pharmacy*, *8*(3), 179-192.

Wheeler, *S.* (1996) *Training Counsellors: The Assessment of Competence,* London: Cassell.

Wheeler, S. (Ed.). (2006). *Difference and Diversity in Counselling: Contemporary Psychodynamic Approaches*. Palgrave macmillan.

Wheeler, S., & Izzard, S. (1997). Psychodynamic counsellor training integrating difference. *Psychodynamic Counselling, 3*(4), 401-417.

Wilk, K. (2014). Using a pluralistic approach in counselling psychology and psychotherapy practice with diverse clients: Explorations into cultural and religious responsiveness within a Western paradigm. *Counselling Psychology Review*, *29*(1), 16-28

Williams, M. W., Foo, K. H., & Haarhoff, B. (2006). Cultural considerations in using cognitive behaviour therapy with Chinese people: A case study of an elderly Chinese woman with generalised anxiety disorder. *New Zealand Journal of Psychology, 35*(3), 153-162. Retrieved from https://www.psychology.org.nz/wp-content/uploads/NZJP-Vol353-2006-7-Williams.pdf.

Woolfe, R. (1996). The nature of counselling psychology. In R. Woolfe, W. Dryden & S. Strawbridge (Eds.), *Handbook of Counselling Psychology* (2nd ed., pp. 3-20). London: Sage.

Yip, K. S. (2005). Chinese concepts of mental health: Cultural implications for social work practice. *International Social Work*, *48*(4), 391-407.

Yontef, G. M. (1979). Gestalt therapy: Clinical phenomenology. *Gestalt Journal, 2*(1), 27-45.

Yoshikawa, H., Weisner, T. S., Kalil, A., & Way, N. (2008). Mixing qualitative and quantitative research in developmental science: uses and methodological choices. *Developmental psychology*, *44*(2), 344.

Zweber, A. (2002). Cultural competence in pharmacy practice. *American Journal of Pharmaceutical Education*, *66*(2), 172.

APPENDICES

APPENDIX 1

Participant Information Sheet – Qualitative Phase

UNIVERSITY OF
WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Participant Information Sheet

Are counselling psychology training courses developing multicultural competencies in their trainees? Comparing cultural competency in health care and counselling psychology trainees.

Umesh Joshi
Trainee Counselling Psychologist

What is the purpose of this study?

Previous research suggests that training in doctoral and master's programmes could integrate intercultural training in western nations. Since the early 1970's literature and graduate programmes have been addressing the need to develop multicultural awareness, knowledge and skills. With recent research still suggesting multicultural developments in training for counsellors and counselling psychologists, it seems an overdue but necessary step for counselling psychology's development as a profession in the UK.

Taking Part

Taking part in this study is entirely voluntary. If you do decide to take park, you are still free to withdraw at any time during the study. If you agree to take part in this study, you will be asked to sign a consent form. This will include consenting to your participation, and consenting to your interview being audio recorded. The interview will be audio recorded and transcribed. The recording will be stored securely in a password protected file and deleted once transcribed. The transcription will be printed and securely stored in a locked cabinet, with only project researchers having access to the information. Withdrawal from the study must be made within two weeks after the Interview has taken place. The interview will take no longer than 50 minutes. You have the option to participate face-to-face, via skype or telephone.

Confidentiality and Anonymity

You will not be identified in any publication or report. Any identifying information specific to you or the university you represent will remain anonymous and confidential. The data from this research will be used only to gather evidence on the current developments of cultural competency training on Counselling Psychology Doctoral courses. The transcribed text will be analysed and compared to other interviews. Confidentiality will be maintained in this study by not divulging information to other personnel, except for those directly involved in the study, such as research supervisors and examiners. Such personnel will be unable to link the data to participants, as the data will be anonymised by using codes on the questionnaires and interview transcripts.

If you have any concerns, please do not hesitate to speak with or contact the research supervisors, who will do their best to answer your questions:

Project Supervisor 1: Niall Galbraith;

Project Supervisor 2: Abigail Taiwo;

Further Information
If you have any further questions or would like further information about this research, please contact me:

Umesh Joshi
Trainee Counselling Psychologist

Thank you very much for your taking part in this study. Your involvement is very much appreciated and will make a real difference to our understanding of developments in cultural competency training on doctoral training courses.

APPENDIX 2

Consent Form

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Consent Form

Are counselling psychology training courses developing multicultural competencies in their trainees? Comparing cultural competency in health care and counselling psychology trainees.

Please tick the following statements to show that you understand your participation in this research. You must tick all boxes in order to participate.

- I have read and understood the Participant Information Sheet in full and have had the opportunity to ask questions. ☐
- I understand that my data will be stored securely and confidentially and that myself and the university I represent will not be identifiable in any report or publication. ☐
- I understand that I am taking part voluntarily and that I am free to withdraw at any time during the interview and within two weeks after the interview. ☐
- I agree for the researcher to use the data I provide for the purpose of this study. ☐
- I understand that the researcher may wish to publish this study and any results found. For which, I give my permission. ☐
- I am aware that audio-recording will be requested of me, and I will have the opportunity to consent/refuse. ☐
- I agree to take part in this study. ☐

Print Name:____

Signature: ____

Date: ____

Researcher:
Umesh Joshi
Trainee Counselling Psychologist

APPENDIX 3
Invitation Letter for Participation – Qualitative Phase

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

[Address]

Dear [Recipient],

As a part of my Doctorate in Counselling Psychology at the University of Wolverhampton, I am conducting a research study exploring the developments and levels of cultural competency in trainee healthcare professionals from different disciplines. To do this, I would require your support by inviting you to participate in an interview considering the developments of multicultural competency on Counselling Psychology doctoral courses.

This study will make original contributions to further understand the development of cultural competencies in trainee counselling psychologists and consider how these may be developed.

The interview will take approximately 50 minutes for each participant. Questions will be open-ended, encouraging your thoughts, opinions and facts related to the course. Any information you provide regarding yourself or the university you represent, will be kept anonymous and confidential. You have the option to participate face-to-face, via skype or telephone.

Considering this, I am writing to seek your permission to conduct this interview with you regarding multicultural competency developments on the doctorate in counselling psychology. I enclose a copy of the research protocol for your information.

I look forward to hearing from you.

Yours sincerely,

Umesh Joshi
Counselling Psychologist in Training

APPENDIX 4
Debrief Sheet – Qualitative Phase

UNIVERSITY OF
WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Debrief

We have now come to the end of the study. Thank you very much for taking part. The aim of this study is to understand if and how counselling psychology doctoral training courses are developing multicultural competencies in their trainees. Therefore, your perspective is the most valuable. In this interview, you answered questions regarding this topic. This data will be used to complete a doctoral thesis, support research and hope to contribute further developments in cultural competency training. I appreciate the time you took to participate in this interview. If you would like to know the outcome of this study, please do not hesitate to contact myself or the project supervisors on the email address provided on the Information Sheet. Thank you, once again.

Umesh Joshi
Trainee Counselling Psychologist

APPENDIX 5
Questions for Interviews – Qualitative Phase

1. Do you mind telling me the fundamental philosophy of this course?
2. In your opinion, what skills does the Doctorate in Counselling Psychology intend to facilitate in trainees?
3. Can you tell me your understanding of cultural competency?
4. What should cultural competency training include?
5. What is your experience of multicultural competency training?
6. Could you explain your experience of working with clients from diverse cultural backgrounds?
7. How equipped have you felt when working with those from diverse cultural backgrounds?
8. What is your opinion on Counselling Psychology doctoral trainees developing cultural competency skills?
9. How might the awareness and development of cultural competency skills be included in the Doctorate?
10. What can you tell me about how your course integrates multicultural competency training?
11. What changes could Counselling Psychology doctoral courses make, to facilitate cultural competency skills in trainees?

APPENDIX 6
Participant Information Sheet – Qualitative Phase

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Participant Information Sheet

Are counselling psychology training courses developing multicultural competencies in their trainees? Comparing cultural competency in health care and counselling psychology trainees.

Umesh Joshi
Trainee Counselling Psychologist

What is the purpose of this study?

Previous research suggests that training in doctoral and master's programmes could integrate intercultural training in western nations. Since the early 1970's literature and graduate programmes have been addressing the need to develop multicultural awareness, knowledge and skills. Considering the importance of health care received by minority patients in systems organised and staffed by majority group members, negative health consequences may result by ignoring differences in culture. This study aims to address and compare the cultural competencies of trainees from different healthcare disciplines in their final year of study.

Taking Part

Taking part in this study is entirely voluntary. If you do decide to take park, you are still free to withdraw at any time during the study. If you agree to take part in this study, you will be asked to sign a consent form. Upon signing the consent form, you will be asked to complete two questionnaires. This should take no more than a few minutes. Consent forms and questionnaires will be securely stored in a locked cabinet, with only project researchers having access to the information.

Confidentiality and Anonymity

You will not be identified in any publication or report. Any identifying information specific to you or the university you represent will remain anonymous and confidential. The data from this research will be used only to gather evidence on the current developments of cultural competency training on post-graduate courses. The data will be grouped together and all identifying information removed.

If you have any concerns, please do not hesitate to speak with or contact the research supervisors, who will do their best to answer your questions:

Project Supervisor 1: Niall Galbraith; [redacted]

Project Supervisor 2: Abigail Taiwo; [redacted]

Further Information

If you have any further questions or would like further information about this research, please contact me:

Umesh Joshi
Trainee Counselling Psychologist
[redacted]

Thank you very much for your taking part in this study. Your involvement is very much appreciated and will make a real difference to our understanding of developments in cultural competency training on doctoral training courses.

APPENDIX 7
Consent Form – Quantitative Phase

UNIVERSITY OF WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Consent Form

Are counselling psychology training courses developing multicultural competencies in their trainees? Comparing cultural competency in health care and counselling psychology trainees.

Please tick the following statements to show that you understand your participation in this research. You must tick all boxes in order to participate.

- I have read and understood the Participant Information Sheet and have had the opportunity to ask questions. ☐
- I understand that my data will be stored securely and confidentially and that myself and the university I represent will not be identifiable in any report or publication. ☐
- I understand that I am taking part voluntarily and that I am free to withdraw at any time whilst completing the questionnaire(s), without giving any reason. ☐
- I agree for the researcher to use the data I provide for the purpose of this study. ☐
- I understand that the researcher may wish to publish this study and any results found. For which, I give my permission. ☐
- I agree to take part in this study. ☐

Print Name:______________________________________

Signature: ______________________________________

Date: ______________________________________

Researcher:

Umesh Joshi
Trainee Counselling Psychologist

APPENDIX 8
Demographic Information Sheet – Quantitative Phase

UNIVERSITY OF
WOLVERHAMPTON
KNOWLEDGE ▪ INNOVATION ▪ ENTERPRISE

Please be aware that all information will be anonymised and non-specific to you. Please answer the following:

Sex:

Age:

Current University Course:

Are you in your final year of study?

Please Circle: Yes No

Have you recently completed your final year of study?

Please Circle: Yes No

Have you attended any courses outside of your university education to inform your cultural competency skills?

Please Circle: Yes No

APPENDIX 9
Lie Scale (Eysenck, 1976)

For each question below, please circle **either** Yes or No

(A1) Have you ever taken the praise for something you knew someone else had really done?	**YES/NO**
(A2) Are all your habits good and desirable ones?	**YES/NO**
(A3) Have you ever taken anything (even a pin or button) that belonged to someone else?	**YES/NO**
(A4) Do you sometimes talk about things you know nothing about?	**YES/NO**
(A5) Have you ever broken or lost something belonging to someone else?	**YES/NO**
(A6) Have you ever said anything bad or nasty about anyone?	**YES/NO**
(A7) Do you always wash before a meal?	**YES/NO**
(A8) Have you ever cheated at a game?	**YES/NO**
(A9) Have you ever taken advantage of someone?	**YES/NO**
(A10) Would you dodge paying taxes if you were sure you would never be found out?	**YES/NO**
(B1) Were you ever greedy by helping yourself to more than your share of anything?	**YES/NO**
(B2) If you say you will do something, do you always keep your promise no matter how inconvenient it might be?	**YES/NO**
(B3) Have you ever blamed someone for doing something you knew was really your fault?	**YES/NO**
(B4) As a child did you do as you were told immediately and without grumbling?	**YES/NO**
(B5) Do you sometimes boast a little?	**YES/NO**
(B6) As a child were you ever cheeky to your parents?	**YES/NO**
(B7) Have you ever insisted on having your own way?	**YES/NO**
(B8) Do you always practice what you preach?	**YES/NO**
(B9) Have you ever been late for an appointment or work?	**YES/NO**
(B10) Do you sometimes put off until tomorrow what you ought to do today?	**YES/NO**
(B11) Are you always willing to admit it when you have made a mistake?	**YES/NO**

APPENDIX 10

Healthcare Provider Cultural Competence Instrument (HPCCI) (Schwarz, Witte, Sellers, Luzadis, Weiner & Domingo-Snyder, 2015)

Scale 1: Awareness and Sensitivity[a]

3. Race is the most important factor in determining a person's culture

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

4. People with a common cultural background think and act alike

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

5. Many aspects of culture influence health and health care

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

6. Aspects of cultural diversity need to be assessed for each individual, group, and organization

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

7. If I know about a person's culture, I do not need to assess their personal preferences for health services

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

8. Spirituality and religious beliefs are important aspects of many cultural groups

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

9. Individual people may identify with more than 1 cultural group (Original item—Individuals may identify with more than 1 cultural group)

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

10. Language barriers are the only difficulties for recent immigrants to the United States

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

11. I understand that people from different cultures may define the concept of "health care" in different ways

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

12. I think that knowing about different cultural groups helps direct my work with individuals, families, groups, and organizations

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

13. I enjoy working with people who are culturally different from me

Strongly disagree 1 2 3 4 5 6 7 Strongly agree

Scale 2: Behavior[b]

14. I include cultural assessment when I do client or family evaluations

Never 1 2 3 4 5 6 7 Always

15. I seek information on cultural needs when I identify new clients and families in my practice

Never 1 2 3 4 5 6 7 Always

16. I have resource books and other materials available to help me learn about clients and families from different cultures

Never 1 2 3 4 5 6 7 Always

17. I use a variety of sources to learn about the cultural heritage of other people

Never 1 2 3 4 5 6 7 Always

18. I ask clients and families to tell me about their own explanations of health and illness

Never 1 2 3 4 5 6 7 Always

19. I ask clients and families to tell me about their expectations for health services (Original item—I ask clients and families to tell me about their expectations for care)

Never 1 2 3 4 5 6 7 Always

20. I avoid using generalizations to stereotype groups of people

Never 1 2 3 4 5 6 7 Always

21. I recognize potential barriers to service that might be encountered by different people

Never 1 2 3 4 5 6 7 Always

22. I act to remove obstacles for people of different cultures when I identify such

obstacles

Never 1 2 3 4 5 6 7 Always

23. I remove obstacles for people of different cultures when clients and families identify such obstacles to me (Original item—I act to remove obstacles for people of different cultures when clients and families identify such obstacles to me)

Never 1 2 3 4 5 6 7 Always

24. I welcome feedback from clients and their families about how I relate to others with different cultures (Original item—I welcome feedback from clients about how I relate to others with different cultures)

Never 1 2 3 4 5 6 7 Always

25. I welcome feedback from coworkers about how I relate to others with different cultures

Never 1 2 3 4 5 6 7 Always

26. I find ways to adapt my services to my clients and their families' preferences (Original item—I find ways to adapt my services to client and family cultural preferences)

Never 1 2 3 4 5 6 7 Always

27. I document cultural assessments

Never 1 2 3 4 5 6 7 Always

28. I document the adaptations I make with clients and their families (Original item—I document the adaptations I make with clients and families)

Never 1 2 3 4 5 6 7 Always

29. I learn from my coworkers about people with different cultural heritages

Never 1 2 3 4 5 6 7 Always

Scale 3: Patient-Centered Communication[a]

30. When there are a variety of treatment options, how often do you give the client and their family a choice when making a decision?

Never 1 2 3 4 5 Very Often

31. When there are a variety of treatment options, how often do you make an effort to give the client and their family control over their treatment?

Never 1 2 3 4 5 Very Often

32. When there are a variety of treatment options, how often you ask the client and their family to take responsibility for their treatment?

Never 1 2 3 4 5 Very Often

Scale 4: Practice Orientation[b]

33. The health care provider is the one who should decide what gets talked about during a visit

Strongly Disagree 1 2 3 4 5 Strongly Agree

34. It is often best for the client and their family that they do not have a full explanation of the client's medical condition

Strongly Disagree 1 2 3 4 5 Strongly Agree

35. The client and their family should rely on their health care providers' knowledge and not try to find out about their condition(s) on their own

Strongly Disagree 1 2 3 4 5 Strongly Agree

36. When health care providers ask a lot of questions about a client and their family's background, they are prying too much into personal matters

Strongly Disagree 1 2 3 4 5 Strongly Agree

37. If health care providers are truly good at diagnosis and treatment, the way they relate to client and their family is not that important

Strongly Disagree 1 2 3 4 5 Strongly Agree

38. The client and their family should be treated as if they are partners with the health care provider, equal in power and status

Strongly Disagree 1 2 3 4 5 Strongly Agree

39. When the client and their family disagree with their health provider, this is a sign that

the health care provider does not have the client and their family's respect and trust

Strongly Disagree 1 2 3 4 5 Strongly Agree

40. A treatment plan cannot succeed if it is in conflict with a client and their family's lifestyle or values

Strongly Disagree 1 2 3 4 5 Strongly Agree

41. It is not that important to know a client and their family's culture and background to treat the client's illness

Strongly Disagree 1 2 3 4 5 Strongly Agree

Scale 5: Self-Assessment[c]

41. As a health care provider, I understand how to lower communication barriers with clients and their families

Strongly Disagree 1 2 3 4 5 Strongly Agree

42. I have a positive communication style with clients and their families

Strongly Disagree 1 2 3 4 5 Strongly Agree

43. As a health care provider, I am able to foster a friendly environment with my clients and their families

Strongly Disagree 1 2 3 4 5 Strongly Agree

44. I attempt to demonstrate a high level of respect for clients and their families

Strongly Disagree 1 2 3 4 5 Strongly Agree

45. As a health care provider, I consistently assess my skills as I work with diverse groups of clients and their families

Strongly Disagree 1 2 3 4 5 Strongly Agree

46. I attempt to establish a genuine sense of trust with my clients and their families

Strongly Disagree 1 2 3 4 5 Strongly Agree

47. I make every effort to understand the unique circumstances of each client and her

or his family

Strongly Disagree 1 2 3 4 5 Strongly Agree

48. I value the life experience of each of my clients and their families

Strongly Disagree 1 2 3 4 5 Strongly Agree

49. The use of effective interpersonal skills is very important in working with my clients and their families

Strongly Disagree 1 2 3 4 5 Strongly Agree

APPENDIX 11

Debrief Sheet – Quantitative Phase

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Debrief

We have now come to the end of the study. Thank you very much for taking part. The aim of this study is to understand the differences in cultural competency between trainees from different healthcare professions. Therefore, your experience is the most valuable. In this study, you answered questions regarding cultural competency. This data will be used to complete a doctoral thesis, support research and hope to contribute further developments in cultural competency training. I appreciate the time you took to participate in this study. If you would like to know the outcome of this study, please do not hesitate to contact myself or the project supervisors on the email address provided on the Information Sheet. Thank you, once again.

Umesh Joshi
Trainee Counselling Psychologist

APPENDIX 12
Audit Trail

As stated in the methodology, Braun and Clarke's (2006) 6 phases for thematic analysis were completed for this research. Please see below an example of data-analysis from each of the six steps of analysis (from coding of the raw data, through to the thematic development of final themes), using the qualitative data from the interviews.

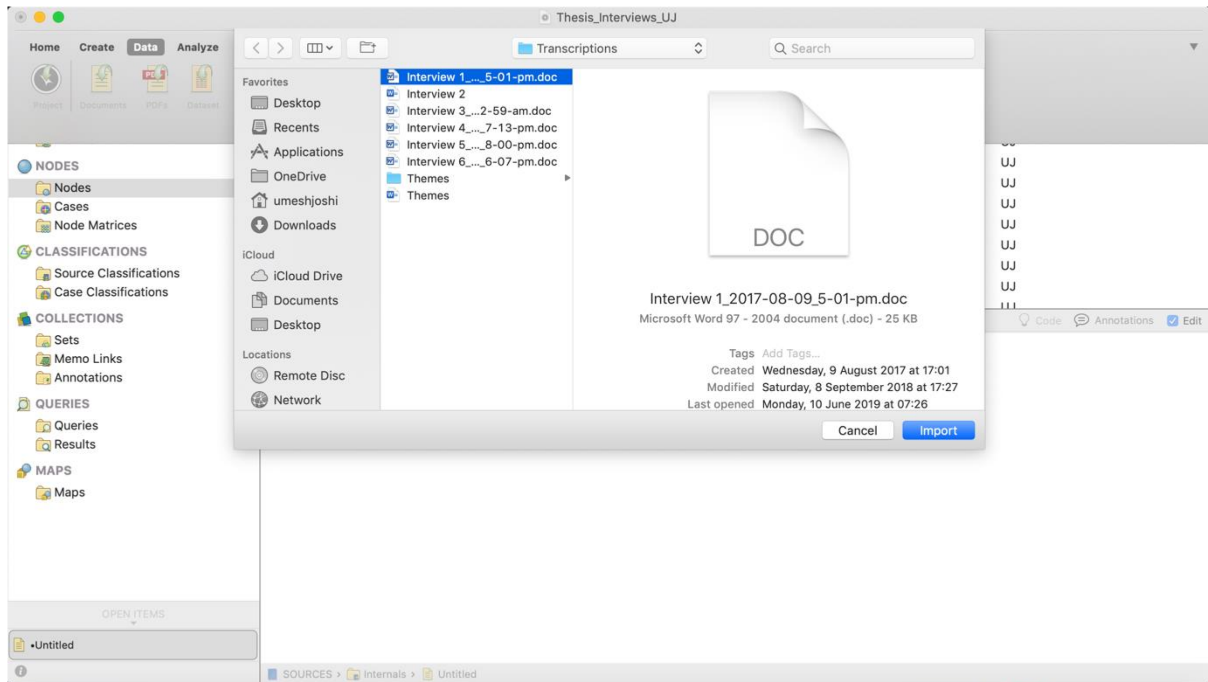
Phase 1. Familiarising yourself with the data

This phase began with the process of transcription. Interviews were transcribed on Microsoft word, with the audio being played and paused accordingly, whilst the data was transcribed. After interviews had been transcribed, the process of immersion had begun. Immersion involves actively re-reading the data to search for meanings and patterns. Please see methodology for further information.

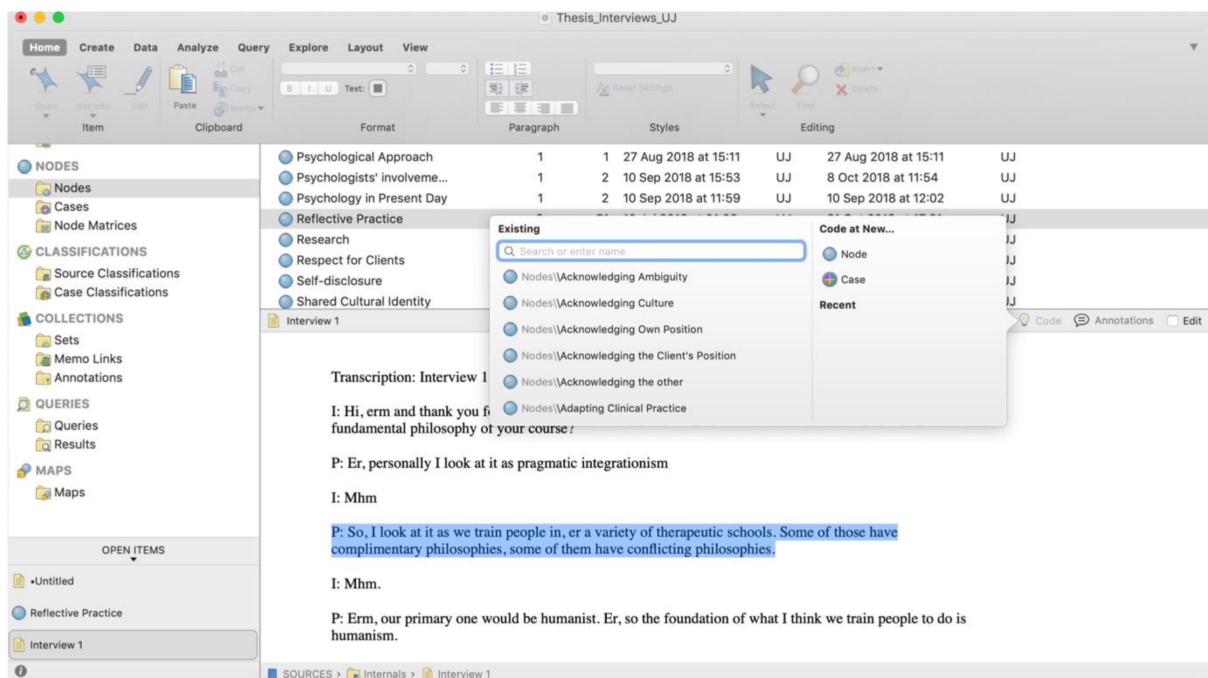
Phase 2. Generating initial codes

Generating initial codes is described to begin once the researcher has familiarised themselves with the data. Having become familiarised with the data, the data was then transferred from word documents to NVivo (a qualitative data analysis computer software package) for the purposes of coding. Codes identify a feature of the data which appears interesting to the analyst and can be assessed in a meaningful way regarding the phenomenon. By using coding as the initial step to organise the data into meaningful groups, the entire dataset was worked through systematically and repeated patterns (themes) were identified. As computer software was used for the purposes of coding, coding was completed in the way which was described by Braun and Clarke (2006), which involves tagging and naming selections of text within each data item. Please see below multiple screenshots demonstrating how initial codes were generated.

1. A new document was created within NVivo to import the transcription from word into the programme for the purposes of analysis. The new document was named (e.g. Interview 1).



2. After the document had been imported, the data was worked through and the coding process was then started. This included highlighting text within the transcription, and then assigning an existing code or creating a new code for the text highlighted.



3. After this step, steps 1 – 2 were repeated until initial codes had been generated for the entire dataset.

Phase 3. Searching for themes

After all the data had been coded, this phase involved sorting codes into potential themes and collating all the relevant coded data extracts within the identified themes. A visual table format was devised in Microsoft Excel to facilitate this process, as is suggested by Braun and Clarke (2006). At this stage, the different themes were developed after analysis of the codes.

Cultural competency	Training	Reflective Practice	Counselling Psychology's development	Inadvertent Learning
Cultural sensitivity	Trainee self-doubt	Clinical judgement	Differences in courses	Attitude towards diversity
Defining culture	Course development	Maintaining flexible and clinical reflective practice	Assessing cultural competency	Embracing diversity
Acknowledging culture	Course expectations	Psychological approach	Cultural norms in psychology	Environmental influences
Differences in client-therapist culture	Cultural competency training	Self disclosure	Trainers' cultural competency	Personal interest
Understnading culture	Undergraduate study	Therapeutic relationship	Differences in professions	Exposing self to difference
Shared cultural identity	Developing cultural competency training	Clinent preferences	Differences in cultural competency training	Inadvertent learning
Cultural awareness	Imbedding cultural competency throughout the course	Human experience	BME counselling psychologists	Personal experience
Differences in CC between colleagues	Applying training	Clinical practice	Counselling psychology's role in society	Exposure to cultural diversity
Cultural context of counselling psychology	Training	Client presentation	\developing psychological theory	
Assuming cultural competency	Current training	Client assumptions	Diversity within counselling psychology	
Diversity	Trainees demonstrating cultural competency	Clinical supervision	Philosophy of counselling psychology	
Intent to develop cultural competency	Ineffective cultural competency training	Competency	Programme marketing	
Understanding cultural competency	Trainer-trainee relationship	Philosophical position	Programme recruitment	
Developing cultural competency	Developing existing training	Client expectations	Psychologists' involvement in politics	
Developing cultural awareness	Training experience	Client experiences	Psychology in present day	
Integrating cultural competency skills	Trainee experience	Professional development	Research	
Applying cultural competency skills	Placements	Personal development	Equal opportunities to access counselling psychology training	
Acknowledging culture	HCPC expectations	Respect for clients	Counselling psychology as a profession	
Acknowledging ambiguity	BPS expectations	Acknowledhing the other	Historical development of counselling psychology	
Acknowledging the client's position	Student feedback	Managing assumptions	Time contraints	
Acknowledging own position	Student diversity	Reflective practice	Theory	
Experiences with minority groups	Training biases	Limitations	Jargon	
Differences between groups	Diverse lecturers	Political correctness		
	Philosophy of the course	Clinical experience		
	Defining doctorateness	Professional experience		
	Cultural competency training development	Adapting clinical practice		
		Professional identity		

Phase 4. Reviewing Themes

As is stated in the methodology, this phase involves two levels to reviewing and refining themes. Level one involved re-reading coded data for each theme to consider if they appear to form a coherent pattern. Level 2 considers what counts as an accurate representation of data by considering whether the thematic map reflects the meanings evident in the dataset as a whole. The data-set was re-read to consider whether the themes "work" in relation to the data set and to code any additional data which may have been missed in earlier phases of analysis. The table above (shown in phase 3) was consistently amended until the final version was produced (above). Once the thematic map worked in accurately representing the dataset, the next phased was then started.

Phase 5. Defining and Naming themes

Themes were then defined and refined, by identifying the essence of each theme and determining which aspects of the data the theme captures. This can be seen in the subsection of this thesis: Definitions and Labels for Selected Themes. By refining themes, as is suggested, it was considered whether or not a theme contains any sub-themes. From this point, the names of the themes were determined and finalised.

Phase 6. Producing the report.

This phase involved providing a detailed account of the data, by exploring and explaining the analysis of each theme one-by-one, aiming to provide a concise, coherent, logical, non-repetitive, and interesting account of the story the data tell – within and across themes. This phase provides the evidence for themes within the data. By using vivid examples and extracts which capture the points demonstrated, an argument was formed in relation to the research question.

APPENDIX 13
Table of Themes and Associated Extracts

Themes	Extracts
Theme 1: Cultural Competency	*P3: "I need to be sensitive to, I need to know something about how cultures might be different and how this might have an impact on my work."* *P5: "more open or comfortable with his sexuality rather than, let's say, someone who has also grown up in London but he's a second-generation Muslim man from Pakistan"* *P3: "I-I-I find myself saying things to clients like, you know, erm, you know you're talking about your experiences as a gay man in growing up and that's something that-that I really want to make sure that I, you know, really understand what that was like for you."* *P6: "You're trying to understand what's going on within the the bigger picture, and therefore, erm making culture a phenomenon to be explored and investigated"* *"Erm, same thing when it comes from from the same cultures, yeah?"* *P2: "P: You tell me. Now feedback to me on how this is. What's this? And also sort of saying, hey! I'm aware of it. We come from different places. This is okay to talk about."* *P4: "So I think actually working with people from diverse backgrounds, I've found that I'm-I'm real- I'm asking a lot of questions about, what is it like?"* *P6: "For some people, it creates comfort to be within the same cultures. For others, it's something that that is not seen as as an advantage."* *P5: "P: You know, I found that sometimes people because they felt that I wasn't English either, I: Mhm. P: that somehow helped them and they felt more comfortable with me."* *P3: "So, in terms of er using, you know, working the transference, I: Mhm. P: er, me not being gay actually produces a lot of useful material because it may be that, let's say this client has had past experiences of feeling that his relationships with straight men have been very one dimensional or he's felt judged in some way or there's been some kind of emotional distance, I: Mhm. P: or er, you know, homophobia, even. I: Mhm. P: Erm, that-that that's something that's he's likely to be sensitised to I: Yeah. P: in his relationship with me."* *P2: "that that effort is our kind of ethical and moral responsibility when we're dealing with the other."* *P3: "P: People have lots of different ways of thinking and being. Er, you know, both in terms of their their culture, their identity, their gender, their religion, erm, you know there's a multiplicity of ways of being, I: Mm. P: ways of thinking."* *P6: "respect of the otherness"*

	P6: "very much there" *P5: "constantly be open to questioning."* *P4: "to have that openness and to have that ability to, to really try to understand the person from their perspective as much as, some of the things that they might come up against."* *P2:* "you tell me how this is for you?" *P6: "What, what do you mean? Can you tell me a bit more? What is the position of, say a father, within a family in India?"* *P6: "the practitioner should further research the individual's environment and what directly informs their beliefs"* *P5: "P: You know, erm that that was that kind of brought down my, no, enriched my cultural competency but nothing from the course." I: So you'd say you were very much responsible for your cultural competency training as a trainee? P: Yeah, yeah. I: And thereafter as well? P: Yeah."* *P4: "need to have that competency to be able to work from, you know, whatever, we don't know who's going to walk through our door"* *P3: "I think it's important that it has a clear presence in the programme"* *P3: "it's also important to give it its own space"* *P3: "P: So I think, I think erm culture's a good word, cultural competency is a, is for me, firstly recognising that there are these multiplicities of culture P: that exist. And also there's a kind of erm, what's the word I'm looking for, a kind of er intersectionality. So we might belong to more than one culture. P: When I say that, it's not just clients, it's our colleagues erm you know, people we work with in teams. Diversity's about having the awareness of that culture exists I: Yeah. P: and what it means."* *P4: "we try not to just focus on cultural aspects, we try and think about it in terms of diversity in general."*
Theme 2: Inadvertent Learning	*P1: "P: So, I guess there's the... experiential aspect of it. By being around people who are from very different background, P: So I can hear certain words and phrases that erm say people who are second or third generation, Indian people use, P: And the similar things I've noticed with erm the people whose parents who came from Jamaica or somewhere else,"* *P2: "P: Both, kind of clinically, collegially, you know, erm, socially, everything, you know, erm, you know, kind of, just walking around, you know, the city and I'm thinking well, that that probably changes you know, unlike the way I probably was growing up in [state] where, you know, one of the things that predict of course fears and assumptions about the other is lack of, lack of,*

	exposure to I: Yeah. P: you know, diversity. And so, you know, and so you have I think that really kind of being in a kind of environment where there it's harder to hold I: Mhm. P: stereotypic assumptions about people from backgrounds different to yourself." *P4: "so, they're, everyone's learning from each other".* *P2: "P: See, that's the thing. I think that you have to have, and of course it goes without saying that if you have a more multi-cultural trainee population and trainee cohort, now, questions and discussions around diversity are going to come up more because they will come up more, you know, from the trainees as well."* *P1: "P: Erm... interestingly, we don't actually have any, on on our main er teaching team, the four of us we don't actually have anybody who's white British. P: Erm, so I think at the minute we kind of, because we have such diverse backgrounds anyway it's it's kind of shown in everything we do. P: And feeds into the work and the lectures."* *P2: "P: Whereas if you're in an area of the U.K. that is much less diverse, you know, I dunno, I guess, most of the places where counselling psychology trainings are situation in the U.K. er, you know, there's a certain level of diversity. But let's say somebody's doing the independent route. I: Mhm. P: Let's say somebody's doing the qualification in counselling psychology and the reason that they're doing that is 'cause they might not have had access to a training programme. I: Yeah. P: Well, somewhere on the portfolio, on the independent route, they're gonna have to prove the competency around multicultural practice or multicultural awareness. So, they're gonna have to do some kind of essay or something, I'm just thinking, what if that person, you know, you know, you know is in a very different kind of environment where you can't have the kind of training experiences and stuff like that. P: Erm, and that relates to erm you know openness and engagement with different cultures and backgrounds. I think that's important. I don't think we should shy away from that."*
Theme 3: Reflective Practice	*P1: "P: So when we do our sessions on ethics and respect for people, we're lookin' at, well the assumptions you make, P: You know, what do you assume about somebody on their walk through the door if they come through, regardless of their skin colour or culture or religion or anything else. P: and what it's like to be somebody from a particular background."* *P5: "You know, what prejudices do I have"* *P2: "P: Well I think that erm, the fundamental thing which won't surprise you erm when I say this, given what I've said this far, er, the base line erm of cultural competency is the awareness that your perspective and your experience is is you know, is not either the only one to have or the normal one to have or the right one to have"* *P2: "recognising your them as your perspectives"*

P4: "trying to bracket off our own assumptions"

P6: "the ability to, to stay with and not to be judgemental and to understand in as much open way as possible."

P5: "P: So, erm, it was erm it was very much a learning curve for me and I'm aware now, looking back at it, that I was very culturally unaware and potentially, I mean hopefully not, but potentially because I was very unaware of my assumptions and my prejudices, P: and erm therefore maybe I didn't pay so much attention to culture"

P3: "P: Very, very, very devout Christian and I'm Christian myself but he had very very, I mean his, it was interesting, his own kind of religious framework was so predominant in his mind
I: Mhm. P: that erm I actually think it was part of his presenting issues, very obsessive P: client. Erm, but we did a very interesting piece of work where I tried to find points of convergence between the religious conceptual framework I: Mhm. P: he had."

P1: "But a lot of it is er to do with exploring your own unconscious biases"

P1: "So although I'm trying, I may screw up."

P2: "P: to acknowledge the difference. To not to assume the difference will be a problem but to include it in the mix and I: Yeah. P: and not assume that it's not an issue for the client. To not assume it is an issue for the client. To not assume it's not an issue for you to be reflexive I: Mhm. P: to sort of think huh, you know, like what's coming up for me as I work for this client who's different"

P3: "P: Erm, but I think reflective, reflective skills are also key I: Mhm. P: across all those domains. That's something that would be central counselling psychologists bring. Er, they have a kind of, because there's an emphasis on personal development and relationships and being self-aware adds context, I think counselling psychologists as helping our trainees to do, whether they're working with a client or conducting research and thinking about their own relationship with their research topic or dealing with some kind of conflict or difficulty in a team they're working in. We're wanting our trainees to have, to bring a kind of certain reflective, erm, skill to I: Mm. P: their interventions."

P6: "it doesn't mean that we're seeing the world in exactly the same way."

P5: "being very aware of the potential kind of nuances and dynamics that will exist between assumptions… of each other."

P2: "P: Like really reflecting, working with, processing. There is your awareness, okay it's not enough to be aware. How are you responding to that awareness?"

	P5: "P: er to think of themselves as different. To acknowledge differences between them I: Mhm. P: and between them and their clients and them and other colleagues and so on. And that really really challenges and develops their reflective ability." *P5: "P: So, feeling safe in being reflective within themselves and in the presence of others."* *P2: "P: I think that, erm, the skills that counselling psychology training is ought to really foster and their trainees has to do with that kind of openness and engagement and flexibility. That willingness to be flexible in all sorts of different modes of thinking and different modes of approaching things. And now whether that's approaching things clinically or whether that's approaching things in terms of research or kind of, you know, kind of appreciating the value of different types of knowledge and different types of, you know, kind of therapeutic activities or different kinds of contributions that psychology can make in the world. I think that erm, em we counselling psychology, if you take the kind of, the really pluralistic ethos as being part of it, that's a- that's a very kind of er pragmatic and helpful and flexible way of going out into the world 'cause you're sort of thinking okay, I wanna keep my ears open and listen and hear from you about what's workable in this situation. I mean I like to think of counselling psychology as being kind of a pragmatic in a good way because it's being focussed on what works, rather than being fixed on ideas about what is right."* *P1: "ready when they graduate"* *P1: "employable"* *P5: "we want our students to have to be integrated personally and professionally. And that comes with self-awareness, really."* *P1: "That's not imbedding it in the practice"* *P2: "that effort is our kind of ethical and moral responsibility when we're dealing with the other."* *P4: "P: So, we kind of see that you know, when a person comes into the therapy room I: Mhm. P: they bring their whole world with them."* *P4: "P: People have very different, you know complex relationships I: Yeah. P: with themselves, with other people, I: Mhm. P: with how they feel about the environment they live in, how they connect in a spiritual way erm, and so all of those things kind of come into play in the therapy room."* *P6: "P: But by stay with, I mean to be in a position I: Mhm. P: to have enough openness I: Yeah. P: so say that the clients' otherness I: Mhm. P: from a culture can exist. Can have space to exist without judgement."* *P5: P: Erm, so it's about, cultural competency I think is really about having*

some knowledge but constantly be open to questioning, I: Mhm. P: wanting to learn more,

P4: "P: Erm, but the thing is, is really, trying to bring in that, the cultural aspect into, into well certainly into the clinical supervision because I think erm, you know, students, we've got to be training students to be able to work with everyone."

P4: "P: Erm, so I think it, you know, definitely bought in in erm in clinical supervision and then in the kinda of maybe a more theoretical way,"

P3: "P: So, we give our supervisors, the clinical supervisors in the placements, I: Mm. P: we ask them to evaluate trainees against various competencies."

P3: "P: So, we get feedback from the supervisors I: Mm. P: that er you know, assessing how well they think that trainee's working in this area."

P2: "P: because I did my, even though I did my clinical psychology doctorate in the [location], I did my er my final two thousand hour internship in NHS, here. Er, 'cause I'd already moved here and so erm and that was in a erm highly diverse erm area erm near [location]. Erm, and erm I saw clients from a-a huge range of cultural backgrounds. When I moved into private practice, in a very central [location] location, was cha- you know, it was- it was quite different."

P2: "P: Erm, I saw clients from a variety of backgrounds, still, but even if they were, they tended to be quite erm, gosh, I wouldn't see, I wouldn't see clients, the clients I saw were all incredibly socio-economically privileged."

P3: "I have worked with people from different kind of religious, ethnic backgrounds and in terms of sexuality and so forth and age ranges."

P5: "I think I learnt quite a lot on the job during the training."

P3: "P: You know, where, you know, er there's loads, I think lots of skills practice is important I: Mhm. P: to develop cultural competency. Roleplays and stuff like that."

P3: "P: Er, and I did get to work with, in my placements, with people who came from a range of different backgrounds, er cultural backgrounds and I think the supervision that I had was very helpful erm, when I was working with clients from different kind of cultures."

P5: "P: Er and also being very aware of their, still what it is that they need to learn because P: you know, I strongly believe that in this profession, if you feel like you don't have any more to learn, then or you know everything, then you're not really P: suited P: for it."

P5: "P: A journey erm and it was the start of the journey and they need to

	keep evolving and they need to keep developing I: Mhm. P: and it's very important to be integrated, how they are as people I: Mhm. P: and how they are as professionals. So this is a real skill I: Mhm. P: that we want our students to have to be integrated personally and professionally. And that comes with self-awareness, really." *P3: "P: And actually I think it's when you get into your independent practice after training, I: Mhm. P: hopefully if you've got a really good foundation, that's when you really start learning I think. Probably about cultural issues, in a different way."*
Theme 4: Training	*P3: "P: Largely because erm the BPS have recently as you might know, they recently introduced, they changed the standard I: Mhm. P: er for counselling psychology training programmes. They've introduced new standards. Er, which includes a whole new section that relates to cultural competency. It was, they were there before but I think it's really positive that the BPS standards now have explicitly referred to and in more detail referred to I: Mm. P: these competencies."* *P3: "They don't say this is this is this is the way you need to do it* *P5: "P: I think that it's really really needed and really really lacking and in a way, in a way I feel that the BPS, the new standards in the Division of Counselling Psychology where they've said, not standards it's competencies, that er courses must erm involve some kind of training on difference and diversity, I: Mm. P: they've left it actually very very vague."* *P5: "P: Erm, so I think that somehow the [brief pause] the BPS what is expected in terms of cultural competence through the training and deepening all trainees you know with this module that we do."* *P2: "you have to make sure that you are doing a good job of incorporating that into your training programme."* *P6: "P: I I I think that generally speaking, when I think of the competencies of counselling psychology, this emphasis on erm otherness, plurality, social justice, cultural spirituality, has come the past ten years. I: Yeah. P: Erm and and has been, you know, very much promoted. Erm, it wasn't there as a competency, say in the standards, which positions a programme director to attend to it explicitly."* *P1: "diversity, cultural diversity, erm, and you know the person who wrote it, I know has this view that this isn't being done on courses."* *P2: "P: we have working with difference and diversity module erm, but then you know, it comes into the discussion, I would say, in most other erm, you know, kind of, modules across the programme in one way or another. For example, er, this er week er we were doing a erm er a lecture in our, we have a, a series of advanced counselling psychology workshops in third year and this term is measurement and evaluation. And we were talking about, erm, and*

working with intelligence testing and neuropsychological testing and particularly in the intelligence testing or the cognitive testing, kind of, week, we were talking about how tests are normed, on whom they're normed I: Mhm. P: and just thinking about the questions that get asked on the [scale] and how your knowledge of the answers to those questions is going to be, you know, to some extent, culturally determined"

P6: "P: Yeah, so, we have created a unit I: Mhm P: er which is called erm counselling er psychology competencies. I: Mhm. P: So think of it as an umbrella. I: Yeah. P: Erm, another umbrella is theoretical models of therapy."

P6: "P: Yeah? So in the umbrella of counselling psychology competencies, we're having seminars and workshops that are focussing on erm, one of these on on multicultural er training and and er theory and skills."

P4: "we try and bring cultural issues into other erm into other modules as well."

P1: "Err, I guess at the moment we try to do it through, no matter what you teach, you try to imbed erm respect for people and a recognition of diversity into everything you do."

P5: "it could be a lot more."

P5: "is if they work in a diverse enough setting"

P5: "we don't really explicitly do anything else actually."

P1: "You know, what do you assume about somebody on their walk through the door if they come through, regardless of their skin colour or culture or religion or anything else."

P1: "... I don't know. It's a little bit like, how should an LGBT session be run."

P1: "well actually we are doing it all, we just don't call it those words".

P4: "whole context"

P5: "that they themselves think as different in relation to others and how this comes across in clinical practice and their professional setting and so on. And that really gets them to think."

P3: "that there isn't just one way of thinking about"

P3: "good therapeutic or research practice"

P3: "P: Skills that you're developing that are not just about how to provide therapy but it's about how to er work well within a team, how to understand erm your role within the team, within the organisation, erm, and how to

facilitate the practice within the team as well. So, erm, those are the kind of skills that we're trying to devel-develop in our trainees as well as being good clinicians, and good researchers."

P1: "reality of the workplace means you need to know a lot about other methods"

P1: "regardless of who you meet, you're attempting to maintain an open mind".

P5: "What we want is to have people who erm are skilled in working but are also very much aware of what is going on for them; very self aware."

P2: "P: Er, you know, if a research supervisor er er said you know, somebody says I'm doing IPA study so it needs to be really homogenous and so therefore I'm only going to er recruit erm white people you know, just in case, you know like I, you know, black people's experiences are different. We'd be like well hold on a second, is that meaningful homogeneity or I: Mm.
P: not meaningful homogeneity because IPA is all about homogeneity that counts with respect to the phenomenon in question."

P2: "P: And so that's why it's gotta be imbedded, it's gotta be interwoven, I: Mhm P: you know, and it cannot be lip service."

P2: "P: Erm, and then thinking about, for example, reflections, process reflections and process reports. Every time a student does a process report, if the student is not talking about the potential or picking up on the potential impact or significance of differences or awareness of difference I: Mhm. P: in a case study or in a process report, we're gonna wonder why. I: Yeah. P: Especially when a really significant cultural difference has been named, has been acknowledged, but there's not been discussed or unpacked or otherwise referred to or
I: Yeah. P: reflected on in any way."

P1: "Err, I guess at the moment we try to do it through, no matter what you teach, you try to imbed erm respect for people and a recognition of diversity into everything you do."

P3: "clinical experiences that trainees get in their placements includes exposure to a variety of cultural backgrounds."

P3: "would not go very far unless trainees are actually experiencing working with people from different cultural backgrounds"

P4: "we want you to tick box check all the different, the diversity of the placements that you're working in."

P5: "So any training, any competency training that they get is if they work in a diverse enough setting".

	P1: “P: our student group is so diverse.” *P1: “P: there's people from every age group and background and”* *P1: “P: ethnicity and culture and religion. Everything, all in pretty much every year group.”* *P2: “P: that if you have a more multi-cultural trainee population and trainee cohort”* *P2: “P: There will be more people, you know, kind of who are, you know, noticing the difference that is there in that room. Like, if you have a completely homogenous, like here's a bunch of like British, you know, kind of caucasian women in a room. Like, it's not gonna occur to you as much I: Mm. P: to sort of talk about difference.”* *P2: “P: Whereas if there's some men and there's some people from different backgrounds, different countries, then there'll be more part of a conversation.”* *P5: “P: er and also hopefully by having a diverse enough student group, peer group, where they openly talk about their experiences either informally or in facilitated discussions I: Mhm.* *P5: P: in the class. And I think on our course we're quite fortunate in that we do have a diverse group of students. It's not just white middle class.”* *P1: “Erm, but I know programmes in [area of England], you know, it's majority, you know, white women ages twenty seven.”* *P1: “And on clin. psych. programmes in tends to be white women aged twenty seven.”* *P1: “P: Erm, having spoken to programme leads on other programmes and having done certain examining for other programmes, I: Mhm. P: er, I know it's, it's covered in a almost a white English way. I: Mhm, yeah. P: So, something a little bit imperial about it. I: Mm. P: Erm, it's almost like the guidelines are written for white English people to stop being so insensitive I: Yeah. P: and clumsy.”* *P3: “But I think historically it probably wasn't doing a good enough job I: No. P: in terms of cultural competence.”*
Subtheme 1: Counselling Psychology’s development	*P2: “P: So, I think that sometimes cultural competence, often cultural competence is not what people think it is.”* *P2: “P: It's-it's not in some sort encyclopaedia entry on I: Yeah P: here's a culture of a certain place. You know? Or certain people, you know.”* *P2: “P: We don't have a module called multi-cultural therapy because we want it to be more broadly defined I: Yeah. P: than that.”*

P2: "P: Th-th-that, you know, that difference and diversity occurs on all sorts of different levels."

P2: "So trainers have to be trained, to sort of say, okay, you're marking a process report, you're asked to comment on issues where how the trainee deals with power or difference or anything like that.

P2: "P: You always, I have to make sure in terms of mentoring, you know, er my team in terms of marking standards and everything else, that they I: Yeah. P: attend to that all the time."

P5: "P: And erm, I get the sense that, I mean I don't know about the course that you're attending, but I get the sense that the module that we do here, in year one, where we ask trainees a lot to talk and reflect and think about difference and diversity is one of the very few that does that. I: Mm. P: And the reason that I get that sense I: Mhm. P: is because we invite erm, people er to come and talk who are familiar with other courses I: Mm. P: in the U.K. and they all say to me, oh it's really good that you do that course. Oh, it would be good if other, this module it would be good if other courses did that."

P1: "no matter what you teach, you try to imbed erm respect for people and a recognition of diversity into everything you do."

P1: "it's kind of shown in everything we do".

P1: P: I guess, most of the places where counselling psychology trainings are situation in the U.K. er, you know, there's a certain level of diversity. But let's say somebody's doing the independent route. I: Mhm. P: Let's say somebody's doing the qualification in counselling psychology and the reason that they're doing that is 'cause they might not have had access to a training programme. I: Yeah. P: Well, somewhere on the portfolio, on the independent route, they're gonna have to prove the competency around multicultural practice or multicultural awareness. So, they're gonna have to do some kind of essay or something, I'm just thinking, what if that person, you know, you know, you know is in a very different kind of environment where you can't have the kind of training experiences and stuff like that."

P5: "different courses do it in a different way"

P2: "P: I think traditionally counselling psychology has been a profession in the U.K certainly, which is ironic because in the United States counselling psychology er that section is devoted to counselling psychology is probably much more focussed on multiculturalism and kind of thinking about multiculturalism than the U.K has historically been. So I think that the U.K counselling psychology is really trying to kind of move in that direction as well."

P2: "P: It's a difficult one that, because in terms of inclusivity and not just across in terms of culturally but also in terms of socioeconomically and also

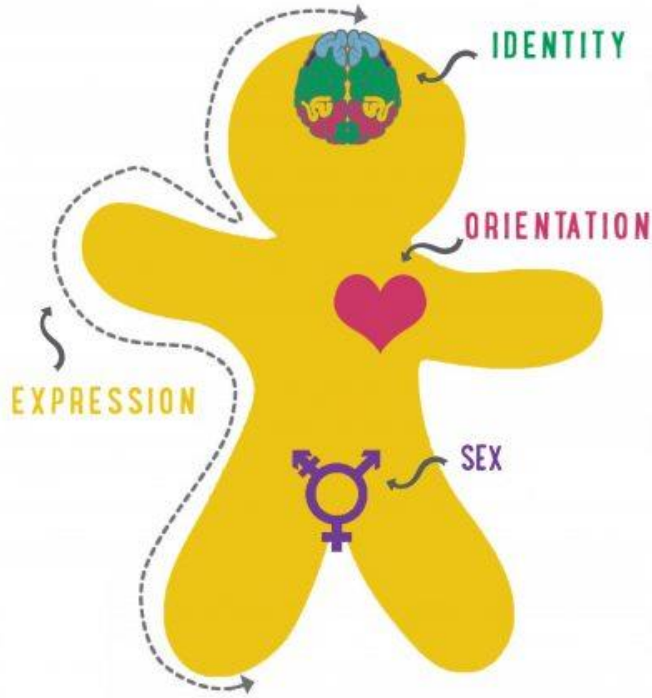
	because counselling psychology courses are really expensive I: Mhm. P: and they have just a lot of limits on what the funding is and so, that's already kind of limiting in certain ways for various kinds of, you know, different socioeconomic backgrounds. There's certain just cannot access counselling psychology training I: Mm. P: which I really hate." *P2: "P: So, the last erm higher education academy, webinar that I did was erm, er around er different ways of engaging in academia as related to kind of culture and backgrounds and whether, you know, kind of the students come from, you know, kind of a British er background or English speaking background versus from somewhere else. So, international students and trying to make sure er you are being maximally, kind of sensitive and questioning of kind of what works best for international students."* *P2: "P: And you know, I'm aware of this because I was sat on the divisional committee a few years ago. That was the last meeting of the committee that I was at when somebody they were starting a sort of special group for black and minority ethnic counselling psychologists because they, you know, and the rational for doing that was like they really felt like they needed a sort of space to grow awareness for more black and minority ethnic people I: Mm. P: in the division I: Mm. P: and sort of training and the profession."*

APPENDIX 14

The Genderbread Person

THE GENDERBREAD PERSON

Original concept by
itspronouncedmetrosexual.com



Your gender identity is how you think about yourself, the gender that you identify with and/or feel that you are. Some people feel as though they do not have a gender at all, and may refer to themselves as agender or non-gendered.

This is how you display your gender and is demonstrated through the ways that you act, dress, behave and interact in the world, in relation to the gender expectations of your society.

This is usually determined at birth, based on observation of your genitals. However, your chromosomes, hormones, genes and internal sex organs also contribute to the make-up of your biological sex.

The types of people, (often based on gender,) that you find yourself attracted to, can help you determine your sexual orientation. Attraction can be emotional, sexual, physical and/or spiritual. Some people experience little or no sexual attraction, and may refer to themselves as asexual.

APPENDIX 15
Critical Reflection on Research Process

Critical Reflection on Research Process

Design of research

The design of the research was a steady process which led to the formation of the current thesis. Initially, I had only thought of the qualitative phase of the research. I considered interviewing course directors, following suggestions in the literature to identify how courses contribute to the development of cultural competency skills. I thought the people who make the decisions about the course and the leaders of courses would be the most appropriate people to interview regarding this issue. With only 13 courses in the U.K. which teach the counselling psychology doctorate, at least 6 participants would be almost half the population. It was through conversation and guidance of my thesis supervisors that the quantitative phase was developed, and the notion of developing the study to be mixed-methods in its design. By giving questionnaires to trainees and those who have been recently qualified, we can measure and compare levels of cultural competency between counselling psychologists and our biomedical colleagues. Whilst the two studies do not directly impact one another, the interviews were intended to provide context for the scores of the counselling psychology group in the quantitative phase.

Data collection

Designing the research process initially seemed simple and straightforward. After completing the research proposal and considering the process of data collection, I found I had to rethink my ideas repeatedly in order to effectively present research which was sensical and credible. My initial ambitions to recruit from different biomedical groups and present them as individual groups (such as nursing, medicine and pharmacy students as individual groups) was soon brought into question by me and my research supervisors, when I was struggling to collect enough participants from each group. Hence, the notion of collapsing groups to represent the biomedical field was required for the purposes of a group which was sufficient in numbers, yet representative of the groups I wanted to analyse. The 8 months of participant recruitment for the quantitative phase felt like a frustrating process, with small, inconsistent gains.

The process of data collection for the qualitative phase was a straightforward process. Course directors were emailed directly, with information regarding the study, asking them to participate. After they had responded to the email, a date and time for the interview was agreed. Using skype for the purposes of interviewing provided me with the opportunity to ensure that all interviews were conducted in the same way. After each interview, I believe my comfortability to conduct interviews increased. Whilst I was not hesitant to engage in the semi-structured interview process, my confidence in doing so steadily increased. This may have impacted the perception the participant had of me and their comfortability in being forthcoming with me during the interview.

Data interpretation / development of themes

The notion of data interpretation and the development of themes for the qualitative phase initially felt intimidating. Having read Braun and Clarke's (2006) recommendations for the process of thematic analysis, I struggled to imagine this process in action. I had not used

thematic analysis previously and hence, was afraid of it. As I went through the data and followed their guidance, step-by-step, it all began to make sense. From the initial transcription, to highlighting codes, and developing themes, I began to see everything come together. Like a jigsaw, the pieces finally began to fit, and I began to feel more confident whilst the picture continued to complete itself with my analysis and understanding of both the method and the data.

Post-positivism

Ryan (2006) states that a critical post-positivist stance suggests that we cannot simply aggregate data to arrive at an overall 'truth'. Further, he states that this does not mean, however, that post-positivist researchers do not take a political or moral stand, or that they avoid taking action. But it does mean that they recognise the complexity of the web of life and experience. They may write with some authority, but they keep it reflexive and avoid dogma or authoritarian tones. With this in mind, it felt natural for me to adopt a post-positivist position in my research. It was important for me to use this research for the purposes of taking a moral stand in developing the notion of culture and how cultural competency skills are developed, whilst maintaining a reflexive and open-minded perspective during the formation of the research and conducting interviews.

Assumptions and Preconceptions Towards the Thesis

My assumptions and preconceptions towards the thesis were informed by my naivete. Having only completed my dissertation from my undergraduate degree, I struggled to know where to start, but I thought I knew what to do. I did what was expected, in regard to the completion of a research proposal, applying for ethical approval and completing a Gantt chart to define how long different aspects of the research process will take. Unfortunately, whilst the intentions and timings on the Gantt chart were representative of a solid research plan, the unexpected delays in participant recruitment delayed me from achieving some of the goals stated on the chart. Hence, completing analysis of quantitative data and the aspects of research which follow on from participant recruitment took longer.

Commentary on Advantages and Disadvantages of Insider Knowledge

Having insider knowledge of the course and experiencing this whilst I was completing the doctorate often left me feeling emotionally torn with the work. Some of the advantages included knowing where to start, and who to ask regarding the participant recruitment for the qualitative phase. My research supervisors were able to guide me, with consideration of who to ask, and which routes to take in the recruitment process. I also had an advantage in knowing what my own experience of the course was like, what my course was teaching and thought about how this lived experience may differ not only from the students on different courses but the course I also attended. Some of the disadvantages included that my own experience of the course skewed my perception and expectations of what participants of the qualitative phase would share during interviews. Whilst this did not impact my neutrality in analysis, in hindsight and on a preconscious level, may have impacted the way I responded to answers in the semi-structured interview. This ties into assumptions and preconceptions I had towards the thesis, and how my own reflective journey as a researcher, a practitioner, a client in therapy and a person, was shaped and influenced by the consistent relationship I had with this work.

APPENDIX 16
Journal Submission

Instructions for Authors

1. SUBMISSION

Authors should kindly note that submission implies that the content has not been published or submitted for publication elsewhere except as a brief abstract in the proceedings of a scientific meeting or symposium.

Once the submission materials have been prepared in accordance with the Author Guidelines, manuscripts should be submitted online at http://www.editorialmanager.com/bjp

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- The author's institutional affiliations where the work was conducted, with a footnote for the author's present address if different from where the work was conducted;
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Please provide an abstract of between 100 and 200 words, giving a concise statement of the intention, results or conclusions of the article. The abstract should not include any sub-headings.

Keywords

Please provide appropriate keywords.

Acknowledgments

Contributions from anyone who does not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

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The main text file should be presented in the following order:

- Title
- Main text
- References
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References should be prepared according to the *Publication Manual of the American Psychological Association* (6th edition). This means in text citations should follow the author-date method whereby the author's last name and the year of publication for the source should appear in the text, for example, (Jones, 1998). The complete reference list should appear alphabetically by name at the end of the paper. Please note that for journal articles, issue numbers are not included unless each issue in the volume begins with page 1, and a DOI should be provided for all references where available.

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Reference examples follow:

Journal article

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Book

Bradley-Johnson, S. (1994). *Psychoeducational assessment of students who are visually impaired or blind: Infancy through high school* (2nd ed.). Austin, TX: Pro-ed.

Internet Document

Norton, R. (2006, November 4). How to train a cat to operate a light switch [Video file]. Retrieved from **http://www.youtube.com/watch?v=Vja83KLQXZs**

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Tables should be self-contained and complement, not duplicate, information contained in the text. They should be supplied as editable files, not pasted as images. Legends should be concise but comprehensive – the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Title: Are counselling psychology training courses developing multicultural competencies in their trainees?

Short title: *Multicultural competencies in counselling psychology courses*

Umesh Joshi*[1], Niall Galbraith[2], and Abigail Taiwo[3]

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Abstract:

The need for professionals to develop multicultural awareness, knowledge and skills has been recognised in literature and mental health practitioner programmes since the early 1970s. Despite the professional growth of the Doctorate in Counselling Psychology (DCoP), recent research still suggests that cultural competency skills must be further emphasised and developed in training courses. Following an integrative philosophical model, this study adopts a mixed methods approach including interviews and cross-sectional surveys to explore how cultural competency skills are facilitated in DCoP training or acquired by professionals compared to biomedical trainees and professionals. Interviews were conducted with the DCoP course directors, while the

Lie scale (Eysenck, 1976) measuring social desirability and the Healthcare Provider Cultural Competence Instrument (HPCCI) (Schwarz, Witte, Sellers, Luzadis, Weiner & Domingo-Snyder, 2015) measuring level of cultural competency skills, were administered to the DCoP and biomedical groups. I hypothesised that the DCoP trainees will score significantly higher on cultural competency compared to trainees from other training programmes and this proved not significant. The results have implications for further developments of cultural competencies in counselling psychology and biomedical training courses.

Keywords:

Cultural Competency, Counselling Psychology, Mixed Methods, Culture, Teaching.

Data availability statement:

The data that support the findings of this study are available from the corresponding author upon reasonable request.