

A PHENOMENOLOGICAL EXPLORATION INTO
THERAPISTS' MULTICULTURAL CASE VIGNETTES

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THERAPISTS' MULTICULTURAL CASE VIGNETTES

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Abstract: Given the consistent diversification of the United States, scholars and professional organizations agree that culturally sensitive mental healthcare is imperative. Research suggests that racially marginalized groups are more likely to suffer from distress as a result of the oppression that they face. Scholars have long emphasized the importance of cultural responsiveness in therapy; however, the evidence for the prevailing tripartite model of multicultural competence is mixed, and most extant research is quantitative in nature, leaving unexamined the intrapsychic processes that therapists engage in when applying (or not applying) a multicultural lens to client conceptualization. Thus, for the study, a qualitative approach was used to explore psychologists' multicultural case conceptualizations and diagnoses based on two vignettes, in an attempt to better understand the internal processes psychologists engage in and what processes do or do not lead to the multiculturally sensitive conceptualization of therapy clients. Six themes emerged from the data: multicultural competence, systems of support, controlling images, biological factors, multicultural orientation, and focus on cognitive therapies. Implications for training programs, practice, and research were also discussed.

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CHAPTER I

INTRODUCTION

The diversity of the United States population has increased over the past several decades and continues to do so at a rapid pace (U.S. Census Bureau, 2020). In fact, the Census Bureau has posited that, in approximately two decades, no single racial group will be the statistical majority. Thus, the need to provide high quality mental healthcare to marginalized groups, particularly racially marginalized individuals is not only imperative, but will also continue to rise rapidly. Unfortunately, however, racial disparities in mental health care persist, with researchers attributing the inequitable treatment to inadequate multicultural competence amongst counselors and counseling psychologists' (hereafter, therapists). For example, clients of color are still more likely to terminate therapy services early than White clients (Imel et al., 2011; Owen et al., 2017). Further, this problem is not shared equally across therapists: some therapists demonstrate higher early termination rates of clients of color than other therapists (Owen et al., 2017). Researchers have long posited that therapists' lack of cultural sensitivity directly contributes to the disparity in mental healthcare services (Constantine, 2001; Owen et al., 2017).

Other factors, compounded by therapist cultural sensitivity, also likely contribute to mental healthcare disparities. Black/African American individuals face persistent

structural discrimination, which contributes to their higher rates of overall distress (Atuahene, 2018; Hayes et al., 2016; Pieterse et al., 2012). Specifically, Black and African American individuals are more likely to suffer from posttraumatic stress disorder, indicating that racism is actually a traumatic stressor (Carter et al., 2017). Other forms of distress due to racism include anger, somatic symptoms, and academic difficulties (Washington et al., 2017). As a result of experiences of oppression, including vicarious and intergenerational trauma, Black and African American individuals are less likely to seek mental health services (Brooks & Hopkins, 2017; Carter et al., 2017); thus, it is critical for therapists to provide culturally sensitive services not only for the benefit of Black and African American individuals, but also for the sake of the overall trust in the institution of mental health on behalf of racially marginalized communities.

CHAPTER II

REVIEW OF LITERATURE

Clients of color are in greater need of mental health services; yet, due to cultural mistrust and therapist differences in cultural responsiveness, research suggests that clients of color are less likely to seek therapy, and when they do, are more likely to terminate therapy early (Owen et al., 2017). As a result, it is imperative that therapists develop strong cultural sensitivity; indeed, detailed guidelines for multicultural practice exist (e.g., APA, 2017; ACA, 2015). Additionally, organizations require commitment to diversity and self-reflection. Incorporation of multicultural considerations into all processes of therapy is required as well (APA, 2017). However, some therapists still demonstrate poorer outcomes with clients of color than others (Owen et al., 2017), and research suggests that therapists may not be taking clients' cultural considerations into account when conceptualizing their distress and treatment (Wilcox et al., 2020; Monceaux et al., in press). Thus, understanding therapists' cultural responsiveness may shed light on the racial disparities that persist in mental healthcare.

Therapist Cultural Responsiveness

A consistent overrepresentation of White non-Latinx therapists may perpetuate

implicit White hegemony in the mental health field (Sue et al., 1992); for example, in the field of psychology, 84% of psychologists were White as of 2018 (APA Center for Workforce Studies, 2018). The institution of mental health has a difficult history, having mistreated people and communities of color in various periods since its inception (Harris, 1996). While Black/African American people were less likely to be formally institutionalized than their White counterparts, they were more likely to be victims of unethical experimentation (Harris, 1996; Maeda, 2016).

However, the field has attempted to move toward emphasizing the importance of cultural responsiveness to provide more culturally sensitive services, to avoid repeating such mistakes, and to restore the trust in mental health providers among marginalized communities (Ivey, 2003; Sue et al., 1982, 1992).

Cultural responsiveness has primarily been informed by two models. The tripartite model of multicultural competence (MCC; Sue et al., 1982, 1992) has been the predominant model of understanding multicultural psychotherapy, and also thus has shaped multicultural training models (ACA, 2015; Pieterse et al., 2009). Recently, researchers have proposed multicultural orientation (MCO) as a complementary model (Davis et al., 2018). The tripartite model posits that the requisite components of multicultural competence are therapists' multicultural knowledge, awareness, and skills. That is, therapists are expected to implement culturally-relevant knowledge, challenge their own beliefs regarding diverse and marginalized populations, and incorporate culturally sensitive interventions when appropriate (Sue et al., 1992). MCO, composed of three pillars (cultural humility, cultural opportunities, and cultural comfort), focuses humility and the therapeutic relationship in the moment (Davis et al., 2018).

Researchers have found that MCO and MCC appear to be positively related to therapy processes and outcomes (Davis et al., 2018; Tao et al., 2015). For example, it has been found that clients who believe their therapist exhibits greater MCC tend to rate their therapy experience as better (Constantine, 2002). Therapists who complete more multicultural training tend to have lower levels of color-blind attitudes, a form of covert racism wherein a White person denies noticing racial differences (Chao et al., 2011; Paone et al., 2015). Therapists completing more multicultural training have been found to be more likely to be willing to confront White privilege as well, particularly if those individuals had completed at least four other multicultural training experiences (Paone et al., 2015). Interestingly, therapist MCC also appears to be correlated with general therapy skills, such as genuineness and empathy (Tao et al., 2015).

The multicultural counseling movement has been called the “fourth force” in psychotherapy (Pedersen, 1990), having led to a movement within psychology that sought to foster greater cultural responsiveness. Certainly, the MCC model has driven significant changes in both research and practice, and in both breadth and depth. Sue and colleagues’ (1982, 1992) original work on the tripartite model has had an undeniable effect on psychotherapy and training.

As noted previously, the empirical evidence for the MCC model is mixed (Tao et al., 2015). Scholars have highlighted that the evidence for the MCC model is actually mixed, and that some studies demonstrate a lack of correlation between MCCs and therapy outcomes (Davis et al., 2018). Further, rigorous research is hampered by measurement limitations (Wilcox et al., 2020; Lantz et al., 2018; Worthington & Dillon, 2011); the vast majority of studies have consisted not only of quantitative analyses, but

predominantly therapist self-report measures of MCC (Hook et al., 2016; Worthington et al., 2007). This latter point is particularly concerning. Firstly, ex post facto response measures cannot fully portray multicultural competencies, as therapist skills are highly based on context rather than universal scales (Worthington et al., 2007). In addition, the defining features of competency involve behaviors; however, most self-report assessments measure beliefs (Sodowski et al., 1994). Further complicating the model is that factor analyses have revealed that most existing self-report measures only capture knowledge and awareness, but not skills; this, again, makes sense given the nature of self-report measures (Worthington et al., 2007). Recent research (e.g., Monceaux et al., in press; Wilcox et al., 2020), however, has sought to extend inquiry into cultural responsiveness through examining performance-based measures of MCC, specifically, case conceptualization. Case may be important to understanding cultural responsiveness because the process informs the treatment.

Case Conceptualization

Case conceptualization is considered a core competency of therapy (Kuyken et al., 2008, Lee & Tracey, 2008). Case conceptualization may be defined as hypotheses about various factors, such as biological or sociocultural, that may be contributing to the current presenting client concerns (Nezu et al., 1997; Page et al., 2008). Case conceptualization helps the therapist gain understanding of the client's overall problems and strengths through synthesis of various sources of information. Importantly, case conceptualization guides the treatment planning process, such as deciding an appropriate theoretical model and specific interventions (Page et al., 2008). While case conceptualization is considered an important skill of therapists, it is difficult to learn from

scholarship alone. Researchers have found that quality of supervision and consistent feedback, rather than quantity of supervision hours, influences a therapist trainee's case conceptualization skills (Page et al., 2008). Further, researchers have found that quality case conceptualization may improve treatment outcomes, likely due to the synthesis of information and guidance throughout treatment (Kendjelic & Eells, 2007). However, case conceptualization research has shown mixed results, and case conceptualization research continues to have several gaps (Lee & Tracey, 2008). The mixed findings may be attributed partially to varying methods, but also, importantly, context, a key factor that has consistently been neglected in conceptualization research. General case conceptualization informs treatment, and, therefore, exploring the multicultural case conceptualization may fill important research gaps and provide understanding of cultural responsiveness.

Multicultural Case Conceptualization

Along with general case conceptualization, researchers have explored therapists' multicultural case conceptualization skills due to the importance of attention to sociocultural and contextual factors in understanding clients' concerns. Multicultural case conceptualization consists of incorporating client cultural and contextual factors into clinical hypotheses and formulating an appropriate treatment plan (Constantine & Ladany, 2000). Courses, workshops, training, and counseling experience appear important to therapists' ability to conceptualize a client's multicultural considerations (Constantine, 2001; Weatherford & Spokane, 2003). Multicultural conceptualization may require greater skill due to incorporating complex presenting concerns and relevant cultural information (Constantine, 2001). The skill becomes more complicated

particularly because many common theory-specific conceptualizations, such as cognitive theory, have been criticized for neglecting cultural considerations (Crumb & Haskins, 2016). Cognitive theories inherently focus on skill building, potentially implying that clients' presenting concerns are skills-based deficits (Crumb & Haskins, 2016).

A few theories have informed the foci of multicultural case conceptualization. Indeed, although rarely discussed in subsequent decades, the original tripartite model theorists addressed this proneness and the ways in which it could hinder culturally sensitive counseling (Arredondo et al., 1996; Lantz et al., 2018; Sue et al., 1982, 1992). Similarly, researchers have studied social dominance theory, or the propensity for societies to organize themselves hierarchically (Sidanius & Pratto, 1999). Researchers have found therapists who align strongly with social dominance orientation (SDO) view the world as fair and accepting of hierarchical in- and out-groups (Lantz et al., 2018). SDT relates to therapy, in that therapists with higher SDO tend to believe in the myth of meritocracy, and, thus, exhibit more racist attitudes (Lantz et al., 2018). These positive and negative views toward success and failure, respectively, maintain privilege and oppression (Jouffre & Croizet, 2016), which, in the context of multicultural counseling is a serious issue given the profession's emphasis not only on culturally sensitive care, but also social justice (Swan & Cabellos, 2020; Vega & Speight, 2003). From the perspective of those higher in SDO, failure (such as less access to capital and resources, resulting in psychological distress) is a direct consequence of lack of personal effort to improve one's own quality of life.

Conceptualization of psychological distress from this perspective errantly results in failure to consider power structures, or other external factors, that play a role in every

individual's life circumstances. In fact, researchers have recently found that therapists overwhelmingly fail to appropriately address cultural factors in vignette studies focusing on conceptualization, indicating compliance to this dominant narrative about individual responsibility (Monceaux et al., in press; Wilcox et al., 2020). As noted earlier, existing individual and systemic oppression matters to the development of individuals' psychological distress; and, further, research suggests that therapists' inability to take these contextual factors into account is also detrimental to the process of multicultural counseling and multicultural conceptualization (Lantz et al., 2018; Lee & Tracey, 2008; Wilcox et al., 2020).

Research on cultural responsiveness and case conceptualization is particularly important given the significant consequences that may arise in the therapeutic relationship with Black/African American clients. Unexamined therapist conceptualization processes may lead to therapists exhibiting implicit bias, not broaching cultural differences, or denying the possibility of possessing beliefs about stereotypes related to marginalized groups (Hook et al., 2016). For example, if one believes oneself to be "colorblind," it follows that one would be unlikely to broach race in therapy. There is evidence that bias indeed appears in conceptualization and diagnosis with clients from marginalized groups, particularly clients of color. For example, therapists diagnose Black and African clients disproportionately with psychotic and behavioral disorders (Barnes, 2008; Bean, 2013). Therapists are also less likely to consider affective disorders and more likely to view Black/African American clients as antisocial or more violent (Garb, 1997; Guy et al., 2008; Whaley, 1997). It is possible that therapists' internal processes related to bias explain why there are between-therapist differences in client cultural

concealment, wherein the client avoids revealing culturally relevant information to the therapist (Drinane, Owen, & Tao, 2018). Cultural concealment tends to lead to poorer therapy outcomes (Drinane et al., 2018). However, extant research has yet to qualitatively examine therapists' internal processes related to multicultural counseling, making it difficult to know how exactly therapists could be engaging their clients differently to improve the cultural sensitivity of counseling.

Gaps in Multicultural Case Conceptualization Research

Despite the now 35-year focus on the importance of culturally sensitive psychotherapy, relatively little research has actually been conducted to evaluate the efficacy of existing models of multicultural competence (Davis et al., 2018). Further, few studies have measured multicultural competencies in the context of multicultural case conceptualization process and outcomes (Lee & Tracey, 2008), although some studies have indeed examined multicultural case conceptualization through written responses to vignettes. Some studies have included multiple case vignettes as a way to examine multicultural competence (Constantine, 2001; Wilcox et al., 2020). Most commonly, multicultural competence research using responses to vignettes has focused on competence with racial and ethnic minority clients, including Indian, biracial, Asian American, Black/African American, and Middle Eastern clients (Aldarondo, 2001; Schomburg & Prieto, 2011; Soheilian, et al., 2014; Steinfeldt & Steinfeldt, 2012; Wang & Kim, 2010; Wilcox et al., 2020). Another recent study examined case conceptualization specific to working with bisexual clients (Monceaux and colleagues, in press). Overall, researchers have found troubling results: despite formal multicultural training and experience, participants often fail to appropriately incorporate cultural

factors when conceptualizing the clients in the vignettes (e.g., Monceaux et al., in press; Schomburg & Prieto, 2011; Wilcox et al., 2020).

Despite the available research on multicultural case conceptualization, it has been difficult to know *why* therapists have failed to incorporate cultural factors into their conceptualizations as a result of the methodological approaches to vignette-based case conceptualization research. As previously noted, existing vignette studies have predominantly been conceptualized and analyzed using quantitative methodology, despite the inherently qualitative nature of narrative responses to vignettes. Indeed, a common instrument used for vignette performance, the Multicultural Case Conceptualization Ability task (Ladany et al., 1997), asks participants to provide written responses to conceptualize a client; then, answers are assigned a score from one to five based on the participants' attention to cultural factors and integrating cultural factors into the treatment plan. Although potentially useful, such a quantitative approach to a qualitative endeavor (i.e., "postpositivizing") may oversimplify participants' responses and miss important data regarding *how* participants are conceptualizing clients and integrating (or not integrating) cultural factors. An inductive, qualitative vignette study allows for attention to the specific language therapists use, and the internal processes therapists use to conceptualize and diagnose clients. Quantitative research has also shown that multicultural case conceptualization ability correlates to White empathy among therapists, further supporting the need for an inductive approach to shed light on the language and thought processes used during the conceptualization process (Spanierman et al., 2008).

To date, no study has taken a truly qualitative, inductive approach related to the processes by which therapists incorporate cultural considerations into conceptualization and diagnosis through the use of vignettes without explicit inquiry. Given the methodological concerns that have been raised, such as the discrepancies between therapists' self-ratings of MCCs as compared to others' ratings (Owen et al., 2017 as well as vignette performance (e.g., Monceaux et al., in press; Wilcox et al., 2020), and the "postpositivizing" of qualitative attempts at examining multicultural case conceptualization, it seems particularly important to inductively, qualitatively examine therapists' internal processes related to multicultural case conceptualization. A constructivist, inductive approach may allow multicultural case conceptualization theory to emerge, rather than deductively imposing existing theory and quantification on the generation of data.

Ponterotto (2005) noted that, in general, psychological research has historically been rooted in positivist and post-positivist (which is to say, quantitative) paradigms, which has limited scientific advancement. This is particularly true for multicultural counseling research, which has rarely seen the inclusion of truly qualitative (rather than "post-positivized"; Ponterotto, 2005) research, and for which qualitative research has, to date, not been used to theory-build in advance of developing quantitative measures. This amounts to a reliance on hypothetico-deductivism, which limits the generation of new knowledge to deductively drawing on existing theories and knowledge, rather than novel theory-building (Willig, 2001). Indeed, the MCC and MCO models have been articulated on the basis of what is already known about multicultural counseling, and the subsequent empirical investigations of the models have been generated on the basis of deductively-

generated measurements. That research has demonstrated mixed results and limited outcomes related to the MCC model over the course of three decades suggests that theorizing would have benefited instead from an inductive approach to understanding multicultural case conceptualization.

The Present Study

No research has included a focus on multicultural case conceptualization from a qualitative methodology. The intersection of the multiple aforementioned gaps in research warrant the present study, which was a qualitative examination of therapists' multicultural case conceptualization that examined therapists' internal processes related to their conceptualization—and particularly, their attention to cultural factors in their conceptualizations—of clients. Participants were presented with two vignettes: one with identified demographic factors to serve as external cues for therapists to consider and address cultural factors in their conceptualization, and one vignette with no explicit demographic factors, such to allow participants to walk through their implicit conceptualization and diagnosis processes in the absence of external cues. Importantly, participants were presented with the latter vignette first, so as to capture their implicit case conceptualization process without priming specifically for multicultural case conceptualization. Given that all therapy is inherently multicultural (Sue et al., 1982), all case conceptualization should seek to incorporate cultural considerations; if and when this does not occur, it is important to understand not just *that* it does not happen, but the *how* and the *why*.

The purpose of the study was to gather insight into how therapists conceptualize vignettes without specific prompting for multicultural information. The process of the

therapists' conceptualizations may help provide insight and specific language that may reveal cultural responsiveness and how to incorporate more meaningful multicultural understanding, social justice advocacy, liberation for clients from marginalized backgrounds (Swan & Cabellos, 2020). Novel research is required to explore what therapists do and do not consider with Black/African American clients. Thus, the research question guiding the proposed study was as follows: What do therapists attend to in multicultural case conceptualization?

CHAPTER III

METHODS

Design

As described above, an inductive, qualitative research design was determined to be the most appropriate, given that little existing inductive examination and theory-building exists as it pertains to multicultural case conceptualization. Qualitative approaches are appropriate when attempting to study complex social phenomena (Gough & Lyons, 2016). Further, qualitative approaches are well-positioned to be used to advocate for social change, noted by scholars to be the necessary work of counselors and counseling psychologists (Marshall & Rossman, 2014). Additionally, complex issues, such as cognitive processes related to bias, require an examination into multiple participant perspectives (Gough & Lyons, 2016).

Qualitative approaches require explication and justification that are often quite different from quantitative paradigms, or underlying assumptions that guide the research process (Ponterotto, 2005; Morrow, 2005). Unlike quantitative paradigms, it is imperative to explicitly address the philosophy of science, ontology, epistemology, and axiology of the researcher (Ponterotto, 2005). Further, as traditional (i.e. quantitative) notions of

reliability and validity do not apply to qualitative inquiry, instead, how quality and trustworthiness will be attended to must be explicated; and, approaches to quality and trustworthiness in qualitative research are both paradigm-specific and applicable to multiple paradigms (Morrow, 2005). There are a multitude of potential qualitative paradigms from which to choose (see Ponterotto, 2005; Morrow, 2005; Morrow et al., 2012), and a researcher's choice of paradigm is often inextricably linked to the researcher's positionality and philosophy of science. Thus, below, I outline the paradigmatic frames of the study; my philosophy of science and positionality; and, how I attended to quality and trustworthiness in the study. Then, I will discuss methodological specifics of the study.

Paradigm and Philosophy

From a more global perspective, I closely align with a constructivist-interpretivist paradigm, meaning that I believe a universal reality cannot fully be extracted (Ponterotto, 2005). Constructivist-interpretivist paradigms are generally assumptions associated with qualitative research and in response to predominately positivist paradigms. Given that the purpose of the current study was to explore therapists' presumably idiosyncratic process of conceptualizing clients, a postpositivist paradigm is an appropriate fit. More specifically, I balance both constructivist-interpretivist and critical-ideological paradigms within the qualitative approach. Broadly speaking, I acknowledge that multiple realities exist and may be co-constructed among people, consistent with a constructivist-interpretivist paradigm (Ponterotto, 2005). I also focus on the power structures that have been co-constructed and the groups benefitting or suffering from such structures, which is consistent with the critical-ideological paradigm (Ponterotto, 2005). Both the

constructivist-interpretivist and critical-ideological paradigms share some philosophical and methodological similarities and important differences (Morrow, 2005; Ponterotto, 2005). I will delineate both the overlapping and differentiating philosophies and methodologies for the constructivist-interpretivist and critical-ideological paradigms below.

The underlying philosophy for qualitative research can be described by ontology, epistemology, axiology, and methodology. Defining ontology, or the nature of reality, is an important part of the qualitative process and can inform the methodology (Ponterotto, 2005). In reference to ontology, I believe that people co-construct reality based on given socio-cultural contexts, consistent with both constructivist and critical paradigms (Crotty, 1998; Ponterotto, 2005). Epistemology refers to the acquisition of knowledge (Ponterotto, 2005); being rooted in constructivist and critical paradigms means my own subjectivity in the research process is considered inherent and valued. Moreover, both paradigms allow for the sharing of lived experiences of participants (Morrow, 2005). As for my axiology, or the role of my values as a researcher in the process, I acknowledge that potential biases are impossible to truly remove from the research process, as I also co-construct meaning with participants. In fact, regarding axiology, I incorporated my values and reality into the research through a critical perspective (Morrow, 2005). Further, it is not uncommon in critical-ideological paradigms for researchers to use their own work as a criticism in order to contribute to the emancipation of oppressed groups from power structures, and indeed, I incorporated the critical paradigm during the interpretation of data in order to amplify the voices of the oppressed group (i.e. Black/African American clients). I attempted to pursue raising of consciousness of the counseling and counseling

psychology fields with regard to the power structures that contribute to the overall mental healthcare disparities. Importantly, I attempted to represent oppressed voices through the research, through the questions asked and interpretation of the data. Therefore, when providing the results of the current study, I assume that my own personal understanding has been intertwined with the results (Ponterotto, 2005; Vagle, 2009).

Subjectivities Statement

I identify as a White, queer, Woman, of middle socioeconomic status who is 29 and pursuing a Ph.D. degree in counseling psychology with a particular focus on social justice and multicultural considerations at Oklahoma State University. I attempted to be mindful of my own cultural factors throughout the research process. I have strong opinions regarding the inadequate state of existing multicultural training, multicultural therapy models, and conceptualizations that have led me to take both a constructivist and critical perspective. Further, I hoped to use my strong opinions to acknowledge and disrupt the power structures that play a role among therapists, a field mostly composed of White individuals. I recognize my own biases are also interpreted in the research, at times intentionally, in order to address oppression in the mental health field. I intentionally incorporated and managed biases through a reflexivity journal and consulting with both internal and external auditors.

Methodology

The methodology of a study consists of the procedures in the study (Ponterotto, 2005). Although constructivist and critical researchers embrace subjectivity, a systematic process is still needed for qualitative research. Given my constructivist and critical paradigms, I utilized both phenomenological and critical methodologies. I delineate

general and paradigm-specific (i.e. phenomenology and critical) methodological processes in the following sections.

Trans-Paradigm Benchmarks for Qualitative Rigor. Research quality, or rigor, refers to the process the researcher uses to analyze and interpret qualitative data (Hays et al., 2016). In qualitative research, the term *trustworthiness* is often used in place of traditional quantitative terminology (Morrow, 2005). Rather than validity and reliability, qualitative researchers usually consider credibility, transferability, dependability, and confirmability when determining the trustworthiness of research (Morrow, 2005). As I operated from a combined constructivist and critical perspective in the current study, I will first delineate criteria for adequacy of data and purposeful sampling. I then outline criteria and then paradigm-specific criteria. In general, there are specific credibility, transferability, dependability, and confirmability standards that I attended to such to help ensure rigor of qualitative inquiry.

Adequacy of data is crucial for qualitative research, through both a constructionist and critical lens (Morrow, 2005). According to Morrow (2005), there are five types of data adequacy in qualitative research: amount, variety, interpretive status, disconfirming evidence, and discrepant case analysis. I attended to adequacy in *amount* of data through focus on depth of data, rather than a set number of participants. In order to ensure adequacy of the data, I conducted two semi-structured interviews.

Purposeful sampling, or selecting participants most likely to provide rich data specific to the phenomena under study, also supported adequacy of the data (Morrow, 2005). I followed a careful procedure and also recruited through the first few participants. The full sampling procedure is detailed under the procedure section. Depth of data was

achieved through the design of the interview (two, semi-structured 45 to 60 minute interviews), as well as through the interview process itself (Morrow, 2005). Two semi-structured interviews allowed participants to guide the process. Additionally, conducting follow-up interviews one after the initial interview provided rich data because of participants' self-reflection between interviews. Credibility is analogous to internal validity for quantitative research, and is important to rigorous qualitative inquiry (Hays et al., 2016; Morrow, 2005). For qualitative studies, the researcher establishes credibility by engaging extensively with participants as well as through the use of reflexivity of the researcher and member checks (Creswell, 2007; Morrow, 2005). I attended to credibility by conducting two, semi-structured interviews with participants. The flexible nature of the interviews allowed for rich data to emerge comparable to internal validity seen in quantitative studies. Further, adding a follow-up interview provided an opportunity for participants to elaborate on their perspectives during the initial interview and "prolonged engagement with the participants" (Morrow, 2005, p. 252).

Dependability refers to consistency of research results, similar to reliability in quantitative analysis (Creswell, 2007). In other words, dependability is the consistency of the data over time and across researchers and techniques. First, I recruited participants from August 2019 to December 2019 through social media posts and emails to counseling psychology listservs. Participants completed a 21-question demographic survey in the Qualtrics program, where the data was stored. I maintained a reflexivity journal weekly, and after interviews, throughout the entire data collection and interpretation process to carefully balance capturing the participants' perspectives while incorporating my own views regarding social justice and to amplify Black/African

American client voices. Interviews were completed between October 2019 and February 2020, including the initial and follow-up interviews, through the Zoom application and transcribed and stored in the encrypted Otter application. I chose to use a transcription application instead of transcribing by hand because of time constraints, and I chose Otter because of the accuracy of the transcriptions. The initial interviews occurred up to 60 minutes with a semi-structured format. Importantly, I engaged with the participants in interviews with a phenomenological approach in an attempt to understand participants' process and perspectives, which led to a natural flow of questions and data. The transcription of interviews occurred the same day through the Otter application, and the transcriptions were stored on the Dropbox Business program to ensure privacy. In both Otter and Dropbox, participants were provided pseudonyms; thus, sensitive information was not provided in either application.

I employed an open coding process in February of 2020 by grouping bits of data together that captured multicultural information. I quickly realized the follow-up interviews did not provide additional data and lasted significantly less time than anticipated; saturation of data appeared to have been met. Thus, I excluded the follow-up interviews from data analysis. I initially coded information and found two themes pertaining to multicultural information in February 2020. Upon consultation with an internal auditor on my dissertation committee later in March 2020, I recoded the information to allow any codes to emerge that provided a broader picture of the foci in the interviews. Further, I reoriented myself to the questions asked in the demographic survey and interview questions, as a participant's answer merely in response to a question did not deem a code. Throughout the coding process (from February to April 2020), I

attended to the data with a critical theoretical paradigm, attempting to emphasize the power of the privileged group, the participants. I paid careful attention to documenting my conflict between empathy toward my participants and the clear deficits of multicultural counseling apparent in the data. I reread relevant phenomenological and critical research analyses and discovered six potential themes. The themes related to cultural responsiveness appeared quickly, within one week of my decision to recode.

In April 2020, I employed assistance from two peer auditors to review my codes, themes, and reflexivity journal through Dropbox Business to ensure privacy. Additionally, I spoke with the auditors over the phone to summarize the previous codes and to gain their impressions in depth in April 2020. Both external auditors overall agreed with my themes and assisted in naming the themes. Importantly, the auditors agreed that the responses to the body language in the second vignette were important data and not a result of priming participants to view the Black/African American client as more aggressive due to his closed body language. Upon agreement among auditors and my dissertation director, the following themes emerged in May 2020: Multicultural Competence, Systems of Support, Controlling Images, Biological Factors, Multicultural Orientation, and Cognitive Therapies. In February 2020, MCC and MCO themes emerged first. The codes in Systems of Support, Biological Factors, and Cognitive Therapies appeared later in April 2020 prior to my consultation with peer auditors. My dissertation director assisted in refining the themes intermittently until the final draft of this document in June 2020. Because I incorporated a critical approach as well, I followed a systematic procedure. described in the data analysis section, to ensure consistency (Morrow, 2005).

Confirmability refers to objectivity in qualitative research, which does not fully occur within either the constructionist or critical paradigms (Morrow, 2005). In this study, I embraced subjectivity and actively contributed to themes that emerge naturally from participants. The overall goal through confirmability with regard to a critical approach, therefore, was to help dismantle power structures that are explored within the study. I maintained a reflexivity journal weekly and after interviews throughout the data collection and analysis. I utilized a phenomenological paradigm in the interviews in order to attempt to reflect the participants' perceptions. I then analyzed the data with a critical paradigm to dismantle such power structures. I balanced both phenomenological and critical paradigms because I was directly studying the group holding power in order to understand their processes and subsequently disrupt the mental health system. Thus, during the coding process, I intentionally incorporated my biases and consulted with an internal auditor, external auditors, and dissertation director to ensure my biases did not overshadow the realities of the participants and their understanding of the vignettes.

Reflexivity is an important part of the subjectivity benchmark and is the researcher's awareness of their own experiences and the interaction with the data (Morrow, 2005). The awareness of Whiteness in the research dynamics has only recently become a focus in qualitative endeavors, and, thus, may lead to imperfect reflexivity practices (Deliovsky, 2007). I engaged in what Deliovksy (2007) coined "radical reflexivity" (p. 2), or that I rooted my own experiences in an understanding of hierarchical, systemic structural oppression that contributes to mental health disparities highlighted in the literature review. I attended to the reflexivity by maintaining a journal throughout the interview and coding process. I wrote my thoughts and experiences before

and after each interview, along with my perceptions of the data and coding process. The external auditors reviewed the reflexivity journal when reviewing the themes in order to gain context and provide feedback regarding how I incorporated my own biases.

Generalizability largely differs between quantitative and qualitative research (Morrow, 2005). In qualitative research, the goal is gathering more in-depth data and gaining understanding of processes rather than attempting to imply the results apply to the general public, also known as transferability (Morrow, 2005). For the current study, I aimed to capture the realities of the participants without implying the results could be generalized to every White practicing therapist. Additionally, the in-depth information could inform further quantitative research and subsequent generalizability.

Phenomenological Benchmarks. I embraced subjectivity while also honoring fairness, ontological authenticity, and educative authenticity, all required for phenomenological analysis (Morrow, 2005). To help ensure fairness, I requested assistance from three external auditors and one internal auditor. Through educative authenticity, I sought to understand context and culture through building rapport with participants. I incorporated my basic counseling skills to build rapport quickly. I engaged in reflexivity, which refers to the self-reflection on how the researcher's worldviews interact with the research process and interpretation of the participants' views. Reflexivity may be attended to in a number of ways; for the current study, I maintained a reflexivity journal weekly throughout the interview and coding process (Morrow, 2005), and I consulted regularly with members of my committee regarding my own processes related to the research. Consulting with the external auditors and their assistance with

auditing promoted a balance between allowing the participants' experiences to emerge naturally.

Regarding the external auditors, I enlisted assistance from two auditors from similar educational backgrounds. One auditor identified as a gay White man who graduated from my current graduate program a few years prior. The other auditor identified as a straight White woman currently in another counseling psychology Ph.D. program. Both auditors have experience in conducting qualitative research, both with constructivist and critical paradigms. Additionally, both auditors currently practice in the field of counseling and actively incorporate a social justice lens in both practice and research.

Variety of data was attended to through the use of different modes of data generation such as open-ended interview questions and responses to case vignettes (Morrow, 2005). Interpretive status of the data was attended to through seeking to develop strong rapport with participants and exploring their context and culture (Morrow, 2005). Exhibiting empathy and active listening skills allowed me to build rapport quickly with participants. Given that I was both the researcher as well as a therapist in training, I consulted with my dissertation director and other committee members to balance my own experiences with participants' experiences. Building rapport through active listening also captured the participants' cultural contexts as White woman therapists.

Finally, I attended to disconfirming evidence and discrepant case analysis through the interviews, consultation, and familiarity with the literature (Morrow, 2005). This was an important balance, because I incorporated both a constructivist and critical lens. I

included my personal understanding while attempting to avoid pushing my personal understanding at the exclusion of participants' experiences.

Phenomenological methodology. Researchers utilizing phenomenological methodology explore shared experiences among participants (Standing, 2009). Phenomenology stems from a constructivist worldview, wherein people gain understanding of the world through their own experiences (Schwandt, 1998). From a constructivist standpoint, it is deemed that people cannot comprehend all of the world's experiences, but that a researcher may desire to collect only a small portion of the experience (Peck & Mummery, 2018). In fact, the researcher embraces multiple realities that the participants share, and recognizes that one reality is not superior to another (Crowther et al., 2017; Hays & Wood, 2011). Researchers approaching a study from a phenomenological perspective may posit that the world and individual realities may co-exist. The experienced reality of the participants was the focus of this phenomenological study, although I also incorporated my own experiences into the interpretation of data (Willis, 2001).

Given the interpretive nature of this qualitative study, a hermeneutic phenomenological approach was taken in the current study. A hermeneutic phenomenological approach provides the researcher with direct, contextual information through semi-structured interviews (Crowther et al., 2017). The researcher assumes that the data reflect the person's beliefs in the moment and evolve in time. Additionally, a hermeneutic phenomenological approach frees participants and the researcher from viewing information in a dichotomous way. It is posited that the phenomena experienced by the participants in this study will never be fully revealed, but that the truths among the

participants provide a shared understanding of experiences. In order to attempt to collect and craft stories, the researcher examines the data and often returns to the data later, to ensure relevant and rich information has been interpreted in stories.

Critical Benchmarks. Critical methodologies are similar to phenomenology; I attended to confirmability, credibility, and reflexivity additionally with critical methodology (Morrow, 2005). From a critical perspective, the researcher actively incorporates their biases into the process (Ponterotto, 2005). The researcher uses their own biases in order to help oppressed groups find liberation. In this study, I readily acknowledged my strong sense for social justice and dissatisfaction toward the current multicultural models and training. I hoped to incorporate my personal values and biases to explore therapists' conceptualizations. Given that therapists have power over clients, and particularly marginalized clients, I hoped to gain information about the process that White therapists use to form clinical opinions of marginalized clients to help dismantle power structures in the mental health field. This specific embracing of subjectivity is also how I attended to confirmability.

With regard to credibility, both constructivist and critical researchers commonly utilize participant checks, where participants review transcripts and themes and offer feedback (Morrow, 2005). This section differentiates the current study from typical phenomenological and critical studies. I was in a somewhat difficult position as both an insider (i.e. a fellow White woman) and a race traitor, meaning that I concealed my full purpose of the study in order to avoid participants providing more socially desirable perspectives (Deliovsky, 2017). Because participants can strategically modify the course of research to follow their own needs or agenda (Deliovsky, 2017), I conducted partial

participant checks, meaning I sent only the first transcript and not the themes. After the first interview, I sent the transcripts to the participants to review and no other material for the participants to review, particularly the themes. The complex power dynamics in the study, particularly with my equal role regarding race, highlighted the “studying up” (Harding & Norberg, 2005, p. 2011) purpose of the study, wherein I explored the power structures directly rather than the oppressed groups affected by the power structures (Deliofsky, 2017).

Critical methodology also includes consequential and transgressive validity, two types of validity unique to critical methodology (Morrow, 2005). Consequential validity refers to the potential of the study promoting social change. I attempted to attend to consequential validity by directly interviewing individuals in a position of power both racially and as therapists. I hope to continue attending to consequential validity by publishing and presenting the findings to mental health practitioners and other groups in power. Transgressive validity refers to evoking discourse to highlight participants’ power and clients in vulnerable and oppressive environments (Morrow, 2005). I attempted to attend to transgressive validity by deciding against participant checks firstly, because the participants may have requested to change the themes imperative to the results of the study (Deliofsky, 2017). Further, I will continue attempting to fulfill transgressive validity by conveying my results in practice and research settings directly to the individuals in power.

Participants

Efforts were made to seek a somewhat diverse sample, in that I sought White therapists only but attempted to find variety in age, gender, and years of experience, of

practicing counselors and psychologists who have graduated in the United States. Therapists in training, social workers, clinical psychologists, and other affiliated mental health groups were excluded from this study, as the focus is solely on counselors and counseling psychologists. The sample intentionally consisted of only White therapists due to the prevalence of White therapists and White hegemony in therapy, as outlined in the introduction. Therapists inside the United States were included due to both the specific training required by APA and ACA and the unique sociocultural history leading to the racial disparities in mental health in the U.S. APA and ACA require a rigorous and systemic approach to education, including teaching multicultural counseling, which is outlined in the literature review. Licensure was not a requirement of participation in order to allow for potentially varying perspectives; therapists who recently graduated may have different conceptualizations of culture than therapists who graduated a decade or more ago.

It is important to note that therapist trainees were excluded because of the more consistent monitoring by professors, fellow trainees, and supervisors required by graduate training programs. Counselors and counseling psychologists were selected as the population of interest because of the focus on multicultural competency within both fields. Therapists no longer practicing were excluded from the study, because of the interest in current therapists' perspectives. Counselors and psychologists were recruited from ACA and APA listservs, respectively. The recruitment email is attached in Appendix B. I also recruited participants through social media posts providing information and the web link to the demographic survey. After recruiting three

participants, I recruited additional participants through referral from the first participants, or snowballing.

Participant Demographics. The final participant sample consisted of seven White therapists, six women and one therapist who identified as genderqueer. Six of the participants were master's level therapists and one was a Ph.D.-level psychologist. All participants except one were licensed, and the participants reported a range of 2 to 28 years of experience in the field with an average age of 8 years of experience. The age of participants ranged from 27 to 55, with an average age of 35. Theoretical orientation varied among participants, from feminist to cognitive behavioral therapy to interpersonal therapy, with most participants reporting cognitive behavioral therapy as at least one theoretical influence. Two participants described their orientation as integrative or eclectic, and one participant did not answer the question. Other theories consisted of: person-centered, somatic, systemic, strengths-based, feminist, interpersonal, existential, dialectical behavioral therapy, and rational emotive behavioral therapy. Participants indicated working community mental health ($n = 4$), a non-profit ($n = 1$), private practice ($n = 1$), and an integrated health agency ($n = 1$). Participants also reported currently working with children/adolescents, individuals with serious mental illness, veterans, LGBTQ+, racially marginalized populations, and older adult populations. Importantly, five out of seven participants identified that they currently worked with racially marginalized populations. None of the participants worked with college students at the time of the study, the specific population mentioned in the vignettes. Four participants indicated they completed one formal multicultural course, and three indicated completing

two multicultural courses, an average of 1.3 courses. Participants were provided with pseudonyms cited throughout the present study.

Instrumentation

Demographic questionnaire. Participants completed a demographic survey prior to the interviews in order to gather basic information about the participants. Specifically, participants were asked about their racial, gender, sexual orientation, socioeconomic status, religious affiliation, identity, and racial/ethnic identities. In addition to demographic information, participants provided information about years of clinical experience, client population, and theoretical orientation. I also asked participants about the number of multicultural courses they completed in their graduate programs, whether participants are counselors or psychologists, and if their respective programs were accredited by APA or CACREP. A detailed demographic form that provides more specific information can be found in Appendix C.

Vignettes. Vignettes, in research contexts, are considered hypothetical scenarios used to explore participants' views on a given topic (Stravakou & Lozgka, 2008). Vignettes facilitate discussion about complex issues, including attitudes. Additionally, vignettes provide a way to explore participant perspectives without potential ethical concerns, because the therapists will not be conceptualizing and potentially diagnosing real clients (Stravakou & Lozgka, 2008). According to Stravakou and Lozgka (2008), providing less information in vignettes may encourage participants' more fully. Although few researchers agree on the appropriate length for a vignette, the recommendation for a maximum of 200 words was used for the current study, due to the vague nature of the vignettes (Stravakou & Lozgka, 2008).

For the current study, the vignettes provided only basic, common symptoms. One vignette identified the race and gender of the hypothetical client, whereas the other contained no such demographic information. Given that the purpose of the study was to explore participants' process of conceptualization and diagnosis, providing vague vignettes allowed more space to understand the participants' processes, and encouraged the participants' themes to emerge naturally. The vignettes are provided in Appendix D.

Semi-structured interviews. The present study consisted of two semi-structured interviews, with the follow-up interview occurring one month after the initial interview. During the initial interview, the participants received two case vignettes that were created based on Stravakou and Lozgka's (2008) vignette structure. The participants answered semi-structured questions regarding their process of conceptualizing and diagnosing the clients in the vignettes. Approximately one month after the initial interview, participants were asked follow-up, semi-structured questions. The semi-structured nature and open-ended questions in the interviews allowed for participant experiences and commonalities to naturally emerge (Creswell, 2007; Merriam, 1998). Both semi-structured interviews are listed in Appendices E and F.

Data Collection

After obtaining IRB approval (Appendix G), I recruited participants through both social media (i.e. Facebook) and professional listservs. Interviews occurred through Zoom, an encrypted video conferencing service, to allow for greater geographical diversity. Participants first completed the demographic questionnaire and then two interviews, approximately one month apart. The purpose of the time between interviews was to allow for potential self-reflection. During the first interview, participants read the

two vignettes and answered semi-structured interviews. The follow-up interview consisted of questions pertaining to the vignettes and how the participants pictured the contrived client. The intention of the follow-up interviews was to provide more information regarding multicultural considerations and any conceptualizations based on the information provided in the vignettes. During both vignettes, I avoided explicitly inquiring about any cultural conceptualizations to avoid prompting of socially desirable responses (Deliovsky, 2007). Participants entered to win three 50-dollar gift cards to Amazon upon completion of the second interview.

Data Handling Procedures

All interviews were stored in video format to provide observation data and for transcription purposes through Otter, an encrypted transcription service. The demographic information was stored on Qualtrics and separated from the interviews and transcripts on a password-protected computer. All transcripts, codes, and journals have been stored on Dropbox Business to ensure confidentiality. External auditors were granted access to the Dropbox in order to review the reflexivity journal and codes and provide feedback. Transcripts uploaded on the Dropbox account were assigned pseudonyms (also used herein) to protect participant confidentiality.

Data Analysis

I utilized critical thematic analysis for the current study, because the process aligns well with both phenomenology and critical methodologies. The predominant method of data preparation and analysis in qualitative studies, coding, refers to assigning categories to various points of data for retrieval (Merriam, 1998). Coding also allows for the researcher to quickly navigate through interviews and themes (Merriam, 1998).

Initially, I engaged in an open coding process, wherein I was guided by “repetition and recurrence” (Lawless & Chen, 2019, p. 89) in the data. Open coding is part of the inductive analysis (Eto & Kyngas, 2007). I included the nonverbal information and setting in the transcriptions from the Otter application to provide context. I searched for common phenomena or experiences among the participants. It is important to note that I combined data from responses to both vignettes. With open coding, I created as many relevant headings as possible within the text to more fully capture the participants’ perspectives. I then grouped categories to describe the phenomenon. I categorized specific pieces of data under headings (Eto & Kyngas, 2007). Later in the analysis, some broader categories subsumed others. I essentially attempted to create an abstraction of the original data (Merriam, 1998).

During the first analysis, I consulted with two committee members who provided feedback that my focus in coding had been too narrow. With one committee member, I verbally processed my experiences and barriers to finding codes. I reviewed the data with an open coding process more successfully during the second analysis.

The next step of the analysis differentiates critical thematic analysis from phenomenology because I engaged in a closed coding process (Lawless & Chen, 2019). Specifically, I intentionally added my values into the analysis by asking “How are particular groups represented in discourses, practices and social systems? What knowledges are silenced, made visible, or erased? What are examples of oppressions (and/or new exclusions) that are being made to sound equitable through various discourses? How do elite groups define values, constructs, and rhetoric in ways that maintain matrices of power?” (Lawless & Chen, 2019, p. 97). I recognized I directly

studied individuals in a position of power and attempted to address oppression in the codes for the purpose of liberation (Deliofsky, 2017; Morrow et al., 2012).

Commonalities among the data quickly emerged, and I incorporated missing information from the interviews that directly related to erasing marginalized groups' experiences and how the elite group, in this case the White therapists, maintained constructs of power (Lawless & Chen, 2019). For example, if a participant did not engage in any cultural responsiveness, I considered that information to be important data for the current study.

During the closed coding process, I consulted with two external auditors and one internal auditor in order to both attempt to capture the participants' perspectives and interpret oppression within the interviews. I consistently tied codes back to overall systemic oppression and asked for feedback from the auditors regarding the careful balance of "studying up" (Deliofsky, 2017). The auditors reviewed the transcripts and themes. One external auditor reviewed the transcripts and noted her own observations before reading the existing codes and themes, in an attempt to view the data with fresh perspectives. The auditors agreed with the codes and broader themes; they also provided feedback on the language used to identify the themes in order to elicit discord.

CHAPTER IV

RESULTS

In this section, I detail the findings from the data analysis. First, I present an overview of the themes to provide contextual information about the participants' experiences. I then detail each theme individually, providing specific quote and quantified data. I also considered the lack of multicultural responsiveness as data in itself, a unique aspect of the current study based on the research questions, participants, and methodology. Specific theme tables can be found in Appendix H.

Importantly, the follow-up interviews were excluded from the results because participants did not generate new data. The purpose of the follow-up interviews was to allow space for self-reflection and an opportunity to edit or add information. In my analysis, I found six overarching themes: MCC, Systems of Support, Controlling Images, Biological Factors, MCO, and Focus on Cognitive Therapies. Each theme was endorsed by at least four out of the seven participants through explicit data, which indicates a commonality of experiences among participants. Themes are also directly or indirectly related to the research question (What do therapists attend to in multicultural case conceptualization?) regarding cultural conceptualizations and the overall racial disparities found in the mental health field, described more thoroughly in the Discussion section.

Multicultural Competence

This theme is characterized by cultural knowledge and skills. Notably, lack of data was considered important data in this theme, because therapists consistently exhibited inadequate cultural responsiveness. Participants either did not inquire about cultural factors or superficially asked about culture. Neglecting cultural factors echoes previous research showing therapists' failure to broach cultural differences with Black/African American clients. Thus, the lack of data in this theme represents important data, in addition to direct endorsement of the MCC theme. As a result, all seven participants were coded into this category.

Five participants directly or implicitly provided data consistent with MCC for the first vignette, and two did not explore any cultural factors or exhibit cultural knowledge. Though participants attended to a higher number of cultural factors for the first vignette, less data arose in response to the first vignette (which lacked identifying cultural information). Essentially, participants inquired about a broader spectrum of identities but more briefly than the second vignette. The data consisted of brief curiosities or questions without elaboration. The five participants demonstrated curiosity about gender, socioeconomic status, family structure, age, and LGBTQ+ identities.

Of note, for vignette one, no participant mentioned race (although one participant, upon reviewing the second vignette, did note that she had not attended to race in the first vignette). Gender, however, appeared particularly salient for participants with the first vignette. Melissa, for example, stated: "I'd be really curious about his family structure, like are they coming out of a foster situation? Is there a gender concern or something else that makes them feel different or not belonging?" Rhonda also immediately observed the

lack of gender mentioned in the vignette. Additionally, Abby and Carol both assumed a woman-identified gender for the first vignette that, not only did not include gender, but also did not include age or a name.

Other factors briefly appeared as well in response to the first vignette. Rhonda wondered about the client's socioeconomic status:

Knowing socioeconomic status kind of gives you an idea of again what barriers might be there, and also maybe what strengths and resilience. Okay, you have someone who's from a lower socioeconomic status and they're doing well, and then they had these things come up, you know, that tells you they have some real resilience.

Sidney had several inquiries: "Are you a first generation college student? You know, are you LGBT, a minority of some sort?" Taylor and Rhonda both inquired about the age of the client in the first vignette as well and hesitated to assume if the client's age was among the average age range for college students. Participants sought cultural knowledge in order to inform their conceptualization, although the participants avoided discussing in depth next steps with the information.

Four participants directly addressed cultural factors when reviewing the second vignette, and three did not mention or inquire about any cultural factors. All four of these participants briefly inquired about the client's racial identity. Rhonda, for example, stated she wanted to "invite this young man to help me understand what it's like being Black on this campus." Taylor stated, "I can't ignore the racial component here and would want to learn more." Taylor was also the only participant who questioned the client's age in the second vignette. Sidney echoed questions from the first vignette and expressed an interest

in learning about the client's race. Her response was also unique, in that she also explicitly stated she wanted to explore how important the client's Black/African American identity is to him and wanted to avoid assuming the identity would be important in therapy. Importantly, none of the participants specifically explored the intersection between race and gender for the second vignette and instead focused on race as a discrete factor. In addition, participants ignored various other cultural identities for the second vignette, potentially because two were explicitly provided. Ignored cultural factors for the second vignette for all participants included religious affiliation, LGBTQ+, ethnicity, geographic location, immigration status, and health status.

Participants who directly addressed cultural factors attempted to incorporate MCC by discussing missing information that would assist in developing a conceptualization. The emphasis on knowledge in MCC has inevitably led to therapists conceptualizing cultural identities as mutually exclusive (e.g., race and gender; Creswell, 1989). Viewing multicultural identities on a single axis essentially erases experiences from multiple marginalized identities (Crenshaw, 1989; Creswell, 1989; Davis et al., 2018). Further, the intersection of identities presents more important and unique experiences of oppression than individual identities alone. Participants, for example, did not explore the intersection of the contrived client's man-identified gender and Black/African American racial identity in the second vignette. Black/African American men's experiences are qualitatively different from White men's experiences or Black/African American women's experiences. Participants ignored the intersection with other identities not included in the vignette as well. Thus, participants struggled to capture the unique

intersecting constellation of identities that were and were not explicitly provided in the vignettes.

Taken together, the MCC theme captured participants who addressed some cultural identities in a manner consistent with the tripartite model, as well as participants who did not inquire about or address the clients' cultural identities. The specific cultural factors varied across participants, with gender being the most commonly addressed factor for the first vignette and race for the second vignette. Meanwhile, two participants assumed gender for the first vignette that contained no gender identification. Participants who asked specific questions touched the surface of multicultural case conceptualization but struggled to expand upon the knowledge facet of MCC and incorporate skills and beliefs. Also important to note is that, for both vignettes, all seven participants ignored various other cultural factors, such as religious affiliation, ethnicity, geographic location, immigrations status, etc.

Systems of Support

All seven participants addressed the importance of various systems of support in college for both vignettes. The participants all expressed concern about the lack of support for the contrived college students and, in some cases, incorporated social support in the treatment plan. Regarding the first vignette, Taylor wanted to understand any interpersonal issues with family, friends, or co-workers, because the specific conflicts would affect the interventions she would utilize in therapy. Abby emphasized the importance of transitioning to college and the effect on relationships (again assuming a woman gender):

Being a college freshman is hard for anybody, I think, regardless of where you're going to school or what you're going to school for. It's just a really big transition period. And, you know, if her isolation, is that because she's moved, and maybe she didn't have some of the same friends of high school, you know, is she working? Is she engaging in things at school that are helping her to meet new people?

For the second vignette, she also included social support in treatment plan asking how “we can build upon” any existing social support.

Other participants wanted to know more information about the cause of recent changes in social support or lack thereof. Some participants wanted to know about the timeline regarding any isolation. Sidney, for example, inquired about “why there is a strain from isolation” after the isolation “has been going on for awhile.” Another participant wanted to explore the potential etiology of the social isolation:

So I want to know, what do they do when they're feeling isolated? What do they do when they're feeling a lack of social support? What do they mean by social support? Is it more of a situation where I just don't have the resources around me, or don't really know how to reach out, or somehow a deeper issue I don't feel worthy, or, you know, I don't feel important? So I want to kind of understand that.

For the second vignette specifically, four participants wanted to know about any social support for Black/African American college students. Participants brought awareness to the lack of information about the college campus in the vignette, aligning with previous research indicating poor physical and mental health on PWI campuses due

to racism (Goodwill et al., 2018). For example, Taylor inquired about the contrived client attending a Predominantly White Institution:

Right off the bat I guess I would want to know what type of college or university this person was attending, just because, I mean, you can't ignore the culture here you have to definitely pay attention to the fact that this is a black African American male and whether gone somewhere where he is absolutely a minority every single day experiencing that or if he going somewhere that might be more of a of a college setting that you know prides itself on being a black college that sort of thing where he might feel more inclusion rather than exclusion.

The remaining three participants addressed social support in general for the second vignette. Rhonda expressed interest in learning information to differentiate between a lack of social issues or “a deeper issue”, such as feeling unworthy, that might be affecting the social isolation. Carol was the only participant who explored how a university or community college campus may affect available campus support, information not stated in the vignette.

Controlling Images

This theme encompassed a wide range of data, including stereotypes, pathologizing language, and disproportionate focus on body language. The theme arose among six of the seven participants in response to the second vignette, where the contrived client identifies as a Black/African American man. “Controlling Images” is a concept proposed by Collins (2004) to describe the stereotypes or distorted ideas about Black/African American individuals to justify racism. For Black/African American men, images of “predatory” (Wingfield, 2007, p.198) and “dangerous criminals” (Wingfield,

2007, p.199) permeate United States culture and are used to justify systemic maltreatment (Walker & Miller, 2001; Wingfield, 2007).

Some of the assumptions the participants articulated pertained to religious beliefs, health concerns, and mental health stigma. Participants used their research knowledge but made some assumptions about the applicability to the current vignette. Sidney, for example, expressed concern about the client's potential medical concerns, stating

You know, fluctuations in appetite to-- hoping you don't have any like crazy heart problems going on, dude. I know that African Americans many times have more problems. I hope his heart's okay. He's kind of young but you never know.

Additionally, regarding religious beliefs, Sidney stated "traditionally it's been said that African Americans are more likely to seek mental health help from, you know, their religious circles." Abby also brought awareness to race by indicating that "the African American community doesn't value therapy as much as some of the other cultures we work with." She based her understanding of the contrived client on her personal experiences in a "super high poverty area" with "95% African American" people.

Importantly, the therapists focused on the stigma among the Black/African American community and seeking therapy without acknowledging how the field has contributed to the hesitancy in seeking mental health services. The inevitable stereotypes in this aspect of the theme reflect the biases that perpetuate the mental health field.

Participants pathologized the contrived client in the second vignette in a variety of ways, from interpretations of body language to the treatment plan. Rhonda, for example, asked "I mean, is he stoned in session?" after reading about the client's crossed arms and avoidance of eye contact. Abby wanted to know his "motive" for entering therapy

considering his “attitude.” Descriptions of the body language as “rigid”, “guarded”, or “defensive” appeared among three participants. With regard to diagnosis, three participants wondered about autism spectrum because of the body language in session. Additionally, Rhonda inquired about bipolar disorder or “odd beliefs” because of his presentation. None of the same information was provided for the first vignette. Taylor also wondered if “there was something more serious with him” because of his presentation. Taylor also expressed doubts about the appropriateness of CBT as a treatment, stating “I do think it'd be hard to do CBT with him though, because it feels like, at least at this point he doesn't have enough reflection to give specifics.”

Importantly, all the participants attempted to incorporate their research awareness regarding trends among the Black/African American community. The intent appeared to lie in engagement in cultural responsiveness. For the second vignette, the fact that participants attended to race and gender may serve as an improvement from a few decades ago. However, the participants endorsing this theme struggled to expand beyond the statistics and explore any relevance or contextual factors with the vignette. Participants may unintentionally engage in microaggressions because of the assumptions, all of which appears to reflect the limitations of MCC and MCO highlighted in the introduction.

Biological Factors

All seven participants specifically addressed the possibility that physical health concerns could be contributing to the presenting concerns and potentially incorporated in the treatment plan. This included medical disorders or medications that could contribute to or alleviate the presenting concerns. Sidney expressed concern about vitamin D

contributing to complaints in the first vignette and potentially hypothyroid levels in the second vignette. Both Melissa and Sidney would have recommended a physical with a primary care provider if financially feasible. Three participants explicitly mentioned psychiatric medications as potential treatment options for the first vignette.

Regarding treatment options, the participants actively considered sleep, diet, and medical concerns in the plan for therapy. Melissa wanted to include a nutritionist in the treatment for both vignettes. She stated the following in response to the first vignette:

I mean this is depending on your finances with this, if the context allows. I'd love to get a doctor or a nutritionist on board just to rule out anything worse and to see about getting some physical support for the weight loss; that could go down a scary path. So just making sure to have nutritional support and a medical doctor medication if that's a rough decline.

Rhonda focused on biological influences for the second vignette, both in conceptualization and therapy.

And just, you know, and more definitely this almost sounded more kind of autonomic self-regulation, psychophysiological. At the beginning, when the appetite fluctuations, the fatigue, probably the kind of just general hyperarousal. The inner personal struggles also kind of suggest maybe something goes a little deeper, but I would probably if they're good start with my just start with sleep because that seems to be the first thing they brought in. And one of the things that I do is, I do biofeedback so I've got this gear and I can do something called heart rate variability biofeedback. So, that can be a way to better regulate the autonomic nervous system to bring the parasympathetic nervous system back online. It's

pretty much a kind of a controlled breathing scale but it's really kind of cool because you can see it on the screen.

Two participants also discussed medications as a potential treatment option, including Abby, who described herself as “normally not a medication person.”

Sleep was an especially important factor for five of the participants, both in conceptualization and treatment, for the first vignette. Abby stated, “we know that it [lack of sleep] can cause problems with blood pressure, it can you know, so many things I think--just lack of sleep can be really dangerous.” Carol considered sleep for both conceptualization and treatment: “Looking at sleep hygiene, what is the cause of, because of course, if there's a sleep issue going on that it within itself could make your impact or mood negatively.” She stated that she would target sleep hygiene during treatment. Interestingly, she did not mention any sleep concerns for the second vignette. Patricia echoed the concern of sleep potentially affecting mood, specifically anxiety. Taylor stated she usually targets sleep first:

One of the other big things that I usually start out trying to work on is sleep because I always feel like that's a really big thing that if a client isn't sleeping well and just, you know, progresses that whole cycle of anxiety or whatever they're experiencing to take it to a more like severe level. I really try to just reel that in and knock that out immediately whether it's, you know, meditation and breathing exercises before bed and cutting out electronics or whatever it is to just try and get more sleep within a short amount, like a shorter time frame, because that can be something that is taken care of pretty immediately.

All seven participants inquired about physical health concerns, reflecting the consistent focus on the medical model in mental health. Participants considered medical issues, sleep, diet, and medication throughout the therapy process. Some participants appeared to consider elements of the medical model during conceptualization, while others considered the medical model for the treatment plan.

Multicultural Orientation

Another theme that arose among the participants was Multicultural Orientation. My external auditors and I differentiated this theme from Multicultural Competence because of the attention to the process, specifically demonstrating cultural comfort or cultural opportunities (or lack of those aspects). Essentially, data coded in this theme pertained to cultural responsiveness in the context of the participant's relationship with the client. Importantly, four participants addressed the relationship with the client and three did not address any awareness of their own presence in the room with the client. Importantly, the participants who did directly address culture related to the process of therapy only did so with the second vignette that mentioned race and gender. No participants addressed this with the first vignette.

The participants' presence as White therapists in the room with the client in the second vignette (self-identified as a Black/African American man) also was a phenomenon that arose for four participants. Melissa incorporated sociocultural context into her presence in the room with the contrived client:

Looking at the rarely making eye contact, and I'd be curious if that's my presence as a White person, or with just that position of power as therapists to clients may be a shame response. I get curious about what experience or do they have with

treatment, if any. And if they haven't had treatment what their, their perception of therapy, might be... I get curious about just epigenetic and family history I think more with with students of color... As a White therapist, I really want to be sensitive and honoring of that, but I think especially folks who are carrying that racial burden that they've got more to deal with and I want to acknowledge and honor as, and usually some psychoeducation at around, around that.

Melissa is not only demonstrating cultural self-awareness here, but is implicitly describing therapy as a two-person endeavor rather than a one-person endeavor, wherein her own existence as a cultural being in the therapy room influences her client (Davis et al., 2018). Abby and Sidney expressed somewhat similar sentiments. Abby described herself as a “five foot tall girl with red hair” and “trying to make that client feel at ease” because of his race. Similarly, participants also wanted the contrived client to explain his own cultural background as a Black/African American man to them (the participants), such as when Rhonda states,

I'd be real interested to find out and, you know, see if I can invite him to help me understand that better since I'm a White female. However, then we get down to lethargic, and I'm like, Huh, because that's not consistent with this autonomic hyperarousal, at least in that session. He's is very guarded, you know with the arms crossed, so I'm going to see if we can kind of join. I'm going to try to kind of, you know, just be disarming and see if we can make a connection.

Sidney also wanted to know “what's it like sitting here talking to this White chick?”, addressing her own presence as a White therapist in the room with the Black/African American client.

It is important to note that three participants did not address how cultural variables might affect the therapeutic relationship in the room. This in itself is important data, because the lack of exploration in this area demonstrates that participants were potentially not considering the cultural processes occurring between therapist and client. That most participants did not acknowledge the Whiteness in the room reflects the perpetuating limitations of how we train therapists for multicultural psychotherapy. This lack of attention to cultural differences and influences in psychotherapy may contribute to higher likelihood of cultural concealment among Black/African American clients (Drinane et al., 2018).

The theme of MCO represented participants' attention to cultural processes in therapy beyond simply inquiring about specific identities. Four participants also expressed interest in the contrived client in the second vignette explaining his experiences and the participants' acknowledgement of their Whiteness in the room. Melissa, specifically, spent a significant amount of time exploring how her identity as a White woman might be affecting the relationship and if she should rearrange the room in order to balance the power differential. The four participants exploring relationship dynamics affected by race also capitalized upon the cultural opportunity presented in the vignette and appeared more comfortable discussing culture than the participants who did not explore this area.

Focus on Cognitive Therapies

Five out of seven participants actively incorporated cognitive-based therapies into their conceptualizations and treatment plan; importantly, these participants differed from the Biological Factors. Of this group, participants focused on a combination of cognitive

behavioral therapy (CBT), dialectical behavioral therapy (DBT), and acceptance and commitment therapy (ACT). CBT, considered to be the second wave of cognitive therapies, consists of modifying thoughts and behaviors (Brown et al., 2011). DBT and ACT belong to third wave cognitive therapies that incorporate a larger variety of techniques and incorporate non-cognitive therapies as well (Brown et al., 2011). Participants provided their general therapeutic orientation, incorporated the modalities in assessment, and used the therapies to guide their treatment plan.

Three participants focused on CBT, while Abby focused on DBT and Rhonda focused on ACT. Patricia, for example, described her graduate training consisting mostly of CBT. She described her process as the following:

That's kind of the next step usually with my patients with the CBT model to be aware of what's going on in our head and bodies, and just increasing awareness to be able to verbalize that. I'm definitely a believer in, you know, some sort of getting it out whether it's talking to someone about their own stuff and bring it to me or, you know, kind of like a journal or maybe like a log on a computer or your cell phone. I know I've had clients in the past that will get asked that they can track and do whatever works for the client, but definitely trying to increase that awareness.

Taylor provided a broader justification for why she preferred using CBT with the vignettes, stating:

I would definitely start with the CBT aspects we look at, you know, breaking it down in terms of what thoughts are present and how can we alter those, and what

behaviors are present, especially avoidance behaviors are ones that I look for pretty immediately.

Meanwhile, Abby operated from a DBT modality for the “ebb and flow” and “working on a lot of mindfulness.” Among these participants, three also stated they would incorporate other therapies to supplement their cognitive therapy or to cater to the client’s preferences, although most of the participants in this group expressed a preference for cognitive therapy. The flexibility in approach aligns with the newest wave of cognitive therapies, in which therapists use more eclectic interventions (Brown et al., 2011). All cognitive therapies address thought patterns, inherently attributing pathology to a deficit in skills, as demonstrated by the participants in the treatment planning phase.

CHAPTER V

DISCUSSION

Racial disparities permeate numerous systems within the United States, including mental healthcare (Brooks & Hopkins, 2017). Cultural mistrust toward mental health providers is considered a justified response to chronic racism that occurs in the counseling relationship (Brooks & Hopkins, 2017). In therapy, racial disparities may vary in manifestations, including pathologized diagnoses and microaggressions toward Black/African American clients. Racial disparities continue to occur, arguably because of limitations of current multicultural training in graduate programs, such as conceptualizing cultural identities as mutually exclusive, and underlying cognitive heuristics or errors (Ratts, 2017). Limitations also arise in research on the racial disparities in mental healthcare, with researchers mostly focusing on the content, rather than the process, of such racial disparities that arise when studying White therapists. Additionally, many studies have consisted of gathering self-report measures from White therapists (Davis et al., 2018; Wilcox et al., 2020). The purpose of the current study was to close a gap in the research foundation by approaching White therapists with an inductive analysis regarding their considerations of culture when conceptualizing and diagnosing clients. This study is also differentiated from other studies because of the critical paradigm used with the group in power in order to amplify the voices of the marginalized group

(Black/African American clients).

The themes observed in this qualitative examination of therapists' multicultural case conceptualization were MCC, systems of support, controlling images, biological factors, MCO, and a focus on cognitive therapies. The results were mixed in terms of participants' attention to cultural factors. For the first vignette, a broader spectrum of cultural factors were mentioned briefly. I was surprised by this finding and wondered if the attention to gender is because of the statistical likelihood of a woman seeking therapy services or because the participants themselves identified as women, or perhaps an intersection of both.

Most participants attended to cultural factors at least minimally; however, no participant attended to race until they were cued to do so, and even then, only slightly over half of the participants attended to race. When participants did attend to race and culture, they tended to do so in ways that were simplistic and reductionistic, rather than providing a truly integrative socioculturally-informed conceptualization from an intersectional perspective. In addition to most attention to race and culture being mostly limited to superficial mention, some participants also made assumptions about the Black/African American man based on the participants' "multicultural knowledge," ranging from cultural assumptions (e.g., assuming religious affiliation or physical ailments) to assigning greater pathology based on body language.

Participants mostly avoided an in-depth discussion about their own Whiteness in the room with the client. Importantly, a few participants mentioned stigma about receiving mental healthcare among the Black/African American community without

acknowledging the maltreatment from therapists directly toward the community, potentially signifying an avoidance or deflection of responsibility. The responses pertaining to the body language in the second vignette highlighted the lack of awareness, because most participants failed to acknowledge their own presence as a White therapist being a potential reason for the contrived client's hesitancy to divulge information; instead the participants used words such as "motive" or "attitude" or "defensiveness" to describe the client's body language or place responsibility of the stigma among the Black/African American community. Further, only one participant included the possibility of racial trauma in her conceptualization of the client in the second vignette.

MCC appeared to influence the participants' answers, particularly the knowledge domain. For the theme of "controlling images," participants relied on their knowledge from graduate training, job training, and personal experiences to inform their conceptualizations. Similarly, participants emphasized learning information about the clients in the vignettes. Participants devoted more time to adapting skills to the clients' presenting complaints than culturally relevant information. Interestingly, participants may have focused more on MCC than MCO, as evidenced by their focus on technical aspects of therapy commonly seen in MCC and overall lack of cultural awareness of either the clients' or their own cultural background. More data appeared in the MCC theme than the MCO theme, consistent with the decades of emphasis on MCC (Davis et al. ,2018).

Controlling images for Black/African American men have evolved over the years, and the data in this theme reflects the current views of Black/African American men (Wingfield, 2007). People in the United States tend to view Black/African American men as aggressive or criminals, and the assumptions about the body language reflect the

overall picture of assuming the client is aggressive. Unfortunately, similar patterns persist in the mental health field, leading to an understandable cultural mistrust toward mental health providers (Whaley, 2001). The description of the body language in the second vignette was intentional and could easily demonstrate cultural mistrust toward the participants (i.e. White women providers). Participants also failed to incorporate stereotype threat into their conceptualization and Black/African American men attempting to present themselves as calmer because of the stereotype of the “angry Black man” (Wingfield, 2007, p. 205). The various microaggressions in this theme are particularly concerning, since most of the participants noted they were currently working with Black/African American clients at the time of the interview.

The stereotyping of the client in the second vignette appeared to reflect the limitations of the MCC model, wherein the participants recalled brief information based on stereotyped information often presented in multicultural training, and unintentionally assumed the information would apply to the client’s current presenting concerns. Participants appeared to somewhat demonstrate cultural humility when attempting to explore relevant cultural information but mostly did not demonstrate overall curiosity and self-reflection associated with cultural humility. Some participants expressed a desire to attend to or create cultural opportunities by addressing the cultural differences between the therapist and the client, but only when race was mentioned (the second vignette). Lastly, some participants appeared uncomfortable when exploring cultural information, such as stammering when inquiring about race for the second vignette, indicating a lack of cultural comfort. Five participants had reported completing one formal multicultural course in their graduate programs; based on the data in the MCC and MCO themes,

participants' training may have emphasized MCC, although the content of their actual multicultural training is unknown.

Systems of support, biological factors, and focus on cognitive therapies were important themes. Participants explored the presence of systems of support throughout the entire process of therapy: conceptualization and treatment. All seven participants inquired about current social support, including four participants who explored Black/African American support on campus for the client in the second vignette. Some incorporated group therapy or Black/African American organizations on campus as part of the treatment plan.

Social support is generally viewed as a strong protective factor with numerous mental health concerns and might reveal why participants provided more data for this theme. Social support, along with other health behaviors, appear especially important for Black men's mental health on college campuses (Goodwill et al., 2018). Black men have reported higher levels of social isolation when feeling depressed but may also rely on social support as a buffer against stress on college campuses. Thus, the emphasis on the social support for both vignettes may reveal higher levels of attention toward cultural responsiveness incorporating social support, including for Black/African American clients.

Biological Factors included various dimensions of health, such as medications, sleep, or physiological disorders. Although biological factors in psychological health are important, the emphasis on biological factors echoes a long history of the medical model in mental health, starting with Freud (Elkins, 2009; Scott, 2017). Therapists continue to utilize the medical model to inform conceptualization and treatment despite decades of

concerns and a substantial amount of empirical support demonstrating that the medical model may miss the mark (Wampold & Imel, 2015). Elkins (2009) summarizes the philosophical problem with the medical problem, stating that the focus is on the clients' symptoms that must be treated. Elkins (2009) further states that therapists are then "superimposing a medical schema" (p.67) on interpersonal problems potentially irrelevant to medicine. Therapists perpetuate the medical model by regularly using words like "patient" or "symptoms" to describe processes unique to the client.

It is important, and potentially confusing to note, that many mental illnesses have shown strong genetic etiology, an additional perpetuating factor of the medical model. Therapists may cling to the medical model in order to justify the merits of the occupation and therapeutic process. Additionally, insurance companies dominate the payment process for therapy and require diagnoses, another aspect of the medical model, for reimbursement (Scott, 2017). Thus, third parties unrelated to the field of therapy that hold significant power also perpetuate the medical model. Critics of the medical are not suggesting abandoning the model totally; rather, therapists should consider contextual factors unique to the client (Elkins, 2009). Participants in the current study exhibited strong awareness of biological processes that might affect the current presentation and potential options in therapy, but the focus on biological processes may highlight the previous point regarding a failure of developing a truly individualized experience in therapy.

The participants relied mostly on CBT, DBT, and ACT therapies to conceptualize and treat presenting concerns. All three cognitive theories identified by participants inherently consist of a focus on internal factors and amplifying an internal locus of

control. Consistent with the focus of these theories, participants focused on internal factors contributing to distress. In contrast, little attention was paid to potential systemic and sociocultural influences, including systems of oppression, that could be affecting clients. The results of the present study are consistent with Crumb and Haskins' (2016) call to integrate CBT with relational cultural therapy in order to more fully address cultural concerns neglected by CBT alone (Crumb & Haskins, 2016). The Cognitive Theories theme, similarly to Biological Factors, likely unquestioned adherence to sociopolitical structures because of the natural gravitation toward internal factors that should be modified to improve well-being.

Implications for Training and Practice

The findings of the current study appear to reflect the multicultural training in graduate programs. While some participants incorporated awareness of Whiteness in the room, the overall focus lied on internal factors; these results, although cannot be generalized, reflect previous studies purporting graduate training programs continue to inadequately train therapists (Wilcox et al., 2020). Most of the participants had completed one multicultural training course, the typical training requirement. Most multicultural counseling courses are driven by the tripartite MCC model, with a week-by-week focus on individual identities, stereotyped knowledge of “others,” and little to no focus on systems of oppression or Whiteness (Pieterse et al., 2009). Participants’ responses paralleled the training overall, by asking introductory questions without being able to elaborate on in-depth factors that might be pertinent to the clients. Further, participants appeared to relay superficial generalizations they may have learned in their multicultural training courses, such as the assumption that Black/African American

people have religious views. Participants also tended to focus on race individually and neglected the intersection between race and gender and other variables not explicitly provided in the vignette.

Firstly, graduate programs foster professional development in the mental health field. Despite years of a persistent call for change, outcomes continue to show poor multicultural training. Standards of accreditation for both APA and CACREP should align more closely with the research regarding the process and comfort with clients, rather than simply obtaining cultural information. Participants inquired about relevant cultural knowledge but struggled beyond the knowledge; they struggled with *how* to incorporate the knowledge. Standards of accreditation for programs would quickly set a precedent for entire systems of training. Moreover, standards of accreditation should include in-depth standards for social justice, a growing movement in therapy that promotes advocacy to address oppression.

On a smaller scale, programs and faculty should consider integrating multicultural competencies and multicultural orientation. MCO may complement competencies by promoting students' humility when exploring culture with clients. Additionally, programs should consider experiential learning activities, rather than relying on research to entirely inform the conceptualization of a client, as the research findings could lead to quick generalizations. Educators might consider emphasizing cultural humility and in-depth self-reflection to promote MCO and MCC. Future therapists would benefit from learning about intersectionality and the relationship among cultural identities, as identity-by-identity (such as race or gender) training is not a realistic representation of people in the United States.

Further, programs should consider incorporating a social justice lens and the investigation of various power structures that may directly impact client functioning, strengths, and presenting concerns. Only one participant discussed empowering the client to “fight” the power structures and only one other acknowledged the systemic racism that might be affecting the presenting concerns. Social justice consists of a focus on distributing goods in an equitable manner; none of the participants mentioned social justice as part of their therapy process. Specifically, programs may consider introducing social dominance theory when discussing oppression and power. Consistent with past research (Wilcox et al., 2020), participants overall failed to acknowledge the power structures, potentially indicating a compliance with social hierarchy. Programs should consider integrating more culturally forward theories with cognitive theories or intentionally teach trainees how to adapt cognitive therapies for contextual client variables, as the participants in this study focused only on building skills and not the influence of external factors. Training programs should also encourage trainees to engage in cultural opportunities and increase cultural comfort; the MCO theme showed that some participants were willing to at least briefly capitalize upon cultural opportunities. Lastly, I propose that programs promote a strong cultural lens throughout the graduate training that manifests regularly with clients, which is strongly supported by the overall avoidance of exploring cultural information for the vignette that contained no such information in the current study. Clearly, the quantity of formal multicultural courses did not equate to the quality of the experiences in the courses. Incorporating social justice into programs should manifest throughout development and encourage the trainee’s political

involvement and involvement in the community through outreach or as a required practicum (Hage et al., 2020; Linnemayer et al., 2016).

Incorporating cultural information should be contextual in nature and intentional for practicing therapists in the field. Awareness of privilege is a life-long process, and therapists should continually challenge their own comfort by challenging their own concepts of privilege to raise awareness of blind spots (Wilcox et al., 2020). Self-efficacy in MCC does not appear to lead to in-depth cultural responsiveness; thus, therapists in the field should remind themselves of the discrepancy between self-assessment of competency and *how* they incorporate cultural information with each client based on the client's context. Therapists should seek continuing education opportunities, particularly opportunities that include experiential learning regarding cultural responsiveness.

Implications for Supervision

Supervision is a vital part of therapist professional development. Supervisees have requested more focus on cultural responsiveness, and preferred supervision includes a variety of foci related to culture (Soheilian et al., 2014). Trainees have expressed appreciation for supervisors who encouraged exploration of various cultural considerations and self-awareness (Soheilian et al., 2014). Trainees have also preferred supervisors who challenged trainees' worldviews and subsequently promoted deeper empathy toward clients presenting with various cultural backgrounds. Researchers have also identified cultural humility has an important trait among supervisors toward trainees and trainees' clients (Hook et al., 2016). The results from the current study reflect a need for supervisors to cultivate cultural humility among trainees, because the participants struggled to incorporate aspects of MCC and MCO beyond the knowledge aspect.

Cultural humility includes noting specific areas for growth or areas where therapists lack experience/understanding (Hook et al., 2016); supervisors cultivating and modeling cultural humility, along with capitalizing upon cultural opportunities may help bridge the reason for trainees struggling to more thoroughly incorporate cultural information in a contextual way.

Implications for Advocacy

Advocacy dismantles power structures that directly oppresses Black/African American clients. Importantly, an emphasis on social justice is more likely to lead to therapist advocacy than an emphasis on multicultural training (Luu & Inman, 2018). Social justice, then, should serve as a significant orientation for therapists throughout professional development.

Firstly, although mental health professionals have proposed social justice ethical guidelines, APA and ACA have yet to formally include social justice in the justice ethical principle (ACA, 2014; APA, 2017). While ACA notes multicultural competencies and social justice, the organization has yet to incorporate in-depth social justice components into the ethical standards (ACA, 2014; ACA, 2015). Because oppression is inherent in the hierarchical structure in the United States, advocacy, and specifically social justice, should be detailed in the core principles guiding ethical behavior. This important change in ethical principles would subsequently lead to changes in training programs and practicing therapists alike.

Although multicultural leanings may provide the foundation for social justice, neither multicultural competency nor multicultural orientation heavily emphasize tackling oppression (Luu & Inman, 2018). Social justice is defined by the pursuit of equitable

distribution of goods; to achieve true social justice, advocacy is imperative. Promoting political and community involvement, as previously highlighted, are both types of advocacy. Providing a voice to the oppressed groups also serves as advocacy in the research. Additionally, larger systemic changes, such as changes to accreditation and ethical guidelines also serve as avenues for advocacy.

Implications for Future Research

Future researchers may consider focusing more on doctoral level therapists, who presumably have received more multicultural training. Additionally, the purpose of the current study included an exploration of language that therapists use without explicit prompts; researchers may consider follow-up questions or otherwise examining social desirability among participants. Researchers may also consider studying both the therapist and client, an important factor after the demographic questionnaire revealed that a few of the participants in the current study were working with Black/African American clients at the time of the study. Researchers may also consider snowball sampling and asking initial participants who they admire regarding cultural responsiveness and then interview said therapists.

Importantly, future researchers should attempt to provide both an open dialogue to allow for natural gravitation toward various factors and a systematic approach for exploring how participants incorporate information. Qualitative research provides important insight into exactly the intentional and contextual cultural responsiveness alluded to with regard to graduate programs. Researchers may ask open-ended follow-up questions regarding next steps for participants after they gather relevant cultural knowledge. As part of the future studies, the researchers should consider obtaining

multicultural course syllabi as part of the artifacts and ask follow-up questions regarding the course material and the relation to their case conceptualization.

Lastly, a large portion of the body of research involves therapist trainees. This emphasis is important because of the crucial role that graduate programs play in development. However, therapist trainees are supervised and mentored throughout the graduate training. Essentially, graduate therapist trainees are provided more oversight and opportunities for consultation and feedback. Therapists in the field, particularly after licensure, are not provided the same oversight and cultural training opportunities. Considering the significant portion of practicing therapists in the United States that have graduated, researchers should continue exploring cultural responsiveness among experienced therapists in the field.

Limitations and Strengths

The current study had several limitations. Despite significant efforts to recruit an equal number of master's and doctoral level therapists, the participant pool consisted only of one doctoral level therapist. An equal participant pool regarding education may have provided different insights and data. This study was unique in using a critical paradigm to study the group that holds power; I attempted to balance a critical-ideological paradigm with phenomenology in order to capture the participants' perspectives. Future researchers may consider the novel "studying up" approach and utilizing only a critical-ideological paradigm to study the group in power.

During the interviews, I intentionally did not ask about multicultural information in an attempt to avoid social desirability and, instead, capture natural responses from participants. It is possible, however, that participants were answering only with

information they thought I was looking for, such as diagnosis. Adding follow-up questions would provide the crucial gap in research regarding *how* participants incorporate cultural responsiveness after obtaining relevant information. Utilizing a coding program, in this case Otter, potentially reduced my own immersion in the data compared to coding by hand. Similarly, lack of data provided codes but overall a lack of understanding what exactly is missing from multicultural counseling and cultural responsiveness and potential remedies. In an attempt to ensure adequate data collection relating to culture, I added body language in the second vignette that could be considered priming, such as crossed arms and avoidance of eye contact, after reviewing the responses.

The study also has notable strengths. First, a qualitative design allowed for more in-depth information than a quantitative study. For example, not only was I able to capture the specific language used, but I also was able to observe the timing of the language and what factors appeared more salient without explicit questions. The marriage of the phenomenological and critical paradigms provided the participants space to express their perspectives while simultaneously calling attention to the power structures in therapy and limitations in cultural responsiveness. Although the results of the study cannot be generalized, the Zoom format of the interviews eliminated geographic barriers, allowing for participants from multiple states, and, thus, varying perspectives. The breadth of the questions also allowed for unexpected themes to emerge, such as social support. The themes indicated gaps in therapy but also potential strengths in training and in practice.

CHAPTER VI

CONCLUSION

The six themes that arose in the current study represent both strengths and weaknesses of foci in therapy. The themes largely align with previous research calling for higher quality cultural responsiveness in the field; the themes also reflect a persistent emphasis of the medical model in the mental health field. The field, in practice, training, and research, continues to neglect contextual cultural information, as evidenced by therapists struggling with how to integrate cultural information in therapy. The current study captured the perspectives of participants while emphasizing the continued gaps in cultural responsiveness. Additionally, the current study captured the nuances in responsiveness because of the qualitative design.

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APPENDICES

APPENDIX A

EXTENDED LITERATURE REVIEW

The United States has a highly diverse population, especially with regard to race, which will continue to grow through 2060 (US Census Bureau, 2012). In fact, by that time, there will be no racial group in the United States that constitutes greater than half the population. The increase in racially diverse populations in the United States, therefore, indicates a greater need for mental health services that appropriately serve the needs of diverse cultural groups. Currently, however, health disparities continue to persist when comparing White clients and clients who identify as people of color (Brooks & Hopkins, 2017).

Disparities may be partly attributed to cultural mistrust toward White therapists (Owen et al., 2017). The evolution of the definition of cultural mistrust reflects the general problem which it defines (Brooks & Hopkins, 2017). Initially, the definition of cultural mistrust identified behavior exhibited by Black/African American clients considered problematic, as inappropriate responses and a method of resisting treatment. However, healthcare providers and therapists now redefine cultural mistrust as a rational result of historical mistreatment of Black/African American individuals and communities, which is to say, interpersonal and systemic racism (Brooks & Hopkins, 2017).

Cultural mistrust appears to be higher among individuals who hold negative views toward mental health and social service organizations such as foster care (Scott, McCoy, Munson, Snowden, & McMillen, 2011). Subsequently, cultural mistrust leads to lower rates of healthcare utilization and early termination rates (Brooks & Hopkins, 2017; Owen et al., 2017). Thus, as a result of mistrust of the institution of mental health engendered by historical and contemporary oppression, racial/ethnic minority clients (and clients who hold other oppressed identities) may not receive the mental health care they need to cope with, and heal from, oppression. Researchers have found that racism contributes to, or exacerbates, mental health problems (Pieterse, Todd, Neville, & Carter, 2012). Racism manifests and impacts marginalized groups across in numerous ways, including institutional discrimination against people of color (Atuahene, 2018). Not surprisingly, researchers have found higher rates of distress among people reporting experiences of racism (Hayes et al., 2016; Pieterse et al., 2012). Distress as a result of racism may manifest in a number of ways, such as somatically, emotionally, or academically for Black/African American clients (Pittman, 2011).

Another potential result is posttraumatic stress disorder, which is more prevalent among Black/African Americans as compared to their White counterparts (Carter et al., 2017). Researchers have begun to study race-related trauma, or the constellation of trauma symptoms one experiences as a result of perceived racism (Pieterse et al., 2012). Specifically, race-related trauma refers to the psychological symptoms that arise in response to racism, but not necessarily life-threatening events (Carter et al., 2017; Carter, Muchow, & Pieterse, 2018). Similarly, researchers have begun to examine intergenerational trauma, or trauma symptoms passed from one generation to the next,

including racial trauma (Carter et al., 2017). Given the role, historically, of mental health and social service institutions in institutional racism, it is likely that such intergenerational racial trauma may manifest as cultural mistrust of these same institutions, contributing to the underutilization of health care. That is, one need not personally experience racism within mental health and social service institutions to feel deterred from their utilization; such racism may be experienced vicariously. As a result, therapists' cultural sensitivity in working with individuals from marginalized groups, and particularly clients of color, is of utmost importance, both in therapy, and in how therapists generally interact with clients and communities of color. It is generally understood that a primary vehicle for developing therapists' cultural sensitivity is their graduate multicultural training.

Current Graduate Multicultural Training

Counselors and psychologists (hereafter, therapists), as well as the institution of mental health, have historically enacted individual and systemic bias against people of color (Sue et al., 1992). For example, therapists used to attribute mental health concerns among people of color as defective genes (Sue et al., 1992). Later, therapists viewed challenges as a result of problematic cultural differences (Sue et al., 1992). Both the American Psychological Association (APA, 2017) and American Counseling Association (ACA, 2015) have endorsed accreditation, education and training, and practice guidelines specific to cultural sensitivity and context.

ACA. ACA (2015) has released updated multicultural guidelines that define multicultural competence. According to the ACA (2015), counselors learn through training how their beliefs, knowledge, and skills affect their practice and worldview. As well, counselors are to advocate for their clients and employ culturally appropriate

interventions. Counselors are to consider their own marginalized and privileged statuses and their influence on their beliefs, knowledge, skills, and actions. Essentially, according to the ACA, multiculturally competent therapists focus on their internal views and the effect on their behaviors in session with clients from marginalized backgrounds.

Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2015) also addresses multicultural training in its accreditation guidelines for graduate training programs. Educators are to incorporate multicultural theories and identity models into training. Per CACREP, training is to include a focus on multicultural characteristics of clients, including help-seeking behaviors and spirituality. Educators should also focus on how differences of power and privilege between counselors and clients may appear in the therapy setting. Therapists are also expected to learn how to eliminate barriers and processes of oppression marginalized clients may face while in therapy.

APA. APA (2017), the primary professional organization for psychologists, details guidelines pertaining to multicultural training and accreditation. For accreditation, APA requires psychologists-in-training to complete at least three years of coursework and one year of practice (APA, 2006). Within this timeframe, psychologists-in-training complete at least one formal multicultural course. Graduate training programs also include a focus on multicultural concerns that may arise in clients. Specifically, APA posits that training should include recognition and understanding of how socialization impacts racial and ethnic identity, for both the client and therapist. Training should include how to promote social justice for clients from marginalized groups, a newer guideline (APA, 2017). Psychologists are to learn how to incorporate cultural

considerations with various theories and assessments, including potential limitations. Overall, APA has created an extensive list of detailed guidelines for psychologists to follow.

The APA released their first comprehensive multicultural guidelines in 2003, and released updated multicultural guidelines in 2017. APA also proposes that psychologists follow specific multicultural guidelines when working with clients, that should be taught during formal training. APA recently updated the new multicultural guidelines (APA, 2017), which are now more complex and detailed than the original, taking an ecological model approach to culturally sensitive work; that is, the guidelines are rooted in Bronfenbrenner's (1979) model. Bronfenbrenner's (1979) model delineated five interconnected systems that affect a person's life, from the most individual-level variables (i.e. intrapersonal factors) to the most overarching contextual systems (e.g., culture; policy). According to the APA (2017), therapists should expand on various social systems, meaning they should explore each area and the impact on the client. Additionally, therapists are to consider all systems when conceptualizing and working with clients. Therapists should also explore how systems change over time (APA, 2017). Further, the updated guidelines not only directly addressed identities beyond race and ethnicity, but also added a focus on intersectionality, described as multidimensional experiences based on individuals' unique combination of identities (Crenshaw, 1989). The stated purpose of the new guidelines is "to provide psychologists with a framework from which to consider evolving parameters for the provision of multiculturally competent services" (APA, 2017, p. 7). The guidelines essentially provide a foundation to

help psychologists begin exploring with a client potentially important and pertinent cultural contexts that affect their daily life.

According to the guidelines, psychologists must understand that identity may be fluid and complex (APA, 2017), including that within-group differences are important to consider, as not all experiences may be generalized to a particular marginalized group (APA, 2017; Sue, 2017). Additionally, psychologists should seek to conceptualize clients beyond personal biases. Psychologists are to consider environmental context, such as oppression and systemic inequity, within the overall biopsychosocial picture. Additionally, psychologists are called upon to use socioculturally appropriate and strength-based approaches to buffer against trauma when applicable.

Formal education for therapists has established standards for training. Both masters- and doctoral-level programs have incorporated multicultural guidelines to improve training. The purpose of the training and guidelines are to educate therapists on multicultural considerations and prepare them for practice with marginalized groups and various multicultural populations.

Support for Current Training

The current accreditation standards and guidelines for both ACA and APA appear to improve therapists' approach to their clients presenting with multicultural identities. Therapists who complete more multicultural training tend to have lower levels of color-blind attitudes, a form of covert racism wherein a White person denies noticing racial differences (Chao, Wei, Good, & Flores, 2011; Pieterse et al., 2012; Paone, Malott, & Barr, 2015). Therapists completing more multicultural training have been found to be more likely to be willing to confront White privilege as well, particularly if those

individuals had completed at least four other multicultural training experiences (Paone et al., 2015). Interestingly, therapist multicultural competency also appears to be correlated with general therapy skills, such as genuineness and empathy (Tao, Owen, Pace, & Imel, 2015). Therefore, training on general skills therapists receive in formal programs may also contribute to higher quality multicultural therapy.

Qualitative researchers have also shown how completion of one multicultural class may evoke positive responses from therapists in training. Researchers discovered that therapists felt a better understanding of uncovering deeper multicultural implications in counseling (Vega, Tabbah, & Monserrate, 2018). Additionally, while therapists may experience discomfort during the formal multicultural class, they also may learn to process the discomfort on a deeper level (Georgiadou, 2015). Some research, therefore, appears to support the quality of the average multicultural class required in graduate training for therapists.

Limitations of Current Education and Training

Despite incorporation of multicultural guidelines in formal education, problems in training continue to persist. In addition to problems in multicultural research, problems have arisen in the multicultural training of therapists as well. Current graduate level multicultural training most often involves focusing on oppressed identities separately, usually spending a week on a specific group (Pieterse et al., 2009). In reality, teasing apart identities from one another in training is not a full representation of human experiences. Further, this training encourages therapists to view identities as mutually exclusive (Ratts, 2017; Shin et al., 2017). All people have intersecting identities and

unique interactions between marginalized and privileged identities; therefore, training does not adequately address multicultural needs.

Further, focusing only on the oppressed identities individually and mutually exclusively assumes that the person's other identities are invisible. In fact, viewing multicultural identities on a single axis essentially erases experiences from multiple marginalized identities (Creswell, 1989). For example, in gender discrimination cases, the focus is solely on one's gender identification, which neglects other identities that may impact the person daily and contribute to an overall complex constellation of factors and identities. Another example may be a Black/African American woman experiencing multiple forms of oppression because of her race and gender that cannot be easily differentiated. Creswell (1989) posits, when talking about Black women specifically, that "[b]ecause the intersectional experience is greater than the sum of of racism and sexism, any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated." Therapists and clients may focus on their own oppressive experiences, but neglect how their privileged identities contribute to inequitable resources. For example, a Black/African American woman experiences multiple forms of oppression because of her race and gender that cannot be easily differentiated (Ratts, 2017). However, her identification as heterosexual is a privileged identity, which unintentionally is a contribution to heteronormative experiences.

Viewing identities as mutually exclusive may deem other identities as privileged as well, or invisible in other ways. Even common language used among therapists limits the scope of identities, such as LGBTQ. Focusing on the language or specific identities

leads to an assumption that other identities are not relevant or important to the individual. Additionally, recent focuses on intersectionality have pertained to gender and race, which neglect numerous other marginalized identities that may interplay and affect one's daily life and interactions. While some therapists focus on intersectionality with regard to multiple marginalized groups, no theories incorporate the intersection of privileged and marginalized identities. In fact, a call for more heterogeneity while examining intersecting identities in trainings, which would provide applied learning, continues to be requested (Shin et al., 2017).

In addition to failing to consider intersectionality in an applied way, briefly addressing multicultural factors in a course fails to foster critical self-reflection (Paone, Malott, & Barr, 2015). Further, multicultural classes are not generally constructed as experiential in nature, meaning that therapists-in-training are missing more meaningful exploration into privilege and oppression that affect multicultural groups.

Therapists-in-training have also expressed the desire for more in-depth training, beyond the one formal class generally provided in graduate programs (Tomlinson-Clarke & Georges, 2014). Tomlinson-Clarke and Georges found a common theme of therapists-in-training wanting more thorough multicultural training after completing a multicultural counseling class. Perhaps the feelings of inadequacy may reflect genuine inadequate training that includes a focus on identity-by-identity conceptualizations.

In sum, training programs fail to capture multicultural identities more fully, especially with regard to awareness of privilege. Therapists fail to deeply see their own cognitive and resulting cultural biases and the relationship with the combination of marginalized and privileged identities. Failing to teach therapists to self-reflect on their

own complexities and resulting discomfort, and promoting the continuance of the practice, appear to result in inadequate multicultural training. This is a crucial point, because therapists incorporate their training in practice.

Current Multicultural Models

Multicultural Competency. The term *multicultural competency* generally refers to a therapist's ability to appropriately incorporate the tripartite model into practice. The tripartite model refers to the cultural attitudes/beliefs, knowledge, and skills necessary to work with clients identifying with marginalized groups (Sue, Arredondo, & McDavis, 1992). The therapist recognizes how preconceived beliefs toward the client, and vice versa, may affect the counseling relationship. Through this process, therapists also acknowledge and challenge their values and biases toward marginalized groups (Sue & Sue, 2012).

Multicultural Orientation. A newer approach to multicultural counseling may bridge some gaps in both research and practice. Complementary to MCC, multicultural orientation (hereafter, MCO) has been described as the level of comfort and sensitivity a therapist has with a client in the moment (Davis et al., 2018). In an attempt to bridge the gaps in theory and in research, researchers have attempted to move toward a more nuanced concept of multicultural sensitivity in counseling. MCO represents "a way of being with clients," or a process-oriented approach to multiculturally sensitive counseling (Davis et al., 2018, p. 91). Multicultural orientation as a construct may be seen as complementary to the multicultural competencies rather than a replacement for the multicultural competencies (Davis et al., 2018). MCO was also inspired by some common factors seen in therapy, such as empathy and the therapeutic alliance.

Three pillars are proposed to comprise the MCO construct (Davis et al., 2018; Owen et al., 2018). Cultural humility, the first and primary pillar, is generally exemplified by an awareness of self and lack of self-centeredness. Cultural humility includes understanding one's limitations as a clinician. It is notable that the most recent edition of the APA multicultural guidelines now includes a focus on cultural humility (APA, 2017). Additionally, therapist cultural humility appears to be important for clients and has been empirically demonstrated to be correlated with more positive therapy outcomes (Davis et al., 2018). The second pillar, cultural opportunities, is defined as openings during sessions that therapists can use to explore a client's relevant cultural information (Davis et al., 2018). Lastly, cultural comfort refers to the self-regulation that occurs during the cultural exploration process. The clinician remains open, even while navigating confusing or unfamiliar territory with regard to culture. MCO may help bridge the gap in both research and practice by identifying factors that help the therapist understand and attend to their levels of comfort and humility, as well as learn how to attune to opportunities in therapy during which they may build rapport and cultural trust with their clients.

Support for MCC and MCO. Although the extant research on the application of multicultural competence models for therapists are limited in scope and significant gaps remain, some researchers have studied client outcomes and satisfaction. For example, it has been found that clients who believe their therapists exhibit greater multicultural competence tend to rate their therapy experience as better (Constantine, 2002). Therapists who complete more multicultural training tend to have lower levels of color-blind attitudes, a form of covert racism wherein a White person denies noticing racial

differences (Chao, Wei, Good, & Flores, 2011; Paone, Malott, & Barr, 2015). Therapists completing more multicultural training have been found to be more likely to be willing to confront White privilege as well, particularly if those individuals had completed at least four other multicultural training experiences (Paone et al., 2015). Interestingly, therapist multicultural competency also appears to be correlated with general therapy skills, such as genuineness and empathy (Tao, Owen, Pace, & Imel, 2015).

The multicultural counseling movement sparked focus on various marginalized groups. Specific multicultural groups emerged, such as Black psychologists, to equip therapists with culturally sensitive skills through practice and research (Arredondo & Tovar-Blank, 2014). In fact, some would argue that the MCC model has driven significant changes in both research and practice, and in both breadth and depth. Further, researchers have argued that students are pushed to feel and process discomfort as a result of privilege and cognitive dissonance. Without the concept of MCC, scholarship and practice would not have improved from the body of knowledge.

According to recent research, therapists exhibit relatively high rates of challenging their own values, indicating that therapists appear multiculturally competent in the area of beliefs and attitudes (Barden, Sherrell, & Matthews, 2017). It would appear, then, that the tripartite model contributes to better mental healthcare in this aspect. Therapists also incorporate their educational knowledge, such as cultural norms, into conceptualization and treatment. Importantly, therapists also utilize culturally appropriate skills into the therapy sessions (Sue et al., 1992).

Through the incorporation of MCO, therapists can more meaningfully explore their own identities, their clients' identities, and the relationship between both people's

identities (Ratts, 2017). Viewing people as complex individuals also allows for the exploration of intersectionality, both with privileged and marginalized identities. Therapists can create a fuller picture of clients with multicultural identities, because therapists consider both internal and external factors influencing clients' current presentation and concerns.

MCC and MCO have provided complementary components. MCC initiated a movement toward more culturally sensitive and appropriate techniques, thereby improving the overall field. Specific professional groups formed to educate and target problems experienced by specific groups, and how those problems may manifest. MCO adds humility and the complex construct of intersectionality.

Limitations of Current Multicultural Models

Despite decades of research on multicultural competence, particularly on the tripartite model, problems continue to persist in both research and practice. From a research standpoint, the vast majority of studies have been based on the tripartite model, despite the lack of empirical support (Worthington, Soth-McNett, & Moreno, 2007). Further, methodology in multicultural competence research has been simplistic and, at times, problematic. In fact, the vast majority of studies have consisted of quantitative analyses and therapist self-report measures (Hook et al., 2016; Worthington et al., 2007). This latter point is particularly concerning. Firstly, ex post facto response measures cannot fully portray multicultural competencies, as therapist skills are highly based on context rather than universal scales. In addition, the defining features of competency involve behaviors; however, most self-report assessments measure beliefs (Sodowski, Taffe, Gutkin, & Wise, 1994). Further complicating the model is that factor analyses

have revealed only knowledge and awareness as multicultural components, rather than beliefs, knowledge, and skills.

Additionally, some measures do not appear to accurately represent skills specific to multicultural competencies. There are also limited outcome and process studies that evaluate the effectiveness of multicultural competencies. Such limited empirical support for the widely-used tripartite model is particularly concerning in the context of the origin of the tripartite model (Sue et al., 1982): it was developed based on committee consensus and meant as a preliminary framework, rather than as the end-point that it became (Atkinson & Israel, 2003). Therefore, the model of MCC that continues to be consistently used in training programs actually has only sparse support for its effectiveness.

Although the extant research on the application of multicultural competence models for therapists are limited in scope and significant gaps remain, some researchers have studied client outcomes and satisfaction. For example, it has been found that clients who believe their therapists exhibit greater multicultural competence tend to rate their therapy experience as better (Constantine, 2002). Somewhat concerning, however, is that marginalized clients' ratings of therapists tend to be lower than counselors' self-report of their multicultural competence (Davis et al., 2018). Therapists who complete more multicultural training tend to have lower levels of color-blind attitudes, a form of covert racism wherein a White person denies noticing racial differences (Chao, Wei, Good, & Flores, 2011; Paone et al., 2015). Therapists completing more multicultural training have been found to be more likely to be willing to confront White privilege as well, particularly if those individuals had completed at least four other multicultural training

experiences (Paone et al.,2015). Interestingly, therapist multicultural competency also appears to be correlated with general therapy skills, such as genuineness and empathy (Tao, Owen, Pace, & Imel, 2015).

Despite the large body of existing research, researchers have neglected to evaluate the basic assumptions of the prevailing multicultural competence theory (Davis et al., 2018). First, that there are a set of competencies that predict therapy outcomes, and that can be easily articulated and taught to others. Research support for the prediction of therapy outcomes is scant and inconsistent, in part because limited psychotherapy (that is, process and outcome) research exists as it pertains to multicultural competencies (Tao et al., 2015). Second, that multiculturally competent therapists can be differentiated from those who are not. Third, the competencies are consistent across clients, which has not been demonstrated consistently (Davis et al., 2018).

Other concerns related to the efficacy of MCCs have arisen as well. Researchers have criticized the tripartite model because research has not supported a link between the competencies and therapy outcomes (Davis et al., 2018). In fact, some researchers have found a high correlation between general counseling competency and MCC, potentially indicating that high client ratings could be attributed to higher general counseling competency, rather than specifically MCC (Tao et al., 2015). Additionally, conflicting results have indicated that MCCs may be contextual in nature and not consistent with all clients, as supported by varying client ratings for the same therapist (Davis et al., 2018). Further, some researchers have even asserted that therapist self-ratings of their MCC fail to correlate with client ratings (Davis et al., 2018). Marginalized clients' ratings of therapists tend to be lower than counselors' self-report of multicultural competence

(Hook et al., 2018). Barden, Sherrell, and Matthews (2017) further criticized the tripartite model, in that the focus has led to a significant discrepancy, wherein therapists focus almost entirely on their own attitudes and beliefs and neglect exploration into the client's attitudes and beliefs.

From a practice standpoint, neither model truly describes the therapist's role as an activist, which is necessary for treatment (Ivey & Collins, 2003). Although some of the ethical guidelines address oppressive structures, neither cultural model includes the fact that clients face significant barriers to individual change while the environmental context remains the same. Without acknowledging the improbability of individual change while power structures remain in place, therapists inherently fail to engage in social justice, a concept referenced in multicultural guidelines. The models, therefore, do not fully complement the multicultural guidelines. Neither MCO nor MCC target oppression through liberation of a client's consciousness. The continuing problems that arise with process and outcomes for marginalized clients likely reflect models that encourage thought without implementation of meaningful social change.

While the current models appear to have improved previous conceptualization of multicultural competency, the models also continue to have limitations. For the tripartite model, the limitations appear within the model itself and in research even evaluating the model. For multicultural orientation, although some new research supports the efficacy, the model is novel. Therefore, researchers have not had the opportunity to more thoroughly evaluate the efficacy over time.

The Discrepancy between Good Intentions and Practice

The inadequate training and models appear to contribute to poor therapy outcomes (Owen, Leach, Wampold, & Rodolfa, 2011). Unfortunately, the lack of cultural humility, comfort, and opportunities appears throughout the therapist's development (Owen et al., 2018). Most therapists likely enter school and therapy with the intention to genuinely help clients (Lantz, Pieterse, & Taylor, 2018). However, therapists may continue to have gaps in training, particularly related to oppression and the therapist's self-awareness of said oppression. Exploring the representativeness heuristic, social dominance theory, and fundamental attribution bias may bridge the gaps in research and training related to a deeper awareness of oppression.

Heuristics are cognitive shortcuts the brain takes to reach conclusions quickly (Richie & Josephson, 2017). The representativeness heuristic is a type of probability heuristic, wherein the person applies information from one group to the general population, based on similarity. When presented with new information about a group, the brain quickly assesses how similar this information is to previously held information (Gilovich & Savitsky, 2002). While the shortcut generally increases efficiency, the consequences may lead to cultural bias. People categorize individuals quickly into in-group and out-group categories. When the person is viewed as a member of the out group, the result may be prejudicial attitudes and assumptive stereotypes (Gilovich & Savitsky, 2002).

One way to understand the development of representative heuristics specific to biases about historically marginalized groups is through Social Dominance Theory. Social Dominance Theory describes individual and systemic oppression across multiple levels of society, rather than only psychological causes of inadequacy in diversity

preparation (Sidanius et al., 2004). In other words, Social Dominance Theory focuses on both structural and psychological factors that perpetuate oppression. Rather than focusing only on standards for a multiculturally competent counselor, Social Dominance Theory helps to explain the need for multicultural training in the first place; the difficulties in enacting multicultural training; and the difficulties in developing multicultural competence or multicultural orientation (Lantz et al., 2018).

Rather than blaming individual therapists for their lack of cultural awareness, or asking why therapists individually perpetuate oppression that affects multicultural clients, Social Dominance Theorists explore the dominant culture's propensity for structural hierarchies (Sidanius et al., 2004). Group-based oppression is consistently driven by discrimination on varying levels of interactions, from interpersonally to structurally. Discrimination, itself an outgrowth of systemic oppression, leads to inequitable allocation of resources, opportunities, and goods, with marginalized groups suffering--which is to say, reifying systemic oppression, creating and perpetuating a cycle. In numerous social institutions, privileged groups receive a disproportionate number of goods and opportunities. In fact, structural discrimination likely perpetuates oppression on smaller levels as well, such as in social interactions. The push for group dominance, or unequal group structures, is called Social Dominance Orientation (SDO) (Sidanius et al., 2004; Stewart & Tran, 2018). Individuals high in SDO generally view the world as fair, believing that inequity exists because there are more and less deserving individuals and groups. Individuals high on SDO tend to believe that people who devote enough work will attain the resources they need (Lantz et al., 2018).

Viewing the world as fair in the face of existing inequity may also be a result of the fundamental attribution error (Forsythe & Burnette, 2010). The fundamental attribution error occurs when one determines that people's failures or successes are a direct result of internal factors (Forsythe & Burnette, 2010). People then view society as a meritocracy, whereby people who work harder will achieve higher statuses of power (Sue et al., 1982). Indeed, people tend to perceive individuals in higher positions of power positively (Jouffre & Croizet, 2016). Conversely, people tend to view people in lower statuses of power more negatively, including the people in the lower positions of power (Jouffre & Croizet, 2016). The positive views toward success and negative views toward lower social positionality maintains privilege and oppression, because only internal factors are considered when examining status or power, while oppressive and privileging social structures are ignored.

Lack of awareness of privilege may be a result of the representativeness heuristic, SDO, and functional attribution error. Privilege, in the context of multicultural counseling, is defined as "unearned advantages that are conferred on individuals based on membership or assumed membership in a dominant group" (Israel, 2012, p.166). Two significant components of privilege are upholding oppressive structures and the lack of conscious awareness of the structures effects on various groups. Others may define privilege as unearned advantages afforded to individuals based upon their actual or perceived group membership(s), that allow for more resources, also supported by Social Dominance Theory (Israel, 2012; Stewart & Tran, 2018). In training for multicultural counseling, therapists tend to focus on clients' oppression, often identity -by-identity covering information about oppressed groups (Pieterse et al., 2009). This recognition is

important, as, therapists are likely to avoid assessing their own privilege, because exploration of one's own privilege requires more discomfort (Israel, 2012). Therapists may be taught about how oppressions affects various marginalized groups, without being taught how therapists may unintentionally contribute to the oppression. For example, White therapists may understand that people of color may not be shown more favorable housing when searching for new homes, but the therapists may not understand how, as White individuals, they unintentionally benefit from and help uphold unfair housing practices. In another common scenario, White therapists may assert they are "color-blind" and deny their contributions to racism (Fu, 2015). Thus, existing multicultural training and education are almost detached or removed, without meaningful self-exploration into how therapists themselves have privilege and contribute to some of the oppression clients face.

Consequences of Inadequate Multicultural Therapy

The multicultural orientation framework has shed light on the problems with previous multicultural theories or approaches. For example, despite the formal training and multicultural competencies, ruptures commonly occur in counseling settings, including microaggressions (Hook et al., 2016; Owen et al., 2017). Clearly, therapists need to revisit existing theories and competencies to improve treatment with clients who have marginalized identities. Preliminary empirical support has been demonstrated for the usefulness of MCO in therapy (Davis et al., 2018). However, the researchers credited for creating the framework also claim the approach is meant to complement other theories and not provide stand-alone support. Therefore, even the multicultural orientation framework, although presenting promising results, has gaps.

Therapist Bias. Without considering a client's cultural context, therapists may allow personal bias to influence their conceptualizations, diagnoses, and treatment of marginalized clients (Hook et al., 2016). Disparities in mental health treatment occur even at the beginning of the process, where therapists are significantly more likely to return calls to clients with stereotypically White-sounding names (Shin et al., 2017). Throughout treatment, therapists working with clients from marginalized backgrounds tend to avoid broaching cultural differences, exhibit stereotypes despite denying having them, and minimize the oppression marginalized clients experience regularly (Hook et al., 2016). However, researchers have failed to directly address how to improve the consequences of inadequate multicultural training.

Despite formal multicultural training being mandated by accrediting bodies and licensing boards much improvement is still needed with regard to therapists' multicultural training and competence (Constantine, 2001; Owen et al., 2016). Therapists may exhibit implicit bias, or attitudes one exhibits outside of conscious awareness, toward clients from marginalized backgrounds (Boysen & Vogel, 2008). In fact, therapists who have completed more multicultural courses have been found to self-report higher multicultural competence, but continue to exhibit the same level of implicit bias toward individuals from marginalized backgrounds (Boysen & Vogel, 2008). Implicit bias may lead to a rupture in the clinician-client relationship, which may lead to clients terminating services early (Hook et al., 2016).

Black/African American clients are more likely to terminate counseling early than White clients, leading to poorer mental health outcomes (Owen et al., 2017). Several factors appear to contribute to attending fewer sessions and terminating early (Owen et

al., 2012). Researchers have focused on therapists' failure to meet marginalized groups' needs, particularly related to sensitivity to the experiences of marginalized groups (Owen et al., 2012). Indeed, therapist cultural sensitivity, or rather, lack thereof, appears to play a significant role in racial/ethnic minority clients' early termination (Constantine, 2002; Owen et al., 2017). Even when controlling for the relationship between therapist and client, individuals from racially marginalized groups are more likely to terminate therapy early, suggesting that lack of therapist cultural sensitivity or comfort may be one cause of termination (Owen et al., 2017).

Although perhaps casting a negative picture of therapists, frequently, implicit biases arise out of good intentions. A relatively common example of implicit bias occurs when therapists say, "I don't see color" (Fu, 2015, p. 281). The intent generally implies that the therapist is attempting to view clients through an equitable lens. Because overt bias is considered socially undesirable, therapists attempt to avoid being associated as having racial biases. The color-blindness, so to speak, may be a defense mechanism against the discomfort that often occurs when recognizing privilege (Fu, 2015).

Many social psychologists would also argue that racial bias generally appears without malice, and more as a cognitive error (Richie & Josephson, 2018). The representativeness heuristic refers to a cognitive shortcut, wherein people quickly categorize information to reach a result. Essentially, the person assesses the probability that information from one source predicts information from another source (Fowler, 2017). From an evolutionary perspective, the general process can provide adaptive survival. If people see or hear movement they perceive is similar to a predatory animal, the heuristic might be beneficial. However, the shortcuts sometimes lead to errors, when

the person reaches results hastily and attributes qualities of the few to the entire population. Bias may result if the therapist becomes overly confident in the shortcut without quickly considering other information.

Implicit bias may specifically manifest as microaggressions toward marginalized groups, or at a systemic level, such as housing discrimination or healthcare disparities as a result of racial biases (Hook et al., 2016). Microaggressions can be difficult to identify, but are considered common, derogatory exchanges. Without considering a client's cultural context, therapists may allow personal bias to influence their conceptualizations, diagnoses, and treatment of marginalized clients (Hook et al., 2016). Therapists working with clients from marginalized backgrounds tend to avoid broaching cultural differences, exhibit stereotypes despite denying having them, and minimize the oppression marginalized clients experience regularly (Hook et al., 2016). However, researchers have failed to directly address how to improve the consequences of inadequate multicultural training.

Another type of blindness may occur in therapy, wherein the therapist simply does not acknowledge culture at all, even when the client expresses culture as a present concern (Moleiro et al., 2018). In an insightful study conducted by Moleiro and colleagues (2018), therapists mostly failed to acknowledge culture at all, extending beyond a conscious statement of something similar to colorblindness. Instead, the majority of the therapists focused on client symptoms and ability to express emotion. Alarmingly, some therapists actually viewed client culture may be a barrier to treatment, rather than as a source of strength. A strength might provide resilience for the client, rather than a problem to be resolved in therapy. The results of this study reflect the

general therapy training, which indicates a focus on symptoms and basic clinical skills. This study shows that the typical one formal multicultural class does not show true competence in therapists, but instead blindness, where the therapists does not acknowledge culture at all, or precompetence, where the therapists specifically states culture is not a concern or might be a problem. The fact that the researchers utilized video vignettes rather than self-report drives home the point that in real-life situations, therapists are not including multicultural factors, either implicitly or explicitly, and instead focusing on presenting symptoms and presentation in session in regard to ability to express, emotion, which could also be affected by culture.

Research, even as recently as summer of 2018, continues to strongly indicate that therapists implicitly avoid multicultural considerations or explicitly deem those considerations as not a concern or as problematic (Moleiro et al., 2018). Therapists' history of inadequately capturing cultural context when treating clients, and current struggles that sometimes still result in termination or distrust toward counseling, therapists have created multicultural guidelines (Sue & Sue, 1992). Another consequence, higher cultural concealment in therapy, results in diminished therapy outcomes (Drinane, Owen, & Tao, 2018). Not revealing relevant cultural information in therapy not only leads to poorer outcomes in therapy, but the influence to conceal the information might be related to inadequate therapist MCC or MCO.

Overpathologization and Misdiagnosis. Historically speaking, racially marginalized groups have experienced numerous injustices in therapy. Bias may appear in conceptualizations and diagnoses of racially marginalized populations as well. Therapists have consistently been more likely to diagnose Black/African American

clients with psychotic disorders, such as schizophrenia, than other racial groups (Garb, 1997; Waley 1997). Conversely, therapists have been less likely to diagnose Black/African American clients with affective disorders, which may indicate a lack of cultural context considerations. In fact, researchers found that the overdiagnosis of schizophrenia occurred even after considering specific symptoms and age of onset (Garb, 1997). Further, one hypothesis for the disparities in psychotic and affective diagnoses lies in the idea that the overdiagnosis of psychotic disorders is due to the lack of consideration of affective disorders (Barnes, 2008). Black/African American individuals may experience higher levels of anxiety and cultural mistrust that may be misperceived as paranoia without considering historical, political, and cultural contexts. Thus, what gets mislabeled “paranoia” may more likely function as an adaptive reaction toward external stressors (Whaley, 2002). Experiencing racism on a daily basis creates long-term fear, leading to distrust for others, lending the term cultural paranoia. Therefore, the chronic fear is a result of legitimate external stressors, rather than an underlying psychotic disorder. Therapists also tend to view Black/African American clients as more violent or antisocial (Guy, Poythress, Douglas, Skeem, 2008).

Behavioral disorders also tend to be disproportionately diagnosed Black/African American children (Bean, 2013). Oppositional defiance disorder, specifically, has a much higher prevalence rate among this population. Black/African American students also appear disproportionately in special education program. While racially marginalized groups certainly face more systemic barriers which could contribute to elevated distress, overpathologizing of such clients, such as overestimating behavioral concerns, continues to appear in the therapy setting.

Psychiatric medication prescription also appears to occur differently between Black/African American and White patients (Barnes, 2008). In fact, Black/African American patients are more likely to be prescribed more and inappropriate levels of psychiatric medications. Further, the same population is more likely to be prescribed older, rather than newer, brands of medications. Black/African American patients are specifically more likely to be prescribed antipsychotic medications. The patterns of psychiatric prescriptions, particularly when considering antipsychotic medications, may reflect similar overpathologization among therapists.

Therapists overpathologizing Black/African American clients more than White clients should be examined outside of specific diagnoses as well. When assessing for prognosis in Black/African American clients with psychotic symptoms in inpatient settings, White therapists tend to significantly overestimate return inpatient stays (Garb, 1997). White therapists tend to overestimate violence when predicting future behavior in Black/African American clients as well, both in inpatient and correctional settings. The inaccurate predictions in multiple settings appears to reflect an overall exaggeration of externalizing symptoms, particularly related to anger and violence, when conceptualizing Black/African clients.

APPENDIX B

Recruitment Email

Dear [participant's name],

My name is McKenna Hereford, and I am a third-year counseling psychology Ph.D. student at Oklahoma State University. I am conducting a study titled "A Phenomenological Exploration into Therapists' Conceptualizations of Vignettes." I am wondering if you would be willing to participate in this study, which involves two 45- to 60-minute interviews. After completion of the second interview, you will enter a drawing for a 50 gift card to Amazon. Participation is voluntary, and answers will remain anonymous.

If you are interested, please click on the link for the survey and additional information

[insert link].

If you have any questions, feel free to contact me at mckenna.hereford@okstate.edu.

Thank you for your time and consideration.

McKenna Hereford

Counseling Psychology Doctoral Candidate

Oklahoma State University

APPENDIX C

Demographic Questionnaire

1. What is your gender identity?
2. How do you identify racially?
3. What is your ethnicity?
4. How do you identify your socioeconomic status?
5. What is your spiritual/religious affiliation, if applicable?
6. How old are you?
7. What is your sexual/affectional orientation?
8. Do you have any disabilities and/or chronic illnesses?
9. Are you licensed?
10. Was your graduate program accredited by CACREP or APA?
11. How many multicultural classes did you complete in your graduate training?
12. How many years of experience do you have in your field?
13. What theoretical orientation(s) do you use most often in your work?
14. What population(s) do you currently provide services to?

APPENDIX D

Case Vignettes

Client “A” is currently a freshman student at a local college. The client presented for therapy reporting feeling “worried all the time.” The client described sleep disturbance, both with falling and maintaining sleep. The client reported feeling hopeless about things improving because the symptoms have been present for months. The client described feeling isolated, and noted lacking social support for years that has recently increased in severity. Additionally, the client has reportedly experienced a lack of appetite the last several months, which has led to significant weight loss.

During the intake, the client appeared restless and uncomfortable. The client often spoke tangentially. The client denied suicidal and homicidal thoughts.

Case Vignette

Client “B,” a Black/African American freshman man, reported feeling more “on edge” within the last few months, which has led to poor academic performance. The client reported difficulty falling asleep at night most nights. The client reportedly “stresses over everything”, which makes it difficult to fall asleep and remember daily responsibilities. The client described appetite fluctuations and fatigue that have recently increased in severity. The client also indicated interpersonal struggles on campus and difficulty “getting used to” college life and the other students.

During the intake, the client appeared lethargic but responsive. The client rarely made eye contact and left his arms crossed for the majority of the intake. The client denied suicidal and homicidal ideation.

APPENDIX E

First Semi-Structured Interview

1. What was your initial reaction after reading this vignette?
2. How would you begin to conceptualize this client?
3. What further information would you need for you to fully form a conceptualization?
4. What provisional diagnoses are you considering?
5. What are some of the details that have led you to this diagnosis?
6. Are there other diagnoses you might consider and why?
7. What more information would you need to feel more confident with your diagnosis?
8. Based on your initial conceptualization and diagnosis, what might be your plan for treatment?

APPENDIX F

Second Semi-Structured Interview

1. Now that you've had time to think about your answers and read through your transcript, what are your thoughts about your first interview?
2. What more information would you like to include now?
3. Based on the additional information you have provided, would you want to change your initial diagnoses and/or plan for treatment for either vignette?
4. How did you picture the client?
5. How do you think your training and experiences have influenced your process of conceptualizing and diagnosing clients?
6. What is some advice you would like to give to other clinicians when they are conceptualizing and diagnosing clients?
7. Is there anything else you would like to add?

APPENDIX G
Informed Consent

IRB Study#

OKLAHOMA STATE UNIVERSITY
STUDY INFORMATION SHEET AND INFORMED CONSENT

You are invited to participate in a research study about therapists' processes of conceptualization and diagnosis. We ask that you read this form and ask any questions you may have before agreeing to be in the study. Your participation in this research is voluntary. There is not penalty for refusal to participate, and you are free to withdraw your consent and participation in this study at any time. You can skip any questions that make you uncomfortable, and you can stop the interview at any time. Your decision whether or not to participate in this study will not affect your relationship with the IRB or researcher.

The study is being conducted by McKenna K. Hereford, M.A. and colleagues at Oklahoma State University.

STUDY PURPOSE

The purpose of this study is to explore therapists conceptualize and diagnose clients.

PROCEDURES FOR THE STUDY

If you agree to participate in this study, you will do the following things:

You will be completing two interviews in person that will take approximately 45-60 minutes, with the second one occurring about two months after the first. As discussed in the confidentiality portion below, the information will be kept anonymous, and the records of the study will be kept private.

RISKS OF PARTICIPATION

There are no risks that are anticipated from your participation in this study. Some of the questions may make you feel uncomfortable, but you are free to decline to answer any questions you do not wish to answer or stop participation in this study.

BENEFITS OF PARTICIPATION

The anticipated benefit of participation is to increase self-reflection among clinicians currently in practice.

CONFIDENTIALITY

You will be provided a pseudonym (fake name) to attach to your interview, instead of your real name, to ensure confidentiality. Research records will be stored on the Dropbox program in a password-protected laptop, and only researchers and individuals responsible for research oversight will have access to the records. Data will be destroyed after three years after the study has been completed.

PAYMENT

You will enter a drawing for two \$50 dollar gift cards after the completion of your second, 45-60 minute interview.

CONTACTS FOR QUESTIONS OR PROBLEMS

For questions about the study, contact the researcher, McKenna Hereford, at mckenna.hereford@okstate.edu, or her advisor, Dr. Melanie Lantz, at mel.lantz@okstate.edu.

For questions about your rights as a research participant or to discuss problems, complaints, or concerns about a research study, or to obtain information or offer input, contact the IRB Office at 223 Scott Hall, Stillwater, OK 74078, 405-744-3377 or irb@okstate.edu

VOLUNTARY NATURE OF STUDY

Taking part in this study is voluntary. You may choose not to take part or may leave at any time. Leaving the study will not result in any penalty or loss of benefits entitled to you. Your decision whether or not to participate in this study will not affect your current relations with Oklahoma State University.

CONSENT DOCUMENTATION:

I have been fully informed about the procedures listed here. I am aware of what I will be asked to do and of the benefits of my participation. I also understand the following statements:

I affirm that I am 18 years or older.

- YES
- NO

I have read and fully understand this consent form. I hereby give permission for my participation in this study.

- YES
- NO

I consent to being video recorded for both interviews.

YES

NO

Appendix H

DEBRIEFING STATEMENT

Thank you for participating in this research. In the study, the researcher explored how therapists conceptualize and diagnose clients with one or no presenting cultural multicultural factors. The purpose of the study was to capture participants' experiences while balancing a critical viewpoint of the overall counseling and counseling psychology fields. If you would like a copy of the results of the study, please contact the researcher and arrangements will be made.

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If you have questions about your rights as a research volunteer, you may contact the Oklahoma State University Institutional Review Board (IRB) Chair.

Thank you for participating.

APPENDIX I

Theme	Participants Endorsed	Significance Statements
MCC	<p>7 participants endorsed</p> <p>1st vignette:</p> <ul style="list-style-type: none"> • 5 directly or indirectly (Abby and Carol assumed woman gender) • 2 did not mention any cultural factors <p>2nd vignette:</p> <ul style="list-style-type: none"> • Four directly endorsed • Three did not mention cultural factors 	<p>-And I guess just that experience with isolation. I'd be really curious about that what was family structure like are they coming out of a foster situation. Is there a gender concern or something else that makes them feel different or not belonging. (Melissa, 1st vignette)</p> <p>-There's no gender mentioned. But I guess I'd want to know any socioeconomic status information, to thriving or disenfranchised in some way...Knowing socioeconomic status kind of gives you an idea of again what barriers might be there, and also maybe what strengths and resilience. Okay, you have someone who's from a lower socioeconomic status and they're doing well, and then they had these things come up, you know, that tells you they have some real resilience. (Rhonda, 1st vignette)</p> <p>-And when you're in a transitional period of time I'm conceptualizing from, you have to confront almost all of the existential givens at one time with major transition things I'm thinking in my head. Are you a first generation college student? You know,</p>

		<p>are you LGBT? a minority of some sort? (Sidney 1st vignette)</p> <p>-I mean, she is a freshman starting school possibly moving away from her family and friends. (Abby 1st)</p> <p>-I would want to invite this young man to help me understand what it's like being Black on this campus (Rhonda, 2nd)</p> <p>-I can't ignore the racial component here and would want to learn more (Taylor, 2nd).</p> <p>-But if it's not an issue for him then it's the same with the LGBT community. If it's not an issue for you, then it's not an issue. (Sidney, 2nd)</p>
Systems of Support	7; all participants endorsed the topic explicitly for both vignettes	<p>-So it seems to me there might be some good attachment and some were in the past, so that they're missing a sense of connection now, as opposed to someone who's very isolated (Rhonda, 1st). What do they do when they're feeling isolated? What do they do when they're feeling a lack of social support? What do they mean by social support? Is it more of a situation of, I just don't have the resources around me, or don't really know how to reach out, or somehow a deeper issue: I don't feel worthy, or, you know, I don't feel important? (2nd)</p>

		<p>-I know that it says noted lack of support for years that has recently increased in severity so I'd like to know more details around that. Generally social support comes a lot from family, so that's particularly lacking. I'd like to know more family history especially (Taylor 1st). Right off the bat, I guess I would want to know what type of college or university this person was attending, just because, I mean, you can't ignore the culture here. You have to definitely pay attention to the fact that this is a black African American male, and is this somewhere where he is absolutely a minority every single day experiencing that? Or if he going somewhere that might be more of a of a college setting that you know prides itself on being a black college that sort of thing where he might feel more inclusion rather than exclusion. (2nd)</p> <p>-Right off the bat I guess I would want to know what type of college or university this person was attending, just because, I mean, you can't ignore the culture here you have to definitely pay attention to the fact that this is a black African American male and whether gone somewhere where he is absolutely a minority every single day</p>
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		<p>-You do isolate yourself, like are there are there times where you are with people or you are socializing? Like it said something about lacking social support for years. What does that look like? (Patricia 1st) What know what's making this person lack stuff, like the socializing piece and wanting to isolate and just kind of be by themselves?(2nd)</p> <p>-So I guess my, my first question would be, it said that her social support system has decreased over the last, like little while or whatever so I'd want to know why. Like is it because she's away at college, your family's not there or is there like some kind of stressors, with her family or her friends.(Carol 1st) Um, I would want to know the support system that he does have in place. And, again, where are you at at college are you going to community college and you're still living at home. Are you living on the college campus you know those kind of things (2nd).</p> <p>-College Freshman is hard, or anybody, I think, regardless of where you're going to school or what you're going to school for, it's just a really big transition period. And, you know, if her isolation, is that because she's moved, and maybe she didn't have</p>
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		<p>some of the same friends of high school, you know, is she working? Is she engaging in things at school that are helping her to meet new people?" (Abby 1st); Like my client was the first one to ever go to college. So he has like very little support from his family because they didn't understand, but also, you know, especially in Oklahoma State, from what I've seen, at least, right It is so dominated by white people. And so that in itself, I mean, depending on where the person lives or where he's going to college could have an impact just the change in culture (2nd)</p> <p>-I mean just developmentally 18 year olds tend to look to their peers for their identity. So I'd be curious if, and maybe that is happening but I'm guessing if they're if they're, they're reporting feeling isolated so whether or not their system is there or whether they're not feeling like it's there (Melissa 1st). Are they the only student of color in any situations of their their college life where if anywhere, are they getting support...I'm guessing but I don't know just based on my contacts that there probably aren't surrounded by by other folks of color, because it doesn't specify the worker at a historically black</p>
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		campus or anything like that. (2nd)
Controlling Images	6 out of 7; this theme arose in response to the second vignette	<p>- I would just rule out any ASD symptoms as well, and figure out what, again, it's linking you up to some kind of support system on campus. Is that helpful at all? He definitely seems like anxiety is the biggest thing and whether or not that anxiety is the adjustment, or whether there's some ASD with the lack of eye contact and social.(Carol)</p> <p>- And I'm going to definitely be looking to see if there's any kind of substance use going on i mean is the guy stoned. You know, so let's find out about that. (Patricia)</p> <p>-I think one thing, but like when you get down to like, he's really made eye contact after his arms crossed, and then even getting used to college life and other students, you know, I have had this with a client before, who was also an African American male. And going into college was difficult because of that changing culture. Like my client was the first one to ever go to college. So he has like very little support from his family because they didn't understand, but also, you know, especially in Oklahoma State, from what I've seen, at least, right It is so dominated by white people. And so that in itself, I mean, depending on where</p>

		<p>the person lives or where he's going to college could have an impact just the change in culture, I think is something that needs to be looked at. Because also these responses, but typically the African American community doesn't value therapy as much as some of the other cultures that we work with. (Abby)</p> <p>- And I'm going to definitely be looking to see if there's any kind of substance use going on i mean is the guy stoned. You know, so let's find out about that... I'm also going to look at whether there's something more serious like kind of a bipolar thing going on, or even if he's a freshman, and he if he's the age typically of a freshman. Is there any kind of emerging severe mental illness, you know. Is he having any kind of odd beliefs or, you know, strange kind of experiences like voices and things like that? So we're going to look at all that too, and find out what's going on. (Rhonda)</p> <p>- You know, fluctuations in appetite to-- hoping you don't have any like crazy heart problems going on, dude. I know that African Americans many times have more problems. I hope his heart's okay. He's kind of young, but you never know...I mean, you know</p>
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		<p>like long term like ASD might be the fan to drop on the table to start with. I mean, I don't know what's changed recently, like to kick up the severity of the symptoms, you know like, you know you've been doing on edge for the last few month (Sidney)</p> <p>- I do think it'd be hard to do CBT with him though, because it feels like, at least at this point, he doesn't have enough reflection to give specifics (Taylor).</p>
Biological Factors	7 participants	<p>- Yeah, I mean, I just I think, when it comes to a point where you are lacking sleep, but you are not all the time. I mean, we know that it can cause problems with blood pressure. I think just lack of sleep is can be really dangerous. So even if that's like, okay, what melatonin or just working on sleep hygiene in generally important to get better if he's still not sleeping? (Abby, 2nd)</p> <p>- Looking at sleep hygiene, what is the cause of, because of course, if there's a sleep issue going on that it within itself could make your impact or mood negatively. Oh, for sure. Oh, what can we look at first to get her to start feeling a little bit better. So, getting more sleep, eating, eating healthy, or whatever, you know, more. (Carol 1st)</p> <p>- I mean this is depending on your finances this, the</p>

		<p>context allows. I'd love to get a doctor or a nutritionist on board just to rule out anything worse. And to see about getting some physical support the weight loss that could go scary path. So just making sure to have nutritional support, and a medical doctor if that's a rough decline. In terms of outpatient work, I think my first, I get really curious about their worldview, and just where'd this conditioning come from? What are the, what's the languaging around it; why they're isolated or why they're worried all the time? What that fear's about, and then doing kind of a strengths based approach of figuring out how do we step around that. (Melissa, 1st)</p> <p>- And then I know I've said this like three times (laughs), eating, obviously it's like super important. So needing to get that back on track because those are two really important factors that, you know, if persons not sleeping well regularly and not eating well. You know, the rest of the stuff isn't necessarily going to like totally I don't want to say matter but not totally resolved because you're still going to have those big missing pieces. So, I would it sound like that sleep disturbance is probably very highly associated with anxiety. (Patricia).</p>
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		<p>- This is sounding more kind of autonomic self-regulation psychophysiological. At the beginning, when the appetite fluctuations the fatigue, probably the kind of just general hyperarousal. The inner personal struggles also kind of suggest maybe something goes a little deeper, but I would probably start with sleep because that seems to be the first thing they brought in. One of the things that I do is biofeedback, so I've got this gear and I can do something called heart rate variability biofeedback. That can be a way to better regulate the autonomic nervous system to bring the parasympathetic nervous system back online. It's pretty much a kind of a controlled breathing scale but it's really kind of cool because you can see it on the screen. I would probably approach and see if we want to use that it can be useful for sleep onset (Rhonda)</p> <p>-Why do you have any like physical problems like if you got, like, okay, like that could contribute, or you know vitamin D? Have you not seen a primary care physician in like five years? You might want to do that. So, towards the end of a session I will kind of just try and get like a quick medical background. I</p>
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		<p>always tell them I am not a doctor right don't look to me to do anything medical, but, by the way, your body and your mind are connected. Make sure that you're aware and go make sure you work with the doctor to make sure you're not having some funky stuff that's going on. I could do all the therapy in the world but it's not going to do anything to help with what is going on if you've got an underlying condition in there. I usually in my intake, at the end, I will ask about that. (Sidney 1st)</p> <p>That makes me feel more confident and leaning more into an anxious area. Then I want to rule out physical things, like hypothyroid. When's the last time you've seen a doctor? I mean, the difference in the presentation about how we're hanging out in the room, you know, makes me a little more like, Okay, are we having difficulty being here in a counseling office (2nd)</p> <p>- One of the other big things that I usually start out trying to work on is sleep, because I always feel like that's a really big thing that if a client isn't sleeping well and just, you know, progresses that whole cycle of anxiety or whatever they're experiencing to take it to a more like severe level. I really try to just reel that in</p>
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		<p>and knock that out immediately whether it's, you know. I talk a lot about different things to do to help them fall asleep better. We look at meditation and breathing exercises before bed and cutting out electronics and whatever it is to just try and get more sleep within a shorter time frame, because that can be something that is taken care of pretty immediately. (Taylor 1st).</p>
MCO	<p>This is in response to the second vignette.</p> <ul style="list-style-type: none"> • 4 participants directly endorsed • 3 did not address presence in the room 	<p>- I was able to pick up a lot of things that just like, tone and inflection and just the word that you use makes such a big difference. Especially because, you know, I'm a five foot tall girl with red hair, like, you know, just trying to make that client feel at ease. I think it's all important. (Abby)</p> <p>- Yeah, I alluded to this earlier, but I really, I get curious about just epigenetic and family history I think more with with students of color. Just know if they're in the US, I think there's. At some point along the line if this clients not been mistreated someone in their family probably has. And I guess really wanting to honor that sometimes what we carry in our body isn't even ours. And they wanting to figure out what we would have anything they want to do with it but just by working</p>

		<p>in my lens of just folks with color in the last come with an extra genetic burden. And as a white clinician I really want to be sensitive and honoring of that, that they didn't know that any of our clients shoes or symptoms but I think especially folks who are carrying that that racial burden that they've got more to deal with and I want to I want to acknowledge and honor as, and usually some psycho at around, around that. There is a lot of good research systematically you're carrying some stuff with just with being with me as a white person, and entering a history of oppression, even if it's not yours. (Melissa)</p> <p>- I'd be real interested to find out and, you know, see if invite him to help me understand that better since I'm a white female.</p> <p>However, then we get down to lethargic, and I'm like, Huh, because that's not consistent with this autonomic hyper arousal, at least in that session. He's is very guarded, you know with the arms crossed, so I'm going to see if we can kind of join, I'm going to try to kind of, you know, just be disarming and see if we can make a connection.</p> <p>- I think all only insofar as acknowledging the dynamic in the room now. He's like, yeah, if I'm having</p>
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		<p>problems with people and I feel like I need space then sure. We'll focus on that, but that's not always the case. Like it's not for me to go back and, be like, I'm gonna, you know like empower you to go fight tonight. If they want that and a solution and then you know sure like we can go down that route and always whatever it is you're looking for. But if it's not an issue for him just like, the same with the LGBT community. If it's not an issue for you, then it's not an issue... What's it like sitting with this White chick in the room? (Sidney)</p>
<p>Focus on Cognitive Therapies</p>	<p>5 out of 7 participants</p>	<p>- I've been doing a lot of DBT lately. Sometimes things kind of ebb and flow within, like, what we're doing with clients and a lot of DBT kind of focused stuff that I need to be doing. I've been working on a lot of mindfulness. I think that can be so helpful. (Abby) -And how can we find ways to meet going forward. So maybe that's a parts language maybe that's EMDR maybe it's sensory motor think maybe it's CBT. I just I don't know.(Melissa) - My grad program was definitely CBT based. That's kind of the next step usually with my patients with the CBT model is to be aware of what's going on in our head and bodies, and</p>

		<p>just increasing awareness to be able to verbalize that. (Patricia)</p> <p>- So very much acceptance and Commitment Therapy is something that I'm pretty invested and organized around because it just makes a lot of sense to me that we have some basic kinds of beliefs and schemas that have formed. We're not going to get rid of those, and they were adaptive at one time. You know, whatever's going on with this person, it has some adaptive function or, they would have already gone by the wayside. It's just that it's not facilitating them living their bigger life. This life. That is functioning in some way. I'm not a fan of the idea that these beliefs are like irrational. (Rhonda)</p> <p>- I would definitely with the CBT aspects we look at, you know, breaking it down in terms of what thoughts are present and how can we alter those what behaviors are present, especially avoidance behaviors are ones that I look for pretty immediately. Then in terms of the social aspect. I usually look at that, with CBT, and the IPT. With CBT, I like to use techniques from all of the areas and I just kind of pull from there based on session the session where the client is that. Also is there more</p>
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		social issues with family members versus friends, versus, like, coworkers? I think that those are appear at different levels and you can kind of benefit more from certain techniques.(Taylor)
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VITA

McKenna Keely Hereford

Candidate for the Degree of

Doctor of Philosophy

Thesis: TYPE FULL TITLE HERE IN ALL CAPS

Major Field: Counseling Psychology

Biographical:

Education:

Completed the requirements for the Doctor of Philosophy in Counseling Psychology at Oklahoma State University, Stillwater, Oklahoma in July, 2020.

Completed the requirements for the Master of Arts in Psychology at University of West Florida, Pensacola, Florida in 2016.

Completed the requirements for the Bachelor of Arts in your major at Mississippi University for Women, Columbus, Mississippi in 2012.

Experience:

Completed pre-doctoral internship at the VA Texas Valley Coastal Bend 2020

Completed practicum experiences at the OSU University Health Services and Counseling and Counseling Psychology Clinic 2017-2020

Completed practicum experiences at the Payne County Jail and Oklahoma City VA Medical Center 2019

Professional Memberships:

American Psychological Association, Division 17

American Psychological Association, Division 41