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Psychological Factors that Impact White Counseling Trainees' Responses to Cultural Ruptures

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Psychological Factors that Impact White Counseling Trainees' Responses to Cultural Ruptures

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ABSTRACT

In the field of counseling and clinical psychology, the last several decades have been characterized by a strengthened recognition of the importance of cultural factors in psychotherapy. While this has been impactful, there is evidence that cultural ruptures, microaggressions, and racial/ethnic disparities in psychotherapy outcomes persist. Aversive racism theory, which provides explanations for the racist tendencies typically associated with progressive White individuals, postulates that a conflict between explicit egalitarian beliefs and implicit negative racial biases impedes White individuals from adequately addressing and acknowledging underlying biases. Therefore, it was hypothesized that psychological factors, such as defense mechanisms, professional self-doubt and self-compassion, may play a role in impeding or enhancing therapists' ability to identify and resolve cultural ruptures in therapy. The present study sought to test these hypotheses by asking White therapists-in-training to respond to video vignettes portraying cultural ruptures. These vignettes were then coded to assess the level of cultural comfort, cultural humility and cultural opportunities demonstrated by participants. Results revealed that self-compassion was positively associated with White trainees' cultural humility and overall effectiveness, specifically in the vignette that included a client-confrontation response. Implications, limitations and future directions are discussed.

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CHAPTER ONE: INTRODUCTION

The fields of counseling and psychology emphasize the importance of attending to issues of multiculturalism, diversity, power, and privilege in the therapy process (Benuto et al., 2019; Hills & Strozier, 1992; Pederson, 1991; Sue et al., 1992; Sue et al., 2009). The American Psychological Association (APA, 2017) updated their guidelines for multicultural competence in therapy to outline a variety of different facets of multicultural counseling. The guidelines emphasize that ethical practice for psychologists includes recognizing the role that culture plays in impacting clients' lives, utilizing strengths-based approaches when encountering cultural differences, and acknowledging the cultural assumptions that underlie psychological practice. Further, psychologists are implored to examine their own cultural biases and identities and to draw upon empirical evidence to inform their multicultural practice (APA, 2017). Despite this increased focus on training psychotherapists in multiculturalism, questions remain about factors that may contribute to continued issues with racism and microaggressions in psychotherapy. The theory of aversive racism (Dovidio & Gaertner, 1986; Dovidio et al., 2016) is utilized in the present study to outline the characteristics of racism in psychotherapy.

Theory of Aversive Racism

Aversive racism theory argues that in the post-civil rights era, the U.S. underwent a dramatic shift in its ideology about race. That is, overt racial discrimination and oppression became illegal and less socially acceptable (Burkard et al., 2001; Dovidio &

Gaertner, 1986; Dovidio et al., 2016). Unfortunately, however, this did not mean that racism and racial oppression disappeared, rather they were subverted into implicit biases instead of explicit prejudice (Jones, 1997). Aversive racism is related to implicit biases in that it may impact the way a person behaves when addressing issues of racial power and oppression, while not necessarily being reflected in their stated beliefs (Rodenborg & Boisen, 2013). This process of subversion does not apply to all persons, as evidenced by the fact that overt racism continues to persist as well (Jones, 1997). Further, other theories like modern racism and ambivalent racism provide alternate explanations for the biases of more conservatively oriented persons; that is, racial biases that are explicit and overt (Dovidio et al., 2016). The aversive racism paradigm, on the other hand, provides a framework for understanding the seemingly contradictory implicit biases of liberal White persons whose stated values are anti-racist (Dovidio et al., 2016).

Aversive racism posits that liberal Whites tend to view themselves as egalitarian and therefore non-prejudicial (Dovidio et al., 2016). Thus, they are motivated to avoid acting in ways that could be construed or interpreted as racist. White persons behaving in ways to avoid being perceived as racist, however, does not ensure that underlying and implicit racial biases are adequately addressed and resolved. This poses an issue given that most all people in the United States have internalized racist norms and beliefs due to the systematic racism that forms the foundation of dominant culture. Therefore, a paradoxical bind occurs in which White individuals who are aversively racist attempt to avoid overtly racist actions/beliefs, which reinforces their self-image as anti-racist, but also inhibits them from addressing implicit racial biases that are still operating underneath the surface (Dovidio et al., 2016).

Frey and Gaertner's (1986) experimental study provided evidence for aversive racism by demonstrating that in a simulation, White participants tended to avoid disadvantaging Black individuals when they had reason to believe that such a decision would be perceived by others as prejudiced and unjustifiable; however, White participants were more likely to disadvantage Black persons when they felt they could more easily justify this decision based on an idea that the Black confederate involved in the study was responsible for their own struggle. Further, prejudicial behavior is more likely to be exhibited by aversively racist White individuals when there is less perceived clarity about what constitutes an acceptable anti-racist response, whereas aversively racist White people are likely to act in accordance with egalitarian values when the anti-racist response is less ambiguous (Pearson et al., 2009).

Similarly, Tao et al. (2017) conducted a study in which participants viewed video vignettes that portrayed a White professor interacting with a Black student. Four iterations of the vignette were created to depict four different conditions: 1) no microaggression, 2) an ambiguous microaggression, 3) a very ambiguous microaggression, or 4) an overt microaggression. Participants were then asked to rate their emotional reactions to the vignettes, as well as their perceptions of the level of racial bias enacted by the professor in the vignette. Results indicated that in comparison to the no microaggression control vignette, the professor in the ambiguous vignette was rated as statistically significantly more biased, which serves to underscore the role that ambiguity plays in the impact of racist incidents. That is, more ambiguity in racist responses may be considered more biased than even overt instances of racism (Tao et al., 2017). This is especially relevant to the present study given that instances of cultural ruptures in

psychotherapy are often characterized by subtle and ambiguous shifts in the session. In other words, there is rarely one prescribed way to respond to issues of culture in therapy, which has the potential to elicit aversive racism reactions by White therapists.

The theory of aversive racism is also especially crucial in the present study given that it proposes a framework to understand the mechanisms of racism that are often present with White persons who self-identify as progressive. Nail et al.'s (2003) summarized the results of three experiments that attempted to test the association between White individuals' political orientations and aversive racism. Two of the experiments examined the relationship between White participants' self-identified political orientations and their tendency to judge a hypothetical court case as fair or unfair based on the race of the defendant and the victim in the simulated case. They found a statistically significant association between White participants' self-identified political orientation and their decisions about the equity of the court case. That is, White participants who identified as liberal were more likely to show favoritism towards Black defendants in comparison to White defendants, whereas conservative White participants were more likely to show favoritism towards White defendants over Black defendants (Nail et al., 2003).

While this favoritism towards Black persons by White liberal participants could be interpreted as a positive and anti-racist view, the third experiment in the study provided evidence that while liberal White people may profess explicitly anti-racist views, intrapsychic tension about race persists on the implicit level. They provided evidence for this theory based on their findings that White participants who self-identified as liberal demonstrated greater physiological arousal compared to White

participants who identified as conservative when they were asked to interact with a Black confederate in the study (Nail et al., 2003).

Further, studies have suggested that White people who identify with a liberal worldview may demonstrate a "bend over backward" effect when interacting with non-White persons (Byrd et al., 2015). That is, they may overcompensate when feelings of guilt or discomfort emerge when engaging in cross-racial interactions. In fact, Son Hing et al. (2002) found statistically significant differences between White liberal participants with low explicit racial bias, but high implicit racial bias (i.e. higher in aversive racism), and White liberal participants with low explicit racial bias and low implicit racial bias (i.e. lower in overall prejudice). That is, White participants higher in aversive racism tended to engage in overcompensation behaviors in response to hypocrisy and guilt primes, while White persons with truly low prejudice did not (Son Hing et al., 2002).

In terms of how the relationship between political orientation and aversive racism applies to therapists, according to several studies, mental health professionals from a variety of training backgrounds tend to be more likely to describe their political ideology as liberal rather than conservative (Norton & Tan, 2019; Parikh et al., 2011; Steele et al., 2014). Additionally, evidence suggests that the beliefs and ideologies of mental health providers impact client care by way of influencing their theoretical orientations, as well as their advocacy behaviors (Norton & Xing Tan, 2019; Parikh et al., 2011). Given this trend towards liberal political beliefs within the mental health field, the theory of aversive racism is likely to better characterize the racist processes that occur in therapy since aversive racism is associated with individuals who express agreement with egalitarian and progressive values. These studies highlight the interesting conundrum that

psychology and counseling psychology in particular face: the APA and most training programs promote liberal values and are committed to social justice, and simultaneously most graduate students in these training programs identify as White women (APA, 2016). Thus, the aversive racism paradigm is critical to addressing the unconscious biases that may persist and may impact White therapists' ability to intervene effectively regarding issues of race despite overt commitments to anti-racist practices. Prominent examples of the persistence of aversive racism in psychotherapy include microaggressions and cultural ruptures in therapy.

Cultural Ruptures

Gaztambide (2012) defines cultural ruptures as subtle misattunements or misunderstandings that occur in the therapeutic relationship or the larger context of therapy. That is, at times the values of both therapists and the broader field of psychology are incongruent with the cultural values of clients (Gaztambide, 2012). Cultural ruptures are conceptually related to microaggressions, although they are less-widely studied (Gaztambide, 2012). Additionally, this definition is drawn from traditional rupture/repair literature in that it argues that cultural ruptures are intrinsically linked with the therapeutic alliance but applied to instances of *cultural* misattunement.

In the traditional rupture/repair literature, ruptures are defined as moments of tension or breakdown in communication between the client and therapist (Eubanks, Muran, & Safran 2018; Safran, 1993; Safran & Muran, 2006; Safran et al., 2011). Eubanks, Muran and Safran (2018) conducted a meta-analysis that included studies in which ruptures were identified through direct report or by examining fluctuations in ratings of the alliance. Their results estimated that a moderate effect size exists between

the successful restoration of the alliance following a rupture and overall outcomes (*d*= .62; Eubanks, Muran, & Safran 2018). Similarly, a moderate effect size (*d*= .50) was found in terms of client outcomes when comparing clients who reported no ruptures to those who reported that ruptures occurred but had been repaired (Eubanks, Muran, & Safran 2018). Further, Stiles et al. (2004) found that clients who exhibited v-shaped alliance trajectories, that is alliance ratings that included sudden dips followed by rapid recovery, showed higher outcomes in terms of depression, general symptoms, and interpersonal functioning (Stiles et al., 2004). While the foci of these studies are general ruptures rather than cultural ruptures, evidence suggest that cultural ruptures and general ruptures are characterized by similar processes, including: misattunement, breakdowns in the alliance, and feelings of misunderstanding and tension. Thus, it is primarily the specific cultural content involved in cultural ruptures that distinguishes the two constructs (Gaztambide, 2012).

Given this definition of ruptures as moments of breakdown in the alliance between the therapist and client, cultural ruptures in the context of this study will be considered as a broader phenomenon wherein therapists and clients experience some tension related to cultural differences in the alliance. This may include more overt instances of tension or communication breakdown, but it may also include subtle encounters in which therapists miss the broader cultural forces impacting the therapy, the alliance and the client's experience (Gaztambide, 2012; Keenan et al., 2005). Therefore, a microaggression will be considered to be an example of a cultural rupture, but cultural ruptures will be considered a broader category that includes even more subtle misattunements or moments of tension. In addition to the nature of the rupture itself,

there are also differences in clients' ways of responding to ruptures. Clients' responses to ruptures have been organized into two primary categories, including ruptures characterized by withdrawal, as well as those characterized by confrontation (Eubanks, Muran, & Safran 2018; Keenan et al., 2005). Therefore, it is important to portray both ends of this spectrum in the present study.

Not only do cultural ruptures represent broader instances of miscommunication, but the cultural ruptures paradigm also implicates the therapeutic alliance (Gaztambide, 2012), which is considered central in psychotherapy (Fluckiger et al., 2018). For example, Owen, Imel and colleagues (2011) found that while cultural ruptures in therapy were associated with negative psychological effects, those effects were attenuated by a strong alliance. Thus, due to the important role that the working alliance plays in mediating the effects of negative racialized interactions, the cultural ruptures paradigm is utilized because it draws on the traditional rupture/repair framework, which also emphasizes the importance of the therapeutic relationship, as well as responsiveness to the experience of the client (Eubanks, Muran, & Safran 2018; Friedlander, 2015; Safran et al., 1990; Safran, 1993; Safran et al., 2011; Stiles et al., 1998).

The rupture and repair framework describes both the signs of ruptures and tenets of the repair process (Eubanks, Burckell et al., 2018; Safran et al., 1990; Rhodes et al., 1994). Rupture and repair studies have suggested that one essential aspect of working effectively with ruptures includes the ability to recognize when ruptures have occurred (Mosher et al., 2017; Muran, 2019; Safran & Muran, 2006). Chen et al. (2018) conducted a naturalistic, time-series design study in which therapists' ratings of alliance at the session level and clients' ratings of session-level alliance were utilized to identify

sessions in which ruptures may have occurred. That is, when ratings of alliance for a given session were significantly lower than the average of the previous three sessions, ruptures were considered to have occurred. Their results suggested that when therapists were able to recognize rupture sessions, client ratings of the subsequent session were not negatively impacted; conversely, when ruptures went unrecognized by therapists, client ratings of subsequent sessions were found to be worse (Chen et al., 2018). Thus, it is evident that to initiate the repair process, it is imperative for therapists to understand when ruptures have taken place in treatment (Chen et al., 2018). For this reason, the present study attempts to understand which psychological characteristics assist or hinder trainees not only from successfully addressing cultural ruptures, but also detecting their occurrence, which is critical given that detection is implicit in the process of addressing ruptures.

Microaggressions

Microaggressions constitute examples of cultural ruptures that continue to persist in psychotherapy (Owen, Tao et al., 2014). Microaggressions are defined as everyday occurrences; they are often considered commonplace instances of racism that people of color endure with frequency (Pierce et al., 1978; Sue et al., 2007). Sue et al. (2007) detailed several different types of microaggressions. These include microassaults, which are more overt put-downs related to a person's race, microinsults, which constitute more subtle put-downs related to a person's race, and microinvalidations, which are defined as instances in which race and/or the impact of racial privilege and oppression are denied, minimized, or ignored (Sue et al., 2007). Microaggressions often leave the target feeling confused, shut down, angry and deflated (Sue et al., 2007). Solorzano et al.'s (2000)

qualitative study on the impact of racial microaggressions on students of color indicated that microaggressions also tend to elicit feelings of frustration, isolation, and exhaustion. Studies have also demonstrated that deleterious psychological effects often occur in therapy when microaggressions are present (Constantine, 2007; Owen, Imel et al., 2011; Owen, Tao et al., 2014). Further, evidence suggests that microaggressions are negatively associated with therapy processes including working alliance (Constantine, 2007; Davis et al., 2016; Morton, 2012; Owen, Imel et al., 2011; Tao et al., 2015). For example, in a psychotherapy study at a large university counseling center, it was concluded that experiencing more microaggressions in therapy was associated with poorer alliance ratings. However, it was demonstrated that strong alliance ratings could help reduce the negative impact of microaggressions on outcomes (Owen, Imel et al., 2011).

Indeed, Owen, Tao et al. (2014) estimated that approximately 53% of racial/ethnic minority clients in their sample reported experiencing a microaggression during their time in therapy. Hook et al. (2016) found that 81.7% of the participants in their study had experienced at least one microaggression throughout the course of their therapy. Further, approximately 76% of clients indicated that the microaggression was never directly addressed (Owen, Tao et al., 2014). Failing to directly address microaggressions may be related therapists' lack of awareness that a microaggression has occurred. Owen et al. (2018) conducted a study using video vignettes to test whether therapists could detect the occurrence of microaggressions. The results demonstrated that between 38% and 53% of therapists who watched the video vignette during which several microaggressions occurred were able to recognize at least one microaggression. Thus, it may be that one reason microaggressions persist in therapy is related to the fact that many therapists may

not be able to recognize them when they occur (Owen et al., 2018), similar to the case with cultural ruptures in the previously reviewed literature.

Multicultural Counseling Training

Although training could potentially be used to increase therapists' awareness of microaggressions, studies examining the training of therapists to increase their multicultural counseling competence (MCC) have yielded mixed results. Smith et al. (2006) conducted a meta-analysis to estimate the effectiveness of MCC training. Their results estimated a moderate effect size (d= .49) in terms of the effect of participating in MCC training. On the one hand, this meta-analysis supported the conclusion that MCC trainings are impactful, but on the other hand, the authors questioned the reliability of self-report measures to assess these changes. That is, it may be more accurate to conclude a moderate effect size and large effect size represent the extent to which participants reported that they have improved due to MCC training, rather than assuming that this report translates into actual changes (Smith et al., 2006). Similarly, Worthington et al. (2007) conducted a content analysis on MCC, including MCC training, as well as psychotherapy processes and outcomes. The authors concluded that the majority if the research pertaining to training therapists in MCC is tenuous due to the reliance upon trainees' self-report of their change in MCC following training (Worthington et al., 2007). This aligns with other literature that presents critiques about the reliability with which MCC in general has been measured and studied, specifically the reliance upon self-report measures (Davis et al., 2018; Drinane, Owen, Adelson, & Rodolfa, 2016; Hook et al., 2017; Owen, Leach et al., 2011; Owen, 2013; Wilcox et al., 2020). Indeed,

evidence suggests that observer ratings of therapists' multicultural competence largely differ from self-reported ratings (Wilcox et al., 2020).

Further, Benuto et al. (2018) conducted a systematic review of studies focused on training psychotherapists in the tenets of multicultural competence. They concluded that there is heterogeneity in terms of how trainings were conducted, as well as the specific topics that were primarily addressed through training. Results also suggested that while studies generally provided evidence of a positive relationship between MCC training and outcomes related to increased knowledge of MCC concepts, there were mixed results in terms of awareness and skills outcomes. That is, while some studies demonstrated that training contributed to increased MCC awareness and skills, other studies yielded null results (Benuto et al., 2018). Specifically, in the eight quantitative studies that examined the impact of MCC training on participants' subsequent MCC knowledge, 18 significant outcomes and only four null outcomes were identified. Alternatively, across the three articles that studied the impact of MCC training on multicultural attitudes, five null outcomes were identified in comparison to four significant outcomes. Additionally, across the six studies that investigated the impact of MCC training on multicultural awareness, 13 null findings in comparison to five significant findings were identified. Four null outcomes and four significant outcomes were identified in the three studies that examined the effects of training on self-reported multicultural skills. Lastly, four null outcomes and four significant outcomes were identified across three studies in which observer reports were used to assess whether MCC impacted multicultural skills (Benuto et al., 2018). This aligns with results from the qualitative study conducted by Benuto et al. (2019) in which psychotherapists who reflected on their experiences with MCC

training concluded that they would have benefited from more applied skills training. This literature suggests that while the field has made strides in terms of increasing the focus on MCC training, there may be some gaps as it relates to translating increased training into more awareness, stronger skills and, ultimately, better client outcomes.

The evidence that microaggressions often go unaddressed suggests that cultural ruptures, which constitutes the broader category under which microaggressions fall, continue to occur in psychotherapy despite the shift in the field attempting to minimize these occurrences through training. In other words, although training has emphasized and promoted egalitarian values in psychotherapy, therapists still struggle to avoid microaggressions and address cultural ruptures. This suggests that there is a discrepancy between the knowledge therapists are gaining through training and their skills to put this knowledge into practice with clients. For this reason, theorists suggest that multicultural competence training may benefit from a reconceptualization that is focused more on developing therapists' actual skills, as well as homing in on in-session processes (Ridley et al., 2021).

The Multicultural Orientation Paradigm

Despite this recognition that there are gaps in terms of translating MCC training into effective practice (Ridley et al., 2021), as well as issues regarding how MCC outcomes are measured (Wilcox et al., 2020), there is evidence that other variables related to cultural processes may provide more information about effective interventions with cultural issues in therapy. Owen, Tao et al. (2011) formulated the multicultural orientation (MCO) framework, which consists of three major components: cultural

comfort, cultural humility, and cultural opportunities (Owen, 2013; Owen, Tao et al., 2011).

Cultural humility is described as an "other-oriented stance" in which the therapist refrains from assuming they know about the client's culture, and instead relies on curiosity and openness to learn from the client about their view of their culture and identity (Hook et al., 2017, Mosher et al., 2017). Cultural comfort refers to a therapist's ability to discuss cultural topics and cultural differences with ease and without verbal and non-verbal displays of discomfort or anxiety (Owen, 2013). That is, cultural comfort can be characterized as a behavioral expression of cultural humility in that it demonstrates an individual's sense of openness to discussing culture (Perez-Rojas et al., 2019). Cultural opportunities refer to the idea that therapists ought to be attuned to clients' cultural experiences and responsive to their individual needs, especially how these needs may be influenced by culture. Further, the MCO framework encourages therapists to facilitate such opportunities and open the conversation to discuss culture while attending to the client's narrative (Hook et al., 2017; Owen, 2013). While at times dominant theories in psychology might suggest that focusing on symptoms or psychological material takes precedence, the MCO framework encourages therapists to take advantage of cultural opportunities rather than solely focusing on disclosures that are considered more clinically relevant (Hook et al., 2017).

There is empirical support for the components of MCO in a variety of studies. Owen et al. (2017) found that there are discrepancies in unilateral termination rates based on the ethnic identity of clients. That is, some therapists experience more unilateral termination with White clients and others experience more with racial/ethnic minority

clients, but cultural comfort explained some of this variability. Hook et al. (2013) conducted a study that aimed to validate the construct of cultural humility through the development of a cultural humility scale. Their results indicated that there is a positive association between cultural humility and measures of working alliance. Indeed, their results demonstrated that cultural humility predicts working alliance above measures of multicultural competence (Hook et al., 2013).

Hook et al. (2016) conducted a study to examine the effect of cultural humility on microaggressions and their impact in psychotherapy with over 2,000 therapy clients who identified as racial/ethnic minorities. The results provided evidence that therapists who were perceived as more culturally humble by their clients were also less likely to commit racial microaggressions at all, and further, the deleterious effects of microaggressions were less severe if they did occur (Hook et al., 2016). Additionally, Davis et al. (2016) asked clients to reflect on the most severe offenses they encountered in their relationships with their therapists. They found support for the hypothesis that experiencing microaggressions and identity-related offenses reduced the extent to which clients viewed their therapists as culturally humble, which in turn negatively impacted the working alliance, again suggesting that cultural humility plays an important role in enhancing the working alliance (Davis et al., 2016). Given the body of evidence suggesting the importance of the working alliance for therapy processes and outcomes (Fluckiger et al., 2018), the association between the working alliance and cultural humility is important. Owen, Jordan et al. (2014) found that cultural humility was all the increasingly more important when clients considered their cultural identities salient. That is, the association

between cultural humility and therapy outcomes was significant for those participants who considered their religious identities important (Owen, Jordan et al., 2014).

In the context of group therapy, further support for the MCO paradigm has been garnered. Kivlighan, Adams et al. (2019a) created and tested the group version of the Multicultural Orientation Inventory with 208 clients in 49 therapy groups. Not only did their results provide support for the reliability and validity of the measure, but they also found that the level of engagement with cultural opportunities and cultural humility in the group positively predicted of general improvement, as well as the presence of therapeutic factors in the group (Kivlighan, Adams et al., 2019). Furthermore, Kivlighan, Drinane et al. (2019) found that cultural comfort in groups was negatively associated with cultural concealment, another conceptually related variable wherein clients may opt to avoid sharing certain aspects of their cultural identity when they do not feel safe to reveal such aspects (Drinane et al., 2018). Inversely, group members' ratings of cultural comfort in the group positively predicted racial and ethnic minority clients' improvements as a result of group therapy (Kivlighan, Drinane et al., 2019). Thus, evidence suggests that even in group therapy, MCO processes are typically associated with positive counseling processes (e.g., group therapeutic factors) and positive outcomes.

Despite the evidence of the importance of promoting MCO variables in psychotherapy, psychotherapists inevitably make some mistakes when it comes to working with culture in therapy (Mosher et al., 2017). Research by Owen et al. (2016) examined clients' retrospective perceptions of their therapists' cultural humility and their therapists' tendency to capitalize on cultural opportunities. They found that cultural humility moderated the negative relationship between cultural missed opportunities and

clients' estimation of their improvement after treatment. That is, missing cultural opportunities was associated with worse therapy outcomes, but higher levels of therapist cultural humility attenuated this deleterious effect (Owen et al., 2016).

Although this body of literature suggests that MCO variables are associated with positive processes and outcomes in psychotherapy, it is also evident that some therapists are more effective in working with White clients, while others are more effective with racial/ethnic minority clients, suggesting that not all therapists can equally facilitate MCO processes in therapy. Several studies provide evidence that therapists differ in terms of their effectiveness in psychotherapy based on the race of their clients, with some therapists performing better on a variety of variables, including: alliance, unilateral termination and symptom reduction, with White clients and others with racial/ethnic minority clients (Drinane, Owen, & Kopta, 2016; Hayes et al., 2015; Hayes, McAleavey et al., 2016; Imel et al., 2011; Kivlighan, Hooley et al. 2019; Morales et al., 2018; Owen et al., 2012). Hayes, McAleavey et al. (2016) attempted to explain this variability in outcomes by examining therapist demographic variables, such as: therapist level of experience, theoretical orientation, degree type, race, and gender; however, none of these emerged as significant predictors of therapist effectiveness with clients based on race.

Given that some therapists appear to be more effective with some clients based on their race, this suggests that some therapists may be more capable of facilitating MCO processes in therapy as it relates to issues of race. The question remains, therefore, regarding which factors contribute to this differential ability to integrate multicultural training and engage with MCO processes in practice. In other words, despite receiving training to enhance the multicultural abilities of White therapists, racial/ethnic disparities

continue to be present in psychotherapy, and the demographic variables that have been studied do not explain these differences (Hayes, McAleavey et al., 2016), which suggests that further study of psychological variables may be necessary to understand this phenomenon more thoroughly.

In the present study, MCO processes are considered to run parallel with cultural ruptures and repair, such that the adequate response and resolution of cultural ruptures inherently implicates MCO processes. Mosher and colleagues (2017) support this line of reasoning by suggesting that cultural humility, cultural comfort, and responsiveness to cultural opportunities are intrinsically linked with a therapist's ability to respond to cultural ruptures in therapy. In other words, effectively responding to cultural ruptures requires that MCO processes be present in therapy. The question that this study seeks to answer is the extent to which certain psychological traits promote or inhibit trainees' ability to respond to cultural ruptures effectively in a way that is characterized by cultural humility, cultural comfort and awareness of and responsiveness to cultural opportunities.

Defense Mechanisms

Due to the emphasis on the tension between the explicit and implicit, and the conscious versus subconscious in the aversive racism paradigm, it stands to reason that theories of ego defenses could also be used to better understand the psychological processes that may impede or enhance White trainees' ability to manage both implicit and explicit beliefs, as well as effectively manage their responses in session. Further, one of the dominant models for understanding White individuals' conception of their own racial identity, the White Racial Identity Development Model (WRID; Helms, 1995), also implicates ego defenses as the potential mechanisms through which White racism is

maintained at various levels of identity development. For example, the earliest stage of the WRID, contact, describes colorblind racism and the use of denial to ignore racial differences. Additionally, the reintegration stage describes White persons using projection and turning on the object to justify White power and privilege in society (Utsey & Gernant, 2002).

Additionally, while racism is a systemic and sociological phenomenon, it is also an individual phenomenon that implicates psychological traits including affect and personality (Dalal, 2006). Hook et al. (2016) found that some common psychological correlates that are evident when microaggressions occur in therapy include the therapists' denial of the importance of race and/or avoidance of topics related to race. Therefore, psychological theories, like psychoanalytic theories, provide a framework that attempts to explain how people use defenses and other intrapsychic mechanisms to engage in avoidance/denial about race and racism.

Psychoanalytic theories argue that unconscious conflicts are avoided using defense mechanisms that prevent people from experiencing the tension related to those conflicts (McWilliams, 2004; McWilliams, 2011; Mitchell & Black, 1995). Further, defenses are inherently defined as unconscious and involuntary, and they are utilized to help cope with threats and stress in the environment (Valliant, 2011). For example, the aversive racism paradigm and WRID theories suggest that White individuals experience conflicts about race (Dovidio & Gaertner, 1986; Dovidio et al., 2016; Helms, 1995). Paradoxically, the power structures in hegemonic culture perpetuate White dominance, but they often do so covertly. Thus, White persons may notice racial disparities on some level, but they may be taught to deny, avoid, and negate topics of race and racism in order

to maintain their power and avoid threats to their identity as an anti-racist person. Therefore, it seems likely that intrapsychic mechanisms, like defenses, may play a role in maintaining White persons self-image as non-racist, while simultaneously maintaining underlying and implicit negative views of non-White individuals (Pearson et al., 2009). Further, given that recognizing implicit biases often requires facing feelings of guilt, anger, and discomfort for White persons (Pearson et al., 2009), defenses may be utilized to avoid experiencing those affective components of White racial identity.

At present, there are few extant studies that utilize theories about intrapsychic mechanisms in order to better understand cultural ruptures and aversive racism in therapy. Utsey and Gernant (2002) conducted a study examining whether relationships exist between ego defense structures and racial identity. The results suggested that White participants that had progressed further in terms of their White identity development (i.e., were estimated to be in later stages of White identity development) also tended to demonstrate less primitive and more flexible defense mechanisms. Conversely, White individuals who had less advanced White identity development tended to engage in less mature defenses to avoid conflicted feelings related to race (Utsey & Gernant, 2002). Further, Juby's (2005) dissertation suggested that White persons with higher racial ambivalence demonstrated more defensiveness when responding to cross-racial counseling scenarios.

As applied to aversive racism, defenses may play a prominent role in that they may help individuals subvert racial biases and keep them out of conscious awareness (Dovidio et al., 2016; Juby, 2005). That is, defense mechanisms like denial, projection, and reaction formation, may be utilized to help progressive White individuals avoid

anxiety and discomfort they feel about discussing race by disavowing those feelings and solidifying their explicit egalitarian views (Nail et al., 2003). Further, given that defenses serve to keep certain affective states or thoughts out of conscious awareness, defenses may also prevent aversively racist White individuals from engaging in self-reflection about their racial power and privilege (Helms 1995; Pearson et al., 2009). The study of defense mechanisms, while yet under-explored, has the potential to provide helpful explanations of the intraspsychic mechanisms that maintain aversive racism in psychotherapy. In addition to understanding mechanisms that uphold racism, the present study examines intrapsychic mechanisms that promote positive responding to cultural ruptures, including professional self-doubt and self-compassion.

Professional Self-Doubt

A potential correlate of humility, the construct of professional self-doubt (PSD; Nissen-Lie et al., 2010) constitutes another intrapsychic trait of interest in the present study that may promote an anti-racist stance and effective interventions with cultural ruptures. Nissen-Lie and colleagues (2010) found that professional self-doubt, defined as some level of uncertainty about the actions one takes as a therapist, positively predicted a significant portion of therapist variance in alliance ratings. They hypothesized that this may be due to the fact that self-doubt may be related to recognizing the complexity of treatment, as well as a willingness to reflect on one's actions as a psychotherapist (Nissen-Lie et al., 2010). Given that professional self-doubt contributes to positive effects on the therapeutic alliance, and the alliance is strongly implicated in the rupture/repair process, this therapist characteristic may promote effective responses to cultural ruptures. Further, Nissen-Lie et al. (2013) found that professional self-doubt was not only

positively associated with alliance scores, but also it was associated with improved interpersonal functioning for clients as a treatment outcome.

Within the trainee population, professional self-doubt is likely to have a unique manifestation. For example, there is evidence that trainees may lack a sense of self-efficacy in their counseling skills, especially early on in training (Moss et al., 2014). While this initial lack of confidence could become apparent in measures of professional self-doubt, it also seems possible that trainees may attempt to compensate for their perceived deficits by denying self-doubt. On the one hand, this precise variability- between trainees who acknowledge their self-doubt versus those who do not- may highlight trainees who may have more difficulty responding to cultural ruptures due to defensiveness and lack of humility about their own limitations. On the other hand, it is possible that their lack of experience in practice may prohibit them from fully assessing the extent of their professional self-doubt.

Therefore, professional self-doubt will also be considered by asking trainees to estimate their effectiveness in responding to the actual video vignettes in the present study. To better understand what distinguishes effective therapists from ineffective ones, Coyne et al. (2019) found that therapists who avoided overestimating their effectiveness and even tended to somewhat underestimate their effectiveness were found to achieve better outcomes in terms of patient improvement. This difference was especially notable when patient severity was high. This way of conceptualizing professional self-doubt may add helpful dimensions to understanding this construct among trainees.

As was explicated by Nissen-Lie et al. (2010), professional self-doubt may be an important characteristic that bolsters overall therapist effectiveness because this trait

promotes therapists' honest self-reflection about their lapses and limitations, sensitivity, and awareness about therapists' impact on their clients, and humility and openness. When extended to therapeutic issues that specifically relate to culture and cultural ruptures, many similar themes emerge related to which traits may promote effective responding to cultural ruptures. That is, cultural humility, responsiveness and willingness to reflect on one's own biases likely play a role in recognizing and responding to cultural ruptures (Mosher et al., 2017). Therefore, professional self-doubt may be a psychological characteristic that can be extended beyond general therapist effectiveness and into effectively responding to cultural ruptures.

Self-Compassion

In addition to professional self-doubt, self-compassion is another intrapsychic mechanism that may play a role in trainees' abilities to effectively integrate multicultural training and intervene with cultural ruptures. Self-compassion is a construct that is rooted in Buddhist philosophy and has been subsequently embraced in western psychology (Bennett- Goleman, 2001; Neff & Vonk, 2009). It is theorized that self-compassion primarily consists of three components: 1) the capacity to respond to oneself with warmth and kindness in the face of personal struggle or failure, 2) the tendency to see one's suffering as a feature of common humanity rather than viewing one's suffering as a solitary experience, and 3) the ability to experience negative thoughts and feelings about oneself, while avoiding become fused with them (Barnard & Curry, 2011; Neff 2003a; Neff & Vonk, 2009). There is empirical evidence that self-compassion is linked to other positive processes that relate to psychological flourishing. For example, Zessin et al. (2015) conducted a meta-analysis to examine the relationship between self-compassion

and well-being, and they calculated an overall weighted correlation of r=.47 for the relationship between self-compassion and various measures of well-being. Moreover, there is evidence that self-compassion is negatively associated with psychopathology, thus making it a protective factor against maladaptive psychological functioning; simultaneously, constructs that are considered antithetical to self-compassion (e.g. self-judgment) are positively associated with psychopathology, thus suggesting that a lack of self-compassion may also be considered a risk factor for mental illness (Muris & Petrocchi, 2017).

The distinction between self-compassion and the concept of self-esteem is important to clarify. Self-esteem, while potentially an important construct in its own right, is typically considered to be based on external markers of success and positive estimations of the self in comparison to others (Neff & Vonk, 2009). In contrast, self-compassion is considered to be an alternative construct wherein individuals are capable of acknowledging their limitations, mistakes and negative traits without obsessively denigrating their sense of self (Neff & Vonk, 2009). Therefore, self-compassion can also be conceptualized as a trait that enables individuals to adaptively cope with threats to the self. Leary et al. (2007) conducted several experiments to test the impact of self-compassion in scenarios that tend to elicit negative reactions from individuals. In one experiment, they provided participants with neutral feedback about themselves, and they were led to believe that this feedback was offered to them by peers. Their results indicated that those high in self-esteem but low in self-compassion still tended to interpret the neutral feedback more negatively; however, those higher in self-compassion tended to view the neutral feedback as less negative. Further, participants who scored low

in terms or self-esteem and self-compassion were found to have the strongest negatively-valenced affective reactions upon receiving neutral feedback; whereas those who scored low in terms of self-esteem but high in terms of self-compassion were found to have the lowest negative affect following receiving the feedback (Leary et al., 2007). In a subsequent experiment, the researchers induced self-compassion reactions and self-esteem reactions using writing prompts that asked participants to reflect on a negative event in their lives that was characterized by failure, rejection, or suffering. Their results suggested that in comparison to those who experienced the self-esteem induction, participants in the self-compassion induction group were simultaneously more likely to attribute the cause of the negative event to themselves, while also experiencing less negative affect. This suggests that self-compassion may be a trait that allows individuals to at once recognize their role in negative events, while also avoiding extreme affective dysregulation in response to that recognition (Leary et al., 2007).

Given this evidence, self-compassion could potentially contribute to White trainees' ability to take advantage of cultural opportunities when cultural ruptures occur, in way that is marked by cultural humility, cultural comfort and overall effectiveness. That is, there is evidence that one barrier that prevents progressive White individuals from acknowledging their racism and working to change it, is the fact that considering themselves to be racist constitutes a significant threat to their identity as progressive and egalitarian (DiAngelo, 2011; Dovidio et al., 2016). Therefore, intrapsycic mechanisms, like defenses, may be implicated to neutralize such threats by denying their racism. On the other end of the spectrum, progressive White individuals may acknowledge that they have benefited from White dominance and racism, but this may cause them to

overcompensate based on feelings of guilt (Byrd et al., 2015). While no known studies have explicitly examined the relationship between self-compassion and aversive racism in White individuals, self-compassion seems to offer a pathway through which White individuals could both acknowledge their role in perpetuating racism, without becoming overwhelmed by feelings of guilt and self-criticism.

It is hypothesized that White trainees with higher self-compassion will be rated as more effective when responding to cultural ruptures. Further, it is hypothesized that an interaction effect will exist between professional self-doubt and self-compassion. That is, while professional self-doubt is hypothesized to be positively associated with effective responding to cultural ruptures, it seems possible that excessive self-doubt without appropriate self-compassion could potentially render responses to cultural ruptures less effective. This notion is somewhat inspired by Nissen-Lie and colleagues (2017) finding that the relationship between professional self-doubt and therapy outcomes was moderated by self-affiliation, another construct characterized as a tendency towards warmth and kindness when responding to oneself and one's needs. They concluded, therefore, that professional self-doubt was a more helpful trait in therapists when therapists also tended to relate to themselves in a positive way. Similarly, the present study seeks to understand whether professional self-doubt that is moderated by self-compassion will be predictive of effective responding to cultural ruptures.

Wampold et al. (2017) suggested that professional self-doubt is a promising construct that could help explain what separates effective therapists from less effective ones in terms of their general competence, but there is a lack of current empirical studies examining professional self-doubt as a potentially important intrapsychic factor that

could impact therapists' effectiveness when addressing issues related to culture. Currently, there is no known literature that has examined the potential role of professional self-doubt and self-compassion in terms of their impact on racism and intervening with cultural ruptures in therapy. Provided that trainees are in the process of forming their professional identities and developing their professional skills, professional self-doubt and self-compassion constitute potentially important predictors that may aid trainees in more fully absorbing and integrating multicultural training, such that are able to identify when cultural ruptures have occurred and respond in ways that are characterized by cultural humility and cultural comfort.

The Present Study

This study examines the role that trainees' defense mechanisms (Valliant, 2011) professional-self doubt (Nissen-Lie et al., 2010) and self-compassion (Neff 2003a; Neff 2003b) play in impacting their ability to respond to cultural ruptures in therapy. Therapists-in-training who self-identified as White/Caucasian were recruited for participation. These participants were asked to respond to a variety of self-report measures aimed at assessing the aforementioned psychological traits. Participants were also asked to watch four video portrayals of cultural ruptures in therapy, and they recorded themselves responding to these vignettes. Participants' responses were coded and evaluated based on the level of cultural comfort, cultural humility, cultural opportunities and overall effectiveness in their responses. The following constitute the hypotheses of the study:

Hypothesis 1a: Trainees who endorse a greater number of adaptive defenses (e.g., humor, sublimation) will be rated as more culturally comfortable, more culturally humble, more

prone to engage with cultural opportunities, and higher in overall effectiveness when they respond to instances of cultural ruptures in comparison to trainees who report fewer adaptive defenses.

Hypothesis 1b: Trainees who endorse a greater number of maladaptive defenses (e.g. denial, displacement) will be rated as less culturally comfortable, less culturally humble, less prone to engage with cultural opportunities, and lower in overall effectiveness when they respond to instances of cultural ruptures in comparison to trainees who report fewer maladaptive defenses.

Hypothesis 2: Trainees who report more professional self-doubt will be rated as more culturally comfortable, more culturally humble, more prone to engage with cultural opportunities, and higher in overall effectiveness when they respond to instances of cultural ruptures in comparison to trainees who exhibit less professional self-doubt.

Hypothesis 3: Trainees who exhibit higher self-compassion will be rated as more culturally comfortable, more culturally humble, more prone to engage with cultural opportunities, and higher in overall effectiveness when they respond to instances of cultural ruptures in comparison to trainees who exhibit lower self-compassion.

Hypothesis 4: There will be a statistically significant interaction between professional self-doubt and self-compassion, wherein the previously hypothesized positive association between professional self-doubt, and cultural comfort, cultural humility, cultural opportunities, and overall effectiveness, will be statistically significantly more positive for those participants who demonstrate more self-compassion in comparison to those who demonstrate less self-compassion

Hypothesis 5a: There will be a positive association between adaptive defense style and trainees' level of underestimation of their effectiveness in responding to cultural ruptures.

Hypothesis 5b: There will be a positive association between maladaptive defense styles and trainees' level of overestimation of their effectiveness in responding to cultural ruptures.

CHAPTER TWO: METHODS

Participants

A total of 90 participants consented to the study and completed both the survey portion and the video portion. Upon reviewing the data, it was determined that two participants had videos that malfunctioned (i.e. no sound). These participants were contacted to re-complete their videos, but both declined to do so. Thus, 88 participants were included in the final analysis. In terms of the sample size, an a priori power analysis was conducted using GPower to determine the targeted sample size for the present study. For linear multiple regression with a medium effect size of .15 (Cohen, 1992), alpha level .05, three predictors and power set at .80, 77 participants are required; alternatively, the number of participants required when power is set at .90 is 99. Thus, the sample size fell within the targeted range.

Data collection began in January 2020 following the approval of the study by the IRB at the University of Denver. All participants were recruited within the United States. Recruitment information was circulated via email to several national Listservs, as well as to local institutions in Denver with psychology, social work, and counseling programs. The only inclusion criteria were that participants self-identified as White/Caucasian and that they were enrolled in a graduate-level program in the field of counseling, psychology, social work or another helping profession at the time of their participation. Participants were able to respond to both the surveys and videos from their laptops using

online platforms. Specifically, Theravue, a website aimed at allowing therapists to improve their skills by recording themselves responding to video vignettes portraying therapy scenarios, was used (Therapy Incorporated, 2020).

All 88 participants self-identified as White/Caucasian, as was required to participate in the study. Approximately 83% identified as women, 13.6% identified as men, 2.3 % identified as non-binary, and 1.1% identified as gender non-conforming. The majority of participants were enrolled in psychology programs, (26.1% clinical psychology and 33% counseling psychology), with 28.4% in counseling programs, 6.8% in social work programs, and 5.7% identifying their programs as "other." The majority of participants (75 %) reported having between 6 months and 2 years of clinical experience, with the average number of direct clinical hours falling close to 300 (M =287.58, SD= 408.78). Participants were asked how many academic courses pertaining to multiculturalism/diversity/privilege/oppression and counseling/therapy they had completed with the options being none, 1, 2, or more than 2. Of the 88 participants, 9.1% had completed no courses, 52.3% had completed 1 course, 20.5% had completed 2 courses, and 18.2% had completed more than 2 courses.

Video Vignettes

Drawing upon Safran and Muran's (1996; 2000; 2006) 2x2 framework for ruptures, four videos were created to reflect different types of ruptures. First, ruptures are considered to take place within the therapeutic alliance, and therefore can typically be conceptualized as tension or breakdown related to 1) therapeutic goals, 2) tasks and/or 3) the emotional bond (Eubanks, Muran, & Safran, 2018; Safran & Muran, 2000). This is based on Bordin's (1979) proposal that these three concepts taken together comprise the

therapeutic alliance. Due to the abbreviated length of the video vignettes, as well as the lack of goal setting that precedes these simulated cultural ruptures, the present study focused on ruptures related to either the emotional bond between therapist and client or agreement on the tasks of therapy. In terms of client responses to ruptures, there are two primary domains: those that are characterized by client withdrawal and those that are characterized by client confrontation (Eubanks, Muran, & Safran, 2018; Safran & Muran, 1996; 2000). Thus, taken together the 2x2 framework included: 1) a bond-related rupture with client withdrawal response, 2) a task-related rupture with a client confrontation response, 3) a task-related rupture with a client withdrawal response, and 4) a bond-related rupture with a client confrontation response. All participants watched the videos in a standardized order (i.e., Chris, Zavier, Harini, Vivian; see more information below).

These video vignettes of cultural ruptures in therapy were created utilizing actors in collaboration with experts in the field regarding cultural ruptures in therapy. The videos followed the 2x2 framework laid out above. The videos included clients from a variety of racial/ethnic backgrounds, but no White-identified clients were included in the videos to focus on cross-racial therapeutic dyads in this simulation. Each video vignette was shorter than one minute to facilitate the ease with which participants could respond in this format, and each video conveyed an example of an in-session cultural rupture. Theravue is an online program designed to help therapists and trainees hone their skills by responding to training videos that depict a variety of challenging scenarios occurring in therapeutic settings. Professors in the field of psychotherapy typically use Theravue to help students practice responses, and students are required to record themselves responding on a webcam (Therapy Incorporated, 2020). The Theravue system was used

in a similar manner in the present study. That is, participants were assigned the module of video vignettes, and they watched each video one by one. After watching a video vignette, they were prompted to record their response on their webcam immediately after the vignette portion of the video ended. This allowed for an ecologically valid way of assessing their skills given that they are asked to respond without being allotted time to plan or write down their response. While there were only four videos created for the study and used in analyses, one practice video was included at the beginning of the module. This video was pulled from Theravue's library of videos, and participants were told that it was only included to familiarize them with the recording process on Theravue. Each video, including the practice video, begins with an audio-only introduction of the client that includes their age, race, and gender identity, as well a brief overview of the therapeutic context. For example, Video 1 (Chris) begins with the following audio: "This is Chris. He is a 25-year-old Black man, and this is the end of your second session with him. You have just asked him how he thinks therapy is going so far."

In order to portray several distinct examples of cultural ruptures, as well as several different client presentations, four videos were created and utilized in the present study. The videos represented a broad spectrum in terms of the explicitness of the cultural rupture moments that are portrayed. In other words, some videos portrayed clients more obviously confronting their therapist about the therapists' lack of attunement to their experience, but others portrayed more ambiguous signs of cultural ruptures through the use of body language cues and vague comments that suggest a rupture. This variability was necessary given that cultural ruptures often constitute subtle misattunements, and

many clients may not feel comfortable addressing such instances directly. See details of each video below and a full script in Appendix E.

Video 1 (Chris)

This video aimed to demonstrate a bond-related rupture with a withdrawal response. This video showed Chris, a 25-year-old Black man, and the introduction indicated that the therapist had just asked his perspective on therapy so far. Chris proceeds to explain that therapy is "going pretty good," but he then tells the therapist he is wants to stop attending because therapy is "not really [his] thing." He explains that the therapist is "nice," but he does not feel he is the best client for the therapist. Chris' video is characterized by non-verbal behavior suggesting that he is uncomfortable, as well as superficial affirmation of the bond with the therapist, but quickly changing the subject by saying he would like to end therapy. This was considered to be related to the therapeutic bond given that he is indirectly sharing that there is lack of connection in the alliance. The withdrawal response is primarily conveyed through body-language and Chris' literal withdrawal from therapy.

Video 2 (Zavier)

The second video attempted to convey a task-related rupture with a confrontation response. In this video, Zavier, a 38-year-old Mexican American man has just been asked by the therapist if he completed the homework from the previous session. Zavier then explains that he has not completed the homework, and furthermore, he does not understand "the point" of the homework. Zavier says he is "trying to keep his head above water," and he is not sure how homework can help him with that. This is considered a task-related rupture in that it portrays Zavier's lack of agreement with the tasks the

therapist has proposed. The confrontation response is conveyed in that Zavier expresses anger and disappointment towards the therapist, stating that "This is like our fifth session right, and you got me doing exercises, for what?"

Video 3 (Harini)

This video displayed a task-related rupture with a withdrawal response. Harini is a 31-year-old Indian American woman, and she was just asked how she feels about the focus of therapy so far. Harini is observed with anxious affect and frequent hesitation. Her body language conveys discomfort, but she states that she trusts the therapist as the "expert" to set the agenda for the sessions. She then quickly changes the topic. This is considered to be task-related in that Harini indirectly communicates she has been dissatisfied with the focus of therapy, but she only indicates this by changing the topic, expressing anxiety and engaging in deferential behavior towards the therapist, all of which is representative of withdrawal.

Video 4 (Vivian)

The final video showed Vivian, a 45-year-old Black woman in her fifth therapy session. She provides the therapist with feedback that she feels the therapist acts as if they really care, but they do not really understand what it is like for her or her family. Vivian says directly, "I know your life is a lot different than mine," and "I don't know how someone like you thinks you can help me." In this video, Vivian is tearful, and she displays both sad and angry affect. This video is considered to be related to the therapeutic bond in that Vivian feels the therapist cannot genuinely empathize with her or understand her. The confrontation response is marked by Vivian stating directly that she feels misunderstood, as well as through Vivian's direct expression of sadness and anger.

Coders

Given that therapists' own reports about their ability to address cultural issues in therapy are prone to self-report bias (Drinane, Owen, Adelson, & Rodolfa, 2016), coders were utilized to rate participants' responses to video vignettes conveying cultural ruptures. A total of nine coders were recruited to assist in rating the videos. Coders were trained using the MCO-PT manual (Haywood Stewart, 2019). First, coders read through the manual and discussed the primary constructs as a group with the lead author. Next, prior to initiating data collection, practice videos were recorded by volunteers to help coders practice using the MCO-PT rating system. Initially, coders discussed their ratings of these practice videos with other coders in order to learn how to apply the coding system. Subsequently, coders were asked to rate different practice videos alone and only discuss their ratings at the end to improve their independent rating skills.

After this process, three coding teams with three coders each were established. Teams were used so that interrater reliability could be analyzed to ensure that coding was reliable. While coders were placed onto teams, the coders watched and rated videos independently. In the data analysis phase, the scores of each coder were compared within teams to assess for reliability. Coders were assigned in such a way to balance those with more experience using the MCO-PT system with less experienced coders. The primary researcher coded all videos and served as a fourth member to each coding team. Once data was collected, coding teams were assigned participants to watch in batches of three or four participants at a time. For the most part, participants were randomly assigned to coding teams. However, given that coders were recruited from the same institution as some of the participants, each participant was asked to indicate any coders they did not

want to watch their videos. They were informed that if the number of indicated coders exceeded six, they should not consent to the study because there would be insufficient options to assign their videos to an alternate coding team. Only six participants identified coders they did not want to watch their videos, and none of the participants identified more than five coders to which they did not consent. In those cases, it was ensured that participants were assigned to coding teams that did not include the coders they indicated.

All coding was done independently. Upon completion of the coding, coders sent spreadsheets of their codes to the primary researcher, who compiled the scores by team. Initially, intraclass correlation analyses were run to assess inter-rater reliability within each team. The original ICCs fell within the excellent agreement range when calculated for the MCO-PT scale as a whole as well as for the individual subscales. Despite the strong initial interrater reliability of the scores, re-coding was done on some videos in an attempt to come closer to consensus. In other words, while re-coding was not statistically necessary and it did not significantly alter the reliability of the scores, it was done to enhance the precision of the coding, seek consensus and illuminate nuances in the data. Videos in which the coders' scores diverged by three or greater (e.g. one coder rating a 1 and another coder rating a 4; one coder rating a 2 and another coder rating a 5) were re-coded. The re-coding process involved meeting as a coding team and re-watching the video together. Coders were asked to blind-rate the video again- that is, without looking at their original scores or the scores of their fellow coders. The new ratings were discussed, and consensus was sought. When coders were unable to reach full consensus, the coding team at least sought to reduce the margin of difference based on their discussion with other coders. In total, coding team 1 rated 28 participants, which amounts

to 112 videos with four videos for each participant. Of those 112 videos, 39 were recoded. Coding team 2 was assigned 31 participants. This totaled to 123 videos with each participant recording four videos, except one participant whose recording for video 1 was unable to be coded due to video distortion. Of these 123 videos, 42 were recoded. Coding team 3 was assigned 29 participants, which amounts to 116 videos. Of the 116 videos, 52 were recoded.

Measures

Defense Style Questionaire-40

The Defense Style Questionaire-40 (DSQ-40) was employed to capture trainees' level of defensiveness. The DSQ-40 is a 40-item measure of defense mechanisms that measures 20 distinctive defense styles by averaging respondents' scores on the pair of items that are employed to capture each defense (Andrews et al., 1993). The DSQ-40 includes a variety of statements, and it asks respondents to select the degree to which they agree with each statement utilizing a Likert scale ranging from strongly disagree (1) to strongly agree (9) (Andrews et al., 1993). It was originally published with 88 items, but it was subsequently paired down to shorten the measure to the DSQ-40, which is now considered the most widely used version of the DSQ (Prout et al., 2018). The theoretical basis of the DSQ-40 is rooted in Valliant's (2011) theory of defenses as intrapsychic mechanisms that help individuals reduce anxiety and cope with threats in the environment. Valliant (2011) describes defense structures as ranging from immature to neurotic (i.e., intermediate) to mature, and these categories correlate with the original three-factor structure of the DSQ-40 (Andrews et al., 1993).

The DSQ-40 has demonstrated concurrent validity in that, across several studies, more severe diagnoses were found to be empirically correlated with less mature defenses, while less severe symptoms have been associated with more mature defensive styles (Bond, 2004). Further, criterion validity has been supported based on evidence that changes in defense styles as a result of psychotherapy, as measured by the DSQ-40, have been found to be associated with changes in symptoms of depression and overall functioning as well (Bond & Perry, 2004; Schauenberg et al., 2007).

Although the DSQ-40 is a common measure of defenses, and has demonstrated acceptable psychometric properties, criticisms also exist regarding several factors of this scale (Bond, 2004; Prout et al., 2018). The primary criticism relates to the heterogeneity of the reliability coefficients that have been reported in various studies (Prout et al., 2018). Prout et al. (2015) utilized the DSQ-40 with a sample of 380 students and estimated the reliability as .91, which is considered to be excellent. Alternatively, Wilkinson and Ritchie (2015) conducted an analysis of the DSQ-40 by using the responses of 780 adults, and they estimated that the Cronbach's alphas were: .59 for the Mature defenses, .53 for the Neurotic defenses, and .79 for the Immature defenses. They suggested that the parceling procedure that is utilized in the DSQ-40 poses challenges given that each pair of items may not accurately assesses only one latent factor (Wilkinson & Ritchie, 2015).

Prout et al. (2018) conducted an exploratory principal factor analysis to assess the factor structure in their recent study of the role that defense mechanisms play in religious coping. The results of their factor analysis suggested that a two-factor structure offers a superior solution compared to the original three-factor solution that was proposed (Prout

et al., 2018). The two factors that emerged were referred to as maladaptive defensive functioning, which was estimated to have a Cronbach's alpha of .89, and adaptive defensive functioning, which was estimated to have a Cronbach's alpha of .79 (Prout et al., 2018). Therefore, based on the internal consistency and overall better fit of the two-factor solution, this framework was utilized in the current study. The adaptive subscale originally had 16 items; however, in the present study, one item was found to have a negative item-to-total correlation and was therefore excluded. The item that was negatively correlated with the total said, "I get satisfaction from helping others, and if this were taken away from me, I would get depressed." The Cronbach's alpha for the remaining 15 items was .67. One example item from the adaptive subscale was: "When I have to face a difficult situation, I try to imagine what it will be like and plan ways to cope with it." The maladaptive subscale originally had 24 items, but again, two were found to have negative item-to-total correlations. These two items said, "If someone mugged me and stole my money, I'd rather they be helped than punished," and "I pride myself on my ability to cut people down to size." After excluding those two items, the Cronbach's alpha was .78. An example from the maladaptive scale was: "If I have an aggressive thought, I feel the need to compensate for it."

Development of Psychotherapists Common Core Questionnaire

The Development of Psychotherapists Common Core Questionnaire (DPCCQ) was first created as part of an international study aimed at understanding empirical correlates linked with therapist development for therapists from a variety of backgrounds, training experiences, settings, theoretical orientations, and countries (Orlinsky et al., 1999). The entire measure contains 370 total items and includes a variety of subscales

meant to capture the broad construct of development in psychotherapists. It was originally tested with 3,800 therapists from several countries and found to have strong internal consistency and construct validity (Orlinksy et al., 1999). Based on the measurement methodology used by Nissen-Lie et al. (2010; 2013; 2017) and the purposes of this study, only the professional self-doubt subscale was used.

One of the subscales on the DPCCQ is the Work Involvement Styles, which includes measures related to therapists' difficulties in practice. Orlinsky and Rønnestad (2005) found a three-factor structure underlying Difficulties in Practice based on responses of 4,923 therapists, including: Professional Self-Doubt, Negative Personal Reaction and Frustrating Treatment Case; however, the factor analysis conducted by Nissen-Lie et al. (2010) found that a two-factor structure emerged including the factors Professional Self-Doubt (PSD) and Negative Personal Reaction (NPR) based on the responses of 68 therapists. The internal consistency estimate for the PSD factor was $\alpha = .90$ (Nissen-Lie et al., 2010; 2017). The factor loadings onto the PSD sub-scale ranged from .49 to .94, with the majority falling above .68 (Nissen-Lie et al., 2010). For the purposes of this study, only the items measuring PSD, rather than NPR, were included based on the hypothesis that higher PSD was a psychological factor associated with more effective responding to cultural ruptures. The PSD items were administered to each trainee following the completion of their video vignettes.

The nine PSD items were originally created to assess difficulties in practice and based on the qualitative research conducted by Davis et al. (1987). The PSD subscale is on a Likert scale with answers ranging from 0 (never) to 5 (very often), and the questions assess a variety of facets of PSD including: therapists' lack of confidence that they have a

beneficial impact on the client, therapists' lack of certainty about how to effectively intervene with clients, therapist distress and feelings of powerlessness about their inability to change clients' tragic life circumstances, and therapist demoralization about their perceived inability to find ways to help the clients, among others (Nissen-Lie et al., 2010). One example item is, "Currently, how often do you feel lacking in confidence that you might have a beneficial effect on a client?" In the present study, the Cronbach's alpha for the PSD scale was .85.

Self-Reflection Items

In addition to capturing the PSD construct using the PSD scale, participants were also asked to reflect on their responses to the vignettes following the completion of each video. First, trainees were asked: "To what extent do you feel you understood your client's issue in this vignette?" This was rated on a six-point scale ranging from 1 (I felt totally confused about my client's issue) to 6 (I am certain that I had a solid understanding of my client's issue). Second, they were asked: "To what extent do you feel that your response would have been helpful to the client in this vignette?" Their responses ranged from 1 (I am doubtful that my response would have been very helpful to this client) to 6 (I am confident that my response was ideal given the client's concern). These will be referred to as the *understanding* self-reflection item and the *effectiveness* self-reflection item throughout the study. The understanding items were averaged across videos, as were the effectiveness items. When comparing the understanding item to the effectiveness item, these scores were found to be correlated (r= 0.654).

These items were used in addition to the PSD scale for several reasons. First, given that trainees are the subjects in this study, some may have limited experience

working with clients in the field. Thus, there was potential for them to have difficulty responding about how they typically feel about their clients, as is required of them on the PSD scale. Therefore, asking them to reflect on their immediate performance gave them a more concrete reference point from which to rate their confidence, as well as their feelings of uncertainty about their helpfulness to clients. Additionally, this method of assessment was drawn from Coyne et al.'s (2019) study in which therapists were asked to estimate their performance. Their results suggested that therapists' overestimation of their effectiveness was associated with worse outcomes, while underestimation was associated with better outcomes. Thus, these items were created in an effort to assess therapists' perceived effectiveness in their responses. In this study, overestimation and underestimation were calculated by comparing trainees' responses on these two self-reflection items to the coders' ratings of the trainees on MCO variables and identifying discrepancies. That is, trainees who rated themselves highly on these two items, but received low ratings from coders were considered to be over-estimators. Similarly, trainees that rated themselves poorly on these two items, but received high ratings from coders were considered under-estimators. It was hypothesized that defense styles would predict over-estimation/under-estimation by trainees.

Self-Compassion Scale- Short Form

The Self-Compassion Scale- Short Form (SCS-SF) was utilized to measure participants' level of self-compassion. The original SCS is comprised of 26 items related to the frequency with which individuals respond to themselves with compassion. Respondents are asked to rate these items on a scale from (1) Almost never to (5) Almost always (Neff, 2003b). This scale sought to capture six facets of self-compassion,

including: Self-kindness, Self-judgment, Common Humanity, Isolation, Mindfulness and Over-identification and was demonstrated to have sound reliability and validity (Neff, 2003b). Raes et al. (2011) piloted the short-form of the SCS, including only 12 items. They eliminated several items from the original, but they maintained the aforementioned six facets, with only two items measuring each facet. Their results provided evidence that a strong correlation exists between the SCS and the SCS-SF ($r \geq .97$; Raes et al., 2011). The overall Cronbach's alpha of the SCS-SF was estimated to be .86 (Raes et al., 2011). Additionally, the results suggested that a model with six two-item factors and one higher-order factor was an adequate fit for the SCS-SF (Raes et al., 2011).

In terms of validity, Hayes, Lockard et al. (2016) found that the overall SCS-SF was significantly negatively associated with all subscales on the Counseling Center Assessment of Psychological Symptoms, including: Depression, Social Anxiety, General Anxiety, Hostility, Academic Distress, Eating Concerns, Family Concerns, and Substance Use. Additionally, a statistically significant negative relationship was found between the overall SCS-SF and the components of perfectionism that are considered to be maladaptive and associated with psychopathology (Hayes, Lockard et al., 2016). While this provides evidence of its utility in a clinical setting, among non-clinical college students, statistically significant positive associations were found between the SCS-SF and measures of individuals' ability to non-judgmentally accept their experiences, overall feelings of satisfaction with life, social connectedness, sense of self-efficacy and optimism. In contrast, statistically significant negative associations were found between the SCS-SF and measures of negative affect, rumination and worry (Smeets et al., 2014). One example item from the SCS-SF states, "I try to be patient and understanding towards

those aspects of my personality that I don't like." In this study, the Cronbach's alpha was estimated to be .81.

Multicultural Orientation-Performance Task (MCO-PT)

The MCO variables, which include cultural comfort (CC), cultural humility (CH), and cultural opportunities (OPP), were the primary outcome variables assessed in the present study. Additionally, the overall effectiveness (OE) of trainees' responses was included as an outcome variable. While individual measures exist to assess the three facets of MCO, they are primarily self-report measures (Hook et al., 2013; Owen et al., 2016; Slone & Owen, 2015), thus they are not appropriate in the present study given that coders needed an external rating system to evaluate performance-based tasks. Fortunately, Haywood Stewart (2019) created the MCO-PT, which is an external rating system that was developed specifically to evaluate performance-based tasks. According to Haywood Stewart (2019), the structure of the MCO-PT was inspired by the Session Evaluation Questionnaire (SEQ) in that it asks coders to select a number that falls on a bipolar continuum with opposing adjectives on each end of the continuum (Stiles et al., 2002). For example, the SEQ asks respondents to rate a session on a continuum from Shallow (1) to Deep (7) in order to capture one facet of the depth of the session (Stiles et al., 2002). In fact, one item in the MCO-PT is drawn directly from the SEQ; that is, the item that asks respondents to rate the session from Bad (1) to Good (7) (Haywood Stewart, 2019; Stiles et al., 2002). This exact item was utilized to assess the overall effectiveness of trainees' responses to the vignettes. Similarly, three items were used assess the level of cultural comfort in each participant's response. These include ratings on the following scales: (1) Uncomfortable to (6) Comfortable, (1) Nervous to (6) Calm,

and (1) Tense to (6) Relaxed (Haywood Stewart, 2019). Three items were included to measure respondents' levels of cultural humility; these include ratings from (1) Disrespectful to (6) Respectful, (1) Close-minded to (6) Open-minded, and (1) Superior to (6) Non-superior (Haywood Stewart, 2019). Lastly, cultural opportunities is assessed with one item that is rated from (1) No cultural discussion to (6) Definitive cultural discussion (Haywood Stewart, 2019). Taken together, these 8 items serve to assess cultural comfort, cultural humility, cultural opportunities and general effectiveness.

The MCO-PT was tested by asking psychotherapists-in-training to respond to a series of video vignettes that portrayed challenging scenarios with relevant cultural factors that may arise in counseling. Coders were then employed to rate participants' responses to these videos using the MCO-PT (Haywood Stewart, 2019). Results estimated the Cronbach's alphas as: .94 for Cultural Comfort, .97 for Cultural Humility and .77 for Cultural Opportunities (Haywood Stewart, 2019). Significant positive relationships were found between the MCO-PT and participants' self-reported multicultural knowledge, skills and awareness, and significant negative correlations were found between the MCO-PT and participants' color-blind racial attitudes (Haywood Stewart, 2019). Given both the sound psychometric properties and the purposes for which this scale was designed and used, the MCO-PT was considered an appropriate measure to capture all three facets of MCO, as well as overall effectiveness, as rated by coders. See more information about the inter-rater reliability of the MCO-PT in the results section.

Procedures

In summary, participants were asked a series of demographic questions regarding their age, degree track, number of direct intervention hours and past experience with

multicultural training. Next, participants completed the DSQ-40. Trainees were then automatically routed to Theravue to complete the video vignette portion of the study. They all watched the videos in the same order, starting with the practice video, and followed by Video 1 (Chris), Video 2 (Zavier), Video 3 (Harini) and Video 4 (Vivian). Immediately after recording their response to each vignette, participants responded to the understanding and effectiveness self-reflection items. The participants were then asked to complete the PSD, followed by the SCS-SF. As data were being collected, coders started evaluating the video responses. Next, data was cleaned, and data analysis began, examining the following hypotheses:

Hypothesis 1a: Trainees who endorse a greater number of adaptive defenses (e.g., humor, sublimation) will be rated as more culturally comfortable, more culturally humble, more prone to engage with cultural opportunities, and higher in overall effectiveness when they respond to instances of cultural ruptures in comparison to trainees who report fewer adaptive defenses.

Hypothesis 1b: Trainees who endorse a greater number of maladaptive defenses (e.g. denial, displacement) will be rated as less culturally comfortable, less culturally humble, less prone to engage with cultural opportunities, and lower in overall effectiveness when they respond to instances of cultural ruptures in comparison to trainees who report fewer maladaptive defenses.

Hypothesis 2: Trainees who report more professional self-doubt will be rated as more culturally comfortable, more culturally humble, more prone to engage with cultural opportunities, and higher in overall effectiveness when they respond to instances of cultural ruptures in comparison to trainees who exhibit less professional self-doubt.

Hypothesis 3: Trainees who exhibit higher self-compassion will be rated as more culturally comfortable, more culturally humble, more prone to engage with cultural opportunities, and higher in overall effectiveness when they respond to instances of cultural ruptures in comparison to trainees who exhibit lower self-compassion.

Hypothesis 4: There will be a statistically significant interaction between professional self-doubt and self-compassion, wherein the previously hypothesized positive association between professional self-doubt, and cultural comfort, cultural humility, cultural opportunities, and overall effectiveness, will be statistically significantly more positive for those participants who demonstrate more self-compassion in comparison to those who demonstrate less self-compassion.

Hypothesis 5a: There will be a positive association between adaptive defense styles and trainees' level of underestimation of the effectiveness of their responses.

Hypothesis 5b: There will be a positive association between maladaptive defense styles and trainees' level of overestimation of the effectiveness of their responses.

CHAPTER THREE: RESULTS

Interrater reliability

Intraclass Correlation Coefficients (ICCs), frequently utilized with interval/ratio data (Hallgren, 2012), were calculated to estimate the reliability of the coders using the MCO-PT. Higher ICC estimates indicate a greater magnitude of agreement among coders, thus constituting a measure of the reliability and accuracy of coders (Hallgren, 2012). Cichetti (1994) put forth the following descriptive categories for ICCs: ICCs below .40 suggest poor interrater agreement, estimates between .40 and .59 are considered fair, values between .60 and .74 are good, and ICCs above .75 are considered excellent agreement. ICCs were calculated using an average measures of two-way random effects model. This is based on several factors. First, two-way models do not assume that new coders are being used for each subject, thus it can account for the patterned contributions of each coder (Hallgren, 2012). Second, the average measures equation was used because each individual subject is rated by multiple coders. This presumes that the average of these distinctive coders constitutes the true score for the subject, and therefore the average of the coders was used in hypothesis testing (Hallgren, 2012). Lastly, the coders in this study are considered random effects, rather than fixed effects, given that they are assumed to be generalizable (Hallgren, 2012).

ICCs were calculated before and after re-coding was done to address discrepant codes (see Table 1). ICCs were calculated for each variable on the MCO-PT, including

cultural comfort (CC), cultural humility (CH), cultural opportunities (OPP) and overall effectiveness (OE). Both cultural comfort and cultural humility ICCs were calculated by comparing the scores of the coders on three comfort items and three humility items and assessing for interrater agreement. The ICC for cultural opportunities was calculated by comparing coders' scores on one item. Similarly, the overall effectiveness ICC was calculated by comparing coders' scores on one item assessing the video overall. Lastly, ICCs were also calculated by comparing coders' ratings for all eight items at once.

When estimating ICCs for all eight items across the subscales, the estimations for all three coding teams already fell in the excellent range (i.e., .84-.86). After refining the codes, all teams continued to fall within the excellent agreement range (around .93). For the subscales, originally CC ratings fell in the excellent category (i.e., .75-.86), and recoding improved them further (i.e., .88-.91). Originally, CH ratings were between .86 and .89, which is considered excellent. After recoding, CH ratings ranged from .94 to .95 (i.e. still the excellent range). For OPP, the original codes ranged from .88 to .92, that is the excellent category. The recoded ratings were between .94 and .95 (i.e., excellent agreement). Lastly, original OE ratings fell between .67 and .70, which constitutes the good range. Following recoding, the ICCs for OE ratings ranged from .84 to .88, that is, the excellent range. In summary, prior to recoding nearly all ICC estimations fell in the excellent range. Recoding was used to improve the precision of the codes, but it did not substantially alter the reliability of the ratings.

Table 1

Intraclass Correlations by Coding Team- Original and Recoded

		CC	CH	OPP	OE	Total
Team 1						
	Original	.85	.86	.89	.67	.84
	Recoded	.90	.95	.94	.88	.93
Team 2						
	Original	.86	.87	.92	.70	.86
	Recoded	.91	.94	.95	.84	.93
Team 3						
	Original	.75	.89	.88	.69	.85
	Recoded	.88	.95	.94	.85	.93

Note. CC= Cultural Comfort; CH= Cultural Humility; OPP= Cultural Opportunities; OE= Overall Effectiveness.

Preliminary Analyses

Descriptive statistics were calculated for the primary predictor and outcome variables to assess for missing data, outliers, and abnormalities. There were several items on the DSQ-40 for which missing data was common. Missing data analyses were conducted (Little's MCAR test), and all missing data was found to be missing at random. Regression assumptions- including assumptions of normality, autocorrelation, linearity, and homoscedasticity- were tested for all regression models using visual examination of P-P plots, histograms, plots of residuals and Variance Inflation Factor (VIF) estimates. No assumptions were found to be violated. See Table 2 and 3 for full summary of descriptive statistics for key study variables. Table 3 show means and standard deviations for outcome variables- CC, CH, OPP and OE- across videos. See the discussion section for an in-depth analysis of differences between video means. Bivariate correlations were also calculated among key study variables (see Table 4).

Table 2

Descriptive Statistics for Key Variables

Variables	*Range of Potential Scores*	*M*	*SD*
DSQ-A	1-9	5.19	0.85
DSQ-M	1-9	3.17	0.79
PSD	0-5	2.17	0.77
SCS	1-5	3.22	0.58
MCO-PT			
CC	1-6	4.09	0.51
CH	1-6	3.79	0.68
OPP	1-6	2.90	0.84
OE	1-6	3.33	0.74

Note. DSQ-A=Defense Style Questionnaire-Adaptive scale; DSQ-M= Defense Style Questionnaire- Maladaptive scale; PSD= Professional Self-Doubt; SCS= Self-Compassion Scale; MCO-PT= Multicultural Orientation-Performance Task; CC= Cultural Comfort; CH= Cultural Humility; OPP= Cultural Opportunities; OE= Overall Effectiveness.

Table 3

Descriptive Statistics for MCO Variables by Video

Videos	CC		CH		OPP		OE	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Chris	4.02	0.64	3.89	0.86	3.25	1.54	3.47	0.99
Zavier	4.09	0.64	3.73	0.95	2.51	0.99	3.25	0.97
Harini	4.19	0.59	3.96	0.82	2.46	1.08	3.51	0.91
Vivian	4.05	0.63	3.57	0.84	3.38	1.49	3.07	0.86

Note. DSQ-A=Defense Style Questionnaire-Adaptive scale; DSQ-M= Defense Style Questionnaire- Maladaptive scale; PSD= Professional Self-Doubt; SCS= Self-Compassion Scale; MCO-PT= Multicultural Orientation- Performance Task; CC= Cultural Comfort; CH= Cultural Humility; OPP= Cultural Opportunities; OE= Overall Effectiveness.

Table 4

Bivariate Correlations Among Key Study Variables

	1	2	3	4	5	6	7
1. DSQ-A	-						
2. DSQ-M	.32**	-					
3. PSD	-.07	.06	-				
4. SCS	.23*	-.23*	-.32**	-			
5. CC	.02	.06	.01	.04	-		
6. CH	.02	.01	-.14	.12	.42**	-	
7. OPP	.02	.10	-.04	-.03	.06	.47**	-
8. OE	.07	.05	-.07	.05	.50**	.96**	.52**

Note. ** $p < .01$, *$p < .05$. DSQ-A=Defense Style Questionnaire-Adaptive scale; DSQ-M= Defense Style Questionnaire- Maladaptive scale; PSD= Professional Self-Doubt; SCS= Self-Compassion Scale; MCO-PT= Multicultural Orientation- Performance Task; CC= Cultural Comfort; CH= Cultural Humility; OPP= Cultural Opportunities; OE= Overall Effectiveness.

Hypothesis 1a

It was predicted that participants who scored higher on the measure of adaptive defenses would have higher ratings on all MCO-PT variables- cultural comfort, cultural humility, cultural opportunities and overall effectiveness, as rated by coders. To test this hypothesis, linear regression analysis was used with the DSQ-A as the predictor and CC, CH, OPP and OE as outcome variables. The results failed to reject the null hypothesis, suggesting that there were no significant associations between MCO variables and adaptive defenses (see Table 5). No statistically significant associations were found between adaptive defenses and cultural comfort ($\beta = 0.02$, $t = 0.18$, $p = .86$), cultural humility ($\beta = 0.02$, $t = 0.22$, $p = .83$), cultural opportunities ($\beta = 0.02$, $t = 0.14$, $p = .89$), or overall effectiveness ($\beta = 0.07$, $t = 0.64$, $p = .52$).

Hypothesis 1b

Similarly, it was predicted that participants who scored higher on the measure of maladaptive defenses would have lower ratings on all MCO-PT measures-cultural comfort, cultural humility, cultural opportunities and overall effectiveness, as rated by

coders. Linear regression analyses were run with the DSQ-M as the predictor and CC, CH, OPP and OE as outcome variables. The results failed to reject the null hypothesis, suggesting that there were no significant associations between MCO variables and maladaptive defenses (see Table 5). No statistically significant associations were found between maladaptive defenses and cultural comfort ($\beta = 0.06$, $t = 0.56$, $p = .58$), cultural humility ($\beta = 0.01$, $t = 0.11$, $p = .91$), cultural opportunities ($\beta = 0.10$, $t = 0.91$, $p = 0.37$), or overall effectiveness ($\beta = 0.05$, $t = 0.50$, $p = .62$).

Hypothesis 2

It was expected that participants who reported higher levels of professional self-doubt would have higher ratings on all MCO-PT variables- cultural comfort, cultural humility, cultural opportunities and overall effectiveness, as rated by coders. To test this prediction, linear regression was used with the PSD as the independent variable and CC, CH, OPP and OE as the dependent variables. The results failed to reject the null hypothesis, indicating that there were no significant associations between MCO variables and professional self-doubt (see Table 5). No statistically significant associations were found between professional self-doubt and cultural comfort ($\beta = 0.01$, $t = 0.05$, $p = .96$), cultural humility ($\beta = -0.14$, $t = -1.34$, $p = .19$), cultural opportunities ($\beta = -0.04$, $t = -0.38$, $p = .71$), or overall effectiveness ($\beta = -0.07$, $t = -0.69$, $p = .49$).

Hypothesis 3

It was predicted that trainees who self-reported higher self-compassion would be rated higher on all MCO variables. This was tested using linear regression with scores on the SCS-SF as the independent variable and CC, CH, OPP and OE as the dependent variables. On the aggregate level- that is, when the analysis was not differentiated by

videos- this analysis revealed no significant findings. No statistically significant associations were found between self-compassion and cultural comfort ($\beta = 0.04$, $t = 0.34$, $p = .73$), cultural humility ($\beta = 0.12$, $t = 1.14$, $p = .26$), cultural opportunities ($\beta = -0.03$, $t = -0.31$, $p = .76$), or overall effectiveness ($\beta = 0.05$, $t = 0.50$, $p = .62$). However, upon testing this hypothesis for each video individually, a significant, positive association was found between self-compassion and participants' levels of cultural humility (rated by coders) for video 4 (Vivian) ($\beta = 0.26$, $t = 2.54$, $p = .01$). A statistically significant positive association was also found between self-compassion and participants' levels of overall effectiveness (rated by coders) in their responses to video 4 (Vivian) ($\beta = 0.25$, $t = 2.42$, $p = .02$; see Table 5). This suggests that participants with higher levels of self-reported self-compassion tended to also be rated more highly in terms of cultural humility and overall effectiveness when responding to this particular video.

Hypothesis 4

This hypothesis predicted a statistically significant interaction between professional self-doubt and self-compassion, wherein the previously hypothesized positive association between professional self-doubt, and cultural humility, cultural comfort, cultural opportunities, and general effectiveness, would be statistically significantly more positive for those participants who demonstrated higher self-compassion. In order to test this hypothesis, both PSD and SCS scales were re-centered. Next, an interaction term was calculated by multiplying re-centered PSD by re-centered SCS. Linear regression analyses were run with the interaction term as the independent variable and CC, CH, OPP and OE as the dependent variables. The results failed to reject the null hypothesis, indicating that there were no significant differences in terms of

MCO-PT scores based on the interaction of professional self-doubt and self-compassion for cultural comfort (β = 0.03, t = 0.30, p = .76), cultural humility (β = -0.07, t = -0.64, p = .53), cultural opportunities (β = -0.11, t = -1.06, p = .29), or overall effectiveness (β = -0.02, t = -0.15, p = .89; see Table 5). No significant changes in r-squared occurred when adding the interaction term to the model.

Table 5

Regression Models Predicting Key Dependent Variables

	CC		CH		OPP		OE	
	β	*SE*	*β*	*SE*	*β*	*SE*	*β*	*SE*
DSQ-A	0.02	0.06	0.02	0.09	0.02	0.11	0.07	0.09
DSQ-M	0.06	0.07	0.01	0.09	0.10	0.12	0.05	0.10
PSD	0.01	0.07	-0.14	0.09	-0.04	0.12	-0.07	0.10
SCS	0.04	0.09	0.12	0.13	-0.03	0.16	0.05	0.14
Video 4	0.04	0.12	0.26*	0.15	-0.07	0.28	0.25*	0.15
PSD x SCS	0.03	0.11	-0.07	0.15	-0.11	0.19	-0.02	0.16

Note. ** p < .01, *p < .05. DSQ-A=Defense Style Questionnaire-Adaptive scale; DSQ-M= Defense Style Questionnaire- Maladaptive scale; PSD= Professional Self-Doubt; SCS= Self-Compassion Scale; MCO-PT= Multicultural Orientation- Performance Task; CC= Cultural Comfort; CH= Cultural Humility; OPP= Cultural Opportunities; OE= Overall Effectiveness

Table 6

R-Squared Values for Primary Analyses

	CC	CH	OPP	OE
DSQ-A	<.001	.001	<.001	.005
DSQ-M	.004	<.001	.010	.003
PSD	<.001	.020	.002	.006
SCS	.001	.015	.001	.003
Video 4	.001	.070	.001	.064
PSD x SCS	.001	.005	.013	<.001

Note. DSQ-A=Defense Style Questionnaire-Adaptive scale; DSQ-M= Defense Style Questionnaire- Maladaptive scale; PSD= Professional Self-Doubt; SCS= Self-Compassion Scale; MCO-PT= Multicultural Orientation- Performance Task; CC= Cultural Comfort; CH= Cultural Humility; OPP= Cultural Opportunities; OE= Overall Effectiveness

Hypothesis 5a & 5b

Hypothesis 5a predicted that there would be a positive association between adaptive defense styles and trainees' level of underestimation of the effectiveness of their responses to the videos. Conversely, hypothesis 5b predicted a positive association

between maladaptive defense style and trainees' level of overestimation of the effectiveness of their responses. First, correlational analysis revealed that the two self-reflection items were significantly correlated (r= 0.654); however, they were not as strongly correlated as was expected. Thus, rather than averaging the two items for an overall self-reflection score, the items were analyzed separately. Next, a Paired Samples T-Test was conducted to assess for significant differences between self-ratings and coder-ratings. This revealed statistically significant differences between scores on the understanding self-reflection item and three of the four subscales of the MCO-PT- CH, OPP and OE. When comparing the effectiveness self-reflection item, statistically significant differences were found with a different set of three of the four subscales of the MCO-PT- CC, OPP and OE (See Table 7 and 8)

Table 7

Descriptive Statistics for Self-Reflection Items and MCO Variables

Variables	*M*	*SD*
Self-Reflection- Understanding (All Videos)	4.07	0.85
Video 1 (Chris)	3.84	1.11
Video 2 (Zavier)	4.28	1.00
Video 3 (Harini)	3.81	1.26
Video 4 (Vivian)	4.37	1.02
Self-Reflection- Effectiveness (All Videos)	3.62	0.89
Video 1 (Chris)	3.73	0.97
Video 2 (Zavier)	3.68	1.00
Video 3 (Harini)	3.94	1.30
Video 4 (Vivian)	3.13	1.29
Cultural Comfort (All Videos)	4.09	0.51
Cultural Humility (All Videos)	3.79	0.68
Cultural Opportunities (All Videos)	2.90	0.84
Overall Effectiveness (All Videos)	3.33	0.74

Table 8

Paired Samples T-Test Comparing Self-Reflection Items and MCO-PT scores

	Understanding			Effectiveness		
	t	SD	*D*	*t*	SD	*D*
CC	0.16	0.11	1.04	4.22**	0.11	1.05
CH	-2.33*	0.12	1.15	1.37	0.12	1.15
OPP	-8.58**	0.14	1.28	-5.48**	0.13	1.23
OE	-5.86**	0.13	1.20	-2.31*	0.13	1.20

Note.** $p < .01$, *$p < .05$. DSQ-A=Defense Style Questionnaire-Adaptive scale; DSQ-M= Defense Style Questionnaire- Maladaptive scale; PSD= Professional Self-Doubt; SCS= Self-Compassion Scale; MCO-PT= Multicultural Orientation- Performance Task; CC= Cultural Comfort; CH= Cultural Humility; OPP= Cultural Opportunities; OE= Overall Effectiveness.

Given that significant differences were identified, difference scores were calculated by subtracting coders ratings on CC, CH, OPP and OE from self-ratings on both self-reflection items. Thus, positive difference scores indicated an overestimation of effectiveness, while negative difference scores signified an underestimation of effectiveness, with scores close to zero suggesting congruence between self and coder ratings. Linear regression analyses were run with difference scores as the outcome variable and DSQ-A as the predictor. No significant associations were found between adaptive defenses and difference scores for understanding ($\beta = 0.06$, $t = -0.57$, $p = .57$) or effectiveness items ($\beta = -0.03$, $t = -0.31$, $p = 0.76$). The same analysis was done, but with difference scores as the outcome and DSQ-M as the predictor. No significant associations were found between maladaptive defenses and difference scores for understanding ($\beta = -0.17$, $t = -1.55$, $p = 0.12$) or effectiveness items ($\beta = -0.08$, $t = -0.70$, $p = 0.49$). While no significant associations were found at the aggregate level, when the same analyses were conducted at the video level, significant findings emerged for Video 2 (Zavier) wherein maladaptive defenses significantly predicted difference scores on the understanding item ($r = -0.45$, $b = -0.30$, $p = .005$), but not in the expected direction (See Table 9). That is,

participants who scored higher in terms of maladaptive defense style tended to underestimate their level of understanding on Video 2.

Table 9

Regression Models Predicting Over and Underestimation From Defense Style

	Understanding Difference Score		Effectiveness Difference Score		Understanding Video 2	
	β	*SE*	*β*	*SE*	*β*	*SE*
DSQ-A	0.06	0.10	-0.03	0.14	-0.09	0.15
DSQ-M	-0.17	0.10	-0.08	0.15	-0.30**	0.16

Note.** $p < .01$, *$p < .05$. DSQ-A=Defense Style Questionnaire-Adaptive scale; DSQ-M= Defense Style Questionnaire- Maladaptive scale

CHAPTER FOUR: DISCUSSION

The purpose of this study was to identify psychological traits and processes that impact White counseling trainees' effectiveness when responding to cultural ruptures in psychotherapy. That is, the study examined the extent to which trainees' defense style, professional self-doubt and self-compassion were associated with their ability to effectively resolve cultural ruptures; effectiveness was characterized as trainees exhibiting cultural comfort and cultural humility, as well as taking advantage of cultural opportunities. One notable aspect of this study was the use of a performance task to measure the participants' effectiveness in responding to cultural ruptures, which was rated by external coders. The video vignettes portraying cultural ruptures were carefully created based on the 2x2 framework put forth by Safran and Muran (1996; 2000; 2006) wherein ruptures are related to either therapeutic tasks or the therapeutic bond. The mock clients' responses were characterized by confrontation or withdrawal. Means and standard deviations for CC, CH, OPP and OE were compared across videos, and several notable differences emerged (see Table 3). To further investigate these differences, paired Samples T-Tests were conducted to test for statistically significant differences on participants' MCO scores between videos. The videos were compared pairwise for scores on cultural comfort, cultural humility, cultural opportunities and overall effectiveness (see Tables 10.1-10.4).

First, for all videos, participants, on average, scored highest on cultural comfort and lowest on cultural opportunities. Next, statistically significant differences between videos emerged especially for cultural humility, cultural opportunities and overall effectiveness. For cultural humility, participants were found to score higher on the Chris video in comparison to the Vivian video, as well as the Harini video in comparison to the Vivian video. Participants also tended to score higher on the Harini video in comparison to the Zavier video for cultural humility. No significant differences were found between the Zavier video and the Vivian video in terms of trainees' scores on cultural humility. When examining cultural opportunities, scores on the Chris video and the Vivian video were found to be statistically significantly higher in comparison to both the Harini and the Zavier videos. For overall effectiveness, participants' scores on Chris' video and Harini's video tended to be higher than both Zavier's and Vivian's videos. In terms of cultural comfort, Harini's video stood out with participants tending to score higher when responding to her video in comparison to the scores on Chris' and Vivian's videos.

In terms of interpreting the differences between the videos, several factors are involved. One important contextual factor to note is that recruitment for this study took place during the Covid-19 pandemic, as well as the widespread protests against racism and police brutality in the United States. This is important to note for several reasons. First, it seems possible that this may have influenced participation in the study. For example, it is feasible that many White therapists-in-training were motivated to participate in research related to race due to the salience of these cultural events. This broader contextual factor could also help explain why there were differences between scores on Cultural Opportunities for Chris' and Vivian's video versus Zavier's and

Harini's video. That is, both actors portraying Chris and Vivian identify as Black, whereas the actors portraying Zavier and Harini identify as Mexican and Indian respectively. Given that the protests were centralized on the experiences of racism and police brutality among Black Americans, it may be that participants were pulled to discuss race and culture more directly when responding to Chris' and Vivian's videos. Other identity factors, such as the intersection of race and gender, may help explain why certain videos, namely Vivian's video, stood out from the others. This will be further addressed in the below discussion of findings.

Table 10.1

Paired Samples T-Test Comparing Means for Cultural Comfort Across Videos

Cultural Comfort	1		2		3	
	t	*D*	*t*	*D*	*t*	*D*
1. Chris	-					
2. Zavier	-1.01	0.53	-			
3. Harini	-2.26*	0.64	-1.48	0.62	-	
4. Vivian	-0.34	0.62	0.60	0.61	2.18*	0.59

*** $p < .001$, ** $p < .01$, * $p < .05$.

Table 10.2

Paired Samples T-Test Comparing Means for Cultural Humility Across Videos

Cultural Humility	1		2		3	
	t	*D*	*t*	*D*	*t*	*D*
1. Chris	-					
2. Zavier	1.55	0.84	-			
3. Harini	-0.72	0.91	-2.25*	0.96	-	
4. Vivian	3.92***	0.80	1.77	0.88	4.33***	3.92***

*** $p < .001$, ** $p < .01$, * $p < .05$.

Table 10.3

Paired Samples T-Test Comparing Means for Cultural Opportunities Across Videos

Cultural Opportunities	1		2		3	
	t	*D*	*t*	*D*	*t*	*D*
1. Chris	-					
2. Zavier	4.34***	1.55	-			
3. Harini	4.67***	1.58	0.44	1.31	-	
4. Vivian	-0.63	1.54	-4.23***	1.89	-5.09***	1.70

Table 10.4

Paired Samples T-Test Comparing Means for Overall Effectiveness Across Videos

Overall Effectiveness	1		2		3	
	t	*D*	*t*	*D*	*t*	*D*
1. Chris						
2. Zavier	2.07*	0.90	-			
3. Harini	-0.54	0.97	-2.76**	0.90	-	
4. Vivian	4.56***	0.85	1.84	0.94	4.32***	0.98

Note. For tables 10.1-10.4, Pairwise comparisons were done in the numerical order in which they are listed (e.g. when comparing videos 1 and 2, the mean for video 2 was subtracted from the mean for video 1; when comparing videos 2 and 3, the mean for video 3 was subtracted from the mean for video 2). Therefore, negative t-values indicate that the higher numbered video in the comparison had a larger mean.

The hypotheses in this study aimed to evaluate the relationship between various psychological traits and observer-rated levels of MCO in participants' video responses. In summary, positive associations were hypothesized for adaptive defenses, professional self-doubt, self-compassion and CC, CH, OPP and OE, with a positive interaction effect between professional self-doubt and self-compassion; while a negative association was hypothesized between maladaptive defenses and CC, CH, OPP, and OE. Lastly, a positive association was hypothesized between adaptive defenses and participants' underestimation of their effectiveness and between maladaptive defenses and participants' overestimation of their effectiveness. The analyses of these primary

hypotheses in the study yielded null results; however, some notable secondary results emerged. First, while no statistically significant relationship was found between self-compassion and the MCO variables, when the analyses were separated by video, statistically significant relationships were revealed. A statistically significant, positive relationship was found between self-compassion and cultural humility on Video 4 (Vivian). Similarly, a statistically significant relationship was also found between self-compassion and overall effectiveness on Video 4 (Vivian). Both of these findings provide evidence that participants higher in self-compassion tended to demonstrate more cultural humility and greater overall effectiveness in resolving the cultural rupture on Video 4 (Vivian). This provides preliminary support for the notion that self-compassion is a psychological trait that can promote effective responding to cultural ruptures.

While this finding was limited to Video 4 (Vivian), there is theoretical and statistical evidence that suggests that Video 4 may stand out from other videos in a variety of ways. First, Video 4 was a bond-related alliance rupture with a confrontation response. That is, the client, Vivian, directly mentioned that a rupture had occurred, and in this case the rupture was related to feeling misunderstood by the therapist. Due to the direct nature, Vivian's video also displayed the most overt and intense negative affect (e.g. hurt, anger, crying). In contrast, two of the other videos- Video 1 (Chris) and Video 3 (Harini)-portrayed withdrawal responses wherein the mock clients avoided direct explanations of the rupture and displayed anxious affect. Statistically, this was supported in that on average participants scored lower on OE on the confrontation videos- Zavier and Vivian- in comparison to both of the withdrawal videos. Further, on average participants scored higher on at least one of the withdrawal videos in comparison to their

scores on Vivian's video for CC and CH (see Tables 9.1, 9.2). This aligns with Hill et al.'s (2003) findings that therapists had more difficulty addressing ruptures when clients presented with direct anger, as opposed to indirect expressions of anger. Similarly, Coutinho et al. (2010) suggested that confrontation ruptures elicited particularly negative affect in therapists due to feelings of incompetence and guilt in response to being confronted by a client. While participants tended to actually score higher for OPP on Vivian's video in comparison to Zavier and Harini, this exception is likely reflective of the fact that Vivian most overtly mentions race and culture, thus participants tended to be more explicit about these factors in their responses as well.

It is important to also compare the two confrontation responses- Zavier and Vivian. While Video 2 (Zavier) was also considered a confrontation response, the content of rupture is focused on the client's dissatisfaction with the topics being covered in therapy. In other words, while Video 2 (Zavier) also displays anger and direct confrontation, it is not overtly targeted at the therapist's lack of understanding and connection with the mock client as is observed in Video 4 (Vivian). Of note when comparing the two confrontation videos is that the actor in Video 4 (Vivian) is as a Black woman, while Video 2 (Zavier) features a Mexican American man. This is significant given the prevalence of stereotypes regarding expressions of emotion, especially anger, by Black women (Ashely, 2014; Walley-Jean, 2009). Indeed, a recent study found empirical support for the notion that expressions of anger by Black women tend to elicit more negative responses from others in comparison to White women and men (Motro et al., 2021). Given these factors, it stands to reason that Video 4 could be considered the most challenging video for participants.

Therefore, this finding, which suggests self-compassion may be associated with more effective responding to cultural ruptures, may be interpreted through the frames provided in previous literature that demonstrates that self-compassion appears to help individuals take responsibility for mistakes, failures and suffering rather than be consumed by negative feelings about themselves (Leary et al., 2007). Further, Gottlieb and Shibusawa (2020) found that higher self-compassion was associated with higher levels of multicultural competence among Social Work students. They suggest that self-compassion may be a skill that students can be taught to help them self-reflect about their privilege and biases in order to more adequately address them in clinical work (Gottlieb & Shibusawa, 2020). Additionally, the hypotheses in this study focused on the notion that White trainees, when confronted about a rupture, especially one that pertains to race, may be likely to interpret it as a threat to one's sense of self as progressive, liberal and anti-racist. Thus, Vivian's confrontation of the trainees may be interpreted as an especially overt threat to a participant's sense of self. Arch et al. (2014) found that a brief self-compassion intervention was effective in reducing the level of affective and physiological arousal elicited in response to social evaluation threats. Therefore, there is evidence to support the conclusion that Vivian's video was especially threatening to participants, and that, as such, there may have been a significant opportunity for self-compassion to make a more poignant impact on trainees' responses to Vivian. Currently, while there is extant literature suggesting that self-compassion is a useful skill for individuals with marginalized identities to cope with the impact of oppression (Hwang & Chan, 2019; Liu et al., 2019), there is limited literature examining it as a tool that may also help address aversive racism- that is, racism that persists on an unconscious level even among

progressive White individuals. This finding, albeit limited to one video, may provide evidence that self-compassion is a useful avenue of future study regarding how to improve White therapists' ability to address cultural ruptures.

While not a primary hypothesis, another important finding was some significant differences between participants' self-ratings and external ratings conducted by coders. These differences emerged on both self-reflection items, which asked participants to rate the extent to which they understood clients' issues, as well as the item asking participants to rate the effectiveness of their response. The item that asked participants to rate their level of understanding of the client's issue in each video was found to be statistically significantly different than participants' scores (as rated by coders) on measures of cultural humility, cultural opportunities and overall effectiveness, but not cultural comfort. When comparing the understanding self-reflection item with coders' ratings on those variables, participants tended overestimate their level of understanding. It may be that participants' beliefs that they thoroughly understood the clients' concerns may have, paradoxically, prevented them from expressing curiosity and asking questions about clients' experiences, which is likely to impact expressions of cultural humility and cultural opportunities, but not necessarily cultural comfort. The item that asked participants to rate the effectiveness of their response to each video was found to be statistically significantly different than participants' scores (as rated by coders) on measures of cultural comfort, cultural opportunities and overall effectiveness, but not cultural humility. On evaluations of their effectiveness participants also tended to overestimate, with the exception of cultural comfort, on which participants tended to be rated higher by coders than by their own estimation. This case of overestimation suggests

that participants either lack awareness of the extent to which they are making cultural processes salient (i.e., taking advantage of cultural opportunities) and/or they undervalue the importance of taking cultural opportunities as a component of effective responding. Previous literature supports the notion that most prominent treatment frameworks emphasize a focus on symptoms and psychological functioning rather than attuning specifically to cultural opportunities (Hook et al., 2017). Lastly, participants tended to rate themselves higher on the understanding item than effectiveness item across videos, which may partially explain why understanding scores were associated with more overestimation than effectiveness scores. This may reflect the finding that multicultural trainings can be effective in increasing trainees' knowledge, but not necessarily skills and awareness (Benuto et al., 2018). That is, participants may have had difficulty translating their understanding of cultural factors in treatment into actual effective responses in real time (skills) and/or their overestimation suggests deficits in self-reflective skills about their actual effectiveness (awareness).

The finding that discrepancies exist between self-ratings of competence and external ratings of competence mirrors results from Kruger and Dunning (1999). In their study, they poignantly articulate the unique challenge of self-identifying areas of incompetence by arguing: "when people are incompetent…they suffer a dual burden: not only do they reach erroneous conclusions and make unfortunate choices, but their incompetence robs them of the ability to realize it" (Kruger & Dunning, 1999, p. 1121). Indeed, the results of their study suggested that not only do individuals with less-developed skills tend to overestimate their competence, but this overestimation also tends to be accompanied by deficits in meta-cognitive skills. These results have been supported

across several domains including deficits in physicians' ability to accurately self-assess competence (Davis et al., 2006), teachers' self-ratings of cultural proficiency in teaching (Debnam et al., 2015), as well as therapists' ability to accurately rate their own cultural competence (Wilcox et al., 2020; Worthington et al., 2000).

The evidence that therapists tend to struggle with accurately assessing their own MCO skills supports several conclusions. First, studies seeking to evaluate therapists on facets of MCO may benefit from using alternative forms of measurement in addition to or instead of self-report alone. This notion has been put forth by previous studies, including Wilcox et al. (2020), which found that self-reported multicultural competence scores were largely uncorrelated with performance-based scores of multicultural competence. Further, positive associations have been found between self-report measures of multicultural competence and measures of social desirability (Constantine & Ladany, 2000; Worthington et al., 2000). Indeed, Larson and Bradshaw's (2017) meta-analysis concluded that across studies, self-report measures of cultural competence tend to be positively associated with social desirability ratings. This suggests, therefore, that self-report measures are insufficient on their own to accurately assess therapists' ability to address issues related to culture in therapy.

Second, this finding provides evidence that therapists may benefit from training that provides them with feedback to improve their meta-cognition, in order to not only correct skills deficits, but ultimately to enhance their ability to identify their areas of incompetence in the future. The Therapists Cognitive Complexity Model (TCCM) identifies meta-cognition as an important capacity that therapists develop that enables them to engage in the effective monitoring of themselves and the therapeutic relationship

(Owen & Lindley, 2010). Metacognition, therefore, appears to be a skill that is well-matched for the task of resolving cultural ruptures in that it allows therapists to engage in accurate self-reflection, and furthermore to translate this reflection into effective intervention by way of therapists attending to both their own reactions and the therapeutic alliance (Owen & Lindley, 2010). The present study adds to the current literature suggesting that there are notable discrepancies between how therapists evaluate themselves and how others evaluate them. Previous literature suggests that this is true across multiple disciplines and topic areas, but this may be especially relevant for White therapists seeking to accurately self-reflect regarding their multicultural skills given that aversive racism among progressive White individuals is most ingrained at an implicit rather than overt level, making it difficult to identify within oneself (Dovidio et al., 2016; Rodenborg & Boisen, 2013). Therefore, other studies illuminate meta-cognition as a potential skill that can help narrow the gap between self-reflection and actual performance.

It was hypothesized that participants' defense style would predict these differences between self and external ratings, wherein participants higher in maladaptive defenses were predicted to be more likely to overestimate their understanding and effectiveness, and participants higher in adaptive defenses were predicted to be more likely to underestimate their understanding and effectiveness. Statistical analyses did not yield support for this hypothesis, thus suggesting that while differences were found between participants' self-ratings and observer ratings, these differences were not explained by defense style.

Apart from these aforementioned findings, no other statistically significant results were revealed through this study. There are several possible reasons that null results were upheld. First, it may be that the psychological traits in question- defense style and professional self-doubt- may indeed be inconsequential traits in the resolution of ruptures. That is, it is possible that in spite of defenses and self-doubt, trainees may still be capable of resolving cultural ruptures. It may also be that the specific measures used did not fully capture the psychological processes being activated by the methods used in this study. For example, while defensiveness may play a role in responding to cultural ruptures, the DSQ-40 is oriented towards general defense style, rather than affective defensiveness that can be elicited in stressful situations. It may be that a measure of affective defensiveness would more accurately capture the processes involved in responding to cultural ruptures. There is support for the notion that affect plays an important role in expressions of defensiveness and racism not only theoretically, as articulated by DiAngelo (2011) who discusses anger, guilt, and fear as common reactions when White individuals are forced to confront their racism, but also empirically. For instance, McManus et al. (2019) found that measures of negative affect (e.g., discomfort) were more predictive than racism measures when examining White individuals' helping behaviors in imagined scenarios where race was a key variable.

In terms of self-doubt, one factor that may have impacted the analysis is the specific parameters of the population. While Nissen-Lie et al. (2010; 2017) concluded that PSD was positively associated with therapeutic outcomes, Odyniec and colleagues (2019) found that with therapists-in-training, PSD was negatively associated with improving clients' interpersonal problems. In the present study, PSD was found to have

neither a positive nor negative impact on MCO outcomes; however, it may be that PSD is contingent on therapist experience, as well as the context in which the therapy is being conducted. It may be that the trainees lacked substantial experience to respond to PSD questions with the same measure of self-reflection.

Limitations

There are several notable limitations in the present study. First, the sample was likely impacted by several factors. Specifically, participation in the study required a significant portion of time- about 50 minutes. Thus, there was a relatively high incidence of participants consenting to the study but failing to complete it, which may have impacted the results. Further, participants were informed at the outset that they must self-identify as White to participate in the study. It is possible that this influenced the type of people who opted to join the study. Self-selection bias may have skewed the sample in that White/Caucasian individuals higher in implicit or explicit bias may have opted out of the study after inferring that race may be a key variable.

Next, there were notable limitations in the terms of DSQ-40. The reliability of one of the primary subscales- the Adaptive subscale- was estimated to be .67, which falls below the often-cited threshold of .70 (Cortina, 1993). While this is not unacceptable, it does suggest that there is some measurement error on this scale. Additionally, Wilkinson and Ritchie's (2015) psychometric analysis of the DSQ-40 also suggested that, due to variability in the factor structures that have been identified, researchers would benefit from factor analyzing the DSQ-40 in each study in which it is used. Given the scope of the present study, this was not done, which constitutes a limitation.

Lastly, while the performance-based method used in this study constitutes a strength that helps bypass shortcomings of relying on self-report measures, limitations of the method still exist. Namely, recording oneself on a webcam can cause performance anxiety that may not be present during in vivo therapy sessions. Along with that, while the actors were trained regarding how to portray realistic therapy scenarios, there are limitations in the ecological validity of using therapy simulations rather than true therapy data. For example, some participants gave very short responses such as clarifying questions or brief restatements. This type of short response was often considered disrespectful given the quantity and depth of content that the clients convey in the videos. This, however, does not account for the fact that in real therapy scenarios, therapists may opt to use a brief clarifying question before providing a more in-depth response. The method used in this study limited each participant to one response, thus any follow-up responses were not able to be considered in the analysis. Furthermore, there may be barriers to affective engagement and the provision of empathy when participants are responding to brief stimulus videos without having a history or greater context with the client as a therapist would have in real therapy scenarios. With all of this in mind, it is important to consider that while conclusions from this study are useful, they do not necessarily translate infallibly to therapy in the real world.

Future Directions

Based on the findings of this study, there is preliminary evidence to suggest that self-compassion may play a positive role in helping White/Caucasian therapists-in-training address cultural ruptures in therapy. This small finding adds to the very nascent body of literature examining self-compassion as a trait that may help combat implicit

racial bias. Future studies may benefit from translating this finding into naturalistic therapy studies. For example, it may be useful to measure practicing therapists' levels of self-compassion and to test for associations with their MCO as rated by their clients or observers in actual sessions. Additionally, it may be helpful to assess the extent to which a self-compassion focused intervention could help with reducing racial bias through instruction/training. That is, while the preliminary evidence from this study and others suggests that self-compassion is a helpful psychological trait for modulating implicit racial bias, it will be important to understand the extent to which this can be cultivated. As was elucidated in the purpose of this study, there remain chasms between the emphasis APA places on training clinicians to be more culturally competent (APA, 2017) and the actual experiences of REM clients in psychotherapy (Hook et al., 2016). Thus, studies that can test the extent to which psychological factors, like self-compassion, can be inculcated through training to improve clinical outcomes would be extremely useful.

Additionally, studying defensiveness and self-doubt on an affective, rather than solely intellectual level, may help illuminate the impact of these processes on cultural rupture resolution. As stated previously, in imagined scenarios where White individuals were asked to rate their willingness to help, negative emotions were more directly predictive of their tendency to help Black individuals than measures of racism (McManus et al., 2019). This suggests that affect plays an important role in the activation of biases. Future studies, therefore, may unlock inroads for identifying implicit racial bias and improving therapists' ability to respond to cultural ruptures by understanding the role that affect plays in this process. For example, studies that can capture differences in affective

states for therapists who effectively use MCO and effectively resolve cultural ruptures versus those who do not may help illuminate paths for training.

Lastly, beyond the scope of psychological traits that impede or enhance White trainees' responses to cultural ruptures, the methodology used in this study also opens new avenues for clinically applied training and empirical study. Given that another finding in this study suggests that trainees' self-rating of their effectiveness tends to exceed observer ratings of their effectiveness, there may be utility in using video vignettes to provide trainees with feedback about their performance. This may help in teaching White trainees to more effectively work with cultural differences and cultural ruptures in therapy. Future studies assessing the impact of this sort of training on actual therapy outcomes may help uncover the effectiveness of various training methods to diminish the negative impact of aversive racism on cross-racial counseling relationships.

Conclusion

In summary, the primary finding of this study is that there is modest evidence to suggest that self-compassion may be a psychological trait that helps White/Caucasian therapists-in-training to respond to cultural ruptures with humility and overall effectiveness, especially when ruptures are characterized by confrontation. While this is an important finding, it is essential to note that it was limited to a small portion of the data in that the finding was only significant for one video. There is also evidence that trainees tend to overestimate their level of understanding and their effectiveness in responding to cultural ruptures. This provides an opportunity for future studies to attempt to understand how this overestimation may impact trainees' effectiveness, as well as how to improve accurate self-reflection of trainees. As was mentioned, metacognition has the

potential to be a useful skill that allows therapists to better identify their own deficits and adjust accordingly. Lastly, no evidence was found to support that defense style and professional self-doubt are key psychological traits that support the effective resolution of cultural ruptures. Future studies may provide distinctive ways of conceptualizing these variables and/or suggest alternative variables that impact cultural rupture resolution.

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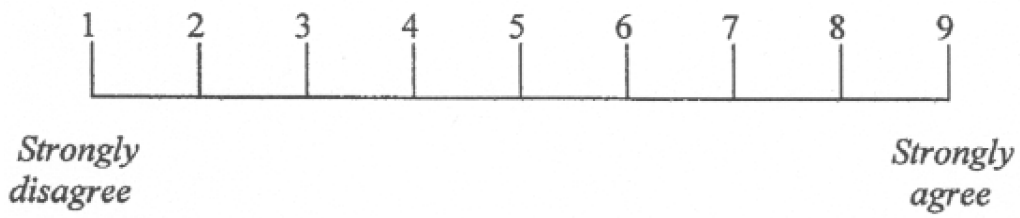
APPENDIX A: DEFENSE STYLE QUESTIONAIRE-40

INSTRUCTIONS: This questionnaire consists of a number of statements about personal attitudes. *There are no right or wrong answers.* Using the 9-point scale shown below, please indicate how much you agree or disagree with each statement by *circling* one of the numbers of the scale beside the statement. For example, a score of 5 would indicate that you neither agree nor disagree with the statement, a score of 3 that you moderately disagree, a score of 9 that you strongly agree.



1. I get satisfaction from helping others and if this were taken away from me I would get depressed.
2. I'm able to keep a problem out of my mind until I have time to deal with it.
3. I work out my anxiety through doing something constructive and creative like painting or woodwork.
4. I am able to find good reasons for everything I do.
5. I'm able to laugh at myself pretty easily.
6. People tend to mistreat me.
7. If someone mugged me and stole my money, I'd rather they be helped than punished.
8. People say I tend to ignore unpleasant facts as if they didn't exist.
9. I ignore danger as if I was Superman.
10. I pride myself on my ability to cut people down to size.
11. I often act impulsively when something is bothering me.
12. I get physically ill when things aren't going well for me.
13. I'm a very inhibited person.
14. I get more satisfaction from my fantasies than from my real life.
15. I have special talents that allow me to go through life with no problems.
16. There are always good reasons when things don't work out for me.
17. I work more things out in my daydreams than in my real life.
18. I fear nothing.
19. Sometimes I think I'm an angel and other times I think I'm a devil.
20. I get openly aggressive when I feel hurt.
21. I always feel that someone I know is like a guardian angel.
22. As far as I'm concerned, people are either good or bad.
23. If my boss bugged me, I might make a mistake in my work or work more slowly so as to get back at them.
24. There is someone I know who can do anything and who is absolutely fair and just.

25. I can keep the lid on my feelings if letting them out would interfere with what I'm doing.
26. I'm usually able to see the funny side of an otherwise painful predicament.
27. I get a headache when I have to do something I don't like.
28. I often find myself being very nice to people who by all rights I should be angry at.
29. I am sure I get a raw deal from life.
30. When I have to face a difficult situation, I try to imagine what it will be like and plan ways to cope with it.
31. Doctors never really understand what is wrong with me.
32. After I fight for my rights, I tend to apologize for my assertiveness.
33. When I'm depressed or anxious, eating makes me feel better.
34. I'm often told that I don't show my feelings.
35. If I can predict that I'm going to be sad ahead of time, I can cope better.
36. No matter how much I complain, I never get a satisfactory response.
37. Often, I find that I don't feel anything when the situation would seem to warrant strong emotions.
38. Sticking to the task at hand keeps me from feeling depressed or anxious.
39. If I were in crisis, I would see out another person who had the same problem.
40. If I have an aggressive thought, I feel the need to compensate for it.

APPENDIX B: PROFESSIONAL SELF-DOUBT SUBSCALE

Please answer the following questions on this scale:

0	1	2	3	4	5
Never	Rarely	Sometimes	Somewhat Often	Often	Fairly Often

Presently, how often do you feel…

1. Lacking in confidence that you might have a beneficial effect on a client.
2. Unsure how best to deal effectively with a patient.
3. Distressed by powerlessness to affect a patient's tragic life situation.
4. Disturbed that circumstances in your private life will interfere with your work.
5. In danger of losing control of the therapeutic situation with a patient.
6. Afraid that you are doing more harm than good in treating a client.
7. Demoralized by your inability to find ways to help a patient.
8. Unable to generate sufficient momentum.
9. Unable to comprehend essence of a patient's problems.

APPENDIX C: SELF-COMPASSION SCALE-SHORT FORM

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				**Almost always**
1	**2**	**3**	**4**	**5**

1. When I fail at something important to me I become consumed by feelings of inadequacy.

2. I try to be understanding and patient towards those aspects of my personality I don't like.

3. When something painful happens I try to take a balanced view of the situation.

4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

5. I try to see my failings as part of the human condition.

6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

7. When something upsets me, I try to keep my emotions in balance.

8. When I fail at something that's important to me, I tend to feel alone in my failure.

9. When I'm feeling down, I tend to obsess and fixate on everything that's wrong.

10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

11. I'm disapproving and judgmental about my own flaws and inadequacies.

12. I'm intolerant and impatient towards those aspects of my personality I don't like.

APPENDIX D: MULTICULTURAL ORIENTATION PERFORMANCE TASK

Please circle the appropriate number to show how you perceive this response.

Comfort

This response was:

Uncomfortable	1	2	3	4	5	6	Comfortable
Nervous	1	2	3	4	5	6	Calm
Tense	1	2	3	4	5	6	Relaxed

Humility

This response was:

Disrespectful	1	2	3	4	5	6	Respectful
Close-minded	1	2	3	4	5	6	Open-minded
Superior	1	2	3	4	5	6	Non-superior

Opportunity

There was:

No cultural discussion	1	2	3	4	5	6	Definitive cultural discussion

Overall

This response was:

Bad	1	2	3	4	5	6	Good

APPENDIX E: VIDEO VIGNETTE SCRIPTS

Video 1: Chris- Bond Rupture; Withdrawal Response

Introduction Audio: This is Chris. He is a 25-year-old Black man, and this is the end of your second session with him. You have just asked him how he thinks therapy is going so far.

Chris Audio: I mean, it's going pretty good. I mean, it's going well...You know, I think I'm just gonna stop coming. I just feel like, I don't know, I feel like therapy is not my thing, and umm, I don't feel like therapy fits me. Look, I mean you're nice, and I know you're doing your job, but I don't know, I just feel like I'm not the best client for you. Thanks for the talk though.

Video 2: Zavier- Task Rupture; Confrontation Response

Introduction Audio: This is Zavier. He is a 38-year-old Mexican American man, and this is the beginning of your 5th session with him. You have just asked him if he completed the homework from the previous session.

Zavier Audio: No I didn't do the homework. You know, I've been thinking, this is like our 5th session, right? And you got me doing exercises, for what? I know you're just trying to do your job, but I don't get the point. I'm trying to talk to you about my family, I'm trying to talk to you about my job. I'm just trying to keep my head above water. That's all I'm trying to do.

Video 3: Harini- Task Rupture; Withdrawal Response

Introduction Audio: This is Harini. She is a 31-year-old, Indian American woman, and this is beginning of your 3rd session with her. You just asked her how she feels about what you all have been focusing on in therapy so far.

Harini Audio: It's fine... umm... It's been going good. I mean... It's fine. It's completely fine. I mean, whatever happens, happens and I'm, you know, I'm looking at you like the expert so as long as you think it's good, I think I'm on track with you. But, umm, so what is the focus of the session today?

Video 4: Vivian- Bond Rupture; Confrontation Response

Introduction Audio: This is Vivian. She is a 45-year-old Black woman, and this is your 5th session with her.

Vivian Audio: You say you understand how I feel, and you act as if like you really care. But you'll never know what it's like, what me and my family face on a day-to-day basis. I don't even know how someone like you, thinks you can help me, or even know what

it's like where *I* come from. I know your life is a lot different than mine. But you'll never understand the struggles that we go through, every day, it's the same thing. You'll never, never, *never* know what it's like.