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LOYOLA UNIVERSITY CHICAGO

THERAPIST BROACHING BEHAVIOR IN CROSS-RACIAL THERAPY:
EXPLORING AFFECTIVE RESPONSES TO RACISM
AND CULTURAL HUMILITY AS PREDICTORS

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN COUNSELING PSYCHOLOGY

BY

SARAH C. GALVIN

CHICAGO, IL

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TABLE OF CONTENTS

ACKNOWLEDGMENTS	iii
LIST OF TABLES	viii
LIST OF FIGURES	ix
ABSTRACT	x
CHAPTER ONE: INTRODUCTION	1
Background of the Problem	2
Broaching	4
White Affective Responses to Racism and White Privilege	6
Cultural Humility	7
Demographic Variables	8
The Present Study	9
CHAPTER TWO: REVIEW OF LITERATURE	11
Broaching	11
Definition	11
Theoretical Components of Broaching	12
Broaching Attitudes and Behavior Survey	18
Empirical Research on the Impacts of Broaching	19
Empirical Research on Providers' Broaching Behaviors	20
Broaching Research Limitations	23
White Affective Responses to Racism and White Privilege	25
Empirical Research on White Affective Responses to Racism	29
White Affective Responses to Racism and Broaching	31
Cultural Humility	32
Empirical Research on Cultural Humility	34
Cultural Humility and Broaching	37
Summary of the Problem	39
CHAPTER THREE: METHODS	42
Participants	42
White Participants (Group A)	45
BIPoC Participants (Group B)	46
Measures	47
Demographic Questionnaire	47
Psychosocial Costs of Racism to Whites Scale (PCRW)	48
White Racial Affect Scale (WRAS)	49
Multidimensional Cultural Humility Scale (MCHS)	51
Broaching Attitudes and Behavior Survey (BABS)	52

Balanced Inventory of Desirable Responding Short Form (BIDR-16)	53
Qualitative Follow-Up Questions	55
Procedure	55
Data Analysis Plan	57
Preliminary Analysis	57
Main Quantitative Analysis	58
Qualitative Analysis	61
CHAPTER FOUR: RESULTS	63
Preliminary Analyses	63
Data Cleaning	63
Missing Values	63
Reliability Analyses	66
Correlations	67
Main Analyses	69
Demographic Covariances	69
Hierarchical Linear Regression	76
Cluster Analysis	79
Post Hoc Analyses	83
BIPoC Correlations	83
Combined Independent-Samples T-Test	83
Qualitative Analyses	86
White Individuals (Group A) Qualitative Themes	86
Group B (BIPoC Individuals) Qualitative Themes	93
CHAPTER FIVE: DISCUSSION	98
Findings	100
Hypothesis 1	100
Hypothesis 2	102
Hypothesis 3	104
Significant Demographic Findings	105
BIPoC Group Findings (Group B)	107
Qualitative Findings	107
Implications	109
Limitations and Future Research	112
Limitations	112
Future Research	114
Conclusion	115
APPENDIX A: RECRUITMENT SCRIPT	116
APPENDIX B: CONSENT FORM	118
APPENDIX C: MODIFIED PSYCHOSOCIAL COSTS OF RACISM TO WHITES SCALE	121

APPENDIX D: WHITE RACIAL AFFECT SCALE	123
APPENDIX E: MULTIDIMENSIONAL CULTURAL HUMILITY SCALE	126
APPENDIX F: BROACHING ATTITUDES AND BEHAVIOR SURVEY	129
APPENDIX G: BALANCED INVENTORY OF DESIRABLE RESPONDING SHORT FORM	131
APPENDIX H: QUALITATIVE FOLLOW UP QUESTIONS	133
APPENDIX I: DEMOGRAPHIC QUESTIONNAIRE	135
REFERENCE LIST	138
VITA	151

LIST OF TABLES

Table 1. Sample Demographic Characteristics	43
Table 2. Correlation Matrix, Means, Standard Deviations, and Cronbach's Alpha For Group A	68
Table 3. Demographic Correlation Matrix for Group A	69
Table 4. Graduation Status Independent T-Test for Group A	71
Table 5. Program Kind Independent T-Test for Group A	71
Table 6. Sexual Orientation Independent T-Test for Group A	72
Table 7. Religious Status Independent T-Test for Group A	72
Table 8. Gender One-Way Analysis of Variance for Group A	74
Table 9. Social Class One-Way Analysis of Variance for Group A	74
Table 10. Theoretical Orientation One-Way Analysis of Variance for Group A	74
Table 11. Program Type One-Way Analysis of Variance for Group A	75
Table 12. Tukey HSD Post Hoc Analysis for Group A by Program Type	75
Table 13. Hierarchical Linear Regression for Group A	78
Table 14. Cluster Independent T-Test for Group A	82
Table 15. Correlation Matrix, Means, Standard Deviations, and Cronbach's Alpha For Group B	83
Table 16. Independent T-Tests for Groups A and B Combined	85

LIST OF FIGURES

Figure 1. Summary of Missing Values	64
Figure 2. K-Means Cluster Groups PCRW & WRAS Patterns	80

ABSTRACT

The present research project utilizes a quantitative methods approach via online survey to better understand the relationships among affective responses to racism, cultural humility, demographic variables, and racial broaching style in White health service psychology (HSP) advanced trainees and early career psychologists. It increases the limited body of knowledge surrounding White HSP advanced trainees and early career psychologists' experiences broaching discussions of race, ethnicity, and culture in hopes to increase overall quality of mental health services for Black, Indigenous, and People of Color (BIPOC) clients, disrupt larger systems of racism prevalent in the field, and improve overall health outcomes.

This project answers the following research questions amongst a sample of 87 White HSP advanced trainees and early career psychologists, with supplemental responses from a sample of 27 BIPOC HSP advanced trainees and early career psychologists included: (1) Do affective variables (i.e., White empathy, White guilt, White shame, White fear, and White negation/apathy) of White HSP advanced trainees and early career psychologists predict an integrated/congruent broaching style? If so, how do these variables predict an integrated/congruent broaching style? (2) Is there a particular makeup of affective variables related to an integrated/congruent style (e.g., high empathy and low shame)? and (3) Does the cultural humility level of White HSP advanced trainees and early career psychologists predict an integrated/congruent broaching style? If so, how do these variables predict an integrated/congruent broaching style?

Findings for the first research question indicate that affective variables did not predict an integrated/congruent broaching style. Findings from the second research question indicate two distinct clusters of White affective responses were present, with cluster one including individuals with relatively higher levels of White apathy/negation and fear and lower levels of White empathy, guilt, and shame. Cluster two included individuals with relatively higher levels of White empathy, guilt, and shame, and lower levels of White negation and fear. The two cluster groups had significantly different associations with broaching, with Cluster two having higher mean scores.

Findings from the third research question indicate that higher levels of cultural humility predicted higher levels of integrated/congruent broaching style. Further exploration of demographic covariances also found that individuals who identified LGBTQIA+ scored higher on the integrated/congruent broaching style compared to those who identified as heterosexual, and those from counseling psychology programs scored higher than those in clinical psychology programs. Comparisons between the two sample groups also found that BIPoC participants scored significantly higher on cultural humility than White participants.

Exploration of qualitative responses from both White and BIPoC HSP advanced trainees and early career psychologists also offer complementary, in-depth suggestions for training programs to better support students and tailor recommendations for training purposes.

CHAPTER ONE

INTRODUCTION

As the fourth and fifth forces of Counseling psychology have continued to move the field forward in pursuit of a multicultural and socially just practice (Ratts & Pedersen, 2014), researchers have explored the efficacy of clinical training programs to prepare trainees in providing effective services for all. However, White health service psychology (HSP) providers continue to have difficulty offering effective, competent, and ethically sound services to racially diverse clients (Smith et al., 2006), with many Black, Indigenous, and People of Color (BIPOC) clients voicing hesitation to engage in counseling services and receiving subpar support (Thompson & Jenal, 1994; Burkard et al., 2016; Pope-Davis et al., 2002; Chang & Berk, 2009; Knox et al., 2003; Owen et al., 2016; Meyer & Zane, 2013). To better clarify why this may be the case, researchers have begun to identify that many White HSP providers struggle to even broach conversations of race in session and acknowledge a client's full existence (Day-Vines et al., 2007; Day-Vines et al., 2013; Knox et al., 2003; Lee & Horvath, 2013; Lee & Bhuyan, 2013), following similar patterns of White individuals avoiding discussions of race in day to day public (Abrams & Gibson, 2007).

In attempts to understand this continued difficulty and pervasiveness in the field, research has begun to further explore the inaction in White HSP providers to broach discussions about race with clients. However, further quantitative research is needed to explore what provider characteristics predict broaching behaviors, including the impact of affective responses to

racism and White privilege, cultural humility, and demographic variables. In particular, additional focus on White HSP advanced trainees and early career psychologists is needed, as previous research has focused primarily on master's level counselors and school counselors that are in training or licensed. Including advanced trainees and early career psychologists allows an exploration of how current multiculturalism and social justice training is impacting approaches, and identify ways to potentially update new training and support. The present study addresses these gaps by exploring White HSP provider characteristics that predict broaching in a population of doctoral level HSP trainees and early career psychologists. Results of the study also tailor recommendations for training programs to better integrate and support students surrounding broaching, with hopes to provide more effective, multicultural, and socially just care.

Background of the Problem

The continued impact of a White Western European framework, which influences the dominant view of the mental health field, has long directed psychological research and practice (Sue, 2015). In attempts to acknowledge and bring about awareness, Sue et al.'s (1992) critique of the counseling field clearly laid out the roadblocks this view can have in the therapeutic relationship (e.g., providers having difficulties understanding the situation and identifying culturally based trauma, unawareness of culturally based strengths, and low empathy). Sue's prolific career, particularly surrounding racism and multicultural counseling, has continued to identify the pervasive thread racism weaves at the individual, systemic, and structural levels, including the way a White HSP provider may conceptualize a client, how therapy courses are taught, and how BIPoC individuals are negatively impacted while navigating an unjust health care system (Sue, 2005). Sue (2005, 2017) argues that in order to truly provide adequate care for

the good of people that minimizes harm, White HSP providers must not continue to be silent, but rather speak up against racism, while also engaging in anti-racist actions in every facet of their personal and professional lives.

This is especially important as the profession continues to move forward into the 21st century, with BIPoC populations significantly increasing in the United States (United States Census Bureau, 2011, 2016), while an overwhelming majority of doctoral level health service psychologists continuing to identify as White (69%; National Center on Educational Statistics, 2017a, 2017b). To continue checking the field's ability to provide ethically sound multicultural services, meta-analyses reviewed cross-cultural therapeutic relationships experiences and found that racial mismatch does not significantly differ from racial match in overall client outcome. However, initial bond and therapeutic alliance can be significantly impacted (Cabral & Smith, 2011; Kim & Kang, 2018), which may impact one's decision to continue treatment or return in the future.

Many BIPoC individuals continue to voice hesitation engaging in counseling services, due to the valid cultural mistrust of the profession based on historical and systemic influences. Many BIPoC individuals express concern in working with White HSP providers, particularly in the lack of understanding and awareness of how race plays a role in their current functioning (Zhang & Burkard, 2008; Burkard et al., 2016). If attempting services, many BIPoC clients voice continued frustration and disappointment in the process, with increased premature termination, therapeutic ruptures, feelings of invalidation, reduced self-disclosures, and dissatisfaction in overall services reported (Sue & Sue, 2003; Sue & Sundberg, 1996; Thompson & Jenal, 1994; Burkard et al., 2016; Pope-Davis et al., 2002; Chang & Berk, 2009; Knox et al., 2003; Owen et al., 2016; Meyer & Zane, 2013). When further explored through qualitative research, many

clients expressed feeling invalidated and unheard, due to White HSP providers avoiding discussions of race, reinforcing Whiteness as the norm, and dismissing the existence of structural and systemic racism (Zhang & Burkard, 2008; Burkard et al., 2016; Lee & Bhuyan, 2013), continuing themes originally identified by Sue et al. (1982) over 30 years ago.

Broaching

Day-Vines et al., (2007, 2013, 2018, 2020, 2021) coined the term broaching to specifically describe HSP providers and trainees having open discussions of race, ethnicity, and culture (REC) with their clients. However, broaching is a multiculturally competent intervention much deeper than just considering or acknowledging sociocultural or sociopolitical factors, requiring an awareness, open attitude, and deliberate and continuous effort of the HSP provider to willingly address and explore the impact of REC factors and power in session. Five different broaching styles have been identified, ranging from avoidance of broaching to regularly incorporated broaching and advocacy effort (Day-Vines et al., 2013). As this study specifically researches White HSP advanced trainees and early career psychologists, it was decided to focus exclusively on integrated/congruent broaching style (i.e., effectively initiating and continuing to engage in broaching behaviors, while understanding the depth and connection to clients at a personal, emic level), as this is on par with ethical and competency benchmarks expected for individuals at this level of training.

Broaching is considered relational in nature and places importance on the provider-client dyad. It can have many different foci, including introducing and responding to client's REC focused conversations, supporting clients to examine how REC factors influence their worldviews, experiences, and presenting concerns, and helping identify REC congruent problem solving and coping strategies Day-Vines et al., (2018, 2020).

When utilized, broaching has been found to enhance provider credibility, deepen client self-disclosure and willingness to return, improve the working alliance, and increase therapeutic outcomes (Thompson, Worthington, et al., 1994; Pope-Davis et al., 2002; Gim et al., 1991; Chang & Berk, 2009; Zhang & Burkard, 2008; Zhang & McCoy, 2009; Thompson & Alexander, 2006). However, exploration with White HSP providers identified that many are still hesitant to approach conversations about race (Day-Vines et al., 2021; Jones & Welfare, 2017) and even become disengaged or respond negatively to client's REC relevant talk (Lee & Horvath, 2014). For example, Knox et al. (2003) found that White providers similarly identify the importance of and willingness to discuss conversations of race, ethnicity, and culture with clients, but typically do so less, felt more uncomfortable, and picked up less on clients' discomfort. As a result, preliminary empirical research has begun to explore provider characteristics' relationship with broaching style, including provider race, work setting, racial identity development, multicultural competency, and cultural humility, in addition to the creation and validation of a broaching scale (Day-Vines et al., 2013).

However, additional research is needed to clarify why White HSP providers, and particularly White HSP trainees and early career psychologists, continue to struggle with engaging this skill. Additional therapist characteristics that may further explain why include affective responses to racism, cultural humility levels, and additional demographic variables. Further explored next, these factors were chosen based on previous research findings that show their potential connection to the different theoretical broaching styles proposed by Day-Vines et al. (2007; 2018), general trends in multicultural research, and their own relationship and impact in the general Whiteness and racism research.

White Affective Responses to Racism and White Privilege

Researchers have begun to look at the affective (i.e., emotional) responses White individuals experience when discussing and/or interacting with racism and White Privilege (Grzanka et al., 2019; Pinterits et al., 2009; Spanierman & Heppner, 2004) in hopes to better comprehend why White individuals struggle to understand, challenge, and engage in change against racism. Indeed, Day-Vines et al. (2020), in their theoretical model, hypothesized that emotional responses of the provider may influence broaching style.

Grzanka et al. (2019) categorized common emotional reactions into: emotions of racism (i.e., perpetuating the continuation of racist systems and beliefs), liminal emotions, (i.e., indicators of possible transition from racist to antiracist identity), and emotions of antiracism (i.e., encouraging action and change). However, no emotional scales focused on antiracist emotions have been developed yet, and thus are not discussed in this current study.

Common emotions of racism include: White apathy (D'Andrea & Daniels, 2001), or finding race unimportant, and White fear (Spanierman & Heppner, 2004; Spanierman et al., 2012), or an irrational mistrust of BIPoC. Common liminal emotions include: White guilt (Spanierman & Heppner, 2004; Pinterits et al., 2009), or distress of realizing one's White privilege and perpetuating racist thoughts and behaviors, White shame (Grzanka et al., 2019), or disgrace at being White and its accompanying power, and White empathy (Spanierman & Heppner, 2004), or having a sense of the experiences BIPoC face in response to White supremacy and oppression.

In addition to multiple scale development and validation studies, empirical research on White affective responses has also found different groupings of emotions, differing associations with multicultural education, racial awareness, cultural sensitivity, inter-racial relationships,

support for affirmative action, multicultural competence, and civic action (Spanierman et al., 2006, 2008, 2009, 2012; Dull et al., 2021). However, no research has looked directly at the relationship among White affective responses and broaching style, including none for White HSP trainees and early career psychologists.

Cultural Humility

Cultural humility is defined by Hook et al. (2013, p. 353) as “having an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual’s cultural background and experience.” This is a move away from the multicultural competency’s limited introspection and evaluation of the self and is ultimately seen as a way of being as opposed to doing. Rather than providers believing they are the expert on a client’s experience based on “mastering” a set of skills, knowledge, and awareness, cultural humility focuses on the idea that a provider can never know or understand a client’s full experience, illustrated by respect and lack of superiority.

Cultural humility involves both an intrapersonal and interpersonal relational focus (Davis et al., 2010; Hook et al., 2013). Intrapersonally, providers should adopt the belief they are lifelong learners and incorporate a sense of openness, self-awareness, focus on the other-orientation, egoless, engagement in supportive interactions, and self-reflection and critique (Foronda et al., 2016). Providers should also evaluate their limited worldviews, reflect on how their beliefs and attitudes impact their therapeutic care, and challenge institutional and systemic-level obstacles. Interpersonally, providers should welcome clients to self-identify their experiences with power and oppression, incorporate intersectionality, acknowledge the power imbalance, and work collaboratively to gain a deeper understanding of the client’s worldview (Hook et al., 2013; Fisher-Borne et al., 2015).

In addition to the development and validation of scales, research has also begun to look at outcomes of cultural humility. This includes cultural humility being rated more important than client-provider identity matching, skills, knowledge, or experience in a provider, higher associations with strong therapeutic alliance, more positive expected therapy outcomes, and higher chances of retention (Hook et al., 2013). Cultural humility has also been found to be associated with lower frequency of microaggressions and ruptures, and lower negative impact if they occur (Hook, Farrell et al. 2016). Similarly, cultural humility was found to influence the relationship between missed opportunities to broach and negative ratings of therapeutic outcomes, making it nonsignificant if present (Owen et al., 2016). Only two other studies have been found to look at the relationship between cultural humility and broaching. King and Borders (2019) found cultural humility levels were rated higher in vignettes where a broaching statement was present. In addition, dissertation work by Askren (2022) found the incorporation of cultural humility in coursework increased the number of broaching statements present for experiential mock therapy sessions. However, none of these studies have looked at the predictive relationship or in White HSP trainees and early career psychologists.

Demographic Variables

Finally, although not a main area of focus for this current study, review of past research on multiculturalism, and more specifically broaching, have found group differences based on provider demographic variables that may be helpful to control for and/or explore their relations with broaching style. This includes race, number of years of experience (Day-Vines et al., 2013; Day-Vines, Bryan et al., 2022; and Day-Vines, Brodar et al., 2022), more clinical training experience, and direct clinical hours (King & Summers, 2020) being significantly associated with higher broaching levels. In addition, general multiculturalism research has found theoretical

orientation (Constantine & Ladany, 2001) and gender identity (Smith et al., 2006) to have a significant positive relationship with multicultural skills, understanding, and approach.

The Present Study

This study utilizes a quantitative methods approach to better understand the relationships among affective responses to racism, cultural humility, demographic variables, and broaching style in White HSP advanced trainees and early career psychologists through an online survey of self-report measures and opportunities for open-ended qualitative comments. Additional responses from BIPoC and bi-racial/multiracial individuals who do not identify as White were included to supplement the main analyses. The primary goal of this study is to increase the limited body of knowledge surrounding White HSP advanced trainees and early career psychologists' experiences broaching discussions of race in hopes to increase overall quality of mental health services for BIPoC clients, disrupt larger systems of racism prevalent in the field, and improve overall health outcomes. Specifically, this was done by increasing opportunities to understand what may predict White HSP advanced trainees and early career psychologists' level of engagement in broaching to tailor recommendations for training programs to better support students in engaging.

The researcher posed the following research questions to guide the study amongst a sample of White HSP trainees and early career psychologists:

- (1) Do affective variables (i.e., White empathy, White guilt, White shame, White fear, and White negation/apathy) predict an integrated/congruent broaching style? If so, how do these variables predict an integrated/congruent broaching style?
- (2) Is there a particular makeup of affective variables related to an integrated/congruent style (e.g., high empathy and low shame)?

(3) Does the cultural humility level predict an integrated/congruent broaching style? If so, how do these variables predict an integrated/congruent broaching style?

The following hypotheses were proposed based on previous research:

- (1) Hypothesis 1: it was hypothesized that affective variables will predict an integrated/congruent broaching style in varying degrees. In particular, it is anticipated that higher levels of White empathy will predict higher levels of integrated/congruent broaching style, while higher levels of White fear and White negation/apathy will predict lower levels. Due to differing impacts on behavior, it is also anticipated that higher levels of White guilt will predict a higher integrated/congruent broaching style, while a higher level of White shame will not.
- (2) Hypothesis 2: it is hypothesized that multiple affective variable clusters will arise, each with a different relationship to overall integrated/congruent broaching style. The specific presence and level within each cluster is unknown at this time, due to limited previous research.
- (3) Hypothesis 3: it is hypothesized that higher levels of cultural humility will predict higher levels of integrated/congruent broaching style.

CHAPTER TWO

REVIEW OF LITERATURE

The following chapter provides a comprehensive review of the relevant literature connected to broaching behaviors, White affective responses to racism and White Privilege, and cultural humility of HSP advanced trainees and early career psychologists. This chapter also analyzes the current theoretical models and empirical studies conducted on the main constructs identified above, providing further rationale as to why this study is needed and important.

Broaching

Definition

At its most basic level, broaching is generally defined as bringing about a discussion or conversation about a topic, particularly one that might be more sensitive in nature (Oxford University Press, section 6). Within the field of psychology, Day-Vines et al., (2007, 2013, 2018, 2020, 2021) coined the term broaching to specifically describe providers having open discussions of race, ethnicity, and culture (REC) with their clients. However, broaching is a multiculturally competent intervention much deeper than just considering or acknowledging sociocultural or sociopolitical factors and requires an awareness, open attitude, and deliberate and continuous effort of the provider to willingly address and explore the impact of RECs and power in session. Day-Vines et al. (2007, 2018, 2021) identified four functions of broaching, including introducing or responding to conversations of REC factors, supporting the client in examining how REC factors may be entrenched in personal experiences and impact their life,

processing the relationship between said factors and presenting concerns, and incorporating the developed insight into effective and REC congruent problem solving and coping strategies that emphasize client empowerment and resilience (Day-Vines et al., 2018). King and Summers (2020) also described broaching as an adaptable intervention based on the situation that does not have specific wording (e.g., Socratic questioning), but rather uses a variety of general counseling skills to facilitate the interaction forward (e.g., asking open ended questions, determining the appropriateness of focus, observing client's nonverbals in the moment, or engaging in self-disclosure).

Theoretical Components of Broaching

Based on the multiple power differences, including between HSP provider and client status, as well as between White and BIPoC identity, it is the White HSP provider's ethical responsibility to set the tone early to disrupt the status quo of using a "color-blind" approach and instead intentionally disrupt and heal the "legacy of silence and shame" (Day-Vines et al., 2007, p.402). In addition, having discussions minimizes the therapist reliance upon etic, stereotypic knowledge, and helps tailor services specifically to the unique experience each client has with regards to REC factors. This provides opportunity to validate and acknowledge the potential impact of racial, ethnic, and cultural trauma experienced by BIPoC clients (Bryant-Davis, 2007; Carter, 2007), ultimately increasing the quality of care and trust in the therapeutic relationship by creating an emotionally safe space. This is crucial, as a secure therapeutic alliance has repeatedly been found to be associated higher with positive client outcomes (Lambert & Barley, 2001).

King (2021), in their review of the literature on the broaching theoretical model, also noted that researchers generally agree broaching is an ongoing process from the start of the relationship, conceptualizes identities as dynamic and intersectional, provides space to explore

the interaction among multiple social identities, oppressive systems, and the current sociopolitical climate, involves understanding a client's identity experience on the individual and system level, and requires flexibility for each client and within each session.

King (2021) also found there are four components of broaching interventions that continue to be explored and deliberated by scholars and providers alike, with King recognizing that a provider might do all of the following at some point, but would be impossible to do in the same broaching statement. This includes the timing of the broaching statement (i.e., to proactively present to clients or to respond to REC factors as they appear in session), the language of the broaching statement (i.e., direct and specific to a certain REC identity or open and unfocused to encourage general exploration), the goal of the broaching statement (i.e., to explore similarities and differences in the provider-client relationship or to explore the client's presenting concerns to experiences of oppression and REC identity), and the approach to exploring similarities and/or differences in the provider-client dyad. This includes solely focusing on differences, solely focusing on similarities (also called bridging by Okun et al., 2017), or incorporating a combination of both.

Continuum of Broaching

Per Day-Vines et al. (2007)'s theoretical conceptualization, broaching can be seen as a continuum of five broaching styles, including avoidant, isolating, continuing/incongruent, integrated/congruent, and infusing. Broaching styles are based on the two-part idea that, for HSP providers to discuss REC factors, one must first have the awareness of RECs, privilege, and oppression, and then second, the ability to facilitate meaningful discussions. A brief description of each broaching style, coupled with the typical behaviors associated, will be further explored below.

Avoidant therapists are seen to hold racially neutral beliefs about their clients, often dismissing the importance of REC factors and relying on limited etic type knowledge when working with BIPoC clients (Day-Vines et al., 2007, 2018). In session, this will appear via ignoring or minimizing actively talk about REC factors, due to the limited awareness in identifying its importance, as well as allowing unexplored biases and fears to continue to dominate the therapist's thoughts and actions (Day-Vines et al., 2007).

Isolating therapists are similar to avoidant individuals as they also have limited awareness and knowledge about the importance of REC factors, yet they differ in that they attempt to broach discussions, albeit in a fairly short and one-time manner. Individuals at this level are unable to address the larger REC experiences of a client, with attempted discussions often remaining superficial and the therapist merely providing a one-time check-in before quickly moving on to topics not related to race (Day-Vines et al., 2007; Day-Vines et al., 2018).

Continuing/Incongruent therapists also have difficulty effectively integrating REC conversations with clients, but unlike the previous two styles, they continue to attempt broaching, although it is often awkward and in a textbook like fashion (Day-Vines et al., 2007).

The final two styles of broaching are more congruent with ethical and competency guidelines of the field, demonstrating more cultural sensitivity and awareness to clients than previous styles. Integrated/Congruent therapists possess the multicultural approach to effectively initiate and continue engaging in conversations about REC factors with clients and understand the depth and connection to clients at a personal, emic level (Day-Vines et al., 2007). Per Day-Vines et al. (2018), individuals at this level are able to smoothly integrate this skill into their repertoire, no longer seeing it as a clunky add-on that needs to be fit into their work.

Infused therapists are similar to integrated/congruent individuals in their ability to approach and regularly engage in in-depth conversations about REC factors with clients. Furthermore, broaching behaviors transcend beyond the counseling session (Day-Vines et al., 2007; Day-Vines et al., 2018). HSP providers at this level view broaching as an integral part of their identity and work at the systemic level to create change for their clients (Day-Vines et al., 2018).

Multidimensional Model of Broaching Behavior

Day-Vines et al. (2020) introduced the Multidimensional Model of Broaching Behavior (MMBB) to complement the original broaching model, identifying four domains and contexts providers can expand their focus on to feel more confident and facilitate more effective broaching. They include: (a) intracounseling dimensions, (b) intraindividual dimensions, (c) intra-REC dimensions, and (d) inter-REC dimensions.

Intracounseling dimensions focus on discussing the provider-client dyad and interpersonal experience in the therapy room. Providers who focus on intracounseling dimensions demonstrate to their clients that it is okay to discuss REC related concerns within the relationship that may be dismissed or off limits in the real world, acknowledge and discuss similarities and differences of social identities in the here and now, or “cultural immediacy” (Day-Vines et al., 2020; p. 110), process relationship concerns related to REC, and reflect a stance of cultural humility (Hook et al., 2013) by recognizing authority of the client and acknowledging instances where the provider may not fully understand their REC related experiences. Focusing on intracounseling dimensions can help strengthen the therapeutic relationship and support the client by increasing trust, authenticity, and commitment while helping the client feel validated and heard.

Intraindividual dimensions focus on exploring how the client's intersectional social identities (Crenshaw, 1989) may interact to create unique and shared experiences of oppression, which in turn impacts clients' presenting concerns, worldview, values, and general experiences. This focus can help with conceptualization skills and pinpointing specific interventions tailored for the client's experience (Day-Vines et al., 2020).

Intra-REC dimensions focus on exploring culturally related similarities and differences between the client and others within the same REC group (e.g., acculturation/enculturation levels, worldviews, values, expectations). Finally, inter-REC dimensions focus on engaging in conversations about the client's experience with multiple levels of -isms and oppression (e.g., overt discrimination, microaggressions, systemic inequality), encouraging development of critical consciousness, and incorporating social advocacy interventions by the provider.

Broaching Behaviors Framework

Day-Vines et al. (2021) also theoretically identified possible factors impacting the variability of broaching behaviors among and within providers, including provider characteristics (e.g., personal beliefs about the need for and significance of broaching, level of knowledge, previous opportunities, emotional response, skill level, belief in ability, racial identity development, and multicultural competence) and client characteristics (e.g., client's own insight, feeling safe and secure, racial identity development, and openness and desire to engage in REC related discussions). The interactions of these characteristics may also impact each other and the therapeutic relationship over time.

Continuing to make broaching an easier intervention to prescribe to, Day-Vines et al. (2021) introduced a stages framework that can help guide providers to broach in a flexible and adaptive manner unique for each client and statement. The four overarching stages include: (a)

joining, (b) assessment, (c) preparation, and (d) delivery. The first three stages occur prior to the broaching event, which occurs during the delivery stage. Joining involves generally building rapport, establishing an authentic therapeutic relationship, and beginning to explore the client's worldview, while specifically making sure to incorporate the client's language, validate, encourage the client to share their understanding of their experiences, and identify the client's strengths and resources. The overarching focus of joining is helping develop a sense of safety and security within the therapeutic relationship and establish the space as an open place to discuss cultural immediacy and REC related concerns.

The assessment stage involves the provider reflecting on six possible areas to better understand the client's worldview, including multicultural case conceptualization (i.e., understanding the client's presenting concerns through a multicultural lens and incorporating into the treatment plan), identifying where the client's racial identity development is at and how they may respond to broaching as a result, reflecting on other relevant intersectional identities, identifying the client's readiness to explore REC factors, the strength of the therapeutic relationship (i.e., the level of authenticity and safety), and the provider's belief in their broaching skill ability. Day-Vines et al. (2021) noted that cultural humility (i.e., openness, curiosity, other-focused) and cultural comfort (i.e., engaging in a calm, relaxed, and non-defensive manner when discussing culturally relevant information; Owen et al., 2017) can help cultivate an authentic therapeutic relationship that allows clients to feel safe and secure in disclosing REC related information.

The preparation stage takes the information gathered during the assessment stage and begins to clarify the potential broaching event. This includes first, identifying the purpose or goal of engaging in broaching. Second, the provider should include information from the assessment

stage, as well as observations about the client's verbal and nonverbal behaviors, in their broaching statement. Third, the provider should plan to label or note to later identify the specific types of oppression and -ism playing a role in the client's experience.

Finally, the delivery stage focuses on engaging in the broaching behavior and involves a five step recipe, including sharing the broaching statement and responding to the client's initial response, incorporating a brief period of silence for the client to reflect, welcoming the client to share their thoughts and reactions, incorporating the client's responses to also identify specific oppression and -isms at play, and further explore the client's concerns surrounding their REC related experiences.

In training programs, Day-Vines et al. (2018) identified the following recommendations to teach and increase broaching skills. First, increase racial self-awareness by creating safe spaces that can support students in exploring their own attitudes, biases, and assumptions about REC and provide support in navigating affective reactions to these topics and self-reflection. Day-Vines et al. also recommend incorporating and strengthening multicultural case conceptualization skills, using case studies and media to portray examples, and utilizing mock counseling sessions to practice skills.

Broaching Attitudes and Behavior Survey

Following the creation of the original theoretical model, Day-Vines et al. (2013) developed the *Broaching Attitudes and Behavior Survey (BABS)* scale, including preliminary structural factor analysis. However, a clear factor structure has not been identified at this time, as the theoretical model proposed a 5-factor model (Day-Vines et al., 2007; Day-Vines et al., 2018), while Zegley's (2007) dissertation found a 3-factor structure (avoidant, continuing/incongruent, and infused only) to have the best fit in a sample of 65 master's-level middle-school counselors.

Day-Vines et al. (2013) found a 4-factor structure (avoidant, continuing/incongruent, integrated/congruent, and infusing) to have the best fit in a sample of 365 BIPoC and White counselor trainees and practicing counselors (6% doctoral degrees) instead.

Empirical Research on the Impacts of Broaching

Previous research has generally looked at the impact of discussing REC factors without specifically focusing on the broaching construct identified by Day-Vines et al. (2007). Scholars have agreed that discussing conversations of race, ethnicity, and culture is related to and requires a multiculturally competent approach (Fuertes et al., 2002; Cardemil & Battle, 2003; Choi et al., 2015; Ratts et al., 2016).

Outcome research has found that providers avoiding conversations surrounding REC factors brought up by clients can lead to poorer quality interactions, negative client emotional responses (e.g., dismissal, invalidation, frustration, disappointment), reduced client satisfaction in services, reduced client self-disclosures, early termination, and general hesitation of clients to engage in services (Thompson & Jenal, 1994; Burkard et al., 2016; Pope-Davis et al., 2002; Chang & Berk, 2009; Knox et al., 2003; Owen et al., 2016; Meyer & Zane, 2013). On the other end, engaging in conversations can lead to enhanced provider credibility, deeper client self-disclosure and willingness to return, improved working alliance, and increased therapeutic outcomes (Thompson, Worthington, et al., 1994; Pope-Davis et al., 2002; Gim et al., 1991; Chang & Berk, 2009; Zhang & Burkard, 2008; Zhang & McCoy, 2009; Thompson & Alexander, 2006).

King and Borders (2019) explored 575 BIPoC and White undergraduate students' ratings of broaching in cross-racial counseling dyads. Results found that BIPoC participants rated White providers at a higher rate than White participants at missed opportunities to broach. Compared to

the control condition, participants evaluated the providers' cultural humility level, using the Cultural Humility Scale, a client-rated scale about the counselor's cultural humility level, and cultural competence higher when broaching behaviors were present. Surprisingly, therapeutic alliance and willingness to return did not differ based on presence of broaching. The researchers also found that participants preferred a proactive broaching approach, a focus of broaching on the relationship, pointed broaching language, and focus on both similarities and differences when broaching did occur.

In a related field similar to the therapist-client dyad, Darby's (2014) qualitative dissertation focusing on White supervisee-supervisor dyads found when supervisors broached conversations of race, supervisees' noted an increased awareness of cultural influence in their clients' presenting concerns and more clearly identified clients' needs. When RECs were not broached during supervision, supervisees reported feeling their needs were not met and that RECs were not as important. In addition, White supervisees engaged in supervision with fellow White supervisors express general concerns with the ability to broach.

Empirical Research on Providers' Broaching Behaviors

When looking at the quality and amount of discussing REC factors, research has found that compared to BIPoC providers, White providers similarly identify the importance of and willingness to discuss conversation of REC, but typically do so less, feel more uncomfortable, and pick up less on client's discomfort (Knox et al., 2003).

Looking more specifically into the broaching construct, providers have mentioned hesitancy about effectively engaging in broaching (Day-Vines et al., 2021) and there has been variation in pinpointing if and how providers broach. Jones and Welfare (2017) explored broaching behaviors in nine BIPoC and White licensed counselors working in addiction

treatment. Qualitative analyses found that the participants varied in broaching directly, indirectly, or not at all, most preferred to follow the client's lead versus being proactive, many felt the intake session was not appropriate to broach in, most identified the importance of provider willingness to engage, and what type of social identity broached was based on provider preference, similarities in the dyad, and context.

Analysis of White provider-BIPoC client dyad sessions in Canada has also found White providers generally did not broach during initial sessions, despite a wide arrange of cultural content presented by clients (Lee & Horvath, 2013) and reinforced Whiteness as the norm and dismissed structural and systemic racism (Lee & Bhuyan, 2013). White providers also became disengaged or responded negatively when REC relevant talk was presented by the client even after engaging positively and appropriately to previous clinical talk (Lee & Horvath, 2014).

Predictors for Broaching Behaviors

King and Summers (2020) explored how multicultural competence and interpersonal communication predicted broaching behaviors for 85 BIPoC and White licensed counselors and counselor trainees. Results indicated that multicultural competence was a strong, positive predictor of broaching. In addition, interpersonal communication as a predictor had a limited impact on broaching and was mediated by multicultural competence. Provider race and client racial similarity/dissimilarity to the provider did not significantly predict broaching. Counselor trainees did not significantly differ in their style of broaching with licensed counselors. However, more training and higher estimated number of direct hours significantly predicted increased broaching behaviors.

Dissertation research has also looked at provider characteristics related to broaching. Zegley's (2007) dissertation on 65 middle school counselors looked at broaching as a predictor

of multicultural competence. Results found that higher levels of broaching (i.e., Infusing subscale) significantly predicted higher multicultural competency levels.

Demographics and Broaching Behaviors. During the creation of the BABS, Day-Vines et al. (2013) found that White counselors and trainees rated themselves higher on the Avoidant and Continuing/Incongruent subscales compared to BIPoC participants. They also found that participants, regardless of race, rated themselves higher on the Continuing/Incongruent subscale when having less years of experience, while those with more years of experience rated themselves higher on the Integrated/Congruent subscale.

Looking at 210 school and clinical mental health counselors and counselor trainees, Day-Vines, Bryan, et al. (2022) explored broaching behaviors and if setting and race were significant predictors. Overall results indicated that White participants rated themselves higher on the BABS Avoidant and Continuing/Incongruent subscales, while no racial differences were identified for scores on the Integrated/Congruent or Infusing subscales. In terms of setting, school counselors scored higher on the BABS Avoidant subscale compared to clinical mental health and trainees and scored higher on the BABS Infusing subscale compared to trainees but not clinical mental health providers. Clinical mental health providers and trainees scored higher on the Continuing/Incongruent subscale compared to school counselors, while no setting effects were identified on the Integrated/Congruent subscale.

Looking at 198 master's level school counselor trainees, Day-Vines, Brodar, et al. (2022) explored broaching styles for White participants versus BIPoC participants. Surprisingly in this population, BIPoC participants rated themselves higher on the BABS Avoidant subscale and lower on the Infusing subscale. In looking at the predictor of participant's racial identity development (i.e., formation of attitudes and beliefs about people and self within the same racial

category; Helms & Cook, 1999), those with lower functioning (i.e., assimilation and self-hatred) rated higher on Avoidant broaching attitudes, while those with higher functioning (i.e., multiculturalist inclusive and ethnic-racial salience) rated higher levels of Infused broaching attitudes.

These findings on demographic group differences for broaching behaviors need further investigation due to their preliminary and at times conflicting nature. Thus, all demographic variables, including those previously identified, were included in the current study to further explore potential relationships with broaching style and control for potential covariance.

Broaching Research Limitations

In reviewing the broaching research, a theoretical model and scale has been constructed and expanded upon. Identifying the need to broach based on client outcomes has also been explored. However, the limited research has only just begun to explore why there is variability in broaching behaviors, focusing on a few possible provider characteristics, with many others (e.g., affective responses to racism, cultural humility) yet to be empirically researched. Exploration of providers' demographic variables has also shown varying impacts on broaching behaviors and requires more clarity.

In addition, the majority of the research focused on providers' self-perceptions of their broaching behaviors has primarily looked at master's level counselors and counselor trainees. No research, to the researcher's knowledge, has explored broaching behaviors and predictors for HSP doctoral trainees and early career psychologists. This warrants further exploration, as HSP doctoral trainees and early career psychologists may provide unique perspectives on broaching compared to other providers previously researched. In incorporating a multicultural and social justice approach, psychology training programs should tailor their interventions to meet the

specific needs of this population. This is especially true as doctoral psychology training programs are often longer than counselor programs. Students in the first year of their program may exhibit different broaching behaviors and needs for support than fifth- or sixth-year students currently on internship.

Researchers have repeatedly established that broaching behaviors can be seen as a multiculturally competent intervention, and yet all studies thus far have looked at the construct of multicultural competency, which has received critiques for ongoing mixed results in the general research, measurement difficulty, and limited change in services (Hook et al., 2013). Some broaching researchers have called for the use of cultural humility to be explored in conjunction with broaching behaviors, as it moves away from an assumption of having expertise over REC in conjunction with clients and towards a sense of humbleness, ongoing awareness and evaluation, and acknowledgement of power differentials, key areas mapping on to the broaching theoretical model. As of this date, the researcher is unaware of any research exploring cultural humility as a predictor for broaching. As such, it was included in the present study and will be discussed further in detail later on in this chapter.

In looking at the research on provider characteristics predicting broaching behaviors and recommendations for training programs, a reoccurring area involves providers' emotional responses, or affective reactions, to broaching (e.g., anxiety, fear, guilt) and discussing REC charged topics. As of this writing, the researcher is unaware of any research that has explored affective reactions as a predictor for broaching. As such, it was included in the present study and will be discussed further in detail next.

White Affective Responses to Racism and White Privilege

Research on affective (e.g., emotional) responses White people exhibit when discussing and/or interacting with racism and White privilege (Grzanka et al., 2019; Pinterits et al., 2009; Spanierman & Heppner, 2004) has been growing steadily over the last 15 years. Findings have begun to point to the significant role emotional responses may play in challenging systems of White supremacy and racist behaviors (Grzanka et al., 2019). Helms' (1990, 1995) White Racial Identity Development model also centers around the varying emotional responses a White person will have and their impact on the lens one views the world with, thus influencing typical behavioral responses.

Spanierman and Heppner (2004) identified these affective reactions as “costs” due to psychological and social ways a White individual can experience distress and/or loss due to being in power in a racially oppressive culture. Spanierman and Heppner (2004) stressed the clarification that these consequences are in no way equal to costs of racism experienced by BIPoC individuals or to be seen as a support for “reverse-racism,” hoping instead that clarifying these consequences can help explore why White individuals struggle in understanding, challenging, and implementing personal change against racism. Grzanka et al. (2019) categorized common emotional reactions into: emotions of racism and liminal emotions, (i.e., indicators of possible transition from racist to antiracist identity). Grzanka also notes emotions of antiracism (e.g., moral outrage, hope, compassion). However, no scales have been developed yet, and thus are not discussed in the current study.

The first racism emotion identified is White apathy (D'Andrea & Daniels, 2001; Grzanka et al., 2020), or not caring about racial inequality, externalizing blame for White privilege, and dismissing the role of race. Grzanka et al. (2020) use the term White negation for White apathy,

to emphasize the approach White individuals use to insulate or distance themselves from the potential for feeling White guilt and shame. Brown et al. (2019) noted White apathy/negation represents a contemporary form of racism, or the movement away from overt Jim Crow ideology to the covert color-blind racial ideology that the United States is post-racism (Bonilla-Silva, 2006; Neville et al., 2000), as it absolves responsibility for racism that no longer supposedly “exists.” However, researchers have found that exposure to diverse opportunities (Neville et al., 2014) and cross-racial mentors (Brown et al., 2019) decreased levels of White apathy/color-blind racial attitudes over time for teenagers and college-aged students.

The second racism emotion is White fear (Spanierman & Heppner, 2004; Spanierman et al., 2012), or an irrational mistrust of BIPoC individuals. Social psychology research on appraisal theory (Lerner & Keltner, 2001; Smith & Ellsworth, 1985) posits that fear happens when one perceives a threat that is high in uncertainty and has a lack of self-control, resulting in more pessimistic risk assessments. The origin of threat perceived in White fear then may come from a combination of the racial power-threat hypothesis (Blalock, 1967; Key [1949] 1984), which theorizes that changes in the size and power of the BIPoC population is perceived as a threat by White individuals to keep control over power and privilege, and social identity theory (Tajfel, 1981; Tajfel & Turner, 2004), in which fear helps maintain self-esteem about one’s own in-group superiority, while helping maintain majority group dominance by keeping valuable resources and power within the group and away from the out-group. White fear may result in similar avoidance or shutting down of conversations about race and racism, but with desire to avoid the potential for loss and negative impact on self-esteem and perceived safety. Previous research has found that lower levels of White fear was associated with higher levels of diversity courses and inter-racial friendships (Todd et al., 2011), while higher levels of White fear were

associated with lower levels of racial awareness and cultural sensitivity (Spanierman & Heppner, 2004).

Liminal emotions include: White guilt (Spanierman & Heppner, 2004; Pinterits et al., 2009; Iyer et al., 2003), or remorse and distress of realizing one's White privilege and the perpetration of racist thoughts and behaviors, White shame (Grzanka et al., 2019), or disgrace at being White and its accompanying power, and White empathy (Spanierman & Heppner, 2004), or having a better understanding of the ongoing pain, degradation, and experiences BIPoC individuals face in response to White supremacy and oppression.

It should be noted that Grzanka et al. (2019) stress the importance of parsing out the differences among White guilt and White shame, as one's responses and impact on behavior are uniquely different. Although White guilt and White shame may feel one in the same, clarifying that guilt is a focus on a behavior, while shame is a focus on the self (Tangney & Dearing, 2002; Lewis, 1971; Brown, 2007) is key. As a result, shame may result in a sense of immobilization, while guilt can motivate behavioral change, acknowledgment, seeking out new learning, and actively addressing wrongdoings (Leach et al, 2006; Tangney & Dearing, 2002). In addition to the distinction of self and behavior, Cohen et al. (2011) also note that shame and guilt are distinguished by a public and private dimension. In this sense, guilt can be seen as a private matter that violates one's own conscience, while shame is seen as being publicly exposed. Higher levels of White guilt have been associated with higher engagement in multicultural courses (Todd et al., 2011), in addition to higher levels of racial awareness and cultural sensitivity

Tangney and Dearing (2002) note that guilt and shame are emotions that have an influence on our interpersonal experiences, involve a self-evaluation, and component of morality

(i.e., values of conduct, what a society considers right and wrong). Individuals experiencing shame may blame others and themselves, feel powerless and unlovable, experience anger and hostility, and have reduced empathy. Individuals experiencing guilt typically have higher empathy than shame, are less angry or can better focus their anger towards helpful solutions, and more able to accept responsibility for negative interpersonal experiences. Brown (2007) noted that individuals experiencing shame are motivated by the fear of being perceived as imperfect and unworthy of acceptance and can experience fight or flight physiological responses of a perceived threat. Tangney (1993b) found undergraduate students experiencing shame more often felt observed by others, were more concerned with other's perception of them, and more isolated than those experiencing guilt. Individuals who experience guilt often describe feeling a sense of tension and remorse, are concerned with their effect on others, and express a desire to repair.

Spanierman and Heppner (2004) labeled the feelings of anger, sadness, helplessness, and/or frustration that result from understanding the ongoing dehumanizing experience BIPoC individuals face in the United States as White empathy. Elliot et al. (2011) summarizes previous research to identify empathy as having three components, including awareness, perspective-taking, and emotion regulation to manage the distress associated with the other person's discomforting experience. This allows for higher order cognitive processes, such as compassion. Research on empathy in the therapeutic space has also identified different modes and expressions of empathy, including empathic rapport, or demonstrating compassion towards the client to indicate understanding of their experience, communicative attunement, or in the moment attunement to the client's reactions and experiences, and person empathy, coined by Elliott et al. (2003), which involves an ongoing effort to understand how the client's past and present experiences impact how they feel, think, act, and see the world. Higher levels of White empathy

have been found to be associated with higher levels of racial awareness, cultural sensitivity, more cross-racial friendships, and gratefulness for diversity (Spanierman & Heppner, 2004; Spanierman et al., 2008; Todd et al., 2011). However, research has indicated that although individuals experiencing White empathy may recognize the injustice, empathy alone does not necessarily lead to accountability and action.

Empirical Research on White Affective Responses to Racism

The Psychosocial Costs of Racism to Whites Scale (PCRW) was constructed and validated by Spanierman and Heppner (2004) to further evaluate White responses to racism, constructing a three-factor model of White empathy, White guilt, and White fear. The exploratory and confirmatory factor analyses were normed on a sample of undergraduate students. Poteat and Spanierman (2008) also normed the PCRW on a sample of 284 employed adults across a variety of professions, finding the three-factor model to load somewhat inconsistently compared to the original college-aged sample. Specifically, the authors found the White Guilt subscale items did not load similarly and had lower reliability ($\alpha = .59$).

Further follow up by Spanierman et al. (2006, 2009, 2012) applied a cluster analysis to the PCRW subscale scores, finding five distinct cluster groups for undergraduate students. First, the oblivious group, consisting of low levels of White empathy and guilt and moderate fear, has individuals who endorsed color-blind attitudes, limited multicultural education, and few interracial friendships. Second, the empathic but unaccountable group, consisting of high levels of White empathy and low levels of guilt and fear, has individuals who have racially diverse friend groups and are aware of racial issues, but have limited awareness of White privilege. Third, the antiracist group, consisting of the highest levels of White empathy and guilt and the lowest White fear levels, had individuals who reported the highest levels of multicultural

education, the most racially diverse friend groups, the highest cultural sensitivity and support for affirmative action, and the lowest color-blind racial attitudes. Fourth, the fearful guilt group, consisting of high levels of White guilt and fear and moderate levels of White empathy, had individuals who were aware of their White privilege and higher levels of multicultural education, but their lower empathy and higher fear towards BIPoC individuals resulted in lower racially diverse friends and engagement. Finally, the insensitive and afraid group, consisting of the lowest White empathy and guilt levels and the highest White fear, had individuals who had the lowest multicultural education, least amount of cultural sensitivity, least exposure and engagement with BIPoC individuals, lowest racial awareness, and lowest support for affirmative action.

Spanierman et al. (2008) also looked at using White racial affect, via the PCRW, to predict multicultural counseling competence in 311 (study one) and 59 (study two) White psychology graduate trainees. In study one, overall mean scores were higher for the PCRW White Empathy and White Guilt subscales, while lower for White Fear subscale, compared to the original undergraduate normed sample. Results from study one found White empathy and White guilt to be significantly, negatively correlated with color-blind attitudes and significantly, positively correlated with multicultural counseling competence. White fear was found to be significantly positively correlated to color-blind attitudes and significantly negatively related to multicultural counseling competence. Overall White fear, White empathy, and White guilt were significant mediators for color-blind attitudes and multicultural competence. In study two, White guilt significantly predicted multicultural case conceptualization, and White empathy significantly predicted supervisors' ratings of participants' multicultural competence.

Todd et al. (2011) also found White affective responses (i.e., White guilt, fear, and empathy) can shift over time, in a longitudinal study of undergraduate students using the PCRW. Grzanka et al. (2020) also constructed the White Racial Affect Scale (WRAS) to further parse out White affective responses to racism. Dull et al. (2021) looked at 404 undergraduate students and their levels of White guilt, using the WRAS, in relation to civic action (i.e., social justice and social advocacy related behaviors and beliefs) and social responsibility. Results found White guilt related to more civic action in the context of high social responsibility. In the context of low social responsibility, White guilt related to less civic action. This again ties in previous discussions of how guilt and shame are emotions that can be shaped by the interpersonal experience.

White Affective Responses to Racism and Broaching

When looking towards the broaching construct (Day-Vines et al., 2007; Day-Vines et al., 2018), one can see how these affective responses may map on and impact broaching. Individuals with a higher level of integrated/congruent style may have higher levels of White empathy and additional exposure to working with BIPoC clients and engaging in multicultural/social justice training. This in turn may increase understanding of their client's lived experiences and ability to manage adverse personal reactions to recognizing, allowing for more effective rapport building, attunement, and conceptualization that takes into account BIPoC identity. Individuals experiencing higher levels of White guilt may demonstrate more medium levels of integrated/congruent style, as there is awareness, but approaches may be more disjointed or uneven as the focus appears more on alleviating the provider's uncomfortable feelings.

On the opposite end, White HSP providers with a lower level of integrated/congruent style may not broach as effectively due to limited awareness and dismissiveness as a result of

higher White apathy/negation, a desire to avoid acknowledgement and potential change due to higher levels of White fear, and/or immobilization due to higher levels of White shame.

Review of the broaching literature also points out that White affective reactions may be a provider characteristic impacting the variation of broaching (Day-Vines et al., 2021), with Day-Vines et al. (2018) stressing the importance of training programs to address feelings of anxiety, fear, and guilt in response to introspection about one's values, biases, and assumptions with REC factors. As noted above, many of the White affective reactions are considered interpersonal in nature and can be influenced by the relationship. This is crucial as broaching is also considered an interpersonal construct in nature. Individuals experiencing a certain emotion in response to REC factors a client brings up or a reminder from supervision to be more multiculturally sound may impact their ability to remain present and aware, identify nonverbal and verbal shifts, and have higher order cognitive processes to effectively reflect and plan out broaching statements. Closely related, the King and Summers (2020) research referenced earlier also found that racial color-blind attitudes, which somewhat overlaps with White apathy/negation, was a moderate negative predictor of broaching style.

Although White affective research has looked at the relationship with multicultural competence, of which broaching is considered an intervention, no direct research has examined the relationship between emotional responses of a provider (i.e., use of the PCRW or WRAS scales) and their broaching approach, particularly for White HSP doctoral level trainees and early career psychologists.

Cultural Humility

The importance of providing effective multicultural services has led to quantifying this ability into an original multicultural competency tripartite model (i.e., self-awareness,

knowledge, and skills; Sue et al., 1992) to ensure standardization of training and clinical services. However, subsequent research on multicultural competency has been rife with mixed-results, measurement difficulty, and limited change in service outcomes (Hook et al., 2013). Fisher-Borne et al. (2015) also critiqued that multicultural competency focuses more on awareness as a sense of being more comfortable with historically excluded social groups instead of exploring how one's own cultural experiences, worldview, and values impact clinical engagement and care, having a mastery of knowledge about other non-dominant groups, and failing to incorporate a more socially just approach to identify and challenge systemic forces. This has resulted in calls for an expansion and shift in focus.

One such evolution that has gained traction in the counseling psychology field is the idea of cultural humility. Cultural humility, originally introduced in the medical and nursing fields by Tervalon and Murray-Garcia (1998), is defined by Hook et al. (2013, p. 353) as “having an interpersonal stance that is other-oriented rather than self-focused, characterized by respect and lack of superiority toward an individual's cultural background and experience.” Cultural humility involves both an intrapersonal (i.e., awareness based on self-reflection and accurate view of the self) and interpersonal (i.e., eliminating beliefs of self-superiority and being open to and respectful of the client's beliefs, values, and worldviews) focus (Davis et al., 2010; Hook et al., 2013).

Rather than focusing on the HSP provider's assumption in having expertise on a client's racial experience based on mastery of particular multicultural skills or knowledge, a culturally humble HSP provider recognizes they can never fully know or understand a client's full experience and encourages a lifelong and curious approach. Hook, Watkins et al. (2016) describes cultural humility as an “initiate-invite-instill approach” (p. 154). Culturally humble

HSP providers welcome clients to self-identify their experiences with power and oppression based on intersectional and fluid social identities (Fisher-Borne et al., 2015). Culturally humble HSP providers also continue to evaluate their limited worldviews, reflect on how their own beliefs and attitudes impact the therapeutic process, acknowledge the power imbalance that occurs within an HSP provider-client relationship, challenge institutional and systemic-level obstacles, and work collaboratively with clients to gain a deeper understanding of their worldview (Hook et al., 2013; Hook & Davis, 2019; Gonzalez et al., 2021; Fisher-Borne et al., 2015). Aptly put, cultural humility is a way of being, as opposed to a way of doing (Hook et al., 2013).

Foronda et al. (2016) conducted a concept analysis to further understand and summarize cultural humility, identifying five attributes that make it up: openness (i.e., having an attitude that is keen to explore new ideas), self-awareness (i.e., being aware of one's strengths, growth edges, worldviews, beliefs, and values), egoless (i.e., being humble or getting rid of one's ego), supportive interaction (i.e., interactions that results in positive human exchanges), and self-reflection and critique (i.e., introspection and evaluation of oneself). They also found that consequences of cultural humility included mutual empowerment and relationships, respect, effective treatment, and lifelong learning.

Empirical Research on Cultural Humility

Much of the empirical research thus far has focused on client-rated cultural humility approaches and scales (e.g., the Cultural Humility Scale; Hook et al., 2013). Hook et al. (2013), across a series of studies, found undergraduate students rated cultural humility as significantly more important than similarity, skills, knowledge, or experience when looking for a therapist. In addition, participants who rated therapists as having higher levels of cultural humility reported a

greater chance of developing a strong therapeutic alliance, more positive expected therapy outcomes, and a higher chance of continuing therapy with them. Hook et al. (2013), in a participant sample of college counseling clients, also found participant opinions of their therapist's cultural humility level significantly predicted working alliance, even when controlling for multicultural skills, knowledge, and awareness. In a sample of adults in the community who identify as Black and actively engaged in therapy services, Hook et al. (2013) also found perceptions of improvement in therapy were significantly explained by a mediated effect of cultural humility through working alliance. Hook, Farrell et al. (2016) also found in a study of 2,212 BIPoC adult participants who had previously engaged in therapy services (comprised of a racially/ethnically diverse counselor group) that client-perceived cultural humility was significantly associated with lower frequency of racial microaggressions and a lower negative impact of racial microaggressions when they occurred. These findings were present, even when controlling for ratings of providers' general and multicultural competency. Of note, the research also found that the most common racial microaggressions experienced by participants were racial color-blind statements and avoidance of discussion of cultural issues.

In a study involving 247 college counseling center clients who had recently finished therapy (Owen et al., 2016), correlations among cultural humility, missed cultural opportunities (i.e., missing openings in session to directly address or broach a client's cultural identity; Owen, 2013), and therapy outcomes indicated a positive, significant association between cultural humility and client outcomes. In addition, cultural humility acted as a buffer or safeguard, with the relationship between missed opportunities and negative therapeutic outcomes being nonsignificant for those therapists rated higher on cultural humility.

In a study with 128 undergraduate students who identified as BIPoC and attended therapy within the past year, Davis et al. (2016) also found that cultural humility mediated the relationship between the client's negative affective response as a result of a rupture and counseling outcomes (i.e., working alliance and perceived improvement). Cultural humility has also been found in dissertation research to significantly predict social justice advocacy attitudes in play therapists (Chase, 2021).

Research focusing on cultural humility within the clinical supervisory relationship has also found similar results to the therapeutic relationship. King et al. (2020) found supervisee-perceived supervisor's level of cultural humility significantly predicted the quality of the working alliance in a study of 67 master's level counseling practicum students with diverse racial/ethnic backgrounds. Cook et al. (2020) found in a sample of 101 recently post-graduate master's level counselors with diverse racial/ethnic backgrounds that the supervisee-perceived cultural humility level of the supervisor significantly predicted supervisee disclosures. Vandament et al. (2021), in a sample of 87 supervisees who identified as BIPoC and primarily doctoral level trainees or early career professionals, found supervisee-perceived cultural humility level of their White supervisor was significantly, positively associated with supervisee openness and working alliance. Wilcox et al. (2021), in a sample of 127 supervisees with diverse racial/ethnic backgrounds and primarily from doctoral level HSP programs, found supervisee-perceived cultural humility level of their supervisor was significantly associated with the supervisees' satisfaction of the supervisory experience. Finally, Jadaszewski's (2020) dissertation research found supervisees' negative affective responses as a result of a rupture were negatively associated with supervisee-perceived cultural humility level of the supervisor, in addition to a positive association between the working alliance and cultural humility level.

The Multidimensional Cultural Humility Scale (MCHS) was constructed and validated by Gonzalez et al. (2021) to further explore cultural humility by incorporating a counselor-based self-report of perceived cultural humility. Eight hundred sixty-one licensed therapists, including master's and doctoral level providers in social work, marriage and family, psychology, and counselor fields, participated in the initial validation study.

Cultural Humility and Broaching

King and Borders (2019), when looking at different vignettes of broaching and cultural humility, found 575 undergraduate students rated cultural humility higher for the scenario that involved a proactive broaching statement focused on therapist-client relationship and included acknowledgement of both similarities and differences, while rating the broaching scenario with no broaching statement as lower in cultural humility.

Askren (2022), in their dissertation research of 45 master's level clinicians with diverse racial/ethnic backgrounds in a foundational counseling skills course, found direct teaching and support on cultural humility, broaching, and intersectionality, compared to a control group ($N = 34$) without specific said teaching, resulted in significantly increased culturally based references in mock counseling dyads. Within this experimental group, the amount of culturally based references also significantly increased across the five days of experiential learning, even when specific broaching prompts were no longer provided. Of note, more than half of the culturally based references were related to religion, with this study being conducted at a Christian university.

In review of the literature, however, no research currently has looked at if cultural humility predicts level of broaching, particularly for White HSP doctoral level trainees and early career psychologists. Theoretically, researchers (Jones & Branco, 2020) hypothesize that

broaching and cultural humility are interconnected and bidirectional in nature, with cultural humility necessary to broach in an effective manner, which in turn positively reinforces cultural humility by creating and strengthening a more genuine therapeutic relationship that supports more open conversations about REC factors. Indeed, Jones and Branco (2020) note that broaching can be seen as an actionable skill expression of cultural humility.

When looking towards the broaching construct (Day-Vines et al., 2007; Day-Vines et al., 2018), one can see how cultural humility may map on and impact broaching. As integrated/congruent HSP providers have the awareness and understanding to initiate and continue engaging in conversations about race with clients, it would imply a need for openness and focus on the other, as well as a sense of humbleness to value an understanding of their clients culturally at an emic, personal level. Individuals who have lower levels of integrated/congruent broaching style may not see the need as they have limited previous experience or may not realize at all the importance of discussing. Cultural humility's focus on the relational way of being with a client also lends itself nicely to processing the experience of cross-racial pairings and humbleness for HSP providers to acknowledge potential limitations, mishaps, and microaggressions.

Demographic Variables, Cultural Humility, and Broaching

Although multicultural competency is a separate, but related construct to cultural humility and broaching, group differences found in the previous research can help identify additional demographic variables to include in the present study. This again can help investigate additional predictors for broaching style and control for potential covariance.

In looking at theoretical orientation, Constantine and Ladany (2001) found that White HSP providers with an eclectic/integrative approach rated significantly higher on multicultural

case conceptualization and treatment skills than White HSP providers with a psychodynamic or cognitive-behavioral approach. Constantine and Ladany (2001) hypothesized this may be due to the flexibility to integrate new and additional approaches. With regards to the Broaching scale (Day-Vines et al., 2013), one's flexibility to incorporate multicultural and social justice orientation specific approaches may help a therapist move towards integrated/congruent broaching style.

In addition, although findings have been mixed, some researchers believe those self-identifying as female may experience higher levels of multicultural counseling competency due to general awareness from one's own oppressed gender status (Smith et al., 2006). In being aware of the intersection of identities in relation to power and oppression, other minority related identities a White HSP provider holds (e.g., religious status, sexual orientation) may impact awareness and openness to learning about race. Similar to theoretical orientation, having a more open approach to understanding REC factors, power, and oppression may allow for more growth towards an integrated/congruent broaching style.

Summary of the Problem

As the literature identifies, broaching is a valuable approach in response to calls to provide more multicultural and socially just therapeutic care. Outcomes research has identified the valuable impact broaching can provide for clients, including retention, satisfaction with services, self-disclosures, and perceived improvement. Yet White HSP providers continue to struggle and engage inconsistently. Preliminary research has begun to look at potential impacts among and within White HSP providers, including the role provider characteristics play. However, many theorized characteristics, including emotional responses and cultural humility, need to be empirically explored and strengthened. As such, the current study aims to contribute

to the literature by continuing to clarify and understand the broaching construct. In addition, as there has been limited broaching research focused specifically on White HSP doctoral level trainees and early career psychologists, further exploration is needed. Focusing on this population can help provide recommendations to help training programs better support their students with regards to broaching and tailor recommendations for training purposes. Additional responses from BIPoC and bi-racial/multiracial individuals who do not identify as White can help supplement the main analyses and provide training recommendations beneficial for all students.

An overarching goal and potential outcome of this research is to help White HSP providers deliver more effective, affirming services for BIPoC clients grounded in a multicultural and socially just approach. Doing so would hopefully increase the overall quality of mental health services, disrupt larger systems of racism prevalent in the field, and improve overall health outcomes for historically underserved communities.

To address this research gap, the researcher posed the following research questions:

- (1) Do affective variables (i.e., White empathy, White guilt, White shame, White fear, and White negation/apathy) predict an integrated/congruent broaching style? If so, how do these variables predict an integrated/congruent broaching style?
- (2) Is there a particular makeup of affective variables related to an integrated/congruent style (e.g., high empathy and low shame)?
- (3) Does the cultural humility level predict an integrated/congruent broaching style? If so, how do these variables predict an integrated/congruent broaching style?

The following hypotheses were proposed based on previous research:

(1) Hypothesis 1. It was hypothesized that affective variables will predict an integrated/congruent broaching style in varying degrees. In particular, it is anticipated that higher levels of White empathy will predict higher levels of integrated/congruent broaching style, while higher levels of White fear and White negation/apathy will predict lower levels. Due to differing impacts on behavior, it is also anticipated that higher levels of White guilt will predict a higher integrated/congruent broaching style, while a higher level of White shame will not.

(2) Hypothesis 2. It is hypothesized that multiple affective variable clusters will arise, each with a different relationship to overall integrated/congruent broaching style. The specific presence and level within each cluster is unknown at this time, due to limited previous research.

(3) Hypothesis 3. It is hypothesized that higher levels of cultural humility will predict higher levels of integrated/congruent broaching style.

CHAPTER THREE

METHODS

This chapter includes the following information: description of sample characteristics, data collection procedure, psychometric characteristics of included instruments, and the data analytic strategy.

The overall study followed a quantitative design approach with supplemental qualitative responses. As the topic of broaching is relatively new and in need of further empirical support, quantitative analysis was chosen to help determine the relation of related constructs to broaching to help establish and generalize findings. In addition, optional qualitative questions were included to provide more nuanced information about a participant's broaching experience to support appropriate training recommendations.

Participants

In order to determine the necessary sample size to have sufficient power to run the hierarchical linear regression analysis, an a priori analysis utilizing G*Power 3.1 program (Faul, Erdfelder, Buchner, & Lang, 2009) was used. Calculation for the G*Power statistical analysis included: a medium effect size of $f^2 = 0.20$, per Cohen (1988), a significance level (α err prob) of 0.05, a power ($1-\beta$ err prob) of 0.80, six tested predictors, and 11 total number of predictors (accounting for possible covariances). The G*Power 3.1 results for the linear multiple regression: fixed model, R^2 increase, indicated at minimum, a total sample size of 76 participants

for sufficient power, although more was recommended to ensure enough power to test the significance of the individual Beta (β) value of each predictor variable.

A total of 114 participants who self-identified as HSP advanced doctoral level trainees (i.e., at least one year of clinical therapy training) and early career psychologists participated. Based on the survey approach and distribution, all were welcome to participate regardless of self-identified race/ethnicity. Participants were then split into (a) those who identified as White, including bi/multiracial individuals who chose to complete the PCRW and WRAS subscales ($N = 87$) from (b) those who identified as BIPoC, including bi/multiracial individuals who chose not to complete the White affect scales ($N = 27$). Moving forward, demographics will be discussed and presented separately for White individuals (group A) and BIPoC individuals (group B) based on data analysis grouping. Please see Table 1 for demographic information of each group and the combined group, including frequencies and percentages.

Table 1. Sample Demographic Characteristics

	Group A ($N = 87$)		Group B ($N = 27$)		Total Sample ($N = 114$)	
	Freq.	%	Freq.	%	Freq.	%
Gender Identity						
Cisgender Woman	70	80.5	21	77.8	91	79.8
Cisgender Man	15	17.2	6	22.2	21	18.4
Nonbinary	2	2.3	--	--	2	1.8
Sexual Orientation						
Bisexual	16	18.4	8	29.6	24	21.1
Gay	4	4.6	1	3.7	5	4.4
Lesbian	6	6.9	--	--	6	5.3
Heterosexual	54	62.1	16	59.3	70	61.4
Pansexual	2	2.3	--	--	2	1.8
Questioning	2	2.3	1	3.7	3	2.6
Prefer not to answer	--	--	1	3.7	1	0.9
Other (i.e., Queer)	3	3.4	--	--	3	2.6

Race / Ethnicity						
Black, African American, of African Descent	--	--	9	33.3	9	7.9
Latinx, Hispanic, of Spanish Descent	--	--	4	14.8	4	3.5
Asian, Asian American, of Asian Descent	--	--	11	40.7	11	9.6
White, of European Descent	80	92.0	--	--	80	70.2
Biracial, multiracial	7	8.0			10	8.8
Religion						
Catholic	11	12.6	3	11.1	14	12.3
Protestant	2	2.3	1	3.7	3	2.6
Christian	12	13.8	7	25.9	19	16.7
Jewish	5	5.7	--	--	5	4.4
Agnostic	15	17.2	2	7.4	17	14.9
Muslim	--	--	1	3.7	1	0.9
Hindu	--	--	2	7.4	2	1.8
Atheist	14	16.1	2	7.4	16	14.0
Secular/nonreligious	8	9.2	1	3.7	9	7.9
Spiritual	6	6.9	5	18.5	11	9.6
Prefer not to answer	1	1.1	1	3.7	2	1.8
Other (e.g., Pagan, pantheist, Unitarian)	4	4.5	1	3.7	5	4.4
Multiple Responses	9	10.3	1	3.7	10	8.8
Social Class						
Lower class	5	5.7	3	11.1	8	7.0
Lower middle class	20	23.0	12	44.4	32	28.1
Middle class	30	34.5	9	33.3	39	34.2
Upper middle class	26	29.9	3	11.1	29	25.4
Upper class	6	6.9	--	--	6	5.3
Graduation Status						
Current student	60	69.0	22	81.5	82	71.9
Early Career Psychologist	27	31.0	5	18.5	32	28.1
Program Kind						
Ph.D.	57	65.5	20	74.1	77	67.5
Psy.D.	30	34.5	7	25.9	37	32.5
Program Type						
Clinical Psychology	41	47.1	8	29.6	49	43.0
Counseling Psychology	40	46.0	18	66.7	58	50.9
School Psychology	2	2.3	1	3.7	3	2.6
Combination Program	3	3.4	--	--	3	2.6
Other (e.g., Clinical Health)	1	1.1	--	--	1	0.9

Theoretical Orientation						
CBT	34	39.1	3	11.1	37	32.5
Psychodynamic	7	8.0	5	18.5	12	10.5
Humanistic	9	10.3	2	7.4	11	9.6
Feminist/Multicultural	7	8.0	5	18.5	12	10.5
Integrated/Eclectic	30	34.5	12	44.4	42	36.8
	Group A (N = 87)		Group B (N = 27)		Total Sample (N = 114)	
	M	SD	M	SD	M	SD
Age	29.68	4.21	30.07	4.62	29.77	4.29
Years in Program Currently	5.03	1.15	5.09	1.23	5.05	1.16
Years Postdoc	4.31	2.81	4.00	3.08	4.26	2.80
Years Direct Clinical Services	4.74	2.76	5.06	2.65	4.82	2.73
Percentage of BIPoC clients	0.37	0.22	0.48	0.25	0.397	0.23

White Participants (Group A)

Eighty-seven participants self-identified as White (92%), while 8% identified as biracial or multiracial, including White, and chose to complete the White affective scales (i.e., PCRW and WRAS). Participants ages ranged from 23 years to 47 years of age, with a mean of 29.68 ($SD = 4.21$). A majority of participants identified as cisgender women (80.5%), 17.2% identified as cisgender men, and 2.3% identified as nonbinary. Regarding sexual orientation, 62.1% identified as heterosexual, 18.4% as bisexual, 6.9% as lesbian, 4.6% as gay, 3.4% as other (i.e., queer), 2.3% as pansexual, and 2.3% as questioning. Participants included those who identified as agnostic (17.2%), atheist (16.1%), Christian (13.8%), Catholic (12.6%), multiple responses (10.3%), secular/non-religious (9.2%), spiritual (6.9%), Jewish (5.7%), other (e.g., pagan, pantheist, Unitarian Universalist; 4.5%), Protestant (2.3%), and prefer not to answer (1.1%). Regarding social class growing up, participants identified as lower class (5.7%), lower middle class (23%), middle class (34.5%), upper middle class (29.9%), and upper class (6.9%). 69% were current doctoral students, while 31% were early career psychologists. 65.5% of participants

reported to be in a Ph.D. program (65.5%), while 34.5% reported to be in a Psy.D. program. Regarding program type, 47.1% individuals identified from a clinical psychology program, 46.0% from a counseling psychology program, 3.4% from a combination program (i.e., clinical/counseling/school), 2.3% from a school psychology program, and 1.1% as other (i.e., clinical health). Participants self-identified their theoretical orientation as 39.1% Cognitive Behavioral Therapy, 34.5% integrated/eclectic, 10.3% Humanistic, 8% Feminist/Multicultural, and 8% Psychodynamic.

Current students noted their number of years in the program ranged from 3 years to 7 years, with a mean of 5.03 ($SD = 1.15$). Early career psychologists noted their years since graduating ranged from 2 years to 10 years ago, with a mean of 4.31 ($SD = 2.81$). Participants noted the number of years they had provided clinical services ranged from 1 year to 13 years, with a mean of 4.74 ($SD = 2.76$). Finally, participants noted their average percentage of BIPoC clients ranged from 0% to 98%, with a mean of 37% ($SD = 22$).

BIPoC Participants (Group B)

Twenty-seven participants self-identified as Asian/Asian American/of Asian Descent (40.7%), while 33.3% identified as Black/African American/of African Descent, 14.8% as Latinx/Hispanic/of Spanish Descent, and 11.1% identified as biracial or multiracial, not including White, and chose not to complete the White affective scales (i.e., PCRW and WRAS). Participants ages ranged from 23 years to 44 years of age, with a mean of 30.07 ($SD = 4.62$). A majority of participants identified as cisgender women (77.8%), while 22.2% identified as cisgender men. Regarding sexual orientation, 59.3% identified as heterosexual, 29.6% as bisexual, 3.7% as gay, 3.7% as questioning, and 3.7% preferred not to answer. Participants included those who identified as Christian (25.9%), spiritual (18.5%), Catholic (11.1%), agnostic

(7.4%), atheist (7.4%), Hindu (7.4%), multiple responses (3.7%), secular/non-religious (3.7%), other (3.7%), prefer not to answer (3.7%), Muslim (3.7%), and Protestant (3.7%). Regarding social class growing up, participants identified as lower class (11.1%), lower middle class (44.4%), middle class (33.3%), and upper middle class (11.1%). 81.5% were current doctoral students, while 18.5% were early career psychologists. 74.1% of participants were part of a Ph.D. program, while 25.9% were of a Psy.D. program. Regarding program type, 29.6% were part of a clinical psychology program, 66.7% in counseling psychology, and 3.7% in school psychology. Participants self-identified their theoretical orientation as 44.4% integrated/eclectic, 18.5% Feminist / Multicultural, 18.5% Psychodynamic, 11.1% CBT, and 7.4% Humanistic.

Current students noted their number of years in the program ranged from 2 years to 7 years, with a mean of 5.09 ($SD = 1.23$). Early career psychologists noted their years since graduating ranged from 2 years to 9 years ago, with a mean of 4.00 ($SD = 3.08$). Participants noted the number of years they had provided clinical services ranged from 2 year to 13 years, with a mean of 5.06 ($SD = 2.65$). Finally, participants noted their average percentage of BIPOC clients ranged from 10% to 95%, with a mean of 48% ($SD = 25$).

Measures

Demographic Questionnaire

All participants from groups A and B completed a demographic survey assessing for race/ethnicity, gender identity, sexual orientation, religious status, social class, age, graduation status, year in program (if current student), year postgraduation (if early career psychologist), program kind (i.e., Ph.D. or Psy.D.), program type (e.g., clinical, counseling, school), theoretical orientation, years of direct clinical services, and percentage of BIPOC clients. A wide array of

demographic information was collected due to limited research to examine potential differences in study variables by demographic variables and control for possible covariates.

Psychosocial Costs of Racism to Whites Scale (PCRW)

Participants in group A responded to the PCRW (Spanierman & Heppner, 2004), which measures the negative emotional responses of White guilt, White fear, and White empathy that White individuals experience when acknowledging White privilege and the racial hierarchy White supremacy upholds in U.S. culture. The PCRW is a 16 item self-report measure that is rated using a 6-point Likert-type scale ranging from 1 (strongly disagree) to 6 (strongly agree), with higher scores representing higher experiences of psychosocial costs. The PCRW is comprised of three subscales, including White Empathic Reactions toward Racism (six items; e.g., “I become sad when I think about racial injustice”), White Guilt (five items; e.g., “Sometimes I feel guilty about being White”), and White Fear of People of Other Races (five items; e.g., “I am distrustful of people of other races”). Recent calls in the relevant literature have noted the importance to distinguish between White Guilt and White Shame due to the difference in outcomes on combatting racism (Grzanka et al., 2020). Thus, for the current study, only the White Empathic Reactions toward Racism and White Fear of People of Other Races subscales from the PCRW were used. White guilt was measured using the White Racial Affect Scale (WRAS), discussed next.

Test-retest reliability over a 2-week period was reported, including 0.84 (White Empathic Reactions Towards Racism) and 0.95 (White Fear of People of Other Races). Ranges for coefficient alphas reported were 0.78-0.85 (White Empathic Reactions toward Racism), and 0.63-0.78 (White Fear of People of Other Races; Spanierman & Heppner, 2004). Initial Cronbach’s alphas in the present study were .50 for White Empathic Reactions and .48 for White

Fear. Due to these low Cronbach's alphas, the researcher reviewed the inter-item correlations and removed lower items to increase reliability. As a result, the PCRW White Empathic Reactions scale had a corrected α of .77 for the retained four items and the PCRW White Fear scale had a corrected α .61 for the retained three items. See chapter four for complete details.

Support for convergent validity was previously demonstrated with a negative association of the PCRW's White Empathic Reactions Towards Racism and a positive association of White Fear of People of Other Races scale towards the Color-Blind Racial Attitudes Scale (CoBRAS; Neville et al., 2000). Additional convergent validity was demonstrated with significant associations towards the Scale of Ethnocultural Empathy's (SEE; Wang et al., 2003), Quick Discrimination Index (QDI; Ponterotto et al., 1995), and the Oklahoma Racial Attitudes Scale (ORAS; LaFleur et al., 2002).

White Racial Affect Scale (WRAS)

To explore additional White affective responses, participants in group A also respond to the WRAS (Grzanka et al., 2020), which measures the negative emotional responses of White Guilt, White Shame, and White Negation (i.e., apathy and externalization). The WRAS was created in response to the weakness identified in psychometric measures of affective responses to further parse out differences among the three connected but distinct constructs. The WRAS is an 18 item self-report measure where participants responded to scenario-based statements using a 5-point Likert-type scale ranging from 1 (not likely) to 5 (very likely). The WRAS is comprised of three subscales, including White Guilt (seven items; e.g., "You would think: 'I wish there was something I could do to make up for all the harm slavery caused Black people.'"), White Negation (seven items; e.g., "You would think: 'Slavery was awful, but people need to get over

it and move on.”), and White Shame (four items; e.g., “You would hate yourself for being White.”). For the present study, participants responded to all three subscales.

Test-retest reliability over a 2-week period was reported, including 0.92, 0.90, and 0.86 respectively. Ranges of coefficient alphas reported were 0.76-0.82 for White Guilt, 0.68-0.73 for White Negation, and 0.68-0.72 for White Shame. For the present study, initial Cronbach’s alphas were .69 for White Guilt, .57 for White Negation, and .54 for White Shame. Due to these low Cronbach’s alphas, the researcher reviewed the inter-item correlations and removed lower items to increase reliability. As a result, the WRAS White Guilt scale Cronbach’s alpha did not change, as removing items lowered it, the WRAS White Negation had a corrected α of .59 for the retained six items, and the WRAS White Shame had a corrected α of .62 for the retained four items. See chapter four for complete details.

Support for convergent validity was previously demonstrated with WRAS-White Guilt and WRAS-White Shame having a positive association with the PCRW-White Guilt scale (Spanierman & Heppner, 2004) and White Guilt Scale (Swim & Miller, 1999), along with a weak but positive association among the WRAS-White Guilt and Test of Self-Conscious Affect-3, Short Form’s (TOSCA-3; Tangney & Dearing, 2002) Guilt-proneness subscale. WRAS-White Shame also demonstrated a positive association with the TOSCA-3 Shame-proneness subscale. Finally, the WRAS-Negation demonstrated a negative association with the PCRW-White Guilt scale (Spanierman & Heppner, 2004) and White Guilt Scale (Swim & Miller, 1999). Support for predictive validity was demonstrated with a negative association with the WRAS-White Guilt and WRAS-White Shame and Racism, as measured by the Racial Argument Scale (RAS; Saucier & Miller, 2003), while the WRAS-Negation demonstrated a positive association with the RAS. Finally, incremental validity was demonstrated using hierarchical linear regression analyses, with

the WRAS-White Guilt scale significantly predicting racist attitudes above and beyond the PCRW-White Guilt (Spanierman & Heppner, 2004), White Guilt Scale (Swim & Miller, 1999), and TOSCA-3 White guilt proneness scale (Tangney & Dearing, 2002).

Multidimensional Cultural Humility Scale (MCHS)

All respondents in groups A and B responded to the MCHS (Gonzalez et al., 2021), which measures a provider's perceived cultural humility levels. Overall measures of cultural humility are currently limited, with the MCHS being the first self-evaluation scale available. The MCHS (Gonzalez et al., 2021) is based on Foronda et al.'s (2016) concept analysis and is a 15 item self-report measure that is rated using a six-point Likert-type scale ranging from 1 (strongly disagree) to 6 (strongly agree), with higher scores representing higher perceived cultural humility. The MCHS is composed of a total score, in addition to five subscales, including Openness (3 items; e.g., "I seek to learn more about my clients' cultural background), Self-Awareness (3 items; e.g., "I seek feedback from my supervisors when working with diverse clients"), Ego-less (3 items; e.g., "I ask my clients to describe their problem based on their cultural background"), Supportive Interactions (3 items; e.g., "I wait for others to ask about my biases for me to discuss them" reverse coded), and Self-Reflection and Critique (3 items; e.g., "I enjoy learning from my weaknesses").

Coefficient alphas reported for the total score were .78-.79, while the subscales were .73-.76, .69-.66, .77-.72, .62-.56, and .59-.53 respectively. Although EFA and CFA analyses supported a five-factor model (Gonzalez et al., 2021), a second CFA analysis also found support for MCHS used as a unidimensional model, due to the low internal consistencies of the Supportive Interactions and Self-Reflection and Critique subscales. As such, only the MCHS total score was used. For the present study, initial Cronbach's alpha for the MCHS total score for

group A was .78, .81 for group B, and .79 for the combined total group. Due to Group A being below .80, the researcher reviewed the inter-item correlations and removed lower items to increase reliability. As a result, the MCHS total score had a corrected α of .82 for group A, a corrected α of .85 for group B, and a corrected α .84 for the combined total group on the retained 12 items. See chapter four for complete details.

Support for validity was previously demonstrated with a positive association of MCHS subscale scores with the Situational Self-Awareness Scale's (SSAS; Govern & Marsch, 2001) three subscales (i.e., public self-awareness, private self-awareness, and awareness of immediate surroundings). Finally, small and nonsignificant associations of MCHS subscale scores and the Multicultural Social Desirability Scale-Short Form (MCSDS; Reynolds, 1982) previously demonstrated discriminant validity.

Broaching Attitudes and Behavior Survey (BABS)

All respondents in groups A and B responded to the BABS (Day-Vines et al., 2013), which measures the continuum of a counselor's orientation towards broaching discussions of race, ethnicity, and cultural factors in session with a client. Broaching behaviors were theoretically conceptualized by Day-Vines et al. (2007) with five categories, including avoidant, isolating, continuing/incongruent, integrated/congruent, and infusing. However, initial development and validation by Day-Vines et al. (2013) found only a four-factor model, with the isolating factor items frequently overlapping with avoidant items and subsequently being dropped.

The BABS is 43 item self-report measure that is rated using a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). It is composed of four subscale scores, including Avoidant (14 items; e.g. "given the time-limited nature of counseling, broaching is not

appropriate for short-term problem solving”), Continuing/Incongruent (10 items; e.g., “I experience a sense of awkwardness when I address racial and cultural factors during the counseling process”), Integrated/Congruent (10 items; e.g., “I generally broach racial and cultural factors throughout my counseling sessions with clients”), and Infusing (nine items; e.g., “as a counselor, I am socially/politically committed to the eradication of all forms of oppression”). For the present study, only the Integrated/Congruent subscale was used, as theoretically it appeared more congruent with where advanced trainees and early career psychologists may be in their broaching compared to the Infusing subscale.

The coefficient alpha for the Integrated/Congruent subscale was previously reported to be .80. For the present study, the Cronbach’s alphas were .82 for group A, .77 for group B, and .81 for the combined total group. All 10 items were retained. Support for overall validity of the BABS was previously demonstrated in Zegley’s (2008) dissertation with a positive association of the BABS’ Infusing scale to all MCI total and subscale scores (Awareness, Knowledge, Skill, Relationship; Sadowsky, 1996; Sadowsky et al., 1994) and the BABS’ continuing/incongruent scale with MCI’s relationship and total score only. Interestingly, the BABS’ avoidant scale had relatively small and negative insignificant associations with the MCI (Sadowsky, 1996; Sadowsky et al., 1994) which may relate to the theory that individuals who typically engage in avoidant broaching styles have limited multicultural counseling competency skills. Finally, a negative association between the BABS Infusing scale specifically and Social Desirability Scale (SDS; Reynolds, 1982) was identified in Zegley’s (2008) dissertation.

Balanced Inventory of Desirable Responding Short Form (BIDR-16)

All participants in groups A and B responded to the BIDR-16 (Hart et al., 2015), which is a 16-item scale for social desirability responding and evaluates the tendency to present oneself in

a favorable way. The BIDR-16 was adapted from Paulhus' (1991, 1998) Balanced Inventory of Desirable Responding (BIDR-40) 40-item scale to provide a valid and practical short form for researchers to use instead of an outdated but popular Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) short form. Specifically, the BIDR (short and original form) is a response to MCSDS critiques, including revised language and incorporation of a two-factor model, distinguishing social desirability between impression management and self-deceptive enhancement (Paulhus, 1984). Impression management involves a purposeful and dishonest response by over-reporting positive behavior or under-reporting negative behavior to appear more favorable to others. Self-deceptive enhancement, on the other hand, is an unconscious tendency to perceive oneself in an honest but overly favorable way (Paulhus, 1984; Hart et al., 2015). Discriminating between these two factors allows for a more nuanced and accurate control of social desirability's potential bias on self-report data.

The BIDR-16 (Hart et al., 2015) is a 16-item self-report measure that is rated using an 8-point Likert-type scale ranging from 1 (totally disagree) to 8 (totally agree). The BIDR-16 is composed of a total score, in addition to two subscale scores, Impression Management (8 items; e.g., "I never cover up my mistakes") and Self-Deceptive Enhancement (8 items; e.g., "I never regret my decisions"). For the present study, only the total score was used.

Overall, Hart et al. (2015) found the BIDR-16 to retain similar reliability, validity, and two-factor conceptual structure of the BIDR-40 (Paulhus, 1991, 1998). Although coefficient alphas reported did not consistently exceed .70, this internal consistency is comparable to the original BIDR-40 (Hart et al., 2015). For the present study, the Cronbach's alphas for the BIDR Total score was .84 for both group A and B, and .85 for the total combined group. All 16 items were retained.

In addition, test-retest reliability of the two subscales ($r = .74, p < .001$ for Impression Management and $r = .79, p < .001$ for Self-Deceptive Enhancement) found higher and stable reliability over a two-week period. Support for validity was also demonstrated by Hart et al. (2015), including positive associations for both subscales with a short form of the MCSDS (Strahan & Gerbasi, 1972) and a positive association of the Self-Deceptive Enhancement subscale with multiple self-enhancement indices.

Qualitative Follow-Up Questions

Finally, to clarify recommendations to support training programs, all participants in groups A and B responded to four optional questions to follow up their responses to the quantitative survey questionnaires. Questions included: (1) “What critical incidents (e.g., classroom experiences, trainings, therapeutic experiences), if any, have helped your approach to thinking about and/or discussing race with clients?”, (2) “What supports (e.g., school, supervision), if any, have helped you navigate experiences in thinking about and/or discussing race with clients?”, (3) “What supports (e.g., school, supervision), if any, have helped you navigate emotional reactions to thinking about and/or discussing race with clients?”, and (4) “What would be most helpful for training programs to know about your experiences with thinking about and/or discussing race with regards to clients to better support you?”

Procedure

Following Loyola University Chicago Institutional Review Board approval, participants completed the survey online via Qualtrics, an online research survey management program. Participants were recruited through online HSP LISTSERVs, including the American Psychological Association (APA) Division 17 (Counseling Psychology)’s Student Affiliate of 17 Forum (SAS) and Division 17 Discussion List (DIV17DISCUSS), Council of Counseling

Psychology Training Programs (CCPTP) general LISTSERV, and the Psych Grad Student Research Participation Request LISTSERV, in addition to word of mouth sharing. The recruitment links included a short description of the study, the researcher and advisor's email addresses for further questions, and a web-based link to the online survey.

The survey package included informed consent, a demographic questionnaire, the MCHS, the BABS, the BIDR, the PCRW White Empathic Reactions subscale, PCRW White Fear subscale, WRAS White Guilt subscale, WRAS White Negation subscale, WRAS White Shame subscale, and qualitative questions.

A branching procedure was used to navigate through the survey package based on the participant's response to race/ethnicity demographic question. For individuals who identified as Black/African American/of African descent, Asian/Asian American/of Asian descent, or Latinx/Hispanic/of Spanish descent, participants were presented with the demographic questionnaire, MCHS, BABS, BIDR, and qualitative questions only. For individuals who identified as White/of European descent, participants were presented with the demographic questionnaire, MCHS, BABS, BIDR, PCRW subscales, WRAS subscales, and qualitative questions. For individuals who identified as bi-racial or multiracial, individuals were also presented with the MCHS, BABS, BIDR, PCRW subscales, WRAS subscales, and qualitative questions. However, on the PCRW and WRAS subscales, instructions were noted that: "the following questions are with regards to self-identifying racially as White/of European descent. If you do not self-identify racially as White/of European descent, please skip to the next page." The full survey took 10-15 minutes to complete.

Participants were asked to read the informed consent once they reached the online survey and were provided a description of the nature and scope of the study, perceived risks, informed

that their participation was voluntary, and permission to withdraw from the study at any time without consequences. Data was kept anonymous and stored safely and securely. To encourage participation and express thanks, participants also had the option to be directed to a separate survey after the original survey where they could submit their email addresses to enter a raffle to win one of four \$25 online Target gift-cards via random drawing. Participants were notified should they choose to participate in the raffle, their survey responses would not be matched with their identifying information.

Data Analysis Plan

Preliminary Analysis

Data was exported into and analyzed using IBM SPSS Statistics Version 27.0.1.0 (IBM Corporation, 2020) following completion of data collection. Data was split into group A: those who identified as White, including bi/multiracial individuals who chose to complete the scales specific to White affect (i.e., PCRW and WRAS; $N = 87$) and group B: those who identify as BIPoC, including bi/multiracial individuals who chose not to complete the White affect scales ($N = 27$). Data from group B was saved and further explored in the post hoc analyses. Moving forward, the following discussion will focus on White individuals (group A) dataset unless otherwise noted.

Missing values were handled through Multiple Imputation via SPSS. All scales and subscales were assessed for normality, homoscedasticity, and linearity. Cronbach's alphas were calculated and reported for each scale and subscale. For scales and subscales that fell below .80, inter-item correlations were reviewed to determine which items to retain to increase reliability.

The mean, standard deviation, skewness, and kurtosis of each scale and subscale were also calculated and reported. Finally, bivariate correlations among the scales and subscales were calculated, with associated Pearson *r* values reported.

Main Quantitative Analysis

Demographic Covariances

For the main analysis, the researcher first explored possible demographic covariances with the BABS scale through the use of correlations, independent-samples *t*-tests, and one-way ANOVAs.

Hierarchical Linear Regression

Once demographic covariances were identified, the researcher conducted a hierarchical linear regression (HLR) analysis in SPSS to assess the hypotheses surrounding the influence of affective responses to racism (i.e., five predictors; PCRW White Empathic Reactions, PCRW White Fear, WRAS White Guilt, WRAS White Shame, and WRAS White Negation) and cultural humility (i.e., one predictor; MCHS) on the integrated/congruent BABS broaching style (i.e., the outcome variable to further explore the first and third research question).

HLR allows for further exploration if independent variables explain a statistically significant amount of variance in a dependent variable, with R^2 being the proportion of variance explained (Jeong & Jung, 2016; Laerd Statistics, 2015). Based on previous research identifying the potential impact of social desirability on various scales utilized for predictor variables, social desirability (i.e., the BIDR) was entered into the step one of the HLR model as a covariate. Based on the demographic covariances analysis, additional identified demographic variables were dummy-coded and entered into step one of the HLR model to control as possible covariates. Although this study technically conducted a HLR by having the step one to control

for the effect of covariates, step two simultaneously included all other predictor variables (i.e., WRAS White guilt, WRAS White shame, WRAS White negation, PCRW White fear, PCRW White Empathic Reactions, and MCHS Cultural Humility), as the research surrounding broaching behaviors is relatively new and further exploration of potential predictors is needed, resulting in no set theoretical rationalization to enter these variables in different steps. As a result, in addition to looking at the R^2 to determine overall variance explained by the variables all together, each variable's beta (β), the standardized regression coefficient, was examined to see how strongly each predictor variable was related to the outcome variable of the BABS' integrated/congruent subscale.

HLR assumptions were reviewed (Jeong & Jung, 2016; Laerd Statistics, 2015). First, normality was assessed through visual inspection of a histogram to determine possible bell shape curve and if points remained relatively close to the diagonal line on a Q-Q plot. Second, independence of errors was assessed by examining if the Durbin-Watson statistic fell between 1.5 and 2.5, which indicates no linear autocorrelation (Ho, 2013). Third, linearity was assessed by calculating and inspecting partial regression plots and a plot of studentized residuals against the predicted values to determine if they presented in a random pattern and absence of a curvilinear array. Fourth, homoscedasticity was assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values to determine if the residuals were randomly scattered around the horizontal line at the zero point. Fifth, unusual points (i.e., outliers, high leverage points, or highly influential points) were assessed by exploring studentized deleted residuals and if their standard deviations were below ± 3 , if leverage values were less than 0.2, and if values for Cook's distance were below 1 (Cook & Weisberg, 1982).

Multicollinearity was also assessed. Multicollinearity is a problem when independent variables in a regression model are highly correlated with one another, resulting in increased variance and difficulty interpreting individual coefficients (Wold et al., 1984). To determine if multicollinearity was an issue, bivariate correlations were calculated and reviewed. Correlations higher than .80 indicate concerns for multicollinearity (Berry & Feldman, 1985). Second, calculation of the variance inflation factor (VIF) and tolerance were completed. Although no cutoff has been agreed, in general, the tolerance value should be greater than 0.1 and the VIF should be less than 10 for there to be no multicollinearity (Hair et al., 2014; Jeong & Jung, 2016; Laerd Statistics, 2015).

Cluster Analysis

To address the second research question, a cluster analysis was proposed to further explore if a possible makeup of affective responses to racism (i.e., level of White guilt, White shame, White negation, White fear, and White empathic reactions) would group in relation to one another and the groupings be significantly different to the level of integrated/congruent broaching style. Cluster analysis is a data reduction method that helps identify different groups of similar participants based on certain variables (Norušis, 2012). The PCRW White Empathy, PCRW White Fear, WRAS White Negation, WRAS White Guilt, and WRAS White Shame were used as grouping variables. To control for differences in scaling among the PCRW and WRAS, z-scores were created and used for each subscale. First, a hierarchical cluster analysis with Ward's clustering method (Ward, 1963; Norušis, 2012) was completed using SPSS software. Ward's method, which is a criterion approach that seeks to create more even-sized clusters that minimizes within-group variability and maximize between-group variability in Euclidean distance. The resulting dendrogram was visually reviewed to determine the number of clusters

most appropriate for the data based on an inconsistently large jump in the similarity measure.

Second, a nonhierarchical k-means cluster analysis was completed using SPSS software, with specifications of k chosen a priori based on the number of clusters identified in the hierarchical cluster analysis. Validation (i.e., stability) of the clusters was assessed by randomly dividing the sample into equal groups and rerunning the analyses to compare and see if a similar cluster structure was found.

An independent-samples t-test was then conducted to determine if cluster groups differed significantly on the BABS total score. Finally, Chi-Square goodness of fit analyses were conducted to determine if the proportion of demographic variables were equal between the cluster groups.

Post Hoc Analyses

Additional post hoc analyses were conducted based on the initial main analysis results. This includes reviewing BIPoC individuals (group B) data and calculating correlations, means, standard deviations, and Cronbach's alphas for the BABS, MCHS, and BIDR. Third, group mean comparisons between White individuals (group A) and BIPoC individuals (group B) on the MCHS, BABS, and BIDR were conducted via independent-samples t-tests.

Qualitative Analysis

As previously noted, optional qualitative questions were provided at the end of the survey for all participants and required relatively short response. As such, comprehensive qualitative analysis methods (e.g., grounded theory, consensus qualitative research) were not employed and instead the researcher reviewed responses to identify any general consistent themes and quantify consistent responses to supplement the quantitative findings and focus recommendations.

Responses for groups A and B were analyzed and reported separately. Of note, due to some

respondents providing multiple answers within a response, multiple coding of the same item occurred.

CHAPTER FOUR

RESULTS

This chapter includes: preliminary analyses of the data, including data cleaning, strategies for handling missing values, reliability analyses, and correlations between key variables, main analyses of demographic variables to determine possible covariances, main analyses of the hierarchical linear regression analysis, main analyses of the cluster analysis, post hoc analyses, and review of qualitative questions' themes.

Preliminary Analyses

Data Cleaning

The data was cleaned and reviewed for missing values and significant outliers. The data set was then split into (a) those who identify as White, including bi/multiracial and chose to complete the scales specific to White affect (i.e., PCRW and WRAS; $N = 87$) from (b) those who identify as BIPoC, including bi/multiracial and chose not to complete the White affect scales ($N = 27$). Data from group B were saved and further explored in the post hoc analyses section of this chapter. Moving forward, the following discussion will focus on group A data unless otherwise noted.

Missing Values

Schlomer et al. (2010) note best practices for handling missing data include noting the amount of missing data (sources include non-responsiveness and participant attrition) and the pattern of missing data (i.e., missing completely at random, missing at random, and not

missing at random). When reviewing the amount of missing data, at the item level, 99.03% were complete and 0.971% of study variables were missing. At the case level, 75.58% of cases were complete while 24.42% were incomplete. Finally, at the variable level, 52.94% of items had at least one missing variable. See Figure 1 for a summary of the missing values.

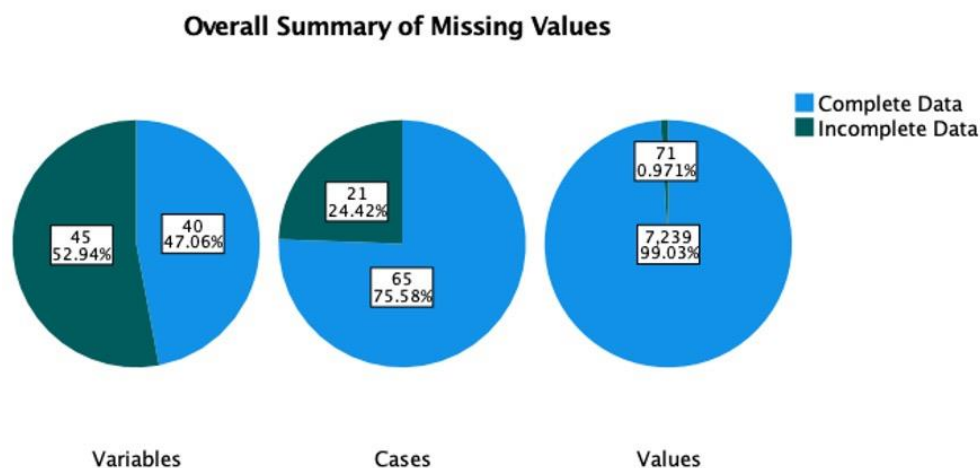


Figure 1. Summary of Missing Values

A single consensus on what percentage of missing values is deemed problematic has not yet been determined, with potential cutoffs ranging anywhere from 5-20%. Instead, Schlomer et al. (2010) recommend further exploring the pattern of missing data to determine a potential biased impact. Missing data patterns include Missing Completely at Random (MCAR), Missing at Random (MAR), and Not Missing at Random (NMAR). MCAR means the missing data has no pattern and the missing values are unrelated to any study variable. MAR means the missingness is related to another variable in the data set and not due to the missed variable itself. Finally, NMAR, or a nonignorable nonresponse, is when the pattern to missing data is related to the participant's score on the missing data variable had they responded (e.g., low versus high response). This is more difficult to define, as we do not know the participant's response value,

and requires one to reflect theoretically if having a certain response may cause one to respond or not respond (e.g., feeling uncomfortable disclosing and choosing not to answer).

When looking towards exploring the pattern of missing data, Little's (1988) omnibus statistical test can help explore if the missing pattern fits an MCAR category. Insignificant p values ($> .05$) are considered MCAR, while significant p values ($< .05$) are considered MAR or MNAR. The Little's MCAR test for the present study indicated a chi-square value of 571.089 and a p value of .515, indicating a high likelihood the missing data is MCAR. To further explore the missing data pattern, the researcher visually examined the missing value patterns through SPSS' Missing Pattern Analysis. Overall, the data was distributed throughout and there was no clustered pattern.

Missing data was handled utilizing multiple imputation, which allows researchers to retain power by keeping cases and is less biased. This is due to the standard errors of the parameter estimates having multiple sources and incorporating each data set's standard errors and the level of similarity or difference among parameter estimates across the data sets. This results in more unbiased standard errors, which in turn provides more accurate significance testing and confidence interval outcomes (Schlomer et al., 2010). Steps for multiple imputation include, first, creating multiple imputed data sets, with three to five recommended as adequate (Schafer, 1997). Second, using the rest of the data to predict values, analyses are then conducted for each parameter set, with parameter estimates (e.g., correlations and regression coefficients), as well as standard errors, saved for each. Third, the saved parameter estimates across imputations are averaged into a final result (Schlomer et al., 2010). For the current study, the researcher imputed and analyzed five data sets, using the default settings of SPSS.

Reliability Analyses

Cronbach's alpha analysis was completed to measure the internal consistency of study scales. Initial results indicated only the BABS total scale (.80) and BIDR total scale (.84) to be above .80, while the MCHS total scale (.78), PCRW White Empathic Reactions subscale (.50), PCRW White Fear subscale (.48), WRAS White Guilt subscale (.69), WRAS White Shame subscale (.54), and WRAS White Negation subscale (.57) fell below. As a result, inter-item correlations were reviewed for those Cronbach's alphas falling below .80 and lowest correlated items were removed. Interestingly, many of the lowest correlated items were reverse coded. Review of the literature suggests that reverse coded items can impact reliability (Weems & Onwuegbuzie, 2001; Herche & Engelland, 1996; Suárez-Alvarez et al., 2018), should be used sparingly (Wejters & Baumgartner, 2012), and improve reliability when removed (Ebesutani et al., 2012).

As a result, for the MCHS total scale, items 10R, 11R, and 12R were removed, resulting in a scale comprised of 12 items and a corrected α of .82. For the PCRW White Empathic Reactions subscale, items 3 and 14 were removed, resulting in a scale comprised of four items and a corrected α of .77. For the PCRW White Fear subscale, items 2R and 5 were removed, resulting in a scale comprised of three items and a corrected α of .61. For the WRAS White Guilt subscale, no items were removed as the resulting Cronbach's alpha actually decreased, resulting in a final α of .69. For the WRAS White Shame subscale, item 15R (labeled 5c in the scale) was removed, resulting in a scale comprised of three items and a corrected α of .62. For the WRAS White Negation, item 10 (labeled 4a in the scale) was removed, resulting in a scale comprised of six items and a corrected α of .59. Moving forward, the MCHS total scale, PCRW White Empathic Reactions subscale, PCRW White Fear subscale, WRAS White Shame subscale, and

WRAS White Negation subscale referenced reflect these item removal changes. See Table 2 for further details on Cronbach's alphas for the current study.

Correlations

Table 2 provides the correlations, mean, standard deviations, and Cronbach's alpha for all major study variables. In terms of correlations, the BABS was significantly positive related with the MCHS ($r = .630, p < .01$) and the WRAS White Guilt ($r = .319, p < .01$), while significantly negatively correlated with the PCRW White Fear ($r = -.251, p < .05$) and the WRAS White Negation ($r = -.214, p < .05$). The two PCRW subscales were significantly negatively correlated with each other ($r = -.274, p < .05$), while only some of the WRAS subscales were significantly correlated. This includes a significant positive correlation between the WRAS White Guilt and White Shame ($r = .541, p < .01$) and a significant negative correlation between the WRAS White Guilt and White Negation ($r = -.295, p < .01$). In addition, there was a significant positive correlation between the PCRW White Empathic Reactions and WRAS White Guilt ($r = .468, p < .01$), and significant negative correlations between the PCRW White Fear and WRAS White Guilt ($r = -.297, p < .01$) and the PCRW White Fear and WRAS White Negation ($r = -.295, p < .01$). Finally, there was only significant negative correlation between the BIDR and WRAS White Negation ($r = -.246, p < .05$).

All variables met the normality assumption and offered satisfactory skewness and kurtosis (skewness < 2.0 , kurtosis < 7.0). As such, all study variables were included in the main analyses.

Table 2. Correlation Matrix, Means, Standard Deviations, and Cronbach's Alpha for Group A

	1	2	3	4	5	6	7	8
1 MCHS	1							
2 BABS	.630**	1						
3 PCRW White Empathy	.126	.147	1					
4 PCRW White Fear	-.233*	-.251*	-.274*	1				
5 WRAS White Guilt	.248*	.319**	.468**	-.297**	1			
6 WRAS White Shame	-.079	.088	.210	-.113	.541**	1		
7 WRAS White Negation	-.156	-.214*	-.134	.281**	-.295**	-.186	1	
8 BIDR	.152	-.042	-.022	-.197	.027	-.050	-.246*	1
Mean	74.20	3.72	22.07	4.48	28.99	5.28	7.82	67.66
SD	6.07	.518	2.18	1.71	3.94	2.14	2.27	15.70
Skewness[^]	0.023	-0.573	-1.492	1.192	-0.492	0.856	1.685	0.065
Kurtosis^{^^}	-0.337	0.707	2.691	1.105	-0.289	0.023	2.731	-0.241
Cronbach's Alpha	.82	.82	.77	.61	.69	.62	.59	.84

Note: $N = 87$; * $p < 0.05$ level (2-tailed), ** $p < 0.01$ level (2-tailed); [^] $SE = 0.258$; ^{^^} $SE = 0.511$

Main Analyses

Two steps of main analyses were conducted. First, possible demographic covariances with the BABS were explored through the use of correlations, independent-samples t-tests, and one-way ANOVAs. Second, a hierarchical multiple regression was performed to test the extent the MCHS, PCRW subscales, and the WRAS subscales predicted BABS integrated/congruent scores, with demographic variables and the BIDR controlled for in step one.

Demographic Covariances

Demographic variables were explored via correlations for the continuous variables of age, program current year, postgraduate year, years of clinical experience, and percent of BIPoC clients. No significant correlations were reported, see Table 3 for more information.

Table 3. Demographic Correlation Matrix for Group A

	1	2	3	4	5	6
1 BABS	1					
2 Age	-.036	1				
3 Program Current Year	.045	-.027	1			
4 Postgraduate Year	.225	.586**	--	1		
5 Years Clinical Experience	.067	.387**	.292*	.623**	1	
6 Percent BIPoC Clients	-.174	-.086	-.070	-.267	-.200	1
Mean	3.72	29.68	5.03	4.31	4.74	0.373
SD	.518	4.208	1.149	2.811	2.760	0.220
N	87	87	60	27	87	87

Note: * $p < 0.05$ level (2-tailed), ** $p < 0.01$ level (2-tailed)

Potential covariance of graduation status, program kind, sexual orientation, and religious status with the BABS was explored with a series of independent-samples t-tests. Due to uneven cell counts, sexual orientation and religious status were collapsed into smaller categories to increase power. For sexual orientation, participants were grouped into two categories:

heterosexual ($N = 54$) or LGBTQIA+ ($N = 33$). For religious status, participants were grouped into two categories: Abrahamic religions ($N = 35$) and non-Abrahamic/Other ($N = 52$).

Individuals who identified as agnostic, atheist, secular/nonreligious, and spiritual were categorized into the non-Abrahamic/other category. For individuals who identified as other or entered multiple responses, the open-ended text and type of religion selected were examined to determine the categorized group. Only sexual orientation had a statistically significant difference. See Tables 4-7 for more information.

For the sexual orientation t-test, the assumption of homogeneity of variances was violated, as assessed by Levene's test for equality of variances ($p = .023$). As such, a Welch t-test was used, with the heterosexual group ($M = 3.58$, $SD = 0.54$) scoring lower than the LGBTQIA+ group ($M = 3.94$, $SD = 0.39$) on the BABS, a statistically significant difference, $t(82.546) = -3.619$, $p < .001$.

Table 4. Graduation Status Independent T-Test for Group A

	Current Doc. Student (<i>N</i> = 60)		Early Career Psychologist (<i>N</i> = 27)		<i>t</i> (85)	<i>p</i>	Mean Difference	SE Difference	95% CI for Mean Difference		Cohen's <i>d</i>
	M	SD	M	SD					Lower	Upper	
BABS	3.71	.524	3.74	0.515	-0.282	.779	-0.03	0.121	-0.274	0.206	.521

Table 5. Program Kind Independent T-Test for Group A

	Ph.D. (<i>N</i> = 57)		Psy.D. (<i>N</i> = 30)		<i>t</i> (85)	<i>p</i>	Mean Difference	SE Difference	95% CI for Mean Difference		Cohen's <i>d</i>
	M	SD	M	SD					Lower	Upper	
BABS	3.79	.493	3.57	0.541	1.954	.054	0.225	0.115	-.004	0.453	.51

Table 6. Sexual Orientation Independent T-Test for Group A

	Heterosexual (<i>N</i> = 54)		LGBTQIA+ (<i>N</i> = 33)		<i>t</i> (82.546)	<i>p</i>	Mean Difference	SE Differenc e	95% CI for Mean Difference		Cohen's <i>d</i>
	M	SD	M	SD					Lower	Upper	
BABS	3.58	0.541	3.94	0.391	-3.619	<.001	-0.363	0.10	-0.562	-0.163	.49

Note: A Welch test is reported because Levene's test indicated that the homogeneity of variances assumption was not met.

Table 7. Religious Status Independent T-Test for Group A

	Abrahamic Religions (<i>N</i> = 35)		Non- Abrahamic & other (<i>N</i> = 52)		<i>t</i> (85)	<i>p</i>	Mean Difference	SE Difference	95% CI for Mean Difference		Cohen's <i>d</i>
	M	SD	M	SD					Lower	Upper	
BABS	3.67	0.457	3.75	0.558	-0.674	.502	-0.077	0.114	-0.303	0.149	.52

Potential covariance of gender, social class, program type, and theoretical orientation with the BABS was explored with a series of one-way ANOVAs. Due to uneven cell counts, social class, program kind, and theoretical orientation were collapsed into smaller categories to increase power. For social class, participants were grouped into three categories: lower class/lower-middle class, middle class, and upper-middle class/upper class. For program type, participants were categorized into three categories: clinical, counseling, and school/combination/other. For theoretical orientation, participants were grouped into three categories: CBT, Integrated/Eclectic, and Other (i.e., Psychodynamic, Humanistic, and Feminist/Multicultural). Only program kind had a statistically significant difference. See Tables 8-12 for more information.

As noted above, for the program kind one-way ANOVA, participants were classified into three groups: clinical, counseling, and school/combination/other. Homogeneity of variance was met, as assessed by Levene's test for equality of variances ($p = .223$). BABS scores were statistically significantly different for the program types, $F(2,84) = 6.394, p = .003$. The BABS score increased from clinical ($M = 3.53, SD = 0.54$) to school/combination/other ($M = 3.70, SD = .322$) to counseling ($M = 3.92, SD = 0.44$), in that order. Tukey HSD tests revealed only the mean increase from clinical to counseling (0.388, 95% CI [0.129, 0.647]) was statistically significant ($p = .002$).

Table 8. Gender One-Way Analysis of Variance for Group A

	Cisgender Woman (<i>N</i> = 70)		Cisgender Man (<i>N</i> = 15)		Nonbinary (<i>N</i> = 2)		<i>F</i> (2,84)	<i>p</i>
	M	SD	M	SD	M	SD		
BABS	3.74	0.483	3.56	0.678	4.00	0.141	1.075	.346

Table 9. Social Class One-Way Analysis of Variance for Group A

	Lower / Lower- Middle Class (<i>N</i> = 25)		Middle Class (<i>N</i> = 30)		Upper Middle / Upper Class (<i>N</i> = 32)		<i>F</i> (2,84)	<i>p</i>
	M	SD	M	SD	M	SD		
BABS	3.75	0.485	3.65	0.568	3.75	0.505	0.343	.710

Table 10. Theoretical Orientation One-Way Analysis of Variance for Group A

	CBT (<i>N</i> = 34)		Integrated / Eclectic (<i>N</i> = 30)		Other (<i>N</i> = 23)		<i>F</i> (2,84)	<i>p</i>
	M	SD	M	SD	M	SD		
BABS	3.68	0.46	3.73	0.63	3.77	0.46	0.205	.815

Table 11. Program Type One-Way Analysis of Variance for Group A

	Clinical (<i>N</i> = 41)		Counseling (<i>N</i> = 40)		School, Combination, Other (<i>N</i> = 6)		<i>F</i> (2,84)	<i>p</i>
	M	SD	M	SD	M	SD		
BABS	3.53	0.544	3.92	0.444	3.70	0.322	6.394	.003

Table 12. Tukey HSD Post Hoc Analysis for Group A by Program Type

	Program Type (A)	Program Type (B)	Mean Difference (A-B)	<i>SE</i>	<i>p</i>	95% CI for Mean Difference	
						Lower	Upper
BABS	Clinical	Counseling	-0.388	0.109	.002	-0.647	-0.129
		School, Combo, Other	-0.173	0.214	.697	-0.683	-0.336
BABS	Counseling	Clinical	0.388	0.109	.002	0.129	0.647
		School, Combo, Other	0.215	0.214	.576	-0.295	0.725
BABS	School, Combo, Other	Clinical	0.173	0.214	.697	-0.336	0.683
		Counseling	-0.215	0.214	.576	-0.725	0.295

Hierarchical Linear Regression

A hierarchical linear regression analysis was used to examine the hypotheses surrounding the influence of affective responses to racism (i.e., PCRW White Empathic Reactions, PCRW White Fear, WRAS White Guilt, WRAS White Shame, and WRAS White Negation) and cultural humility (i.e., MCHS) on the integrated/congruent broaching style (i.e., BABS). Based on previous research and data from the researcher's independent-samples t-test and analysis of variance, social desirability (i.e., BIDR), dummy-coded sexual orientation, and dummy-coded program type were entered into the first step to control for covariance. The second step included all other predictor variables (i.e., MCHS, PCRW White Empathic Reactions, PCRW White Fear, WRAS White Guilt, WRAS White Shame, and WRAS White Negation), as research surrounding broaching behaviors is relatively new and there is no set theoretical rationalization to enter these variables in different steps.

First, assumptions involved with regression were reviewed. The assumption of normality was met. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.156. There was linearity, as evidenced by partial regression plots and a plot of studentized residuals against the predicted values presenting in a random pattern with the absence of a curvilinear array. There was homoscedasticity, as evidenced by a plot of studentized residuals versus unstandardized predicted values being randomly scattered around the horizontal line at the zero point. There was no evidence of multicollinearity, as evidenced by the largest correlation being .630, tolerance values ranging from 0.401 to 0.926, and VIF values ranging from 1.080 to 2.496. There were no unusual points (i.e., outliers, high leverage points, or highly influential points), as assessed by no studentized deleted residuals greater than ± 3 standard deviations, no leverage values greater than 0.2, and no values for Cook's distance above 1.

The first predictor block was statistically significant, $F(4,82) = 5.312, p < .001$, accounting for 20.6% of the variance of broaching behaviors ($R^2 = .206$, adjusted $R^2 = .167$). Counseling program type had a significant beta weight ($\beta = .316, p = .003$). Sexual orientation (i.e., LGBTQIA+ based on dummy coding) also had a significant beta weight ($\beta = .284, p = .007$). Social desirability (BIDR), clinical program type, and school/combination/other program type had nonsignificant beta weights.

The second predictor block was statistically significant, $F(6,76) = 9.703, p < .001$, accounting for 55% of the variance of broaching behaviors ($R^2 = .550$, adjusted $R^2 = .491$). The change in R^2 added in this step was .345, which was statistically significant ($p < .001$). In reviewing beta weights, only cultural humility (MCHS) had a significant beta weight ($\beta = .545, p < .001$). Table 13 provides a summary of these analyses.

Table 13. Hierarchical Linear Regression for Group A

		BABS							
Model	Variable	Model 1				Model 2			
		B	β	t	Sig.	B	β	t	Sig.
Step 1	Constant	3.004		9.923	<.001	-.034		-.045	.965
	BIDR	.002	.062	.602	.549	-.004	-.107	-1.221	.226
	Counseling	.327	.316	3.014	.003	.176	.170	1.989	.050
	School/Combo/Other	.139	.068	.668	.506	.353	.174	1.925	.058
	Sexual Orientation	.302	.284	2.757	.007	.207	.195	2.295	.024
	R^2	.206							
F	5.31***								
Step 2	MCHS					.053	.545	6.262	<.001
	PCRW White Empathic Reactions					-.002	-.007	-.076	.939
	PCRW White Fear					-.020	-.066	-.762	.448
	WRAS White Guilt					.021	.157	1.295	.199
	WRAS White Shame					.006	.023	.240	.811
	WRAS White Negation					-.010	-.044	-.513	.609
	R^2			.550					
F			9.30***						
ΔR^2			.345						
ΔF			9.70***						

Note: $N = 87$. *** $p < .001$

Cluster Analysis

As previously noted, to control for differences in scaling among the PCRW and WRAS subscales, z-scores were transformed. First, a hierarchical cluster analysis was completed, with the accompanying dendrogram using Ward linkage indicated a two-cluster model was most appropriate for the current data. Second, results of the nonhierarchical k-means cluster analysis reported groups that ranged from 42 to 45 participants. Validity of the clusters indicated a cluster structure that was similar to each other between the groups.

To quantify PCRW and WRAS group subscale cluster scores, scores were divided into thirds. This resulted in group subscale z-scores being identified as low if they fell in the lower third (i.e., z-score < 0.43), medium if they fell in the middle third (i.e., z-score \geq 0.43 & z-score \leq 0.4125) and high if they fell in the upper third (i.e., z-score > 0.4125).

Cluster Groupings

Cluster 1. Cluster 1 ($N = 42$) included individuals with low White Empathy, White Guilt, and White Shame, while high White Fear and White Negation.

Cluster 2. Cluster 2 ($N = 45$) included individuals with high White Empathy, White Guilt, and White Shame, while lower levels of White Fear and White Negation. See Figure 2 for further depiction of the cluster groupings.

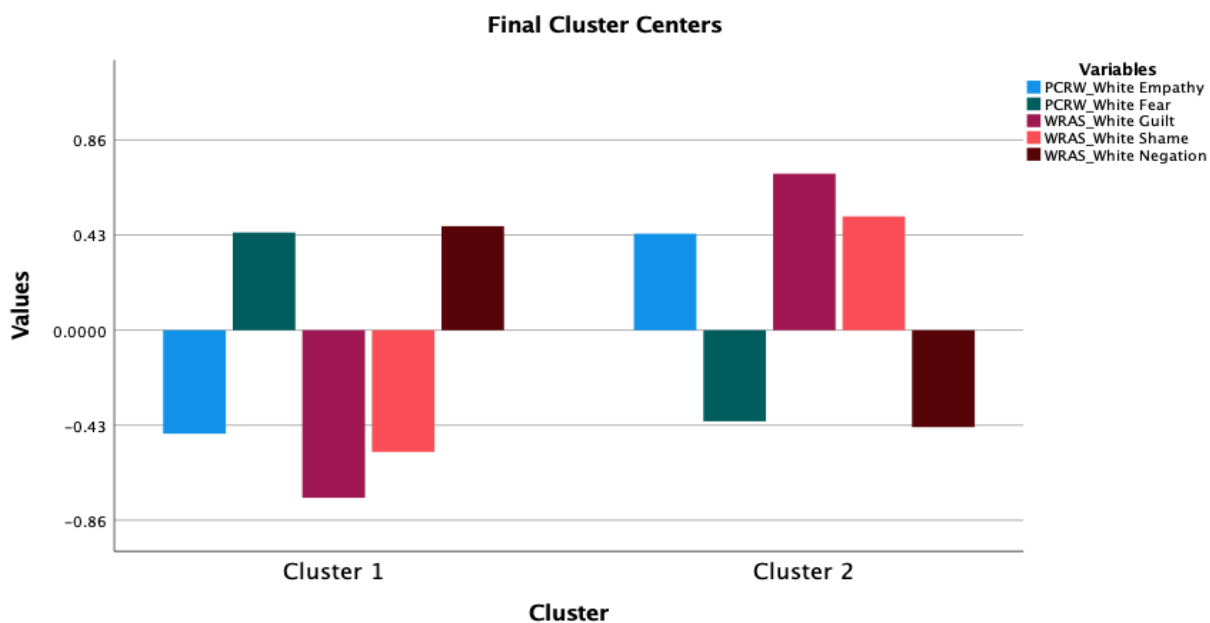


Figure 2. K-Means Cluster Groups PCRW & WRAS Patterns

Comparison of Cluster Patterns with BABS

Potential cluster group differences on the BABS total score were explored using an independent-samples t-test. Homogeneity of variance was met, as assessed by Levene's test for equality of variances ($p = .299$). Cluster 2 ($M = 3.86$, $SD = 0.462$) scored higher than Cluster 1 ($M = 3.56$, $SD = 0.534$) on the BABS, a statistically significant difference, $t(85) = -2.854$, $p = .005$. See Table 14 for more information.

Chi-Square Goodness of Fit Analyses

A Chi-Square Goodness of Fit Test was performed to determine whether the proportion of demographic variables were equal between the cluster groups. Results found the proportions were only significantly different for program type, $\chi^2(2, N = 87) = 7.530$, $p = .023$. Review of the clusters found Counseling numbers were different than expected, including lower counts in Cluster 1 (38% versus expected 46%) and higher counts in Cluster 2 (53% versus expected

46%). School/Combination/Other numbers were also different than expected, including higher counts in Cluster 1 (14% versus expected 6.9%) and lower in Cluster 2 (0% versus expected 6.9%).

Table 14. Cluster Independent T-Test for Group A

	Cluster 1 (<i>N</i> = 42)		Cluster 2 (<i>N</i> = 45)		<i>t</i> (85)	<i>p</i>	Mean Difference	SE Difference	95% CI for Mean Difference		Cohen's <i>d</i>
	M	SD	M	SD					Lower	Upper	
BABS	3.56	0.534	3.86	0.462	-2.854	.005	-3.049	0.107	-0.517	-0.092	.498

Post Hoc Analyses

BIPoC Correlations

Table 15 provides the correlations, mean, standard deviations, and Cronbach's alpha for the MCHS, BABS, and BIDR in group B (BIPoC individuals). In terms of correlations, only the BABS was significantly positively related with the MCHS ($r = .581, p < .01$). All variables met the normality assumption and offered satisfactory skewness and kurtosis (skewness < 2.0 , kurtosis < 7.0) and were included.

Table 15. Correlation Matrix, Means, Standard Deviations, & Cronbach's Alpha for Group B

	1	2	3
1 MCHS	1		
2 BABS	.581**	1	
3 BIDR	.319	-.150	1
Mean	62.81	3.91	73.00
SD	5.561	.466	16.108
Skewness[^]	-.387	.017	-.467
Kurtosis^{^^}	-.602	-.882	-.774
Cronbach's Alpha	.85	.77	.84

Note: $N = 27$; ** $p < 0.01$ level (2-tailed); [^] $SE = 0.448$; ^{^^} $SE = 0.872$

Combined Independent-Samples T-Test

Finally, group mean comparisons on the MCHS, BABS, and BIDR were conducted between the White identifying (group A) and BIPoC identifying (group B) groups using independent-samples t-tests. Regarding the MCHS, the assumption of homogeneity of variances was met, as assessed by Levene's test for equality of variances ($p = .740$). Individuals who identified as BIPoC ($M = 62.81, SD = 5.561$) scored higher on the MCHS than individuals who identified as White ($M = 60.02, SD = 5.335$), a statistically significant difference, $t(112) = 2.352, p = .020$.

Regarding the BABS, the assumption of homogeneity of variances was also met, as assessed by Levene's test ($p = .747$). Individuals who identified as BIPoC ($M = 3.91$, $SD = 0.466$) scored higher on the BABS than individuals who identified as White ($M = 3.72$, $SD = 0.518$), but was not statistically significant different, $t(112) = 1.771$, $p = .079$.

Finally, regarding the BIDR, the assumption of homogeneity of variances was again met, as assessed by Levene's test ($p = .750$). Individuals who identified as BIPoC ($M = 73.00$, $SD = 16.108$) scored higher on the BIDR than individuals who identified as White ($M = 67.66$, $SD = 15.700$), but was not statistically significant different, $t(112) = 1.536$, $p = .127$. Please see Table 16 for more information.

Table 16. Independent T-Tests for Groups A and B Combined

	Group A White (<i>N</i> = 87)		Group B BIPoC (<i>N</i> = 27)		<i>t</i> (112)	<i>p</i>	Mean Difference	SE Difference	95% CI for Mean Difference		Cohen's <i>d</i>
	M	SD	M	SD					Lower	Upper	
MCHS	60.02	5.335	62.81	5.561	2.352	.020	2.792	1.187	0.440	5.144	5.389
BABS	3.72	0.518	3.91	0.466	1.771	.079	0.198	0.112	-0.024	0.419	0.507
BIDR	67.66	15.70	73.00	16.108	1.536	.127	5.345	3.480	-1.550	12.239	15.795

Qualitative Analyses

Based on the data, responses were split into (1) participants from group A and (2) participants from group B. Of note, due to respondents providing multiple answers within a response, multiple coding of the same item occurred.

White Individuals (Group A) Qualitative Themes

Question 1

For Question 1 (“What critical incidents [e.g., classroom experiences, trainings, therapeutic experiences], if any, have helped your approach to thinking about and/or discussing race with clients?”), a total of 77 participants responded. The following themes were identified from the analysis, in order of amount.

Academic Classes. The most commonly cited critical incident was graduate academic classes ($N = 47$). Specifically, people noted experiencing these incidents during multiculturally focused courses and due to being in a program that infuses discussions of race and multiculturalism throughout all courses ($N = 26$). One participant stated,

My PhD program has two mandatory multicultural counseling psychology courses. These were fantastic and helped me to see race in everything. My entire program centers race and other issues of diversity in all our courses, and so I have continuously been learning about race and white supremacy and systems level approach so I'm able to better understand my own Whiteness and learn more about race and thus be able to broach race with clients.

More specifically, people identified classroom discussions ($N = 16$), specific class activities that elicited self-reflection and hands on learning ($N = 3$), and experiencing discrimination in the classroom on other social identities ($N = 2$).

Diverse Clinical Training. The second most commonly cited critical incident was diverse clinical training experiences ($N = 31$). In addition to identifying diverse clinical training

generally ($N = 15$), individuals also identified direct interactions and moments with a specific client of a different race ($N = 14$). One participant noted,

Experiences with discussing race with clients and it going well or feeling "awkward", times earlier on when I didn't discuss race with a client and it became very clear that it was a contributing factor to the situation and my bias made me clueless.

Additional Educational Training Opportunities. The third most commonly cited critical incident was additional diverse training opportunities ($N = 26$). In addition to identifying general trainings ($N = 20$), participants specifically noted engaging with intergroup dialogues and diversity groups ($N = 3$), as well as multicultural and diversity conferences ($N = 3$).

Supervision. The fourth most commonly cited critical incident was clinical supervision ($N = 23$). In addition to generally identifying supervision ($N = 17$), individuals also noted more specifically engaging in supervision that focused directly on broaching ($N = 4$) and having supervisors and supervisees of diverse backgrounds ($N = 2$). One participant noted, "My supervisor at the time used CRT and helped me grow by using supervision to discuss culture and identity and helped me explore that with clients more. Seeing how broaching these conversations benefited treatment really excited me."

Outside Readings and Media. The fifth most commonly cited critical incident was through the use of outside readings and media ($N = 10$). In addition to identifying multiculturally focused reading and media ($N = 8$; e.g., "books about indigenous genocide, reading *New Jim Crow*, watching the *Hate U Give*"), three individuals also identified seeking further readings on broaching specifically.

Family and Friends Outside the Program. The sixth most commonly cited critical incident was engaging with family and friends outside of the program ($N = 9$) who identified as BIPoC.

Clinical Peers. The seventh most commonly cited critical incident was engaging with clinical peers ($N = 8$). Individuals identified having specific conversations and receiving direct feedback from peers.

Previous Schooling and Work. The eighth most commonly cited incident was previous work and schooling prior to the graduate program ($N = 8$). One participant noted, “Being involved in social agency work before graduate school provided better training than graduate school. I brought what I already knew to the trainings.”

Socio-Political Events. The ninth most commonly cited incident was engaging in socio-political events going on during the graduate program ($N = 6$). Individuals referenced events such as Black Lives Matter protests and the murder of George Floyd.

Teaching Others. The 10th most commonly cited incident was teaching others ($N = 4$). This includes leading intergroup dialogues, being a diversity education facilitator, anti-racism trainer, and teaching assistant.

Personal Exploration of Own Race/Culture. The 11th most commonly cited incident was personal exploration of one’s own race and culture ($N = 3$).

Research. The 12th most commonly cited incident was engaging in research labs and dissertation research on race ($N = 2$).

None. Finally, one participant noted they did not have any critical incidents.

Question 2

For Question 2 (“What supports [e.g., school, supervision], if any, have helped you navigate experiences in thinking about and/or discussing race with clients?”), a total of 79 participants responded. The following supports were identified from the analysis, in order of amount: supervisors ($N = 60$), clinical peers/colleagues ($N = 49$), professors/academic advisor (N

= 24), classes/program ($N = 15$), family and friends outside the program ($N = 10$), workshop/trainings/training leaders ($N = 6$), clients ($N = 5$), research/readings ($N = 5$), support groups/committee memberships ($N = 2$), community organizers ($N = 1$), research lab ($N = 1$), and none ($N = 1$).

Question 3

For Question 3 (“What supports [e.g., school, supervision], if any, have helped you navigate emotional reactions to thinking about and/or discussing race with clients?”) a total of 78 participants responded. The following supports were identified from the analysis, in order of amount: supervisors ($N = 51$), clinical peers/colleagues ($N = 46$), family and friends outside the program ($N = 19$), professors/academic advisor ($N = 16$), workshop/trainings/events ($N = 6$), self-care ($N = 6$; e.g., personal therapy, journaling, setting good boundaries, self-compassion), class ($N = 5$), readings/media ($N = 2$), research ($N = 2$), none ($N = 2$), previous work ($N = 1$), and community organizers ($N = 1$).

Question 4

For Question 4 (“What would be most helpful for training programs to know about your experiences with thinking about and/or discussing race with regards to clients to better support you?”), a total of 63 participants responded. The following themes were identified from the analysis, in order of amount.

More Explicit Training. The most commonly cited feedback was programs having more explicit training about broaching and the ability to regularly practice broaching ($N = 18$). Individuals noted a desire to have training opportunities before going into their first session, moving beyond just awareness of the need to broach, role plays, having scenario or video examples to review, exploring how to regularly integrate broaching (vs. a one-time event), and

having opportunities to practice difficult conversations about race in general. One participant noted,

Current emphasis on awareness-only isn't helpful for a student/trainee trying something out for the first time; I don't believe it's ethical to have clients serve as guinea pigs for first-time discussions as the new counselor will likely cause harm plus this creates additional burdens on the client; I have had supervisors direct/order me to initiate conversations with clients and then criticize me because it sounds like an assignment; modeling and role play would be far more helpful; I would imagine that some elaboration on tasks/skills would be very useful and how these discussions then feed back into therapeutic alliance, assessment, client's better understanding, goal consensus, etc.

More Integration in the Program. The second most commonly identified feedback was for training programs to better integrate and infuse the topics of broaching and race/culture throughout every class ($N = 12$). One participant noted,

I think programs should go above and beyond what APA requires and promote cultural broaching in all areas of training, from the beginning of one's time in graduate school. This could also help marginalized students feel they can voice their opinions and experiences, and not be accused of "having an agenda" or "being intolerant" - as if racism is a valid alternate point of view.

Another participant noted,

Race/ethnicity/culture/white supremacy must be incorporated into everything. All courses, practicum, research. Hire and retain BIPOC professors, graduate students. Increase funding so BIPOC students don't have to work another job in addition to being a full-time student. When our programs are more diverse, it benefits everyone. White people need to do more of this work, and we benefit from learning from our BIPOC peers, yet they should not be overburdened with the task of educating white people. Programs need to incorporate and infuse a critical theoretical perspective into training, research, and practice. The personal is the professional. Students, especially white students, should work toward reflexively considering race in all interactions every day. When considering race/ethnicity/culture all the time, then broaching race will become second nature and part of the theoretical approach/professional identity.

Providing Ongoing Opportunities for Reflection and Discussion. The third most commonly identified feedback was programs deliberately providing ongoing opportunities for self-reflection and discussion outside of class ($N = 8$), including two identifying this need

specifically in supervision. One participant noted, “Practice is important! And talking about it. If no one talks about it, it is more difficult for a clinician to talk about it.”

Safe Space. The fourth most commonly identified feedback was programs creating safe spaces to help manage affective responses and receiving feedback ($N = 8$). One participant noted, “Give white students space to process discomfort/guilt/anxiety when activated in order to break down defensiveness and open them up to vulnerability.” Another participant noted,

They should know that the first and second year classes are particularly uncomfortable and different from classes taken in undergrad because of their emphasis on self-reflection, self-disclosure, and being vulnerable! The faculty are aware that it's hard, and they acknowledge it and try to be supportive, but I still think there were times where my classmates and I felt singled out and uncomfortable in class. Maybe it would help if there was more explicit acknowledgement up front that those conversations are uncomfortable and maybe some work upfront on helping us deal with that discomfort and set up healthy professional boundaries with what we do and don't share in class.

Incorporating More Advanced Multicultural Topics. The fifth most commonly identified feedback was programs incorporating more advanced multicultural topics and approaches ($N = 6$). Individuals identified the need to further incorporate intersectionality, systemic racism, and liberation and decolonizing frameworks to better understand the importance of broaching conversations.

Training Programs “Walking the Walk.” The sixth most commonly identified feedback was programs actually “walking the walk and not just talking the talk” about diversity. This includes demonstrating a commitment to social justice and modeling how to be vulnerable and have conversations about race/ethnicity/culture ($N = 5$). One participant noted,

We have to practice this and live this. If the training cohort is all white, no matter how much practice and discussion you have, it's not going to work. Programs should expect and embrace the challenge of disrupting a paradigm of silence.

Starting Learning Earlier. The seventh most commonly identified feedback was programs starting learning about broaching and multiculturalism earlier in the program ($N = 4$).

One participant noted,

I wish culture was not treated like some advanced topic that people can only approach once they have mastered other skills. Clients who hold historically excluded/marginalized identities are aware of the impact their social identities have on how they most through the world. By ignoring or being hesitant to discuss their lived realities, we are doing a disservice to these clients and perpetuating harms long supported by the field of psychology. I think programs should go above and beyond what APA requires and promote cultural broaching in all areas of training, from the beginning of one's time in graduate school. This could also help marginalized students feel they can voice their opinions and experiences, and not be accused of "having an agenda" or "being intolerant" - as if racism is a valid alternate point of view.

Encouraging Vulnerability and Identity Development. The eighth most commonly identified feedback was programs encouraging students to engage in ongoing vulnerability, learning and unlearning, and infusing broaching into one's self-identity ($N = 4$).

Not Sure. The ninth most commonly identified feedback was that individuals noted they were unsure ($N = 3$). One participant noted, "Not sure. It's tough to pinpoint what difficulties arise, and I think that's part of the barrier."

Other. Finally, the 10th most commonly identified feedback fell into the other category ($N = 3$). Participants in this category identified more emphasis on incorporating clients and how clients would like it to be addressed, incorporating mindfulness to navigate affective responses and thoughts, and learning how to broach conversations with peers who do not believe broaching is important.

BIPoC Individuals (Group B) Qualitative Themes

Question 1

For Question 1 (“What critical incidents [e.g., classroom experiences, trainings, therapeutic experiences], if any, have helped your approach to thinking about and/or discussing race with clients?”), a total of 21 participants responded. The following themes were identified from the analysis, in order of amount.

Own Lived Experiences as BIPoC. The most commonly cited critical incident was participants’ own lived experiences identifying as BIPoC ($N = 9$). In addition to identifying generally ($N = 5$), four participants also specifically noted experiences of microaggressions and discrimination. One participant noted,

Experiencing microaggressions in the classroom while becoming more aware of my own racial and cultural identity helped my approach to thinking about and discussing race with clients. In other words, both my own negative and even traumatic experiences of racism pushed me to have a stronger desire to ensure that BIPOC clients have the space to process their own racially traumatic experiences in addition to having space to simply explore and process their racial identity.

Academic Classes. The second most commonly cited critical incident was graduate academic classes ($N = 8$). Specifically, people noted these incidents during multiculturally focused courses and due to being in a diverse program or HBCU.

Supervision. The third most commonly cited critical incident was during clinical supervision ($N = 5$). Multiple participants noted the need for open dialogue with their supervisors, including the following participant, who stated, “Having supervisors who openly talk and discuss race and ethnicity during supervision or case conceptualization.”

Clinical Peers. The fourth most commonly cited critical incident was engaging with clinical peers ($N = 4$) to further process and explore.

Additional Educational Training Opportunities. The fifth most commonly cited critical incident was additional diverse training opportunities ($N = 4$). In addition to general trainings, individuals also identified multicultural and diverse conferences and trainings that engaged in critical consciousness raising.

Direct Interactions with Clients. The sixth most commonly cited critical incident was direct clinical interactions with clients who identify as BIPoC ($N = 4$). Multiple participants noted discussing police brutality and other social injustice events with their clients.

Other. The seventh most commonly cited critical incident fell within the other category ($N = 3$). Individuals cited experiences with academic advisors ($N = 1$), personal therapy experiences ($N = 1$), and advocacy work outside of school ($N = 1$).

Question 2

For Question 2 (“What supports [e.g., school, supervision], if any, have helped you navigate experiences in thinking about and/or discussing race with clients?”), a total of 21 participants responded. The following supports were identified from the analysis, in order of amount: clinical peers/colleagues – especially those who identify as BIPoC ($N = 15$), supervisors – especially those who identify as BIPoC ($N = 13$), family and friends outside the program ($N = 4$), professors/academic advisors/faculty – especially those who identify as BIPoC ($N = 4$), classes/program ($N = 4$), diverse clinical training sites ($N = 2$), research/readings ($N = 2$), personal therapy ($N = 1$), and undergraduate education ($N = 1$).

Question 3

For Question 3 (“What supports [e.g., school, supervision], if any, have helped you navigate emotional reactions to thinking about and/or discussing race with clients?”) a total of 20 participants responded. The following supports were identified from the analysis, in order of

amount: clinical peers/colleagues – especially those who identify as BIPoC ($N = 13$), supervisors – especially those who identify as BIPoC ($N = 13$), family and friends outside the program ($N = 4$), professors/academic advisors/faculty – especially those who identify as BIPoC ($N = 4$), classes ($N = 2$), and personal therapy ($N = 2$).

Question 4

For Question 4 (“What would be most helpful for training programs to know about your experiences with thinking about and/or discussing race with regards to clients to better support you?”), a total of 19 participants responded. The following themes were identified from the analysis, in order of amount.

More Explicit Training. The most commonly cited feedback was programs having more explicit training about broaching ($N = 11$). This includes moving beyond just awareness of the need to broach or broaching once and instead regularly integrating into clinical work, opportunities for role plays and modeling from professors, and more robust toolkits for students. One participant noted,

I think more modeling opportunities directly from those we are learning from would be helpful. This may include mock role-plays where the instructor is exemplifying an appropriate encounter of broaching the topic of race with students, or even instructors showing sessions of tape in which issues of race have been discussed in a way that is thorough and in-depth. This would be especially important to learn in the context of issues concerning racial trauma.

Three participants also noted more targeted feedback regarding programs’ approaches with broaching. This includes expanding broaching conversations beyond just BIPoC clients to White clients and more support for BIPoC students on how to broach conversations with White clients.

Training Programs “Walking the Walk.” The second most commonly identified feedback was programs actually “walking the walk and not just talking the talk” about

commitment to diversity ($N = 4$). Participants expressed a desire for training programs to incorporate this commitment on multiple levels and more explicitly address biases and microaggressions, especially faculty and peers who identify as White, while also acknowledging the impact of White Supremacy and colonization in higher education and exploring nuances among BIPoC experiences. One participant noted,

I think it's important for training programs to recognize how much race is NOT talked about in higher education and even more so in Christian institutions. Additionally, I think it's important that training programs also include overarching systems in which we all live such as White supremacy and colonization. Without the history, it can be very challenging for more privileged people to grasp why racism is as harmful as it is. There's a lot of generalization which can minimize or dismiss the reality of differences between White people and BIPOC people. Additionally, it's important to also name Asian American experiences in addition to the Black and White dynamic. I think if training programs can contribute to building each trainees self-awareness into their own cultural context which is under the umbrella of unjust systems, it can help spark more critical thinking on how one might discuss race with clients in the therapy room.

Creating a Brave/Safe Space. The third most commonly identified feedback was programs creating a safe and brave space to encourage vulnerability, accountability, and self-reflection ($N = 4$).

More Integration in Supervision. The fourth most commonly identified feedback was more integration of broaching and acknowledgement of race/ethnicity into clinical supervision regularly ($N = 3$), particularly for White supervisors working with BIPoC supervisees. One participant noted,

It helps for supervisors to bring attention to these experiences of race and be open about their own experiences and take a self-reflection posture. It is very hard and harmful working with supervisors who are not open to having these conversations when they work primarily with people of color and trainees who are non-white. An ongoing self-reflection stance helps create some sense of safety and for the supervisor to be aware of their own biases with trainee's of color seems to also be important.

Other. Finally, the fifth most commonly identified feedback fell into the other category ($N = 2$). One participant noted the need to expand broaching beyond just racial/ethnic/cultural

discussions, while another participant noted, “Patients are generally welcoming when the topic is broached.”

CHAPTER FIVE

DISCUSSION

This chapter provides a summary of the results and interpretation of the findings, while identifying how the findings fit with the current body of research. This chapter also discusses implications for clinical training and supervision, in addition to identifying and exploring limitations of the study and suggestions for future research. Finally, concluding statements are provided.

The present study sought to examine and better understand the relationships among affective responses to racism, cultural humility, demographic variables, and broaching style in 87 White (including bi-racial/multiracial individuals who responded to the White affective responses to racism) health service psychology (HSP) advanced doctoral level trainees and early career psychologists via an online survey of self-report measures. Opportunities for open-ended comments were also presented to enhance and provide further nuance to the quantitative findings. In addition, 27 BIPoC (including bi-racial/multiracial individuals who chose not to respond to the White affective responses to racism scales) HSP advanced doctoral level trainees and early career psychologists' responses were also collected and reviewed to ensure recommendations provided took into account all students' needs and not just White trainees and early career psychologists.

An overarching goal and potential outcome of this research is to help White HSP providers, including advanced doctoral level trainees and early career psychologists, deliver

more effective, affirming services for BIPOC clients grounded in a multicultural and socially just approach. Doing so would hopefully increase the overall quality of mental health services and disrupt larger systems of racism prevalent in the field and improve overall health outcomes. By exploring the potential provider characteristics that predict a more regularly integrated broaching style (i.e., a multicultural and socially just approach), recommendations in education, training, and research can be provided.

Previous research has found positive client and therapeutic outcomes for the use of broaching in therapy (Thompson, Worthington, et al., 1994; Pope-Davis et al., 2002; Gim et al., 1991; Chang & Berk, 2009; Zhang & Burkard, 2008; Zhang & McCoy, 2009; Thompson & Alexander, 2006). However, research has found White HSP providers continue to struggle with regularly engaging (Knox et al., 2003; Lee & Horvath, 2013; Lee & Bhuyan, 2013; Day-Vines, Bryan, et al., 2022). In addition, although theories (Day-Vines et al., 2007, 2018, 2020, 2021; King, 2021) have identified potential reasons for this to occur, limited empirical research has been conducted on provider characteristics that impact broaching. Of the research that has been conducted on broaching in general and provider characteristics (Day-Vines et al., 2013; King & Borders, 2019; Darby, 2014; Day-Vines et al., 2021; Jones & Welfare, 2017; Lee & Horvath, 2014; Lee & Bhuyan, 2013; King & Summers, 2020; Day-Vines, Bryan, et al., 2022; Day-Vines, Brodar, et al., 2022), little to none has focused on White, HSP advanced doctoral level trainees and early career psychologists.

As such, the researcher proposed the following three research questions in attempts to fill the gap in the literature:

- (1) Do affective variables (i.e., White empathy, White guilt, White shame, White fear, and White negation/apathy) predict an integrated/congruent broaching style? If so, how do these variables predict an integrated/congruent broaching style?
- (2) Is there a particular makeup of affective variables related to an integrated/congruent style (e.g., high empathy and low shame)?
- (3) Does the cultural humility level predict an integrated/congruent broaching style? If so, how do these variables predict an integrated/congruent broaching style?

Findings

Hypothesis 1: Affective variables will predict an integrated/congruent broaching style in varying degrees; higher levels of White empathy will predict higher levels of broaching; higher levels of White fear and White negation/apathy will predict lower levels of broaching; higher levels of White guilt will predict a higher broaching, while a higher level of White shame will not.

Findings from this study indicated that White affective responses did not significantly predict an integrated/congruent broaching style for White HSP trainees and early career psychologists, and thus how those levels of affective responses were associated with the level of broaching style could not be determined. This was surprising to the researcher, as it contradicts broaching theory and related empirical research. For example, Day-Vines et al. (2021) theorized that variation between and within providers' broaching habits may in part be explained by emotional responses. In addition, although not the same construct, Spanierman et al. (2008) found PCRW White affective responses to significantly predict multicultural counseling competency. In turn, King and Summers (2020) found multicultural competency to be a strong, positive predictor of broaching. Based on this, one possible reason affective reactions were

nonsignificant in predicting broaching may be due to a possible mediating effect that needs to be explored further.

Review of the significant correlations among White affective responses and broaching did find lower levels of fear and negation and higher levels of guilt were associated with higher levels of integrated/congruent broaching. Although this does not equal causation, these significant findings do make sense in the theoretical context of White affective responses and their accompanying approach versus avoidance behaviors. For example, individuals experiencing negation/apathy may be more likely to avoid or engage in broaching less frequently as it is evaluated as unimportant and doing so would counteract color-blind beliefs that racism no longer exists. Although similar in behavior, individuals experiencing fear may engage in broaching less frequently to avoid and reduce the associated distress. For some experiencing high fear, engaging in broaching conversations may feel unsafe as it could result in directly confronting their irrational, stereotyped fear about BIPOC individuals and the potential for losing perceived safety, power, and self-esteem. On the other hand, individuals experiencing White guilt may be more likely to engage in broaching. Although distressing to recognize one's privilege and possible violation of moral standards for behaviors, guilt, unlike shame, has been found to be related to feelings of remorse and desire for repair, resulting in motivation to change previous behaviors, learn, and engage. In addition, lower anger and higher empathy associated with guilt can help providers facilitate broaching conversations, including accepting responsibility for microaggressions and missed opportunities.

One important thing to note is the overall lower than expected reliability scores for the PCRW and WRAS subscales. Although original research has indicated these subscales' reliability scores to fall below 0.70 at times, overall scores on the current study were lower. As

such, rather than nonsignificant findings, low power and measurement error may be playing a role in the sensitivity of the regression analysis to pick up on significant findings. This is especially true as these results appear to contradict additional findings discussed next.

Hypothesis 2: multiple affective variable clusters will arise, each with a different relationship to overall integrated/congruent broaching style.

Findings from this study indicated White affective responses did cluster into two, distinct groups for White HSP trainees and early career psychologists. This includes a group dominated by high White fear and negation and low White empathy, guilt, and shame (cluster one) and a group dominated by high White empathy, guilt, and shame and low White fear and negation (cluster two). Although not perfectly matching Spanierman et al.'s (2006, 2009, 2012) cluster analyses that indicated five distinct clusters, the present study's two distinct groups do have some overlap with the original findings. Cluster one appeared most similar to Spanierman et al.'s insensitive and afraid group, while cluster two appeared most similar to the antiracist group. Difficulty replicating the five distinct clusters may have been due to multiple factors, including replacing the PCRW White Guilt subscale with the WRAS White Guilt subscale, as well as incorporating the WRAS White Negation and WRAS White Shame subscales. In addition, participants in the current study tended to skew higher in White empathy and lower in White negation, White fear, and White shame than Spanierman's undergraduate samples. This may be due to the type of person typically drawn to become a psychologist (i.e., higher empathy), as well as having additional opportunities for learning and self-reflection to dissipate more immobilizing feelings of negation, fear, and shame. Finally, the inability for additional clusters was most likely impacted by low sample size, low power, and poor measurement in the present study.

Regarding part two of the hypothesis, results did find the two clusters had a significantly different relationship with integrated/congruent broaching style, with cluster two being associated with higher broaching levels than cluster one. This maps theoretically, as the emotions commonly linked to engagement behaviors (i.e., empathy, guilt) were associated with higher broaching behaviors, while those commonly linked to avoidance (i.e., fear, negation/apathy) were associated with lower levels of broaching. Spanierman et al.'s (2006, 2009, 2012) cluster results support this notion, as those in the antiracist group were also found to engage in other approaching behaviors related to race, including higher multicultural education, more racially diverse friend groups, higher cultural sensitivity and support for affirmative action, and lower color-blind racial attitudes compared to the insensitive and afraid group. Interestingly, cluster two also reported higher levels of White shame, which is typically associated with avoidance behaviors. However, higher levels of White empathy and guilt may have mitigated this impact. In addition, construct clarification among WRAS White guilt and shame subscales is warranted for White HSP advanced doctoral trainees and early career psychologists, as previous scale development has focused on undergraduate samples. This could help clarify how much the shame subscale is overlapping with guilt for this specific population.

Although the regression results in the current study were nonsignificant, cluster analysis results, correlations among the main variables, and qualitative data, discussed later in this chapter, indicated that White affective responses appear to have a significant role in broaching behaviors for White HSP trainees and early career psychologists. White affective emotions appear to influence approach versus avoidance behaviors when engaging with topics of race, racism, and White Privilege, including specifically broaching these conversations in therapy.

Based on this, the researcher believes the regression results may not be fully accurate, due to lower sensitivity of the analyses as a result of low power and measurement error previously discussed. In addition, significant cluster findings may indicate that rather than one White affective response solely predicting broaching behaviors, a combination of White affective responses may be needed to find significant results.

Hypothesis 3: Cultural humility will predict an integrated/congruent broaching style; higher levels of cultural humility will predict higher levels of broaching.

Findings from this study indicated higher levels of cultural humility significantly predicted higher levels of integrated/congruent broaching style above and beyond when controlling for other variables for White HSP trainees and early career psychologists. The final step (step two) in the hierarchical regression analysis accounted for 55% of the variance in broaching behaviors, a 34.5% increase from step one, which included social desirability and demographic covariances. More specifically, as cultural humility scores increase by roughly 6 points, broaching level score is expected to increase by 0.282. Over a 25% point increase on the broaching scale is rather impactful, as total scores on the integrated/congruent broaching subscale range from 1-5.

This finding matches previous empirical research results, including ratings of therapists in a mock session who incorporated broaching having higher perceived cultural humility (King & Borders, 2019), and that direct teaching on cultural humility was associated in more frequent broaching instances during an experiential learning exercise with master's level clinicians (Askren, 2022). In addition, higher multicultural competency, a separate, but related construct to cultural humility, has been found to be associated with higher levels of broaching behaviors (Jones & Summers, 2020).

Theoretically, the idea that broaching and cultural humility are related and possibly interconnected makes sense. Jones and Branco (2020) posit that the two constructs are bidirectional in nature, requiring and reinforcing each other as they continue to be engaged by the provider. Broaching can be viewed as an actionable skill expression of cultural humility, and to engage in effective broaching, one needs the mindset and approach outlined by cultural humility. This includes the importance of a strong therapeutic alliance and sense of openness to authentically engage. Both also focus on the client as the expert, rather than the provider, and welcome ongoing exploration of one's racial, ethnic, and cultural experiences to navigate therapeutic services. Cultural humility and broaching also both incorporate a need for ongoing self-reflection on the provider's part to be more self-aware of potential biases and minimizing missed cultural moments. Finally, broaching and cultural humility both stress the importance of recognizing and incorporating not just individual experiences, but the interaction and influence of structural and systemic oppressive forces at play.

However, the impact of measurement error and limited conceptual clarity may be underestimating the true correlation between cultural humility and broaching behaviors, resulting in a higher potential for multicollinearity. This in turn may be undermining the statistical significance between cultural humility and predicting broaching behaviors in the current study and should be interpreted with some caution. After correcting for attenuation, the correlation between cultural humility and broaching was estimated to be $r = .768$. Although still below the 0.80 threshold for multicollinearity, it does pose a threat and should be further explored.

Significant Demographics Findings

Although not a main focus of the current study, findings also found significant group differences for sexual orientation and program type demographic variables among White HSP

trainees and early career psychologists. Specifically, individuals who identified as LGBTQIA+ predicted higher levels in broaching compared to individuals who identified as heterosexual. In addition, individuals from counseling psychology programs predicted higher levels in broaching compared to students from clinical psychology programs. Group differences between counseling psychology and school/combination/other and clinical psychology and school/combination/other were nonsignificant.

Although not having a full understanding or having the same oppressive experience, White LGBTQIA+ individuals may pull from their own experiences navigating homophobia to increase a sense of self-awareness and openness. They may value and want to offer a therapeutic relationship that validates lived experiences in the context of oppression, moving towards intentionally disrupting and healing the "legacy of silence and shame" (Day-Vines et al., 2007; p. 402).

In terms of the distinction between counseling versus clinical psychology program scores, exploring the underlying core values and guiding framework of counseling psychology can shed some light. While clinical psychology's origins have been rooted in pathology, individualism, and seeing the provider as an expert, counseling psychology emphasizes a holistic, strengths-based and multiculturally inclusive approach, prevention, community-centered, focus on the individual's experience in their particular context, system, and intersecting social identities, actively addressing oppression with social justice advocacy, and encouraging self-reflection to support ongoing growth (Society of Counseling Psychology Division 17, n.d.). As a result, individuals who value this approach may seek out counseling psychology programs. Once in the program, these values may be reinforced and strengthened, providing ongoing emphasis,

training, and discussions on multiculturalism and social justice, including aspects of broaching, cultural humility, privilege, and oppression.

BIPoC Group Findings (Group B)

Again, although not a main focus of this present study, a small sample (i.e., group B) of individuals who self-identified as Black, Indigenous, or Person of Color (BIPoC), including bi/multiracial individuals who did not complete the White affective subscales, participated in the study. BIPoC participants also had a strong, positive association between broaching and cultural humility.

Comparing between group A (White individuals & bi/multiracial individuals who completed the White affective subscales) and group B (BIPoC individuals), results found overall broaching group mean scores did not statistically differ. However, cultural humility group mean scores were significantly different, with BIPoC individuals scoring higher than White individuals. This again follows previous research that finds White individuals continuing to struggle with incorporating multicultural and social justice approaches with racially diverse clients compared to BIPoC counterparts.

Qualitative Findings

Responses to the four qualitative questions for both group A (White individuals) and group B (BIPoC individuals) provided rich details on participants' experiences in training programs with regards to broaching. In general, these findings support and further clarify the significant quantitative results discussed above. Although exhibiting lower cultural humility levels compared to their BIPoC counterparts, White participants still expressed a desire to move towards more integrated broaching styles, identifying a need for additional opportunities to strengthen broaching skills, having an ongoing, supportive training culture, and needing a space

to process through the associated emotions. Through reflecting on critical incidents, positive supports, and direct suggestions, recommendations for training programs were specifically tailored.

First, with regards to critical incidents, White participants overwhelmingly identified moments while in the graduate training program (i.e., academic courses and diverse clinical training opportunities) as the most common situation to introduce and increase awareness of broaching. BIPoC participants, on the other hand, most commonly identified personal experiences growing up prior to the training program. This maps on to the general White privilege research, which finds White individuals often do not have to think about or engage in dialogue regarding race, ethnicity, and culture (Sue & Sue, 2003) at a young age.

Both White and BIPoC individuals also identified additional opportunities outside of the classroom to be critical for their learning. Almost like a parallel process, individuals seeking to learn about broaching wish to do so in an ongoing manner, while recognizing the importance of acknowledging, reflecting on, and incorporating the current socio-political events to better understanding broaching and its importance.

Participants also overwhelmingly identified the importance of supervision to increase awareness and receive direct feedback in vivo. In addition to being able to identify concrete cultural moments in a session, supervisors can support trainees to enact and continue engaging with broaching over the course of a therapeutic relationship. However, BIPoC participants stressed that White supervisors need to acknowledge and further integrate broaching in supervision. This follows previous research that indicates White HSP providers in general struggle with broaching even in supervisory spaces. Finally, question four elicited feedback for training programs regarding broaching, which will be discussed next.

Implications

Several implications for HSP graduate training programs were identified based on the present study's findings and review of the literature. First, broaching is an important and useful approach that needs to be more regularly incorporated in therapeutic services. Broaching has been found to not only mitigate and reduce the negative experiences often felt by BIPoC clients, but also improve perceived outcomes. However, many providers avoid or engage sparingly due to feeling inadequate or overwhelmed. To combat this, training programs should increase their emphasis on broaching earlier in the program (i.e., in an experiential counseling skills course) and provide plenty of case examples, mock demonstrations, and opportunities to practice to support skill development alongside awareness. As many participants identified professors as a key support for learning broaching skills, instructors should make attempts to acknowledge both positive and negative experiences attempting to broach to normalize learning. Programs should also integrate more advanced multicultural topics (e.g., intersectionality, structural and systemic oppression, and decolonizing and liberation frameworks) and discussions about current socio-political events to provide context for why broaching is important. When reviewing broaching, training programs should make sure to also expand their focus to support BIPoC trainees broaching conversations with White clients and explore other social identities (e.g., sexual orientation, religion).

Based on the current results, one area training programs may wish to focus on to increase broaching behaviors is cultural humility. As cultural humility is a way of being, as opposed to way of doing, training programs may need to get creative. Courses with opportunities to provide direct feedback (e.g., counseling skills, practicum/externship courses) may be useful. Programs may wish to also incorporate cultural humility values in their practicum/externship evaluations.

As social learning theory (Bandura, 1977) suggests, the importance of providing positive modeling experiences is also true for graduate trainees. Many participants, both White and BIPoC, expressed a need for training programs to model the very skills and values emphasized in broaching. Trainees may feel conflicted in being told the importance of broaching while observing their training programs doing the opposite. To combat this, training programs should move away from avoidance and work towards acknowledging mistakes and instances of microaggressions, while engaging in social justice advocacy to challenge structural oppression impacts. As the broaching research tells us, an authentic and genuine relationship will ultimately help trainees foster more openness, vulnerability to take risks, and willingness to engage in ongoing difficult conversations.

Training programs and professors are particularly important for White trainees to increase self-awareness and knowledge when it comes to broaching, as academic classes are often one of their first critical incidents. Training programs should also focus on providing opportunities for ongoing reflection outside of the classroom, with added emphasis to create a safe or brave space that supports vulnerability, accountability, and exposure to difficult conversations about race. This may include facilitating intergroup dialogue programs (Nagda, 2006) and providing brown bag training series on the topic. Special focus should be made to provide safe BIPoC spaces for students and mentoring opportunities with BIPoC faculty.

Having opportunities to desensitize overwhelming feelings and apply skills in vivo with diverse clients should be continued as much as possible by training programs. This can be particularly useful when paired with supervision that not only demonstrates broaching in the supervisory relationship, but provides ongoing support and feedback for trainees. Doing so can also ensure ethically sound care while navigating this process. Training programs should take

care to emphasize in their supervision courses the importance of translating broaching behaviors to the supervisory space as well. This is particularly true for white supervisors working with BIPoC supervisees. Supervision also appears to be a critical support for navigating emotional responses to race, racism, and oppression. As such, supervisors should make sure to also spend time on emotion identification and regulation surrounding broaching, and encourage supervisees to seek outside resources (e.g., peers, family and friends, personal therapy) as needed.

Although not a significant predictor for broaching, findings from the current study indicate associations among specific White affective responses and broaching behaviors. In addition to normalizing and providing psychoeducation on affective responses and potential impacts, training programs may wish to support their White trainees in navigating these emotions and encouraging opportunities to explore with peer groups. Cluster analysis and literature review also found that individuals may be experiencing multiple emotional responses at once and this may shift over the years.

Finally, findings from the current study indicate that participants from counseling psychology programs, compared to clinical psychology programs, predicted higher broaching behaviors. Counseling psychology programs should continue to monitor and evaluate if their training program aligns with counseling psychology's mission and values, in addition to the aforementioned suggestions above. Clinical psychology programs may also wish to collaborate with counseling programs and psychologists to ensure a culture and training that supports broaching behaviors.

Limitations and Future Research

Limitations

The present study had several limitations, which subsequently impacts the results, implications, and generalizability of the results. First, there was overall low reliability on several of the main variable measures, particularly the PCRW and WRAS. Having low reliability may have resulted in lower power and subsequently reduced the sensitivity in finding significant effects. In review of the PCRW and WRAS scale development literature (Spanierman & Heppner, 2004; Grzanka et al. (2020), some of the subscale reliability scores were in the 0.60-0.70 range. The PCRW and WRAS were also primarily normed on undergraduate populations (Spanierman et al., 2004, 2006, 2009). Compared to the original population, an adult community sample (Poteat & Spanierman, 2009) found the PCRW White Guilt subscale did not load similarly and had lower reliability. Spanierman et al. (2008) also found in a group of psychology graduate trainees that overall mean scores for White Empathy and White guilt were higher, while scores for White fear were lower compared to the original normed group. As such, issues with measurement error may also be negatively impacting the results. For the current study, PCRW Empathy scores skewed more positively, while the WRAS White Negation, WRAS White Shame, and PCRW White Fear skewed more negatively. Thus, the current scales may not be consistently measuring the same construct for this specific White HSP advanced trainee and early career psychologist sample and may not fully capture the White affective emotions they experience. This makes sense theoretically, as it is expected that White HSP trainees and early career psychologists may have more exposure and training compared to the general undergraduate and adult population.

Additional sample issues that pose as limitations include overall low sample size and sampling method. Although 87 White participants met the minimum standard identified by G*Power analysis, a larger sample size would have been beneficial due to the impact hierarchical approaches have on power at each level (Usami, 2011). A potential increase in type II error may have occurred, resulting in decreased sensitivity to pick up on potential significant effects. In addition, a larger sample size would most likely have helped provide more nuance for the White affective cluster analysis. A smaller sample size also required the researcher to collapse underrepresented social identity groups (e.g., sexual orientation, religion) into larger groups (e.g., LGBTQIA+ and heterosexual) to increase the power, but at the expense of understanding the considerable variability within the underrepresented group.

With regards to sampling method, the researcher primarily used LISTERVs geared towards counseling psychologists, individuals invested in graduate research, and word of mouth. While these approaches were more easily accessible and allowed for a decent sample to be collected, doing so may have resulted in a more specific, as opposed to wide, range of responses based on the type of participant who would have engaged. Targeting more counseling psychology related places may have resulted in individuals with higher cultural humility and broaching behaviors. Paradoxically, individuals who would have lower broaching behaviors or higher White negation and fear would most likely avoid the study.

Another limitation was the use of self-reports for cultural humility. While again making it easier to distribute, cultural humility theorists recommend the ideal use of both a self-report and client-report measure, as potential concerns with validity and respondents potentially over or underscore themselves compared to clients (Davis et al., 2010). As such, scores on the cultural humility scale may have over or underrepresented the participants' true score.

Finally, one critique within the counseling psychology research is the amount of overlap variables may have with one another. Due to cultural humility and broaching behaviors being somewhat highly associated with each other, especially when correcting for attenuation, this may have impacted the overall ability to examine the relationships accurately. Indeed, cultural humility and broaching researchers note that the two constructs appear interconnected and bidirectional in nature (Jones & Branco, 2020).

Future Research

Future research on White affective responses, cultural humility, and broaching would benefit from the following areas. First, additional scale evaluation is needed for the PCRW and WRAS subscales, particularly for White HSP trainees and early career psychologists. Rerunning an exploratory factor analysis on this specific population may be helpful to correct for measurement error and increase the present low reliabilities. In addition, additional construct evaluation among the affective variables, and between cultural humility and broaching is warranted. Continuing to explore provider characteristics that predict broaching, including affective responses and cultural humility, would also help affirm the original findings and continue to support training teams and supervisors in supporting their trainees. Doing so with a larger, more diverse sample size would also be beneficial. While this study focused primarily on White HSP trainees and early career psychologists, future research should also center on BIPOC experiences of broaching to ensure more inclusive training outcomes.

Gonzalez et al. (2021) also recommended additional research look at the difference between self-reported cultural humility and client-reported scales. Doing so could help correct for the potential overreporting previously found. Finally, additional research is warranted to examine the relationship among White affective responses and broaching, based on the mix of

nonsignificant and significant results. Looking at possible mediating effects between affective responses and broaching may be a good start, as previous research (Spanierman et al., 2008; King & Summers, 2020) in multicultural competency, affective responses, and broaching have indicated this possibility. In addition, further cluster analysis may help provide more nuance to explore if particular White affective groupings play a role in broaching behavior.

Conclusion

This present study attempts to fill the gap in the research by exploring potential provider characteristics that predict broaching behavior. It is the first of its kind to shed some light on the relationships among cultural humility, White affective responses to racism, and demographic variables with broaching style, looking specifically at a sample of White health service psychology (HSP) advanced trainees and early career psychologists. Qualitative responses were collected to further illuminate training suggestions. Additional responses were also collected and analyzed from BIPoC HSP advanced trainees and early career psychologists to supplement the main analyses. The findings from the study indicated the importance of cultural humility and White affective responses in relation to broaching behaviors, while providing recommendations related to graduate HSP training programs, supervision, and research.

APPENDIX A
RECRUITMENT SCRIPT

Research Study: Therapist Predictors for Broaching Behavior in Cross-Cultural Therapy

Dear Participant,

My name is Sarah Galvin and I am a doctoral candidate in the Counseling Psychology Program at Loyola University Chicago. I am currently recruiting participants for my **dissertation examining the factors that influence how therapists broach conversations of race, ethnicity, and culture in therapy.**

I am inviting you to participate in this study if you meet the following criteria:

1. You are an **advanced doctoral student** (i.e., completed at least one year of supervised, direct clinical experience providing therapy in an official externship/internship training) OR an **early career psychologist** (i.e., graduated within the last 10 years) from a **Clinical, Counseling, School, or combination, psychology program**
2. You are age 18 or older
3. You currently reside in the United States

Completing this study will take approximately 10-15 minutes. Approximately 300 individuals will be asked to participate in this study.

At the completion of the survey, there will be an option to participate in a raffle to win **one of four \$25 Target e-gift cards.**

Your participation is entirely voluntary and responses will be confidential. You may choose to leave the survey at any time without penalty. If you are interested in participating, please click the link below.

Link: https://luc.co1.qualtrics.com/jfe/form/SV_5C2YuWQilyQpu4K

This study has been approved by Loyola University Chicago's Institutional Review Board (IRB# 3296).

If you have any questions, please contact me or my chair. Your help is greatly appreciated.

Warmly,

Sarah Galvin, M.Ed.
Doctoral Candidate
Counseling Psychology
Loyola University Chicago
sgalvin2@luc.edu

Elizabeth Vera, Ph.D.
Professor/Dissertation Chair
Counseling Psychology
Loyola University Chicago
evera@luc.edu

APPENDIX B
CONSENT FORM

CONSENT TO PARTICIPATE IN RESEARCH

Project Title: Therapist Predictors for Broaching Behavior in Cross-Cultural Therapy

Researchers: Sarah Galvin, M.Ed. and Elizabeth Vera, Ph.D.

Introduction: You are being asked to take part in a research study being conducted by Sarah Galvin, a doctoral candidate in Counseling Psychology at Loyola University Chicago, as part of a dissertation project. The study is being overseen by Dr. Elizabeth Vera's supervision.

Please read this form carefully and ask any questions you may have before deciding whether to participate in this voluntary study.

Purpose: The purpose of this study is to examine the factors that influence how therapists broach conversations of race, ethnicity, and culture in therapy.

Inclusion/Exclusion Criteria: If you are an advanced doctoral student (i.e., completed at least one year of supervised, direct clinical experience providing therapy in an official externship/internship training) OR an early career psychologist (i.e., graduated within the last 10 years) from a Clinical, Counseling, School, or combination, psychology program, you are at least 18 years or older, and you reside in the United States, then you may participate in this study. Approximately 300 individuals will be asked to participate in this study.

Procedures: If you agree to be in the study, you will be asked to answer a series of questionnaires about your demographic information, level of competence in multicultural care, emotional reactions to racism, your attitudes and behaviors towards broaching the topics of race/ethnicity/culture, and four open-ended questions. It should take you approximately 10-15 minutes.

Risks/Benefits: There are no foreseeable risks involved in participating in this research beyond those experienced in everyday life. There are no direct benefits from your participation, but you may gain a greater understanding about your experience working with culturally diverse clients. You will also be helping those who train psychology professionals better support the development of effective multicultural care.

Compensation: At the completion of the survey, you will be given the opportunity to enter a raffle, through a separate link, to win one of four \$25 Target e-gift cards for your voluntary participation. Your email will not be associated with your responses and will only be used for the purpose of the gift card drawing and awarding. You do not have to include an email address if you do not wish to be entered into the drawing.

Confidentiality: All information collected is anonymous and no identifying information will be gathered. Information obtained as a result of this survey will be kept confidential. Only the researchers will have access to the data, which will be entered into a software program and saved on the researcher's password protected computer.

After this study is complete, unidentifiable study data may be shared with other researchers for use in other studies without asking for your consent again or as may be needed as part of publishing our results. The data we share will NOT include information that could identify you.

Voluntary Participation: Participation in this study is voluntary. If you do not want to be in this study, you may simply disregard this invitation. Even if you decide to participate, you are free to not answer any question or to withdraw from participation at any time without penalty.

Contacts and Questions: If you have any questions about this research study, please contact Sarah Galvin at (872) 265-1642 or sgalvin2@luc.edu or my dissertation chair, Dr. Elizabeth Vera, at (312) 915-6958 or evera@luc.edu. If you have questions about your rights as a research participant, you may contact the Loyola University Office of Research Services at (773) 508-2689.

Statement of Electronic Consent: By selecting “agree” below, you agree to participate in the survey and are indicating consent for an informed participation. If you decide not to participate in this study, simply disregard this survey. You may print a copy of this consent form for your records.

Thank you very much for your time and effort.

Warmly,

Sarah Galvin, M.Ed.

Elizabeth Vera, Ph.D.

Clicking on the “Agree” button indicates that:

- You have read and understood the above information and had an opportunity to email or call the PI to answer any of your questions
- You are 18 years or older and residing in the United States
- You are an advanced doctoral student (i.e., completed at least one year of supervised, direct clinical experience providing therapy in an official externship/internship training) OR an early career psychologist (i.e., graduated within the last 10 years) from a Clinical, Counseling, School, or combination, psychology program

Agree

Disagree

APPENDIX C

MODIFIED PSYCHOSOCIAL COSTS OF RACISM TO WHITES SCALE

Modified Psychosocial Costs of Racism for Whites Scale (PCRW)

Please respond to the following statements by inserting only one number next to the item from the chart below. **Your possible choices range from 1-6.** Please answer honestly, as there are no right or wrong answers. Avoid answering as you think you “should” feel or as how you would expect others to answer. All responses are completely anonymous.

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

- _____ 1. When I hear about acts of racial violence, I become angry or depressed.
- _____ 2. I feel safe in most neighborhoods, regardless of the racial composition (R).
- _____ 3. I feel helpless about not being able to eliminate racism.
- _____ 5. I have very few friends of other races.
- _____ 6. I become sad when I think about racial injustice.
- _____ 9. I am fearful that racial minority populations are rapidly increasing in the U.S., and my group will no longer be the numerical majority.
- _____ 10. I am angry that racism exists.
- _____ 11. I am distrustful of people of other races.
- _____ 13. I often find myself fearful of people of other races.
- _____ 14. Racism is dehumanizing to people of all races, including Whites.
- _____ 16. It disturbs me when people express racist views.

Source. Spanierman, L. B., & Heppner, M. J. (2004). Psychosocial Costs of Racism to whites scale (PCRW): Construction and initial validation. *Journal of Counseling Psychology, 51*, 249-262. doi:10.1037/0022-0167.51.2.249

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APPENDIX D
WHITE RACIAL AFFECT SCALE

The White Racial Affect Scale (WRAS)

Below are situations that people are likely to encounter in day-to-day life, followed by several common reactions to those situations. As you read each scenario, try to imagine yourself in that situation. Then indicate how likely you would be to react in each of the ways described. We ask you to rate all responses because people may feel or react more than one way to the same situation, or they may react different ways at different times.

For example:

You wake up early one Saturday morning. It is cold and rainy outside.

- a) You would telephone a friend to catch up on news. 1 - - 2 - - 3 - - 4 - - 5
not likely very likely
- b) You would take the extra time to read the paper. 1 - - 2 - - 3 - - 4 - - 5
not likely very likely
- c) You would feel disappointed that it’s raining. 1 - - 2 - - 3 - - 4 - - 5
not likely very likely

In the above example, I’ve rated all of the answers by selecting a number. I selected a “1” for answer (a) because I wouldn’t want to wake up a friend very early on a Saturday morning – so it’s not at all likely that I would do that. I selected a “5” for answer (b) because I almost always read the paper if I have time in the morning (very likely). I selected a “3” for answer (c) because for me it’s about half and half. Sometimes I would be disappointed about the rain and sometimes I wouldn’t – it would depend on what I had planned.

Please do not skip any items – rate all responses.

1. In a class, you are corrected for your usage of the term, “Blacks.”

1 - - 2 - - 3 - - 4 - - 5
not likely very likely

- a) You would think: “Labels don’t really matter.”
- b) You would apologize and ask your instructor for the correct/appropriate usage of the term.
- c) You would think: “It’s not my fault – I can’t keep up with all this political correctness.”

2. You read a news story about White students at large private university dressing in “Blackface” for a theme party.

1 - - 2 - - 3 - - 4 - - 5
not likely very likely

- a) You would think: “That’s so awful. I hope they have to face consequences for their behavior.”
- b) You would wish you weren’t White.
- c) You would think: “I’m sure the students didn’t mean any harm.”

3. One of your White friends uses the N-word in a joke and you laugh.

1 - - 2 - - 3 - - 4 - - 5
not likely very likely

- a) You would feel small and think about it for days.
- b) You would think: “If Black people can use the N-word, why can’t White people?”
- c) You would stop laughing and tell the friend that don’t think racist language is OK, even when joking.

4. You read a news article about a recent hurricane in which wealthy White people were able to evacuate and the poorer Black majority was left behind; many people died.

1 - - 2 - - 3 - - 4 - - 5
not likely very likely

- a) You would think: “That’s not a race issue. That’s a social class issue.”
- b) You would feel sad and send whatever money you could to the relief effort.
- c) You would hate yourself for being White.

5. You realize that all characters on your favorite television show are White.

1 - - 2 - - 3 - - 4 - - 5
not likely very likely

- a) You would feel bad for not noticing sooner and never watch the show again.
- b) You would think: “It wouldn’t be realistic if there were lots of minorities on the show.”
- c) You would think: “I don’t care what the characters look like as long as the show is entertaining.”

6. You read a Civil War novel about American slavery that describes violent abuse of Black slaves by White slave-owners.

1 - - 2 - - 3 - - 4 - - 5
not likely very likely

- a) You would feel depressed and sad about the history of racism in the United States.
- b) You would think: “I wish there was something I could do to make up for all the harm slavery caused Black people.
- c) You would think: “Slavery was awful, but people need to get over it and move on.”

Source. Grzanka, P. R., Frantell, K. A., & Fassinger, R. E. (2020). The White Racial Affect Scale (WRAS): A measure of White guilt, shame, and negation. *The Counseling Psychologist*, 48(1), 47-77. doi:10.1177/0011000019878808

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APPENDIX E

MULTIDIMENSIONAL CULTURAL HUMILITY SCALE

Multidimensional Cultural Humility Scale (MCHS)

Please take a moment and read each of the following statements. Then, rate the level of agreement for which each statement best reflects your work with clients from diverse cultural backgrounds. **Your possible choices range from 1-6.**

Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
1	2	3	4	5	6

1. I am comfortable asking my clients questions about their cultural experience (1)	1	2	3	4	5	6
2. I seek to learn more about my clients' cultural background (2)	1	2	3	4	5	6
3. I believe that learning about my clients' cultural background will allow me to better help my clients. (4)	1	2	3	4	5	6
4. I seek feedback from my supervisors when working with diverse clients (11)	1	2	3	4	5	6
5. I incorporate feedback I receive from colleagues and supervisors when I am faced with problems regarding cultural interactions with clients. (13)	1	2	3	4	5	6
6. I am known by colleagues to seek consultation when working with diverse clients. (14)	1	2	3	4	5	6
7. I ask my clients about their cultural perspective on topics discussed in session. (12)	1	2	3	4	5	6
8. I ask my clients to describe the problem based on their cultural background. (27)	1	2	3	4	5	6
9. I ask my clients how they cope with problems in their culture. (28)	1	2	3	4	5	6
10. I wait for others to ask about my biases for me to discuss them. (R) (42)	1	2	3	4	5	6
11. I do not necessarily need to resolve cultural conflicts with my clients in counseling. (R) (43)	1	2	3	4	5	6
12. I believe the resolution of cultural conflict in counseling is the client's responsibility. (R) (44)	1	2	3	4	5	6
13. I enjoy learning from my weaknesses. (49)	1	2	3	4	5	6
14. I value feedback that improves my clinical skills. (50)	1	2	3	4	5	6
15. I evaluate my biases. (52)	1	2	3	4	5	6

Source. Gonzalez, E., Sperandio, K. R., Mullen, P. R., & Tuazon, V. E. (2021). Development and initial testing of the Multidimensional Cultural Humility Scale. *Measurement and Evaluation in Counseling and Development*, 54(1), 56-70.
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APPENDIX F
BROACHING ATTITUDES AND BEHAVIOR SURVEY

Broaching Attitudes and Behavior Survey (BABS) – Integrated/Congruent Subscale

This survey examines the extent to which counselors discuss or broach the subject of race, ethnicity, and culture with their clients of color during the counseling process. Essentially, broaching refers to the counselor's effort to determine the extent to which race, ethnicity, and culture may be related to the client's presenting problem. Using the Likert scale below, please select the response that best describes your behavior. **Your possible choices range from 1-5.**

Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
1	2	3	4	5

3. I typically broach one or two times over the course of the counseling relationship. (4)	1	2	3	4	5
12. When I am working with a person of color, I broach issues of race and ethnicity several times throughout the course of the counseling relationship. (25)	1	2	3	4	5
13. I invite my clients to explore the relationship between their presenting problems and issues related to race, ethnicity, and culture. (27)	1	2	3	4	5
14. I initiate discussions that help my clients understand that their problems may be connected to a larger set of system issues such as race and culture. (30)	1	2	3	4	5
15. I have integrated the concept of broaching into my professional identity. (31)	1	2	3	4	5
18. I have a repertoire of questions that I typically use to initiate discussions of cultural factors. (39)	1	2	3	4	5
35. I generally broach racial and cultural factors throughout my counseling sessions with clients. (64)	1	2	3	4	5
37. I encourage my clients to make culture specific interpretations of their counseling concerns. (71)	1	2	3	4	5
38. I typically broach racial and cultural factors within the first two counseling sessions. (91)	1	2	3	4	5
39. I use language to facilitate discussion of race, ethnicity, and culture. (79)	1	2	3	4	5

Source. Day-Vines, N. L., Bryan, J., & Griffin, D. (2013). The Broaching Attitudes and Behavior Survey (BABS): An exploratory assessment of its dimensionality. *Journal of Multicultural Counseling and Development, 41*(4), 210-223. doi: 10.1002/j.2161-1912.2013.00037.x.

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APPENDIX G
BALANCED INVENTORY OF DESIRABLE RESPONDING
SHORT FORM

Balanced Inventory of Desirable Responding Short Form (BIDR-16)

Using the scale below as a guide, select a number for each statement to indicate how much you agree with it.

Response scale: 1 (totally disagree) – 8 (totally agree)

- ___ 1. I have not always been honest with myself.
- ___ 2. I always know why I like things.
- ___ 3. It's hard for me to shut off a disturbing thought.
- ___ 4. I never regret my decisions.
- ___ 5. I sometimes lose out on things because I can't make up my mind soon enough.
- ___ 6. I am a completely rational person.
- ___ 7. I am very confident of my judgments
- ___ 8. I have sometimes doubted my ability as a lover.
- ___ 9. I sometimes tell lies if I have to.
- ___ 10. I never cover up my mistakes.
- ___ 11. There have been occasions when I have taken advantage of someone.
- ___ 12. I sometimes try to get even rather than forgive and forget.
- ___ 13. I have said something bad about a friend behind his/her back.
- ___ 14. When I hear people talking privately, I avoid listening.
- ___ 15. I never take things that don't belong to me.
- ___ 16. I don't gossip about other people's business.

Source. Hart, C.M., Ritchie, T.D., Hepper, E.G., & Gebauer, J.E. (2015). The Balanced Inventory of Desirable Responding Short Form (BIDR-16). *SAGE Open*, 5(4), 1-9. doi: 10.1177/2158244015621113

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APPENDIX H
QUALITATIVE FOLLOW UP QUESTIONS

Qualitative Questions

1. What critical incidents (e.g., classroom experiences, trainings, therapeutic experiences), if any, have helped your approach to thinking about and/or discussing race with clients?
2. What supports (e.g., school, supervision), if any, have helped you navigate emotional reactions to thinking about and/or discussing race with clients?
3. What supports (e.g., school, supervision), if any, have helped you navigate experiences in thinking about and/or discussing race with clients?
4. What would be most helpful for training programs to know about your experiences with thinking about and/or discussing race with regards to clients to better support you?

APPENDIX I
DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

1. What is your age? _____

2. What is your gender identity?

_____ Transgender woman _____ Transgender man _____ Cisgender woman
 _____ Cisgender man _____ Nonbinary _____ Genderqueer _____ Prefer not to
 answer _____ Other (please specify)

3. What is your sexual orientation?

_____ Bisexual _____ Gay _____ Lesbian _____ Heterosexual _____ Pansexual
 _____ Asexual _____ Questioning _____ Prefer not to answer _____ Other (please
 specify)

4. What is your race/ethnicity?

_____ Black, African American, or of African Descent _____ Latino/a/x, Hispanic, or of
 Spanish Descent _____ Asian, Asian American, or of Asian Descent _____ Indigenous,
 American Indian, Alaskan Native, First Nations, Métis, or Inuit _____ Native Hawaiian,
 Pacific Islander, or of Pacific Islander Descent _____ White or of European Descent _____
 Middle Eastern, Arab, or of Arab Descent _____ Biracial, Multiracial _____ Prefer not to
 answer _____ Other (please specify)

5. What is your religious/spiritual affiliation?

- | | |
|---------------|---------------------------|
| a. Catholic | h. Taoist |
| b. Protestant | i. Confucianist |
| c. Christian | j. Agnostic |
| d. Jewish | k. Atheist |
| e. Muslim | l. Secular/nonreligious |
| f. Hindu | m. Spiritual |
| g. Buddhist | n. Other (please specify) |

6. How would you describe your social class growing up?

- Lower class
- Lower-middle class
- Middle class
- Upper-middle class
- Upper class

7. What is your graduation status?

- Current doctoral student
- Early career psychologist (graduated within the last 10 years)

8. What kind of program do/did you attend?
- Ph.D.
 - Psy.D.
 - Other (please list)
9. What type of program do/did you attend?
- Clinical Psychology
 - Counseling Psychology
 - School Psychology
 - Combination of Clinical/Counseling/School
 - Other (please specify)
10. IF you are a current doctoral student, what program year are you in?
- | | |
|-------------------------|--------------------------|
| a. 1 st year | e. 5 th year |
| b. 2 nd year | f. 6 th year |
| c. 3 rd year | g. 7 th year+ |
| d. 4 th year | h. N/A (post graduate) |
11. IF you are a post graduate, how many years ago did you graduate?
- | | |
|-------------|--------------------------|
| a. < 1 year | g. 6 years |
| b. 1 year | h. 7 years |
| c. 2 years | i. 8 years |
| d. 3 years | j. 9 years |
| e. 4 years | k. 10 years |
| f. 5 years | l. N/A (current student) |
12. Approximately how many years have you provided direct clinical services? _____
13. On average, what percentage of your caseload is non-White clients? _____
14. What is your theoretical orientation/approach? _____

REFERENCE LIST

- Abrams, L. S., & Gibson, P. (2007). Teaching notes: Reframing multicultural education: Teaching white privilege in the social work curriculum. *Journal of Social Work Education, 43*(1), 147-160. doi:10.5175/JSWE.2007.200500529
- Askren, K. (2022). *Integrated model for teaching multicultural competence: Incorporating broaching as a basic skill for counseling students* (Publication No. 3662) [Doctoral dissertation, Liberty University]. Liberty University Digital Commons.
- Bandura, A. (1977). *Social learning theory*. Prentice Hall.
- Berry, W. D., & Feldman, S. (1985). *Quantitative Applications in the Social Sciences: Multiple regression in practice*. SAGE Publications, Inc.
- Blalock Hubert M. (1967). *Toward a Theory of Minority-Group Relations*. Wiley.
- Bonilla-Silva, E. (2006). *Racism without racists: Color-blind racism and the persistence of racial inequality in the United States*. Rowman & Littlefield Publishers.
- Bryant-Davis, T. (2007). Healing requires recognition: The case for race-based traumatic stress. *The Counseling Psychologist, 35*, 135–143. doi:10.1177/0011000006295152
- Brown, B. (2007). *I thought it was just me: Women reclaiming power and courage in a culture of shame*. Gotham Books.
- Brown, T. N., Bento, A., Gorman Jr, Q., Koku, L., & Culver, J. (2019). “Who Cares?”: Investigating Consistency in Expressions of Racial Apathy among Whites. *Socius, 5*, 1-10. doi:10.1177/2378023119839518
- Burkard, A. W., Edwards, L. M., & Adams, H. A. (2016). *Racial color blindness in counseling, therapy, and supervision*. In Neville, H.A., Gallardo, M.E., and Sue, D.W. (Eds.), *The myth of racial color blindness: Manifestations, dynamics, and impact* (pp. 295-311). American Psychological Association. doi: 10.1037/14754-018
- Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*, 537–554. doi:10.1037/a0025266

- Cardemil, E. V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice*, 34(3), 278-286. doi:10.1037/0735-7028.34.3.27
- Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, 35,13–105. doi:10.1177/0011000006292033
- Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of counseling psychology*, 56(4), 521-536. doi:10.1037/a0016905
- Chase, L. R. (2021). *Exploring factors impacting social justice advocacy attitudes among play therapists* (Publication No. 28321914) [Doctoral dissertation, The University of North Carolina at Charlotte]. ProQuest Dissertations Publishing.
- Choi, G., Mallinckrodt, B., & Richardson, J. D. (2015). Effects of international student counselors' broaching statements about cultural and language differences on participants' perceptions of the counselors. *Journal of Multicultural Counseling and Development*, 43(1), 25–37. doi:10.1002/j.2161-1912.2015.00062.x
- Constantine, M.G., & Ladany, N. (2001). *New visions for defining and assessing multicultural counseling competence*. In J.G. Ponterotto, J.M. Casas, L.A. Suzuki, & C.M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed, pp. 482-498). Sage.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. Erlbaum Associates.
- Cohen, T. R., Wolf, S. T., Panter, A. T., & Insko, C. A. (2011). Introducing the GASP scale: a new measure of guilt and shame proneness. *Journal of personality and social psychology*, 100(5), 947-966. doi:10.1037/a0022641
- Cook, R. M., Jones, C. T., & Welfare, L. E. (2020). Supervisor cultural humility predicts intentional nondisclosure by post-master's counselors. *Counselor Education and Supervision*, 59(2), 160-167. doi:10.1002/ceas.12173
- Cook, R. D., & Weisberg, S. (1982). *Residuals and influence in regression*. Chapman & Hall.
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *The University of Chicago Legal Forum*, 139-167. doi:10.4324/9780429500480
- Crowne, D.P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Counseling Psychology*, 24, 349-354. doi:10.1037/h0047358

- D'Andrea, M., & Daniels, J. (2001). *Respectful counseling: An integrative multidimensional model for counselors*. In D. Pope-Davis, & H. Coleman (Eds.), *The intersection of race, class, and gender in multicultural counseling* (pp. 417–466). Sage.
doi:10.4135/9781452231846.n17
- Darby, T. M. (2014). *White counselor trainees' and White supervisors experiences of cross-racial/ethnic counseling supervision* (Publication No. 3672617) [Doctoral dissertation, Kent State University]. ProQuest Dissertations Publishing.
- Davis, D. E., DeBlaere, C., Brubaker, K., Owen, J., Jordan, T. A., Hook, J. N., & Van Tongeren, D. R. (2016). Microaggressions and perceptions of cultural humility in counseling. *Journal of Counseling & Development, 94*(4), 483-493. doi:10.1002/jcad.12107
- Davis, D. E., Worthington, E. L., Jr., & Hook, J. N. (2010). Humility: Review of measurement strategies and conceptualization as a personality judgment. *Journal of Positive Psychology, 5*, 243–252. doi:10.1080/17439761003791672
- Day-Vines, N. L., Ammah, B. B., Steen, S., & Arnold, K. M. (2018). Getting comfortable with discomfort: Preparing counselor trainees to broach racial, ethnic, and cultural factors with clients during counseling. *International Journal for the Advancement of Counselling, 40*(2), 89-104. doi:10.1007/s10447-017-9308-9
- Day-Vines, N. L., Brodar, J. R., Hicks, D., Fernandez-Korto, E. B., Garcia, C., & Jones, K. (2022). An investigation of the relationship between school counselor trainees' broaching behavior and their racial identity attitudes. *Journal of Counseling & Development, 100*(1), 3-13. doi:10.1002/jcad.12406
- Day-Vines, N. L., Bryan, J., Brodar, J. R., & Griffin, D. (2022). Grappling with race: A national study of the broaching attitudes and behavior of school counselors, clinical mental health counselors, and counselor trainees. *Journal of Multicultural Counseling and Development, 50*(1), 25-34. doi:10.1002/jmcd.12231
- Day-Vines, N. L., Bryan, J., & Griffin, D. (2013). The Broaching Attitudes and Behavior Survey (BABS): An exploratory assessment of its dimensionality. *Journal of Multicultural Counseling and Development, 41*(4), 210-223. doi:10.1002/j.2161-1912.2013.00037.x
- Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development, 85*(4), 401-409.
doi:10.1002/j.1556-6678.2007.tb00608.x
- Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., & Gubara, S. (2021). Strategies for broaching the subjects of race, ethnicity, and culture. *Journal of Counseling & Development, 99*(3), 348-357. doi:10.1002/jcad.12380

- Day-Vines, N. L., Cluxton-Keller, F., Agorsor, C., Gubara, S., & Otabil, N. A. A. (2020). The multidimensional model of broaching behavior. *Journal of Counseling & Development, 98*(1), 107-118. doi:10.1002/jcad.12304
- Dull, B. D., Hoyt, L. T., Grzanka, P. R., & Zeiders, K. H. (2021). Can White Guilt Motivate Action? The Role of Civic Beliefs. *Journal of Youth and Adolescence, 50*(6), 1081-1097. doi:10.1007/s10964-021-01401-7
- Ebesutani, C., Drescher, C. F., Reise, S. P., Heiden, L., Hight, T. L., Damon, J. D., & Young, J. (2012). The loneliness questionnaire—short version: An evaluation of reverse-worded and non-reverse-worded items via item response theory. *Journal of Personality Assessment, 94*(4), 427-437. doi:10.1080/00223891.2012.662188
- Elliott, R., Bohart, A.C., Watson, J.C., & Greenberg, L.S. (2011). Empathy. In J. Norcross (ed.), *Psychotherapy relationships that work* (2nd ed.) (pp. 132-152). Oxford University Press.
- Elliott, R., Watson, J., Goldman, R., Greenberg, L.S. (2003). *Learning emotion-focused therapy: The process-experiential approach to change*. American Psychological Association. doi:10.1037/10725-000
- Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods, 41*, 1149-1160. doi:10.3758/BRM.41.4.1149
- Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*(2), 165-181. doi:10.1080/02615479.2014.977244
- Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing, 27*(3), 210-217. doi:10.1177/1043659615592677
- Fuertes, J. N., Mueller, L. N., Chauhan, R. V., Walker, J. A., & Ladany, N. (2002). An investigation of European American therapists' approach to counseling African American clients. *The Counseling Psychologist, 30*(5), 763-788. doi:10.1177/0011000002305007
- Gim, R. H., Atkinson, D. R., & Kim, S. J. (1991). Asian-American acculturation, counselor ethnicity and cultural sensitivity, and ratings of counselors. *Journal of counseling psychology, 38*(1), 57-62. doi:10.1037/0022-0167.38.1.57
- Gonzalez, E., Sperandio, K. R., Mullen, P. R., & Tuazon, V. E. (2021). Development and initial testing of the Multidimensional Cultural Humility Scale. *Measurement and Evaluation in Counseling and Development, 54*(1), 56-70. doi:10.1080/07481756.2020.1745648

- Govern, J. M., & Marsch, L. A. (2001). Development and validation of the Situational Self-awareness Scale. *Consciousness and Cognition: An International Journal*, 10(3), 366–378. doi:10.1006/ccog.2001.0506
- Grzanka, P. R., Frantell, K. A., & Fassinger, R. E. (2020). The White Racial Affect Scale (WRAS): A measure of White guilt, shame, and negation. *The Counseling Psychologist*, 48(1), 47-77. doi:10.1177/0011000019878808
- Grzanka, P. R., Gonzalez, K. A., & Spanierman, L. B. (2019). White supremacy and counseling psychology: A critical–conceptual framework. *The Counseling Psychologist*, 47(4), 478-529. doi:10.1177/0011000019880843
- Hair, J. F., Black, W. C., Babin, B. J., & Anderson, R. E. (2014). *Multivariate data analysis* (7th ed.). Pearson.
- Hart, C. M., Ritchie, T. D., Hepper, E. G., & Gebauer, J. E. (2015). The Balanced Inventory of Desirable Responding Short Form (BIDR-16). *SAGE Open*, 5(4), 1-9. doi:10.1177/2158244015621113
- Helms, J. E. (Ed.). (1990). *Contributions in Afro-American and African studies, No. 129. Black and White racial identity: Theory, research, and practice*. Greenwood Press.
- Helms, J. E. (1995). *An update of Helm's White and People of Color racial identity models*. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–198). Sage.
- Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process*. Allyn & Bacon.
- Herche, J., & Engelland, B. (1996). Reversed-polarity items and scale unidimensionality. *Journal of the academy of marketing science*, 24(4), 366-374. doi:10.1177/0092070396244007
- Ho, R. (2013). *Handbook of univariate and multivariate data analysis with IBM SPSS*. CRC Press.
- Hook, J. N., & Davis, D. E. (2019). Cultural humility: introduction to the special issue. *Journal of Psychology and Theology*, 47(2), 71-75. doi:10.1177/0091647119842410
- Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, 60(3), 353–366. doi:10.1037/a0032595

- Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology, 63*(3), 269-277. doi:10.1037/cou0000114
- Hook, J. N., Watkins Jr, C. E., Davis, D. E., Owen, J., Van Tongeren, D. R., & Ramos, M. J. (2016). Cultural humility in psychotherapy supervision. *American Journal of Psychotherapy, 70*(2), 149-166. doi:10.1176/appi.psychotherapy.2016.70.2.149
- IBM Corporation. (2020). *IBM SPSS Statistics* (Version 27.0). IBM Corporation.
- Iyer, A., Leach, C. W., & Crosby, F. J. (2003). White guilt and racial compensation: The benefits and limits of self-focus. *Personality and Social Psychology Bulletin, 29*(1), 117-129. doi:10.1177/0146167202238377
- Jadaszewski, S. (2020). *Supervisee perceptions of cultural rupture and cultural humility: Impact on the supervisory relationship* (Publication No. 28186360) [Doctoral dissertation, The University of Akron]. Proquest Dissertations Publishing.
- Jeong, Y., & Jung, M. J. (2016). Application and interpretation of hierarchical multiple regression. *Orthopaedic Nursing, 35*(5), 338-341. doi:10.1097/NOR.0000000000000279
- Jones, C. T., & Branco, S. F. (2020). The interconnectedness between cultural humility and broaching in clinical supervision: Working from the multicultural orientation framework. *The Clinical Supervisor, 39*(2), 178-189. doi:10.1080/07325223.2020.1830327
- Jones, C. T., & Welfare, L. E. (2017). Broaching behaviors of licensed professional counselors: A qualitative inquiry. *Journal of Addictions & Offender Counseling, 38*(1), 48-64. doi:10.1002/jaoc.12028
- Key, V. O. [1949] (1989). *Southern Politics in State and Nation*. Knopf.
- Kim, E., & Kang, M. (2018). The effects of client–counselor racial matching on therapeutic outcome. *Asia Pacific Education Review, 19*(1), 103-110. doi:10.1002/jcad.12283
- King, K. M. (2021). “I Want to, But How?” Defining Counselor Broaching in Core Tenets and Debated Components. *Journal of Multicultural Counseling and Development, 49*(2), 87-100. doi:10.1002/jmcd.12208
- King, K. M., & Borders, L. D. (2019). An experimental investigation of white counselors broaching race and racism. *Journal of Counseling & Development, 97*(4), 341-351. doi:10.1002/jcad.12283
- King, K. M., Borders, L. D., & Jones, C. T. (2020). Multicultural orientation in clinical supervision: Examining impact through dyadic data. *The Clinical Supervisor, 39*(2), 248-271. doi:10.1080/07325223.2020.1763223

- King, K. M., & Summers, L. (2020). Predictors of broaching: Multicultural competence, racial color blindness, and interpersonal communication. *Counselor Education and Supervision, 59*(3), 216-230. doi:10.1002/ceas.12185
- Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, L. A., & Ponterotto, J. G. (2003). African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads. *Journal of Counseling Psychology, 50*(4), 466-481. doi:10.1037/0022-0167.50.4.466
- Laerd Statistics (2015). Hierarchical multiple regression using SPSS Statistics. *Statistical tutorials and software guides*. Retrieved from <https://statistics.laerd.com/>
- LaFleur, N. K., Leach, M. M., & Rowe, W. (2002). Manual: Oklahoma Racial Attitudes Scale. Unpublished manual.
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 357-361. doi:10.1037/0033-3204.38.4.357
- Leach, C. W., Iyer, A., & Pedersen, A. (2006). Anger and guilt about ingroup advantage explain the willingness for political action. *Personality and Social Psychology Bulletin, 32*(9), 1232-1245. doi:10.1177/0146167206289729
- Lee, E., & Bhuyan, R. (2013). Negotiating within whiteness in cross-cultural clinical encounters. *Social Service Review, 87*(1), 98-130. doi:10.1086/669919
- Lee, E., & Horvath, A. O. (2013). Early cultural dialogues in cross-cultural clinical practice. *Smith College Studies in Social Work, 83*(2-3), 185-212. doi:10.1080/00377317.2013.802639
- Lee, E., & Horvath, A. O. (2014). How a therapist responds to cultural versus noncultural dialogue in cross-cultural clinical practice. *Journal of Social Work Practice, 28*(2), 193-217. doi:10.1080/02650533.2013.821104
- Lerner, J. S., & Keltner, D. (2001). Fear, anger, and risk. *Journal of personality and social psychology, 81*(1), 146-159. doi:10.1037//0022-3514.81.1.146
- Lewis, H. B. (1971). Shame and guilt in neurosis. *Psychoanalytic review, 58*(3), 419-438.
- Little, R. J. A. (1988). A test of missing completely at random for multivariate data with missing values. *Journal of the American Statistical Association, 83*, 1198-1202. doi:10.1080/01621459.1988.1047872

- Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of community psychology, 41*(7), 884-901. doi:10.1002/jcop
- Nagda, B. A. 2006. Breaking barriers, crossing boundaries, building bridges: Communication processes in intergroup dialogues. *Journal of Social Issues 62*(3), 553-576. doi:10.1111/j.1540-4560.2006.00473.x
- National Center for Education Statistics. (2017a). *Bachelor's, master's, and doctor's degrees conferred by postsecondary institutions, by sex of student and discipline division: 2014-15* [Data file]. Retrieved from https://nces.ed.gov/programs/digest/d16/tables/dt16_318.30.asp?current=yes.
- National Center for Education Statistics. (2017b). *Doctor's degrees conferred by postsecondary institutions, by race / ethnicity and sex of student: selected year, 1976-77 through 2014-15* [Data file]. Retrieved from https://nces.ed.gov/programs/digest/d16/tables/dt16_324.20.asp?current=yes.
- Neville, H. A., Lilly, R. L., Duran, G., Lee, R. M., & Browne, L. (2000). Construction and initial validation of the color-blind racial attitudes scale (CoBRAS). *Journal of Counseling Psychology, 47*(1), 59-70. doi:10.1037/0022-0167.47.1.59
- Neville, H. A., Poteat, V. P., Lewis, J. A., & Spanierman, L. B. (2014). Changes in White college students' color-blind racial ideology over 4 years: Do diversity experiences make a difference? *Journal of counseling psychology, 61*(2), 179-190. doi:10.1037/a0035168
- Norušis, M.J. (2012). Chapter 17 Cluster Analysis. In *IBM SPSS statistics 19 statistical procedures companion* (Vol. 496, pp. 375-404). Prentice Hall.
- Okun, L., Chang, D. F., Kanhai, G., Dunn, J., & Easley, H. (2017). Inverting the power dynamic: The process of first sessions of psychotherapy with therapists of color and non-Latino White patients. *Journal of Counseling Psychology, 64*, 443-452. doi:10.1037/cou0000223
- Oxford University Press. (section 6). Broaching v.1. In *Oxford English Dictionary*. Retrieved May 29, 2022, from <https://www.oed.com/view/Entry/23496?rskey=61xNDb&result=1&isAdvanced=false#eid>
- Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy, 50*, 496-502. doi:10.1037/a0034617

- Owen, J., Drinane, J., Tao, K. W., Adelson, J. L., Hook, J. N., Davis, D., & Fookune, N. (2017). Racial/ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research, 27*(1), 102-111. doi:10.1080/10503307.2015.1078517
- Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice, 47*(1), 30-37. doi:10.1037/pro0000046
- Paulhus, D. L. (1984). Two-component of socially desirable responding. *Journal of Personality and Social Psychology, 46*, 598-609.
- Paulhus, D. L. (1991). *Measurement and control of response bias*. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measures of personality and social psychological attitudes* (pp. 17-59). Academic Press.
- Paulhus, D. L. (1998). *Manual for the Paulhus deception scales: BIDR version 7*. Toronto, Ontario, Multi-Health Systems.
- Pinterits, E. J., Poteat, V. P., & Spanierman, L. B. (2009). The White Privilege Attitudes Scale: Development and initial validation. *Journal of Counseling Psychology, 56*(3), 417-429. doi:10.1037/a0016274
- Ponterotto, J. G., Burkard, A., Rieger, B., Grieger, I., D'Onofrio, A., Dubuisson, A., et al. (1995). Development and initial validation of the Quick Discrimination Index (QDI). *Educational and Psychological Measurement, 55*, 1026-1031. doi:10.1177/0013164495055006011
- Pope-Davis, D. B., Toporek, R. L., Ortega-Villalobos, L., Ligiéro, D. P., Brittan-Powell, C. S., Liu, W. M., ... & Liang, C. T. (2002). Client perspectives of multicultural counseling competence: A qualitative examination. *The Counseling Psychologist, 30*(3), 355-393. doi:10.1177/0011000002303001
- Poteat, V. P., & Spanierman, L. B. (2008). Further validation of the Psychosocial Costs of Racism to Whites Scale among employed adults. *The Counseling Psychologist, 36*(6), 871-894. doi:10.1177/0011000007310002
- Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice: Integration, theory, and application* (4th ed.). John Wiley & Sons.
- Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44*(1), 28-48. doi:10.1002/jmcd.12035

- Reynolds, W. M. (1982). Development of reliable and valid short forms of the Marlow-Crowne Social Desirability Scale. *Journal of Clinical Psychology, 38*(1), 119–125. doi:10.1002/1097-4679(198201)38:1<119::AID-JCLP2270380118>3.0.CO;2-I
- Saucier, D. A., & Miller, C. T. (2003). The persuasiveness of arguments as a subtle measure of racism. *Personality and Social Psychology Bulletin, 29*, 1303–1315. doi:10.1177/0146167203254612
- Schafer, J. L. (1997). *Analysis of incomplete multivariate data*. Sage.
- Schlomer, G. L., Bauman, S., & Card, N. A. (2010). Best practices for missing data management in counseling psychology. *Journal of Counseling Psychology, 57*(1), 1-10. doi:10.1037/a0018082
- Smith, T. B., Constantine, M. G., Dunn, T. W., Dinehart, J. M., & Montoya, J. A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology, 53*(1), 132-145. doi:10.1037/0022-0167.53.1.132
- Smith, C. A., & Ellsworth, P. C. (1985). Patterns of cognitive appraisal in emotion. *Journal of personality and social psychology, 48*(4), 813-838. doi:10.1037/0022-3514.48.4.813
- Society of Counseling Psychology Division 17 (n.d.). *SCP Mission and Values*. <https://www.div17.org/mission-values>
- Sodowsky, G. R. (1996). *The Multicultural Counseling Inventory: Validity And applications in multicultural training*. In G.R. Sodowsky & J.C. Impara (Eds.). *Multicultural assessment in counseling and clinical psychology* (pp.283-324). Buros Institute of Mental Measurements.
- Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41*(2), 137-148. doi:10.1037/0022-0167.41.2.137
- Spanierman, L. B., Beard, J. C., & Todd, N. R. (2012). White men's fears, White women's tears: Examining gender differences in racial affect types. *Sex Roles, 67*, 174–186. doi:10.1007/s11199-012-0162-2
- Spanierman, L. B., & Heppner, M. J. (2004). Psychosocial Costs of Racism to whites scale (PCRW): Construction and initial validation. *Journal of Counseling Psychology, 51*, 249-262. doi:10.1037/0022-0167.51.2.249
- Spanierman, L. B., Poteat, V. P., Beer, A. M., & Armstrong, P. I. (2006). Psychosocial costs of racism to whites: Exploring patterns through cluster analysis. *Journal of Counseling Psychology, 53*(4), 434-441. doi:10.1037/0022-0167.53.4.434

- Spanierman, L. B., Poteat, V. P., Wang, Y. F., & Oh, E. (2008). Psychosocial costs of racism to white counselors: Predicting various dimensions of multicultural counseling competence. *Journal of Counseling Psychology, 55*(1), 75-88. doi:10.1037/0022-0167.55.1.75
- Spanierman, L. B., Todd, N. R., & Anderson, C. J. (2009). Psychosocial costs of racism to Whites: Understanding patterns among university students. *Journal of Counseling Psychology, 56*, 239–252. doi:10.1037/a0015432.
- Strahan, R., & Gerbasi, K. C. (1972). Short, homogenous versions of the Marlowe–Crowne Social Desirability Scale. *Journal of Clinical Psychology, 28*, 191-193. doi:10.1002/1097-4679(197204)28:2<191::AID-JCLP2270280220>3.0.CO;2-G
- Suárez Álvarez, J., Pedrosa, I., Lozano, L. M., García Cueto, E., Cuesta Izquierdo, M., & Muñiz Fernández, J. (2018). Using reversed items in Likert scales: A questionable practice. *Psicothema, 30*(2), 149-158. doi:10.7334/psicothema2018.33
- Sue, D. W. (2005). Racism and the conspiracy of silence: Presidential address. *The Counseling Psychologist, 33*(1), 100-114. doi:10.1177/0011000004270686
- Sue, D. W. (2015). Therapeutic harm and cultural oppression. *The Counseling Psychologist, 43*(3), 359-369. doi:10.1177/0011000014565713
- Sue, D. W. (2017). The challenges of becoming a white ally. *The Counseling Psychologist, 45*(5), 706-716. doi:10.1177/0011000017719323
- Sue, D.W., Arredondo, A., & McDavis, R.J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development, 70*, 477-486. doi:10.1002/j.2161-1912.1992.tb00563.x
- Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*(2), 45-52. doi:10.1177
- Sue, D., & Sundberg, N. D. (1996). *Research and research hypotheses about effectiveness in intercultural counseling*. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (4th ed., pp. 323–352). Sage.
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). Wiley.
- Swim, J. K., & Miller, D. L. (1999). White guilt: Its antecedents and consequences for attitudes toward affirmative action. *Personality and Social Psychology Bulletin, 25*(4), 500–514. doi:10.1177/0146167299025004008

- Tajfel, H. (1981). *Human groups and social categories: Studies in social psychology*. Cup Archive.
- Tajfel, H., & Turner, J. C., (2004). An integrative theory of intergroup conflict. In Hatch, M.J., & Schultz, M. (Eds.), *Organizational identity: A reader* (pp. 56-65). Oxford University Press.
- Tangney, J. R (1993b). Shame and guilt. In C. G. Costello (Ed.), *Symptoms of depression* (pp. 161-180). Wiley.
- Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt*. The Guilford Press.
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125. doi:10.1353/hpu.2010.0233
- Thompson, V. L. S., & Alexander, H. (2006). Therapists' race and African American clients' reactions to therapy. *Psychotherapy: Theory, Research, Practice, Training, 43*(1), 99-110. doi:10.1037/0033-3204.43.1.99
- Thompson, C. E., & Jenal, S. T. (1994). Interracial and intraracial quasi-counseling interactions when counselors avoid discussing race. *Journal of Counseling Psychology, 41*(4), 484-491. doi:10.1037/0022-0167.41.4.484
- Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures. *Journal of counseling psychology, 41*(2), 155-161. doi:10.1037/0022-0167.41.2.155
- Todd, N. R., Spanierman, L. B., & Poteat, V. P. (2011). Longitudinal examination of the psychosocial costs of racism to Whites across the college experience. *Journal of Counseling Psychology, 58*(4), 508–521. doi:10.1037/a0025066
- United States Census Bureau (2016). U.S. Census Bureau 2016 estimate, Quickfacts. Available from U.S. Census Bureau web site, <https://www.census.gov/quickfacts/fact/table/US/PST045216>.
- United States Census Bureau (2011). U.S. Census 2010, Summary Files 1 and 2. Available from U.S. Census Bureau web site, <http://www.census.gov>.
- Usami, S. (2011). Statistical power of experimental research with hierarchical data. *Behaviormetrika, 38*(1), 63-84. doi:10.2333/bhmk.38.63

- Vandament, M. L., Duan, C., & Li, S. (2021). Relationships among supervisee perceived supervisor cultural humility, working alliance, and supervisee self-efficacy among white supervisor and supervisee of color dyads. *Training and Education in Professional Psychology*. Advance online publication. doi:10.1037/tep0000370
- Wang, Y., Davidson, M. M., Yakushko, O. F., Savoy, H. B., Tan, J. A., & Bleier, J. K. (2003). The Scale of Ethnocultural Empathy: Development, validation, and reliability. *Journal of Counseling Psychology, 50*(2), 221–234. doi:10.1037/0022-0167.50.2.221
- Ward, J. H. (1963). Hierarchical grouping to optimize an objective function. *Journal of the American Statistical Association, 58*, 236–244. doi:10.2307/2282967
- Weems, G. H., & Onwuegbuzie, A. J. (2001). The impact of midpoint responses and reverse coding on survey data. *Measurement and evaluation in counseling and development, 34*(3), 166-176. doi:10.1080/07481756.2002.12069033
- Weijters, B., & Baumgartner, H. (2012). Misresponse to reversed and negated items in surveys: A review. *Journal of Marketing Research, 49*(5), 737-747. doi:10.1509/jmr.11.0368
- Wilcox, M. M., Drinane, J. M., Black, S. W., Cabrera, L., DeBlaere, C., Tao, K. W., Hook, J. N., Davis, D. E., Watkins, C. E., & Owen, J. (2021). Layered cultural processes: The relationship between multicultural orientation and satisfaction with supervision. *Training and Education in Professional Psychology*. Advance online publication. doi:10.1037/tep0000366
- Wold, S., Ruhe, A., Wold, H., & Dunn, Iii, W. J. (1984). The collinearity problem in linear regression. The partial least squares (PLS) approach to generalized inverses. *SIAM Journal on Scientific and Statistical Computing, 5*(3), 735-743. doi:10.1509/jmr.11.0368
- Zegley, L. A. (2007). *An investigation of the relationship between self-reported multicultural counseling competence and middle school counselors' efforts to broach racial, ethnic, and cultural factors with students* (Publication No. DP19251). [Doctoral dissertation, Virginia Tech]. ProQuest Dissertations Publishing.
- Zhang, N., & Burkard, A.W. (2008). Client and counselor discussions of racial and ethnic differences in counseling: An exploratory investigation. *Journal of Multicultural Counseling and Development, 36*, 77–87. doi:10.1002/j.2161-1912.2008.tb00072.x
- Zhang, N., & McCoy, V. A. (2008). Discussion of racial difference in counseling: A counselor's perspective. *Journal of College Student Psychotherapy, 23*(1), 3-15. doi:10.1080/87568220802367479

VITA

Dr. Galvin was born in York, Pennsylvania and proceeded to live in Hong Kong, London, England, and Sydney, Australia before moving to Glen Ellyn, Illinois. She received her B.S. in psychology and minor in human relations from the University of Iowa, and her M.Ed. in community counseling from Loyola University Chicago. Dr. Galvin enrolled in the Counseling Psychology Ph.D. program at Loyola University Chicago in 2017. While at Loyola, Dr. Galvin served as a graduate, research, and teaching assistant within the School of Education and a graduate assistant for the Center for the Human Rights of Children. She was also part of the Student Development Committee and co-founder and group facilitator for the counseling psychology department's Multicultural Dialogue Group. Dr. Galvin also served as an adjunct instructor for the counseling psychology department's graduate group counseling course.

Throughout her years in the program, Dr. Galvin was awarded Loyola University Chicago's Child and Family Fellowship Research Award and was inducted into the Alpha Sigma Nu Jesuit Honors Society. Dr. Galvin completed her APA-accredited pre-doctoral internship at the National Psychology Training Consortium–Compass Health Network, where she will also complete her postdoctoral training.