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Mental Health Care Practitioners' Construing about non-White people: Implications for Cultural Competence and the Therapeutic Alliance

Tinashe Moira Dune

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Dr Tinashe Moira Dune

Supervisory Panel:

Professor Peter Caputi, Associate Professor Catherine MacPhail and Dr Katarzyna Olcon

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Author's Certification

I certify that this thesis and the research reported in it are original. It contains no material which has been submitted for the award of any other degree or graduate diploma in any other university, and that to the best of my knowledge and belief this thesis contains no copy or paraphrase of material previously published or written by another person, except where due reference is made in the text of the thesis.

Dr Tinashe Moira Dune

This research is dedicated to my children, Yarran and Naya. This work reflects my desire and belief that the world will be ready to provide you, and all people, with the care, support, opportunities, and lessons needed to thrive now and in the future.

With all my love,

Mum

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Abstract

Australia is a country known for its multicultural population. The country has a broad range of visa schemes and a rapidly increasing overall intake of migrants. Australia thus provides a particularly rich case study of a migrant-receiving country undergoing rapid transformation. This diversity results in the need for mental health care systems and practitioners to adapt to a range of health and wellbeing needs of individuals and groups across cultural, linguistic, and ethnic backgrounds. This goal is challenged by the prevailing and overarching sociopolitical and ethnocultural construct of Whiteness, which is present in Australia, other Western nations and much of the world.

To both acknowledge and understand this construct, and its consequences, within the context of mental health and wellbeing, this thesis examined the ways in which mental health practitioners in Australia construe non-White people. The research also sought to ascertain the links between practitioners' construals of Whiteness and their cultural competence as well as their therapeutic alliance with non-White clients. This research is important as it helps to expose the modes by which Whiteness may influence construing and may provide more clarity on how Whiteness, its invisibility and processes work in the context of mental health care.

To answer the research questions, this thesis was guided by the Personal Construct Psychology (PCP) and used a sequential, convergent, mixed methods approach. Data collection methods included: 1) a systematic literature review; 2) qualitative semi-structured interviews using a modified laddering technique; and 3) an online questionnaire consisting of demographic questions and three measures. These methods and findings are summarised in the following review:

Systematic Review: The constructs and perspectives of 5,870 mental health workers with regards to minority populations are represented across the 38 studies included. Data was synthesised qualitatively and analysed thematically. The therapeutic alliance was most at risk when practitioners displayed low levels of cultural competence and high levels of racial and ethnic blindness. The changing and increasingly multicultural context within Western countries means that mental health systems and workers need to prepare for an increasing range of culturally and linguistically diverse clients in need of support.

Laddering-informed Interview: Twenty White and non-White Australian mental health care practitioners and trainees were purposively sampled and interviewed using an adapted version of the laddering interview technique. Data was analysed thematically and interpreted drawing on PCP. The findings highlight the persistent role of Whiteness based on mental health practitioners' perceptions of modern constructions about White and non-White people. Even so, the results also suggest that a potential disciplinary shift is occurring whereby practitioners indicate movement away from being blind to difference and towards acknowledgement of the inequities and inequalities experienced by diverse groups. Practitioners demonstrated cultural competence in their acknowledgement of the impact of negative construals of ethnic, cultural, religious, social, racial, and linguistic diversity on client wellbeing. Psychologists sought to address these negative impacts on clients by drawing on the client-practitioner relationship to improve the therapeutic alliance.

Online Questionnaire: An online questionnaire was completed by 139 Australian mental health practitioners. The measures included: the Multicultural Counselling Inventory (MCI); the Color-Blind Racial Attitudes Scale (CoBRAS); and the Balanced Inventory of Desirable Responding (BIDR). Descriptive statistics were used to summarise participants'

demographic characteristics. One-way ANOVA and Kruskal-Wallis tests were conducted to identify between-group differences (non-White compared to White practitioners) in cultural competence, therapeutic alliance, and racial and ethnic blindness. Correlation analyses were conducted to determine the effect of participants' gender or age on cultural competence and therapeutic alliance. Hierarchical multiple regression analyses were conducted to predict cultural competence and therapeutic alliance. The thesis demonstrates that higher MCI total scores (measuring cultural competence and therapeutic alliance) were associated with non-White status, older age, greater attendance of cultural competence-related trainings, and increased awareness of general and pervasive racial and/or ethnic discrimination. Practitioners with higher MCI total scores were also likely to have higher self-deceptive positive enhancement scores on the BIDR than those with lower MCI total scores. The findings highlight that the current one-size-fits-all and skills-development approach to cultural competence training ignores the significant role that practitioner diversity and differences play in the therapeutic alliance. The recommendations from this thesis can inform clinical educators and supervisors about the importance of continuing professional development relevant to practitioners' age, racial/ethnic background, and professional experience.

The thesis findings support recommendations for improvements in training, practice, and research in relation to practitioner construals and their relationship with cultural competence, the therapeutic alliance and, therefore, client wellbeing outcomes. Core recommendations include:

1. Improvements in practitioner self-awareness via cultural competence training
2. Improvements in the demonstration of social awareness in cross-cultural practice

3. The need for complementarity in the development of research on cultural competence and therapeutic alliance.

This is the first Australian study to explore mental health practitioners' construing of Whiteness and its impact on non-White people. The findings demonstrate practitioners' awareness of the persistent role of Whiteness including, but not limited to, prejudice, unconscious bias, colour-blindness, stereotyping and discrimination faced by non-White people in society and in mental health care. The findings indicate that the ability to loosen one's construct system enough to embrace and value difference while also tightening one's construct system to sufficiently restrict the impact of Whiteness is a product of regular engagement in cultural competence training. Importantly, the therapeutic alliance between non-White clients and practitioners is most at risk when practitioners exhibit resistance to training and negative constructions about non-White people; these attitudes are correlated with low levels of cultural competence. PCP highlights the need for practitioners not only to tolerate but desire and, therefore, seek out opportunities to consistently loosen and reconstruct their construing about themselves and others. The study demonstrates that understanding our construction systems through a PCP lens is a fruitful platform from which cross-cultural psychological research, training, and practice can look towards the development of practitioner cultural competence and safe therapeutic alliance in Australia.

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List of Abbreviations

AHPRA: Australian Health Practitioner Regulatory Agency
BIDR: Balanced Inventory of Desirable Responding
CoBRAS: Color-Blind Racial Attitudes Scale
C-P-C Cycle: Circumspection-Preemption-Control Cycle
CPD: Continuing Professional Development
MCI: Multicultural Counselling Inventory
NHMRC: National Health and Medical Research Council
PCP: Personal Construct Psychology

Chapter 1: Introduction

Australia is known for its diversity of cultural, ethnic, religious, and linguistic groups. In addition to its Aboriginal and Torres Strait Islander groups (3% of the population), over 27% of Australians were born overseas and another 20% have at least one parent born overseas (Australian Bureau of Statistics, 2014b). Further, net overseas migration contributes to over 60% of Australia's total population growth. Australia has also committed to the resettlement of over 12,000 new refugees in addition to the current 13,500 new refugees arriving annually (Australian Bureau of Statistics, 2014a). Consequently, Australia has a broad range of visa schemes and a rapidly increasing overall intake of migrants. Australia thus provides a particularly rich case study of a migrant-receiving country undergoing rapid transformation. This diversity results in the need for health care systems and practitioners to adapt to a range of health and wellbeing needs for individuals and groups across cultural, linguistic, and ethnic backgrounds. Success in this respect requires genuine acceptance—and integration—of diversity into all aspects of Australian health care systems.

Manifestation of this goal is challenged, however, by a prevailing and overarching sociopolitical and ethnocultural framework of Whiteness, which is present in Australia, other Western nations and much of the world (Anderson, 2003; Crass, 2002; Gram, 2007; Magdalena Tascón, 2008; Moreton-Robinson, 2004; Schech & Haggis, 2001). As King and Springwood (2001, p. 160) explain,

> Whiteness is simultaneously a practice, a social space, a subjectivity, a spectacle, an erasure, an epistemology, a strategy, an historical formation, a technology, and a tactic. Of course, it is not monolithic, but in all of its manifestations, it is

unified through privilege and the power to name, to represent, and to create opportunity and deny access.

Implicit in this definition of Whiteness is a delineation of those who reap benefits from Whiteness and those who do not—those who are White and those who are non-White. Here non-White refers to individuals who are excluded from being beneficiaries of Whiteness as a result of their racial, ethnic, cultural, religious, linguistic or national identities (Guess, 2006; King & Springwood, 2001; Lewis, 2004; Sue, 2006). Describing those who are White is, however, a more challenging task (Anderson, 2003; Lewis, 2004; Sue, 2006). This is because Whiteness is more concerned with analysing, describing, characterising and excluding those who do not belong within it but provides little clarification about what defines or characterises Whites (Anderson, 2003; Crass, 2002; Gram, 2007; King & Springwood, 2001; Magdalena Tascón, 2008; Moreton-Robinson, 2004; Schech & Haggis, 2001; Sue, 2006). This ambiguity results from a colloquial, quotidian, and unquestioned sociocultural framework in which Whiteness is the invisible benchmark from which non-Whites are evaluated.

In order to both acknowledge and understand these constructs and their consequences, within the context of mental health and wellbeing, this thesis examines the ways in which mental health practitioners and trainees construe White and non-White people. With such an understanding this thesis also seeks to ascertain the links between these constructions on the therapeutic alliance (with non-White clients) and on practitioner cultural competence. This research is important as it helps to expose the modes by which Whiteness may influence construing and may provide more clarity on how Whiteness, its invisibility and processes work. In previous research Sue (2006, p. 15) explains,

> Whiteness is a default standard…from which all other groups of color are compared, contrasted, and made visible. From this color standard, racial/ethnic minorities are evaluated, judged, and often found to be lacking, inferior, deviant, or abnormal. Because Whiteness is considered to be normative and ideal, it automatically confers dominance on fair-skinned people in our society.

In this respect a particular "luxury of belonging to the advantaged racial group is that one's own racialness often is invisible to oneself" (Lewis, 2004, p. 641) and seemingly requires no explanation (Sue, 2006). As explained by Lewis (2004, pp. 624-625), this phenomenon leads individuals to perceive of those in non-White groups as "social problems" and results in "a failure to situate one's self in one's whiteness, and within the larger racial discourse". Importantly, Whites are in no way a homogenous group (as with non-Whites)—nor are their group/collective identities under examination in this inquiry. Whiteness, however, and its consequences for how non-Whites are perceived and engaged is an important piece of this thesis. Further, Whiteness would not be a problem if, as Sue (2006, p. 15) expounds,

> …it weren't (a) predicated on White supremacy, (b) imposed overtly and covertly on People of Color, and (c) made invisible to those who benefit from its existence. Seen from this vantage point, Whiteness is an invisible veil that cloaks its racist deleterious effects…The result is that White people are allowed to enjoy the benefits that accrue to them by virtue of their skin color. Thus, Whiteness, White supremacy, and White privilege are three interlocking forces that disguise racism so it may allow White people to oppress and harm persons of color while maintaining their individual and collective advantage and innocence.

This is not to say that all Whites experience the same advantages and to the same degree, that Whiteness has always looked the same or that it lacks permeable and flexible boundaries. It is acknowledged that Whiteness and the delineators for those who benefit or are excluded from it are constantly under negotiation (Lewis, 2004).

Even within this constant state of flux, the role of Whiteness and its consequences are enduring and important to consider in order to identify the impact of this construct on the whole of Australian society, especially non-Whites. As described by Guess (2006, pp. 651-652),

> The idea and conception of whiteness derives from the dynamics of racism by intent, a type of racism that is founded upon custom and tradition, but shatters against social scientific principles. Racism by consequence operates at the macro level of society, and represents an historical evolution. It constitutes a gradual shift away from a conscious, almost personalized conviction of the inferiority of an "othered" "race." Such conviction expresses itself in attitudes of prejudice and is acted out in discriminatory behavior. In its place follows social practices that are essentially depersonalized through institutionalization…At the institutional level, racism by consequence tends typically not to be recognized by [whites]…Racism by consequence then is reflected in differential educational opportunities, economic differentials between whites and non-whites, residential segregation, health care access, and death rate differentials between whites and non-whites.

This excerpt reiterates that Whiteness as it relates to societal norms, systems and structures is central to discussions of disadvantage and privilege. It also reinforces, as in this inquiry, that Whites and non-Whites are not the focus of investigation but instead that the

framework of Whiteness impacts on collective ways of construing, understanding, being and experiencing life and its outcomes. Given the invisible and pervasive nature of Whiteness, the power imbalances required to sustain it, as well as its construction of non-Whites as social problems, the consequences for non-Whites are profound. It is these pervasive constructions within societal systems and structures, like health care, which are of interest to this thesis.

Experiences of Non-White Mental Health Care Service Users

The negative health outcomes and experiences of non-Whites within health care settings are well documented and related to health care systems and health care workers that harbor constructions of health and wellbeing based on frameworks of Whiteness (Anderson, 2003). In doing so, health systems and practitioners demonstrate resistance to incorporating alternative constructions of health and wellbeing into service provision (Anderson, 2003; Sue, 2006; Tummala-Narra, 2007). This is because Western health care systems are based on the biomedical model of health which values Eurocentric/White-centric ways of understanding and engaging with health (Anderson, 2003). The biomedical model of health reinforces cultural, racial and ethnic hierarchies where "the racialisation of whites has always been tied intimately to a history of defining self both through the symbolic construction of the other and through the actual domination of others" (Lewis, 2004, p. 630).

Such frameworks result in limited access to a range of health services and opportunities for improved health outcomes among non-Whites—and mental health care systems and practitioners are no exception (Flores, 2013; Klimidis et al., 2006; Lewis, 2004; Moodley, 2007; Rathod et al., 2010; Steele, 2011; Tanner et al., 2014; Weisman de Mamani et al., 2010). However, considering practitioners' role in the support of mental health and wellbeing, their constructions of non-White people can have a significant impact on non-

White individuals' overall health and ability to engage in Australian society. In order to circumvent negative outcomes, it is acknowledged that increasing (mental) health care practitioners' cultural competence is central to minimising and reconstructing negative ways of construing and engaging with non-White people within the health care system (Manderson & Allotey, 2003; Maroney et al., 2014; Olson et al., 2016).

Cultural Competence

Parallel to an increasing recognition of Whiteness as an ethnocultural construct is the development of strategies to educate health care practitioners on how to be culturally competent within multicultural settings. In support of this, the development of cultural competence pedagogies in Australia draws on federal legislation (e.g., *Age Discrimination Act 2004*, *Australian Human Rights Commission Act 1986*, *Disability Discrimination Act 1992*, *Racial Discrimination Act 1975*, *Sex Discrimination Act 1984*) which inform Australian social, economic, legal, political, educational, health care and workplace policies, practices, and cultures. For instance, tertiary mental health training programs are required by regulatory agencies like the Australian Health Practitioner Regulatory Agency (AHPRA) to have cultural competence components in their curricula and professional codes of conduct developed in line with Australian legislation (AHPRA, 2020).

In accordance with this legislation, the National Health and Medical Research Council (NHMRC) (2014) in Australia has developed a comprehensive framework with guidelines for how to embed—and increase Australia's engagement with—cultural competence at all levels towards the improvement of health outcomes. In the publication, *Cultural Competency in health: A guide for policy, partnerships and participation*, the NHMRC (2014) defines cultural competence as,

A set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations (NHMRC, 2014, p. 6).

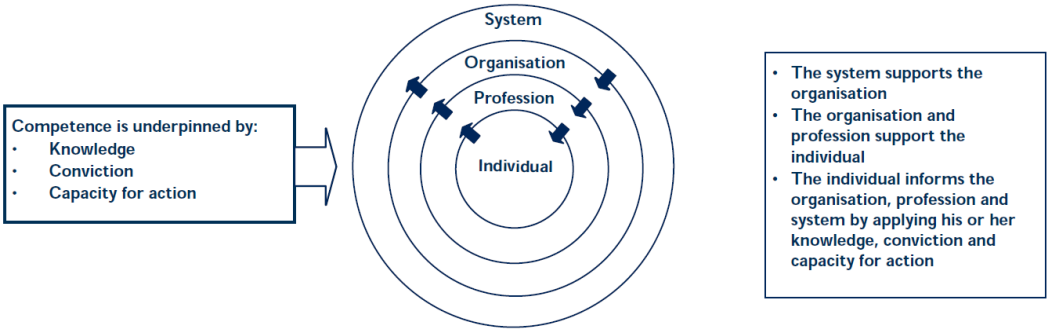

Figure 1.1 Interplay between the dimensions of cultural competence (NHMRC, 2014)

Embedded within the concept of cultural competence are "knowledge, conviction and capacity for action at an individual and organisational level" (Audigier 2000, p. 6). An important aspect of cultural competence training includes building health care workers' ability to become self-aware and to reflect on their constructions of others (Olson et al., 2016). As such, health care workers are encouraged to develop a set of skills that will enable them to interrogate their perceptions, and deconstruct and neutralise constructions of others in ways which support service delivery. The primary goal of this (re-)education is to improve the health and wellbeing outcomes of clients by improving the practitioner-client therapeutic alliance within effective interventions.

The Therapeutic Alliance

Effective engagement in cultural competence promotes the development and maintenance of the therapeutic alliance between health care workers and their clients (Olson et al., 2016). The therapeutic alliance is broadly defined as "the collaborative and affective bond between therapist and patient… [and] is an essential element of the therapeutic

process" (Martin et al., 2000, p. 438). With its origins in early psychoanalytic theories (e.g., Freud, 1912, 1913, 1958; Greenson, 1967; Zetzel, 1956) the concept is now a staple of contemporary understandings of the therapeutic process. This is because it is now well understood that the therapeutic alliance is correlated to clients' therapeutic outcomes (Martin et al., 2000). For non-White people impediments to the therapeutic alliance resulting from limited cultural competence can result in patient disengagement from some or all health care services (Crans, 2013; Dasgupta, 2009).

There is a long history of research exploring the therapeutic alliance and non-White clients' perceptions and experiences of mental health care and practitioner cultural competence (Atkinson & Thompson, 1992; Dasgupta, 2009; Flores, 2013; Ito & Maramba, 2002; Lee et al., 1983; Moodley, 2000, 2007; Noda, 2011; Sue & Zane, 1987; Uhlemann et al., 1988; Wampold et al., 1981; Wood & Mallinckrodt, 1990). This research demonstrates that practitioners with low levels of cultural competence fail to respond to non-White clients' experiences of mental health, resulting in more severe diagnoses compared to White clients, higher rates of disengagement, less effective interventions and longer prognosis for improved mental health. There is also a growing body of research on different health practitioners' cross-cultural attitudes, beliefs, values, awareness, responsiveness and their cultural competence (Arthur & Januszkowski, 2001; Beagan & Chacala, 2012; Consoli et al., 2008; Constantine, 2002; Cross & Bloomer, 2010; Dogra & Karim, 2005; Fuertes & Brobst, 2002; Harris, 1991; Horevitz et al., 2013; Lineman, 2011; Moleiro et al., 2013; Neville et al., 1996; Olson et al., 2016; Owen et al., 2014; Pope-Davis et al., 1995; Pope-Davis & Ottavi, 1994; Ruelas, 2000). This research demonstrates that allied, nursing and mental health practitioners continue to experience resistance to cultural competence training, struggle with applying cultural competence principles in their practice and are restrained by Whiteness in health care

systems that limit culturally responsive care. Notably, very few of these studies explore the perspectives of Australian mental health practitioners. This research aims to fill that gap, but also provides important evidence and recommendations that may assist health care practitioners and systems in many countries to improve patient outcomes and engagement. The following describes how this thesis builds on existing research with a focus on the Australian context.

The Significance of the Research in the Australian Context

Following a search on mental health care practitioners, less than a handful of studies were found from Australia that discuss practitioner constructions, construals or construing of non-White clients. Given the relative lack of research on Australian mental health care practitioners, the bulk of research on cultural competence, the therapeutic alliance and practitioner constructions of non-Whites stems from the United States. As such, missing from Australian discourses of cultural competence is a clearer understanding of how health care practitioners construe non-White people or clients within a sociocultural context of Whiteness. In addition, little is known about what this construal means for both practitioners' cultural competence and their ability to build a therapeutic alliance with non-White clients. The findings from such an investigation are therefore significant to the development of cultural competence training and evaluation which reflects the learning needs of mental health practitioners and trainees. The findings thus validate Australia's ability (and ambition) to support its increasingly multicultural population through genuine acceptance—and integration—of diversity.

Thesis Aims and Conceptual Framework

As part of a larger call to investigate and neutralise the health inequities and poor health outcomes for non-Whites in Australia (AHPRA, 2020, 2021; NHMRC, 2014), this thesis seeks to investigate mental health care practitioners' construing about non-White people. In so doing, the research expounds on the impact of these constructions on practitioner cultural competence and the therapeutic alliance. In line with a constructivist approach, this thesis will draw on personal construct theory to explore the aforementioned foci.

This thesis makes use of literature from multiple sources to comprehensively explore mental health practitioner construing about whiteness, non-White people and the implications of practitioner construing on cultural competence and the therapeutic alliance. Figure 1.2 provides a visual representation of these conceptual components in relation to the thesis's aim of gaining a better understanding of mental health practitioner construing. These conceptual components culminated in a conceptual framework that helped to: 1) determine current epistemological gaps and relevant research objectives and questions; 2) guide the thesis methodology; 3) interpret the study findings; and 4) develop recommendations for training, practice, and research.

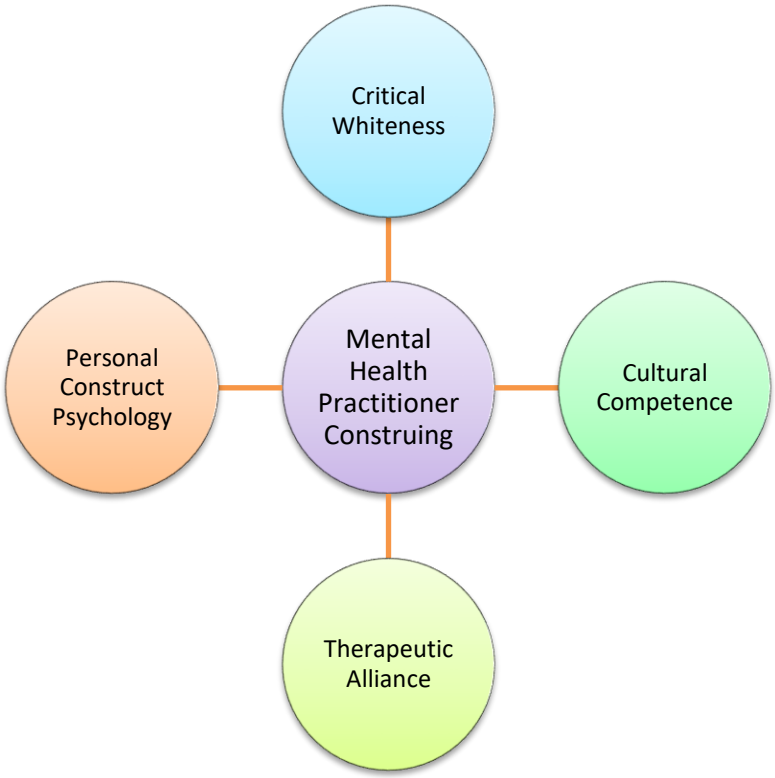

Figure 1.2 Conceptual Framework for Understanding Mental Health Practitioner Construing

In line with the above conceptual framework (see Figure 1.2), the following research objectives and research questions are presented. Thereafter the theoretical framework and methods for the thesis will be described. Information about ethical, intellectual property and safety issues are then presented. Following this, an outline of chapters included in this thesis (papers by publication) is provided.

Research Objectives

This thesis sought to:

1) Explore mental health care practitioners' and trainees' (practitioners)[1] construing and constructions of non-White people, drawing on Personal Construct Psychology (PCP) (Kelly, 1955).
    - To investigate the role and impact of Whiteness on practitioners' construing and constructions of non-White people.
    - To investigate the role and impact of their construing and constructions on practitioner cultural competence.
    - To investigate the role and impact of their construing and constructions on the therapeutic alliance.
2) Identify the factors which influence changes to constructs about or ways of construing non-White people.
3) Provide guidance on ways to minimise potential negative impacts on the therapeutic alliance.

Research Questions

To address the above research objectives, the following questions were asked:

1) How do practitioners construe and construct non-White people?
    a. What characterises their construing and constructions?
    b. What role or impact does Whiteness have on their constructions?
    c. What impacts do their construing and constructions have on practitioner cultural competence?

1 In the interest of brevity, the term 'practitioners' is used, where required, to denote all varieties of mental health practitioners and trainees.

d. What impacts do their construing and constructions have on the therapeutic alliance?

2) In what ways can PCP help to identify and describe practitioners' constructs about or ways of construing non-White people?
3) What factors (or events) influence and/or mediate changes to constructs about or ways of construing non-White people?
4) What strategies do practitioners employ to support culturally competent ways of construing (and therefore engaging with) non-White people?

As noted, this research draws on PCP (Kelly, 1955) to address the research objectives and questions. As such, the following section provides an overview of PCP and an indication of how this framework can assist in answering the research questions.

Theoretical Framework: Personal Construct Psychology

PCP is a theory, practice and research methodology developed by American psychologist George Kelly in the 1950s. Kelly's theory focuses on constructive alternativism, which proposes that our experiences of the world, and our understanding of events and people, including ourselves, are open to a wide variety of interpretations. In this context it is how we construe events, people, or ourselves which is the point of interest and the process by which we engage in construal – Kelly's "Fundamental Postulate". This Fundamental Postulate is elaborated in 11 original corollaries (Kelly, 1955) with a further eight added after 1979 (Winter, 2013), which help to explain and employ PCP.

Given the focus of the thesis, gaining a better understanding of construing is of particular importance. As per Winter (2013, p. 4), construing is defined as "an active, ongoing process in which we each constantly try to give meaning to our world and to predict future

events by operating rather like a scientist: making hypotheses, testing them out, and if necessary revising them on the basis of the evidence which we collect". According to Kelly, constructs are bipolar (e.g., the construct of temperature may include hot vs. cold). Further, some constructs may be more superordinate, while others are more subordinate. That is, some constructs may be more important or inclusive of other constructs within an individual's construal system than others (e.g., 'positive self-esteem' may be more superordinate than 'putting on make-up', a potential means for 'positive self-esteem'). Additionally, constructs do not exist in isolation but within systems that help individuals make sense of the multiple stimuli they encounter on a daily basis.

It is through these constructs that individuals are able to hypothesise or anticipate what may happen in any given situation (Kelly, 1955); "then we test our predictions or anticipations through the behaviours we adopt, similar to scientists engaged in experimentations" (Naffi & Davidson, 2016, p. 201). For a construct to maintain its relevance or applicability, the predicted situation must be validated. Validation occurs when "we see whether any event falls smack on this imaginary point so as to fulfil all of its presupposed conditions" (Kelly, 1955, p. 86)—our predictions. This is important to our engagement or avoidance of others, given that "our processes – thoughts, feelings and behaviors – operate in a structured manner and are determined by our predictions of the future" (Naffi & Davidson, 2016, p. 202). Within the Australian context, there are several variables inherent in the identities, behaviours, experiences and understanding of all people including non-Whites. For instance, O'Dowd (2011) notes that 'pioneer identity' has been used to support decades of nationalism in Australia. Notably this White identity is personified by a man who will do whatever it takes for land and country including dispossessing Indigenous people of their land and dispatching Indigenous people (killing them) where/when the nation deemed necessary

(O'Dowd, 2011). This identity has been glorified in Australian culture (O'Dowd, 2011) and continues to resonate in contemporary constructions of what it means to be an Australian. The pioneer identity is most commonly ingrained in constructions of Australian blue-collar identity but also persists in individual and systemic xenophobic resistance to diverse constructions and representations of being Australian across all social arenas (O'Dowd, 2011).

As explained earlier in this Introduction with respect to Whiteness, in Western settings these variations are interpreted through the lens of White supremacy, which reinforces constructions of non-Whites as (social) problems. Guided by PCP, the work of Naffi and Davidson (2016), examining the integration and inclusion of Syrian refugees in Europe and North America, found that members of the host society who demonstrated racialised habitus and anticipated real or symbolic threats from Syrian refugees felt frustrated and assertively opposed their settlement. Further, Syrian refugees who anticipated that their Western counterparts did not welcome their settlement, or chose to avoid them, distanced themselves and/or "created self-fulfilling prophecy by adopting a stereotypical behaviour that validates unfounded mistrust expressed by the host society" (p. 202). If a similar pattern exists in relation to non-White people in Australia, the need for change in attitudes towards non-White people is evident as it may also inherently impact on how mental health care is accessed/delivered, potentially further perpetuating racial discrimination and exclusion.

Within the Australian context, however, it is unclear if such constructs exist among mental health practitioners, are predicted and validated in the same ways, and/or have the same implications as they do amongst other health care professionals and in other parts of the world. With this in mind, this thesis draws on scant research which has used PCP to explore the ways in which various non-White groups have been constructed across a range of contexts

and settings (Naffi & Davidson, 2016). In line with Kelly's theory, extant research reinforces that individuals are in control of their construals and their ability to make changes or transition their construing of the world towards positive community outcomes (a key component of cultural competence and the establishment of an effective therapeutic alliance) (Bentley et al., 2008; Chao, 2006; Chao, 2013). In that sense "the aim of [engaging with] personal constructs, put at its most pious, is liberation through understanding" (Bannister & Fransella, 1971, p. 201).

Drawing on PCP can help provide more clarity on mental health care providers' construing about Whiteness and non-White people and what processes and factors may impact on practitioner cultural competence and therapeutic alliance. In particular, PCP helps us develop a better understanding of the processes of transition experienced by mental health practitioners in their construing of and engagement with non-White people.

Personal Construct Psychology: Processes of Transition

To help elucidate his fundamental postulate, Kelly identified processes for construing that are especially applicable in relation to the development of practitioner cultural competency and the therapeutic alliance. These are the processes of transition, including the Circumspection-Preemption-Control Cycle, Creativity Cycle and Experience Cycle (Kelly, 1955). The processes of transition are therefore cycles within a cycle. Figure 1.3 illustrates how these processes work together to support constructive revision. Constructive revision is the ability to change how one construes and the ability to apply new construals to real life.

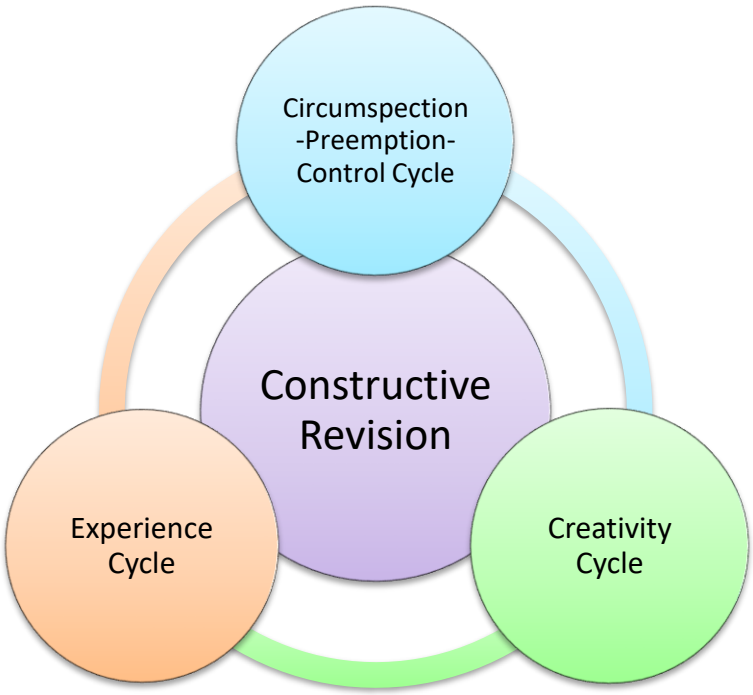

Figure 1.3 PCP Processes of Transition and Constructive Revision (Kelly, 1955)

According to Kelly (1955), the processes of transition characterise the constant changes in construing that occur as individuals attempt to anticipate an ever-changing world. As such, it is argued that the ability to make changes in one's construing is an integral component of transitioning constructions about Whiteness/non-Whiteness and White/non-White people within one's construct system. As mentioned earlier in this chapter, this capacity for constructive revision demonstrates cultural competence and supports engagement in an effective therapeutic alliance with clients. The processes of transition therefore reflect practitioners' construing in diverse and ever-changing sociocultural landscapes, like Australia, and within the diverse and ever-changing psychological mindscapes of both clients and practitioners. The following therefore describes each of the processes of transition that will be used to interpret the findings of this thesis and make meaning out of the interconnections between Whiteness, cultural competence and the therapeutic alliance.

Circumspection-Preemption-Control Cycle

Kelly (1955) described the Circumspection-Preemption-Control (C-P-C) cycle as a decision-making process required for changes in a person's construct system. He defined it as: "a sequence of construction involving, in succession, circumspection, preemption, and control, and leading to a choice which precipitates the person into a particular situation" (Kelly, 1955, pp. 379-390). During the *circumspection* stage, we consider issues from a variety of angles. In the *preemption* stage, we select what we believe to be the critical issue and eliminate the other options from consideration. Finally, in the *control* phase we choose the alternative action through which we anticipate the greater possibility for extension or definition of our construct system (Kelly, 1955). The decision-making that Kelly describes is more than a simple process of considering options, choosing one, and then taking action.

Creativity Cycle

Kelly's Creativity Cycle helps to explain how individuals move forward or backwards in their construing. The creativity cycle is a process of construing that moves from loose construing to tight construing and back and forth until an individual feels that something has been 'created' that they can then test. Kelly explains, "The Creativity Cycle is one which starts with loosened construction and terminates with tightened and validated construction" (Kelly, 1955, p. 7). The Creativity Cycle is central to the purpose of cultural competence training, which aims to improve therapeutic alliance. Kelly (1955) elucidates:

> Loosened construction...sets the stage for creative thinking…The loosening releases facts, long taken as self-evident, from their conceptual moorings. Once so freed, they may be seen in new aspects hitherto unsuspected, and the creative cycle may get underway. (p. 1031)

The ability to engage in both loose and tight construing is therefore integral to providing culturally competent mental health services. If not done well or in balance it can result in a kind of constructive stasis which is incongruent to the dynamic nature of mental health service provision. Fransella (2004b) explains the pitfalls of remaining in a loose constructions state.

> A person who uses only loose constructions never gets out of the stage of mumbling to himself. He cannot get around to testing out that construction. The creative person must have the ability to move from loosened to tightened construing. For with loose construing, we lose control of things, we do not know where such construing might lead. Those locked into loose construing find it very difficult to come to any firm conclusions. (para. 7)

Fransella (2004b) sheds further light on the pitfalls of tight construing:

> The person using mostly tight constructions produces a lot of things but nothing that has not already been created…Those who prefer to construe the world from a generally tight position may well find loose construing anxiety-making. (para. 7)

By engaging in the process of loosening and tightening one's way of construing, new ideas come together that have never been considered in that way before (Fransella, 2004b). If practitioners regularly engage in this process they are likely to experience the sudden collision of ideas "that make [them] sit up and, thereby, tighten our construing" (Fransella, 2004b, para. 6). According to PCP, when individual practitioners "experience several of those occasions…[they] are convinced that this new idea really would work. We then have to go and test it out" (Fransella, 2004b, para. 6).

Experience Cycle

The Experience Cycle includes five phases: anticipation, investment, encounter, confirmation or disconfirmation, and constructive revision. Kelly (1955) proposed that "a person's construction of experience varies as he (sic) successively construes the replication of events" (p. 72). This process of psychological evolution has a cyclical pattern, hence the experience cycle (Walker et al., 2000). Figure 1.4 illustrates this process, which forms the essence of all construing.

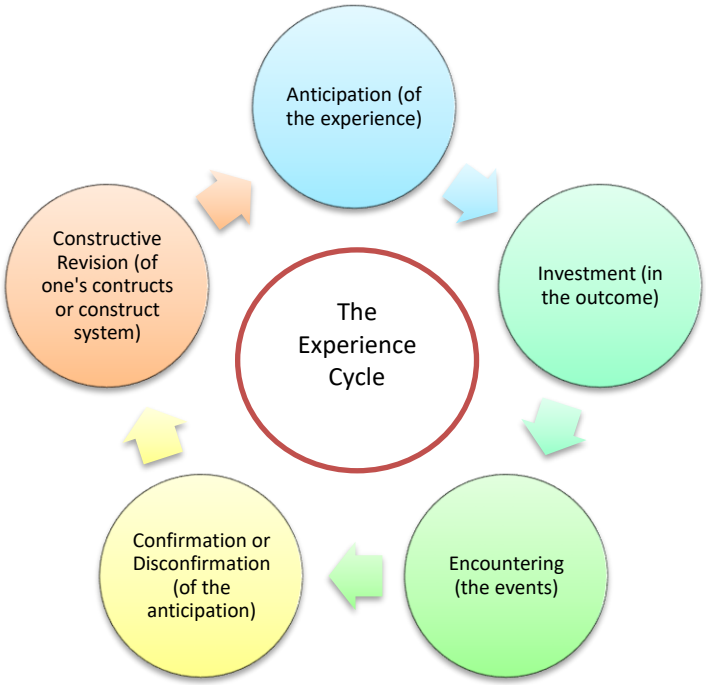

Figure 1.4 PCP experience cycle (Kelly, 1955)

The experience cycle describes how an individual applies, develops, and modifies their construct system—again, a necessary process in the provision of culturally competent mental health care. Importantly, experience in PCP is not simply about cultural encounters. According to PCP, the experience cycle is activated when there is a discrepancy between how we anticipate an event and our construction of actual events (Buckenham, 1998). Such a

discrepancy results in experience invalidation (Kelly, 1955). While this may be disconcerting to the individual, invalidation leads to both a search for more information and to constructive revision (Buckenham, 1998). This testing of experience occurs within the following five phases:

Anticipation: The first stage in the experience cycle is anticipation, where "a prediction is formulated concerning a particular event" (Winter, 2013, p. 13).

Investment: Following anticipation, an individual must then fully involve themselves in their prediction by becoming invested in the outcome of the event (Buckenham, 1998).

Encounter: Once invested in the outcome of their prediction, the practitioner then faces an encounter, "an open and active experiencing of the event" (Winter, 2013, p. 14), for example, with a non-White client in need of mental health support.

Confirmation or disconfirmation: During and after the encounter (e.g., with the non-White client) the practitioner must then conduct an "assessment of this encounter in relation to the initial anticipation" (Winter, 2013, p. 14).

Constructive revision: Once they have assessed the encounter, the practitioner "engages in any reconstructing which is deemed necessary following evaluation of the evidence obtained during the encounter" (Winter, 2013, p. 14). As noted by Buckenham (1998, p. 878), "this constructive revision will take place from within the person's construct system, therefore the direction and nature of change will be channelled by that person's existing constructions".

PCP Corollaries Relevant to Cultural Competence and the Therapeutic Alliance

The processes of transition discussed above help to understand practitioner construing that has emerged since the 1950s when Kelly first developed his ideas. However, a mechanism through which recommendations can be developed from the information gathered from this thesis is needed. Again, PCP can provide guidance. To assist in operationalising the findings of this thesis into clear recommendations for training, practice and research, PCP corollaries are useful. Within Kelly's original PCP theory, he identified 11 corollaries[2] to elaborate on his Fundamental Postulate. He indicated that the corollaries "are assumptive in nature, and they lay the groundwork" for his theory "at work" (Kelly, 1955, p. 561). Bannister and Fransella (1986) explain how the corollaries can help us to find meaning out of the processes of our construing and the behavioural experiments we conduct:

> Our purposes and issues are our own, but they can only be furthered to the degree and in the way that we understand external reality. This picture of us as striving for personal meaning is elaborated in the corollaries. (p.8)

The corollaries therefore serve as a clear guide that can be used in practitioners' efforts to understand their external reality and its influence on their own and Others' construing (Winter, 2013).

Since Kelly's original theory was developed, social and psychological science has evolved, resulting in the development of several new corollaries that help describe processes of construing. Considering the aims of this thesis, three additional corollaries assist in

[2] Kelly's (1955) 11 corollaries include: the construction, experience, dichotomy, organisational, range, modulation, choice, individuality, commonality, fragmentation, and sociality corollary.

operationalising the implications of the results. These are the Self-Awareness Corollary, Social Awareness Corollary and Complementarity Corollary (Thomas, 1979). These corollaries were developed by Laurie Thomas in response to the need to explain construing within co-constructed conversational settings, like face-to-face therapy, and relevant to increasingly multidimensional, complex and contemporary psychosociocultural environments and mental health concerns.

Self-Awareness Corollary

The role of a mental health practitioner is to seek and consolidate information in a way that helps the practitioner and then the client make sense of (both) their construing. In doing so, both individuals can become more conscious of themselves and one another. As noted by Thomas (1979),

> …the construing of another's processes of construction is a necessary prerequisite to entering into social interaction with them. (p. 10)

Without the ability to think about one's own thinking while simultaneously trying to understand the thinking of another, practitioners will fail to learn how to be culturally competent, let alone how to help their clients. Thomas (1979, p. 4) explains that "a person who construes another's constructions but does not construe his own, will generate a different form of social process from someone who construes his own constructions in addition to the other's". Thomas (1979) explains the self-awareness corollary as follows:

> To the extent that a person construes his own constructions of experience, he or she acquires consciousness. To the extent that a person construes his or her own

> processes of construction he or she acquires more complete awareness of themselves as a person. (p. 4)

Although awareness of one's own constructions is particular to the human condition (Thomas, 1979), practitioners, especially those who are resistant to changes to their construct systems, may simply construct cultural competence training as a way to better understand Others. While this is partially true, cultural competence training must also increase practitioner consciousness in relation their own constructions.

Social Awareness Corollary

The therapeutic alliance requires practitioners and clients to engage in a mutually recognised social process in which they are both invested. This dynamic therapeutic setting (both physical and psychological) results in a partially overlapping construction of each individual's construing of their experience of their social interactions. Herein lies the social process which Kelly (1955) explains is animated by each individual's own constructions of social experience. This multi-dimensional, multi-directional and dynamic form of construing aligns with Thomas's (1979) social awareness corollary, which states that,

> The forms in which a person construes his or her constructions of social interactional processes condition their ability to consciously influence their processes of interaction with others. (p. 12)

Recognising the importance of social awareness as foundational to cultural competence ensures that practitioners do not construct themselves as separate or purely objective observers of others' construing. Understanding construing in this way allows for practitioners to develop, test and redesign "an experiential-behavioural framework from

within which to understand what is going on. This insight offers a taxonomy of methodologies from which to choose methods appropriate to situations and purposes" (Thomas, 1979, p. 15). To ensure that practitioners activate the process of deconstructing Whiteness, their role in it and its impacts on individuals, they must be able to see how these constructs manifest in practice and within the therapeutic alliance.

Complementarity Corollary

Core to this thesis is the recognition of the vast diversity and intersectionality that exists amongst practitioners. This thesis therefore highlights the relevance of difference as an ethnic/racial/religious identifier within practitioner construing, constructions and in relation to cultural competence and therapeutic alliance. While practitioners may share "an innate construction of experience" (Thomas, 1979, p. 15) (e.g., a client's interpersonal issues relate to attachment theory), differences across practitioner groups (e.g., racial/ethnic) may result in different constructions and behaviours. For instance, on the one hand, a White practitioner may perceive that a non-White client's interpersonal issues at work are the result of poor employee training. On the other hand, a non-White practitioner may perceive that the non-White client's interpersonal issues at work are the result of a culture of institutionalised racism in the workplace. As noted by Thomas (1979),

> But even in the most elementary of communities it is rare for all members to behave similarly...There is differentiation of function implying that specialists are endowed with different constructions; and yet the whole community functions as if the complexity of organisation arises not from total commonality but from a "complementarity" of individual constructions of experience. The ethologists

have described how these mesh together to form a social system which develops characteristics that transcend the sum of the characteristics of the parts. (p. 15)

In applying PCP to social investigation, Thomas (1979) developed a complementarity corollary. She described it as follows:

> When people share in a common pool of events including each other, but by virtue of their position sample these events differently, their constructions of experience will develop to complement each other. This complementation will produce a social system which exhibits greater complexity of stable organisation than exists in the constructions of any individual contributing to it. (p. 15)

This corollary helps to expand on the influences of professional organisations and institutions, as well as societies and national cultures, on personal construct systems (Thomas, 1979). The complementarity corollary acknowledges that mental health practitioners "share constructions of experience which embody implicit rules and regulations" (Thomas, 1979, p. 15).

Research Methods

This thesis utilised a sequential, convergent, mixed methods approach to address the research objectives and research questions in line with the principles of PCP. The use of a mixture of methods also allows for triangulation and supports a multidimensional presentation and interpretation of the results (Thomas, 1979). The methods are described below, followed by a description of the sample, the project recruitment plan, and ethical considerations. Finally, reflections on the trustworthiness of the qualitative elements of the thesis are discussed before the thesis outline is presented.

Data Collection Strategies and Outputs

Data for this thesis was collected in three phases using different methods. The following provides an overview of each data collection strategy, a summary of the emergent findings, and relevant publication outputs. Further details on methods for recruitment, data analysis and interpretation for each phase of the research are provided within each publication in Chapter 2: Systematic Literature Review, Chapter 3: Qualitative Interviews, and Chapter 4: Quantitative Survey.

Phase 1: Systematic Literature Review

A systematic literature review of research published in English was conducted across seven electronic databases in psychology, health, and social sciences. The aim was to ascertain the nature of mental health care workers' constructions about culturally and linguistically diverse individuals to facilitate provision of culturally appropriate service delivery and multicultural training. The constructs and perspectives of 5,870 mental health workers with regards to minority populations are represented across the 38 studies included. The data was synthesised qualitatively and analysed thematically.

Phase 2: Qualitative Semi-Structured Laddering Interviews

To examine the impact of Whiteness on practitioner construct systems, cultural competence, and the therapeutic alliance, this thesis explored practitioner constructions about and preference for Whiteness or non-Whiteness. Twenty White and non-White mental health practitioners and trainees providing psychology services were convenience-sampled and interviewed using an adapted version of the laddering interview technique. Laddering seeks to establish an individual's superordinate personal constructs and involves asking

participants to indicate their preferred pole of a specified construct (Hinkle, 1965). Once this is identified, the interviewee is asked the reason for their preference. This process continues until a statement of the values that underlie the participant's construing is articulated. It is these values that may have a wide range of implications and are less likely to be open to change than more subordinate constructs (Hinkle, 1965). Data was analysed thematically and the impact of construals on practitioner cultural competence and the therapeutic alliance were interpreted drawing on PCP (Kelly, 1955).

Phase 3: Quantitative Questionnaire

To triangulate the findings from the systematic review and the interviews, a sample of 139 Australian mental health practitioners completed a set of quantitative measures online, including: a Demographic Questionnaire; the Multicultural Counselling Inventory; the Race and Ethnic Blindness Scale – Australia; and the Balanced Inventory of Desirable Responding. These internationally validated measures were used to help contextualise and contrast Australian mental health care workers' constructions of non-White people with those from other places in the world.

Overview of the Sample

The sample comprised mental health practitioners training and working in Australia. Mental health care workers include a diverse range of professionals, including counsellors, youth workers, social workers, psychologists, psychiatrists, general practitioners, and mental health nurses, to name a few. Statistics from the Australian Institute of Health and Welfare (2021) indicate that in 2019 there were 3,615 psychiatrists (13.7 FTE per 100,000 population), 24,111 mental health nurses (90.2 FTE per 100,000 population) and 28,412 psychologists (95.3 FTE per 100,000 population) employed in Australia. Although the diversity in experience and

clinical foci across mental health professions is vast, all share the same goal of improving mental health outcomes. This thesis was therefore interested in exploring the perspectives of all types of mental health workers, across all levels of practice (trainees to fully licensed practitioners), within all sectors (private, public or a mixture), including those with minimal experience (0-1 year) through to those with significant clinical experience (15+ years). Further details on the samples for each phase of the thesis are described in the publications presented in Chapters 2, 3 and 4.

Recruitment Strategies

Interview participants were purposively sampled from a regional university and two metropolitan mental health services through the researchers' existing networks. The sample included five each of White practitioners, non-White practitioners, White psychology trainees, and non-White psychology trainees, across a range of other demographic variables (Liamputtong, 2013). Including 10 White and 10 non-White trainees and practitioners ensured opportunities for varied perspectives across racial and experience groups and data saturation within each group (Liamputtong, 2013). Purposive sampling ensured that the sample was diverse and helped to exclude participants who did not engage in clinical mental health care with clients.

Survey participants included individuals aged 18 years and over, living in Australia and self-identifying as a mental health care practitioner or trainee. Participants were recruited via distribution of advertising to the Australian Psychological Society and the Australian Clinical Psychology Association. Additional recruitment took place via social media including Facebook, Twitter, Instagram, and LinkedIn. Participants were invited to complete the survey online or request a paper copy.

Ethics Approval and Considerations

This thesis received human ethics approval from the University of Wollongong Human Research Ethics Committee (Approval No. HE 2017/105). Ethics considerations and procedures relevant to each phase of the research are described within the published manuscripts in Chapter 3: Qualitative Interviews and Chapter 4: Quantitative Survey.

Qualitative Trustworthiness

Mixed method research provides researchers with opportunities for triangulation and can therefore enhance the validity of a study's findings. To ensure this possibility, it is important to consider trustworthiness of the research design (Lavelle et al., 2013). Despite the popularity of mixed methods research, means for determining rigour are not clear (Halcomb & Hickman, 2015). Methodologists suggest that mixed methods research should use the same criteria that are available to qualitative and quantitative research to demonstrate rigour (Creswell & Clark, 2007). Lavelle et al. (2013) advocate that researchers using a mixed method design should provide a clear description of the research process, with convincing rationale for the decisions made regardless of the specific method chosen. In an attempt to address the issue of rigour in this mixed methods study, trustworthiness criteria proposed by Guba and Lincoln (1989) have been adopted and are discussed below. Although the guide was initially proposed for qualitative research, it can also be applied to demonstrate rigour in mixed methods research (Sale & Brazil, 2004).

Credibility

The concept of credibility focuses on "how congruent are the findings with reality?" (Merriam, 1998). Researchers argue that establishing trustworthiness in any research requires

addressing the issue of credibility (Guba & Lincoln, 1985). To ensure credibility, research methods well established in mixed methods health research were adopted, and data collection tools were piloted and revised before data collection (Erlandson, 1993). Another approach that was applied to ensure credibility in this research was triangulation in different forms (Brewer & Hunter, 1989). For example, different data collection methods (systematic literature review, survey, and semi-structured interviews) were mixed to overcome the methodological limitations of involving a single methodological approach. Another form of triangulation was the recruitment of diverse mental health practitioners in relation to their profession, work experience, ethnicity and educational status, which helped to capture a rich account of the topic. "Site triangulation" was also achieved by recruiting participants from public and private therapeutic settings as well as those working in universities and public health institutions, to capture perspectives across a range of sectors. Van Manen (2016) argues that "collaborative analysis", which opens the opportunity to discuss the research process among team members, enhances credibility. Regular supervisory panel discussions, higher degree research seminars, research workshops and conference presenting and attendance helped me refine understandings and insights about the research, therefore promoting credibility of the analysis through the use of multiple viewpoints.

Transferability

The concept of transferability of research describes the extent to which its findings can be applied to other contexts (Shenton, 2004). As such the investigator should provide adequate contextual information about the research process to help readers make judgements about how and where the findings can be transferred into other contexts (Firestone, 1993). To achieve transferability in this research, clear and detailed descriptions of

the research protocol, including data collection approaches for all stages, how codes and conceptual themes were identified, a description of practitioner characteristics, and how PCP was applied to interpret the findings, are provided. A sample representing diverse professional groups, ethnic and work experience backgrounds was achieved to ensure a wide range of perspectives was captured (Horsburgh, 2003).

Dependability

In order to address the issue of dependability in research, the study process needs to be adequately elaborated, thus allowing other researchers to repeat the process (Shenton, 2004). The design, data collection, analysis and interpretation approaches for the three phases of the study have been documented at length to achieve dependability in this research. Dependability of a study could also be improved by triangulation and reflexivity (Shenton, 2004; Harding & Whitehead, 2013). In this thesis, triangulation has been achieved by employing several data collection approaches to make sure that the weaknesses of relying on a single data collection approach are moderated.

Confirmability

Confirmability is achieved in research when the conclusions of the study reflect participant perspectives, rather than the thoughts and preferences of the researcher (Shenton, 2004). In this thesis, a robust interpretive description is provided in the Discussion and Conclusion chapter to enable readers to track how the research methods led to the findings, which led to the interpretations and reflected Personal Construct Psychological theory. Additionally, quotes that support arguments are presented to demonstrate that data analysis and interpretation processes were data driven (Liamputtong, 2010, 2020). Figure 1.5 represents the research process and traces the course of the research highlighting the

integration of methods towards a comprehensive interpretive framework.

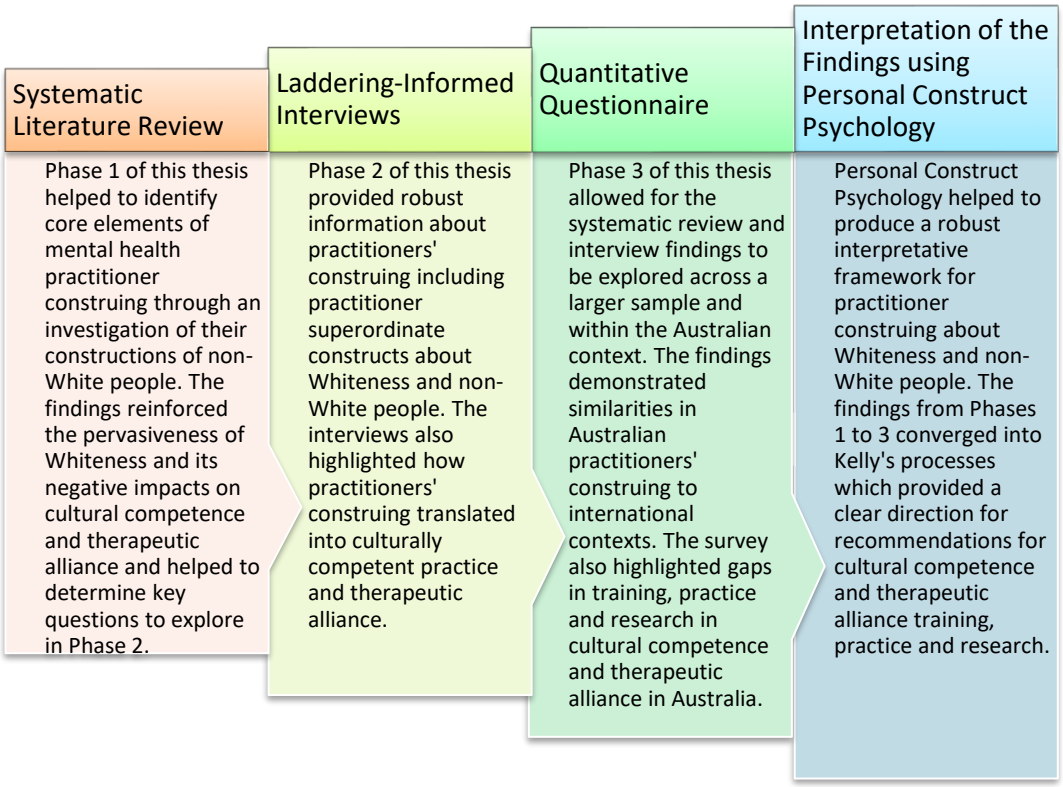

Figure 1.5 Sequential, convergent, mixed methods approach to exploring mental health practitioner construing and implications for cultural competence and therapeutic alliance

Thesis Outline

In the following Chapters (2, 3 and 4), readers are presented with a summary of the manuscripts discussing the research findings and their implications, as well as an overview of the role of each author listed on the manuscript. Chapter 5: Discussion and Conclusion integrates the findings from each phase of the thesis within a book chapter that presents recommendations for cultural competence training, practice and research driven by the principles of PCP. The thesis ends with a conclusive summary focused on the future of cultural competence and therapeutic alliance within the Australian mental health care system. Appendices are included thereafter.

Chapter 2: Systematic Literature Review

Chapter Overview

Chapter 2 presents the methods, findings, and recommendations from Phase 1 of this study. Phase 1 sought to identify core elements of mental health practitioner construing through an investigation of their constructions of non-White people and helped to answer the following research questions:

1) How do practitioners construe and construct non-White people?
    a. What characterises their construing and constructions?
    b. What role or impact does Whiteness have on their constructions?
    c. What impacts do their construing and constructions have on practitioner cultural competence?
    d. What impacts do their construing and constructions have on the therapeutic alliance?

The findings from Phase 1 reinforced the pervasiveness of Whiteness and its negative impacts on cultural competence and therapeutic alliance, and helped to determine key questions to explore in Phase 2 and appropriate terminology about difference to be used in the rest of the thesis. Included in Chapter 2 is the first publication of the thesis:

Dune, T., Caputi, P., & Walker, B. (2018). A Systematic Review of Mental Health Care Workers' Constructions about Culturally and Linguistically Diverse People. *PloS one, 13*(7), 1-20. doi: http://dx.doi.org/10.1371/journal.pone.0200662.

This publication presents a thematic meta-synthesis of 38 papers, representing 5,870 mental health workers, identified following a systematic search of seven databases. Key

themes comprised: Aetiology of Constructions; Content of Constructions, Factors that Influence Constructions; Implications for Cultural Competence, Implications for the Therapeutic Alliance, Recommendations for Training, Recommendations for Practice, and Recommendations for Research. The therapeutic alliance was most at risk when practitioners displayed low levels of cultural competence and high levels of racial and ethnic blindness. The role of Anglocentric systems and practices (also known as frameworks of Whiteness) was highlighted as a primary barrier to productive constructions of non-White people and a hindrance to the development of practitioner cultural competence and engagement with the therapeutic alliance.

Author Contributions

Author TD conceptualised the study with the supervision and guidance of authors PC and BW. Author TD engaged in the data curation and analysis process which was validated by authors PC and BW. Author TD drafted the manuscript and received conceptual and editorial feedback from authors PC and BW. Author TD conducted editorial revisions and finalised the article for publication.

Paper 1: A Systematic Review of Mental Health Care Workers' Constructions about Culturally and Linguistically Diverse People

PLOS ONE

RESEARCH ARTICLE

A systematic review of mental health care workers' constructions about culturally and linguistically diverse people

Tinashe Dune[1,2]*, Peter Caputi[1], Beverly Walker[1]

1 Faculty of Social Science, School of Psychology, University of Wollongong, Wollongong, New South Wales, Australia, 2 School of Science and Health & Translational Health Research Institute, Western Sydney University, Penrith, New South Wales, Australia

* t.dune@westernsydney.edu.au, tmd999@uowmail.edu.au

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Abstract

A systematic review of research published in English was conducted across seven electronic databases in psychology, health and social sciences. The aim was to ascertain the nature of mental health care workers' constructions about culturally and linguistically diverse individuals in order to facilitate provision of culturally appropriate service delivery and multicultural training. The constructs and perspectives of 5,870 mental health workers with regards to minority populations are represented across the 38 studies included. Key themes comprised: *Aetiology of Constructions*; *Content of Constructions*, *Factors that Influence Constructions*; *Implications for Cultural Competence*, *Implications for the Therapeutic Alliance*, *Recommendations for Training*, *Recommendations for Practice* and *Recommendations for Research*. The therapeutic alliance was most at risk when practitioners displayed low levels of cultural competency and high levels of racial and ethnic blindness. The changing and increasingly multicultural context within most countries means that mental health systems and workers need to prepare for an increasing range of culturally and linguistically diverse clients in need of support. Recommendations are explored for training, practice and research.

Introduction

Migration within an international context has increased exponentially especially in recent decades. Migrants are often required to learn a new language, cultural, ethnic customs and/or religious ideologies [1]. They may also contend with changed roles as well as becoming a minority in their adoptive countries. Being a minority can also apply to indigenous populations, like those in countries where the colonisers never left. Minority populations are sometimes characterised as culturally and linguistically diverse (CALD)–a term intended to acknowledge those who identify as being of a different cultural, ethnic, religious, linguistic and/or racial background than the dominant group in a particular country [2]. The term CALD is acknowledged to be problematic and its use widely debated. While such debate is beyond the purview of this paper the term CALD was used in light of its broad scope in

relation to minority populations. Further reflection on the term CALD and other alternatives is included within the Discussion section of this review.

The process of adapting to fundamental changes of identity, beliefs, behaviours and/or values between cultures can exacerbate or trigger mental health concerns, depending on the host context in which change occurs (e.g., hospitable versus inhospitable host societies) [3].

Not only do migrants need to acculturate in order to adapt to their new environments but the host society must also adapt to accommodate an increasingly multicultural society [4, 5]. This is particularly imperative for health care systems and their practitioners, who must address a wide range of individual and group health and wellbeing needs [6]. To adequately support CALD clients, health care workers are expected to espouse principles of cultural competency that support an effective therapeutic alliance [7, 8]. However, success in this respect requires wide-ranging acceptance and integration of diversity across systems, institutions and personal practice. Without this type of commitment, the health and wellbeing of CALD people cannot be adequately supported.

To explore these issues a systematic literature review was conducted to better understand (i) how mental health care workers construct CALD people or clients, (ii) what might be the implications of these constructions for cultural competence and the therapeutic alliance and (iii) their significance for both CALD people and mental health care workers. This paper therefore draws on Kelly's (1955) Personal Construct Theory whereby constructions of an individual's reality are based on how the individual construes social events, people, and/or themselves (i.e., constructs) and the processes by which they engage in construal–Kelly's 'Fundamental Postulate'.

Mental health workers' constructions about CALD people and the role of cultural competency

Little is known regarding mental health workers' constructions about CALD people. Current understandings of their constructions are implied from the extensively documented negative health outcomes and experiences of CALD people across a range of health care settings (see for example [9]). In general, the core of these experiences are related to health systems and workers harbouring constructions of health and wellbeing based on Euro/ethno-centric frameworks [10]. As such, mental health systems and practitioners often demonstrate resistance to incorporating alternative constructions of health and wellbeing into service provision [11, 12]. To circumvent negative outcomes researchers advocate for increased cultural competency [2].

"Knowledge, conviction and capacity for action at an individual and organisational level" are embedded within the concept of cultural competence [13]. Eisenbruch [14] also emphasises the skill-based notion of competence that encompasses the system (including health workers) no less than the patients or clients. As such, cultural competency is defined as:

> A set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations [15].

Building health care workers' abilities to become self-aware and to reflect on their constructions about others is an important aspect of cultural competency training [2]. The primary goal of this training is to improve the health and wellbeing outcomes of clients by improving the practitioner-client therapeutic alliance. Effective engagement in cultural competency is designed to promote the development and maintenance of a positive therapeutic alliance between practitioners and their clients [2].

The therapeutic alliance and mental health outcomes

The therapeutic alliance is broadly defined as "the collaborative and affective bond between therapist and patient. . . [and] is an essential element of the therapeutic process" [16]. With its origins in early psychoanalytic theories (e.g., [17–19]), the concept is now a staple of contemporary understandings and evaluations of the therapeutic process. It is well understood that the therapeutic alliance is related to clients' mental health engagement and outcomes–for better or for worse [16]

Exploring constructions about CALD people

There is a long history of research on minority clients' perceptions and experiences of health care, practitioner cultural competency and the therapeutic alliance. A systematic review exploring the barriers and enablers to ethnic minority patient engagement with health services found 54 articles from around the world [20]. Three levels of barriers were identified: patient level, provider level and system level. Barriers at all levels included beliefs, attitudes, skills, behaviours and systems that valued Western constructions of health and wellbeing as well as the 'other' [20]. This aligns with a systems approach to cultural competence and the need for all levels of society to 'acculturate' to the realities of multiculturalism. There is also growing research on health practitioners' cross-cultural attitudes, beliefs, values, awareness, responsiveness and their cultural competency (see for example [4, 21–25]), indicating that the therapeutic alliance is most at risk when practitioners demonstrate low levels of cultural competency and high levels of racial and ethnic blindness. This can result in the perception that people of culturally and linguistically diverse backgrounds should be treated equally to all others, irrespective of the impact of their diversity on health. Prevailing Euro/ethnocentric attitudes and values embedded within all aspects of social, health, economic, and political structures that reinforced racism, discrimination, prejudice and exclusion [6] reduced cultural competency and limited therapeutic alliance.

The above studies focused on a broad range of health practitioners, including doctors, nurses and allied health practitioners. Relatively few studies addressed similar themes with mental health practitioners and mental health care systems, despite researchers such as Chao [26] arguing that similar concerns apply. A paucity of research collating and presenting a collective perspective on the aetiology of mental health practitioner constructions, the content of those constructions, the factors which influence or mediate constructions and the impact of constructions on cultural competence and the therapeutic alliance is available.

To address these queries a systematic literature review was conducted exploring: how do mental health care workers construct CALD people or clients and what might be the implications of these constructions on cultural competence and the therapeutic alliance?

Methods

In line with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [27], a systematic review was conducted to identify research that investigated mental health care workers' constructions about CALD people (see **S1 Table**). The implications of these constructions on cultural competence and the therapeutic alliance were also considered.

Search strategy

The focus was seven electronic databases in psychology, health and social sciences: PsycINFO, ProQuest Central, PubMed, ScienceDirect, Scopus, CINAHL Plus and Infomit. The search for

Table 1. Inclusion/Exclusion criteria and keywords.

Parameters	Inclusion	Exclusion	Key words/steps
Location	International	None	N/A
Language	Written in English	Other languages	Select for English only
Time	Any	None	N/A
Population	Literature which include mental health care workers	Literature which do focus on mental health care workers	((Abstract) Psychologist OR Psychiatrist OR Mental health nurse OR Mental health worker OR Counsellor OR Social worker OR Psychotherapist OR Therapist)
Phenomena/ Target	Studies concerned with the participants' constructions, beliefs, attitudes, views and perceptions of CALD clients	Not concerned with the participants' constructions, beliefs, attitudes, views and perceptions of CALD clients	AND ((Abstract) Construct OR Beliefs OR Values OR Attitudes OR Perceptions OR Stereotypes) AND ((Abstract) Visible minority OR Visual minority OR Culturally and Linguistically Diverse OR Non-White OR ethnic minority OR racial minority OR linguistic minority OR language minority OR English as Second Language OR Language other than English OR Language Background other than English OR English as an Additional Language or Dialect)
Study/ literature type	Published primary research including qualitative, quantitative and mixed method designs	Published literature which DO NOT include qualitative, quantitative and mixed methods of data collection and analysis	N/A

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published literature in English was undertaken during April and November 2016. Following Mengesha et al. [6], a step-by-step search strategy was employed.

A preliminary search of ProQuest Central was undertaken by the first author with the goal of identifying the key words contained in study titles and abstracts and ascertaining index terms used to describe articles. Pertinent key words were discussed, expanded and refined with the other authors. A second search, using all identified keywords, was conducted across the seven databases indicated. Finally, the reference lists of all included literature were examined for additional studies. Details of the search strategy, including the search terms and combinations, are summarised in Table 1.

Data synthesis

The review analysed literature by a thematic approach developed by Thomas and Harden [28] that extracted, synthesised, analysed and interpreted the findings of the included literature. Three steps were followed: 1) line by line coding of the results, discussion and conclusion sections of the primary studies; 2) development of descriptive themes; and 3) generation of analytical themes towards a synthesised presentation of results. The first author completed a preliminary synthesis of primary data followed by a review and disagreement resolution by all authors.

Quality assessment

In order to assess the quality of the quantitative papers included in this systematic review we used the Effective Public Health Practice Project's *Quality Assessment Tool (QAT) for Quantitative Studies* [29]. The QAT was used to appraise 27 of the 38 studies included, those that employed quantitative or mixed methods approaches to collecting, analysing and interpreting the data. Studies that used only qualitative methods were not evaluated using the QAT. The first author assessed the quality of studies with the second and third authors reviewing the article assessments.

Results

From the 583 potentially relevant articles identified, 38 articles were included in the systematic review (S1 Fig).

Sample

The characteristics of each study are summarised in Table 2. The perspectives of 5,870 mental health workers with regards to CALD people were synthesised and are presented under Theme 1 below. Most studies (77%) did not focus on a specific CALD population. CALD groups discussed in the remaining 23% included: Eastern Europeans, Asians and/or Asian-Americans, Blacks and/or African Americans, Latinos and Mexicans, Arabs or those from the Middle East, Jews, refugees and migrants. Fifteen papers included the perspectives of mental health graduate students. There were 11 papers focused on mental health workers in a range of occupations (e.g., occupational therapists, social workers, special education teachers, nurses and general practitioners). There was a low presence of research with clinical psychologists or psychotherapists (6), psychiatrists (2), speech pathologists/therapists (2) and school counsellors (2). The vast majority of research was conducted in the United States (28), with the remainder being in Canada (3), Australia (3), Japan (1), Tanzania (1), the United Kingdom (1) and Germany (1). The total number of studies included may not add up to the number of papers with a particular focus area, sample or country as some studies included more than one of the above in their analyses.

Research foci and theoretical approach

The studies primarily focused on evaluating practitioner attitudes, skills and behaviour related to (multi)cultural competency (20) or the impact of cultural competency training (8). Other research directly or indirectly explored the impact of these measures on health care outcomes (8), patient/client diagnosis (4) and the therapeutic alliance (6) within mental health settings. All studies implicitly or explicitly aimed to make recommendations about (multi)cultural competency training and practice as well as means for improving the therapeutic alliance and CALD patient/client outcomes.

Only five papers explicitly indicated the use of a theoretical approach to guide the research. Among those that did were auto-ethnography, experiential family therapy, non-experiential descriptive design, consensual qualitative research and critical incidents.

Research design and methodology

Quantitative methodology using surveys were the most common data collection strategy. Eleven used qualitative approaches, with interviews and focus groups being most common. Nine used a mixed methods approach. Given the emphasis on quantitative methods, a variety of statistical analyses were applied including descriptive statistics, multilevel modelling, multiple regression, MANOVA, ANOVA and hierarchical regression. Qualitative studies undertook thematic or content analyses. Nine studies did not specify the analytical approach used (see Table 2).

Study quality

As shown in Table 3 the QAT included six major assessment criteria: a) selection bias, b) study design, c) confounders, d) blinding, e) data collection methods and f) withdrawals and drop-outs. Fifteen specific quality assessment sub-criteria where weighted according to the guidelines described for use of the QAT [29]. Global scores for each major criterion, based on the

Table 2. Characteristics of 38 studies included in the systematic review.

Reference No.	Literature Type	Type of Mental Health Worker/s	CALD group/ Country	Mental Health Care/ Setting	Theoretical approach	Sample size	Design/data collection	Analytical approach
[30]	Journal Article	Counsellors	CALD/Canada	N/A	N/A	181	Qualitative: Critical Incidents	Content Analysis
[31]	Journal Article	Therapists	Ethnic minorities/ USA	Family Therapy	Experiential family therapy	6	Qualitative	N/A
[32]	Journal Article	Counsellors	Ethnic minorities/ Tanzania	Counselling university students	N/A	1	Autoethnography	N/A
[33]	Journal Article	Psychotherapists	Mexican-American, "Negroes", Japanese-Americans, Chinese-Americans and Jews/USA	Therapeutic relationship	N/A	16	Qualitative: interviews	N/A
[34]	Journal Article	Counselling graduate students	CALD/USA	Multicultural Training	N/A	84	Quantitative: surveys	Multilevel modelling
[35]	Journal Article	Counsellors	CALD/USA	Multicultural competency	N/A	338	Quantitative: surveys	Hierarchical multiple regression
[26]	Journal Article	School counsellors	CALD/USA	Multicultural competence	N/A	259	Quantitative: surveys	ANOVA, regression analysis
[36]	Journal Article	School counsellor trainees	CALD/USA	Multicultural counselling competence	N/A	99	Quantitative: surveys	MANOVA, hierarchical multiple regression
[37]	Journal Article	School counsellors	Immigrant students/USA	Counselling immigrant students in schools	N/A	139	Multicultural case conceptualisation, Quantitative: surveys	Hierarchical multiple regression
[38]	Journal Article	GPs, nurses, psychologists, occupational therapists & social workers	CALD/ Australia	Acute adult inpatient	N/A	53	Qualitative: focus groups	Thematic analysis
[39]	Journal Article	Counselling students	CALD/USA	Multicultural training	N/A	516	Quantitative: surveys	Multiple regression, ANOVA, hierarchical regression
[40]	Journal Article	Social workers and psychologists	Racial minorities and women/USA	N/A	N/A	705	Quantitative: surveys	Descriptive statistics
[41]	Journal Article	White counselling and clinical psychology trainees	Racial minorities/ USA	N/A	N/A	177	Quantitative: surveys	Multivariate multiple regression
[42]	Journal Article	Health and human service professionals	Refugees/ Australia	Refugee-specific services	N/A	22	Qualitative: semi-structured interviews	Thematic analysis
[43]	Journal Article	Special education teachers	CALD students/ USA	Special education	N/A	17	Quantitative: online survey	N/A
[44]	Journal Article	Counsellor	CALD/USA	Multicultural counselling training	N/A	1	Auto-ethnography	N/A
[45]	Journal Article	Psychology trainees	Refugees/ Canada	Culturally grounded supervision of Psychotherapy practica	N/A	9	Mixed Method: Quantitative (pre/post survey) Qualitative (journal entries) Auto-ethnography	Exploratory analyses, t-tests and thematic analysis

(*Continued*)

Table 2. (Continued)

Reference No.	Literature Type	Type of Mental Health Worker/s	CALD group/ Country	Mental Health Care/ Setting	Theoretical approach	Sample size	Design/data collection	Analytical approach
[46]	Journal Article	Psychiatrists, doctors, psychiatric social workers and psychologists, nurses, medical students	Black and ethnic minorities/UK	Psychiatric diagnosis	N/A	339	Clinical vignette, Quantitative: questionnaire	N/A
[47]	Journal Article	School speech-therapists	CALD students/ USA	Schools	N/A	9	Qualitative: semi-structured interviews	Thematic analysis
[48]	Journal Article	Counselling students	Minority clients/ USA	N/A	N/A	120	Quantitative: survey	Multiple regression analyses
[49]	Journal Article	European American mental health practitioners	CALD/USA	Multicultural counselling competencies	N/A	412	Quantitative: survey	MANOVA
[50]	Journal Article	Social Worker	CALD social worker/ Australia	Child Protection	Auto-ethnography	1	Auto-ethnography	N/A
[51]	Journal Article	Private Psychotherapists	Cross-cultural interactions/ Germany	Outpatient mental health care service	N/A	485	Quantitative: survey	Chi-squared, t-tests, one-way ANOVA, Mann-Whitney U test, factor analysis
[52]	Journal Article	Multicultural therapy trainees	CALD/USA	Multicultural therapy training	N/A	38	Quantitative: survey and Guided Inquiry	MANOVA, frequency and percent ratings
[53]	Journal Article	Mental health workers, applied psychology students	CALD/USA	Multicultural counselling competencies	N/A	130	Quantitative: survey	MANOVA
[54]	Journal Article	Counselling graduate students	Refugee, Immigrant/USA	Mental health outreach program	N/A	12	Qualitative: Interviews	Thematic analysis
[55]	Journal Article	Psychiatrist	Japanese/ Canada	Transcultural psychiatry	N/A	1	Autoethnography	N/A
[56]	Journal Article	White counselling graduate students	CALD/USA	Multicultural counselling competencies	N/A	128	Quantitative: survey	Hierarchical regression
[57]	Journal Article	White counselling graduate students	CALD/USA	Multicultural training	N/A	116	Quantitative: survey	Factor analysis, 2 x 2 mixed model ANOVA, primary ANOVA, ANCOVA
[58]	Journal Article	Counsellors	CALD/USA	Multicultural counselling competencies	N/A	220	Quantitative: survey	Descriptive analysis, MANOVA & ANOVA
[59]	Journal Article	Counsellors	CALD clients/USA	Multicultural counselling competencies	N/A	220	Quantitative: survey	Descriptive analysis, MANOVA & ANOVA
[60]	Journal Article	Counsellors, speech pathologists, special education teachers	CALD/ USA	Schools	Non-experimental descriptive design	75	Mixed Methods: survey	Descriptive analysis & thematic analysis
[61]	Journal Article	Counselling trainees	CALD/USA	Mentoring of ESL students	Consensual qualitative research	67	Qualitative: self-reflection process notes Quantitative: survey	Thematic analysis, ANOVA, Pearson correlations, Mean Difference

(*Continued*)

Table 2. (Continued)

Reference No.	Literature Type	Type of Mental Health Worker/s	CALD group/ Country	Mental Health Care/ Setting	Theoretical approach	Sample size	Design/data collection	Analytical approach
[62]	Book Chapter	Doctoral counsellor trainees	Immigrant school children/USA	A middle school English as a Second Language Program/ Multicultural Counselling Training	N/A	16	Qualitative: trainees' process notes and Quantitative: survey	Thematic analysis, Chronbach's alpha, Pearson correlation coefficient
[63]	Journal Article	Counselling trainees	CALD/USA	Multicultural Counselling Training	Critical Incidents Technique	124	Qualitative and Quantitative: Critical incidents	Content analysis, chi-square
[64]	Journal Article	White counselling trainees	CALD/USA	Multicultural counselling competencies	N/A	311	Quantitative: survey	Descriptive analysis, MANOVA & ANOVA
[65]	Journal Article	Regular and special educators	Multicultural students/USA	(Special) Education	N/A	403	Quantitative: survey	N/A
[66]	Journal Article	Counselling psychology graduate students	CALD/USA	Ethnic bias in counselling	N/A	20	Illusory correlation paradigm & questionnaire	Independent group t-test, paired t-test

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responses to the sub-criteria, provided an overall indication of a study's quality level: Strong = 1, Moderate = 2 and Weak = 3. Although study quality varied significantly across the 15 quality assessment sub-criteria all 27 studies assessed where found to be Weak given that they attracted more than two Weak scores across the six major criteria indicated above.

Major findings

Following line-by-line coding of the extracted results and discussion sections from individual studies, three major themes with subthemes emerged: *Construing CALD People*, *Impact of Constructions* and *Recommendations*. In the interest of brevity and readability major findings are accompanied by only some example citations. The terms 'workers' or 'practitioners' is used in place of 'mental health care workers' for ease of reading.

Theme 1: Construing CALD people. Aetiology: Practitioners constructions about CALD people originated from social, cultural, political, religious and economic hierarchies that valued ethnocentric norms and values [30, 31, 46, 59, 65]. With the majority of research originating from Western countries, Eurocentric norms and values prioritised Whiteness and manifestations of White supremacy (e.g., racism and institutionalised discrimination). In these papers [41, 52, 53, 57, 67], CALD people were constructed as social problems and were perceived as causes of societal instability within a range of cultural, political, religious and economic arenas. The ethno/Eurocentric aetiology and hierarchies produced both challenging and contradictory constructions about CALD people.

Content: All studies indicated that constructions about CALD people manifested in worker attitudes, beliefs, assumptions and biases as well as stereotypes and prejudices. These constructions, especially prior to cultural competency training, were noted as barriers to CALD people's health outcomes and were a major focus of training interventions. Even so, constructions about CALD people sat on a spectrum from negative (e.g., migrants are economic drains), to neutral (e.g., racial/ethnic/colour blindness), to positive (e.g., they add social and economic wealth to their adoptive societies). While some studies did not articulate specific constructions (most were simply indicated to be 'attitudes' or 'stereotypes') the majority of perspectives could be grouped into construct sets. These constructs, their place on this spectrum and the

Table 3. Quality assessment results.

QAT major criteria	Selection Bias			Study Design				Confounders				Blinding			Data Collection Methods			Withdrawals and dropouts			Global QAT Rating
Reference No.	Representative Sample	% ppl agreed to participate	Overall SB rating	Type	Randomised —Y/N	Randomisation described?	Appropriate Method?	Overall SD rating	Diff. b/w groups?	Type	% controlled confounders	Overall Confounders rating	Blinded researchers?	Blinded Participants?	Overall Blinding rating	Valid data collection tools?	Reliable data collection tools?	Overall DC rating	Withdrawals reported? w/ reasons?	% part. who completed intervention	Overall WD rating	
[34]	2	5	3	3	N	n/a	n/a	2	N	n/a	n/a	3	2	2	3	1	1	1	2	n/a	3	3
[35]	2	5	3	7	N	n/a	n/a	3	3	n/a	n/a	3	2	2	3	1	1	1	4	n/a	3	3
[36]	1	3	2	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	4	3	3	3
[38]	2	5	3	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	4	4	3	3
[37]	1	2	2	7	Y	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	1	2	2	3
[39]	1	2	2	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	1	2	2	3
[40]	1	3	2	7	Y	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	1	3	2	3
[44]	2	5	3	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	4	4	3	3
[43]	1	1	1	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	3	3	3	1	4	3	3
[45]	3	5	3	5	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	4	4	3	3
[46]	1	1	1	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	3	3	3	1	1	1	3
[48]	2	5	2	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	4	4	3	3
[49]	1	3	2	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	3	4	3	3
[51]	1	1	1	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	3	3	3	1	1	1	3
[52]	2	4	3	5	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	4	4	3	3
[53]	2	4	3	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	1	4	2	3
[56]	1	2	2	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	1	2	2	3
[57]	2	1	2	3	Y	n/a	n/a	2	Y	training	Y	2	2	2	3	1	1	1	2	3	3	3
[58]	1	2	2	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	1	2	2	3
[59]	1	2	2	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	1	4	2	3
[60]	4	4	3	7	N	n/a	n/a	3	Y	profession	4	3	2	2	3	1	1	1	4	4	3	3
[61]	2	4	3	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	4	4	3	3
[62]	2	4	3	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	4	4	3	3
[63]	4	4	3	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	3	3	3	4	4	3	3
[64]	4	4	3	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	1	1	1	4	4	3	3
[65]	2	3	3	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	3	3	3	1	3	2	3
[66]	4	5	3	7	N	n/a	n/a	3	N	n/a	n/a	3	2	2	3	3	3	3	4	4	3	3

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Table 4. Constructions about CALD people in each of the 38 studies.

Constructions	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38
Negative																																						
CALD people have backward values/beliefs	x					x		x					x				x			x	x		x	x		x	x	x						x			x
CALD clients do not know what is best for them	x							x									x			x	x		x	x		x		x						x			
CALD people's behaviours are limited to stereotyped caricatures		x			x	x		x					x									x		x		x		x						x			x
CALD people are economic and social drains				x		x							x							x		x		x			x	x						x			
CALD people display more antisocial behaviours than non-CALD people																		x		x		x		x		x	x	x						x			x
CALD people are poor and uneducated				x															x	x		x		x		x		x						x			x
CALD people are defensive/ sensitive	x	x		x													x	x	x	x		x		x				x							x		
Neutral																																						
CALD people see things differently than non-CALD people	x					x	x	x					x		x	x			x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x	x
CALD people are quite different to non-CALD people		x			x	x		x	x	x			x	x			x		x	x	x	x	x	x	x		x	x	x	x		x		x	x	
CALD people are compared against the dominant group		x			x	x	x	x	x				x	x	x	x			x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	
Not all CALD people only want to interact with people of their background			x						x	x			x	x		x			x	x	x	x	x	x	x		x	x	x	x			x		x	x	
Positive																																						
CALD people are not simply stereotypes		x	x				x	x	x	x			x	x	x	x	x	x	x		x	x		x		x			x	x			x	x			
Not all CALD people and groups are the same			x				x	x	x	x		x	x	x		x	x	x	x		x	x		x		x			x	x			x				
CALD people experience prejudice across generations		x					x	x	x	x		x	x	x		x	x		x		x	x		x		x	x		x	x			x	x			
CALD people are important sources of information and knowledge							x	x	x	x		x	x	x	x	x	x	x	x		x	x	x	x		x			x	x		x	x	x			
CALD people are important and necessary in society									x	x		x		x		x			x		x	x		x		x			x	x		x	x				
CALD people are grateful for the mental health support they receive										x					x	x			x			x				x	x		x								

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literature that discussed these constructions are presented in Table 4, with an 'x' indicating presence of construction. Although some constructions were negative or problematic prior to cultural competency training, changes to such constructions were dependant on a range of moderators and mediators within, and external to, workers' control.

Factors that influence constructions about CALD people: In addition to cultural competency training, major influences included workers' sex, ethnocultural background and exposure to CALD people both within and external to counselling practice. The importance of practitioner characteristics were examined through a range of quantitative measures related to cultural competency, ethnic/racial/colour-blindness, White Racial Identity as well as qualitative explorations of critical incidents and autoethnographic accounts. For the most part no gender/sex differences were statistically significant with regards to constructions about CALD people, cultural competence, racial identity or colour-blind attitudes. In a few studies, female mental health workers' espoused more positive constructions about CALD people than males and perceived themselves to be more culturally competent than their male counterparts [39]. Generally, workers' who identified as being CALD had higher levels of cultural competency prior to multicultural training [26, 59, 64] while other studies demonstrated no such differences [63]. These results became relatively equal after multicultural training, with non-CALD workers' improving marginally more than their CALD counterparts [64]. Most research indicated that workers who had social and/or clinical experience with CALD people had higher levels of cultural competence, less ethnic/racial/colour-blind attitudes and/or more advanced White Racial Identity frameworks. "Advanced" White Racial Identity refers to Whites who operate primarily from the later stages of this racial development framework. These stages include: Contact, Disintegration, Reintegration, Pseudo-independence, and Autonomy. In the final stage, for example, "Whites internalize a positive racial identity by no longer imposing arbitrary racial definitions on others and by displaying an intellectual and emotional appreciation of racial differences and similarities" (Constantine, 2002, p. 164). These factors further influenced practitioners' multicultural knowledge, awareness, relationship and counselling skills–with higher scores in each area being linked to positive constructions about CALD people and higher cultural competence.

Theme 2: Implications of constructions. Implications for cultural competency: Constructions about CALD people were intimately linked to practitioner levels of cultural competence. This was explicitly evident in studies using the Multicultural Counselling Inventory (MCI) [34, 35, 39, 45, 49, 56, 58, 59, 61, 68]. Within each subscale (i.e., Skills, Knowledge, Awareness and Relationship), items that revealed respondents' constructions (e.g., stereotypes, beliefs and values) were assessed in relation to mental health support tasks, skills and knowledge. Across several studies using the MCI and/or other competence scales, workers' perception of their skills- and knowledge-based competence was generally higher than their awareness- and relationship-based competencies. Positive correlations were also present between negative or neutral/positive constructions and limited or heightened cultural competency, respectively. This is corroborated by other scales (e.g., White Racial Identity or Color-blind Racial Attitudes Scale) analysed independently and alongside the MCI as well as other methodologies (e.g., critical incidents and qualitative methods).

Although cultural competency training is designed with these associations in mind, practitioners with negative constructions were more likely to resist changing their constructions or were more dissatisfied with such training [36, 52, 53, 61, 62, 64, 69]. Conversely, those with more neutral and positive constructions found that cultural competency training increased their interest in, and comfort with cultural diversity [44, 45, 63] as well as their desire to engage with those from cultures unlike their own [32, 50, 55]. As such, workers constructions are important to development of the therapeutic alliance.

Implications for the therapeutic alliance: Mental health workers' felt that their constructions could result in minor limitations to the therapeutic alliance [38, 42, 46]. Limitations include the inability to bridge cultural differences [30], micro-aggressions [41], value conflicts [44] or racial/ethnic/colour-blindness [35]. Even so, practitioners perceived themselves to have appropriate constructions and therefore appropriate levels of cultural competence as well as good engagement with clients/CALD people [38, 42, 46]. Notably, before cultural competency training, workers were often oblivious of the impact of some of their constructions on the therapeutic alliance and client outcomes [70]. This was demonstrated in studies that assessed worker constructions, competencies and engagement with clients' pre and post training [45], particularly those including assessments of MHCWs racial/ethnic/colour-blindness [26, 34] and racial identity [41]. All the studies acknowledged that competency gaps could be addressed in practitioner training, practice and research.

Theme 3: Recommendations. Training: Further developments in training that reflect and accommodate the dynamic nature of culture and society were advocated in all studies. Key recommendations included the infusion of cultural competence in all aspects of practitioner training [30] in addition to stand alone units of study that tie all areas of learning together [34]. Further, cultural competency training should consistently focus on the role and impact of culture and diversity on the development and/or maintenance of practitioners' constructions about CALD people. Training could move away from a focus on building awareness, knowledge or skills related to culture [52, 53], towards developing a habit of reflexivity in counselling practice [37, 42, 50, 55]. Oandasan and Reeves [71] reflexivity refers to:

> "self and group reflective exercises, within safe learning environments, [where] students may begin to develop the reflective skills necessary for developing an appreciation and understanding of each other's roles, their unique backgrounds and the professional perspectives on clinical decision making that ensures each profession is distinctive [. . .]. Reflection can only occur if opportunities are provided [. . .] that expose students to issues that they must grapple with".

In doing so, learners should be supported "to explore and resolve possible racist [colour-blind] and intolerant attitudes and to make these efforts an ongoing feature of their continuing growth and self-exploration" [37]. In saying that, training must also respond to learner diversity, with cultural competency programs often focusing on the experiences of non-CALD people's level of awareness, knowledge, skills and engagement, leaving these potentially bored and disengaged [26]. According to Chao (26) such individuals' lived experience provides them with first hand exposure and engagement with cultural diversity, with current training doing little to improve their capacity for cultural competency.

Given the importance of the lived experience, most studies suggested that exposure to, and engagement with, people from culturally and linguistically diverse backgrounds through placement and cross-cultural supervision benefited all workers both during and post-study [45]. Greater exposure and engagement with CALD people manifests in more positive constructions and improved cultural competence [48]. This aspect of training is intimately linked with practitioner ability to support the therapeutic alliance. Trainees who only receive knowledge, awareness and skill-based training do poorly on the Relationship sub-scale of the MCI because they do not know how to apply what they have learnt to actual human beings [56]. Exposure and engagement is therefore an important opportunity for trainees to apply theory and become comfortable with being uncomfortable [44], breakdown resistance to cultural competency training [61, 72] and to effectively work through it [69].

Studies that collected data on continuing education found that the majority of their sample had not engaged in CALD-specific training since becoming a practitioner, with others (particularly those who had been practicing for over a decade) not having received any such training during their preparatory education [30]. The literature indicated that regular participation in continuing education, with a specific focus on CALD people, is required to keep up with changing and increasingly multicultural societies [39, 40, 45]. This could be supported by increased representation of cultural diversity amongst mental health students, faculty, placement experiences and supervisors [48].

Practice: To avoid a one-size-fits-all approach [38] applying the principles of cultural competence via culturally appropriate interventions is suggested [69]. This strategy reinforces the aims of training for cultural awareness and reflexivity [41]. Resources that focus on value conflicts in cross-cultural settings, and how to manage them, are necessary [55], as well as those that provide some guidance on cultural expectations or protocols within major ethnic groups [51]. The importance of interpreters in the provision of accessible and responsive mental health care was also mentioned [50]. In particular, practitioners needed to know how to access them and utilise their skill set [38]. In situations where practitioners worked with a large number of clients from a particular CALD group, the literature encouraged them to learn some of their clients' language, to make home visits and to attend cultural events [47]. Services would also benefit from a diverse workforce [48] and actively supporting the inclusion of diverse clients in their practice. Practitioners are therefore encouraged to engage family members, where appropriate, as this may be of great importance to collectivist cultural groups [50]. Doing so also acknowledges clients and their families as knowers or experts on their own experiences and health needs [26, 35, 36, 47, 60]. This however may require more time than currently budgeted for counselling and educating CALD clients as compared to some non-CALD clients [53, 54, 65]. These inclusions in practice, amongst many other factors, are important institutional, organisational and systemic precursors to access and utilisation of mental health care services for CALD people [51, 55, 66].

Research: Future research can focus on the processes through which cultural competency training transfers into reflexivity, awareness, knowledge and skills and then into effective practice with CALD clients [30, 65, 66]. As such, differences in how various training experiences (e.g., didactic and experiential) influence constructions about CALD people requires further investigation [36, 73]. More information is also needed about trainees who are resistant, ambivalent or non-receptive to the principles of cultural competence and the means for supporting the therapeutic alliance [63]. This information would allow for the development and delivery of effective pedagogy as well as learning environments with a cultural ambiance conducive to attitudinal and behavioural change [39].

Further investigation of worker demographics can help to explore their influence on cultural competence and the therapeutic alliance [36, 47, 68]. A better understanding of the cultural competence and constructions about CALD people held by supervisors can reveal what trainees are taught 'on-the-job' about the therapeutic alliance and how to manage it [34, 56, 64]. Differences between experienced/practicing workers versus trainees could also be explored within varying global contexts, using a range of methodologies [52, 53].

With regards to research methods, a variety of theories and data collection techniques were advocated in order to provide a multidimensional understanding of slippery concepts like 'constructions about CALD people' and 'CALD clients' needs' within the 'therapeutic alliance'. Recognition was given to the difficulty of their assessment due to the likelihood of participants responding in socially desirable ways and reliance on self-report data [68]. Ways to mediate and/or account for these confounders of valid data were welcomed [52, 53]. The representativeness of the research samples were noted by authors as a limitation, with more research

needed to develop a strong evidence base for training and practice [57]. Authors suggested that research move away from a deficit-model of CALD people, which may reinforce them as being "problems" that workers have to "deal" with, but are not sure how to. Instead a strengths-based model where CALD people are engaged in research to develop and challenge workers was proposed [32, 47, 50, 51, 55].

Discussion

A systematic review of 38 studies published in English was conducted to ascertain the nature of mental health care workers' constructions about culturally and linguistically diverse individuals in order to facilitate provision of culturally appropriate service delivery and multicultural training. The findings demonstrate that constructions about CALD people are intimately linked to workers' ability to engage in ways that are culturally competent and supportive of an effective therapeutic alliance. This review has also highlighted that little is known about the explicit constructions that workers hold regarding CALD people as well as the views held outside of the United States. While some constructs were easy to identify, others were simply discussed as negative or positive 'values' or 'biases' or 'stereotypes', with a limited indication of their content–especially regarding negative constructs. This perhaps reinforces the insidious nature of negative constructions about CALD people which are not explicitly or fully articulated, but pervasive in all areas of society–making them hard to pinpoint and address [11, 74].

Even so, constructions were for the most part positive, particularly after multicultural competency training. While training improved competency for the majority of workers involved in such programs [61, 62, 72], there remain practitioners, across all helping professions, who reject or resist the premise of cultural competency training [2]. This is concerning given the positive benefits of such professional development. However, it may not be cultural competency training itself that some practitioners take issue with, but instead the way in which it is taught and the relatively limited gains which they perceive can come from it. For instance, CALD practitioners may already have the fundamental background knowledge required to be culturally competent. Consequently, their cultural competency scores start off higher than non-CALD practitioners and then level out post training. Given the limited post-training gains experienced by this group, cultural competence training may be perceived as boring, resulting in disengagement. For these practitioners the basic level at which some training occurs may not capitalise on the insights and experience that CALD workers already have.

While further research is warranted to explore differences and similarities with regards to constructions about CALD people, cultural competency and the therapeutic alliance, such explorations can be problematic and fraught with methodological, theoretical and conceptual difficulties. For instance, when trying to extract or identify such constructions we are reminded that not all CALD people are the same and therefore may not be construed similarity. Even the term 'CALD' fuels much debate as it lacks meaning for many scholars [75]–after all isn't everyone a CALD person? As such, research can benefit for a more explicit and unapologetic delineation of the groups who are being discussed–which several of the included studies had done (e.g., focusing on Black Americans, Asians and/or Latinos). Given that the majority of studies discussed Whiteness, not simply as a colour but as the foundation for social/cultural/economic/political/religious systems, the term non-White may be appropriate for exploring several minority groups at once and acknowledging the role of Anglo/European culture on minority people [10, 11, 76]. Although Whiteness, as a societal system, is increasingly a global phenomenon these terms may not be useful in contexts where the dominant culture is not White (e.g., Japan).

The recommendations presented are therefore very important–with training as a necessary starting point [2, 77] and an understanding that a 'one-size-fits-all' approach is ill-advised. In an era of educational entitlement within tertiary settings [77], the ways in which cultural competency is taught needs reform to 'reach' and re/educate practitioners from a range of backgrounds and levels of 'experience'–whether clinical or otherwise. Such reform would benefit from the development of evidence-based cultural competency training programs relevant to specific national contexts. This may include a focus on developing worker engagement and understanding of local (and international) CALD people through experiential learning and opportunities to apply theoretical knowledge. However, accreditation processes and institutional bureaucracy often limit the speed at which this can occur.

Limitations

While this review presented a comprehensive synthesis of published research a potential limitation is that literature like unpublished masters and doctoral theses were excluded from the search. Even so Vickers and Smith [78] noted that after a review of the Cochrane Library, only one of 878 systematic reviews included data from theses that could have fundamentally altered the conclusions of those reviews. Nevertheless, Vickers and Smith [78] noted that the benefits of including dissertations in systematic reviews are minimal as they rarely influence the conclusions, whilst retrieving and analysing unpublished dissertations involves considerable time and effort.

This study is further limited by the disproportionate number of papers conducted in the US. As such the views presented are limited to those of a particular sociocultural, political and economic setting in which multiculturalism has been a long standing discussion resulting from America's extensive history of migration and the aftermath of that history for many ethnic groups. Second, this means that the experiences and views of mental health care workers in other contexts, which have very different (and some with much shorter) histories of migration, are not heard, or drown in those from the USA. Whilst this may simply indicate that such conversations are in their infancy or adolescence (e.g., like in Australia) the lack of perspectives from other geographic regions limits insights for both the therapeutic alliance and cultural competency in relation to minority populations in those countries (e.g., Indigenous Australians). Third, given that only studies published in English were included bias exists when trying to make inferences about people from non-English speaking backgrounds. For instance, countries like France, Italy, Greece and Spain (to name a few) receive large numbers of migrants who are faced with integrating into a new sociocultural environment. Perspectives from these contexts would enrich understandings of mental health care workers' constructions about CALD people. As such, more research that can inform locally relevant training and practice models in other languages than English and from regions outside of the US is required.

Conclusion

Multiculturalism within an international context has increased exponentially, especially in the past two decades. While some CALD people arrive to their adoptive countries with existing mental health concerns, others develop such concerns following migration. To assist these clients in managing their mental health needs this systematic review reinforces that mental health care workers who construe CALD people in line with principles of cultural competency are better able to support a robust therapeutic alliance. This synthesis of existing evidence concerning mental health care workers' constructions about CALD people reiterates that the provision of culturally-appropriate services are contingent on the cultural competency training delivered to mental health trainees. This review has found that the therapeutic alliance between

minority clients and mental health care workers is most at risk when practitioners have negative constructions about CALD people that are correlated with low levels of cultural competency.

Within our multicultural global context the issue of cultural competency, or the lack thereof, requires urgent attention. While this does not mean that individuals and ethnocultural groups cannot retain their identities and beliefs, it *does* mean that:

> We must prepare ourselves for a future that has arrived. We must educate our children to be global citizens who can live with all the paradoxes of identity, who can change while retaining a core sense of self. [79]

The changing and increasingly multicultural context of all nations means that mental health systems and workers need to be prepared for the range of clients in need of support. As the included literature notes, such a feat requires commitment to developing dynamic and responsive training, research and practice models.

Supporting information

S1 Table. PRISMA 2009 checklist.
(DOC)

S1 Fig. Article selection process.
(DOCX)

Author Contributions

Conceptualization: Tinashe Dune, Peter Caputi, Beverly Walker.

Data curation: Tinashe Dune.

Formal analysis: Tinashe Dune.

Investigation: Tinashe Dune.

Methodology: Tinashe Dune, Peter Caputi, Beverly Walker.

Project administration: Tinashe Dune.

Resources: Tinashe Dune.

Supervision: Peter Caputi, Beverly Walker.

Validation: Peter Caputi, Beverly Walker.

Writing – original draft: Tinashe Dune.

Writing – review & editing: Tinashe Dune, Peter Caputi, Beverly Walker.

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Chapter 3: Qualitative Semi-Structured Laddering Interview

Chapter Overview

Chapter 3 presents the methods, findings, and recommendations from Phase 2 of this study. Phase 2 sought to produce robust data about practitioners' construing including practitioner superordinate constructs about Whiteness and non-White people. Phase 2 also explored how practitioners' construing translated into culturally competent practice and therapeutic alliance. Phase 2 therefore helped to answer the following research questions:

1) How do practitioners construe and construct non-White people?
    a. What characterises their construing and constructions?
    b. What role or impact does Whiteness have on their constructions?
    c. What impacts do their construing and constructions have on practitioner cultural competence?
    d. What impacts do their construing and constructions have on the therapeutic alliance?
2) In what ways can PCP help to identify and describe practitioners' constructs about or ways of construing non-White people?
4) What strategies do practitioners employ to support culturally competent ways of construing (and therefore engaging with) non-White people?

The findings from Phase 2 highlight how practitioners engage with construals of Whiteness and non-White people and how changes to their construing vary the impact of Whiteness on cultural competence and therapeutic alliance. Included in Chapter 3 are the second and third publications of the thesis:

Dune, T., Caputi, P., Walker, B. M., Olcon, K., MacPhail, C., Firdaus, R. & Thepsourinthone, J. (2021). Construing Non-White and White Clients: A Qualitative Inquiry of Mental Health Practitioners' Preferences and Superordinate Constructs related to Whiteness and Non-Whiteness in Australia. *Journal of Constructivist Psychology.* 1-21. https://doi.org/10.1080/10720537.2021.1916662

Dune, T., Caputi, P., Walker, B. M., Olcon, K., MacPhail, C., Firdaus, R. & Thepsourinthone, J. (2021). Australian Mental Health Practitioners' Construals of Non-White and White people: A Qualitative Inquiry with Implications for Practitioner Cultural Competence and the Therapeutic Alliance. *BMC Psychology*. *9*(85), 1-17. https://doi.org/10.1186/s40359-021-00579-6

To examine the impact of Whiteness on practitioner construct systems, cultural competence, and the therapeutic alliance, this phase explored practitioner constructions about and preference for Whiteness and non-Whiteness. Twenty White and non-White mental health practitioners and trainees providing psychology services were convenience-sampled and interviewed using an adapted version of the laddering interview technique (Hinkle, 1965). Data was analysed thematically and the impact of construals on practitioner cultural competence and the therapeutic alliance were interpreted drawing on PCP (Kelly, 1955).

The findings reiterate the persistent role of Whiteness on constructs of White and non-White people. Even so, practitioners' superordinate constructs demonstrated a focus on humanity, equity, and holistic wellbeing irrespective of the practitioners' pole preference. Practitioners demonstrated cultural competence in their acknowledgement of the impact of construals of ethnic, cultural, religious, social, racial, and linguistic variance on client

wellbeing. Mental health practitioners sought to address the negative impacts on clients as a result of the framework of Whiteness by drawing on the client-practitioner relationship to improve the therapeutic alliance. The results reinforce the need for mental health care workers to develop cultural competence with a focus on developing awareness of the impact of frameworks of Whiteness on the experiences of both non-White and White people. This is central to the development of a therapeutic alliance where patients feel understood and assured that their mental health concerns will not be constructed (and treated) through a framework that constrains both White and non-White people's opportunities for improved mental health and wellbeing.

Author Contributions

Author TD conceptualised the research with the supervision and guidance of authors PC, BW, KO and CM. Author RF engaged in the data collection and analysis process with author TD. Author TD drafted the manuscripts and received conceptual and editorial feedback from authors PC, KO and CM. Author JT assisted in the editorial review and presentation of the article for publication. Author TD attended to editorial reviews with feedback from authors PC, KO and CM.

Paper 2: Construing Non-White and White Clients: Mental Health Practitioners' Superordinate Constructs related to Whiteness and Non-Whiteness in Australia

Tinashe Dune, Peter Caputi, Beverly M. Walker, Katarzyna Olcon, Catherine MacPhail, Rubab Firdaus & Jack Thepsourinthone (2022) Construing Non-White and White Clients: Mental Health Practitioners' Superordinate Constructs Related to Whiteness and Non-Whiteness in Australia, Journal of Constructivist Psychology, 35:3, 1037-1057, DOI: 10.1080/10720537.2021.1916662

Paper 3: Australian Mental Health Practitioners' Construing of Non-White and White people: Implications for Cultural Competence and Therapeutic Alliance

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Australian mental health care practitioners' construing of non-White and White people: implications for cultural competence and therapeutic alliance

Tinashe Dune[1,2*], Peter Caputi[1], Beverly M. Walker[1], Katarzyna Olcon[3], Catherine MacPhail[3], Rubab Firdaus[2] and Jack Thepsourinthone[2]

Abstract

Background: The development of cultural competence is central to the therapeutic alliance with clients from diverse backgrounds. Given that the majority of Australia's population growth is due to migration, mental health practitioner construing of non-White and White people has a significant role and impact on client engagement.

Method: To examine the impact of mental health practitioner construing on their strategies for cultural competence and the therapeutic alliance, 20 White and non-White mental health practitioners and trainees providing mental health services were purposively sampled and interviewed face-to-face or via videoconferencing. Data was analysed thematically and the impact of construing on practitioner cultural competence and the therapeutic alliance were interpreted using Personal Construct Psychology.

Results: Practitioners demonstrated cultural competence in their acknowledgement of the impact of negative construing of ethnic, cultural, religious, social, racial and linguistic diversity on client wellbeing. Practitioners sought to address these negative impacts on clients by drawing on the client-practitioner relationship to improve the therapeutic alliance.

Conclusions: The results reinforce the need for mental health care workers to develop cultural competence with a focus on developing awareness of the impact of frameworks of Whiteness on the experiences of non-White people. This is central to the development of a therapeutic alliance where clients feel understood and assured that their mental health concerns will not be constructed (and treated) through a framework that constrains both White and non-White people's opportunities for improved mental health and wellbeing.

Keywords: Personal construct psychology, Mental health practitioner, Cultural competence, Therapeutic alliance, Whiteness, Non-White people, White people, Australia

Background

Australia's cultural, ethnic, religious and linguistic diversity has been changing rapidly, especially within the last 50 years [1]. Over 27% of Australians were born overseas and another 20% have at least one parent born overseas [1]. Further, Australia's Aboriginal and Torres Strait Islander groups are steadily increasing, from 2%

*Correspondence: t.dune@westernsydney.edu.au
[1] Faculty of Arts, Social Sciences and Humanities, School of Psychology, University of Wollongong, Wollongong, NSW, Australia
Full list of author information is available at the end of the article

in 1999 to 3.3% in 2016. With its commitment to resettle 20,000 refugees a year since 2012 [2], Australia is a rich and nuanced case study of a migrant-receiving country undergoing rapid change. It can therefore be assumed that with migration having increased significantly within the last decade, the number of non-White clients requiring mental health support has also increased. This diversity requires mental health care systems and practitioners to develop new skills to meet the needs of individuals and groups across cultural, linguistic, racial and ethnic backgrounds.

Mental health professions in Australia have typically been dominated by people from White backgrounds [3, 4]. For instance, the Department of Health [5] reported that out of 26 311 registered psychologists, 73.3% were born in Australia and 0.7% were of Aboriginal and Torres Strait Islander background. There is no clear data on the ethnicity of mental health practitioners beyond Indigeneity in Australia—giving the impression that, besides being Indigenous, the remainder of are White Australians. As such, the number of non-White mental health practitioners is not likely to be representative of the actual diversity in Australia's population. Much of this is because Australia's ethnocultural contemporary history of racial dichotomies and hierarchies presents challenges in which all people, and particularly those who are non-White, are subject to the constraints of what researchers refer to as 'Whiteness'.[1] Whiteness as social construction was first introduced by W.E.B. Du Bois in 1920 in his essay, *The Souls of White Folk* [7, 8] (p16) where he represents Whiteness as sense of supremacy and entitlement:

> *But what on earth is whiteness that one should so desire it? Then always, somehow, someway, I am given to understand that whiteness is the ownership of the earth, forever and ever, Amen!*

According to Fanon [9] (p128), Whiteness leads the White man to believe himself to be the "predestined master of the world", or as DiAngelo [10] (p56) recently explained: "Whiteness itself refers to the specific dimensions of racism that serve to elevate White people over people of color".

These descriptors of Whiteness clarify the nature of the racial dichotomies and hierarchies and, importantly, indicate who reaps benefits from Whiteness and those who do not. Frankenberg [11] defined Whiteness as "a location of structural advantage, of race privileges" and a "standpoint, a place from which White people look at ourselves, at others, and at society" (p. 1). Here then, non-White refers to individuals who are excluded from being beneficiaries of Whiteness as a result of their racial, ethnic, cultural, religious, linguistic, or national identities [12].

It is acknowledged that not all Whites experience the same privileges or to the same degrees, or that Whiteness has always looked the same, or that it lacks impermeable and flexible boundaries. It is further recognised that Whiteness (and the delineators for those who benefit, or are excluded, from it) is constantly under negotiation [13]. Even within this constant state of flux, the role of Whiteness and its consequences endure [14]. It is therefore important to consider and identify the impact of this construct on practitioner construing of non-White (and White) people in Australia.

Importantly, the negative health outcomes and experiences of non-Whites within (mental) health care settings are well documented and related to systems and practitioners that harbor constructions of health and wellbeing based on frameworks of Whiteness [15–18]. To circumvent negative outcomes, it is acknowledged that increasing (mental) health care practitioners' cultural competency is central to improving client health outcomes [19]. While not directly addressed by standard Australian cultural competence training, this paper posits that explicitly naming and critiquing Whiteness is necessary for practitioners to minimise and reconstruct negative ways of construing and engaging with non-White people within the health care system.

The role of cultural competence and its impact on the therapeutic alliance

In Australia, little is known regarding mental health workers' constructions about non-White people. Current understandings of their constructions are implied from the extensively documented negative health outcomes and experiences of minority populations across a range of health care settings (see for example [20]). In general, the core of these experiences are related to health systems and workers harbouring constructions of health and wellbeing based on Anglo-centric and racist frameworks [21]. Researchers and practitioners advocate for increased cultural competency [19] which comprises knowledge, conviction and capacity for action at an individual and organisational level in order to appropriately address the health needs of diverse populations [22]. Eisenbruch [23] also emphasises the skill-based notion of competence that encompasses the system (including health workers) to no less a degree than the clients. As such, cultural competency is defined as "a set of congruent behaviours,

[1] The capitalisation of the 'W' in White and non-White is one of contentious scholarly debate. A capital W is used in this paper in line with *The Diversity Style Guide* (2019) to acknowledge the racialisation and concomitant characterisation of ethnic, religious, cultural and linguistic affiliation in terms of proper nouns used to construct identities and not simply to inaccurately describe phenotypical traits.

Fig. 1 Components of culturally competent mental health care

attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" [24][2] (p7).

Building health care workers' abilities to become self-aware and to reflect on their constructions about others is an important aspect of cultural competency training [19]. According to Campinha-Bacote [26], health professionals, specifically those working in mental health care, need to consistently access training to develop capacity in cultural awareness, knowledge, skill, encounters, and desire.[3] See Fig. 1, which presents an adaption of De Beer and Chipps [27] cultural competence framework to specifically address the skills required of mental health care workers.

By internalising and enacting these components, cultural competence promotes the development and maintenance of a positive therapeutic alliance between practitioners and their clients [19]. Therapeutic alliance is broadly defined as "the collaborative and affective bond between therapist and patient … [and] is an essential element of the therapeutic process" [28] (p438). The therapeutic alliance is characterised by mutual and bi-directional partnerships between practitioners and clients that are dependent on a humanistic healthcare culture [29] and founded on a mutually nurtured psycho-socio-emotional connection [30]. With its origins in early psychoanalytic theories (e.g., [31]), the concept is now a staple of contemporary understandings and evaluations of the therapeutic process. It is well understood that the therapeutic alliance is related to clients' mental health engagement and outcomes [28]. As such, models of therapeutic alliance often include the following elements: Care, Accept, Respond and Empower (CARE), see for example Sharma and Sargent [32]. In line with the components of cultural competence discussed above and in response to Kirmayer ([25], see footnore 2), Fig. 2 presents a model of therapeutic alliance that was adapted by Escudero et al. [33] to include Safety—a central element for effective engagement with diverse clients.

Theoretical framework

Personal Construct Psychology (PCP) was developed by George Kelly [34] and is a psychological theory, research methodology and a framework for psychological practice. Originally developed in the 1950s, it has subsequently been extended by many theorists and practitioners [35]. PCP focuses on constructive alternativism; proposing that our experiences of the world, including our understanding of events and people (including ourselves) are open to a variety of interpretations. The particular focus of PCP on individuals as "proactive makers of meaning, as predictors as well as mediators of their psychological reality" [36] (p.39) is preferred over other constructivist approaches. Unlike other approaches (e.g., social constructivism or socioecological theory), PCP was designed to help practitioners understand individual psychology as well as the basis for clinical practice. Consequently, its postulates and principles align well with the concepts of cultural competence and the therapeutic alliance as

[2] It is acknowledged that these somewhat simplistic, skill-based and practitioner-focused constructions of cultural competence are limited in their recognition of the impact of racial dichotomies and hierarchies that result in the perpetuation of disadvantage and devaluation of non-White frameworks, perspectives or people.

[3] These constructs are explained in depth in Campinha-Bacote J. The process of cultural competence in the delivery of healthcare services: A model of care. Journal of Transcultural Nursing, 2002:13(3):181–184.

Fig. 2 CARES model of therapeutic alliance

settings in which practitioners and clients create meaning of one another and then act on their construing within the therapeutic setting. Within the aims of this study, understanding the process of construing is particularly important. Construing is defined as:

> *an active, ongoing process in which we each constantly try to give meaning to our world and to predict future events by operating rather like a scientist: making hypotheses, testing them out, and if necessary revising them on the basis of the evidence which we collect [37] (p4).*

Kelly has further explained that construing is bipolar (e.g., the construct of colour may include black vs white).

Individuals are able to hypothesise what may happen in any given situation through these constructs [34] and "then we test our predictions or anticipations through the behaviours we adopt, similar to scientists engaged in experimentations" [38] (p201). Ideally, in order for a construct to maintain its relevance or applicability, the predicted situation must be validated. Validation occurs when "we see whether any event falls smack on this imaginary point so as to fulfil all of its presupposed conditions" [34] (p86)—our anticipations. This is important to our engagement or avoidance of others given that "our processes—thoughts, feelings and behaviors—operate in a structured manner and are determined by our predictions of the future" [38] (p202).

Existing research reinforces the notion that individuals are in control of their construing and their ability to change their construing of the world towards positive outcomes (a key component of cultural competency and building an effective therapeutic alliance), as demonstrated in Kelly's theory. In that sense "the aim of [engaging with] personal constructs, put at its most pious, is liberation through understanding" [39] (p201). Using PCP will therefore contribute to a currently limited evidence-base on White and non-White practitioners' construing and the implications for mental health services in Australia. Given that improved cultural competence and therapeutic alliances depend on revising individual (and societal) constructions, a PCP approach was employed in the design, analysis, and interpretation of the study.

Significance of the current study

In Australia, there is a dearth of research investigating how mental health practitioners construe and respond to their construing of non-White and White clients. Our recent systematic review [15], which included 5,870 mental health practitioners, demonstrated that constructions about non-White people are intimately linked to workers' perceived ability to be culturally competent and supportive of an effective therapeutic alliance. The review highlighted that little is known about the impact of construing about non-White people on the strategies that practitioners employ. The review also revealed that training improved cultural competency for the majority of practitioners involved in such programs [40–42]. Across all mental health care professions there remained practitioners however, who rejected or resisted the premise of cultural competency training [19]. It is possible that it may not be cultural competency training itself that some practitioners take issue with, but instead the way in which it is taught and the relatively limited gains which they perceive can come from it. A better understanding of the strategies that Australian practitioners employ in light of their construing of non-White and White people is needed to develop responsive cultural competence training, including strategies for building the therapeutic alliance.

Without research on Australian mental health care practitioners, the bulk of existing research focuses on a nation with a longer history of multiculturalism, viz.

the United States [15]. Discussions about race and ethnic dynamics have been taking place in the United States for over 500 years, compared to Australia whose national engagement in such debates is relatively recent (about 150 years) [12, 15, 21, 43, 44]. As such, missing from Australian discourses is a clearer understanding of how mental health care practitioners respond to their own and societal construing of non-White clients within a sociocultural context of Whiteness and what this means for practitioner engagement in culturally competent practice and their ability to effectively support a therapeutic alliance with non-White clients. Given this research gap, the current paper presents findings on the ways in which mental health care practitioners who provide counselling services (fully registered and trainee practitioners) perceive:

1. The impact of their construing of non-White and White people, and Whiteness and non-Whiteness, on Non-White people.
2. The strategies used by practitioners to engage and support clients (non-White and White) while working in the context of their construing and in the context of Whiteness.

Research context

A qualitative exploratory approach was utilised to explore the role of practitioner construing in cultural competence and the therapeutic alliance. This qualitative study is part of a larger body of work using a sequential mixed methods design. This larger study commenced with an international systematic literature review (see [15] discussed above) which helped to identify research gaps and informed the foci and questions for the qualitative portion of the study. The findings from the qualitative research have informed the final quantitative portion of the project which used validated survey measures as well as open-ended questions on cultural competence and the therapeutic alliance to assess the potential relationships between the variables identified in the qualitative research with a broader sample of Australian mental health care providers (forthcoming).

Method

The current paper reports on part of the findings from a qualitative semi-structured interview which was adapted from laddering interview techniques to explore participant construing, superordinate constructs, and strategies to engage and support non-White and White clients [45]. Interviews ranged from 45 to 90 min with the average time being 60 min. Interviews were conducted in the practitioner's office space or other preferred space (e.g., private room at a university campus or via videoconference). The interviews were audio-recorded and professionally transcribed verbatim. Fourteen interviews were conducted by the first author, TD, a Black Afro-Canadian-Australian. The remaining six were conducted by RF, an Indian permanent resident in Australia. Ethics approval was granted by the university's Human Ethics Research Committee.

Interview protocol

In the initial stages of the interview, participants were asked to define two construct poles (e.g., White people and non-White people) and then to select one of those two construct poles (see Table 1). Each participants' preferred pole was then "laddered", based on work by Hinkle [46]. This was achieved by continually questioning "why?" after each answer until the participant was no longer able to answer in-depth or with originality. Continuing with this process allows for determining a statement of the values underlying the participant's construing. It is these identified values that are less likely to be changeable than more subordinate constructs and may have wide ranging implications. For instance, 'deserving of respect' may be a subordinate construct to 'equality' the more superordinate construct. This laddering process was conducted for three additional ladders on the following constructs: non-Whiteness and Whiteness; how non-White and White people are portrayed; and how non-White and White people are treated (see Table 1).

Practitioner cultural competence was explored throughout the interview by asking participants, where appropriate, about the perceived impact of their construing on engaging with non-White and White clients. These questions served as a gauge of practitioner cultural competence in line with the Campinha-Bacote [26] components of cultural competence discussed in the Introduction. Participants were also asked about the strategies they use to engage clients to support therapeutic outcomes amidst their own and social constructions of non-White and White people. This served as a means for exploring practitioners' engagement with the therapeutic alliance in line with the CARES model described in the Introduction. The findings reflecting practitioners' construing and pole preferences are discussed elsewhere.[4] The data on practitioner perceptions of being interviewed by a non-White person will also be discussed in a further separate paper.

[4] Dune, T., Caputi, P., Walker, B.M., Firdaus, R., Olcon, K., MacPhail, C. & Thepsourinthone, J. (in press). Construing Non-White and White Clients: Mental Health Practitioners' Superordinate Constructs related to Whiteness and Non-Whiteness in Australia. *Journal of Constructivist Psychology*.

Table 1 Semi-structured interview protocol

Interview questions
1. How would you define "non-White" people?
2. How would you define "White" people?
3. Which definition do you prefer?
4. Why do you prefer the definition you have chosen? (Continue asking "why" questions following the participant's response until no new responses emerge)
5. Have you ever heard of the term "Whiteness"?
6. What do you think it means?
7. With that in mind, how might you define non-Whiteness?
8. Which definition do you prefer?
9. Why do you prefer the definition you have chosen? (Continue asking "why" questions following the participant's response until no new responses emerge)
10. How would you say non-White people are portrayed in Australia?
11. How would you say White people are portrayed in Australia?
12. Which portrayal do you prefer?
13. Why is that? (Continue asking "why" questions following the participant's response until no new responses emerge)
14. How would you say non-White people are treated in Australia?
15. How would you say White people are treated in Australia?
16. Which treatment do you prefer?
17. Why is that? (Continue asking "why" questions following the participant's response until no new responses emerge)

*Where appropriate, ask the participant what impact their construing have on engaging with non-White and White clients

**Where appropriate, ask the participant what strategies they use to engage with non-White and White clients to support therapeutic outcomes

At the end of the interview, all participants were asked about their experience being interviewed by a non-White person and how this might have influenced their responses or response style

Recruitment and sample

Participants were purposively sampled from a regional university and two metropolitan mental health services through the researchers' existing networks. The sample, included five each of White practitioners, non-White practitioners, White psychology trainees, and non-White psychology trainees, across a range of other demographic variables [47] Including 10 White, 10 non-White as well as 10 trainees and 10 practitioners ensured opportunities for varied perspectives across racial and experience groups but also data saturation within each group [47]. Purposive sampling also ensured that the sample was diverse and helped to exclude participants who did not engage in clinical mental health care with clients. Participants self-reported a range of clinical employment settings, including public, private, or mixed, their level of experience in terms of both time in practice and engagement with non-White clients, sex, age group, and where they conducted training and practice. Both mental health care trainees and practitioners were included to explore perspectives across diverse levels of experience and training. Participants self-reported on their ethnicity and whether they perceived themselves to be White or non-White. Participant demographics are summarised in Table 2.

Data analysis and interpretation

Data analysis and interpretation of the interviews included the following steps. In the first step, data underwent conceptual analysis [48] by authors TD and RF in line with the conceptual structures of cultural competence and therapeutic alliance as described in the Introduction. Bender [49] (p82) explains that "conceptual structures are a way of representing knowledge. They can be used to capture knowledge as humans understand it. A conceptual model provides a working strategy, a scheme containing general, major concepts and their interrelations". Accordingly, conceptual analysis of the interviews included distinguishing terms, identifying the constructs they referred to, and representing these in line with the aforementioned conceptual structures, thus allowing us to make sense of the findings [48]. Myburgh and Tammaro [48] note that conceptual analysis:

> *is not simply used to discern a set of definitions that are appropriate for the field, but rather the concepts that such definitions might express. The focus is, therefore, of discovering the narratives that are operationalised in this discourse, which is not detectable through the atomising analysis of selected words and phrases, but in those whole-text "explanations" or "procedures" through which pro-*

Table 2 Participant demographics

Demographics	Non-White mental health trainees (n = 5)	White mental health trainees (n = 5)	Non-White mental health practitioners (n = 5)	White mental health practitioners (n = 5)
Sex				
Female	2	4	4	4
Male	3	1	1	1
Ethnicity	Aboriginal Australian (n = 1)	Anglo-Australian (n = 4)	Aboriginal Australian (n = 1)	Anglo-Australian (n = 5)
	Asian (n = 3)	Serbian (n = 1)	Indonesian (n = 1)	British (n = 1)
	Turkish-Muslim (n = 1)		Italian (n = 1)	
			Fijian-Indian-Muslim (n = 1)	
			Zimbabwean (n = 1)	
Languages other than English	Arabic (n = 1)	Serbian (n = 1)	Italian (n = 1)	N/A
	Cantonese (n = 1)		Hindi (n = 1)	
	Mandarin (n = 1)		Shona (n = 1)	
	Teo-Chew (Chinese) (n = 1)			
Age range	19–39 years	20–25 years	33–44 years	28–46 years
Highest level of education	Bachelors (n = 3)	Bachelors (n = 5)	Postgraduate (n = 2)	Postgraduate (n = 5)
	Some tertiary education (n = 1)		Bachelors (n = 3)	
	High school certificate (n = 1)			
Year highest level of education obtained (range)	2005–2019	2014–2016	2007–2016	1998–2016
Country highest level of education obtained	Australia	Australia	Australia	Australia
Citizenship/visa status				
Australian citizen	4	5	5	5
Student visa	1	0	0	0
Role at the time of interview	Psychology intern (n = 4)	Psychology intern (n = 4)	General psychologist (n = 2)	Clinical psychologist (n = 1)
	Youth worker (n = 1)	Youth worker (n = 1)	Health promotion officer (n = 1)	General psychologist (n = 3)
			Social worker (n = 2)	Practice manager (n = 1)
Years practicing psychology (range)	0–1 years	0–1 years	1–14 years	1–21 years
Service type				
Public practice	4	1	5	5
Private practice	1	0	0	3*
No. of non-white clients seen per week (range)	0–6	4–9	1–10 +	4–10 +
Psychology training prepared participant to provide culturally competent services for non-White clients				
Yes	1	3	1	1
No	3	1	4	3
Neutral	1	1	0	1
No. of cultural competence-related professional development since participants last qualification (range)	0	0	7–10 +	0–3

*Three of the White practitioners who worked in the public sector also worked in private practice

fessionals run their daily practice.

To support this process, *Quirkos,* a visually intuitive data management software that assists researchers in the coding and analysis of qualitative data [50], was used to organise the participants narratives in line with the constructs explored in this study [51].

In the second step, a lens of PCP processes of transition was used to interpret the results of the above conceptual analysis. According to Kelly [34], "processes" refer to the

conglomeration and interaction between our thoughts, feelings, experiences, and behaviours, all of which are determined, not only by society but, also by our efforts to anticipate the world, other people, and ourselves in the moment, in the short-term, and in the long-term. The processes of transition include a Creativity Cycle, Experience Cycle and Decision-making Cycle,[5] all of which overlap and interrelate in ways that help or hinder us from making sense of the world and how then to react to it, ourselves, and others [34]. Kelly proposes that "the Creativity Cycle is one which starts with loosened construction and terminates with tightened and validated construction" [34] (p7). He further explains that:

> *loosened construction ... sets the stage for creative thinking .... The loosening releases facts, long taken as self-evident, from their conceptual moorings. Once so freed, they may be seen in new aspects hitherto unsuspected, and the creative cycle may get underway [34] (p330).*

The Experience Cycle, consists of five phases: anticipation, investment, encounter, confirmation or disconfirmation, and constructive revision. Finally, the Decision Making Cycle, consists of first circumspection, pre-emption, and control. These overlapping, cyclical, and parallel cycles can make it hard for even the most culturally proficient person to holistically and continuously dismantle, reorganise, and reconstrue constructs, constructions and construing of themselves and others.

These dynamic processes link conceptual analysis to transition given that "concepts correspond to ideas, and are conditional and provisional, rather than fixed: they are not neutral, as they correspond to and are motivated by paradigms and ideologies" [52] (p70). While conceptual analysis helped to identify processes, as articulated by the participants, in line with the conceptual structures of cultural competence and therapeutic alliance, interpreting these through Kelly's processes of transition helped to make sense of participants' thoughts, feelings, experiences, and behaviours in relation to working with non-White clients. This framework for analysis and interpretation helped the authors to reflect on the impact of practitioner construing, as well as the strategies used to support cultural competence and the therapeutic alliance. This process also assisted in the development of recommendations for research, teaching, and practice, which are presented in the Discussion section.

[5] While outside of the scope of this paper, full descriptions of these three cycles in the process of construing are described in Kelly G. The psychology of personal constructs. New York: W. W. Norton & Company; 1955.

Results

Conceptual analysis of participant responses helped to identify narratives that reflected components of the Campinha-Bacote [26] cultural competence conceptual model and elements of the CARES therapeutic alliance conceptual model. Quotes that were most representative of participant narratives were used to illustrate where practitioners' perspectives and experiences aligned (or not) with the components and elements within the aforementioned conceptual models. The impacts of practitioner construing of Whiteness on cultural competence are presented within *Enacting Cultural Competence in the Context of Whiteness* and practitioner strategies to improve the therapeutic alliance are presented within *Knowing Me, Knowing You...Despite Whiteness*.

Enacting cultural competence in the context of Whiteness

As noted in the introduction, central components of cultural competence to be addressed within the context of Whiteness are cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (see Fig. 1 in the Introduction). Representative participant quotes are included to highlight the role of each component in their re/construing.

Cultural awareness

An integral starting point is the ability for health care providers to be aware of and understand the impact of their construing, and subsequent behaviours, on their clients. Several practitioners demonstrated cultural awareness in their analysis of terms like "culturally and linguistically diverse" and its limitations. For example, an Anglo practitioner stated:

> *Why do we say culturally linguistically diverse? It is, apparently, more culturally sensitive. It's not as branding. We're not defining someone by the colour of their skin ... I think it's exactly what we're doing ... It's like a circular term, to say the same thing without saying that thing. Why don't we want to say it? Why don't we want to say non-White? There are connotations of power imbalance.*

This practitioner views these terms as meaningless and highlights that they are likely to perpetuate ignorance about the impact of Whiteness and the practitioners' role in erasing race by being afraid to name it. While it may be easier to identify who one is not (e.g., 'the Other'), identifying oneself as White and identifying the implications of that Whiteness are needed for White practitioners to develop cultural awareness. Another Anglo practitioner explained:

> *It means that our language, our power structures,*

our social hierarchies have been formed on the basis of being White, again, there's that real historical impact in terms of colonisation ...With that history, that's what we've built on and so that's what we exist with today, here.

This practitioner highlights the importance of having information about the past to better engage in cultural competence. As such, the ability to recognise the power structures and roots of Whiteness and to then articulate its impact on non-White people requires practitioners to have a adequate levels of historical and cultural knowledge.

Cultural knowledge

The majority of non-White and White practitioners (70% of all participants) felt that their cultural knowledge was inadequate. Perhaps due to a lack of adequate cultural competence training, White practitioners' failure, or resistance, to ask questions about diversity were perceived by non-White practitioners as barriers to White practitioners' engagement with clients. For instance, the Aboriginal practitioner who ran cultural competence training noted the conundrum faced by White professionals who may resist asking questions:

I used to do cultural training and stuff like that, there was no right or wrong questions. If you don't ask the questions you are not going to grow as a professional, as a White professional, you are going to constantly have these barriers between you and Aboriginal culture. Ask it, it's not offensive; it's more offensive when you don't ask because we know when you're not asking.

For this practitioner, it was important for others to confront Whiteness and its impacts by engaging in difficult or uncomfortable discussions or asking seemingly silly questions. However, being able to do so requires practitioners to both have and seek opportunities to develop cultural skill.

Cultural skill

Cultural skill is concomitant with mental health practice skills, with both ensuring accurate assessment, diagnosis, and intervention within a client-centred framework. An Anglo trainee describes the development of both cultural and psychological skills to ensure a nuanced assessment of an older Aboriginal man:

One of them was for an assessment, so learning assessment for an Aboriginal man, and untangling, the complication was untangling for dyslexia assessment ... He was old and lived through the Stolen generation, so trying to entangle what would be dyslexia, what would be a psychological disorder, what's pathological, what's gone wrong versus what was systematic kind of racism; what's happening at a society and it would be understandable with this reading and you know and kind of there wasn't a guide book for that.

This trainee continued to expound on their pursuit of opportunities for repeated construing and reconstruing, through a range of pathways including supervision and additional research. This process demonstrates the importance of analysing the needs of the client within a historical context of racial oppression. Without this approach, the trainee may have reproduced the oppressive practices of Whiteness by pathologising the client's symptoms.

Cultural encounters

The development of cultural competence requires practitioners to directly engage with people different from themselves and to actively seek opportunities to learn from diverse people. Practitioners indicated that the more cultural encounters they had, the less comfortable they felt with stereotyping others. This was not limited to White identifying practitioners and trainees. A Muslim Turkish trainee explained:

I don't like to generalise a lot ... I just can't, because then you meet somebody and you're so surprised about their knowledge, you're so mind blown you're like "I should never be stereotyping" and I've had that happen to me quite a few times when I get so caught up in my judgements so to speak and my stereotyping and it just slaps me in the face going no, don't do that. So I'm just so hesitant to do that nowadays ... let them present themselves before I make a judgement.

As noted by this trainee, reconstruing one's perceptions and understandings of clients requires practitioners to consciously critique their own construing and reconstrue their role in the therapeutic setting. This is not always easy and therefore requires that the practitioner have cultural desire to engage in this often uncomfortable and confronting process.

Cultural desire

Learning from cultural encounters and engaging with cultural difference and the potential for discomfort requires practitioners to desire the challenge and the benefits of working towards cultural competence. The African practitioner used the following analogies to describe her desire to be culturally competent:

For me I can think of it in the sense of I want to have

done something significant in my career ... I want to live to my full potential, but I feel like to live to your full potential doesn't have to be just in terms of career things, so even if it's mothering that you raise your child well, you raise them to be good citizens, you raise them to be, you know, honest, decent people. If it's friendship that you become the best friend that you can. It's just doing the best that you can in any of the roles that you embody ... like philosophers would say it's always a project, always in the making.

These analogies highlight that cultural desire comes from a craving to understand and to construe differently such that one's view of the system is challenged and revised. In doing so changes in construing then manifest into action and changes in behaviour. One Anglo practitioner explained:

I like this [engaging in the interview about Whiteness], because you learn a lot and, to be honest, I think there's so much of this that needs to be brought into these discussions .... I just find it intriguing. I enjoy meeting and connecting with other people, that's a reason why I do the job. That's the big picture and I just try and understand different ways of people seeing the world. A different way they do the things, from my own and from the current thing and just learn a bit about it.

With a broadened world-view, that goes beyond Whiteness as the privileged default, practitioners can develop a robust therapeutic alliance with non-White clients. This allows practitioners to considers the client as a part of a larger system that influences their experiences, perceptions, and, therefore, their mental health. An Asian trainee explained:

Considering and then thinking beyond Whiteness allows me to gain a better understanding and appreciation of the culture and the systems here, so the education system, the legal system, how everything works and runs here so I don't—I'm not disrespecting anyone or clashing, having a clash of ideologies and values, because I feel like if you can understand how things work or understand how someone behaves or thinks then that's where you can be more respectful. Because normally acts of disrespect come when you don't understand or don't have a knowledge of their culture or their person, so I feel like it's important for me to understand so I can prepare in advance in a sense.

This desire to engage with systemic and broadened perspectives allows for the development of a therapeutic alliance that is safe and respectful. In such a space clients and practitioners can develop competencies in construing and re-construing themselves, each other, and the world in ways that improve (mental) health and wellbeing outcomes.

Knowing me, knowing you...despite Whiteness

Therapeutic alliance is reliant on the client and the practitioner acting as partners in the therapeutic process. However, mutual partnership cannot be achieved if the practitioner fails to understand individual non-White clients as products (and potentially agents) within a system—in this case a White system. The CARES model (see Fig. 2 in the Introduction) for therapeutic alliance seeks to guide practitioners towards this goal. Despite the impact of Whiteness, participants described how they were able to *Connect, Accept, Respond, Empower,* and ensure *Safety* with their non-White clients.

Connect

A foundational element of therapeutic alliance is the practitioner's ability to develop a connection with the client that demonstrates respect instead of judgement or stereotyping. An Anglo practitioner described their strategy to connect with non-White people in the following way:

I'm thinking about [non-White] friends and just may be opening a bit of dialogue. It's often not a topic of conversation. I guess the more you look, the more you know or if there is gaps you're looking and talking at it. Asking more about, you know, how we can connect in a deeper level with [the] other and how we can share those things. There may be times when they [non-White people] need something different from me.

Seeking deep connections with different others ensures that practitioners can develop more meaningful alliances with their non-White clients and encourages construing revisions within the client and the practitioner. An Italian practitioner explained how this kind of connection improves future individual and community health and wellbeing outcomes:

If we commit to really knowing ourselves and others we will have a better society, again, we'll have more happy, compassionate people that I think will be able to give more to themselves, to give more to their families, give more to their friends. But, more importantly give more to children who are our future.

This long-term and communal sense of health and wellbeing requires an acknowledgement of the limits to our knowledge and perceptions to fuel the desire for

connection with diverse people and contexts. However, this kind of openness to connection requires acceptance of uncertainty and being comfortable engaging with the unknown.

Accept

Mental health practitioners are trained to thrive within the unknown, such that they continue hypothesising (construing and reconstruing) about their client throughout their entire relationship. Such training ensures that practitioners are able to accept a client's worldview and experiences and to actively seek to understand how these impact on the client's health and wellbeing. An African practitioner describes how manifesting such acceptance can support the therapeutic alliance:

> *[working with diverse clients] it's important because otherwise—because it gets me to accept that there are things that are beyond my control that will have huge implications for my life. That in fact a lot of the things that happen in my life are beyond my control. The only thing that is certain that I have control over is how I react to things or how I feel about things. It's important to be comfortable with uncertainty, to live with uncertainty because it is going to happen now and again in the future .... I have to be able to learn with those things because they are beyond my control.*

The African practitioner reflects on learning about acceptance through the therapeutic alliance, as a means to help them to develop increased self-awareness and knowledge about the impact of social systems on herself and her client. This type of acceptance creates a mutual space in which the power of the practitioner and client become more balanced, with the client teaching the practitioner and the practitioner developing their capacity to appropriately respond to that individual client within the context of the system.

Respond

Responding to working with different others can be challenging when the practitioners' value system is at odds with that of their client. Non-White practitioners seemed to experience this more intensely, or more consciously, given that they have always had to navigate the consequences of being non-White in a White world. When working with White clients they have had to recalibrate their "cultural compass" in order to respond in ways that recognise that White people are also imbued in a White system that also has significant impacts for them too. An Aboriginal practitioner reflected:

> *I suppose White people also have languages, religions, practices and traditions and I suppose their value system and their morals are formed by this cultural compass that you're constantly carrying around with you all the time. It's like a lens that you see the world in.*
> *Interviewer: Cultural compass, I like that. So it's the way they see life, engage in life?*
> *Aboriginal practitioner: Yeah. And people, like relationships, make decisions, experience the world and experience other people, particularly in psychology the way that you formulate someone, just a simple case formulation, your interpretation of a theory, your interpretation of a technique and an intervention.*

This practitioner references "relationship" as a central point through which people "make decisions" and "experience the world and other people". This is central to construing and the therapeutic alliance as a place for reconstruction and action. Notably, the practitioner acknowledges that the "way you formulate someone" and "your interpretation" are in response to one's cultural compass. Being aware of this cultural compass and its role in case formulation and "interpretation of a technique and an intervention" is central to responding to clients in their context—in this case, the context of being non-White, working with a White person, and amidst a socio-cultural context of hierarchical Whiteness. The Italian practitioner explained the impact of this context on their response to disadvantage:

> *I think if you are poor and White you have it really tough. But, if you are White with money, then again you've got more opportunities, better access. Yes. So, I think if you're poor and White then you fall into this multicultural kind of community. You kind of like move over because you're getting maybe the same services and accessibly as what non-Whites would be getting. You have to adapt for that, right? Like, we can't just say 'yeah forget about what is missing and sort it yourself because they are White.' There is more to consider, more to do.*

The dynamism presented in the above quote requires the practitioner to "adapt" and therefore respond in ways that acknowledge diversity in client experiences in the context of Whiteness. Such adaptation requires that both parties, especially the client, feels empowered to be an agent in that process and not just an object, as Whiteness would often relegate them.

Empower

Empowerment within the therapeutic alliance requires genuine collaboration focused on client strengths,

abilities, capacity, and potential toward the fulfilment of therapeutic goals. Practitioners supported empowerment of non-White clients by drawing on various sources and, most importantly, the client themselves. The White British practitioner explains how she takes an empowering approach to their work with non-White clients:

> *I would take it [culture] into account when I'm designing a treatment plan rather than making assumptions that, this has evidence so therefore it will be successful for my entire client base – CBT – No! For example, so in my individual interactions I'm getting to know people and their cultural context then I can, ask them at their level to individualise I can seek information from research based on country of origin or culture of origin or particular language or religious practices and then show them you know 'this is what I'm planning I know you don't necessarily have an understanding about psychology in general but you do have an understanding of you so how does this sound?' I do this anyway but open up discussion I'm going you know please give me feedback I'm open to feedback. I welcome complaints and feedback; I welcome you bringing a family member; I welcome you contacting us outside the session if you need something other than what you're getting.*

By centring culture and feedback, this practitioner's strategy to empower supports the client's ability to be an agent within the therapeutic setting and to define the model of mental health care that works best for them. Importantly, the client is drawn into the practitioner's learning process and is provided with opportunities to correct the practitioner if they are misunderstanding the cultural context and/or developing strategies that are not aligned with the clients' values or perspectives. In this way, the therapeutic alliance can become a safe place for mental health improvements aligned with the client's goals.

Safety

The development of interventions that deviate from a one-size-fits-all approach supports the therapeutic alliance and setting as a safe space where clients do not have to act White in order to have their needs met. The ability to be oneself within the therapeutic setting encourages the practitioner and the client to consistently transition their construing in ways that promote wellbeing and progress—both clinically and systemically. An Anglo practitioner describes this process with an Asian client with social anxiety:

> *Interviewer: Similarly, what does your role, as a White person, perhaps interacting with a non-White person, what does that do in the room? What happens to the therapeutic alliance in that sense?*
> *Anglo practitioner: I have been conscious of it, some of the different clients that I have .... She's a young Cambodian girl with social anxiety and she was talking the other day about being the only Asian on the field. She's playing sport and how difficult it is as the only Asian on the field. She's saying she just doesn't like communicating with White people at all, because it's difficult ... This girl has so many communication difficulties, but in part of my thinking, and because I'm White, I've thought, you know what, I should keep her [as a client] because I think this will help her build relationships outside of what she is comfortable with.*
> *Interviewer: Relationships with White people?*
> *Anglo practitioner: Yes.*
> *Interviewer: That in itself is therapeutic*
> *Anglo practitioner: That's informed some of my thinking ... creating a safe place for her to develop her communication skills.*

For most non-White people, communicating about the frustrations caused by Whiteness with a White person is, at best, a nerve-racking experience. Such an experience could easily be panic-inducing for a non-White person with social anxiety. However, the fact that such a discussion could happen with this practitioner indicates that the therapeutic alliance was strong enough to allow the client to be an agent and communicate about her discomforts in a safe setting. Here, the practitioner used the relationship as a therapeutic tool—supporting both the objective and outcome of a strong therapeutic alliance. As explained by an Aboriginal trainee, a robust therapeutic alliance cannot be faked or fabricated. Such true alliance with a client is one where the client and practitioner feel safe enough to be open, vulnerable, and open with each other in ways that breed empathy and understanding in the same way that reciprocal and mutual love cannot be faked:

> *Aboriginal trainee: If you disagree then disagree but stick by it so that you know who you are and you are authentic to that, because if you are not authentic to yourself and your beliefs and stuff how can you be authentic to ours, or empathic, at least empathic to ours.*
> *Interviewer: Right. So based on that you can't fake it. It's not possible then?*
> *Aboriginal trainee: I don't think you can. Like in a relationship with someone, we talked about therapy alliance you can't fake loving someone, so you can't fake having a therapeutic alliance on a cultural level, you can't fake it.*

Discussion

The current study presents the findings from interviews with White and non-White mental health practitioners and trainees providing psychology services. The study explored how clinicians construed: (1) the impact of constructions of non-White and White people and Whiteness and non-Whiteness on Non-White people, and (2) the strategies used by practitioners to engage and support clients (non-White and White) while working in the context of Whiteness. These inquiries were used to qualitatively examine the role of practitioner construing in cultural competence and the therapeutic alliance.

No major differences were found in terms of sex, age, areas of practice or education. However, non-White and White practitioners as well as Non-White trainees produced more strategies for cultural competence and therapeutic alliance than did White trainees. This is likely because non-White practitioners and trainees may already have the fundamental background knowledge required to be culturally competent which practice only amplifies. This is corroborated by other research [40–42] in which non-White trainee cultural competency scores start off higher than White practitioners and then level out post training. As found by Bitney [20], it is likely that White practitioners also produced more strategies than their trainee counterparts as a result of their experience working with non-White people, given that cultural encounters are a core element towards developing cultural competency [26].

Notably, only one White practitioner (a British self-identified expatriate) and all non-White practitioners had engaged in further cultural competence training outside of their formal education. In an American study on social workers' perceived cultural competence near equal proportions of African American and Anglo-American participants had attended between one and three cultural competence continuing professional development courses since their formative qualification [53, 54]. The findings from the current study may therefore be unique to the Australian context where pressure to engage with cultural competence is relatively recent. Further it may speak to the fact that, in the balance of priorities, continued engagement in the challenging task of cultural competence is not high on the list for mental health practitioners' continuing professional development. Our current quantitative research with a broader Australian cohort assesses the generalizability of this assertion.

Making sense of practitioner construing

Campinha-Bacote [26] notes that the process of continuously developing cultural competence requires practitioners to demonstrate cultural desire. This desire was characterised by practitioners' ability to consistently seek out, engage in, and to tolerate the disintegration and transitioning of their cultural constructs—central aspects of Kelly's Process of Transition. The findings of this study demonstrate that practitioners were consistently engaged in the Creativity Cycle as they expressed being in a relatively constant state of constructive openness, despite the pervasive constraints of Whiteness that bear down on us all. Despite this, it is acknowledged and well documented that the development of, and continuous engagement in, cultural competence is challenging given the requirement to confront and change one's construct systems to align with the needs of the client [13, 18, 55–58]. Participants demonstrated the Experience Cycle by drawing on cultural competencies like skill, knowledge, and, especially, encounters to challenge themselves to reconstrue, revise, and redevelop the strategies they used to develop and support the therapeutic alliance with non-White clients. In this study, practitioners demonstrated the utility of the Decision Making Cycle by actively seeking out opportunities for cultural awareness that assisted them in working collaboratively with non-White clients to develop and then use the therapeutic alliance as a tool to support the client in taking an empowered and more agentic role in their wellbeing. This is, of course, a challenge given that society and the health systems therein are constructed to align with biomedical models based on Eurocentric ways of knowing and behaving. In the absence of a society and systems that adapt at the same speed as diversity occurs, practitioners are tasked with finding common ground with their clients.

This common ground is the therapeutic alliance which is characterised by mutual partnerships between practitioners and clients, dependent on a humanistic healthcare culture [29]. This is not to say that practitioners should be blind to difference and treat everyone the same—a position widely contested by scholars, researchers and practitioners alike [13, 58, 59]. Strategies used by practitioners in this study provided real-life examples of each element within the CARES model and offered both the client and the practitioner a space where difference and the re/construing of oneself and others could be explored within the safety of an interpersonal interaction occurring at a discrete point in time. Thinking about the process of cultural competence in this way can potentially alleviate many mental health care practitioners' resistance to cultural competence training and construing transitions [60]. With cultural desire as motivation; when done repeatedly; and with a variety of clients, cultural competence increases and more impactful therapeutic relationships can be established. This is a reward for both the client and the practitioner for whom improved mental

health outcomes are the goal and to which the therapeutic alliance is positively correlated [59].

Implications for theory, research, teaching, and practice

It is acknowledged that Kelly's Personal Construct Psychology was based on his work with White people for working with White people and within the framework of Whiteness. Despite its Anglocentrism, the relevance of his theory has been tested and utilised in a diverse range of non-White and marginalised population settings [38, 61–64]. Importantly, it offers a way for practitioners, who are trained to focus and "work on" the individual, a framework to expand their understanding of the systems and influences in which psychological practice occurs for the client and the practitioner. While other systems theories provide a robust understanding of various levels of influence on individuals, they do not provide an operational framework from which practitioners can develop practical processes to support the development of cultural competence and the therapeutic alliance. This study confirms the utility of PCP as an effective means of understanding and contextualising the challenges practitioners may experience when working with non-White people and their potential resistance to developing cultural competence and culture-informed therapeutic alliances as a result of Whiteness and its rigidity.

Further research is therefore needed into the impact of practitioner construing of diverse populations on culturally competent practice to help mental health care practitioners and systems better respond to the needs of diverse populations with the development of cultural awareness, knowledge, and skills in mind. To better understand why this might be, a scoping review exploring the contents of cultural competence training might be an appropriate starting point. Further, perspectives from psychology educators and students can be sought to determine what works and what does not within an Australian context. This would help to identify gaps in content with the goal of developing a best practice model for training and assessment.

Based on the findings of this study, a key element of training should include an acknowledgement of the role of practitioner construct systems and processes of construing that result in resistance to training and construing transition. This should be done initially and regularly across psychology training programs. The Australian Psychological Society [65] acknowledges this gap on their website stating that "one of the challenges for the future will be working towards embedding relevant cultural awareness and curriculum content across 40 higher education providers". Addressing this gap may improve cultural desire and circumvent restrictions in learning, development, and client health outcomes as a result of psychological resistance [66].

This study therefore reiterates the role of the therapeutic alliance as a prime setting for practitioners to deconstruct and reconstruct their construing about "others" and the frameworks through which construing are made. Such a process supports the development of a therapeutic alliance where clients feel understood and assured that their mental health concerns will not primarily be constructed (and treated) through Whiteness—a framework that constrains both White and non-White people's opportunities for improved mental health and wellbeing.

Limitations

A few limitations should be recognised in interpreting the study results. First, generalisability of findings is limited given the small sample size and the ability within this sample to account for diversity. The qualitative sampling methods are, however, appropriate for exploring the unique and rich perspectives required to fulfil the aims of the study and fulfil the imperative in qualitative research for trustworthiness [67]. Second, despite their vast diversity, the locations (Illawarra Region and South West Sydney of New South Wales) from which participants were recruited may not reflect the experiences of other practitioners across Australia. To expand the representativeness of this exploration, the authors are currently conducting further research using validated quantitative methods to investigate practitioners' construing, perceived cultural competence, and role of the therapeutic alliance across diverse practitioner and client populations. Finally, while the adapted laddering interview technique helped to elucidate practitioners' constructs and construing, the forced construct of non-White and White, and Whiteness and non-Whiteness, does restrict the participants' opportunities to delineate and define what these concepts mean and how, if at all, they are related to one another. Further investigations could use different interview techniques to assess the trustworthiness of the findings from this study.

Conclusion

In this study, 20 White and non-White mental health practitioners and trainees providing psychology services were purposively sampled and interviewed using a semi-structured interview that drew on the laddering technique. This study aimed to provide evidence to advance Australia's capacity to holistically support its increasingly multicultural population through genuine acceptance, and integration, of diversity. Using Personal Construct Psychology to interpret the findings in relation to processes of transition helped to explain the development of practitioners' cultural competence. It

also helped to understand the quandary of the resistance faced by practitioners to cultural competence training and their concomitant cultural desire which allowed them to acknowledge the impact of Whiteness on (non)White clients. Personal Construct Psychology highlights the need for practitioners to, not only tolerate but, desire and, therefore, seek out opportunities to consistently loosen and reconstruct their construing about themselves and others. While the classroom is often considered the place for the development of cultural competence, the authors suggest that the associated skills are best honed within the safety of the therapeutic alliance.

Interactions with clients become opportunities for the development of the therapeutic alliance, but also a space where both the practitioner and the client can safely loosen their construing of one another. The benefit, for both parties, is the opportunity to deliver and engage in treatment with full recognition of the impact of Whiteness but without having to be bound by it. The relationship can be the site for and source of reconstruing of the other. This is in line with Personal Construct Psychology, specifically Faidley and Leitner [68] (p72), who noted that "we interact out of, and at the same time create mutually constructed meaning [within the interpersonal process]". With an increasingly diverse population, the challenge for all people is to welcome interpersonal processes and the concomitant discomfort of engaging with re/constructions that confront the ways that we make sense of the world—providing avenues for constructive alternativism. The findings from this investigation are therefore significant for the development of cultural competency training, practice, and theory that reflects the learning needs of mental health practitioners.

Abbreviations
CARE: Care, accept, respond, empower; CARES: Care, accept, respond, empower, safety; PCP: Personal construct psychology.

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Authors' contributions
Author TD conceptualised the project with the supervision and guidance of authors PC, BW, KO and CM. Author RF engaged in the data collection and analysis process with author TD. Author TD drafted the manuscript and received conceptual and editorial feedback from authors PC, BW, KO and CM. Author JT assisted in the editorial review and presentation of the article for publication. All authors have reviewed this article and consent to its publication.

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Availability of data and materials
Upon request, all relevant raw data will be freely available to any scientist wishing to use them for non-commercial purposes and without breaching participant confidentiality.

Declarations

Ethics approval and consent to participate
Before engaging in recruitment and data collection, ethics approval was obtained from the Human Ethics Research Committee at the University of Wollongong [2017/105]. Participants were provided with a Participant Information Sheet before the interviews were scheduled and oral consent (as approved by the Ethics committee) was obtained and digitally recorded before the interviews commenced.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

Author details
[1]Faculty of Arts, Social Sciences and Humanities, School of Psychology, University of Wollongong, Wollongong, NSW, Australia. [2]School of Health Science, Translational Health Research Institute, Diabetes Obesity and Metabolism Translational Research Unit, Western Sydney University, Penrith, NSW, Australia. [3]Faculty of Arts, Social Sciences and Humanities, School of Health and Society, University of Wollongong, Wollongong, NSW, Australia.

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Publisher's Note

Chapter 4: Quantitative Questionnaire

Chapter Overview

Chapter 4 presents the methods, findings, and recommendations from Phase 3 of this study. Phase 3 sought to triangulate the findings from the systematic literature review and interviews across a larger sample and within the novel Australian context. Phase 3 also identified similarities and differences between Australian mental health practitioners and those in other international contexts. Phase 3 answered the following research questions:

1) How do practitioners construe and construct non-White people?
    c. What impacts do their construing and constructions have on practitioner cultural competence?
    d. What impacts do their construing and constructions have on the therapeutic alliance?
3) What factors (or events) influence changes to constructs about or ways of construing non-White people?

Importantly, Phase 3 highlighted gaps in training, practice, and research in cultural competence and therapeutic alliance in Australia. Included in Chapter 4 is the fourth publication of the thesis:

Dune, T., Chimoriya, R., Caputi, P., MacPhail, C., Olcon, K. & Ogbeide A. (2022). Australian Mental Health Care Practitioners' Racial and Ethnic Attitudes: Implications for Cultural Competence and the Therapeutic Alliance. *BMC Psychology, 10*(119), 1-17. https://doi.org/10.1186/s40359-022-00818-4

Given the relationship between practitioner cultural competence and the mental health outcomes of non-White clients (Chao et al., 2012), this study aimed to identify factors that influence non-White and White practitioners' cultural competence. An online questionnaire was completed by 139 Australian mental health practitioners. The measures included: the Balanced Inventory of Desirable Responding (BIDR); the Multicultural Counselling Inventory (MCI); and the Color-blind Racial Attitudes Scale (CoBRAS). Descriptive statistics were used to summarise participants' demographic characteristics. One-way ANOVA and Kruskal-Wallis tests were conducted to identify between-group differences (non-White compared to White practitioners) in cultural competence and racial and ethnic blindness. Correlation analyses were conducted to determine the association between participants' gender or age and cultural competence. Hierarchical multiple regression analyses were conducted to predict cultural competence.

The study demonstrates that non-White mental health practitioners are more culturally aware and have better multicultural counselling relationships with non-White people than their White counterparts. Higher MCI total scores (measuring cultural competence) were associated with older age, greater attendance of cultural competence-related trainings and increased awareness of general and pervasive racial and/or ethnic discrimination. Practitioners with higher MCI total scores were also likely to think more highly of themselves (e.g., have higher self-deceptive positive enhancement scores on the BIDR) than those with lower MCI total scores. The findings highlight that the current one-size-fits-all and skills-development approach to cultural competence training ignores the significant role that practitioner diversity and differences play. The recommendations from this study can inform clinical educators and supervisors about the importance of continuing professional

development relevant to practitioners' age, racial/ethnic background and practitioner engagement with prior cultural competence training.

Author Contributions

Author TD conceptualised the study with the supervision and guidance of authors PC, KO and CM. Author AO engaged in the recruitment, data collection and cleaning of the data with author TD. Author RC engaged in the data cleaning and data analysis with author TD. Author TD drafted the manuscript and received assistance in quantitative results reporting from author RC. TD received conceptual and editorial feedback from authors PC, KO and CM. Author AO assisted in the editorial review and presentation of the article for publication.

Paper 4: White and non-White Australian Mental Health Care Practitioners' Desirable Responding, Cultural Competence, and Racial/Ethnic Attitudes

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White and non-White Australian mental health care practitioners' desirable responding, cultural competence, and racial/ethnic attitudes

Tinashe Dune[1,2,3,5*], Ritesh Chimoriya[1,2,3,4], Peter Caputi[5], Catherine MacPhail[6], Katarzyna Olcon[6] and Anita Ogbeide[1]

Abstract

Background: Racial, ethnic, religious, and cultural diversity in Australia is rapidly increasing. Although Indigenous Australians account for only approximately 3.5% of the country's population, over 50% of Australians were born overseas or have at least one migrant parent. Migration accounts for over 60% of Australia's population growth, with migration from Asia, Sub-Saharan African and the Americas increasing by 500% in the last decade. Little is known about Australian mental health care practitioners' attitudes toward this diversity and their level of cultural competence.

Aim: Given the relationship between practitioner cultural competence and the mental health outcomes of non-White clients, this study aimed to identify factors that influence non-White and White practitioners' cultural competence.

Methods: An online questionnaire was completed by 139 Australian mental health practitioners. The measures included: the Balanced Inventory of Desirable Responding (BIDR); the Multicultural Counselling Inventory (MCI); and the Color-blind Racial Attitudes Scale (CoBRAS). Descriptive statistics were used to summarise participants' demographic characteristics. One-way ANOVA and Kruskal–Wallis tests were conducted to identify between-group differences (non-White compared to White practitioners) in cultural competence and racial and ethnic blindness. Correlation analyses were conducted to determine the association between participants' gender or age and cultural competence. Hierarchical multiple regression analysis was conducted to predict cultural competence.

Results: The study demonstrates that non-White mental health practitioners are more culturally aware and have better multicultural counselling relationships with non-White people than their White counterparts. Higher MCI total scores (measuring cultural competence) were associated with older age, greater attendance of cultural competence-related trainings and increased awareness of general and pervasive racial and/or ethnic discrimination. Practitioners with higher MCI total scores were also likely to think more highly of themselves (e.g., have higher self-deceptive positive enhancement scores on the BIDR) than those with lower MCI total scores.

Conclusion: The findings highlight that the current one-size-fits-all and skills-development approach to cultural competence training ignores the significant role that practitioner diversity and differences play. The

*Correspondence: t.dune@westernsydney.edu.au; tmd999@uowmail.edu.au

[1] School of Health Sciences, Western Sydney University, Campbelltown, NSW 2560, Australia
Full list of author information is available at the end of the article

recommendations from this study can inform clinical educators and supervisors about the importance of continuing professional development relevant to practitioners' age, racial/ethnic background and practitioner engagement with prior cultural competence training.

Keywords: Mental health, Practitioner, Desirable responding, Cultural competence, Whiteness, Australia, Racial and ethnic blindness

Background

Australia is increasingly known for its diversity and multiculturalism. By June 2020, there were over 7.6 million migrants living in Australia, 29.8% of Australia's population were born overseas and Australia's population increased by 194,400 people due to net overseas migration [1]. This is in addition to Australia's 798,400 Aboriginal and Torres Strait Islander people, which was a 19% increase between 2011 and 2016 [2]. While the region of largest immigration remains the United Kingdom, migration from Asia, Sub-Saharan Africa and the Americas has increased by 500% in the last 10 years [2]. Sixty percent of migrants, who can demonstrate high levels of English proficiency, educational attainment, and financial independence, arrive to Australia on skilled worker and/or study visas with an additional 30% arriving as partners or family to these migrants. Australia also has a humanitarian visa program which accounts for less than 10% of Australian migration and includes asylum seekers who may have limited English, education, and access to financial support [2]. This level of diversity requires the Australian society as well as its systems, services, and support providers to consistently adapt to meet the needs of a rapidly changing population. However, despite increased diversity, Australian society and its health care systems continue to operate within the framework of Whiteness[1] [4, 5].

Whiteness in Western society and mental health care

Indigenous scholars like Moreton-Robinson [6–9] demonstrate the insidious role and persistence of Whiteness since the invasion of Australia by the British in 1788 through to the present day. Scholars focused on the study of Whiteness assert that it is a colonial and post-colonial ideology and a power structure characterised by racial dichotomies and ethnic hierarchies [10–13]. DiAngelo [14], for example, explains that "Whiteness itself refers to the specific dimensions of racism that serve to elevate White people over people of color" (p. 56). As such, other scholars indicate that Whiteness leads Whites to believe themselves to be the "predestined master[s] of the world" [15]. These definitions of Whiteness clarify that across historical and contemporary Australian society, those who reap the benefits of Whiteness are those who are White [8, 9]. Hence, in this paper, the term non-White[2] refers to individuals who are excluded from being beneficiaries of Whiteness as a result of their racial, ethnic, cultural, religious, linguistic, or national identities [13, 16, 17]. This definition of "non-White" also includes individuals who may appear White yet identify as being of an ethnic minority because they experience prejudice or discrimination due to other aspects of their identity (e.g., wearing a hijab, having a non-Australian accent, or having non-Anglo family members).

We recognise that not all Whites encounter the same privileges, or that Whiteness has maintained the same parameters over time, or that it is impermeable and inflexible [18, 19]. Additionally, we recognise that Whiteness (and how those who benefit, or are excluded, from it are defined) is constantly under revision [20]. Even within this consistent state of flux, Whiteness and its consequences endure [21] and are present across all areas of Western (if not global) environments, systems, and practices [22].

One such system is the mental health care system. Mental health is a core element of human health and wellbeing. In 2020, the Australian Institute of Health and Welfare (AIHW) [23] indicated that 45% of all Australians aged 16 to 85 years—8.7 million people—will experience mental illness at some point in their life. According to 2015 statistics, mental illness and substance misuse were the second largest contributor (23%) of the

[1] The capitalisation of the 'W' in White and non-White is one of contentious scholarly debate. A capital W is used in this paper to acknowledge the racialisation and concomitant characterisation of ethnic, religious, cultural and linguistic affiliation in terms of proper nouns used to construct identities and not simply to inaccurately describe phenotypical traits (see also [3]).

[2] It is acknowledged that other terms are increasingly being used in Australia and internationally to describe minority peoples. This includes terms like culturally and linguistically diverse (CALD) or Black, Indigenous and People of Colour (BIPOC). Importantly, the term CALD is widely criticised for its lack of specificity and erasure of various minority identifiers including ethnicity and religion. While the term BIPOC is more specific, again it is criticised for its lack of inclusion of religious diversity as well as its descriptive nature which sanitises and/or ignores the realities of power, supremacy and privilege within Whiteness. These terms also fail to identify White people and explicitly name Whiteness. This invisibility of Whiteness perpetuates its invincibility in mental health training, practice and research and negatively effects non-White (and White) people's mental health outcomes (see [8, 9]).

non-fatal burden of disease in Australia [24]. During the 2017 and 2018 financial year, $9.9 billion [23] was spent on mental health, with spending increasing in 2018–2019 to $10.6 billion [25]. Given the prevalence and social and economic costs of mental illness, access to and effectiveness of mental health services is crucial. Mental health is therefore an area in which systems and practitioners need to adapt and demonstrate flexibility to support clients [26].

The impact of Whiteness on mental health systems and outcomes

Despite consistent efforts and improvements, (mental) health practitioners and systems struggle to adapt or to be flexible when working with clients who do not fit within rigid frameworks of Whiteness in health care [4, 5]. The rigidity of Whiteness in health care is evident, for example, in the medicalisation and pathologising of social experiences (like racism and discrimination) into mental health problems (e.g., schizophrenia) which are then relegated to the individual to overcome through (largely) self-funded talk-therapy and medication [27]. For instance, a 2019 U.S. study of 599 Blacks and 1058 non-Latino Whites, found that mental health clinicians failed to effectively consider mood symptoms when diagnosing schizophrenia among African-Americans [28]. The study authors indicated that the findings suggest the presence of racial bias, whether conscious or subconscious, as a factor in the comparatively higher levels of diagnosis of schizophrenia in Black populations. Despite the fact that discrimination based on race, ethnicity, culture or religion is a key contributing factor in the onset of and severity of disease—resulting in disparities in physical and mental health among non-White people—mental health practitioners continue to manifest prejudicial attitudes that hinder equitable health care and improved health outcomes for non-White people [29].

From overt to covert racism and discrimination: colour-blind attitudes and beliefs

The negative health outcomes and experiences of non-Whites within (mental) health care settings are well documented and relate to systems and practitioners that harbor prejudicial attitudes and beliefs about non-White people. While contemporary attitudes and beliefs about non-White people are moving away from overtly racist (for the most part) manifestations of discrimination, covert forms of racism persist [5]. A notable example of covert racism are colour-blind attitudes and beliefs [20, 30]. These include the assertion that everyone is equal, racism is no longer a problem and that all people (regardless of their race, ethnicity, religion, language or culture) can achieve the same social, political, economic and health outcomes [20]. However, this widely researched perspective has been determined to be a manifestation of Whiteness whereby race, privilege and power are erased to avoid the discomfort of explicitly naming and identifying responsibility for addressing Whiteness [20, 30–33].

Evidence demonstrates that mental health practitioners that espouse colour-blind racial and/or ethnic attitudes have lower levels of cultural competence [34–37]. This was a key finding in our 2018 systematic review, representing 5870 mental health care practitioners, that explored practitioner attitudes and beliefs about non-White people. The review found that practitioners who perceived non-White people negatively or through a colour-blind belief system were less likely to engage in culturally competent health care approaches while working with non-White people [34]. However, most of the studies in the aforementioned systematic review were from the United States (twenty-eight), and only three were from Australia. Given Australia's increasing diversity, it is important to consider and identify Australian mental health practitioners' attitudes and beliefs about non-White people and their impact on cultural competence and the counselling relationship. In doing so, advances can be made in Australian (and international) practitioner training and clients' mental health outcomes. However, consideration about how such an exploration is conducted is important to ensure that the data collected from mental health practitioners' self-reports are not confounded by socially desirable responding [32].

Whiteness and socially desirable responding

Given that this study is interested in understanding practitioner perspectives about non-White people, some practitioners may be inclined to respond in socially desirable ways in order to downplay or underrepresent their true attitudes and beliefs [32]. Desirable responding in relation to perceptions of non-White people therefore helps an individual distance themselves from the guilt, frustration and anxiety about as well as their role and responsibility in the perpetuation of Whiteness [32, 33, 38–40]. As such, evidence indicates that assessing for social desirability is integral to interpreting cultural competence self-report data [41]. To assess and moderate for this possibility, research exploring practitioner self-report cultural competence data often includes specific questionnaires that measure participants' propensity to respond in desirable ways. In this study, desirable responding was assessed in line with international research indicating that people are more likely to respond in deceptive and/or desirable ways due to the sense of confrontation and discomfort that often results from

thinking or talking about Whiteness, racism, privilege and their impacts on non-White people [32, 33, 38–40].

Solutions to the impact of Whiteness in mental health care

To manage and reduce the impact of Whiteness and its perpetuation in mental health care, practitioners and researchers advocate for open discourse about Whiteness, racism, privilege, supremacy and power imbalances via cultural competence training [22]. Cultural competency is defined as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" [43].[3] When taught comprehensively (e.g., inclusive of in-depth discussions about Whiteness, its impacts and the practitioner's role in its manifestations and management), the skills, knowledge and awareness gained within cultural competency training helps to reduce barriers to trust and power imbalances between clients and practitioners thereby improving the therapeutic relationship [44]. In a 2019 U.S. Delphi study exploring mental health care providers training needs, Baima and Sude [11] found that the panel of 20 practitioners of diverse ethnic backgrounds endorsed the need for mental health professionals to understand historical and contemporary Whiteness within the mental health fields and larger social systems. The panel of participants also indicated the need for the therapist to understand their role in Whiteness as well as the need for practitioners to identify the challenges to understanding Whiteness within clinical training and practice. Importantly, the panel of practitioners in that study identified that mental health practitioners needed to transform their cognitive and emotional attitudes and beliefs in order to address Whiteness within the context of mental health service provision and to support client trust and participation in therapy. These findings align with international evidence indicating that when practitioners internalise and enact the principles of cultural competence, they are able to cultivate and maintain a positive multi-cultural counselling relationship between themselves and their clients [22, 45–47].

The counselling relationship is broadly defined as "the collaborative and affective bond between therapist and patient … [and] is an essential element of the therapeutic process" [48]. This relationship is exemplified by bi-directional and mutual collaborations between mental health care providers and clients, are dependent on a person-centred health care ethos [49] and based on a mutually nurtured psycho-socio-emotional connection [50]. While the concept of the counselling relationship has its origins in early psychoanalytic theories (e.g., [51]), it is now a staple of contemporary evaluations and conceptualisations of the therapeutic process. Notably, international evidence indicates that the multi-cultural counselling relationship is a core component of cultural competence and is strongly associated with clients' mental health engagement and outcomes [48, 52]. Operationally then, culturally competent mental health care is inclusive of an effective counselling relationship and requires practitioners to consistently utilise and improve on their cross- and multi-cultural skills, knowledge, awareness and relationships with non-White people [53]. Figure 1 illustrates these components of cultural competence.

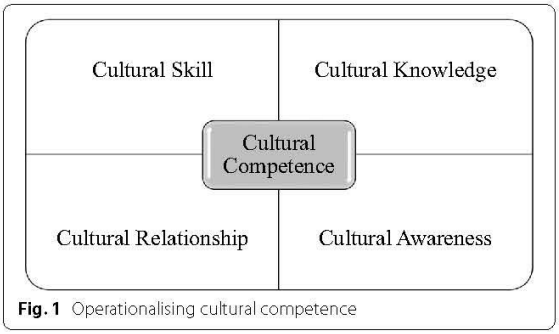

Fig. 1 Operationalising cultural competence

Importantly, international research demonstrates that practitioner cultural competence is dependent on a range of factors. The most notable factors include mental health practitioner race/ethnicity and engagement in cultural competence training. For instance, a U.S. study of 220 counsellors found that Asian and Latino counsellors reported having higher multi-cultural knowledge than White counsellors and Black, Asian and Latino counsellors reported more competence in multi-cultural awareness and relationships than did White counsellors [54]. However, comprehensive cultural competence training can moderate this discrepancy in cultural competency between White and non-White practitioners [32].

Significance of the current study and the Australian context

In Australia, little is known regarding mental health workers' attitudes towards non-White people let alone the factors that influence practitioner cultural competence. While health care provider attitudes can be implied from the well documented negative health experiences and outcomes of non-White populations in Australia

[3] It is acknowledged that these somewhat simplistic, skill-based and practitioner-focused constructions of cultural competence are limited in their recognition of the impact of racial dichotomies and hierarchies that result in the perpetuation of disadvantage and devaluation of non-White frameworks, perspectives or people [22].

[55], a better understanding of Australian mental health care practitioners' attitudes and beliefs about non-White people and their cultural competence is needed. By identifying and exploring this gap, robust recommendations for practitioner training, practice and research can be developed with the aim of improving non-White people's mental healthcare experiences and outcomes.

Given that this study is the first of its kind in Australia, we have followed the structure of international research from other Western nations which compare and contrast desirable responding, cultural competence, and colour-blind racial and ethnic attitudes across White and non-White practitioners [30, 33, 54, 56, 57]. Collecting and comparing racial/ethnic data in line with international research is important because Australia does not currently collect robust data about practitioner ethnicity. This failure to collect basic demographics about Australian mental health care practitioners attests to the impact of Whiteness, which erases difference within the health care system and workforce [13, 20, 27, 58]. Given the limited data available in Australia, the following example of Australian registered psychologists is used to illustrate the dearth of demographic information.

According to Mathews, Stokes, Crea, and Grenyer [59], of the 11,897 psychologists who completed the 2008 Australian Psychology Workforce Survey, only 54 were of Indigenous background. The authors also found that minority population groups such as culturally and linguistically diverse and Indigenous clients made up 54.65% and 15.99%, respectively, of psychologists' workloads—a significant proportion. It can therefore be assumed that with Australian migration having increased significantly within the last decade, the number of non-White clients has also increased. More recently, the Department of Health [60] reported that out of 26,311 registered psychologists, 73.3% were born in Australia and 0.7% were of Aboriginal and Torres Strait Islander background. There is no clear data on the ethnicity of psychologists beyond Indigeneity in Australia—giving the impression that, besides being Indigenous, the remainder of psychologists are White Australians. However, drawing on data from the Australian Bureau of Statistics [61], it is likely that at least 20% of the Australian born psychologists are likely to have at least one parent who was born overseas. Psychology has, however, typically been a profession dominated by people from White backgrounds [62, 63]. As such, the number of non-White psychologists is not likely to be representative of the actual diversity in Australia's population [63, 64]. This omission of diversity in the collection of demographic data regarding the Australian mental health workforce is an example of how frameworks of Whiteness perpetuate racial hierarchies and the erasure of difference within Australian society.

This study therefore focused on the following research questions comparing White and non-White practitioners:

1. To what degree do Australian mental health care practitioners respond in socially desirable ways?
2. How culturally competent are Australian mental health care practitioners?
3. To what degree do Australian mental health practitioners ascribe to colour-blind racial and ethnic attitudes?
4. What variables (e.g., desirable responding, demographics, experience with non-White clients, attendance at cultural competence training, and racial/ethnic attitudes) predict cultural competence?

Methods

This quantitative study is part of a larger body of work using a sequential mixed methods design (see publications [18, 19, 34]). The current study used a cross-sectional design with non-probability sampling and validated survey measures.

Recruitment and participants

Participants included individuals aged 18 years and over, living in Australia and self-identifying as a mental health care practitioner or trainee. Participants were recruited via distribution of advertising to the Australian Psychological Society and the Australian Clinical Psychologists Association. Additional recruitment took place via social media including Facebook, Twitter, Instagram, and LinkedIn. Participants were invited to complete the survey online or request a paper copy. The purpose of the study was described to the participants as an exploration of practitioner cultural competence and attitudes towards non-White clients.

One hundred and eighty-two practitioners commenced the survey. The majority engaged in the survey online (n = 175) while seven elected to complete the survey in hardcopy. After screening for completeness of all the demographic, MCI, CoBRAS and BIDR items, 139 participants remained. The study was approved by and conducted within the guidelines of the University's Human Research Ethics Committee (Approval Number 2017/105) at the University of Wollongong.

Quantitative survey measures

The survey included the following measures:

Demographic questionnaire

The demographic questions collected information about participants' age, gender, ethnicity and country of origin,

highest degree achieved, year highest degree achieved, mode of professional practice/training (private and/or public), years of experience and engagement with post-qualification cultural competency training. Participants were also asked where they completed or are engaged in their mental health training and how many non-White clients they see in a month.

Balanced Inventory of Desirable Responding

The Balanced Inventory of Desirable Responding (BIDR) [65] measures the tendency to respond and exhibit behaviours or thoughts that are viewed as socially desirable but are not accurate representations of an individual's real attitudes and behaviours [66]. Scholars have used BIDR to assess and control for counsellors' social desirability in self-report data [33].

The BIDR consists of 40 items and two subscales, each with 20 items. Subscale 1: Self Deceptive Enhancement (SDE) measures positive self-descriptions that a respondent actually believes to be true [67]. The SDE subscale consists of the first 20 items of the BIDR. Example SDE items include: "My first impressions of people usually turn out to be right", "I never regret my decisions" and "I always know why I like things." Subscale 2: Impression Management (IM) measures a respondent's conscious biasing of responses to create a favourable self-image [67]. The IM subscale consists of the last 20 items of the BIDR. Example IM items include: "I never swear", "I always declare everything at customs" and "I never take things that don't belong to me."

The BIDR is composed of a response format consisting of a 7-point Likert scale ranging from 1 (not true) to 7 (very true); 1 point is scored for each extreme answer (6 or 7) with a total score ranging from 0 to 40. Higher scores indicate a greater tendency to respond and exhibit behaviours or thoughts that are viewed as socially desirable. The BIDR has been used successfully with various racial/ethnic and cultural groups [33]. Chao [32] reported a coefficient alpha of 0.85 with a sample of graduate students in psychology and mental health professions. Our study reports the coefficient alpha of 0.88 for total score, 0.73 for Subscale 1: Self Deceptive Enhancement, and 0.86 for Subscale 2: Impression Management. This questionnaire is a valid measure and has been used extensively within health and education professionals internationally [68–70].

Multicultural Counselling Inventory (MCI)

This 40-item self-report inventory [71] assesses behaviours and attitudes related to four multicultural competencies on a 4-point Likert scale from very inaccurate (1) to very accurate (4). For each item, a score of 1 indicates low multicultural competence and a score of 4 indicates high multicultural competence [41]. Scale scores are obtained by adding the items specific to each subscale. The MCI total score ranges from 40 to 160 with higher scores indicating greater multicultural competence. Higher subscale scores also indicate greater multicultural competence in the respective subscale areas (see below). In this study, the MCI total score is the dependant variable. As explained in Ottavi et al. [72], the four areas of multicultural competency are as follows:

1. Skills—11 items measuring general counselling and specific multicultural counselling skills. Sample items include "When working with all clients, I am able to be concise and to the point when reflecting, clarifying, and probing" and "When working with minority clients, I monitor and correct my defensiveness." Minimum score = 11, maximum score = 44.
2. Knowledge—11 items measuring treatment planning, case conceptualisation, and multicultural counselling research. Sample items include "When working with minority clients, I keep in mind research findings about minority clients' preferences in counselling" and "When working with minority clients, I apply the socio-political history of the clients' respective minority groups to understand them better." Minimum score = 11, maximum score = 44.
3. Awareness—10 items measuring multicultural sensitivity, interactions, and advocacy in general life experiences and professional activities. Sample items include "I am involved in advocacy efforts against institutional barriers in mental health services for minority clients" and "When working with international students or immigrants, I understand the importance of legalities of visa, passport, green card and naturalization." Minimum score = 10, maximum score = 40.
4. Relationship—8 items measuring the counsellor's interaction process with the minority client (e.g., comfort level, worldview, and counsellor's trustworthiness). Sample items include "When working with minority individuals, I am confident that my conceptualization of individual problems do not consist of stereotypes and biases" and "When working with minority clients, I perceive that my race causes the client to mistrust me." Minimum score = 8, maximum score = 32.

Internal consistency reliabilities (Cronbach's alphas) reported by Sodowsky et al. [71] were 0.80 for Multicultural Awareness, 0.80 for Multicultural Counselling Knowledge, 0.81 for Multicultural Counselling Skills, 0.67 for Multicultural Counselling Relationship, and 0.86 for the full scale. Our study reports 0.78 for Multicultural

Awareness, 0.83 for Multicultural Counselling Knowledge, 0.87 for Multicultural Counselling Skills, 0.69 for Multicultural Counselling Relationship, and 0.90 for the full scale. This measure is valid and has been used extensively with diverse groups of counsellors and therapists [73–75].

Color-Blind Racial Attitudes Scale (CoBRAS)

This study used an adapted version of the Color-Blind Racial Attitudes Scale [31] to assess practitioners' constructions of non-White people. The CoBRAS consists of 20 items to assess attitudes with a 6-point Likert scale of 1 (strongly disagree) to 6 (strongly agree). The CoBRAS was designed to assess cognitive dimensions of colour-blind racial attitudes including the degree to which respondents distort, deny, and/or minimise the existence of institutional racism. Sample items include: "Everyone who works hard, no matter what race they are, has an equal chance to become rich," and "Racism may have been a problem in the past, but it is not an important problem today". Total scores can range from 20 to 120, with higher scores representing greater colour-blind racial beliefs [31] which are an indication of greater levels of unawareness or blindness to the existence and impact of Whiteness on people and systems.

The CoBRAS assesses blindness in three areas: Racial & Ethnic Privileges, Institutional Discrimination, and Blatant Racial & Ethnic Issues. The Racial & Ethnic Privilege subscale measures blindness to the existence of privileges attributed to Anglo-Australians. The Institutional Discrimination subscale measures limited awareness of the implications of institutional discrimination and exclusion. The Blatant Racial and Ethnic Issues subscale measures unawareness of general and pervasive racial/ethnic discrimination.

Although the CoBRAS is based on the U.S. context and uses terminology relevant to racial dynamics in the U.S., many of these dynamics (e.g., institutional racism and systemic discrimination) are also present within the Australian context. As such, the content of the items did not require amendment, however their context 'American' versus 'Australian' or 'United States' versus 'Australia' or 'African American' versus 'Afro-Australian' did require revision. In place of the term 'White', the term 'Anglo-Australian' was used as many individuals who identify as being of an ethnic minority may appear White but may experience prejudice or discrimination due to other manifestations of their ethnicity (wearing a hijab, having a non-Australian accent, or having non-Anglo family members for example). Finally, for those items which only mention race, and not race and ethnicity, the word ethnicity or ethnic has been added to reflect the realities of multiculturalism in Australia where ethnicity may be mutually exclusive of race (e.g., "Racial problems in the U.S. are rare, isolated situations" was changed to "Racial problems in Australia are rare, isolated situations". American spellings (e.g., color versus colour) were also amended in line with Australian spelling conventions.

Neville et al. [31] reported that the coefficient alpha for the total CoBRAS was 0.91. Our study demonstrates the coefficient alpha for the total CoBRAS was 0.87, Factor: Unawareness of Racial Privilege was 0.78, Factor: Unawareness of Institutional Discrimination was 0.71, and Factor: Unawareness of Blatant Racism Issues was 0.71. This questionnaire is a valid measure and has been used extensively with diverse U.S helping professionals and within lay populations [30–33, 76, 77].

Data analysis strategy

Sample size was estimated to be $N=134$ (at 90% power, $\alpha=0.05$, $\beta=0.1$, anticipated MCI mean total score in study population = 122), which is adequate for anticipated effect size on the basis of previously published literature [78, 79]. A sample of $N=139$ was recruited in this study, which also appears to be appropriate according to Cohen's guideline which suggests $N=97$ is adequate for medium effect size [80]. Reliability analyses were also conducted to assess internal consistency of each measure and to ensure their reliability within this novel sample. Descriptive statistics were used to summarise participants' demographic characteristics. Kolmogorov–Smirnov test and Shapiro–Wilk test were conducted to check the normality of the data. One-way ANOVA and Kruskal–Wallis test were performed to identify the between-group (White and non-White practitioners) differences in socially desirable responding, cultural competence and racial and ethnic blindness (research questions 1, 2, and 3). A correlation analysis was conducted to determine the association (if any) between participants' gender, age and cultural competence (MCI total score) (research question 4).

Following steps similar to those used by Chao [32, 33], who conducted a similar analysis amongst school counsellors in the U.S., we performed a hierarchical multiple regression analysis to predict practitioner cultural competence (MCI total score). Furthermore, a hierarchical regression analysis allowed to observe whether adding a variable significantly improves a model's ability to predict criterion variable. A linear relation between the independent variable and dependent variables were observed prior to the consideration to the model. In the first step, social desirability (measured by BIDR subscales) was entered to elucidate the relation of social desirability with the cultural competence. In the second step, participants' age, ethnicity (for the two groups—White and

non-White[4]—entered with dummy codes), and participants' speaking a language other than English were entered. This step demonstrated the impact of demographic variable on the relation between social desirability with the cultural competence. In the third step, cultural competency variables including the number of cultural competence-related workshops, conferences or training sessions attended since beginning practicing mental health care, number of non-White clients[5] seen a week, and whether their formal training prepared them to work with non-White clients were entered. Anticipating the impact of the cultural competency variable on the existing model, step 3 was adopted to demonstrate the impact of those variable in the criterion variable. In the fourth step, racial and ethnic blindness attitudes (measured by CoBRAS subscales) were entered to demonstrate the impact of color-blind racial attitude in the model. This analysis addressed research question 4.

Results

Table 1 summarises the demographic, professional, and cultural competency related characteristics of the participants. The mean age of the participants was 37.3 ($SD = 11.3$) years, with majority being female (89.2%). Most of the participants were White (64.7%), and an Australian citizen (91.4%). Most participants had completed a postgraduate degree (80.6%) and had completed their highest level of academic qualification within last five years (59.7%). All participants received their academic qualifications from Commonwealth countries, and the majority did not speak a language other than English (66.2%). Of the 139 participants, 76.7% were psychologists with varied duration working in mental health and types of practice. In terms of cultural competency related characteristics, most participants (93.5%) were seeing at least one non-White client per week, 82% of the participants had attended cultural competence-related workshops, conferences, or training sessions since the beginning of their mental health care practice, and over half of the participants (51.5%) agreed that their qualifying mental health training sufficiently prepared them to provide culturally competent services for non-White clients.

To examine whether the cultural competence as measured by MCI total score varied as a function of participants' gender and age, we conducted an analysis of variance (ANOVA) of gender and a correlation analysis of age with the dependent variables. The ANOVA results revealed no significant main effects for participants' gender on MCI total score, $F(2,139) = 0.863$, $p = 0.424$. A correlation analysis showed that age was weakly but statistically significantly correlated with the total score of MCI ($r = 0.183$, $p = 0.032$) and thus was considered a predictor variable in the final analysis.

Differences in desirable responding across White and non-White practitioners

The average total BIDR score of all participants was $M = 10.4$ ($SD = 6.8$) (Table 2). The total score was not statistically different across the two groups despite the non-White group having a higher score than the White group ($M = 11.8$, $SD = 7.2$ vs. $M = 9.6$, $SD = 6.3$, $p = 0.094$). This finding suggests that the groups did not differ in terms of desirable responding. No significant multicollinearity was observed in the model (Variance Inflation Factor -VIF for BIDR subscale 1 = 1.44 and BIDR subscale 2 = 1.41).

Differences in cultural competence across White and non-White practitioners

The average total MCI score of all participants was $M = 122.9$ ($SD = 14.0$) (Table 2). The average scores for Subscale 1: Multicultural Counselling Skills, Subscale 2: Multicultural Awareness, Subscale 3: Multicultural Counselling Relationship, and Subscale 4: Multicultural Counselling Knowledge were $M = 37.1$ ($SD = 5.0$), $M = 27.5$ ($SD = 5.0$), $M = 27.5$ ($SD = 5.0$), and $M = 33.7$ ($SD = 4.8$), respectively. The total MCI score was higher in the non-White group compared to the White group, but the difference was not statistically significant ($M = 125.5$, $SD = 14.6$ vs. $M = 121.5$, $SD = 13.6$, $p = 0.069$). A similar trend was observed for Subscale 4: Multicultural Counselling Knowledge ($M = 33.9$, $SD = 5.4$ vs. $M = 33.7$, $SD = 4.5$, $p = 0.433$). While an inverse trend was observed for Subscale 1: Multicultural Counselling Skills ($M = 36.7$, $SD = 5.0$ vs. $M = 37.3$, $SD = 5.0$, $p = 0.554$), the differences between the non-White and White groups were not statically significant. However, the scores for Subscale 2: Multicultural Awareness ($M = 29.5$, $SD = 5.0$ vs. $M = 26.4$, $SD = 4.6$, $p < 0.001$) and Subscale 3: Multicultural Counselling Relationship ($M = 25.4$, $SD = 3.5$ vs. $M = 24.2$, $SD = 3.3$, $p = 0.049$) were significantly higher in the non-White group compared to the White group.

[4] Participants were asked to select any and all relevant ethnic identifiers including Asian, Pacific Islander, African, Latin American, Western European, Eastern European, Aboriginal and/or Torres Strait Islander, Indigenous Canadian and/or American, Middle Eastern, Mediterranean and Caucasian. Those who chose Caucasian and/or Western European were categorised as White for the purposes of analysis in line with our previous research in which participants of Western European descent self-identified as White.

[5] To ensure conceptual clarity survey participants were presented with the definition of non-White people indicated in the Background section of this paper.

Table 1 Practitioners' demographic, professional, and cultural competency related characteristics ($n = 139$)

Variable	n (%) or mean (SD)
Demographic characteristics	
Age (in years)	37.3 (11.3)
Gender	
Female	124 (89.2%)
Male	14 (10.1%)
Other	1 (0.7%)
Ethnicity	
Asian	19 (13.7%)
African	4 (2.9%)
Latin American	6 (4.3%)
Eastern European	13 (9.4%)
Aboriginal and/or Torres Strait islander	5 (3.6%)
Middle Eastern	4 (2.9%)
Mediterranean	12 (8.6%)
White	90 (64.7%)
Australian Residency Status	
Australian citizen	127 (91.4%)
Australian permanent resident	3 (2.2%)
Work visa holder	3 (2.2%)
Student visa holder	4 (2.9%)
Other (temporary visa holder and New Zealand citizen)	2 (1.4%)
Professional (cultural competency and other work related) characteristics	
Highest level of education	
Completed postgraduate degree	112 (80.6%)
Completed university degree	25 (18.0%)
Not completed degree at university	1 (0.7%)
Completed high school diploma or equivalent	1 (0.7%)
Year of obtaining qualification	
Within last 5 years (since 2016)	83 (59.7%)
Before 5 years	54 (38.8%)
Participants speaks another language in addition to English	
Yes	47 (33.8%)
No	92 (66.2%)
Occupational role	
Clinical psychologist	58 (41.7%)
Psychologist (general)	36 (25.6%)
Psychology trainee (provisional)	13 (9.4%)
Social worker (or trainee)	6 (4.3%)
Counsellor (or trainee)	7 (2.9%)
Other (Youth/ Community worker, Health Promotion Officer, Medical student, Psychotherapist/or trainee, Pharmacist, Allied health managers, Occupational therapist, Clinical psychologist registrar, Nurse practitioner and Psychology student)	19 (13.7%)
Years working in mental health	
0–1 years	19 (13.7%)
2–5 years	52 (37.4%)
6–10 years	27 (19.4%)
11–14 years	12 (8.6%)
≥ 15 years	28 (20.1%)
Type of service	
Private practice	59 (42.4%)
Public practice	48 (34.5%)

Table 1 (continued)

Variable	n (%) or mean (SD)
Both private and public practice	21 (15.1%)
Other (none, NGO, disability services, project consulting, research, community clinic)	5 (3.6%)
Both private and other practice	3 (2.2%)
Cultural competency experience variable	
Number of non-White clients per week	
None	9 (6.5%)
1–3	59 (42.4%)
4–6	39 (28.1%)
7–9	16 (11.5%)
≥ 10	16 (11.5%)
Engagement in cultural competence-related workshops, conferences or training since beginning practicing mental health care	
None	25 (18.0%)
1–3	75 (54.0%)
4–6	30 (21.6%)
7–9	3 (2.2%)
≥ 10	6 (4.3%)
Did your professional mental health training sufficiently prepare you to provide culturally competent services for non-White clients	
Agree	71 (51.1%)
Neutral	18 (12.9%)
Disagree	50 (36.0%)

Table 2 Differences between White and non-White practitioners' cultural competence, desirable responding, and racial and ethnic blindness

Scores/variable Mean (SD)	All participants ($n=139$)	White ($n=90$)	Non-White ($n=49$)	*p* value
Age	37.3 (11.3)	38.5 (11.6)	34.7 (10.2)	0.077*
Multicultural Counselling Inventory (MCI)				
Composite score (MCI total)	122.9 (14.0)	121.5 (13.6)	125.5 (14.6)	0.069
Subscale 1: Multicultural Counselling Skills	37.1 (5.0)	37.3 (5.0)	36.7 (5.0)	0.554
Subscale 2: Multicultural Awareness	27.5 (5.0)	26.4 (4.6)	29.5 (5.0)	< 0.001*
Subscale 3: Multicultural Counselling Relationship	27.5(5.0)	24.2 (3.3)	25.4 (3.5)	0.049*
Subscale 4: Multicultural Counselling Knowledge	33.7 (4.8)	33.7 (4.5)	33.9 (5.4)	0.433
Balanced Inventory of Desirable Responding (BIDR)				
Composite score (BIDR Total)	10.4 (6.8)	9.6 (6.3)	11.8 (7.2)	0.094
Subscale 1: Self Deceptive Enhancement (SDE)	4.2 (3.1)	3.9 (2.9)	4.8 (3.2)	0.135
Subscale 2: Impression Management (IM)	6.2 (4.5)	5.7 (4.3)	7.0 (4.8)	0.132
Color-Blind Racial Attitudes Scale (CoBRAS)				
Composite score (CoBRAS Total)	43.8 (13.6)	41.5 (13.6)	48.0 (13.0)	0.007*
Factor 1 (URP-Unawareness of Racial Privilege)	18.8 (6.4)	17.6 (6.2)	20.9 (6.4)	0.003*
Factor 2 (UID-Unawareness of Institutional Discrimination)	14.4 (5.3)	13.9 (5.5)	15.4 (4.9)	0.059
Factor 3 (UBRI-Unawareness of Blatant Racism Issues)	10.6 (4.3)	10.0 (4.0)	11.9 (4.6)	0.013*

*$p < 0.05$

Difference of Color-Blind Racial Attitudes Scale (CoBRAS) across White and non-White practitioners

The average total CoBRAS score of all participants was $M=43.8$ ($SD=13.6$) (Table 2). The scores for Factor 1: Unawareness of Racial Privilege, Factor 2: Unawareness of Institutional Discrimination, and Factor 3: Unawareness of Blatant Racism Issues were $M=18.8$ ($SD=6.4$), $M=14.4$ ($SD=5.3$), and $M=10.6$ ($SD=0.3$),

Table 3 Hierarchical multiple regression analysis predicting cultural competence

Variable	*B*	*SE B*	β	t	R^2	ΔR^2	ΔF	*df*
Step 1					0.141	0.141	10.706***	(2,130)
BIDR Subscale 1: Self Deceptive Enhancement (SDE)	1.378	0.433	0.306	3.183**				
BIDR Subscale 2: Impression Management (IM)	0.346	0.302	0.110	1.148				
Step 2					0.207	0.065	3.485*	(3,127)
Age	0.299	0.101	0.239	2.968**				
Ethnicity (being White)	1.890	2.934	0.066	0.644				
Participants speaks another language other than English	−2.742	3.031	−0.095	−0.905				
Step 3					0.278	0.072	4.102**	(3,124)
Number of non-White clients per week	1.805	1.001	0.143	1.804				
Perception of preparedness to provide culturally competent services following formative training	−0.695	1.006	−0.054	−0.691				
Number of cultural competence-related continuing professional development	3.350	1.301	0.221	2.574*				
Step 4					0.374	0.095	6.142***	(3,121)
CoBRAS Factor 1 (URP-Unawareness of Racial Privilege)	0.117	0.211	0.054	0.557				
CoBRAS Factor 2 (UID Unawareness of InstitutionalDiscrimination)	0.413	0.253	0.158	1.629				
CoBRAS Factor 3 (UBRI Unawareness of Blatant Racism Issues)	−1.323	0.329	−0.410	−4.023 ***				

$n = 139$, *$p < 0.05$. **$p < 0.01$. ***$p < 0.001$

respectively. The total CoBRAS score was significantly higher in the non-White group than the White group ($M = 48.0$, $SD = 13.0$ vs. $M = 41.5$, $SD = 13.6$, $p = 0.007$). A similar trend was observed for Factor 1: Unawareness of Racial Privilege ($M = 20.9$, $SD = 6.4$ vs. $M = 17.6$, $SD = 6.2$, $p = 0.003$) and Factor 3: Unawareness of Blatant Racism Issues ($M = 11.9$, $SD = 4.6$ vs. $M = 10.0$, $SD = 4.0$, $p = 0.013$). The score for Factor 2: Unawareness of Institutional Discrimination was also higher in the non-White group than the White group ($M = 11.9$, $SD = 4.6$ vs. $M = 10.0$, $SD = 4.0$, $p = 0.059$), however, the difference was not statistically significant. Similarly, no significant multicollinearity was observed in the model (Variance Inflation Factor -VIF for CoBRAS factor 1 = 1.00, CoBRAS factor 2 = 3.663 and CoBRAS factor 3 = 3.83).

Predictors of cultural competence

Table 3 summarises the variables predicting participants' cultural competence. Self-deceptive enhancement (SDE: Subscale 1 of BIDR), the age of participants, attendance of cultural competence-related workshops, conferences, or training sessions since the beginning of mental health care practice, and Unawareness of Blatant Racism Issues (UBRI: Factor 3 of CoBRAS) were observed to contribute significant variance to multicultural competence. The total proportion of variance for the dependent variable, which is explained by the independent variables in the model at Step 4, was calculated as total $R^2 = 0.374$.

Self-deceptive enhancement was observed to contribute to the variance of cultural competence, F (2,130) change = 10.706, $p < 0.001$, $R^2 = 0.141$, and R^2 change = 0.141, but not Impression Management. In Step 2, age was the only variable which contributed to the variation in cultural competence in addition to Self-Deceptive Enhancement from Step 1, F (3,127) change = 3.485, $p = 0.018$, $R^2 = 0.207$, and R^2 change = 0.065. The ethnicity of the participants (White and non-White) and the ability of the participants to speak a language other than English did not contribute to variance in cultural competence. Similarly, in Step 3, variables related to practitioners' cultural competence experience were added to social desirability (BIDR subscales), age, ethnicity, ability to speak another language other than English. Cultural competence experience variables included: attendance at cultural competence-related workshops, conferences, or training sessions; number of non-White clients seen per week; and perceived preparedness to work with non-White clients following qualifying mental health training.

Step 3 yielded additional significant variance in cultural competence, F (3,124) change = 4.102, $p = 0.008$, $R^2 = 0.278$, and R^2 change = 0.072. However, the number of non-White clients per week and the belief that professional mental health training sufficiently prepared them to provide culturally competent services for non-White clients did not contribute any significant effect on cultural competence. In the final step (Step 4), the three subscales of CoBRAS were added in addition to all the variables in the previous steps. The analysis revealed that

Unawareness of Blatant Racism Issues, together with the variables added in Steps 1 to 3, contributed to additional significant variance in cultural competence with a large effect size, F (3,121) change = 6.142, $p < 0.001$, $R^2 = 0.374$, and R^2 change = 0.095.

Discussion

The purpose of this study was to identify the factors that influence Australian mental health practitioners' cultural competence. The findings indicate that practitioners in this study valued cultural competence training given their high level of engagement in this type of continuing professional development. This may be because the majority engaged with at least one non-White client a week and/or wanted to maintain and/or improve their ability to provide culturally competent services to their non-White clients [44, 55].

Participants in the current study reported a similar level of cultural competence to those reported in previous studies. The MCI total score ($M = 122.9$, $SD = 14.0$) for the sample is approximately equivalent to data reported by Bellini [78] ($M = 125.1$, $SD = 14.32$) and Green et al. [79] ($M = 126.71$) for rehabilitation counselors ($n = 372$) and social workers ($n = 344$), respectively. The findings also indicate that non-White practitioners had higher levels of multi-cultural awareness and better multi-cultural counselling relationships with non-White people compared to White practitioners. This finding is consistent with research from other countries where non-White health practitioners demonstrate higher levels of cultural competence [32, 33]. Extant literature indicates that non-White people have personal experiences related to the various challenges that Whiteness presents in their own lives (e.g., being teased because of their race, ethnicity or religion as children) which may result in a high level of awareness of Whiteness and its impact on non-White people [47, 81–83]. Consequently, non-White people are more likely to build a more robust connection with non-White clients due to their increased ability to be empathetic to their clients' experiences particularly with regards to discrimination-related distress [81, 84, 85]. Notably, comprehensive cultural competence training can moderate this discrepancy in cultural competency between White and non-White practitioners [32]. For example, Chao [32] found that following comprehensive cultural competence training, White practitioners' cultural competence levels matched those of their non-White counterparts. Chao's research demonstrated that training changes the association between race/ethnicity and cultural competence because such training increases mental health practitioners' awareness of self and others and the impact of Whiteness on non-White people.

In line with international samples of mental health practitioners, the current sample demonstrated low to moderate levels of colour-blind racial and ethnic attitudes with average CoBRAS total scores of $M = 43.8$ ($SD = 13.6$). For instance, Neville et al. [31] reported that their sample of 152 American mental health workers and trainees "held low to moderate levels of color-blind racial beliefs" (p. 483) with mean CoBRAS score of $M = 48.59$ ($SD = 12.79$). Interestingly, non-White practitioners in the current study were more likely to be in denial about racial privilege and the pervasiveness of racial/ethnic issues in Australia compared to their White counterparts. This may be because the non-White practitioners in this study consider themselves, at least to some degree, beneficiaries of Whiteness. This may include their ability to access limited and competitive opportunities for higher education, their ability access health and social benefits enjoyed by those in higher socioeconomic brackets and the power and elevated social position that their career capital offers them [18, 19, 86]. Non-White practitioners working with a diversity of clients may therefore see parallels between White and non-White clients from low socioeconomic backgrounds and be less likely to attribute disadvantage to experiences of racial/ethnic discrimination [22]. Additionally, non-White practitioners may not want to buy-in to the idea that Australia suffers from pervasive and insurmountable institutional racism as this may hinder their own wellbeing and ability to encourage their non-White clients towards a fulfilling life.

In this study, the average BIDR Subscale 1: Self Deceptive Enhancement (SDE) score of all participants was $M = 4.2$ ($SD = 3.1$) and the average BIDR Subscale 2: Impression Management (IM) score was $M = 6.2$ ($SD = 3.1$). These findings are in line with normal ranges reported in other counsellor samples including Schomburg and Prieto [87] who reported trainee couples therapists' BIDR SDE and IM mean scores as $M = 5.3$ ($SD = 3.21$) and $M = 6.68$ ($SD = 4.05$), respectively. The results of the hierarchical multiple regression indicate that highly favourable perceptions of self and protection of self-image (BIDR Subscale 1: Self Deceptive Enhancement SDE) was positively associated with practitioner cultural competence (MCI total score). As such, an increase in a respondent's self-deceiving positive perception of their self-image, or at least an honest but overly positive perception of self, was found to be linked with greater multicultural competence. This may be because practitioners who perceive themselves more positively may have a higher sense of confidence in their abilities and therefore rate themselves as more culturally competent [44]. It could also be that participants protected their self-image due to the fear of being perceived as culturally incompetent, or even worse, being perceived

as a bigot and/or racist. This fear may be so strong, that practitioners may be inclined to internalise the perception that they are more accepting, benevolent, self-aware and/or altruistic than they actually are to avoid facing the reality of their shortcomings. These interpretations align with other literature indicating that mental health care provider may experience a sense of identity threat when confronted with information and/or discussions about Whiteness, racism and privilege and their role in the perpetuation of prejudice and discrimination against non-White people [32, 88–90].

The relationship between social desirability and cultural competence was unexpected. While some researchers [41] proport that social desirability is an important issue in relation to self-report in cultural competence, others have not found any relationship between these variables [31, 32]. Following Chao (2013), the BIDR was included in this study. However, unlike Chao (2013) or Neville (2006) who found no relationship between these variables, the current study found a significant relationship between the self-deceptive enhancement subscale and higher MCI scores.

The hierarchical analysis also showed that participant's age as well as the number of cultural competence-related workshops, conferences, or training sessions attended since the beginning of mental health care practice were positively associated with cultural competence. This finding suggests that cultural competence grows with clinical experience, regular engagement in training and maturity as a practitioner.

The hierarchical multiple regression also revealed that higher levels of unawareness of general and pervasive racial/ethnic discrimination (CoBRAS Factor 3: Unawareness of Blatant Racism Issues (UBRI)) are negatively associated with cultural competence (total MCI score). This finding mirrors those in other studies [30, 31, 77] and highlights that addressing race and racism is central to cultural competence training. Notably, the lack of training on race and racism may be why 48.9% of the sample were either neutral or disagreed that their qualifying training had prepared them to work with non-White people.

In summary, the study results demonstrate that non-White practitioners reported being more culturally aware and having better multi-cultural counselling relationships with non-White clients than their White counterparts. In this study, higher overall cultural competence is associated with practitioner's age, greater attendance of cultural competence-related trainings and increased awareness of general and pervasive racial and/or ethnic discrimination. Practitioners with higher cultural competence are likely to perceive of themselves more favourably than those with lower levels of cultural competence.

Implications and recommendations for training and practice

The findings of this study reinforce the need for continued engagement in cultural competence training across the full trajectory of a practitioner's mental health career. The current study reiterates the importance of continuously addressing Whiteness by explicitly discussing White supremacy, privilege and power (for example) in Western mental health care settings and clearly identifying their impact on all people, not only those identifying as non-White [91–93]. This reflects a growing national focus on key components of cultural competence training and implementation, namely multicultural awareness, and relationships. For instance, the *Australian Heath Practitioner Regulation Agency* (AHPRA) encourages health practitioners not only to learn about why difference is a significant factor in therapeutic relationships but also how to engage with diverse clients in culturally competent ways [94]. While their current guidelines are focused on Indigenous Australians, many of the principles apply to other non-White groups. Given the lack of cultural competency guidelines from AHPRA relevant to the many other non-White groups in Australia, the development of such training and best-practice models is needed to ensure mental health practitioner's preparedness to work with diverse populations. This recommendation is reinforced by the fact that cultural competence, is an integral part of all 15 health professions regulated by AHPRA and their professional codes of conduct.

Training should, however, be focused on addressing the particular needs of practitioners at various levels of experience and consider practitioner race and ethnicity. Pragmatically, practitioners could, for example, begin by completing demographic items as well as questions related to their existing counselling competence skills. Their responses would then determine allocation to training relevant to their age, racial/ethnic background as well as their professional experiences and expertise. For instance, younger, less experienced, White practitioners could engage in training that include frank discussions about Whiteness and anti-racism in mental health practice and services to increase their racial and cultural awareness. Additionally, those practitioners with higher levels of cultural competence can work on developing, implementing, or enhancing therapeutically safe mental health practises and those with lower levels can be introduced to the concepts and implications for their practice.

Aligned with the study findings, mental health care practices should actively engage with non-White populations to increase opportunities for cultural encounters between mental health practitioners and non-White clients [95, 96]. This can be done by offering home visits or providing services within community centres. Such

engagement activities can also serve to decrease ethnic and racial colour-blindness amongst practitioners and offer opportunities for clients to develop effective counselling relationships with mental health care providers [89]. Given that many mental health practitioners, particularly psychologists, work in one-on-one settings engagement with their professional networks, case conferencing and clinical practice supervision can assist in increasing their awareness of general and pervasive racial and/or ethnic discrimination experienced by their clients [97–99]. Such forums would be especially effective where topics of race and Whiteness are directly addressed so that practitioners can be regularly challenged by their peers to reduce their racial and ethnic blindness and minimise the harm of practitioner ignorance on non-White clients.

Limitations and future research

There are limitations to this study. First, the majority (76.7%) of the sample were psychologists which may limit the generalisability of the results to other mental health practitioners given that psychologists often work one-to-one with mental health clients. Further research including a more diverse sample of mental health practitioners would provide a more robust representation of cultural competence within the mental health sector. In addition, because of the limited number of non-White practitioners from diverse groups they were combined into a single group. Consequently, the results cannot be generalised to any particular group of non-White practitioners (e.g., Asian Australians, African Australians, Indigenous Australians). Additionally, the sample may be limited by selection bias with participants being specifically interested in the topic of cultural competence and/or those invested in the health outcomes of non-White clients. Research including a more diverse sample of mental health professionals may provide more information about the relationships between cultural competence and other variables like sex, age, duration of practice, and ethnicity. With a more diverse sample between groups difference can be explored more rigorously.

Second, the collected data drew on mental health practitioners' self-report. It is well documented that self-report may not reflect actual levels of cultural competence [38, 40, 100]. Given that this study found a positive correlation between self-deceptive enhancement and cultural competence, additional methods for determining practitioner cultural competence are needed. This may include a comparison between clients' perceptions of their therapist's cultural competence versus their practitioners' self-perceptions [101–103]. Further, observations and/or analysis of recordings of mental health sessions can be used to determine the provider's cultural competence. While these recommendations present their own methodological limitations, they may be more in line with a culturally competent approach [104]. Self-report may also contribute to the surprising relationships found between socially desirable responding and cultural competence. As such, future studies with larger and more diverse samples should examine the association between social desirability and cultural competence.

Conclusion

This is the first Australian study to explore the complex relationships among mental health care practitioners' sociodemographic variables, cultural competence, multicultural training, colour-blind racial attitudes, and social desirability. Additionally, it is one the few studies to use a series of regressions to analyse diverse variables and their effect on cultural competence. The study sheds light on the attributes of mental health practitioners in Australia working with diverse clients while also navigating their own diversity and difference. The findings highlight that the current one-size-fits-all and skills-development approach to cultural competence training ignores the significant role that practitioner diversity and differences play in the counselling relationship. The recommendations from this study can inform clinical educators and supervisors about the importance of continuing professional development relevant to practitioners' age, professional experience, and ethnic/racial background.

Abbreviations

MCI: Multicultural Counselling Inventory; CoBRAS: Color-blind Racial Attitudes Scale; BIDR: Balanced Inventory of Desirable Responding; AHPRA: Australian Health Practitioner Regulation Agency.

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Author contributions

Author TD conceptualised the project with the supervision and guidance of authors PC, KO and CM. Author AO engaged in the recruitment, data collection and cleaning of the data with author TD. Author RC engaged in the data cleaning and data analysis with author TD. Author TD drafted the manuscript and received assistance in quantitative results reporting from author RC. TD received conceptual and editorial feedback from authors PC, KO and CM. Author AO assisted in the editorial review and presentation of the article for publication. All authors have reviewed this article and consent to its publication. All authors read and approved the final manuscript.

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Availability of data and materials

Upon request, all relevant raw data will be freely available to any scientist wishing to use them for non-commercial purposes and without breaching participant confidentiality.

Declarations

Ethics approval and consent to participate
The study was approved by the Human Research Ethics Committee (Approval Number 2017/105) at the University of Wollongong. Before completing the survey, participants were asked to tick a box indicating that they had read the Participant Information Sheet and consented to participate. Participants were advised that only those who completed the survey in full would be provided with a $25 electronic gift voucher which could be redeemed at an Australian grocery store or its subsidiaries.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

Author details
[1]School of Health Sciences, Western Sydney University, Campbelltown, NSW 2560, Australia. [2]Translational Health Research Institute, Western Sydney University, Campbelltown, NSW 2560, Australia. [3]Diabetes, Obesity and Metabolism Translational Research Unit, Western Sydney University, Campbelltown, NSW 2560, Australia. [4]School of Medicine, Western Sydney University, Campbelltown, NSW 2560, Australia. [5]School of Psychology, University of Wollongong, Wollongong, NSW 2522, Australia. [6]School of Health and Society, University of Wollongong, Wollongong, NSW 2522, Australia.

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Publisher's Note

Chapter 5: Discussion and Conclusion

Chapter Overview

This thesis examined the ways in which mental health practitioners construed non-White people to better understand the implications of practitioner construals on the therapeutic alliance (with non-White clients) and on practitioner cultural competence. Chapter 5 presents an interpretive discussion of the thesis findings drawing on PCP. Doing so helps to produce a robust framework for mental health practitioner construing about Whiteness and non-White people. This chapter addresses all the research questions with a particular focus on research question #2: In what ways can PCP help to identify and describe practitioners' constructs about or ways of construing non-White people?

This chapter begins with a summary of the mixed methods used within this thesis which helped to name and understand Whiteness, and its consequences, within the context of mental health practitioners' construing. It then summarises the key findings that emerge from this thesis. The implications of the key findings were integrated into recommendations for mental health care training, practice, and research drawing on contemporary PCP corollaries. This chapter concludes with a discussion of the relevance of PCP in exploring practitioner cultural competence and the therapeutic alliance.

Summary of Research Methods

This thesis utilised a sequential, convergent, mixed methods approach to address the research objectives and research questions. The use of a mixture of methods also allowed for triangulation of the findings (Thomas, 1978) and supported a multidimensional interpretation of the results drawing on PCP (Kelly, 1955).

Phase 1: Systematic Literature Review (see Dune et al., 2018)

A systematic literature review was conducted across seven electronic databases in psychology, health, and social sciences. The aim was to ascertain the nature of mental health care workers' constructions about culturally and linguistically diverse individuals to facilitate provision of culturally appropriate service delivery and cultural competence training. The constructs and perspectives of 5,870 mental health workers with regards to minority populations are represented across the 38 studies included in this review. The data was synthesised qualitatively and analysed thematically.

Phase 2: Qualitative Semi-Structured Laddering Interviews (see Dune et al., 2021a; Dune et al., 2021b)

To examine the impact of Whiteness on practitioners' construct systems, cultural competence, and the therapeutic alliance, this phase of the thesis explored practitioner constructions about and preference for Whiteness and non-Whiteness. Twenty White and non-White mental health practitioners and trainees providing psychology services were convenience-sampled and interviewed using an adapted version of the laddering interview technique (Hinkle, 1965). This process helped to reveal core values (superordinate constructs) that underlie the participant's construing. These values have a wide range of implications and are less likely to be open to change than more subordinate constructs. Data was analysed thematically and the impact of construals on practitioner cultural competence and the therapeutic alliance was interpreted drawing on PCP.

Phase 3: Quantitative Questionnaire (Dune et al., 2022)

In the final phase of the thesis, a questionnaire was used to identify factors that influence non-White and White practitioner cultural competence. The questionnaire also

helped to triangulate the findings from the systematic review and the interviews. The questionnaire was completed by 139 Australian mental health practitioners. The measures included: the Balanced Inventory of Desirable Responding (BIDR) (Paulhus, 1994); the Multicultural Counselling Inventory (MCI) (Sodowsky et al., 1994); and the Color-blind Racial Attitudes Scale (CoBRAS) (Neville et al., 2006). Descriptive statistics were used to summarise participants' demographic characteristics. One-way ANOVA and Kruskal-Wallis tests were conducted to identify between-group differences (non-White compared to White practitioners) in cultural competence and racial and ethnic blindness. Correlation analyses were conducted to determine the association between participants' gender or age and cultural competence. Hierarchical multiple regression analyses were conducted to predict cultural competence.

Summary of Key Findings

The findings of this mixed method thesis demonstrate a robust interrelationship between practitioner construing, construals of non-White and White people, cultural competence, and therapeutic alliance. A summary of the core findings for each phase of the thesis is described below.

Phase 1: Systematic Literature Review (see Dune et al., 2018)

Key themes explored in the systematic literature review comprised: Aetiology of Constructions, Content of Constructions, Factors that Influence Constructions, Implications for Cultural Competence, Implications for the Therapeutic Alliance, Recommendations for Training, Recommendations for Practice, and Recommendations for Research. The findings demonstrate that therapeutic alliance was most at risk when practitioners displayed low levels of cultural competence and high levels of racial and ethnic blindness. The changing and

increasingly multicultural context within most countries means that mental health systems and workers need to prepare for an increasing range of culturally and linguistically diverse clients in need of support.

Phase 2: Qualitative Semi-Structured Laddering Interviews (see Dune et al., 2021a; Dune et al., 2021b)

In relation to practitioners' construct systems, including their constructions of and preference for non-White and White people, the interview findings highlight the persistent role of Whiteness on constructs of non-Whiteness, as well as on White and non-White people. The results suggest that a potential shift of moving away from "blindness" to acknowledgement of difference and awareness of racial inequalities has occurred in the discourse on constructions of White and non-White people amongst mental health practitioners. This change in practitioner discourse and attitudes may allow both White and non-White clients increased opportunities for access to and engagement with culturally competent practitioners and supports resources aimed at improving psychological wellbeing.

In relation to the impact of mental health practitioner construing on their strategies for cultural competence and the therapeutic alliance, practitioners demonstrated cultural competence in their acknowledgement of the impact of negative construing of ethnic, cultural, religious, social, racial, and linguistic diversity on client wellbeing. Practitioners sought to address these negative impacts on clients by building on the client-practitioner relationship to improve the therapeutic alliance. The results reinforce the need for mental health care workers to develop cultural competence with a focus on developing awareness of the impact of frameworks of Whiteness on the experiences of non-White people. This is central to the development of a therapeutic alliance where clients feel understood and assured that their mental health concerns will not be constructed (and treated) through a

framework that constrains both White and non-White people's opportunities for improved mental health and wellbeing.

Phase 3: Quantitative Questionnaire

The study demonstrates that non-White mental health practitioners are more culturally aware and have better multicultural counselling relationships with non-White people than their White counterparts. Higher MCI total scores (measuring cultural competence) were associated with older age, greater attendance of cultural competence-related trainings and increased awareness of general and pervasive racial and/or ethnic discrimination. Practitioners with higher MCI total scores were also likely to think more highly of themselves (e.g., have higher self-deceptive positive enhancement scores on the BIDR) than those with lower MCI total scores.

The findings highlight that the current one-size-fits-all and skills-development approach to cultural competence training ignores the significant role that practitioner diversity and differences play. The recommendations from this study can inform clinical educators and supervisors about the importance of continuing professional development relevant to practitioners' age, racial/ethnic background and practitioner engagement with prior cultural competence training.

Interpretation of the Findings

Overall, the findings reinforce Kelly's fundamental postulate that: "A person's processes are psychologically channelized by the ways in which he anticipates events" (Kelly, 1955, p. 46). The ways in which mental health practitioners anticipated (and responded to) events aligned with the processes of transition (described in the Introduction). Therefore, the cycles within the process of transition are discussed below to assist in interpreting this thesis's

findings and their implications. These include the Circumspection-Preemption-Control (C-P-C) Cycle, Creativity Cycle and Experience Cycle.

Circumspection-Preemption-Control Cycle

Kelly (1955) described the Circumspection-Preemption-Control (C-P-C) cycle as a decision-making process required for changes in a person's construct system. During the *circumspection* stage, we consider issues from a variety of angles. In the *preemption* stage, we select what we believe to be the critical issue and eliminate the other options from consideration. Finally, in the *control* stage we choose the alternative action through which we anticipate the greater possibility for extension or definition of our construct system (Kelly, 1955). Kelly's theory highlights the difficulty and complexity of decision-making that practitioners in this thesis experienced in their efforts to identify all the issues related to Whiteness (*circumspection*). This included isolating a critical issue (e.g., how non-White people are treated) in that moment (*preemption*) and then choosing an action (e.g., taking more time to assess their client's needs) that will extend or further define their construct system (*control*). As explained below, the thesis findings indicate that practitioners did not always easily transition through the three stages.

Circumspection

The ability to be culturally competent and engage in an effective therapeutic alliance with non-White mental health clients required practitioners in this thesis to constantly confront elements that did not fit within their construct system (Kelly, 1955). For instance, the systematic literature review demonstrated that practitioners were confronted with a variety of positive, negative, and neutral constructions of non-White people to consider within their existing construct systems (Dune et al., 2018, p. 10). For example, practitioners

had to challenge stereotypes, in others and/or themselves, of non-White people as poorly educated while simultaneously considering that some non-White clients may not have high levels of health literacy, while also trying to treat all clients equally. In the interviews, practitioners presented a variety of constructions of Whiteness/non-Whiteness and White/non-White people (Dune et al., 2021b, pp. 9-14).

In an effort to describe their experiences, practitioners' constructions of Whiteness/non-Whiteness and White/non-White people were confronted by the variety and lack of clarity of these constructs (Dune et al., 2021a, p. 11). For instance, many of the White practitioners indicated that they were not sure what Whiteness or non-Whiteness was, how to define it and/or articulate its psychosocial meaning or impact. Whiteness literature reiterates this challenge to circumspection, given that Whiteness is focused on defining (stereotyping and discriminating against) those who are not beneficiaries of Whiteness (non-White people) but does not clearly define those who are (i.e., White people) and how those who benefit go about doing so (Lewis, 2004). The unmarked nature of Whiteness thus limits practitioners' ability to circumspect (e.g., be aware of the multiple aspects of a situation) in relation to all relevant constructions about Whiteness.

As with existing international studies (Chao, 2006; Chao, 2013; Constantine, 1995; Constantine, 2002; Dickson & Jepsen, 2007; Lu, 2017), the questionnaire findings (Dune et al., 2022, p. 8) revealed that non-White practitioners had higher multicultural awareness than their White counterparts. This may indicate non-White practitioners' greater awareness of the vast and sometimes conflicting constructions about non-White people and Whiteness. Mapedzahama and Kwansah-Aidoo (2017) reflect on this in their research on the burden of Blackness wherein African Australians perceived a large array of Whiteness-related constructs

through which they must navigate Whiteness in every moment of their lives in Australia. As such, non-White practitioners would be better at circumspection about diverse constructions relating to race. However, this can present as a challenge to construing because "the variation in a person's construction system is limited by the permeability of the constructs within whose range of convenience the variants lie" (Winter, 2013, p. 79).

Where such challenges to the construct system occur, the practitioners in this thesis were forced to think in a manner that allowed for some constructive compromise. For instance, many of the trainee practitioners in this thesis identified Whiteness as being detrimental to non-White people but made little reference to the impact of Whiteness on all people. In such instances when multiple constructions may be true, circumspection permits individuals to "make exceptions" to a constellatory construct (Fransella, 2004a). For example, stereotyped or typological thinking may include the perception that Whiteness has a negative impact on non-White people only. However, in order to ensure that the substituted outcome still makes sense to the individual, they may consider that Whiteness has a negative impact on any disadvantaged person. Circumspection can therefore be likened to "what if" thinking:

> This "what if" allows us to include exceptions within our definitions of expected behaviors….the choices available under circumspection may not be easy or pleasant, but if a person is to move on, a choice must be made. (Cote, 1995, p. 15)

As acknowledged by Lewis (2004), Whiteness and the delineators for those who benefit—or are excluded from it—is constantly under negotiation. Despite this, the role of Whiteness and its consequences endure, thus forcing practitioners to make a choice, even from limited constructive options of which they may know little.

Preemption

The issue chosen from the many possibilities that present during the circumspection stage "becomes the one which preempts the other construct elements. It is chosen because of its relevance to the previously held construct" (Cote, 1995, p. 15). In line with international research on Whiteness in health care (Malat et al., 2010), when faced with the many constructions and implications of Whiteness, practitioners in the interviews (Dune et al., 2021a, p. 11; 2021b, p. 12) chose to construe Whiteness as a sociocultural construct that had a negative impact on non-White people more than White people—with the notable exception of White people from low socioeconomic backgrounds (see also Malat et al., 2018). In the systematic literature review (Dune et al., 2018, p. 11), cultural competence training influenced practitioners' circumspection and preemption by presenting them with new ideas and then requiring them to make a choice of how to construe these new ideas in ways that could be integrated into their existing construct system.

However, the above may present an oversimplified explanation of practitioners' process of circumspection to preemption. According to Kelly, the circumspection phase may be bypassed if individuals construe preemptively (Cote, 1995). This would mean that they consider few, if any, alternatives to their first ideas. For instance, findings from the questionnaire indicate that practitioners who perceived themselves as having high levels of cultural competence (i.e., higher Multicultural Counselling Inventory scores) were also more likely to respond in ways that amplified their sense of self (Balanced Inventory of Desirable Responding (BIDR): Self Deceptive Enhancement: Subscale 1 (Dune et al., 2022, p. 11). This may be because they failed to consider the multiple potential ways of construing their own construing and may therefore have preemptively determined that, because they were a

"good person", they were more culturally competent. This aligns with international Whiteness and health research indicating that mental health practitioners who responded in more socially desirable ways were more likely to rate themselves as having a high level of cultural competence (Barratt, 2008; Bitney, 2012; Chao, 2006; Chao, 2013).

As noted in previous literature (Larson & Bradshaw, 2017), self-report produces this conundrum whereby one's construing of one's own way of thinking is limited by one's ability to circumspect about all possible ways one may be construing. This may result in our construction of the situation being so simple that we "quickly run out of angles from which to view it" (Frances, 2004, para. 5). In some instances, preemptive decisiveness may be valued and required (e.g., a quick decision whether to admit a suicidal patient to hospital or send them to their general practitioner for follow-up). However, as found in all phases of this thesis, when trying to establish a strong therapeutic alliance with a client, time must be taken before making a decision on what the core issues are and how to construe them. Taking time before making decisions was construed by practitioners as culturally competent and aligns with the importance of a critical view of Whiteness in health care (Malat et al., 2010; Malat et al., 2018).

Additionally, preemption may be restricted when the range of possibilities we are willing to consider is constricted. This may occur when practitioners seek to reduce the anxiety and threat involved in opening up to multiple ways of construing. The experience occurs when an impermeable construct is invalidated (threat) and the individual realises that they must abandon it but have no replacement immediately available (anxiety). An impermeable construct rejects new events characterised by a preoccupation with old constructs and leaves the individual stuck in the past. According to Marguet (2017, p. 53),

"This type of individual can only perceive 'more of the same', and hence must exclude all new experiences that the world might offer him or her". To avoid such situations, Frances (2004, para. 6) notes that "we construe the situation preemptively, casting it into a single issue in an impulsive attempt to escape anxiety". In the interviews, non-White practitioners may have done this when asked which construct pole, White or non-White people, they preferred. Despite having defined non-White people with far more negative constructions than they defined White people,

> Non-White participants chose their pole preference quickly and seemingly without any difficulty, hesitation, or apology and with comments like: "Without a doubt…I choose non-White!," "What else would I pick?!," "I am proud with who I am…absolutely non-White. (Dune et al., 2021b, p. 8)

While this kind of preemption may be seemingly accelerated, the findings from the systematic review (Dune et al., 2018, p. 12) and questionnaire (Dune et al., 2022, p. 12) suggest that non-White practitioners may have already had multiple opportunities to circumspect and preempt due to their personal daily experiences of marginalisation resulting from Whiteness (see also Moreton-Robinson, 2000). As such, it may not be possible nor desirable for these practitioners consistently to have loose construct systems (e.g., the ability to dilate our construing and allow for an increasing number of constructions of experiences, ourselves, others and the world). As mentioned in Chapter 1, Fransella (2004b) explains,

> For with loose construing, we lose control of things, we do not know where such construing might lead. Those locked into loose construing find it very difficult to come to any firm conclusions. (para. 7)

As such, a persistently loose construct system may in fact reduce (White and non-White) practitioner cultural competence and the ability to create a strong therapeutic alliance with their clients, as they would be so preoccupied by the options that they would waste therapeutic time while struggling to choose one.

On the other hand, construing in a relatively loose way makes the preemption stage difficult. As found in the interviews, White practitioners' loose construing with regards to Whiteness/non-Whiteness and choosing a non-White or White people construct pole may have resulted in their "trepidation (e.g., extended hesitation and/or apprehension with their response)" (Dune et al., 2021b, p. 8). Importantly, many White practitioners noted that they had never before considered Whiteness in their construct systems until it was being discussed in the interview. This may have resulted in the presentation of new constructs in their potentially loose system of construing race and difference. The multiple options, loose construing, and difficulty making a choice as experienced by these White practitioners challenged their construing to such an extent that they appeared psychologically confronted and guilty about their own construing (Dune et al., 2021b, p. 8). DiAngelo (2018) describes this experience as a manifestation of White fragility where "the mere suggestion that being white has meaning often triggers a range of defensive responses" (p. 2).

The above finding is of major significance as it corroborates the perceptions of the large majority (70%) of the interviewed practitioners' reports that their formative mental health training did not adequately prepare them to work with non-White people. This reinforces what was found in the systematic review indicating that cultural competence training lacks depth with regards to discussions about Whiteness and racism (Dune et al., 2018, p. 12). However, these topics may be excluded because of the discomfort they arouse

in trainees and educators. Practitioner discomfort was highlighted in some of the systematic literature review in relation to practitioners who were resistant to culturally competent practice/s due to feelings of hostility towards cultural competence training and culturally responsive adjustments in care (Dune et al., 2018, p. 11). In PCP terms, this hostility is characterised by "the continued effort to extort validational evidence in favor of a type of social prediction which has already proved itself a failure" (Winter, 2013, p. 12). This suggests that new information presented about Whiteness may cause some White practitioners to be overloaded and overwhelmed, leaving them in a constructive stalemate between what they knew and what they are learning. As seen in Dune et al. (2021b, p. 12), a White trainee expressed their lack of clarity about Whiteness which left them with a sense of constructive confusion.

Consequently, "staying in circumspection too long holds us well back from any form of action" (Frances, 2004, para. 7). This is again corroborated by the systematic review findings that indicate that, while awareness of the implications of Whiteness on non-White people is important, cultural competence cannot stop there if one wants to support an effective therapeutic alliance with non-White people (Dune et al., 2018, p. 12). Practitioners must also take steps to develop critical self-awareness, which is a first step towards decolonisation, (Bennett et al., 2011) and educate themselves about race, racism and Whiteness to undo their own racist socialisation and actively engage in anti-racism practice (Olcon, 2020).

This link between construing and behaviour is also implied from the questionnaire findings wherein practitioners who had high multicultural counselling relationship subscale scores (therapeutic alliance) also had high multicultural awareness subscale scores (a

foundational element of cultural competence) (Dune et al., 2022, p. 13). This indicates their self-perceived ability to circumspect (be aware of the multiple aspects of a situation), preempt (choose one issue to focus on) and then control (act upon one's construing)—thereby turning construing into action.

Control

Kelly explains that a proportional balance of circumspection and preemption allows us to become architects of action that can allow us to run "behavioural experiments" appropriate to the situation (Fransella, 2004a). This aligns with Kelly's proposition that the person is a scientist and that individuals conduct behavioural experiments to test their perceptions and interpretations of others and the world (Kelly, 1955). In support of this concept, Fransella (2004a) notes that:

> A clear choice and robust experimental design are the features of the control phase. While we are encouraged by Kelly to jump in with both feet, we are also cautioned to make sure there is somewhere to land. We aim to elaborate our predictive system through action, but we also need to maintain its essential features, rather than find ourselves thrown into chaos. (para. 7)

Herein lie the core elements of cultural competence and the therapeutic alliance whereby practitioners must choose an action and then test it out according to a predictable system. This may include choosing to engage in additional continuing professional development (CPD) (as seen in the systematic review (Dune et al., 2018, p. 12) and questionnaire findings (Dune et al., 2022, p. 13), to seek out cultural encounters to build cultural knowledge and skill, or invest in developing connections and culturally safe approaches (as seen in the interview findings (Dune et al., 2021a, p. 9). The caveat is that this

cannot be done in a tokenistic fashion (just to tick the CPD box) and must be engaged in authentically (to increase one's competence to work with non-White clients). Such dedication helps move practitioners out of complacency about Whiteness and its implications and turns them into agents who are responsible for how Whiteness is de/constructed in their interactions with their clients (Applebaum, 2010).

Once behavioural experiments are run, practitioners can then collect more data from others and their environments to help them re-design or revise their actions towards a desired outcome. In this endeavour, one of the desired outcomes of such action would be less anxiety in the therapeutic process for both the practitioner (because of increased cultural competence) and the client (because of a safer therapeutic alliance).

Given the environment of constant diversity and change discussed earlier, practitioners must be humble enough to be creative in their engagement with their clients. As noted by one of the Aboriginal practitioners in the interviews, asking questions was integral to professional growth. She explained,

> …If you don't ask the questions, you are not going to grow as a professional. As a White professional, you are going to constantly have these barriers between you and Aboriginal culture. Ask it, it's not offensive; it's more offensive when you don't ask because we know when you're not asking. (Dune et al., 2021a, p. 9).

This quote highlights that if a practitioner cannot face and manage the discomfort of not knowing by asking more questions more offence can be caused to the client and damage the therapeutic alliance. As such, mental health workers must be willing and able to open their

construct system enough to recognise that they are not the fonts of all knowledge and then develop a means for addressing their information gaps. Although Whiteness prohibits this kind of constructive permeability by creating rigid epistemological hierarchies (Tummala-Narra, 2007), practitioners must be courageous enough to overcome this in order to offer effective mental health support to non-White people (Baima & Sude, 2020).

Creativity Cycle

The Creativity Cycle is a process of construing that moves from loose construing to tight construing and back and forth until an individual feels that something has been "created" that they can then test. The Creativity Cycle is central to the purpose of cultural competence training, which aims to improve the therapeutic alliance. For instance, the questionnaire findings indicate that practitioners who engaged in additional post-registration cultural competence training were more culturally competent than those who did not. This suggests that the Creativity Cycle potentially played a part in allowing practitioners who undertook additional cultural competence training to broaden their perspective to such an extent that they were able to enter a state of suspended construing (Dune et al.,2022, p. 13). In such a psychological state, practitioners' constructions of Whiteness/non-Whiteness and White/non-White people can be loosened. Notably, the Creativity Cycle requires practitioners to construe cultural competence training as potentially informative and valuable (e.g., display cultural desire) to allow them to engage in the uncomfortable process of loosening one's constructions. Whiteness can restrict practitioners' willingness to engage in such training as it can trigger a tightening instead of a loosening of constructs. This may be due to the threat experienced by some practitioners when the constructs, central to their identity, within their

construct system are challenged and invalidated (Dune et al., 2018, p. 11). As explained by Abrams and Gibson (2007),

> [R]esistance to learning about White privilege is even more profound than resistance to learning about the effects of racism, because racism as a problem could conceivably belong to others, whereas White privilege can and should be internalized more personally (p. 154).

In the systematic review, many of the included studies indicated practitioners' resistance as a major barrier to the effectiveness of cultural competence training. Those practitioners who resisted training or perceived it to be of little value were also more likely to have negative constructions of non-White people and lower multicultural counselling relationship scores (e.g., poorer therapeutic alliance) (Dune et al., 2018, p. 11). These practitioners clearly struggled with allowing their constructions to be loosened to allow the opportunity to construe creatively about non-White people (see also Hytten & Warren, 2003). Creative construing in this regard may include the understanding that not all non-White people have language barriers, suffer financial disadvantage, or have low levels of health literacy. As noted in the systematic review, this propensity for tight construing may be due to an unwillingness to challenge or be open to diverse constructions of Whiteness/non-Whiteness (Dune et al., 2018, p. 12).

Hytten and Warren's (2003) research on educating graduate students about Whiteness highlights resistance to loosening one's construct system similar to the experiences of some practitioners in the systematic review. Here is an example of this relevant to one of the students in their study:

> Carl's consistent citation of Marxist thought also functions as subtle form of resistance. Even when he is asked explicitly about his own experiences…This occurs, for instance, when he is asked to write about whether or not he does anything in his life to combat racism. Here he moves rapidly away from himself to Marx (Hytten & Warren, 2003, p. 82).

Previous research (Bitney, 2012; Constantine, 2002) and the current thesis findings imply that practitioners with lower cultural competence scores may well experience a sense of threat to their superordinate constructs and therefore their construct system and ultimately their sense of self. Lester (2009) explains that "threat was defined by Kelly as an awareness that a comprehensive change was imminent in your core constructs and, therefore, in your conception of yourself" (p. 92). To avoid this confronting experience, triggered by cultural competence training, resistant practitioners avoided and shunned creativity—the ability to loosen and tighten their construing about Whiteness/non-Whiteness and non-White/White people (see also DiAngelo, 2018).

For those practitioners who identified the potential benefits of experiences that could challenge their construing and constructions, including cultural competence training and/or cultural encounters, creativity became possible and freeing. In the interviews, participants discussed this challenging but freeing experience as aligned with the empowerment element of therapeutic alliance. As noted in an interview with a White British practitioner in Dune et al. (2021a, p. 12), the Creativity Cycle was enacted in her ability to take a client's culture into account when designing a treatment plan. She described her eclectic, holistic and collaborative approach which highlighted her ability to be flexible and adaptable, thereby ensuring a therapeutic approach that was both evidence-based and client-centred.

This adaptability exemplifies the Creativity Cycle as experienced by those practitioners who were willing to loosen their constructions to work effectively with non-White clients. This also highlights this practitioner's willingness to reconstruct her White power and White privilege in an attempt to deconstruct the structures of Whiteness within mental health care that may restrict open communication and collaboration (see also Zufferey, 2013). In line with Kelly's theory, the interviews reiterate that creativity frees the practitioner from the anxiety, threat, fear and guilt of having to know everything and frees the client from the anxiety, threat, fear and guilt of having to justify and defend their experiences of Whiteness within the therapeutic context (Dune et al., 2021b, pp. 16-17; Fransella, 2004b).

It is therefore acknowledged that the therapeutic context requires both the helper and the helped to engage creatively. This also reduces the burden on non-White people to educate practitioners about race, racism and Whiteness (Kow, 2010). In doing so, the practitioner can become better at providing therapeutically safe mental health care by being more comfortable with loosening and tightening their constructions on a regular basis. It also allows clients to experience improvements in their mental health sooner because the therapeutic alliance and interventions become a safe space for them to engage in the challenges (e.g., loosening or tightening their constructions) needed to review, refine and/or redesign their construct system/s.

Guidance from a practitioner who can demonstrate how to use the Creativity Cycle for construing within the therapeutic alliance can assist clients to move out of overly loose construing and become clearer about their goals and the means to achieve them. This may include reflecting back to the client how the practitioner revised their formulation of the client's mental health symptoms and interventions over the course of therapy, and learning

more about who the client is and what is important to them. In doing so, the practitioner is able to demonstrate how cognitions and emotions (construing) can be changed and harnessed towards making choices (firm conclusions) which can then be tested via actions (behavioural experiments).

The questionnaire findings (Dune et al., 2022, p. 13) also reinforce the role of the Creativity Cycle in practitioner construing and its impact on cultural competence and therapeutic alliance. For instance, practitioners with high levels of cultural competence and therapeutic alliance had also attended multiple continuing professional development courses on these topics since completing their qualifying course. Given that the correlation between engagement in cultural competence training and culturally competent practice is well documented (Dune et al., 2018), it is clear that consistent engagement in the Creativity Cycle allows practitioners to continually loosen and tighten their constructions to support new ways of engaging with non-White people (see also Olcon, 2020).

This is also reinforced by the questionnaire data, which reiterates international evidence of non-White people being more culturally competent than their White peers (Chao, 2013; Dickson & Jepsen, 2007; Dune et al., 2018; Dune et al., 2022; Kuo & Arcuri, 2014; Pope-Davis et al., 1995; Roysircar et al., 2005). As noted in the C-P-C cycle above, the persistent confrontation between Whiteness and being non-White may force non-White practitioners to exist in a near constant state of creativity cycling in order simply to navigate their day-to-day lives, thus giving them an advantage in this process of transition.

Construing creatively is therefore integral to the therapeutic alliance and effective therapy because it teaches both the client and the practitioner to “explore new ways of

dealing with life…without creativity our lives would be one monotonous continuum of well-worked out events" (Fransella, 2004b, para. 8)—hence the importance of experience.

Experience Cycle

The Experience Cycle includes five phases: anticipation, investment, encounter, confirmation or disconfirmation, and constructive revision. Kelly (1955) proposed that "a person's construction of experience varies as he (sic) successively construes the replication of events" (p. 72). The Experience Cycle is important in interpreting the findings of the current thesis as it describes how an individual applies, develops, and modifies their construct system—again a necessary process in the provision of culturally competent mental health care.

Anticipation

The first stage in the Experience Cycle is anticipation, where "a prediction is formulated concerning a particular event" (Winter, 2013, p. 13). In relation to therapeutic encounters (the event/s), the systematic review revealed that practitioners who constructed non-White people as having backward values and beliefs predicted that non-White people could not make appropriate decisions about their health and wellbeing (Dune et al., 2018, p. 10). These practitioners therefore predicted that non-White clients would struggle to interact with mental health services and would therefore have difficulty engaging and complying with mental health intervention/s (Dune et al., 2018, p. 10).

Investment

Following anticipation, individuals must fully involve themselves in their prediction by becoming invested in the outcome of the event (Buckenham, 1998). Continuing with the

above example, the interview narratives indicated that practitioners who constructed non-White people as unable to make educated health care decisions may hold this construction in mind when preparing to encounter a non-White client (Dune et al., 2021b, p. 10). Despite the cultural incompetence of such an approach, this way of construing would allow practitioners to feel secure and safe about their way of thinking and therefore reduce any anxiety or threat which may be produced when anticipating an unknown event (e.g., meeting a new non-White person).

Encounter

Once invested in the outcome of their prediction, practitioners then face an encounter, "an open and active experiencing of the event" (Winter, 2013, p. 14), with a non-White client in need of mental health support. Drawing on the interview findings (Dune et al., 2021a, p. 10), the practitioner may encounter a non-White person who does not seemingly construe mental health in the way that Whiteness constructs it. That is, they may construe mental health in spiritual/religious, cultural/ethnic, or socioecological terms that seem misaligned with DSM-V or ICD-10 criteria (see for example Baima & Sude, 2020). The non-White client may also construe mental health treatment in ways that seem obstructive to interventions that are embedded in Whiteness models of health care (Dune et al., 2018, p. 10). However, as seen in the interview narratives, the culturally competent practitioner may notice that when they discuss mental health in diagnostic and interventionist terms the client seems to distance themselves from the therapeutic alliance (see also Anderson, 2003; Clark et al., 2012). However, when the practitioner discusses mental wellbeing in culturally relevant terms, they may perceive the client as more receptive and responsive to the therapeutic alliance (Roysircar, 2005). As found in the interviews, by exploring the client's ability to

participate as they would like in family relationships or to engage in religious and social activities, the practitioner may notice that the client is more open to constructive revision and more willing to return for additional support (Dune et al., 2021a, p. 12).

Confirmation or disconfirmation

During and after the encounter with the non-White client, the practitioner must then conduct an "assessment of this encounter in relation to the initial anticipation" (Winter, 2013, p. 14). Continuing with the above example, the practitioner's anticipation may seem to have been confirmed regarding the non-White client's construing about mental health symptoms and interventions. However, the practitioner's investment in the anticipated outcome (that the client would refuse ongoing care) was not confirmed because the client did want to continue seeking mental health support. This demonstrates that while the client's construct system was different to that of the practitioner, they were able to make appropriate decisions about their own care. Such a process is reflected in the interview findings where practitioners demonstrated the ability to absorb new information which allowed them to revise their construing and engage competently with non-White clients (Dune et al., 2021a, p. 9).

Constructive revision

Once they have assessed the encounter, the practitioner "engages in any reconstructing which is deemed necessary following evaluation of the evidence obtained during the encounter" (Winter, 2013, p. 14). As noted by Buckenham (1998, p. 878), "this constructive revision will take place from within the person's construct system, therefore the direction and nature of change will be channelled by that person's existing constructions". For instance, interviewees perceived that practitioners with low levels of cultural competence constructed non-White people as uneducated about mental illness and health interventions

and thus as being less likely to participate in help-seeking (Dune et al., 2021b, p. 10). While this construction may be true for many non-White people (Dune et al., 2018, p. 3), interview participants also indicated that practitioners with high levels of cultural competence were able to use the therapeutic alliance to help non-White clients understand mental health symptoms and services in terms that resonated with the clients' core beliefs and values (Dune et al., 2021a, p. 10). Practitioners who embraced this approach were able to use their experiences to revise their construing about *communication* with non-White people without having to change their *construction* that some non-White people/groups may construe mental health and services negatively and therefore be more likely to avoid help-seeking or comply with intervention protocols (Dune et al., 2021a, p. 12). This demonstrates the practitioners' ability to go beyond awareness about the impacts of structural Whiteness and move into "understanding and challenging the system of power that supports White privilege" (Applebaum, 2010, p. 31).

Practitioners' abilities to engage in constructive revision may also be inferred from the questionnaire findings. Notably, practitioners who were older and those who had engaged in more post-qualifying training were more culturally competent than those who were younger or who had not attended further training (Dune et al., 2022, p. 13). Given that practitioners in the questionnaire sample saw (on average) one non-White client a week, those with more years of practice and training had more experience and therefore more opportunity for their construing to repeatedly oscillate through the Experience Cycle. This kind of longitudinal experience allowed practitioners to develop stronger and more effective therapeutic alliances with diverse clients due to their increased ability to engage in multiple types of constructive

revision. This includes: “a change in the construction of an element (slot change)”,[3] “change in patterns of construct relationships (pattern change)”,[4] or the “development of new constructs (construct innovation)”[5] (Buckenham, 1998, p. 878). Constructive revision, therefore, sets the stage for fresh anticipation and further Experience Cycles (Winter, 2013)—a process that for mental health care practitioners is continuous, albeit challenging. As noted by Kelly (1955, p.77), “the variation in a person’s construction system is limited by the permeability of the constructs within whose range of convenience the variants lie”. To assist practitioners in navigating this process, appropriate cultural competence training, practice guidelines and more research about practitioner construing is needed.

Key Reflections on the Thesis Findings

The findings of this thesis culminate in three key personal reflections of relevance to clinical practice and mental health care provision to non-White people. Based on these reflections, Australian mental health care practitioners should:

1) Construe non-White people and Whiteness in ways that align with PCP’s processes of transition.
2) Construe and engage with non-White people through frameworks of Whiteness.

3 “If our construction of an element is invalidated then the most obvious direction of movement is to reconstrue this element at the other end of the construct” (Buckenham, 1998, p. 878).

4 “When a construction of an element changes, but is not invalidated then there may be changes in the relationships between constructs or the meaning of constructs” (Buckenham, 1998, p. 878).

5 “This change involves developing new constructs to make sense of an event. Kelly (1955) suggests this is the most difficult form of change, but acknowledges the individual is in constant motion to redefine their situation” (Buckenham, 1998, p. 878).

3) Experience training as central to their development of cultural competence and therefore their ability to develop the therapeutic alliance with non-White clients.

The following section provides recommendations towards improvements in practitioner training, practice, and research that emerge from the findings.

Recommendations for Training, Practice and Research

The processes of transition discussed above help us understand practitioner construing in relation to the findings of this thesis. To operationalise these processes into clear recommendations for training, practice and research, the corollaries of PCP are useful. Since Kelly's original theory was developed, several new corollaries that help describe processes of construing in a modern age have been developed. Based on the aims and findings of the thesis, three additional corollaries assist in operationalising the implications of the results. These are the Self-Awareness Corollary, the Social Awareness Corollary and the Complementarity Corollary (Thomas, 1979). As discussed in Chapter 1, these corollaries were developed by Laurie Thomas in response to the need to explain construing within co-constructed conversational settings, like face-to-face therapy, and relevant to increasingly multidimensional, complex, and contemporary psychosociocultural environments and mental health concerns.

In the section below, the self-awareness corollary has been used to operationalise recommendations for training, given that self-awareness is a necessary first step towards the development of cultural competence and one which helps practitioners recognise the need to consistently engage in cultural competence professional development (Campinha-Bacote, 1994). The social awareness corollary has been used to operationalise recommendations for practice because the therapeutic alliance is contingent on the practitioners' understandings

of social interactions and how these influence their own and their clients' experiences in therapy and in life (Dune et al., 2021c). The complementarity corollary has been used to operationalise recommendations for research given the great, yet under-researched, diversity in practitioners and non-White clients in Australia and the limited number of methods used more broadly for exploring the impact of Whiteness on cultural competence and therapeutic alliance (Larson & Bradshaw, 2017).

Self-Awareness and Recommendations for Training

The findings of this thesis highlight the importance of practitioners' ability to engage with non-White people's construals of themselves and their experiences, which may differ considerably from the practitioner's own personal constructs and construing. However, based on the results of this thesis, self-awareness is not only difficult but also influenced by the practitioner's ethnic/racial background, age, and engagement in cultural competence training. While a practitioner's age and ethnic/racial background cannot be altered, their engagement in cultural competence training throughout their professional trajectory can be influenced.

As per the findings described in this thesis, training is central to assisting practitioners to develop critical self-awareness so that the impact of Whiteness on individuals, systems and societies can be exposed and systematically deconstructed. Given that the ability to construe another's constructions (a component of cultural competence) is a prerequisite for entering into a social process with that other (an element of therapeutic alliance), the following recommendations for training are proposed. These recommendations are drawn from the thesis findings and elaborated upon below. Figure 5.1 demonstrates how these

recommendations can be integrated towards improvements in practitioner cultural competence.

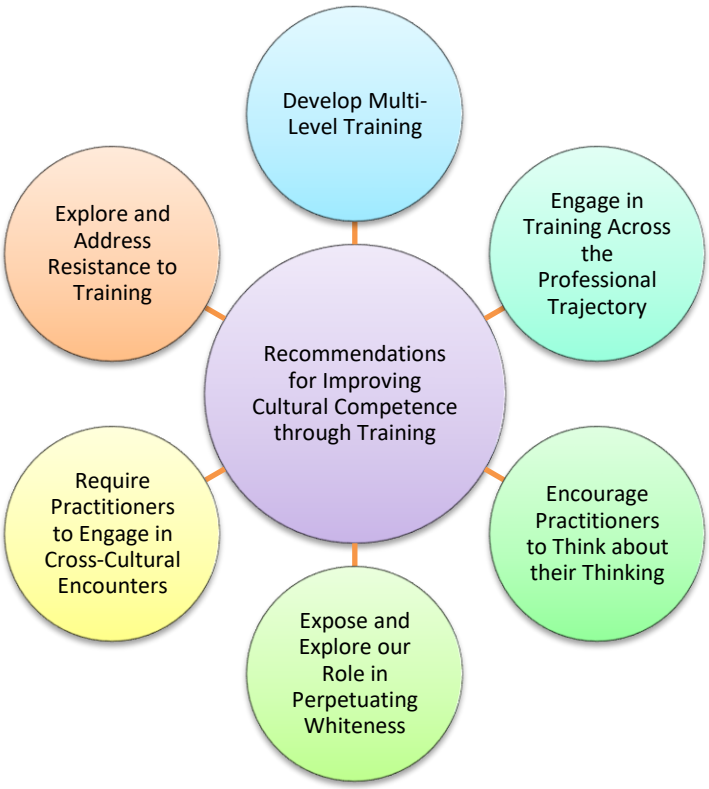

Figure 5.1 Recommendations for Improving Cultural Competence through Training

Training Recommendation 1: Develop Multi-Level Training

Training organisations (e.g., university/college courses and private training providers) should offer multiple levels of training relevant to practitioner age, race/ethnicity, and prior cultural competence training. Pragmatically, practitioners could, for example, begin by completing demographic items as well as questions related to their existing counselling competence and therapeutic alliance skills. Their responses would then determine allocation to training relevant to their age, racial/ethnic background as well as their professional experiences and expertise. For instance, younger, less experienced, White practitioners could engage in training that included discussions about Whiteness and anti-racism in mental health

practice and services. Additionally, those practitioners with higher levels of cultural competence and therapeutic alliance could work on developing, implementing, or enhancing therapeutically safe mental health practices and those with lower levels could be introduced to the concepts and implications for their practice.

Training Recommendation 2: Engage in Training Across the Professional Trajectory

Cultural competence training should be a requirement at regular intervals throughout a practitioner's studies and career (e.g., professional networking, case conferencing, clinical practice supervision). It is not sufficient for such training to be delivered only during qualifying training or solely based on practitioners' continuing professional development preferences. This requirement could be embedded within the university course accreditation requirements wherein explicit units and embedded content must be identified within training programs. These units and content must be scrutinised by practitioner training regulatory bodies like the *Australian Health Practitioner Regulatory Agency* (AHPRA) and the professional associations that report to it (e.g., Psychology Board of Australia) and the *Australian Quality Framework* (AQF), which regulates tertiary education programs, before a training program can be accredited. Once practitioners complete this formative training, continuing professional development on cultural competence should be expected at least every two to three years. Although many large organisations encourage staff to complete some form of low-level sociocultural competence training (e.g., Indigenous, LGBTIQ+, sexual harassment, mental health awareness training), few include or mandate their staff to complete robust and multi-dimensional cultural competence training. To avoid this inconsistency between organisations and practices, AHPRA and other professional regulation boards could enforce a schedule for

cultural competence training relevant to practitioners' work environments, professional experiences, and demographic features.

Training Recommendation 3: Encourage Practitioners to Think about their Thinking

Training should focus on helping practitioners develop a habit of cross-cultural reflexivity in their mental health practice. This could be achieved through opportunities for inter-professional learning, given that such training environments expose students to other ways of thinking from both professional (e.g., views on Whiteness in social work versus psychology) and individual perspectives (e.g., learning about how one's own thinking differs from that of others). This could be facilitated through placement opportunities in settings that are inherently multidisciplinary, including hospitals, community health practices and public health organisations. Most trainees must complete some form of reflection about their placement experiences as part of their formative training. Within these reflective assessments, trainees could be asked to reflect on how their thinking about Whiteness and/or culturally competent practice was revealed, confronted and/or changed while on placement and how their thinking differed to others in their profession and across professions. By reflecting on themselves and others across diverse professions, mental health trainees could be exposed to a large variety of ideas to help them distil core themes within their own thinking that need to be addressed for them to be more culturally competent.

Training Recommendation 4: Expose and Explore our Role in Perpetuating Whiteness

Training should explicitly expose and explore Whiteness, privilege, racism, colour-blindness, and intolerant attitudes with a focus on engaging practitioners' self-exploration of how these constructs manifest in their experiences and construing. This means that cultural competence training must go beyond encouraging cultural awareness, skill, knowledge,

encounters, and desire and move into challenging practitioners to recognise, identify, unpack, and deconstruct Whiteness in therapeutic settings where possible. Importantly, training on anti-racism and the role of individual practitioners in advocating for racial equity is paramount. In addition to explicitly and unapologetically engaging practitioners in discussions about Whiteness, privilege, racism, colour-blindness, and intolerant attitudes, end-of-training assessment could include questions about how practitioners will enact anti-racism principles in their practice in the short, medium and long term. This would force practitioners out of being passive receivers of cultural awareness content and direct them towards being culturally competent change agents within their sphere/s of influence.

Training Recommendation 5: Require Practitioners to Engage in Cross-Cultural Encounters

Following foundational training, practitioners should be exposed to structured, education-focused, cross-cultural encounters so they can test the relevance and applicability of their newfound awareness, knowledge and skills. While this is implicit within many workplaces and client engagement structures, mental health staff promotion frameworks should make cross-cultural engagement more formal and include clear indications of the aspects of practitioner development that must be demonstrated. For instance, mental health practitioners should participate in local events, be active in the multicultural community and try to build real connections with people who are different from themselves. Doing so in diverse and robust ways (e.g., volunteering for an event, not just attending) would demonstrate the practitioners' ability to accept challenges to their construing and subsequently revise and/or replace invalidated constructions.

Training Recommendation 6: Explore and Address Resistance to Training

Training should explicitly address practitioner resistance to training by engaging practitioners in identifying their construct systems and processes of construing. In order to do so, training should be focused on addressing the antecedents to cultural competence, including:

> …1) openness to learning about new cultures, arising from a flexible attitude and willingness to reflect on one's own ethno-culture, beliefs and behaviors; 2) motivation to want to be more knowledgeable, skilful and aware of others' cultures; and 3) cultural sensitivity, a cognitive and affective component that involves attitudes, perceptions and values that illustrate awareness of one's own culture and recognition and respect for others' cultures. (Micheal et al., 2021, pp. 9-10)

Given that resistance may be due to practitioners' (especially trainees') lack of these critical antecedents to cultural competence, foundational training should focus on helping trainees reflect on themselves, their thinking, and their role in perpetuating Whiteness. Additionally, more clarity for trainees about how cultural competence aligns with their professional practice is needed. This could be done by orienting training to specific professional roles, given that practitioners may disengage from general cultural competence training as it does not go into the depths of how Whiteness and cultural competence play out within professions and within organisations. Advocates within diverse mental health professions are therefore needed to assist skilled cultural competence trainers to address training antecedents and professional specifications that impact on anti-racism actions and individual practitioner agency. This would ensure that practitioners revisit topics at different

stages of their career with content specifically directed to their professional level and the types of resistance experienced across one's professional trajectory.

By implementing these recommendations into cultural competence training, practitioners could engage in critical self-awareness (Crans, 2013; Olcon, 2020; Zufferey, 2013). Doing so could result in the construction of new social processes that change practitioner-client interactions (therapeutic alliance) for the better (Thomas, 1979; Thomas et al., 2011).

Social Awareness and Recommendations for Practice

The therapeutic alliance requires practitioners and clients to engage in a mutually recognised social process in which they are both invested. This dynamic therapeutic setting (both physical and psychological) results in a partially overlapping construction of each individual's construing of their experience of their social interactions. Herein lies the social process which Kelly (1955) explains is animated by each individual's own constructions of social experience. As demonstrated in the results of this thesis, awareness of this social process is necessary for practitioners to understand their clients and to observe both themselves and their client in relation to the macro-level social process of Whiteness. This multi-dimensional, multi-directional and dynamic form of construing aligns with Thomas's (1979) social awareness corollary. To support practitioners' understanding of and engagement within this social process, the following recommendations for practice are proposed. These recommendations are drawn from the thesis findings and publications and elaborated upon below. Figure 5.2 demonstrates how these recommendations are integrated towards improvements in practitioner cultural competence and therapeutic alliance.

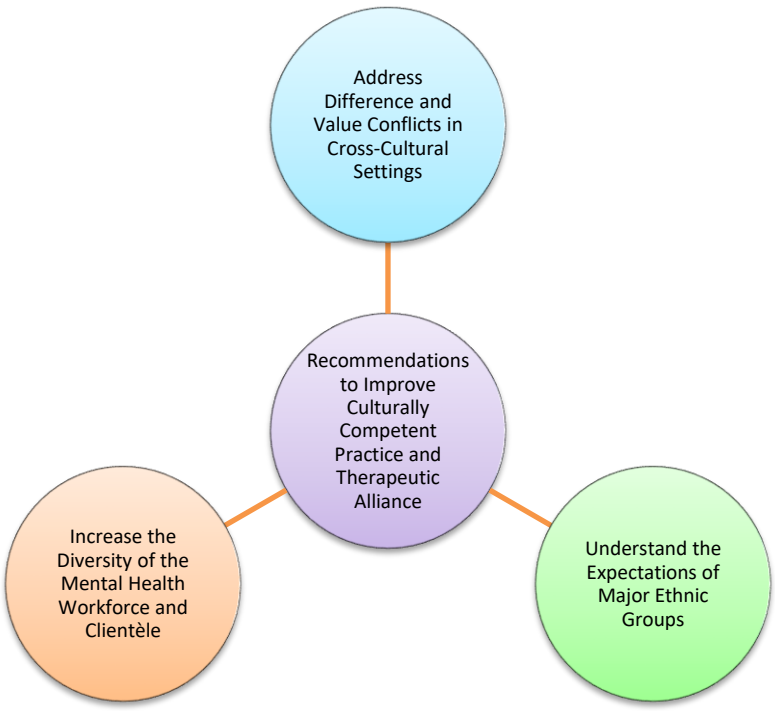

Figure 5.2 Recommendations for Improving Culturally Competent Practice and Therapeutic Alliance

Practice Recommendation 1: Address Difference and Value Conflicts in Cross-Cultural Settings

Culturally competent practice could be supported by the development, implementation and utilisation of resources that help practitioners competently address and engage in uncomfortable discussions about difference and value conflicts in cross-cultural settings. This could be facilitated by providing practitioners with a cross-cultural engagement guide within their induction packs when they commence a new position. This resource could highlight the diversity within the staff, organisation and amongst clientele. It could reiterate the importance of cross-cultural engagement and core difference and value conflicts that hinder mental health and wellbeing amongst staff and with clients. To promote culturally competent practice such a resource could include guidance on how to access support when working across cross-cultural differences, including interpreters, cultural liaisons and/or

multicultural support organisations. Such a resource could be formalised into practitioner performance evaluations or regular supervision discussions with questions/discussions focused on how practitioners have addressed—or struggled to address—value conflicts in ways that supported their own cultural competence and therapeutic alliance with their client/s.

Practice Recommendation 2: Understand the Expectations of Major Ethnic Groups

Cultural competence also requires resources that provide guidance on cultural expectations or protocols within major ethnic and/or religious groups. While this is a rather traditional and existing aspect of culturally competent practice approaches, the findings of this thesis suggest that practitioners found information about major racial and ethnic groups helpful. In addition to formal training pathways for accessing this information, practitioners could take practical steps by learning some of their clients' languages, making home visits and attending cultural events.

Primarily, information about major racial and ethnic groups helps practitioners know that they need to ask more questions about certain topics and/or avoid spending too much of their clinical time antagonising clients with questions to which they should already have the answers. For example, on the one hand, a better understanding of the experiences of the Islamic community in which a practitioner works could help the practitioner ask if it is appropriate to shake hands with a client of the opposite sex before they reach out to do so, which might create discomfort for both parties (and any witnesses) and therefore impact on the therapeutic alliance. On the other hand, a more robust understanding of Islamic cultures may help a practitioner avoid saying or asking things that could be perceived by the client as microaggressions, such as suggesting a client with obsessive compulsive disorder reduce the

number of times they pray per day as part of a clinical behavioural experiment to challenge their experience of anxiety. A client may perceive this suggestion to be insensitive and ignorant and disengage from service.

Without basic and core understandings of the major groups that a practitioner works with, significant damage can be done to the therapeutic alliance. Such damage can occur not only at the individual level but also at the community and professional level given that engagement with mental health services and practitioners remains taboo and stigmatised amongst many communities. As such, even minor missteps by practitioners or services could result in client disengagement and distrust of the practitioner and the profession, and negative appraisals of both within the community. While mistakes are human and expected, perceived racial and ethnic ignorance, prejudice or discrimination is often considered to be intolerable in a setting where a client is at their most vulnerable and the practitioner has significant power. Where possible, practitioners should therefore learn more about their clientele to avoid unnecessary and preventable damage to the therapeutic alliance.

Practice Recommendation 3: Increase Diversity in the Mental Health Workforce and Clientele

Mental health services should recruit and select skilled practitioners to ensure diversity in the overall workforce. Services should also be proactive about the inclusion of heterogenous clients in their practice. The recruitment of a diverse workforce within mental health services directly acknowledges difference and the pitfalls of colour-blind approaches to diversity. Organisations could do this by advertising roles for bilingual practitioners, which would simultaneously increase access to services by non-White clients from that language group. In order to ensure the availability of bilingual and/or non-White practitioners, training

programs could seek to recruit mental health trainees from a wide range of backgrounds. While this would give opportunity to non-White practitioners, it would concurrently increase the esteem and perception of mental health services within their communities. In doing so, members of their communities may be more likely to engage with mental health services, given that they would know someone like them who is a mental health practitioner.

Importantly, many non-White people avoid engagement in—or disengage from—mental health services because they perceive or have experienced a lack of understanding from practitioners in relation to their experiences of Whiteness and its impacts. Given this reality, knowing there are practitioners who are more like them and therefore more likely to understand them may increase their trust in mental health practitioners and services more broadly. This proposition could be further supported by services that advertise the diversity of their workforce on their websites and highlight the collaborative nature of the team in their service descriptions. This could also draw in non-White clients by implying or explicitly indicating that practitioners, regardless of being White or non-White, learn from one another to ensure a robust client experience and therapeutic outcomes. This may increase the non-White client's trust in mental health practitioners, even White ones, given their proximity and potential likelihood of increased cultural competence because of their collaborative work environment.

Finally, mental health services could attract non-White clients by including images of non-White people in their marketing and advertising materials. When clients see people like themselves in mental health promotional material, they are more likely to perceive that the service is inclusive and welcoming. Given the wide availability and accessibility of creative commons images online, there is no excuse for services to perpetuate Whiteness as the status

quo and persist in including only images of affluent White people in their marketing, promotional and internal materials.

These recommendations support the development of therapeutic alliances with clients that challenge the practitioner to continually increase their cultural competence (Roysircar et al., 2003). These recommendations for practice also provide clients with opportunities to reconstruct their social and psychological processes for the better (Zane et al., 2005). In doing so, practitioners can expand their construct systems to accommodate more complexity with less discomfort and resistance (Thomas, 1979). When done consistently, both the practitioner and the client can move towards decolonising the therapeutic interaction and deconstructing rigid scripts of Whiteness within their construct systems (Bennett et al., 2011).

Complementarity and Recommendations for Research

The findings from this thesis highlight the relevance of difference as an ethnic/racial/religious identifier within practitioner construing, constructions and in relation to cultural competence and therapeutic alliance. The findings demonstrate that there are many points where practitioners share "an innate construction of experience" (Thomas, 1979, p. 15) (as can be seen in the superordinate constructs extracted in the laddering interviews). While this may be the case, findings from the thesis (systematic review and questionnaire Phases) indicate that differences across practitioner groups (e.g., racial/ethnic) result in different constructions and behaviours.

For instance, all mental health practitioners may share similar conscious or sub-conscious constructions of non-Whiteness/Whiteness and non-White/White people (as seen in the interviews) that govern how they interact with other practitioners, clients, and the

services/systems where they work. While this is true, the findings of this thesis indicate that, within individual practitioners and subgroups of practitioners, diversity of construing is evident. The following recommendations for research stem from the need for more understanding of the similarities and differences (complementarity) of the Australian mental health workforce with regards to construing about non-Whiteness/Whiteness and non-White/White people, and the implications for cultural competence and therapeutic alliance. These recommendations are drawn from the thesis findings and publications and elaborated upon below. Figure 5.3 illustrates how these recommendations support improvements in evidence about practitioner cultural competence and therapeutic alliance.

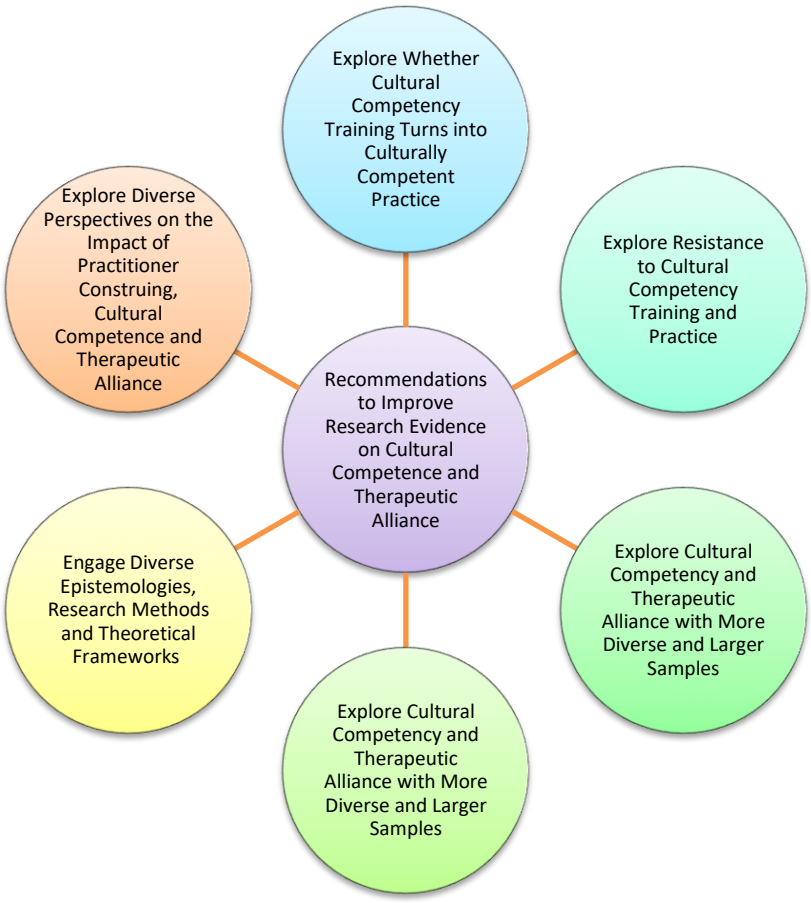

Figure 5.3 Recommendations for Improving Research Evidence on Practitioner Cultural Competence and Therapeutic Alliance

Research Recommendation 1: Explore Whether Cultural Competence Training Turns into Culturally Competent Practice

Future research should focus on the processes through which cultural competence training transfers into reflexivity, awareness, knowledge, and skills and then into effective practice with non-White clients. Differences in how various training experiences (e.g., didactic and experiential) influence constructions about non-White people require further investigation. This could be done, for example, via a longitudinal investigation of pre-licensure trainees from enrolment into formative training, after completion of training and then at regular intervals across their careers.

Research Recommendation 2: Explore Resistance to Cultural Competence Training and Practice

More information is also needed about trainees who are resistant, ambivalent, or non-receptive to the principles of cultural competence and the means for supporting the therapeutic alliance. This information would allow for the development and delivery of effective pedagogy as well as learning environments with a cultural ambiance conducive to attitudinal and behavioural change. More information could be sought on this by exploring why trainees embarked upon a mental health profession course in the first place and what they hoped to achieve from it. This information could be triangulated with psychometric measures related to personality, dogmatism and, of course, cultural competence and colour-blindness to determine what core elements are related to resistance so that strategies for addressing them can be developed.

Research Recommendation 3: Explore Cultural Competence and Therapeutic Alliance with More Diverse and Larger Samples

Further investigation of practitioner demographics (i.e., age, race/ethnicity and cultural competence experience) could help to explore their influence on cultural competence and the therapeutic alliance. Such research should also explore differences between experienced practitioners versus mental health trainees and across diverse mental health professions. Future studies with larger and more diverse samples should also examine the association between social desirability and cultural competence and therapeutic alliance more thoroughly. A more diverse sample would allow more rigorous exploration of difference between groups.

Research Recommendation 4: Explore Mental Health Supervisor Construing and Constructions

A better understanding of the cultural competence and constructions about non-White people held by supervisors could reveal what trainees are taught "on the job" about the therapeutic alliance and how to manage it. While one's formative training may have prepared practitioners in this thesis to work with non-White clients, the role of their placement supervisors within their formative training and employment supervisors after completing training on cultural competence is unclear. The perspectives of supervisors in relation to their training of trainees/subordinates regarding cultural competence is therefore of interest. Notably, due to power imbalances many trainees and/or subordinates may adjust their values, beliefs, and practices (whether they perceive them to be culturally competent or not) in order to swiftly complete their placement and/or receive a satisfactory (or better) performance evaluation. An exploration of both trainees/subordinates and supervisor cultural competence in theory (e.g., Whiteness, racism, privilege, discrimination, etc.) and in practice (e.g., anti-racism, colour-blind approaches, etc.) is required.

Research Recommendation 5: Engage Diverse Epistemologies, Research Methods and Theoretical Frameworks

A variety of theories and data collection techniques are needed to provide a multidimensional understanding of slippery concepts like "constructions about Whiteness/non-Whiteness and White/non-White people" and "the needs of non-White clients" within the "therapeutic alliance". Notably, Western models of mental health care and research methods are underpinned by White ways of knowing. The lack of epistemological diversity in cultural competence research restricts the potential for more comprehensive ways of understanding practitioner construing. The expansion of epistemologies supports the diversification of methods and interpretive frameworks for exploring Whiteness in mental health care. For instance, Australian Indigenous Women's Standpoint Theory and yarning focus groups with non-White practitioners could produce a more robust understanding of the challenges of integrating non-White approaches into mental health training and practice. Such an approach could also engage non-White clients to expose the impact of power imbalances in therapy and the mechanism by which culturally (in)competent practitioners de/construct and/or de/colonise the therapeutic alliance.

Research Recommendation 6: Explore Diverse Perspectives on the Impact of Practitioner Construing, Cultural Competence and Therapeutic Alliance

Further research is needed into the impact of practitioner construing of diverse populations on culturally competent practice to help mental health care practitioners and systems better respond to the needs of diverse populations. This may include a comparison between clients' perceptions of their therapist's cultural competence versus practitioners' self-perceptions. Further, observations and/or analysis of recordings of mental health sessions could be used to determine the provider's cultural competence. While such studies

exist in other nations, the dearth of client perspectives of mental health practitioner cultural competence in Australia is startling and requires investigation across a variety of non-White groups and mental health settings.

These recommendations for research indicate the novelty of this area of research, namely practitioner construing of difference and its implications, especially in Australia. Notably, there is a lack of information about the core concepts addressed within this thesis and their impact on practitioners and their clients. These recommendations provide direction for researchers and help fill the many epistemological (and ontological) gaps identified in this thesis. The development of more evidence on these highly nuanced, complementary, and opposing constructs can help to illuminate pathways for cultural competence training, practice and policy that are more responsive to the changing needs of a changing society.

Reflections on the Utility of Personal Construct Psychology in Exploring Practitioners' Construing

It is acknowledged that Kelly's (1955) PCP was based on his work with White people and within the framework of Whiteness. Evidence of this can be seen in Kelly's proposition that every construct is bipolar (e.g., hot vs. cold). This binary and dualistic framework is a standard element of Whiteness and is prevalent in Western culture (Sue, 2006). Despite its Anglocentrism, the relevance of his theory has been tested and utilised in a diverse range of non-White and marginalised population settings (Chaplin, 1985; Hamad, 2012; Moradi et al., 2009; Naffi & Davidson, 2016; Thomas et al., 2011). As such, PCP offers new theoretical avenues for exploring practitioners' construing in relation to insidious constructs like Whiteness and its impact on the mental health treatment process. In this thesis, PCP

influenced the conceptual framework and methodological approach, and reinforces the practical significance of the findings.

Conceptually, PCP is unlike other approaches (e.g., social constructivism or socioecological theory), given that it was designed to help practitioners understand individual psychology as well as to be the basis for clinical practice. Consequently, its postulates and principles align well with the concepts of cultural competence and the therapeutic alliance as settings in which practitioners and clients create meaning about one another and then act on their construing within the therapeutic setting. As demonstrated by the findings of this thesis, Kelly's theory highlights that practitioners regularly undergo a process of hypothesising what may happen in any given situation through their own predetermined (e.g., Whiteness) constructs (Kelly, 1955). Aligned with the elements and principles of cultural competence and therapeutic alliance, practitioners can then test and re-test their predictions or anticipations through the behaviours (or experiments) they design and implement.

While the thesis did not strictly adhere to traditional PCP methodologies (e.g., repertory grids or perceiver-element grids), they influenced the design of the thesis, data collection techniques (e.g., a modified laddering technique for the interviews) and interpretive framework used in this thesis. PCP highlights the importance of triangulation in the data collection process conducted by practitioners in their efforts to better understand their clients' mental states and experiences (Thomas, 1979). Thomas (1979, p. 4) explains,

> There is almost infinite scope for the development of methods for eliciting and processing and displaying an individual's constructions of experience and for using these to generate powerful and relevant learning conversations in education, training, and therapy.

While Thomas indicates the use of diverse methods in "education, training, and therapy", these principles are relevant to methodological triangulation in research. As such, the use of a systematic literature review, semi-structured interviews, and questionnaire to explore practitioners' construing and constructions helped to reveal, assess, and confirm the role of Whiteness in cultural competence and the therapeutic alliance. This demonstrates that, despite the use of non-PCP methods, the findings align with the theory given that the experiences and perspectives represented in this thesis characterise practitioners' abilities to reflect on the role of identity for themselves, their clients, and social interactions more broadly.

Practically, PCP helped to elucidate how practitioners understood their constructs, how constructs fit (or did not) within practitioners' construct systems, and how they went about testing, assessing, and acting on their construing. Interpreting the findings drawing on PCP demonstrates the persistence of Whiteness in practitioner construing and its role in practitioner engagement or avoidance of Others. PCP indicates that "our processes—thoughts, feelings and behaviors—operate in a structured manner and are determined by our predictions of the future" (Naffi & Davidson, 2016, p. 202). The findings of this thesis therefore allow us to predict what demographic, experiential and psychological aspects influence practitioner cultural competence and therapeutic alliance. This confirmation has meaningful implications for both psychological research and practice. Notably, this adaptation of PCP methodology confirms that by engaging clients (and ourselves) to look deeply into personal (and social) constructs and construing, we are able to identify constructions and values that are common to us all. This aligns with Kelly's (1955) encouragement for practitioners to adopt a credulous approach, imploring them to be open and accepting in order to understand how the client experiences the world. Accordingly, a credulous attitude requires the practitioner

to subsume the client's construing system and suspend their own construing system when working with diverse people.

For practitioners who are trained to focus and "work on" the individual, PCP offers a framework to help expand their understanding of the systems and influences in which psychological practice occurs for themselves and their clients. While other systems theories provide a robust understanding of various levels of influence on individuals, they do not provide an operational framework from which practitioners can develop practical processes to support the development of cultural competence and therapeutic alliance. This thesis therefore confirms the utility of PCP as an effective means of understanding and contextualising the challenges practitioners may experience when working with non-White people and their potential resistance to developing cultural competence and culture-informed therapeutic alliances as a result of Whiteness and its rigidity.

Conclusion

This is the first Australian study to explore mental health practitioners' construing of Whiteness and its impact on non-White people. The findings highlight the persistent role of Whiteness on construing White and non-White people. While constructions of Whiteness and non-Whiteness were acknowledged, and their impact noted, these constructs were not internalised into practitioners' construct systems. The findings of this thesis indicate that the ability to loosen one's construct system enough to embrace and value difference while also tightening one's construct system to sufficiently restrict the impact of Whiteness is related to regular engagement in cultural competence training. Such training helps to transition practitioners' construing, thus allowing them to engage clients in ways that do not constrict them (practitioners and clients) within rigid frameworks that constrain mental health and

wellbeing. Importantly, the therapeutic alliance between non-White clients and practitioners is most at risk when practitioners are resistant to training and maintain negative constructions about non-White people.

The results therefore suggest that advancement in the discourse on constructions of White and non-White people amongst Australian mental health practitioners is sorely needed to increase the impact of cultural competence training, especially for non-White and more experienced practitioners.

Drawing on PCP to interpret the findings in relation to processes of transition helped to explain the development of practitioners' cultural competence and therapeutic alliance. PCP highlights the need for practitioners to not only tolerate but desire and, therefore, seek out opportunities to consistently loosen and reconstruct their construing about themselves and others. While the classroom is often considered the place for the development of cultural competence, the findings indicate that the skills learnt in training are best honed within the safety of the therapeutic alliance.

Interactions with clients become opportunities for the development of the therapeutic alliance, but also a space where both the practitioner and the client can safely loosen their construing of one another. The benefit—for both parties—is the opportunity to deliver and engage in treatment with full recognition of the impact of Whiteness but without having to be bound by it. The relationship can be the site for and source of reconstruing of the Other. With an increasingly diverse population, the challenge for all people is to welcome interpersonal processes and the concomitant discomfort of engaging with re/constructions that confront the ways we make sense of the world—providing avenues for constructive alternativism.

The thesis demonstrates that understanding our construction systems through a PCP lens is a fruitful platform from which cross-cultural psychological research, training, and practice can look towards the development of practitioner cultural competence and safe therapeutic alliance in Australia.

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Appendix A: Ethics Approval Confirmation

Reply all | Delete Junk | ...

HREC Approval of Application 2017/105

irma-support@uow.edu.au
Wed 10/05, 11:34 AM
Tinashe Dune; pcaputi@uow.edu.au; bwalker@uow.edu.au; rso-ethics@uow.e

Reply all |

Inbox

Dear Dr Dune,

I am pleased to advise that the application detailed below has been **approved**.

Ethics Number:	2017/105
Approval Date:	09/05/2017
Expiry Date:	08/05/2018
Project Title:	Practicing Psychologists' Constructions of non-White people: Implications for Cultural Competence and the Therapeutic Alliance
Researchers:	Caputi Peter; Walker Beverly; Dune Tinashe
Documents Approved:	Research Application v1 1-3-17 Response to Ethics Queries v2 02-05-2017 PIS for Phase 1 Participants v2 02-05-2017 PIS and Consent for Phase 2 and 3 Participants v2 02-05-2017 Phase 1 Telephone Recruitment Script v2 02-05-2017 Phase 2 and 3 Participant Advertisement v2 02-05-2017 Written and Verbal Consent Form-Script for Phase 1 Participants Q Sorting Grid v1 26-11-16 Confidentiality Agreement v1 12-12-16 Data Collectors v1 28-11-16 Investigator Details Forms v1 01-12-16

Sites:

Site	Principal Investigator for Site
University of Wollongong	Tinashe Dune

The HREC has reviewed the research proposal for compliance with the *National Statement on Ethical Conduct in Human Research* and approval of this project is conditional upon your continuing

Reply all | Delete Junk | •••

Approval is granted for a twelve month period; extension of this approval will be considered on receipt of a progress report **prior to the expiry date**. Extension of approval requires:

- The submission of an annual progress report and a final report on completion of your project.
- Approval by the HREC of any proposed changes to the protocol or investigators.
- Immediate report of serious or unexpected adverse effects on participants.
- Immediate report of unforeseen events that might affect the continued acceptability of the project.

If you have any queries regarding the HREC review process or your ongoing approval please contact the Ethics Unit on 4221 3386 or email rso-ethics@uow.edu.au.

Yours sincerely,

Melanie Randle

Associate Professor Melanie Randle,
Chair, UOW & ISLHD Social Sciences Human Research Ethics Committee

The University of Wollongong and Illawarra and Shoalhaven Local Health District Social Sciences HREC is constituted and functions in accordance with the NHMRC National Statement on Ethical Conduct in Human Research.

Appendix B: Participant Information Sheets

UNIVERSITY OF WOLLONGONG AUSTRALIA

PARTICIPANT INFORMATION SHEET FOR PHASE 1 PARTICIPANTS (INTERVIEW)

TITLE: *Mental Health Care Practitioners' Constructions of White and non-White people: Implications for Cultural Competence and the Therapeutic Alliance*

PURPOSE OF THE RESEARCH

This is an invitation to participate in a study conducted by researchers at the University of Wollongong. This project examines the ways that clinical psychologists and psychology trainees construe non-White people and the impact of their constructions on the therapeutic alliance and cultural competence. The project will use multiple means for exploring construing and constructions. Phase 1 includes an interview and sorting of statements related to non-White people. Participants in Phase 1 will be compensated for their time with a $25 Coles-Myer Gift Voucher.

INVESTIGATORS

Dr Tinashe Dune (PhD Clinical Psychology Candidate): tmd999@uowmail.edu.au

Assoc Prof Peter Caputi (Dean, School of Psychology): pcaputi@uow.edu.au

Assoc Prof Beverly Walker (Research Fellow, School of Psychology): bwalker@uow.edu.au

METHOD AND DEMANDS ON PARTICIPANTS

Interview: Participants will be asked to engage in an interview to help understand the construal processes and outcomes regarding non-White people. The interviews will be done online or face-to-face where possible. Participants will also be asked to complete a short sociodemographic questionnaire which can be done before, during or after the interview and emailed to Dr Dune where appropriate. *This will take about 60 minutes.*

POSSIBLE RISKS, INCONVENIENCES AND DISCOMFORTS

The risks to participants may include reliving possible negative personal experiences that could resurrect distressing thoughts and issues. Some participants may also perceive some of the statements or questions within the data collection tools to be discomforting, irritating or confronting.

If you feel distressed as a result of participating in the study do not hesitate to contact Dr Tinashe Dune at tmd999@uowmail.edu.au (or any of the above named researchers) to discuss your concerns. Participant who experiences distress can also contact Lifeline 13 11 14 and/or BeyondBlue 1300 224 636 for more support.

Your involvement in the study is voluntary and you may withdraw your participation from the study at any time. The decision not to participate, or to withdraw from the study, will not affect any current or future relationship with the University of Wollongong. To opt out or

withdraw from the study, or for further information, e-mail: tmd999@uowmail.edu.au

FUNDING AND BENEFITS OF THE RESEARCH

The study is not funded by any external body. The findings from this investigation are significant to the development of cultural competency training and evaluation which reflects the learning needs of clinical psychologists and psychology trainees. The findings support Australia's ability (and ambition) to holistically support its increasingly multicultural population through genuine acceptance, and integration, of diversity.

ETHICS REVIEW AND COMPLAINTS

This study has been reviewed by the Social Sciences Human Research Ethics Committee of the University of Wollongong (Approval #2017/105). If you have any concerns or complaints regarding the way this research has been conducted you can contact the UOW Ethics Officer on (02) 4221 3386 or email rso-ethics@uow.edu.au

Thank you for your interest in this study.

UNIVERSITY OF WOLLONGONG AUSTRALIA

PARTICIPANT INFORMATION SHEET

TITLE: *Mental Health Care Practitioners' Constructions of White and non-White people: Implications for Cultural Competence and the Therapeutic Alliance*

PURPOSE OF THE RESEARCH

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The first 100 participants who fully complete the questionnaire will be sent a $25 Woolworths group e-voucher.

INVESTIGATORS

Dr Tinashe Dune (PhD Clinical Psychology Candidate): tmd999@uowmail.edu.au

Prof Peter Caputi (Dean, School of Psychology): pcaputi@uow.edu.au

Assoc Prof Catherine MacPhail (School of Health and Society): cmaphai@uow.edu.au

Dr Katarzyna Olcon (School of Health and Society): kolcon@uow.edu.au

METHOD AND DEMANDS ON PARTICIPANTS

Questionnaires: Participants will be asked to complete a Demographic Questionnaire, the Brief Social Desirability Scale, the Multicultural Counselling Inventory and the Race and Ethnic Blindness Scale - Australia.

This will take about 25 minutes and can be completed online or on hardcopy. Please contact Dr Tinashe Dune via email (tmd999@uowmail.edu.au) to have a hardcopy of the questionnaire mailed to you with a postage paid return envelope for your convenience.

POSSIBLE RISKS, INCONVENIENCES AND DISCOMFORTS

The risks to participants may include reliving possible negative personal experiences (triggered by the questionnaires) that could resurrect distressing thoughts and issues. Some participants may also perceive some of the statements or questions within the data collection tools to be discomforting, irritating or confronting.

If you feel distressed as a result of participating in the study do not hesitate to contact Dr Tinashe Dune at tmd999@uowmail.edu.au (or any of the above named researchers) to discuss your concerns. Participant who experiences distress can also contact Lifeline 13 11 14 and/or

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AUSTRALIA

BeyondBlue 1300 224 636 for more support.

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Thank you for your interest in this study.

V4 – 3.2.21

Appendix C: Quantitative Online Questionnaire

Mental Health Care Practitioners' Cultural Competence and Therapeutic Alliance Questionnaire

PARTICIPANT INFORMATION & CONSENT

PURPOSE OF THE RESEARCH

This project examines the ways that mental health care practitioners and trainees construe White and non-White people and the impact of their constructions on the therapeutic alliance and cultural competence.

The project will use multiple means for exploring construing and constructions. Phase 2 includes responding to an online questionnaire.

In recognition of the time participants give to this research the first 100 participants to fully complete the survey will receive a $25 Woolworths Group e-Voucher.

INVESTIGATORS

Dr Tinashe Dune (PhD Clinical Psychology Candidate): tmd999@uowmail.edu.au

Prof Peter Caputi (Dean, School of Psychology): pcaputi@uow.edu.au

Assoc Prof Catherine MacPhail (School of Health and Society): cmacphai@uow.edu.au

Dr Katarzyna Olcon (School of Health and Society): kolcon@uow.edu.au

METHOD AND DEMANDS ON PARTICIPANTS

Questionnaires: Participants will be asked to complete a Demographic Questionnaire, the Brief Social Desirability Scale, the Multicultural Counselling Inventory and the Race and Ethnic Blindness Scale - Australia. This questionnaire will take about 25 minutes.

POSSIBLE RISKS, INCONVENIENCES AND DISCOMFORTS

The risks to participants may include reliving possible negative personal experiences (triggered by the Q items or questionnaires) that could resurrect distressing thoughts and issues. Some participants may also perceive some of the statements or questions within the data collection tools to be discomforting, irritating or confronting.

If you feel distressed as a result of participating in the study do not hesitate to contact Dr Tinashe Dune at tmd999@uowmail.edu.au (or any of the above named researchers) to discuss your concerns. Participant who experiences distress can also contact Lifeline 13 11 14 and/or BeyondBlue 1300 224 636 for more support.

Your involvement in the study is voluntary and you may withdraw your participation from the study at any time. The decision not to participate, or to withdraw from the study, will not affect any current or future relationship with the University of Wollongong. To opt out or withdraw from the study, or for further information, e-mail: tmd999@uowmail.edu.au

FUNDING AND BENEFITS OF THE RESEARCH

The study is part of a doctorial training program funded by an Australian Government Research Training Program Scholarship. The findings from this investigation are significant to the development of cultural competency training and evaluation which reflects the learning needs of clinical psychologists and psychology trainees. The findings support Australia's ability (and ambition) to holistically support its increasingly multicultural population through genuine acceptance, and integration, of diversity.

ETHICS REVIEW AND COMPLAINTS

This study has been reviewed by the Social Sciences Human Research Ethics Committee of the University of Wollongong (#2017/105). If you have any concerns or complaints regarding the way this research has been conducted you can contact the UOW Ethics Officer on (02) 4221 3386 or email rso-ethics@uow.edu.au

Thank you for your interest in this study.

1. Please note that ticking on the "YES" below constitutes your consent to participate in this study.

NB: This questionnaire will take about 25 minutes.

I consent to participate in this study.

-) Yes
-) No

Mental Health Care Practitioners' Cultural Competence and Therapeutic Alliance Questionnaire

Section 1

Please fill out the following demographic information.

1. I am

- ( ) Male
- ( ) Female
- ( ) Other (please specify)

2. Which racial/ethnic group(s) do you self-identify with? (tick all that apply)

- [ ] Asian
- [ ] Pacific Islander
- [ ] African
- [ ] Latin American
- [ ] Western European
- [ ] Eastern European
- [ ] Other (please specify)
- [ ] Aboriginal and/or Torres Strait Islander
- [ ] Indigenous Canadian and/or American
- [ ] Middle Eastern
- [ ] Mediterranean
- [ ] Caucasian

3. Do you speak any languages other than English?

- ( ) No
- ( ) Yes

If yes, which language/s do you speak?

4. Age in Years

5. Marital Status

- ( ) Married or de facto
- ( ) Single
- ( ) Divorced
- ( ) Seperated
- ( ) Widowed

6. Highest level of education

- Some high school or less
- High school diploma or equivalent
- Some university
- University degree
- Postgraduate degree

7. In what country did you obtain your highest level of education?

8. In what year did you complete your highest level of education?

9. I am a

- Australian citizen
- Permanent resident
- Student visa holder
- Work visa holder

Other (please specify)

10. What is your current role?

- Clinical psychologist
- Psychologist (General)
- Psychology trainee (Provisional)
- Psychiatrist
- General Practitioner
- Social Worker (or trainee)
- Mental Health Nurse (or trainee)
- Youth/Community Worker
- Health Promotion Officer
- Medical Student
- Counsellor (or trainee)
- Psychotherapist (or trainee)

Other (please specify)

11. How many years have you been working in mental health care?

- 0-1
- 2-5
- 6-10
- 11-14
- 15 and above

12. Where do you provide service? (tick all that apply)

- [ ] Private practice
- [ ] Public practice

Other (please specify)

13. How many non-Caucasian/non-White clients do you provide service to per week?

- None
- 1 to 3
- 4 to 6
- 7 to 9
- 10 or more

14. Did your professional mental health training sufficiently prepare you to provide culturally competent services for non-Caucasian/non-White clients?

- Definitely
- Somewhat
- Neutral
- Not really
- Definitely not

15. How many cultural competence-related workshops, conferences or training sessions have you attended since you began practicing mental health care?

For students consider any extracurricular activities in this area after commencing your studies.

- None
- 1 to 3
- 4 to 6
- 7 to 9
- 10 or more

Mental Health Care Practitioners' Cultural Competence and Therapeutic Alliance Questionnaire

Section 2

The following statements cover counselling practices in multicultural counselling.

Indicate how accurately each statement describes you as a counselor, psychologist, or student in a mental health training program when working in a multicultural counseling situation.

Give ratings that you actually believe to be true rather than those that you wish were true.

1. When working with minority clients:

	Very Inaccurate	Somewhat inaccurate	Somewhat accurate	Very accurate
I perceive that my race causes clients to mistrust me	○	○	○	○
I have feelings of overcompensation, over-solicitation, and guilt that I do not have when working with majority clients	○	○	○	○
I am confident that my conceptualisation of client problems does not consist of stereotypes and value-oriented biases	○	○	○	○
I find that differences between my worldviews and those of the clients impede the counselling process	○	○	○	○
I have difficulties communicating with clients who use a perceptual, reasoning, or decision-making style that is different from mine	○	○	○	○
I include the facts of age, gender roles, and socioeconomic status in my understanding of different minority cultures.	○	○	○	○
I use innovative concepts and treatment methods	○	○	○	○

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	Very Inaccurate	Somewhat inaccurate	Somewhat accurate	Very accurate
I manifest an outlook on life that is best described as "world-minded" or pluralistic				
I examine my cultural biases				
I tend to compare client behaviours with those of the majority group				
I keep in mind research findings about minority clients' preferences in counselling				
I know what are the changing practices, views, and interests of people at the present time.				
I consider the range of behaviours, values, and individual differences within a minority group				
I make referrals or seek consultations based on the clients' minority identity development				
I feel my confidence is shaken by the self-examination of my personal limitations				
I monitor and correct my defensiveness (e.g., anxiety, denial, anger, fear, minimizing, overconfidence)				
I apply the sociopolitical history of the clients' respective minority groups to understand them better				
I am successful at seeing 50% of the clients more than once, not including intake				
I experience discomfort because of the clients' different physical appearance, colour, dress, or socioeconomic status				

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	Very Inaccurate	Somewhat inaccurate	Somewhat accurate	Very accurate
I am able to quickly recognise and recover from cultural mistakes or misunderstandings				
I use several methods of assessment (including free response questions, observations, and varied sources of information and excluding standardized tests)				
I have experience at solving problems in unfamiliar settings				
I learn about clients' different ways of acculturation to the dominant society to understand the clients better				
I understand my own philosophical preferences				
I have a working understanding of certain cultures/minority groups (including Indigenous Australian, African, Asian, Islander, refugees/asylum seekers and international students)				
I am able to distinguish between those who need brief, problem-solving, structured therapy and those who need long-term, process-oriented, unstructured therapy				
When working with international students or immigrants, I understand the importance of legalities of visa, passport, green card, and naturalization				

2. Evaluate the degree to which the following multicultural statements can be applied to you.

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	Very inaccurate	Somewhat inaccurate	Somewhat accurate	Very accurate
My professional or collegial interactions with minority individuals are extensive				
In the past year, I have had a 50% increase in my multicultural case load				
I enjoy multicultural interactions as much as interactions with people of my own culture				
I am involved in advocacy efforts against institutional barriers in mental health services for minority clients (e.g., lack of bilingual staff, multiculturally skilled counsellors, religious, racial and ethnic minority counsellors, minority professional leadership, and outpatient counselling facilities)				
I am familiar with non-standard English				
My life experiences with minority individuals are extensive (e.g., via ethnically integrated neighborhoods, marriage, and friendship)				
In order to be able to work with minority clients, I frequently seek consultation with multicultural experts and attend multicultural workshops or training sessions				
I am effective at crisis interventions (e.g., suicide attempt, tragedy, broken relationship)				
I use varied counselling techniques and skills				

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	Very inaccurate	Somewhat inaccurate	Somewhat accurate	Very accurate
I am able to be concise and to the point when reflecting, clarifying, and probing				
I am comfortable with exploring sexual issues				
I am skilled at getting a client to be specific in defining and clarifying problems				
I make my nonverbal and verbal responses congruent				

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Mental Health Care Practitioners' Cultural Competence and Therapeutic Alliance Questionnaire

Section 3

The following is a set of questions that deal with social issues in Australia.

Please be as open and honest as you can; there are no right or wrong answers.

1. Using the 6-point scale, please give your honest rating about the degree to which you personally agree or disagree with each statement.

	Strongly disagree: 1	2	3	4	5	Strongly agree: 6
Everyone who works hard, no matter what race they are, has an equal chance to become rich.	○	○	○	○	○	○
Race or ethnicity plays a major role in the type of social services (such as type of healthcare or daycare) that people receive in Australia	○	○	○	○	○	○
It is important that people begin to think of themselves as Australian and not African Australia, Lebanese Australian or Indian Australian	○	○	○	○	○	○
Due to racial or ethnic discrimination, programs such as equal opportunity provisions are necessary to help create equality	○	○	○	○	○	○
Racism is a major problem in Australia	○	○	○	○	○	○
Someone's race or ethnicity is very important in determining who is successful and who is not	○	○	○	○	○	○
Racism may have been a problem in the past, but it is not an important problem today	○	○	○	○	○	○

	Strongly disagree: 1	2	3	4	5	Strongly agree: 6
Racial and ethnic minorities do not have the same opportunities as Anglo-Australians						
Anglo-Australians are discriminated against because of the colour their skin						
Talking about issues of race or ethnicity causes unnecessary tension						
It is important for political leaders to talk about issues of race and ethnicity to help work through or solve society's problems						
Anglo-Australians have certain advantages because of the colour of their skin						
Migrants should try to fit into the culture and adopt Australian values						
English should be the only official language in Australia						
Anglo-Australians are more to blame for racial and ethnic discrimination in Australia than racial and ethnic minorities						
Social policies, such as equal opportunity provisions, discriminate unfairly against Anglo-Australians						
It is important for schools to teach about the history and contributions of racial and ethnic minorities						
Racial and ethnic minorities in Australia have certain advantages because of the colour of their skin						
Racial or ethnic problems in Australia are rare, isolated situations						

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	Strongly disagree: 1	2	3	4	5	Strongly agree: 6
Race or ethnicity plays an important role in who gets sent to prison						

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Mental Health Care Practitioners' Cultural Competence and Therapeutic Alliance Questionnaire

Section 4

1. Using the scale below as a guide, click on the number beside each statement to indicate how true it is for you.

	Not True: 1	2	3	Somewhat: 4	5	6	Very True: 7
My first impressions of people usually turn out to be right	○	○	○	○	○	○	○
It would be hard for me to break any of my bad habits	○	○	○	○	○	○	○
I don't care to know what other people really think of me	○	○	○	○	○	○	○
I have not always been honest with myself	○	○	○	○	○	○	○
I always know why I like things	○	○	○	○	○	○	○
When my emotions are aroused, it biases my thinking	○	○	○	○	○	○	○
Once I've made up my mind, other people can seldom change my opinion	○	○	○	○	○	○	○
I am not a safe driver when I exceed the speed limit	○	○	○	○	○	○	○
I am fully in control of my own fate	○	○	○	○	○	○	○
It's hard for me to shut off a disturbing thought	○	○	○	○	○	○	○
I never regret my decisions	○	○	○	○	○	○	○
I sometimes lose out on things because I can't make up my mind soon enough	○	○	○	○	○	○	○
The reason I vote is because my vote can make a difference	○	○	○	○	○	○	○
My parents were not always fair when they punished me	○	○	○	○	○	○	○

	Not True: 1	2	3	Somewhat: 4	5	6	Very True: 7
I am a completely rational person							
I rarely appreciate criticism							
I am very confident of my judgements							
I have sometimes doubted my ability as a lover							
It's all right with me if some people happen to dislike me							
I don't always know the reasons why I do the things I do							
I sometimes tell lies if I have to							
I never cover up my mistakes							
There have been occasions when I have taken advantage of someone							
I never swear							
I sometimes try to get even rather than forgive and forget							
I always obey laws, even if I'm unlikely to get caught							
I have said something bad about a friend behind his/her back							
When I hear people talking privately, I avoid listening							
I have received too much change from a salesperson without telling him or her							
I always declare everything at customs							
When I was young I sometimes stole things							
I have never dropped litter on the street							
I sometimes drive faster than the speed limit							

	Not True: 1	2	3	Somewhat: 4	5	6	Very True: 7
I never read sexy books or magazines	○	○	○	○	○	○	○
I have done things that I don't tell other people about	○	○	○	○	○	○	○
I never take things that don't belong to me	○	○	○	○	○	○	○
I have taken sick-leave from work or school even though I wasn't really sick	○	○	○	○	○	○	○
I have never damaged a library book or store merchandise without reporting it	○	○	○	○	○	○	○
I have some pretty awful habits	○	○	○	○	○	○	○
I don't gossip about other people's business	○	○	○	○	○	○	○

Mental Health Care Practitioners' Cultural Competence and Therapeutic Alliance Questionnaire

Contact Details

The first 100 participants to fully complete the survey will receive a $25 Woolworths Group e-Voucher.

In order to receive your $25 Woolworths Group e-Voucher please provide your email address below.

****Only participants who complete all relevant survey questions will receive a gift voucher****

1. Email Address