“I DON’T SEE COLOR, I ONLY SEE BEHAVIORS”:

THERAPISTS’ CONCERNS IN WORKING WITH

CLIENTS OF COLOR

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Abstract: Although there have been significant gains in the field of multicultural counseling, including the development of multicultural competencies for counseling clients of color, the importance of examining the role of therapists’ racial attitudes and biases, as they relate to their level of concerns in counseling clients of color, has not received much attention in the multicultural research and counseling literature. Also, cross-cultural psychological capital and its influence on therapists’ level of concern in working with clients of color is unknown. These aspects of cross-cultural capital include optimism and hope in working with clients of color, viewing them as resilient individuals, and believing in one’s ability to help this group, otherwise known as self-efficacy. The purpose of this study was to explore therapists’ general racial attitudes, their use of psychological capital in sessions with clients, and their levels of multicultural competence as potential predictors of their level of concern in working with clients of color in therapy. Therapists recruited from various fields of psychotherapy (e.g., clinical, counseling, school psychology, couples, and family therapists, social workers, counselors) participated in the study. A total of 177 participants completed an online survey, which included a demographic page as well as the following questionnaires: the Mental Health Practitioner’s Racial Socialization Practices Measure, the Cross-Cultural Psychological Capital Scale, the California Brief Multicultural Competence Scale, and the Concerns about Counseling Racial Minority Clients Scale. Results indicated that therapists’ general racial attitudes, cross-cultural psychological capital, and multicultural competence were significantly and linearly related to their level of concern in working with clients of color. However, cross-cultural psychological capital was the only significant individual predictor of therapists’ level of concern in working with clients of color. Thus, helping mental health professionals be more hopeful, optimistic, and self-efficacious with this client population, and feeling resilient in their work with culturally diverse clients will help them feel more comfortable in working with clients of color.

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CHAPTER I

INTRODUCTION

Despite the increase of communities of color residing in the United States, clients of color (e.g., Black, Hispanic/Latino, American Indian, Middle Eastern, and Asian Americans) receive a lesser quality of health care when compared to White Americans (Fiscella et al., 2000). For example, provider characteristics may interfere with quality care, including prejudices and biases. Clients of color are more likely to encounter biases, specifically those related to health care when compared to White clients (Smedley et al., 2003). Clients of color may be perceived by their healthcare providers to be less knowledgeable about health services or perceived as engaging in noncompliance or belligerent behaviors, as providers may be unaware of the language and approaches used by these groups (Smedley et al., 2003).

Healthcare providers' behaviors and their interactions with their clients impact the quality of care for communities of color (Saha et al., 2003). In a study comparing attitudes held by White Americans and persons of color towards their healthcare providers, researchers found clients of color were more likely to rate their provider as rude, perceived them as not providing an adequate amount of time to address health concerns, and reported providers were less likely to include them in the treatment planning process (Saha et al., 2003). In summary, healthcare providers' biases and treatment towards clients of color impacts the disproportionate quality of healthcare services received by this group, and

consequentially, they rate the quality of healthcare services lower than their White counterparts (Smedley et al., 2003). Clients of color also have less access to healthcare, even when they seek services. Mayberry et al. (2000) found clients of color were less likely to be seen by healthcare specialists for their conditions during hospitalization (e.g., a cardiologist for heart concerns, an endocrinologist for diabetes), receive specific services (e.g., dialysis, organ transplantation), technologically-advanced procedures, and rehabilitation services. Although health insurance and socioeconomic status (e.g., the ability to afford costs to receive healthcare) are the strongest determinants of receiving access to healthcare, race and ethnicity continues to have independent effects. For example, when controlling for socioeconomic variables, Black and Latinx clients were still less likely to have any contact with their physician when compared to White people, often being referred to mid-level practitioners (i.e., advanced practice registered nurse, physician assistant; Mayberry et al., 2000). Although these professionals can perform routine examinations, the absence of higher levels of care could have devastating effects on clients of color.

Clients of color receive not only fewer healthcare services and lower quality services but also different types of healthcare services than White individuals. For severe medical conditions such as cancer, Black people were less likely to receive surgery or radiation than White people (Cook and Manning, 2009). Overall, opportunities for care, such as routine screenings, preferences for medications, and diagnostic errors due to miscommunication (i.e., lack of thorough explanation of diagnoses or treatment planning) were lower for clients of color (Brach and Fraserirector, 2000).

Mental Health Disparities for Clients of Color

While much of the research focuses on health care disparities of clients of color, there is also evidence that mental health care disparities exist for them when compared to White individuals. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), mental health disparities exist when there are power imbalances that impact practices influencing access, quality, and outcomes among clients of color when compared to the general population (Safran et al., 2009). The access and quality of mental health service for persons of color and those individuals experiencing poverty continues to be a significant problem (National Institute of Mental Health, 2015). Clients of color experience significant disparities in their mental health care when compared to their White counterparts. They are more likely to use inpatient hospitalization and emergency room services, receive less quality care (e.g., high wait times, unavailable services/providers), and abstain from accessing resources available in community mental health (e.g., counseling, crisis management; Substance Abuse and Mental Health Services Administration [SAMSHA], 2015). Even after receiving mental health care treatment, clients of color are less likely to engage in these types of services (i.e., psychotherapy), are more likely to be misdiagnosed (i.e., as having more severe pathology), and are more likely to terminate mental health services with their therapists than White individuals (Atdjian and Vega, 2005). The consequences to these mental health disparities lead to poorer mental health outcomes (i.e., likely to experience re-hospitalization or adverse reactions to treatment) and lower quality of life (SAMSHA, 2015) than White clients. In general, mental health disparities are due to many factors, including the lack of insurance in communities occupied by clients of color (Miranda et al., 2008). The consequences of less access to psychotherapy are often persistent illness (Miranda et al.,

2008). Furthermore, clients of color are less likely to seek or maintain mental health services, and unfortunately, there is no current trend of changing disparities found in psychiatric settings (Miranda et al., 2008).

The disproportionate amount of providers' biases experienced by clients of color could be an explanation for mental healthcare disparities, as treatments received are lesser in quality even when controlling for other factors, such as access, insurance, and income (Smedley et al., 2003). Regardless of these controls, such differences are pervasive in areas of low socioeconomic status. However, Gushue and Constantine (2007) posited that biases held by mental health clinicians are related to their racial attitudes towards persons of color and their adoption of color-blind ideology. For example, mental health clinicians holding strong attitudes against the existence or prevalence of racism were more likely to engage in overt forms of biases (Gushue and Constantine, 2007). Additionally, those clinicians were more likely to engage in microaggressions, which are verbal, nonverbal, or environmental, intentional or unintentional racial slights towards persons of color (Sue et al., 2007; Gushue and Constantine, 2007).

Of interest, in the present study, is to explore factors that might help therapists feel more comfortable in working with clients of color. We explored therapists' general racial attitudes, their use of cross-cultural psychological capital, and their level of multicultural competence with their level of concern in working with clients of color.

CHAPTER II

REVIEW OF THE LITERATURE

The theoretical and research literature related to mental health practitioners' racial attitudes, multicultural competence, use of cross-cultural psychological capital, and level of concern in working with clients of color will be summarized in this section. We broadly examine racial attitudes by summarizing research on interpersonal group conflicts through a social psychological lens to better capture the dynamics of healthcare professionals' relationships with persons of color. We then focus on the values and cultural approaches used in the field of mental health to reveal proposals for addressing racial and cultural conflict. Next, we introduce cross-cultural psychological capital as a positive psychological factor that may be pertinent in increasing interpersonal relations across races and ethnicities. Lastly, we discuss the importance of focusing on concerns of mental health practitioners as their reactions to working with persons of color can impact the outcome of treatment for this group.

Racial Attitudes

Persons of color are more likely to encounter disparities in any field of healthcare. Clients of color seeking healthcare often receive a lower quality of services within these environments and have disproportionate outcomes (Hall et al., 2015). Services such as preventative services, acute treatment, and chronic disease management have been

identified by researchers to be areas of health care that are often lower in quality for people of color (Hall et al., 2015). Authors have attributed this to the behaviors and attitudes of healthcare providers and researchers believe it is due to their implicit biases (Hall et al., 2015). Hall and colleagues (2015) indicate these biases impact their communication styles, lack of positive emotions, less collaboration when developing treatment, and care not deemed to be patient-centered.

With such differences in healthcare, clients of color are more likely to be misdiagnosed, require ongoing treatment, and develop preventable ailments. Hall et al. (2015) cited numerous health disparities affecting communities of color (e.g., Black, Latinx, American Indian, and Asian Americans). They found that they were more likely to suffer from asthma, early childbearing, diabetes, HIV/AIDS, hypertension, obesity, and tuberculosis. White individuals are also permitted healthcare privileges and services not typically made available to their counterparts. White people received more visitation hours (even after hours were made available), gained a more welcoming approach by healthcare providers, and have an opportunity to contribute to their treatment (Hall et al., 2015).

The effects of disparities in healthcare have led some researchers to attribute the difference in care to genetic populations' susceptibility to different diseases, socioeconomic status, exposure to environmental hazards and stressors, and health-related attitudes and behaviors (Dovidio et al., 2006). In addition to these, psychological factors related to prejudice and stereotypes of practitioners serving clients of color relate to the level of care received by this group. Researchers have consistently linked prejudice and racism experienced by persons of color to disparities in health, which is in

addition to the stress they feel outside of these environments (Gee, 2008). Persons of color are less likely to receive care from someone of their similar race, therefore, it is important to examine the biases and attitudes of healthcare providers of the majority race (i.e., White people).

White people's racial attitudes may influence their behaviors during interactions with persons of color, and researchers conclude that similar views exist among people of color (Richeson et al., 2005). Depending on the level of racial bias held by people of color towards White people, it may lead to avoidance of outgroup behaviors and interactions (Richeson et al., 2005). These specific behaviors were found by researchers to be attributed to White Americans' anti-Black prejudice and being concerned about prejudicial acts towards them (Richeson et al., 2005). The same is present with White people as racism may be responsible for their resentment towards pro-Black groups, such as Black Lives Matter (Fiske, 2002).

Racial attitudes refer to perceptions of prejudice, bias, and stereotypes of racial groups or individuals, and have affective and cognitive components (Dovidio and Gaertner, 2010). Like many other attitudes, racial attitudes are both implicit and explicit. They are affected by exposure to environments (i.e., people of similar or different cultural backgrounds), positive and negative conditioning through intragroup behaviors, direct experiences, and social persuasion (Albarracin and Vargas, 2010). Mental health practitioners possessing negative racial attitudes are at risk of harming their clients as biases can influence mental health treatment. Examples of negative racial attitudes include misunderstanding the impact of racial discrimination, assuming persons of color to have equal opportunities as White people and ignoring the history of racism.

Awareness of racial attitudes is essential for therapists working with clients of color, as racial attitudes influence how people view themselves and those they work with (Cumming-McCann and Accordino, 2005).

The need to consistently address racial issues is imperative to the ongoing development of multicultural competence among mental health practitioners (Smith et al., 2008). We anticipate practitioners may foster their development through an examination of their racial attitudes and identities. The exploration of racial identities and attitudes occurs in various fields of mental health. Most recently, there has been more discussion around these topics in the field of psychotherapy as they relate to multicultural counseling (Cumming-McCann and Accordino, 2005). Because one of the tenets of multicultural counseling includes awareness of oneself, trainees and clinicians may need to reflect on their racial identities to understand the impact they have on their clinical work. Researchers who have conducted studies related to multicultural competencies and racial attitudes are specifically interested in how clinicians view themselves as racial beings, as it is known to influence those with whom they work, whether they are colleagues or clients (Cumming-McCann and Accordino, 2005).

Racial attitudes develop with racial identity, and many theorists believe such development occurs in stages. There are different models of racial identity, however, it is common for the initial stage of these models to focus on confirming the values of the dominant culture (Cumming-McCann and Accordino, 2005). During the second stage, dissonance or conflict occurs, which leads to increased awareness about stereotypes (Cumming-McCann and Accordino, 2005). For persons of color, this is noticing the difference in language used to describe these groups and access to some of the

relationships afforded to the majority group. During the third stage, immersion into one's own culture occurs through ethnocentrism occurs and the individual possibly rejects others due to their different race and ethnicity (Cumming-McCann and Accordino, 2005). During the last stage, the individual develops positive regards for one's own racial identity, gains awareness of oppressive events others experience, and gains an understanding of other races (Cumming-McCann and Accordino, 2005). Through this process, therapists may become aware of their biases, stereotypes, prejudices, and discrimination that has affected them and other groups of people.

Biases are often regarded as being related to stereotypes, prejudices, and discrimination (Dovidio and Gaertner, 2010), and reflects people's cognitive, affective, and behavioral reactions to groups of individuals (Fiske, 2002). Dovidio and Gaertner (2010) emphasized the distinction between these terms by primarily providing an operational definition of biases. Dovidio and Gaertner (2010) concluded that biases encompassed beliefs about the traits and characteristics of groups, individuals, or group membership, and the unfair evaluations projected onto these groups. Furthermore, the researchers postulated that stereotypes were related to generalized beliefs, discrimination that captured the unfair treatment of individuals, and prejudices represented in their biased attitudes (Dovidio and Gaertner, 2010). These beliefs, attitudes, and evaluations could have an implicit or explicit impact on others.

Hewstone et al. (2002) made similar references wherein discrimination was regarded as the behavioral response, prejudice as specific attitudes, and stereotyping as belonging to one's cognitions. Dovidio and Gaertner (2010) distinguished between explicit and implicit biases, stating discrimination is behaviorally expressed, and

stereotypes and prejudices are internal. Dovidio and Gaertner (2010) reported that explicit biases tend to be a part of an individual's awareness, whereas implicit biases may not be fully accessible cognitively. This differentiation may present another debate if consideration and attention to external behaviors are not recognizable or acknowledged, as the absence of such could decrease not only intergroup tensions but also reinforce harmful external behaviors. One of these biases is racial attitudes, and although implicit, it could have profound effects on racially marginalized groups.

Attitudes related to racial discrimination are present in the majority population. Although few White people support segregation, many reject interventions designed to foster this change, as they are in favor of sustaining their belief that Black people and other persons of color should endure their minority statuses (Dixon, et al., 2007). This belief is due primarily to contemporary racism being less overt and ingrained within those who are well-intentioned (Smith et al., 2008). These individuals are more likely to oppose policies that threaten their resources and the dominant culture, as it could disturb the presumed racial hierarchy (Dixon et al., 2007). This perception changes when White people attribute persons of color's problems to external hardships or conditions, as they are more likely to be in favor of government programs that assist these groups (Kim, 2015). This outlook is accurate for some White people when viewing Black people and their use of affirmative action. However, Black people's use of these policies may result in White people viewing them as having access to more opportunities than them; this perspective about Black people is not consistent with their views of opportunities that exist for Latino and Asian populations (Kim, 2015), which is often viewed as modern racism. Believing that Black people and other people of color no longer experience

discrimination, racism, oppressive policies, and that they are allotted privileges not afforded to majority groups are also additional examples of modern racism (Chrobot-Mason, 2012). For therapist serving persons of color, modern racism may impact their ability to acknowledge some of the policies that prevent this group from accessing mental health treatment.

Negative racial attitudes held by White people are fostered in their immediate environments and possibly occurs within their homes. Conversations about race in White households intensify following harmful racial incidents or when it causes disruptions in their environments (Bartoli et al., 2015). This approach may be considered dangerous as it solely considers race-relations when a threat is presented, which reinforces the stigma that underlies the restriction of such discussion of race and privilege. However, it is essential to recognize when White people discuss race, they may risk being labeled White supremacists or racists (Bartoli et al., 2015). This approach possibly delays the development of their own racial identity and perhaps the awareness of privilege and racism. For White therapists, this is essential as it could affect their perception of their clients and their presenting concerns, especially if they have cultural relevance.

One type of prejudice of interest is the color-blind ideology, which is the tendency to discount, minimize, or deny the existence of racism and conclude it does not exist due to racial progress (Gushue et al., 2017). This belief inadvertently ignores essential aspects of discrimination while reinforcing racial prejudice and the negative experiences of clients of color (Gushue et al., 2017). Furthermore, this assumption assists those who adhere to color-blind ideology to promote racial equality to make them appear less racist (Gushue et al., 2017). Lacking an understanding of the effects of this ideology may

present issues when attempting to form therapeutic relationships, as the failure to acknowledge differences in worldviews could create barriers for therapists when working with their clients (Loya, 2011). For persons of color seeking psychotherapy, they may be more hesitant to engage or remain in treatment as the therapeutic relationship is essential for effective treatment, growth, and outcomes.

Dovidio and Gaertner (2010) attempted to highlight the contemporary prevalence of racism brought on by racial attitudes (i.e., a type of discrimination) by recognizing in a study conducted by Nosek et al. (2002) that White participants who completed the Implicit Association Test (IAT) had more prejudicial attitudes than non-White people. This conclusion was due to their preferences towards White people and more explicit biases when compared to Black people (Nosek et al., 2002). Dovidio and Gaertner (2010) concluded that this phenomenon could be due to intergroup bias. Similar studies (Richeson and Nussbaum, 2003) found converging evidence and proposed that racial preferences are due to the automatic racial attitudes held by racial groups and that White individuals are more likely to see their groups more favorable than other communities of color (e.g., Black people). It is possible these beliefs are related to previous experiences of groups and intergenerational biases. Hewstone et al. (2002) concluded that intergroup bias, which is a preference for one's group, could also be responsible for racial preferences, specifically systematic choice for one's group. Researchers believe that the automatic implicit biases held by some groups could be responsible for some of the explicit biases expressed (Richeson and Nussbaum, 2003).

Racial attitudes may be influenced by how one views persons of color socioeconomic status and opportunities. Kim (2015) evaluated the racial attitudes of

White people towards persons of color and how their perceptions influenced their view of their opportunities and socioeconomic status. Therefore, White people may believe that racial progress occurred, and fewer racial problems exist for communities of color if they have access to education, income, healthcare, and jobs (Kim, 2015). Black people and other persons of color rely on these essential elements to thrive in the U.S.; hence, White people may evaluate them on these factors in diverse climates (Kim, 2015). White people's racial attitudes towards specific racial and ethnic groups differ substantially, as various others have found the presence of a racial hierarchy, which is structured with White people at the top, Black people at the bottom, and Asian and Latinx groups in-between (Kim, 2015). This established order may impact White people's attitudes towards diversity and representation. White people who believe communities of color are getting better tend not to support the representation of persons of color when increasing diversity and are more likely to focus on other cultural differences such as sex, gender, and sexual orientation (Kim, 2015).

Color-blind racial attitudes impact several fields of mental health. Some disciplines, such as social work, emphasize learning about persons of color during diversity training (Loya, 2011). Loya (2011) explored racial attitudes in White social workers to examine their perceptions of racial privilege and biases and posited that specific emphasis on working with clients of color is one aspect of cultural training, and ignoring the influence of one's cultural values, biases, and perceptions of the race with clients could be harmful. When social workers accept color-blind ideologies, they tend to ignore the manifestation of race, experience discomfort when their achievement is perceived to be related to their race, and possess misunderstandings about discriminatory

practices (Loya, 2011). This phenomenon may be due to their lack of multicultural education and their educators' lack of awareness of these issues due to their discomfort in teaching such material (Loya, 2011). With a lack of multicultural training during formal or continuing education, the opportunity to develop skills, knowledge, or awareness regarding the effects of racism and other biases on the process of mental health treatment is lost (Loya, 2011). This loss could have profound effects on the people served by these social workers, mainly clients of color. Loya (2011) believed to acquire cultural competencies for working with clients of color, social workers to develop cultural responsiveness with their clients, which can assist them in understanding and recognizing the racial dynamics present in the room and using self-disclosure in therapy.

Loya (2011) found that social workers in her sample were less aware of their racial privileges and were less concerned about blatant racial issues. This finding is pertinent considering that awareness of one's race and their values regarding racial issues is imperative to the treatment process with clients of color. The failure to develop this awareness could harm the therapeutic relationship as clinicians may be less inclined to discuss the dynamics of the therapeutic relationship and cultural factors that may be affecting their clients.

Vocational rehabilitation counseling is another field of health care that has gained attention in the literature on the importance of multicultural issues when providing these types of services. Similar to the field of mental health, vocational rehabilitation counseling expects an increase in services sought by clients of color due to the increasingly diverse U.S. population (Cumming-McCann and Accordino, 2005). Several variables contribute to multicultural competencies developed by counselors within this

specific field, such as their demographics, education, and clinical experiences. These areas are foundational areas where trainees receive their instruction in their respective fields; therefore, it is vital to learn about multiculturalism during their training experiences and beyond. Outside of these experiences, multicultural coursework, workshops, and clinical supervision are related to the development of multicultural competencies for vocational rehabilitation counselors (Cumming-McCann and Accordino, 2005). Cumming-McCann and Accordino (2005) were interested in the attitudes of White vocational rehabilitation counselors and how they related to their reported multicultural competencies and other variables. These researchers found that multicultural competencies were a better predictor for perceived multicultural competencies than other variables (e.g., education, demographics, and experience). Additionally, there was an inverse relationship between counselors' self-reported multicultural competence with clients and the number of clients of color on their caseload (Cumming-McCann and Accordino, 2005). This finding is of importance as developing multicultural competencies are often related to the amount of exposure practitioners have with clients of color. Furthermore, counselors' lack of multicultural competence is related to their lack of awareness of their racial identities (Cumming-McCann and Accordino, 2005). This conclusion is concerning for the field of counseling as the promotion of developing multicultural counseling competencies has increased. However, counselors' ability to accept the acquisition of multicultural counseling skills, awareness, and knowledge may inadvertently halt their development in these areas.

In addition to the development of racial identity, ethnocentrism seems to be a determinant of racial attitudes as it offers what Thomas (1996) refers to as race-based

privilege. Race-based privilege develops when the majority or dominant group adopts the perspective that their lives are regular, average, or ideal (Thomas, 1996). With this value, White people in the U.S. may view persons of color as different, abnormal, or resistant to socially acceptable norms. Ethnocentric behaviors do not only offer perspectives for out-group members, but in-group members as well when considering the role of race. White people with ethnocentric values about their race may see their race as virtuous, superior, and universal while seeing other groups of people as "others" (Thomas, 1996). For White therapists, this is problematic. When working with clients of color, White therapists who are unaware of their ethnocentric values may impose their values onto their clients and may see them as inferior. This perspective of inferiority could interfere with the therapeutic process and catalyze inappropriate interventions, overlooking cultural factors, and fostering assimilation to the majority culture.

Ethnocentric attitudes held by White people residing in the U.S. could offer psychological privileges. With these privileges, White people may be unaware that persons of color work and live in two environments, and in some cases, they may have to develop what some scholars refer to as a double consciousness (Thomas, 1996). Double consciousness, described by W.E.B. DuBois as Black people's function of navigating two realities, presents situations rarely experienced by White people (Thomas, 1996). Unlike persons of color, White people who are ethnocentric may have little fear about ignoring the perspectives of other races (Thomas, 1996). In contrast, persons of color experience environments wherein few people resemble them, have their credibility challenged because of their race, and experience anxiety when seeking promotions (Thomas, 1996). Chrobot-Mason (2012) asserted that it is crucial to overcome psychological privilege as it

is a step to understand racial issues while taking an active role in supporting those who are affected by racial challenges. Psychological privilege is as an invisible package of unearned assets that serve as a basis to marginalize others while preventing theme monetary or social privileges (Chrobot-Mason, 2012). Unfortunately, psychological privilege allows for psychological freedom that enables majority members to accept their actions, attitudes, and beliefs as correct. (Chrobot-Mason, 2012). White therapists who are unaware of their psychological privilege may have unrealistic or unreasonable therapeutic goals for persons of color, which may impact treatment outcomes (i.e., retention)

Multicultural Competence and Multicultural Training

Researchers have found a relationship between privilege, racism, and multicultural counseling competence, mainly that there is an inverse relationship between racial attitudes and multicultural counseling competence (Hays, 2008). Therefore, to engage in effective multicultural counseling and develop the competence to do so, therapists must become aware of their privilege and racial attitudes. This process involves managing feelings of anger, guilt, confusion, sadness, and a sense of responsibility (Hays, 2008). By increasing their awareness, therapists may facilitate meaningful discussions around oppression and privilege, which increases client satisfaction and decreases attrition among marginalized groups (Hays, 2008). The willingness to engage in multicultural education, as well as how important the process is, differs across races and gender, with persons of color and women valuing multicultural education more than White people and men, which attributes to the acknowledgment of power dynamics in North America (Smith et al., 2006).

The need to develop multicultural competence in the mental health field was appropriate following the increase in diversity of the U.S. population. Persons of color may encompass half of the U.S. population by the year 2050 (Hays, 2008). With the increase, therapists must be able to provide culturally sensitive interventions when serving communities of color. There are several methods of developing multicultural competencies. Pieterse et al. (2009) posit that skill-based and experiential learning offers several approaches, as students receive the opportunity to engage in self-awareness exercises, multicultural skill development, and cultural immersion experiences. Researchers also reported that other resources, such as videos, guest speakers, cross-cultural contact, and class discussions of multicultural material as being a catalyst for the development of multicultural competence (Hays, 2008).

There has been a steady movement toward multicultural education and the acquisition of multicultural counseling competencies for therapists, not only in training programs, but also in continuing education and the licensure processes. This movement is in response to potential biases and negative impacts of mental healthcare professionals have toward clients of color. Training in multicultural counseling in the field of mental health is a relevant experience for developing seasoned practitioners due to its ability to capture the negative consequences of oppression in the lives of communities of color (Constantine et al., 2007). The goal of the training experiences, whether didactic or practical, is for practitioners to develop competencies in working with racially diverse populations. These acquired skills of multicultural competencies include practitioners' level of self-awareness, knowledge, and skills in working with those who are from culturally diverse backgrounds (Constantine et al., 2007). Multicultural competencies

may be necessary for practitioners working with clients of color, in particular, as these clients are more likely to experience oppression in the form of biases related to racial attitudes in their relationships with others and in society, which includes their therapists.

Developing multicultural competence, specifically cultivating knowledge of their awareness, knowledge, exposure, and experience, can influence therapists' skills with communities of color and could address negative racial attitudes held by clinicians. Whereas addressing racial attitudes is one aspect of multicultural competence and training, developing multicultural competence focuses on the experience of acknowledging various cultural differences within oneself and how these differences affect and influence others, reflecting on the presence and absence of specific knowledge about groups, and considering the skills needed for cultural interactions. Engaging in the former process (i.e., acknowledging various cultural differences in oneself) includes recognizing the multiple identities present in oneself (i.e., sexual, racial, gender, relationship, and religious identities), how they intersect, and what impacts they have on interpersonal relationships, as they catalyze developing knowledge and awareness of other groups.

The need to address biases was highlighted by Sue et al. (2007), wherein the authors described the need to address the unintentional and intentional acts committed by those in power and to understand the effects they have on persons of color. Sue et al. (2007) listed two useful competencies for therapists and other practitioners serving this group, which include 1) an awareness of oneself as being an agent of biases, stereotypes, and assumptions, and 2) understanding the world's perceptions of clients of color. With such competencies and understanding presented in the fields of mental health, the

potential to address unfair treatment and their effects on communities of color appears to be a relevant issue faced by these populations. Although biases and prejudices are not limited to mental healthcare (Hall et al., 2015), mental healthcare providers often develop close professional relationships with their clients due to the amount of time they interact with them. Therefore, it may be essential for these providers to become aware of their biases and prejudices towards clients largely underrepresented in other areas. More research is needed to understand the racial attitudes and the multicultural competence of therapists who serve clients of color, which is addressed in the present study.

For many years, multicultural competencies remained theoretical, however, over the last decade, the competencies have become an expectation for students adhering to their accrediting bodies as the training is part of the accreditation process (Pieterse et al., 2009). This requirement exists for two of the largest accrediting organizations of counseling and psychology programs (American Psychological Association and The Council for Accreditation of Counseling and Related Educational Programs). However, they variy on the standards, with APA requiring multicultural competencies and CACREP stipulating development in social justice advocacy and multiculturalism (Pieterse et al., 2009). Scholars emphasized these requirements for all aspects of training programs. Unfortunately, many of the content and instruction related to diversity, inclusion, culture, and social justice occurs in a single course (Pieterse et al., 2009). APA issued ethical guidelines regarding services received by historically oppressed groups, which discussed the need for trainees and practitioners to receive training, experiences, and supervision that promotes working with these groups (Smith et al., 2006). This

guideline is in stark contrast to students developing multicultural competencies during coursework, clinical placements, research, and interactions with professors.

An assumption that therapists who develop these competencies could effectively work with persons of color is erroneous (Holcomb-McCoy and Meyers, 1999). Furthermore, such competencies and understanding presented in the field of mental health increases the potential to address unfair treatment and their effects on communities of color, which appears to be a relevant issue faced by these clients. Therefore, these providers need to become aware of any biases and prejudices they may have towards groups that are primarily underrepresented in other areas, especially persons of color. Although mental healthcare providers receive specialized training in multicultural counseling, their level of competence can vary greatly. This difference is due to the varying definitions of multicultural competence and counseling, and different models of development of multicultural competence employed in training programs (Holcomb-McCoy and Meyers, 1999).

The need to address racial attitudes is imperative as it associated with higher levels of racial prejudice and lower levels of multicultural counseling competencies (Loya, 2011). Multicultural training in counseling has primarily focused on racial identity, therapeutic alliances, and the process of therapy as these are competencies therapists should develop during their work with clients of color (Bartoli et al., 2015). During this process, therapists are encouraged to engage in racial socialization as it offers significant insight into the interaction of their racial identity and those of their clients. Specifically, racial socialization is a learning process that assists therapists with learning about their racial group, interactions within their group, and those that occur with other

racial groups (Bartoli et al., 2015). The practice of racial socialization encompasses implicit and explicit messages that therapists use to communicate their thoughts and feelings about racial hierarchies and how to manage racial conflicts and the norms for interacting with other racial groups. These messages are detrimental if therapists are unaware of the effects they have on clients of different races.

For White therapists, racial socialization is unique in that it considers their place in North American culture, as well as their understanding of race (Bartoli et al., 2015). Unfortunately, White racial socialization opposes the goals of persons of color and aims explicitly to easing racial tension while promoting positive self-regard (Bartoli et al., 2015). For persons of color, this is the opposite of their goals as they consider their safety, positive self-regard, and adaptability (Bartoli et al., 2015). These differences risk the promotion of assimilation and ultimately dismissal of the culture of persons of color if the therapeutic relationship is between White therapists and clients of color. When considering the role of cultural competency in therapeutic relationships, racial socialization should be a tool that advances beyond awareness of privilege and prejudices. It then becomes an opportunity for assisting clients with understanding the role of race and how it impacts their functioning in different areas of their lives (i.e., school, community, occupational) (Bartoli et al., 2015).

Psychotherapy is an impetus for the development and utilization of coping skills. Therapists acknowledging the adverse effects and challenges of race relations in the U.S. may equip clients of color with practical coping skills by validating the impact of racial hierarchies on their environments. This approach is an essential step for White therapists adhering to multicultural competencies as reinforcing racial tensions as situational or

personal could be detrimental to the therapeutic relationship (Bartoli et al., 2015). This change is systemic and could start at the individual, program, and institutional level. For training programs, it is vital to infuse social justice issues into courses. White students that receive instruction on how to work with clients of color and systematic racism will experience a disruption in the classroom, educational institution, clinical placements, and communities and lead to a discontinuation of the perpetuation of prejudice and systematic silence, which historically benefits White people (Bartoli et al., 2015).

Mental health practitioners are required by their governing organizations (i.e., CACREP, ACA, APA) to acquire multicultural competence to become competent and ethical practitioners. Holcomb-McCoy and Meyers (1999) surveyed 500 counselors to examine the cultural competence of professional counselors. The sample was predominately White (66%) and female (68%) and members of ACA (Holcomb-McCoy and Meyers, 1999). Holcomb-McCoy and Meyers (1999) were interested in factors contributed to multicultural counseling, how counselors perceive their multicultural competence, differences of competencies between accredited and non-accredited programs, the influence of their training, and if demographic factors were related to multicultural counseling competence. They found that 63% of the variance of competence was due to five factors, which included knowledge of multicultural issues, awareness, definitions of multicultural terms, racial identity development, and skills. Three of the factors (knowledge, awareness, and skills) are consistent with Sue et al. (1992) definition of multicultural competence. Respondents to the survey perceived themselves to be competent on the definitions and awareness factors, and less competent on the racial identity and knowledge factors (Holcomb-McCoy and Meyers, 1999). When

assessing for differences in perception of multicultural competence and training due to accreditation status, there were no significant differences (Holcomb-McCoy and Meyers, 1999). The researchers concluded ethnicity was the sole demographic variable that influenced knowledge, awareness, skills, and racial identity; a posthoc analysis found that this demographic factor did not have a significant interaction effect with taking a multicultural course (Holcomb-McCoy and Meyers, 1999). However, Holcomb-McCoy and Meyers (1999) concluded that this finding suggests that merely being a person of color provided experiences that were relevant to multicultural counseling. This conclusion is vital for White therapists as it proposes that exposure to clients of color is essential to develop specific multicultural counseling competencies. Additionally, Holcomb-McCoy and Meyers (1999) concluded that although counselors perceived themselves as knowledgeable on awareness, skills, and definitions, this pertained to their culture rather than their clients. Although this type of introspection is relevant to developing competencies in multicultural counseling, lacking awareness of clients' culture is problematic.

Barden et al., (2017) replicated Holcomb-McCoy and Meyers' (1999) study to examine if they would have similar findings. The sample for this study was predominately White (67.8%, n = 116) and female (77.8%, n = 133) and mostly graduates of CACREP programs (71%, n = 122). Although the demographics were similar to Holcomb-McCoy and Meyers (1999) study, the sample was smaller (n = 171). They found five factors (Knowledge, Awareness, Skills, Racial Identity Development, and Definitions) as opposed to two in the original study. Additionally, two factors, Knowledge of Multicultural Issues and Awareness of Multicultural Issues, accounted for

60% of the variance of multicultural competencies, with knowledge of multicultural issues accounting for much of the variance (51.7%) (Barden et al., 2017). Regarding their perception of multicultural competence, counselors perceived themselves to more competent in awareness and less in knowledge (Barden et al., 2017). The differences found based on accreditation status were consistent with McCoy and Meyers' (1999) study in that there were no significant differences between programs that were CACREP accredited and non-accredited. However, the two types of programs differed in their perception of the multicultural course offering, with CACREP programs rating the effectiveness of the course lower than the non-accredited programs (Barden et al., 2017). Their examination of demographics and their effects on the perception of multicultural competence was similar to the earlier study (McCoy and Meyers, 1999). Non-White respondents reported higher levels of multicultural competence due to their perception of possessing higher multicultural knowledge (Barden et al., 2017). However, the effect size was small (4.5 %) and was not significant to imply the significant influence of racial and ethnic differences of counselors (Barden et al., 2017).

Barden et al. (2017) study differed from Holcomb-McCoy and Meyers' (1999) earlier study as it identified a two-factor model for multicultural competence, which suggests a significant relationship and overlap between multicultural knowledge and multicultural skills. The authors concluded that this finding is consistent with recent research that suggests the two factors must coexist for professional counselors to deliver culturally sensitive treatment (Barden et al., 2017). Furthermore, counselors' perception of their multicultural competence was consistent with Holcomb-McCoy and Meyers' (1999) study in that they perceived themselves to be multiculturally competent,

specifically more in awareness and less in knowledge. This consistency could be troublesome, considering the increased focus on developing multicultural competencies over the last two decades and suggests additional work is needed to foster knowledge and skills counselors must develop to work with clients of color. This clinical development is the responsibility of training programs, therapists entering the field of psychotherapy, and organizations that promote such competencies.

The availability of practitioners equipped to provide culturally competent services to communities of color is limited (Smith et al., 2006). The shortage is concerning for the field of mental health when considering the large number of communities of color residing in the U.S. and the inequity of services offered to these groups. A consequence of the insufficient availability of culturally competent practitioners is that clients are often receiving assistance from those who lack knowledge, skills, and awareness to work with specific groups of people. Although the availability of multicultural education has increased over the last two decades, scholars are concerned with the effectiveness of the approaches the issues addressed, and the lack of focus on practitioners' competence (Smith et al., 2006). This concern is not surprising considering the history of therapeutic services offered to clients of color, and the lack of quality of care when compared to their White counterparts. A shift in these practices occurred within the field of counseling psychology during the 1980s when participants expressed dissatisfaction with services offered to historically oppressed groups (Smith et al., 2006). Despite the increased focus, trainees reported that multicultural education minimally addressed inequitable practices (Smith et al., 2006). This dissatisfaction was possibly due to the subfields of applied psychology (i.e., counseling, clinical, community psychology) and the differences in

training. Clinical and counseling psychology training programs were more likely to receive multicultural education and experiences when compared to community psychology (Smith et al., 2006). The differences in training are troublesome, considering the field of community psychology focuses on improving the needs of those residing in community settings to address inequities experienced by these residents.

Students often rate experiential learning activities as more effective than didactic training when developing multicultural competence and working with diverse clients is a strong predictor of acquiring relevant skills to work with these groups (Smith et al., 2006). Unfortunately, researchers found that many APA-accredited programs lacked sufficient focus on the development of skills and placed more emphasis on knowledge and awareness (Smith et al., 2006). Despite researchers finding conflicting results (Holcomb-McCoy and Meyers, 1999; Barden et al., 2017), when it came to the emphasis placed on multicultural counseling skills, the focus on multicultural knowledge and multicultural awareness consistently remained a priority.

Smith et al. (2006) examined the effectiveness of multicultural education on perceived multicultural competence by conducting a study with therapists who completed multicultural education during their graduate programs. These researchers found that participants who received multicultural education scored higher on measures evaluating multicultural competence than those who did not (Smith et al., 2006). However, participants of different studies did not complete the same multicultural competence measure, and those that specifically measured racial identity, racial privilege, and therapeutic alliance were not included in the study (Smith et al., 2006). Researchers of this study acknowledged possible (although unfounded) publication bias as they excluded

studies that did not achieve publication (Smith et al., 2006). Additionally, although therapists of color had effect sizes of a higher magnitude than White therapists, significant racial group differences were not found regarding the multicultural competence of these groups (Smith et al., 2006). This finding contrasts with earlier findings that therapists of color have higher multicultural competence than White therapists.

The second meta-analysis, which included an examination of 37 studies and 2,132 participants, researchers found that multicultural education affected multicultural competence, racial prejudice, racial identity, and client-counselor relationships (Smith et al., 2006). The method of delivery education was different across studies with extant theory accounting for the largest effect sizes in the study (Smith et al., 2006). Regarding publication biases noted in the first meta-analysis, researchers concluded that the same issues applied as unpublished studies excluded in this study.

Historically, racism has been examined separately from multicultural competence, with researchers often focusing on White privilege and White people who hold racist attitudes (Smith et al., 2008). In a laboratory setting, researchers concluded that when White participants experienced anxiety during interracial interactions, they were more likely to engage in aversive racism (i.e., supporting Black equality, but also holding negative views about this group). Smith et al. (2008) posited that this causes avoidance and fear, as White participants feared racists labels. For practitioners, this is a pertinent finding, as their conscious views can significantly differ from racial attitudes that are less apparent. The consequences of aversive racism are inequitable often leading to insensitive cultural practices and severely impacting persons of color.

Cross-Cultural Psychological Capital of Mental Healthcare Professionals

Few researchers have considered variables outside of the field of multicultural counseling literature that may influence the counseling experience for therapists who work with clients of color. Psychological capital (PsyCap), a construct studied within the field of industrial organization, is an umbrella term for constructs found within the field of positive psychology such as hope, resilience, self-efficacy, and resilience. Psychological capital now includes cultural variables, as it is vital to utilize these skills when working with those from different cultural backgrounds (Reichard and Dollwet, 2014).

PsyCap was initially coined by Luthans et al. (2007) in When assessing for organizational behaviors as they pertain to performance and satisfaction, Luthans et al. (2007) combined the constructs above (hope, resilience, optimism, and self-efficacy) to define PsyCap as a positive construct. Psychological capital is an individual's positive psychological state. The construct illustrates their confidence in taking on challenging tasks, being optimistic about future successes, persevering to attain goals, utilizing redirection when necessary, sustaining in the face of adversity, and overcoming challenges to secure achievements (Luthans et al., 2007). Furthermore, PsyCap is believed to be a "state-like" construct as opposed to a "trait-like" construct as they are stable, open to change, and development (Luthans et al., 2007). Research findings indicated psychometric support for self-efficacy, hope, and resilience as they pertain to work performance and satisfaction and stated the overall measure as being a better predictor than the individual facets (Luthans et al., 2007). Richard et al. (2014) measure

differs from the original scale as it aims to assess an individual's perceived ability, willingness, and perseverance when working with people from different cultures.

The recent shift in the field of psychology emphasizes strengths in human behavior while decreasing the attention given to dysfunction or problematic behaviors (Reichard et al., 2014). Luthans et al. (2007) explored the distinctive properties of PsyCap via a confirmatory factor analysis, which supported the construct as a higher-order factor for the overall measure. Additionally, the authors found PsyCap to have a significant relationship with work performance and satisfaction when compared to the individual components that make up the construct (i.e., hope, resiliency, self-efficacy, and optimism) (Luthans et al., 2007). Furthermore, PsyCap served as a mediator of the relationship between cognitive complexity and cultural intelligence when considering cultural trigger events (Reichard et al., 2014). Lastly, PsyCap plays a role in organizational commitment, engagement at work, and organizational citizenship. When considering ethical and clinical principles set forth by APA for working with clients of color, PsyCap may ensure these principles are consistent in individual settings as there is an emphasis placed on relationships.

Traditionally studied within the workplace, PsyCap extends to health and relationships (Reichard et al., 2014). It is also considered in the context of cross-cultural interactions, as it is essential for diversity and cross-cultural relationship skills. In the field of counseling, this connection manifests in the therapeutic relationship, which is conducive for effective communication and progress and decrease attrition among groups underserved in the counseling profession. Interested in the higher constructs composed of psychological capital, Reichard et al. (2014) explored self-efficacy, hope, optimism, and

resilience independently as aspects of a new construct, cross-cultural psychological capital. and found it was responsible for cultural intelligence and positive emotions.

While cross-cultural psychological capital is a recent construct in the multicultural psychology research literature, it may serve as a protective factor in helping mental healthcare professionals combat biases, stereotypes, and racial attitudes they may have toward culturally diverse clients. Developed from Luthans et al.'s (2007) construct of psychological capital, cross-cultural psychological capital, refers to the positive attitudes people have in working with culturally diverse individuals in four domains. The four domains include people's interest and willingness to work with clients of color (self-efficacy), their possession of a positive outlook for future interactions with persons of color (optimism), their ability to be resilient and to persevere in cross-cultural communication and interactions (resilience), and their perception of hope in helping clients of color (hope). Little is known about the cross-cultural psychological capital of therapists and how this relates to their multicultural competence and their quality of services they provide to culturally diverse clients.

Cross-cultural psychological capital was found to be related to positive cultural interactions and well-being for people in organizational settings (Reichard et al., 2014). Reichard et al. (2014) found gender differences in psychological capital in that women were more likely to possess psychological capital than men. However, these researchers did not find socioeconomic or racial group differences in the use of cross-cultural psychological capital with others. Additionally, cross-cultural psychological capital was related to openness to experience, cultural intelligence, and lower levels of ethnocentrism among participants (Reichard et al., 2014).

Cross-cultural self-efficacy refers to an individual's belief in their ability to succeed in their cross-cultural relationships and interactions (Reichard et al., 2014). Albert Bandura, a prominent psychologist that studied self-efficacy, defines it as people's belief in their abilities to influence events that affect their lives (Bandura, 2010). Based on Bandura's efficacy model, efficacy within cultural contexts accounts for mastery, social persuasion, development, and self-regulated cognitive processes (i.e., observational and vicarious cognitive processing; Reichard et al., 2014). For mental health practitioners, this is essential as it focuses on their willingness to learn new ways of thinking and behaving with clients from different cultural backgrounds. This approach fits within the multicultural approach to counseling as well, as it requires clinicians to examine their knowledge, awareness, and skills. Furthermore, cross-cultural self-efficacy serves as a motivator to understand and adapt to new environments (Reichard et al., 2014). For clinicians working in communities much different from their own, this construct may serve as a catalyst for understanding issues relevant to those environments, which is vital for persons of color.

Those who report more cross-cultural hope are more likely to pursue and attain goals related to working with people from different cultural backgrounds and often possesses the ability to address challenges present in cross-cultural interactions (Reichard et al., 2014). Illustrated in their process of developing relationships with clients from different cultural backgrounds, mental health practitioners who are more hopeful discuss barriers to communication, treatment, and growth. Like cross-cultural self-efficacy, cross-cultural hope is conducive to multicultural environments, as it relates to self-

awareness and self-knowledge, which fosters authenticity, autonomy, independence, thinking, and resourcefulness (Reichard et al., 2014).

Reichard et al. (2014) acknowledged cross-cultural hope's relation to job satisfaction, work happiness, and commitment and stated they were relevant for those working in cross-cultural environments as information and resources are limited; this includes language barriers, norm differences, and assumptions. Lastly, when used in cross-cultural interactions, hope increases knowledge and awareness of intolerance, cultural biases, and discomfort of working in cultural settings with culturally diverse individuals, which makes agency and pathways crucial to navigating these concerns; agency being goal-directed and pathways as the planning of the goal (Snyder, 2002; Reichard et al., 2014).

The third component of cross-cultural psychological capital, optimism, refers to the expectancy of positive outcomes when interacting with those of different cultural backgrounds (Reichard et al., 2014). Optimism instills effort when interacting across cultures as it assists with goal attainment when experiencing adversity, which often occurs during intergroup communication (Reichard et al., 2014). People who have this positive outlook usually are high in self-awareness, thus helping them retain favorable outcomes about future cross-cultural interactions, even if they experienced setbacks (Reichard et al., 2014). Not unusual for clinicians to experience conflict when interacting with clients, those high in optimism view these instances as opportunities to become more productive in future interactive experiences. Like hope, optimism facilitates clinicians' navigation of uncertainty, ambiguity, risk-taking, and learning from mistakes (Reichard et al., 2014). Those high in optimism also attribute failed cross-cultural

interactions to external events and seek ways to be successful in future interactions (Reichard et al., 2014). This external attribution decreases the opportunity for clinicians to develop or strengthen biases they hold towards groups of different cultural backgrounds.

As previously noted, cross-cultural interactions may result in adverse outcomes due to adversity, conflict, or failure (Reichard et al., 2014). The fourth component of cross-cultural psychological capital, resilience, refers to the capability of recovering from adverse events (i.e., coping) and is due to relationships, social skills, and initiatives, and the familiarity with managing risk factors (Reichard et al., 2014). Clinicians with these skills avoid discussions around culture following negative cross-cultural interactions and are less likely to be adversely impacted by them. Therefore, those high in cross-cultural resiliency perform well when working with persons of color and are better at navigating cultural shock, language barriers, and cross-cultural conflicts (Reichard et al., 2014). Cross-cultural resilience fosters proactive learning during moments of hardships and is crucial for adaptation, especially those that are novel (Reichard et al., 2014). Resilience is imperative for clinicians serving persons of color, as it requires significant learning, compromise, and adaptability.

The four components of cross-cultural psychological capital intersect and collectively fosters one's ability to navigate cross-cultural interactions (Reichard et al., 2014). For example, in situations where people are striving to be successful during intergroup communication, self-efficacy and optimism are fundamental to increasing hope, which creates successful cultural interactions (Reichard et al., 2014). Although these skills and traits possibly develop during other experiences, cultural training is

needed for them to be transferrable and effective. For mental health practitioners, they may receive cultural training (i.e., diversity and multicultural course, didactics, clinical experiences) during their formal training. However, because not all programs are alike, there is no guarantee of the trainings' effectiveness or whether the experience was required or available. Receiving training in multiculturalism and diversity is required by organizations, such as APA and ACA, and often by states' licensing boards. Therefore, there is an expectation for mental health practitioners holding professional licenses to become familiar with concepts related to cross-cultural psychological capital.

For cross-cultural psychological capital, it is possible to develop skills in classroom settings. For efficacy, its development takes place via incremental task mastery, vicarious learning, verbal persuasion, and arousal (Reichard et al., 2014). When considering hope, its development requires strategies that involve creative thinking, action planning, goal setting, and mastery of goal orientation and accomplishment (Reichard et al., 2014). In terms of increasing optimism, reframing past events, and attributing positive outcomes to internal factors and negative factors to external factors is necessary (Reichard et al., 2014). Developing resilience requires increasing assets needed to navigate adverse experiences and those necessary for recovery (Reichard et al., 2014). Mental health practitioners seeking to develop components of cross-cultural psychological capital to work with culturally diverse populations possess opportunities in the classroom and applied settings.

Cross-cultural psychological capital measures competencies that are generalizable across cultural boundaries and assists with successful intergroup interactions. Mental health practitioners, this extends beyond cultural norms present in the U.S. to immigrants

and those residing in other countries. Dollwet and Reichard (2014) found that cross-cultural psychological capital positively relates to the openness of experiences and cross-cultural adjustment, and negatively correlates with ethnocentrism for those high in cross-cultural psychological capital. Therefore, mental health practitioners open to working with clients of color are likely to experience success with these groups compared to clinicians with opposing preferences and will possess lower amounts of biases. This proposal is imperative when considering the racial attitudes and cultural competence of clinicians as it can reduce instances wherein prejudices and lack of cultural skills adversely affect treatment.

Cross-cultural psychological capital may result in additional types of cultural intelligence, as previous studies conducted by researchers, found a relationship between self-efficacy and motivational cultural intelligence, which is an individual's motivation and interest in adapting to cultural variations (Yunlu and Clapp-Smith, 2014). Those high in motivational cultural intelligence are also more likely to possess other components of cross-cultural psychological capital (i.e., hope, resilience, optimism; Yunlu and Clapp-Smith, 2014). Those high in motivational cultural intelligence have intrinsic interests, and hope, optimism, resilience, and efficacy have similar properties to intrinsic interest (Yunlu and Clapp-Smith, 2014). Additionally, the relationship between motivational cultural interest and cross-cultural psychological capital is possible as those who have more motivational cultural intelligence tend to be more likely to have the capacity to learn about and function in environments culturally different from their own (Yunlu and Clapp-Smith, 2014). Yunlu and Clapp-Smith, (2014) posited that this relationship is due to metacognitive awareness, which refers to the ability to reflect upon, understand, and

control one's experiences of learning and processing. For mental health practitioners engaging in cultural competence development, this approach happens when considering their knowledge and awareness of themselves and other cultures.

In the present study, we explored therapists' racial attitudes, cross-cultural psychological capital, and perceived multicultural competence with their level of concern in working with clients of color receiving services in mental health settings. Cross et al. (1989) posited that cultural competence is a developmental process and attained by valuing diversity, performing cross-cultural assessments, becoming conscious of the dynamics of cultural interactions, adequately integrating cultural knowledge into institutions, and developing adaptations to diversity. Although this definition has since become universally accepted and strides have been made in the mental health field to encourage cultural competency with clients of color, these groups continue to experience inadequate availability, access, and quality to mental health services (Shushansky, 2017). Few researchers have explored the relationship of mental healthcare professionals' racial attitudes, cross-cultural psychological capital, and multicultural competence, and instead, have historically concentrated on the perspectives of those receiving mental health services (Nickerson et al., 1994; Chao et al., 2011) or the racial identity development of students in training as it relates to providing clinical services (Ottavi et al., 1994; Constantine, 2002; Gushue and Constantine, 2007).

Concerns in Working with Clients of Color

Indeed, having more cross-cultural psychological capital might be a protective factor against racial attitudes (i.e., biases, prejudices) as well as a building block for multicultural competence and for concern in working with culturally diverse clients.

Researchers believe that although practitioners and trainees may possess knowledge of multicultural training, they may not demonstrate the emotional capacity to carry out their work, which could be detrimental to racially diverse client populations receiving psychotherapy (Wei et al., 2012). The same is true for their perceived self-efficacy with clients of color. Without believing they are proficient in counseling clients of color, therapists may inadvertently provide inadequate services to this population, and thus, become at risk of not self-monitoring for any harmful racial attitudes or biases. Therefore, being comfortable (i.e., having less concern) in working with clients of color is being free from fear or concerns about working with this group (Wei et al., 2012). Lastly, mental healthcare professionals' level of concern in working with clients of color may affect their beliefs regarding how their clients view them as helping professionals. Having a stable therapeutic relationship and a clear understanding of clients' cultural backgrounds is needed to support and advocate for clients and their well-being in the psychotherapy process.

The professional alliance that develops between therapists and their clients continues to be one of the best predictors of successful treatment outcomes (Slone and Owen, 2015). This relationship is often described as stable and consistent regardless of therapeutic modality (i.e., cognitive-behavioral, psychodynamic, solution-focused), and accounts for rough 7.5% of treatment outcomes (Slone and Owen, 2015). Although this percentage appears small, when considering the robust number of variables that affect treatment outcomes, it is vital. Numerous definitions for therapeutic alliance exist, but one of the most utilized ones in the literature describes it as a bond between therapists and clients, and the degree to which they conform to established goals and tasks (Slone

and Owen, 2015). Without these components, treatment outcomes would likely lead to attrition. When working with clients of color, the therapeutic alliance may depend on counselors' willingness and openness to discuss race and race-related issues.

Although APA and other counseling organizations acknowledge the importance of multicultural counseling, this does not guarantee therapists will discuss issues relevant to their clients' racial or ethnic background or that they will feel comfortable doing so (Wei et al., 2012). Various variables explain the absence of discussing race-related issues or even feeling prepared to work with clients of color, such lacking the skill to inject multicultural knowledge into sessions or finding the appropriate time to discuss differences that exist between therapists and clients (Wei et al., 2012). Owen et al., (2017) regarded this skill as racial or ethnic comfort and defined it as observable levels of ease that clients with different racial and ethnic backgrounds perceive their therapists as engaged and aware of their cultural identities. When therapists do not engage in this awareness, consequences arise due to their discomfort. When therapists fail to discuss race during mental health treatment, clients of color often feel frustrated and ignored (Wei et al., 2012). Feeling frustrated and ignored often leads to an inability to connect with therapists, which can prevent successful treatment outcomes.

Clients of color may also neglect to bring up race or race-related issues and may have concerns or fear around the topic (Wei et al., 2012). It may be necessary for therapists working with this population to acknowledge such discomfort may exist with their clients and attempt to engage them in cross-racial counseling dialogue to promote a strong working alliance. Therapists do not frequently engage in cross-racial discussions because, for some, it is challenging to manage the strong emotional reactions (e.g., fear,

anger, shame) to race-related incidents, fear of making insensitive comments that may appear prejudicial or offensive, and having anxiety around saying the wrong thing (Wei et al., 2012). Concern around discussing these issues are common during clinical training and considered appropriate, as it is part of trainees clinical and multicultural development. When working with clients of color, trainees often report lower levels of confidence when compared to White clients (Owen et al., 2017). If the concern around discussing race with clients of color does not serve as a motivating factor to become culturally competent during training, it runs the risk of becoming overly anxious when serving this group, which can affect their performance and their clients' wellbeing (Wei et al., 2012).

When assessing the validity and reliability of the Counselors' Concerns in Counseling Racial Minority Clients Scale (CCRMC), Wei et al. (2012) explored therapists' concern in counseling clients of color. The authors were not only interested in counselors' discomfort, but their level of efficacy (i.e., multicultural efficacy, self-efficacy) of working with clients of color and their attitudes towards this group (Wei et al., 2012). In a sample of 256 graduate trainees (53 males, 199 females, 2 transgender) of counseling, counseling psychology, clinical psychology, and counseling related programs (e.g., marriage and family therapy, mental health counseling) fear of negative evaluation was positively related to overall concerns and specific concerns about managing cultural differences (Wei et al., 2012). Furthermore, counseling self-efficacy and multicultural intervention self-efficacy was negatively correlated with overall concerns, suggesting that those high in the areas of efficacy experienced lower concerns and vice versa (Wei et al., 2012).

Concerns in working with clients of color can also lead to attrition among this group, further strengthening the disparities found in mental health treatment. Therapists influence the benefits clients of color receive from treatment, and if they decide to terminate (Owen et al., 2017). According to Owen et al. (2017), cultural comfort serves as an additional factor as it relates to therapists' ability to orient their clients to psychotherapy culturally. This process occurs when therapists incorporate three dimensions, which are cultural humility, cultural opportunities, and cultural comfort (Owen et al., 2017). When applied together, therapists incorporate a culturally humble approach, create opportunities to discuss race, and authentically engage with clients in a supportive manner (Owen et al., 2017). Therapists achieve these connections by acknowledging their strengths and weaknesses in cross-racial psychotherapy and accept what they do and do not know (Owen et al., 2017).

There are benefits to matching mental health therapists and clients based on race, and perhaps this could be a solution to the discrepancy found in cross-racial psychotherapy relationships. Although Black people are more likely to prefer therapists of the same race, there is no evidence that outcomes differ (Mensinger and Diamond, 2005; Good-Cross and Grim, 2016). However, Black clients matched with Black therapists experience factors that enhance the therapeutic relationship, such as similar terminology (i.e., lingo, vernacular), intervening in a more culturally congruent way, mentorship, and shared experiences (e.g., successes, oppressive, historical; Mensinger and Diamond, 2005; Goode-Cross and Grim, 2016). This connection often results in higher utilization and retention of clinical services (Mensinger and Diamond, 2005). At the same time, several obstacles can occur between Black clients and therapists, such as

the denial of identification with clients (i.e., cultural separation or classism), over-identification with clients (i.e., countertransference), gender and sexual identity, and managing differences in socioeconomic statuses (Goode-Cross and Grim, 2016). When assessing the role of race and alliance as it influenced treatment outcomes, Mensinger and Diamond (2005) found race did influence treatment retention, and White therapists treating clients of color experienced the highest retention when compared to other groups, which authors hypothesized was related to racial or ethnic comfort (i.e., discussing race-related issues).

Goode-Cross and Grim (2016) explored the success of successful treatment Black practitioners had with Black clients. Through a phenomenological study, the authors found several themes, which included: understanding racial socialization messages, understanding the challenges faced by Black clients, understanding the prevalence of mental health stigma within the Black community, communicating in a culturally-congruent and direct way, serving as mentor or role-model, doing therapy with Black clients, attending continuing education workshops, and receiving mentorship by more experienced therapists. Therapists of different races and ethnicities may address many of these areas, however, the approach delivered in a culturally appropriate, respectful manner fosters successful outcomes.

There is existing research that examines the healthcare disparities of clients of color compared to White people, and research that supports emerging factors that influence the quality of the services received by clients of color, including their healthcare providers' racial attitudes, ability to see the positive aspects of their clients' situations, and their level of multicultural competence. Practitioners' level of concern in

working with persons of color is an emerging area in the research literature in psychotherapy. Practitioners' level of concern in working with clients of color is essential to provide the best services possible. Another factor that has not yet examined in mental health settings is cross-cultural psychological capital. While psychological capital research has been conducted primarily in industrial organizational psychology fields, more researchers and clinicians are interested in the ability of health care professionals to be more hopeful and optimistic with their clients, which is addressed by the aspects of psychological capital included in the present study. One of the purposes of our study was to examine the influences of mental health practitioners' biases on their work with clients of color to inform practitioners about the factors that may positively and negatively relate to their therapy work with this client population.

Purpose and Significance of the Study

The purpose of this study was to understand the perceptions of practitioners providing mental healthcare to clients of color in community mental health settings, in particular, how their racial attitudes, perceived multicultural competence, and cross-cultural psychological capital relate to their level of concern in working with clients of color. The results of this study will inform therapists about culturally relevant issues in counseling practice. These findings will draw attention to culturally relevant training issues to hopefully address potential biases, approaches, and struggles for mental healthcare professionals providing services for and with clients of color. The goal of such training is to enhance therapists' awareness of how their racial attitudes, use of positive psychology approaches, and their multicultural competence might affect their level of concern in working with clients of color. We hope the findings of this study will inform

future research in training mental healthcare practitioners, specifically in the areas of multicultural counseling, and provide more direction regarding the training needs of those who aspire to work in community settings with clients of color.

Research Questions, Research Hypotheses, and Proposed Statistical Analyses

The research questions and hypotheses of this study were as follows:

1) What are the bivariate relationships between and among the main study variables, including therapists' racial attitudes, multicultural competence, cross-cultural psychological capital, and their level of concern in working with clients of color?

   Hypothesis: There will be an association among the main study variables, including general racial attitudes, cross-cultural psychological capital, multicultural competence, and levels of concern in working with clients of color. We hypothesized that less concern in working with clients of color will be associated with fewer negative racial attitudes/biases, more cross-cultural psychological capital when working with clients, and more multicultural competence for the therapists in this study.

2) What is the linear relationship of therapists' racial attitudes (overall score), cross-cultural psychological capital (overall score), and multicultural competence (overall score) with their level of concern in working with clients of color (overall score)?

   Hypothesis: Therapists' racial attitudes (fewer), cross-cultural psychological capital with clients of color (more), and their multicultural competence levels (more competence) will be associated with their level of concern in working with clients of color.

3) What is the linear relationship of aspects of therapists' multicultural competence (i.e., Multicultural Knowledge, Awareness of Cultural Barriers, Sensitivity and Responsiveness to Consumers, and The Sociocultural Diversities) with their level of concern in working with clients of color?
   Hypothesis: Therapists' levels of Multicultural Knowledge, Awareness of Cultural Barriers, Sensitivity and Responsiveness to Consumers, their Sociocultural Diversities will be associated with their level of concern in working with clients of color.
4) What is the linear relationship of therapists' cross-cultural psychological capital (i.e., Optimism, Resilience, Hope, and Self-Efficacy) with their level of concern in working with clients of color (overall score)?
   Hypothesis: Therapists' levels of Optimism, Resilience, Hope, and Self-Efficacy will be associated with their level of concern in working with clients of color.
5) What is the linear relationship of therapists' racial attitudes (i.e., Critical Awareness and Preparation, Knowledge of Opportunity Structure, Spiritual Coping, Cultural Pride and Self-Knowledge, and Color-blind ideology) with their level of concern in working with clients of color (overall score)?
   Hypothesis: Therapists' racial attitudes, specifically their Color-blind ideology, will be associated with their level of concern in working with clients of color (overall score).

CHAPTER III

METHODOLOGY

Participants

The participants in this study were 177 mental health practitioners with at least 4 months of counseling experience. Most of the participants were women (i.e., 157 women, 14 men, 3 non-binary gender, 2 transgender men, and 1 transgender woman). Participants self-identified primarily as either Caucasian or White ($N = 74$) or Black or African-American ($N = 57$), with other groups represented including Asian or Pacific Islander ($N = 13$), Hispanic or Latinx ($N = 7$), Native American or American Indian ($N = 7$), or specified another racial identity ($N = 6$). Participants ranged in age from 23 to 68 years ($M = 35.30$, $SD = 10.44$).

All the participants indicated they have worked with clients of color. Participants identified as counselors (i.e., Licensed Professional Counselors and those eligible), therapists (i.e., Licensed Marriage and Family Therapists and those eligible; clinical social workers and those eligible), or psychologists (i.e., Health Service Psychologists and eligible), or trainees in master's and doctoral programs in counseling, applied psychology (i.e., clinical and counseling), and couples and family therapy. Trainees were actively working with clients and received coursework with supervised clinical experience. A large portion of the participants were master's level clinicians

(59%) and not currently licensed (53%). Most of the participants listed counseling psychology (38%), clinical psychology (34%), clinical social work (11%), and marriage and family therapy (11%) as their primary specialization field. Participants' years of professional therapy experience ranged from 4 months to greater than 10 years. Almost all the participants (97%) indicated they completed a multicultural or diversity course as part of their graduate education, but over half (59%) completed such a course or training following their degree attainment. In terms of clinical settings, participants were mainly employed in private or group practices (29%), community mental health centers (28%), hospital or academic medical centers (14%), and university counseling centers (9%). See Table 1 for the demographics of the sample.

Procedure

We recruited participants through social media platforms (i.e., Facebook and LinkedIn) and email. They were recruited with the help of training directors and coordinators of these programs, with emails informing them of this study. Programs that received emails were Clinical Psychology, Counseling Psychology, Counseling, and Marriage and Family Therapy. Listservs were also used and included the American Psychological Association (APA) Divisions of 17, 44, 45, and 12, the American Counseling Association, the American Association for Marriage and Family Therapist, and the Association of Black Psychologists. Those who agreed to participate in the study belonged to mental health and counseling-related forums or publicly presented themselves as mental health professionals.

The age of consent for participation was 18 years of age. Because of the required education, we assumed that most of the participants practicing as a therapist were of the

age of legal consent. There were no restrictions with regards to racial, gender, or sexual identity, sexual or affectional orientation, religious or spiritual beliefs, ability status, or socioeconomic status. Additionally, participants were required to have a minimum of one semester of supervised clinical experience. With regards to multicultural training, it was expected that participants had either completed a course that focused on providing therapy to racially diverse client populations, attended a seminar that provided instruction on this topic, worked with clients of color, or received didactic training through supervised clinical experiences.

Measures

The online survey included five questionnaires and a demographic page. The five questionnaires included in the survey were: Mental Health Practitioner's Racial Socialization Practices Measures (MHPRSPM; Brown, Blackmon, Schumacher, and Urbanski, 2013), Cross-Cultural Psychological Capital Scale (Dollwet and Reichard, 2014), California Brief Multicultural Competence Scale (CBMCS; Garnst et al., 2004), and Concerns about Counseling Racial Minority Clients Scale (CCRMC; Wei, Chao, Tsai, and Botello-Zammaron, 2012).

Mental Health Practitioner's Racial Socialization Practices Measures

The MHPRSPM is a 33-item scale intended to measure mental health practitioners' racial socialization messages (i.e., racial attitudes) and the likelihood of incorporating them into therapy. Respondents identify their level of racial socialization practices using a 7-point Likert scale that ranges from 1 (not likely) to 7 (very likely). An overall score assesses the level of racial socialization; higher scores on the scale indicate respondents have fewer negative beliefs about race and racism, whereas lower scores

indicate a presence of potential racial biases. Adapted from previous scales used in racial socialization studies (i.e., Experience with Racial Socialization and Scale of Racial Socialization), the MHPRSPM measures behavioral and attitudinal components of racial socialization and evaluates the extent of which practitioners engage in prejudicial messages, such using microaggressions against people of color when providing therapy (Brown et al., 2013).

The MHPRSPM consists of five subscales, including Critical Awareness and Preparation, Knowledge of Opportunity, Spiritual Coping, Cultural Pride and Self-Knowledge, and Color-Blind Ideology. Critical Awareness and Preparation measures awareness and preparation for the possibility of racism in the world (e.g., "It is important to understand the psychological impact of racism"). Knowledge of Opportunity assesses attitudes toward clients of color and how they are affected by their race in society (i.e., discrimination; "You may experience racial discrimination in your daily experiences"). Spiritual Coping measures spiritual activities to cope with racism, (e.g., "Spirituality can protect you from racial hatred.)" The fourth factor, Cultural Pride and Self-Knowledge, considers racial acceptance and importance (e.g., "Never be ashamed of your racial background."). The final factor, Color-Blind Ideology, assesses denial of racial differences and racism (e.g., "Focusing on racism will keep you from reaching your life goals."). Factor analysis findings indicated that these five factors accounted for almost 65% of the variance in MHPRSPM and that they had high internal reliability, with Cronbach alphas ranging from .81 to .93 (Brown et al., 2013).

The internal consistency reliability estimates for the overall score as well as the subscale scores of the MHPRSPM for the current sample were as follows: .79 for the

overall score, .73 for Critical Awareness and Preparation, .67 for Knowledge of Opportunity, .83 for Spiritual Coping, .75 for Cultural Pride and Self-Knowledge, and -.13 for Color-Blind Ideology. The color-blind ideology subscale items did not significantly correlate with one another; therefore, it does not appear to measure a unified psychological construct. Despite the low internal consistency reliability estimate for the color-blind ideology subscale of the MHPRSPM, we decided to include it in the correlational analysis and one regression analysis for exploratory purposes.

There are limited scales available to researchers to measure mental health practitioners' racial socialization. The study conducted by Brown et al. (2013) sufficiently identified potential differences between therapists of color and White therapists in spiritual coping and color-blind ideology. Participants in the current study responded to each item to identify the racial socialization messages to which they adhere. To represent all clients of color, we modified the scale to ask participants to reflect on the statements with "clients of color" in mind.

Cross-Cultural Psychological Capital Scale

The CCPCS is a 20-item self-report measure developed to assess cross-cultural psychological capital, a measurement of an individual's positive psychological state (i.e., self-efficacy, hope, optimism, and resilience) that influences their work with individuals and groups in the context of cross-cultural interactions. Generally, psychological capital is a person's ability to develop positive relationships with others effectively. Items are rated on a 7-point Likert scale, ranging from 1 (strongly disagree) to 7 (strongly agree). There are four subscales of this measure: Self-Efficacy, Optimism, Hope, and Resilience. These constructs assess an "individual's positive psychological state" (Richard et al.,

2014, p. 150). Higher scores on this measure indicate more self-efficacy, hope, optimism, and resilience, and the ability to utilize these aspects when working with clients from different cultural backgrounds. In comparison, lower scores may impede their work (i.e., lead to negative interactions) with clients of different cultural backgrounds (Richard et al, 2014).

Self-efficacy measures an individual's confidence in taking on challenging tasks when working with clients of color (e.g., "I am confident that I can perform effectively on many different tasks when working with individuals from different cultures."). Optimism is an individual's outlook about future successes and persevering to attain goals with clients of color (e.g., "When facing difficulties in cross-cultural interactions, I usually expect the best."). Hope measures a person's utilization of redirection and their motivation in helping clients of color set realistic goals in the face of adversity (e.g., "At the present time, I am energetically pursuing goals related to working with individuals from different cultures than me."). Resilience refers to an individual's ability to sustain in the face of adversity and overcome challenges to secure achievements in their work with diverse clients (e.g., "When I interact with individuals from a different culture, I am able to successfully overcome many challenges." Richard et al., 2014).

In addition to subscale scores, there is a total score for the CCPCS. The internal consistency reliability estimate for the overall score was .92 for the original sample. The CCPCS has been associated with similar constructs measured in other questionnaires, including cultural intelligence (Cultural Intelligence Scale; Ang et al., 2004), ethnocentrism (Black, 1990), openness to experience (Gosling et al., 2003) and cross-cultural adjustment (Black and Stephens, 1989), providing evidence of convergent

validity. The CCPCS was significantly and positively related to Openness, Cultural Intelligence, and Cross-Cultural Adjustment, but negatively related to Ethnocentrism (Dollwet and Reichard, 2014), thus demonstrating convergent and divergent validity of the CCPCS. The internal consistency reliability estimates for the overall score, as well as the subscale scores, for the current sample were as follows: .94 for the overall CCPCS score, .80 for Hope, .93 for Self-Efficacy, .83 for Resilience, and .94 for Optimism.

California Brief Multicultural Competence Scale

The CBMCS is a 21-item self-report measure that assesses for multicultural competence among mental health practitioners. Respondents indicate to what degree they agree with the statements, using a 4-point Likert scale ranging from 4 (strongly agree) to 1 (strongly disagree). Higher scores on the CBMCS indicates more cultural competence and related skills, while lower scores indicate more deficits in cultural knowledge, awareness, and skills. The CBMCS has a total score but also consists of four subscales. The first subscale, Sociocultural Diversities (7 items), measures therapists' ability to assess the intersecting identities of clients. The second subscale, Awareness of Cultural Barriers, (6 items) measures practitioners' ability to recognize their own culture and how it influences their work with clients of color. The third subscale, Multicultural Knowledge, (5 items) is a measure of mental health practitioners' knowledge of ethnic and racial differences and the clinical implications for working with clients of color. The final subscale, Sensitivity to Consumers, (3 questions) measures therapists' awareness of barriers (i.e., values, institutional barriers, communication skills) that could impact their clients. Examples of items for each subscale include: "I have excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons

from different cultural, racial, and ethnic backgrounds" (Multicultural Knowledge); "I am aware that being born a minority in society brings with it certain challenges that White people do not have to face" (Awareness of Cultural Barriers); "I am aware of institutional barriers that affect the client" (Sensitivity and Responsiveness to Consumers); and "I have an excellent ability to assess accurately the mental health needs of persons who come from very poor socioeconomic backgrounds" (Sociocultural Diversity; Garnst et al., 2004).

Originally developed to assess the rigor training programs used to prepare future psychologists to work with culturally diverse populations, the CBMCS measures clinical practitioners in various settings. Additionally, the scale measures multicultural counseling competencies for those providing direct services with culturally diverse clients in community mental health care. The scale has broad areas of cultural competence, such as attitudes/beliefs, knowledge, and skills, and several competencies of counseling organizations. The CBMCS differs from other measurements of multicultural competence as it captures the skills of practitioners, including their knowledge, beliefs, and abilities to work with culturally diverse populations as opposed to just their self-efficacy (Garnst et al., 2004).

The CBMCS was found by researchers to have sufficient reliability on the overall scale, yielding a Cronbach alpha of .89. The Cronbach alphas for the four subscales were .90 for Non-ethnic Ability, .78 for Awareness of Cultural Barriers, .80 for Multicultural Knowledge, and .75 for Sensitivity to Consumers. To assess convergent validity, the CMBMC was compared to the Multicultural Counseling Inventory (MCI) and found to be significantly and positively correlated ($r = .89$; Garnst et al., 2004). The internal

consistency reliability estimates for the overall score as well as the subscale scores of the CBMCS for the current sample were as follows: .87 for the overall CBMCS score, .81 for Multicultural Knowledge, .68 for Awareness of Cultural Barriers, .55 for Sensitivity and Responsiveness to Consumers, and .82 for Sociocultural Diversities.

Concerns about Counseling Racial Minority Clients Scale

The CCRMC is a 20-item self-report measure that assesses mental health professionals' emotions related to their clinical work with clients of color, especially how anxious or fearful they are when applying multicultural approaches and their level of concern when working with clients of color. Respondents indicate to what extent they agree with each statement, using a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Most researchers use the overall score to indicate one's level of concern in working with clients of color. Higher scores on this measure indicate practitioners experience more concerns when working with clients of color, whereas lower scores indicate fewer concerns and more comfort with clients of color.

There are four subscales of the CCRMC: (1) Managing Cultural Differences (i.e., managing cultural differences when an opportunity arises during therapy; "I do not know how to handle my clients' feelings if issues of racism are addressed in a session."), (2) Offending or Hurting Clients (i.e., concerns of adversely affecting clients; "I may say/do something that would be seen as ignorant by my clients."), (3) Biased Thoughts and Behaviors (i.e., level of awareness of one's own biases and behaviors; "I may underestimate how issues of diversity are linked to my client's presenting problems."), and (4) Client Perceptions (i.e., concerns regarding clients' attitudes towards them; "My clients may not feel comfortable about opening themselves up to me."; Wei et al., 2011).

The CCRMC is a reliable and valid measure of mental health professionals' level of concern in working with clients of color. The internal consistency reliability of the overall score for the original sample was .90, whereas the subscales (Managing Cultural Differences, Offending or Hurting Clients, Biased Thoughts and Behaviors, and Client Perceptions) yielded Cronbach alphas ranging from .77 to .86. Test-retest was also satisfactory for the measure as the subscales ranged from .75 to .96 (Wei et al., 2011).

The internal consistency reliability estimates for the overall score as well as the subscale scores of the CCRMC for the current sample were as follows: .92 for the overall CCRMC score, .89 for the Managing Cultural Differences subscale score, .93 for the Offending or Hurting Clients subscale score, .83 for the Biased Thoughts and Behaviors subscale score, and .82 for the Client Perception subscale score.

For the original sample, the four factors of the CCRMC accounted for approximately 55% of the variance in CCRMC scores (Wei et al., 2011). Small to moderate positive correlations (r = .19 to .40) between CCRMC subscales and similar measures of practitioners' evaluation of clients (e.g., Fear Negative Evaluation; Leary, 1983). Additionally, the CCRMC subscales were significantly and inversely related to self-efficacy, such as the General Counseling Self-Efficacy(r = -.30 to -.46), and those measuring multicultural competence, such as the Multicultural Interventions (r =.-30 to -.64) (Wei et al., 2011), all of which provide evidence of the convergent validity of the CCRMC.

CHAPTER IV

FINDINGS

Results

The descriptive statistics for the main study variables are presented in Table 2. To address research question 1, Pearson correlational analyses were conducted to explore the bivariate relationships between and among the main study variables, including racial attitudes, multicultural competence, cross-cultural psychological capital, and level of concern in working with clients of color. See Table 3 for the correlation matrix.

Level of concern in working with clients of color was significantly and negatively related to cross-cultural psychological capital (r = -.54, p< .05) and multicultural competence (r = -.33, p < .05), but was not significantly related to general racial attitudes (r = -.07, p > .10). These findings suggest that mental health practitioners with higher levels of cross-cultural psychological capital and multicultural competence had fewer concerns in counseling clients of color as they were more likely to use skills to foster positive relationships when providing mental health treatment.

There were significant and negative bivariate relationships between level of concern in working with clients of color and three aspects of multicultural competence including Multicultural Knowledge (r = -.32, p < .05), Sensitivity Responsiveness (r = -.27, p < .05), and Sociocultural Diversities (r = -.31, p < .05), but no significant

relationship between the level of concern in working with clients of color and one's Awareness of Cultural Barriers for clients (r = -.03, p = .39). Mental health practitioners who believed they held knowledge about various cultures had skills to respond appropriately with those of different backgrounds and were cognizant of other intersecting identities (i.e., ability, sexual orientation, gender, and age) of their clients held fewer concerns in their clinical work with clients of color. At the same time, there was no clear relationship between practitioners' level of concern in working with clients of color and the barriers that may arise in mental health treatment due to their differences in culture.

For this sample of mental health practitioners, there is no clear association between mental health practitioners' general racial attitudes and their level of concern in working with clients of color. However, there was a significant negative relationship between the level of concern in working with clients of color and one subscale of general racial attitudes (Cultural Pride and Self-knowledge; r = -.27, $p < .05$). Therapists' level of concern in working with clients of color was not related to any of the other general racial attitude subscales. These findings suggest that although mental health practitioners incorporate low racial socialization practices within their work with clients of color, their knowledge of their racial background and how highly they regarded their own identity was associated with their perceived concerns in counseling clients of color.

Some other notable correlational findings were that mental health practitioners' overall level of multicultural competence was significantly and negatively related to their use of all of the cross-cultural psychological capital elements, including hope (r = -.23, p < 05), self-efficacy (r = -.56, $p < 0.05$), optimism (r = -.51, $p < .05$), and resilience (r = -

.50, $p < .05$). These findings suggest that mental health practitioners who viewed themselves as more multiculturally competent in working with clients were less likely to incorporate cross-cultural psychological capital with their clients.

In summary, we confirmed most of the hypotheses related to research question 1. Cross-cultural psychological capital and multicultural competence were negatively associated with the level of concern in working with clients of color. However, therapists' general racial attitudes were not related to their level of concern in working with clients of color. Also, the specific aspects of cross-cultural psychological capital (i.e., all four subscales) were significantly and negatively associated with therapists' level of concern in working with clients of color.

A series of multiple regression analyses were conducted to answer the remaining research questions of this study. Before interpreting the regression findings, we used diagnostics tests to evaluate assumptions related to linearity, independence, homoscedasticity, and whether errors correlated with the independent variables. Specifically, we were interested in the dependent variable's influence on any of the independent variables, the validity, and reliability of independent variables, and whether the regression analyses included all common causes of the presumed cause of the presumed effect (Keith, 2015). We did not find any significant violations. Therefore, we did not perform adjustments to the data or the analyses.

To answer research question 2, we explored the linear relationship of therapists' racial attitudes, multicultural competence, and cross-cultural psychological capital (i.e., predictor variables) with their level of concern in working with clients of color (i.e., outcome variable). The overall model was significant, and these three variables (i.e.,

racial attitudes, multicultural competence, and cross-cultural psychological capital) accounted for 30% of the variance in mental health practitioners' level of concern in working with clients of color, $R^2 = .30$, F (3, 173) = 6.42, $p < .01$. Examination of the beta weights revealed that cross-cultural psychological capital was the only significant individual predictor of mental health practitioners' level of concern in working with clients of color ($\beta = -.55$, $p < 0.01$). See Table 4. Thus, the hypothesis for research question 2 was confirmed.

For answer research questions 3, 4, and 5, multiple regression analyses were conducted to explore how specific aspects of practitioners' multicultural competence, cross-cultural psychological capital, and racial attitudes were linearly related to their level of concern in working with clients of color respectively. The overall regression model for the linear relationship of specific aspects of multicultural competence (i.e., Multicultural Knowledge, Awareness of Cultural Barriers, Sensitivity and Responsiveness to Consumers, and The Sociocultural Diversities) with mental health practitioners' level of concern in working with clients of color (Research Question 3) was statistically significant, $R^2 = .18$, F (4, 172) = 9.52, $p = .000$., accounting for 18% of the variance. The Multicultural Knowledge ($\beta = -.26$, $p < 0.01$) Awareness of Cultural Barriers ($\beta = .24$, $p < 0.01$) and Sensitivity Responsiveness ($\beta = -.23$, $p < 0.01$) subscales of the CBMCS were the only significant individual predictors within the model. See Table 5. Thus, higher levels of perceived multicultural knowledge and less awareness of cultural barriers and sensitivity responsiveness were associated with and predictive of mental health practitioners experiencing less concern when working with clients of color.

The overall regression model for the linear relationship of the specific aspects of practitioners' cross-cultural psychological capital (i.e., Optimism, Resilience, Hope, and Self-Efficacy) with mental health practitioners' level of concern in working with clients of color was statistically significant, $R^2 = .36$, F (4, 172) = 25.51, $p = .000$, accounting for 36% of the variance. Except for Resilience ($\beta = -.08$, $p = .43$), the other three subscales of the CCPC, Hope ($\beta = .16$, $p < 0.05$), Self-Efficacy ($\beta = -.46$, $p < 0.05$), and Optimism ($\beta = -.23$, $p < 0.05$) were significant individual predictors of mental health practitioners' level of concern in working with clients of color. Mental health practitioners' level of hope (i.e., agency and ways to help clients achieve their goals) in their work with clients of color predicted more concerns in their work with clients of color, whereas having higher levels of self-efficacy and optimism in their work with clients of color predicted fewer concerns in working with clients of color.

The overall regression model regarding the linear relationship of the specific aspects of mental health practitioners' racial attitudes (i.e., Critical Awareness and Preparation, Knowledge of Opportunity Structure, Spiritual Coping, Cultural Pride and Self-Knowledge, and Color-blind Ideology) with their level of concern in working with clients of color was statistically significant, $R^2 = .10$, F (5, 171) = 3.86, $p = .000$, accounting for 10% of the variance. The Cultural Pride and Self-Knowledge subscale ($\beta = -.35$, t = $p < 0.05$) was the only significant individual predictor of mental health practitioners' level of concern in working with clients of color. Therefore, mental health professionals who are prideful of their racial background and are aware of the history of clients of color, as well as their own culture in the U.S., are more likely to have fewer concerns when working with clients of color.

In summary, therapists low in racial attitudes deemed problematic, who had moderate to high levels of multicultural competence and cross-cultural psychological capital, were less likely to have concerns in counseling clients of color. While mental health practitioners' racial attitudes, cross-cultural psychological capital, and multicultural competence were linearly related to their level of concern in working with clients of color, cross-cultural psychological capital was the only significant individual predictor of practitioners' level of concern in working with clients of color. Lastly, therapists' pride associated with one's racial background and their awareness of the history of clients of color, as well as therapists' own culture in the U.S., was predictive of having therapists having fewer concerns when working with clients of color. Therefore, attention should be given to these areas in training, especially cross-cultural psychological capital for mental health professionals, which may ultimately lead to successful therapeutic outcomes for clients of color, is discussed next.

Posthoc Analyses

While examining group differences in practitioners' experiences was not the focus of the present study, because a large number of respondents were mental health practitioners of color, particularly, Black therapists, we decided to conduct posthoc multiple regression analyses for White ($N = 74$) and Black ($N = 57$) mental health practitioners separately. Racial attitudes, cross-cultural psychological capital, and multicultural competence (overall scores) as the predictor variables and the level of concern in working with clients of color was the outcome variable in these two multiple regression analyses. Cross-cultural psychological capital was found to be the only significant individual predictor of the level of concern in working with clients of color (β

= -.50, p = .00) for White mental health practitioners. Racial attitudes (β = -.31, p = .02) and cross-cultural psychological capital β = -.40, p = .01) were the only significant individual predictors of level of concern in working with clients of color for Black mental health practitioners. These findings are important considerations as it provides insight into cultural factors that may impact psychotherapy with clients of color.

CHAPTER V

CONCLUSION

Discussion

Our primary goal was to examine the impact of mental health practitioners' racial attitudes and the protective factors they employ in their work with clients of color (i.e., cross-cultural psychological capital) as well as the impact of their beliefs and skills (i.e., multicultural competence) when working with this population. The results of this study indicated that mental health practitioners' racial attitudes, use of cross-cultural psychological capital, and their multicultural competence were significant predictors of their level of concern in working with clients of color, accounting for 30% of the variance. More specifically, mental health practitioners were more likely feel comfortable and to have fewer concerns in counseling clients of color when they exhibited higher levels of multicultural competence, utilized cross-cultural psychological capital, and incorporated discussions around race into their work with clients of color (i.e., more positive racial attitudes).

Furthermore, mental health practitioners were more comfortable in their psychotherapy work with clients of color when they were culturally aware of racially diverse backgrounds and found it acceptable to utilize appropriate skills and intervention

in their work with these groups (i.e., multicultural competence). Our findings were consistent with previous research detailing the need for effective multicultural counseling (Sue et al., 1992) and how beneficial this approach is in addressing impasses in psychotherapy (Tummala-Narra et al., 2012). We posit multicultural counseling approaches enable mental health practitioners to have more impactful cultural interactions with clients.

Results of the present study also revealed that mental health practitioners feel more comfortable with clients of color if they believe they will have positive experiences with them during cross-cultural interactions (i.e., cross-cultural psychological capital), which is a new finding. This finding was consistent with previous research that concluded the use of cross-cultural psychological capital yields better work outcomes in professional relationships (Dollwet and Reichard, 2014). Lastly, we found that mental health practitioners who were aware of their own specific beliefs about clients of color and the treatment of this group historically in the U.S. (i.e., particular aspects of racial attitudes) were more likely to experience less concern when counseling this client population. Our finding was consistent with previous researchers (Neville et al., 2006) who concluded that those who deny, minimize, or distort existing racism in the U.S. exhibit lower levels of multicultural counseling awareness and knowledge. Consequently, this may result in more negative or insincere perceptions of clients' problems. Such attitudes present in the therapeutic relationship may result in significant concerns for mental health practitioners and for the clients they serve. For White practitioners, such recognition is essential for less racial stress (Bartoli et al, 2015), which could be a catalyst for fewer concerns in their work with clients of color.

Of interest, cross-cultural psychological capital was the only significant individual predictor of mental health practitioners' level of concern in working with clients of color. While previous researchers primarily focused on the importance of addressing racial attitudes and multicultural training, this is the first study of its kind to find cross-cultural psychological capital as an essential predictor of mental health practitioners' level of concern in working with clients of color. Therefore, we propose that mental health practitioners will benefit from learning and developing skills related to cross-cultural psychological capital in their training and education as therapists. Developing mental health practitioners' level of hope, self-efficacy, resilience, and optimism with clients of color will help enhance their level of concern in working with clients of color in therapy.

In the present study, we primarily focused on factors that may influence mental health practitioners' perceived concerns in working with clients of color. After recognizing mental health practitioners' racial attitudes, cross-cultural psychological capital, and multicultural competence were related to their level of concern in counseling clients of color, we became interested in the specific aspects of those main predictor variables that held the most influence. We adhered to previous definitions of multicultural competence, which is mental health practitioners' perceptions of their cultural competency including their multicultural knowledge, awareness of cultural barriers in the therapeutic relationship, how they utilized skills to respond during moments of contention brought on by cultural differences, and how they viewed other identities that influence working with clients of color. All of these unique aspects of multicultural competence were related to their level of concern in working with clients of color, accounting for 18% of the variance.

Multicultural knowledge, awareness of cultural barriers, and sensitivity responsiveness were among the most significant individual predictors of mental health practitioners' level of concern in working with clients of color. Therefore, these areas appear to be beneficial aspects of multicultural competence in helping mental health practitioners feel more comfortable, and thus have fewer concerns, in their work with clients of color. Mental health practitioners who demonstrate such knowledge are aware of their own culture, seek additional knowledge through curiosity and utilize consultation and resources when appropriate. Additionally, they may appear comfortable when asking difficult questions around race and ethnicity, acknowledge their limitations in relating to clients of different cultural backgrounds, and possess skills to discuss their values with their clients. Those high in multicultural knowledge may also incorporate appropriate interventions for specific racial groups.

Sensitivity and responsiveness was another aspect of multicultural competence that was significantly predictive of mental health practitioners' level of concern in working with clients of color. We believe this could be due to the considerable number of therapists of color included in the sample, and that their own cultural experiences may have shaped their view of working with clients of color. Consequently, we believe engaging in such practices, including sensitivity and responsiveness, can enhance the retention of clients of color in therapy, destigmatize mental health services, and improve clients' overall well-being. Perhaps these mental health practitioners were aware of some of the cultural and institutional barriers faced by clients of color and were able to communicate those concerns with this population. This conclusion is consistent with

previous researchers' (Barden et al., 2017) findings that having knowledge and skills to work with clients of color is necessary for positive outcomes.

Cross-cultural psychological capital refers to one's ability to incorporate self-efficacy, hope, resilience, and optimism in their work with individuals from diverse backgrounds. In the present study, we examined specific aspects of cross-cultural psychological capital with mental health providers' level of concern in working with clients of color to gain an understanding of their attitudes and behaviors when working with this group. These four aspects of cross-cultural psychological capital explained 36% of the variance in therapists' level of concern in working with clients of color. Self-efficacy, hope, and optimism (but not resilience) were significant individual predictors as well. Mental health practitioners who were more self-efficacious, more optimistic about their abilities, and had more hope in working with clients of color also had fewer concerns in working with clients of color. Thus, to be effective in providing counseling services to clients of color, mental health practitioners must make it a priority to work with this group. They may achieve this by increasing their interactions with members of communities of color, demonstrate a level of confidence in learning about the cultural backgrounds that are different from their own, and remain encouraged when experiencing problems with different racial groups. As mental health practitioners, we cannot always predict or select the racial and cultural backgrounds of those we provide services to, therefore, seeing the importance of developing positive internal perspectives about working with a variety of clients from different backgrounds and experiences is crucial. Our stance is consistent with Reichard et al. (2014) findings of the importance of cultural intelligence and awareness of ethnocentrism in cross-cultural relationships.

When measuring racial attitudes of mental health practitioners, we examined their incorporation of racial socialization messages into their work with clients of color. Although general racial attitudes were not identified as a significant individual predictor of their level of concern when working with clients of color (when considered with cross-cultural capital and multicultural competence), we explored specific aspects (i.e., subscales) of racial attitudes as they related to mental health practitioners' level of concern in working with clients of color. When considered independently of other predictor variables, specific racial attitudes were significant predictors of mental health practitioners' level of concern in working with clients of color, accounting for 10% of the variance. Of interest, the only significant individual predictor was Cultural Pride and Self-knowledge (i.e., mental health practitioners' views regarding what it is like to be a person of color in the U.S. and some of the historical recognition of slavery). This finding may be due to an appreciation for mental health practitioners who self-identify as a person of color or those who value their clients' cultural backgrounds. Like engaging in culturally competent practices, being aware of the conditions faced by clients of color both historically and currently affords mental health practitioners the opportunity to recognize the plights faced by their clients of color and to empathize with them.

Implications for Clinical Training and Counseling Practice

The U.S. population will continue to diversify culturally. With the increase in attention given to mental health needs, the number of clients of color seeking mental health treatment will continue to increase. The acknowledgment of the importance of multicultural training for mental health professionals (Sue et al., 1992), as well as the importance of becoming aware of one's own biases and racial attitudes (Neville et al.,

2006), is essential. By addressing these areas of training, we posit that mental health practitioners will be prepared to provide mental health services to culturally diverse client populations. While in agreement with these perspectives, we propose that mental health practitioners engage in processes that promote hope, self-efficacy, and optimism about cross-cultural interactions with clients to enhance their comfort and reduce their concerns when serving this group. Promoting the cross-cultural psychological capital of mental health practitioners is paramount. Developing cross-cultural psychological capital as an additional area of training and experience may yield better therapeutic outcomes with clients of color as it presents possible dialogic conversations around cultural barriers.

Tummala-Narra (2007) explored the importance of acknowledging skin color and the recognition of different cultures as these processes contribute to the therapist-client relationship. Because this is a predictor of retention and successful outcomes, it is pertinent for graduate programs to continue to provide education and training around multicultural knowledge, awareness, and skills. Additionally, examining how trainees view cross-cultural relationships and the incorporation of practices that improve their cross-cultural psychological capital would aid in their professional development. Specifically, it may be helpful for programs to promote cross-cultural interactions within their training programs and encourage trainees to engage in experiences and training around their examination of the levels of hope, optimism, and self-efficacy they have for cultural groups. For mental health practitioners who have already completed their graduate training and who are licensed, it may be imperative for state and provincial licensing boards to require more face-to-face multicultural training as part of the continuing education requirements (CEUs) in maintaining licensure to ensure therapists

are continually updating their knowledge and experience with culturally relevant therapy practices. This recommendation would provide an opportunity to incorporate the importance of cross-cultural relationships from the perspective of developing hope, optimism, and self-efficacy for those with different cultural backgrounds. Engaging in these practices may lower mental health practitioners' concerns in working with clients of color and enhance their comfort in serving them. Similar to Fisk's (2002) recognition of the importance of intergroup contact to decrease biases and conflict, we believe mental health practitioners engaging in cross-cultural interactions may lower their biases towards these groups while developing positive views of clients' cultural backgrounds.

Strengths and Limitations of this Study

This study has many strengths. Our study is the first of its kind to explore cross-cultural psychological capital among mental health practitioners as it relates to their level of concern in working with clients of color. Our findings may contribute to the field of multicultural counseling by providing additional factors pertinent to providing mental healthcare services to clients of color. Although cross-cultural psychological capital as a construct was developed for and used in organizational and career environments, we believe this overarching multidimensional construct emphasizes aspects of cross-cultural relationships that are relevant in therapeutic relationships. Additionally, our study is also the first to measure mental health professionals' concerns for counseling clients of color since the original study by Wei et al. (2012). The findings of the present study indicate the importance of mental health practitioners becoming aware of attitudes, fears, and barriers they may have when providing services to persons of color.

This study has some potential limitations as well. It is important to note that the sample in this study was composed primarily of women of color. Although we recognize the importance of representation of women of color in research, we acknowledge the limitations in generalizability as they are not representative of all mental health practitioners. Additionally, many of the participants were master's level clinicians. Although we did not analyze differences across the types of providers in our sample, there may be unique findings based on the types of therapist training providers receive (i.e., counseling, social work, couples and family therapy, counseling psychology, and clinical psychology) as well as the duration of the training (e.g., master's versus doctoral) as well as the number of diversity classes required in their training. We are aware of the variability of diversity classes present in programs and recent changes that have made these courses an important training requirement.

Additionally, practitioners' age and years of experience as therapists could undoubtedly be variables that affect therapists' concerns in working with clients of color due to possible generational differences. The range of professional experience in general (i.e., 4 months to 10 years) may have been too variable and consequently may not have captured the professional growth of clinicians as well as those who have been in the field longer. The demographics of respondents are another concern. Because the study mostly consisted of White and Black female therapists, these findings may not apply to therapists who are men and are of other racial backgrounds. Thus, potential differences and similarities within and across these groups of therapists remain unknown.

The method of data collection may have limited the generalizability of our findings. Although our data collection promoted anonymity due to it being online, the

participants completed self-report measures and we did not account for social desirability. Therefore, it is possible participants were not completely truthful and forthcoming in their responses. This may be especially true for the racial attitudes survey. We acknowledge that admitting one's biases and prejudices can be difficult due to the perceived judgment that accompanies such recognition.

Given that the data was collected online, this may have limited certain mental health practitioners from participating in this study, especially if they do not have access to online technology and did not receive the invitation to participate. Also, if mental health professionals were not members of their professional associations and organizations, then they were not aware of the invitation to participate in our study either. As a result, the findings of this study may be generalizable only to therapists who are professional members of their respective organizations. Lastly, there were a few respondents excluded from the survey (3%) as they indicated they did not have any experience working with clients of color, which was concerning to the authors of this study. Future research exploring factors related to their lack of knowledge or access to clients of color is of interest.

Lastly, another possible limitation is the lack of qualitative data collected as part of the study. Although the data collected in this study was quantitative in nature, qualitative data is also beneficial as it provides the richness of personal narratives as they relate to racial attitudes and biases that may impede or advance therapy for clients of color. Qualitative studies exploring in-depth experiences and underlying themes related to mental health professionals' level of concern in working with clients of color may provide richer data including unique details not captured in our findings. For example,

future research could be conducted to further explore the specific impacts of self-knowledge and cultural pride on therapeutic relationships and whether these experiences change as the result of professional experience and work with clients of color.

Recommendations for Future Research and Future Directions

Conducting this study and finding meaning in the results prompts considerations for future research studies. Specifically, more research is needed to explore the experiences of mental health professionals who have never worked with clients of color. It may be prudent to investigate if there were differences in perceived multicultural competences, cross-cultural psychological capital, racial attitudes, and levels of concern in working with clients of color for those with differing levels of experience with this client population. Such an exploration is pertinent to understanding the access of mental health care for clients of color, career decision-making for mental health professionals, and the relationship of multicultural training and seeking to work with those underserved in mental health treatment.

As mentioned previously, few researchers have explored cross-cultural psychological capital as a positive psychological factor among mental health professionals. Traditionally applied in organizational settings, cross-cultural psychological capital is a construct used to primarily explore relationships between employees and employers who are providing a service to those with culturally different backgrounds. Although this makes our study unique, we believe conducting more research on cross-cultural psychological capital in mental health settings as it relates to practitioners serving clients of color would be beneficial. One area of investigation might include factors that our study did not examine, such as within-group stereotypes (i.e.,

stereotypes clients of color have about their groups), the social and economic mobility of clients, and the influences these identities may have on therapeutic relationships.

We recognize that mental health practitioners' decisions to serve clients of color may be unique. Therefore, questionnaires need to be developed to measure therapists' experiences in seeking opportunities to provide mental health treatment for clients of color is pertinent. Such insight may provide information about these practitioners' characteristics, values, and beliefs, which could provide the impetus to design more relevant multicultural training for mental health professionals. In a time when mental health treatment for clients of color is still inequitable, disseminating research findings focused on social justice-oriented approaches is a necessary step in addressing an imbalance in the quality and access to mental healthcare services for underserved groups of people. Without doing so, we may contribute to the view that mental healthcare is a privilege and not a right as the socially unjust processes that benefit those who have the necessary resources to access it.

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APPENDIX A

TABLES

Table 1

Demographics of the Sample (n = 177)

Variables	N	M	SD	Range
Age	177	35.30	10.44	23 - 68
Gender				
Women	157			
Men	14			
Transgender	3			
Non-Binary	3			
Provider Status				
Practicum Student	32			
Master's Degree	104			
Education Specialist	1			
Doctoral Intern	20			
Post-Doctoral	20			

Degree Specialization	
Clinical Psychology	34
Counseling Psychology	68
School Psychology	3
School Counseling	7
Marriage and Family Therapy	19
Clinical Social Work	19
Rehabilitation Counseling	6
Career Counseling	3
Other	18
Clinical Setting	
University Counseling Center	16
Community Mental Health	50
Hospital/Academic Medical Center	24
School	14
Inpatient	14
Academic Program/Department Clinic	7
Private/Group Practice	52

Table 2

*Descriptive Statistics for the Main Study Variable*s

Variables	*M*	*SD*	*Range*
Cross-Cultural Psychological Capital	5.63	.75	20-140
California Brief Multicultural Competence Scale	3.32	.33	21-84
Mental Health Practitioner's Racial Socialization Practices Measure	182.73	13.3	33-231
Concerns in Counseling Racial Minority Clients Scale	2.56	.65	20-100

Table 3

Correlation Matrix for the Main Study Variables

Variable	1	2	3	4
1. CCPC	-			
2. CBMCS	.59**	-		
3. MHPRSP	.31**	.39**	-	
4. CCRMC	-.54**	-.33**	-0.72	-

** = $p < .01$ * = $p < .05$

CCPC = Cross-Cultural Psychological Capital

CBMCS = California Brief Multicultural Competence Scale

MHPRSP = Mental Health Practitioners' Racial Socialization Practices

CCRMC = Concerns in Counseling Racial Minority Clients

Table 4

Significant Predictors Therapists' Level of Concern in Working with Clients of Color

Predictors	R	R^2	F	*SE*	β	*t*
Overall Model	.55	.31	25.41	.54		
CCPC					-.55*	-6.98
MHRSP					.12	1.74
CBMCS					-.05	-.65

** = $p < .01$ * = $p < .05$

CCPC = Cross-Cultural Psychological Capital

CBMCS = California Brief Multicultural Competence Scale

MHPRSP = Mental Health Practitioners' Racial Socialization Practices

Table 5

Multicultural Competence as Predictor of Therapists' Level of Concern in Working with Clients of Color

Predictors	R	R^2	ΔR^2	F	*SE*	*β*	*t*
Overall Model	.43	.18	.16	9.52	.59		
Multicultural Knowledge						-.26**	2.93
Awareness of Cultural Barriers						.24**	2.85
Sensitivity and Responsiveness						-.23**	2.65
Sociocultural Diversities						-.15*	1.77

** = $p < .01$ * = $p < .05$

Table 6

Cross-Cultural Psychological Capital as Predictors of Therapists' Level of Concern in Working with Clients of Color

Predictors	R	R^2	ΔR^2	F	*SE*	β	*t*
Overall Model	.61	.37	.36	25.51	.52		
CCPC Hope						.16*	2.10
CCPC Self-Efficacy						-.46*	-4.63
CCPC Optimism						-.23*	-2.62
CCPC Resilience						-.08*	-.79

** = $p < .01$ * = $p < .05$

CCPC = Cross-Cultural Psychological Capital

Table 7

Racial Attitudes as Predictors of Therapists' Level of Concern in Working with Clients of Color

Predictors	R	R^2	ΔR^2	F	*SE*	β	*t*
Overall Model	.32	.10	.08	3.86	.62		
Cultural Awareness and Preparation						.15	1.60
Knowledge of Opportunity Structure						.04	.44
Spiritual Coping						.03	.45
Cultural Pride and Self Knowledge						-.35**	-4.23
Color-Blind Ideology						-0.00	-.05

** = $p < .01$ * = $p < .05$

APPENDIX B

INFORMED CONSENT

Project Title: Therapists' Perceptions of Their Counseling with Racial Minority Clients

Investigators: Dathan C. Freeman, M.S. and Dr. Carrie Winterowd, Ph.D.

Purpose: The present study aims to explore factors that influence therapists' experience in working with racial minority clients. Your participation would be greatly helpful to explore ways to improve counseling approaches for underserved populations.

Eligibility to participate:

We are limiting this study to mental health practitioners (age 18 and over) who have completed at least one semester (i.e., 4 months) of counseling in a formal clinical setting.

Procedures:

Your participation will involve filling out an online survey that will take about 15-20 minutes to complete. There are no right or wrong answers; simply fill in the response that first comes to your mind. No personally identifiable information will be stored in the research database.

Risks of Participation:

There are no known risks associated with this project which are greater than those ordinarily encountered in daily life.

Benefits:

Your participation in this study may contribute toward the advancement of counseling interventions aimed for practicing clinicians, students, and populations they serve.

Compensation:

You will be entered to win 1 of 4 $50 VISA gift cards!! *Thus, please do not forget to enter your main email address. A separate link to another survey will be included at the end of the initial survey. If you do not click on this link to enter your main email address, you will not be eligible for a gift card. Your email address will be kept confidential and use for only sending a gift card.

Your participation is voluntary. You are free to discontinue participation at any time. However, should you decide to discontinue participation of the survey, you will forfeit your chance to win a gift card.

Confidentiality:

The records of this study will be kept confidential. Any written results will discuss group findings and will not include information that will identify you as a participant nor your individual findings. Research records will be stored on a password protected computer in a locked office and only researchers and individuals responsible for research oversight will have access to the records. Data will be destroyed three years after the study has been completed. You will not be identified individually; we will be looking at the group as a whole.

Contacts:

You may contact the principal researchers at the following addresses and phone numbers, should you desire to discuss your participation in the study and/or request information about the results of the study: Dathan Freeman, M.S., 211 Student Union, Stillwater, OK 74078, Oklahoma State University or Dathan.Freeman@okstate.edu; Carrie Winterowd, Ph.D., 434 Willard Hall, Counseling and Counseling Psychology Program, Oklahoma State University, Stillwater, OK 74078, (405) 744-6040 or Carrie.Winterowd@okstate.edu.

If you have questions about your rights as a research volunteer, you may contact the IRB Office at 223 Scott Hall, Stillwater, OK 74078, 405-744-3377 or irb@okstate.edu.

Participant Rights:

I understand that my participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time, without penalty.

By clicking "I agree" below, I am indicating my consent to participate in this study.

Yes
No

APPENDIX C

DEMOGRAPHIC QUESTIONS

1. Do you have experience counseling/working with racial minority clients?

Yes
No

2. Specify your race: (check all that apply)

Caucasian/White
Black/African American
Latino/Latina
Native American/American Indian
Asian/Pacific Islander

3. Have you completed at least 4 months (e.g., the equivalent of one academic semester) of counseling practice in a clinical setting?

Yes
No

4. What is your current age? _____

5. What is your gender?

Male
Female
Transgender
Specify:

6. What is your citizenship status?

Citizen
Legal Resident
Undocumented Immigrant

7. How would you describe your sexual orientation?

Heterosexual/Straight
Gay
Bisexual
Queer
Asexual
Specify:

8. What is your relationship status?

Single
Partnered/Married
Divorced
In a Committed Relationship
Widowed
Specify:

9. What is your average annual income?

0-10,0000
10,001-20,000
100,001-100,100
over 150,000

10. What is your current field of counseling/therapy/psychology?

Clinical Psychology
Counseling Psychology
Industrial Organization Psychology
School Psychology
School Counseling
Marriage and Family Therapy
Clinical Social Work
Rehabilitation Counseling
Career Counseling
Art Therapy
Specify:

11. What is your provider status?

Practicum Student
Post-Masters

Intern (PhD, PsyD, EdD)
Post-Doctorate

12. Select your educational degree:

Master's Degree
Educational Specialist Degree
Doctorate Degree

13. How many years of counseling experience do you possess?
    0-1 Year
    1-5 Years
    6-10 Years

    10+ Years

14. Are you currently licensed?
    Yes
    No

15. Did you take a multicultural/diversity course during your formal education for your degree?
    Yes
    No

16. Did you take a multicultural/diversity course following your degree attainment (i.e., seminar, continuing education)
    Yes
    No

17. Select your clinical setting:
    University Counseling Center
    Community Mental Health Center
    Hospital/Academic Medical Center
    School
    Inpatient Unit

APPENDIX D

IRB APPROVAL

Oklahoma State University Institutional Review Board

Date:	09/10/2018
Application Number:	ED-18-103
Proposal Title:	THERAPISTS' RACIAL ATTITUDES IN THERAPY, AND THEIR USE OF CROSS CULTURAL PSYCHOLOGICAL CAPITAL IN SESSIONS AS PREDICTORS OF THEIR MULTICULTURAL COMPETENCE AND COMFORT IN WORKING WITH RACIAL MINORITY CLIENTS
Principal Investigator:	Dathan Freeman
Co-Investigator(s):	
Faculty Adviser:	Carrie Winterowd
Project Coordinator:	
Research Assistant(s):	

Status Recommended by Reviewer(s): Approved
Approval Date: 08/17/2018
Expiration Date:

The requested modification to this IRB protocol has been approved. Please note that the original expiration date of the protocol has not changed.

Modifications Approved:
Modifications Approved: add LinkedIn and FaceBook recruitment

The IRB office MUST be notified when a project is complete or you are no longer affiliated with Oklahoma State University.

All approved projects are subject to monitoring by the IRB.

The final versions of any recruitment, consent and assent documents bearing the IRB approval stamp are attached. These are the versions that must be used during the study.

Sincerely,

Hugh Crethar, Chair
Institutional Review Board

VITA

Dathan Christopher Freeman

Candidate for the Degree of

Doctor of Philosophy

Dissertation: "I DON'T SEE COLOR, I ONLY SEE BEHAVIORS": THERAPISTS' CONCERN IN WORKING WITH CLIENTS OF COLOR

Major Field: Counseling Psychology

Biographical:

Education:

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

Completed the requirements for the Master of Science in Educational Psychology, specialization Counseling Psychology at Oklahoma State University, Stillwater, Oklahoma in 2016.

Completed the requirements for the Bachelor of Arts in Psychological and Social Sciences at Pennsylvania State University, Abington, Pennsylvania in 2013.

Experience:

Psychology Intern
CMC VA Medical Center, Philadelphia, PA August 2019 – Current

Adjunct Professor of Psychology
Saint Joseph's University, Philadelphia, PA January 2020 – Current

Professional Organizations:

Member, The Association of Black Psychologist
Member, Pennsylvania Psychological Association
Member, Pennsylvania Counseling Association