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Yolonda Young Armstrong
An Exploratory Study of Cultural
Competence in Clinical Practice
Behaviors

ABSTRACT

This qualitative research study explores clinical practice behaviors that influence the perceptions of college students' of color regarding cultural competence in the therapeutic dyad. Interviews were used to obtain data from six college students of color in Western Massachusetts who had a history of engagement in outpatient therapy. This study uses Object Relations Theory as a conceptual framework for understanding social constructions of privilege and identity development and as a learning tool for examining interpersonal behavior as a reflection of one's internalized perceptions. More specifically, for this study, Object Relations Theory provides academic context for understanding how external social phenomena such as racism are internalized and subsequently reenacted through interpersonal behaviors, including those demonstrated during therapeutic interactions between a client and the clinician.

The findings of this study highlight the importance of socio- cultural attunement in determining clients' perception of therapists' cultural competence. Because mental health professionals need to have significant knowledge of social and cultural issues, in addition to self-awareness of their own identities, this study aims to identify clinical practice behaviors that contribute to cultural competence, as well as those behaviors that interfere with cultural competence. Of the range of clinical practice behaviors discussed by participants, open discussion of socio-cultural differences was labeled as having primary importance in participants' perceptions of clinicians' cultural competence.

**AN EXPLORATORY STUDY OF CULTURAL COMPETENCE
IN CLINICAL PRACTICE BEHAVIORS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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2013

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CHAPTER I

Introduction

Because racial diversity continues to increase in the United States, it is important that the delivery of psychological services address the changes of the population by implementing the practice of cultural competency. As the demography of the United States continues to diversify there is a growing need to understand how cultural factors influence the therapeutic environment (Worthington, Soth-McNett, & Moreno, 2007). The proposed research study will explore how college students of color perceived the demonstration of cultural competence in their clinical relationships with mental health professionals.

The notion that culturally competent services should be available to members of ethnic minority groups has been articulated for at least four decades (Sue, Zane, Nagayama, & Berger, 2009). Both the American Psychological Association (2003) and the National Association of Social Workers (2001) have published documents asserting the importance of cultural competency. The American Psychological Association has defined the term cultural competency as an ability to “articulate respect and inclusiveness for the national heritage of all groups, recognition of cultural contexts as defining forces for individuals’ and groups’ lived experiences, and the role of external forces such as historical, economic, and socio-political events” (APA, 2003, p. 382).

The National Association of Social Workers (2001) explains that historically, the field of social work was primarily concerned with ensuring cultural competence around race and

ethnicity, but now equal emphasis is placed on the sociocultural experiences of people of different races, ethnicities, genders, social classes, religious and spiritual beliefs, sexual orientations, ages, and physical and mental abilities. While the importance of culturally competent treatment has been confirmed by many empirical studies and psychological theory that offer copious contemplative explanations for the way that we think about cultural competency in practice, we need further explication of the process for implementation of theory into practice, as well as specific practice behaviors. Sue, Zane, Nagayma, and Berger (2009) emphasize the importance of randomized clinical trials and “unpackaging” research that examines which cultural adaptations are effective in order to make it possible to implement these interventions into practice.

A Kleinian (1964) framework will be used to examine sociological and psychological aspects of racism, as they are experienced in the clinical encounter. The proposed qualitative study will explore the following research question: What clinical practice behaviors convey cultural competence to the client?

CHAPTER II

Literature Review

While there is significant theoretical writing regarding the clinical work with people of color, the literature largely lacks recommendations about the implementation of theory into culturally competent practices. This literature review will survey the existing research regarding the impact of racism on mental health. The review will include studies that investigate racism and mental health, culturally adapted interventions and cultural competency in the clinical dyad. Additionally, the review will also include an overview of Object Relations Theory as developed by Melanie Klein (1964). In Object Relations Theory there is an emphasis on inner images of the self and the other and how these representations are expressed in interpersonal relationships. A Kleinian (1964) framework will be utilized in this research study to explore the foundations of racism identity development and how this might influence perception of relationships and interpersonal behavior.

Object Relations Theory

Object Relations Theory can be used to examine racism and used as a framework for understanding internal representations of race and racism and how they manifest in society. A contemporary of Freud, Melanie Klein was one of a group of psychodynamic clinicians who wrote during the 1930s through 1950s and developed Object Relations Theory as a foundation for examining the relationship between the social and the psyche. She was most interested in the internalization of attachment relationships formed in early life, a process that lays a template for identity, sense of self, perception of relationships, and interpersonal behavior (Flanagan, 2008).

While Freud's original theories framed humans as motivated by the impulses of internal sexual and aggressive drives, Klein revises her theories to include a relational component; she understands humans to be motivated by the relational pulls of love and hate (Rasmussen & Salhani, 2010).

Projection: Although Klein (1964) never directly addressed the concepts of race and racism, her work offers metaphorical language that is used by contemporary psychoanalytic theorists to highlight the cause and effects of racism from a relational perspective. Rasmussen and Salhani (2010) use Klein's concepts of projection, projective identification, splitting, developmental positions, envy and reparation to analyze the psychodynamic dimensions of racism. Rasmussen and Salhani (2010) assert that the concept of projection is commonly employed by psychoanalysts to explain racism. They define projection as an unconscious mental process whereby an individual places unbearable and overwhelming feelings and impulses onto another person, who becomes an external receptacle for the projected qualities. The internal attributes that individuals loathe and find to be unbearable representations of their world tend to mirror the qualities that society devalues; for example, qualities such as aggression and weakness are commonly denied within the self and projected onto others. "In deploying this defense [projective identification] to manage ideas, feelings, and impulses [regarding] race, one begins to fill the empty container of race with projections that are shaped in part by historical influences, current culture, and media discourse" (Rasmussen & Salhani, 2010, p.497). Although race is purely a social construct and often the result of projection, racial discrimination based on racist ideology produces the real effects of racism, resulting in the psyche wounding of people of color, including emotional, psychological, spiritual, economic, and social oppression. Projection can

contribute to racism on individual and societal levels, as expressed in the social devaluation of people of color and elevation of white people.

Projective identification: Individuals seek to rid themselves of their unacceptable attributes through projection; however, Klein asserts that when they cannot completely break ties with the unacceptable parts, they instead seek ways to control and manage these feelings in others through projective identification (Flanagan, 2008). Flanagan (2010) writes: “The projective part of projective identification is the same as in simple projection, but in projective identification the projector does not want to lose the projected part completely, hence the identification” (2010, p. 147). Moore and Bernard (1990) define projective identification similarly:

Parts of the self and internal objects are split off and projected onto an external object, which then becomes ‘identified’ with the split-off part as well as possessed and controlled by it. Its defensive purposes include fusion with the external object in order to avoid separation; control of the destructive, so-called bad object, which is a persecutory threat to the individual; and preservation of good portions of the self by splitting them off. (p. 109).

Clarke (2003) extends the concept of projective identification to include its particular relevance to racism; “The most obvious way to view projective identification in terms of the explanation of racism and ethnic hatred is as a violent expulsion of affect which renders the recipient in a state of both terror and self-hatred” (p. 156).

Paranoid-schizoid and depressive positions: While Freud postulated identity development as a stage-by-stage progressive modulation from primitively motivated sexual and aggressive drives, instead Klein focuses on two oscillating positions; paranoid-schizoid and depressive. The depressive position builds upon the paranoid- schizoid; however, one’s behavior alternates between these two modes throughout life. Rasmussen and Salhani explain (2010):

Although the depressive position follows developmentally from the paranoid-schizoid position, Klein and her followers emphatically believe that fluctuation between the stages never ends. This idea of fluctuating mental states is important to the current discussion and presents a unique perspective that may enable comprehension of the shifting qualities of racism and ethnic hatreds. (p. 499).

The paranoid-schizoid position describes a primitive attempt to manage difficult emotions, causing individuals to relegate all aspects of experiences into two categories; good and bad. When it is too frightening and overwhelming to conceptualize that good and bad can coexist within one individual, splitting enables one to organize experience into manageable form. For example, a white client in an eating disorder clinic (where this author worked as an intern) made this comment about incarcerated inmates of color: “I don’t know how you work with those people!” In contrast, she referred to her eating disorder as “a good girl’s problem.” This example illustrates the way that the client has been able to accept her own symptoms only by projecting her badness and shame onto others. In contrast to the paranoid-schizoid position, the depressive position speaks to achieving an integration of “good and bad” in oneself and others without splitting.

Since the depressive position offers an internal sense of resolution and integration; being able to accept that good and bad can reside within the same individual, it often includes recognition of guilt. Guilt arises when one acknowledges the split psyche and hateful, destructive urges that occur in the paranoid-schizoid position, thus inducing a desire to mend the split. Klein (1964) refers to this mend as reparation. According to Rasmussen and Salhani (2010), reparation is an important concept in Kleinian thinking because it provides a ray of hope in an otherwise despairing view of societal norms.

As Rasmussen and Salhani (2010) make clear, “reparation integrates love, hate, and the realization of the wholeness of the other” (p. 505). They go on to explain that in the recognition

that splitting caused pain to the object (individual), the reparation relieves the pain, both imaginatively and in reality. This concept brings into play the notion of empathy or being able to imagine oneself in the position of the wounded individual. Given that individuals are constantly shifting in perspective between the paranoid-schizoid and depressive positions, Klein's theory posits the question: what makes empathy possible?

The Contemporary Enactment of Racism

Unless clinicians understand the connection between race, racism, and cultural competence, it is likely that therapeutic relationships will continue to perpetuate racism. According to Rasmussen and Salhani (2010), "one must understand the root concept of race in order to analyze racism" and furthermore to conceptualize the invalidity of racism (p. 493). Rasmussen and Salhani (2010) go on to explain that "the differentiation of the human family into categories ranked by forms of superior or inferior pheno-typical characteristics is false" (p. 493). Despite the scientific falseness of hierarchical racial categorization, the practice of racial hierarchy is upheld and perpetuated through patterns of social behavior. Winant (2006) asserts that racism consists of one or more of the following: "(1) Signifying practice that essentializes or naturalizes human identities based racial categories or concepts; (2) Social action that produces unjust allocation of socially valued resources, based on such significations; (3) Social structure that reproduces such allocations" (p. 999). All three of the forms of racism that Winant describes can be enacted in the therapeutic environment.

In considering the impact of unconsciously expressed racism in clinical practice behaviors, it is important to reflect upon research that indicates that racism has morphed from overt forms such as cross-burnings, lynching, and racial segregation of housing and education, into forms that produce vague and less obvious behaviors such as misunderstandings and

impasses “in the counseling process that are likely to occur outside the awareness of well-intentioned therapists” (Constantine, 2007, p. 2). The term “aversive racism” is used to describe this contemporary form of racism, referring to racism that avoids causing physical harm but is characterized by the harboring of unconscious negative racial feelings and beliefs toward people of color. Aversive racism is particularly insidious because its perpetrators often perceive themselves to be egalitarian, fair, and nonracist (Constantine, 2007). Instances where aversive racism is enacted are commonly referred to as “racial micro-aggressions” (Constantine, 2007, p.1).

The term “racial micro aggression” encompasses all of the myriad forms of subtle and commonplace social interaction that convey insulting or demeaning messages to people of color. People who perpetrate racial micro-aggressions are often unaware of their behaviors or the potential effects of those behaviors on people of color. Even when the intention is innocuous, some people will communicate micro-aggressions that convey denigrating messages to people of color (Constantine, 2007). Perpetrators of micro-aggressions who deny responsibility for causing harm to people of color in these encounters may be employing the defenses of splitting and projection; when they have projected badness onto people of color and placed blame for the error outside of themselves, splitting leaves no room to integrate responsibility.

Building upon the Kleinian (1964) framework for exploring the foundations of racism presented above, this review will now offer an overview of the impact of racism on mental health through discussion of racial trauma, as well as the potential for enactments of unconscious racism to derail the therapeutic alliance.

Racism and Mental Health

Racism continues to influence social, cultural, political and economical aspects of society. The permeating stain of historical and current institutionalized oppression including Slavery, Internment Camps, Jim Crow Laws, Apartheid, Anti-Semitic consciousness and the legalized slavery of people of color via the Prison Industrial Complex continues to shape our thoughts and ultimately, our behavior. The corruption seeps into every aspect of the whole (macro) making the clinical (micro) relationship between the client and the therapist ripe for the enactment of these historical and current tensions (Suchet, 2004).

Closer examination of the history of psychoanalysis reveals a glaring presence of racial difference. According to Suchet (2004) and Gilman (1993), Freud's Jewish identity was at the center of his work, influencing psychoanalysis from the beginning. Freud, a Jewish Austrian born neurologist focused his psychoanalytic research on white European women. Suchet (2004) reminds us that during the 19th century religious differences were categories of racial differences (Aryan/Jew), and the "dark" Jew was typically described as psychologically, intellectually, and sexually disordered-- inherently pathological. Gilman (1993) suggested that Freud's work took shape on the heels of the 19th century and focused on the inferiority of the woman at the same time that society was focusing on the inferiority of the Jew. In the 21st century, in the United States, people of color are culturally and racially marginalized and their prospective are often devalued and ascribed lower social, intellectual and genetic worth than their white counterparts. Examples of how this type of socialization of race is demonstrated in the clinical dyad may include a clinician minimizing the importance of racial and cultural issues of clients of color, or assuming that the cultural values and communication styles of clients of color are pathological and normalizing, potentially dysfunctional behaviors on the basis of the person of color's race or

cultural group (Sue et al., 2007). Due to the longstanding wounding that people of color have experienced, the relationship between clients of color and a white mental health professional could unconsciously take on the elements related to the trans-generational legacy of racism thereby weakening the clinical relationship.

In a study of African-American clients, Constantine (2007) found that expressions of more current and frequently subconscious racist attitudes were predicative of a weaker therapeutic alliance. By researching the client's perception of the clinician's cultural competency skills and developing strategies for shaping trainings that focus on cultural competency in the clinical dyad, it might be possible to decrease the potential for pre-mature terminations of psychotherapy and ruptures in the clinical relationship.

Even though there are clinically based counseling programs that offer training courses about multi-cultural issues, many mental health professionals struggle with how and when it is appropriate to address racial and cultural differences in their therapeutic relationships with clients (Cardemil & Battle, 2003). Due to the range of clinical needs, experiences and perceptions, gaining a better understanding of ways to bridge cultural differences is the essence of the Cardemil and Battle (2003) article. They suggest that clinicians engage their clients in conversations about race and ethnicity. The goal of this thesis is in alignment with their ideas and will hopefully include insight into ways that clients of color perceive cultural competence and offer suggestions that will lead to improvement in clinical treatment, client retention, therapeutic alliance and treatment outcomes.

Racial Trauma

In order for psychotherapy to be effective, treatment strategies must include and develop from comprehensive consideration of the client's history, including the client's relationship with

the social environment, its impact on their internal world, and the external manifestations of these factors. “In psychodynamic therapy, memories are critical resources for understanding the etiology of current affective states and behaviors” (Daniel, 2000, p. 127). People of color have an extensive trans-generational history of traumatic memories that are intricately linked to racism. The salience of race as an important social characteristic is an inevitable part of living in the United States (Daniel, 2000).

Image Distortion

At the same time that race is merely a social construct racism has real psychological consequences. Image distortion is an example of a way that racial trauma seeps into the fabric of a society and repeatedly wounds people of color psychologically. “In the media the physical features of African Americans have been distorted to make them appear grotesque” (Daniel, 2000, p. 132). Internalized self-hatred of people of color imposed by those with white skin privilege and the economic power to decide what is programmed into the collective consciousness via use of media has been the outcome of these tactics (Daniel, 2000).

Accounts of sexual trauma experienced by African-American women at the hands of white slave owners and heads of white households have been narrated in the literary world but are often told as interesting fictional stories rather than being seen as of the egregious acts of sexual, physical, psychological and spiritual rape of African American women, intentionally traumatized by white men (Daniel, 2000). People of color have been traumatized by both actual and threatened acts of physical and psychological trauma for multiple centuries (Kelly & Greene, 2010). Slavery, genocide, the burning of Black churches, the beatings and hanging of Black people from crosses and trees have been the tools of oppression used by whites to humiliate, denigrate, obliterate and annihilate the constitution of people of color.

Due to racism, the judicial system has also been the site of trauma for African Americans (Kelly & Greene, 2010). Medical research, limited access to health care, so-called scientific racism that created myths of the inherent inferiority of Blacks (Greene, 1995), segregated housing and schools has resulted in the abuse and memories of trauma lodged deep in the psyches of both the victims of racial trauma and also in the minds of the perpetrators of oppression and according to author, Toni Morrison (2012), “both are left bereft” (Rose (Interviewer) & Morrison (Interviewee) [Interview video file]). Unless therapists are aware of the dynamics of racism and attend to the presence of racism in their own unconscious, well-meaning clinicians may inadvertently re-enact oppressive racial dynamics in clinical settings (Leary, 1997; Suchet, 2004). With a theoretical framework for understanding racism and its conscious and unconscious manifestations, it is possible to develop and implement culturally competent therapeutic interventions.

Working with Race as a Clinician

Suchet (2004) suggests that clinicians are responsible for metabolizing experiences of race that have shaped them, in order to protect against unconsciously infusing racialized re-traumatization into the clinical setting and “recreate[ing] the racial dynamics of slavery” (p. 423). Fracturing the therapeutic alliance is the probable consequence if we fail to acknowledge the historical impact of racism on the individual and collective consciousness. In addition to weakening the therapeutic working alliance, the perception of white counselors as biased or prejudiced may lead to the premature termination of counseling relationships by clients of color (Constantine, 2007).

Given both the potential for the reenactment of racism, and a growing understanding of clinical practice behaviors that convey cultural competency, this study aims to articulate the

process by which clinicians can employ and convey cultural competence. In an effort to do so now, this researcher will reiterate that the intention of this study is to focus on cultural competency in the psychotherapeutic environment: provider and treatment strategies. Historical context for the relationship between psychoanalysis, race, racism and cultural competence will inform recommendations for treatment.

With this in mind, Suchet's explanation for race as a subjective experience suggests that the meaning of race goes beyond skin color. She defines race as a set of complex psychological and social experiences. Race has no significant or consensual biological definition (Helms & Cook, 1999). Nonetheless, the traumatic impact of emotional, economical and psychological maltreatment is greatly associated with the history of ongoing unequal and unfair treatment of those who are descendants of slaves and other people of color. "It acquires significance and meaning from the prevailing social conditions, which carry the weight of past significations, especially the history of slavery" (Suchet, 2004, p. 42).

Instead of a simple classification of color, race can be viewed as a continuum of variables including skin color, education, income, and geographic location (Suchet, 2004). Historical, socioeconomic, political, familial, and intra-psychic events all contribute to a racialized identity (Suchet, 2004). While race carries multiple meanings, the suffering of racism continues to threaten the well-being of society, people of color, and the therapeutic alliance between clinician and client.

Carter et al. (2011) created a clinical tool that was developed to assess the psychological and emotional stress reactions to racism and racial discrimination. This empirical and quantitative study used existing measures of stress associated with racial trauma and models of trauma and applied these tools to 330 individuals who were racially different. Seven scales and

52 items were utilized to collect data for this study. Findings from this work revealed that depression, anger, physical responses, avoidance, intrusion, hyper-vigilance/arousal and low self-esteem are possible reactions and reflections that the client may experience due to race based traumatic stress. This study provides clinicians and patients with information that can help support quality service delivery for patients who are suffering from race-based trauma while offering clinicians more insight into the patient's inner world. This study also offers insight into how the psychotherapeutic process can be enhanced for patients who have been impacted by racial trauma. The use of this insight by clinicians can help to enhance their understanding of the patient's emotional distress symptoms that are related to racial trauma as well as help clinicians to show a higher level of consideration for the potential for re-traumatization in the clinical experience.

Cultural Competence in the Clinical Dyad

Comas-Diaz and Jacobsen (1991) examine the importance of ethno-cultural factors on the clinical dyad. It has become common knowledge that culture and ethnicity are key influences on the clinical relationship and that some of these influences are based on perceptions of the clinician's cultural competency (Comas-Diaz & Jacobsen, 1991). In his article, *In Search of Cultural Competence in Psychotherapy*, author Stanley Sue (1998) describes cultural competence as one of the most talked about concepts among scholars and those who practice psychotherapy. He goes on to define cultural competence as an appreciation and recognition of other cultural groups and the ability to work effectively with them. While some scholars suggest that merely opening up the dialogue about race and ethnicity as a key way for therapists to integrate cultural competence into the clinical dyad, there are other scholars who advocate for mental health professionals to examine their own relationship with power, class, privilege, race, discrimination,

prejudice and racism as a preface for engaging clients into conversations about race, culture, and ethnicity (Comas-Diaz & Jacobsen, 1991).

If we define racism as a system of oppression based on perceived racial categorical differences and rely on a fixed and unchanging view of human beings that are manifested culturally, interpersonally- intra-personally, we can begin to make room for the probability that there can be direct, indirect, intentional and unintentional contours of racism. In addition, there is potential for variations of the frequency and magnitude of these unconscious manifestations of intra psychic ideas about perceived racial difference or sameness and a myriad of ways that these culturally shared notions of social and psychological hierarchy can enter into the clinical dyad in various forms, either subtly or overtly (Suchet, 2004).

Social images of Blacks make them easier targets for their therapist's negative perceptions (Jones, 1985). When a therapist brings these imprinted images of social stereotypes into the clinical relationship, the transference and countertransference tend to reflect these associations (Riess, 1971). Comas-Diaz and Jacobsen (1991) frame the variety of possible transference reactions that are likely to manifest in cross-cultural clinical dyads into three categories: over compliance and friendliness; denial of ethnicity and culture; and mistrust, suspicion and ambivalence. Comas-Diaz and Jacobsen (1991) speak about power differentials and how race, privilege, and class impact the clinical relationship.

For more than 20 years, calls for cultural competence in clinical practice have stressed the importance of recognizing how therapist characteristics impact effective service delivery to clients of color: (a) awareness of oneself as a racial cultural being and of the biases, stereotypes, and assumptions that influence worldviews and (b) awareness of the world views of culturally diverse clients (Sue et al., 2007). Despite the importance of clinicians acknowledging the

influence of race on clients' experiences and their own, studies suggest that white clinicians typically receive minimal or no practicum or supervision experiences that address race and tend to be uncomfortable broaching the subject (Knox, Burkard, Johnson, Suzuki, & Pontero, 2003). The greatest challenge society and the mental health professions face "is the insidious ethnocentric aspect of our cultural conditioning" (Sue, 2006, p. 7). According to Sue et al. (2007), "when clinician and client differ from one another along racial lines, the relationship may serve as a microcosm for the troubled race relations in the United States" leading to cultural clinical impasses (p. 280). Because racism in the form of micro aggressions is so embedded in social patterns, psychological research, education, and practice must move beyond illustrating how racial micro-aggressions create impairs in the therapeutic alliance. Research suggests that therapists' own self-awareness and ability to engage in culturally sensitive intervention is as relevant as the client's culture and perspective in shaping the therapeutic relationship (Sue, 2006).

In contrast to many of the large scale quantitative studies surveyed in this literature review, Leary (1995) offers a qualitative analysis of race in the psychodynamic clinical dyad. Leary examines the "impact of race and ethnicity on the psychotherapeutic process of three patients in psychoanalytic psychotherapy with an African-American therapist" (p.12). The strength of this study is that it offered a more detailed narrative of a small sample of cases in which the therapist examined racial themes in treatment. Leary (1995) concludes that, "Race and ethnicity represent amalgams of reality and fantasy that lend themselves to psychoanalytic scrutiny, but cultural prohibitions and ego ideals make counteractions at the level of the clinician and the clinical institution quite likely, and even inevitable" (p. 12). Given the lack of a strong conclusion, this study failed to specify how the impact of racial and ethnic differences influences

the psychotherapeutic process between clinicians and their patients. Modeling successful strategies for psychodynamic focused clinical treatment will lead to a corrective cultural experience for the client; at the same time this will challenge the clinician to address personal feelings of ambivalence and dread around cultural difference (Freire, 1972; Owen, Tao, Leach, & Rodolfa, 2011).

CHAPTER III

Methodology

This study explored perceptions of college students of color about cultural competency within the context of the clinical relationship with a mental health professional. Using qualitative interviewing, the study examined social and psychological aspects of racism, racial trauma, and cultural transference and counter-transference in the clinical dyad. The process consisted of collecting, summarizing, coding, and further analysis of the data from the participant's narratives about their perception of the role of race, ethnicity, and cultural differences in previous clinical relationships with mental health professionals.

The primary focus of this study was to explore how students of color perceived their clinician's body language or verbal communication as a conveyer of their beliefs, attitudes or ability to work effectively with people from cultural groups that differ from their own. To support collection of data relevant to the intention of the research study, participants were invited to freely share their reflection about their salient identities, including race and ethnicity.

Participants discussed how these aspects of their identities were supported within a clinical dyad of therapist and client in individual outpatient therapy.

Sample and Procedures

The sample included 6 college students who were recruited to voluntarily participate in the study. A convenience sampling procedure was used. All six participants identified as female, although one responded to the question about gender with a comment about the complexity of gender identity. Participants ranged in age from 21 to 29 with a mean 24.2, representing a fairly

traditional spread of undergraduate and graduate school student ages. None of the participants was married at the time of interview. Participants identified their socio-economic statuses within the range of lower to working to middle class.

In addition to age, marital, and socio-economic status, participants were asked to self-identify their racial, ethnic and cultural identity. Data collected during the research interviews included a narrative reflection of previous experiences with one or more clinicians, and the racial and ethnic background of the clinician, as well as how this related to the participant's salient social identities.

Participant 1 identified as Latina/Puerto Rican. At the time of the interview, she was a 29 year-old graduate student, middle class, female and single. She had been in therapy when she was age 15 to 23 years old. Her therapist during this time was a white Euro-American male who was in private practice when the participant was in psychotherapy. Participant was seeking treatment to address Obsessive Compulsive Disorder symptomology.

Participant 2 identified as Kenyan/American. At the time of the interview she was a 22 year-old undergraduate student, middle class, female and single. She sought therapy in her second year of college. Her therapist during this time was a female of Hispanic descent who worked at a college counseling center. Participant was seeking treatment to address undisclosed issues related to her physical and mental health.

Participant 3 identified as Afro-Caribbean/ Belize- American. At the time of the interview she was a 26 year-old graduate student, working to middle class, female and single. Her therapist was a white Euro-American male who was in private practice at the time when the participant was in psychotherapy. Participant was seeking treatment to address issues related to acclimating to graduate school.

Participant 4 identified as Native/White American. At the time of the interview she was a 26 year-old undergraduate student, middle class, female and single. Her therapist was a white Euro-American male who was in private practice at the time when the participant was in psychotherapy. Participant was seeking treatment to address the trauma of a close family member's suicide attempt.

Participant 5 identified as Asian American/Japanese-American. At the time of the interview she was a 21 year-old undergraduate student, middle class, female and single. Her therapist was a female Asian-American/white Euro-American and at the time that she treated the participant, worked at a college-counseling center. The participant sought treatment to address concerns with acclimating to college.

Participant 6 identified as Multi-Racial/South East Asian-American. At the time of the interview, she was a 21 year-old undergraduate, lower middle class, female and single. Her therapist was a white Euro-American female who worked at a college counseling, during the time that the participant sought treatment. The participant sought treatment for an undisclosed issue.

Universities: Advertisements for participation in this research study were placed at two institutions of higher education local to the researcher, Smith College and the University of Massachusetts at Amherst. Located in the Pioneer Valley of Western Massachusetts, both colleges are known to be prestigious academic institutions and each carry a wide range of majors and degree programs. Both colleges serve students from across the country, as well as international students. Data from Fall 2012 admissions at the University of Massachusetts at Amherst indicates that 18.21% of 20,604 undergraduate students who are U.S. citizens identify as people of color, while 14.62% of 6,308 graduate students who are U.S. citizens identify as

people of color (the University of Massachusetts Office of Institutional Research, 2012). At Smith College, data published in 2012 by the College Boards reports that 32.9% of 3,162 students at all levels identify as people of color (2012).

Data Collection

Because the study intended to explore clinical practice behaviors that influence college students of color perception of cultural competency in the clinical dyad, eligibility criteria required that participants be enrolled in college, self-identify as a person of color, be over the age of 18, have a history of being in psychotherapy, speak English, and be a resident of the United States. With permission of school officials, research recruitment flyers were placed at two colleges located in the Pioneer Valley of Western Massachusetts, Smith College and University of Massachusetts at Amherst (See Appendix A: Letters of Permission to Post Recruitment Flyers; Appendix B: Recruitment Flyer). The researcher's professional contacts at these colleges helped to circulate recruitment information. Additionally, the researcher used Facebook to recruit because its social network reach is world- wide and can potentially reach people of various cultural backgrounds and experiences who might have had experiences with a mental health professional.

When individuals expressed an interest in participating in this research study via email, the researcher determined who was selected to participate based on whether or not they met the inclusion criteria (See Appendix C: Screening Questions). All people who contacted the researcher expressing interest did meet the eligibility criteria and voluntarily agreed to participate in the research study. The researcher asked local participants to either meet at a campus location such as a campus center or library. Those who were not available to meet in-person were invited

to be interviewed via Skype, and a mutually agreeable time was arranged. Two (2) interviews were conducted in-person, while four (4) were conducted via Skype.

An interview guide composed of open-ended and demographic questions was used to collect data (See Appendix E: Demographic Questionnaire; Appendix F: Interview Guide). Using a pre-determined list of questions, the researcher asked the participants about their perception of cultural competence in a past clinical experience with a previous mental health professional. Prior to each interview the researcher asked each subject if she/he voluntarily agreed to participate in the study. The researcher explained the purpose, benefits and risks of the study. Each participant read and signed the consent to participate in a research study form (See Appendix D: Informed Consent Form). In the interest of increasing mutual understanding between the researcher and participants, participants were all provided with a list of concepts and definitions central to the research topic, which the researcher anticipated might be discussed during the interview (See Appendix G: Key Concepts and Definitions). Most of the interviews lasted 30-45 minutes.

Using Dragon Speaks, speech recognition software for voice writing, the interviews were partially transcribed and then the researcher for clarity edited the data collected by Dragon. The data was organized using the researcher's conceptual framework, integrating demographic information and the participants' articulated perceptions about their previous clinician's ability to convey cultural competence.

Interview questions were designed by the researcher in order to elicit participants' perspectives on their experience of cultural competence in the clinical dyad (See Appendix F: Interview Guide). The reliability and validity of this instrument is unknown because it has not previously been used.

Data Analysis

After the interviews were completed, the researcher compiled demographic data from the sample in order to describe the demographic characteristics of the participants as a group. Qualitative descriptions of participants' therapy experiences were coded for the purpose of identifying themes common among the participants. The researcher reviewed the transcripts to determine the frequency of explicitly articulated references made to cultural competence (to be categorically referenced as explicit occurrences). The researcher also noted the frequency of instances of probable cultural competence that were articulated by participants but non-explicitly identified as evidence of cultural competence (to be referenced as possible occurrences). Next, the researcher categorized the explicit and possible occurrences of cultural competence and clinical outcomes that resulted from a consistent therapeutic alliance, a ruptured alliance or a repaired alliance.

The researcher also sought out and coded participants' specific references to their mental health professional's body language, verbal articulations, or some other type of behavior that conveyed their attitudes or beliefs related to the professional's ability to practice psychotherapy in a culturally competent way. The analysis of all of the aforementioned categories provided gave this researcher an opportunity to further examine the perceptions of the participants. During this section of the analysis, it became clear that policies of therapeutic agencies and the environment in which therapy took place were also important factors in participants' experience of culturally competent therapy.

CHAPTER IV

Findings

The major findings of this research illustrate that cultural competence plays a major role in the forming of a therapeutic alliance and the possibility of unresolved ruptures in the clinical dyad. Participants reported that verbal language was the major way that clinicians displayed their attitudes and beliefs about cultural differences, more than any other factor. The study suggested that in cross-cultural clinical dyads, a corrective experience is possible. Further it suggests that a clinician with a different cultural background from the client can forge a therapeutic alliance with the client if attention to practicing with cultural competence is carefully navigated.

The narratives of those who participated in this research study suggest that avoiding making assumptions about social identities is an important step towards cultural competence. In other words, being aware of and acknowledging differences, being informed about the cultural background of the client and opening up dialogue about the role of race, ethnicity, gender and other social identities improves the outcome of therapy. All participants made explicit references to cultural competence as it related to their experiences with mental health professionals. Social and cultural identities are shaped by one's relationship to all of the salient parts of the self; race, ethnicity, gender, abilities or disabilities, age, social class, social orientation, religious or spiritual beliefs (Suchet, 2004). With this in mind, the researcher noted and catalogued the participants' experiences of cultural competence in the clinical dyad, ranging beyond race and ethnicity to also include references to the impact of gender and socio-economic status. All participants shared multiple explicit occurrences that are clearly relevant to cultural competence or the lack

of it in the clinical dyad. Only one participant reported having experienced a corrective therapeutic encounter specifically related to how cultural competence was demonstrated in the clinical process with her mental health professional. The remaining five participants, who did not perceive their mental health professional to be able to practice in a culturally competent manner, reported ruptures in the therapeutic alliance. In fact, all of these participants stated that they terminated with their mental health professional due to ruptures related to a lack of cultural competence in the clinical dyad. Five participants, who perceived a lack of cultural competence in their prior experience with psychotherapy, reported abrupt termination was the consistent outcome.

Verbal language was the behavior that the research study participants consistently referenced as the primary indicator of cultural competence in psychotherapy. For example, one participant stated, "I can't remember exactly, but he said... but I remember that he talked down to me and was matter of fact." In contrast, the participant who felt she had a corrective cross-cultural experience in therapy reported, "I think that my therapist was very comfortable talking about issues of race and ethnicity and gender. He was very engaging and comfortable bringing up the differences between us. He called attention to the obvious, I am black and he is white. I was really put off by it, but then I was able to see how helpful it was to our therapeutic alliance. It was great to get that out there." This data from the sample regarding verbal communication implies that cross-cultural therapy has a better chance of working when both the therapist and the client can talk about their racial and ethnic identities and the differences between them.

In addition to the impact of verbal communication, one participant noted that policies and the aesthetic appeal of the clinical environment influenced her perception of cultural competence. Specifically, two participants used the word "sterile" in reference to the clinical

environment where they were seen, and saw this as a negative attribute. Transference and countertransference related to clinicians' and clients' previous experiences with race and ethnicity and seemed to have been a factor impacting the therapeutic alliance for multiple research study participants. Consistently, the findings of this study strongly suggest that culture is an ever-present influence inside the clinician-client dyad because both the client and the mental health professional bring components of their relationship to culture into the therapy process. Despite the cultural context of all clinical relationships, all participants denied that their previous experiences with psychotherapy produced or triggered racial trauma.

The findings seem to reflect that most clinical relationships with clients of color are challenged by the day-to-day influence of racism, sexism and other imbalances of power. With participants who saw a clinician of color, there appeared to be an expectation that the clinical experience would be positive because of shared aspects of social identities. In those cases of cultural matching, cultural transference from the client towards the therapist initially facilitated a sense of connection. Although the match appeared meaningful at first to some of the participants, in order for the relationship to sustain its effectiveness, it needed to be accompanied by cultural competency, clinical skills, and open discussion of similarities and differences.

Several participants remarked on the damage caused to the therapeutic relationship when the obvious differences were not discussed. One participant explained,

It was a difficult experience. The therapist was a white male. I had just experienced the suicide of close family member. The therapy was for my family. Everyone in my family is from the South and dark skinned except for me. I feel that the therapist had a lot of stereotypes about our family. This caused me to shut down, and I really didn't open up to him because of this.

This client's experience of being stereotyped became an obstacle to the effectiveness of therapy. Another participant stated similarly, "A lot of times, I felt like they [the therapist] were trying to figure out what I was without actually asking. Often, it felt disconnected and lacking

cultural competence.” This latter statement appears to show a slight improvement over the example above, because the therapist seems to be searching for the client’s meaning, rather than simply assigning her own meanings derived from cultural stereotypes.

Related to the perception that therapeutic outcome is negatively influenced by inadequate attention to mutual exploration of race, ethnicity and culture in the clinical relationship, another participant recalled her experience with cross-cultural counseling by saying that she did not feel her therapist understood the complexity of her racial and cultural identities. She said,

I feel as though when it came to race and ethnicity the counselor wasn't... aware of the negative associations that are tied into people of different races, especially African-Americans. I also am a first generation American and I identify as Kenyan American. Then, I also identify as an African-American Black.

In this statement, the participant pointed out that the mental health professional she worked with did not seem to know about stereotypes or “negative associations” that are frequently imposed on people of different races. The participant specified, especially African-American, and went on to indicate the importance of her particular way of self-identifying herself as a first generation American, African-American Black and Kenyan American. Cumulatively, the participant noted that her clinician lacked knowledge related to cultural differences, stereotypes, and the challenges associated with having multiple social identities. Without such awareness, it seems unlikely that the participant could have felt understood and affirmed in her multiple identities by her clinician.

Interestingly, the participant quoted above, who references her African- American, Black, and Kenyan American identities, further explained that the experience she describes occurred with a clinician of color. She summarized her experience by saying,

The counselor was Hispanic so she was a woman of color, but I didn't feel it. I honestly didn't even know that she was woman of color. The office told me that she was a woman of color, but her complexion looked White. Her behaviors reflected whiteness.

In asking for clarification about how the participant defined “whiteness”, she answered,

I guess I'm referring to how she was formal all of the time. You know, women of color or people of color tend to talk a bit differently to each other and we tend to be more warm and it's like we can kickback just relax a bit with another woman of color. I was expecting her not to be so tense. When I came to the counseling services my issues had to do with my health and my physical health and my mental health and I feel as though the counselor was not aware of the stigma of mental health like how the Black community combined with the Christian faith can complicate one's decision of trying to decide whether or not to get on medication. Coming from you know, a very religious family and how you know you are supposed to put your faith in God can be difficult. Sometime, there can be a conflict between the younger generation of Black women and older women in our community.

We are young women and at the same time in our generation there's a lot of things against us especially the fact that STDs are so common within our age group and that a lot of us, are having sex whether it's consensual or not and so I wanted to talk to her about that. I wanted to talk about what was going on with my body and she didn't know what I was talking about. She made me feel isolated and just like odd and upset that she that she was servicing the college population knew nothing about these things. Maybe I said a word and you know maybe I pronounced it in a way that she didn't understand or whatever, but it wasn't just that, it was that she didn't understand once I explained it to her, so didn't go back. When there are two people of color the dynamic is different because there is something more culturally familiar, more relaxing and a safer space. It's that sense of “I am here with you.”

The researcher was struck by this participant's frequent use of the term “you know” and “our,” which seemed to imply that the participant felt a sense of familiarity with the researcher based on our shared racial and ethnic identities. This is particularly notable because the participant is discussing an experience with a therapist of color, whom she did not feel culturally identified with, which contrasts the familiarity implied in her communication with the researcher.

Participants also reflected on the intersectionality of identifies as it relates to their connection with their therapist. One participant stated:

I have had therapy with four therapists. I didn't feel safe with the male therapist. I think that I would have felt safer if he had been a female. It would have felt safer emotional with a female therapist. I felt like he was blunt; it seemed like he was reading off a laundry list and tried to tell me what my issues were. With the college counseling experience, I felt that there was a disconnection around class. I think that it would have been different with a woman of color.

The male therapist referenced above by this participant was also described as White, leading the researcher to wonder whether race may have also played a role in the participant's experience of discomfort, and whether it may be easier or more acceptable to attribute this discomfort to gender difference rather than racial difference. The theme of transference related to culture appeared again when a participant who identifies as Japanese- American articulated being uncomfortable when her previous mental health professional spoke about "Asian Dads" as if all Asian dads are the same. She said,

When I started the process of looking for a therapist, it was important to me find an ethnic match. My therapist was half white and half Asian. She was biracial; Korean-American. When I called the college-counseling center to make an appointment, I requested a therapist of Asian descent. At first this was helpful. In the beginning I felt that she was able to relate to my family and social identities. This supported my identity development process in America. After a while, the therapy process became redundant. I felt that she just stayed focused on the racial and ethnic aspect of my identity instead of looking at things like gender.

She was comfortable with certain aspects of my identity, racial identity, yes. It seemed that she talked from her own experiences more than from a formal education on cultural competence. She grouped Asians together. She would say things about "Asian dads" that were generalizations about Asian dads. She would talk about the experiences of her friends who had Asian dads. Sometimes, these generalizations reflected stereotypes that fit my dad, but at other times, they didn't. The difference between Koreans and Japanese people didn't seem reflected in her knowledge about cultural competence. I didn't guide the therapy or correct her because I thought that as a therapist she should understand these things.

In addition to the role of cultural and/or ethno-cultural transference in the clinical relationship, environment and policies were suggested as factors that could sway a client's perception of cultural competence in the clinical relationship. One participant articulated this by saying the following:

The environment felt sterile. There wasn't anything outside of American culture in the office. I remember that there was something like American comic strips on the walls. It would have been helpful to see something in the environment that indicated that the therapist was interested in people from other parts of the world; a world map would have been helpful.

Regarding policies, one participant's response is as follows:

In the very first session, the therapist told me that there would be a limited number of sessions because that is all that would be covered under my insurance. Each time that I saw her, she reminded me of this. I felt like the policy around insurance didn't consider socio-economic status and how this might impact some people of color. It was hard to hear about the insurance three times in a row. It felt like the insurance policy was more important than the issues that motivated me to seek therapy. After the 3rd session, I ended up not going back there.

CHAPTER V

Discussion

This study explored cultural competence in clinical practice behaviors. The study's findings suggest that a client's perception of the clinician's ability to work in a culturally competent manner is integral to the therapeutic alliance. One of the major findings reveals that an exact prescription for behaviorally demonstrating cultural competence in clinical practice remains challenging. While challenging, clinical outcomes and cultural competence are indivisibly linked to the extent that the client feels understood and valued. Without this, the chance of effective outcomes diminishes significantly.

For clients' of color, being "colored" by social constructions of the meaning of being other than white creates varying degrees of psychological and emotional strain in their day-to-day lives. Regardless of the presenting problem which brings clients of color into therapy, it is not possible to divorce these issues from the intra-psychic reality of ongoing exposure to culturally shared negative stereotypes and discrimination. Sociological biases related to biological sex, gender expression, ability, economic status, sexual orientation and immigration status add additional barriers to psychological well-being.

Both the client and the therapist are bringing their individual cultural schema into a mutual clinical experience; however, the clinical relationship is situated in a particular type of hierarchy, presenting a challenge to dismantling notions of power and privilege. Object Relations Theory provides insight into how the therapeutic relationship can provide opportunities for examining one's internal and external worlds of relating, the intra-psychic influences that shape

perception and experience, as well as create new paradigms for engagement with self and others. This particular psychodynamic model may provide a framework for understanding individual behavior in the context of the social environment and how it is internalized. As stated in the introduction, Rasmussen and Salhani (2010) use Melanie Klein's concepts of projection, projective identification, splitting, developmental positions, envy and reparation to analyze the psychodynamic dimensions of racism.

This study brings to light the narratives of college students of color and included in several of their reflections, it appeared that some of the participants felt that their clinicians made assumptions about them. In hearing this as a possible theme, it was noted that during the clinical process, associations and notions of representation seem to arise for both the clinician and therapist. This seemed possibly relevant to the literature review's reference to how the employment of projective identification may be used to manage ideas, feelings, and impulses [regarding] race, one begins to fill the empty container of race with projections that are shaped in part by historical influences, current culture, and media discourse (Rasmussen & Salhani, 2010). While there may be potential for both the clinician and the client to engage in projective identification, the nature of the relationship puts the onus of discerning when, how and why this is happening on the clinician, not the client. The process by which insight is derived by the clinician depends on this professional's awareness of their own vulnerabilities, strengths and weaknesses related to imbalances of power and cultural schemas. This process is constantly unfolding and invites ongoing reflection followed by action that supports reparation that makes the realization and wholeness of the other, more apparent. As often as this occurs, there may be the possibility for a corrective therapeutic experience to occur within the clinical dyad. The development of an effective therapeutic alliance is contingent on a number of factors. The

client's cultural transference toward the therapist, the therapist's cultural countertransference toward the client, and the real relationship are all important ingredients in the development of the therapeutic alliance (Daniel, 2000).

Several of the participants felt that one way to possibly convey cultural competence was for the clinician to apply inquiry while refraining from generalizing based on common stereotypes. Acknowledging power differentials appears to support a sense of awareness, responsible transparency and competence. In doing this, it is important for the clinician to avoid burdening the client with being the voice of their cultural affiliation. In addition, it is necessary to understand the role of a client's cultural background in relationship to any display of diagnosable symptoms. Ethno-centric diagnosis may appear to scripted and experienced by one participant as a "laundry list" being read versus an authentic and reflexive process of demonstrating a client-centered approach to treatment. Additionally, privileging a language that is not the client's first language or having preconceived ideas about certain types of body language (looking the clinician in the eye) may create feelings of shame or embarrassment for client. This may lead to a rupture in the clinical relationship. This study consistently showed that a perception of inadequate cultural competence leads to the demise of a healthy therapeutic attachment. Unless, the clinician is attuned to the rupture, the client may not feel comfortable discussing it and instead, abruptly terminate.

The clinician needs to be aware that the clinical relationship has the potential to be a place where imbalances of power may be re-enacted if she/he does not pay careful attention to intercepting this potentially triggering and re-traumatizing experience. According to Sue (2006), "when clinician and client differ from one another along racial lines, the relationship may serve as a microcosm for the troubled race relations in the United States" leading to cultural clinical

impasses (p. 280). Because racism in the form of micro aggressions is so embedded in social patterns, psychological research, education, and practice must move beyond illustrating how racial micro-aggressions create impairs in the therapeutic alliance.

Limitations of Study

The sample selection was comprised of women; therefore, there were no conclusions drawn about male students' of color and their perceptions and experiences of cultural competence in the clinical dyad. All of the participants identified as middle class and educated. In general, this does not necessarily represent a wider range of people of color who have been in psychotherapy. It is notable that many of the participants have focused their learning in academic disciplines that involve social justice education. Due to the nature of the sophisticated academic backgrounds of the sample selection, those who participated might have above average familiarity with issues related to race, ethnicity and other social identities, cultural diversity and cultural competence. Insight around the nature and implications of the research question might have been influenced by the participants' academic knowledge about social justice education. Since the qualitative data found in this research is drawn from participants with varying cultural backgrounds, this diversity adds to the richness of the study. While all identify as American, many of them are first generation American and came to this country from other continents including Central America, Asia, Africa and the Caribbean.

Implications for Practice

This research study suggests that the skills of mental health professionals need to encompass a broad range of knowledge and cultural competence skills. Values, beliefs, and professional knowledge inform clinical practice behaviors. Therapists' ability to recognize the influence of social-cultural factors on clinical relationships impacts the overall efficacy of

psychotherapy treatment and outcomes. Whether consciously or sub-consciously, there is ongoing communication about one's relationship with racial differences, sameness, and perceptions of the self and others based on the internalization of these experiences.

Since this study examined college students of color and their perception of how cultural competence was conveyed in clinical dyads, the data collected might inform how mental health professionals could improve their understanding of the clinical needs of clients of color, related to being seen as a whole person. Race, ethnicity, economic status, gender and sex identity, sexual orientation and varying abilities all impact clients' perception of internal and external factors, both within and outside of the clinical environment. In essence, attunement to and open discussion of the bi-directional lines of cultural communication are critical to the process of diagnosis, assessment, overall treatment, and outcomes.

All of the participants in this study expressed that their perception of the clinician's ability to work effectively and compassionately was impacted by the clinician's ability to demonstrate a core knowledge, understanding, and acceptance of the salient social and cultural identities represented in the clinical dyad. Transparency of professional values and knowledge was perceived as helpful, especially when an empathetic and open dialogue about cultural sameness and differences was invited into the clinical relationship. Verbal communication, the aesthetic environment of the clinical space, as well as policies that impact affordability and accessibility of services communicated information to the client about the clinician's cultural competency.

Indications for Future Research

Future exploration of cultural competence in clinical practice behaviors should involve research with a larger sample, comprised of individuals who reflect a broader range of diversity,

specifically including men and a wider range in the age of participants. While all of the participants of this study identified as middle class, placing them at a similar socio-economic level to their therapists, the researcher also sees the need for exploration of the intersection of race and social class, through exploration of the perspectives of people of color with fewer economic and educational resources. Because of the complexity and nuance of cultural issues, this researcher feels that qualitative interviewing methods are best suited for investigating the topic of cultural competence.

If this study were to be repeated on a larger scale, the researcher would recommend changing the final interview question regarding racial trauma, to allow for greater common understanding between the researcher and participants. It was notable to the researcher that all participants denied experiencing racial trauma in their previous clinical relationships; however, their descriptions of these relationships sometimes did match the researcher's conception of racial trauma. The researcher hypothesizes that this misunderstanding may result from a societal tendency to frame emotional injury as a personal matter, disregarding the salience of race.

While the researcher did not specifically solicit participants' opinions about the impact of agency policies on their therapy experience, several participants spoke about policies becoming barriers to accessing treatment, specifically around affordability and insurance. Regardless of the setting in which therapy takes place (at an academic, private, or public agency), it is important that policies reflect cultural competence, taking into account the social and economic barriers that clients face. The ability to engage in meaningful therapy requires that accessibility and payment not become obstacles to people of color who are seeking therapeutic treatment. Further research on cultural competence in clinical practice should include an intentional exploration of the impact of agency policies.

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APPENDIX A

HSR Committee Letter of Approval



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

March 7, 2013

Yolanda Young-Armstrong

Dear Yolanda,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads 'Marsha Kline Pruett' followed by a stylized flourish.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: Marian Harris, Research Advisor

APPENDIX B

Letters of Permission to Post Recruitment Flyers

UMass Center for Women and Community

Hello Yolanda,

The only people who use fliers in the organization are us. I will be happy to have one or two on the table in our office to let women know about this.

Good luck,
Hind

Hind Mari, Ed. D, Director
Women of Color Leadership Network
Center for Women & Community
[Formerly Everywoman's Center]
127 New Africa House
UMass-Amherst
Amherst, MA 01003

www.umass.edu/ewc/programs/wocln

The Office of Multi-Cultural Affairs, Smith College

To Whom it May Concern,

In response to Yolanda Young Armstrong's request to post flyers regarding her academic research, the Office of Multicultural Affairs will designate a staff member to post flyers (1 per building) in the cultural spaces known as Unity House and the Mwangi Cultural Center on the campus of Smith College.

Sincerely,

L'Tanya Richmond

APPENDIX C

Recruitment Flyer

‘An Exploratory Study of Cultural Competence in Clinical Practice Behaviors’

A Qualitative Research Study

I am seeking to interview people of color to explore their experience in psychotherapy. Because we live in a society that is pervasively impacted by racism all mental health professionals risk unconsciously re-creating the dynamics of racism in clinical settings. I hope that this research can serve as a guide for mental health professionals to increase their cultural competence in clinical practice.

Inclusion criteria are as follows:

- Current college student
- 18 years of age or older
- Self-identify as a person of color
- History of being in psychotherapy
- Speak English
- Resident of United States

Exclusion Criteria for participants are as follows:

- Individuals who are under the age of 18;
- Those who are not currently enrolled in college;
- Those who are not self-identified people of color;
- Individuals who do not speak English or who live outside of the United States;
- Individuals who have never been in psychotherapy, as well as those who are currently in therapy will be ineligible.
- If in active counseling or psychotherapy.

Please contact Yolonda Young Armstrong

(Smith College School for Social Work Student) at [REDACTED] or [REDACTED]@smith.edu if you meet the inclusion criteria and are interested in voluntarily participating in this research study.

Interviews will take place in March and April, 2013 and will be one hour in length. Participation is voluntary and your confidentiality will be protected.

Thank you for your interest!

APPENDIX D

Screening Questions

Dear Potential Participant (name will be filled in),

Thank you for your interest in my research study. The purpose of this email is to ensure that you meet the inclusion criteria for participation in this study.

1. Are you currently enrolled in college?
2. Are you 18 years of age or older?
3. Do you identify as a person of color?
4. Have you been in therapy in the past?
5. Do you currently reside in the United States?

If you meet all of the above, you meet criteria to participate. If you are interested in participating, please contact me via email and provide a few times that I might be able to reach you via phone or times you may be available for an in-person interview if you live in the Pioneer Valley. If you do not meet the criteria listed above, I sincerely appreciate your interest but unfortunately will not be able to include you in this research study. Thank you for answering the screening questions.

Sincerely,

Yolonda Young Armstrong, MSW Candidate

Smith College School for Social Work

APPENDIX E

Informed Consent Form

Dear Potential Participant,

My name is Yolonda Young Armstrong and I am conducting this research study through Smith College in Northampton, Massachusetts, where I am a student in the Master of Social Work (MSW) Program.

I am interested in exploring the experiences of people of color in psychotherapy. Specifically, this study will look at the types of behavior that convey cultural competence to clients by mental health professionals. As defined by author Stanley Sue, cultural competence as an appreciation and recognition of other cultural groups and the ability to work effectively with them. By delivering culturally competent, services mental health clinicians, social justice educators, policy makers, and the general community may be in a better position to understand the various variables that potentially influence a clients' perception of cultural competency. In particular I am interested in a population of people of color who have past psychotherapy experience.

The data from these interviews will be used for my MSW thesis and for possible presentation and publication. "An Exploratory Study of Cultural Competence in Clinical Practice Behaviors" is the title of my proposed research.

The criteria for participation in this study are: (a) current college student; (b) 18 years of age or older; (c) self-identify as a person of color; (d) history of being in psychotherapy; (e) speak

English; and (g) resident of United States. If you voluntarily agree to be interviewed about your therapeutic experience, we will meet for a one-hour long interview. The interview will take place at an agreed upon time between March 2013-April 2013. The interviews will be audio taped and transcribed by a professional transcriptionist. The professional transcriptionist will sign a confidentiality agreement prior to receiving access to any tapes for transcription. If possible, I would like to meet you in person, but we can also talk via Skype or Face Time.

There is some potential for risk to individuals who participate in the research study. Some participants may have emotional difficulty when they discuss their prior psychotherapy experiences. Being part of a study that is intended to shed light on the client's perception of a past clinician's cultural competency may offer the participant a cathartic outlet while supporting learning in the field of clinical social work.

Your confidentiality will be protected by the following measures (in compliance with Federal Guidelines):

- 1) No names will be attached to the data or transcripts.
- 2) The tapes of the interviews will be kept in a locked storage box, and will be taken out when they are given to a professional transcriptionist for transcription.
- 3) Following the study, tapes will be locked in a file cabinet for a period of 3 years and then destroyed.
- 4) My research advisor will not have access to any identifying information on the interview data.

- 5) All Consent Forms will be kept separate from the interview data and linked through a randomly chosen code number.
- 6) As a participant, you have the right to (a) decline to answer any question, (b) end the interview at any time and (c) withdraw from the study at any point up until April 15, 2013. If you choose to withdraw from the study prior to this date, all material pertaining to you will be destroyed immediately.
- 7) When the information is summarized in the research study, responses will be disguised and your real name will never be used.
- 8) The transcriptionist will sign a confidentiality agreement.

Please remember, participation in this research study is voluntary.

The researcher will provide a copy of this form to you. PLEASE KEEP A COPY FOR YOUR RECORDS.

Should you have concerns about your rights or about any aspect of the study, you are encouraged to call either the researcher or the Chair of the Smith College School for Social Work HSR Committee at (413) 585-7974.

Feel free to ask me any questions, and thank you for participating in this study.

Yolonda Young Armstrong, [REDACTED]

[REDACTED]@smith.edu

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

If the research interview brings up thoughts that you would like to discuss further, or if you experience emotional distress following the interview, please seek assistance at your local college counseling center.

- Smith College Counseling Service: (413) 585-2843
- University of Massachusetts, Amherst, Center for Counseling and Psychological Health: (413) 545-2337.
- After 5 p.m., on weekends or holidays, call UHS, (413) 577-5000, and ask for the CCPH clinician on-call
- University of Massachusetts, Amherst, Center for Women and Community: 413.545.0883

If you do not attend one of the colleges above and feel that you need psychological support following the interview this researcher will be happy to assist you in finding contact information for your local college counseling service.

APPENDIX F

Demographic Questionnaire

1. What is your racial/ethnic/cultural identity? _____
2. What is your age? _____
3. What is your socio-economic status? _____
4. What is your gender? _____
5. What is your marital status? _____

APPENDIX G

Interview Guide

- 1) Describe your experience with a mental health professional, as it relates to your social identities including race and ethnicity.
- 2) Describe your perception of your mental health professional's comfort level discussing issues regarding race, ethnicity, cultural similarities or differences.
- 3) Discuss how you perceived your mental health professional's ability to decipher between you as an individual versus the common stereotypes attributed to your racial, ethnic or cultural group.
- 4) Describe any type of racial trauma that resulted from psychotherapy with a mental health professional.

APPENDIX H

Key Concepts and Definitions

To ensure that the participant and the researcher have co-shared definitions of key terms concepts, each participant was provided with a list of definitions for these words:

Stereotype_ a generalization imposed on individuals based on a real or perceived characteristics of a group to which that person belongs; stereotypes tend to be intra psychic ideas that tend to be shared culturally.

Prejudice_ an (often negative) attitude, opinion and feeling formed without adequate reason or consideration of the current facts.

Discrimination_ act (behavior) of systemically and unjustly favoring or dis-favoring someone on the basis of their group membership.

Majority Status_ denotes power and privilege with the capacity to define and determine what is normal.

Minority Status_ denotes membership in a group that is marginalized, oppressed or discriminated against.

Race_ a categorization that is partially based on apparent physical differences (e.g., skin tone, hair color and texture, facial features) and partially linked to relative geographic isolation and limited geographic crossbreeding. It is also partly socially constructed (in the eye of the beholder).

Racism_ a system privilege, equality and oppression based on perceived categorical differences and relying on a fixed, unchanging view of human beings. It is manifested politically, socially, economically, culturally, interpersonally and intra-personally.

Cultural Competence_ the ability to be aware of cultural differences, appreciate them and work effectively with them.

Racial Trauma_ mental and emotional distress that results from harassment and/or discrimination.