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Client Perspectives on Clinician Multicultural Competence in Racially and/or Ethically  
Cross-Cultural, Strengths-Based Psychotherapy

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor of  
Philosophy in Counseling, Clinical, School Psychology

by

Evelyn Iley Plumb

Committee in charge:

Professor Collie Conoley, Chair

Professor Heidi Zetzer

Professor Miya Barnett

September 2019

The dissertation of Evelyn Iley Plumb is approved.

---

Professor Heidi Zetzer

---

Professor Miya Barnett

---

Professor Collie Conoley, Committee Chair

September 2019

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Setting: Department-based Assessment Clinic  
Supervisors: Erik Lande, Ph.D. & Jordan Witt, Ph.D.  
**Advanced Practicum Student** 2014 – 2015  
Agency: *Hosford Counseling & Psychological Services Clinic, Goleta, CA*  
Setting: Department Training Clinic  
Supervisors: Collie Conoley, Ph.D. & Toni Zander-Starr, Ph.D.

**SUPERVISION & CLINICAL LEADERSHIP EXPERIENCE**

**Clinic Coordinator** 2017-2018  
Agency: *Hosford Counseling & Psychological Services Clinic, Goleta, CA*  
Setting: Department Training Clinic  
Supervisor: Heidi Zetzer, Ph.D.  
**Advanced Practicum Supervisor** 2017-2018  
Agency: *Hosford Counseling & Psychological Services Clinic, Goleta, CA*  
Setting: Department Training Clinic  
Supervisor: Heidi Zetzer, Ph.D.  
**Clinical Training Team Committee Representative** 2017-2018  
*Clinical, Counseling, & School Psychology Program, UCSB*  
**Basic Practicum Supervisor** 2016-2017  
Agency: *Hosford Counseling & Psychological Services Clinic, Goleta, CA*  
Setting: Department Training Clinic  
Supervisor: Heidi Zetzer, Ph.D.

**TEACHING APPOINTMENTS**

**Teaching Associate**  
*CNCSP 101: Introduction to Helping Skills (UCSB)* Summer 2017  
*CNCSP 112: Positive Psychology (UCSB)* Summer 2016  
**Graduate Teaching Assistant**  
*SOC 100: Introduction to Sociology (UCSB)* Spring 2016  
*SOC 100: Introduction to Sociology (UCSB)* Winter 2016  
**Graduate Teaching Assistant**  
*CNCSP 110: Vocational Guidance (UCSB)* Winter 2015  
*CNCSP 110: Vocational Guidance (UCSB)* Fall 2014

**GUEST LECTURES & INVITED PRESENTATIONS**

*Applications of Interpersonal Neurobiology in Pediatric Trauma* 2019  
 Denver Health Medical Center, Outpatient Behavioral Health Services  
*Culturally-Modified Trauma-Focused Cognitive Behavioral Therapy* 2017  
 CNCSP 260: Basic Practicum, University of California, Santa Barbara  
*Integrating Assessments into Psychotherapy: Implementation, Monitoring, & Feedback* 2017  
 CNCSP 270: Advanced Practicum, University of California, Santa Barbara  
*Preventive Mental Health Strategies: Proactively Cultivating Well-Being* 2016  
 UCSB Mental Health Conference, University of California, Santa Barbara  
*Developing a Professional Identity* 2015  
 CNCSP 110: Vocational Guidance, University of California, Santa Barbara

**PUBLICATIONS**

- Winter Plumb, E.I.**, Hawley, K. J., Scheel, M. J., & Conoley, C. W. (2018). Goal Focused Positive Psychotherapy: An Integration of Positive Psychology and Psychotherapy. *British Journal of Guidance & Counselling*, 1-11.
- Winter Plumb, E.I.**, et al. (2017). Case Studies: "Peter Pan." In Conoley, C.W. & Scheel, M.J. (Ed.), *Goal-Focused Positive Psychotherapy*. New York, NY: Oxford University Press.
- Conoley, C.W. and Hawley, K.J. and **Winter Plumb, E.I.**, (2017) Review of the Substance Use Disorder Diagnostic Schedule-5 ACCESSION #: (20093988), *Mental Measurement Yearbook*. Buros Institute: Lincoln, NE.
- Conoley, C.W., **Winter Plumb, E.I.**, Hawley, K., Spaventa-Vancil, K., & Hernández, R. (2015). Integrating Positive Psychology into Family Therapy: Positive Family Therapy. *The Counseling Psychologist*, 43(5), 703-733.
- Bridgeman, B., Gaunt, J., **Plumb, E.I.**, Quan, J., Chiu, E., & Woods, C. (2008). A Test of the Sensorimotor Account of Vision and Visual Perception. *Perception*, 37(6), 811.

### **MANUSCRIPTS UNDER REVIEW**

- Winter Plumb, E.I.**, Hawley, K.J., Bello, B.D.C., Boyer, M.P., Damiani, T., & Conoley, C.W. (2019). *A Consensual Qualitative Study of Goal Focused Positive Psychotherapy*. Manuscript under review.
- Winter Plumb, E.I.**, Hawley, K.J., & Conoley, C.W. (2019). *From Cosmetics to Compassion: A Case Study in Goal Focused Positive Psychotherapy*. Manuscript under review.
- Zetzer, H.A., Hill, C.E., Hopsicker, R.J., Montojo, P.C., Hoffman, M.A., **Winter Plumb, E.I.**, & Donohue, M.D. (2019). "Parallel Process in Psychodynamic Supervision: The Supervisor's Perspective." Manuscript under review.

### **SYMPOSIA & POSTER PRESENTATIONS**

- Hopsicker, R., **Zetzer, H.A.**, Hill, C.E., Montojo, P.C., **Winter Plumb, E. I.**, & Hoffman, M. (August, 2018). "A qualitative investigation of parallel process: Purpose, methods and results." In H.A. Zetzer (Chair), Back to the Future: Investigating parallel process in psychodynamic supervision. Paper presented for a symposium at the Annual Meeting of the American Psychological Association, San Francisco, CA.
- Winter Plumb, E.I.**, & Hawley, K.J. (August, 2016). "Client Responses to Goal-Focused Positive Psychotherapy." Symposium topic presented for Division 17 at the Annual American Psychological Association Conference, Denver, CO
- Winter Plumb, E.I.**, & Conoley, C.W. (August, 2015). "Constructing Pathways to Possible Selves: A Quasi-Experimental Intervention to Increase Hope in College Students." Poster presented for Division 17 at the Annual American Psychological Association Conference, Toronto, CAN.
- Hawley, K., **Winter Plumb, E.I.**, & Conoley, C.W. (August, 2015). "Teaching Positive Empathy and Increasing Life Satisfaction Through Psychoeducational Groups." Poster presented for Division 17 at the Annual American Psychological Association Conference, Toronto, CAN.
- Damiani, T., **Winter Plumb, E.I.**, & Conoley, C.W. (August, 2015). "Increasing Self-Compassion in a College Class: Quasi-Experimental Study of a Psychoeducational Group." Poster presented for Division 17 at the Annual American Psychological Association Conference, Toronto, CAN.



Bartholomew, T. et al. & **Winter Plumb, E.I.**, (August, 2015). “Positive Psychology Prevention Offered Through College Classes.” Symposium presented for Division 17 at the Annual American Psychological Association Conference, Toronto, CAN.

### **GRADUATE RESEARCH EXPERIENCE**

**Resident Researcher**, *HRSA Grant for Families Impacted by the Opioid Crisis* 2018-2019  
Denver Health Medical Center

Faculty Advisor: J. Christopher Sheldon, Ph.D., & Colleen Fischer, Ph.D.

- Conducted grant-funded research on barriers to accessing treatment; ethical incentives and recruitment approaches; and psycho-social outcomes associated with parents, children, and families impacted by the Opioid Crisis
- Researched and assembled evidence-based multi-family group curriculum for children and families affected by substance abuse, domestic violence, and food/housing insecurity
- Developed organizational initiatives and trained professionals in allied fields to enhance effectiveness of identification and referral processes for pediatric patients/parents impacted by the Opioid Crisis
- Managed logistical and administrative tasks of outreach, recruitment, enrollment, and database management for current and prospective program patients

**Principal Investigator**, *Dept. of Clinical, Counseling, & School Psychology* 2016-2019  
University of California, Santa Barbara

Faculty Advisor: Collie Conoley, Ph.D.

Committee Members: Collie Conoley, Ph.D., Heidi Zetzer, Ph.D., Miya Barnett, Ph.D.

Dissertation title: Client Perceptions of Clinician’s Multicultural Competence in Cross-Racial, Strengths-Based Psychotherapy

- Conducted an analysis using Consensual Qualitative Research of interviews with clients identifying as racial/ethnic minorities regarding appraisals of their White clinicians’ multicultural competence when utilizing a strengths-based approach to psychotherapy
- Managed all logistical and administrative tasks of project launch, implementation, and analysis
- Trained and supervised team of 7 undergraduate Research Assistants in research, ethical, and analytical policies/procedures associated with the project

**Invited Collaborator**, *Dept. of Clinical, Counseling, & School Psychology* 2016-2018  
University of California, Santa Barbara

Principal Investigator: Heidi Zetzer, Ph.D.

- Performed coding and analysis for a team project utilizing Consensual Qualitative Research to analyze interviews with psychodynamic supervisors examining their experiences with the phenomenon of Parallel Process in supervision
- Received training, consultation, and auditing from seminal developer of the Consensual Qualitative Research method (Clara Hill, Ph.D.)
- Served as sole graduate student member on a coding team of licensed psychologists

**Research Practicum**, *Dept. of Clinical, Counseling, & School Psychology* 2014-2015  
University of California, Santa Barbara

Faculty Advisor: Collie Conoley, Ph.D.

- Developed research project examining psychotherapy process and outcome variables through both quantitative and qualitative methods based on data produced by

department training

- Analyzed psychotherapy process/outcome instrument results to track treatment effectiveness
- Coordinated IRB approval, collected, transcribed, and coded data, wrote and edited literature reviews, clinic, collaborated with research team to produce manuscripts, chapters, posters, symposia, and presentations to disseminate findings

**Research Practicum**, *Dept. of Clinical, Counseling, & School Psychology* 2014-2015

University of California, Santa Barbara

Faculty Advisor: Collie Conoley, Ph.D.

- Developed large-scale, preventively-oriented interventions to enhance the mental health and well-being of first-generation college student populations: designed and led workshops to facilitate adaptive/resilient coping and trained other workshop presenters
- Co-wrote grant for American Psychological Foundation Grant to expand intervention for additional vulnerable populations
- Collected, coded, and statistically analyzed data, conducted analyses on “fit” of participant culture and interventional approach

**Graduate Student Researcher**, *Office of Dean Jane Conoley* 2013-2014

University of California, Santa Barbara

Employer: Dean Jane Conoley, Ph.D.

- Conducted media research in the areas of psychology, education, psychotherapy, and other topics germane to Gevirtz Graduate School of Education
- Vetted and summarized media pieces for the Dean’s review, proposing opportunities for community engagement/outreach and department improvements

### **BACCHALAUREATE & POST- BACCHALAUREATE RESEARCH EXPERIENCE**

**Research Assistant**, *Walton/Dweck Stereotype Threat Lab* 2012-2013

Stanford University

Principal Investigators: Carol Dweck, Ph.D., Greg Walton, Ph.D., & Lauren Aguilar, Ph.D.

- Executed and documented experiments examining effects of race and gender stereotype threats on well-being and academic success among undergraduate students
- Coded, transcribed, and analyzed audio and video data using standardized behavioral scales
- Conducted group-format pilot sessions for evidence-based classroom interventions to increase academic success and well-being of racial/ethnic minority students

**Research Assistant**, *Spatial & Cognitive Perception Lab* 2006

University of California, Santa Cruz

Faculty Advisor: Bruce Bridgeman, Ph.D.

- Performed and analyzed standardized cognitive testing on research participants in a cognitive neuroscience lab conducting spatial awareness research in conjunction with the National Aeronautics and Space Administration (NASA)
- Directed participants through complex computer simulations and spatial/cognitive tasks
- Managed participant recruitment, scheduling, follow-up and credit-allotment

**Research Assistant**, *Psycholinguistic Analysis Lab* 2005-2006

University of California, Santa Cruz

Faculty Advisor: Avril Thorne, Ph.D.

- Designed and operationalized conversational coding and analysis schemes for a series of studies examining dispositional influences on psycholinguistics of dyadic interactions
- Coded, transcribed, and analyzed qualitative and quantitative personality data and presented results during weekly meetings with principal investigator

### **GRANTS, HONORS, & AWARDS**

- Susan A. Neufeldt Award for Excellence in Clinical Supervision 2018
- Carol Ackerman Center Fellow 2017
- Hosford Clinic Research Grant 2017
- Family Strengths Center Fellowship 2016
- Ray E. Hosford Award for Excellence in Professional Behavior 2015
- UCSB Block Grant 2013
- Hosford Clinic Citizenship Award (Hosford Hero) 2013

### **SELECT PROFESSIONAL TRAININGS, WORKSHOPS, & CERTIFICATIONS**

- Considerations for Treating Trauma & PTSD in Primary Care Settings February 2019
  - *Trainers: Jeremy Vogt, Ph.D., Sarah Murray, LCSW, & Hugo Duenas, LCSW*
    - Denver Health Medical Center, Denver, CO
- Emotionally-Focused Family Therapy November-December 2018
  - *Trainers: Robert Allan, Ph.D., & Priscilla Zynda, Ph.D.*
    - Denver Health Medical Center, Denver, CO
- Motivational Interviewing in a Hospital Setting August-September 2018
  - *Trainers: Christian, Thurstone, M.D., & Julia Timmerman, LCSW*
    - Denver Health Medical Center, Denver, CO
- Parent-Child Interaction Therapy Training Intensive June-September 2017
  - *Trainer: Miya Barnett, Ph.D., certified PCIT Trainer*
    - Parent-Child Interaction Therapy Clinic, UCSB, Goleta, CA
- Alcohol & Drug Abuse Counseling (CADTP) July 2017
  - *Online Training & Certification*
    - California Association of DUI Treatment Programs
- Postpartum/Perinatal Mood Disorders Assessment & Treatment April 2017
  - *Trainer: Jenn Paul, L.M.F.T.*
    - New Beginnings Counseling Center
- Substance Abuse Assessment & Treatment January-March 2017
  - *Trainer: Jacquelyn Kurta, Psy.D., L.M.F.T.*
    - New Beginnings Counseling Center
- Play Therapy December 2016
  - *Trainer: Lynn Stadler, L.M.F.T., certified Violet Oaklander Model Trainer*
    - New Beginnings Counseling Center
- Trauma Resilience Model October-November 2016
  - *Trainer: Jenn Paul, L.M.F.T.*
    - New Beginnings Counseling Center
- Cognitive Processing Therapy (Basic) June 2016
  - *Online Training Course*
    - CPTWeb, Medical University South Carolina Department of

## Psychiatry & Behavioral Science

- Community Resilience Model April 2016
  - *Online Training Course*
    - National Child Traumatic Stress Network
- Acceptance & Commitment Therapy February 2015 & March 2016
  - *Trainer: Diana Hill, Ph.D.*
    - Workshop Series with Santa Barbara County Psychological Association
- Gottman Couples Therapy Level I Training: Bridging the Couple Chasm Jan. 2016
  - *Trainers: John Gottman, Ph.D., and Julie Schwartz Gottman, Ph.D.*
    - Workshop hosted at University of California, Santa Barbara
- Trauma-Focused Cognitive Behavioral Therapy September 2015
  - *Online Training Course*
    - TF-CBT*Web*, Medical University South Carolina Dept. of Psychiatry & Behavioral Science
- Assessing Suicide Risk February 2015
  - *Trainer: Turi Honegger, Ph.D.*
    - Hosford Counseling & Psychological Services Clinic, Goleta, CA
- Being a Gender-Competent Clinician June 2014
  - *Trainer: Max Rorty, L.C.S.W.*
    - Santa Barbara County Psychological Association Salon Series
- Pick the Right Medicine: Coordinating Psychiatric Care in Psychotherapy May 2014
  - *Trainer: Robert Nagy, M.D.*
    - Hosford Counseling & Psychological Services Clinic, Goleta, CA

## **OTHER DEPARTMENT, UNIVERSITY, & PROFESSIONAL SERVICE**

- APA Student Poster Reviewer, Division 17 2018
- Assistant Reviewer, *Prevention Science* 2016
- Student Representative, Faculty Search Committee 2015
- Associate Editor, Positive Psychology Newsletter 2013-2016
- Climate Committee, Student Representative 2013-2014
- Outreach Representative, Hosford Clinic Community Tabling Events 2013-2018

## **PROFESSIONAL AFFILIATIONS**

- American Psychological Association of Graduate Students (APAGS)
- New Mexico Psychological Association (NMPA)
- Santa Barbara County Psychological Association (SBCPA)
- Student Affiliate of Division 12 (Society of Clinical Psychology)
- Student Affiliate of Division 17 (Society of Counseling Psychology)
- Student Affiliate of Positive Psychology, Section 17 (PP)
- Student Affiliate of Supervision & Training, Section 17 (STS)
- Student Affiliate of Division 37 (Society for Children & Family Policy & Practice)
- Student Affiliate of Division 37-1 (Child Maltreatment)
- Student Affiliate of Division 45 (Psychology of Culture, Ethnicity, & Race)

## ABSTRACT

### Client Perspectives on Clinician Multicultural Competence in Racially and/or Ethnically Cross-Cultural Strengths-Based Therapy

by

Evelyn Iley Plumb

Multicultural competence and strengths-based approaches are both theoretically foundational elements of contemporary counseling psychology. However, very few studies have examined how these two copstones of the field intersect in practice, despite the promise they both have empirically demonstrated in enhancing treatment. There is a particular dearth of data on the technical aspect of multicultural competence. Those studies that do exist overwhelmingly rely on clinician-side perspectives or solicit client input in delimited quantitative formats.

The purpose of the present study is to better understand client perceptions of multicultural competence in the context of a strengths-based approach to cross-racial/ethnic therapy. Fourteen college students were recruited to participate in an in-person semi-structured interview that asked them to reflect on their positive and negative experiences in therapy with White clinicians, with a focus on the ways that their personal and cultural strengths were or were not incorporated into treatment. Participants were prompted during the interview to reflect on their cultural strengths and provide feedback about their experience of this intervention and their recommendations for how cultural strengths could be effectively explored and utilized in therapy. Participants all identified as a racial and/or ethnic minority and had participated in therapy with a white clinician during the past two years.

Consensual Qualitative Research methodology was used to identify emergent themes in the participant's responses. Participants reported widely varying experiences regarding the multicultural competence of their White clinicians. Two of the participants reported that cultural strengths had been explored in therapy, and the majority of the remainder indicated that they would have liked to do so. None of the participants indicated that they would prefer not to explore cultural strengths, and the majority expressed a belief that it would be a positive contribution to the therapy experience, particularly with respect to improving client self-knowledge and therapist understanding of client. Feedback regarding phrasing and delivery of the intervention included the importance of acknowledging cultural vulnerabilities alongside strengths and incorporating the exploration of cultural strengths into broader discussions of client culture as a whole.

These findings are important because they may provide new interventional avenues for enhancing the delivery of multiculturally competent strengths-based cross-racial/ethnic psychotherapy. Specifically, the findings contribute further to our understanding of how exploring cultural strengths can benefit clients, and how best to implement interventions that utilize cultural strengths in a multiculturally competent manner.

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## CHAPTER 1

### Introduction

Across the long arc of its evolution, the field of Counseling Psychology has increasingly promoted a vision of mental healthcare with multiculturally-informed and strengths-based approaches at its heart. The American Psychological Association's (APA) most recent Multicultural Guidelines foregrounded this commitment in their mandate that *"Psychologists actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context"* (APA, 2017, p.88). Yet despite the ascent of multiculturalism as the heralded "fourth force" of psychotherapy nearly two decades ago and the territory gained in the interval, the movement has yet to fulfill its promise of creating an accessible, affirming, empirically-grounded model of pluralistically representative psychotherapy.

Moreover, while an impressive body of research has vigorously sought to articulate, classify, and replicate Multicultural Competencies (MCC) in psychotherapy training and application, the preponderance of this work has neglected to examine effects of MCC on either the process or outcome of psychotherapy. There is a conspicuous dearth in particular of studies pertaining to the technical aspects of MCC, such as interventions that facilitate multiculturally-competent services. Most importantly, the extant literature on MCCs has largely failed to capture client perspectives on this phenomenon and its incorporation (or lack thereof) into their treatment.

## **Statement of the Problem**

While MCCs and strengths-based approaches are both cornerstones of counseling psychology, relatively little is known about client perspectives regarding how the two may potentially complement or contradict each other in treatment. The preponderance of existing research on MCC privileges the therapist's perspective and/or constricts client contributions by utilizing instrumentation developed from *a priori* assumptions regarding the nature and form of MCC. Furthermore, there is a notable dearth of empirical evidence concerning the Skill-based dimensions of MCC in comparison to the other established dimensions of Attitudes/Beliefs and Knowledge within cross-cultural dyads.

## **Rationale & Significance**

Researchers in the domain of MCCs have explicitly called for an investment in qualitative methodologies to better capture client understandings of MCCs and document how these competencies manifest within cross-cultural treatment at the level of skills and interventions. While many researchers advocate for the use of a strengths-based approach when working with Racial and/or Ethnic Minority (REM) populations, client perceptions of such an approach in the context of MCC mental health services remain poorly-understood. Concerns regarding definitions, delivery, and contextual considerations of a strengths-based approach in cross-cultural dyads warrant examination to ensure that such interventions are executed with appropriate sensitivity to socio-cultural context, and to better understand the circumstances and characteristics which support or contraindicate this approach. Consequently, this study seeks to explore REM client perspectives of White clinicians' MCC in the context of a culturally-grounded, strengths-based approach to psychotherapy, including a focus on interventions that specifically highlight Cultural Strengths (CSs) of the client.

As noted in APA's current Multicultural Guidelines (2017) in their exhortation to clinicians to incorporate clients' cultural materials more systematically into treatment, REM individuals who engage in education about and engagement with their ethnic traditions report improvements in resilience and well-being. The Guidelines further observe that "*the wider people's reach for resources and the greater the security and nurturance of their environment, the more resilience outcomes they will manifest*" (2017 p. 95).

Positioning Cultural Strengths (broadly including positively-experienced traditions, values, resources, systems of knowledge, belief structures, and other cultural assets) as an explicit intervention in treatment may be one way of linking clients to the nurturing, healing, and galvanizing properties of their cultures while also improving the MCC of cross-cultural psychotherapy services by providing a technical means of exploring client cultures in empowering and illuminating ways. Findings from this study yielded specific recommendations on technical- and process-oriented considerations to improve delivery of multiculturally-competent services in the context of racial-ethnic cross-cultural strengths-based counseling.

## **Overview of Methodology**

As the APA Multicultural Guidelines (2017) point out, in cases where the fit of a specific therapy tool is unclear or unsubstantiated, further research is an ethical and professional obligation. Hall, Yip, & Zárte (2016) and Ramos & Alegría (2014) concur that qualitative research—including community involvement, focus groups, piloting studies, and other forms of research that privilege the perspective of the group in question—are the preferred mode of inquiry for cultural adaptation. Because of their sensitivity to individual subjectivities and social complexities in comparison to exclusively quantitative methods of

inquiry, qualitative and mixed-methods studies are also considered a more accurate and empowering means of gathering exploratory data on phenomenological and identity-based subject matter (Grzanka & Grzanka, 2018).

Accordingly, this study followed a Consensual Qualitative Research model design (CQR: Hill, Thompson, & Williams, 1997). The structure and methodology of the study is based on Knox et al.'s (1997) CQR study of effects of therapist self-disclosures as reported by clients, as this provides a relevant approach to examining the therapy process variable of client perceptions of both discrete and ongoing therapist-initiated events, as well as within-interview prompts to reflect on therapy interventions.

CQR analysis requires a team of individuals working together, often in multiple units, to ascertain themes that are identified and verified through a non-hierarchical consensus-building process. The themes identified through this analysis are then organized into broad domains, which are further refined into categories and sub-categories during cross-analysis to track the frequency of themes across participant cases. The final product combines the qualitatively-grounded perspectives of the clients represented as emergent themes via their quantitative summary as frequencies.

Axiologically and epistemologically, Hill (2005) positions CQR at the midpoint between Constructivism and Post-Positivism. It is consequently a fitting methodological tool to begin bridging the conspicuous gap between the phenomenological knowledge offered in narrative form by client participants and the characteristically positivist forms of quantitative data traditionally valued by the culture of the academy.

## **Research Questions & Hypotheses**

The nature of Qualitative research in general and CQR in particular discourages an emphasis on explicit research questions and hypotheses due to the *a priori* assumptions involved in such processes. In terms of guiding thematic-content principles, however, it was expected that the results would provide a glimpse into prevailing themes concerning client's responses to strengths-based exploration of culture during therapy, and consequently inform the field's understanding of how this MCC skill is experienced from the client's perspective. Particular themes of interest included: 1) Is there a perceived positive or negative valence to the exploration of clients' cultural strengths in therapy? 2) Is a strengths-based approach to cultural topics associated with client evaluations of the counselor's competence in addressing cultural issues? 3) Does a strengths-based approach to cultural topics influence the therapeutic alliance?

## **Organization**

The following Literature Review outlines the constructs of Multicultural Competencies and Strengths-Based approaches in psychotherapy, as well as examining their complementary niches within the pantheon of counseling psychology. The extant as well as conspicuously-absent research on client-based perspectives regarding MCC is additionally examined, focusing on the ethical, theoretical, and technical benefits of incorporating qualitative feedback from clients in this vein of research.

Next, an account of the methodology utilized in this study is presented. Per the recommendations for Qualitative approaches, this section includes an examination of the ways in which power dynamics of the research team and the interviewer and participants were managed; highlights and challenges of the consensus-building process; and measures taken to improve the trustworthiness of the data-gathering and analytic processes, among

other quality markers of the CQR protocol.

A review of the results follows, including the domains, categories, and sub-categories most pertinent to the guiding research questions of the project. While a full accounting of all data gathered was beyond the scope of this study, the frequency table in the Appendices (please see Table 2 in Appendix E) includes the frequency counts of all domains. Analysis of the results are frequently presented alongside direct quotes from the participants to illustrate the original context that engendered the analytical results.

Lastly, a discussion of the results and the process is offered. This section includes an examination of the strengths and limitations of the study as well as recommendations for future researchers in this area of inquiry.

## CHAPTER 2

### Literature Review

#### Multicultural Competence

Multicultural competence as a driving force in Counseling Psychology arose largely in response to increasingly unambiguous documentation of the “widespread ineffectiveness” (Sue, Arredondo, & McDavis, 1992) of orthodox counseling techniques in working with clients from racial and ethnic minority backgrounds (Casas, Ponterotto, & Gutierrez, 1986; Hayes, Owen, & Bieschke, 2015; Ibrahim & Arredondo, 1986; Lee, Martins, Keyes & Lee, 2011). As social scientists in general and exponents of the movement in particular have noted, the increasingly multi-ethnic constitution of the U.S. virtually demands that North American counselors be prepared to work effectively with clients from a wide array of populations, and in 1973 the American Psychological Association (APA) identified the provision of multiculturally competent mental health services as an “ethical imperative” (Ridley, 1985).

While previous generations of research and application did not entirely bypass the challenges and opportunities of an increasingly ethno-racially diverse society, these developments had historically been couched in the dichotomous rhetoric of assimilation versus pluralism (Johannes & Erwin, 2004; Nguyen & Benet-Martinez, 2010), giving rise to a primarily ideological debate that offered little in the way of “on the ground” skills for counselors seeking to enhance the effectiveness of their work with Racial and/or Ethnic Minority (REM) clients. As Sue (1998) observed regarding the emerging alternative: “multicultural competence is less controversial...how can one argue against *competencies* of any kind?”



The APA concurred, and in 2008 their Task Force on the Implementation of the Multicultural Guidelines produced recommendations for infusing MCC throughout all levels of the field of psychology, from policy to practice (APA, 2008). Consequently, while the precise nature and effective application of MCCs remains somewhat abstract, most contemporary professional organizations and training programs acknowledge their important role in providing ethical and effective psychotherapy to a diverse population of clients (Dietz et al., 2017; Gillem et al. 2016; Vera & Speight, 2003).

Since the introduction of formally organized MCC by Sue et al. in 1982, the concepts have been continuously refined and redefined by each generation of researchers while still largely hewing to the originally-presented tripartite arrangement. Rather than identifying them as categories, Sue et al. articulated three dimensions of multicultural competence in reference to cross-cultural counseling with REM clients<sup>1</sup>: 1) Attitudes & Beliefs; 2) Knowledge; and 3) Skills. According to Sue (2006), the most accurate and widely used definition of this conceptual framework is as follows, from D. W. Sue, Ivey, and Pedersen (1996): “*Attitudes and Beliefs*: Provider’s sensitivity to her or his personal values and biases and how these may influence perceptions of the client, client’s problem, and the counseling relationship. *Knowledge*: Counselor’s knowledge of the client’s culture, worldview, and expectations for the counseling relationship. *Skills*: Counselor’s ability to intervene in a manner that is culturally sensitive and relevant.”

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<sup>1</sup> Notably, most contemporary MCC research advances the position that multiculturalism is a construct inclusive of all dimensions of identity, including gender, religion, age, socio-economic status, and many others (Pope-Davis et al., 2001; Hardy & Bobes, 2016). Similarly, multiculturally-informed counseling is generally viewed within the field as best practice for counseling regardless of the cross- or mono-cultural arrangement of the therapeutic dyad (Arredondo & Toporek, 2004). Nevertheless, Sue’s original inception of multicultural competencies in reference to cross-cultural counseling with Visible Racial Ethnic Minority Groups is used here in order to enhance clarity regarding the relevant terms of this analysis.

Numerous researchers have endeavored to expand on this model—perhaps most notably, Sadowsky et al. (1998), who lobbied vigorously for the inclusion of a fourth dimension of “*Multicultural Counseling Relationship*,” a construct which insistently reappears under various guises across several generations of the research, perhaps indicating its salient yet ineffable nature. However, the original three concepts have remained the most consistent benchmarks across decades of research in assessment, training, implementation, and measurement of MCCs.

In their bellwether “Call to the Profession” manifesto, Sue, Arredondo & McDavis (1992) foregrounded the need for definitional consilience, rigorous assessment, and applied standards to ground this burgeoning pursuit of multicultural competence in empirical evidence. They also expanded the aforementioned framework by emphasizing the importance of a dynamic and contextually-attuned interpretation of each term. In the first dimension (Attitudes & Beliefs), they noted the role of attending to intersubjective reflexivity in preventing (or at least ameliorating) ethnocentrism in the counseling relationship. With regard to the second dimension (Knowledge), they highlighted the key role of flexibility and a nonjudgmental stance in pursuing understanding of the worldviews of culturally different clients: without requiring agreement with those worldviews, it is essential that counselors communicate “respect and appreciation” for their client’s way of being—a caveat that clearly holds particular significance for strengths-based approaches to counseling. Lastly, they emphasize the importance of sensitively matching modalities, language, and goals to the values and lived experiences of the client when applying interventional and technical skills within a cross-cultural therapeutic relationship. A quarter-century after Sue et al.’s (1992) hortatory vanguard, consilience regarding definitions, standards, and measurement continues to elude the field, yet substantive gains have been made in further investigating these

concepts as they apply to a variety of populations and contexts.

Ambiguities in the operationalization of multicultural competencies have resulted in an abundance of notably varied assessment approaches. Broadly, these can be organized into two categories: direct and indirect measures. The former assesses constructs within specifically-defined models of MCC and include foci on characteristics specific to individual counselors (Worthington, Mobley, Franks, & Tan, 2000), skills & techniques (Sue & Sue, 2012), and broad process measures (Sue et al., 2009). Direct self-report measures of MCC include the Multicultural Counseling Knowledge & Awareness Scale (Ponterotto, Gretchen, Rieger, & Austin, 2002); the Cross-Cultural Counseling Inventory (LaFromboise, Coleman, & Hernandez, 1991); and the Multicultural Awareness, Knowledge & Skills Survey (D'Andrea, Daniels, & Heck, 1991).

Indirect measures more often assess conceptual correlates of therapist's MCCs. These include measurement of constructs that are "parallel" to MCC, such as cultural humility (Cultural Humility Scale; Hook, Davis, Owen, Worthington, & Utsey, 2013), and those that are antipodal, such as micro-aggressions (the Racial Microaggressions in Counseling Scale, Owen, Tao, Imel, Wampold, & Rodolfa, 2014). The latter are conceptualized for assessment purposes as inverse indicators of MCCs, inasmuch as that counselors who exhibit a higher frequency of racial microaggressions are more likely to be deficient in at least one if not all of the classic competency domains (Owen et al., 2011).

For all the heterogeneity in measurement approaches, there does appear to be consensus with regard to the findings that MCC improves service delivery across a variety of populations and treatment contexts. A meta-analysis by Tao, Owen, Pace & Imel (2015) encompassing 20 independent samples and 53 effects yielded "strong and positive effects" of the measures of client-perceived therapist MCC on core clinical processes (with correlations

reaching from .58 to .72 across measures), as well as a “moderate” relationship ( $r = .29$ ) between indicators of MCC and client outcomes. Responding directly to Kleinman & Benson’s (2006) demand for empirical evidence that “culture really improves clinical services,” (p.1673) Tao et al. conclude that therapist’s MCC “should be considered an important empirically supported therapeutic relational factor,” placing it within the same category as working alliance, goal consensus and collaboration, and empathy, among others (Elliott, Bohart, Watson, & Greenberg, 2011; Horvath, Del Re, Flückiger, & Symonds, 2011; Norcross & Lambert, 2011).

While this analysis provided a much-needed consolidation of the existing process-oriented research on MCCs, the authors observe that their findings only serve to illuminate the dearth of skill-based interventional and behavioral details of client-perceived assessments of MCC, querying: “What exactly are providers doing in sessions? For MC psychotherapy research to progress, a greater willingness to wade into the raw data of actual counselor–client interactions is required” (p.346). Not only is tremendous nuance lost as a result of the categorical nature of the assessment instruments, it is also unclear to what degree clients are typically capable of recognizing the manifestation and impact of MCC on their services without prompting (Ridley & Shaw-Ridley, 2011), as well as the capacity of researchers to frame MCCs in ways that are accessible and meaningful to client-participants. For example, intra-class correlations of MCC ratings of therapists by multiple mutual clients indicated significant disagreement regarding both the therapist’s perceived competence and the definitional clarity of the measurement terms (Owen & Leach, et al., 2011).

While more voluminous and clearly-defined research exists on therapist self-reports of MCC, the instruments associated with this vein of research have been widely critiqued for their subjectivity as well as their notable vulnerability to socially desirable responding

(Constantine & Ladany, 2000; Worthington et al., 2000). For example, analyses of the correlation between observer and therapist self-report ratings of therapist MCC yielded non-significant results (Constantine, 2001), while Fuertes et al. (2006) similarly found a nonsignificant relationship between the self-report rating of therapist MCC and the ratings of their clients. These findings suggest that only incremental additions to the empirically-validated research on MCC have accrued since Ponterotto et al.'s (1994) lament at the crest of the Multiculturalism movement's ascendance that the current instruments and assessments were as yet insufficient for advancing its cause.

Furthermore, the majority of the research that has been gathered on therapist MCC beyond self-report measures has been collected via analogue and convenience samples, raising doubts as to the external validity of such findings (Fuertes & Brobst, 2002; Worthington et al., 2007). Numerous researchers examining the vulnerabilities of these instruments have expressly called for methodologies that utilize real client populations and collect data that capture *in situ* MCC skills and effectiveness as perceived by clients and/or observers (Ang & VanDyne, 2015; Arredondo et al., 2006; Constantine, Miville, & Kindaichi, 2008; Constantine, Kindaichi, Arorash, Donnelly, & Jung, 2002; Gillem et al, 2016; Ratts et al., 2016; Tao et al., 2015). Consequently, support for mixed-methods and qualitative approaches to capturing client-side and process-oriented data on therapist MCC has been emphatic (Constantine & Ladany, 2000; Hays, 2008; Holcomb-McCoy & Myers, 1999; Ponterotto, Rieger, Barrett, & Sparks, 1994; Worthington et al., 2000), and Ponterotto et al. (2002) specifically called for nontraditional methods of inquiry, including “qualitative research using phenomenological, grounded theory or consensual qualitative research methods.”

To date, the best-known study answering this call comes from Pope-Davis et al.'s

(2002) Grounded Theory analysis of qualitative client interviews, which was used to generate a dynamic interaction model of client perceptions of and responses to therapist MCC in cross-cultural dyads. In rationalizing the use of grounded theory for the study, the authors observed that any method used to divine truly new and useful information regarding client perspectives would have to circumvent the *a priori* assumptions of MCC categories embedded within the instruments and interviews by the researchers, who were so steeped in the traditional academic conceptualization of MCC that they were unlikely to be able to transcend this useful but possibly limited paradigm. Invoking critiques by Atkinson & Wampold (1993) and D.W. Sue et al. (1992), they note that “when researchers set forth certain theoretical ideas to be measured, the only option for clients is to endorse or not endorse those ideas” (p.360).

The findings from the Pope-Davis et al. (2002) study added considerable dimensionality to the classic MCC framework in the form of the “Client Strategic Interaction Model,” an interpolated cycle of reinforcing influences incorporating Client Processes, Client Appraisals, Client Characteristics, and Client-Counselor Relationship (please see Appendix D for graphic model). The authors noted that while the traditional framework established a useful foundation for counselors, a more dynamic, nuanced, and client-centered approach was likely a necessary complement to the tripartite conceptualization in order to incorporate MCC into therapy in a truly global yet also individually-attuned manner. While many of these elements are by definition specific to the client and the client-therapist relationship, several specific findings from the Pope-Davis et al. study point to “critical ingredients” in those therapeutic relationships which clients found most satisfying with respect to MCC. This was especially true with regard to factors that enhanced the client’s sense of agency, safety, and confidence in processing cultural topics and issues in therapy.

One of the emergent themes in this vein—and one with particular relevance to a process-focused approach to MCC—was that clients themselves were far more active arbiters in negotiating the role of cultural exploration in therapy than expected or previously documented. Underlining the aforementioned critiques of MCC instrumentation that focused on therapist perspectives at the expense of acknowledging client agency and perception, Pope-Davis et al. concluded on the basis of the client interviews that truly multiculturally competent therapists were those that cultivated a relationship in which the client perceived that it was both permissible and welcome for them to explore a nuanced and multidimensional concept of themselves as cultural beings. The authors note that “the counselor’s role in this process may be to create an environment in which clients feel that the totality of their experience is welcomed and relevant in addressing their presenting issue...this goal may be achieved, in part, by communicating some understanding of the role of culture, affirming of the salience of clients’ various identities, and assessing and describing the presenting problem within a cultural context” (p.388).

This finding aligns with a smaller body of literature within MCC research highlighting clients’ positive appraisals of therapists who acknowledge the “totality” of their experience. Beyond the standard admonitions to avoid the “cookbook” approach in automatically applying academic knowledge of discrete or categorical findings on specific REM groups to individuals without the therapeutic attunement and dynamic sizing (Sue, 1998) required to calibrate its “fit” with the individual, clients expressed a particular appreciation for the multicultural acumen of therapists who actively sought and facilitated a “big picture” view of their cultural selves.

While it is a niche body of research, Pomales, Claiborn, & LaFromboise (1986), Pope-Davis et al. (2001 & 2002), Sadowsky et al. (1998), and others consistently found that

clients tend to perceive counselors in cross-cultural dyads as being more competent, credible, and trustworthy when the counselor communicates an interest in their “holistic experiences as cultural beings,” (Constantine, Miville, & Kindaichi, 2008) recognizing more nuanced and multidimensional aspects of their cultural heritage than the broad strokes communicated by textbook knowledge of a particular population. These findings are particularly relevant to a strengths-based approach to MCC, which expressly seeks to provide a more balanced, voluminous, and thorough view of a client’s cultural inheritance and influence than those which focus more narrowly on the challenges faced by REM individuals (please see below for an extended review of strengths-based approaches).

A related notable finding from the Pope-Davis et al. (2002) study with similar relevance to a strengths-based approach addressed the themes of Power and Equality in the therapeutic relationship. Clients who perceived that they were “on equal footing” with their therapist were less inclined to prematurely terminate (or passively withdraw from) therapy when concerned that their therapist had misunderstood or overlooked important cultural issues and were instead more likely to provide constructive feedback that facilitated a repair in the alliance and consequently a more rich and sustainable orientation to the therapeutic relationship.

This finding aligns with a body of literature from social work and other allied fields in which a solution-focused approach is taken in working with clients from exploited and disadvantaged backgrounds with the express intention of “shifting the balance of power in the therapeutic relationship, [and] acknowledging clients as knowers of their experiences” (Lee, 2003, p.389) in order to mitigate the disempowerment experienced by these clients in the larger world and at times re-enacted within psychotherapeutic frameworks that are less collaborative and egalitarian (Berg & Miller, 1992; Franklin & Moore, 1998). It may be the



case that a strengths-oriented approach would contribute to a sense of equality, particularly in cross-cultural dyads in which the therapist's visible identities represent a historically oppressive group or groups and the client's salient identities represent a historically oppressed group or groups. While focusing on challenges faced by the client could reinforce the dynamics of power and privilege within which these dyads are already socio-politically framed (Conoley, Morgan Consoli, Zetzer, Hernandez, & Hernandez, 2015), an emphasis on strengths may help to "even the playing field."

When considering clients as active co-constructors of MCCs, an especially relevant point comes from Sue & Zane's (2009) critique of current approaches to MCC. Among other proposed reformulations, the authors note that the current guidelines focus on theoretical and abstract dimensions of competencies at the expense of treatment skills and procedures. In particular, they identify "credibility" and "gift-giving" as skill-based components that provide positive, galvanizing signals to the client regarding the therapist's multicultural competence. Briefly, Sue & Zane define these strategies as follows: "Credibility refers to the client's perception of the therapist as an effective and trustworthy helper. Giving is the client's perception that something was received from the therapeutic encounter. The client has received a 'gift' of some sort from the therapist" (p.7).

The authors themselves note that these two strategies are by no means novel to the field or exclusive to the realm of MCC: they overlap considerably with well-known Common Factors such as Faith, Expectancy, Trust, and Effectiveness (Budge & Wampold, 2015; Lin, 2016; Ottens & Klein, 2005). They are, however, especially relevant in the context of providing therapy to REM clients due to the understandable apprehension and skepticism with which many such clients view the process of psychotherapy and by extension, therapists themselves—particularly in the case of cross-cultural dyads (Sue, 2013; Sundberg, 2013).

The skill of Gift-Giving is especially relevant in a strengths-based approach to multiculturally competent counseling because a recognition of client strengths is indeed one of the pre-eminent gifts identified as a classic early-session intervention to establish the client's sense of trust and investment in therapy (Lettenberger-Klein, Fish, & Hecker, 2013; Sue, 2006; Sue & Zane, 2009). At the heart of such interventions is the induction of a sense of hope and faith in the client of their ability to overcome their presenting problems, as well as an opportunity to build rapport through the therapist's expression of a positive, affirming, and multidimensional perspective towards the client (Sue, Zane, Nagayama Hall, & Berger, 2009).

An important caveat here is the critical role of dynamic sizing in determining whether a reflection or exploration of strengths is congruent with the client's self-concept and expectations for therapy: emphasizing strengths in an initial encounter with a client whose cultural background prizes modesty, for example, could prompt considerable discomfort and potentially create a rupture or termination of treatment (Leong & Lee, 2006). Consequently, an examination of cultural strengths and the potential benefits, considerations, and roles of a multicultural strengths-based approach to therapy follows.

### **Culturally Contextualized Strengths**

While there are a number of well-studied and thoroughly-indexed individual strengths documented in the literature of positive psychotherapy (Louis & Lopez, 2014; Peterson & Seligman, 2004), research on how the development, identification, and execution of strengths manifests within the overlapping spheres of identity, culture, development, and other macro-level contextual arenas is in its infancy. The majority of the present research in this area addresses immediate environments at the individual level (Quinlan et al., 2012), while recent

studies have just begun to probe the embedded and dynamic nature of strengths within a developmental and cultural context rather than looking at process and context factors within narrowly-circumscribed life domains (e.g. Gillham et al., 2011; Proctor et al., 2011).

For example, Theron et al. (2012) notes that the distinction between inter- and intra-personal strengths in resilience research highlights the recognition that resilience is a “culturally congruent, bidirectional process between children and their environment.” The research that has been conducted in this area highlights the importance of conceptualizing strengths with consideration to both internal and external factors influencing the fluctuating trajectory of development and expression, as well as the benefits of reinforcing these strengths over time and across different life roles and contexts (Bonnano, 2004; Owens et al., 2018).

Given the relative paucity of psychotherapy research on the construct of cultural strengths and adjacent concepts, a broad definition of strengths taken from Owens (2011) and adapted to reflect an emphasis on client culture is used for the purposes of this study: positive cultural traits, skills, or resources that promote optimal functioning.

### **Multicultural Strengths-Based Approaches to Therapy**

A strengths-based approach to therapy is consonant with the foundational identity of counseling psychology in its commitment to advance social justice causes (Constantine, Hage, Kindaichi, & Bryant, 2007; Toporek & Williams, 2006; Vera & Speight, 2003), as well as a direct expression of the field’s dedication to psychotherapeutic approaches that acknowledge, affirm, and mobilize client’s cultural resources (Dispenza et al., 2016; Grothaus, McAuliffe, & Craigen, 2012; Riggle et al., 2011). Gelso & Woodhouse (2003) observe that “the field of counseling psychology, from its inception, has been deeply invested

in the concept of the psychological strengths and assets of people,” highlighting this identity as an exemplification of Super’s (1977) assertion that professionals in more traditional models of psychotherapy orient to “what is wrong and how to treat it, whereas counseling psychologists look for what is right and how to help use it.”

More recently, the field of positive psychology has sought to expressly incorporate cross-cultural considerations into its hallmark emphasis on resource activation, personal strengths, and increasingly, cultural assets (Pedrotti & Edwards, 2014). The 2017 update to the APA’s Multicultural Guidelines (“An Ecological Approach to Context, Identity, and Intersectionality”) advance this call in Guideline 10, which is summarized as “Psychologists actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context” (p.88).

In many senses, the strengths-based approach is also at the heart of counseling psychology’s differentiation from the deficit-based model associated with culturally-*incompetent* treatment models of previous eras (Oades et al., 2016; Smith, 2006), and from the more pathology-grounded diagnostic approach inherited from Psychology’s roots in the Medical Model, which can give rise to narrowly circumscribed and deficit-focused client conceptualizations (Clauss-Ehlers & Weist, 2004; Magyar-Moe, Owens, & Conoley, 2015). In this respect, a therapeutic focus on both individual and cultural strengths is particularly salient to clients from REM minority backgrounds precisely because the field of mental health has historically often maligned these cultures when not marginalizing them entirely (Domínguez, Bobele, Coppock, & Peña, 2015; Sheely-Moore & Kooyman, 2011; Vera & Speight, 2003). The initial consolidation of the movement towards multiculturalism in counseling psychology emerged in part from the observations by early theorists that many of

the assumptions of orthodox therapy models were founded on “inherent biases” (Smith, 2006) towards clients from REM cultures and that these models not only minimized the contributing role of societal injustices to exacerbation of mental health symptoms (Padilla, Cervantes, Maldonado, & Garcia, 1988; Parham & Helms, 1981), but obscured the psychological assets that had allowed these minorities to survive despite such adversities (Ponterotto & Casas, 1991).

APA’s Multicultural Guidelines (2017) exhort psychologists to utilize a strengths-based approach that acknowledges and validates these struggles while also highlighting positive ways in which oppressed individuals and communities have promoted their well-being, flourishing, and in particular, resilience. While reminding psychologists of the importance of acknowledging clients’ historical and community trauma, this exhortation underscores the potential proclivity of the psychologist to focus on trauma or vulnerabilities to the exclusion of strengths, despite the well-established body of literature demonstrating that dispositional and cultural strengths, such as resilience, often remain quite robust in the face of significant adversity (Clauss-Ehlers, Yang, & Chen, 2006; Nicolas, DeSilva, Grey, & Gonzalez-Eastep, 2006; Seligman & Csikszentmihalyi, 2000).<sup>2</sup>

One of counseling psychology’s largest contributions to the field during the ascent of the multicultural movement was to position cultural strengths as the keystone of conceptualized client protective factors (Sue, Arrendondo, & McDavis, 1992), and to advance a recognition of the healing properties of culture itself (“*La cultura cura*,” Hurtaldo,

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<sup>2</sup> A particularly illustrative example of this encouraging phenomena can be found in Roysircar et al’s (2015) study examining Haitian children in the wake of a series of profoundly traumatizing events: more than half of the participants returned higher resilience scores than vulnerability scores in spite of exposure to continuous re-traumatization events in a short period of time.

2000). Sue et al. (1992) identify a strengths-focus as one of the most powerful vessels of the multicultural movement's ultimate sociopolitical aspirations at the level of paradigm, insomuch as that it held the promise of "a powerful means of combating stereotypes and correcting biased studies...[highlighting] the positive attributes and characteristics of minorities as well as biculturalism...and [representing] biculturalism as a positive and desirable quality that enriches the full range of human potential." (p. 479) Clearly, a focus on client cultural strengths is not only the birthright of counseling psychology, but an inseparable element of its commitment to multiculturalism.

Nevertheless, critics have observed that despite the devotion to a focus on client strengths principle to the field's identity, many practitioners who identify as Counseling Psychologists fail to incorporate this commitment in their applied work (Gelso & Woodhouse, 2003; Harris, Thoresen, & Lopez, 2007; Lent, 2004). Indeed, Gelso & Fassinger (1992) once identified a conceptually global orientation to client strengths as "counseling psychology's unfulfilled promise" (p. 275).

As Owens & Woolgar (2018) point out in their proposal for a diagnostic impressions model incorporating a balanced view of strengths and vulnerabilities, it is not enough to desultorily incorporate strengths-focused interventions into sessions from time to time: for a true paradigm shift in the field away from the negative bias (Wright, 1988) and monocultural assumptions that can hamper client well-being and occlude clarity of clinician insight into client cases, a cultural focus and strengths-orientation must become inextricable aspects of the assessment, conceptualization, and treatment planning processes. In fact, while a wide variety of psychotherapeutic orientations both within and adjacent to the guild of counseling psychology often include reflection and exploration of client strengths as a potential therapeutic skill, few approaches expressly foreground client strengths as a primary

component of the treatment model: therapies based in Positive Psychology are chief among those that do (Harbin, Gelso & Pérez-Rojas, 2014; Magyar-Moe, Owens & Scheel, 2015; Rashid, Howes & Louden, 2017; Rashid, 2015).

A qualitative study published in *The Counseling Psychologist* remarked on this paradigmatic consilience between the identity of Counseling Psychology and the practice of Positive Psychotherapies and emphasized the need to create a more systematic approach to incorporating client strengths into counseling interventions. These authors defined the strengths-based approach as including the following skills and intentions: “to broaden client perspectives and create hope and motivation, to create positive meanings through reframing and metaphors, to identify strengths through the interpersonal therapeutic process, to match client contexts through strengths, and to amplify strengths through encouragement and exception finding” (Scheel, Davis, & Henderson, 2013, p.1).

Gelso & Woodhouse (2003) further refine the application of client strengths in therapy by noting that while general attention to clients’ strengths & resources fall under the broad umbrella of “positive therapeutic processes,” specific strengths-based interventions can be categorized as a process of either therapist conceptualization or enactment. Strengths-based conceptualization includes attending to and actively acknowledging client’s resources alongside their deficits and includes points such as interpersonal strengths revealed through the therapeutic process; strengths developed from or embedded within challenges or deficits; and daily expressions of internal and external client resources. Notably, the researchers emphasized “empathy to understand client strengths and the client’s culture as a mediator of the meaning and expression of strengths” as a critical ingredient in the strengths-based conceptualization process.

Strengths-based therapist enactments, by contrast, involve discrete interventions that

leverage client strengths as an element of the change process. These include reflecting noted strengths to the client (including progress made in counseling), pointing out strengths that are interpolated within defenses or deficits, positive reframing of perceived weaknesses as strengths that are inconsistent with the client's current goals (particularly those that were adaptive in an earlier context but have become maladaptive in current circumstances), and pointedly, "interpretation of a strength within one cultural context but not another" (Gelso & Woodhouse, 2003).

A panoply of both classic and current process/outcome-based research attests to the utility of incorporating client strengths into psychotherapy in the aforementioned manners (Duckworth, Steen, & Seligman, 2005; Fitzpatrick & Stalikas, 2008; Orlinsky, Rønnestad, & Willutzki, 2004). With an express focus on clinical outcomes, utilization of strengths is associated with benefits ranging from increased well-being, functioning, and decreased stress (Lavy, Littman-Ovadia, & Bareli, 2014; Wood, Linley, Maltby, Kashdan, & Hurling, 2011), among other broadly salutary psychotherapy outcomes. While it has also long been recognized that amplifying and explicitly incorporating client strengths into psychotherapy is helpful in enhancing cooperation, "buy-in" for therapeutic processes, and compliance with treatment recommendations (Conoley, Padula, Payton, & Daniels, 1994; Rashid, 2015; Scheel, Seaman, Roach, Mullin, & Blackwell-Mahoney, 1999), more recent research has spotlighted some of the specific processes and outcomes associated with a strengths-focused approach.

Flückiger et al. (2009) conducted a pairwise matched control group design which examined specific "pathways" of client strengths activation in CBT and concluded that this approach served as a "global intervention strategy" predictive of a cascade of positive change processes including enhanced self-esteem, clarification of goals and self-concept, and



experiences of mastery. This research builds on previous findings indicating that establishing a strengths-focus early in therapy is predictive of positive outcomes for diverse client populations, treatment settings/approaches, and symptoms, including social phobia (Willutzki, Neumann, Haas, Koban, & Schulte, 2004) depression (Hayes et al., 2007), and hope therapy with a community sample (Cheavens, Feldman, Woodward, & Snyder, 2006). The latter two studies each indicated that strengths-based interventions were associated with hope-induction, while Flückiger et al. (2009) identified further associations with enhanced therapeutic alliance and increased openness to examining aversive and maladaptive personal tendencies (i.e. “problem actuation.” Smith & Grawe, 2005). Consequently, Flückiger et al. (2009) posited that strengths-focused approaches were—contrary to previous critiques—more than an “unspecific and inconsistently curative factor” (Renaud et al., 1998), and could in fact be classified as a therapeutic strategy on a superordinate level (Castonguay & Beutler, 2006; Castonguay & Grosse Holtforth, 2005).

While a therapeutic focus on strengths clearly offers tremendous promise as an overarching interventional approach for a heterogeneous array of client populations, a number of caveats accompany such findings, particularly with respect to REM clients. On one hand, numerous researchers identify a strengths-based approach as especially beneficial for clients from REM backgrounds precisely because their marginalized position within a profoundly disempowering majority culture inherently and often aggressively obscures and undermines their cultural strengths (Bryant-Davis & Tummala-Narra, 2017; Hays, 1995; Petkari & Ortiz-Tallo, 2016; Rainey & Nowak, 2005; Smith & Silva, 2011; Tate, Rivera, & Edwards, 2015). Indeed, the ability of minority populations to not only survive but often flourish within an undeniably hostile majority-culture context has been roundly identified as an indication in itself of tremendous reservoirs of psycho-social strengths and thus a primary

target for amplification in treatment (Constantine et al., 1999; D'Andrea, 1999; Lopez et al., 2002; Hanna, Talley, & Guindon, 2000).

In particular, the ability of the strengths-based approach to capitalize on pre-existing cultural assets has been highlighted as an affirming and emancipatory process in itself. As Teater (2014, p.182) notes: “a focus on client strengths fully utilizes the indigenous, culturally based resources and strengths available within the client’s socio-cultural milieu. It is respectful of cultural differences in developing an empowering, collaborative, therapeutic search for viable solutions to a client’s difficulties.”

Examples of cultural strengths that have been identified as moderators, mediators, and predictors of positive mental health outcomes for REM clients include *familismo* as a significant buffer of eating disorders among acculturating Mexican-American women (Bettendorf & Fischer, 2009); *Respeto*, *Religiosidad*, and Traditional Gender Roles as predictors of Resilience among Mexican-American college students (Morgan Consoli & Llamas, 2013); and Ethnic Identity as a protective factor against substance use for both Puerto-Rican and African-American adolescents (Brook et al., 1998a; Brook et al., 1998b).

On the other hand, serious concerns have been broached about the viability of cross-cultural “translations” regarding what constitutes a client strength, as well as the appropriate timing and delivery of strengths-based intervention, given the wide variability in cultural conceptions of the nature and purpose of psychotherapy. Cautions abound in the cross-cultural clinical assessment and treatment literature regarding the substantive variability in self-construal both between and within REM groups, and a client-led approach in gathering and analyzing this information is widely regarded as paramount for ethics and effectiveness (Oyserman, Koon, and Kimmelmeier, 2002).

Accordingly, Sue & Constantine (2003) emphatically caution against a monolithic

rendering of client strengths based on the indices derived from European-American client samples, as such “transplanted” definitions are indivisible from the cultural context from which they emerged and are subsequently unlikely to represent the values of minority clients with any significant fidelity. Prototypical examples of the clinical gaffes that can result from such culture-blind approaches to working with client strengths often feature misapplications based in relational orientation (Wong et al., 2006). In such instances, a therapist from an individualistically-oriented culture that prizes autonomy, personal achievement, and self-efficacy over communal cooperation might engender considerable client confusion and mistrust when attempting to amplify such culture-bound “strengths” while working with a client from a more collectivistic culture, who might consider such features not only irrelevant but perhaps fundamentally undesirable (Sandage et al. 2003; Constantine and Sue 2006).

The corollary of such misapplications of majority-culture strengths is a failure to recognize the culture-consonant strengths of the REM client; strengths which may in turn appear unimportant or even objectionable to a majority-culture counselor overly-focused on an orthodox profile of individualistically-oriented client strengths derived from a European-American population. Examples of such oversights abound in the literature on prominent Latinx cultural strengths, which include a pronounced appreciation for self-sacrifice and submissiveness (Arredondo, 2002); strong endorsements of allocentric features such as conformity and personal interdependence (Marín & Marín 1991); and a veneration of *simpatia*, behaviors that promote harmony through non-confrontational relational strategies (Delgado-Romero et al. 2013). A culturally-grounded, client-centered process of assessing what constitutes a strength to the client may be a critical means of highlighting and consequently disrupting the conscious and unconscious biases of their majority-culture clinician (Capielo, Mann, Nevels, & Delgado-Romero, 2014).

A broader but similarly noteworthy concern lies in one of the more common critiques of positive psychotherapeutic approaches in general: that focusing on the strengths, resources, and positive experiences of disadvantaged populations may be perceived as trivializing the tremendous challenges that they face in both everyday life and their efforts to improve their mental health within the context of a fundamentally oppressive and racist society (Christopher & Hickinbottom, 2008; Christopher, Richardson, & Slife, 2008; McDonald & O'Callaghan, 2008; Miller, 2008; Sundararajan, 2005; Yen, 2010). While there appears to be a dearth in the literature of direct substantiation of this concern from the client side, the logic is compelling and the implications align with findings from general client populations that there are clearly instances in which a focus on strengths can be experienced by clients as mis-attuned or insensitive.

According to a qualitative investigation of strengths-based interventions in therapy, these include cases in which clients were “more intensely influenced” by their problems, and clients who were experiencing crises (Scheel, Davis, & Henderson, 2013). A separate body of research notes that even though strengths-based approaches have been identified as effective treatment models for individuals with moderate depression, these same approaches may not be effective with actively suicidal populations, and that in fact a deficit-based approach is more appropriate in these cases. One hypothetical rationale for this finding is that attending to strengths with suicidally-depressed individuals may exacerbate symptoms by drawing attention to the dissonance between desired and current states of self-concept (Wingate, Van Orden, Joiner, Williams, & Rudd, 2005).

Taylor (2006) similarly warns that over-relying on a strengths-focus without a complementary emphasis on medical treatment in cases of severe psychiatric symptomatology—including active, intense suicidality or paranoid delusions—could

dangerously downplay the risks of such conditions and potentially promote suicide attempts or medication noncompliance. Clearly, the potent promise of a strengths-based approach must be balanced with an appreciation for the potential costs of its misapplication.

## CHAPTER 3

### Methodology

The study utilized a Consensual Qualitative Research model design (CQR; Hill, Thompson, & Williams, 1997) to obtain and analyze perceptions of strengths-based exploration of client culture in therapy from the client's perspective. As Burkard et al. (2006) observed in a related study on therapist self-disclosure, "CQR affords the researcher an opportunity to understand more fully the inner experiences of participants, providing a more complete picture of the phenomenon under investigation" (p.5). CQR's relevance in examining constructs that are relatively unknown or poorly-understood was a similarly compelling factor in selecting this approach (Creswell, 2013). The structure and methodology of the study is based on Knox, Hess, Petersen, & Hill's (1997) CQR study of effects of therapist self-disclosures as reported by clients, as this provides a relevant approach to examining the therapy process variable of client perceptions of both discrete and ongoing therapy events.

Per the rationale outlined in the Literature Review, the preponderance of research in this area of psychotherapy has been collected from clinicians rather than clients, and the data that has been solicited from the client perspective has typically been limited to more categorically-oriented collection methods, such as survey or short-answer formats. These quantitative formats run the risk of artificially compressing or otherwise over-simplifying participant responses on complex topics that resist compaction into nominal and ordinal categories, such as explorations of intersecting identities (Grzanka, 2014). Thus the selection of CQR as the method of inquiry for this study aligns both with Ponterotto's (2002) recommendations for the use of qualitative methods in general in cross-cultural process

research, and specifically with the initiative to improve upon past efforts in this research area by allowing more nuanced, voluminous, and consequently “thick” descriptive (Geertz, 1973) results as an exploratory study of a complex and caliginous topic.

CQR analysis requires a team of individuals working together to ascertain themes that are identified and verified through a non-hierarchical consensus-building process. The prototypical structure of the process as described by Hill et al., (2012) is as follows: data is collected from participants via interview, then transcribed before being sorted into broad thematic Domains (Domaining), after which the raw data is distilled by the team into Core Ideas (Coring), which are then further differentiated into internal Categories and Sub-Categories (Cross-Analysis). An External Auditor who is kept separate from the consensus-building meetings reviews the material at each juncture of the analytical process in order to provide a check on potential “GroupThink” effects, and to generally provide an additional perspective and feedback on the process (Schlosser, Dewey, & Hill, 2012). The last step in the sequence entails the construction of a Frequency Table that summarizes and sorts the findings into a format that allows a quantitative reference point for the relative prevalence of the identified themes.

Each phase of analysis requires consensus from the full team, and one round of analysis will often generate conclusions that prompt the team to return to an earlier phase to review and—if relevant—reconstruct their original Core Ideas, Domains, Categories, or Sub-Categories in order to accommodate these emergent findings. In this way, similar to many qualitative approaches, CQR is often more iterative than linear, and frequently requires minor adjustments from the standard protocol in order to accommodate the idiosyncrasies of the phenomenon under study (Levitt et al., 2018). Consequently, a more detailed description of

the CQR process as it was conducted by this research team is warranted for clarity and context.

### **Recruitment & Participant Selection Process**

Participants were recruited via the subject pool platform (SONA) used by the research team's university and was thus made accessible and known to potential participants via the department's general advertising of its availability as well as via the courses which required students to participate in studies for course credit or offered this option for additional course credit. The SONA system identifies students that are eligible for current studies within the department based on prescreening characteristics. Students who are eligible for active studies based on these characteristics are provided descriptions of the studies to allow them to determine if they would like to either volunteer as a participant or to participate in exchange for course credit. The following questions were used to prescreen students for this study, and required an affirmative response in order for students to participate:

- 1) Do you identify as coming from a racial/ethnic minority background?
- 2) Have you participated in therapy with a white therapist within (approximately) the past two years?

An additional question was included as a general demographic item but was not used as a prescreening item. This item was "While we believe that the construct of gender exists on a continuum, for the purpose of some of the research projects in this pool, we must ask in a nearly dichotomous format the following question: What is your gender identity?"

Students who were eligible for the study based on a positive response to the prescreening items were then provided with the following description of the study, titled "Client Experiences in Cross-Cultural Psychotherapy:"



*In this study, you will meet with a CNCSP Graduate Student for a confidential, audio-recorded interview that will last approximately 30-50 minutes. We are asking open-ended questions about client experiences in cross-cultural psychotherapy.*

*Specifically, we hope to learn more about the experiences of clients from a racial and/or ethnic minority background who have worked with therapists from a racial and/or ethnic majority background (white therapists). The questions are focused on client perceptions of the psychotherapy process rather than on the content of therapy: participants are not expected to disclose information about any symptoms, presenting problems, or any other personal information that may feel uncomfortable to discuss.*

*The purpose of this study is to enhance the quality and effectiveness of psychotherapy for clients from cultural-minority backgrounds. No preparation is required to participate in this study.*

Please refer to Appendix A for the full Recruitment Screening Form.

### **Data Collection**

In order to make the study as accessible as possible to students with a range of transportation options and working schedules, interviews were conducted on campus, and interview slots were offered at various times (as early as 8am and as late as 6pm) throughout the weekdays and weekends across a two-month period. The initial meeting place for the participant and the interviewer was a Student Lounge inside the Applied Psychology Department, selected for its ease of accessibility for students and for its informal atmosphere.

A significant focus for the research team during this time concerned design considerations that would reduce the power distance between the white Graduate Student Researcher and the racial and/or ethnic (REM) undergraduate student participants. This included the development of a protocol dictating that the interviewer wear relatively casual

clothing, meet with the participants in a room with informal décor and seating rather than a laboratory-style office, and offer the participants tea and/or water as a preface to the interview. These social architectural considerations were generated principally through recommendations from the six undergraduate researchers (four of whom identified as REM), based on their perceptions of what factors might reduce perceived power distance and promote feelings of empowerment and openness in the context of an interview with a white graduate student.

After meeting the interviewer in the Student Lounge, the participant and the interviewer moved to a closely-adjacent private office equipped with a noise masking machine to reduce potential participant concerns regarding privacy. The interviewer introduced herself and briefly reviewed the purpose and structure of the study. Informed Consent was introduced and reviewed verbally; the participant was invited to ask questions and express concerns in an effort to ensure that they felt ready to participate and felt empowered to inform the interviewer at any point if they preferred not to answer a question, or if they wanted to end the interview early. Once the participants had verified that they understood and agreed to the terms of Informed Consent and had signed the form, the audio-recorder was activated and the semi-structured interview proceeded. Please refer to Appendix B to review a complete version of the Informed Consent form.

The interview questions started out with open-ended “Grand Tour” questions (Spradley, 2003) about the client’s general experiences in therapy to provide broader context and progressed from broad questions about the course and context of the participant’s therapy/therapist experience(s) to questions about how their intersecting identities and cultural backgrounds were addressed in therapy, whether their cultural background and

cultural strengths<sup>3</sup> were explored in therapy, how they responded to such interventions, their impressions of their clinicians' competence in addressing cross-cultural content in therapy, and their perceptions of an *in vivo* intervention exploring cultural strengths.

A full transcript of the semi-structured interview question template is included in the Appendices (please see Appendix C); the standard questions were frequently modified by elaboration within individual interviews in order to allow participants to contribute relevant, unanticipated commentary on processes related to the research questions. The audio recordings of the interview were immediately transferred to a HIPAA-compliant online storage platform (UCSB BOX), where they were stored while awaiting transcription and analysis. The recordings were preserved after transcription and transcription verification to comply with CQR standards, which encourages researchers to return to the original audio files to assist in building consensus on sections of raw data for which tone of voice and other contextual considerations not preserved by transcription may create conflicting interpretations of the data (Hill, 2012).

## **Data Analysis**

The interviews were transcribed, de-identified, and formatted according to Hill, Thompson, & Williams' (1997) recommendations for optimizing organizational efficiency while maximizing the researchers' exposure to the data. In order to facilitate immersion in the data and thereby the familiarity necessary to detect thematic clusters for analysis (Hill, 2015), each member of the team other than the External Auditor participated in the

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<sup>3</sup> Cultural Strengths were defined for the participants as “any aspects of your culture(s) that you have found to be helpful or enjoyable during your life: this could include beliefs, behaviors, values, traditions, social support networks, spiritual systems, resources, activities, etc..”

transcription process. Every person on the team completed two first-draft transcripts, and then each transcript was reviewed by another team-member who listened to the audio recording and verified that the transcript was complete and accurate, or edited it as warranted to increase accuracy. In accordance with Lincoln & Guba's (1985) recommendation to include "member checking" as a means of enhancing trustworthiness and accuracy of the data, the participants were each notified when their transcript had been completed and verified and were given one month to review the transcript and submit any questions, concerns, or amendments. None of the participants elected to submit any changes to the transcripts.

Every member of the team read each transcript in its entirety while reviewing the "chunked" version of the transcript, in which the raw data was sequentially divided into discrete parcels—usually consisting of several sentences on a particular topic—before being placed into a spreadsheet in preparation for the Domaining & Coring processes. Team members offered feedback regarding whether the chunks accurately preserved the intention of the participant in terms of continuity and cogency, a process which procedurally dovetailed with the construction of Domains.

### **Domaining**

The process of Domaining entails identification of broad thematic categories within the material to organize the content of the interviews. Rather than utilizing the approach in which Domains are generated via a review of the pertinent literature and the interview protocol, the research team chose the more inductive approach to developing domains, in which each researcher reviewed every transcript and discussed as a team which domains appeared relevant across the majority of cases (Thompson, Vivino, & Hill, 2012). This

inductive approach was preferred by the team due to the variability of responses to the interview protocol, as well as the breadth of unanticipated but relevant material contributed by the participants, which may not have been sufficiently captured by domains based on the initial interview questions.

During the initial round of Domaining, the team reached consensus on nine domains, including a “Junk Data” domain which contained pieces of the interview that were consensually-identified as being irrelevant or otherwise “un-codable” for the purposes of the study. During the subsequent Coring process, three additional Domains were generated as the team-members consensually-identified emergent broad themes that were large enough to serve as independent domains, but not so granular that they would be better delineated as Categories or Sub-Categories. Several Domains were also recombined prior to Cross-Analysis when it became apparent that there was not sufficient differentiation between them to warrant separate Domains.

The domain structure was eventually stabilized during Cross-Analysis as follows:  
Domain 1: “Logistics of Therapy,” referring to descriptions of therapy and therapists that were essentially objective, such as time period, type of agency, race/ethnicity of clinician, etc..

Domain 2: “Impressions of Participants’ Own Therapy Process,” referring to how the client perceived, experienced, evaluated, and reacted to the process of therapy, including specific items that they found helpful or unhelpful about the process and institutions of therapy as a whole.

Domain 3: “Impressions of Therapist(s),” referring to how the client perceived, experienced, evaluated, and reacted to specific therapist(s), including specific skills and strategies implemented by the therapist.

Domain 4: “Client Identity Markers & Reflections,” referring to descriptions of primary cultural markers and affiliations as well as musings on the nature of intersecting identities and their influence on the individual and society.

Domain 5: “Exploration of Cultural Background in Personal Therapy Experience,” referring to descriptions of participants’ exploration of Cultural Background during therapy (or lack thereof).

Domain 6: “Exploration of Personal Strengths in Personal Therapy Experience,” referring to descriptions of participants’ exploration of Personal Strengths during therapy (or lack thereof).

Domain 7: “Exploration of Cultural Strengths (CS) in Personal Therapy Experience,” referring to descriptions of participants’ exploration of Cultural Strengths during therapy (or lack thereof).

Domain 8: “Recommendations for Implementing CS Intervention & Cross-Cultural Therapy,” referring to descriptions of what participants believed would be helpful techniques and considerations in implementing a CS Intervention in therapy (i.e. clinicians with a racially and/or ethnically cross-cultural relationship to their client asking about cultural strengths, such as aspects of their culture that have been helpful, motivating, inspiring, protective, etc. for the client) as well as for cross-cultural therapy in general. This included systems-level recommendations such as training models for clinicians, avenues for increasing racial and/or ethnic diversity in clinical programs, and contextual considerations for working with cross-cultural therapy relationships.

Domain 9: “Junk Data,” referring to data that did not appear relevant or code-able by the standards of the study, such as off-topic asides from participants and closing remarks such as “I don’t think I have anything to add.”

Domain 10: “Impressions of/Feedback Regarding the Interview,” referring to participant responses to queries regarding their experience of and reactions to the interview, feedback to improve the interview experience, and appraisals of this research project and process.

Domain 11: “Response to Exploring CS during Interview,” referring to descriptions of participants’ experience exploring their CS for the first time during the interview.

Domain 12: “Reflections on Cultural Strengths & Vulnerabilities,” referring to descriptions of both specific types of cultural strengths and vulnerabilities as well as meta-cognitive reflections and process themes regarding what these terms meant to the participant and how they were enacted in individual experiences.

### **Coring**

The Coring process requires the team to distill the raw data into condensed “Core Ideas” that are consensually-identified as representing the pith of the participants’ meaning while removing irrelevant “filler” material and rendering the information into terminology and formatting that permit analysis. This distillation process allows for the quantitative sorting process that ultimately yields the Cross-Analytic themes. As dictated by CQR protocol, great care was taken during Coring to ensure that the researchers were not overly inferential in their efforts to capture participants’ expressed meaning in a more concise format (Thompson, Vivino, & Hill, 2012). Multiple rounds of consensus-building were required for each transcript before the whole team agreed that all Core Ideas adequately and succinctly represented the participant’s response. When an unusual amount of time had been dedicated to debate over coring a particular quote without reaching consilience, the team noted this as a potential flag of researcher bias in action, per Strauss & Corbin’s (1998) observations regarding excessive acquiescence or insistence during consensus-building. In

these cases, the team first paused to reflect on what researcher biases or expectations may have been activated by the data and endeavor to bracket them as warranted. They then returned to the audio files to assess whether intonation and other contextual information attenuated or concealed by transcription could illuminate the participant's intended meaning.

The Coring process began with the whole team meeting after reviewing the transcript to build consensus on Core Ideas together. After practicing this approach all together with the first several transcripts to hone the technique and develop a more uniform process, the research team divided into two teams of four (the graduate student researcher participating on both teams) in order to expedite the coring process, given scheduling limitations on meeting weekly as a full team. Each transcript and its Core Ideas were then reviewed by the team that had not directly cored it, and feedback was provided to the original coring team on core ideas that were identified as potentially inaccurate or incomplete. This reciprocal process continued until both teams agreed that the cored transcript accurately reflected the responses of the participants.

The coring process prompted the most frequent and extensive reflections on the Biases & Expectations (see below) that each team member had documented and shared prior to beginning Domaining. At times, differences as granular as synonyms catalyzed lengthy explorations of intersubjective reflexivity and the challenges of recognizing one's own preconceived notions and blind spots. A point of protocol generated during the community norming process at the start of the project allowed each member to respectfully point out to another member instances in which they observed that individual factors may have been unduly influencing the phrasing of the raw data as it was transformed into Core Ideas. This interpersonal aspect of consensus-building was widely acknowledged within the team as one of the more challenging and also critical aspects of the analysis. Core ideas were not



approved until consensus of the full team was reached, at which time they were sent to the External Auditor for review and feedback.

### **Cross-Analysis**

Following the consensus-approved incorporation of External Audit feedback from the Coring and Domaining processes, the data was further sorted within each Domain into Categories and internal Sub-Categories that reflected more nuanced thematic material than the broad denomination of the Domains and allowed actuarial analysis of cross-case findings. Categories and Sub-Categories were generated via a discovery-oriented process in which the team sought to create an organizational structure that was voluminous enough to capture the important subtleties of the participant's responses, but also specific enough to allow for identification of commonalities between the participants; the objective of Cross-Analysis is to determine the representativeness of themes across the participant cases (Ladany, Thompson, & Hill, 2012).

Starting with Domain 1, Cross-Analysis required each team member to independently review the consensus version of the domain and identify "clusters" of motifs across cases to generate a category structure that reflected thematic commonalities between participants. The members then met to review and discuss one another's proposed Categories and Sub-Categories, and build consensus on which of them to preserve, discard, or modify. As with the prior stages of analysis, discrepancies in interpretation of the core ideas prompted a review of the raw text and at times, the original audio, in order to enhance fidelity to the participant's original meaning and ensure that it had not been diluted or distorted during the course of the analysis.

Each of the domains required multiple rounds of consensus-building before stabilizing this final stage of analysis, and the majority of the time in Cross-Analysis was spent addressing the unexpectedly rapid proliferation of Categories and Sub-Categories. While there is no set limit to the number of Categories and Sub-Categories allowed during the Cross-Analysis phase (Ladany, Thompson, & Hill, 2012), the initial round of category-generation in several of the larger domains returned more than fifteen categories with multiple additional internal sub-categories, which significantly exceeded any examples that the research team could locate in the classic CQR studies used as reference materials. The team members devoted considerable time to mutually identifying the most salient of these Categories with reference to the research questions, and strove to find credible, meaningful ways to re-conceptualize the chosen Categories in order to accurately accommodate the more esoteric material of the original, extended set of Categories.

Material that was so idiosyncratic that it could not plausibly be placed in an established Category or Sub-Category was designated as “Other” and (in most cases) excluded from the Frequency Tables, per protocol (Ladany, Thompson, & Hill, 2012). In a select few cases, the “Other” Sub-Categories were preserved in the Frequency Tables because they served as useful reference points to indicate the relative proportion of participants that had contributed material that was thematically cohesive with other participants but was too esoteric in terms of specific content to be designated within a titled Sub-Category.

The Cross-Analysis was submitted for External Auditing, and the auditing feedback was reviewed by the team members. The audits were incorporated following this consensus, and the final Frequency Tables were constructed based on these results. The descriptive frequency labels identify how “typical” core ideas were across cases by condensing the

clusters found throughout the participant descriptions into Categories and Sub-Categories labeled as “General” when they appeared across 13-14 of the cases, “Typical” when they appeared across 8-12 of the cases, and “Variant” if they appeared in 2-7 of the cases (please refer to Table 2 in Appendix E).

### **Study Participants**

Based on Hill, Thompson, & Williams’ (1997) recommendations for CQR studies, a total of 12-15 participants is ideal for generating sufficiently informed results. As with most Qualitative approaches, acceptable sample sizes are considerably smaller than Quantitative approaches because the intent is not to obtain generalizable results, but to reach consistency in results across participants (Hill & Nutt Williams, 2012). Because Hill et al. caution that several interviews may yield un-useable results, the research team chose to include 14 participants to ensure that saturation would be attained even if several of the interviews had to be discarded.

According to the pre-screening mechanism of the online recruitment system, which collected basic demographic information about the participants, twelve females and two males participated in the study, all identifying as members of a REM group. Within the interview, participants were provided with an open-ended prompt requesting that they describe their demographic identity in whatever terms they felt comfortable sharing in this context. This approach to expanding the self-identification options from the survey-style prescreen results were offered in accordance with Trimble & Dickson’s (2005) observation that broad, prefabricated categories of identity-designations significantly limit researchers’ understanding of how formative life experiences and circumstances define and influence identity for individual participants. Indeed, the heterogeneity of responses to this prompt

reflected a wide variety of interpretations of the term “identity,” and its salient features in this context.

Per these responses, Participant 1 identified as a Hispanic male. Participant 2 identified as a heterosexual Mexican-American (first-generation American) female from a low-SES background. Participant 3 identified as an Asian-American female from a middle-class-SES background. Participant 4 identified as an Agnostic, Latinx female from a low-SES background, with ancestry from mixed Latin-American Countries. Participant 5 identified as a Mexican female raised in a single-caregiver, low-SES household. Participant 6 identified as a Cambodian-American female of ancestral Chinese descent (“both my parents were born and raised in Cambodia, but our ancestors were from China”). Participant 7 identified as an Asian-American, heterosexual female who was born in Hong Kong, raised in California, and was a first-generation college student. Participant 8 identified as a cisgender, heterosexual middle class-SES male and a “three-quarters Chinese and one-quarter Vietnamese, California-born American.” Participant 9 identified as a lower-middle class-SES Catholic Filipina female. Participant 10 identified as a lower-SES Chicana female. Participant 11 identified as a working-class, African-American, cisgender female, and a first-generation college student. Participant 12 identified as a queer, Afro-Latina Female. Participant 13 identified as a working-class, Asian-American female, and a first-generation college student raised in California. Participant 14 identified as a Chinese Female.

### **Team Process & Researcher Descriptions**

The team was composed of seven Undergraduate Student Researchers, one Graduate Student Researcher, and a Faculty External Auditor. The Faculty External Auditor’s relevant experience spanned several decades of mixed-methods and qualitative research experience,

including training the Graduate Student Researcher on CQR methodology for a prior study. The Graduate Student Researcher's CQR experience included individual training by the Faculty External Auditor as well as participation as a team member on two previous CQR studies. The Undergraduate Student Researchers were trained by the Graduate Student Researcher as part of the curriculum for the Independent Study Research Course through which they joined the study. In addition to reading assignments exploring the methodology chapters of Hill et al. (2012) textbook on CQR, the undergraduate students met with the graduate student researcher for ongoing seminars addressing cultural, ethical, and otherwise contextual considerations in qualitative research.

Per protocol in CQR research (Vivino, Thompson, & Hill, 2012), the team sought to conduct every coding meeting in a heterarchical manner, to reduce the likelihood that the analytical process would be disproportionately shaped by any one individual. In order to promote an egalitarian consensus-building process, several techniques for qualitative team-process were implemented, including generation of community norms at the start of the project to agree on respectful ways to communicate and arbitrate disagreement; temporarily setting aside particularly controversial items of analysis and marking them for further review; and deliberately taking turns with which team member spoke first regarding each item to avoid inadvertently privileging one perspective over another. During phases of analysis in which the team was separated into smaller internal teams for efficiency, the constituency of these sub-teams were changed on a weekly basis to reduce the likelihood of a particular team developing a more hierarchical structure or an excessively convergent micro-culture of analysis.

An important aspect of the Community Norming process included brain-storming ways to reduce the inherent power differential between the Graduate Student Researcher and

the Undergraduate Student Researchers, who initially all contributed to the study in exchange for course credit (many of the Undergraduate Student Researchers continued to participate as team members after completing the available course credit and/or graduating). Precautions taken to limit this differential included a stipulation that all Undergraduate Researchers who participated for a letter grade rather than solely course credit operated under a syllabus which explicitly defined their grade in terms of meeting objective expectations for research productivity, with the only subjective component being calculated based on the other undergraduate team members' ratings of that member's perceived contribution to the team meetings. While the hierarchy imposed by differences in educational attainment, specific training in the methodology, and the configuration of grader to student cannot be entirely discounted, anonymous feedback solicited from the undergraduate team members at the end of each academic quarter indicated that they felt empowered to contribute freely and express disagreement with the Graduate Student Researcher and the Faculty External Auditor throughout the analysis.

The full course of data collection and analysis occurred across a period of fifteen months, spanning multiple significant life transitions for many of the team members, including graduations, semesters abroad, predoctoral internship, and other life events that altered the geographical locations and consequently the configuration of the team. Following the Coring phase, the majority of team meetings occurred online via video, in order to accommodate team members working in different cities or states and at times, different countries. During the final phase of Cross-Analysis, the team was reduced to less than half its original size, with three members remaining in addition to the External Auditor. All members of the team were given the opportunity to review the results of each phase of

analysis, even if they had not been able to participate in its formation, and this feedback—where provided—was incorporated by consensus.

As recommended to provide readers with a sense of the context of the members of the research team (Vivino, Thompson, & Hill, 2012), the following descriptions of the Research team outlines the primary demographic identifiers of each member of the research team in their own words (with minor edits for brevity and clarity). The members of the team were encouraged to include descriptions of identity-markers as well as cultural and developmental experiences that they felt might influence their perspective on the data in ways that were more abstract than what could be captured within the traditional structure of the “Biases and Expectations” section. The team-members returned to these descriptions after completing the Coring and Domaining processes in order to add further personal details that they had recognized as influential after becoming more familiar with the data. Except as noted, all of the student researchers were between 18-24 years old.

**Undergraduate Student Researcher 1** identifies as a cisgender female, heterosexual, Filipina-American, middle class, third generation student: *“my grandmother received her Masters degree in Education and my mother is currently pursuing a doctorate in educational leadership.”*

**Undergraduate Student Researcher 2** identifies as a 28-year-old, cisgender, heterosexual, White, English-speaking female. *“My faith (Christian) is also an important aspect of my identity because it guides my judgement and perspective.”*

**Undergraduate Student Researcher 3** identifies as a biracial, American, cisgender, heterosexual woman. She speaks English and basic conversational Spanish.

**Undergraduate Student Researcher 4** identifies as a heterosexual female.

*I am a Chinese American, who is the first in my family to attend a four-year university in the United States. As far as what generation I am, that gets a little bit confusing. My great-grandfather came to the U.S. in the 1930s but he was moving back and forth between China and the United States. My grandparents, parents, and I were all born in China. So I would say I am a first generation American but I have deeper ties to the United States than most first generation Americans do. I am bilingual in English and Chinese; I am able to speak 3 different dialects of Chinese fluently.*

After completing the Coring and Domaining, Student Researcher 4 expressed a particular interest in the themes reflected within the interviews with participants who actively identified themselves as bicultural, and noted that her own experience of moving between and within adjacent cultural worlds likely shaped her focus on and understanding of these dimensions of the interviews:

*Growing up, I had a difficult time being bilingual 'comfortably' because I was around many other Chinese American immigrant families who wanted their children to be able to speak English very well. And to the Chinese American community at the time, speaking broken Chinese was a sign of assimilation into the mainstream American life. My parents, on the other hand, really wanted me to be bilingual and master both languages with equal fluency. Some kids would tell me that I was born in China so it only makes sense that my Chinese is better than theirs. Some kids told me that it didn't make sense to them that I have better English grammar than them because I was born in China. It wasn't until very recently, probably around the time I started college, when I recognized that being bilingual is such a beautiful thing—a cultural strength! Some of the participants said that they enjoyed hearing another person*



*point out their cultural strengths and in my case, I was recently told by a friend (a white male), who has been learning Chinese for 6 years, that he thinks it's such an amazing thing that I am able to live comfortably in the United States and take on so much of American culture while at the same time retaining a lot of Chinese culture in different aspects of my life. Now, I embrace and love the hybridity of being Chinese and American.*

**Undergraduate Student Researcher 5** identifies as a 20-year-old female (preferred pronouns are she, her, and hers), heterosexual, and Asian American. *“More specifically, I am 3/4 Chinese and 1/4 Taiwanese, but do not speak fluently in any other language than English.”*

**Undergraduate Student Researcher 6** identifies as a cisgender and heterosexual white male. *“I come from a Northern European background and to my knowledge am predominantly Danish and Irish. I am fluent in English and have some knowledge of American Sign Language and Korean. My dad is a Mechanical Engineer, and my mother is a Special Education Teacher. I graduated with a degree in Psychology and minor in Applied Psychology.”*

**Undergraduate Student Researcher 7** identifies as a cisgender, heterosexual Black woman, with the preferred pronouns she, her, and hers.

The **Graduate Student Researcher** identifies as a cisgender, heterosexual, white female of primarily Western European (Dutch and Portuguese) descent. Her mother is a first-generation North American from South Africa and her father is a fourth-generation North American. She is a monolingual English-speaker and has cumulatively spent several years traveling in Central and Southern Africa, the Middle East, Southeast Asia, and Western Europe.

The **Faculty External Auditor** identifies as a cisgender, heterosexual, white male of primarily Western European (Scottish and Irish) descent, who is “*somewhat bicultural and bilingual having grown up in a Mexican-American community.*” Both of his families have been in the United States for approximately 7 generations.

### **Biases & Expectations**

An essential aspect of qualitative research involves a recognition that the context in which the research is performed—and especially individual factors of the researchers themselves—will significantly influence both the collection and the analysis of the data. While qualitative researchers endeavor to the extent that it is possible to “bracket” these intervening influences by making them explicit, setting them aside when plausible, and accounting for their influence (Fischer, 2009), acknowledgement and consideration of their interactions with the data remains a critical step in enhancing credibility and interpretability (Finlay, 2002).

One step of this commitment to working within an acknowledgement of reflexivity involves writing out, examining, and sharing biases and expectations relevant to the project within the research team (Sim, Huang, & Hill, 2012). Each member’s biases and expectations were shared within the team, and iterative discussions were facilitated as to how best to help one another recognize, monitor, and account for these predispositions as they arose during analysis. Given that participant identity lay at the crux of the research material, much of the discussion around biases and expectations began with the research team’s reflections on their own intersecting identities, and how these were likely to shape their understanding of the research material. All members of the research team explored an understanding that they shared the agent-culture identities of being able-bodied and cis-

gendered and were thus less cognizant of the additional barriers and deterrents to accessing and maintaining competent mental healthcare faced by participants of these multiple-target-identity groups.

Similarly, the White members of the research team noted that their racial identities were likely associated with a decreased sensitivity to and understanding of the nuanced challenges of REM individuals participating in psychotherapy with a White clinician. On the whole, the White team members reported generally positive experiences in therapy with their same-race clinicians, and only one of these members had participated in a cross-racial therapeutic relationship. In contrast, the majority of the REM team members who had participated in therapy had done so with a White clinician, and several reported disappointing experiences with their clinician's ability to address their intersecting identities in a sensitive, informed, and helpful manner.

The majority of the REM team members expressly identified an expectation that the participants would describe predominantly negative reactions to clinicians' efforts to engage their cultural backgrounds, particularly with respect to a lack of sensitivity to and understanding of the intersecting identities of the participants. While these team members' biases and expectations tended distinctly towards a lack of clinician competence in addressing multicultural identity issues, the white team members reported an expectation that most participants would not have had the experience of a clinician acknowledging or attempting to engage them on the topic of their cultural background at all.

An additional facet to this divergence in expectations based on the racial and/or ethnic background of the team members concerned the presumed reaction of participants to the historical or *in vivo* intervention regarding cultural strengths. While the white team members generally expected this to be a positive experience for the participants, the REM

team members were initially divided as to whether this was expected to be a negative, neutral, or positive experience. Each of these team members noted that the delivery of the intervention would likely determine its experienced valence; much discussion was given to the potentially iatrogenic effects of a well-intentioned clinician inadvertently minimizing a client's concerns, or offending a client by invoking a broad stereotype, when attempting to engage them on the topic of cultural strengths.

This point stood out in *post-hoc* reflection, when the team members reconvened after the primary phases of analysis to explore which of their biases and expectations had surfaced most consistently throughout the consensus-building process, as well as which had been borne out and which had been revised based on the research experience. After completing the analysis, while the team still had mixed expectations as to whether or not this intervention should be consistently included in cross-cultural therapy, every one of the members noted that the research process had prompted them to reflect more on their own cultural strengths, and that this had been an enjoyable, interesting, and helpful process for them. The one point in this matter with unanimous agreement at the conclusion of analysis was that clinicians should be trained to sensitively gauge a client's relationship to their culture before proceeding with any culture-specific interventions or inquiries; this was a point that had notably not been broached prior to performing the analysis.

## CHAPTER FOUR

### Results

While a full accounting of the results is included in Table 2 (please see Appendix E), the results outlined in this chapter represent the emergent domains most relevant to the project's Research Questions and are represented below in Table 1. From within these domains, the categories and sub-categories that were endorsed most widely among the participants were examined, as well as those variant responses that represented novel or unexpected data in this area of research. Per CQR guidelines (Hill, 2012), if 13-14 of the participants responses were coded within one category or sub-category, it was considered "general," "typical" if it included responses from 8-12 participants, and "variant" if it included responses from 2-7 participants. Direct quotes from the raw data are provided to illustrate the material that comprised the categories and sub-categories in the participants' own words. These quotes have been edited to enhance clarity and brevity by deleting tangential material (indicated by ellipses), filler verbiage such as "like," and "you know," and common dysfluencies.

Table 1.

*Selected Domains, Categories, Subcategories, and Frequencies of Findings*

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#### **Impressions of Own Therapy Process**

Institutional Barriers to Access & Retention	10 (Typical)
Limited availability/accessibility of services	8 (Typical)
Transferring to new therapist was difficult/frustrating	4 (Variant)
Objection to professional rules, roles & boundaries	2 (Variant)
Unprepared for/hurt by Termination process	2 (Variant)
Positive Appraisal of Therapy Process	14 (General)
Generic	11 (Typical)

Appreciated someone safe to talk freely to	9 (Typical)
Gained perspective, insight, awareness	8 (Typical)
Improved MH functioning	7 (Variant)
Supported Growth/Progress	5 (Variant)
Received Validation	4 (Variant)
Appreciated venting	3 (Variant)
Hedonically felt good	2 (Variant)
Negative Appraisal of Therapy Process	9 (Typical)
Unmet Expectations	8 (Typical)
Felt Uncomfortable	4 (Variant)
Difficulty opening up to & trusting a stranger	3 (Variant)
Inability to connect	3 (Variant)
Wanted more Directiveness	2 (Variant)
Neutral Appraisal of Therapy Process	3 (Variant)
<b>Impressions of Therapist(s)</b>	
Positive Appraisal of Therapist	12 (Typical)
Offered Useful Interventions & Skills	9 (Typical)
T perceived as genuinely invested in C	8 (Typical)
Understanding & Accepting	8 (Typical)
Generic (Helpful/Positive)	6 (Variant)
Connected C to Resources	5 (Variant)
C appreciated Nondirectiveness	4 (Variant)
Individual Personality Characteristics	3 (Variant)
Provided helpful guidance	3 (Variant)
Culturally Responsive	2 (Variant)
Negative Appraisal of Therapist	12 (Typical)
Not a good fit (Discomfort & Lack of understanding)	9 (Typical)
Did not satisfactorily address & resolve presenting concerns	6 (Variant)
Irrelevant or Ineffective Interventions	6 (Variant)
Generic (Dissatisfied)	5 (Variant)
Invalidating	4 (Variant)
Wanted more Directiveness	3 (Variant)
Referred out against client preferences	2 (Variant)
Perceived incompetence	2 (Variant)
Perceived lack of competence re/multicultural issues	7 (Variant)
Cultural Barriers to Connection & Understanding	6 (Variant)
Culturally Dystonic Interventions	3 (Variant)
Neutral Appraisal of Therapist	2 (Variant)
<b>Client Reflections on Identity</b>	
Reflections on complex nature of social locations & identities	7 (Variant)
Family & community tension & conflict re/Cultural Values	5 (Variant)
Autobiographical Context	5 (Variant)
Identifies more with one aspect of cultural background than another	3 (Variant)
Experiences some incongruence with cultural background	3 (Variant)
Challenges in negotiating bicultural identities	2 (Variant)
<b>Exploration of Cultural Background (CB) in Personal Therapy Experience</b>	
CB was not explicitly addressed	6 (Variant)
CB minimally addressed	3 (Variant)

C's presenting concern focus was elsewhere 3 (Variant)  
 C would have liked to discuss CB 1 (Variant)  
 CB was explicitly addressed 5 (Variant)  
 CB discussion explored culture in relation to family 3 (Variant)  
 CB discussion explored feeling out of place at school 2 (Variant)  
 CB discussion explored challenges relating to conflicting cultural values 2 (Variant)  
 Positive Appraisal of exploring CB 3 (Variant)  
 Exploring CB enhanced contextual self-understanding 3 (Variant)  
 CB exploration helped improve MH Functioning 2 (Variant)  
 Exploring CB felt Comfortable/Natural 2 (Variant)  
 Negative Appraisal of exploring CB 2 (Variant)  
 Communicating cross-cultural material to T was challenging 2 (Variant)  
 Neutral Appraisal of CB 1 (Variant)

**Exploration of Personal Strengths (PS) in Therapy**  
 PS were explored 12 (Typical)  
*Outcomes*  
 Increased awareness of PS 10 (Typical)  
 Exploring PS was helpful 9 (Typical)  
 Exploring PS produced helpful perspective change 4 (Variant)  
 Exploring PS resulted in Positive Feelings 7 (Variant)  
 Identified strengths were mobilized as MH resources 7 (Variant)  
 Exploring PS was empowering/affirming 4 (Variant)  
*Themes of PS Explored*  
 Miscellaneous Strengths Types 7 (Variant)  
 Academic/Analytical Strengths 6 (Variant)  
 Strength of Resilience/Perseverance 5 (Variant)  
 Interpersonal Strengths 4 (Variant)  
 Growth recognized as Strength 3 (Variant)  
 Strengths can be double-edged swords 2 (Variant)

PS were not addressed 2 (Variant)

**Exploration of Cultural Strengths (CS) in Therapy**  
 CS were not explored 13 (General)  
 Exploring CS would have changed therapy experience 6 (Variant)  
 Exploring CS would not have changed therapy experience 5 (Variant)  
 Exploring CS would have been neutral 4 (Variant)  
 Exploring CS would have been helpful/positive 10 (Typical)  
 Would have enhanced T's understanding of C 5 (Variant)  
 Would have enhanced Therapeutic Alliance 4 (Variant)  
 Would have enhanced C's cultural self-understanding 4 (Variant)  
 Would have enhanced C's understanding of cultural socio-politics 4 (Variant)  
 Potential Problems & Concerns with CS exploration 6 (Variant)  
 Exploring CS might have been confusing or awkward 4 (Variant)  
 Concern that T would have been incapable of understanding C's culture 2 (Variant)

CSs were explored 2 (Variant)

**Recommendations for CS Intervention & Therapy Process**  
 Concerns re/exploring CS 10 (Typical)  
 Individual client factors will determine response to CS intervention 7 (Variant)  
 Concern re/lack of context of CS 5 (Variant)

- Concern re/clarity of CS construct 5 (Variant)
- Could seem racist 2 (Variant)
- Could reinforce stereotypes 4 (Variant)
- Potential Benefits to exploring CS 11 (Typical)
  - C can then better understand self & improve functioning 7 (Variant)
  - T can better understand C 6 (Variant)
  - Would be empowering to C 3 (Variant)
  - Would feel good for C 3 (Variant)
- Process Recommendations for exploring CS 14 (General)
  - Address CS within broader context of C's community/culture 11 (Typical)
  - Use an open-ended & client-centered approach 11 (Typical)
  - Ask open-ended Qs re/positive & helpful aspects of C's culture 9 (Typical)
  - Consider that C's relationship to own culture will predicate response 6 (Variant)
  - Resist stereotyping/assumptions 6 (Variant)
  - Recognize that this exploration may be difficult for C 5 (Variant)
  - Be sure to also explore CB generally 4 (Variant)
  - Be straightforward 4 (Variant)
  - Be sensitive about wording 4 (Variant)
  - T needs to demonstrate respectfulness & humility 4 (Variant)
  - Also acknowledge Cultural Vulnerabilities 4 (Variant)
- Cross-Cultural Competence Considerations 12 (Typical)
  - Therapists should be prepared to work effectively cross-culturally 11 (Typical)
  - Therapists should be knowledgeable about client culture 5 (Variant)
  - Therapists should implement culturally-syntonic interventions 3 (Variant)
  - Therapists should acknowledge cultural differences 2 (Variant)
- C/T Pairing Considerations 8 (Typical)
  - There should be more diverse therapists in the field 3 (Variant)
  - T from same/similar background may better understand C 3 (Variant)
  - Ethnic matching does not guarantee positive therapy experience 2 (Variant)
  - Different T/C backgrounds doesn't preclude positive experience 2 (Variant)

### **Responses to Exploring CS in Interview**

- Would have liked to explore specific CS in Therapy 6 (Variant)
- Positive Appraisal of CS Exploration in Interview 5 (Variant)
- Difficulty answering Qs about CS 5 (Variant)
  - CS is new idea to P 4 (Variant)
  - Typical focus is on Cultural Vulnerabilities 3 (Variant)
  - Difficulty identifying/articulating CS 3 (Variant)
  - CS is not talked about a lot 3 (Variant)
  - Confusion re/concept of Cultural Strengths 2 (Variant)

### **Reflections on Cultural Strengths & Vulnerabilities**

- P identified a CS 11 (Typical)
  - Collectivism/Close family ties 6 (Variant)
  - Hard Work 6 (Variant)
  - Emphasis on Education 5 (Variant)
    - Elders/caregivers didn't have access to education 3 (Variant)
  - Other 4 (Variant)
  - Respect for Elders 4 (Variant)
  - Empathy 3 (Variant)



Competitiveness	3 (Variant)
Resilience	3 (Variant)
Do things well	2 (Variant)
Persistence	2 (Variant)
Openness	2 (Variant)
CS Process Themes	9 (Typical)
CS Embedded in anecdote or example	8 (Typical)
Struggle of previous generations motivates	5 (Variant)
C feels connected to/influenced by CS	5 (Variant)
C's choices reflect on family/community	4 (Variant)
Overlap of Cultural Strengths & Vulnerabilities	9 (Typical)
Strengths emerging from Adversity	6 (Variant)
Strengths & Vulnerabilities are intertwined	5 (Variant)
Identified Cultural Vulnerabilities	6 (Variant)
High parental/community expectations cause pressure	5 (Variant)
Other	2 (Variant)

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Note.  $N=14$ ; General = 13-14 cases, Typical = 8-12 cases, Variant = 2-7 cases

### **Exploration of Cultural Strengths in Therapy**

Participants generally (13 interviewees)<sup>4</sup> reported that they had not explored Cultural Strengths (CSs) during their therapy experience. The interviewer requested that the participants consider how such exploration, had it occurred, may have influenced their feelings about the therapy experience(s) and/or their therapist(s). Those who had not explored CSs typically (10 participants) indicated that they believe doing so would have been a helpful or positive addition to their therapy experience, with variant attributions of the prospective utility of the intervention including expectations that it would have helped the therapist understand them better (5 participants, variant); that it would have enhanced the therapeutic alliance (4 participants, variant); that it would have enhanced their cultural self-

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<sup>4</sup> Please note that one of the participants indicated that she had Explored CS in Therapy in one of her therapy experiences but had Not Explored CS in her other therapy experiences. She contributed input on each of the experiences and was consequently counted in both categories.

understanding in a meaningful way (4 participants, variant); and that it would have enhanced their understanding of cultural socio-politics (4 participants, variant).

Participant 8 summarized several of these points in his reflection on why he would have liked to explore CS with his therapist:

*Because I'm born and raised into my culture; it's not something I can notice, it's just normal for me. But from an outside perspective, it's like 'oh, you're like this,' and oh really I didn't know that cause it's just me normally. So I would like to know how me being Chinese-Vietnamese plays a part in my strengths. Specifically within a Western society, because I'm still having trouble—like I can sort of identify a few things but I don't know completely what my strengths are, what my cultural strengths are. And I'd like to know.*

Participant 10 focused on the potential therapeutic relational benefits of the intervention, stating *“I feel like it would've established a deeper connection,”* and noting that it might have prevented her premature termination: *“I think I would've wanted to maybe keep the connection longer than I did.”* Participant 1 succinctly expressed a similar impression: *“It would have made me feel more comfortable knowing they have that understanding of where I'm coming from.”*

Participant 12, meanwhile, shared an unfulfilled wish for deepened cultural self-knowledge amplified by her phase-of-life context as a college student: *“Because you know, there is a difference between my strengths versus my hetero-white male classmates' strengths. And I would have liked to explore more, about that...I feel like it's played a huge part in who I am now as an individual, especially as a student here.”*

In considering their hypothetical reaction to exploring CS, none of the Participants indicated that they would object to the intervention or would prefer not to explore CS in

therapy. However, slightly fewer than half the participants (6 interviewees, variant) raised concerns about potential problems in implementing it based on how they theorized they would have received it during their current or previous therapy experiences. Four of them (variant) noted that it could be a confusing or awkward process under certain circumstances, while 2 of the participants (variant) expressed a worry that their therapist would not understand their culture well enough to properly facilitate the intervention. The former point was highlighted by Participant 13, who stated:

*It would have been nice but probably, I think I would have felt uncomfortable bringing it up. I am for the most part, conditionally white passing, or I look like European American or Caucasian American, so I feel like it's difficult to interject like, 'oh I'm Asian American and these are the ideals that I have been raised with, I represent, and I also hold.' I think I would have liked to but I think that would have been a bit odd or awkward to like, bring up. But I think it would have been nice to be able to talk about cultural values...*

Her point underscores the responsibility of the clinician to establish an understanding of the client's perception of their intersecting identities—and effectively gauge the client's relationship to those identities—so that initiating these important discussions do not become incumbent on the client.

Participant 2, meanwhile, illuminated the latter point with a sense of skepticism both as to a clinician's ability to understand her cultural strengths, and also the clinician's motives in asking about them:

*I don't know, I mean when it comes to talking about culture, I think it's a very sensitive topic you know, because there's a lot of stigma associated with different cultural backgrounds so I think if we would have been talking about cultural*

*strengths, I think I might have been skeptical because I would be like, 'we come from different cultural backgrounds. Like, do you genuinely mean this? Do you...it's like how can you talk about this? Do you know what you're talking about?' In terms of you know... shining light on the cultural strengths, I would just have been skeptical about it I guess.*

Participant 14 addressed a similar worry briefly but wistfully in musing about whether she would have felt differently about therapy if her clinician had explored CS with her. *"Probably, yes. But...I think it would be really rare to find someone who [long pause] understands where I came from."*

While only two of the participants indicated that they had in fact explored CSs in therapy, providing a very small sample for this branching logic category, the team was naturally very interested in their perception of the process. While their accounts differ in notable ways, it was striking that both of these participants alluded to how their process of exploring CSs in therapy intertwined with reflections on Cultural Vulnerabilities, perhaps substantiating the themes raised in this vein by the other participants in both their Recommendations for CS Intervention & Therapy Process and their Reflections on Cultural Strengths & Vulnerabilities (see below).

In her description, Participant 7 identified the CSs that she explored in therapy and foreshadowed later commentary about the pressures of adhering to the values of her culture:

*Respect is a really big thing for Asian cultures, making a lot of money, the hardworking aspect and don't give up. Not 'do whatever you want,' but instead, make a name for your family kind of thing. Cause I feel like other cultures are more like: do what makes you happy, you know, but I feel like Asian cultures are like: 'do what's gonna make the family proud.'*

She goes on to respond to questions about how exploring CSs affected her experience of therapy and her perception of her therapist, communicating a sense of nonchalance about the process that contrasts notably with the other participants' consistency in reporting that this intervention is not in fact a standard element of treatment. She additionally seems to indicate a sense of confidence in her clinicians' ability to effectively navigate the cross-cultural relationship that may explain her apparent indifference regarding discussion of cultural material generally in treatment.

*I don't know if it really affected my clinicians in college because I feel like we're so diverse here, I feel like at some point we expect to be so diverse and so cultural here that we're not acknowledging that because it's expected. We have the multicultural center, it's very forward already, and I feel like sometimes it's not ignored, but kind of put to the side because it's already such—like, 'hello we're a college, of course we're inclusive.' ... I guess don't know, I never thought about that. Cause it's not, it's not ever something like 'oh, you're white, you must not understand [laughs].' It was just kind of like: 'ok, here's what I'm going through.'*

Participant 3's description of her experience exploring CSs in therapy suggested that it felt comparatively more meaningful to her. She highlights the ways in which it helped her to better understand herself and her social location and intersecting identities, as well as providing a new perspective on the confluence of her culturally-grounded assets and struggles.

*It was a topic of our therapy sessions in terms of the very cross-sectional cultural identity that I had. And that because I was more westernized, I had certain, more individualistic values, and that we did promote growth of the self rather than looking back to make the family proud, and it was a factor in why I struggled but also why it*

*could be a good thing instead...[The strengths that were identified]: I'd say probably from the more western American [identity], it would be giving power to the self and the fact that you can come from nothing kind of growth. And with my more Asian identity, it's a lot of hard work and the academic influence that I had, and I think another one is for like the family support I had from the western identity and the more open mindedness that it has cultivated, that I think we have in western identities...I think [exploring CSs] was really helpful, and kind of eye opening. There were a lot of times you forget that—you think of yourself as these identities but they are so much a part of you that you kind of just forget, and being a minority is something in itself....It was a lot of introspective work that we did and that made me realize how important each of these identities are, and how important it should be to me as a person, and what I can do for society as well. It's kind of like looking back on what I've done, and what I could do.”*

Notably, Participant 3's description of how the process of exploring CSs benefitted her—as well as how it coincided with introspection regarding Cultural Vulnerabilities—align with several prospective benefits identified by the other participants in this domain and the next one, including improved cultural and socio-political self-understanding and feelings of empowerment.

### **Recommendations for Cultural Strengths (CS) Interventions & Therapy Process**

After considering how a CS exploration intervention might have affected their previous therapy experiences, participants offered feedback on the *in vivo* intervention itself (“As we are talking about this, what cultural strengths of yours come to mind? Can you tell me about them and how they have influenced you?”), as well as contextual considerations of

such an intervention's potential delivery in a racially and/or ethnically cross-cultural therapy relationship. This input included caveats designed to mitigate the risk of a client being offended or confused by the intervention, hypotheses as to how it could benefit the therapeutic process, steps that clinicians could take to enhance the likelihood of positive outcomes for the intervention, and general considerations as to clinician multicultural competence while exploring CSs.

In terms of hypothetical benefits of the intervention, 11 of the participants (typical) predicted that exploring CS could be helpful or useful to a REM client in a cross-cultural therapy relationship. A variety of themes emerged as participants prospectively considered how and why it could be beneficial, including the possibility that the client could better understand themselves and thereby improve their mental health functioning (7 participants, variant); that the therapist could then better understand the client (6 participants, variant); and that the intervention in itself would be empowering (3 participants, variant) or simply hedonically feel good for the client (3 participants, variant).

Participant 8 summarized several of these potential benefits with his hypothesis about how it could improve the client's sense of agency and consequently their ability to manage their presenting problems.

*It would help remind the client about what they can do. When they're in a state of emotional distress, or there's a loss, help them be reminded of what they're capable of. It could help build their confidence and self-esteem and help give them their own direction. Help them, help themselves, essentially.*

Participant 3 presaged several of the caveats (see below) to exploring CS—primarily that it could be difficult or uncomfortable for some clients—while pointing out that this

discomfort in itself could be an avenue to enhanced self-understanding regarding cultural context and identity formation.

*I think in terms of how it could be helpful, talking about the strengths is definitely good to get perspective on these cross-cultural issues, and I guess in terms of unhelpful, some people might have trouble talking about it, or not realizing it. But I think in that sense it could be turned positive, making them realize that it is such an important part of their identity, or maybe part of issues that they've had.*

Participant 4 similarly emphasized enhanced client self-understanding and the creation of a rare opportunity to elucidate an under-explored topic, while also noting that this intervention would be a valuable learning experience for the clinician both with that client specifically, and in general for their cross-cultural work.

*It's probably helpful on both sides because I mean, you have the client getting a chance to talk about their culture, and strengths, and give them more opportunity to explore, because a lot of times I feel like it's not explored that often. Like I said I didn't know what they really were for me. And I guess for the therapist, it would also be helpful to just learn about how their clients feel about their culture because everyone has a different opinion. So just getting more insight from different clients, different cultures, or even the same culture would be helpful for them.*

All fourteen of the participants (General) offered process-oriented recommendations for exploring CS, primarily in the areas of phrasing, delivery, and preparatory interventions. Typically (11 participants), participants encouraged the use of an open-ended, client-centered approach, in which the clinician took a “one-down” stance and followed the client’s lead in both inquiring about CS and facilitating associated exploration and reflection. In describing this preferred relational orientation of the intervention, Participant 13 characterized the ideal



clinician stance as *"having a sense of openness and the ability to communicate and for the therapist to have the idea of openness to learn from their client rather than just provide for their client is very important."*

Participant 2 focused similarly on the importance of the clinician demonstrating deference towards the client with this intervention and provided specific phrasing cues that could help clinicians communicate their humility and openness:

*Rather than trying to put one and two together, rather than putting your own assumptions on the issue, asking the client to elaborate on the issue. So instead of stating your assumption, taking a moment to be like: 'am I right when I'm connecting 1 and 2?' Rather than 'I'm connecting 1 and 2.' It makes a difference the way you initiate the question, you know? Even just saying 'okay, let me just get this straight' rather than just saying it. It's just the little things that will ease up the situation.*

Also typical (11 participants) was a technical focus in this vein suggesting that clinicians ask open-ended questions regarding positive and helpful aspects of client's culture as a segue to the CS intervention. Participant 1 highlighted the solution-focused benefits of this approach, as well as its capacity to illuminate otherwise unspoken aspects of the client's identity and self-concept:

*I guess a good way to go about it would be to talk about how their identity and culture has helped them up to that point of their life. Reflecting upon certain strengths that could help the therapist understand their cultural strengths and the client themselves because then it gives them a chance to reflect on how they got here, what strengths have focused and pushed them to get to where they're at now. I think it would help both of them because as a client, I feel like if you're not asked to reflect you don't really know what really helped the issue. And then that gives the*

*understanding to the client and it also gives the therapist an idea of where they think their strengths are coming from. So I feel like they both would learn a little bit about each other with that reflection.*

Participant 9 envisioned a similarly contextual and indirect yet more specific means of opening a dialogue about CS by inquiring about the client's perception of their close friend group, which (per the participant) would likely reflect the client's own racial and/or ethnic background:

*Maybe being like, 'what do you think is helpful or successful for you, or what qualities do you think that you have or people that you're close to have?' Because a lot of people that people are close to are usually their same ethnicity. It's interesting cause going to college here there's so many people here, and I find that all the Filipinos hang out with each other, most all the other groups they hang out within their own group and even though the school's pretty diverse it's like...people tend to hang out with the same group. So the therapist could ask like, 'anyone close to you, what qualities do they have...that you like? Or what's been helpful for them?' And then I think that would kind of lead into culture. Cause I feel like if a therapist, especially if they weren't Asian, just straight asked me: 'oh, so what do your Filipino friends do to help themselves get better?' Or: 'what are traits in them that are positive?' I'd be like, 'that's an interesting question [laughs]!' And be kind of caught off guard.*

This response also underscores the potential for clients to feel offended or disconcerted (“caught off guard”) if they feel that the clinician is focusing too narrowly on a particular aspect of their identity or leaping too quickly to the topic of CS without first establishing a broader reference point for the client's cultural identity. This concern was

typical (11 participants) among the interviewees, who recommended that clinicians ground their inquiries about CS within the broader context of the client's community and cultural identity. Participant 10 endorsed this tactic as a means of broadly prefacing the intervention and thereby reducing its pointedness, allowing the client to build towards exploring CS from a wider view of their general cultural background.

*I think really understanding and asking them a little bit first about how they grew up or just their family ties. Because family plays a really major role in everyone's lives and it has so much power that is not really concentrated on. You can really figure out someone, who they are, when they have a really close connection to their culture, their family, things like that...I would say something as basic as 'tell me a little bit about how you grew up.' It doesn't have to be elaborate, just something really casual and like 'let me know more about your background.' I just feel like it's allowing the person to feel comfortable and that's when they are able to express more about things that happen when they know it's just...it's not really something that's like 'oh is it this or this.' Not like a really high stakes thing that puts you on the spot, just something really casual and just like 'I wanna get to know you.'*

Participant 1 proposed a similarly “bottom up” approach to preparing both clinician and client for the intervention by first gathering more information about the client's intersecting identities, a strategy notably informed by his introductory courses in clinical/counseling psychology and reflective of a culturally responsive preamble to further intervention:

*I guess a way that they could go about it is just asking them—let's say if a therapist is aware of their cultural backgrounds, it's better for them to ask because if not, from what I've learned, from my CNCSP (Counseling, Clinical, and School Psychology)*

*classes is not to assume that a certain culture is just based off of a gender or certain cultural identities. So I feel like if they were to ask first what do the clients identify as, to give an understanding of where they maybe come from might be a strategy for how to go about that. Then they could elaborate...*

Participant 2 voiced a similar concern about client perceptions of the intervention without sufficient preface of more general cultural exploration and alluded to an adjacent sub-category in this domain voiced by 4 (variant) participants which encouraged clinicians to also acknowledge clients' Cultural Vulnerabilities.

*Having gone through these experiences I can speak on them, you know? So I think that's like the main issue when it comes to having a therapist that's from a different culture. It's like, you, if you were, if you're telling me 'yeah you know great job for doing this,' or 'you accomplished this.'" Are you just praising me, or do you actually know my struggle? You have to build up to that praise, you know? And then maybe after that, she could shine a light on, or point out some strengths after that. I would be like 'okay, well now I know why you're saying that after like I told you,' and you know rather than just coming out of her, like if she were to approach it first, then like I would be like 'what gives you the right to say that?'*

This theme of acknowledging Cultural Vulnerabilities and challenges reappeared as a prominent process theme in participants' response to the intervention within the interview, and their reflections on the connections between Cultural Strengths and Vulnerabilities (see below).

The typical (10 participants) sub-category identifying ways to mitigate potential negative reactions to the intervention broached a related consideration which highlighted participants' variant (7 interviewees) observation that a variety of individual factors—most

prominently including the client's relationship to their culture—will influence their perception of the intent and utility of the intervention. This most often yielded an admonition to gauge the client's relationship with their culture before deciding whether to proceed with questions related to cultural strengths, as Participant 6 advised:

*If somebody is similar to me—if they're really connected to their culture—they might be really maybe happy or excited to talk about it. But I think if somebody was kind of distant from their culture, not really understanding it, or doesn't want to be a part of it, then maybe I would imagine they wouldn't want to talk about it as much. I don't know if [clinicians] should ask directly per se, I would think that they would kind of lead into the topic first and then get a feel if what the patient had identified before was a positive cultural connection, then yes they can lead into that and start talking right away. Because if you just ask the question straight forward with a patient who had some conflict or disconnection with their culture, they might feel like taking it back and kind of like really have to think about 'where is this session going?'*

While several of the participants verbalized similar precautions about assessing the client's relationship to culture before choosing whether to implement a CS intervention, Participant 14 directly demonstrated the importance of this consideration in reflecting on her response to the intervention itself: *"I don't think I gain anything like strength from my own culture. I feel kind of nervous talking about it because sometimes I just feel like a fake Chinese, I don't feel like a real one. I don't feel authentic."* Her response poignantly illustrates what a sensitive and nuanced topic one's relationship to culture is, and how important it is for clinicians to assess this relationship both in order to apply helpful interventions and to better understand the client overall.

Additional variant (5 participants) caveats about limiting misconstruals of and iatrogenic reactions to the CS intervention pointed out the importance of clearly delineating the context and construct of “Cultural Strengths.” In musing on her own reaction to encountering the concept for the first time, Participant 4 noted *“It might just not translate as well, but I’m not sure, because it’s something I’ve never done. It’s a hypothetical thing in my head, but yeah maybe it would be helpful, maybe it would be unhelpful, if it didn’t come across the right way. I don’t even know; I haven’t experienced that ever.”*

For several of the participants who spoke to this concern, the primary risk in a dearth of clarity or context of the concept of CS was the possibility of the intervention being construed as racist (variant, 2 participants) or as a reinforcement of REM stereotypes (variant, 4 participants). Participant 10 pointed this out with respect to the possibility of a clinician inadvertently committing a REM microaggression that alienates the client.

*The only thing I can think of is the way it's asked, maybe it could come off as accusatory or, in a negative manner, that makes the client feel a little uncomfortable with that and makes them not want to speak out about it. So maybe, not what is being asked but how it is being asked. I just feel like there's a big gap between minorities and it can...it wouldn't even be like them purposely trying but it can be something like a microaggression that can come out, that they don't realize it and that can really affect the outcome.*

Participant 8 underscored this concern while observing the need for delicacy on the part of the clinician not only to avoid subscribing to REM stereotypes, but also to be sensitive in delivering it in such a way that it does not indicate a sense of condescension or assumption. His recommendations again reflect the previously-noted mandate to take an open and deferential stance towards the client that acknowledges their expertise.

*It's just the way that it might be phrased? Like assuming stuff. People always—it's kind of annoying—like, 'you're this, does that mean you do this?' Don't assume that. It's not cool. I guess it's really all based on the way the question is phrased. So, I would advise a therapist or whomever to maybe be more open about it; be more open about your questions essentially. It's very tricky, you're walking on eggshells here. I can understand why this is so controversial. It's almost scary. Because any word can set someone off. It's pretty hard. I don't know how to completely give an answer as to how it would be best to phrase the question. It's just, do not imply, do not have a condescending tone, don't assume. Just be more open I guess, you can ask questions, but respectfully and, it might help to act like you don't know. Just be like: 'I'm sorry I don't know this—could you please let me know, in this culture, how do you do this, or stuff like that?'*

In addition to these recommendations regarding the delivery of the intervention itself, the participants exhorted clinicians to be wary of generalizing the client's responses to other clients or individuals in the same demographic group. Participant 12 spoke to this with respect to the importance of recognizing individual construals regarding what constituted a strength: “[an unhelpful thing about the intervention] *could be the stereotypes you'll get from it...something you would consider a strength, others would consider as maybe negative, like a stereotype, in terms of like 'oh, now because you're from this background, everyone who is from this background should be this way...'*”

Participant 9 echoed this concern with an emphasis on the need for the clinician to avoid generalizations both within and between clients:

*I think that maybe each person is individual, they're just different, so maybe some cultural generalizations wouldn't apply. I just feel like maybe not all of them would*

*apply to everyone. So making sure that it doesn't overstep into 'well then you must be feeling this way or thinking this way,' because people have different personality types and everything.*

This focus on avoiding over-generalizations and stereotyping aligned with a complex sub-category of responses in which typical participants (12 participants) emphasized important considerations for clinicians' competence in working cross-culturally. A typical (11 participants) auxiliary sub-category in this area highlighted the importance of clinicians' preparation to work with culturally-different clients. Participant 2 phrased this broadly in her exhortation to enhance the field of psychotherapy generally through more advanced multicultural training:

*If therapists would just be trained more on cultural backgrounds, it's such a huge thing, and I don't know if maybe there could be more extensive training on that it would probably just improve the field overall.*

Participant 14 was more specific in musing about both the challenges to and importance of a clinician's knowledge base regarding client culture:

*And I know there's a lot of cultures in the world, but I think it would be a little bit nice if the therapist would know at least, some basic, very basic, background, like how the family likes to raise their children and stuff, and their expectations. But it's also really hard cause I know, like, there is many, many cultures in the world.*

She elaborated further on the importance of clinician fluency with client culture in reflecting on how it would affect her engagement in therapy to work with a clinician who was not knowledgeable about her cultural background:

*I would have to stick with basic things, things that the person might understand. Like I wouldn't talk about the sort of things my grandparents would do on a certain*



*Chinese holiday or something, or what they said to me about how I'm supposed to behave a certain way. I wouldn't be talking about that, but I would talk about, just things that I think the regular Americans would like do, or not do, or want to do, or can't do, I guess.*

The typical participants (8 interviewees) who contributed feedback in this area, recommendations included input on the racial and/or ethnic pairing between client and clinician. Several (variant, 3 interviewees) participants reported that a clinician who shared their racial/ethnic background would better understand them regarding cultural norms, values, and identities, and that this would improve the therapy experience as a whole. Participant 2 explained that beyond a language barrier that hindered her clinician's ability to facilitate a family session, the clinician's culturally different background limited her ability to feel understood and connected as a client within the therapeutic relationship.

*The language barrier is huge. Because I mean the language barrier with me—she was focusing on me, right? And then there was no language barrier there, but then there was a lack of connection between what I was feeling and her understanding. Because, I do want to say it was because...I don't know, it's like, you open up to somebody and you tell them your issues and whatever but, like say if I were to have a Hispanic clinician and when she would shake her head to my issues, I would feel like I am completely understood because she has probably been through like some similar situations. Rather than when this therapist was shaking her head, you know I was like 'yeah you know, she's shaking her head, but like does she really understand?' In the back of my head I was still questioning it. Like 'do you really know what I'm talking about, do you really know the struggle?'*

Other participants (2 interviewees, variant) noted that racial/ethnic client/clinician matching does not guarantee a positive therapy experience, particularly with respect to the significant differences between individuals within the same cultural groups, and that this again underscores the importance of training that prepares clinicians to work with clients from a variety of cultural backgrounds. This was summarized by Participant 11 as:

*I understand that it will be helpful sometimes to have a therapist that is of your same race but even then they may not be able to relate to what you're talking about, you know? So I think that everyone should just be trained in that overall, not even deep into it. They can't you know, nobody can put their feet into your shoes exactly, but no matter who the therapist is they all should be trained to be able to help anyone. I know that's maybe difficult but even with a Black therapist, I might not be able to work out with them either. So I feel like in general just being able to tie that in would be really helpful.*

### **Responses to Exploring Cultural Strengths within the Interview**

While prompting the participants to explore their own CSs within the interview was not intended to directly replicate a traditionally therapeutic experience of the intervention, the team did collect information on the participants' experience of and perception of the process. The majority of this data was elicited via the open-ended query "what was it like for you to reflect on your cultural strengths here in this interview?" This generated a range of responses that highlighted the novelty of the task, and to a lesser degree, yielded direct descriptive appraisals of the experience.

Five of the participants (variant) indicated that it was a positive experience for them to reflect on their CSs within the interview itself (none of the participants described a neutral

or negative experience of the task). These responses consistently characterized the task as engaging and thought-provoking, and several observed that it felt notably distinct from traditional approaches to therapy.

Participant 10 pondered the felt difference between the CS intervention and the somewhat more familiar task of examining one's personal strengths in therapy.

*I feel like I've never really been asked that. So it's a lot...it's a new topic that I had to really explore and think about. But it's pretty nice being acknowledged. They've asked me about personal strengths but never connected them to my culture. I feel like I've never experienced that so it's nice...like I'm really connected to my culture so it's something that plays a really big part of me. When they've asked me about my strengths it's just been me as a person, but not me as a part of my culture.*

Participant 12 similarly noted that it was a new and meaningful line of thought for her, particularly with respect to contextualizing her own identity and the associated sense of empowerment:

*I think it was interesting because it's not something people really think about, but it is important. It's bringing importance to who you are and what you can bring to the table, and that's important because no matter who you are, your culture and your background has a story to it, and, you bring that story with you. And that's important.*

She additionally reflected on how application of the intervention might improve therapeutic services for clients who participated in treatment with her former therapist, whom she had previously described as having unsatisfactorily acknowledged important cultural facets of her identity: “*looking into it now is a step forward from where I've been. Hopefully, this would maybe help another student who's going to see the same person I did...*”

A variety of observations were made about the novelty of the intervention, including that CSs were a new idea to the participant (variant, 4 interviewees); that identifying and articulating CSs was somewhat challenging (variant, 3 interviewees); that CSs are rarely discussed in either therapy or in general (variant, 3 interviewees); and that the concept of CSs was unclear or confusing to the participant (variant, 2 interviewees). A complementary sub-category in this vein was the observation that Cultural Vulnerabilities are a much more common focus of exploration in therapy (variant, 3 interviewees), a note which reoccurred and was further developed in a later domain (please see “Reflections on Cultural Strengths & Vulnerabilities for process themes on this topic). The participants who mused over this point alluded to the relative ease of accessing negative associations with their culture in comparison to strengths.

Participant 9 exemplified this negative bias with her observation:

*I think that it's easier for me to just come up with the negative things, with the weaknesses. For example, I remember one time my boss was like, 'oh, you should be a more assertive leader and maybe your family taught you to be more quiet and more submissive,' and then when I heard that I was just so offended. That's what I think of like cultural weakness, like on the other end of the spectrum...I just can't think of any strengths that come to mind and it's weird. I think that it's making me think really hard about it and I'm wondering, 'why can't I think of anything in particular?' I think that because people don't really talk about stuff like that typically, especially in a therapy setting that's an interesting way to incorporate it. I think that it's really important.*

Participant 2 similarly focused on the typical orientation towards negative culturally-grounded experiences and pondered how this propensity affected his ability to identify CSs.

*The cultural strengths part is a little complicated, and I think maybe it's because that question isn't really asked often, you know? Usually when it comes down to culture and stuff, everybody gets stuck on all the negative stuff, or all the stuff that's wrong so it's like when you ask about the strengths I was like 'I don't know I've literally never thought about it, you know?' So that was a little bit...I had to actually really think about it.*

Participant 5 noted that when CSs were discussed, it was almost invariably in the context of a type of post-traumatic growth, in the sense that the strength was a reaction to a struggle.

*I feel like cultural strengths are always used in a negative sort of way. Like for example, I was saying: 'you have to be strong.' But that's because we've had so much oppression in the past. It's always used with a negative connotation. So I think it will be helpful to draw on what like positive experiences like what strengths have come from positive experiences, from your culture. Any positive experiences from your culture, what strengths do you have from that, and that way we can....sort of see the whole picture and see if maybe we can combine these strengths, in a way.*

This idea of the interpolation and reciprocally-generative nature of Cultural Strengths and Vulnerabilities was highlighted as a process theme by many participants in the last domain (see below).

### **Reflections on Cultural Strengths & Cultural Vulnerabilities**

This domain captured both the concrete responses of participants when identifying their CSs and the process themes that accompanied this exploration. In keeping with the aforementioned warnings from the participants about the dangers of generalizing individual

accounts of cultural strengths to other members of the same REM group, the team assembled an inventory of identified CSs not as a reference point for REM group-specific strengths, but as a representation of both the overlap and divergence in identified CSs between and among the participants. Typically (11 interviewees), participants were able to identify at least one of their Cultural Strengths during the interview. The most common identified CSs were grouped under the sub-categories of Close Family Ties (6 participants, variant) and Valuing Hard Work (6 participants, variant).

Participant 6 described her cultural strength of family closeness and collection in terms of their commitment to maintaining their relationships and visiting despite geographic separation.

*I guess the main thing is keeping in touch with family, because at least when I have talked to my friends, they don't have particularly big families and when they do, they don't really keep in contact with their cousins. Or, you know, not many of them even know who their second cousins are. Whereas I have so many family members all around the world pretty much, and I know who my great grandparents, my great aunt and uncles are—all on the East Coast—and I have second cousins in New Zealand, and so there's a huge family. Growing up, my parents and I would take the summers to go to the East Coast so I'd see my distant family there.*

Participant 1 described a similar phenomenon from a more sociological perspective, perhaps underlining the aforementioned point that the values and customs of one's own culture becomes clearer to most people through contrast with other cultures.

*Some cultural strengths that I've learned is how Latino-based families are very focused on close family relationships. Versus the people that I've met that are from White families, they're more separate because they don't really have close relations*

*with their extended family. It's usually just them within themselves versus a Latino-based family, where we are very close with all our cousins, our aunts, and we're always spending so much time with them even living in close proximity. So I feel like one cultural strength is learning how important family relationships are, like relations to have in your family.*

For many of the participants, the Close Family Ties CS overlapped with the Hard Work CS, as well as with several of the less frequent but still notable themes, such as on Emphasis on Education (5 participants, variant); Respect for Elders (4 participants, variant); Empathy (3 participants, variant); Persistence (2 participants, variant); Openness (2 participants, variant); and Doing Things Well (2 participants, variant). Several participants furnished descriptions of CSs that highlighted the interconnected nature of several of these themes, and how they were galvanized or reinforced by experiences of displacement, immigration, or marginalization.

This reciprocally-informing interpolation of strengths with circumstances characteristic of many REM groups is evident in Participant 13's complex and highly-narrative response to the CS intervention. She additionally points to the difficulty of literally translating some of these strengths from the language and context of her parents' racial/ethnic culture of origin.

*There's the resilience which I feel a lot of Asian Americans and Asian—especially first-generation students—hold. Just a lot of setbacks and me, I guess ethnically as a Filipina-American woman, there's some values within the culture that in Filipino or in Tagalog there are words for them but not so much in English. Some values include, for example: hospitality is one of them, which is why I feel like you see so many Filipino nurses. Hospitality, kindness, generally joy, like if or whenever possible; an*

*orientation to family, education, and I think the one that I personally like to think that I uphold and have tried to uphold is resilience. And I feel like I see that on a global scale, a lot of Filipino overseas workers work wherever they can get jobs and provide for their families. For example, my mother who immigrated to America in her 20s, she was working from the age of 15 or 13 as a domestic helper. She nannied and she settled here, had me, tried to instill those values in me, which I think are instilled in me. But just the idea of resilience of the community and meeting other Asian-Americans growing up and even in college and hearing all the stories there seems to be this common theme of resilience and hard work. Which is both very comforting and also there is a lot of pressure, but I like to think that at this point in my life I find it really comforting to surround myself with like-minded people and stuff, we all want to work hard and get somewhere and then eventually have enough money to start a family and take care of our parents and accomplish the whole idea of the American dream, within the terms of the Asian-American dream. I think that would have been nice—I feel like that is a wonderful value that I think I would have liked to discuss.*

With its many layers and abundance of nuance, this description exemplified the types of responses that gave rise to the typical CS Process Theme category in this domain, which were identified in 9 of the participant cases. These sub-categories captured motifs that were often a “background feature” of the participant responses yet appeared with notable repetition across cases. These included the typical (9 participants) idea of the overlap of Cultural Vulnerabilities or challenges and CSs, such as strengths that emerged from adversity (6 participants, variant), and the intertwined nature of CSs and Cultural Vulnerabilities (5 participants, variant).



Similarly, several participants spontaneously responded to the prompt for CSs by remarking on Cultural Vulnerabilities (6 participants, variant), which were then often linked in the participant description to the aforementioned CSs such as values for Education and Hard Work. In these responses, it became evident that strengths were often inextricable from vulnerabilities: the struggle experienced by previous generations from the participants' culture motivated and inspired them (5 participants, variant), and they felt both connected to and influenced by their culture (5 participants, variant), but these strengths were often associated with high expectations from parents or participants' cultural community, which consequently caused significant stress and anxiety to the participant (5 participants, variant).

Participant 7 illustrated the complexity of these interlocking feelings of gratitude and frustration with respect to cultural strengths and expectations while simultaneously highlighting the corresponding fretfulness and hopefulness of a first-generation college student.

*My mom and my aunt pretty much raised me; I didn't really have that much of a father figure. I think they have this expectation of me to kind of be the man of the household, and I think they want me to...I realize that because I'm a first-generation college student, there's so many things that I'm not smart enough to do and I can't understand, but I have such an advantage over my mom and aunt, because they barely speak English and we're in America. And I see them getting really shitty jobs and telling me, 'this is why you're in school.' But it's a lot of pressure, it's like, 'what if I suck, you know?' And 'what if I'm not good enough?' And I feel like Asian cultures always make you feel like you're not good enough and I've always struggled with that. My boyfriend's Mexican, he would tell me: 'you need to stand up to your mom sometimes, you need to tell her 'don't treat you like that, and don't say these*

*mean things to you,' but I don't because, I tell him 'I can't, you don't understand, it's respect, you gotta respect your elders.' ... Right now I'm dealing with some financial trouble, but as I reflect on my mom and my aunt when they were seventeen or eighteen, they farmed rice and I'm just like 'oh my god I would never do that,' but it's something that they had to do before they moved to America. And I just feel like I'm very blessed to be in this situation because even though it takes me longer to understand something—because I feel like I had no one to really look up to that had the education—I feel very lucky because I'm like: 'ok, if anyone's gonna do it, it's gonna be me,' you know?*

Participant 10 shared about a similar impression that support for higher education was a CS paired with a frustrating culturally-rooted challenge, illuminating the double-bind of parental expectations that call simultaneously for their child to maintain close family ties while also forging accomplishments that require them to venture outside the family's traditionally locally-circumscribed territory. She also points out the ways in which her clinician's failure to grasp the gravity of this dilemma limited his therapeutic helpfulness.

*When I think of cultural strengths, the one thing that I think of is my parents always telling me to go for higher education. So understanding the value of...I wouldn't speak for everyone, but my parents as Hispanic parents are always telling me like 'I wasn't able to go to school and now you have all these opportunities.' So it's like having the pressure of wanting to make them happy in an educational manner. I think it would be more helpful if [participant's former clinician] had understood the severity of that...And I'm the youngest out of five, and for me being the only one to want to go away—they wanted me to go to school but like I said, they wanted me to stay local, which is a very, very, common thing in Hispanic parents and maybe parents in*

*general; they don't want their children to leave. But having the pressure that they want you to go to college but they don't want you to go to that college but they want you to do good and...it was just like a really weird relationship that I had to deal with my parents because, like I said, I always tell my parents 'Oh I'm gonna go away for college,' and then I was really close to my mom so she's like 'Yeah, you're gonna go' but like, in the back of her head, she never really thought I was going to leave.*

In addition to the prominent motif of overlaps and intersections between Cultural Strengths and Vulnerabilities, the Process Themes sub-categories also typically (8 participants) included the team's observation that interviewees embedded their descriptions of CSs in anecdotes or examples. As with Participant 13's aforementioned description in which the cultural values of resilience, hard work, education, and perseverance were both named and illustrated in the narrative arc of her mother's immigration trajectory and that of the Filipino individuals who she invoked as examples, many participants responded to the CS intervention by sharing a story that exemplified their CSs.

Participant 5, for example, initially struggled to verbalize her response to the CS intervention before responding poignantly by describing a series of memories in which her grandfather transmitted cultural values to her through a refrain that continues to guide her now.

*Ever since I was growing up—my grandparents started watching me at 8 weeks old when my mom went to work and they lived across the street, so my mom was able to just take me across the street and I would stay with them or my grandma would come over. And even learning to count coins, learning how to jump rope, my grandpa would be there saying, "learn to do things right, don't go, you know don't try to do it half way, learn to do things right completely.' So that's one thing that resonates with*

*me. I always hear, 'learn to do things right,' you know, master the skill, learn about it,' It's just always in my brain, I hear his voice. Even to this day he still tells me, 'learn to do things right.' And you have to do it and it has to be right or it's not—not like it's not going to be good enough, but—it's not gonna help you in the future. That's what it is.*

Participant 11 similarly pondered how to put into words a complex sense of empowering connection that she shared with other Black residents of a predominantly White city.

*Well, I like being Black, I don't know how to say it. I feel like even if you are in these kinds of situations when you do see another person, it feels clear you can say hi to them even if you don't know them, but they have your back a little bit. I think that's a strength. Because here it's like there's not that many Black people here, but if I see an older Black person on the street they'll say hi to me. I don't know them but they'll acknowledge me, my presence. So I think that's a strength, you know. I just feel like there's more bias than anything because I'm Black. But I feel like we have a lot of strengths but I just don't know how to exactly explain them...it's like a community. Sometimes it's just really helpful when you see somebody that looks like you and some people—maybe they're just in their own world or maybe going through something, I don't know. They may not say hi but I like to make sure to say hi to them because I know maybe they could be frustrated or something, and I don't want them to get the idea, the same experience that I had before [referring to earlier description of feeling isolated on campus]. You know? So I like when people are like 'hi, how are you doing?' Or stuff like that, you know. Because I think that we should be like that because it is pretty difficult to be here if you're not used to the environment.*

Such embedded descriptions stood out to the coding team both for their potency in comparison to simply labeling CSs, and also because they seemed to point to the difficulty of identifying or describing aspects of culture in which one is or has been fully immersed. Participant 14 observed this dilemma succinctly in noting that the implicit nature of cultural transmission and absorption made it difficult for her to respond to questions about cultural strengths, particularly to a clinician who was not knowledgeable about her cultural background. *“It’s not like I grew up sitting in front of a desk studying what my family was all about. You know, what they do, how they pray, how many times they bow on a certain day, how many incidents are allowed or not allowed. I don’t know most of that. So I wouldn’t know how to talk to someone who doesn’t know about it.”*

### **Exploration of Personal Strengths in Therapy**

While—as previously noted—a much vaster and better-established body of literature already exists on the use of Personal Strengths (PSs) as opposed to Cultural Strengths interventions in therapy, the team was interested in how an interventional approach incorporating PSs was perceived in the context of a racially and/or ethnically cross-cultural relationship. Participants typically (12 interviewees) endorsed having explored Personal Strengths in at least one of their therapy experiences. While many of the strengths that they identified as having been a topic in therapy were of a miscellaneous variety (7 participants, variant), there were also several clusters of types of strengths that were shared across multiple cases, including Analytical strengths (6 participants, variant); the strength of Resilience (5 participants, variant); Interpersonal strengths (4 participants, variant); and the recognition that Personal Growth represented a strength (3 participants, variant).

In terms of perceived outcomes from interventions addressing personal strengths, participants identified a range of benefits, with 9 participants (typical) explicitly noting that they found it helpful to have discussed their Personal Strengths in therapy. Typically (10 interviewees), participants described a sense that the intervention had resulted in an increased awareness of Personal Strengths. Half of the participants (7 interviewees, variant) elaborated on this point to note that the exploration of PS resulted in the experience of positive feelings, and half of the participants (7 interviewees, variant) also described ways in which the PS that they identified in therapy were mobilized as resources that improved their mental health. Four of the participants (variant) additionally expressed a belief that exploring PS in therapy was an affirming and empowering process for them, while four participants (variant) also endorsed a perception that the exploration process helped galvanize a new and helpful change in perspective regarding themselves and/or their presenting problems.

Participant 9 summarized several of these adjacent outcomes in describing how his experience focusing on Personal Strengths in therapy had helped him to view himself and his challenges in a way that allowed him to feel more hopeful while also enjoying his life more.

*It was really good because I think that at the time, I used to think that my problems were everywhere, like in all aspects of my life and that felt really hopeless. So that was really good for me to think 'oh, it's only part of your life that sucks and not all of it,' so I think that was helpful so I wouldn't think about all the bad stuff as being so overwhelming. So yeah, just making sure that I wasn't overthinking what I was going through I guess. And then being able to be happy about the other things I'm doing well at, and understanding that I still have that.*

Similar to Participant 9's shift in perspective—and also reminiscent of Participant 8's observation about the ways in which identifying and exploring CS could help a client feel

more resourced and efficacious (“*help them help themselves,*” see above)—was Participant 5’s recollection of how highlighting PS in therapy had helped her find a new way to manage her symptoms while also enhancing her sense of agency.

*The therapist would always say that I'm smart and resourceful so I like to research everything, I wanna try everything to help me so they would always draw on that. 'Oh you go to UCSB, you have a lot of resources you can...you know you are always researching, you always come up with something.' So that was another strength...and that felt good. I never had someone tell me, 'you can use those strengths.' I only used it for academics to just get by being calm, studying, being smart. So I had never realized that I can actually apply it to my everyday life and use that to help with my disorder and everything. Like I'm really good at—my mom always calls me 'her researcher.' And I was able to be like 'okay well, I can research this about anxiety or this and learn what's going on in my brain, learn on my own, do all this studying and then come back and be ready, saying 'okay, I understand what's happening to me now, now I can tackle it.'*

### **Client Reflections on Identity**

Likely due to the aforementioned open-ended format in which self-descriptions were elicited in the interview, participants shared substantive details about their intersecting identities as well as the construct of identity itself. These included direct references to demographic identity markers as well as more general exploration of the intricate nature of cultural identities and their influence on the participants in daily life. In addition to those elaborated upon below, categories and sub-categories in this domain included Identifies More with One Aspect of Cultural Background than Another (3 participants, variant); Experiences

Incongruence with Cultural Background (3 participants, variant); and Challenges Experienced in Negotiating Bicultural Identities (2 participants, variant). While these closely-adjacent sub-categories included only a small proportion of the participants, the team felt compelled to preserve them due to the emphasis the participants placed on them as a spontaneous reflective process during the interview. The more prominent categories described below capture similar themes of participants' struggles in articulating and navigating variegated identities.

The most prominent of the categories in this domain captured Reflections on Complex Nature of Social Locations and Identities. Half of the participants (7 interviewees, variant) contributed their musings on this topic, with observations that ranged from the concrete to the philosophical. Many of the participants commented on the distinctions between their experience of themselves in terms of identities, and the perceptions of others, particularly with respect to visible versus invisible identities. Participant 3 alluded to this dichotomy with her thoughtful description of intersecting and diverging societal expectations of her in terms of gender, race and ethnicity, and upbringing.

*I'm from a pretty middle class Asian-American background, with more emphasis on the westernized American identity. But I definitely feel that society looks at me as an Asian-American and that I am a person of color and a minority in that sense. And there are certain social values—and expectations of me— as an Asian American but also, I notice, as a woman. So it's a lot of intersectional aspects that I really have come to think about, that affect my outlook and perspective on myself and society.*

Other participants' responses demonstrated the struggle of describing qualitative experiences of identity in quantitative terms. This was particularly evident with respect to the differences between veins of identity that merged and dissected across demographics of



biology, culture, geography, socio-economic status, and phase-of-life hurdles. Participant 8 illustrated this complexity in his thoughtfully parsed self-description:

*I am mostly Chinese. Race-wise, I'm probably about three-quarters Chinese. And one quarter Vietnamese, by race biologically. But even though my parents were mostly Chinese by race, they were both born in Vietnam. Which was different, so ethnically, I'm more Vietnamese. I identify more with Vietnamese culture and stuff, but biologically I'm more Chinese. So it's like a little more mixed. My nationality is: I'm American. I was born in California. I consider myself middle-middle class, dead center middle class. It kinda sucks though, when you get too much financial aid. No, I'm not rich enough to pay it all off so...*

Reflections and demonstrations on the difficulty of articulating one's social location often prompted observations from participants regarding the challenges of navigating cultural differences between the community in which they were raised and their current community in college. These variant (5 participants) responses were captured as Family and Community Tension regarding Cultural Values, an unanticipated emergent category that was deemed as particularly notable by the coding team due to its relevance to potential presenting problems in therapy. Participant 13 illustrated this connection between self-identification and phase-of-life struggles over cultural values with her highly-detailed description of contributing influences to her and her family's identities and beliefs.

*I am Asian-American and Caucasian-American, but I was raised in a very big city in California so I had a lot of multicultural interactions. For the most part, in terms of cultural values, I identify more with the Asian-American values, I guess. In terms of Authoritarian parenting. So more stringent in education, more stringent ideas of education, more conservative ideas, I guess of behavior for females, young adult*

women....In terms of my own personal identity, I'm in my 20's, I grew up in a big multicultural city and I am, I guess, colloquially, I am White and Asian. So I grew up in a bi-racial, bi-ethnic household with two very different parenting styles based on their ethnicity, their social status growing up, and I guess their race. So in terms of that, I feel like those were—that was very defining. In terms of socioeconomic status, I came from, the working class, or the lower middle class. So, the idea of therapy and mental health, were very nonexistent in high school and I learned more about it in college if not all of it in college. Because for the most part the idea of mental health is not readily discussed, I don't even think now really, in the Asian-American or Asian community. Whether it be on the continent of Asia or in America or elsewhere or even among my own peers. For example, freshman year I lived on the Asian/ Pacific Islander floor, even among my own peers it was a stigma to have like a psychological or mental health issue or problems. But now that I'm in my fourth year as a Psych major, and having experienced psychotherapy and medication myself, I don't see it as a stigma and neither do a lot of my peers which is awesome. But in terms of coming up to my parents who—my mother is an immigrant from Asia, and my dad grew up in the city that I was born in but in a rougher part of town I would say. So the idea of mental health and psychotherapy or psychological health to them, even describing my major, as a psychology major for them was difficult to understand. But now I'm making attempts to reach out and explain myself and what I want to do in mental health in terms that they understand, which is difficult but I feel, very important.

Participant 4 also offered a nuanced view on the divergence between the identity markers of her family of origin and her emerging values and beliefs as a college student. Her explicit connection of these tensions to her presenting problems in therapy illustrates the

coding team's interest in highlighting the relevance of this complex topic for effective client conceptualization and treatment.

*I am Latinx because I come from two different like Latino countries, so I just don't really go by one because there's a lot of cross barriers between all those different countries. And our family, our socioeconomic status is really, really low right now, we're struggling with money, so I also feel like that affects a lot of what goes on in the house. I've seen a huge difference of when we were doing better with money compared to now. And how much that caused problems. And then, I personally am agnostic but my family's Catholic, so that also caused a lot of tension, all the time, because they always argue with me about that...I do feel like as I've grown older and built my identity, it doesn't really match what my parents want from me sometimes, so it gets really complicated at times...It has come up a lot [in therapy], because my parents want one thing and I want another.*

Such poignant observations illuminate the territory of cultural values and beliefs as a primary site of the college student's phase-of-life struggle to differentiate while also preserving important family relationships and at times, cultural assets. They also serve as a reminder that simple demographic categories rarely suffice to capture the multidimensionality of identity as it relates to self-perception—and by extension, therapy. This is a particularly important consideration for clinicians working in a cross-cultural therapy context, wherein misunderstandings and oversights regarding important aspects of identity can hinder or even disrupt entirely the therapeutic alliance and the course of treatment.

### **Exploration of Cultural Background in Personal Therapy Experience**

Cross-cultural communication on matters of identity was highlighted in this domain, which captured participants' experiences (or lack thereof) in exploring their cultural backgrounds (CBs) during therapy. The branching logic responses in this domain explored how participants perceived this experience as well as the reactions of participants to having their CB either minimally addressed or not at all. Strikingly, nearly half of the participants (6 interviewees, variant) stated that their CB was never explicitly addressed in therapy, while 3 other participants (variant) reported that their CBs were minimally addressed, for example in the form of a brief series of demographic questions at intake.

For those whose CB was addressed during therapy (5 interviewees,<sup>5</sup> variant), participant reactions spanned a gamut from a positive appraisal of the experience (3 interviewees, variant), to a negative appraisal (2 interviewees, variant), to a neutral appraisal (1 participant, variant). The context in which CB topics arose for these participants included Exploring CB in Relation to Family (3 interviewees, variant); Exploring CB in Relation to Feeling Out of Place at School (2 interviewees, variant); and Exploring CB in Relation to Conflicting Cultural Values (2 interviewees, variant). The complex and deeply personal nature of these prompts for CB exploration in therapy highlights CB as rich territory for therapy conceptualization and intervention.

For those participants who endorsed a positive experience exploring CB, the benefits of the experience included Enhanced Contextual Self-Understanding (3 interviewees, variant); Improved Mental Health Functioning (2 interviewees, variant); and a process-oriented sub-category noting that Exploring CB felt Comfortable and Natural (2 interviewees, variant). Participant 3 highlighted the benefit of Enhanced Contextual Self-

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<sup>5</sup> Please note that these sub-categories include 6 responses from the 5 participants within this category because one of the interviewees described two distinct appraisals of separate experiences with two different therapists.

Understanding in her description of an ongoing dialogue between herself and her clinician about her intersecting identities that proved to be a positive and illuminating therapy experience.

*We talked a lot about how there is so much an emphasis on grades, and there are certain parts of the identity that they choose to press down, in terms of the Asian identity that the only thing that matters is that you reach the top, and that you provide for your family, nothing else, you know your mental health, and other aspects of your, like you don't matter. I felt like it was really, eye opening and it gave me more perspective on just cultures in general...I'd say it was positive in that, in the past I hadn't really considered it so much, and now it's something that I do almost daily: considering what aspects of any of my identities affect social interaction and even more generally, how the world and societies come to look at those, and look at me. I think it was really good of them to be as open minded as they were, and I guess it's not something that I didn't expect, but it's something I feel like I kind of took for granted. I guess because of the way that I was brought up, more westernized, I had come to feel like I identified more in that respect, so I felt like it was a really good experience.*

One response in this domain emphasized how influential acknowledging CB can be on the course of treatment. Participant 7 describes two very different therapy experiences and corresponding outcomes with one therapist who incorporated the participant's CB context into treatment in a way that she found helpful versus a subsequent therapist who did not explore or even acknowledge the role of CB on her presenting problems.

*I did [discuss CB] with my high school therapist, but not with my college therapist. Because my mom was really hard on me, so [participant's high school*

*clinician] would always tell me, 'oh it's because you know, your culture's kinda different.' Because I know 'white cultures are always telling their kids 'oh, you did a great job doing this,' but Asian cultures are always like: 'that wasn't good enough, you got a B+, that's not good enough. You need to get an A.' And she's like, 'yeah, I think that's a cultural thing.' So my high school therapist made it ok for me to not be so hard on myself. But then my college therapist kinda made it more like: 'do you realize that you're doing this to yourself?' I don't know if that makes sense, they're very like: 'do you know that you're perpetuating this behavior, this attitude towards yourself?' But I was just kind of like: 'well, it's not my fault that I'm feeling this way, because I was brought up in this manner, you know?' Yeah. So, I think my high school therapist was a lot more understanding about that...I feel like [participant's college clinician] thought that: 'yeah well this happened a long time ago and you're still on it because of your own mindset,' you know what I mean? They just made me feel, like 'it's not that you need help, it's that you need to change your own mindset,' and I'm like, 'no I need help.'*

While the outcomes of failing to explore CB in therapy clearly had negative ramifications in this case, it also became evident from the participant responses that in cases where clinicians did explore CB, there was still plenty of room for error. Participants endorsing a negative appraisal of the experience (2 interviewees, variant) identified Challenges in Communicating Cross-Cultural Material to Therapist (2 interviewees, variant) as a significantly difficult aspect of exploring their CB in therapy, and at times a notable hindrance to the therapeutic alliance.

Participant 4 conveyed the frustration of wanting to explain a key aspect of her presenting problem to her clinician but feeling that the gap between their racial-ethnic

cultures was too significant to effectively communicate culturally-grounded factors. She returned to this theme later in her contributions to the aforementioned sub-category in which some participants expressed a belief that racial-ethnic clinician/client matching could improve therapy experience for clients, highlighting what a significant obstacle this was for Participant 4 in her treatment.

*Yes [CB was explored] and that was where I know it's hard to explain sometimes, especially cause I would talk about my family and how sometimes because of the culture my dad comes from, he's very difficult. And it's just really hard for me to explain to my therapist why my dad is so difficult because it all had to do with culture. So that was a bit hard communicating across, when I was talking to her. I mean, I tried to explain the best I could but, I just feel like as much as I try to explain you have to like, know. Have some understanding of it...it's just hard to explain in words, like 'machismo' in my culture it's just hard to put into words that would be understandable in an American context because it's just so prevalent in my culture that it's really hard to just explain it cause if I just said that to anyone in my culture they would understand immediately...My dad was being very difficult that summer. So, that's what I was talking about how I didn't know like how to deal with not feeling comfortable at home or at school. I mean, I feel like she did try to understand, but it's hard to get that across. And I mean, yeah I feel like she did try to understand the best she could but yeah it's just that those kind of things are—there's always that little barrier between the culture and context. It was hard to see if she was really getting what I was saying, I couldn't know if she actually was getting it, but I was trying the best I could to get it across.*

## **Impressions of Therapist**

The interview included a brief series of questions focusing on the participants' impressions of their therapist(s), with an emphasis on what they felt was helpful or unhelpful about the therapist in their professional role. While there is a vast body of literature on client perceptions of their therapists, the team was interested in assessing this topic with a focus on responses that may pertain to multicultural competence in the context of a racially and/or ethnically cross-cultural therapy relationship. As previously noted, most studies of multicultural competence have been grounded in predetermined definitions of the construct: here the team attempted to identify participants' extemporaneous perceptions of the therapist qualities that contributed to positive and negative cross-cultural therapy experiences. The emergent themes in this domain included several technical points and also a swath of relational ones for both valences<sup>6</sup>; participants typically (12 interviewees) endorsed positive appraisals of their therapist(s) and also typically (also 12 interviewees) endorsed negative appraisals of their therapist(s).

The typical category of Positive Appraisals was divided into multiple typical sub-categories, including Offered Useful Interventions & Skills (9 interviewees); Therapist was Perceived as Genuinely Invested in Client (8 interviewees); and Therapist was Experienced as Understanding & Accepting (8 interviewees). Additional variant sub-categories included Connected Client to Resources (5 interviewees); Client Appreciated Nondirectiveness (4 interviewees); Therapist Provided Helpful Guidance (3 interviewees); Positive Individual Personality Characteristics (3 interviewees); and Therapist was Culturally Responsive (2 interviewees).

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<sup>6</sup> Note that Positive and Negative Appraisals of Therapists were not mutually exclusive: the majority of participants endorsed both.



Participant 4's description of her positive impressions of her clinician encompasses several of these sub-categories, including what might seem to be an unlikely endorsement of an appreciation of non-directiveness paired with specific and directive interventions and guidance that she found to be helpful. Such seemingly-contradictory responses were common in this domain, and likely reflect the dynamic and highly-contextual nature of treatment, such that approaches and interventions that might be unwelcome at one point in therapy become valued at a later junction (and vice versa).

*I did like that my therapist was very— she tried to be as understanding as possible so that was good. And then I felt like she gave me a chance to talk a lot about what was going on with me and, instead of asking me so many questions or telling me what to do, like I was able to just talk a lot. And then some of the activities that she would help me do to think about my problems were also pretty helpful. So yeah, I enjoyed that, and I felt that it did it worked pretty well...I remember that she was just trying to characterize problems in ways that I would see them. She would give me ways to approach them in ways that I would feel more comfortable in approaching them, stuff like that. She gave me a lot of like school advice, like she originally had recommended I take a quarter off, but then she left it up to me to see how I felt after Winter break. And then I came back because I felt like, like I'd been doing better than I had been...She was very kind and she had a very soothing voice so I felt really comfortable talking to her. She sounded like she actually wanted to listen.*

Many of the participants contributing to this category similarly emphasized relational facets of treatment and elements associated with enhancing or reinforcing the therapeutic alliance, such as attunement and an experience of genuine caring for the client's well-being. Participant 8 reflected on the contribution of these less tangible yet potent aspects of therapy

in his description of how a nonjudgemental and attentive clinician helped him to better understand and organize his experiences and himself.

*This sounds generic, but she was very open. Very open, very good at listening. Cause sometimes when I'm talking, I'll stare off into space and just start thinking and try to see where my thoughts are at. But she would just be there waiting intently. And that helped me get back on track, that made me feel that she was really listening, which was helpful. She wasn't ever judgmental but I feel like that's what most therapists are, hopefully [small laugh]. I was a rambler at that time because I was so emotionally distraught I was just like 'ramble ramble ramble,' but she was able to get all of it. It was crazy, even I didn't know I said that, like 'oh did I just really say that?' And she was like 'yeah you said it like a couple minutes ago.' And then she'd catch that and I'd be like 'oh that's cool.' So she was able to listen and get everything down, she was a really good listener, she was open, nonjudgmental...I'm not sure if it was within her training, or just something she experienced herself, but she was able to relate back to me—like name some situation—like 'oh maybe it's the way you feel right now or the thing you're going through is sort of like this,' and I'm like 'oh yeah she's right, it is so like that.' And then it gave me clarification because she went and labeled it. Cause sometimes I'd feel something and I wouldn't know what this is so I didn't know what was happening or if this had happened before, and then she'd label it and like 'oh ok, it's categorized now, so I know what it is.' So she basically organized everything for me, that's what I liked about her, she knows when to listen and be on the spot. If that makes sense.*

In addition to these types of Common Factor elements of positive cross-cultural therapy experiences, the team was particularly interested in clinician qualities that

participants associated with clinician competence regarding explicitly cultural aspects of therapy. While it was a proportionally very small variant sub-category, the emergent theme of Culturally Responsive Clinician qualities was highly informative.

Participant 5 shared a recollection of an exchange with a therapist in the context of a residential outpatient treatment center, where the participant had worked with a number of different therapists with varying outcomes. In this case, cross-cultural normalization and validation seemed to be a critical ingredient in addressing the participant's presenting problem, whereas the other clinicians had only offered culturally dystonic interventions.

*My mom and I, we have a rocky relationship, we always have. And at one point I was talking about a fight with my mom and the therapist that I had, she was just like 'Oh yeah, I know what you're going through, my mom was just very snippy too,' and was telling me about her story and that made me feel like okay it's not just my family, like culturally. Because all the other therapists were like 'Maybe you should just move out to your grandparents'. ' But I'm just like, 'in my culture, in Latina culture, family is...you have to stick together.' So she understood, she's just like 'maybe you should just talk to your mom and set boundaries,' and I understood that. So if there were a lot more instances like that I think I would've appreciated it more. I guess from her own culture, she knows that family is family. She still had to take care of her mom no matter what, so she understood too.*

In contrast, Participant 3's description highlighted the importance of a clinician's ability to communicate openness in acknowledging, exploring, and expressing an understanding of culturally-different identities and value systems. Notably, Participant 3 was the only interviewee who endorsed having explored Cultural Strengths extensively with her clinician.

*I think it was the fact that we kind of talked about all these intersecting identities that I had, and what they were able to offer even though they didn't identify with me, but what they understood and how they responded to what I would say was very helpful, I think. Yeah, that they were more open to certain aspects that we'd talk about like gender, sexuality, and just a lot more topics that in Asian culture aren't talked about or are kind of taboo in a certain sense.*

The category of Negative Appraisals of Therapist(s) featured a similar mix of relational and technical elements, with a more pronounced emphasis on the extent to which the participants' presenting problems were accurately identified and effectively addressed. Typically (9 interviewees), participants identified a perceived poor fit with the clinician as a significantly negative aspect of therapy, as manifested in experiences of feeling uncomfortable and misunderstood by their clinician. Slightly less than half of the participants (6 interviewees, variant) expressed that their clinician Failed to Satisfactorily Address and Resolve Presenting Concerns, and the same amount described disappointment in clinicians' use of Irrelevant or Ineffective Interventions. Three of the participants (variant) endorsed a desire for greater Directiveness, a notable contrast to those who had identified their clinicians' Lack of Directiveness as a positive feature of their approach to treatment. More concerning from an ethical perspective were the participant reports that described experiences of being Invalidated by their clinician (4 interviewees, variant); Referred out Against Client Preferences (2 interviewees, variant); and Perceived Professional Incompetence (2 interviewees, variant).

The team spent additional time reviewing the variant sub-category of Perceived Lack of Competence Regarding MultiCultural Issues (7 participants), which was comprised of

auxiliary sub-categories including Cultural Barriers to Connection and Understanding (6 interviewees, variant); and Culturally Dystonic Interventions (3 interviewees, variant).

Participant 5 offered a disturbing description of an experience with a therapist in her residential outpatient program who exemplified several of the most egregious points in this category.

*It was different, every day I had a different experience but as the weeks went on and as I got to know the therapists, I got to know their styles and knew which ones to avoid if I knew they weren't gonna help me culturally. There was one therapist that we all knew just to avoid and she offended many people whether it be culturally, the LGBTQ community, whatever. We ended up hearing about different experiences and then experiencing her on our own...At one point—because I do not talk to my father; I have not talked to him since I was 14 and I'm 22 now—she asked about my father and I explained the situation and she was just like, 'oh, well you need your dad.' And I was just like 'oh, well he was more toxic so I'm better without him.' And then I said 'I honestly don't feel anything, I don't feel hatred or anger, sadness, I just felt like it was the right decision,' and she looked at me and just said 'I don't believe that.' So that was like the first indication that she was gonna be trouble. And there was another girl who I knew and she didn't talk to her father either and she said [the clinician] didn't say that to her. So at this point my friends and I were thinking maybe it's a cultural thing, since I am Mexican that maybe she sees me as more troubled or something. So that's...yeah that's one instance that stood out to me....and because she would always be after me in the group therapy saying I didn't speak, I didn't talk and sometimes I would be the only Hispanic in there and I explained to her many times during the first couple of weeks that I was new to my medications so I was very*

*drowsy in the morning and I was falling asleep so I wouldn't want to talk and she still was after me about that and there was another patient who I had become friends with—he was white—and he was always asleep in the morning, he would always pass out but she left him alone and let him sleep through the sessions.*

While this Participant 5's descriptions of these negative cross-cultural encounters struck the team as the most conspicuous and unsettling examples of multicultural (and general professional) incompetence, other participants shared less flagrant but nevertheless insidious experiences with clinicians whose preconceived notions and biases about them and their background obstructed the therapeutic alliance. Participant 12 provided an example of this in describing her disappointment in encountering her clinicians' assumptions about the culture of her home community, after noting that an intervention asking about CSs and CVs would have provided her the opportunity to disrupt these stereotypes and also to make explicit the elephant in the room of cross-cultural differences within their relationship.

*I think I would have appreciated that opportunity [exploring CSs and CVs]. Not that I wanted her to feel uncomfortable, but I want her to know that it's okay to feel uncomfortable. Like you're helping students of color, and so it's fine for you to be like 'yes, I understand that I'm very privileged as a white woman, and my experience as a student was very different from yours.' ...Because even when I'll tell people where I'm from, they're automatically like 'oh, really, have you ever seen this? Or has this ever happened?' And she never explicitly said that, but she did ask a few questions where I was just like 'and that's definitely just the movies, it's not like that.' I think she was just trying to assess what was going on, but she put in factors that weren't even factors to begin with.*

While Participant 11 was keenly aware that her therapy providers were from a different cultural background, she had hoped that they would be able to try and understand her culture and how it did and did not relate to her presenting concerns, and to focus on the issues that were most important to her. Instead, her efforts to engage support were continuously rebuffed by a series of White clinicians who recommended that she see a Black provider instead. Their refusal to even attempt to reach across the cultural divide of race left her feeling discouraged and alienated and drove her away from therapy for several years.

*And the few sessions then with her, she was like, 'do you think maybe you want to get a different doctor? Like for more racial identity, a Black doctor?' Cause she said there was a female Black doctor is in the same office. So at the time I didn't get it, so I was like 'no, why you just can't help me?' So I just told my mom I didn't wanna go back anymore. Because in the beginning I felt like it doesn't matter the race of the therapist; I just really want somebody to help me out with what I was going through at the time...and then at [counseling agency] it was the same thing, where he felt like I should have an appointment with a Black doctor. And I just still feel like he wasn't listening. he was just like 'oh you're fine.' I said all that stuff but he didn't give me advice on that stuff. He just said 'I think you should go to—we have a Black therapist here.' You know? And I felt like that wasn't helpful either, so...it felt like I was saying a lot of important stuff and then at the end all I could hear is that, 'oh I know a Black therapist that could help you,' and after that I didn't go back for a long time until last year when I decided to seek therapy again...Because it took a lot for me to go and tell them everything so I understand maybe it could relate to what I was feeling but I just felt like I was gonna get more out of it than I did... I know that they were White but I felt like they could address certain things about where culture comes into my*

*experience and stuff. But I felt like they weren't maybe comfortable or just felt like it wasn't their lane or something so I felt like they could have, you know, elaborated more on cultural strengths and stuff like that. But I feel like they just wrote it off as 'we just need to get you a Black therapist,' you know, so...like maybe it's not in their expertise. I know, because we're different races, but I felt like maybe they felt like 'okay, this is not something I can relate to, so maybe we should find somebody else,' but I felt like the things that I was saying were able to be addressed if they, you know, just knew some small things. I didn't expect them to know the exact feeling of being Black in a more Whiter area, but I did expect them to understand that it is different for me, you know? That it's a new experience. I feel like anybody could really kinda see that. You know?*

Other participants described more subtle deficits or missteps in their clinicians' multicultural competence, such as providing interventions that did not fit with the client's perception of an acceptable problem-solving strategy. Participant 9 described a sense of mild confusion in response to her clinician's recommendation of a journaling intervention, which she experienced as incongruent with her culture's way of addressing problems. Notably, while describing this interaction during the interview, the participant illustrated her reaction to the intervention by making a perpendicular motion with her hands.

*At least for my ethnicity, one thing that's a common issue is just that people don't really talk about their problems. And then, like when I was talking earlier, about how my therapist suggested 'oh, maybe you should journal.' And then I was like 'oh, writing my problems down, like we don't even talk about them, so that's like an, uh, interesting [laughs] way to go about it.' That's just like, something I never do...it was just interesting, I was like, 'oh, that's just not an activity that I typically do' and then,*



*I just don't talk to my friends about my problems, so it's like writing them down is also a really weird thing for me to do too.*

### **Impressions of Therapy Process**

Lastly, in addition to probing participants' impressions of their therapists, the interview additionally requested input on their experiences with therapy as a whole. Recognizing that the field of psychotherapy has its own culture—and one that may not always act in the best interests of its clients—the interviewer asked participants to describe their positive, negative, and neutral impressions (as relevant) of the process of seeking and engaging in therapy. To the degree that it was possible to do so, these perceptions were differentiated from the participants' descriptions of their individual therapists, though at times these impressions overlapped significantly. The primary discriminant factor in dividing these responses between this domain and the domain of “Impressions of Therapists” was the distinction between whether the participant appeared to be attributing the process or outcome factor to qualities of the individual clinician, or to the process of participating in therapy in general.

Generally (14 interviewees), participants communicated a Positive Appraisal of Therapy as a whole. Beyond a typical (11 participants) “Generic” sub-category capturing participants' responses which did not elaborate on why they found it to be a helpful or positive experience, this category highlighted several Common Factor components of the practice of therapy that participants endorsed as being useful, meaningful, or hedonically pleasant benefits of participating in treatment. These included Appreciation for Someone Safe to Speak Freely to (9 participants, typical); Gained Perspective, Insight, or Awareness (8 participants, typical); Improved Mental Health Functioning (7 participants, variant); Supported Personal Growth/Progress (5 participants, variant); Received Validation (4

participants, variant); Appreciated Venting (3 participants, variant), and Hedonically Felt Good (2 participants, variant).

Participant 4 provided a broad sense of the positive role of therapy in her college experience:

*I've found therapy really helpful. I've been through it a couple of times in my life, across a couple of the last few years and yeah, usually its generally helpful. And I would say, just going there and getting someone to talk to is—like I have so much going on and that really, that really makes a difference, with my mental health and everything. So I'm glad I've gone. I also did a kind of group therapy, Yoga for Depression...it was very good, very relaxing and it kept me moving so it was good.*

Participant 9 summarized several of the Positive Appraisal sub-categories in her more detailed description delineating how therapy provided a space for her to be, feel, and speak differently than she did in everyday life. As many of the participants did, she alludes to the fast-paced nature of undergraduate life, and the corrective emotional experience of being able to take the time to be honest about how she felt.

*It was really beneficial at the time because it was a really good space where I could just get all my emotions out and just talk to someone about things that my friends don't really know how to talk about, and family it's kinda hard to talk about issues with, especially when you're here at the university...I liked like, being able to like, sit there and kinda just cry and not feel judged. I feel like when I'm home I try to—or not even just being home—but kinda nowadays everyone's like: 'I have to be on to the next thing, I can't be sad, or I can't just be upset about things.' I have to just get better and so it's just having that time to just be sad about something and really let it out was really good for me, because I wouldn't do that at home or with my*

*friends...And I think that it gave me a lot of techniques with managing my emotions so that's why I eventually stopped going.*

While the team was pleased to hear a variety of heartfelt attestations to the benefits of the therapy experiences that these students had participated in, it was also typical (9 interviewees) for participants to describe Negative Appraisals of Therapy Process, in which they identified disappointing aspects of their therapy experiences. These sub-categories typically included Unmet Expectations (8 participants) and variably included Feelings of Discomfort with the process (4 participants); Difficulty Opening Up to/Trusting a Stranger (3 participants); Inability to Connect (3 participants); and Wanting more Directiveness (2 participants).

Participant 6's disappointment with a non-directive treatment model spanned several therapists and agencies and encompassed a mismatch in terms of both process and outcome. In responding to a query regarding the source of her dissatisfaction with therapy, she explained

*I think their advice not being specific enough or in the direction that I wanted. I think when going to therapy I was really looking forward to somebody telling me, 'Ok, this is the answer. You need to follow this,' instead of 'there are so many options out there in life in general.' I'll be graduating in Spring and there's so many options, I still don't know which to follow.*

Participant 2 aptly summarized the unusual and challenging relational expectations of therapy when remarking on her frustration with the constraints of sessions that only lasted an hour long: *"I felt like I was just thrown out there with somebody, and it was hard to just start speaking because I didn't know where to begin. I just didn't really know the person, and it*

*was just like, I'm literally talking to a stranger about deep things, you know. It was hard to open up in that aspect."*

Participant 2's perception that sessions did not last long enough presages the overlap between negative experiences with the therapy process and negative experiences with certain logistical aspects of therapy. These typical (10 participants) frustrations were captured in the last category in this domain, Institutional Barriers to Access and Retention. The sub-categories in this area typically included Limited Availability/Accessibility of Services (8 participants) and variantly included Transferring to a New Therapist was Difficult (4 participants); Objections to Professional Rules, Roles, and Boundaries (2 participants); and Unprepared for Termination (2 participants).

Participant 7 shared a lament with one-third of the participants about the exasperating process of continuously transferring to new therapists after breaks from treatment: *"When I got to college, it was a lot of empty gaps when you switch therapists cause they just have to restart to get to know you...when a new therapist would get to know me, it's exhausting for me cause I'm just like, 'ok now I have to tell you my whole life story again.'"*

While Participant 7 appeared more irritated than hurt by her experience with therapist transfers, Participant 8 reflected at length on the relational discomfort caused by therapist turn-over. His initial mystification with the seemingly-standard boundaries set by his therapist reflect how foreign this arrangement may be to clients who are not yet well-versed in the field's commonly-accepted cultural etiquette regarding the circumscription of therapeutic relationships. His wistfulness with the lack of relational resolution also underscores the importance of effectively orienting clients to one of the defining traditions of psychotherapy culture: termination.

*It's a weird thing...I think therapists have policies and it's not like they have to have limits, but boundaries when interacting with clients? Which I get now. But at the same time, back then it was like 'why can't I talk about this?' Or why can't I—I think I was treating her like a friend almost? Like an acquaintance rather than a professional relationship. Cause I was like 'oh can I like get your number and text you whenever I need you?' She's like 'mm no you can't do that.' ...[Therapy] helped me a lot, but I wish I got more out of it. Mainly because she had to leave. Yeah, she either got a new job or she changed to another school, I'm not sure what she did; I forgot. But she had to go, and I felt like, although it was really helpful, and we didn't like leave on a bad note, it just felt like there was no really closure to it because we were—I know therapists have these things where it's like they have to have a closure thing with the client? Right? I feel like after spending weeks with them and you have to end it, it's like it might be a little, it might affect the client in some weird way...It's something where it's like 'huh, I wish I could see her again just to say hi or something.' ...A few more times at least, cause at that time when she left, the situation was resolved or was almost resolved. So I think, she left at around a good time. To when I was getting back on track like 'ok, I'm feeling better now,' but at the time it wasn't resolved yet, so I still needed her but she was gone. And it worked out fine for me, but I just wish I could update her. Like 'oh yeah by the way, this is what happened in the end, and yeah you know, how are you doing on that?' But I didn't get to do that...I tried emailing her after, actually, and she was like 'oh sorry I can't talk to you about this anymore because this isn't my job anymore.' I was like 'oh, that kinda sucks.'*

Participant 3 described mixed feelings about the mental health services available to students in the area, advising that while the quality of the services was high, they were difficult to access. Given the aforementioned disparities in mental health provision for REM clients and the significant role of barriers in perpetuating these disparities, such perceptions—particularly when widespread, as indicated by her description—may exacerbate the challenges that REM clients face in engaging and maintaining relevant services.

*It wasn't the therapist itself, but kind of the institution. There was a lot of time in between, and it was kind of hard to schedule appointments because of my class schedule. Even though I know we have a really good mental health resources here, it's still lacking in the general sense of the availability. And I've had other friends who went to [counseling agency] who said the same thing; it's really hard to schedule.”*

Participant 9 also made a distinction between the therapist and the institution when describing her perception that the agency preferred a rapid client turnover model, and that this dissuaded her from continuing therapy. Such testimonies highlight the ability of a caring and competent clinician to off-set some of the barriers erected against clients by both logistical hurdles and alienating implicit messaging from mental health institutions.

*With my individual therapist it just felt really nice that I didn't have to keep explaining things to them, they really remembered what I had said from each session and it felt like they knew me really well, but they were also very patient with me. They didn't rush me through things even though [counseling agency] is very like: 'oh are you done yet? Are you done with your process, are you good?' Cause there were a lot of students, so I definitely felt that, but my therapist never rushed me through the sessions to talk about other things, so yeah, it was nice that we spent time on the stuff I needed. I felt that [rushing] more so in my group therapy just because I*

*did that for two quarters, and then after the second quarter they were like, 'ok so do you think you're returning with us?' It wasn't really phrased like, 'oh so we're gonna see you again?' It was like, 'do you think that you'll come back now that you've done it twice?' And I'm like, 'well, I mean, I guess not.' Then I didn't do it again, so...*

## CHAPTER 5

### Discussion

This study examined client perceptions of and responses to a strengths-based approach to cross-cultural therapy between White clinicians and Racial and/or Ethnic Minority (REM) clients. Interview questions probed several areas broadly related to clinician Multicultural Competence (MCC), including participants' perceptions of their therapist and the therapy process, how and to what extent clinicians acknowledged and incorporated participants' cultural backgrounds and identities, and the extent to which participants felt understood and supported by their clinician. Beyond these general areas of inquiry adjacent to MCC, the interview questions emphasized clinicians' interventional implementation of Personal Strengths (PSs) and Cultural Strengths (CSs) in therapy, and participants' perceptions of strengths-based interventions and approaches.

Having found that vanishingly few participants had worked with clinicians who addressed their cultural strengths in any way, the interviewer solicited input regarding how such an intervention might have affected the participants' experiences with and perceptions of therapy and their clinician. Additional feedback was elicited as to if and how the participants would recommend implementing such an intervention; their expectations of such an intervention's potential positive and negative consequences; and their immediate impressions of exploring CSs within the interview.

From the data, it appears that overt interventions incorporating CSs into treatment are a rarity in cross-cultural therapy between White clinicians and REM clients. The two participants who had directly identified and/or explored CSs during therapy respectively described the experience in neutral and highly positive terms. In the case of the former



participant, cross-cultural competence appeared to be expected and unquestioned from her white clinicians, and the intervention seemed to neither contribute nor detract substantively from her therapy experience. In the case of the latter participant, exploring both CSs and Cultural Vulnerabilities (CVs) with her white clinician yielded multifarious benefits, including enhanced self- and cultural-knowledge and a more engaging perspective on her role in society.

The descriptions from these two participants of their real-life experience with a CS intervention aligned moderately with the prospective descriptions from the participants of how they imagined such an intervention could or would have influenced their therapy relationship, process, and outcomes. While a few participants indicated neutrality towards the idea of incorporating exploration of CSs into their therapy, a larger percentage endorsed a sense of enthusiasm towards this prospect, and an expectation that it could enhance their therapy experience in meaningful ways. None of the participants indicated that they would prefer *not* to engage in such an intervention. Nevertheless, most of the participants foresaw potential gaffes and therapeutic ruptures if the intervention were delivered carelessly, and thus offered recommendations on key points regarding phrasing, delivery, and contextual considerations of the intervention.

Perhaps the most easily-addressed of these concerns were those that identified the novel and potentially confusing nature of the construct of CS: many of the participants described feeling puzzled by the concept, or expressed difficulties in articulating their response, while others pointed out that it was a thought-provoking topic that had not often or never been addressed in either therapy or everyday life. These responses highlight the rarity with which the concept of CSs are explicitly invoked in therapy. It also points to the importance of providing an accessible prompt or a description of CSs that will facilitate an

open-ended dialogue with clients to avoid “*putting them on the spot,*” as Participant 10 worded it in her suggestion to preface the intervention with more broad exploration of Cultural Background.

While it is tempting to respond to this obstacle by developing a more formal operationalization of the term, this emphasis on easing a client into the idea of CS calls to mind the more circuitous approaches to gathering initial assessment information advanced by the American Psychiatric Association’s Cultural Formulation Interview (CFI: American Psychiatric Association, 2014), which seeks to enhance multicultural competence during transcultural psychiatric intake processes by gathering therapy-relevant information from clients with less pointed and technical language than is utilized in a standard assessment interview.

The CFI implements phrasing that probes for culturally-grounded conceptualizations and expectations regarding mental health concerns and their treatment instead of seeking to fit clients’ descriptions of their symptoms into the Procrustean Bed of DSM-5 language. This involves providing an array of potential explanatory pathways and queries that solicit a community perspective on the presenting problem and treatment. (Lewis-Fernández et al., 2016). For example, the section “Cultural Perceptions of Cause, Context, and Support,” prompts the clinician to ask follow-up questions about the client’s presenting problem and etiology such as “*Some people may explain their problem as a result of bad things that happen in their life, problems with others, a physical illness, a spiritual reason, or many other causes...what do others in your family, your friends, or others in your community think is causing your problem?*” (APA, 2014, p.2)

The participants that advocated for open-ended questions about helpful or positive aspects of clients’ culture and community seemed to be pointing to a similarly broad

approach to gathering important client data, such as Participant 9's suggestion to ask about positive cultural qualities of the client's close friends, or Participant 10's idea of asking about family ties, traditions, and qualities. This sort of top-down approach to procuring information about a client's CSs may simultaneously avoid the confusion or awkwardness that some participants envisioned with a more direct solicitation of information while also providing salient, therapy-relevant contextual information about the client's community and relationships well beyond the scope of a CS intervention itself.

This client-centered approach also aligns with the participant recommendations that White clinicians utilize an open-ended and deferential stance when asking REM clients about their culture in general. This was one of the most widely-endorsed suggestions across participants, emphasizing the importance of taking an open and respectful "one-down" approach in exploring cultural material. The participant descriptions in this category bore a remarkable resemblance to the definition of cultural humility provided by Owen et al. (2016, p.31): "*The concept of cultural humility has also been referred to as "an other-oriented stance, which is marked by openness, curiosity, lack of arrogance, and genuine desire to understand clients' cultural identities"*"

Participant 13 provided a representatively incisive description of the client-clinician dynamic in such a culturally humble approach with her exhortation "*for the therapist to have the idea of openness to learn from their client rather than just provide for their client is very important.*" On the same topic, Participant 8 offered a shrewd piece of advice to clinicians: "*it might help to act like you don't know.*"

Also notable was the participants' emphasis on the importance of the clinician's stance towards the client, and the lead-up that precedes the intervention as a determinant of the outcome. Addressing CSs within the broader context of the client's community and

culture was a very popular recommendation paralleling the suggestions for an open-ended and client-centered approach and was frequently associated with cautions about the dangers of inadvertent stereotyping or assumptions about the client's culture. Even when discussing positive cultural attributes, clients clearly resent feeling pigeon-holed, and a suspicion that the clinician may be operating under preconceived notions about what to expect from them based on broad representations of their racial and/or ethnic group is understandably likely to efface the therapeutic alliance quite rapidly.

At the same time, participants roundly endorsed the importance of clinicians being prepared to work effectively cross-culturally, and this was closely linked to an expectation that clinicians should be knowledgeable about their clients' cultures. The desire to work with clinicians who resist the influence of cultural stereotypes while also cultivating a robust knowledge base about common features of their clients' cultural identities aligns felicitously with Sue's (1998) concept of Dynamic Sizing, a pillar of multicultural competence (MCC) and an invaluable asset to contextually-responsive forms of psychotherapy. Dynamic Sizing refers to the "skillful art" in multicultural assessment and counseling of balancing individualization and generalization in conceptualizing and treating a client's presenting concerns (Roisircar-Sodowsky & Kuo, 2001, p. 237).

A related caution from the participants foregrounded the need for clinicians to assess and consider a client's relationship to their culture before determining whether an intervention involving CS would be helpful. Many participants pointed out that individual client factors would influence response and outcomes to a CS intervention, and while this included the client's presenting concerns and dispositional style, the primary concern was whether or not they felt positively connected to their culture. Much as with the aforementioned findings indicating that Personal Strengths (PSs) intervention could be

unhelpful or even iatrogenic for a small sub-set of severely-depressed clinical populations when it accentuated discrepancies between clients' depressed-state and desired-state selves (Wingate, Van Orden, Joiner, Williams, & Rudd, 2005), these caveats focused on the potential distress caused to clients by being asked to reflect on how their culture had been helpful or positive for them when they felt disappointed by, anxious about, oppressed by, or simply disconnected from some aspect of their culture.

As Dee Watts-Jones (2010) points out, identifying and exploring cultural identities requires considerable vulnerability on the part of the client, and a clinician's ability to create a relational environment in which the client feels willing to be open while also feeling in control of what information is disclosed and how it is processed is key to facilitating positive client outcomes in a cross-cultural therapy relationship. The importance of a clinician's ability to gauge a client's relationship to their culture in order to determine the suitability and utility of a CSs intervention emerged as one of the primary "take-aways" for the research team.

A related concern that was broached by only two participants with reference to CSs interventions but was also endorsed across multiple cases with reference to the process of therapy in general was the challenge of effectively communicating REM cultural material to White clinicians. While this is clearly not a multicultural competence dilemma specific to CS interventions, it caught the attention of the research team both because the associated participant accounts were at times quite poignant and because several of the participants indicated a belief that a CS intervention could be a way to begin bridging this gap.

Slightly less than half of the participants spontaneously described a prospective benefit of the CS intervention that the therapist would be able to use it to better understand their client. This sub-category was nearly commensurate in frequency with the most widely-

identified prospective benefit that the client would better understand themselves via such an intervention. That participants saw the intervention as almost equally useful for enhancing the therapist's understanding of the client as for enhancing the client's understanding of themselves underscores the contribution that this intervention may make to a clinician's perceived multicultural competence.

Nevertheless, clinicians eager to implement a CS intervention to enhance their understanding of the client's culture are advised, per the participants, to understand that such exploration could be difficult for the client and could even arouse suspicion if not prefaced or contextualized thoughtfully. As Participant 2 pointed out in demonstrating aloud her skeptical thought process if a clinician asked about her CSs without effective preamble or contextualization, *"We come from different cultural backgrounds. Do you genuinely mean this? It's like how can you talk about this? Do you know what you're talking about?"*

Her wariness echoes Terrell & Terrell (1984) concept of cultural mistrust, which describes the adaptive skepticism that marginalized cultural groups often exhibit towards traditionally White institutions and systems of power—notably including research and practice in the medical and mental health fields—based on their historical experiences of exploitation and malpractice. Ward (2002) notes that validation of this mistrust and utilization of practices demonstrating cultural humility—through openness to processing racial dynamics and concerns—can ultimately fortify the therapeutic alliance and even improve treatment outcomes. As Sue & Sue (2016) point out, clinicians working with REM clients must strive to create an environment of safety and comfort for their clients to disclose painful experiences by demonstrating a willingness towards discussing sociocultural issues.

The challenge, importance, and nuance of bridging this cross-racial gap was highlighted by the mixed participant responses on the topic of racial-ethnic client/clinician

matching. The participants who contributed input on this topic were split nearly evenly as to whether being matched with a clinician of one's own race and/or ethnicity would be helpful in therapy. This split somewhat reflects the findings from a CQR study that directly examined REM clients' perceptions of the significance of race in cross-racial therapy relationships (Chang & Yoon, 2011).

The study found that the majority of participants believed that a white clinician would be unable to comprehend critical aspects of their cultural experiences and identities, and these participants consequently avoided discussing racial or cultural issues in treatment. However, the study also found that these differences could be mitigated through clinician qualities such as compassion and acceptance, as well as demonstrations of clinician willingness and comfort in addressing racial, ethnic, and cultural issues. A sub-set of that study's participants indicated a positive expectation of client-clinician racial/ethnic mismatch and an expectation of disadvantages of racial/ethnic matching. The study's recommendations were particularly salient to this study: that clinicians actively seek to develop skills for sensitively addressing racial, ethnic, and cultural perceptions and beliefs that could affect the therapeutic alliance.

Recognizing the potentially damaging effects of REM clients feeling that a White clinician could not accurately understand their experience was perhaps best reflected in an informal thematic cluster that spanned several domains and that the research team came to call "make sure they get the full story." This cluster was first identified during a team consensus-building discussion on stereotyping in which participants' fears of being stereotyped were short-handed as a "fear of cultural compression;" a worry that one's phenomenological complexity would be reduced to a bland demographic category by a

clinician who made assumptions about their background and identities based on stereotypes and uncontextualized slivers of biographical information.

While this theme turned out to be too abstract and diffuse to be included categorically in the cross-analysis with appropriate rigor, the team was particularly struck by the subtextual concern communicated by many of the participants that if clinicians engaged in racial or ethnic stereotyping, focused too narrowly on CSs, or in general over-emphasized or made assumptions about any one aspect of the client's identity or history, the clinician would not be able to meaningfully grasp the clients' complex and multidimensional experience of their cultural identities and influences. Although this sort of myopic clinical focus was by no means the therapeutic approach envisioned by the team, the participants' worry that this might be the case—and that it could compromise the client's opportunity to feel meaningfully understood—provided insight into how high the stakes were for participants in feeling accurately known by their clinicians.

This concern was represented most potently through the aforementioned emphases on addressing CSs within the context of broader exploration of cultural background and taking an open-ended approach to therapy, and also featured prominently in the categories and sub-categories that explored overlaps and intersections of Cultural Vulnerabilities (CVs) and CSs. While the philosophical implications of this “double-edged sword” concept—that CSs and CVs were inextricable or that they generated and reinforced each other—were intriguing enough to merit investigation on their own, the duality was also interpolated with this participant concern that their full experience would not be acknowledged if only CSs were discussed. It also appeared in participants' cautions against assuming that a quality that a clinician believed to be a strength could actually be neutral or negative in the participants' experience.



A representative example of this interpolation of culturally-grounded strengths and vulnerabilities appeared in participants' reflections on their sense of gratitude for the sacrifices made by their parents and elders to provide them with a higher quality of life and access to education (most often characterized as a CS) and the corollary feelings of stress and pressure to achieve and succeed in order to make their family proud (most often characterized as a CV). Participant 7 exemplified this duality in her identification of "*hard work ethic*" as a CS and her description of feeling "*blessed*" that her mother and aunt had farmed rice and worked hard manual labor for many years to provide her with a college education, while also noting that she correspondingly felt "*a lot of pressure*" to do well in school as the first member of her family to participate in higher education. As Participant 10 noted in her wistful recollection of her therapist's inability to comprehend the pressure she was under from her parents to realize their cultural value of higher education (which she identified as a CS): "*I think it would be more helpful if [clinician] had understood the severity of that...*"

Such accounts make clear that as much as exploring CSs may be one avenue to opening up the channels of cultural understanding and comprehension across the divide of racial and ethnic experiences, it is essential for clinicians to also acknowledge the totality of the client's sociocultural biography, including the struggles and bittersweet qualities that they associate with their cultural identities, and to ensure that the client is the one leading the assignation of strengths versus vulnerabilities. These tenets align with Owen et al.'s (2016) findings that a clinician's ability to prioritize clients' expressions of what aspects of their identities are most salient (instead of making assumptions based on the clinician's perceptions) contributes substantively to the formation of a strong therapeutic alliance and positive client outcomes.

As many participants observed, CVs are a much more common topic in therapy and everyday life and were significantly more readily cognitively accessible to participants than were CSs. These observations suggest that many clinicians are already providing opportunities for exploration of CVs, and that the participants' recommendations to make room for both (as well as the grey areas among and between them) is more likely to refer to adding a strengths-focus to complement an existing vulnerability-focus. By incorporating this more balanced approach to learning about clients' cultural back-grounds, clinicians may have a better chance of facilitating a therapeutic environment in which clients feel that their full cultural experience is being acknowledged to the extent that it is possible.

In this vein—and also echoing the recommendations to explore CSs via open-ended queries about positive or helpful qualities of clients' families and communities—the process theme of CSs being embedded in anecdotes or examples stood out as an accessible narrative-constructivist means of identifying CSs for incorporation in therapy. As Tummala-Narra (2016) observes in her text on psychoanalytically-oriented approaches to multicultural competence, attunement to clients' self-definition requires close attention on the part of the clinician to self-defined narratives, particularly with respect to those multidimensional and at times ineffable understandings pertaining to family, culture, and values. Such knowledge is so deeply rooted in immersive experience and phenomenology that they may be quite difficult on average for clients to retrieve or articulate—and for clinicians to comprehend. As Participant 14 pointed out *“It's not like I grew up sitting in front of a desk studying what my family was all about.”*

Narrative approaches may provide a means of transmitting such knowledge in a more direct form than a request to label or define CSs, a notion reinforced by the spontaneous disclosure of several such anecdotes as participants worked to verbalize their CSs.

Participant 11's description of feeling affirmed by exchanging greetings with other Black individuals in a predominantly White community, and of musing through how that sense of community might constitute a CS, illustrates the rich opportunity available to clinicians to discern CSs when listening to client stories with an ear tuned for strengths.

Similarly, Participant 5 responded to queries about her CSs by describing memories of learning important cultural values from her grandfather through the refrains he taught her as she learned to skip rope and count coins with him. A trove of untapped CSs may be available within positive client memories of influential family and community members. Questions such as "who did you look up to growing up?" or "who in your family or community taught you about what was important in life?" may be accessible narrative-constructivist interventional approaches that honor the participants' recommendations to take an open-ended querying approach that focuses on positive aspects of clients' communities and cultural backgrounds.

As APA's Multicultural Guidelines note in their precept that clinicians should strive to take a strength-based approach in building resilience and decreasing trauma: "*From a multicultural approach, practitioners recognize that resilience may be defined in distinct ways across sociocultural contexts, and that resilience and coping may be expressed in individual and collective forms*" (APA, 2017, p.88). Accessing such definitions via clients' stories of resilience, coping, and other narratives that highlight sociocultural demonstrations of strengths may reduce the likelihood that clients feel misunderstood or "*put on the spot*" by clinicians eager to identify CSs.

In addition to this generous argosy of wisdom on how to refine and optimize CS interventions, the participants described a wealth of prospective benefits available to clients and clinicians exploring CSs within a respectful and attuned therapeutic relationship. The

bulk of the expected positive outcomes from the intervention focused on gains for the client's intra-psychic well-being and improved mental health, including growth in their personal, cultural, and socio-political understandings of self; feelings of empowerment as well as a hedonic experience of positive feelings; and improved functioning in daily life.

However—as noted—a considerable focus in the sub-categories of “benefits” of a CS intervention was devoted to potential improvements to the therapy relationship and process, broadly including enhancement of the therapist's knowledge and understanding of the client and a strengthening of the therapeutic alliance. Considering the emphasis that the participants (and the aforementioned research on cross-cultural therapy relationships) placed on the significance of a therapist accurately understanding their clients—and the corollary importance of a client feeling at ease with the clinician—improvements in these areas are likely to contribute powerfully to a positive therapy experience.

Given that most of the caveats proffered by the participants regarding the possibility of iatrogenic effects of the intervention fell under the umbrella of general therapeutic and multicultural competencies (e.g., avoid stereotyping; demonstrate respect and humility; take a client-centered approach in establishing goals and topics; acquire knowledge of a client's culture but utilize Dynamic Sizing in applying it, etc.), CS interventions appear to be an under-utilized and potentially promising approach to enhancing client well-being and improving the therapy process and relationship between REM clients and White clinicians. The research team's superordinate conclusion from the data was that an intervention exploring a client's Cultural Strengths may be a highly beneficial and multiculturally-inclusive addition to racially and/or ethnically cross-cultural therapy given that it is delivered sensitively in the context of an attuned, respectful, multiculturally competent client-clinician relationship.

## **Strengths & Limitations of the Study**

While this exploratory study generated findings that the team hopes will be useful for enhancing both theory and application of multiculturally-competent, strengths-based psychotherapy, there were several notable limitations in its execution and analysis that bear acknowledgement. These limitations are reviewed here in order to guide recommendations regarding future research efforts and in hopes of improving the quality and clarity of future findings in this area of study.

The phrasing and scope of the interview questions represents a particularly promising area for methodological improvement. While the aim of avoiding predetermined responses and allowing participants to respond freely and authentically on the subject matter was largely accomplished via the open-ended and semi-structured nature of the interview, this flexible interview structure produced significant variation in the interpretation and emphasis of various areas of content by the participants. In particular, the profusion and heterogeneity of follow-up questions—although likely valuable for putting participants at ease by indicating curiosity about the nuances of their responses—resulted in notably diffused topic areas.

A similar dilemma arose in operationalizing the construct of “Cultural Strengths:” in an effort to avoid delimiting participants’ responses, a very open-ended definition was used, giving rise to a widely-varied array of participant interpretations. While a more tightly-circumscribed operationalization would likely yield significantly more tractable data, the problem of pre-determining participant responses and thereby violating the spirit of qualitative inquiry nevertheless remains.

Consequently, the various thematic tributaries of responses across participants diverged more significantly than they likely would have had the interviewer implemented a more formal and structured interview approach and construct operationalization, rendering a less cohesive data set for analysis. However, given that the power distance between the interviewer and the participants was already of significant concern, an overly-formal question set and protocol would likely present its own array of drawbacks. In retrospect, simply limiting the scope of the interview protocol while sustaining the semi-structured format may have accomplished both aims more effectively.

One exception to narrowing the range of follow-up questions would be to include queries that assessed participants' ideas of how clinicians could make it easier, safer, and more comfortable for clients to broach and discuss topics of culture. While several participants spontaneously provided input of this nature, it became evident retrospectively that it was a lost opportunity for intervention-enhancement data not to include questions of this sort as a standard component of the interview. Lastly, in terms of the phrasing and delivery of the interview, the overwhelmingly clear finding that Cultural Strengths were a novel and often confusing concept for the participants suggests that sending out an open-ended but brief definition and potentially a discussion prompt ahead of the interview might allow participants more time to integrate and reflect upon the concept, thus likely providing richer data in this area.

As noted, the power dynamics of both the interview and the analysis bear examination. A clear strength of the research team was the majority constituency of Racial and/or Ethnic Minority (REM) undergraduate members, many of whom had participated in therapy with a white clinician. This provided avenues of insight that enriched debates during coring and cross-analysis as to the more sub-textual content of the data. Given that the Lead

Graduate Researcher is a White clinician, she undoubtedly carried significant personal and professional biases and blind spots of her own into the analytical process and may generally have had difficulty in accurately and fully comprehending the impressions and perceptions of the REM participants in their experiences as therapy clients. Consequently, the inclusion of a majority percentage of undergraduate research team members who were in a similar developmental phase as the participants and also shared an identity with the participants as an REM individual was an important factor in enhancing the trustworthiness of the analysis phase. The varied perspectives and experiences contributed by the heterogeneity of identities and cultural backgrounds of the research team augmented the reliability of the study by illuminating discrepancies in interpretations of the data and thereby providing some mitigation of the influence of individual biases.

However, both the racial/ethnic and professional hierarchical differences in the team may also have hindered the undergraduate team members' willingness and ability to be forthcoming in their analytical contributions. Precautionary measures taken against this possibility included curricular arrangements to separate undergraduate team members' grades from their analytical input (as described in the Methods section), and the length and amount of time that the members spent acquainting themselves with the Graduate Student Lead Researcher in an informal context. With acknowledgement that this type of feedback carries obvious inherent social desirability biases: the undergraduate team members universally indicated that they felt empowered to be open and honest during the various analytical phases and perceived that they were treated as equals throughout the consensus-building processes. A clear limitation of the research team was also the lack of previous experience in CQR methodology for the undergraduate members. While they received extensive, one-on-one immersive training and practice prior to beginning the project, a team with more seasoned

members (including the Graduate Student Lead Researcher) would likely have been more expeditious and perhaps generated a more stable final data set.

Another strength of including undergraduate team members was their generation of numerous and perceptive recommendations regarding how to put participants at ease with the White graduate student clinician based on their own experience in unequal-power relationships, as described in the Methods section. Nevertheless, the participants may still have felt intimidated in discussing the vagaries of cross-cultural therapy with a White interviewer who was identified in the research protocol as a clinician and a graduate student, and consequently been less disclosive than if the interviewer had been an REM undergraduate student.

The selection and recruitment of the participants represents another clear area for improvement. The selection process was not randomized in any fashion, and in fact several of the participants remarked after the interview that they had chosen to participate in the study despite easier alternatives because of their interest in and strong feelings about cross-cultural psychotherapy, indicating a significant self-selection bias. Conversely, this may have also been a minor strength of the study inasmuch as that many of the participants were consequently enthusiastic and elaborative in providing responses on a topic that they considered important. Beyond the obvious limitations presented by exclusively including college students, the participants were recruited out of the Department's study pool, likely narrowing even further the demographic, dispositional, and other contextual factors that undoubtedly influenced participant responses.

Although the inclusion of 14 participants falls generously within the recommended target range of 8 to 15 participants, the addition of more participants would have increased the validity of the findings (Hill et al., 2005), and may have provided opportunities for



charting complex examinations of intersecting and potentially predictive factors in participant experiences (Hill, Thompson, & Williams, 1997), particularly in combination with the aforementioned narrowed scope of querying. As with most qualitative inquiries, generalizability is not the aim of CQR studies (Hill et al., 2012), however inclusion of participants from wider and more socio-culturally diverse samples would nevertheless improve external validity.

### **Future Directions**

Future researchers in this area of study would do well to treat the present study as an informal piloting venture, and to focus on the domains and associated queries that yielded the most significant results. This type of focused investigation would allow for more generous and concrete theory-building opportunities with respect to the intersection of multicultural competence and strengths-based approaches to treatment than the preliminary offerings presented here.

Based on the sample represented in this study, clinicians have rarely made use of interventions involving CSs, and clients appear receptive and—in many cases—eager to experience the potential benefits conferred by their incorporation into treatment. Now that open-ended contextual data has been gathered regarding REM clients' general perceptions of possible positive and negative consequences of a CS intervention, a formal analog study assessing the outcomes and impressions associated with the intervention could be assembled with the guidance of the participant recommendations provided here regarding delivery, phrasing, and other contextual considerations.

Future research on either the theory or application side should clearly be expanded to include REM clients from a wider demographic background, and also to include participants

whose primary cultural identities extend beyond the relatively readily-identified categories of race and/or ethnicity. For example, the intervention presented here might be utilized with minimal modification with clients identifying as sexual or gender minorities. Recalling that true multicultural competence in therapy acknowledges and benefits clients of all backgrounds—including majority-status cultural identities—studies that examine this intervention with a wide range of clients and clinicians are most likely to yield meaningful data as to whether it is worthy of incorporation into the wider pantheon of strengths-based interventions in current psychotherapy approaches.

On the technical side, an illuminating next step might be to evaluate whether Cultural Strengths are suitable for incorporation into more specific therapy interventions in the way that Personal Strengths have been in many traditional psychotherapy approaches. The literature on assessing, operationalizing, and utilizing PSs is particularly robust in the field of Positive Psychology, where PS interventions include—among many others—an empirically-derived inventory of strengths called the Values in Action Inventory of Character Strengths & Virtues (VIA; Peterson & Seligman, 2004) that assists individuals in identifying their signature strengths and suggests strategic means of utilizing them in order to improve well-being. Many PS interventions may require negligible adaptation in order to accommodate the perspective shift required to identify and mobilize CSs rather than PSs: one example is the “Family Strengths Tree” (Rashid, 2015), a strengths-based genogram emphasizing intergenerational and community-grounded strengths and virtues. As this study’s participants noted, simply identifying CSs can initially be a confusing task, yet these strengths seemed readily accessible in the form of family- and community-based anecdotes and axioms. Perhaps versing oneself in the strengths of one’s family and community is a more systematic way to access and categorize this concept.

Similarly, analog studies on CSs might consider implementing narrative-constructivist interventions as an embedded form of inquiry. The research team retrospectively wondered whether participants might have responded more readily and with less apprehension to a prompt such as “What did you learn about what was important in life from the choices that your [elders] made?” or “What were sayings or lessons that were important in your family/community?”

In a related vein, the research team noted that values seemed by far the most frequent type of CSs identified by the participants. This association fits with Peterson & Seligman’s characterization of strengths as “values in action” in the VIA inventory. Determining whether participants consider these terms to be interchangeable would constitute a substantive step towards diversifying the options for phrasing this intervention in more approachable and familiar terms. For instance, a more accessible form of the intervention might be to ask about values that were important to the participants’ families and communities.

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## **SONA Recruitment Screening Form**

**STUDY NAME:**

Client Experiences in Cross-Cultural Psychotherapy

**BRIEF ABSTRACT:**

In this study, you will meet with a CNCSP Graduate Student for a confidential, audio-recorded interview that will last approximately 30-50 minutes. We are asking open-ended questions about client experiences in cross-cultural psychotherapy. Specifically, we hope to learn more about the experiences of clients from a racial and/or ethnic minority background who have worked with therapists from a racial and/or ethnic majority background (white therapists). The questions are focused on client perceptions of the psychotherapy process rather than on the content of therapy: participants are not expected to disclose information about any symptoms, presenting problems, or any other personal information that may feel uncomfortable to discuss. The purpose of this study is to enhance the quality and effectiveness of psychotherapy for clients from cultural-minority backgrounds.

**ELIGIBILITY REQUIREMENTS:**

Participants must identify as a racial and/or ethnic minority and have participated in therapy with a white therapist within (approximately) the past two years.

**DURATION:**

*30-50 Minutes*

**CREDITS:**

1

**PREPARATION:**

No preparation is required for this study.

**RESEARCHER:**

Evelyn I. Winter Plumb, M.A.

Under the supervision of Dr. Collie Conoley, Ph.D.

**ADDITIONAL INFORMATION & DIRECTIONS:**

This study involves meeting in a confidential setting with a Graduate Student who will facilitate a semi-structured interview, which includes both standard and follow-up questions.

**ORahs APPROVAL CODE:**

49-17-0946

**ORahs APPROVAL EXPIRATION:**

Expires March 23, 2018

## Appendix B: Consent Form

Protocol Number: 49-17-0946

Approved by the UCSB Human Subjects Committee for use thru: 12/06/2018

### **PURPOSE:**

You are being asked to participate in a research study. The purpose of the study is to learn about and improve the multicultural competence of clinicians engaging in cross-cultural psychotherapy. We want to know what you did and did not find helpful during your experiences in cross-cultural psychotherapy.

### **PROCEDURES:**

If you decide to participate, we will ask you to talk with a researcher about what you liked and what could have been improved during your experience in cross-cultural psychotherapy. With your permission, we will be audio-recording this interview. Your name and the interview recording will not be released to anybody outside of the research team.

### **RISKS:**

Some participants may find it uncomfortable to reflect on their experiences in psychotherapy. Your participation in this experience is voluntary and you may withdraw your consent at any time. Likewise, your participation in this research project may be terminated if it becomes apparent that you are distressed by the experience.

The information you give us will not be shared with anyone outside of the research team. Your information will be kept confidential and will be stored according to safety standards approved by the Human Subjects committee. Just like all your records, legally the courts can obtain your information. To reduce risks to your confidentiality, we ask that you refrain from stating your own name or the names of others during your interview. The principal investigator of this study is a mental health professional and therefore a mandated reporter. UCSB's institutional mandatory reporting requirements also apply during this interview, so in order to preserve your confidentiality, please refrain from sharing any information that may require a mandated report. Mandatory reports may be initiated if you share information concerning past or present child abuse, abuse of an elderly individual or dependent adult,

or plans to harm yourself or someone else. In this context, abuse may include physical, sexual, emotional, or financial forms.

### **BENEFITS:**

There is no direct benefit to you anticipated from your participation in this study beyond the SONA course credit you will be given in return for your participation in our interview. We hope the information that you supply may help make cross-cultural counseling more helpful for future clients.

**[PLEASE TURN OVER TO CONTINUE READING]**

### **CONFIDENTIALITY**

We will not keep your name, identifying information, or audio recordings past completion of the research study. Absolute confidentiality cannot be guaranteed, since research documents are not protected from subpoena. After completion of the study, the data we collect will not be linked to your identity in any way. Digital recordings of your interview will be deleted once the interviews have been transcribed and de-identified.

### **COSTS/PAYMENT:**

You may decide to withdraw from the study at any. During the interview, you may refuse to answer any questions and decide to stop the interview and still receive SONA course credit commensurate to the time that you spent in the study. The rate of credit is 0.5 credits for 30 minutes. Your decision of whether or not to participate in this research will not negatively affect your grades or your course standing.

### **RIGHT TO REFUSE OR WITHDRAW:**

You may refuse to participate and still receive any benefits you would receive if you were not in the study. You may change your mind about being in the study and quit after the study has started. You may choose not to answer any questions that you prefer not to answer.

### **QUESTIONS:**

If you have any questions about this research project or if you think you may have been injured as a result of your participation, please contact: Evelyn Plumb (eplumb@education.ucsb.edu) (707) 367-4039 between the hours of



9am- 5pm, PST, M-F. If you have any questions regarding your rights and participation as a research subject, please contact the Human Subjects Committee at (805) 893-3807 or hsc@research.ucsb.edu. Or write to the University of California, Human Subjects Committee, Office of Research, Santa Barbara, CA 93106-2050

**PARTICIPATION IN RESEARCH IS VOLUNTARY. YOUR SIGNATURE BELOW WILL INDICATE THAT YOU HAVE DECIDED TO PARTICIPATE AS A RESEARCH SUBJECT IN THE STUDY DESCRIBED ABOVE. YOU WILL BE GIVEN A SIGNED AND DATED COPY OF THIS FORM TO KEEP.**

Signature of Participant or Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

## Semi-Structured Interview Protocol

*State aloud to the participant that the audio-recorder is now on.*

- 1) What was your experience in therapy like?
  - a. What was/were the time period(s) when you attended therapy?
  - b. At what type of agency did you attend therapy?
  - c. *If participant worked with multiple clinicians, establish how many and which/when were white clinicians.*
- 2) What—if anything— did you like about therapy?
- 3) What—if anything— did you not like about therapy?
- 4) What—if anything— did you like about your therapist?
- 5) What—if anything— did you not like about your therapist?
- 6) Were/are you satisfied with your outcomes/progress from therapy?
- 7) Was your culture discussed or addressed during therapy?
  - a. If so, how?
  - b. How did you feel/what did you think about this?
- 8) Were your personal strengths explored during therapy?
  - a. If so, what were these strengths?
  - b. How did you feel/what did you think about this exploration?
- 9) Were your cultural strengths<sup>7</sup> explored during therapy?

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<sup>7</sup> In this context, “cultural strengths” were defined for the participant as “any aspects of your culture(s) that you have found to be helpful or enjoyable during your life: this could include beliefs, behaviors, values, traditions, social support networks, spiritual systems, resources, activities, etc..”

- a) What were these strengths?
- b) How did you feel about this exploration?
- c) How did this exploration affect your perception of your clinician, if at all?

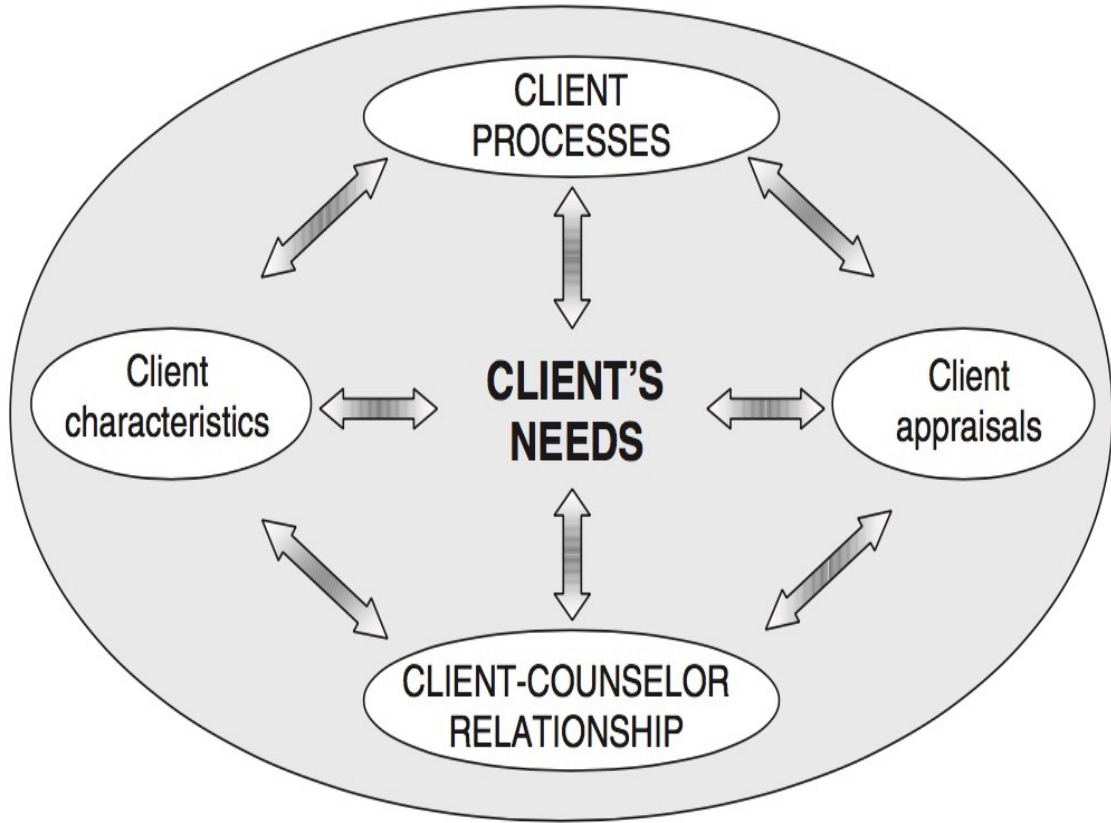
*Participants who respond to question #9 by indicating that it did not apply to their experience will skip directly to the following questions to conclude the interview:*

- A) Would you have liked to explore this topic with your clinician?  
*If so, what sorts of strengths would you have liked to explore?*
- B) Would you have felt differently about your clinician, or about therapy, if this topic *had* been explored?
- C) As we are talking about this, what cultural strengths of yours come to mind?  
*Can you tell me about them and how they have influenced you?*
- D) What is it like for you to reflect on your cultural strengths here in this interview?
- E) What—if anything—do you think could be helpful about clinicians asking their clients about cultural strengths?
- F) What—if anything—do you think could be unhelpful about clinicians asking their clients about cultural strengths?
- G) What do you think would be a good way for clinicians to ask about their clients' cultural strengths?
- H) What has this interview been like for you?
- I) Are there any questions that you wish I had asked?
- J) Any questions you wish I had not asked?
- K) Is there anything else you'd like to ask or say?

*Inform participant that you are turning the audio-recorder off.*

Appendix D: Client Strategic Interaction Model

Client Strategic Interaction Model (Pope-Davis et al., 2012)



**Figure 1. Client Strategic Interaction Model**

(Pope-Davis et al., 2012)

Appendix E: Full Frequency Table

Table 2

Table 2.

*Domains, Categories, Subcategories, and Frequencies of Findings*

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**Logistics of Therapy**

Therapist Ethnicity

White 14 (General)  
 Additional therapists were Unknown Ethnic Minority 4 (Variant)  
 Additional therapists were Asian 2 (Variant)  
 Additional therapists were Black 1

Number of Therapists

2-4 Therapists 8 (Typical)  
 1 Therapist 4 (Variant)  
 5 or more Therapists 2 (Variant)

Number of Sessions Total

11 or more sessions 10 (Typical)  
 3-5 sessions 2 (Variant)  
 6-10 session 1  
 Unknown (“a lot”) 1

Therapy Time Period

During College 8 (Typical)  
 Both during & before College 6 (Variant)

Modality/Modalities

Individual 13 (General)  
 Group & Individual 2 (Variant)  
 Group Only 1

**Impressions of Own Therapy Process**

Institutional Barriers to Access & Retention 10 (Typical)

Limited availability/accessibility of services 8 (Typical)  
 Transferring to new therapist was difficult/frustrating 4 (Variant)  
 Objection to professional rules, roles & boundaries 2 (Variant)  
 Unprepared for/hurt by Termination process 2 (Variant)

Positive Appraisal of Therapy Process 14 (General)

Generic 11 (Typical)  
 Appreciated someone safe to talk freely to 9 (Typical)  
 Gained perspective, insight, awareness 8 (Typical)  
 Improved MH functioning 7 (Variant)  
 Supported Growth/Progress 5 (Variant)  
 Received Validation 4 (Variant)  
 Appreciated venting 3 (Variant)  
 Hedonically felt good 2 (Variant)

Negative Appraisal of Therapy Process 9 (Typical)

Unmet Expectations 8 (Typical)  
 Felt Uncomfortable 4 (Variant)

Difficulty opening up to & trusting a stranger	3 (Variant)
Inability to connect	3 (Variant)
Wanted more Directiveness	2 (Variant)
Neutral Appraisal of Therapy Process	3 (Variant)
<b>Impressions of Therapists</b>	
Positive Appraisal of Therapist	12 (Typical)
Offered Useful Interventions & Skills	9 (Typical)
T perceived as genuinely invested in C	8 (Typical)
Understanding & Accepting	8 (Typical)
Generic (Helpful/Positive)	6 (Variant)
Connected C to Resources	5 (Variant)
C appreciated Nondirectiveness	4 (Variant)
Individual Personality Characteristics	3 (Variant)
Provided helpful guidance	3 (Variant)
Culturally Responsive	2 (Variant)
Negative Appraisal of Therapist	12 (Typical)
Not a good fit (Discomfort & Lack of understanding)	9 (Typical)
Did not satisfactorily address & resolve presenting concerns	6 (Variant)
Irrelevant or Ineffective Interventions	6 (Variant)
Generic (Dissatisfied)	5 (Variant)
Invalidating	4 (Variant)
Wanted more Directiveness	3 (Variant)
Referred out against client preferences	2 (Variant)
Perceived incompetence	2 (Variant)
Perceived lack of competence re/multicultural issues	7 (Variant)
Cultural Barriers to Connection & Understanding	6 (Variant)
Culturally Dystonic Interventions	3 (Variant)
Neutral Appraisal of Therapist	2 (Variant)
<b>Client Reflections on Identity</b>	
Reflections on complex nature of social locations & identities	7 (Variant)
Family & community tension & conflict re/Cultural Values	5 (Variant)
Autobiographical Context	5 (Variant)
Identifies more with one aspect of cultural background than another	3 (Variant)
Experiences some incongruence with cultural background	3 (Variant)
Challenges in negotiating bicultural identities	2 (Variant)
<b>Exploration of Cultural Background (CB) in Personal Therapy Experience</b>	
CB was not explicitly addressed	6 (Variant)
CB minimally addressed	3 (Variant)
C's presenting concern focus was elsewhere	3 (Variant)
C would have liked to discuss CB	1 (Variant)
CB was explicitly addressed	5 (Variant)
CB discussion explored culture in relation to family	3 (Variant)
CB discussion explored feeling out of place at school	2 (Variant)
CB discussion explored challenges relating to conflicting cultural values	2 (Variant)
Positive Appraisal of exploring CB	3 (Variant)
Exploring CB enhanced contextual self-understanding	3 (Variant)
CB exploration helped improve MH Functioning	2 (Variant)
Exploring CB felt Comfortable/Natural	2 (Variant)

Negative Appraisal of exploring CB	2 (Variant)	
Communicating cross-cultural material to T was challenging		2 (Variant)
Neutral Appraisal of CB	1 (Variant)	
<b>Exploration of Personal Strengths (PS) in Therapy</b>		
PS were explored	12 (Typical)	
<i>Outcomes</i>		
Increased awareness of PS	10 (Typical)	
Exploring PS was helpful	9 (Typical)	
Exploring PS produced helpful perspective change		4 (Variant)
Exploring PS resulted in Positive Feelings	7 (Variant)	
Identified strengths were mobilized as MH resources		7 (Variant)
Exploring PS was empowering/affirming	4 (Variant)	
<i>Themes of PS Explored</i>		
Miscellaneous Strengths Types	7 (Variant)	
Academic/Analytical Strengths	6 (Variant)	
Strength of Resilience/Perseverance	5 (Variant)	
Interpersonal Strengths	4 (Variant)	
Growth recognized as Strength	3 (Variant)	
Strengths can be double-edged swords	2 (Variant)	
PS were not addressed	2 (Variant)	
<b>Exploration of Cultural Strengths (CS) in Therapy</b>		
CS were not explored	13 (General)	
Exploring CS would have changed therapy experience		6 (Variant)
Exploring CS would not have changed therapy experience		5 (Variant)
Exploring CS would have been neutral	4 (Variant)	
Exploring CS would have been helpful/positive	10 (Typical)	
Would have enhanced T's understanding of C		5 (Variant)
Would have enhanced Therapeutic Alliance	4 (Variant)	
Would have enhanced C's cultural self-understanding	4 (Variant)	
Would have enhanced C's understanding of cultural socio-politics	4 (Variant)	
Potential Problems & Concerns with CS exploration	6 (Variant)	
Exploring CS might have been confusing or awkward	4 (Variant)	
Concern that T would have been incapable of understanding C's culture	2 (Variant)	
CS were explored	2 (Variant)	
<b>Recommendations for CS Intervention &amp; Therapy Process</b>		
Concerns re/exploring CS	10 (Typical)	
Individual client factors will determine response to CS intervention		7 (Variant)
Concern re/lack of context of CS	5 (Variant)	
Concern re/clarity of CS construct	5 (Variant)	
Could seem racist	2 (Variant)	
Could reinforce stereotypes	4 (Variant)	
Potential Benefits to exploring CS	11 (Typical)	
C can then better understand self & improve functioning	7 (Variant)	
T can better understand C	6 (Variant)	
Would be empowering to C	3 (Variant)	
Would feel good for C	3 (Variant)	
Process Recommendations for exploring CS	14 (General)	
Address CS within broader context of C's community/culture		11 (Typical)

- Use an open-ended & client-centered approach 11 (Typical)
- Ask open-ended Qs re/positive & helpful aspects of C's culture 9 (Typical)
- Consider that C's relationship to own culture will predicate response 6 (Variant)
- Resist stereotyping/assumptions 6 (Variant)
- Recognize that this exploration may be difficult for C 5 (Variant)
- Be sure to also explore CB generally 4 (Variant)
- Be straightforward 4 (Variant)
- Be sensitive about wording 4 (Variant)
- T needs to demonstrate respectfulness & humility 4 (Variant)
- Also acknowledge Cultural Vulnerabilities 4 (Variant)
- Cross-Cultural Competence Considerations 12 (Typical)
  - Therapists should be prepared to work effectively cross-culturally 11 (Typical)
  - Therapists should be knowledgeable about client culture 5 (Variant)
  - Therapists should implement culturally-syntonic interventions 3 (Variant)
  - Therapists should acknowledge cultural differences 2 (Variant)
- C/T Pairing Considerations 8 (Typical)
  - There should be more diverse therapists in the field 3 (Variant)
  - T from same/similar background may better understand C 3 (Variant)
  - Ethnic matching does not guarantee positive therapy experience 2 (Variant)
  - Different T/C backgrounds doesn't preclude positive experience 2 (Variant)

### **Impressions of Interview**

- Positive Appraisal of Interview 10 (Typical)
- Approval of exploration of study topics 8 (Typical)
- Feelings of Hope that study will have positive impact 8 (Typical)
- Interview was P's first time reflecting on study's subject matter 7 (Variant)
- Interview helped P to Self-Reflect 7 (Variant)
- Acknowledgement that this Study's Topic is rarely addressed 3 (Variant)
- P felt happy to contribute to study 3 (Variant)
- Neutral/undefined appraisal of interview 3 (Variant)
- Study should also examine non-white cross-cultural therapy relationships 2 (Variant)

### **Responses to Exploring CS in Interview**

- Would have liked to explore specific CS in Therapy 6 (Variant)
- Positive Appraisal of CS Exploration in Interview 5 (Variant)
- Difficulty answering Qs about CS 5 (Variant)
  - CS is new idea to P 4 (Variant)
  - Typical focus is on Cultural Vulnerabilities 3 (Variant)
  - Difficulty identifying/articulating CS 3 (Variant)
  - CS is not talked about a lot 3 (Variant)
  - Confusion re/concept of Cultural Strengths 2 (Variant)

### **Reflections on Cultural Strengths & Vulnerabilities**

- P identified a CS 11 (Typical)
  - Collectivism/Close family ties 6 (Variant)
  - Hard Work 6 (Variant)
  - Emphasis on Education 5 (Variant)
    - Elders/caregivers didn't have access to education 3 (Variant)
  - Other 4 (Variant)
  - Respect for Elders 4 (Variant)
  - Empathy 3 (Variant)



Competitiveness	3 (Variant)
Resilience	3 (Variant)
Do things well	2 (Variant)
Persistence	2 (Variant)
Openness	2 (Variant)
CS Process Themes	9 (Typical)
CS Embedded in anecdote or example	8 (Typical)
Struggle of previous generations motivates	5 (Variant)
C feels connected to/influenced by CS	5 (Variant)
C's choices reflect on family/community	4 (Variant)
Overlap of Cultural Strengths & Vulnerabilities	9 (Typical)
Strengths emerging from Adversity	6 (Variant)
Strengths & Vulnerabilities are intertwined	5 (Variant)
Identified Cultural Vulnerabilities	6 (Variant)
High parental/community expectations cause pressure	5 (Variant)
Other	2 (Variant)

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Note.  $N=14$ ; General = 13-14 cases, Typical = 8-12 cases, Variant = 2-7 cases