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Examining Clinical Behaviors That Demonstrate Intersectionality and Cultural Humility in Mental Health Treatment

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This is to certify that the doctoral study by

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MS, Walden University, 2018

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Project Submitted in Partial Fulfillment

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Abstract

Cultural humility is an ethical standard within the social work profession. As the United States becomes more diverse, there are increasing rates of failure to implement cultural humility in social work practice in mental health settings. The purpose of this generic qualitative study was to examine how clinical social workers demonstrate cultural humility and intersectionality in mental health settings. The theoretical basis on which the research was conducted include the person-centered theory and the feminist theories, which provided a strong framework for understanding the influences of cultural dynamics and intersectionality on the quality of patient outcomes in mental health care. Seventeen clinical social workers in Washington State participated in Zoom or telephone interviews to offer examples of behaviors of clinical practice that demonstrate cultural humility and intersectionality. The interview transcripts were thematically analyzed, resulting in the following themes (a) genuine interests in the culture of the clients, (b) therapist congruence, (c) unconditional positive regard, and (d) empathic understanding. The implications of this study for social change and social work practice include the application of research findings to the formulation of relevant interventions to promote the adoption of cultural humility and intersectionality as clinical behaviors to improve the quality of patient outcomes in mental health care settings.

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Section 1: Foundation of the Study and Literature Review

Cultural humility is a fundamental clinical practice standard within the social work profession and is usually reinforced by the person-centered approach of the profession (Zeitlin et al., 2016). Even though social workers are guided by a person-centered theory designed to understand the client's worldview, a prevalent problem found in the social work practice is the failure to integrate cultural humility in mental health settings (R. A. Rogers, 2006). The Code of Ethics of the National Association of Social Workers (NASW; 2015) requires that social workers understand the functions of culture in both the society and in the lives of clients.

The provisions of NASW (2015) also oblige social workers to develop the skills needed to work effectively with diverse populations and to obtain knowledge of other cultures. In 2015, the standards of cultural competency were revised by NASW, which led to the development of the indicators and standards for cultural competence in the practice of social work. Intersectionality and cultural humility were two concepts identified by these revised standards as practice indicators for social work (NASW, 2015). In this qualitative study, I used a qualitative research approach to examine the clinical behaviors that can help to demonstrate intersectionality and cultural humility in mental health treatment.

The first section of this capstone project is divided into two main subsections. In the first section, I describe the problem inhibiting the integration of cultural humility within the settings of mental health; the purpose, nature, and significance of the study; and the theoretical framework that guided the study. This section also includes a literature

review, in which I provide historical context on the topic, a summary of current clinical applications, and the rationale supporting this study on intersectionality and cultural humility in mental health treatment. In the second section, I described the research design and data collection process to explain the methodology adopted in the study. The methodology section also includes a description of the participants, procedures of recruitment, rationale for using Zoom and telephone interviews for data collection, design of the study related to obtaining informed consent and protecting participants, instrumentation, description of the data analysis process, and the ethical procedures used to ensure that the study participants were protected.

Problem Statement

Because the population of the United States continues to grow more diverse over time, for clinical social work to be effective, it is necessary for the practice to incorporate cultural humility and intersectionality. However, it is unclear how cultural humility and intersectionality are specifically integrated into mental health clinical social work practices in Washington State. To address this problem in the study, I focused on examining the clinical behaviors that clinical social workers use to demonstrate cultural humility and intersectionality when offering mental health treatment to patients. Cultural humility is the awareness of the privilege and power present in the self-monitoring process and relationships to help address any existing power imbalances (Kohn-Wood & Hooper, 2014). Cultural humility bestows the obligation upon social workers to recognize their distinctive positions of power so that they can actively be involved in mediating the imbalances in their relationships when working with diverse groups of clients.

Intersectionality is regarded as the process by which social workers effectively and respectfully respond to people of all diversity factors, such as sexuality, race, culture, language, class, ethnic background, and religion, to communicate and protect the worth and dignity of all individuals. Such intersecting qualities in clients require social workers to build positive working alliances with clients to achieve positive treatment outcomes (Worthington Jr. &Utsey, 2013). E. Lee and Horvath (2014) conducted a study where they examined the adverse outcomes of treatment when there is lack of intersectionality in the therapists' dialogue. They discovered that the responses of the therapist helped minimize the gender and power related factors in social relations, such as the moral values, beliefs, language, and traditions that are involved in the process of decision-making for the client (E. Lee & Horvath, 2014). Notably, they found the actions of the therapist strained the working relationship, consequently leading to less engagement of the client in the treatment.

The problem pertaining to the lack of understanding of the integration of cultural humility and intersectionality in clinical social workers' practice has been exhibited through the issues of implicit and explicit power differentials and acceptance and fostered therapy (Tourse, 2016). Tourse (2016) argued that the existence of explicit and implicit power differentials embedded within cultures is usually taken for granted. Social workers have ignored and continue to overlook cultural power dynamics, and clients have progressively been disempowered in the process of treatment by identifying the behaviors that are culturally specific and imposing interventions that are culturally sensitive (Edwards, 2016). However, Edwards (2016) suggested that the recognition of the client's

culture in treatment planning and mental health interventions is associated with an increase in participation from the client.

In Washington State, cultural competence is a necessity for clinical social work practice owing to the diversity of its population to ensure that every person's unique needs are considered in the provision of mental health treatment services. The state's population consists of African Americans; Native Americans; Cuban Americans; Vietnamese Americans; European Americans; Hispanics; lesbian, gay, bisexual, and transgender (LGBT) persons; and large number of people living in poverty (U.S. Census Bureau, 2016). Washington State is unique from other states in the United States since it has the highest percentage of Hispanics, approximated at 48% of its total population (World Population Review, 2017). Of the total Hispanic population, 17% are immigrants from Latin America and 83% are native-born. Washington is third in terms of its population of Native Americans, estimated at around 16% of its total population (U.S. Census Bureau, 2016). Washington State is one of the four states in the United States to have an ethically minority-majority population. Additionally, about 10% of the residents of Washington State live in poverty, and it is ranked 53rd as the poorest state in the United States (Center for America Progress, 2017). In addition, Washington State is ranked as one of the top five states for the LGBT people (The Daily Best, 2018). Considering that Washington State is culturally diverse with a considerable population still living in poverty, the needs of the community require service providers who are culturally competent and socially diverse.

In the interest of the public, there is the need to determine whether the practice that entails integrating cultural humility and intersectionality is a necessity to adequately address the mental health needs of the population in Washington State. This study sought to examine how the integration of cultural humility and intersectionality helps clinical social workers understand the client's worldview during mental health assessment. Bubar et al. (2016) determined that a gap exists between social workers' social oppression and power dynamics knowledge and their integration of that knowledge into clinical practice. Based on this gap, when it comes to mental health treatment, it is still evident that there continues to be a lack of effective clinical social work practice that incorporates cultural humility and intersectionality to address the needs of the ethnically and culturally diverse population (Yasui, 2015). In this regard, the primary goal of this study was tailored towards examining the current efforts to integrate cultural humility and intersectionality in clinical social work practice when working with diverse patient population at the grassroots level in Washington State by extensively researching the clinical behaviors of clinical social workers in mental health treatment setting.

Purpose Statement

The purpose of the study was to examine the clinical behaviors used in demonstrating cultural humility and intersectionality in the mental health in Washington State. The focus was to determine how the integration of cultural humility and intersectionality help social workers acquire knowledge and skills that enable them to exhibit suitable clinical behaviors needed to provide quality mental health treatments to clients from culturally diverse backgrounds. Person-centered theory guided the research

to facilitate the process of examining how the integration of cultural humility and intersectionality can help the social workers understand the worldview of the clients and their respective incongruence.

Research Questions

The following research questions guided this study:

1. What clinical behaviors do social workers use in the different stages of mental health treatment (i.e., engagement, assessment, intervention, and evaluation) to convey cultural humility and to address intersectionality?
2. What are the perceptions of clinical social workers regarding training to aid in knowledge and skills for the integration of cultural humility and intersectionality when working with clients receiving mental health treatment?
3. How do clinical social workers describe their understanding of a client's worldview and the role this plays in conducting a mental health assessment?

This study advanced the professional practice of clinical social workers in two distinct ways. I focused on behaviors of clinical social workers that seek to promote knowledge and skills for demonstrating cultural humility and intersectionality guided by the different worldviews specific to the clients in Washington State. In addition, the findings of the study provided specific examples of clinical behaviors that are used in conveying cultural humility and intersectionality. According to Seedall et al. (2014), additional research concerning the integration of cultural humility and intersectionality in the mental health treatment is needed to facilitate the process of educating therapists in

the social work practice on how to improve the competency for developing effective relationships with their clients from diverse populations.

Nature of the Study

In this study, I used a generic research design combining exploratory and descriptive approaches to data collection and analysis as a reliable framework for generating detailed insights into the behavioral practices that demonstrate cultural humility and intersectionality by mental health clinicians (see Percy et al., 2015).The generic qualitative research framework entails collaborative inquiry through interactions with the selected social workers involved in clinical practice in Washington State to examine the demonstration of cultural humility and intersectionality in mental health settings.

In this study, I employed the generic qualitative methodology to examine how the integration of cultural humility and intersectionality helps social workers understand the client's worldview and mental health assessment. The generic method was chosen because of the ability to gather descriptive clinical behaviors (see Percy et al., 2015). Zoom and telephone interviews were specifically used to collect data. I conducted Zoom and telephone interviews with 17 social workers recruited from different locations across, Washington State. The rationale for using a small sample size of only 17 social workers was to help reduce the transferability and generalization of the data collected. In this regard, the interview process respected the cultural diversity of the participants. Participants had to be willing to utilize Zoom or the telephone to take part in the

interview process. The acknowledgment of their contributions was a valuable approach for encouraging participation in the research (see Sheridan et al., 2013).

Participants in the study were clinical social workers providing mental health treatment across Washington State. I recruited these participants from the Washington State Department of Health list of approved clinical social workers supervisors available in Washington State Society for Clinical Social Work (WSSCSW) and NASW Washington chapter website. Although the list is not all-inclusive of practicing social workers in Washington State, the social workers on the list possessed the license that permits them to provide mental health services. The list is a public record that contains names of approved licensed clinical social work supervisors and their contact information, specifically mailing address, emails, and mobile phone numbers. As a result, I used emails and phone calls to communicate with potential participants in the research. Phone calls were made to the selected participants to seek their consent and inform them of the request to engage in the research on a voluntary basis. An introductory email was also sent to potential participants explaining the research project. Accepted participants willing to participate in the study received a follow-up email that included the demographic sheet and consent form. I kept the information provided by the participants confidential by not revealing their names, faces, or addresses to limit access to identifiable information and storing the data in a locked location.

Because the study's focus was clinical behaviors during mental health treatment, I designed the recruitment to obtain participants who had firsthand experience in the

provision of mental health services. The interview data were analyzed and organized using thematic data analysis to look for common patterns and themes.

Significance of the Study

The study contributed to the advancement of social work practice in cultural competency with research, practice, and policy. The revised NASW (2015) cultural competency standard identifies cultural humility and intersectionality as practice indicators for social work. The data collected from the current study provided information on how to improve current policy standards put forth by the agencies in the social work profession on cultural humility and intersectionality required to be demonstrated by social workers. Understanding how cultural humility translates into practice behaviors that contribute to the development of measures specific to the social work profession is critical (Jani et al., 2016), and the data from this study indicated the specific clinical behaviors that demonstrate intersectionality and cultural humility. The data from this study also show practical clinical examples of how to improve cultural competency in offering direct services to clients.

This study supported the social change efforts in Washington State that started in 2006, tailored towards helping improve mental health services. The initiative was termed Cultural Competence in the Delivery of Healthcare Services and was focused on supporting the integration of cultural awareness, cultural skill, cultural knowledge, cultural desire, and cultural encounters across clinical practice settings; these elements are the pillars of cultural humility and intersectionality (Foronda et al., 2016). Since Washington is a state with a highly diverse population, the data gathered from the current

study provided insight into the integration of intersectionality and cultural humility in mental health practice. I also sought to identify social workers' continuing education needs and resources for cultural humility and intersectionality. As a generic research study that is action-oriented, the promotion of collaborative efforts among the communities to improve cultural competency in Washington State was the predicted outcome of the study.

Theoretical Framework

The practice concepts of the social work profession are based on the person-centered theory and are aligned with the research on cultural humility and intersectionality. Person-centered theory helps the social workers to view the world of their respective clients (i.e., patients) through different lenses, considering the unique needs of the client based on their race and diverse experiences and difficulties (Rogers, 1979) person-centered theory allows the clinical social workers to understand their patients and the associated struggles with cultural, ethnic, and racism experiences. Rogers (1979) explained that clients often enter therapy in conditions of incongruence and changes systematically occur in the presence of empathic environments. The fundamental tenets of person-centered theory are that (a) people are inherently trustworthy, (b) people are intrinsically moved towards attaining self-actualization and good health, (c) people have inner resources to propel themselves towards positive directions, (d) people respond to their world as they uniquely perceive, and (e) people interact with the external factors that form the basis of their fundamental beliefs (Rogers, 1942).

Rogers (1942) created an emphasis on justifying the relationship between clients and therapists as a crucial factor in facilitating the change process of the client. According to Rogers (1942) the cultivation of the therapeutic relationships lies in the congruence of the therapists. The therapists' congruence allows for the development of genuine relationships to foster specific conditions necessary for change. Rogers identified six core conditions that serve the critical role necessary for the promotion of constructive change and growth: (a) the clients and therapists are in contact; (b) the clients are in conditions of incongruence; (c) the therapists are congruent in the relationships; (d) therapists demonstrate unconditional positive regard; (e) therapists display empathic understanding; and (f) therapists communicate genuineness, acceptance, and warmth, which is often minimally achieved.

In this study, I used person-centered theory to explore cultural humility and intersectionality in the mental health practice. Person-centered theory is in recognition of the clients as the experts of their lives (C. Rogers, 1942), which is often supported by the practice of cultural humility. Cultural humility requires the social workers to let go of the professional power and be in recognition of the clients' power (Joseph & Murphy, 2013). Furthermore, person-centered theory emphasizes the need to understand the worldview of the clients and intersectionality (Tourse, 2016). Intersectionality explains understanding the client's worldview through the lens of multiple identities in the social structure promoting discrimination, oppression, and privilege (Crenshaw, 1989). The use of the person-centered approach facilitated the provision of a comprehensive framework that helped me to explore cultural humility and intersectionality in mental health treatment.

Values and Ethics

The NASW (2018) released the amendments to the Code of Ethics on January 1, 2018, and there was a change in Section 1.05 heading from “cultural competence and social diversity” to “cultural humility and social diversity” The revisions provided are a reflection of the insights presented in NASW’s (2015) The Standards and Indicators for Cultural Competence in Social Work Practice. Since NASW implemented these changes as recent as 2018, I used the terms of competence and competency throughout this capstone project for the purpose of aligning with the terminologies used in the literature reviewed.

The NASW (2015) revised cultural competency standards made an incorporation of expanded definitions of cultural humility and intersectionality. Cultural humility and intersectionality incorporate the recognition of the innate human rights regardless of the status or identity of the clients for the social workers to step into action (Azzopardi& McNeill, 2016; Cho et al., 2013; Fisher-Borne et al., 2015).Ethical Standard 1.05,Cultural Humility and Social Diversity, details the requirements of knowledge in different cultures, having an understanding of the influence of culture on society and human behaviors, and developing awareness of the nature of oppression and diversity (NASW, 2018). In this capstone project, I focused on examining cultural humility and intersectionality in the mental health practice; therefore, Ethical Standard 1.05 was in support of this study.

Cultural humility and intersectionality align with the core ethical values of social work that considers the worth and dignity of social justice and the person (NASW, 2018).

The concepts of cultural humility and intersectionality are the awareness of oppression, power, and privilege in the larger society and the client–social worker relationships (Ratts, 2017). Cultural humility and intersectionality integrate social justice and advocacy actions (Cho et al., 2013). Standard 6.04, Political and Social Action, mandates social workers advocate for change for the betterment of all people and promoting respect for cultural diversity (NASW, 2018). The NASW (2018) Code of Ethics guides social work advocacy and practice with diverse cultures and are aligned with the purpose of this study to facilitate the process of examining cultural humility and intersectionality in mental health practice.

The Washington Board of Social Work Examiners (WBSWE; 2018) is the governing and licensing entity for all the social workers in the state, and the board holds cultural competency in high esteem in compliance with the licensing requirements of the state. The WBSWE mandates that all social workers providing mental health services to possess social work license issued by the state. Social workers can apply for social work license at any level ranging from bachelor, master, to independent, but they need to meet the standard of cultural competency either by a three-credit, hour course in Washington cultures; a board-approved course, workshop, or seminar; or proof of previously passing the Washington cultural examination. The cultural competency expectations do not stop after making an initial application. At the time when applying for renewal of license, the board requires social workers to must have obtained 6of the 30continuing education hours in cultural humility. The WBSWE's commitment to the cultivation of cultural

competency by the social workers will be in alignment with this study on cultural humility and intersectionality in mental health practice.

This study on cultural humility and intersectionality in social work in Washington promoted the ethical service values of the NASW. The ethical principle of service mandates that the primary goal of social workers is to help the people in need and to address the social work problems (NASW, 2018). In this capstone project, I examined the practice behaviors needed to explore the integration of cultural humility and intersectional issues that come up in practice when collaborating with clients with mental health services. The knowledge gained from this study can be used to improve the delivery of service in mental health treatment and encourage the participation of clients in mental health services.

In this study, I followed the ethical standards when conducting generic research on human subjects. All the selected participants received information on the purpose of the study, any of the potential risks that were encountered by participating in the study, and their explicit rights to stop participation at any time as well as my contact information for any question a participant had regarding the study. All the participants were required to sign the consent form prior to their interview and were provided with a copy of the form for their records.

Review of Professional and Academic Literature

The term cultural competence infers the social workers can gain understanding of another culture (Fisher-Borne et al., 2015; Hollinsworth, 2013; Horevitz et al., 2013). The term cultural competence implies that the social workers execute their roles

professionally (Fisher-Borne et al., 2015). Numerous researchers have used other terminologies that create emphasis on the function of cultural competence practice, for example, cross-cultural competencies (Lee, 2011), cultural equity (Almeida et al., 2011), cultural consciousness (Azzopardi& McNeill, 2016), critical cultural competence (Danso, 2015), cultural awareness (Furlong & Wight, 2011), cultural intelligence (Edwards, 2016), and cultural humility (Fisher-Borne et al., 2015). The terminology presented creates a shift in the social workers' roles as the learners and facilitates the establishment of the clients as the experts (Hollinsworth, 2013); this shift highlights the need for and importance of establishing working alliances and empowering the clients within the social work practice context.

Although cultural competence is an on-going procedure of learning, the terminology suggests an endpoint (Azzopardi& McNeill, 2016). With the increasing demand for evidence-based practice, much focus has been tailored towards minimizing risks and increasing cost effectiveness, the implementation of cultural competence practice turns out to be less of a priority (DelVecchio et al., 2015; Huey Jr. et al., 2014). The importance of cultural competence becomes more of a task than a clinical practice goal (Furlong & Wight, 2011; Hollinsworth, 2013). When cultural competence becomes a task, the focus is vested upon meeting the task through continuing education training requirements instead of clinical practice engagement with clients (Furlong & Wight, 2011; Huey Jr. et al., 2014). The consideration of cultural competence as task prevents integration of culture into clinical practice. Cultural competency being an on-going learning process has led to the interpretation of competency by the overworked

professionals as administrative duties whose competent execution is attained by education.

The term cultural competencies are related to social workers' moral obligation and ethical responsibility, while agencies and system-level approaches avoid scrutiny (Delphin-Rittmon et al., 2013). Most social workers are employed by government agencies, non-profit organizations, and private organizations managed by nonsocial workers (Hays, 2009). The management of entities has chiefly focused on outcomes and finances and failed to hold culturally competent standards (Hays, 2009; Huey Jr. et al., 2014). The burden to meet the standards of cultural competency is bestowed as a sole responsibility of the social workers (Delphin-Rittmon et al., 2013; DelVecchio et al., 2015), again transforming it to a task. As the term cultural competency is frequently used, its significance is lost and it is consequently translated into tasks (Azzopardi& McNeill, 2016; Boyle & Springer, 2001; Chu et al., 2016; Comas-Díaz, 2014; DelVecchio et al., 2015; Edwards, 2016; Fisher-Borne et al., 2015). When cultural competency loses its value as a practiced behavior, the social worker-client relationship cannot manage to develop its maximum potential capacity.

There are several cultural competence terminologies, which creates confusion for social workers and clients (Boyle & Springer, 2001). The terminologies are too broad, questionable, ambiguous, or abstract (Azzopardi& McNeill, 2016; Edwards, 2016; Fisher-Borne et al., 2015). The variety of these terminologies lack consensus, which creates challenges in measuring, tracking, and training social workers in clinical behaviors (Chu et al., 2016; Jani et al., 2016). Cultural humility (Tervalon& Murray-

Garcia, 1998) and intersectionality (Crenshaw, 1989) are two terms that were introduced into the social work competency standards (NASW, 2015). The literature on cultural humility and intersectionality are emerging (Fisher-Borne et al., 2015; M. A. Robinsonet al., 2016). The challenge is defining and characterizing cultural humility and intersectionality into clinical practice behaviors (Almeida et al., 2011; Azzopardi& McNeill, 2016; Boyle & Springer, 2001; Bubar et al., 2016; M. A. Robinson et al., 2016). The challenge to define, characterizes, and quantify culturally competent behaviors makes cultural competency an altruistic goal rather than a change to clinical practice behaviors to foster working alliances.

I conducted searches of the holdings of the Walden University Library over the course of this capstone project to collect extensive literature on the selected themes. The following databases were used: PsychInfo, SocIndex, Education ProQuest, Ebscohost, Sources, Social Science Citation, and the Academic Journal. I searched these databases because they supply the extensive past, scholarly literature on the issues of cultural competency in mental health practice. The following key terms were used in my searches: *cultural competence, awareness, cross-cultural practice, cultural responsiveness, cultural sensitivity, diversity, multicultural practice, social work, clinical practice, cultural humility, intersectionality, mental health,* and *therapy*.

I included peer-reviewed, scholarly articles published in the past 5 years in this literature review. Older articles were also incorporated because they are works that reflect the original core concepts of the writers. For example, the original work of Rogers (1942, 1957, 1979) was utilized to support the person-centered theory. I also used the original

work of Crenshaw (1989) to describe intersectionality. Finally, Tervalon and Murray-Garcia (1998) were perceived as the primary supporters of the idea of cultural humility, so they were included in the study.

My search of the literature exhibited a massive range of research on cultural competence. The research was organized into three fundamental themes: the critiques of cultural competence, clinical practice, and the working alliances in mental health. I divided each theme into subcategories to examine them in detail. The result was a literature review that supported this examination of cultural humility and intersectionality in mental health settings Washington State.

Cultural Competence: Significance and Critiques

The mental health professions, such as medical doctors, marriage and family counselors, and social work therapists, value cultural competency as an ethical practice and as a socio-political merit (Chang et al., 2012; Edwards, 2016; Horevitz et al., 2013; Kohn-Wood & Hooper, 2014; Seedall et al., 2014). A vast range of professional associations integrate the guidelines of cultural competency into their ethical practice codes, for example, the American Psychologist Association (Chu et al., 2016), the American Psychiatric Nurses Association (Nardi, 2014), the American Counseling Association (Ratts et al., 2016), American Association for Marriage and Family Therapy (Seedall et al., 2014), and the NASW (2015). As demonstrated by emerging research that shows culturally competent practice can help address health disparities among people of color (Chu et al., 2016; Jackson et al., 2016), cultural competence continues to be of prime importance in mental health treatment.

The evolution of culturally competent practice started during the 1950s when the idea of diversity promoted the melting pot analogy; hence, treatment distinctively focused only on interventions and problems (Kohli et al., 2010). As the social injustices against the people of color were exposed by the Civil Right Movement in the 1960s, minimizing discrimination colorblindness became the approach that was increasingly advocated for (Fong, 2001). From the 1980s through the 1990s, the cross-cultural practice proceeded into multicultural and cultural sensitivity, then transformed into the framework of social constructionist ethno-cultural structure in the past decade (Boyle & Springer, 2001; Kohli et al., 2010; Lee & Greene, 1999).

The definition of cultural competency acknowledged across disciplines is that provided by Cross et al. (1989), who stated that cultural competence is behaviors and values shown among professionals and supported by agency policies to empower effective and successful cross-cultural interactions. Although cultural competence is immensely valued, the literature critiques the existing array of cultural competency frameworks (Azzopardi& McNeill, 2016; Danso, 2016; Edwards, 2016; Sheridan et al., 2013). The critiques are: (a) logical inconsistency and contradiction in cultural competency terminology, (b) competency needs to go beyond knowledges and skills frameworks, and (c) the clinical and cultural integration into practice. These critiques of cultural competence are of great contribution to the integration of cultural humility and intersectionality into NASW's (2015) standards of cultural competency.

Cultural Competence as a Framework for Practice

Across disciplines, Sue's (1981) framework is the most used to conceptualize cultural competency. The American Psychological Association, American Counseling Association, and the NASW utilize Sue's framework as the foundational pillar for culturally competent skills and the development of multiple cultural competency measures (Boyle & Springer, 2001; Krentzman& Townsend, 2008; Kumaş-Tan et al., 2007).

In the cultural competence framework, Sue et al. (1992) described that therapists need to (a) create self-awareness of their cultural values, biases, and recognition of the influences in the therapeutic alliance through their perceptions of the presenting problem and the clients; (b) gain knowledge of the client's cultural background and the function of their worldview; and (c) improve skills needed to provide culturally sensitive interventions. Sue's framework inspired research, educators, and clinical social workers to incorporate cultural knowledge, skills, and self-awareness as cultural competency standards. Sue's framework provides the foundation for the standards of cultural competency. As the demographics of the population of the United States and Washington State continue to diversify, the sufficiency of the standards based on cultural competency foundations are increasingly being questioned by modern scholars.

Cultural competency frameworks require social workers to increase their knowledge about diverse cultures, such as possible language barriers, traditions, and historical events (Lusk et al., 2014). Despite some researchers arguing that increased knowledge on diverse cultures improves clinical practice and culturally specific

behaviors (Berg, 2014; Tourse, 2016), other scholars argued that the knowledge is concerned with making the social workers feel more "comfortable" with the "others" within the clinical setting (Fisher-Borne et al., 2015). Besides, social constructionist ethno-cultural frameworks have defined culture as sexuality, economic class, language, religion, ethnicity, and race among other aspects identified to be important by the clients (Azzopardi& McNeill, 2016; Fisher-Borne et al., 2015; M. A. Robinson et al., 2016). The process of gaining knowledge on the clients' culture is more complex than defined by the cultural competency frameworks.

As the diversity of communities expands and individuals continually embrace multiple identities, social workers encounter the complexity of structural oppressions and discriminations in society (Davis &Gentlewarrior, 2015; Jimenez et al., 2013; McCall, 2005; Mora-Rios & Bautista, 2014; M. A. Robinson et al., 2016). Many researchers have presented the argument that cultural competence requires more than knowledge, such as a critical lens to help have an improved understanding of the complexities of the experience of minority cultures in middle-class, White, and heterosexual mainstream culture (Cho et al., 2013; Furlong & Wight, 2011; Krumer-Nevo&Komem, 2015; Manseau& Case, 2014; McCall, 2005). Through the oppression, power, and privilege lens of intersectionality, the functioning of the clients is assessed by considering the oppressive experiences (Cho et al., 2013).

Diverse populations, such as the poor, LGBT, and racial and ethnic minorities, often experience discrimination in different degrees depending on the intersection of their multiple identities (Cho et al., 2013). Arthur (2015) conducted a systemic review of

research studies on LGBT elder patients in end-of-life care and reported that the needs of the LGBT clients were minimized in the clinical assessment because of the use of the heterosexual perspective. In survey data from 577 participants in the National Epidemiologic Survey of Alcohol and Related Conditions, Bostwick (2014) showed that LGBT clients experienced greater extents of discrimination that caused them to suffer from severe and higher rates of mental health problems. The findings of Arthur and Bostwick (2014) are consistent with other studies because they supported the need to integrate critical assessments of privileges and oppressions in clinical practice.

Gaining knowledge, a component of cultural competency frameworks, propagates the existence of power imbalances that consequently results in oppressive perspectives on minority cultures (Davis &Gentlewarrior, 2015; Ratts et al., 2016; Seedall et al., 2014; Eunjung-Lee, 2011). As cultural competency frameworks place emphasis on gaining knowledge of cultures, the separations between clients and social workers become clear. The separation is focused on making the social worker to be expert, while the client is the "sick other" for not conforming to the status quo (Williams & Parrott, 2014).

In reviews of the cultural competence literature, Azzopardi and McNeill (2016) and Fisher-Borne et al. (2015) demonstrated that the prevailing assumption is that the social workers are viewed as coming from the dominant culture, resulting in the promotion of "othering." When the focus is vested on gaining knowledge about the "other" culture, the practices of the dominant culture are deemed as normal functioning (Eunjung-Lee, 2011; Hollinsworth, 2013). Therefore, the assessment of the functioning of the non-dominant clients is negatively skewed. The othering fuels the prevalence of

power imbalances owing to the consideration that implies the social workers are competent because of gaining knowledge of the other cultures (Chang et al., 2012). When cultural competency frameworks emphasize gaining knowledge and neglect critical analyses of intersectionality and cultural humility, this hinders clinical practice.

Skills and Interventions

Research on cultural competency has contributed to the development of intervention and skills. Studies have gathered information on clinical practice behaviors and facilitated the development of practice resources (Ratts, 2017; Yasui, 2015; Zeitlin et al., 2016). The practice tools that assist social workers to integrate knowledge of the clients' cultures include cultural background, race, ethnicity, religion, and economic status (Yasui, 2015). The integration of the clients' cultural knowledge is regarded as the predominant intervention in cultural competency frameworks (Zeitlin et al., 2016). Edwards (2016) argued that the unilateral focus on the knowledge of cultural frameworks neglects the recognition of within-group diversity. The interventions can thus contribute to the stereotyping of cultures and impede self-determinations. Although knowledge of cultures has a positive contribution to cultural competency, the emphasis must be on critical analysis.

Recent qualitative cultural competency studies by Mulder (2015) and Nagai (2013) demonstrated the advancements in the process of incorporating previously taboo topics such as religion and spirituality in clinical practice. The researchers, Mulder and Nagai, examined the importance of inquiring about the spiritual practice of the clients to improve planning for treatment and demonstrated similar findings in their respective

studies. Mulder studied ten master social work students using photo-voice method that included the use of individual interviews. Nagai conducted focus groups with clinicians. The two distinct groups of participants reported spirituality as an important aspect of their lives and were opened to incorporating it into their treatments. The process of incorporating the spirituality of the clients in treatment is an example of the integration of cultural knowledge into clinical practice and respected the cultural competence practice.

However, the intersectionality and cultural humility studies demonstrate oppression, power, and privilege as concepts that must also be integrated into clinical practice (Cho et al., 2013; Davis &Gentlewarrior, 2015; Holley et al., 2016). Clients live with social contexts, which allow the clients to experience situations that influence their functioning (Muntaner et al., 2015; Prins et al., 2015; Su et al., 2016). Muntaner et al. (2015), Prins et al. (2015), and Su et al. (2016) argued that the social experiences of the clients need to be examined to help in developing culturally just practices. The researchers introduced the social justice and multicultural counseling competencies assessment forms to facilitate identifying the therapists and client and improve their relationships by promoting privilege and power in their working alliances. The assessment form helps provide opportunities for discussing the privilege and power in therapeutic relationships, which allows addressing the imbalances. The integration of intersectionality and cultural humility are skills for enhancing the social workers-client working alliances in clinical social practice.

Self-Awareness and Self-Reflection

Self-awareness and self-reflection are used interchangeably and often integrated into cultural competency training (Mirsky, 2013). Social workers engage to build self-awareness such as beliefs and values, defining and identifying their culture, and assessing how the cultural difference with the clients influences the social worker-client relationships (Mlcek, 2014). Although power, discrimination, and privilege are often discussed in cultural competency training, little discussion has been provided on how these standards translate into clinical practice behaviors (Block et al., 2016; Bubar et al., 2016; Garran &WerkmeisterRozas, 2013; Jani et al., 2016; Mirsky, 2013; Mlcek, 2014; Varghese, 2016).Tervalon and Murray-Garcia (1998) argued that self-awareness must incorporate actions for mediating the privileges and power in the working relationships so that it presents cultural humility. Self-reflection requires critical lens to identify privilege and the possible use of power in the social workers' working relationships with the clients.

The knowledge of power imbalances and oppressive societal structures that lack action perpetuate the oppression of clients (Danso, 2016). Bubaretal (2016) qualitative study on graduate students demonstrated the gap between cultural competency and the integration of oppression, privilege, and power into clinical practice. The study examined 19 master social work student narratives in a clinical practice assignment (Bubar et al., 2016). Even though the students offered a demonstration of the ability to engage in self-awareness and possessed knowledge of oppression, privilege, and power, the students, however, failed to apply this knowledge to their clinical practice (Bubar et al., 2016). The

narratives of the students had omitted an analysis of the clients' culture beyond class, race, and gender and lacked assessments of the intersectionality within the social context. Also, the narratives lacked cultural humility, awareness of the students' professional power and the associated influence on the client. Bubar's (2016) findings are like other studies on social work students in relation to the translation of the concepts of cultural competency into practice behaviors (Block et al., 2016; Jani et al., 2016; Mlcek, 2014; Pivorienė&Ūselytė, 2013).

Azzopardi and McNeill (2016) presented the argument that missing a critical lens on discriminatory and oppressive personal actions and thoughts has impact on the practice behaviors. Culturally competent practice is not possible to realize when there is failure by the social worker to examine the power dynamics in the worker-client relationship and insights on personal privileges. Self-awareness, widely promoted as the optimal effective cultural competency behavior, if practiced as an isolated activity is ineffective to produce culturally competent practice (Mirsky, 2013). Critical self-awareness to oppression, power, and privilege as an application in clinical practice is imperative necessity for empowering clients in the working relationships (Almeida et al., 2011; Edwards, 2016). Self-awareness lacking clinical behaviors inhibits the working alliances.

Cultural Competence and Pedagogy Critique

The WBSWE is the governing and licensing entity for all the social workers in the state and the board holds cultural competency in high esteem in compliance with the licensing requirements of the state. The Washington board mandates that all social

workers providing mental health services to possess social work license issued by the state. Social workers can apply for social work license at any level ranging from bachelor, master, to independent, but they need to meet the standard of cultural competency either by a three-credit hour course in Washington cultures; a board-approved course, workshop, or seminar; or proof of previously passing the Washington cultural examination. The cultural competency expectations do not stop after making an initial application. At the time when applying for renewal of license, the board requires social workers to must have obtained six of the thirty continuing education hours in cultural humility. The commitment to the cultivation of cultural competency by the social workers will be in alignment with this study on cultural humility and intersectionality in mental health practice.

The process of bridging cultural competency into clinical practice behaviors often begins in social work education. However, recent studies have demonstrated that cultural competency pedagogy does not offer any connection of ideology to practice behaviors (Block et al., 2016; Bubar et al., 2016; Jani et al., 2016). Although there has been the emergence of innovative approaches tailored towards teaching cultural competency, the primary focus of the curriculum has been on facilitating the integration of knowledge into clinical practice. Lusket al. (2014) taught a clinical social work practice graduate course in Spanish. The students reported that the course broadened their cultural competency skills through the experiential learning of the culture in Spanish. In this case, social workers gained knowledge of the Hispanic cultures to conduct linguistically and culturally appropriate interventions and assessments (Lusk et al., 2014). However, Block

et al. (2016) indicated that the predominant approach for teaching cultural competency is in the dominant language by basing focus on the knowledge of diverse cultures. Education and training of cultural competence often lack the connection into practice behaviors (Block et al., 2016).

Mlcek (2014) demonstrated that the focus of cultural competency pedagogy is insufficient and narrow to address the diverse of the current societies. The cultural competency training concentrates on skills development, self-awareness, and increasing knowledge on culture, while the integration of oppression, power, and privilege as clinical social practice behaviors are missing. Nadan and Ben-Ari (2013) conducted research on social work students and demonstrated the limited integration of intersectionality and cultural humility into clinical social work practice. According to the qualitative studies of Williams and Parrott (2014) and Garran and Werkmeister-Rozas (2013), determined that the social constructs of oppression, power, and privilege were usually overlooked as relevant factor practice behaviors, and even though the students recognized these constructs, they did not integrate this knowledge into their assessments of the clients.

Block et al.'s (2016) study of 168 bachelor social work students reported improved cultural competency post-test after attending cultural diversity courses. Delphin-Rittmon et al. (2013) agreed that cultural competency is necessary for social work education as it helps improve practice behaviors. Since oppression, power, and privilege are components of cultural competency standards, the integration of intersectionality and cultural humility into cultural competency education has the

potential of providing positive impact on practice behaviors (Varghese, 2016). There are numerous bodies of literature on cultural competency that present its advantage on clinical practice (Azzopardi& McNeill, 2016; Edwards, 2016; Fisher-Borne et al., 2015).

The critiquing research reinforces the standard that cultural competency is an on-going process that requires reassessment, modification, and change (NASW, 2015). Power, privilege, and oppression require additional attention in clinical practice (Azzopardi& McNeill, 2016; Fisher-Borne et al., 2015). As communities advance in complex diversity, more studies in cultural humility and intersectionality are important to comprehend their integration in clinical practice (Chu et al., 2016; Ratts et al., 2016; Seedall et al., 2014).

Clinical Practice: Power, Privilege, and Oppression

In 2015, NASW revised the indicators and standards of cultural competency to facilitate the incorporation of cultural humility and concepts known as intersectionality as social work practice indicators. Cultural humility and intersectionality primarily focus on promoting equality by addressing oppression, privilege, and power. These practices have often been associated with the activities of community organizing (Chun et al., 2013). However, the revised standards have created an expectation of cultural humility and intersectionality at the social work practice levels (NASW, 2015). Cultural competency framework focuses on the skills, cultural knowledge, and self-awareness as the basis of the measures of cultural competency (Edwards, 2016). In this section, the measures of cultural competency are reviewed, and a discussion is provided on the cultural humility and intersectionality in social work practice.

A cultural competency measure specific for social work does not exist (Jani et al., 2016). However, Boyle and Springer (2001) and Krentzman and Townsend (2008) carried out two distinct meta-analyses specifically focused on measures of cultural competency across social work disciplines. They agreed on four scales of measures that are universally appropriate to be applied in social work: a) Quick Discrimination Index, b) Multicultural Counseling Awareness Scale, c) Multicultural Counseling Inventory, and d) Cross-Cultural Counseling Inventory-Revised. The psychometric support for these four scales, that is, determining the opinions of the clinical social workers regarding the mental challenges experienced by clients, depicts promising outcomes that are easy to administer and score. Boyle and Springer and Krentzman and Townsend inform that these scales are responsible for measuring self-awareness, awareness of the worldview of the client, and the implementations of interventions that are culturally appropriate.

However, these scales used in measuring cultural competency face some critiques. One of the critiques relates to the concept that there is self-administering of all the measures by the social workers. The self-administration presents the risk of a bias perspective being demonstrated by the evaluation since each social workers would provide their independent perspectives based on self-interests (Tao et al., 2015). The other critique pertains to the argument that cultures, although they are supported by theoretical constructs, have vast complexity and diversity, and this is likely to lead to the behavioral indicators that are rarely measured and defined (Boroughs et al., 2015). There are scholars, Baker and Beagan (2014) and Eunyoung-Lee (2016), who argue that owing to the diversity of cultures, the use of measures that are culturally diverse is the best

approach that should be adopted in the evaluation of cultural competency. These scholars, therefore, posit that the scales of measures for self-awareness as proposed by Boyle and Springer (2001) and Krentzman and Townsend (2008) do not include cultural humility and intersectionality, hence presenting challenge in measuring cultural competency.

As further argued by Jani et al. (2016), the challenge involved in the development of measures of cultural competency pertains to the length of time taken in validating the instrument. In the situations where cultural humility and intersectionality in measures of cultural competency are not a compulsory requirement, there is often a high probability of these components being overlooked by social workers as aspects of clinical practice (Azzopardi& McNeill, 2016). Emerging research considers cultural humility and intersectionality as integral aspects of mental health treatment (Davis &Gentlewarrior, 2015; Hook et al., 2013; Ortega & Faller, 2011; Rivers & Swank, 2017). In addition, there is additional research about cultural humility and intersectionality geared towards the identification of practice behaviors contributing to the development of measures of cultural competency (Bubar et al., 2016; Garran &Wekmeister-Rozas, 2013).

Cultural Humility in Practice

Cultural humility refers to the awareness of the privileges and power present in different relationships and the practice of self-monitoring focused on addressing the imbalances of power (Fisher-Borne et al., 2015). Cultural humility requires the social workers to have recognition of their respective positions of power. Fisher-Borne et al. (2015) inform that in professional roles, social workers are placed in the positions of power where their primary mandate is to influence the clients' lives. Clinical social

workers who had practiced their respective roles for a minimum of 10 years were studied by Davis and Gentlewarrior (2015), the researchers asked participants matter concerning the mediation of White privileges in working alliances, specifically in the client-therapist relationships. The tools that were identified that addressed the power imbalances in the therapeutic relationship were recognition of self-reflection, privilege, and humility (Davis &Gentlewarrior, 2015). The incorporation of action, philosophy, and continuous practice are the requirements for the integration of cultural humility into social work to address power imbalances related to self-reflection by clinical practices workers for the privilege of the clients they serve. However, as posited by Tervalon and Murray-Garcia (1998), cultural humility extends beyond the power imbalance and suggest that knowledge and action are necessary for the mediation of the imbalance.

Cultural humility facilitates the identification of privileges and mediation of power imbalances by ensuring the that their unique care needs affiliate to the diversity of their cultural backgrounds are considered by the clinical social workers when delivering mental health treatment (Fisher-Borne et al., 2015). In a 2015 study conducted by Davis and Gentlewarrior using a focus group of clinical social workers, the researchers reported self-reflection to be an imperative component needed to propel the process of integrating cultural humility and intersectionality in mental health treatment. Reflective practices on White privileges were identified by the participants as a way of improving the working alliances with clients when social workers actively bring power dynamics to their awareness. The study by Davis and Gentlewarrior (2015) thus created the dialog that the awareness and practice of cultural humility is an important skill and practice behavior in

clinical social work practice. As a result, cultural humility is a vital action in social work practice within clinical settings rather than just being mere ethical values to pursue.

Ratts (2017) developed a chart that was intended to be used in session with a client and the purpose was to specifically help in identifying power imbalance and discuss the issue bilaterally between the therapist and client. The subject that has been reported to be commonly focused on in clinical practice setting is the psycho educational experiences to help promote the empowerment of clients by considering their unique mental health needs. Ratts et al. (2016) floated the argument that privilege, and power are topics that are often challenging to holistically discuss, and further that this makes social workers to embrace efforts of achieving culturally competent practice. This argument was similarly supported by researchers Azzopardi and McNeill (2016), Fisher-Borne et al. (2015), and Seedall et al. (2014). Likewise, Hook et al. (2013) conducted a study that examined the use of cultural competence practice by social workers. The researcher specifically focused on the client administered measures for the assessment of cultural humility of the therapists. It is demonstrated by the research that clients positively received the cultural humility practice, which reflects improved cultural competence practice.

Intersectionality in Practice

Intersectionality is a concept grounded in the feminist theory, which focuses on examining the prevalence of gender inequalities within the structures of power and confines of social relations (Crenshaw, 1989). Intersectionality concept offers detailed explanation of multiple cultural identities on matters relating to poverty, race, and gender

with the goal of helping to identify the experience of clients on issues of domination, oppression, and discrimination by the society (Ratts, 2017). Intersectionality provides a revelation of the design of societies inhibiting the progress and interaction of the marginalized groups through the different forms of discrimination and oppression, and chiefly creates emphasis on working towards the attainment of social justice and equity for all (Cho et al., 2013).

Krumer-Nevo and Komem's (2015) study with a sample participant of female adolescents found out that there a positive response by these study's subjects to group therapy where the topics of intersectionality such as sexuality, class, race, and gender were integrated led by social workers who had competent training in intersectionality. The training of social workers in intersectionality helped in improving the analysis of problematic behaviors for the female adolescents through the lens of intersectionality to increase understanding serving to foster the creation of unconditional empathic environments (Krumer-Nevo&Komem, 2015). The researchers, Krumer-Nevo and Komem, offered a demonstration of the integration of intersectionality in the practice of social work through the empowerment of social workers to enhance the response to clients in positively unconditional manners as well as advancing the efforts to educate the clients in intersectionality.

Intersectionality recognizes that discrimination, power, and privilege are the experiences of the clients that get intensified in the situation where there is intersection of multiple marginalized identities (Cho et al., 2013). There are studies that have examined mental health through the framework of intersectionality and its integration into the

mental health treatment as clinical practice behaviors and have provided consistent reports that the higher health disparities rates are experienced by the marginalized population. Krumer-Nevo and Komem (2015) and Matsuoka (2015) demonstrated creativity within the context of integrating psycho education on oppression, power, and privilege into group work treatment and supported the idea that the intersectionality awareness by the social workers is the key factor of translating this knowledge and experience into practice. The data gathered by Krumer-Nevo and Komem were those from narratives of staff reporting positive outcomes on mental health with female Arab and Jewish adolescents aged between 12and 18 years old after they had participated in the group sessions covering the oppression and privilege topics. Matsuoka collected secondary data as part of the 6 weeks group session evaluation with sample participants of eight Canadian older adults and offered the demonstration that positive outcomes on mental health were realized.

Both Krumer-Nevo and Komem (2015) and Matsuoka (2015) reported that the clients exhibited increased insights within the social context into their personal experiences. Majority of the clients were determined to have reported reduced anxiety symptoms but gained a sense of increased empowerment (Krumer-Nevo&Komem, 2015; Matsuoka, 2015). These scholars, therefore, agreed that intersectionality serves an imperatively essential component of the practice of cultural competence, and suggested the needed for additional research to be conducted to fuel the process of operationalizing the integration of intersectionality into the clinical practice behaviors.

Training Cultural Humility and Intersectionality

The assessment of discrimination, privilege, and power in clinical practice usually begins in social work training. The cultivation of self-reflective practices of privilege and power serve as integral components for designing graduate-level experiential course assignments stimulating critical discussions of intersectionality. When social worker students manage to draw on respective individual experiences and examine the paradigms of intersectionality, there is an associated resonance in developing and transferring them into clinical practice (Robinson et al., 2016). Deliberate attention is a prerequisite requirement of cultural humility and intersectionality when providing training on cultural competence coupled with the need for integration into all the diverse aspects of social work training.

There are studies that have demonstrated the gap between training cultural humility and intersectionality and their consequent operationalization into clinical practice. The research by Block et al. (2016), Bubar et al. (2016), and Jani et al. (2016), for instance, which focused on studying graduate social work students, did demonstrate that there are deficits in the integration of oppression, privilege, and power into the clinical practice behaviors. The researchers reported that the students could articulate good knowledge of the issues of discrimination and power knowledge; however, this knowledge could not still be translated in the assessment of client vignettes. It is not only the students who can be regarded as social workers struggling with the process of integrating cultural humility and intersectionality into clinical practice.

In a different study conducted by Varghese (2016), the researcher analyzed the responses of 15 university faculty on case vignettes that presented issues on clinical practice. Varghese's qualitative study of social work faculty members offered a demonstration of the views on racism and race as primarily individual ethnics and cultural identities that failed to integrate structural oppression knowledge in modern society. Varghese is one of the few studies that examined operationalization of power and privilege in the faculty of social work. Seedall et al. (2014) informed that since cultural humility and intersectionality are standards of cultural competence, it has been deliberated that there is need for more studies to connect these two concepts to the clinical practice behaviors. As cultural humility and intersectionality gain momentum in clinical practice literature, there have been additional studies such as Cho et al. (2013), Chu et al. (2016), and Ratts et al. (2016) that have focused on examining the practice behaviors contributing to the development resources and tools necessary for improving the clinical social workers behaviors.

Cultural Humility and Intersectionality – Building Alliance

There is contradiction in literature concerning whether cultural competence practice can conclusively improve the outcomes in mental health because majority of the studies fail to meet the rigorous empirical standards of research. Chu et al. (2016) identified some of the challenges in the study of cultural competency: 1) the operational definition inconsistencies in the instruments responsible for measuring cultural competency, 2) the mandates and guidelines of cultural competency practice lack detailed and explicit strategies of implementation, 3) there is little knowledge regarding the

contribution of cultural competence on the change processes therapeutic mechanisms. However, ethical codes of professional associations serve to facilitate the upholding of culturally competent practice as the optimal approach of best practice (Renzaho et al., 2013).

However, the studies by Manseau and Case (2014), Cook et al. (2014), Jimenez et al. (2013), and Kohn-Wood and Hooper (2014) demonstrated that cultural competence practices had a positive impact by increasing the participation of clients in treatment. They argued that positive social worker-client working alliances are fostered by culturally competent practice. Strong working alliances improve the involvement of the clients in the change process, hence, justifying that positive work alliances are essential in helping attain positive treatment outcomes (Manseau& Case, 2014; Cook et al., 2014; Jimenez et al., 2013; and Kohn-Wood & Hooper, 2014). The quality of the working alliances that is developed can, therefore, be influenced by cultural humility and intersectionality as cultural competency components.

Hook et al. (2013), E. Lee and Horvath (2014), and Tourse (2016) all reported that the process of integrating intersectionality and cultural humility into clinical practice helped foster positive social worker-client working alliances. Positive working alliances have immense contribution to the change process of the clients owing to the consideration that the clients often experience the safety held and promoted within the therapeutic environments (C. Rogers & Koch, 1959). The ability of the clients to change and challenge incongruence requires the willingness to take risks, which can only be realized in safe environments (C. Rogers, 1957). It was highlighted by Tourse (2016) and

Berg (2014) that integrating cultural humility and intersectionality in clinical practice has the potential of help prevent the re-victimization of clients. Safety needed to contribute to the process of building strong working alliances is thus created by cultural humility and intersectionality.

Building strong working alliances is a fundamental requirement in mental health treatment (C. Rogers, 1957). Since the working alliances are the core to positive outcomes in treatment, the process of examining intersectionality and cultural humility as clinical practice behaviors provides great contribution to the emerging literature on cultural competency. Emerging literature on cultural competency has tried of operationalizing cultural competence practices to demonstrate evidence-based practice outcomes (Henry Jr. et al., 2014; Chu et al., 2016). Cultural humility and intersectionality, as per the standards of cultural competency enshrined in NASW (2015), require further examination to be conducted on mental health treatment to document the clinical practice behaviors.

Based on the literature review, there are challenges in the translation of cultural competence into clinical practice behaviors, this qualitative research study captured reports from diverse clinical social workers within the mental health practice, and these professionals were required to be those with the ability to provide behavior details specific to cultural humility and intersectionality. Therefore, the two key concepts that this study focused on are cultural humility and intersectionality. Cultural humility pertains to the awareness power and privilege that are often present in therapist–client relationships and the process of self-monitoring to help in addressing the prevailing

power imbalances (Tervalon& Murray-Garcia, 1998). In the execution of professional roles, social workers are often automatically in positions of power with the intention of influencing the clients' lives (Danso, 2016). Because of this power differential, in examining the practices of cultural humility and intersectionality, social workers must facilitate the recognition of their respective positions of power so that they can be actively involved in the mediation of any existing culturally based power imbalances when working with clients.

The concept of intersectionality is explicitly grounded in the feminist theory, which focuses on examining the inequalities affecting gender within social and power structures (Crenshaw, 1989). The concept of intersectionality offers a comprehensive explanation of multiple cultural identities impacted by various combinations of poverty, race, and gender to intensify the experiences of discrimination and oppression by individuals in society (Ratts, 2017). Intersectionality is based on the argument that the design of society often fuels discrimination and oppression of marginalized groups, and, therefore, emphasizes the need to work towards social justice and equity for all (Cho et al., 2013).

The literature on cultural competency, therefore, demonstrates wide range of research on the frameworks of clinical practice, critiques, and the influence of cultural competency in the mental health treatment outcomes. NASW's (2015) two components, cultural humility and intersectionality, address oppression, power, and privilege in practice. The current literature demonstrates a gap in the operationalizing of cultural humility and intersectionality into clinical practice. The literature review will support this

study to examine cultural humility and intersectionality in mental health settings in Washington State.

Summary

As the updated ethical standards of NASW (2015) demonstrate, cultural humility is a value of social work clinical practice that is held in high esteem. The purpose of this capstone project was to examine the clinical practice behaviors specifically in the settings of mental health across Washington State. The project employed a qualitative research design to help in examining the concepts of cultural humility and intersectionality. The study reflected the core values of social work needed in pursuing cultural competence to promote social justice.

The current literature has demonstrated the existence of a gap in the operationalization of cultural humility and intersectionality into clinical practice. The study thus sought to address this gap by contributing to the cultural competency literature based on examining cultural humility and intersectionality in clinical practice. The data from this study provided examples of specific clinical behaviors intended to convey cultural humility and intersectionality in mental health treatment. The data contributed to the development of social work cultural competency measures and resource tools to be used in practice. The study contributed to the development of a training curriculum on cultural humility and intersectionality for both the professional social workers and students.

Section 2: Research Design and Data Collection

The NASW (2017) Code of Ethics for social work stipulates cultural humility to be a standard of practice that applies within diverse, if not all, areas of social work practice. Considering that the profession of social work is ever evolving based on society and new scholarly research, NASW (2015) had pursued the incorporation of cultural humility and intersectionality as distinct indicators of standards of cultural humility practice. One problem in the practice of social work is when the standards of cultural humility fail to be integrated into the respective social work practice (Azzopardi& McNeill, 2016; Fisher-Borne et al., 2015). In Washington State, in 2016, for instance, community organizers working at the grassroots level noted that the mental health clients were experiencing services that were culturally insensitive (U.S. Census Bureau, 2016). The culturally insensitive practices were prevalent despite the fact that the state embodies a population that is highly diverse. In this project, I conducted a qualitative study of the clinical behaviors of 17 social workers who demonstrate cultural humility and intersectionality within the settings of mental health treatment to help other social workers learn how to practice the profession with cultural humility.

Research Design

In this study, I employed a generic research design to sample selection, data collection, and analysis. A generic qualitative approach is defined as research that seek to find and understand a phenomenon, a process, or the perspectives and worldviews of the people involved (Caelli, Ray & Mill, 2003). Generic qualitative research examines people's reports of their subjective opinions, attitudes, beliefs, or reflections on their

experiences, of things in the outer world (Percy, Kostere& Kostere, 2015). In fact, this approach is appropriate when a fully qualitative survey approach is desired. Actually, researchers considering any study of people's subjective "take" on actual external happenings and events should consider generic qualitative design as their approach according to Percy et al., 2015. To sum it up, If a study is more interested in the actual outer-world content of their questions (the actual opinions themselves, the life experiences themselves, the participants' reflections themselves) and less on the inner organization and structure of the participants' experiencing processes, then it be appropriate to use generic qualitative design.

The goal of this research was to apply participatory and systematic inquiry to examine the demonstration of cultural humility and intersectionality in the clinical behaviors of mental health workers. I conducted this systematic inquiry of the current behavioral practices of mental health clinicians based on their demonstration of cultural humility and attention to intersectionality as a source of actionable insights into the improvement of patient-physician relationships during mental healthcare processes. Generic research into such clinical issues with far-reaching implications on the patient outcomes is an important source of knowledge on various improvement interventions for the continuous assessment of diversity perspectives to mental health care (Kahalke, 2014). I used this research design to focus on the variations in clinician's ability to demonstrate a rational understanding of social problems, such as discrimination and other forms of identity prejudices, faced by mental health patients to inform the implementation of personalized treatment interventions. Accordingly, clinical social

workers with the responsibility of providing mental health treatment in Washington State were interviewed regarding their integration of cultural humility and intersectionality during patient interactions. The study was guided by the following three research questions:

> **Research Question 1:** What clinical behaviors do social workers demonstrate at different stages of mental health treatment (i.e., engagement, assessment, intervention, and evaluation) to convey cultural humility and address intersectionality?
>
> **Research Question 2:** What are the perceptions of social workers regarding training to aid in knowledge and skills for the integration of cultural humility and intersectionality in managing mental health patients?
>
> **Research Question 3**: How do social workers describe their understanding of a client's worldview and how does it shape their behavioral modifications to optimizing interactions with mental health patients?

I conducted Zoom and telephone interviews with participants to collect data on their understanding of the concepts of intersectionality and cultural humility as well as how the participants' applied these concepts to mental health treatment. The generic research design was employed in this study to provide a candid demonstration of cultural humility coupled with gathering descriptive behaviors of clinical practice professionals (i.e., social workers).

The research as in line with the goal of this study in seeking to improve the delivery of mental health services to culturally diverse populations. The prevalence of

cultural insensitivity in the provision of mental health treatment services in Washington State is reported to be a critical issue of concern in the community (Cronin, 2014). Since cultural humility is regarded as of the standards of ethical practice in social work, qualitative research was the most appropriate approach for engaging with the clinical social workers in Washington State during the research process. Systematic inquiry into this clinical problem through generic research provided a reliable framework for generating practical insights to guide policy formulation and the implementation of personalized care interventions for diverse mental health patient populations (Cronin,2014). In this study, I focused on investigating the role of different psychological principles that influence complex variable relationships that define intersectionality and cultural humility in mental health care. Systematic inquiry provided me with a framework for exploring the behavioral characteristics of healthcare workers and evaluating their contribution towards the clinical outcomes of mental health patients. The research design underlies the conceptualization of intersectionality and cultural humility as behavioral attributes with a considerable influence on the clinicians' perception of sociocultural diversity in mental health patient populations as well as the implications on treatment outcomes.

I focused the sampling and recruitment of participants on a population of experienced clinicians in mental health services. The target participants for this generic research were the social workers involved in the care delivery to mental health patients in Washington.

Though I employed a generic research design, due to the current COVID-19 crisis I did not physically meet with the participants but rather conducted the interviews via Zoom and the telephone. Diverse sample participants were recruited from both rural and urban communities in Washington State. Zoom or telephone interviews were used as part of the data collection process for the purpose of helping capture the participants' nonverbal and verbal cues because it was possible to capture both the audio and video aspects of communication. The interviews were recorded audio-visually, and detailed notes were taken during the interviews.

Methodology

Data

Walden University Institutional Review Board's (IRB) approval number for this study is 04-27-21-0666243. In this study, I conducted Zoom and telephone interviews with participants. Zoom interviews were used in areas where the participants had a good network/internet connectivity. Telephone interviews were used for the participants from rural areas with poor network connection. The interviews were semi-structured to help keep myself and the interviewees attentive on the specific topic under study and adhere to the timeframe of 40 to 60minutes per interview. I audio recorded the interviews and written notes of the participants' responses. I conducted interviews with participants because interviews provided me with the opportunity to explore themes of clinical behaviors in mental health practice within the concepts and areas of oppression, privilege, and power.

Participants in seven cities and one town across Washington State participated in this study. Due to the current COVID-19 pandemic, the interviews were carried out online using the Zoom platform or the telephone at a planned time that had been agreed upon by the participants and I via email prior to the interview taking place. I conducted the interviews during business hours from 9:00 a.m. to 5:00 p.m.

I maintained the participants' confidentiality and privacy throughout the study, seeking to ensure that data were not compromised. There are several ways through which data can be compromised, specifically in relation to researcher bias and electronic problems. I am a mental health clinical social worker; therefore, considering that the researcher is a person who is professionally associated with the field of practice under study, there was the possibility of having internal judgments and influence on the research process. To avoid researcher bias, it was imperatively necessary to write process recordings after conducting the interviews. These process recordings involved reflecting on how the questions were presented by me and responded to by the participants. The process helped in monitoring my worldviews and values that might have presented the potential of affecting the interviews and the data gathered. An additional possibility that might have compromised the data collection process was problems associated with the audio recording equipment.

Participants

Licensed, independent clinical social workers providing mental health treatment comprised the target population for this study. Participants were recruited from the Washington State Department of Health list of approved social workers working across

Washington State. Although the list is not all-inclusive of all the professionals practicing social work in Washington State, the selected social workers on the list possessed the license permitting them to be qualified personnel for providing mental health services. The recruitment of social workers from the Washington State Department of Health list increased the chances of interested individuals meeting the study's inclusion criteria of eligibility: social workers who possessed the necessary professional license at the masters' social work level to practice in the Washington state. The Washington State Department of Health list of approved social workers is located on the department's website and is freely accessible to the public. The list includes the names, emails, and phone numbers of the each of the social workers.

When recruiting participants across Washington State, I made all necessary efforts to ensure a diverse sample because this was an important consideration to facilitate the implementation of cultural humility in the research process. The participants were required to provide demographic information, and this helped to ensure the data were organized in accordance with the number of years that the social workers spent in providing mental health treatment services. The years that a social worker has been working in mental health were categorized on a 5-year range from below 4 years, 5–9 years, and 10 years and above. I also categorized the various mental health settings where the social workers have been involved, ranging from nonprofit, private practice, to small or large agencies. The consideration of the participants' diversity contributed to the credibility of the data collected.

Recruitment

I sent recruitment emails to all the potential participants whose details were obtained from the Washington State Department of Health list of approved licensed social workers. The emails were sent through Mail Chimp, an online newsletter service. Participants with undeliverable email addresses were mailed standard letters through the U.S. postal services. The licensed independent clinical social workers who expressed interest in participating in the study were sent follow-up emails after being randomly sampled and selected to participate in the study. The emails included the consent form and demographic questionnaire.

The demographic information requested of the participants was based on the information gathered by the U.S. Census of Bureau pertaining the age, gender, race, and experience of individuals in providing mental health treatment. The demographic questionnaire also asked the social workers about the day and time that they preferred to conduct the interview. Once participants completed the interview, I sent another email to remind them that, as described in the consent form, a summary of the findings of the study would be emailed to them once the study received final approval through the Walden University dissertation approval process. I provided each participant with a gift card in the amount of $10 as an expression of appreciation for their willingness and efforts to participate in the study.

Sampling

I used purposeful sampling in this study. Purposeful sampling is a technique frequently used when the researcher seeks knowledge from specific participants (Gentles

et al., 2015). I used this sampling technique to help in examining cultural humility and intersectionality as the desired clinical behaviors of social workers in the treatment of mental health. The target population was the clinical social workers providing mental health services. The recruitment process helped in screening out social workers who were not actively providing mental health services; therefore, the inclusion criteria were developed to specifically gather information from social workers currently working in mental health environments.

Purposeful sampling contributed to thematic saturation because it allowed for the use of a small population of sample participants to facilitate convenience in data collection. The process was facilitated by the consideration that the participants possessed specific knowledge on the subjects of cultural humility and intersectionality intended to be studied. The sample size was 17 social workers who met the eligibility criteria and were professionals from different locations across Washington State. The use of a small sample size, as with the case in this study, ensured that the data collected promoted the credibility and trustworthiness of the study by making it possible to reach the participants for any follow-up activity that might have been needed.

The use of a small sample size helps to increase the credibility and trustworthiness of the data collected (Hagaman&Wutich, 2017). I conducted Zoom and telephone interviews with participants, and this allowed me to maximize reaching thematic saturation by maintaining the integrity of each individual interview. Maintaining the integrity of the interviews was an important requirement because the sample participants were recruited purposefully to access diversity in the number of the social

workers' years of experience, area where they are practicing mental health treatment, and types of employment agency.

Hagaman and Wutich (2017) conducted qualitative research with 32 respondents using 25 Zoom interviews and demonstrated to have attained data saturation at the 32nd interview. Therefore, it is recognized that the key to allowing qualitative research reach saturation is by using purposeful sampling. Therefore, in relation to the case of this qualitative research, purposeful sampling was used to help gather data from sources containing specific information that were researched by the study, and this can be facilitated by using a small population of respondents, which inspired the decision to use a small sample size of only 17 as the study's participants.

Instrumentation

The interview questions were developed based on the guidance offered by Percy et al. (2015) provided the necessary guidance on how to carry out a successful interview process when conducting generic research. Guided by this information, the questions for this study were organized to examine: (a) the concept of social workers regarding cultural humility and intersectionality, (b) engagement, intervention, assessment, and evaluation of social workers; (c) understanding of the social workers concerning the difference in the clients' worldview, and (d) input of the social workers.

Examples of these questions included the following: "During your initial contact with the client, what do you do to demonstrate cultural humility?" "How do you incorporate intersectionality into the assessment process?" "How do you demonstrate cultural humility and intersectionality to understand the situation and problem of the

clients?" (See Appendix A for details). These questions provided for the opportunity to have open discussion and were specific enough to facilitate the process of gathering information regarding cultural humility and intersectionality in mental health treatment so that it can allow for producing thematic saturation.

The design of the interview questions was in such a manner that stimulates discussion guided by the description of qualitative research method by Percy et al. (2015). In addition, the questions were designed from the principles of qualitative research specifically geared towards helping stimulate discussion so that they can foster the active engagement of the participants. The capstone committee reviewed the interview questions to ensure that they have maximal alignment with the formulated research theory and questions.

Data Analysis

The thematic analysis was used for this study, which according to Fereday and Muir-Cochrane (2006), entails searching data and identifying common patterns and themes. Cultural humility and intersectionality were used as the framework for identifying themes in clinical behaviors of the social workers. The thematic analysis process for this study identified main themes based on participants responses to the interview questions and an analysis process including initial coding, developing of categories based on initial codes and the development of eventful themes.

The following describes the data analysis process followed: (a) becoming familiar with the data by going through it line by line, (b) generating initial codes using NVivo software, (c) searching for themes, (d) reviewing the themes, (e) defining the themes, and

(f) producing the report. During the data analysis process, memo was used to demonstrate reflexivity in the analysis process. As reported by Birks et al. (2008), the use of memos is a suitable technique for data analysis when conducting qualitative research because it allows the researcher to make conceptual leaps from the collected data to the specific abstractions explaining the research phenomena in the context in which it is specifically examined.

The study used Zoom or telephone interviews, which, as reported by O. C. Robinson (2014), is a common method used for data collection when conducting qualitative research. The rigor of a qualitative study often starts with the research design and the associated techniques employed in capturing and conveying the details of the research process (Shenton, 2004).

Ethical Procedures

NASW (2018) requires ethical standards to be implemented when conducting research with human participants. The study followed standards aimed at protecting the human participants, by the National Institutes of Health. The core principle needed to ensure the protection of human participants is the use of informed consent. In this study, the participants received copies of consent forms before the interviews via email and other additional copies were made available during the interviews to ensure that the participants provided informed consent for their participation in the research.

The consent form covered the information required to obtain the participants' informed consent. The consent form provided the study's participants with the information pertaining to the following areas (a) describing the study's purpose, (b)

considering the expectations of the participants, (c) allowing the right and freedom for the participants to stop their participation at any time, (d) ensuring that there is minimal risk associated with providing information by guaranteeing that being in the study did not pose any threats to the participants' wellbeing and safety, (e) providing contact information that allowed the participants to seek clarification for any questions regarding the study, (f) protecting confidentiality limits and statements, (g) explaining how data gathered were to be used, (h) providing the opportunity for submitting any concerns and grievances, (i) informing about privacy, and (j) informing the participants how the study data and information were to be used.

In addition, as part of complying with the ethical procedures, the confidentiality statement was included in the consent form including the associated limitations for participation. During each interview process, the participants were reminded on how the information gathered was to be used for this capstone project at Walden University. The reports that came out of this study did not share the identities of the participants. To ensure the protection of the participants' information guided by the ethical standards obligation, the personal information of the participants was not used for any purposes outside the jurisdiction of this research project.

The data collected were kept secure using password protection, data encryption, and applying numbers for the identification of the participants in the information documentation. There was no documentation of the personal identities of the participants. However, to ensure easy identification on the consent form, audio records and notes taken during the interviews and for data entry in NVivo, each of the participants was

assigned a numerical number to ensure their confidentiality is protected by concealing their personal identities. The data will be kept for a maximum of 5years, after which all the paper records for the research will be shredded and the information stored electronically erased.

Trustworthiness of the Study

Trustworthiness

Trustworthiness refers to validity and reliability in qualitative research (Darawsheh, 2014; Leung, 2015). According to Whittemore et al. (2001), qualitative studies demonstrate trustworthiness through credibility, authenticity, criticality, and integrity. In this generic research, I established the credibility of the research by ensuring the appropriateness of the research design to gather data to answer the research questions. The study upheld authenticity by maintaining the accuracy of the data collected from the original source, and criticality, established by ensuring that the data reached thematic saturation. Finally, in this study, I adhered to integrity by collecting data that showed critical reflection throughout the research process to the findings.

Credibility

This study established credibility in four dimensions. First, in-depth interviews are an appropriate research method to gather descriptive data (Fusch & Ness, 2015). I used in-depth interviews to gather data on specific clinical behaviors in mental health settings. The second method to establish credibility is to recruit research participants who provide accurate data for the research question (Leung, 2015; O. C. Robinson, 2014). The study's target population was social workers that provide mental health treatment. Hence,

the interviews gathered data from appropriate sources that can report on the desired data to answer the research questions.

Thirdly, credibility of the study findings is ensured by ensuring high-level accuracy in recording the data values and aligning the research procedures to its objectives and the questions it sought to answer (Shenton, 2004; Whittemore et al., 2001). To ensure credibility of this study, I collected data by audio recording the interviews and transcribed them to obtain textual variable representations in the form of notes, which are all deemed as valid qualitative methods for accuracy (see Whittemore et al., 2001). In addition, the participants were recruited from different mental health settings and different areas for diversity in the participants' demographics.

Dependability

This study documented authenticity in the data collection process and data analysis. Authenticity is preserved in the data analysis process by maintaining quotes and words used by participants through use of the transcriptions of the audio-recorded interviews (Whittemore et al., 2001). During the data gathering process, I asked the participants to answer in their own words, comments, and phrases. In addition, I asked clarifying questions to confirm I documented the meaning of their statements correctly. I maintained the originality and only edited a quote in presentation of the findings to ensure protection of the participant, taking in consideration to keep the clarity of the meaning of the quote. Reflexivity, such as memoing, establishes authenticity (Berger, 2015; Whittemore et al., 2001). I maintained a journal for memoing during the data analysis process and used the activity for the accuracy and analysis process.

I interviewed clinical social workers in mental health services with more than 1year of clinical experience. Furthermore, to establish thematic saturation, 17 in-depth interviews were conducted as suggested by (Britten, 1995; Dworkin, 2012; Fusch& Ness, 2015; Guest et al., 2006; Hagaman &Wutich, 2017). During the data collection process, I stored the recordings safely after each interview to avoid tampering or loss of the data. In addition, I used memoing during the data analysis process through reflective journaling to examine biases and identify emotional variations across the datasets. This study achieved criticality through thematic saturation and reflexivity.

Confirmability

The current study displayed integrity. I conducted comprehensive data reviews and accuracy checks to identify possible recording or repetition errors as well as ensuring that the values are correctly matched to the relevant variables. Moreover, incorporated multiple checks for data collection by utilizing personal process recordings, personal note taking during the interviews and appropriate check and balance strategies identified in qualitative research (Shenton, 2004; Whittemore et al., 2001). Furthermore, I used reflexivity, supervision by the research review committee, and following the NASW Code of Ethics to demonstrate integrity employed by me the researcher.

Transferability

In qualitative research, transferability is the extent to which the findings or methods can transfer to other contexts or with other subjects (Thomas &Magilvy, 2011). A dense description of the study process and a detailed description of the demographics contribute to high transferability of a study (Shenton, 2004; Thomas &Magilvy, 2011).

The design of this study is described in detail to ensure it can be replicated in another setting. Thorough data collection procedures focusing on validity and reliability based on the research question was ensured through accurate variable measurements, consistency checks, and credibility evaluation to ensure generalizability of the research findings to other social issues in the context of clinician behaviors. The study findings are aligned to the measurement variables such that they can be statistically generalized to related scenarios in the healthcare settings.

Summary

This capstone project utilized a generic research design that uses qualitative method. Social workers specialized in the provision of mental health treatment in Washington State were recruited for semi-structured interviews to gather data leading to research conclusions. Thematic analysis was used in the analysis of data to help with the identification of common themes in the discussions. The consent form followed the ethical research standards of Walden University Institutional Review Board (IRB). This study contributed to the existing body of literature and will aid Washington State social workers to better assist clients of greater diversity.

Section 3: Presentation of the Findings

The purpose of this qualitative research was conducted to examine the clinical behaviors in mental health treatment that demonstrate cultural humility and intersectionality. The results of this study support grassroots efforts in Washington State to understand the quality of culturally sensitive mental health services in a state with a highly diverse population (Generation Justice, 2016). In this study, I examined data from 17 in-depth interviews with clinical social workers who are providing mental health treatment services. Rogers's (1957) person-centered theory guided the study as a comprehensive framework to examine the implementation of cultural humility and intersectionality in mental health treatment. The study was guided by the following three research questions:

1. What clinical behaviors do social workers use in the different stages of mental health treatment (i.e., engagement, assessment, intervention, and evaluation) to convey cultural humility and to address intersectionality?
2. What are clinical social workers' perceptions regarding training to aid in knowledge and skills for the integration of cultural humility and intersectionality when working with clients receiving mental health treatment?
3. How do clinical social workers describe their understanding of a client's worldview and the role this plays in conducting a mental health assessment?

As a component of the qualitative research design, I developed interview questions to elicit input from the research participants regarding the challenges related to the integration of cultural humility and intersectionality into mental health treatment.

In Section 3, I provide a summary of the data collection process and findings from the in-depth individual interviews. The section begins with a description of the recruitment process and the period of the data collection, followed by step-by-step description of data analysis. In the analysis subsection, I discuss the validation procedures and limitations of the study. Additionally, it includes a discussion of the findings regarding the three research questions, including demographics and visual representations of the findings. Finally, Section 3 concludes with an overall summary and the introduction to Section 4.

On March 22, 2020, I sent 376 potential participants on the WBSWE list of approved social work supervisors the initial recruitment email (see Appendix C). I used Mail Chimp, an online software program, to send the bulk email. According to Mail Chimp's status report, 63% of the email recipients opened the email. In addition, I posted a recruitment flyer on social media via Facebook, Twitter, and LinkedIn. From March 22, 2020, to June 1, 2020, 15 clinical social workers responded to the recruitment email. On June 1, 2020, using Mail Chimp, I sent a second batch of the recruitment email to the same WBSWE list. At this time, according to Mail Chimp's status report, 30 people had unsubscribed from the bulk emails; hence, 346 potential participants received the email, and 52% opened the email. From June 1, 2020, to June 25, 2020, an additional 15 clinical social workers responded to the recruitment email for a total of 30 clinical social workers who had shown interest via email in participating in the study.

I then sent the 30 clinical social workers a follow-up email with the following attachments: the demographic sheet (see Appendix D) and a consent form. Twenty social

workers responded to the follow-up email, returning the completed demographic sheet and signed consent form. Due to coordination of schedules and the intention to gather participants from different areas of the state, only 17 clinical social workers received the third email (see Appendix E) to confirm their status as a research participant with the specific meeting daytime, and location for the interview. I intentionally confirmed 17 participants, or one over the proposed sample size, in case of an unforeseen last-minute cancellation. The three social workers not chosen for the study received an email from me thanking them for their interest and informing them that they would not be included in the study because the maximum number of participants had been reached. The last day of data collection was June 28, 2020, and the final resultant sample size was 17 participants.

Setting

Due to the COVID-19 pandemic, which has led to the establishment of measures restricting movement and social relationships, I conducted the interviews via telephone and online via Zoom, a video communication platform. The length of the interviews varied, ranging from 45 minutes to 60 minutes, depending on the amount of description shared by the participants. The 17 interviews were conducted online and recorded in audiovisual format for reference during analysis. During each interview, I took notes and used an interview outline (see Appendix A).

Data Analysis

I thematically analyzed the data from the 17 interviews, which is an approach often used in qualitative research (see Braun & Clarke, 2006). The overall analysis

process involved three steps: (a) preparing the interviews for coding, (b) coding, and (c) reviewing the codes for meaningful themes. In this study, I used deductive theory and the knowledge of cultural humility and intersectionality to deduce potential relationships (see Fereday& Muir-Cochrane, 2006). The reexamining and reorganizing of the data were ongoing and required revisiting the literature on cultural humility, intersectionality, and the person-centered theory.

The first step of the data analysis process was to have the interviews transcribed verbatim. I hired an independent contractor, who signed a confidentiality agreement (see Appendix B), to transcribe the 17 interviews. The transcriber and I exchanged the audio recordings and the transcriptions through an online file storage system that met Health Insurance Portability and Accountability Act (HIPAA) standards. Once the transcriber completed the last transcription, I deactivated her access to the files. The electronic files were stored in my profile in the online file storage system, and I am the only person who can access the profile. In addition, the online site is encrypted and secured by a password-protected login.

I used the NVivo Version 1.0 computer software, commonly used for qualitative research (Welsh, 2002), to organize the data. Because the software cannot distinguish between my statements and the interviewees' statements, I manually edited the 17 transcriptions to remove my own statements. Then, I input my field notes to the transcriptions to add clarity and details of the interviewees' statements. After this final edit to the transcriptions, the interview transcriptions were uploaded into the NVivo software.

The second step was to code the interviewees' statements. I assigned a number to each interview to ensure the anonymity of the research participants. The demographic data were organized in a Microsoft Excel spreadsheet to link the demographic information to the assigned interview number. The sequential steps in the thematic analysis were as follows:

1. Open coding: Searching for significant phrases, topical transitions, and keywords using emergent codes.
2. Organization of the codes: The emergent codes were categorized into mutually exclusive and non-overlapping categories.
3. Categories further divided into sub-categories.
4. Categories and sub-categories analyzed for themes.

During the open coding step, I reviewed each interview transcription line by line. Each line was read, re-read, and considered in the coding process. I then used NVivo to organize the interviewees' statements into emergent codes as nodes. The nodes made it easy to keep track of codes and re-categorize. After completing the open coding step, I organized the nodes into an initial codebook, which I redefined after coding approximately a third of the interviews and comparing the literature on cultural humility and intersectionality. I then coded the previously coded interviews and the remaining interviews using the redefined codebook.

The last step in the data analysis process was to determine meaningful themes. The interview guide allowed for specific datasets devoted to the individual research questions as categories. The categories focused on four areas of the clinical social

workers' experience in mental health treatment to provide insight on cultural humility and intersectionality: (a) clinical behaviors, (b) understanding the client's world, (c) participants' input, and (d) participants' challenges. From the recursive review of the categories and sub-categories with the literature on the person-centered theory, the following themes emerged: (a) genuine interest in the client's culture, (b) unconditional positive regard toward clients, (c) therapist congruence, and (d) empathic understanding. Table 1 provides examples of the data analysis process and the evolution of the codes, categories, and themes.

Table 1

Examples of the Stages in the Analysis

Meaning bearing	Condensed meaning-bearing unit	Code	Category	Theme
There are other cultures that we can learn from, and other people come from all parts of life and culture is many things. So, it could be a part of the country. It could be ethnicity. It could be LGBTQ. It could be the deaf community as a culture. Therefore, I think of it as many walks of life in terms of culture.	There are other cultures that we can learn from, and other people come from all parts of life and culture is many things.	Open to learn	Ask the client about their culture.	Genuine interest in the client's culture

Meaning bearing	Condensed meaning-bearing unit	Code	Category	Theme
I believe that I am encouraging him to be proud of who he is. Be proud of his culture and not be ashamed of it because there is a lot of shaming that goes on. You know, I have clients, I have friends when they started school, they only spoke Spanish, and it was pretty much beaten out of them since they were not fluent in the English language that many are accustomed to in the United States.	I believe that I am encouraging him to be proud of who he is and be proud of his culture and not be ashamed.	Help client to trust self	Empower	Unconditional positive regard toward clients
Intersectionality is something that people are talking about more often and the thing that scares me about that being used is that there is not only just cultural humility but also structural humility because for myself as a white woman, I cannot just be like I am queer, and I am white, and I grew up working class. And that me being working class is similar to your experience being Chicana because I have to have the structural humility to look at where I am positioned within the systems of power and oppression. I have to have the humility to be able to position myself within that.	As a white woman, I cannot just be like I am queer, and I am white, and I grew up working class. And that me being working class is similar to your experience of being Chicana because I have to have the structural humility to look at where I am positioned within the systems of power and oppression	Know your own privilege	Self-awareness	Therapist congruence
I think we recognize well that the only small population within our society that does not experience oppression are the white males within a certain age. When we look at the percentage of population that has not experienced some kind of oppression, it is probably going to be those white males aged 25 to55. These are productive years when one can become independent and not suffer many chronic diseases.	When we look at the percentage of the population that has not experienced some kind of oppression, it is probably going to be those white males between the ages of 25 and 55, as these are the productive years they experience.	Productivity valued by society	Culture is part of the client's narrative	Empathic understanding

Table 1 shows the meaning bearing in relation to the four themes of genuine interest in the client's culture, unconditional positive regard toward clients, therapist congruence, and empathic understanding. The theme of genuine interest in the client's culture specifically focuses on creating the openness to learn by asking the clients about their cultures. The theme of unconditional positive regard toward the clients primarily considers the need to help the clients trust themselves through empowerment. The theme of therapist congruence considers the importance of knowing personal privilege by improving self-awareness among the clients. The theme of empathic understanding focuses on the necessity for enhancing the productivity valued by society through considering cultures as a critical component of the clients' narratives.

Data Validation

The data collection process contributes to the credibility of a qualitative study (Shenton, 2004; Whittemore et al., 2001). The validation of data in this study involved reviewing the audio recordings, authenticity, and reflexivity. The validation of data was an ongoing process. The validation of the data occurred during the interviews and while the data were prepared for analysis. I collected the data by audio recordings of the interviews, my process recordings, and my researcher's notes. The participants were recruited from different mental health settings (e.g., non-profit, private practice, small and large agencies) and from different cities in of the State of Washington.

During the data gathering process, I asked the participants to define their conceptualization of the research variables and the perceived implications on treatment outcomes for mental health patients. Clarifying the participants' understanding of the

behavioral attributes from related studies provided a framework for measuring authenticity (see Shenton, 2004; Whittemore et al., 2001). At the end of the interview, I summarized the key points of the participant's responses and asked the participant if I accurately understood their statements. I then noted any clarifications or additional comments from the participant. The field notes were integrated into the interview transcriptions. In addition, the data were coded by maintaining the quotes and words used by participants verbatim. The data demonstrated thematic saturation, considering that all the participants were accorded the freedom of providing their independent responses to the questions asked and provided answers to all the areas until they were satisfied. Although the sample size was small, with 17 interviews, according to the literature, thematic saturation is possible with 16 in-depth interviews (see Britten, 1995; Dworkin, 2012; Guest et al., 2006; Hagaman &Wutich, 2017).

As stated previously, in ensuring the validation of this study, I conducted memoing, reflective internal dialogue, and reflective journaling during in the data analysis process. The validation of the data was an ongoing process. The design of the study helped validate the data because I used interviews to collect firsthand data/information from the participants. The purposeful recruitment of research participants contributed to thematic saturation by considering all the responses provided by the participants and analyzing them. The multiple activities I used to demonstrate reflexivity and revisiting/re-listening to the audio-recorded interviews also contributed to the data validation process by determining how appropriate and relevant the participants' responses were to every question answered.

Memoing

During the data analysis, I wrote in a composition book for memoing to demonstrate reflexivity in the analysis process. Memoing provided an opportunity to reflect on the personal thoughts, biases, and interpretations of the data. The memoing process is recognized as a quality control strategy (Berger, 2015). The audio recordings were revisited during the coding process when meanings of sections of the transcription were difficult to comprehend. I used thematic analysis to analyze the data. The thematic analysis focused on the participants' reports of clinical behaviors observed in their mental health practice. The literature on cultural humility, intersectionality, and person-centered theory was used as the basis of the analysis.

Limitations or Problems Conducting the Study

In qualitative research, the researcher is a key component in the research process (Bradbury & Reason, 2003). Some of the problems I encountered were nervousness, long hours in front of a computer screen, resulting in eye strain, and struggling to follow the interview guide. Consequently, it is possible that my inexperience may have affected the data collection. For example, I could have probed more deeply into the participants' responses. When reviewing the demographic sheet on the participants, I realized that 16 of the participants had 10 years of experience and some had over 20 years of experience in the field. I became intimidated when talking with the participants who had so much experience. In addition, I scheduled multiple interviews in 1 day and after long hours in front of the computer, my eyes were watering. I was fatigued when doing the last interview of the day and did not ask as many probing questions. Finally, the interviews

easily morphed into collegial conversations. The participants were passionate about cultural awareness and easily engaged in the discussion on cultural humility and intersectionality. It was a challenge for me to redirect the participants to other interview questions because the participants enjoyed talking about their experiences. Also, some of the participants were nervous and wanted to answer questions correctly and were frequently seeking reassurance from me. In qualitative research, the participants and I collectively contributed to the data.

Findings

The study applied purposeful sampling to examine clinical behaviors in mental health settings. The study's target populations for data were clinical social workers who provided mental health services. Although the interviews were from clinical social workers from Washington State, they represented diversity in the county's population.

Demographics

Participants were recruited to reflect the diversity of the population of the state in which the study was being conducted. Table2 illustrates the demographic profiles of the 17 participants of the study. The ages of the participants ranged from 34 to 81 years, with a mean of 52.4 years. Three (17.6%) participants were male, and 14 (82.4%) were female. Seven of the participants identified as White (41.2%), four as Hispanic (23.5%), two as Black (11.8%), and four as two or more races (23.5%). Of the participants who identified as two or more races, two identified as Native American and White, one as Native American and Hispanic, and one as Hispanic and White. In general, most of the participants had experience in their field. For example, 16 of the participants had 10+

years of experience in mental health, and one had between 5-9 years of experience. Five of the social workers who participated in the study were bilingual (English/Spanish) as described in Table 2.

Table 2

The Participants' Demographics

Assigned Number	Age	Gender	Race	Languages	Place of work	Years in Mental Health
#1	57	Female	Hispanic	English/Spanish	Government and Private Practice	10+
#2	59	Female	Native American and White	English	Government	10+
#3	71	Male	White	English/Spanish	Non-profit	10+
#4	46	Female	Hispanic	English/Spanish	Government	10+
#5	65	Female	Native American and White	English/Spanish	Private practice	10+
#6	49	Female	White	English	Government	10+
#7	43	Female	White	English	Government and private practice	10+
#8	51	Female	Hispanic	English	Non-profit	10+
#9	34	Female	Black	English	Private practice	10+
#10	46	Female	Hispanic and Native American	English/Spanish	Non-profit and private for profit	10+
#11	81	Male	White	English	Private practice	10+
#12	58	Female	White	English	Private for profit	10+
#13	41	Female	Black	English	Private practice Non-profit	5 to 9
#14	57	Male	Black	English	Non-profit	10+
#15	35	Female	White	English	Non-profit	10+
#16	59	Female	White	English	Non-profit	10+
#17	39	Female	Hispanic	English	Private practice Non-profit	10+

Participants Definitions of Cultural Humility

After the introductions, the participants were asked to define cultural humility and intersectionality. Six of the 17 participants were familiar with the terminology of cultural humility. Of these six, three participants (CSW7, CSW15, and CSW17) were knowledgeable due to their personal interest and their activity in their organizations' cultural awareness efforts. The remaining three participants had been exposed to the term cultural humility through an academic setting. Participant CSW6 had taught a college course on diversity and cultural awareness, while Participant CSW3 was introduced to the concepts in a recent training, and participant CSW4 was introduced through the student interns she supervised. These six participants reported motivation to participate in the study due to the research topic of cultural humility.

Although 11 of the participants were not familiar with cultural humility, their interest in the study was due to appreciating culturally sensitive clinical practice. Two participants (CSW2 and CSW13) were involved in activism and community organizing in efforts to challenge discrimination. Their practice naturally acknowledged the awareness of power dynamics in the client-social worker relationship. In describing their clinical practice, the remaining nine participants appeared to be well-versed in the concept of cultural humility. For instance, CSW10 stated:

> It's not a term that I'm very familiar with, but it makes me think of having that ability to self-reflect and step back. And in terms of like knowing where our blind spots are. Knowing that there are other cultures that we can learn from, and other people come from all parts of life and culture is many things.

A key component of cultural humility is to know one's personal biases (Tervalon & Murray-Garcia, 1998). When a social worker is aware of their personal biases, the social worker can prevent impulsive, emotional reactions. CSW14 further emphasized cultural humility as the ability to balance knowledge of others and knowledge of self:

> It is the fine line between arrogance and competence or arrogance and confidence, and so humility is a sense of who you are, and then you also are aware that other cultures are who they are and therefore cultural humility for me is about cultural awareness, both of yourself and of others' cultures.

Another dimension of cultural humility is not deeming one culture as superior and the standard (Danso, 2016). CSW12 demonstrates this value:

> Cultural humility? Oh, my! The words say it. Have humility for someone else's culture. Understand their culture may not be like yours, but your culture is not the barometer or the measuring point of what is right or wrong about a culture because there really isn't a right or wrong about a culture. It is something that evolves stemming from our language, and it evolves through the way that we interact together, and we decide as a culture what is right and what is wrong. That's why every culture is different.

Similarly, CSW16 expressed:

> The term "cultural humility," I don't think I've heard it before, but certainly as a social worker, becoming culturally aware of both my culture and how that impacts me. And being aware of my client's culture and how that impacts them

> and then how our two cultures impact our interaction is what I try to recognize from them, how they see life and how they see it differently than me.

A final component of cultural humility entails accountability and action on behalf of the social worker. Fisher-Borne et al. (2015) mentioned that social workers have the knowledge of the power difference and are responsible for mediating the inequalities explicitly. An example of mediating inequalities is the social worker's willingness to learn from the client (Tervalon& Murray-Garcia, 1998), as demonstrated by CSW8, who reported:

> I think it's understanding my own position in terms of what I bring, whether it's my own experience or knowledge of a culture and maybe what I don't know. So really, I come with an open mind, expecting to learn, whether seeking out resources or for my client or a liaison, so it's really just not having all the information. It is just being opened to learning about a culture.

In addition, CSW11 provided an example of the significance of acknowledging one's ignorance to mediate the power difference:

> "But what I would do is ask, especially if they're Native American, because one tribe is different from another. So, I ask. I just let them know. I don't know about your culture".

In the example provided by CSW5, she demonstrated her awareness of the power imbalance and ways to address the imbalance:

> Sometimes I'll use self-disclosure [about being Native] as a way to give permission for people [to share about their culture]. I use myself a lot in therapy,

> and part of that is to deal with the power differential. Part of it is to say I'm a human being. I've been through this.

The social workers' willingness to not be the expert empowers the client. CSW1 described how she used humor to address the power inequality during a supervised family visit:

> On the third visit, it was pretty much the same except for the kids were being rowdy, and I stopped and blocked them at the door and said, "No, we're not allowed to leave the room." Then I made a comment, "I know, this silly White lady has these rules," and that was the joke that broke the tension. From then on, [we] became a partnership. We all laughed, and the parents laughed, and from then on, I was able to engage [with the family]. Because I felt like I needed to let them know that I'm not the expert here. You are the expert. You are the expert in your family. I'm simply here, this lady, trying to reinforce some rules that are silly looking.

Cultural humility is the practice of dismantling the power dynamics that are naturally present in the client social worker relationship (Tervalon& Murray-Garcia, 1998). These nine participants demonstrated an awareness of the power difference in mental health sessions, although not all of them were familiar with cultural humility.

Participants' Definitions of Intersectionality

After the introductions, the participants were asked to define intersectionality. All the participants were familiar with intersectionality and acknowledged that multiple marginalized identities influenced the client's individual experience in society.

Intersectionality emphasizes the multidimensionality of a client's experience with structural oppression and discrimination (Crenshaw, 1989). The participants expressed their knowledge of intersectionality when they answered research question 2. For instance, CSW11 described the multi-layered experiences of adolescent clients that affect their mental health:

> It includes especially culture, the kid's peer group and kid's school. Those are the two things that bear on whether the kid wants to live or not. And too often the schools are bearing out a cultural bias against the kids being Hispanic and not knowing English very well or being a migrant or being poor or being an asshole, you know? And the school is blaming and dividing instead of coming together as a team with the kid and the family.

CSW10's example demonstrated her knowledge of intersectionality by the complexity of a client's situation due to immigration status:

> For instance, maybe there's an undocumented family and the husband is abusive, but the husband is the one that's working. And it's difficult because the other members of the family are not working and are undocumented, so they choose to stay with their abuser. I understand that the reason why the woman isn't leaving the situation is part of survival in the U.S., because things have been turning more and more anti-immigrant so that to go to receive services [increases] the danger of being deported.

CSW17 introduced the complexity of the military as an additional component that reflects the power dynamic with her clients' experience:

> What are we looking at? Are we looking at military? You know if we have a military person positive for alcohol or drugs that is huge. They have a different code that they go by, whereas you know if I had a 20-year-old positive for alcohol that is not in the military, we don't have to call anybody. If they are in the military, we have to call. So, there is a different code for them.

CSW2's example explained the influence of the incarceration facility and an additional layer of power dynamics:

> There is absolutely no such thing as voluntary. I mean, some of the young men want to do therapy and want to make changes, and that is great, but it's within the context of being incarcerated. They are not free to go where they want. They do not leave the facility. They have to ask to use the restroom. They have to ask to stand up. It is a correctional facility. The power dynamic in that intensifies because it's visceral. It is right there every day, every minute.

In CSW3's agency, the understanding of intersectionality is so imperative that it's part of their interviewing process when hiring new staff:

> Every time we have a new employee or new volunteer come on board, one of the questions in that interview is why do you think people are homeless? Why do you think people experience homelessness? We know from our [social work] knowledge, there are many, many structural reasons. There are economic reasons. There is a lack of affordable housing. There is the idea that people experience trauma and sometimes unhealthy coping strategies, and those unhealthy ones can lead to homelessness. There is the issue of chronic medical conditions or disease.

> There is a traumatic brain injury. There is a lack of opportunities in their past to develop skills and knowledge that can help someone function well in this society that we have all created.

When clients face immigration issues or experience incarceration or homelessness, the social structures that contribute to these situations are limitless. These statements demonstrate the participants' awareness of the influence of social factors on mental health. The awareness of these factors is an example of intersectionality in practice. Although all participants acknowledged the importance of addressing power, privilege, and oppression in clinical practice, the terminology of cultural humility was less commonly known.

Research Question 1

During the interviews, the descriptions of how the participants worked with clients interwove throughout the treatment stages, and at times the same behaviors overlapped in the stages. Three themes emerged from the participants' responses describing the clinical behaviors (see Table 3). The themes of the clinical behaviors were cultural humility and intersectionality and were defined by parameters such as genuine interest in the client's culture, therapist congruence, and unconditional positive regard.

Table 3

Question 1 – Themes

Theme	Categories	Number of coded statements
Genuine interest in the client's culture	Ask the client about their culture	33
	Allow the client's language in the session	27
	Allow the client's family during the session	25
Therapist congruence	Self-awareness	55
	Self-reflection	16
Unconditional positive regard	Empower	86
	Build a relationship	78
	Nonjudgmental attitudes	55
	Trauma-informed care	22

Theme 1: Genuine Interest

During the stages of engagement and assessment with clients, asking about the client's culture was predominant. Rogers (1957) described genuineness, warmth, and acceptance as core conditions to foster a therapeutic environment for change. Genuine interest was demonstrated by three sub-categories: a) inquiring about the client's culture, b) allowing the client to speak their language, and c) allowing the client's family to participate in mental health sessions. The participants demonstrated genuine interest when they inquired about the client's culture in detail rather than just "checking the box," as expressed by participants CSW2, CSW4, and CSW13. Fisher-Borne, Cain, and Martin (2014) asserted the importance of social workers challenging institutional systems in insensitive cultural practices. When social workers demonstrate a genuine interest in the client's culture, it epitomizes cultural humility and intersectionality. A total of 85 statements documented the participants' genuine interest in the client's culture.

Sub-theme 1: Ask About Culture.

All 17 participants made at least one statement that demonstrated genuine interest. CSW1 stated, “Making it known to the client that you’re a learner and that you’re willing to have them also teach you as you’re providing service to them.” Furthermore, ten participants made statements that included “be willing to learn” and “ask them” about their culture. CSW5 shared an example of a session with a youth who was shut down, and she was able to get the youth engaged by inquiring about his culture: “Well, tell me about your Apache grandma. What did she give you when you were little? Suddenly, he opens up.”

The probing for specific information about the client’s culture demonstrated genuine interest and contributed to engaging the client in the therapeutic process. CSW13 shared how she integrated the conversation about culture with her clients:

> I’m just very authentic with who I am, and so I allow a person to be authentic with who they are. And ask them if they want to bring something in from their culture to use to help with the process or if they have an idea that comes from their culture. If I am not culturally aware about it, I do not know all the Native American tribes and all the different things that they do, you know? If they have some sort of healing that they do, I ask them to bring it in, explain it to me, and incorporate it in what I’m trying to do with them.

Genuine interest is demonstrated by initiating the conversation about culture, which engages clients in the treatment process.

Sub-theme 2: Allow language. Another way that participants exhibited genuine interest was by giving the clients the opportunity to use their own languages. Language is a common area of discrimination and challenges social workers to act against it (Kiehne, 2016). I identified 27 statements that reflected how the participants integrated the client's innate language into mental health sessions. Both CSW1 and CSW5 indicated they got "forms translated" into the client's language to demonstrate awareness of the clients' linguistic needs. CSW2 and CSW4 stated they allowed the clients to speak "gang language" to promote freedom of expression. The five bilingual participants disclosed the importance of allowing clients to "correct" their Spanish. CSW1 stated:

> When I started working, with primarily monolingual Spanish-speaking clients, my Spanish was different growing up than Mexican clients. There was so much difference in dialect, and there were times that I didn't have the words and I would have to ask, "I don't know how you say this word?" I'd have to give examples, kind of went the long way, and then they would say, "Oh, this is good to know" That also became part of cultural humility. You know, thank you for educating me. I didn't know that word.

This exchange between the client and the social worker demonstrated cultural humility and contributed to building a strong working alliance (Hook et al., 2013).

When clients are denied the opportunity to express themselves in their own language, this represents an act of oppression (Kiehne, 2016). CSW4 shared witnessing the oppression of language at her workplace:

> I have a client who is Mexican, and his grandparents speak only Spanish, and he slips, and he speaks a lot of Spanish. The other day he was coming out of the day room; it was around dinner time, and he was like, "Cuandonos van a dar de cenar" a one of the Hispanic staff members—that's what pissed me off—is like, "What?" And he was like, "Cuandovamos a cenar?" And [the staff member] was like, "I don't understand you. You need to speak that in English." And I said, "He's asking you when dinner is going to be served." And he was like, "Oh, I understood him." And I said, "Well then why are you having him repeat it?"

CSW4 not only witnessed the act of oppression, but also intervened and advocated on behalf of the client. According to Tervalon and Murray-Garcia (1998) and Kiehne (2016), such actions against discriminatory and oppressive acts are necessary to change the structural systems that reinforce oppression. A total of 12 participants made a statement regarding the importance of the client's language in the mental health session. When social workers allow clients to use their language, they demonstrate a genuine interest in the client and their culture.

Sub-theme 3: Allow family. A third way in which participants demonstrated a genuine interest in their clients' culture was considering the important role family plays in the lives of clients. Alegría et al. (2016) argued that to eliminate barriers to minority clients accessing behavioral health, there is a need to understand the client's values (i.e., family) and needs. There were 25 statements that demonstrated the participants' willingness to integrate family into the mental health sessions. Family therapy is an intervention that communicates genuine interest in the client and their cultural needs.

Three participants (CSW8, CSW10, andCSW11) reported that they recognized the people the clients' identified as their family. For instance:

> One time in a family session; the mom said that she wanted to bring a Medicine Man to come in to do a healing and I'm like, okay let's do it. That's not the norm [at my workplace], like we have certain standards. This is not something that usually happens, so you have to create that space. It's going to be done in my office, and even though it's framed as a family session, this is what they need. It's basically a space for them to be able to do this because they can't just go do it in the cafeteria or outside, you know? (CSW10)

When CSW10 accepted the Medicine Man as part of the family, the participant demonstrated a genuine interest in the family's culture. The genuine interest in the client's culture contributed to engaging in treatment.

Moreover, CSW4 explained the importance of not judging the client's family norms and the powerful intervention of accepting the family's current functioning as the norm:

> I have another White client. Mom is in her late 20s, on disability, very negative, "He doesn't do anything right." So, when I've talked to him [the client] about it to see how he feels about it, he's like, "That's my mom." And I'm like, "Well, does it upset you?" "Well, why would it upset me? That's just my mom. That's the way she is." So that's the norm in that family. We can't really judge and say, "You know what, this client can never go back to his mother because she's crazy

> and she's rude and sarcastic." No, we kind of must find the positives because that's the cultural norm for them.

CSW4 demonstrated a genuine interest in the client's culture through unconditional acceptance of the client's family. The unconditional acceptance was an intervention (C. Rogers, 1957) that allowed the social worker and the client and the client's family to continue to work together toward a common goal of discharge.

When a social worker demonstrates a genuine interest in the client's culture and family, there is an opportunity to engage the client in treatment and use a natural resource (i.e., family) as an intervention. CSW5 provided an example of using family therapy as an intervention to gain client engagement:

> Another time I did a thing, I had a mother and a daughter. They were from Clark County. They couldn't agree on anything. Oh, they fought. They were horribly fighting all the time. The only thing I could find to try to bring them together was helping them plan a Quinceanera. It was the only thing that could get them to talk. So sometimes my sessions look very unorthodox. I'm not doing 'therapy' the way some people would say, but I'm doing therapy in a way that makes sense to them [the clients].

The family was able to find a common topic to focus on in the session, which contributed to improved communication in the family system. Family therapy was identified by 12 participants as a regular intervention to demonstrate an interest in the client's culture.

All 17 participants made at least one statement to demonstrate a genuine interest in the clients' culture. The genuine interest was demonstrated throughout the engagement and assessment process by probing for details about cultural activities, rituals, and family. In addition, genuine interest was demonstrated by allowing the clients to utilize their own language in session. The third clinical behavior that demonstrated a genuine interest in the client's culture was allowing the involvement of family in mental health sessions. Furthermore, family therapy was identified as an intervention often used in the treatment process to demonstrate cultural humility and intersectionality.

Theme 2: Therapist Congruence

Therapist congruence is necessary throughout the engagement, assessment, intervention, and evaluation process. C. Rogers (1957) first identified therapist congruence as the therapist's comfort with self that allowed the therapist to be transparent with clients. These clinical behaviors exhibit cultural humility and intersectionality (Fisher-Borne et al., 2015). The therapist demonstrates comfort with self through self-awareness, an understanding of personal values, beliefs, and experiences. Self-reflection is the process that leads to self-awareness. Fisher-Borne et al. (2015) argued that self-awareness and self-reflection are vital dimensions of cultural humility and intersectionality. A total of 59 statements reflected self-awareness and self-reflection, a component of therapist congruence. Specifically, self-awareness was represented by the following sub-themes: a) know your biases, b) know your limitations, c) be comfortable in your own culture, d) know your privilege. Furthermore, self-reflection refers to a) notice blind spots, b) do not take it personally, and c) cultural appropriation (see Table 4).

Table 4

Summary of Data for Therapist Congruence

Theme	Category	Subcategory	Number of coded statements
Therapist congruence	Self-awareness	Know your biases	7
		Know your limitations	7
		Be comfortable in your own culture	14
		Know your privilege	9
	Self-reflection	Notice your blind spots	9
		Do not take it personally	10
		Cultural appropriation	3

Sub-theme 4: Know your biases. Self-awareness begins with being honest with oneself and recognizing the beliefs and experiences that contribute to biases. The awareness of biases allows social workers to practice with cultural humility and intersectionality by not imposing personal agendas. CSW16 described her ability to acknowledge her biases regarding parenting style in her work with a mother:

> I try not to impose my cultural definition of good parenting for sure. I don't feel comfortable with spanking, but my client feels like it's appropriate in the circumstances. And so, I'm going to listen to her about that, and I'm going to not judge her for that. And as I develop a relationship with her, we will begin to talk about ways to manage the children's behaviors outside of spanking so that she has another resource because a lot of times parents do not know what else to do.

Another illustration of assessing personal biases was shared by CSW4 when her caseload included a client with a history of a sexual offense. CSW4 confronted her personal feelings about sex offenders, so they did not interfere with her work with the client:

> They are sex offenders. They are child sex offenders. I mean, the word sex offender is something that is very negative to begin with. You know, at the prison, it was a huge red flag not only for the other inmates but for the staff. You know it is like he's a sex offender. We need to be careful. He could get hurt. There was that type of stuff. Then you have this, I mean, c'mon, it is an issue that most of us are not comfortable with. It was an issue that I was not comfortable with working at the prison. I was just lucky enough that I did not have to address their sex offending issues in any type of therapeutic way.

A different participant (CSW2) shared an experience with a youth claiming he was Native American and requiring special accommodation; however, this youth did not have the physical appearance common to Native Americans. CSW2 was able to acknowledge her biases:

> I think the example I just gave. My own bias came through pretty clearly that I assumed because of the way this young man looked, that he was not Native American. I bring my own history, my own biases with that because of having been a Native activist and people thinking it was cool to be Indian and just the whole history with the New Age movement. That was kind of my transference, at least partially.

Biases are normal because they arise from our personal knowledge and experience in the world. These examples demonstrate how acknowledging the biases contributes to self-awareness and prevents imposing power over clients.

Know your limitations. Another component of self-awareness is to know one's limitations. According to Azzopradi and McNeill (2016), when the social worker knows their limitations, they practice with cultural humility and intersectionality by not making assumptions. Participant CSW8 emphasized the importance of knowing one's limitations and staying current in clinical training: "We're not going to know it all, but if I don't understand what it's like to be Trans, what that might feel like, then I shouldn't be working with that person, or I better get some training."

Similarly, CSW14 shared:

> Well, how do we presume that we know somebody's culture and try to come up with solutions for them that may not be the right solutions? It may be something totally different than what they are thinking. I think that this is very important to drill down on as it relates to really getting to know people so you can help them.

Due to the diversity in clients because of age, race, gender, ethnicity, socio-economic status, and language, it is impossible to know the specific needs of the clients without first listening to them and learning about them. Part of humility is knowing one's strengths and limitations. Acknowledging limitations is an example of self-awareness.

Know your own culture. The third component of self-awareness is the ability to be comfortable with yourself, which displays therapist congruence (C. Rogers, 1957). Ten (58.8%) of the participants identified as other than White or as mixed. During the

interviews, ten of these participants mentioned that their culture influenced their work with the clients. Their comfort in their own culture allowed them to use themselves as a therapeutic intervention in the treatment process, an example of therapist congruence (C. Rogers, 1957). In addition, they explained that their firsthand experience with intersectionality was part of what contributed to understanding their client's worldview (these quotes are shared in the section dealing with question 2).

Participant CSW5 shared a poem by a Native American author that contributed to her growth in self-awareness:

> Years later when I started Native American traditions, I understood. I always had an indigenous worldview. I did not have a mainstream worldview. How I saw the world was like this, like [the author] said. And so, my worldview was different. And I was always able to be much more circular than I was linear, and I have to understand the different processes, so a lot of the work I do is much more holistic. You know, for us in the Native world, the Medicine Wheel tells us everything, and in a way, which is another grid for me [when I work with clients].

CSW5's growth in her Native American heritage increased her self-awareness and allowed her to bring cultural knowledge into her sessions with clients.

CSW7 indicated how her self-awareness contributed to valuing the cultures of her clients:

> I am an Irish Italian born in the southern part of Washington State and raised and educated right here in Washington. I speak about that much Spanish [holding a measurement with her finger and thumb]. I had a tier who spoke to me in Spanish.

> So [I'm] super White, but I still understand what it means when you walk into someone's home, and they offer you water and even if it's not the best house in the world, [you say] thank you and you drink it.

The interaction with clients is authentic when the social worker is comfortable with themselves and open to their client's culture. Participant CSW4 shared an example of how her upbringing influenced her work with in-home services:

> My grandparents raised me, so I grew up old school. You have got to have respect. You always try to make the people that you are working with comfortable. Usually, you are going into their home, so the last thing that you want to do is go into someone's home and disrespect them. It's kind of one of those things that's very difficult in social work ethics. You go into a 70-year-old woman's home, and she's cooking. You do not say no to what she offers. That is extremely disrespectful.

Being comfortable with one's culture is an aspect of self-awareness and contributes to the social worker's ability to practice with therapist congruence.

Know your privilege. The fourth subcategory of self-awareness that emerged from the interviews was to know one's own privilege. According to the study by Davis and Gentlewarrior (2015), the therapist's ability to identify their privilege contributed to cultural humility in clinical practice. CSW11 described the awareness of power in the client–social worker relationship: "A therapist has to be nonjudgmental, yet he's paid to make judgments." The awareness of power is necessary to be deliberate with actions that promote equity. CSW15 demonstrated her awareness of her privilege in the following:

> I cannot just be like oh, like I am queer, and I'm White, and I grew up working class. And that is like your experience being Chicana because I have to have the structural humility to look at where I'm positioned within the systems of power and systems of oppression.

Participant CSW12 expressed her awareness of attire expressing power and its influence in the client–social worker relationship:

> And if I think I am holier than thou, if I am on my power and I'm looking all—I mean, I wouldn't wear this [sweatpants] when I saw a client, but I certainly would wear a decent t-shirt and jeans and you know, sneakers because I don't think a suit is what's going to make me relatable as a therapist.

Finally, CSW13, as a mixed-race participant, described her privilege: "I have light skin, so I am perceived as part of the dominant culture. I pass. I'm privileged from it." CSW13 explained she sees the difference in the way she is treated compared to her daughter, who is darker skinned. She explained that people make comments such as, "How nice, you adopted," implying CSW13 did a noble act. CSW13 recognizes her light skin influences how others perceive her and treat her. She brings this awareness into her clinical practice. The participants demonstrated self-awareness with statements that acknowledged biases, limitations, comfort with their culture, and awareness of privilege.

Blind spots. Self-reflection is another component of therapist congruence. Self-reflection is the process of noticing emotions during situations in power, privilege, and discrimination. In the interviews, statements about noticing blind spots demonstrated self-

reflection, cultural humility, and intersectionality. CSW15 shared her process of self-reflection while in college that magnified her limited perspective on race:

> It took me time and then eventually in another class, I had a female Black professor. We were all in a circle, and I said, "I'm struggling to understand like why as a society like we can't just get rid of racism." Totally like that super-annoying White girl student. She kind of came over to me, and she put her hand on my shoulder, and she said, "Are you telling me that I should just get over race?" And it just helped to put it together because I grew up in a White, rural Christian town.

Self-reflection is an ongoing process and does not stop with completing school, continuing education, or a job promotion. CSW10 emphasized the self-reflection process as basic social work practice:

> Having that ability to self-reflect and step back. And in terms of knowing where your blind spots are. Knowing you know, I mean, but that's the whole thing with social work anyway. Any community you work with, you need to be able to work with the community, not go in there trying to tell people what to do. But go in as a change agent, as a resource, and be able to follow their lead.

Self-reflection to identify your blind spots is one part of the process of dismantling inequalities in the client–social worker relationship.

Don't take it personally. Through the process of self-reflection, social workers increase their comfort with self and decrease sensitivity to client comments. Fisher et al. (2015) maintained that critical self-reflection is a key component of cultural humility and

intersectionality because professional power is often not questioned or challenged by clients. Hence, the social worker has to self-monitor their actions and ensure that they do not enact power over a client due to a personal emotional reaction. CSW1 demonstrated the role of self-reflection when a client may want to work with a different therapist and her process of not taking it personally:

> I think that part of our humility is recognizing and giving the client permission to move on if that connection has not been made. I think we do a disservice when we allow our pride or our professional expertise to dictate to our clients. We connect with people and therapy has to be about a connection. If not, it is not therapy. When you have clients that you are just not connecting with, I think it's important to say, "You know what, I have sensed that you're not feeling the connection and that's okay."

Building a relationship is necessary to support clients through the change process (C. Rogers, 1957). CSW13 shared a similar experience of not taking it personally when a client wants a different therapist:

> I'm very upfront and matter of fact; I let them know like it's okay to therapist shop as well. I have learned through my life that some people, some personalities just do not mix. I think it makes them feel like it is okay, like I've had clients say, "You know, I just don't think we're going to be a good match." And am like, "Cool. What are you looking for so maybe I can help you find somebody who might be?" For me, it does not bother me.

CSW10 also exhibited insight regarding not taking it personally when clients do not follow treatment interventions or discharge plans:

> We don't know better than them. They are the ones living in that experience. Even though we are like, "We're going to send you to the shelter because we need to have a [discharge] plan," and they are like, "No, I'm not going to go to the shelter. I am going to go to this bridge over here because I'm safer there because in the shelter, I get targeted." And it is like, as an agency, we have to show all these things [discharge plans] of how we connected them to resources, but they're going to make their own decisions about it. And that decision might be better than anything we can come up with.

Not taking it personally comes from self-reflection. It is the ability to recognize emotional reactions to situations and to respond candidly.

Cultural appropriation: The self-reflection process includes reflecting on the influence of the client's culture. One participant used three different statements throughout the interview to refer to cultural appropriation and how it demonstrates a lack of self-reflection. Cultural appropriation occurs when a person uses another culture's symbols, artifacts, genres, rituals, or technologies without an empathic understanding of their sacredness (R. A. Rogers, 2006). When social workers use cultural appropriation, it does not demonstrate cultural humility and intersectionality. CSW13 defined cultural appropriation by saying:

> So, taking from somebody else's culture and not actually appreciating it and using it to benefit you. We have a lot of folks who like to light sage and burn sage to

> cleanse the area, but they aren't Native. They aren't Hispanic. They are not Medicine Men, and so I see it as cultural appropriation.

Social workers demonstrate therapist congruence throughout the engagement and assessment process through self-awareness and self-reflection. Self-awareness is demonstrated by recognizing biases, limitations, comfort with one's culture, and privilege. Self-reflection is the process of assessing emotional responses in situations. Self-reflection and self-awareness are recognized as necessary to demonstrate cultural humility and intersectionality in mental health practice.

Research Question 2

Theme 1: Unconditional Positive Regard

Unconditional positive regard was described in the engagement, assessment, intervention, and evaluation process. Unconditional positive regard is the therapist's ability to look beyond the client's attitude and behavior and respond with compassion (C. Rogers, 1957). A total of 241 statements reflected clinical behaviors that demonstrated unconditional positive regard. The statements were grouped into the following sub-themes: (a) empowering clients, (b) building relationship, (c) nonjudgmental attitudes, and (d) trauma-informed practice. Table 5 displays the sub-categories connected to each of these sub-themes that make up the theme of unconditional positive regard.

Table 5

Summary of Data for Unconditional Positive Regard

Theme	Sub-themes	Subcategories	Number of coded statements
Unconditional Positive Regard	Empower clients by	Asking questions	4
		Asking what pronoun	2
		Referring to client's choice	17
		Accepting the client's choice	9
		Magnifying strengths	6
		Not giving solutions	10
		Pronouncing their names	11
		Providing information	1
		Working as partners	25
	Build relationship by	Accepting the glass of water	6
		Acknowledging the differences	5
		Advocating on behalf	14
		Being genuine	5
		Being present	8
		Believing in them	8
		Building trust	9
		Introducing yourself	9
		Motivational interview	4
		Diversity in office décor	2
		Seeing them as human	3
		Self-disclosure	5
		Thanking them	3
	Nonjudgmental attitude	Acknowledge the importance of culture	3
		Diversity within cultures	17
		Follow their cultural norms	6
		Harm reduction	6
		Meet the clients where they are	8
		Non-judgmental language	6
		Not ask immigration status	2
		Understand the source of the behavior	4
	Trauma-informed care	Trauma-informed	22

Empowering clients. Empowering clients is the process of allowing clients to make informed decisions over matters in their lives (Ocloo& Matthews, 2016). The participants shared a variety of clinical behaviors that demonstrated empowering clients. It begins with the social worker's genuine belief that clients can exhibit good judgment. CSW1 described her role as being to empower clients:

> Whether its court ordered or a personal crisis that they [clients] need direction, so they're not there because they want to be. And from that perspective, I think that it's important that they also feel part of the process. The obligation of the therapist is not to give them the solution because we don't have it. Our obligation is to empower that client in letting them know that they have the solution.

She further explained that she viewed clients as the experts, a premise in cultural humility and intersectionality:

> I do not have solutions to give. They have their own solutions, and sometimes they think part of what keeps them stuck is that they keep rehashing comfort solutions and comfort solutions are not growth solutions. I think it is our job to remind them. I think that 90% of humility is [knowing] that you are not the expert. They are. They know what they need. What you identify as a problem may be the one thing that is working perfectly for them.

CSW9 further supports empowering clients to be part of the treatment process: "I want them to feel like it's their session. [I say] 'I'm here to walk this journey with you. It's not my place to tell you what to do.'" CSW13 explained that empowering does not involve fixing the client:

> I am not fixing you. I do not have a magic wand. I am magical, but not that magical. It is often something I say to my teenagers. I cannot fix you. I can help you grow and change and learn ways to adapt and have better coping skills.

CSW10 introduced empowering clients through unconditional acceptance of their choices:

> To understand why a person would make those decisions and be supportive. Well, that is my work in domestic violence(sic); it is really about the client and if they choose to stay in the relationship, how do you support them with that because it is not [safe]. You cannot make somebody leave an abusive relationship so yeah [it is] tough.

Although CSW10 provided her client with information about shelters and housing resources, CSW10 understood that stigma and discrimination could not change the client's challenges despite empowerment efforts. Six other participants shared that part of empowering is unconditional acceptance of the client's choice.

In addition, other participants described empowerment as simple actions that are often overlooked. Such actions may be to simply ask permission to give them information (CSW5, CSW8, &CSW15) or to ask how to "pronounce their name correctly" (CSW4). CSW13 and CSW17 pointed out it is empowering the client to "ask what pronoun" they prefer to be referred to by. The action of asking the client communicates that their input matters and creates an empowering experience. Ultimately, empowering clients aligns with cultural humility and intersectionality since it is a conscious effort to eliminate the power differential.

Building a relationship: C. Rogers (1957) described a set of therapeutic conditions to create an environment for clients to change. When these conditions are present, they foster an environment for the client and therapist to build an equitable relationship, which demonstrates cultural humility and intersectionality. Therapist congruence, the ability to be comfortable with self and present as a genuine human being, is one of the therapeutic conditions (C. Rogers, 1957) that fosters relationships. CSW12 elaborated on how to build a relationship:

> Typically, in the first meeting, I am going to shake the client's hand if they are comfortable doing that. When they are talking, I am attentive. I am focused on what they are saying. If for some reason I'm distracted, I will let them know I got to do this one thing very quickly because I keep thinking about it, and if I don't do that, I can't be present with you. At least one occasion, if not two, he remarked about my authenticity and he felt comfortable.

CSW12 further explained her underlying belief that influences her interactions with clients and defuses power dynamics:

> And most importantly, the belief in the actualizing tendency. The belief that everyone has within themselves vast resources for growth and self-understanding and most of all, a curiosity that can be awakened if trauma has extinguished it…. If I really believe you have inside yourself the vast resources, then I do not have to be the expert. I can share my power with you and value you. I can feel okay with telling them, "You know that last session, you taught me a really important lesson and I thank you."

In the following statement, CSW13 described how she builds a relationship with her clients by informing them how they have power and freedom in the session:

> I use a lot of humor in my sessions and just kind of get them to relax into themselves. And by asking how they identify, if I am unsure of what that means, I can ask them more. I can go, tell me more about that. People don't often allow people to talk about who they are. This is an opportunity for you to talk about who you are and figure out who you are.

Another component of building a relationship is reciprocity, acknowledging that both parties have something of value to contribute. In the following example, CSW4 identified the reciprocity process and how it dismantles power in the client–social worker relationship:

> You do not say no. That is extremely disrespectful. To anything that they offer you, and its usually food. So, you know that was one of the things that we [student and CSW] used to discuss, and I'm sorry, but I believe that the Code of Ethics was written by White people. It is very disrespectful to go into a Hispanic's home and if they offer you something, you say, "No." That was one of the things where, you know—it's like okay, well we're not going to sit and have a full four-course meal with them, however, and usually, it would be like, "Do you want a cup of coffee?" To say no is very disrespectful.

Building a relationship is an exchange and sees both participants as important and of equal value. Social workers who present themselves as capable, experts, and valuable are building a working alliance.

Nonjudgmental attitude. An aspect of unconditional positive regard is a non-judgmental attitude toward the clients' ideas, concerns, and solutions (Roger, 1957). A non-judgmental attitude is vital to cultural humility and intersectionality. CSW11 presented an example of cultivating a non-judgmental attitude while mentoring a supervisee concerning a difficult client:

> You love your clients with all your heart and soul. Unabashedly, love them with all your heart and soul. And she said, "But I don't even like him when he comes in, and I wish he wouldn't come in." "I know. He's a sonofabitch, and you really don't like him so here's what you do. You say [to yourself] if I loved with all my heart and soul, what would I say next? What would I want to know?"

CSW11 further explained that the judgments come from not knowing the client as a person and simply focusing on their deficits. The following explanation by CSW3 expands on this idea. CSW3 explained that his organization follows a harm reduction model. The goal is not to eliminate or cure a problem; rather, the emphasis is to celebrate small gains and to improve quality of life:

> One of my most powerful experiences here is doing a support group for clients that are using Suboxone as a medical treatment for opioid addiction. The most moving part is the pride that they take in having made that change, even though that they're using a medically assisted opioid treatment and some of them have some guilt about that. They say, "Well, this is just another form of addiction," but we believe in a harm reduction philosophy, so we think it is a very, very valid way to increase your quality of life.

Another form of a nonjudgmental attitude is to meet the client where they are. A total of eight participants made this statement. According to C. Rogers (1957), it is necessary for a therapist to let go of expectations of a client's functioning and be opened to understanding the client's current state of incongruencies. Unconditional compassion was demonstrated by CSW10 when working with a delusional client:

> There was a psychotic patient who was really stuck in her delusion, and I just met her where she was at. You know, she was saying that she was upset and that she was pregnant. She is like 60 years old. There is no way she's pregnant, but I just met her where she was at. Tried to help her breathe and talked about her feelings. Not say that is not true. The nurse had already checked. Just to honor what she was feeling at the time.

No positive outcome results when a social worker argues with a client about what they believe is true. CSW6 shared another example of accepting the client's truth:

> You always have to meet them where they are and have them tell you what their story is. I have a Hispanic female right now who hears voices all the time, and she feels that that's normal and that's been her life. To some cultures, that's really normal. So just normalizing.

Meeting clients where they are mentally is one realm of acceptance. In the following example, CSW5 shared meeting clients at their communication needs:

> I have my tablet here, and if I make a recommendation, I pull it up, and I give them a website to look at because especially when I have millennial, which is how

> I'm going to get them. Right? Look, here is a website! It is real. They tell me all the time, so I give them in their language; I show them on the tablet.

In the following explanation, CSW13 shared her thoughts on meeting the client where they are, as she described cultural humility:

> I think that if people would just open their eyes and accept people for who they are like, you know, meet the clients. Accept them for who they are. Ask them questions and be actually interested in their responses. It is not just checking off the box.

A nonjudgmental attitude requires constant self-reflection to prevent unintentional assumptions. Twelve participants identified understanding diversity within cultures as necessary to demonstrate a nonjudgmental attitude. Cultural humility and intersectionality require this understanding. As CSW2 described intersectionality, she shared this statement: "First of all, even assuming that people within one group have the same experiences. It depends on so many things: the level of acculturation, the level of assimilation, and gender. I mean everything."

CSW3 offered the following statement as a demonstration of diversity within cultures:

> I think if you look at the old concept that I remember because I've been doing this for a long time. It was so simple and elementary that the perspective was if you know one African American, you know all of them. Or you could go online and read about someone from Cabo Verde or Somalia or Ecuador, and then you could

> become an effective professional with anybody that fits that description. I think it's so much more complex and difficult than that.

Participant CSW4 introduced diversity by generations:

> I think that first you need to assess the age of the client that we will be meeting with to kind of see. You know, nowadays there is a huge difference between traditional and non-traditional and a lot of your clients, your younger clients, even your younger Hispanic clients, are very non-traditional. You would not address their treatment needs the way you would address, for example, a 70-year-old Hispanic.

Other ways participants demonstrated nonjudgmental attitudes was to "acknowledge the client's culture" (CSW2 andCSW4) and follow the client's "cultural norms" (CSW4, CSW5, CSW6 andCSW10). Another advocated using "nonjudgmental language" (CSW2, CSW8, CSW9, CSW16, andCSW17), while CSW5 and CSW13 pointed out that a nonjudgmental attitude included "not ask[ing] about immigration status." Finally, a social worker demonstrates a nonjudgmental attitude when they understand the source of the client's behaviors, i.e., trauma (CSW3 andCSW11).

As a social worker, even with a nonjudgmental attitude, one's power over the lives of clients cannot be ignored. CSW11 emphasized the power inequality in the client–social worker relationship:

> A therapist must be nonjudgmental, yet he is paid to make judgments. He is paid to give a diagnosis. He is paid to come up with a treatment plan. He is paid to make decisions about whether the children should stay with their parents or not.

Having this awareness of power can help the social worker monitor their judgments. Practicing with a nonjudgmental attitude is a component of practicing with unconditional positive regard.

Trauma-informed care. During the interviews, nine (52.9%) participants mentioned they were trained in trauma-informed care. The six principles of a trauma-informed approach are: a) safety; b) trustworthiness and transparency; c) peer support; d) collaboration and mutuality; e) empowerment, voice, and choice; and f) cultural, historical, and gender issues (Harris &Fallot, 2001). The principles of trauma-informed practice resemble unconditional positive regard that is crucial to cultural humility and intersectionality. CSW13 defined the populations she commonly worked with:

> I am a certified trauma specialist, so I work a lot with out-patient therapy with clients, primarily with teenagers, my population of choice, but because I'm a social worker and I can take Medicare, I work with pretty much all age groups, 11 and up. I do not work with the little [ones].

When describing the assessment process at his organization, CSW3 described the trauma-informed approach:

> A high percentage of our population has experienced trauma somewhere along the way in their lifetime, whether as a child or adolescent, and anything from sexual assault to being in an automobile accident, having a traumatic brain injury, to being a victim of violence on the street. Being aware that many of them are traumatized, we have a section in our assessment about trauma, but we don't insist that they even go there.

CSW15 similarly expressed her awareness of trauma-informed practice when describing the assessment process:

> I'm able to identify how to be trauma-informed so that I'm not probing and I'm not just letting them dissociate into a narrative. I'm able to kind of position myself in a way where I'm giving power back, but they do understand that they've had multiple experiences that are invalidating. That anyone that's gone through what they have gone through might feel this way so I'm able to give power back in a way where they can trust themselves.

CSW12 described her assessment process as integrating a trauma-informed approach and awareness of intersectionality:

> If I have got a client whom I know has most likely experienced varying degrees of trauma. If their socioeconomic status is, living in poverty, that is going to impact everything. If their education is maybe they got through high school. Maybe they did not even get their GED; I need to keep that in mind. If their physical health is a distracting factor or their psychiatric health is a distracting factor, I have to factor that in there. I have to factor everything in their environment. Everything in their lifestyle as they sit before me because if I discount any of it, I have discounted that person.

CSW2 contributed to the discussion on trauma-informed approach by disclosing her personal experience about trauma:

> I think I am mostly a trauma therapist and while I've had some traumas in my life, I think my ability to go to that place has more to do with a really deep personal

> understanding of historical traumas, so I'm already there. It may not be the same traumas that these people that I work with experience, but it is. It is real. It is there. It is part of who I am. It allows me to be truly empathic with them.

The trauma-informed practice was mentioned in a total of 22 statements. The key principles of trauma-informed practice are aligned with conditional positive regard. The practice of unconditional positive regard demonstrates cultural humility and intersectionality.

Summary of Findings to Research Questions 1 and 2

The research questions focused on identifying specific clinical behaviors to demonstrate cultural humility and intersectionality during the engagement, assessment, intervention, and evaluation processes of mental health treatment. Person-centered theory guided the organization of the participants' responses into the following themes: genuine interest in the client's culture, therapist congruence, and unconditional positive regard. The themes represented the categories and sub-categories of specific clinical behaviors participants described in a mental health setting. The themes align with the literature on cultural humility and intersectionality. Cultural humility and intersectionality are the processes of arbitrating the power difference between the therapist and the client. The literature on cultural humility, intersectionality, and person-centered theory supports the three themes that emerged from the responses to research questions 1 and 2.

Research Question 3

One theme emerged from the participants' responses when they described how they understood the client's worldview (Table 6). Empathic understanding creates equity

in the client–social worker relationship, the foundation of cultural humility and intersectionality.

Table 6

Question 2 – Theme

Theme	Categories	Number of coded statements
Empathic understanding	Culture is part of the client's narrative	25
	Client's experience is multi-layered and complex	40
	Trauma influences client's experience	22
	Personal experience with discrimination and oppression	45

Theme 1: Empathic Understanding

Empathic understanding is the social worker's ability to go deeper than a cognitive understanding of the client's experience and connect with the client's emotions (C. Rogers, 1957). Empathic understanding was represented by statements in the following categories: a) understanding culture is part of the client's narrative, b) the client's experience is multi-layered and complex, c) trauma influences the client's experience, and d) the social worker's individual experiences with discrimination and oppression. Empathic understanding is necessary for cultural humility and intersectionality. Cultural humility and intersectionality refrain from pathologizing marginalized groups due to structural oppression and discrimination (Crenshaw, 1989; Tervalon& Murray-Garcia, 1998). A total of 132 statements from the participants demonstrated empathic understanding when assessing the client's worldview.

The client's narrative: The client's narrative is the story the client talks about themselves, which is influenced by their experiences in the environment (C. Rogers, 1957). The environment, hence, plays a role in the client's view of themselves. When clients are marginalized by a society and experience oppression and discrimination, the client's narrative is skewed (Almeida et al., 2011). When an environment produces negative experiences, the client internalizes the negativity. CSW10 provided an example of youth through the school system:

> I mean even in the schools, the whole tracking and how it's the schoolhouse to the jailhouse. And how young minority men get targeted and don't get a lot of chances and then they're quick to suspend. And then they basically lead them to begin that life of getting arrested and all those things. Then just the whole way that the prison industrial complex works, you know. It's privatized, and there's a lot of money in this. And there's not enough money in education. There's room for growth about doing restorative justice and really doing [rehabilitation]. Looking at making amends instead of just criminalizing youth.

Restorative justice is an intervention that focuses on repairing relationships rather than blaming and punishing (Hopkins, 2002). Understanding the client's narrative and how it is influenced is part of cultural humility and intersectionality. Similarly, CSW2 emphasized understanding the client's narrative and how the narrative serves a purpose in situations such as incarceration. Then she explained incorporating culture as a treatment intervention to repair moral injury:

> So, if you have a young man who stabbed and killed a woman, and he has to maintain this kind of I'm macho; I'm tough; I'm in prison; I'm badass; I can't get punked-out; I can't let myself feel, right? When you finally get rid of those, help this man take down those barriers, he starts feeling. It is going to hurt. It hurts them. That is the moral injury when you realize what you have done is so horrible. Getting these guys to identify their own moral code. I think culture is inherently part of that because I think culture shapes our morals and values.

CSW14 stressed that culture is ever evolving, and it is necessary for the social work profession to evolve to understand the narrative of the next generation:

> You know we're coming up with a generation, for example, who are glued to their electronic devices and how are we thinking in terms of reaching them. So, things like electronic therapy or online therapy or things like how you do E-clinics, and things like that always come into play as we're moving in an information technology era… an awareness that culture is always changing and that people are always regrouping, acculturating, and becoming different in their culture.

The client develops a narrative, and the narrative is influenced by the environment. Cultural humility and intersectionality emphasize that power dynamics present in society negatively impact marginalized populations. The understanding of these influences creates empathic listening.

Multi-layered complexity: Multi-layered complexity is the concept that Crenshaw (1989) argued for when introducing intersectionality. The oppressive experiences cannot be generalized across one segment of society, i.e., women. The

continuum is multidimensional when marginalized identities are stacked. Empathic understanding considers the multi-layered complexity of the client's experience. For instance, CSW11 reported:

> If somebody is black and disabled and gay and poor. There are poor minority disadvantages that intersect, and they come together and some of the women's rights or gay rights. The truth is these things intersect, and they compound each other. Women's rights and gay rights, cultural rights are kind of the same, but different. It is a complex world.

CSW1 further identified the additional layers of trauma and disability, which adds to the multi-layered complexity:

> I saw a little girl yesterday that I have seen on and off for years; she is17 years old. She is developmentally delayed but has had horrific child abuse. Horrific, and so you are also dealing with somebody with a history of trauma. Unresolved grief and loss issues. Has abandonment issues and in addition to that, now you have a person who has limited cognitive abilities that brings all that into awareness. Where do I even begin? That is not for me to decide. That is up to the client to decide. What is bothering her? What is troubling her?

When working with clients, their experience in the world due to their culture cannot be ignored in mental health treatment, as explained by CSW6:

> You're a Hispanic male who's gay, who's got a criminal record, who's substance using, so you have all these strikes against you and you're going to have to work extra hard to get off probation because it's hard here. They are going to violate

> you every opportunity; they must put you back in jail. We will look at the things that are going against you and that make you up as a person.

The multi-layered complexity begins in childhood; CSW12 synthesized in the following:

> The kids are eating sugar, white flour, so they have elevated blood sugar all the time, which is going to be affecting brain development and every organ in their body. So, the kids have impaired neurological systems—perhaps physical, emotional, sexual abuse at home. They will have elevated cortisol levels because they have so much trauma. Then if you put in all those intersecting factors when they go out into the community, they get messages. When they watch TV, what do they see? The White rich people. They get [messages] again.

The impact of the complexities of childhood adversities has long been recognized as multi-layered complexity and influences functioning in adult life (Felitti et al., 1998). The individual cannot be assessed outside the context of their environmental experiences. Empathic understanding is the awareness of the client's multi-layered complexity.

Trauma influences the client's experience: Trauma-informed principles developed as research confirmed the emotional, mental, and physical effects of trauma (Harris &Fallot, 2001). Due to the psychological and physiological effects, trauma-informed care principles were developed to improve mental health practice (Substance Abuse and Mental Health Services Administration, 2015). The Substance Abuse and Mental Health Services Administration (2015) identified trauma-informed care as part of their Treatment Improvement Protocol. The nine participants with trauma-informed knowledge assessed the client's worldview through this framework. SW15 described how

she used trauma-informed care: “When people come to emergency services, I’m able to be trauma informed so that I’m not probing and I’m not just letting them dissociate.”

The reactions to environmental stimuli or memories by traumatized people can be awkward, dramatic, or nonresponsive (Harris &Fallot, 2001). CSW12 described the behaviors of a traumatized client in her practice:

> Have you ever met people and they are like unaffected by physical sensations all the time and they don’t even know it? Because they are disconnected from their body. Why do they disconnect from their body? [Because they experienced] trauma.

CSW3 described the variety of trauma a client can experience:

> We have a high percentage of our population [who] experienced trauma somewhere along the way in their lifetime. Whether as a child or adolescent and anything from sexual assault to being in an automobile accident, having a traumatic brain injury, to being a victim of violence on the street. Our clients face that kind of trauma on a daily basis. They are always worried about their own personal safety. Acknowledging that is important.

One of the principles of trauma-informed care is to familiarize clients about the effects of trauma (SAMHSA, 2015). CSW5 shared how she explained the effect of trauma on a client who was a military veteran:

> She struggled with anger. She has been through the VA, and she is still dealing with things. So, I was talking to her the other day, and I said, “It’s kind of like, did you ever see those pictures in Hiroshima?” She said, “Yeah.” I said,

> "Remember like that atomic bomb went off and then there were like the shadows were kept on the wall?" She was like, "Yeah, I saw it," and I am like, "That's kind of what trauma is like. It's like our brain gets that imprint."

An aspect of trauma-informed practice is the ability to listen to the client's trauma without judgment (Harris&Fallot, 2001). CSW7 stated, "If you can't sit with somebody in that present moment and their present trauma, then maybe you're not the right person."

When discussing the populations in Washington State, CSW8 discussed the effects of trauma in the community:

> It was a huge part of intergenerational trauma, so we were really looking at almost every person that we interviewed had been traumatized; either directly or indirectly they had witnessed some form of trauma. And so culturally, it had been a part of their culture. Being colonized and so it is hard not to have it interwoven. It is hard not to look at it. It is part of their being. It's a factor, I mean, so we always have to look at culture in terms of treatment.

During the interviews, nine of the participants described in detail their experience with trauma-informed care. Their trauma-informed training influenced how they understood their client's worldview and contributed to the multi-layered complexity. The awareness of multi-layered complexity demonstrates empathic understanding and congruence with cultural humility and intersectionality. Perhaps the experience of trauma should be considered a factor of intersectionality.

Experience with discrimination and oppression: During the interviews, there were 12 (70.6%) participants who disclosed firsthand experiences with oppression and

discrimination. A component of empathic understanding is to emotionally connect with the client's experiences (C. Rogers, 1957). The self-disclosures commented on by the participants coincide with the ability to connect with the clients emotionally. CSW10 shared her first-hand experience: "I'm Chicana, but I'm also a woman so that's where we intersect, so if you're talking about oppression, you're looking at racism and you're looking at sexism, there's where they intersect so you can't separate me."

While discussing the engagement process with clients, CSW2 reported a personal experience to connect with her clients:

> I am half Native American; my mother [was] Episcopalian, [and] my father [went]back and forth between traditional and Christian Science. How can anyone understand that experience? And then overlay that with all the traveling I've done. I guess that's why I kind of get excited when you talk about the use of mixed-race cultural humility because that actually says I have no clue, so I'm just going to let you do it. You tell me who you are. My primary identification is Native… tribe, but because of the timeframe, I grew up in a time where you really had to choose.

The firsthand experience with oppression and discrimination is difficult; however, witnessing these acts toward people you care about is heartbreaking. CSW12 shared her experience:

> My husband would say all the time that he felt when he would go to a counter, if there was a White person there, he would be ignored. And I used always to think it was in his head. And then we were at a place, and he was there first. Then I walked up, and the guy didn't come until I was there. My husband taught me

> about racism. My education in social work school certainly informed me, but what taught me was my husband. Living with him and being with him and day-to-day and seeing the kinds of things that happened. And seeing that's not really in his head. That really is going on. Micro-aggressions really do exist.

CSW13 also spoke about how she and her daughter get treated differently in the world: "I have light skin, so I am perceived as part of the dominant culture. I get White privilege because I have light skin. My daughter's half Native American; walking through the world, she gets perceived differently."

CSW6 disclosed a similar experience of being treated differently than other members of her family:

> I think the fact that my children are bi-racial, and I lived as the only White person in a Black family for 16 years was a lot of [my] firsthand experience of oppression and discrimination. When the house went up for sale, and the family wanted to buy the house, and they were told no, I went without them and asked to see the house, and I was shown the house, and it was a possibility for me to buy.

Twelve participants shared various experiences of oppression and discrimination firsthand or witnessing it with their family. The personal experience with oppression and discrimination contributes to the participants' ability for empathic understanding. Empathic understanding is a necessary ingredient in order to practice with cultural humility and intersectionality.

Summary of Findings for Research Question 3

Research question 3 focused on how participants integrated the knowledge of cultural humility and intersectionality to assess the client's worldview. The analysis of the participants' responses indicated one theme, empathic understanding. The categories that demonstrated empathic understanding were the client's narrative, the multi-layered complexity, the influence of trauma, and the social workers' personal experiences with discrimination and oppression. The participants' responses verified that the framework of privilege, discrimination, and oppression was used to assess the client's mental health. In addition, a majority of participants reported a firsthand experience with discrimination, which created an emotional connection with clients. Empathic understanding is evaluating the client's experience through an emotional connection. The literature on cultural humility, intersectionality, and person-centered theory supports the theme and categories that emerged from the responses to research question 3.

Section 4: Application to Clinical Practice and Implications for Social Change

The purpose of this study was to examine the clinical behaviors that demonstrated cultural humility and intersectionality in mental health treatment. As part of this qualitative research study, 17 clinical social workers in Washington State; participated in in-depth interviews to describe their clinical practice in mental health. The study complements grassroots efforts in Washington State to understand the quality of mental health treatment in a state with high cultural diversity (see Generation Justice, 2016). I thematically analyzed the interviews to identify common themes. The following themes emerged for the first research question: (a) genuine interest in the client's culture, (b) therapist congruence, and (c) unconditional positive regard. The descriptive data provided specific clinical behaviors to create an equitable working alliance. The following theme emerged to address the second research question: empathic understanding as the method to understand the client's worldview. Toward the end of the interviews, there was a discussion on the challenges of integrating cultural humility and intersectionality in mental health practice. The six themes related to research question 3 were (a) agency structure, (b) insurance companies, (c) continuing education, (d) government bureaucracy, (e) research not culturally diverse, and (f) the political climate. In this section, I discuss the findings, the applications for social work practice, recommendations for social work practice, and the implications for social change.

Discussion of the Findings

In the following subsections, I discuss the study findings. The findings highlight the clinical behaviors used by social workers to demonstrate cultural humility and

intersectionality in mental health settings. The findings overlap key concepts with highly respected frameworks. In comparing the findings of the study with the person-centered theory, cultural humility framework, and trauma-informed care, I found them consistent with the existing knowledge base. In the following subsection, I also discuss how these frameworks support the findings.

Genuine Interest in the Client's Culture

The theme of genuine interest addressed the first research question: What clinical behaviors do social workers use in the different stages of mental health treatment (i.e., engagement, assessment, intervention, and evaluation) to convey cultural humility and to address intersectionality? Participants demonstrated a genuine interest in the client's culture. Demonstrating genuine interest in clients' culture is a key component of cultural awareness in social work practice. Previous studies, such as Yasui (2015), have found that integrating culture into mental health treatment improves the working alliance. Yasui found that a genuine interest in the client's culture increased client engagement and allowed for cultural tailoring of the treatment plan. Cook et al. (2013) confirmed an increased participation of Latino and African American clients in mental health services when the therapists connected to their culture. When social workers take an interest in the client's culture, there is an opportunity to increase engagement in treatment.

Furthermore, this finding can be interpreted with reference to trauma-informed care, where the emphasis is on creating safety for effective mental health treatment. Levenson (2017) stated that the social worker's role in trauma-informed care was to create collaboration through a trustworthy and genuine relationship. The participants in

the current study repeatedly reported asking the client about their culture. This is in line with Hallett's (2015) findings, in which the treatment of a client with dissociative identity disorder demonstrated improvement through the social worker purposely inquiring about the client's culture in her daily life. As described in the previous section, genuineness is one of C. Rogers' (1957) core conditions in the person-centered theory. Moreover, demonstrating a genuine interest in a client's culture is consistent with the NASW's (2017) ethical value of practicing with cultural awareness. The client's culture is an important aspect of their life and requires social workers' curiosity and willingness to learn and build a positive working alliance.

Therapist Congruence

The theme of therapist congruence also addressed the first research question Self-reflection and self-awareness were determined as essential for the effective integration of cultural humility into mental health treatment. In fact, self-reflection and self-awareness are consistently identified as critical components in the array of multicultural practice frameworks (Boyle & Springer, 2001; Fong, 2001; Kohli et al., 2010; Lee & Greene, 1999). In cultural humility, as part of self-awareness, the social worker explores individual experiences with privilege and reflects on possible inappropriate use of power in the client–social worker relationship (Azzopardi& McNeill, 2016; Fisher-Borne et al., 2015). When therapists lack self-awareness in their own privilege, there are negative outcomes, such as minimizing the cultural factors involved in the client's decision-making process (Lee & Horvath, 2014).

In addition, self-awareness is determined to be imperative in the trauma-informed care model to prevent secondary trauma (Knight, 2015; Levenson, 2017). To prevent secondary trauma, a social worker needs to incorporate self-reflection as a regular practice and advocate for self-care (Salloum et al., 2015). The social work profession recognizes self-awareness as imperative in social work practice and considers it to be a cultural competency standard (NASW, 2015). Therapist congruence is achieved when critical self-reflection is part of clinical social work practice and encourages a culturally sensitive approach in mental health treatment.

Unconditional Positive Regard

The theme of unconditional positive regard answered the second research question: What are the perceptions of clinical social workers regarding training to aid in knowledge and skills for the integration of cultural humility and intersectionality when working with clients receiving mental health treatment? "Participants identified descriptive clinical behaviors, such as empowerment, to demonstrate unconditional positive regard, a component of the person-centered theory (see C. Rogers, 1957). In a qualitative study of African American women in substance abuse treatment, Davis et al. (2015) found that when therapists made a point of considering diversity and were intentional with empowerment interventions, the clients reported a stronger working alliance with their therapist.

Another clinical behavior identified by the participants was accepting clients' choices. This clinical behavior is consistent with the trauma-informed care principle of empowering clients to have a voice and choice in their treatment process (Harris &Fallot,

2001; Knight, 2015; Levenson, 2017). Owen and Hilsenroth (2014) reported better outcomes when the therapists were flexible with treatment interventions and supported clients' choices. Similarly, Osofsky et al. (2017), who conducted a study in a primary care clinic, reported a decrease in posttraumatic stress symptoms when the clients' choices were respected by the clinicians. The NASW's (2015) ethical principle to respect the dignity and worth of the clients upholds the theme of unconditional positive regard.

Empathic Understanding

The theme of empathic understanding addressed the third research question: How do clinical social workers describe their understanding of a client's worldview and the role this plays in conducting a mental health assessment? The participants' personal experiences with discrimination contributed to their ability to empathically connect with clients. The literature on mental health treatment emphasizes the importance of the working alliance and how this is influenced by the social worker's ability to connect with clients (Taber et al., 2011). When there was a personal connection between the therapist and client, there was a stronger therapist–client working alliance (Taber et al., 2011).

Moreover, Cook et al. (2013) discovered that, as the number of minority-ethnic mental health providers increased, a concomitant increase was observed in the number of minority-ethnic clients in treatment. Cultural connection assists in engaging the clients in mental health treatment. Similarities between the client and the social worker enhance the meaning of the client's life and improve treatment engagement (Schnyder et al., 2016). When social workers recognize the importance of human relationships through empathic understanding, the social worker upholds a core ethical principle (NASW, 2018).

Empathic understanding is a clinical practice behavior that encourages the client's engagement in mental health treatment.

Role of the Findings on Extending Knowledge

According to Bubar et al. (2016) and Jani et al. (2016), there is a gap in teaching and applying knowledge in addressing issues of privilege and structural oppression in clinical practice. Their recommendations included additional studies to document specific behaviors that demonstrate culturally sensitive direct practice. In the results of this study, I identified specific clinical behaviors to address power, privilege, and oppression in mental health assessment and treatment.

Furthermore, Levenson (2017) advocated the integration of trauma-informed care into social work practice because it is an appropriate model across populations. The Council on Social Work Education (2018) concurred with the integration of trauma-informed care in social work education, as evidenced by the 2018 release of their *Specialized Practice Curricular Guide for Trauma-Informed Social Work Practice*. Although I did not focus on trauma-informed care in the current study, the findings contribute to the broader body of knowledge by documenting the trauma care approaches used by clinical social workers.

Finally, the findings helped confirm that there are challenges outside the social worker's control in integrating culture into mental health treatment. Other researchers (i.e., Bekemeier et al., 2012; Cook et al., 2015) argued that these challenges need to be addressed to decrease mental health disparities. Specifically, this study contributes to the literature on culturally appropriate practice in mental health settings in Washington.

Application for Professional Ethics in Social Work Practice

The NASW Code of Ethics guides the social work profession with practice standards that span all levels of social work. The NASW (2018) released revisions of the Code of Ethics and incorporated the current literature on appropriate practice with diverse populations. One of the revisions was that the title of Standard 1.05 changed from Cultural Competence and Social Diversity to Cultural Awareness and Social Diversity (NASW, 2017). This title change demonstrates the integration of cultural humility and intersectionality; because eliminating competency eliminated the implication of mastering a skill (Tervalon& Murray-Garcia, 1998). Cultural awareness demonstrates an ongoing learning process (Azzopardi& McNeill, 2016).

The current study findings are related to four ethical principles that promote culturally appropriate social work practice. These findings are supported by NASW's (2017) Standard 1.05, which focuses on the main theme of cultural awareness through improved cultural sensitivity and includes measures for promoting competency in mental health practice by social workers as they consider the diversity of their clients by being responsive to their unique care needs. In the current study, the theme of cultural awareness was divided into four subthemes. First, I identified the clinical social worker's genuine interest in the client's culture as necessary to work with clients in mental health. Second, the findings accentuated self-awareness and self-reflection as essential to culturally appropriate practice. The NASW (2015) identified self-awareness as a competency standard to work with diverse populations. Third, the results of this study emphasized practice with unconditional positive regard. This finding is supported by

NASW's (2017) ethical principle to respect the dignity and worth of clients. Finally, the findings of the study indicated the importance of empathic understanding and connecting with clients on an emotional level to engage them in mental health treatment. NASW's (2017) ethical principle to recognize the importance of human relationships supports the validity of this finding.

The outcomes of the study indicated challenges to the integration of cultural awareness into mental health settings. The findings contribute to the grassroots campaign to improve mental health services in Washington State. The results of the current study align with the NASW's cultural awareness standard and provide a foundation from which to make an impact in Washington State.

Recommendations for Social Work Practice

Cultural awareness is critical in mental health settings because the literature identified the integration of culture into treatment as a factor that can decrease mental health disparities among minorities (Alegría et al., 2016; Alvarado &Chunhuei, 2016; Bekemeier et al., 2012; Bostwick et al., 2014; Cook et al., 2013). The findings from this study can guide social workers in clinical practice, policy development, and research. At the clinical practice level, one action step I recommend is to create continuing education training on cultural humility and intersectionality. According to Foronda et al. (2016), although cultural humility is frequently used as the expectation for the quality of services in healthcare, providers do not often understand it. Such training might include topics on critical self-reflection as a cultural humility practice, empathically listening to understand intersectionality, and the process of daily self-reflection to minimize privilege in practice.

Having experience with developing and presenting trainings, I can create a continuing education course examining the intersection of trauma and cultural norms to explore diversity and its link to cultural humility. In addition, I am certified as a continuing education provider in the state of Washington; hence, the trainings can count as continuing education credits for social workers in Washington. The training course would also be accessible through my mental health business website as a free course for all healthcare professionals.

At a policy level, the findings indicated the challenges of integrating cultural awareness into organizations. An action step I recommend is to share the findings with the WBSWE. Because the WBSWE is committed to cultural awareness, a committee could be created to discuss options to support social workers at their place of employment. According to Bekemeier et al. (2012), leadership is the key to integrating cultural awareness into policy and agency structure. The committee could explore ways to educate organizational leadership on cultural humility and integration of intersectionality awareness.

The current study builds on the work of Jani et al. (2016) that attempted to develop a measure of cultural awareness specific to social work practice. This study builds on their work by gathering descriptive behaviors to help operationalize cultural awareness in clinical practice. Furthermore, this study complements the work of Levenson (2017) and Knight (2015) on trauma-informed practice in social work by affirming the presence of social workers knowledgeable in trauma-informed care. In

addition, the study provides descriptive behaviors to support the trauma-informed principle on cultural, historical, and gender issues.

Usefulness, Limitations, and Dissemination

Usefulness

The study contributes to micro, mezzo, and macro levels of social work practice. The study findings are supported by highly respected theoretical frameworks. The study described specific clinical behaviors to address power, privilege, and oppression in mental health assessment and treatment. Krumer-Nevo and Komem (2015) and Mora-Rios and Bautista (2014) confirmed positive treatment outcomes when the discussion of privilege and structural oppression are part of treatment. The descriptive clinical behaviors support the NASW (2017) cultural awareness and social diversity practice standard.

At the mezzo level, this study contributes to the trauma-informed communities' movement. Participants identified that the trauma-informed care model is often used in mental health settings. Trauma-informed care is becoming a standard of practice beyond mental health and is present in school systems (Walkley& Cox, 2013), inpatient facilities (Muskett, 2014), child welfare settings, juvenile justice programs, and among first responders and overall communities (Ko et al., 2008). The trauma-informed care framework is beneficial in multiple settings, and this study's findings confirm it is implemented in mental health treatment.

Finally, this study identified challenges to the integration of culturally appropriate practice in mental health settings. The study identified challenges encountered and

contributed to the grassroots campaign to improve mental health services. The findings provide knowledge for action steps at the macro level, such as sharing the findings with the social work board. Since the board is committed to cultural awareness, the overall findings can guide the board on the needs of the social work community in the Washington State.

Limitations of the Study

The purpose of the study was to gather data on clinical behaviors in mental health settings. However, the study only focused on social workers, and in the field of mental health, there are a vast number of mental health professionals who come from different disciplines. Therefore, the findings may not be generalized to other mental health professionals. In addition, the study was conducted in Washington, and therefore cannot be generalized.

Dissemination of Information

The study findings will be disseminated in multiple mediums. First, the findings will be organized into continuing education training. Training will be presented at the NASW Washington's chapter statewide conference. Second, the same training will be converted to online training that will be available on my mental health business website for free. In addition, the presentation will be shared with Vision Care, a nonprofit organization in Washington that provides mentorship to college students pursuing careers in the profession. An executive summary of this study will be shared with the board. Finally, the current study was revised to meet publishing expectations to be considered for publication. The following are a list of journals that were approached to publish the

findings: *Journal of Ethnic & Cultural Diversity in Social Work*, *Journal of Health Disparities Research & Practice*, *Clinical Social Work Practice*, *Qualitative Research*, and *Qualitative Social Work*.

Implications for Social Change

The study supports social change by improving clinical social workers' contribution to promoting the delivery of mental health treatment to diverse populations of patients from diverse cultural backgrounds. Therefore, the research findings are beneficial for social change at the micro, mezzo, and macro levels in Washington. At a micro level, the study increases cultural awareness in mental health settings since its findings are disseminated as continuing education training at local professional conferences. Throughout the State of Washington, there is a shortage of mental health professionals. The literature on cultural humility advocates increasing the representation of minorities in mental health practice (Cook et al., 2013; Tervalon& Murray-Garcia, 1998). Therefore, at the mezzo level, the study helps mentor college students to complete their college education and start their career in mental health, as it facilitates offering training on cultural humility and intersectionality. As a result, the study provides students with the opportunities to complete internships at my mental health practice to get firsthand experience in a mental health setting. In addition, the study allows for developing a mental health treatment model that promotes cultural awareness in care settings. At the macro level, the study contributes to social change by contributing to future research. The literature on cultural awareness reports a gap between academic knowledge on power, privilege, and oppression, and how these dimensions are

operationalized in practice. Hence, this study contributes to additional research in this area, which will hopefully promote social change consciousness. Oppression and discrimination of marginalized groups can adversely affect their mental health. While there is a lack of awareness of structural oppression, mental health professionals can inadvertently reinforce oppressive practices. Therefore, contributing to research increases the knowledge base on how to practice with cultural humility.

Conclusion

This qualitative research project served to examine the clinical behaviors that cultivated cultural awareness, an NASW (2017) ethical standard, in clinical social work practice in mental health settings. This study complements grassroots efforts in Washington to advocate for improved mental health services to minority populations. The key findings were the social workers' genuine interest in the clients' cultures, therapist congruence, unconditional positive regard, and empathic understanding. These clinical behaviors create a healthy working alliance by addressing power, privilege, and oppression. Integrating the client's culture into mental health treatment is necessary to build a strong working alliance, which can increase engagement in treatment and reduce mental health disparities. As an active social worker in Washington, I can disseminate this information in a variety of settings, while mentoring college students pursuing a career in mental health to contribute to future research.

References

Alegría, M., Alvarez, K., Ishikawa, R. Z., DiMarzio, K., &McPeck, S. (2016). Removing obstacles to eliminating racial and ethnic disparities in behavioral health care. *Health Affairs*, *35*(6), 991–999.https://doi.org/10.1377/hlthaff.2016.0029

Almeida, R., Hernandez-Wolfe, P., & Tubbs, C. (2011). Cultural equity: Bridging the complexity of social identities with therapeutic practices. *International Journal of Narrative Therapy and Community Work*, *1*(3), 43.https://search.informit.com.au/documentSummary;dn=711681632630835;res=IELHEA%3eISSN:1446-5019

Alvarado, C. S., &Chunhuei, C. (2016). Intersecting positions of social disadvantage and self-reported health status disparities. *Journal of Health Disparities Research & Practice*, *9*(2), 184–215.

Arthur, D. P. (2015). Social work practice with LGBT elders at end of life: Developing practice evaluation and clinical skills through a cultural perspective. *Journal of Social Work in End-of-Life and Palliative Care*, *11*(2), 178–201. https://doi.org/10.1080/15524256.2015.1074141

Azzopardi, C. & McNeill, T. (2016). From cultural competence to cultural consciousness: Transitioning to a critical approach to working across differences in social work. *Journal of Ethnic and Cultural Diversity in Social Work, 25*(4), 282–299.https://doi.org/10.1080/15313204.2016.1206494

Baker, K., &Beagan, B. (2014). Making assumptions, making space: An anthropological critique of cultural competency and its relevance to queer patients. *Medical Anthropology Quarterly*, *28*(4), 578–598.https://doi.org/10.1111/maq.12129

Bekemeier, B., Grembowski, D., Yang, Y., &Herting, J. R. (2012). Leadership matters: Local health department clinician leaders and their relationship to decreasing health disparities. *Journal of Public Health Management and Practice*, *18*(2), E1. https://doi.org/10.1097/PHH.0b013e318242d4fc

Berg, K. K. (2014). Cultural factors in the treatment of battered women with privilege: Domestic violence in the lives of White European-American, middle-class heterosexual women. *Affilia*, *29*(2), 142–152.

Birks, M., Chapman, Y., & Francis, K. (2008). Memoing in qualitative research: Probing data and processes. *Journal of Research in Nursing*, *13*(1), 68-75.https://doi.org/10.1177/1468794112468475

Block, A. M., Rossi, A. N., Allen, C. D., Alschuler, M., & Wilson, V. B. (2016). Assessing cultural competence in a BSW student population. *Social Work Education*, *35*(6), 643–658.https://doi.org/10.1080/02615479.2016.1158248

Boroughs, M., Bedoya, C., O'Cleirigh, C., &Safren, S. (2015). Toward defining, measuring, and evaluating LGBT cultural competence for psychologists. *Clinical Psychology Science and Practice, 22*(2), 151–171.https://doi.org/10.1111/cpsp.12098

Bostwick, W. B., Boyd, C. J., Hughes, T. L., West, B. T., & McCabe, S. E. (2014). Discrimination and mental health among lesbian, gay, and bisexual adults in the

United States. *American Journal of Orthopsychiatry*, *84*(1), 35. https://doi.org/10.1037/h0098851

Boyle, D. P., & Springer, A. (2001). Toward a cultural competence measure for social work with specific populations. *Journal of Ethnic and Cultural Diversity in Social Work*, *9*(3–4), 53–71.https://doi.org/10.1300/J051v09n03_03

Bubar, R., Cespedes, K., & Bundy-Fazioli, K. (2016). Intersectionality and social work: Omissions of race, class, and sexuality in graduate school education. *Journal of Social Work Education, 52*(3), 283–296.https://doi.org/10.1080/10437797.2016.1174636

Caelli K, Ray L, Mill J. 'Clear as mud'. Towards a greater clarity in generic qualitative research. *Int J Qualitative Methods* 20032(2)1–23. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2658349/#ref23

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society*, *38*(4), 785–810.https://doi.org/10.1086/669608

Chu, J., Leino, A., Pflum, S., & Sue, S. (2016). A model for the theoretical basis of cultural competency to guide psychotherapy. *Professional Psychology, Research and Practice, 2*(1), 18.https://doi.org/10.1037/pro0000055

Chun, J. J., Lipsitz, G., & Young, S. (2013). Intersectionality as a social movement strategy: Asian immigrant women advocates. *Signs: Journal of Women in Culture and Society*, *38*(4), 917-940.https://doi.org/10.1086/669575

Cronin, C. (2014). Using case study research as a rigorous form of inquiry. *Nurse researcher*, *21*(5). https://journals.rcni.com/nurse-researcher/using-case-study-research-as-a-rigorous-form-of-inquiry-nr.21.5.19.e1240

Comas-Díaz, L. (2014). *Multicultural psychotherapy.* Routledge.http://psycnet.apa.org/books/2013-02670-024/024

Cook, B. L., Doksum, T., Chen, C., Carle, A., &Alegría, M. (2013). The role of provider supply and organization in reducing racial/ethnic disparities in mental health care in the U.S. *Social Science and Medicine*, *84*, 102–109.https://doi.org/10.1016/j.socscimed.2013.02.006

Cook, B. L., Liu, Z., Lessios, A. S., Loder, S., & McGuire, T. (2015). The costs and benefits of reducing racial-ethnic disparities in mental health care. *Psychiatric Services*, *66*(4), 389–396.https://doi.org/10.1176/appi.ps.201400070

Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing racial/ethnic disparities in treatment across episodes of mental health care. *Health Services Research*, *49*(1), 206–229.https://doi.org/10.1111/1475-6773.12095

Council on Social Work Education. (2018). *Specialized practice curricular guide for trauma-informed social work*. https://www.cswe.org/getattachment/Education-Resources/2015-Curricular-Guides/2015EPAS_TraumaInformedSW_Final-WEB.pdf

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics.

University of Chicago Legal Forum, *4*(1), 139.https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Toward a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Georgetown University Child Development Center.https://spu.edu/~/media/academics/school-of-education/Cultural%20Diversity/Towards%20a%20Culturally%20Competent%20System%20of%20Care%20Abridged.ashx

Danso, R. (2015). An integrated framework of critical cultural competence and antioppressive practice for social justice social work research. *Qualitative Social Work*, *14*(4), 572–588.https://doi.org/10.1177/1473325014558664

Danso, R. (2016). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work, 1*(6), 41-54. https://doi.org/10.1177/1468017316654341

Davis, A., &Gentlewarrior, S. (2015). White privilege and clinical social work practice: Reflections and recommendations. *Journal of Progressive Human Services*, *26*(3), 191–208.https://doi.org/10.1080/10428232.2015.1063361

Davis, T. A., Ancis, J. R., & Ashby, J. S. (2015). Therapist effects, working alliance, and African American women substance users. *Cultural Diversity and Ethnic Minority Psychology*, *21*(1), 126–135.https://doi.org/10.1037/a0036944

Delphin-Rittmon, M. E., Andres-Hyman, R., Flanagan, E. H., & Davidson, L. (2013). Seven essential strategies for promoting and sustaining systemic cultural competence. *Psychiatric Quarterly*, *84*(1), 53–64. https://doi.org/10.1007/s11126-012-9226-2

DelVecchio Good, M.-J., & Hannah, S. D. (2015). "Shattering culture": Perspectives on cultural competence and evidence-based practice in mental health services. *Transcultural Psychiatry*, *52*(2), 198–221.https://doiorg.10.1177%2F1363461514557348

Edwards, J. (2016). Cultural intelligence for clinical social work practice. *Clinical Social Work Journal, 44*(3), 211–220.https://doi.org/10.1007/s10615-015-0543-4

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80–92. https://doi.org/10.1177/160940690600500107

Fisher-Borne, M., Cain, J. M., & Martin, S. L. (2015). From mastery to accountability: Cultural humility as an alternative to cultural competence. *Social Work Education, 34*(2), 165–181.https://doi.org/10.1080/02615479.2014.977244

Fong, R. (2001). Culturally competent social work practice: Past and present. *Culturally Competent Practice: Skills, Interventions, and Evaluation*, 1–9.https://doi.org/10.1177/1043659615592677

Furlong, M., & Wight, J. (2011). Promoting “critical awareness” and critiquing “cultural competence”: Towards disrupting received professional knowledge. *Australian Social Work*, *64*(1), 38–54.https://doiorg.org/10.1080/0312407X.2010.537352

Garran, A. M., &Werkmeister-Rozas, L. (2013). Cultural competence revisited. *Journal of Ethnic and Cultural Diversity in Social Work*, *22*(2), 97–111.https://doi.org/10.1080/15313204.2013.785337

Gentles, S. J., Charles, C., Ploeg, J., &McKibbon, K. A. (2015). Sampling in qualitative research: Insights from an overview of the methods literature. *The Qualitative Report; Fort Lauderdale*, *20*(11), 1772–1789

George, S., Duran, N., & Norris, K. (2014). A systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders. *American Journal of Public Health, 104(*2), e16-31.https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3935672/

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, *18*(1), 59–82.https://doi.org/10.1177/1525822X05279903

Hagaman, A. K., &Wutich, A. (2017). How many interviews are enough to identify metathemes in multisited and cross-cultural research? Another perspective onGuest, Bunce, and Johnson’s (2006) landmark study.*Field Methods*, *29*(1), 23–41.https://doi.org/10.1177/1525822X16640447

Hays, P. A. (2009). Integrating evidence-based practice, cognitive–behavior therapy, and multicultural therapy: Ten steps for culturally competent practice. *Professional*

Psychology: Research and Practice, *40*(4), 354–360.https://doi.org/10.1037/a0016250

Holley, L., Tavassoli, K., &Stromwall, L. (2016). Mental illness discrimination in mental health treatment programs: Intersections of race, ethnicity, and sexual orientation. *Community Mental Health Journal*, *52*(3), 311–322.https://doi.org/10.1007/s10597-016-9990-9

Hollinsworth, D. (2013). Forget cultural competence; ask for an autobiography. *Social Work Education*, *32*(8), 1048–1060.https://doi.org/10.1080/02615479.2012.730513

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr., E. L., &Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353.https://doiorg.10.1037/a0032595

Hopkins, B. (2002). Restorative justice in schools. *Support for Learning*, *17*(3), 144–149.https://doi-org.ezp.waldenulibrary.org/10.1111/1467-9604.00254

Horevitz, E., Lawson, J., & Chow, J. C.-C. (2013). Examining cultural competence in health care: Implications for social workers. *Health and Social Work, 38*(3), 135–145.https://doi.org/10.1093/hsw/hlt015

Jackson, J. W., Williams, D. R., & Vander-Weele, T. J. (2016). Disparities at the intersection of marginalized groups. *Social Psychiatry and Psychiatric Epidemiology*, *51*(10), 1349–1359.https://doi.org/10.1007/s00127-016-1276-6

Jani, J. S., Osteen, P., &Shipe, S. (2016). Cultural competence and social work education: Moving toward assessment of practice behaviors. *Journal of Social Work Education, 52*(3), 311–324.https://doi.org/10.1080/10437797.2016.1174634

Jimenez, D. E., Cook, B., Bartels, S. J., &Alegría, M. (2013). Disparities in mental health service use of racial and ethnic minority elderly adults. *Journal of the American Geriatrics Society*, *61*(1), 18–25.https://doi.org/10.1111/jgs.12063

Joseph, S., & Murphy, D. (2013). Person-centered approach, positive psychology, and relational helping: Building bridges. *Journal of Humanistic Psychology*, *53*(1), 26–51.http://dx.doi.10.1586/erp.10.30

Kahlke, R. M. (2014). Generic qualitative approaches: Pitfalls and benefits of methodological mixology. *International Journal of Qualitative Methods*, *13*(1), 37-52.https://doi.org/10.1177/160940691401300119

Kirmayer, L. J., & Ryder, A. G. (2016). Culture and psychopathology. *Current Opinion in Psychology*, *8*, 143–148.https://doiorg.10.1016/j.copsyc.2015.10.020

Kohli, H. K., Huber, R., &Faul, A. C. (2010). Historical and theoretical development of culturally competent social work practice. *Journal of Teaching in Social Work*, *30*(3), 252–271.https://doi.org/10.1080/08841233.2010.499091

Kohn-Wood, L., & Hooper, L. (2014). Cultural competency, culturally tailored care, and the primary care setting: Possible solutions to reduce racial/ethnic disparities in mental health care. *Journal of Mental Health Counseling, 36*(2), 173–188.https://doi.org/10.17744/mehc.36.2.d73h217l81tg6uv3

Krentzman, A. R., & Townsend, A. L. (2008). Review of multidisciplinary measures of cultural competence for use in social work education. *Journal of Social Work Education*, *44*(2), 7–32.https://doi.org/10.5175/JSWE.2008.200600003

Krumer-Nevo, M., &Komem, M. (2015). Intersectionality and critical social work with girls: Theory and practice. *British Journal of Social Work*, *45*(4), 1190–1206.https://doi.org/10.1093/bjsw/bct189

Kumaş-Tan, Z., Beagan, B., Loppie, C., MacLeod, A., & Frank, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine*, *82*(6), 548–557.https://doi.org/10.1097/ACM.0b013e3180555a2d

Lee, E. (2011). Clinical significance of cross-cultural competencies (CCC) in social work practice. *Journal of Social Work Practice*, *25*(2), 185–203.https://doi.org/10.1080/02650533.2011.573654

Lee, E. (2016). The cultural competency for working with Asian American clients scale: Development and validation. *Research on Social Work Practice*, *28*(4), 463–474.https://doi.org/10.1177/1049731516652730

Lee, E., & Horvath, A. O. (2014). How a therapist responds to cultural versus noncultural dialogue in cross-cultural clinical practice. *Journal of Social Work Practice, 28*(2), 193–217.https://doi.org/10.1080/02650533.2013.821104

Lee, M.Y., & Greene, G. J. (1999). A social constructivist framework for integrating cross-cultural issues in teaching clinical social work. *Journal of Social Work Education*, *35*(1), 21–38.https://doi.org/10.1093/sw/swx001

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care*, *4*(3), 324–327.https://doi.org/10.4103/2249-4863.161306

Lusk, M., Baray, S. C., Palomo, J., & Palacios, N. (2014). Teaching clinical social work in Spanish: Cultural competency in mental health. *Journal of Teaching in Social Work*, *34*(4), 443–453.https://doi.org/10.1080/08841233.2014.932321

Manseau, M., & Case, B. G. (2014). Racial-ethnic disparities in outpatient mental health visits to U.S. physicians, 1993–2008. *Psychiatric Services*, *65*(1), 59–67.https://doi.org/10.1176/appi.ps.201200528

Matsuoka, A. K. (2015). Ethnic/racial minority older adults and recovery: Integrating stories of resilience and hope in social work. *British Journal of Social Work*, *1*(2), 135.https://psycnet.apa.org/record/2015-58687-009

McCall, L. (2005). The complexity of intersectionality. *Signs: Journal of Women in Culture and Society*, *30*(3), 1771–1800.https://doi.org/10.1080/02615479.2012.701279

Mirsky, J. (2013). Getting to know the piece of fluff in our ears:Expanding practitioners' cultural self-awareness. *Social Work Education*, *32*(5), 626–638.https://doi.org/10.1080/02615479.2012.701279

Mlcek, S. (2014). Are we doing enough to develop cross-cultural competencies for social work? *British Journal of Social Work*, *44*(7), 1984–2003.https://academic.oup.com/bjsw/article-abstract/44/7/1984/1712615

Mora-Rios, J., & Bautista, N. (2014). Structural stigma, mental illness, gender, and intersectionality. Implications for mental health care. *Salud Mental*, *37*(4), 303–312.https://www.researchgate.net/publication/290194216_Structural_stigma_mental_illness_gender_and_interseccionality_Implications_for_mental_health_care

Mulder, C. (2015). From the inside out: Social workers' expectations for integrating religion and spirituality in practice. *Journal of Religion and Spirituality in Social Work*, *34*(2), 177–204.https://doi.org/10.1080/15426432.2014.993106

Muntaner, C., Ng, E., Prins, S. J., Bones-Rocha, K., Espelt, A., & Chung, H. (2015). Social class and mental health: Testing exploitation as a relational determinant of depression. *International Journal of Health Services*, *45*(2), 265–284.https://doi.org/10.1177/0020731414568508

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, *23*(1), 51–59.https://pubmed.ncbi.nlm.nih.gov/23363398/

Nadan, Y., & Ben-Ari, A. (2013). What can we learn from rethinking 'multiculturalism' in social work education? *Social Work Education*, *32*(8), 1089–1102.https://doi.org/10.1080/02615479.2012.723686

Nagai, C. (2013). Responding to culturally based spiritual experiences in clinical practice from East Asian perspectives. *Mental Health, Religion and Culture*, *16*(8), 797–812.https://doi.org/10.1080/13674676.2012.721348

Nardi, D. A. (2014). Guidelines for culturally effective psychiatric-mental health nursing worldwide.*Journal of Psychosocial Nursing and Mental Health Services,*

Thorofare, *52*(5), 3-4.http://dx.doi.org.ezp.waldenulibrary.org/10.3928/02793695-20140331-99

National Association of Social Workers (NASW). (2015). *Standards and indicators for cultural competence in social work practice*. Washington, DC: Springer.https://www.socialworkers.org/LinkClick.aspx?fileticket=7dVckZAYUmk%3D&portalid=0

National Association of Social Workers (NASW). (2018). *Code of ethics of the National Association of Social Workers*.Washington, DC: Springer.https://www.socialworkers.org/About/Ethics/Code-of-Ethics

Ortega, R. M., & Faller, K. C. (2011). Training child welfare workers from an intersectional cultural humility perspective: A paradigm shift. *Child Welfare*, *90*(5), 27.https://pubmed.ncbi.nlm.nih.gov/22533053/

Owen, J., &Hilsenroth, M. J. (2014). Treatment adherence: The importance of therapist flexibility in relation to therapy outcomes. *Journal of Counseling Psychology*, *61*(2), 280–288.https://doi.org/10.1037/a0035753

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative Social Work*, *1*(3), 261–283.https://doi.org/10.1177/1473325002001003636

Percy, W. H., Kostere, K., &Kostere, S. (2015). Generic qualitative research in psychology. *The Qualitative Report*, *20*(2), 76-85. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.674.8560&rep=rep1&type=pdf

Pivorienė, J., &Ūselytė, M. (2013). Development of multicultural competence in social work education. *SocialinisDarbas, 12*(1), 63–74.https://search-ebscohostcom.ezp.waldenulibrary.org/login.aspx?direct=true&db=sih&AN=88008108&site=ehost-live&scope=site

Ponterotto, J. G., Burkard, A., Rieger, B. P., Grieger, I., D'Onofrio, A., &Dubuisson, A. (1995). Development and initial validation of the Quick Discrimination Index (QDI). *Educational and Psychological Measurement*, *55*, 1026–1031.https://doiorg.ezp.waldenulibrary.org/10.1177%2F0013164495055006011

Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). *A revision of the Multicultural Counseling Awareness Scale (MCAS), 1*(30), 153–165.https://doi-org.ezp.waldenulibrary.org/10.1002/j.2161-1912.2002.tb00489.x

Prins, S. J., Bates, L. M., Keyes, K. M., &Muntaner, C. (2015). Anxious? Depressed? You might be suffering from capitalism: Contradictory class locations and the prevalence of depression and anxiety in the USA. *Sociology of Health and Illness*, *37*(8), 1352–1372.https://doi.org/10.1111/1467-9566.12315

Priscilla, P. (2015). Intergenerational cultural conflict, mental health, and educationaloutcomes among Asian and Latino/Americans: Qualitative and meta-analytic review. *Psychological Bulletin*, *141*(2), 404–446. https://doi.org/10.1037/a0038449

Ratts, M. J. (2017). Charting the center and the margins: Addressing identity, marginalization, and privilege in counseling. *Journal of Mental Health Counseling*, *39*(2), 87–103.https://doi.org/10.17744/mehc.39.2.01

Ratts, M. J. L., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and social justice counseling competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development*, *44*(1), 28–48.https://doi.org/10.1002/jmcd.12035

Renzaho, A. M. N., Romios, P., Crock, C., &Sønderlund, A. L. (2013). The effectiveness of cultural competence programs in ethnic minority patient-centered health care: Asystematic review of the literature. *International Journal for Quality in Health Care*, *25*(3), 261–269.https://doi.org/10.1093/intqhc/mzt006

Rivers, B., & Swank, J. M. (2017). LGBT ally training and counselor competency: A mixed-methods study. *Journal of LGBT Issues in Counseling*, *11*(1), 18–35.https://doi.org/10.1080/15538605.2017.1273162

Robinson, M. A., Cross-Denny, B., Lee, K. K., Werkmeister-Rozas, L. M., & Yamada, A.-M. (2016). Teaching note-Teaching intersectionality: Transforming cultural competence content in social work education. *Journal of Social Work Education*, *52*(4), 509–517.https://doi.org/10.1080/14780887.2013.801543

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology*, *11*(1), 25–41.https://doi.org/10.1080/10437797.2016.1198297

Rogers, C. (1942). *Counseling and psychotherapy:Newer concepts in practice*. Oxford, England: Houghton Mifflin. https://www.worldcat.org/title/counseling-and-psychotherapy-newer-concepts-in-practice/oclc/165705

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, *21*(2), 95–103.https://doi.org/10.1037/h0045357

Rogers, C. (1979). Foundations of the person-centered approach. *Education, 100,* 98–107.https://eric.ed.gov/?id=EJ214882

Rogers, C., & Koch, S. (1959). *A theory of therapy, personality, and interpersonal relationships: As developed in the client-centered framework*.http://bibliotecaparalapersonaepimeleia.com/greenstone/collect/ecritos2/index/assoc/HASH01a5/4583605e.dir/doc.pdf

Rogers, R. A. (2006). From cultural exchange to transculturation: A review and reconceptualization of cultural appropriation. *Communication Theory*, *16*(4), 474–503.https://doi.org/10.1111/j.1468-2885.2006.00277.x

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout, and secondary trauma among child welfare workers. *Children and Youth Services Review*, *49*, 54–61.https://doiorg.ezp.waldenulibrary.org/10.1016/j.childyouth.2014.12.023

Santiago, C. D., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: How do low-income adults and children fare in psychotherapy? *Journal of Clinical Psychology*, *69*(2), 115-126.https://doi.org/10.1002/jclp.21951

Scherrer, K. (2013). Culturally competent practice with bisexual individuals. *Clinical Social Work Journal*, *41*(3), 238–248.https://doi.org/10.1007/s10615-013-0451-4

Schnyder, U., Bryant, R. A., Ehlers, A., Foa, E. B., Hasan, A., Mwiti, G., &Yule, W. (2016). Culture-sensitive psychotraumatology. *European Journal of Psychotraumatology*, *7*(1), 31179.https://doi.org/10.3402/ejpt.v7.31179

Seedall, R. B., Holtrop, K., & Parra-Cardona, J. R. (2014). Diversity, social justice, and intersectionality trends in C/MFT: A content analysis of three family therapy journals, 2004-2011. *The Journal of Marital and Family Therapy,1*(2), 139.https://doi.org/10.1111/jmft.12015

Seng, J. S., Lopez, W. D., Sperlich, M., Hamama, L., & Reed Meldrum, C. D. (2012). Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality. *Social Science and Medicine*, *75*(12), 2437–2445.https://doi.org/10.1016/j.socscimed.2012.09.023

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75.https://search-ebscohostcom.ezp.waldenulibrary.org/login.aspx?direct=true&db=eue&AN=502939739&site=ehost-live&scope=site

Sheridan, M. J., Bennett, S., &Blome, W. W. (2013). Cultural humility and shared learning as hallmarks for international teaching: The SWEP experience. *Social Work Education*, *32*(6), 818–833.https://doi.org/10.1080/02615479.2013.805190

Shippee, N. D., Garces, J. P. D., Lopez, G. J. P., Wang, Z., Elraiyah, T. A., Nabhan, M.,&Murad, H. (2015). Patient and service user engagement in research: A

systematic review and synthesized framework. *Health Expectations*, *18*(5), 1151–1166.https://doi.org/10.1111/hex.12090

Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology*, *41*(2), 137–148.https://doiorg.ezp.waldenulibrary.org/10.1037/0022-0167.41.2.137

Stall, R., Matthews, D. D., Friedman, M. R., Kinsky, S., Egan, J. E., Coulter, R. W. S., &Markovic, N. (2016). The continuing development of health disparities research on lesbian, gay, bisexual, and transgender individuals. *American Journal of Public Health*, *106*(5), 787–789.https://doi.org/10.2105/AJPH.2016.303183

Stennis, K. B., Purnell, K., Perkins, E., &Fischle, H. (2015). Lessons learned: Conducting culturally competent research and providing interventions with black churches. *Social Work and Christianity*, *42*(3), 332–349.https://www.netcestudents.com/coursecontent.php?courseid=2141

Stewart, M. (2014). Spiritual assessment: A patient-centered approach to oncology social work practice. *Social Work in Health Care*, *53*(1), 59–73.https://doi.org/10.1080/00981389.2013.834033

Su, D., Irwin, J. A., Fisher, C., Ramos, A., Kelley, M., Mendoza, D. A. R., & Coleman, J. D. (2016). Mental health disparities within the LGBT population: A comparison between transgender and non-transgender individuals. *Transgender Health*, *1*(1), 12–20.doi:http://dx.doi.org.ezp.waldenulibrary.org/10.1089/trgh.2015.0001

Sue, D. W. (1981). *Counseling the culturally different: Theory and practice.* New York: Wiley.https://journals.sagepub.com/doi/abs/10.1177/136346158302000104

Sue, D. W., Arredondo, P., &McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, *70*(4), 477–486.https://doiorg.ezp.waldenulibrary.org/10.1002/j.2161-1912.1992.tb00563.x

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125.doi:http://dx.doi.org.ezp.waldenulibrary.org/10.1353/hpu.2010.0233

Tourse, R. W. C. (2016). Understanding cultural sway: An essential component for competent practice. *Smith College Studies in Social Work (Haworth)*, *86*(2), 84–100.https://doi.org/10.1080/00377317.2016.1151751

U.S. Census Bureau. (2016). *Quick facts: Washington State*https://www.census.gov/quickfacts/table/PST045216/35

Varghese, R. (2016). Teaching to transform? Addressing race and racism in the teaching of clinical social work practice. *Journal of Social Work Education*, *52*(sup1), S134–S147.https://doi.org/10.1080/10437797.2016.1174646

Walkley, M., & Cox, T. L. (2013). Building trauma-informed schools and communities. *Children and Schools*, *35*(2), 123–126.https://search-ebscohostcom.ezp.waldenulibrary.org/login.aspx?direct=true&db=rzh&AN=1080

17596&si

te=ehost-live&scope=site

Welsh, E. (2002). Dealing with data: Using NVIVOin the qualitative data analysis process. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Researchon Clinical Practice*, *3*(2), 155-161.http://www.qualitative-research.net/index.php/fqs/article/view/865

Yasui, M. (2015). The cultural ecogram: A tool for enhancing culturally anchored shared understanding in the treatment of ethnic minority families. *Journal of Ethnic and Cultural Diversity in Social Work*, *24*(2), 89–108.https://doi.org/10.1080/15313204.2014.991980

Zeitlin, W., Altschul, D., & Samuels, J. (2016). Assessing the utility of a toolkit for modifying evidence-based practice to increase cultural competence: A comparative case study. *Human Service Organizations: Management, Leadership and Governance*, *40*(4), 369–381.https://doi.org/10.1080/23303131.2016.1153551

Appendix A: Interview Outline

I. Introduction (5 minutes)

A. Greeting

B. Statement of purpose of the 60 – minute interview

C. Review Inform Consent and check for questions

II. Clarification of Terms (10 minutes)

A. Establish the knowledge base of key terms through questions

- What comes to mind when you hear cultural humility?
- What comes to mind when you hear intersectionality?
- In your opinion, how are the concepts of cultural humility and intersectionality connected to NASW cultural competence standards?

B. Provide definitions of key terms

III. Interview questions (35 minutes)

A. Engagement, assessment, intervention, and evaluation

- During your initial contact with the client, what do you do to demonstrate cultural humility? (Probe: How do you engage clients to build rapport?)
- How do you incorporate intersectionality into the assessment process? (Probe: How do you document power, privilege, and oppression with marginalized clients)
- How do you use interventions to demonstrate cultural humility and awareness of intersectionality?

- How do you incorporate cultural humility and intersectionality when evaluating treatment outcomes?

B. Client's worldview and their state of incongruence

- How do you demonstrate cultural humility and intersectionality to understand the situation and problem of the clients?

C. Participant input

- What are some of the challenges you have encountered in an attempt to integrate cultural humility and intersectionality in settings of mental health?
- Do you have any thoughts on what would make it much easier for incorporating cultural humility and intersectionality in the aspects of clinical practice relating to engagement, assessment, intervention, and evaluation?
- Is there any person that might be having other comments or questions concerning cultural humility and intersectionality?

IV. Wrap up (10 minutes)

A. Identify and organize the major themes from the responses of the participants

B. Member check and accuracy of the gathered information

Appendix B: Confidentiality Agreement

Name of Transcriber:

During course of my activity in the collection of data for this research: *Examining cultural humility and intersectionality in mental health treatment: A research study in Washington State,* I will have access to information, which is confidential and will not be disclosed. I acknowledge that it is mandatory for the information to be kept confidential since any improper disclosure of the existing confidential information has a potential risk of damaging the participants' privacy.

By signing this confidentiality agreement, I am in agreement that:

1. I will neither discuss nor disclose any confidential information about the participants with others, either family or friends.
2. I will not sell, copy, release, divulge, destroy, loan, or alter any confidential information except with prior authority.
3. I will not discuss any confidential information where others can overhear the conversations. I have an understanding that it is unacceptable to hold discussion of any confidential information even in the situations where the names of participants are not used.
4. I will not make unauthorized purging, modification, inquiries, or transmissions of confidential information.
5. I recognize that my obligations under this agreement will continue even after the termination of the job I am performing.

6. I understand that the risk of violating this agreement has legal implications.
7. I will only use and access devices and systems that I have the official authorization to access, and I will not demonstrate the functions and operations of devices and systems to unauthorized persons.

The signing of this document is an acknowledgment that I have read and agreed to comply with all the presented terms and conditions as stated above.

Transcriber Signature Date

Witness Signature Date

Appendix C: Demographics

The demographics requested is based on the information gathered by the U.S. Census Bureau (U.S. Census Bureau, 2016).

What county and city are you residing or employed in?	
What is your race? White, not Latino or Hispanic African American Native American Asian Native Hawaiian or Pacific Islander Hispanic or Latino Two or More Races	
What languages other than English do you provide mental health treatment?	
What is your current age?	
What is your gender?	
What is the number of years working in mental health? 4 years or less 5 to 9 years 10 years +	
What is your place of work? Non-profit Private for Profit Private Practice Government agency	
INTERVIEW COORDINATION INFO	
Please provide several dates and times you are available the next 30 days to participate in the interviews	
The interview will be conducted online via Zoom due to the current COVID-19 pandemic that has restricted social interactions in an effort to curb the crisis.	