2019

Examining Cultural Humility and Intersectionality in Mental Health Treatment

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This is to certify that the doctoral study by

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MSW, New Mexico Highlands University, 2003

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Project Submitted in Partial Fulfillment

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Abstract

Cultural awareness is an ethical standard in the social work profession and, as the diversity in the United States continues to grow, it is a social work practice problem when cultural awareness is not implemented in mental health settings. The National Association of Social Workers revised the cultural awareness standards to include cultural humility and intersectionality as practice indicators. The purpose of this action research study was to examine how clinical social workers demonstrated cultural humility and intersectionality in mental health settings. Person-centered theory guided this study and a total of 17 clinical social workers in New Mexico participated in in-depth interviews to give examples of clinical practice behaviors that demonstrated cultural humility and intersectionality. Thematic analysis was used to identify common themes, which included (a) genuine interest in the client's culture, (b) therapist congruence, (c) unconditional positive regard, and (d) empathic understanding. The implications of this study for social work practice and social change are that findings could contribute to improved cultural awareness in mental health settings and decrease mental health disparities among minorities. Recommendations include creating continuing education, mentoring minority college students on their career path in mental health, and developing a mental health business model that integrates cultural awareness.

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Dedication

I dedicate this capstone project to my beloved family; without them this was not possible. To my husband for "trying" to be supportive during late nights and weekends. Thank you for believing in me. At times, you believed in me more than I believed in myself. Thank you for your unconditional love and unbelievable faith in me. Your faith is what got us to the end.

To my parents for planting the seed, "I can do anything," when I was a child. They had no clue how powerful those words were and where those words would lead me. They supported me through all my educational endeavors and were still available now to babysit. My mom always surprised me with home-cooked meals to take home, so I could feed my family and continue to write. My father, an exceptional example of a hard worker, taught me the value of education. Thank you both for teaching me the meaning of unconditional love.

And to my wonderful daughter whose smile and laughter fueled me to finish. Because of you, Marisol, I pushed myself the hardest I ever have in school, so that you could have a future with limitless opportunities. Just like your grandparents did for me.

Acknowledgments

I would like to acknowledge my chair, Dr. Alice Yick, for her amazing leadership, patience, and compassion. Dr. Yick provided the guidance I needed to gain knowledge and skills as a researcher. I also like to acknowledge my second committee member Dr. Susan Parlier and University Research Reviewer, Dr. Cynthia Davis for their invaluable contributions and feedback in the process. I am thankful for the experience and excited to be done.

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Section 1: Foundation of the Study and Literature Review

Cultural awareness is a fundamental clinical practice standard in the social work profession and reinforced by the profession's person-centered approach (National Association of Social Workers [NASW], 2017). Although person-centered theory guides social workers to engage with unconditional positive regard and to understand the client's worldview (C. Rogers, 1957), a social work practice problem is not integrating cultural awareness in mental health settings. The *Code of Ethics* of the NASW (2017) mandate social workers to understand the function of culture in the lives of clients and society, obtain knowledge of other cultures, and develop skills to work effectively with diversity. In 2015, NASW revised the cultural competency standards to develop *The Standards and Indicators for Cultural Competence in Social Work Practice*. The revised standards identified cultural humility and intersectionality as practice indicators (NASW, 2015). This qualitative study used an action research approach to examine the clinical behaviors that demonstrate cultural humility and intersectionality in mental health treatment. This study promotes social change by contributing to the literature on cultural awareness in social work practice.

The first section of this capstone project describes the problem of not integrating cultural awareness in mental health settings, then a description of the purpose and significance of the study and concludes with the theoretical framework that guided the study. The literature review provides the historical context, a summary of current clinical applications, and the rationale to support this study on cultural humility and intersectionality in mental health treatment. The second section describes the research

design and the data collection process. The methodology section includes a description of the participants, a rationale for the use of in-depth interviews, and the design of the study to protect participants and obtain informed consent. Finally, this capstone project concludes with the description of the data collection and analysis process, a discussion of the findings, and the implications for social work practice.

Problem Statement

In mental health treatment, effective clinical social work incorporates cultural awareness and is needed as the diversity in the United States continues to grow. Cultural awareness is the process by which social workers respond respectfully and effectively to people of all cultures, races, ethnic backgrounds, languages, classes, religions, sexuality, and other diversity factors in a manner that communicates and protects the dignity and worth of all individuals (NASW, 2017). Cultural awareness requires social workers to build positive working alliances with clients to achieve positive treatment outcomes (Hook, Davis, Owen, Worthington Jr., & Utsey, 2013; Lee, 2011). Lee and Horvath (2014) demonstrated the potential for adverse treatment outcomes when the therapist's dialog lacked cultural awareness. The therapist's responses minimized the cultural factors involved in the client's decision-making process (Lee & Horvath, 2014). The therapist's action strained the working alliance, and the client was less engaged in treatment (Lee & Horvath, 2014).

Tourse (2016) argued that implicit and explicit power differentials are embedded in culture and taken for granted. Social workers can overlook power dynamics and disempower clients in the treatment process by pathologizing cultural specific behaviors

and imposing culturally insensitive interventions (Berg, 2014; Tourse, 2016). However, when mental health interventions and treatment planning recognized the clients' culture as a resource, clients' participation increased (Hook et al., 2013; Kohn-Wood & Hooper, 2014; Lee, 2011; Lee & Horvath, 2014). When client participation increases in treatment there is an increase in positive mental health outcomes.

Positive mental health outcomes occur in a strong client-therapist working alliance (Hook et al., 2013). Hook et al. (2013) replicated four studies and demonstrated strong working alliances predicted improvements in functioning as reported by clients. Strong working alliances developed when clients perceived the therapist respected their culture and demonstrated cultural humility (Hook et al., 2013). According to C. Rogers (1979), effective therapy occurred through an alliance that fostered empathy and acceptance. In an unconditional accepting environment, clients can explore their state of incongruence (C. Rogers, 1957, 1979; C. Rogers & Koch, 1959). A state of incongruence is the discrepancy between the client's perception of self and a life situation, and the perception causes the client mental and emotional distress (C. Rogers, 1957). The internal conflict contributes to symptoms related to anxiety and depression (C. Rogers, 1957, 1979; C. Rogers & Koch, 1959). A positive working alliance provides an environment that allows clients to enter the change process (C. Rogers, 1957). The purpose of mental health treatment is to assist clients through the process of change to alleviate symptoms.

Although understanding the client's culture can build a strong working alliance, a power imbalance influences the working alliance (Berg, 2014; Chang, Simon, & Dong,

2012; Hook et al., 2013; Prins, Bates, Keyes, & Muntaner, 2015; Tourse, 2016). The revised cultural competency standards incorporated the concepts of cultural humility and intersectionality to recognize power dynamics (NASW, 2015). Cultural humility and intersectionality are concepts that examine power, privilege, and oppression that exist in interpersonal relationships and present in society (Azzopardi & McNeill, 2016; Danso, 2016; Horevitz, Lawson, & Chow, 2013; Mirsky, 2013). Cultural humility and intersectionality emphasize social justice principles and the implementation of advocacy skills (Danso, 2016; Fisher-Borne, Cain, & Martin, 2015; Krumer-Nevo & Komem, 2015).

Cultural humility is the awareness of the power and privilege present in relationships and the self-monitoring to address the power imbalances (Tervalon & Murray-Garcia, 1998). Cultural humility obligates social workers to recognize their positions of power (Fisher-Borne, Cain, & Martin, 2015). In a professional role, social workers are in a position of power to influence the lives of clients (Danso, 2016; Fisher-Borne et al., 2015). Davis and Gentlewarrior (2015) studied clinical social workers practicing for a minimum of 10 years and asked how they mediated White privilege in the client-therapist relationship, also known as a working alliance. Recognizing privilege, humility, and self-reflection were tools identified to address power imbalances in the therapeutic relationship (Davis & Gentlewarrior, 2015). Integrating cultural humility into social work requires continuous practice, an integration of the philosophy, and action (Tervalon & Murray-Garcia, 1998). Cultural humility goes beyond the

knowledge of power imbalances and requires action to mediate the imbalance (Tervalon & Murray-Garcia, 1998).

The concept of intersectionality is grounded in feminist theory, which examines gender inequality in power and social structures (Crenshaw, 1989). Intersectionality theory explains multiple cultural identities (e.g., gender, race, poverty) intensify the client's experience of oppression, discrimination, and domination by society (Cho, Crenshaw, & McCall, 2013; Crenshaw, 1989; Davis & Gentlewarrior, 2015; Ratts, 2017). Intersectionality reveals the design of society to inhibit marginalized groups through various forms of oppression and discrimination and emphasizes working towards equity and social justice for all (Cho et al., 2013). Krumer-Nevo and Komem's (2015) study with female adolescents demonstrated the participants responded positively to group therapy that integrated topics of intersectionality (e.g., gender, race, class, and sexuality) lead by social workers trained in intersectionality. The intersectionality training for the social workers analyzed the female adolescents' problematic behaviors through the lens of intersectionality to increase understanding to foster an unconditional empathic environment (Krumer-Nevo & Komem, 2015). Krumer-Nevo and Komen (2015) demonstrated the integration of intersectionality in social work practice by empowering social workers to respond to clients in an unconditional positive manner and educating clients in intersectionality.

Culturally competent clinical social work practice is imperative in New Mexico due to the diversity of the state's population. The population consists of Hispanics; Native Americans; African Americans; Vietnamese American, Cuban American;

Lesbian, Gay, Bisexual, Transgender (LGBT), and a large number of people living in poverty (U.S. Census Bureau, 2016). New Mexico is unique from other states by having the highest percentage of Hispanics at 48 % (World Population Review, 2017). Although 83% of the Hispanic population is native-born, 17% are immigrants from Latin America (World Population Review, 2017). New Mexico is second to Alaska to have a large Native American population at 16% (U.S. Census Bureau, 2016). New Mexico is one of four states to be ethnically a minority-majority state (World Population Review, 2017). In addition, 20% of New Mexico residents live in poverty, and the state is ranked 50th as the poorest states in the United States (Center for American Progress, 2017). Also, New Mexico ranked as one of the top 10 states for LGBT people (The Daily Beast, 2011). New Mexico is culturally diverse with a large population in poverty (U.S. Census Bureau, 2016), the needs of the community require culturally competent service providers.

After an abrupt termination of mental health services across the state in 2013, grassroots community organizers sought to understand the mental health needs of New Mexico residents (Generation Justice, 2016). Organizers recorded 62 interviews and documented that New Mexico residents experienced long waiting lists to see a mental health therapist, a constant turnover of mental health providers, and the services lacked cultural sensitivity (Generation Justice, 2016). New Mexico's population is racially and ethnically diverse, open to mixed sexual orientations, and houses a high number of people in poverty (U.S. Census Bureau, 2016). The integration of cultural humility and

intersectionality is imperative to adequately address the mental health needs of the population in New Mexico.

This study supports the current grassroots efforts to improve mental health services in New Mexico by researching the clinical behaviors in mental health treatment. More specifically, examine the clinical behaviors social workers use to demonstrate cultural humility and intersectionality. When treatment neglects to assess power, privilege, and oppression, clients demonstrated poor mental health outcomes (Bostwick, Boyd, Hughes, West, & McCabe, 2014; Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013; Holley, Tavassoli, & Stromwall, 2016; Jimenez, Cook, Bartels, & Alegría, 2013; Lee & Horvath, 2014; Stall et al., 2016; Su et al., 2016; Tourse, 2016). Studies demonstrate the integration of cultural humility and intersectionality into clinical practice in mental health treatment improve client outcomes (Hook et al., 2013; Kohn-Wood & Hooper, 2014; Krumer-Nevo & Komem, 2015; Lee & Horvath, 2014; Priscilla, 2015). The current study can contribute to understanding what clinical behaviors demonstrate cultural humility and intersectionality.

Purpose Statement and Research Questions

The purpose of the research study was to examine the clinical behaviors used to demonstrate cultural humility and intersectionality in mental health treatment in New Mexico. In this study, I gathered examples of clinical behaviors social workers use to acknowledge power dynamics and mediate power imbalances in the process of engagement, assessment, intervention, and evaluation in mental health treatment. Person-centered theory guided the research to examine how the integration of cultural humility

and intersectionality help the social worker understand the client's worldview and their state of incongruence.

Research Questions

The study focused on the following 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 intersectionality?
2. How does the integration of cultural humility and intersectionality help the social worker understand the client's worldview and mental health assessment?

This study contributes to advance the professional social work practice in three distinct manners. First, the study can support the grassroots efforts started in New Mexico to improve mental health services to residents. I examined the cultural awareness of clinical social workers. The clinical social workers can provide examples of successful interventions specific to the clients in New Mexico. The study findings can contribute to developing continuing education training for the social work community in New Mexico. In addition, the study findings can provide examples of specific clinical behaviors that convey cultural humility and intersectionality to complement the research of Jani, Osteen, and Shipe (2016) to develop a social work cultural competency measure. Also, according to Seedall, Holtrop, and Parra-Cardona's (2014) review of 8 years of literature, additional research regarding the integration of cultural humility and intersectionality in mental health treatment is needed to educate therapists in practice

behaviors and the importance of the understanding of power dynamics in treatment. Finally, NASW (2015) cultural competency standards endorse research on cultural competency issues such as cultural humility and intersectionality.

Nature of the Doctoral Project

Through this action research study, I examined the clinical behaviors social workers used in New Mexico to demonstrate cultural humility and intersectionality in mental health practice. Specifically, individual in-depth interviews were used to collect data. An action research design was chosen because of the collaborative nature to inspire social action, to demonstrate cultural awareness, and gather descriptive clinical behaviors (Bradbury & Reason, 2003; Buettgen et al., 2012; Coghlan, 2016). The action research method's core principle is the collaboration between the researcher and the participants to gain insight on community issues and inspire social action (Bradbury & Reason, 2003; Buettgen et al., 2012; Coghlan, 2016). Cultural insensitivity in mental health treatment has been identified as a community issue in New Mexico (Generation Justice, 2016). Since cultural awareness is a social work ethical practice standard, action research is an appropriate approach to engage New Mexico clinical social workers in the research process; and the process can inspire participants to promote change (Bradbury & Reason, 2003; Buettgen et al., 2012; Coghlan, 2016). Because the focus of the study is clinical behaviors in mental health treatment, the recruitment is purposeful to obtain participants with first-hand experience providing clinical mental health services (Gentles, Charles, Ploeg, & McKibbon, 2015; Patton, 2002).

Specifically, I used in-depth interviews in this action research study. In-depth interviews captured both verbal and nonverbal responses and cues (Britten, 1995). This interview process promotes and respects the cultural diversity of the participants. New Mexico is a culturally minority-majority state hence this diversity is expected to be reflected in the social workers (U.S. Census Bureau, 2016). The in-depth interview is a data collection method that respects the participants' expertise and is well received by research participants that are ethnic minorities (Danso, 2015; Ocloo & Matthews, 2016; Sheridan, Bennett, & Blome, 2013; Stennis, Purnell, Perkins, & Fischle, 2015). Including participants in the decision-making during the research process acknowledges their contributions as valuable and encourages their participation in research (Ocloo & Matthews, 2016; Shenton, 2004; Sheridan et al., 2013).

Clinical social workers that provide mental health treatment were interviewed. The target group of social workers is the clinical social work supervisors approved by the New Mexico Board of Social Work Examiners (NMBSWE). Social workers were recruited from the NMBSWE approved list of social work supervisors available on the website (New Mexico Regulation & Licensing Department, 2016). Potential participants were recruited by emails, social media, and face-to-face networking.

The two concepts being examined is cultural humility and intersectionality in clinical social work practice. In-depth individual interviews gathered detailed, rich data that includes verbal and nonverbal responses. Clinical social workers were recruited from the public list on the New Mexico Social Work Board of Examiners. I used

thematic data analysis to organize and analyze the data and look for common themes and patterns.

Significance of the Study

This study contributes to the advancement of social work practice knowledge in cultural competency with policy, research, and practice. The revised NASW (2015) cultural competency standard, is a policy that explicitly identifies cultural humility and intersectionality as competency indicators. The data collected from the study provided information on the integration of the current policy standards. Furthermore, Jani et al. (2016) argued that understanding how cultural awareness translates into practice behaviors contributes to developing a measure specific to the social work profession. The data from this study described specific clinical behaviors that demonstrated cultural humility and intersectionality. Finally, Bubar, Cespedes, & Bundy-Fazioli (2016) demonstrated a gap between the knowledge of power dynamics and societal oppression and the integration into clinical practice. The data from the study provides clinical practice examples to improve cultural competency in direct services to clients (Fisher-Borne et al., 2015).

The study supports social change efforts in New Mexico that started in 2013 to improve mental health services. Since New Mexico's population is highly diverse, data gathered from the study can provide insight into the integration of cultural humility and intersectionality in mental health practice. This study identified continuing education needs or identified resources for cultural humility and intersectionality. As an action

research study, the promotion of community collaborative efforts to improve cultural competency in New Mexico is a predicted outcome of the study.

Theoretical/Conceptual Framework

The social work profession's practice concepts are based on person-centered theory and align with the research on cultural humility and intersectionality. C. Rogers (1979) explained that people enter therapy in a state of incongruence and change occurs in the presence of an empathic environment. Person-centered theory's fundamental tenets include (a) people are trustworthy, (b) intrinsically moved toward self-actualization and health, (c) have inner resources to move themselves in positive directions, (d) respond to their uniquely perceived world, and (e) there is an interaction of these fundamental beliefs with external factors (C. Rogers, 1957, 1979; C. Rogers & Koch, 1959). C. Rogers (1942) emphasized that the relationship between therapist and client was a crucial factor in the clients' change process.

According to C. Rogers (1942), the cultivation of the therapeutic relationship lies in the congruence of the therapist. The therapist's congruence allowed a genuine relationship to develop to foster specific conditions for change. C. Rogers (1942) identified six core conditions that promote constructive growth and change, (a) the therapist and client are in psychology contact,(b) the client is in a state of incongruence, (c) therapist is congruent in the relationship, (d) therapist demonstrates unconditional positive regard, (e) displays empathic understanding, (f) and therapist communicates genuineness, warmth, and acceptance, which is minimally achieved (C. Rogers, 1957, 1979; C. Rogers & Koch, 1959).

Person-centered theory aligns with this study on cultural humility and intersectionality in mental health practice. Person-centered theory recognizes the client as the expert on their life (C. Rogers, 1942), which is supported by cultural humility practice. Cultural humility requires social workers to let go of professional power and recognize the clients' power (Joseph & Murphy, 2013; Tourse, 2016). Furthermore, person-centered theory has an emphasis on understanding the client's worldview (C. Roger, 1979) and intersectionality. Intersectionality explains understanding the client's worldview through the lens of multiple identities in the social structure that promotes privilege, oppression, and discrimination (Crenshaw, 1989). The intersection of multiple identities predicts the degree of discrimination the individual encounters. A person-centered approach provides a comprehensive framework to explore cultural humility and intersectionality in mental health treatment.

Values and Ethics

On January 1, 2018, the NASW released the amendments to the *Code of Ethics*. The heading for section 1.05 changed from "Cultural Competence and Social Diversity" to "Cultural Awareness and Social Diversity" (NASW, 2017). The revisions reflect the insights presented in NASW's (2015) *The Standards and Indicators for Cultural Competence in Social Work Practice*. Since NASW implemented the change in 2018, the terms *competence* and *competenc*y are still used throughout this capstone project to align with the terminology used in the literature reviewed.

The NASW (2015) revised cultural competency standards incorporated expanded definitions of cultural humility and intersectionality. Cultural humility and

intersectionality is a recognition of innate human rights regardless of clients' identity or status and for social workers to step into action (Azzopardi & McNeill, 2016; Cho et al., 2013; Fisher-Borne et al., 2015). The ethical standard 1.05 Cultural Awareness and Social Diversity requires knowledge in different cultures, understanding the influence of culture on human behavior and society, and having an awareness of the nature of diversity and oppression (NASW, 2017). I examined cultural humility and intersectionality in mental health practice. The ethical standard 1.05 supports this study.

Cultural humility and intersectionality align with the core social work ethical values the *dignity and worth of the person* and *social justice* (NASW, 2017). The concepts of cultural humility and intersectionality are the awareness of power, privilege, and oppression in the social worker-client relationship and the larger society (Fisher-Borne et al., 2015; Ratts, 2017). Cultural humility and intersectionality integrate advocacy and social justice actions (Cho et al., 2013; Danso, 2016). The standard 6.04 Social and Political Action mandates that social workers advocate for change for the betterment of all people and promote conditions that respect cultural diversity (NASW, 2017). The *Code of Ethics* guide social work practice and advocacy with diverse cultures and align with the purpose of this study to examine cultural humility and intersectionality in mental health practice.

The New Mexico Social Work Board of Examiners (Board) is the licensing and governing entity for all social workers in the state holds cultural competency in high esteem as demonstrated by the state's licensing requirements. First, the New Mexico Board mandates that all social workers that provide mental health services possess a State

issued social work license. In order to apply for a social work license at any level (i.e., bachelor, master, or independent), social work applicants need to meet the cultural competency standard either by a three-credit hour course in New Mexico cultures listed on the applicants' transcripts; or a board-approved course, workshop, or seminar in New Mexico cultures; or proof of previously passing the New Mexico cultural examination (New Mexico Regulation & Licensing Department, 2016). The cultural competency expectation does not stop after the initial application. At the time of license renewal, the Board requires social workers to obtain six of the thirty continuing education hours be in cultural awareness (New Mexico Regulation & Licensing Department, 2016). The Board's commitment to cultivating cultural competency in social workers is aligned with this study on cultural humility and intersectionality in mental health practice.

This study on cultural humility and intersectionality in social workers in New Mexico promotes NASW's ethical value of service. The ethical principle of service states social workers' primary goal is to help people in need and to address social problems (NASW, 2017). I examined practice behaviors that integrate cultural humility and intersectionality to promote clients' self-actualization, which promotes service. The knowledge gained from this study can improve service delivery in mental health treatment and encourage client participation in mental health services.

This study followed the ethical standards when conducting an action research study on human subjects (McNiff, 2016; Stringer, 2013). All participants received information on the purpose of the study, contact information for any questions, informed

of any potential risks for participating in the study, and their right to stop participation at any time. All participants signed a consent form and received a copy of the form.

Literature Review

The steps for collecting literature began in October 2016, using the Walden University Library. The library searches occurred monthly until this capstone project was completed. The following were the databases used: PsychInfo, SocIndex, Education Sources, Social Science Citation, and the Academic Journal. I used these databases because they supplied the literature on cultural competency issues in mental health practice. The following are the list of key terms used in the searches: *cultural competence; awareness; diversity; multicultural practice; cultural sensitivity; cross-cultural practice; cultural responsiveness; cultural humility; intersectionality; social work*; clinical practice; mental health;* and *therapy.* The array of terms was used to contribute to an exhaustive search of the literature. Peer-reviewed articles published in the past 5 years were used. I incorporated older articles because the articles were the original writers for core concepts. For instance, the original work of C. Rogers (C. Rogers, 1942, 1957, 1979) was used to support person-centered theory. The original work by Crenshaw (1989) was used to describe intersectionality. Finally, Tervalon and Murray-Garcia (1998) are recognized as the main contributors to the concept of cultural humility.

The search in the literature demonstrated a vast array of research on cultural competence. The research was organized into three main themes: the critiques of cultural competence, clinical practice, and the working alliance in mental health. Each theme is

divided into subcategories to examine each theme in detail. The result is a literature review to support this study to examine cultural humility and intersectionality in mental health settings in New Mexico.

Cultural Competence: Significance and Critiques

The mental health professions (e.g. medical, social work, counselors, marriage & family 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). The vast array of professional associations integrate cultural competency guidelines in their ethical practice codes such as the American Psychologist Association (Chu, Leino, Pflum, & Sue, 2016), the American Psychiatric Nurses Association (Nardi, 2014), the American Counseling Association (M. J. 1 Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016), American Association for Marriage and Family Therapy (Seedall et al., 2014), and the National Association of Social Workers (NASW, 2015). As emerging research demonstrates cultural competent practice can address health disparities in minority clients (Chu et al., 2016; Jackson, Williams, & VanderWeele, 2016), cultural competence continues to be of prime significance in mental health treatment.

The evolution of culturally competent practice began in the 1950s when the concept of diversity promoted the Melting Pot analogy; hence, treatment focused only on the problem and interventions (Kohli, Huber, & Faul, 2010). As the Civil Right Movement in the 1960s exposed the social injustices against Blacks, to minimize discrimination colorblindness was the approach taken (Fong, 2001). From the 1980s

through the 1990s the evolution of cross-cultural practice continued into multicultural and cultural sensitivity; then transformed into the social constructionist ethnocultural framework in the past decade (Boyle & Springer, 2001; Kohli et al., 2010; Lee & Greene, 1999). The cultural competency definition accepted across disciplines is Cross, Bazron, Dennis, and Isaac's (1989) which described cultural competence as values and behaviors displayed among professionals and supported by agency policies to enable effective cross-cultural interactions. Although cultural competence is valued, the literature critiques the array of cultural competency frameworks (Azzopardi & McNeill, 2016; Danso, 2016; Edwards, 2016; Sheridan et al., 2013). The critiques are: (a) contradiction in cultural competency terminology, (b) competency needs to go beyond knowledge and skills frameworks, and (c) the clinical and cultural integration into practice. These critiques of cultural competence contribute to the incorporation of cultural humility and intersectionality into NASW's (2015) cultural competency standards.

Critique of terminology. Terminology influences the role of the social worker and how the social worker functions in that role. The term cultural competence implies the social worker can gain mastery of another culture and conveys there is an endpoint (Fisher-Borne et al., 2015; Hollinsworth, 2013; Horevitz et al., 2013). The term competence presents the social worker in the role of the expert (Fisher-Borne et al., 2015) and disempowers clients in the working alliance. Many scholars present other terminology that emphasize the function of cultural competence practice such as cross-cultural competencies (Lee, 2011), cultural equity (Almeida, Hernandez-Wolfe, & Tubbs, 2011), cultural consciousness (Azzopardi & McNeill, 2016), critical cultural competence

(Danso, 2015), cultural intelligence (Edwards, 2016), critical awareness (Furlong & Wight, 2011), and cultural humility (Fisher-Borne et al., 2015). The terminology presented shifts the role of the social worker as the learner and establishes the client as the expert (Hollinsworth, 2013). Terminology sets the mood of the working alliance, and empowering clients is social work practice.

Although cultural competence is an on-going process of learning, the terminology implies an endpoint (Azzopardi & McNeill, 2016). With the increased demands for evidence-based practice to minimize risk and increase cost effectiveness, the implementation of cultural competence practice becomes less of a priority (DelVecchio Good & Hannah, 2015; Huey Jr., Tilley, Jones, & Smith, 2014). The significance of cultural competence decreases to a task instead of a clinical practice goal (Furlong & Wight, 2011; Hollinsworth, 2013). When cultural competence becomes a task, the focus turns to meet the task through continuing education training requirements instead of clinical practice engagement with clients (Furlong & Wight, 2011; Huey Jr. et al., 2014). Viewing cultural competence as a task prevents the integration of culture into clinical practice. Cultural competency is an on-going learning process; however, the administrative duties and over worked professionals interpret competency as destination achieved by education.

The term cultural competence is associated with social workers ethical responsibility, while agencies and system-level approaches avoid the scrutiny (Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013). Most social workers are employed by government agencies, nonprofit organizations, and private corporations

managed by nonsocial workers (Hays, 2009). Managing entities focus on finances and outcomes and not held to culturally competent standards (Hays, 2009; Huey Jr. et al., 2014). The burden to meet the cultural competency standard lands on the social worker (Delphin-Rittmon et al., 2013; DelVecchio et al., 2015), again turning into a task. As the term cultural competency is a frequently used term, it loses its significance and morphs into a task (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 develop to its full potential.

There are hundreds of cultural competence terminology, which creates confusion for social workers and clients (Boyle & Springer, 2001). The terminology is either too broad or ambiguous or to abstract (Azzopardi & McNeill, 2016; Edwards, 2016; Fisher-Borne et al., 2015). The array of terminology and the lack of consensus on terms creates a challenge to measure, track, and train in clinical behaviors (Chu et al., 2016; Jani et al., 2016). Cultural humility (Tervalon & Murray-Garcia, 1998) and intersectionality (Crenshaw, 1989) are two terms introduced into the social work cultural competency standards (NASW, 2015). The literature on cultural humility and intersectionality are emerging (Fisher-Borne et al., 2015; M. A. Robinson, Cross-Denny, Lee, Werkmeister Rozas, & Yamada, 2016). The challenge is defining 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 and quantify culturally competent behaviors, cultural competency

becomes an altruistic goal rather than clinical practice behaviors to foster a working alliance.

Critique of Frameworks. Across disciplines, Sue's (1981) framework is the most widely used to conceptualize cultural competency. The American Psychological Association, American Counseling Association, and the NASW use Sue's framework as the foundation for cultural competent skills and the development of multiple cultural competency measures (Boyle & Springer, 2001; Krentzman & Townsend, 2008; Kumaş-Tan, Beagan, Loppie, MacLeod, & Frank, 2007). The cultural competence framework described that therapists need to (a) develop self-awareness of their cultural values, biases, and recognition of the influence in the therapeutic alliance through their perception of the client and presenting problem, (b) gain knowledge of the client's cultural background and the function of their worldview, and (c) hone skills to provide culturally sensitive interventions (Derald Wing Sue, Arredondo, & McDavis, 1992). Sue's framework inspired scholars, educators, and clinical social workers to incorporate self-awareness, cultural knowledge, and skills as cultural competency standards (Azzopardi & McNeill, 2016; Boyle & Springer, 2001; Fisher-Borne et al., 2015). Sue's framework provides the foundation for the standards of cultural competency, as the demographics of the U.S. population continues to diversify, the cultural competency foundations are being questioned by modern researchers if these standards are enough.

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 in activities to build self-awareness such as inventorying values

and belief, identifying and defining their culture, and assessing how the cultural difference with clients influences the social worker-client relationship (Mlcek, 2014). Although power, privilege, and discrimination are often discussed in cultural competency training, little is discussed how do these standards translate into clinical practice behaviors (Block, Rossi, Allen, Alschuler, & Wilson, 2016; Bubar et al., 2016; Garran & Werkmeister Rozas, 2013; Jani et al., 2016; Mirsky, 2013a; Mlcek, 2014; Varghese, 2016). Tervalon and Murray-Garcia (1998) argued self-awareness need to take action to mediate the power and privilege in the working relationship and present cultural humility. Self-reflection requires a critical lens to identify privilege and the possible use of power in the working relationship with clients.

The knowledge of power imbalances and an oppressive societal structure without action perpetuates the oppression of clients (Danso, 2016). Bubar et al.'s (2016) qualitative study on graduate students demonstrated the gap between cultural competency and the integration of power, privilege, and oppression into clinical practice. The study examined 19 Master Social Work student narratives in a clinical practice assignment (Bubar et al., 2016). Although the students demonstrated the ability to engage in self-awareness and possessed knowledge of power, privilege, and oppression, the students did not apply that knowledge to the case vignettes (Bubar et al., 2016). The students' narrative omitted an analysis of the client's culture beyond race, gender, and class and lacked an assessment of the intersectionality in the social context (Bubar et al., 2016). Also, the narratives lacked cultural humility, an awareness of the students' professional power and its influence in relation to the client (Bubar et al., 2016). Bubar et al.'s (2016)

findings are similar to other studies on social work students on translating cultural competency concepts into practice behaviors (see Block et al., 2016; Jani et al., 2016; Mlcek, 2014; Pivorienė & Ūselytė, 2013). Azzopardi and McNeill (2016) argued missing a critical lens on oppressive and discriminatory personal thoughts and actions impacts practice behaviors. Culturally competent practice is not possible when social workers fail to examine the power dynamics in the client-worker alliance and insight on personal privilege.

Self-awareness, promoted as the most effective cultural competency behavior (Mirsky, 2013a; M. A. Robinson et al., 2016; Tourse, 2016), practiced as an isolated activity is ineffective to produce culturally competent practice. Critical self-awareness to power, privilege, and oppression as an application in clinical practice is necessary to empower clients in the working relationship (Almeida et al., 2011; Azzopardi & McNeill, 2016; Chu et al., 2016; Comas-Díaz, 2014; Edwards, 2016; Fisher-Borne et al., 2015; Furlong & Wight, 2011; Ratts et al., 2016; Varghese, 2016). Self-awareness lacking clinical behaviors impedes the working alliance.

Gaining knowledge. Cultural competency frameworks require social workers to increase their knowledge about different cultures such as historical events, traditions, and possible language barriers (Lusk, Baray, Palomo, & Palacios, 2014). Although scholars argue increased knowledge on diverse cultures improves clinical practice to prevent pathologizing cultural specific behaviors (Berg, 2014; Tourse, 2016), other scholars argue it is about making the social worker more "comfortable" with the "others" (Fisher-Borne et al., 2015). Furthermore, a social constructionist ethnocultural framework

defines culture as race, ethnicity, language, economic class, religion, sexuality, and any aspect identified as important by the client (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015; M. A. Robinson et al., 2016). The process to gain knowledge on a client's culture is more complex than defined in cultural competency frameworks.

As the diversity of communities expand and individuals embrace multiple identities, social workers encounter the complexity of structural discrimination and oppression in society (Davis & Gentlewarrior, 2015; Jimenez et al., 2013; McCall, 2005; Mora-Rios & Bautista, 2014; M. A. Robinson et al., 2016). Many scholars argue cultural competence needs more than knowledge but a critical lens to understand the complexity of the experience of minority cultures in a Euro-ethnic, White, middle-class, heterosexual mainstream culture (Cho et al., 2013; Furlong & Wight, 2011; Krumer-Nevo & Komem, 2015; Manseau & Case, 2014; McCall, 2005). Through the power, privilege, and oppression lens of intersectionality, a client's functioning is assessed by considering oppressive experiences (Cho et al., 2013).

Diverse populations such as ethnic and racial minorities, LGBT, and the poor experience discrimination in varying degrees depending on the intersection of their multiple identities (Cho et al., 2013). Arthur (2015) conducted a systematic review of research studies on LGBT elder patients in end-of-life (EOL) care and showed the needs of LGBT clients were minimized in the clinical assessment because using a heterosexual perspective. Bostwick (2014) study demonstrated LGBT clients experienced greater discrimination and suffered mental health problems at higher rates. Bostwick (2014) studied survey data from 577 participants from the National Epidemiologic Survey of

Alcohol and Related Conditions (NESARC). Arthur (2015) and Bostwick (2014) findings are consistent with other studies and support the need to incorporate a critical assessment of oppression and privilege in clinical practice (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015).

Gaining knowledge, a component of cultural competency frameworks, perpetuates power imbalances and creates an oppressive perspective on minority cultures (Azzopardi & McNeill, 2016; Cho et al., 2013; A. Davis & Gentlewarrior, 2015; Fisher-Borne et al., 2015; Eunjung Lee, 2011; M. J. 1 Ratts et al., 2016; Seedall et al., 2014; Varghese, 2016). As cultural competency frameworks emphasize gaining knowledge of cultures, a separation between social worker and client begins to form. The separation is the social worker is the expert, and the client is the "sick" "other" for not conforming to the status quo (Williams & Parrott, 2014).

Azzopardi and McNeil (2016) and Fisher-Borne et al. (2015) review of the cultural competence literature demonstrated the prevailing assumption is the social worker is from the dominant culture hence promoting "othering." When the focus is gaining knowledge about the "other" culture, the dominant culture's practices are deemed as normal functioning (Hollinsworth, 2013; Eunjung Lee, 2011). Hence, the assessment of nondominant clients functioning is negatively skewed. The "othering" perpetuates power imbalances because it implies the social worker is competent because of gaining knowledge of other cultures (Azzopardi & McNeill, 2016; Chang et al., 2012; Danso, 2016; Fisher-Borne et al., 2015). When cultural competency frameworks emphasize gaining knowledge and neglect a critical analysis of intersectionality and cultural

humility, clinical practice is hindered (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015).

Skills and interventions. Research on cultural competency contributes to skill and interventions development. Studies gather information on clinical practice behaviors and aid in the development of practice resources (M. J. Ratts, 2017; Yasui, 2015; Zeitlin, Altschul, & Samuels, 2016). The cultural genogram (Yasui, 2015) and the *Toolkit for Modifying Evidence-Based Practices to Increase Cultural Competence* (Zeitlin et al., 2016) are examples of practice tools. These tools assist social workers in integrating knowledge of the client's culture into practice skills (Yasui, 2015; Zeitlin et al., 2016). The integration of knowledge of culture is the predominant intervention in cultural competency frameworks (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015). Edwards (2016) argues the focus on knowledge on culture frameworks neglects recognizing within-group diversity. Hence interventions can contribute to stereotyping cultures and impede self-determination (Edwards, 2016). Although knowledge of cultures contributes to cultural competency, a critical analysis needs emphasis (Azzopardi & McNeill, 2016; Edwards, 2016; Fisher-Borne et al., 2015).

Recent cultural competency studies demonstrate advancement with the incorporation of previously taboo topics such as spirituality and religion. In two separate qualitative studies on spirituality, Mulder's (2015) and Nagai's (2013) examined the importance of inquiring about a client's spiritual practice for treatment planning and demonstrated similar findings. Mulder (2015) studied ten MSW students using photovoice method that included individual interviews. Nagai (2013) conducted focus

groups with clinicians. The two different groups of participants reported spirituality as an important aspect of their life and reported being open to integrating it into treatment (Mulder, 2015; Nagai, 2013; Stewart, 2014). The incorporation of the client's spirituality in treatment is an example of integrating cultural knowledge into clinical practice and respected as cultural competent practice (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015). The current edition of the *Diagnostic and Statistical Manual of Mental Disorders* provides guidelines for the cultural formulation interview to gain an understanding of the client's cultural context (Kirmayer & Ryder, 2016). The literature demonstrates that culturally competent practice is gathering cultural knowledge and integrating that knowledge into the clinical assessment and interventions (M. J. Ratts, 2017; Yasui, 2015; Zeitlin et al., 2016).

However, intersectionality and cultural humility research demonstrate power, privilege, and oppression are concepts that also need integration into clinical practice (Cho et al., 2013; A. Davis & Gentlewarrior, 2015; Holley et al., 2016). Clients live within a social context, which provides the clients an experience that influences their functioning (Muntaner et al., 2015; Prins et al., 2015; Su et al., 2016). Scholars argue that the client's social experience needs an examination to develop culturally just practices (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015). For instance, Ratts (2017) introduced the Multicultural and Social Justice Counseling Competencies-Assessment Form (MSJCC-AF) to chart the identity of the therapist and the client and identify the power and privilege in the working alliance. The MSJCC-AF provides an opportunity to discuss power and privilege in the therapeutic relationship which allows

addressing the imbalances quickly (M. J. Ratts, 2017). The integration of cultural humility and intersectionality are skills to enhance the working alliance.

Pedagogy Critique. Bridging cultural competency into clinical practice behavior begins in social work education. However, recent studies demonstrate that cultural competency pedagogy does not connect ideology to practice behaviors (Block et al., 2016; Bubar et al., 2016; Jani et al., 2016). Although innovative approaches emerged to teach cultural competency, the curriculum primarily focused on the integration of knowledge into clinical practice.

Lusk, Baray, Palomo, and Palacios (2014) taught a clinical social work practice graduate course in Spanish. The students reported that the course to broaden their cultural competency skills through the experiential learning of the culture in Spanish (Lusk et al., 2014). Social workers gain knowledge of Hispanic cultures to conduct culturally and linguistically appropriate assessments and interventions (Lusk et al., 2014). However, the predominant approach to teach cultural competency is in the dominant language and focusing on knowledge of diverse cultures (Block et al., 2016; Bubar et al., 2016; Jani et al., 2016). Scholars argue the training and education of cultural competence lacks the connection into practice behaviors (Block et al., 2016; Bubar et al., 2016; Garran & Werkmeister Rozas, 2013; Jani et al., 2016; Mirsky, 2013a; Nadan & Ben-Ari, 2013; Pivorienė & Ūselytė, 2013; M. A. Robinson et al., 2016; Varghese, 2016).

The literature demonstrates that the focus of cultural competency pedagogy is narrow and insufficient to address the diversity present in society (Mlcek, 2014; M. A. Robinson et al., 2016; Varghese, 2016). The cultural competency training concentrates

on self-awareness, increasing knowledge on cultures, skill development, while the integration of power, privilege, and oppression as practice behaviors are missing (Block et al., 2016; Bubar et al., 2016; Jani et al., 2016; M. A. Robinson et al., 2016; Varghese, 2016). The research of social work students demonstrate the limited integration of cultural humility and intersectionality into social work practice (Nadan & Ben-Ari, 2013; Pivorienė & Ūselytė, 2013; M. A. Robinson et al., 2016; Varghese, 2016; Williams & Parrott, 2014). According to Bubar et al. (2016) and Garran and Werkmeister Rozas (2013), qualitative studies on graduate social work students demonstrated similar findings that power, privilege, and oppression were overlooked as relevant factors. Although the students recognized the social constructs of oppression, the students did not integrate this knowledge into their assessment of the client (Bubar et al., 2016; Garran & Werkmeister Rozas, 2013).

Block et al. (2016) study of 168 bachelor social work students, demonstrated improved cultural competency post-test after attending a cultural diversity course. Scholar agrees that cultural competency is necessary for social work education and improves practice behavior (Delphin-Rittmon et al., 2013). Since power, privilege, and discrimination are components of cultural competency standards (NASW, 2015), the integration of cultural humility and intersectionality into cultural competency education can positively influence practice behaviors (Varghese, 2016).

Summary. The plethora of literature on cultural competency present significant benefits and critiques (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 and modification (NASW, 2015). Power, privilege, and oppression require additional attention in clinical practice (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015). As communities evolve in complex diversity, more studies in cultural humility and intersectionality are necessary to understand their integration in clinical practice (Chu et al., 2016; M. J. Ratts et al., 2016; Seedall et al., 2014).

Clinical Practice: Power, Privilege, and Oppression

The NASW (2015) revised the *Cultural Competency Standards and Indicators* to incorporate cultural humility and intersectionality as practice indicators. Cultural humility and intersectionality address power, privilege, oppression and promote equality. These practice behaviors are often associated with community organizing (Cho et al., 2013; Chun, Lipsitz, & Young Shin, 2013). However, the revised standards expect cultural humility and intersectionality at all levels of social work practice (NASW, 2015). The main cultural competency framework focuses on self-awareness, cultural knowledge, and skills and is the basis for the cultural competency measures (Azzopardi & McNeill, 2016; Edwards, 2016; Fisher-Borne et al., 2015). In the following section, there is a review of cultural competency measures and a discussion on cultural humility and intersectionality in practice.

Measures. 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) conducted two distinct meta-analyses of cultural competency measures across disciplines and agreed on four measures appropriate for social work: 1) Quick

Discrimination Index (Ponterotto et al., 1995), 2) Multicultural Counseling Awareness Scale (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002), 3) Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994), and 4) the Cross-Cultural Counseling Inventory-Revised (LaFromboise, Coleman, & Hernandez, 1991). Overall the psychometric support for these four scales are promising and are easy to administer and score (Boyle & Springer, 2001; Krentzman & Townsend, 2008). The scales measure the self-awareness, awareness of the client's worldview, and the implementation of culturally appropriate interventions (Boyle & Springer, 2001; Krentzman & Townsend, 2008).

The scales to measure cultural competency face critiques. First, the critique is that all the measures are self-administered by the social worker; hence, how can the evaluation demonstrate a non-bias perspective (Tao, Owen, Pace, & Imel, 2015). Another critique argues that the diversity and complexity of cultures are vast although supported by theoretical constructs, the behavioral indicators are rarely defined and measured (Boroughs, Bedoya, O'Cleirigh, & Safren, 2015). Other scholars argue that because of the diversity of cultures; cultural specific measure is the best approach to evaluate cultural competency (Boyle & Springer, 2001; Eunyoung Lee, 2016). The last critique, these measures do not include cultural humility and intersectionality (Baker & Beagan, 2014).

The challenge of developing cultural competency measures is the length of time to validate the instrument (Jani et al., 2016). When cultural humility and intersectionality are absent in cultural competency measures, social workers overlook these components as

aspects of clinical practice (Azzopardi & McNeill, 2016; Edwards, 2016; Fisher-Borne et al., 2015). Emerging research demonstrates cultural humility and intersectionality as an integral aspect of mental health treatment (A. Davis & Gentlewarrior, 2015; Hook et al., 2013; Krumer-Nevo & Komem, 2015; Ortega & Faller, 2011; Rivers & Swank, 2017; Scherrer, 2013; Seng, Lopez, Sperlich, Hamama, & Reed Meldrum, 2012; Su et al., 2016). Additional research on cultural humility and intersectionality to identify practice behaviors can contribute to developing cultural competency measures (Bubar et al., 2016; Garran & Werkmeister Rozas, 2013; Jani et al., 2016).

Cultural Humility in Practice. Cultural humility identifies privilege and mediates power imbalance (Fisher-Borne et al., 2015). Davis and Gentlewarrior's focus group study with ten clinical social workers (2015) reported self-reflection as an imperative component in the integration of cultural humility and intersectionality in mental health treatment. The participants identified a reflective practice on White privilege improved the working alliance with clients because the social workers actively brought to their awareness of power dynamics (A. Davis & Gentlewarrior, 2015). The study begins the dialog on how to make cultural humility a behavior in the clinical practice. Cultural humility becomes an action in practice rather than just an ethical value to pursue.

Furthermore, Ratts (2017) developed a chart to use in session with a client to identify the power imbalance and talk about the imbalance with the client. A topic commonly avoided in clinical practice becomes a psychoeducational experience to empower client (M. J. Ratts, 2017). Scholars argue power and privilege are difficult

topics to discuss, and they are the critical lens missing in culturally competent practice (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015; M. J. 1 Ratts et al., 2016; Seedall et al., 2014). Although still in the validation process, Hook et al. (2013) present a client administered measure to assess a therapist's cultural humility. The research demonstrates that the practice of cultural humility is positively received by clients (Hook et al., 2013; Tao et al., 2015).

Intersectionality in Practice. Intersectionality recognizes power, privilege, and discrimination is the client's experience and intensifies when multiple marginalized identities intersect (Cho et al., 2013). Numerous studies examine mental health through an intersectionality framework consistently report marginalized populations experience higher rates of health disparities (Alegría, Alvarez, Ishikawa, DiMarzio, & McPeck, 2016; Alvarado & Chunhuei Chi, 2016; Calabrese, Meyer, Overstreet, Haile, & Hansen, 2015; Cook et al., 2014; Evans & Cassells, 2014; Fredriksen-Goldsen et al., 2013; Jackson et al., 2016; Jimenez et al., 2013; Mora-Rios & Bautista, 2014; Prins et al., 2015; Santiago, Kaltman, & Miranda, 2013; Su et al., 2016). However, few studies examine intersectionality integrated into mental health treatment as a clinical practice behavior.

The social workers' awareness of intersectionality is the key to translate this knowledge into practice. Krumer-Nevo and Komem (2015) and Matsuoka (2015) demonstrated creativity with the integration of psychoeducation on power, privilege, and oppression into group work treatment. Krumer-Nevo and Komem (2015) gathered data from staff narratives that reported positive mental health outcomes with Jewish and Arab female adolescents (twelve to eighteen years old) after participation in group sessions that

covered the topics of privilege and oppression. Matsuoka (2015) did secondary data collected as part of an evaluation of a 6-week group session with eight participants of Japanese-Canadian older adults and demonstrated positive mental health outcomes. In both studies, clients reported increased insight into their personal experience in a social context (Krumer-Nevo & Komem, 2015; Matsuoka, 2015). Most clients reported gaining a sense of empowerment and decrease of anxiety symptoms (Krumer-Nevo & Komem, 2015; Matsuoka, 2015). Scholars agree intersectionality is an essential component of culturally competent practice and additional research is needed to operationalize into clinical practice behaviors (Cho et al., 2013; Chu et al., 2016; M. J. 1 Ratts et al., 2016; Seedall et al., 2014).

Training Cultural Humility and Intersectionality. Assessing power, privilege, and discrimination in clinical practice begins in social work training. Cultivating a power and privilege self-reflective practice is an integral component of Robinson et al. (2016) design of a graduate-level experiential course assignment to stimulate critical discussion of intersectionality. When social worker students draw on personal experiences and examine the intersectionality paradigm, resonance develops and transfers into clinical practice (M. A. Robinson et al., 2016). Cultural humility and intersectionality require deliberate attention when training cultural competence and require integration into all aspects of social work training (Bubar et al., 2016; Garran & Werkmeister Rozas, 2013; M. A. Robinson et al., 2016; Varghese, 2016)

However, more studies demonstrate a gap between training cultural humility and intersectionality and the operationalization into clinical practice (Block et al., 2016;

Bubar et al., 2016; Garran & Werkmeister Rozas, 2013; Jani et al., 2016; Nadan & Ben-Ari, 2013; Pivorienė & Ūselytė, 2013). Studies of graduate social work students demonstrated a deficit in the integration of power, privilege, and oppression into clinical practice behaviors (Bubar et al., 2016; Garran & Werkmeister Rozas, 2013; M. A. Robinson et al., 2016). The students could articulate the knowledge of power imbalances and discrimination; however, this knowledge did not translate into the assessment of client vignettes (Bubar et al., 2016). Students are not the only social workers struggling with the integration of cultural humility and intersectionality into clinical practice.

In a different study, Varghese (2016) analyzed the responses of fifteen university faculty on case vignettes that presented clinical practice issues. Varghese's (2016) qualitative study of social work faculty members demonstrated views on race and racism as primarily an individual ethnic or cultural identity and failed to integrate knowledge of structural oppression in modern society. Varghese (2016) one of a few studies to examine operationalization of privilege and power in social work faculty. Since cultural humility and intersectionality are cultural competence standards; more studies are needed connecting cultural humility and intersectionality to clinical practice behaviors (Seedall et al., 2014). As cultural humility and intersectionality gain momentum in the clinical practice literature, additional studies examining practice behaviors contribute developing tools and resources for clinical social workers behaviors (Cho et al., 2013; Chu et al., 2016; M. J. 1 Ratts et al., 2016; Seedall et al., 2014).

Cultural Humility and Intersectionality: Building an Alliance

Literature contradicts whether culturally competent practice conclusively improves mental health outcomes because many of the studies do not meet the rigorous empirical research standards (Manseau & Case, 2014; Renzaho, Romios, Crock, & Sønderlund, 2013). Chu, Leino, Pflum, and Sue (2016) identified the following as challenges to studying cultural competency: 1) the inconsistencies in the operational definition and the instruments that measure cultural competency, 2) the cultural competency practice guidelines and mandates lack explicit and detailed implementation strategies, and 3) little is known how cultural competence contributes to the therapeutic mechanisms in the change process. However, professional associations' ethical codes uphold culturally competent practice as the best practice approach (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015; Lee, 2011).

However, studies demonstrate that cultural competent practice increased client participation in treatment (Cook et al., 2014; Jimenez et al., 2013; Kohn-Wood & Hooper, 2014). Cultural competent practice fosters a positive social worker-client working alliance (Hook et al., 2013; Tao et al., 2015). Roger (1979) argued that a strong working alliance assists clients in the change process. A positive working alliance is essential in positive treatment outcomes (Hook et al., 2013; Tourse, 2016). Cultural humility and intersectionality, as cultural competency components, can influence the quality of the working alliance that develops (Hook et al., 2013; Tao et al., 2015).

Negative Impact. Since Crenshaw(1989) presented intersectionality as significant in client functioning, numerous studies document the lack of an

intersectionality framework corresponds to adverse mental health outcomes (Bostwick et al., 2014; Cook, Liu, Lessios, Loder, & McGuire, 2015; Cook et al., 2014; Fredriksen-Goldsen et al., 2013; Holley et al., 2016; Jimenez et al., 2013; Manseau & Case, 2014; Prins et al., 2015; Stall et al., 2016; Su et al., 2016). Holley et al.'s (2016) qualitative study reported LGBT clients from minority ethnicities reported mental health treatment programs did not listen too, not viewed as complex, condescending, lack respect, violation of privacy or other rights, and presumed a lack of intelligence. These clients reported their experience contributed to ceasing services or not following treatment recommendations (Holley et al., 2016). The lack of intersectionality awareness negatively impacted the working alliance.

When clients' identities and their life experience minimized, the working alliance is impaired (Bostwick et al., 2014; Cook et al., 2015, 2014; Fredriksen-Goldsen et al., 2013; Holley et al., 2016; Jimenez et al., 2013; Manseau & Case, 2014; Prins et al., 2015; Stall et al., 2016; Su et al., 2016). Emerging research provides guidelines for culturally competent practice with specific populations, such as LGBT clients (Baker & Beagan, 2014; Boroughs et al., 2015; Scherrer, 2013). However, scholars argue the guidelines lack a description of clinical behaviors that promote cultural humility and intersectionality (Chu et al., 2016; M. J. 1 Ratts et al., 2016; Seedall et al., 2014).

Positive Alliances. Emerging studies demonstrate the integration of cultural humility and intersectionality into clinical practice fostered positive social worker-client working alliances (Hook et al., 2013; Eunjung Lee & Horvath, 2014; Tourse, 2016). Positive working-alliances contribute to the clients' change process because the client

experiences the safety held in the therapeutic environment (C. Rogers & Koch, 1959). The client's ability to change or challenging incongruence requires taking a risk, which can only occur in a safe environment (C. Rogers, 1957). Berg (2014) and Tourse (2016) highlighted that the integration of cultural humility and intersectionality in clinical practice prevented revictimizing clients. Cultural humility and intersectionality create safety contribute to building a strong working alliance (Hook et al., 2013; Eunjung Lee & Horvath, 2014; Tourse, 2016).

Building a strong working alliance is fundamental to mental health treatment (C. Rogers, 1957). Since the working alliance is core to positive treatment outcomes, examining cultural humility and intersectionality as practice behaviors contribute to the emerging cultural competency literature (Azzopardi & McNeill, 2016). Emerging cultural competency research attempt to operationalize cultural competency to demonstrate evidence-based practice outcomes (Chu et al., 2016; Huey Jr. et al., 2014). Cultural humility and intersectionality, as NASW (2015) cultural competency standards, require further examination in mental health to document clinical practice behaviors.

The cultural competency literature demonstrates a vast array of research on critiques, clinical practice frameworks, and the influence of cultural competency in treatment outcomes. Cultural humility and intersectionality, two components of NASW's (2105) revised standards, address power, privilege, and oppression in practice. The current literature demonstrates a gap in operationalizing cultural humility and intersectionality into clinical practice (Bubar et al., 2016; Jani et al., 2016). The literature

review supports this study to examine cultural humility and intersectionality in mental health settings in Albuquerque, New Mexico.

Summary

Cultural awareness is a social work clinical practice value held in high esteem as demonstrated by the sophisticated ethical standards published by NASW (2015). The purpose of this capstone project was to examine clinical practice behaviors in mental health settings in Albuquerque, New Mexico. This project was an action research design to examine the two concepts highlighted in the revised NASW (2015) cultural competency standards, cultural humility, and intersectionality. The study reflects the core social work values to pursue cultural competence and promote social justice.

The current literature demonstrates a gap in operationalizing cultural humility and intersectionality into clinical practice (Bubar et al., 2016; Jani et al., 2016). This project contributes to the cultural competency literature by examining cultural humility and intersectionality in clinical practice. The data from this study provided examples of specific clinical behaviors that convey cultural humility and intersectionality in mental health treatment. The data can contribute to the development of a social work cultural competency measure or resource tool to use in practice (Jani et al., 2016). In addition, this study contributes to the development of a training curriculum on cultural humility and intersectionality for student and professional social workers (M. A. Robinson et al., 2016). Finally, NASW (2015) cultural competency standards endorse research on cultural competency issues. Section 2 of this capstone project describes the research design, the methodology, and the data analysis process.

Section 2: Research Design and Data Collection

The social work *Code of Ethics* stipulates cultural awareness as a practice standard in all areas of social work practice (NASW, 2017). Since the social work profession remains current with research findings, NASW (2015) incorporated cultural humility and intersectionality as indicators of cultural awareness practice standards. A social work practice problem occurs when cultural awareness standards are not integrated into social work practice (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015). In New Mexico during 2013, grassroots community organizers revealed that mental health clients experienced culturally insensitive services in a state with a highly diverse population (Generation Justice, 2016). In the action research study, I examined the clinical behaviors that demonstrate cultural humility and intersectionality in mental health treatment.

Section 2 of this capstone project focused on the description of the research design for the study. The study's methodology is discussed, which includes the description of the participants, the recruiting procedures, and the rationale for the questions for the in-depth interviews. In addition, Section 2 presents a description of the data analysis procedure used on the data collected. Finally, this section concludes with an explanation of the implemented ethical procedures to ensure the protection of the study participants.

Research Design

The purpose of this study was to examine the clinical behaviors in mental health treatment that demonstrate cultural humility and intersectionality. Clinical social workers

who provide mental health treatment in New Mexico were interviewed. This study focused on two research questions. The first research question was: 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 intersectionality? The second research question was: How does the integration of cultural humility and intersectionality help the social worker understand the client's worldview and mental health assessment? The study used in-depth interviews to gather detailed, rich data that contributed to a deeper understanding of cultural humility and intersectionality in mental health treatment (Knoblauch, Flick, & Maeder, 2005).

I used individual in-depth interviews to capture detailed, rich data for this study. An action research design was chosen because of the collaborative nature to inspire social action, to demonstrate cultural awareness, and gather descriptive clinical behaviors (see Bradbury & Reason, 2003; Buettgen et al., 2012; Coghlan, 2016). It emphasized collaborating with the community to improve mental health services in New Mexico (Generation Justice, 2015). One of action research's core principle is the collaboration between the researcher and the participants to inspire change (Bradbury & Reason, 2003; Buettgen et al., 2012; Coghlan, 2016). Cultural insensitivity in mental health treatment has been identified as a community issue in New Mexico (Generation Justice, 2015). Since cultural awareness is a social work ethical practice standard, action research is an appropriate approach to engage New Mexico clinical social workers in the research process; and the process can inspire participants to promote social action (Bradbury & Reason, 2003; Buettgen et al., 2012; Coghlan, 2016). Since the focus of the study is

clinical behaviors in mental health treatment, the recruitment is purposeful to obtain participants with first-hand experience providing mental health services (Gentles et al., 2015; Patton, 2002).

Specifically, the action research study used face-to-face in-depth interviews to capture the verbal and nonverbal cues of participants. The interviews were audio recorded and detailed notes were taken during the meeting. A diverse sample was recruited, and participants in the study came from both urban and rural communities in New Mexico. The in-depth interview demonstrates respect of the participants' expertise and is well received by participants that are ethnic minorities (Danso, 2015; Ocloo & Matthews, 2016; Sheridan et al., 2013; Stennis et al., 2015). The literature review demonstrated that the challenge is in translating cultural competency into practice behaviors. The action research study captured reports from clinical social workers in mental health practice, who can provide behavior specific details to cultural humility and intersectionality.

The two key concepts in the study are cultural humility and intersectionality. Cultural humility is the awareness of the power and privilege present in relationships and the self-monitoring to address the power imbalances (Tervalon & Murray-Garcia, 1998). In a professional role, social workers are automatically in a position of power to influence the lives of clients (Danso, 2016; Fisher-Borne et al., 2015). Cultural humility obligates social workers to recognize their positions of power and actively mediate the imbalance while working with clients (Fisher-Borne et al., 2015).

The concept of intersectionality is grounded in feminist theory, which examines gender inequality in power and social structures (Crenshaw, 1989). Intersectionality theory explains multiple cultural identities (e.g.., gender, race, poverty) intensify the client's experience of oppression and discrimination in society (Cho et al., 2013; Crenshaw, 1989; A. Davis & Gentlewarrior, 2015; M. J. Ratts, 2017). Intersectionality argues the design of society oppresses and discriminates marginalized groups and emphasizes working towards equity and social justice for all (Cho et al., 2013). The goal of the action research study was to examine how clinical social workers demonstrate cultural humility and intersectionality, and how their awareness of cultural humility and intersectionality influences their assessment of the client's mental health.

Methodology

Prospective Data

Walden University's IRB approval number for this study is 05-08-18-0504694. In this study, I conducted in-depth interviews. The interviews were semistructured to keep the interviews attentive on the desired topics and adhere to the 60-minutes timeframe (see Britten, 1995, refer to Appendix A). The face-to-face interviews were audio recorded, and I took written notes. The individual in-depth interview method was selected as the data collection method because the interviews provide an opportunity to explore themes in clinical behaviors in mental health practice in the much-needed area of power, privilege, and oppression (M. J. Ratts, 2017; Seedall et al., 2014; Seng et al., 2012). The interviews last up to 60 minutes

Participants in rural communities in New Mexico participated in the study. Interview locations afforded privacy and confidentiality and were agreed upon by the participant and the researcher via email before the scheduled interview. The interviews did not occur in the private residence of participants; rather interviews were held in business offices, community centers, or other public locations that offer privacy and confidentiality. The interviews occurred during the business hours 9 a.m. and 5 p.m.

Video conference (i.e., Skype, Adobe Connect, Face-Time) was an alternative option when face-to-face meetings could not be arranged due to barriers in travel, scheduling conflicts due to distance, and unforeseen challenges to meeting in person (George, Duran, & Norris, 2014). I hired a professional transcriber for the transcription of the interviews. The transcriber signed a confidentiality agreement (Refer to Appendix B).

There are several ways in which the data could be compromised: researcher bias and electronic problems. In terms of researcher bias, I am a mental health social worker in New Mexico. I am aware of my influence on the interviews and my research responsibility to monitor my influence and internal judgments. Hence, I wrote up process recordings after meetings. These process recordings involved my reflections on how I presented the questions and responded to the participants' responses. This process helped me to monitor how my values and worldviews could have affected the interviews and the data gathered. Another possibility of compromised data collection was problems with technology and audio recording equipment. During one interview the recording stopped working but there was a backup recorder so no data was lost.

Participants

Social workers that provide mental health treatment comprised the study's target population. Participants were recruited from the NMBSWE list of approved social work supervisors. Although the list is not all-inclusive of all practicing social workers in New Mexico, the social workers on the list possess the license that permits them to provide mental health services. Recruiting social workers from the NMBSWE list increased the chance of the sampling frame meeting the eligibility criteria, which is the social workers who provide mental health services. The list consists of 248 social workers across New Mexico that possess an independent license (New Mexico Regulation & Licensing Department, 2016). The NMBSWE list is located on the website and is free and accessible to the public. The list includes the names, emails, phone numbers, and physical address location. Social workers were being recruited for 30 days. To access social workers not on the NMBSWE list and increase data saturation (see Kerr, Nixo, & Wild, 2010), I used LinkedIn and Facebook to recruit.

All efforts were made to recruit participants across the state to ensure diversity in the sample as this is an important component in implementing cultural awareness in the research process (Danso, 2016; Stennis et al., 2015). Since participants completed demographic information, data were organized according to the number of years working in mental health (4 years or less, 5-9 years, and 10 years or more) and composed of various mental health settings (e.g., nonprofit, private practice, small to large agencies). The diversity of the participants contributed to the credibility of the data gathered (Shenton, 2004; Whittemore, Chase, & Mandle, 2001).

Recruitment. A recruitment email was emailed to all potential participants on the NMBSWE list (Refer to Appendix C). The email was sent through Mail Chimp, an online software program to ensure confidentiality when sending bulk emails. For participants whose emails that bounced back because their email addresses were no longer valid, they were mailed a standard letter through the United States Postal Services. The recruitment email was resent after 2weeks.

Social media is a resource to access research participants (Ellison, Steinfield, & Lampe, 2007). In addition to emailing, I posted the recruitment flyer (Appendix F) on social media via LinkedIn in my information thread and the following Facebook groups: Social Worker of New Mexico, New Mexico Private Practice Therapists, New Mexico Highlands University Postgraduate Support Group, NASW NM-Chapter, and Wellness From Within PC. A letter of permission from the administrators of these Facebook pages was obtained.

Social workers who expressed an interest in participating received a follow-up email that included: the demographic sheet and consent form. The demographics requested was based on the information gathered by the U.S. Census Bureau (U.S. Census Bureau, 2016). The demographic sheet asked about a day, time, and location preferences for the interview. The social workers were identified as research participants when they returned the completed demographic sheet and signed consent. A third email was sent to confirm the social worker as a research participant, with the day, time, and location for the interview. The third email also reminded participants (as stated in the consent form) that the summary of the study findings would be emailed to them upon

approval of the review committee, and they would receive a gift card of $5 to express appreciation for their participation.

Sampling. The study used purposeful sampling. Purposeful sampling is commonly used when seeking knowledge from specific participants (Gentles et al., 2015). The intention was to examine cultural humility and intersectionality as clinical behaviors in mental health treatment. The target population was social workers who provide mental health services. The recruitment process screened out social worker that were not working in mental health through the demographic information sheet. Purposeful sampling contributes to thematic saturation because the participants possess specific knowledge in the area being studied (Kerr et al., 2010).

The sample size was 17 social workers who met the eligibility criteria and were from different locations across the state. The eligibility criteria for the study were (a) social workers, (b) provide mental health treatment, and (c) from different locations in New Mexico. Sixteen interviews allowed for the exploration of common themes and maintain the integrity of the individual interview (Hagaman & Wutich, 2017; Robinson, 2014). The integrity of the individual interview was important since the recruitment of participants was purposeful to access diversity in the number of years of experience, type of employment agency, and area of the state and provided triangulation for data saturation (Fusch & Ness, 2015). Although a small sample size decreased the generalization and transferability of data collected, it is sufficient for in-depth interviews to maximize the possibility to reach thematic saturation (see Britten, 1995; Dworkin, 2012; Guest, Bunce, & Johnson, 2006; Hagaman & Wutich, 2017). Guest, Bunce, and

Johnson's (2006) study demonstrated that in-depth interviews could reach saturation after the first 12 interviews and meta-themes as early as six interviews. Their study involved systematically assessing the degrees of saturation throughout thematic analysis of 60 in-depth interviews (Guest et al., 2006). Hagaman and Wutich's (2017) analysis of a study with 132 respondents and Hennink, Kaiser, and Marconi's (2017) study of 25 in-depth interviews demonstrated that data saturation occurred by the 16th interview. The key to reaching data saturation was the use of purposeful sampling to gather data from sources with the specific information the study was researching (Fusch & Ness, 2015; Patton, 2002; Robinson, 2014). In qualitative research, thematic saturation is a validity indicator, since this study gathered data from a specific population, thematic saturation was achieved.

Instrumentation

The interview questions developed based on the literature review on cultural humility, intersectionality, and mental health treatment (Azzopardi & McNeill, 2016; Boyle & Springer, 2001; Comas-Díaz, 2014; Fisher-Borne et al., 2015; Kirmayer & Ryder, 2016). The questions were organized to examine the following areas: a) the social workers' concept of cultural humility and intersectionality, b) the social workers' engagement, assessment, intervention, and evaluation, c) the social workers' understanding of the client's worldview and state of incongruence, and d) the social workers' input (Azzopardi & McNeill, 2016; Fisher-Borne et al., 2015; M. A. Robinson et al., 2016). The questions provided open discussion and specific enough to gather

information about cultural humility and intersectionality in mental health treatment and produce thematic saturation (Kerr et al., 2010).

The design of the questions stimulates discussion as described by action research method (McNiff, 2016; Stringer, 2013). In addition, the questions were designed from action research principles to stimulate discussion and foster participant engagement (McNiff, 2016; Stringer, 2013). The capstone committee reviewed the interview questions to ensure they aligned with the research questions and the theory

Data Analysis

The thematic analysis was used for this study. By using thematic analysis, the researcher searches the data and identifies common themes and patterns (Braun & Clarke, 2006). I used cultural humility and intersectionality as the framework to identify semantic themes in the social workers' report of clinical behaviors (Braun & Clarke, 2006). The study used deductive theory, which uses previous knowledge and research on cultural humility and intersectionality to deduce potential relationships (Fereday & Muir-Cochrane, 2006). The thematic analysis focused on essentialist themes the participants report as the clinical behaviors they employ in their mental health practice (Braun & Clarke, 2006).

I took the following steps in the data analysis process. I used NVivo computer software, commonly used for qualitative research (Welsh, 2002) to organize the data. The chronological steps in the thematic analysis were: (a) to become familiar with the data by going line-by-line; (b) to generate initial codes using NVivo software; (c) to search for themes; (d) to review the themes; (e) to define the themes; (f) to produce the

report (Braun & Clarke, 2006). During the data analysis, I used memoing to demonstrate reflexivity in the analysis process (Berger, 2015).

This study used in-depth interviews, a common qualitative research methods in social research studies (Britten, 1995; Hagaman & Wutich, 2017; Patton, 2002; Robinson, 2014). The rigor of a qualitative study begins with the study design and the techniques used to capture and convey the details of the research process (Shenton, 2004; Whittemore et al., 2001). The study demonstrated rigor through credibility, authenticity, criticality, and integrity (Whittemore et al., 2001).

The first step to establish credibility is in the design of the research study (Berger, 2015; Shenton, 2004). The study intended to examine cultural humility and intersectionality in clinical behaviors in mental health treatment. First, to establish credibility, the study needs to use an accepted method to gather data (Shenton, 2004; Whittemore et al., 2001). The study used in-depth interviews, a widely used research method in the social sciences (Britten, 1995; Deakin & Wakefield, 2014; Drabble, Trocki, Salcedo, Walker, & Korcha, 2016). Another method to establish credibility is the alignment between the research participants and the data pursued by the study (Fusch & Ness, 2015; Patton, 2002; Robinson, 2014). The study's target population are social workers that provide mental health treatment. Hence, the interviews gathered data from sources (social workers in mental health treatment) that can report on the desired data (clinical behaviors) on the study's variables (cultural humility and intersectionality).

The data collection process contributed to the credibility of a qualitative study (Shenton, 2004; Whittemore et al., 2001). The data was collected using audio recording,

process recordings, and the handwritten notes. By collecting data from multiple sources, the study creates triangulation and contributes to credibility (Shenton, 2004; Whittemore et al., 2001). Another form of triangulation in the study is gathering data from multiple informants (Kerr et al., 2010). The data came from social workers with differing years of work experience (i.e., four years or less, five to nine years, and ten years or more). In addition, the social workers were recruited from different mental health settings (i.e., non-profit, private practice, small to large agencies). The diversity in the participants demonstrates triangulation and contributes to credible data (Whittemore et al., 2001).

The study maintained rigor by demonstrating authenticity (Whittemore et al., 2001). During the data gathering process, I asked participants to define their own words, comments, and phrases (Shenton, 2004; Whittemore et al., 2001). The process to clarify the participants' meaning demonstrates authenticity efforts. In addition, authenticity was maintained in the data analysis process. The data was organized and coded by maintaining quotes and words used by participants (Whittemore et al., 2001). The research used memoing as another tool to create authenticity in the data analysis process through reflexivity (Berger, 2015; Whittemore et al., 2001).

The study demonstrated criticality through the research design, which demonstrates rigor in qualitative studies (Whittemore et al., 2001). Criticality is demonstrated through the studies strategies to obtain thematic saturation (Kerr et al., 2010; Shenton, 2004; Whittemore et al., 2001). Thematic saturation occurs when the study targets participants with the knowledge to produce data the study seeks (Kerr et al., 2010). The study's target population are social workers with the credentials to provide

mental health services with more than one year of experience. Researchers report saturation is possible with sixteen in-depth interviews (Britten, 1995; Dworkin, 2012; Guest et al., 2006; Hagaman & Wutich, 2017).

Another tool to achieve criticality is reflexivity (Whittemore et al., 2001). Reflexivity is the researcher's self-appraisal during the research process to foster a critical lens (Berger, 2015). During the data collection process, I completed process recordings after each interview to document the behaviors of participants and reflect on my internal dialog. In addition, I used memoing during the data analysis process to demonstrate reflexivity (Whittemore et al., 2001). Finally, I engaged in reflective journaling throughout the research study process to examine biases, notice emotional experiences, and critically assess my data analysis process (see Berger, 2015; Whittemore et al., 2001).

Integrity is another aspect of rigor in qualitative studies (Whittemore et al., 2001). The integrity of a study is demonstrated by repetitive checks and humble presentation of research finding (Whittemore et al., 2001). The data was collected using audio recording, process recordings, and the notes. By collecting data from multiple sources, the study creates checks and balances of data gathered and contributes to integrity (Shenton, 2004; Whittemore et al., 2001). Threats to integrity occur through researcher bias, not paying attention to discrepancies in data, or ignoring alternative explanations to data (Whittemore et al., 2001). I used reflexivity, supervision by the research review committee, and following the NASW *Code of Ethics* to demonstrate the integrity of the study.

In summary, the study used interviews to examine cultural humility and intersectionality in mental health treatment. The study used thematic analysis for data analysis of the interviews with social workers practicing in mental health settings. The methodology, participants, and the researcher's reflective activities demonstrate rigor through credibility, authenticity, criticality, and integrity (Whittemore et al., 2001). The following section describes the strategies in the study to demonstrate ethical research practices.

Ethical Procedures

A study with human participants required that the NASW (2017) ethical research standards were implemented. The study followed the standards to protect human participants by the National Institutes of Health. A core principle to protect participants is informed consent. In this study, all participants received a copy of the consent form before the meeting via email and additional copies of the form were available at the interviews to ensure participants can provide informed consent.

The consent form covered the required information to obtain informed consent from participants. The consent form provides participants with the following information: (a) a description and the purpose of the study, (b) participants expectations, (c) participants' right to stop at any time of the study process, (d) information to minimal risk [i.e., minor discomfort due to participating in a 60-minute interview, fatigue by a large amount of information in a short amount of time, being in this study would not pose a risk to your safety or wellbeing] and provided information how to locate private practitioners to attend to their minimal harm, (e) contact information for any questions

about the study, (f) confidentiality statement and limits, (g) explanation how data gathered will be used, and (h) contact information to submit a grievance or concern.

Additional keys principles of ethical research are informing participants of privacy and confidentiality, how information will be used, and how data will be stored. The location of the interviews occurred in a space that can offer privacy and confidentiality (i.e., business office, community center, library). In addition, a confidentiality statement was included in the consent form including the limitations. At each interview, the participants were reminded how the information gathered was used for a capstone project at Walden University. The reports coming out of this study did not share the identities of the participants. In addition, to protect the participants' information, as obligated by ethical standards did not use the participants' personal information for any purpose outside of this research project. The data is kept secure through password protection, data encryption, and using numbers to identify a participant in the documentation. The data is kept for at least five years, as required by the university and the identities of the participants will not be documented. After five years, all paper records will be shredded, and electronically stored data will be erased.

Summary

This capstone project is an action research study that used a qualitative method, in-depth interviews. Social workers who provide mental health treatment in New Mexico were recruited. The interviews followed a semi-structured guide to ensure the research objectives were met in the sixty-minute meeting. Thematic analysis was used to analyze the data to identify common themes in the discussions. A consent form was designed to

meet the ethical research standards so that participants can give informed consent. In Section 3, the findings of the research study are summarized.

Section 3: Presentation of the Findings

The purpose of this action research was to examine the clinical behaviors in mental health treatment that demonstrate cultural humility and intersectionality. The study supports grassroots efforts in New Mexico to understand the quality of culturally sensitive mental health services in a state with a highly diverse population (Generation Justice, 2016). For this study, I examined data from 17 in-depth interviews with clinical social workers who provide mental health treatment in New Mexico. Roger'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 focused on two 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 intersectionality?
2. How does the integration of cultural humility and intersectionality help the social worker understand the client's worldview and mental health assessment?

In addition, as a component of the action research design, the interviews included questions to elicit input from the research participants regarding challenges to integrating cultural humility and intersectionality into mental health treatment.

In Section 3, the focus is the summarization of the data collection process and the findings from the individual in-depth interviews. The section begins with a description of the recruitment process and the time frame of the data collection, followed by a

description of the step-by-step data analysis process. The analysis section concludes with a discussion of the validation procedures and the limitations of the study. In addition, Section 3 includes a discussion of the findings per research question, including demographics, and visual representation of the findings. Finally, Section 3 concludes with an overall summary and an introduction to Section 4.

Data Analysis Techniques

On May 11, 2018, 376 potential participants on the NMBSWE list of approved social work supervisors received the initial recruitment email (see Appendix C). I used Mail Chimp, an online software program, to send the bulk emails. 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 LinkedIn and Facebook. From May 11, 2018, to June 1, 2018, 15 clinical social workers responded to the recruitment email. On June 1, 2018, using Mail Chimp, I sent a second batch of the recruitment email to the same NMBSWE list. At that time, Mail Chimp's status report, 30 people unsubscribed to the bulk emails. Hence, 346 potential participants received the email, and 52% opened the email. From June 1, 2018, to June 25, 2018, an additional 15 clinical social workers responded to the recruitment email. I did not mail a standard recruitment letter through the United States Postal Services because 30 people had demonstrated interest to participate via email.

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

and signed a 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 day and time, and the location for the interview. I intentionally confirmed 17 participants, 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 used for the study because the maximum number of participants had been reached. The last day of data collection was June 28, 2018, and the final resultant sample size was 17.

Setting

I traveled across the state to conduct interviews with participants in rural communities in New Mexico. Four of the participants were from the Northern Region, three participants from the Eastern Region, two participants from the Southern Region, one from the Western Region, and seven in the Central Region. The participants chose the location of the meeting through email via the demographic form (see Appendix D). The locations offered privacy and confidentiality. Three interviews occurred at my office, three occurred at a coffee shop (sitting at a discreet table), and 11 interviews occurred at the participants' work office. The length of the interviews varied, ranging from 45 minutes to 60 minutes, depending on the amount of description the participants shared. One interview started 20 minutes late because I underestimated the travel time between interview locations. The 17 interviews were face-to-face and were recorded. During the interview, I took notes and used an interview outline (see Appendix A). I also

brought the signed copy of the consent form in case the research participant wanted a copy.

Data Analysis

To organize the data from the 17 interviews, I used thematic analysis, an approach often used in qualitative research (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. For this study, I used deductive theory and the knowledge of cultural humility and intersectionality to deduce potential relationships (Fereday & Muir-Cochrane, 2006). The reexamining and reorganizing of the data were on-going and required revisiting the literature on cultural humility, intersectionality, and person-center theory.

The first step of the data analysis process was to have the interviews transcribed verbatim. A hired independent contractor, who signed a confidentiality agreement (see Appendix B), transcribed the 17 interviews. The transcriber and I exchanged the audio recordings and the transcriptions through an online file storage system that met 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.

The NVivo computer software, commonly used for qualitative research (Welsh, 2002), was used 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 added the 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 confidentiality of the research participants. The demographic data was organized by an Excel spreadsheet to link with the demographic information to the assigned interview number. The chronological steps in the thematic analysis were as follows:

1. Open coding: searching for significant phrases, topical transitions, and line-by-line using emergent codes;
2. Organization of the codes: the emergent codes where categorized into mutually exclusive and non-overlapping categories;
3. Categories further divided into subcategories;
4. Categories and subcategories analyzed for themes (Braun & Clarke, 2006).

During the open coding, I reviewed each interview transcription line by line. Each line was read, reread, 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 recategorize. After the open coding, 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 final step in the data analysis process was to determine meaningful themes. The interview guide (see Appendix A) allowed for specific datasets devoted to the specific research questions as categories. The categories focused on four areas of the clinical social worker's 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 ongoing review of the categories and subcategories with the literature on person-centered theory, the following themes emerged: (a) genuine interest in the client's culture, (b) unconditional positive regard towards clients, (c) therapist congruence, and (d) empathic understanding. Table 1 is an example 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
That 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 is a culture so 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
I believe that I'm encouraging him to be proud of who he is. Be proud of his culture and not be ashamed of it because there's 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.	I believe that I'm encouraging him to be proud of who he is. Be proud of his culture and not be ashamed	Help client to trust self	Empower	Unconditional positive regard towards clients
… intersectionality being something that people are talking about more and the thing that scares me about that being used is more is that there's not only just cultural humility, that there's not structural humility cause for myself like as a white woman, I can't just be like oh like I'm queer, and I'm white, and I grew up working class. And that me being working class is similar to like your experience like 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. I have to have the humility to be able to position myself within that.	as a white woman, I can't just be like oh like I'm queer, and I'm white, and I grew up working class. And that me being working class is similar to like your experience like 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.	Know your own privilege	Self-Awareness	Therapist congruence
I think we recognize well that the only small population within our society doesn't experience oppression are white males within a certain age. When we look at the percentage of the population that hasn't experienced some kind of oppression, it's probably going to be those white males between the ages of maybe 25 and 55 are those productive years they experience. When they can become independent when they don't chronic disease.	When we look at the percentage of the population that hasn't experienced some kind of oppression, it's probably going to be those white males between the ages of maybe 25 and 55 are those productive years that they experience.	Productivity valued by society	Culture is part of the client's narrative.	Empathic understanding

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 sections of the transcription were difficult to comprehend the meaning.

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-center theory was used as the basis of the analysis.

Validation

The data collection process contributed to the credibility of a qualitative study (Shenton, 2004; Whittemore et al., 2001). The validation of data involved reviewing audio recording, triangulation, authenticity, and reflexivity. The validation of data was an on-going process. The validation of the data occurred during the interviews and while the data was prepared for analysis.

The data was collected by audio recording, my process recordings, and my researcher's notes. Since the data was captured through multiple modalities, I was able to compare the raw data for accuracy.

Furthermore, collecting data from multiple sources created triangulation and credibility (see Shenton, 2004; Whittemore et al., 2001). Triangulation occurred due to the diversity within the participants. The participants were recruited from different

mental health settings (e.g., nonprofit, private practice, small to large agencies) and from different regions of the State of New Mexico. The study demonstrated triangulation by having multiple data collection modality and the diversity in the participants.

During the data gathering process, I asked participants to define their own words, comments, and phrases. Clarifying the participants' meaning helped establish 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 noted any clarifications or additional comments from the participant. The field notes were integrated into the interview transcriptions. In addition, the data was coded by maintaining quotes and words used by participants.

In addition, the data demonstrated thematic saturation because the recruited participants had the knowledge to produce data regarding cultural humility and intersectionality in mental health practice. The target population recruited for the study were social workers with the credentials to provide mental health services. 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).

During the data collection process, I completed process recording after each interview to document the behavior of participants and reflect on my internal dialog. In addition, I used memoing during the data analysis process to demonstrate reflexivity (see Shenton, 2004; Whittemore et al., 2001). Finally, I engaged in reflective journaling throughout the research study process to examine biases, notice emotional experiences,

and critically assess my data analysis process (see Berger, 2015; Whittemore et al., 2001).

The validation of the data was an on-going process. The design of the study helped validate the data as I used multiple data collection processes. The purposeful recruitment of research participants contributed to triangulation and thematic saturation. The multiple activities I used to demonstrate reflexivity also contributed to the data validation process.

Limitations or Problems Conducting the Study.

In action research, the researcher is a key component in the research process (Bradbury & Reason, 2003; Buettgen et al., 2012; Coghlan, 2016). Some of the problems I encountered were nervousness, the toll of traveling, 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 face-to-face with the participants who had so much experience. In addition, two of the participants were my previous supervisors when I was a student intern. The connection was not made prior to the interviews as my last name has changed and it had been 22 years since the last encounter with these people. The nervous energy contributed to me not asking the questions the exact same way in every interview, even though there was an interview guide.

In addition, I underestimated the toll of traveling. I scheduled multiple interviews in one day when traveling over 100 miles to prevent multiple trips to the same region. I was fatigued when entering 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 questions because the participants enjoyed talking of their experiences. Also, the participants were nervous and wanted to answer questions correctly and were frequently seeking reassurance from me.

In action research, the participants and I collectively contributed to the data. Some problems I encountered were a result of the intimate structure of face-to-face in-depth interviews. I was nervous or fatigued and this contributed to the facilitation of the interview.

Findings

The study used purposeful sampling to examine clinical behaviors in mental health settings. The study's target population for data were clinical social workers who provided mental health services. I traveled the State of New Mexico to gather interviews from rural communities. Although most of the interviews were from clinical social workers from the central metropolitan area (41.2 %), there was at least one interview from each region in New Mexico.

Demographics

Participants were recruited to reflect the diversity of the population of the State. Table2 illustrates the demographic profiles of the 17 participants of the study. The ages of the participants ranged from 34-81 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%). From the participants that identified as two or more races, two identified as Native American and White, one Native American and Hispanic, and one Hispanic and White. In general, the majority of the participants had a lot of experience in their field. For example, sixteen of the participants had 10+ years of experience in mental health, and one had 5-9 years of experience. Five of the social workers that participated in the study were bilingual (English/Spanish).

Table 2

The Participants' Demographics

Assigned Number	Age	Gender	Race	Languages	Place of work	Years in Mental Health	Region in New Mexico
#1	57	Female	Hispanic	English/ Spanish	Government & Private Practice	10 +	Central
#2	59	Female	Native Amer. & White	English	Government	10 +	Central
#3	71	Male	White	English/ Spanish	Non-profit	10 +	Central
#4	46	Female	Hispanic	English/ Spanish	Government	10 +	Northern
#5	65	Female	Native Amer. & White	English/ Spanish	Private Practice	10 +	Eastern
#6	49	Female	White	English	Government	10 +	Eastern
#7	43	Female	White	English	Government & Private Practice	10 +	Eastern
#8	51	Female	Hispanic	English	Non-profit	10 +	Western
#9	34	Female	Black	English	Private Practice	10 +	Central
#10	46	Female	Hispanic & Native Amer.	English/ Spanish	Non-profit & Private for Profit	10 +	Central
#11	81	Male	White	English	Private Practice	10 +	Northern
#12	58	Female	White	English	Private for Profit	10 +	Northern
#13	41	Female	Two or more	English	Private Practice	5 to 9	Northern
#14	57	Male	Black	English	Non-profit	10 +	Central
#15	35	Female	White	English	Non-profit	10 +	Central
#16	59	Female	White	English	Private Practice	10 +	Southern
#17	39	Female	Hispanic	English	Non-profit	10 +	Southern

Definitions of Cultural Humility and Intersectionality

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 (SW7, SW15, and SW17) were knowledgeable due to their personal interest and their activity in their organizations' cultural awareness efforts. The remaining three participants were exposed to the term cultural humility through an academic setting. Participant SW6 had taught a college course on diversity and cultural awareness. While participant SW3 was introduced to the concepts in a recent training, and participant SW4 was introduced through the student interns she supervised. These six participants reported motivation to participate in the study due to the research topic on cultural humility.

Although eleven of the participants were not familiar with cultural humility, their interest in the study was due to appreciating the culturally sensitive clinical practice. Two participants (SW2 and SW13) 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. As the remaining nine participants described their clinical practice, they were well-versed in the concept of cultural humility. For instance, SW10 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. The SW14 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 other's cultures.

Another dimension of cultural humility is not deeming one culture as superior and the standard (Danso, 2016). SW12 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 of the measuring point of what is right or wrong about a culture 'cause 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, SW16 expressed:

> The term “cultural humility” I don't think I've heard before actually, 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 do is 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, Cain, and Martin (2015) mentioned 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 SW8 who reported:

> I think it's having an understanding of 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 with an open mind expecting to learn from whether seeking out resources or for my client or a liaison or so it's really just not having all of the information. I think it's just being open to learning about a culture.

In addition, SW11 provided an example of the significance of acknowledging you don’t know 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 SW5, she demonstrated her awareness of the power imbalance and ways to address the imbalance in the following explanation:

> …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 and empowers the client. SW1 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're the expert. You're 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 familiar with cultural humility.

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, SW11 described the multi-layered experiences of adolescent clients that effects 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 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.

While participant SW10'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 if 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 that to go to receive services, [increases] the danger of being deported.

Participant SW17 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's huge. They have a different code that they go by whereas you know if I had a 20-year-old, positive for alcohol that's not in the military, we don't have to call anybody. If they're in the military, we have to call. So there's a different code for them.

Participant SW2'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's great, but it's within the context of being incarcerated. They're 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's right there every day, every minute.

In SW3'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's many, many structural reasons. There's economic reasons. There's a lack of affordable housing. There's the idea that people experience

> trauma and sometimes unhealthy coping strategies and those unhealthy ones can lead to homelessness. There's the issue of chronic medical conditions or disease. There's 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've 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

The first research question was: 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 intersectionality? During the interviews, the descriptions on 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 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. C. Rogers (1957) describes genuineness, warmth, and acceptance as a core condition to foster a therapeutic environment for change. Genuine interest was demonstrated by three subcategories: 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 SW2, SW4, and SW13. Fisher-Borne, Cain, and Martin (2014) argued the importance of social workers to challenge 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.

Ask about culture. All 17 participants made at least one statement that demonstrated genuine interest. SW1 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. Participant SW5 shared an example of a session with a youth that 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. Participant SW13 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'm not culturally aware about it … I don't know all of the Native American tribes and all of the different things that they do, you know? So if they

> have some sort of healing that they do, I ask them to bring it in and 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.

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). The study identified 27 statements that reflected how the participants integrated the client's innate language into mental health sessions. Both SW1 and SW5 indicated they got "forms translated" into the client's language to demonstrated awareness of the clients' linguistic needs. SW2 and SW4 stated they allowed the clients to speak, "gang language" to promote freedom of expression. The five bilingual participants disclosed the importance to allow clients to "correct" your Spanish. Participant SW1 stated:

> When I started working at… with primarily monolingual Spanish speaking clients, my Spanish was different growing up than Mexican clients. It 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…" 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 by their language is an act of oppression (Kiehne, 2016). SW4 shared witnessing the oppression of language at her workplace:

> I have a client that is Mexican, and his grandparents speak only Spanish, and he slips, and he speaks a lot of Spanish. So the other day he was coming out of the day room it was around dinner time, and he was like,*"Cuando nos van a dar de cenar"* and… one of the Hispanic staff members, that's what pissed me off is like, "What?" And he was like *"Cuando vamos a cenar?"*. And [staff] 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?

Participant SW4 not only witnessed the act of oppression, but she also intervened and advocated on behalf of the client. According to Tervalon and Murray-Garcia (1998) and Kiehne (2016), it is the actions against the discriminatory and oppressive acts that is 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.

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. Alegria et at. (2016) argued 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 participant's 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 (SW8, SW10, & SW11) reported they recognized the people the clients' identified as their family. For instance:

> One time when I was at… there was 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? (SW10)

When participant SW10 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, Participant SW4 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 have to find the positives because that's the cultural norm for them.

The participant SW4 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 towards 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. SW5 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 Mexico. 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 *Quinceañera*. 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 the clients, and 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 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 subcategories: 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) don't 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
		Don't take it personally	10
		Cultural appropriation	3

Know 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. Participant SW16 described her work with a mother and the participant's ability to acknowledge her biases regarding parenting style:

> [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 cause a lot of times parents don't know what else to do.

Another illustration of assessing personal biases was shared by SW4 when her caseload included a client with a history of a sexual offense. SW4 confronted her personal feelings about sex-offenders, so it did not interfere with her work with the client:

> They're sex offenders. They're 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 by the other inmates but by the staff. You know it's 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's an issue that most of us aren't comfortable with. It was an issue that I wasn't comfortable with working at the prison. I was just lucky enough that I didn't have to address their sex offending issues in any type of therapeutic way.

A different participant (SW2) 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 American. SW 2 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 limitations. Another component of self-awareness is to know your limitations. According to Azzopradi and McNeil (2016), when the social worker knows their limitations, they practice with cultural humility and intersectionality by not making assumptions. Participant SW8 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, SW14 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're 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, social-economic status, 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 other than White or as mixed. During the interviews all of the ten participants mentioned 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 first-hand experience with intersectionality was part of what contributed to understanding their client's worldview (these quotes are shared in question 2).

Participant SW5 shared a poem by a Native America 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, that's another grid for me [when I work with clients].

SW5's growth in her Native American heritage increased her self-awareness and allowed her to bring cultural knowledge into her sessions with clients.

Participant SW7 indicated how her self-awareness contributed to valuing the cultures of her clients.

> I'm an Irish-Italian born in the southern part of New Mexico and raised and educated right here in New Mexico. I speak about that much Spanish [holding a measurement with her finger and thumb]… I had a *tía* 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 SW4 shared an example of how her upbringing influenced her worked in-home-services:

> My grandparents raised me, so I grew up old school. You've gotta have respect. You always try to make the people that you're working with comfortable. Usually, you're 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 don't 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. Participant SW11 described the awareness of power in the client-social worker relationship, "A therapist has to be non-judgmental, yet he's paid to make judgments." The awareness of power is necessary in order to be deliberate with actions that promote equity. Participant SW15 demonstrated her awareness of her privilege in the following:

> I can't just be like oh like I'm queer, and I'm White, and I grew up working class. And that's similar to 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 SW12 expressed her awareness of attire expressing power and its influence in the client-social worker relationship:

> And if I think I'm holier than thou. If I'm on my power and I'm looking all … I mean, I wouldn't wear this [sweat pants] when I saw a client, but I certainly would wear a decent tee-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, SW13 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." SW13 explained she sees the difference in the way she is treated compared to her daughter who is darker skin. She explained that people make comments, "How nice, you adopted," implying SW13 did a noble act. SW13 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 and demonstrated cultural humility and intersectionality. Participant SW15 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're 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 'cause I grew up in a White, rural Christian town...

Self-reflection is an on-going process and does not stop with completing school, continuing education, nor a job promotion. Participant SW10 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 to dismantle 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 not to enact power over a client due to a personal emotional reaction. Participant SW1 demonstrates 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 hasn't been made. I think we do a disservice when we allow our pride or our professional expertise dictate to our clients. We connect with people and therapy has to be about a connection. If not, it's not therapy. When you have clients that you're just not connecting, and I think that 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). Participant SW13 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've learned through my life that some people, some personalities just don't mix. I think it makes them feel like it's okay like I've had clients say, "You know, I just don't think we're going to be a good match." And I'm like, "Cool. What are you looking for so maybe I can help you find somebody who might be?" For me, it doesn't bother me.

Participant SW10 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're the ones living in that experience. Even though we're like we're going to send you to the shelter because we needed to have a [discharge] plan. And they're like, "No, I'm not going to go to the shelter. I'm going to go to this bridge over here because I'm safer there 'cause in the shelter, I get targeted." And it's 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's 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 referred to cultural appropriation with three different statements throughout the interview and how it demonstrates the lack of self-reflection. Cultural appropriation occurs when a person uses another's culture's

symbols, artifacts, genres, rituals, or technologies, without an empathetic understanding of the sacredness (R. A. Rogers, 2006). When social workers use cultural appropriation, it does not demonstrate cultural humility and intersectionality. SW13 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 lite 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 recognizing 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.

Theme 3: 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 categories: (a) empowering clients, (b) building relationship, (c) non-judgmental attitudes

and (d) trauma-informed practice. Table 5 displays the subcategories connected to each of these categories that make up the theme unconditional positive regard.

Table 5

Summary of Data for Unconditional Positive Regard

Theme	Category	Subcategories	Number of coded statements
Unconditional Positive Regard	Empower clients by	Asking permission	4
		Ask what pronoun	2
		Refer to client as an expert	17
		Accept the client's choice	9
		Magnify strengths	10
		Not give solution	11
		Pronounce their name	1
		Provide information	25
		Work as partners	6
	Build relationship by	Accepting the glass of water	6
		Acknowledging the differences	5
		Advocate on behalf	14
		Being genuine	5
		Being present	8
		Believing in them	8
		Build trust	9
		Introducing yourself	9
		Motivational Interviewing	4
		Diversity in office decor	2
		See them as human	3
		Self-disclosure	5
		Thank them	3
	Nonjudgmental attitude	Acknowledge the importance of culture	3
		Diversity within cultures	17
		Follow their cultural norms	6
		Harm reduction	6
		Meet the client where they are	8

	Nonjudgmental 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 are capable of. Participant SW1 described her role is to empower clients:

> Whether it's court ordered or whether 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 don't 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's our job to remind them. I think that's 90% of humility is that you're not the expert. They are. They

> know what they need. What you identify as a problem may be the one thing that's working perfectly for them.

Participant SW9 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.'" Participant SW13 expanded that empowering does not involve fixing the client:

> I'm not fixing you. I don't have a magic wand. I'm magical, but not that magical. It's often something I say to my teenagers. …I can't fix you. I can help you grow and change and learn ways to adapt and have better coping skills.

Participant SW10 introduced empowering clients through unconditional acceptance of their choices:

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

Although SW10 provided her client with information to shelters and housing resources, SW10 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 (SW5, SW8, & SW15) or to ask how to "pronounce their name correctly" (SW4). SW13 and SW 17 pointed out it is empowering the client to "ask what pronoun" they identified. The action of asking the client communicates 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), which fosters relationship. SW12 elaborated on how to build a relationship:

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

Participant SW12 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 don't 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, participant SW13 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'm 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 that both parties have something of value to contribute. In the following example, participant SW4 identified the reciprocity process and how it dismantles power in the client-social worker:

> You don't say no. That is extremely disrespectful. To anything that they offer you and it's usually food. So you know that was one of the things that we [student and SW] 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 and 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 that see participants as capable, experts, and valuable are building a working alliance.

Nonjudgmental attitude. An aspect of unconditional positive regard is a nonjudgmental attitude toward the clients’ ideas, concerns, and solutions (Roger, 1957). A nonjudgmental attitude is vital to cultural humility and intersectionality. Participant SW11 presented an example of cultivating a nonjudgmental 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?”

SW11 further explained that the judgments come from not knowing the client as a person and simply focusing on their deficits. The following explanation by participant SW3 expands on this idea. SW3 explained 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 that they made 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's 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 at. 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 open to understanding the client's current state of incongruences. Unconditional compassion is demonstrated by participant SW10 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's like 60 years old. There's no way she's pregnant, but I just met her where she was at. Try to help her breath and talked about her feelings. Not say that's not true. The nurse had already checked. Just to honor what she was feeling at the time.

No positive outcome happens when a social worker argues with a client about what they believe is true. In Participant SW6 statement she 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 at mentally is one realm of acceptance. In the following example, participant SW5 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, that's how I'm going to get them. Right? Look, here's a website! It's real… They tell me all the time, so I give them in their language, I show them on the tablet.

In the following explanation, participant SW13 shared her thoughts on meeting the client where they are at as she described cultural humility:

> I think that if people would just open their eyes and accepted people for who they are like, you know, meet the client where they're at. Accept them for who they are. Ask them questions and be actually interested in their responses. It's 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 non-judgmental attitude. Cultural humility and intersectionality require this understanding. As participant SW2 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.

The following statement demonstrated diversity within cultures as participant SW3 discussed intersectionality:

> I think if you look at the old concept that I remember 'cause 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 SW4 introduced diversity by generations:

> I think that first of all you need to assess the age of the client that we will be meeting with to kind of see. You know, nowadays that it's 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 wouldn't 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," (SW2 & SW4) and follow the client's "cultural norms" (SW4, SW5, SW6. & SW10). Another five participants made statements to use "non-judgmental language" (SW2, SW8, SW9, SW16, & SW17). While SW5 and SW13 pointed out, a

nonjudgmental attitude included to "not ask about immigration status." Finally, a social worker demonstrates a nonjudgmental attitude when they understand the source of the client's behaviors, i.e., trauma (SW3 & SW11).

As a social worker, even with a non-judgmental attitude, the power over the lives of clients cannot be ignored. Participant SW11 emphasized the power inequality in the client-social worker relationship:

> A therapist has to be non-judgmental, yet he's paid to make judgments. He's paid to give a diagnosis. He's paid to come up with a treatment plan. He's paid to make decisions about whether the children should stay with their parents or not.

By having this awareness of power, it can help the social worker to monitor their judgments. Practicing with a non-judgmental 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. Participant SW13 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 is 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 don't work with the littles.

When describing the assessment process at his organization, participant SW3 described the trauma-informed approach:

> We have 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…

Participant SW15 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.

While participant SW12 described her assessment process, she integrates a trauma-informed approach and awareness of intersectionality:

> If I've 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 didn't 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've discounted that person...

Participant SW2 contributed to the discussion on trauma-informed approach by disclosing her personal experience about trauma by saying:

> 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's real. It's there. It's 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 Question One.

The research question focused on identifying specific clinical behaviors to demonstrate cultural humility and intersectionality during the engagement, assessment, intervention, and evaluation process 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 support the three themes that emerged from the responses to questions one.

Research Question 2

The second research question was: How does the integration of cultural humility and intersectionality assist the social worker to understand the client's worldview and mental health assessment? 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 the client's experience.	22
	Personal experience with discrimination and oppression.	45

Theme: 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). The 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 multilayered and complex, c) trauma influences the client's experience, and d) the social workers' personal 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 tells 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. Participant SW10 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 of those things. Then just the whole way that the prison industrial complex works you know. [I]t's privatized, and there's a lot of money in this. And there's not enough money in education. There's room for and growing 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, participant SW2 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 a badass; I can't get punked; I can't let myself feel, right? When you finally get rid of those. Help this man take down those barriers; they start feeling. It's gonna hurt. It hurts them. That is the moral injury when you realize what you've 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.

Participant SW14 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 do 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 that narrative is influenced by the environment. Cultural humility and intersectionality emphasized that power dynamic present in society negatively impact marginalized populations. The understanding of these influences creates empathic listening.

Multilayered complexity. Multi-layered complexity is the concept that Crenshaw (1989) argued 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, participant SW11 reported:

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

Participant SW1 further identified the additional layers of trauma and disability, which adds to the multi-layered complexity:

> I saw a little girl yesterday that I've seen on and off for years… she's 17-years-old. She's developmentally delayed but has had horrific child abuse. Horrific and so you're also dealing with somebody that has historical trauma… Unresolved grief and loss issues. Has abandonment issues and in addition to that, now you have a person that has limited cognitive abilities that brings all that into awareness. Where do I even begin? That's not for me to decide. That's 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 participant SW6:

> You're a Hispanic male who's gay, who's got a criminal record whose 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're going to violate you every opportunity they have to put you back in jail... We'll look at what are the things that are going against you and that make you up as the person.

The multi-layered complexity begins in childhood; SW12 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 have long been recognized as multilayered complexity and influences functioning in adult life (Felitti et al., 1998). The individual cannot be assessed outside of the context of their environmental experiences. Empathic understanding is the awareness of the client's multilayered 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 (SAMHSA, 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. Participant SW15 described how she used trauma-informed cared:

> "[W]hen 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). Participant SW12 described the behaviors of a traumatized client in her practice:

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

Participant SW3 described the variety of trauma a client can experience:

> We have a high percentage of our population 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). Participant SW5 shared how she explained the effect of trauma on a client who was a military veteran:

> …and she struggled with anger. She's been through the VA, and she's 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?" And 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'm like, "That's kind of what trauma's like. It's like our brain gets that imprint."

An aspect of trauma-informed practice, it the ability to listen to the client's trauma without judgment (Harris & Fallot, 2001), participant SW7 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 New Mexico, SW8 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 as part of their culture. Being colonized and so it's hard not to have it interwoven. It's hard not to look at it. It's 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 multilayered complexity demonstrates empathic understanding and congruent 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 twelve (70.6%) participants that disclosed first-hand 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 by the participants coincides with the ability to connect with the clients emotionally. SW10 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, participant SW2 reported a personal experience to connect with her clients:

> I mean I'm half [Native American] …. [my] mother Episcopalian, [my] father, going 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 time frame, I grew up in a time where you really had to choose.

The first-hand experience with oppression and discrimination is difficult; however, witnessing these acts towards people you care about is heartbreaking. Participant SW12 shared her experience:

> My husband would say it all the time that he felt when he would go to a counter, and 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… 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 is 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. Microaggressions really do exist.

Participant 13 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….

Participant SW6 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] first-hand 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 first-hand 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 to Research Question Two.

Research question two 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 the framework of privilege, discrimination, and oppression was used to assess the client's mental health. In addition, a majority of participants reported a first-hand 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 support the theme and categories that emerged from the responses to question two.

Challenges.

The last question in the interview was: What challenges have you encountered when integrating cultural humility and intersectionality in mental health settings? Although this was not a research question, participants were passionate in their discussion, and as a result, the challenges are presented here. The participants' statements can be organized into six themes: a) agency structure, b) insurance companies, c) continuing education, d) government bureaucracy, e) research not culturally diverse, and f) political climate (see Table 7). Regardless of the participant's knowledge and commitment to promoting equity in the client-social worker relationship, they encountered barriers that were out of their control.

Table 7

List of Challenges Participants Encountered

Themes	Number of coded statements
Agency structure	28
Insurance companies	11
Cultural continuing education	11
Government bureaucracy	9
Research not culturally diverse	4
Political climate	3

Agency structure. Agency structure refers to the way the agency functions, which includes the mission statement, billing practices, policies and procedures, and employee relations. Thirteen (76.5%) participants identified agency structure itself as a challenge to integrating cultural humility and intersectionality into practice. Although there were 28 statements regarding agency structure, the statements varied from documentation (SW5) to agency operations (SW17). Participant SW11 explained that the agency could begin to treat staff with the values of cultural humility and provide support for the social worker's wellbeing:

> It could start with the agencies treating their staff with cultural awareness and cultural humility. And… realize that when the staff sees these terrible things [with clients] when they're happening, they get PTSD just watching it… I've seen things that I wish I hadn't ever had to see.

SW13 connects that when leadership lacks direct service experience they are disconnected to the staff and the clients, and the disconnection contributes undervaluing culture:

> [You] have to work in the trenches before you can go to the top because otherwise, you don't know what it's like to be me… I find a lot of the time, people have never done it. And I'm just like you're a CEO of this organization. You have no idea what's important [to the client].

SW 14 also mirrored the importance of leadership by saying, "It's organic. It grows up from within the organization when we set out to do good work, so companies meet mission statements and vision statements." Meanwhile, participant SW7 clarified, "[We]

need to have the backing from the administration or the agencies to be able to make the integration of culture a priority." The leadership in an organization models the quality of interpersonal interactions and influences the incorporation of culture into services:

Another barrier to integrating cultural humility and intersectionality into mental health practice is working within multidisciplinary teams. Although many benefits come from these types of teams due to the varying perspectives and expertise, it also comes with challenges. Participant SW10 indicated the complexity due to varying professional perspectives:

> …look at therapists versus police... They're in a different paradigm and so they're about the bad guy and this is what's legal, illegal and very black and white [thinking]. Whereas social workers, we see the whole systems and integrate all that knowledge.

SW3 and SW4 echoed the same challenges when working in multidisciplinary teams. While SW1 introduced the idea "training on cultural diversity across disciplines" is necessary within agencies for assessment consistency regarding culture.

Finally, mental health agencies are a business and face normal business challenges. Participant SW 15 commented on the challenge of a mental health agency running as a business:

> It's run as a business, and I think that there are issues that come with healthcare being run as a business… [T]he bottom line is always the dollar. It's something that starts to happen like fiscally driven decision making rather than best practice or clinical decision making.

SW 9 stated her move into private practice was influenced by the pressure of "productivity" from agencies, which referred to quantity (see more clients) over the quality of services. SW5 reported over the years, she witnessed mental health services shifting from "human values to corporate values." Again, the real-life logistics of running a business can impede a culturally sensitive practice.

Insurance companies. Insurance companies are the primary financial institutions that pay for mental health services. Since they pay for services, they dictate how many sessions they are willing to pay. SW17 explained her experience with the insurance company, "You have somebody who needs treatment, but right now they're not actively suicidal or homicidal, [the conversation with the insurance representative] 'I'm sorry if they're homeless, but they have to go cause they're not meeting [medical] criteria.'" SW1 provided another example of how insurance companies dictate treatment by setting timeframes, "Six sessions are all we're allowing, for example. I'd like to be able to say that I'm going to wave a magic wand and this client is going to live happily ever after in six sessions."

In addition, insurance companies can stop payments when their treatment recommendations are not followed. Insurance reviews follow checklists and can deny payment when specific clinical terminology is not present in medical records. Six participants referred to insurance companies as a barrier. Participant SW3 has been in the field over 20 years and witnessed the evolution of the world of mental health treatment:

> The world that we work in is very different than it was 10 years ago or 20 years ago so there's insurance companies that are making decisions for us, there's

> funders that are making decisions for us, there's audit requirements, standards for documentation and productivity expectations… All of that interferes or competes for that idea of being culturally humble.

SW5 worked for an insurance company and completed comprehensive assessments that were entered into a database. She challenged the company for having clients sign consent forms that were not in the client's primary language. SW5 expressed her concern regarding insurance companies retaining such detailed records on clients on Medicaid:

> Why do you need this much information and this comprehensive needs assessment for the State of New Mexico? The only thing I can see is the insurance companies want it as a form of social control. And they want to gather an intensive database, not to provide care to people, not to make sure they get wrap around diabetic and behavioral health. No, you want to have reasons to drop them off the plan.

Participant SW10 emphasized, "Some things aren't paid for. If somebody needs traditional healing or even like massage or acupuncture insurance might not pay for it and those holistic healings can really help especially with trauma." Although empirical research supports alternative treatments as effective for mental health (SAMHSA, 2015), these options are not paid by insurance companies and require out-of-pocket payment. Out-of-pocket payment is not an option for the majority of clients seen by the social workers.

Continuing education training. Continuing education in cultural awareness is required in the state of New Mexico. Nine participants made 11 statements that

expressed concerns about the continuing education training they have attended. The concerns included the trainings only focus on giving information on cultures or the training presented research findings with no practical tools. Participant SW 10 reported, "I'm actually learning more about intersectionality from my niece, and she's getting her master's in education." SW11 reported on his continuing education experience as "they wanted us to learn about cultures. And when you learn [only] about cultures, you become ignorant about that person in that culture." SW11 identified the need to understand the diversity within cultures. The other 7 participants expressed similar statements.

Government bureaucracy. Government bureaucracy refers to the legislative process that creates or denies policies that channel funds to programs. Six (35.3%) participants made nine statements that identified the government as a challenge to cultural humility and intersectionality in mental health practice. Participant SW10 gave an example of the "privatization of the prison system" and how the industry is focused on "making money." According to the Bureau of Justice Statistics (2014), of males incarcerated in the U.S., 37% are Black; 22% areHispanic, and 32% White males. The over-representation of minorities in the incarceration system represents structural oppression, which contributes to intersectionality, which then plays a role in marginalizing at-risk groups (Cho et al., 2013). SW13 highlighted that there is a "lack of cultural awareness in the bigger community," and this statement was reinforced by four other participants. Government bureaucracy is a system that the participants have to navigate on a daily basis; however, it is out of their direct control.

Research not being culturally diverse. Although cultural awareness is recognized by the helping professions (i.e., medical doctors, nurses, social workers), empirical research reflects a lack of diversity in study samples and represent "tokenistic efforts" (Shippee et al., 2015, p. 1152). Shippee at al. (2015) explained tokenistic as the researcher's minimal efforts to include minorities in studies. Two participants made four statements that research as a barrier to cultural humility and intersectionality in mental health practice. Participant SW14 provided an example at his work when a standardized program was implemented, "This whole program was built on research done in a Midwestern… a sample that was White, professionals, college students. How do you translate those findings to Native American, Southwestern Latino, Hispanic cultures and not miss something in the translation?" SW3 made a similar statement:

> What works for the Latino clients in Southern California where they did this research study, does that data provide any reliability and validity… for an intervention for your Latino client that grew up in Northern New Mexico and had a very different experience?

Political climate. The President, the people in Congress, and the judges in the Supreme Court generate a mood that is felt across the nation. When politicians target immigration policies, Medicaid or Medicare, they negatively influence the interactions among people. Three participants made three statements that referred to the political climate as a barrier to cultural humility and intersectionality in practice. They stated that the United States current leadership is promoting discrimination and oppression. When

social workers advocate for culturally appropriate services, they encounter minimization of such services by administrative leadership. (SW5, SW11, & SW12).

The discussion on the challenges was extensive, which included agency structure, insurance companies, continuing education, government bureaucracy, lack of research that is culturally diverse, and the current political climate. They were passionate about integrating practices that promoted cultural awareness into their setting, but they encountered barriers out of their control.

Unexpected Findings.

Two unexpected findings emerged in this study, which requires further research. First, only six participants (35.3%) were familiar with the terminology of cultural humility. Even though cultural humility has been discussed in social work literature for the past four years when NASW (2015) adopted cultural humility as a practice standard indicator. Nevertheless, as the participants described their clinical practice with culturally diverse clients, they described behaviors that constitute cultural humility. In addition, participants identified the continuing education on culture and diversity the have attended was missing practical tools and only disseminating facts about different cultures. There is a possibility there is a gap between the current research and continuing education trainings on cultural awareness in practice. This unexpected finding encourages further research in the area of the content of continuing education training on cultural awareness.

The second unexpected finding was the high frequency "trauma" or "trauma-informed" presented in the data. There was a total of 44 statements categorized as trauma-informed. Both research questions presented findings with a category related to

trauma-informed care. In addition, nine (52.9%) participants identified as trauma therapists. One of the key principles of trauma-informed care is understanding the role of cultural, historical, and gender issues in mental health treatment (SAMHSA, 2014). Perhaps the trauma-informed training is presenting social workers sufficient guidance to practice with cultural humility. There is an opportunity for further research the connection between cultural humility and trauma-informed care principles.

Summary

In Section 3, the data collection process was described, and the specific steps outlined. I recruited participants via email and completed 17 in-depth interviews over a six-week timeframe. I used purposeful sampling to interview clinical social workers in mental health settings. I traveled across the State of New Mexico to create diversity in the sample. The thematic data analysis process including coding, re-coding, and identifying themes. The analysis section discussed the validation procedures and the limitations of the study.

The findings from the individual in-depth interviews were supported by the literature on cultural humility, intersectionality, and person-centered theory. Research question one produced the following themes: genuine interest in the client's culture, therapist congruence, and unconditional positive regard. Research question two identified one theme, empathic understanding. The themes summarized the categories of specific clinical behaviors that addressed the power, privilege, and oppression in the lives of clients. These findings will be discussed in Section 4, regarding the application to professional practice and the implication for social change.

Section 4: Application to Professional 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 action research study, 17 clinical social workers in New Mexico participated in in-depth interviews to describe their clinical practice in mental health. The study complements grassroots efforts in New Mexico to understand the quality of mental health treatment in a state with high cultural diversity (see Generation Justice, 2016). The interviews were analyzed using thematic analysis to identify common themes.

The following were the themes 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 second research question identified the following theme: empathic understanding as the method to understand the client's worldview. Towards the end of the interview, there was a discussion on the challenges of integrating cultural humility and intersectionality in mental health practice. The six themes were (a) agency structure, (b) insurance companies, (c) continuing education, (d) government bureaucracy, (e) research not culturally diverse, and (f) the political climate. This section provides a discussion of the findings, the application in social work practice, recommendations for social work practice, and the implications for social change.

Discussion of the 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 person-centered theory, cultural humility framework, and trauma-informed care, the findings from this study are consistent with the existing knowledge base (see Table 8). The following section discusses how these frameworks support the findings.

Table 8

Comparing Themes with Existing Concepts in Literature

	Findings	Person-Centered Theory (C. Rogers, 1957)	Cultural Humility (Tervalon & Murray-Garcia, 1998)	Intersectionality (Crenshaw, 1989)	Trauma-Informed Care (Harris & Fallot, 2001)
Research Question 1	1. Ask the client about their culture. Allow the client's language in the session. Allow the client's family during the session.	1. The therapist communicates genuineness, warmth, and acceptance.	1. Patient-focused interviewing and care.		1. Collaboration and mutuality
	2. Self-awareness Self-reflection	2. The therapist is congruent.	2. Self-reflections and lifelong learning		2. Trustworthiness and transparency
	3. Empower, Build a relationship, Nonjudgmental attitude, Trauma-informed care	3. The therapist demonstrates unconditional positive regard.	3. Readdressing the power imbalances.		3. Empowerment, voice, and choice
Research Question 2	4. Understanding culture is part of the client's narrative, The client's experience is multi-layered and complexity, Trauma influences the client's experience, The social workers' personal experiences with discrimination and oppression	4. The therapist displays empathic understanding.	4. Institutional consistency	4. Systems of privilege, oppression, and discrimination in society.	4. Cultural, historical, and gender issues

Genuine Interest in the Client's Culture

Participants demonstrated a genuine interest in the client's culture. Demonstrating genuine interest in clients' culture is a key component in cultural awareness in social work practice. Previous studies, such as Yasui's (2015) study, 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 culturally tailoring of the treatment plan. Cook's et al. (2013) study 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 creating safety for effective mental health treatment. Levenson (2017) described that the social worker's role in trauma-informed care was to create collaboration with a trustworthy and genuine relationship. The participants repeatedly reported asking the client about their culture. In line with Hallett's (2015) case study, her treatment of a client with dissociative identity disorder demonstrated improvement by 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 person-centered theory. Moreover, demonstrating a genuine interest in a client's culture is consistent with the NASW's (2017) ethical value to practicing with

cultural awareness. The client's culture is an importance aspect of their life and requires social workers curiosity and willingness to learn and build a positive working alliance.

Therapist Congruence.

The participants identified self-reflection and self-awareness as necessary to effectively integrate culture 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; M.-Y. Lee & Greene, 1999). In cultural humility, as part of self-awareness, the social worker explores personal 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 lacked 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 as 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, Kondrat, Johnco, & Olson, 2015). The social work profession recognizes self-awareness as imperative in social work practice and is a cultural competency standard (NASW, 2015). Therapist congruence is achieved when critical self-reflection is part of clinical social work practice, and encourages culturally sensitive approach in mental health treatment.

Unconditional Positive Regard.

Participants identified descriptive clinical behaviors such as empowerment to demonstrate unconditional positive regard, a component of person-centered theory (C. Rogers, 1957). In Davis, Ancis, and Ashby's (2015) qualitative study with African American women in substance abuse treatment, the researchers 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 was accepting clients' choices. This clinical behavior is consistent with 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 therapist was 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 client's choices were respected by the clinicians. The NASW's ethical principle to respect the dignity and worth of the clients upholds the unconditional positive regard theme.

Empathic Understanding.

When answering the second research question, the participants' responses demonstrated empathic understanding. The participants' personal experience 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,

Leibert, and Agagskar, 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 as race/ethnicity mental health providers increased, there was an increase of race/ethnicity clients in treatment. The importance of cultural connection assists in engaging minority 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.

Challenges.

Participants reported challenges to integrating cultural awareness into clinical practice. Mental health agencies are not meeting the needs of the growing multicultural and diverse populations in the United States. Numerous researchers reported high disparities in mental health services use among minorities, LGBT, and people in poverty due to the lack of culturally appropriate services (Cook et al., 2015; Fredriksen-Goldsen et al., 2013; Holley et al., 2016; Jimenez et al., 2013; Manseau & Case, 2014; Su et al., 2016). For instance, in Holley's et al. (2016) study, the researchers reported culturally insensitive practices by providers and agencies contributed to marginalized clients not returning for services, and clients were discouraged from seeking services elsewhere. Bekemeier et al. (2012) identified leadership in organizations as key to cultivating an

atmosphere that either welcomes diversity or not. The disparities in mental health treatment requires review of agency processes to increase culturally sensitive practices.

Role of the Findings 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 the 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 Practice concurs with the integration of trauma-informed care in social work education as evidenced by the 2018 release of the *Specialized Practice Curricular Guide for Trauma-Informed Social Work Practice* (Council on Social Work Education, 2018). Although this study did not focus on trauma-informed care, this qualitative study contributes to the broader body of knowledge by documenting that clinical social workers are using trauma-informed care.

Finally, my findings helped confirm that there are challenges outside of the social worker's control of integrating culture into mental health treatment. Other researchers (Bekemeier et al., 2012; Cook et al., 2015) argued to decrease mental health disparities among minorities these challenges need to be addressed. Specifically, this study

contributes to the literature on culturally appropriate practice in mental health settings in New Mexico.

Application for Professional Ethics in Social Work Practice

The NASW *Code of Ethics* guides the social work profession with practice standards that span across all levels of social work. In January 2018, NASW released the revisions of the *Code of Ethics* and incorporated the current literature on appropriate practice with diverse populations. One of the revisions was 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 on-going learning process (Azzopardi & McNeill, 2016).

The current study findings are related to four ethical principles that promote culturally appropriate social work practice. First, the study identified the clinical social worker's genuine interest in the client's culture as necessary to work with clients in mental health. This finding is supported by NASW's (2017) Standard 1.05. Second, this study 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, 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 study highlighted the importance of empathic understanding and connecting with clients on an emotional level to engage

clients 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 identified challenges to the integration of cultural awareness into mental health settings. The findings contribute to the grassroots campaign to improve mental health services in New Mexico. The current study aligns with the NASW's cultural awareness standard and provides a foundation to make an impact in New Mexico.

Recommendation for Social Work Practice

Cultural awareness is critical in mental health settings as 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 Chi, 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 is to create a 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, it is not often understood by providers. Such trainings might include topics on critical self-reflection 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. In addition, I am certified as a continuing education provider in the State of New Mexico. Hence the trainings can count as continuing education credits for

social workers in New Mexico. The training course can also be accessed through my mental health business website as a free course for all healthcare professionals.

Secondly, at a policy level, the findings highlighted the challenges of integrating cultural awareness into organizations. An action step is to share the findings with the New Mexico Board of Social Work Examiners. Since the Board is committed to cultural awareness, perhaps a committee can be created to discuss options to support social workers at their place of employment. According to Bekemeier's et al. (2012), leadership is the key to integrating cultural awareness into policy and agency structure. The committee can explore ways to educate leadership in organizations on cultural humility and integration of intersectionality awareness.

Lastly, the study builds on the work of Jani et al. (2016), which attempt 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.

Trustworthiness, Credibility, and Transferability

Trustworthiness refers to validity and reliability in qualitative research (Barusch, Gringeri, & George, 2011; Darawsheh, 2014; Leung, 2015). According to Whittemore et al. (2001), a qualitative study demonstrates trustworthiness through credibility,

authenticity, criticality, and integrity. Credibility is established by the appropriateness of the research design to gather data to answer the research questions (Leung, 2015). In addition, authenticity is maintaining the accuracy of the data collected from the original source (Whittemore et al., 2001). While, criticality is established when the data reaches thematic saturation (Kerr et al., 2010; Shenton, 2004; Whittemore et al., 2001). Finally, integrity is evidenced by strategies that show critical reflection throughout the research process (Campbell, Quincy, Osserman, & Pedersen, 2013).

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 that 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 is established through the accurateness of the data collection process (Shenton, 2004; Whittemore et al., 2001). For this study, I collected data by audio recording the interviews, completing personal process recordings, and writing notes during the interviews, which are all deemed as valid qualitative methods for accuracy (see Whittemore et al., 2001). Finally, collecting data from multiple sources (Shenton, 2004; Whittemore et al., 2001) and variety in the participants (Kerr et al., 2010) creates

triangulation and establishes credibility. This study was designed to create triangulation by gathering data from multiple sources. In addition, the participants were recruited from different mental health settings and different areas for diversity in the participants' demographics. This study demonstrated credibility by accurateness of the data collection process and through triangulation.

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 (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 to ensure 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. Authenticity was established in this study because I documented quotes as stated and used memoing for accuracy in the analysis process.

This study demonstrated criticality by purposeful sampling to ensure achieving thematic saturation (Kerr et al., 2010). I interviewed clinical social workers in mental health services with more than one year of experience. Furthermore, to establish thematic saturation, at least 16 in-depth interviews are necessary (Britten, 1995; Dworkin, 2012; Fusch & Ness, 2015; Guest et al., 2006; Hagaman & Wutich, 2017). For this study, I completed 17 interviews that goes beyond the recommended number of interviews. Another tool to achieve criticality is reflexivity, a self-appraisal to ensure a

critical lens (Berger, 2015; Whittemore et al., 2001). During the data collection process, I completed process recordings after each interview to document the behaviors of participants and reflect on my internal dialog. In addition, I used memoing during the data analysis process and engaged in reflective journaling throughout the process to examine biases and notice emotional experiences. This study achieved criticality through thematic saturation and reflexivity.

The current study displayed integrity. Integrity is represented by repetitive checks and humble presentation of research findings (Whittemore et al., 2001). I incorporated multiple checks for data collection by audio recordings, personal process recordings, and the personal notetaking, appropriate check and balance strategies 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 the integrity of the study.

Transferability

In qualitative research, transferability is the extent to which the findings or methods can transfer in 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. As previously described, the data collection and analysis process demonstrate high credibility. The discussion of the findings section indicates the findings of the study are supported by the core conditions of person-center theory, the key factors in cultural

humility framework, and trauma-informed care principles. The findings, hence, demonstrate high transferability.

Usefulness, Limitations, and Dissemination

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 that 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.

In the mezzo level, this study contributes to the trauma-informed communities' movement. Participants identified 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, 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 in New Mexico and contributed to the grassroots campaign to improve mental health services.

The findings provide knowledge for actions steps at the macro level such as to share the findings with the New Mexico Board of Social Work Examiners. Since the Board is committed to cultural awareness, the overall findings can provide the Board guidance on the needs of the New Mexico social work community.

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 that come from different disciplines. Therefore, the findings may not be generalizable to other mental health professionals. In addition, the study was conducted in New Mexico, which also limits generalizability.

Dissemination of Information.

The study findings will be disseminated in multiple mediums. First, the findings will be organized into a continuing education training. A training will be presented at the NASW New Mexico'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 El Puentes de Encuentros, a non-profit in Albuquerque, New Mexico that provides mentorship to minority college students pursuing careers in the healthcare profession. In addition, an executive summary of this study will be shared with the New Mexico Board of Social Work Examiners. Finally, the current study will be revised to meet publishing expectations to be considered for publication. The following are a list of journals that will be 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 research findings are beneficial for social change at the micro, mezzo, and macro levels in the state of New Mexico. At a micro level, to increase cultural awareness in mental health settings, the findings will be disseminated as continuing education training at local professional conferences. In addition, the online trainings will be available on my business website and accessible by anyone in the healthcare profession. As a mental health provider, I will continue to serve primarily Spanish-speaking clients and incorporate cultural humility and intersectionality.

Throughout the state of New Mexico, 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, I work will with El Puentes de Encuentros, to help mentor minority college students to complete their college education and start their career in mental health. I will work with the program in two specific ways. I will offer training on cultural humility and intersectionality. In addition, I will offer students opportunities to complete internships at my mental health practice to get first-hand experience in a mental health setting. In addition, as an owner of a mental health practice, I can develop a business model that integrates the findings from this study. By developing a business

model that promotes cultural awareness, this business model can be presented at the local chamber of commerce to influence other business owners.

Finally, at a macro level, I can contribute to social change by contributing to future research. The literature on cultural awareness reports a gap between academic knowledge on power, privilege oppression and how these dimensions are operationalized in practice. I can contribute 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. Hence contributing to research increases the knowledge base on how to practice with cultural humility.

Conclusion

In conclusion, this action 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 New Mexico to advocate for improved mental health services to minority populations. The key findings were the social worker's genuine interest in the client's culture, 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 decrease mental health disparities. As an active social worker in New Mexico, I can

disseminate this information in a variety of settings, mentor minority college student pursuing a career in mental health, and contribute to future research.

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Appendix A: Interview Outline

I. Introduction (5 minutes)

A. Greeting

B. Statement of the purpose of the 60- minute interview

C. Review Inform Consent & check for questions

II. Clarification of Terms (10 minutes)

A. Establish the knowledge base of key terms through questions

1. What comes to mind when you hear cultural humility?

2. What comes to mind when you hear intersectionality?

3. In your opinion, how are these concepts connected to NASW cultural awareness standards?

B. Provide definitions of key terms

III. Interview Questions (35 minutes)

A. Engagement, assessment, intervention, and evaluation

1. What do you during your initial contact with the client to demonstrate cultural humility? (Probe: How do you engage clients to build rapport?)

2. How do you incorporate intersectionality into the assessment process? (Probe: How do you document power, privilege, and oppression with marginalized clients)

3. How do you use interventions to demonstrate cultural humility and awareness of intersectionality?

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

B. Client's worldview and their state of incongruence

1. How do you demonstrate cultural humility and intersectionality when understanding the client's situation and problem?

C. Participant input

1.What challenges have you encountered when integrating cultural humility and intersectionality in mental health settings?

2. Any thoughts on what would make it easier to incorporate cultural humility and intersectionality in any aspect of the clinical practice: a) engagement, b) assessment, c) intervention, and d) evaluation?

3. Does anyone have any other questions or comments about cultural humility and intersectionality?

IV. Wrap up (10) minutes

A. Identify and organize the major themes from the participant's responses

B. Member Check or accuracy of information gathered

Appendix B: Confidentiality Agreement

Name of Transcriber: _____

During the course of my activity in collecting data for this research: **Examining Cultural Humility and Intersectionality in Mental Health Treatment: An Action Research Study in New Mexico**, I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Transcriber Signature **Date**

Witness Signature **Date**

Appendix C: Recruitment Email/Letter

Dear Colleague,

My name is Sandra Herrera-Spinelli, LCSW. As a New Mexico Highlands University Alumni, I have been practicing as a clinical social worker in New Mexico since 2003. Since I am committed to our State and the social work profession, I have returned to school to at Walden University, the Barbara Solomon School of Social Work and Human Services to obtain a doctoral degree to contribute to social change in our community.

I am inviting you to take part in a research study about cultural competency in mental health settings. You are being invited to this study because you were listed in the Approved Supervisors List on the Board of Social Work Examiners website.

The purpose of this study is to examine how clinical social workers translate Cultural Awareness into clinical practice behaviors. Specifically, how power, privilege, and oppression are addressed in the treatment process in mental health settings. The study consists of individual face-to-face interviews scheduled on days/times that are at your convenience.

If you agree to be in this study, you will be asked to:

- Communicate via email to complete forms, receive instructions, and information on the location and day/time for the interview
- Complete a demographic form
- Engage in one interview that will last 60 minutes
- Receive a summary of study outcomes via email

Here are some sample questions:

- What comes to mind when you hear cultural humility?
- What comes to mind when you hear intersectionality?
- In your opinion, how are these concepts connected to NASW cultural competency standards?

As an appreciation for your participation, you will receive a $5 gift card.

If you are interested, please email_____ Or you can call, please leave a message stating your interest in the study with a phone number where you can be reached.

I greatly appreciate taking the time to consider this opportunity.

Respectfully, Sandra Herrera-Spinelli

Appendix D: Demographics

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

What city and county are you employed in? or reside in?	
What is your race? White, not Hispanic or Latino Black or 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 location of the interview needs to offer privacy and confidentiality. Some options are your office, community center, or public library. Please provide two options you feel comfortable to have the interview.	

Appendix E: Welcome Email

This email is to announce you have been selected to participate in the study.

You agreed to an interview on _____ date at _____ time at the following

confidential location_____.

Here is a quick reminder regarding the day of the interview:

- The interview will be only for 60-minutes
- The interview will be recorded

Reminder after your participation you will:

- Receive a gift card
- Receive a summary of study outcomes via email upon committee approval

Welcome to the study facilitated by Sandra Herrera-Spinelli, a doctoral student at Walden University, the Barbara Solomon School of Social Work and Human Services.

Appendix F: Recruitment Flyer

Seeking Clinical Social Workers in Mental Health Practice for Study

My name is Sandra Herrera-Spinelli, LCSW. I am a doctoral student at Walden University, the Barbara Solomon School of Social Work and Human Services.

The purpose of this study is to examine how clinical social workers translate Cultural Awareness into clinical practice behaviors. Specifically, how power, privilege, and oppression are addressed in the treatment process in mental health settings. The study consists of individual face-to-face interviews scheduled on days/times that are at your convenience.

If you are interested, please email. Or you can call_____ please leave a message stating your interest in the study with a phone number where you can be reached.

I greatly appreciate taking the time to consider this opportunity.

Respectfully,

Sandra Herrera-Spinelli