ABSTRACT

Title of Dissertation:	EXPLORING COUPLE AND FAMILY THERAPIST INVOLVEMENT IN SOCIAL JUSTICE PRAXIS
	Laura A. Golojuch, Doctor of Philosophy, 2023
Dissertation directed by:	Mona Mittal, PhD Associate Professor, Family Science Department

As the nation becomes more diverse, multicultural competence and social justice are being increasingly recognized as essential components to effective therapy practice (Hays, 2020; Ratts et al., 2016; Vera & Speight, 2003). While some scholars in the field of Couple and Family Therapy (CFT) have urged the importance of infusing social justice into training and clinical practice for years (see Hardy, 2001; Knudson-Martin et al., 2019; McDowell et al., 2019; McGoldrick, 2007), this topic is understudied and underprioritized by the field at large. Recent CFT scholars also acknowledge the importance of advocacy as an accompaniment to therapy (J. M. Goodman et al., 2018, Jordan & Seponski, 2018a, 2018b). Counseling and social work fields have prioritized social justice advocacy and codified it into mission statements and ethical codes (Ratts et al., 2016; Ratts & Greenleaf, 2018; Toporek & Daniels, 2018). Although CFTs are trained systemically, and may be enacting micro-level advocacy intervention in the therapy room, they do not always view themselves as advocates or enact macro-level advocacy interventions (J. M. Goodman et al., 2018; Holyoak et al., 2020; Jordan & Seponski, 2018b).

This study utilized a sequential transformative mixed methods design to assess multicultural competence, social justice commitment and self-efficacy, and advocacy competence in a nationally representative sample of CFTs (n = 101) using survey methods. A subsample of 22 participants were interviewed to further explore their practices as multiculturally competent and socially just clinicians. Three complementary frameworks were utilized to ground the study: The Multicultural and Social Justice Counseling Competencies (MSJCC), critical consciousness, and Public Health Critical Race praxis. Overall, multicultural competence, social justice commitment, and social justice self-efficacy scores were high in this sample, while advocacy competence scores were lower. Results showed that identifying as Black or African American and completing additional training in multicultural competence and social justice were associated with multicultural competence. Results also showed that working in an agency setting vs. other settings was associated with lower levels of multicultural competence. Results showed that identifying as female compared to male, having a higher level of oppression, a higher level of civic engagement, and more additional training in multicultural competence were all associated with social justice commitment. Results showed that being older, completing more additional training, and having a higher level of oppression were all associated with higher levels of social justice self-efficacy. Finally, results showed that identifying as non-binary compared to male, completing more hours of additional training, and experiencing higher levels of oppression were all associated with advocacy competence. Additionally, receiving more post-graduate hours of training in multicultural competence, social justice, and advocacy competence was associated with higher multicultural competence, social justice, and advocacy competence. Qualitative findings revealed ways in which CFTs developed and embodied socially just clinical practice and explored recommendations for training.

EXPLORING COUPLE AND FAMILY THERAPIST INVOLVEMENT IN SOCIAL JUSTICE PRAXIS

by

Laura A. Golojuch

Dissertation submitted to the Faculty of the Graduate School of the
University of Maryland, College Park, in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
2023

Advisory Committee:
Professor Mona Mittal, Chair
Professor Patricia Barros
Professor Amy A. Morgan
Professor Kevin Roy
Professor Richard Q. Shin

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

Statement of the Problem

Living through the last few years in the United States of America has meant simultaneously confronting a pandemic and reckoning with a racial and social justice movement. The COVID-19 pandemic has exacerbated longstanding inequities in the United States and Americans are facing a "K-shaped recovery" wherein the wealthy benefit from economic recovery while the rest of the country continues to struggle (Tappe, 2021; Villarreal, 2020). Furthermore, Black and Brown Americans, low-income Americans, and women have suffered disproportionate impacts of the economic fallout of the pandemic compared to other demographic groups (Villarreal, 2020). A Pew Research study conducted in August of 2020 found that 38% of people who had someone in the household lose a job had trouble paying bills, compared to 11% of people without a job loss in the household (K. Parker, Minkin, et al., 2020). The same report details race and class-based inequities, with Black and Hispanic adults (43%) and low-income adults (46%) being more likely to have trouble paying their bills (K. Parker, Minkin, et al., 2020).

In addition to living through a pandemic, Americans have also recently faced a renewed reckoning with social injustice and systemic racism. The killing of George Floyd by law enforcement officers led to a new wave of protests in 2020, culminating in tens of millions participating in demonstrations (Buchanan et al., 2020). Incidents of police brutality in 2021 and 2022 continued to reopen wounds and ignite cries for social change. While the Black Lives Matter movement began in 2013, a 2020 Pew Research Report found that support overall for the movement increased exponentially in 2020 with a significant majority of Americans (67%

overall) showing support for the Black Lives Matter movement (Cohn & Quealy, 2020; K. Parker, Horowitz, et al., 2020). Scholars and activists have noted the differences in the racial justice movements of 2020 compared to those in decades past, highlighting a greater number of non-Black (especially White) participants across a broad geographic spread (Buchanan et al., 2020; Nawaz & Khan, 2020; Sugrue, 2020). For some, the past few years' racial justice movement provides hope for sweeping social change and policy reform, however, Americans remain divided on whether they believe the current attention to the topic will lead to long lasting policy change to address inequity (Fisher, 2020; Horowitz et al., 2020). Because of recent events, systemic racism and social justice have come to the forefront in public discourse and have even been acknowledged in recent federal policy. President Biden introduced his first executive order to advance racial equity in January of 2021 and is working to further address these issues (Biden, 2021; Wootson & Jan, 2021).

Therapists have been tasked with shepherding their clients through the twin epidemics of COVID-19 and racial/ social injustice throughout the last few years. While the mental health needs of all Americans are predicted to continue to grow amidst the isolation and unrest of the past few years, this is especially true for Black Americans, whose mental health needs are compounded by racial trauma and disproportionate impacts of the pandemic (M. A. Garcia et al., 2020; Novacek et al., 2020). Mental health professionals are on the front lines of support for Americans, yet most have received little guidance on how to deliver effective services during a pandemic while also dealing with their own experiences of burnout (Fish & Mittal, 2021; Mittal et al., 2022). While the need for mental health services is high, little is known about clinician readiness to address social justice issues and advocate for the needs of their clients, even in systemic therapy professions.

Therapists have long been confined to their role within the therapy room, however, calls for more activism and involvement in social change have built over the last few years. Scholars in fields such as art therapy (Potash, 2011), occupational therapy (Hocking & Townsend, 2015), counseling (Lee, 2007), and marriage and family therapy (J. M. Goodman et al., 2018; Kelly et al., 2020) have all recognized the role of therapists in promoting social change. Today, many counseling fields prioritize social justice and highlight the importance of mental health professionals advocating for social change, though Couple and Family Therapy (CFT)[1], a systemic field, is not one of them. Some argue that social justice is a moral imperative for counselors and therapists and that they must work to intervene at the systemic level to challenge oppression (Hardy, 2001; Lee, 2007). According to Lee (2007), "it is [counselors'] ethical and moral obligation as helpers to actively participate in social justice initiatives and in the process promote the development of a more equitable society that promotes access for all people." The National Association of Social Workers' (NASW) ethical code includes the ethical principle "social workers challenge social injustice." In fact, the social work field considers social justice among its core values (National Association of Social Workers, 2016, 2017). Similarly, the American Counseling Association (ACA) holds "promoting social justice" among its five core values. In 2017, the ACA approved three additional statements regarding social justice and human rights, and the following year updated its advocacy competencies to better highlight advocating at the systemic level (American Counseling Association, 2014; Toporek & Daniels, 2018). Although the American Psychological Association (APA) includes justice as a core principle, a 2021 article called for a more complete explanation of social justice work within the

[1] Note that the field of Marriage and Family Therapy (MFT) is now widely referred to as Couple and Family Therapy (CFT) to reflect a more inclusive client base. This dissertation will prioritize the use of CFT but considers the use of MFT and CFT to be interchangeable.

field of psychology (Hailes et al., 2021). These professional organizations all codify the intention for their members to work to confront injustice and systemic racism.

Several counseling-related professional fields use multicultural competence-based frameworks when addressing social injustice and racism. Multiculturalism is cited as the fourth force in counseling, largely based on increasing recognition of cultural diversity in the United States (Essandoh, 1996). This paradigm follows three major theories or "forces" in the counseling field: psychoanalytic, cognitive- behavioral, and existential humanistic. Each of these paradigms have guided theory and practice and brought on a new understanding of human development (Ratts & Pedersen, 2014). Derald Wing Sue first discussed the importance of cross-cultural counseling competence in a 1982 position paper, citing the need to address health disparities and provide quality counseling services to minority clients (Sue et al., 1982). Sue and colleagues put forth a framework for multicultural counseling in 1992, citing the importance of broadening the scope of the counseling field beyond the traditional White middle-class lens. Sue, Arredondo, and McDavis's Multicultural Counseling Competencies (MCC) focus on three therapist characteristics across three dimensions, for a total of nine competency areas to guide the counseling profession (Sue et al., 1992). They consider counselors' beliefs and attitudes, knowledge, and skills along the domains of counselor awareness of own assumptions, values and biases, understanding the worldview of a culturally different client, and developing appropriate intervention strategies and techniques. This tripartite 1992 model, which focuses largely on individual counseling, has served as the foundation for frameworks and measures of multicultural competence.

Over the last two decades, calls have increased to move beyond the idea of multicultural competence, highlighting social justice and advocacy as essential to effective counseling (Hays,

2020; Paré, 2014; Vera & Speight, 2003). In 2009, Ratts put forth a call to the counseling field to include social justice as a fifth force along with psychodynamic, cognitive behavioral, existential-humanistic, and multicultural forces (Ratts, 2009). Since then, the Multicultural and Social Justice Counseling Competencies (MSJCC) have been developed and endorsed by the ACA to update Sue, Arredondo, and McDavis's 1992 MCC (Ratts et al., 2016). This update to include social justice reflects more of a commitment to recognize the deleterious effects of oppression on mental health and wellbeing, to further understand individuals within their embedded contexts, and to focus on social justice advocacy (Ratts et al., 2016). The model also attends to intersections of privilege and oppression and the multifaceted nature of identity. Recent articles paint a vision for the future of the MSJCC, focusing on counselors as social justice change agents and human rights activists and utilizing the framework to decolonize the practice of counseling (Singh, Appling, et al., 2020; Singh, Nassar, et al., 2020). The advent of social justice focused frameworks and research measures (see Social Justice Scale (SJS); Torres-Harding, Siers, & Olson, 2012 and the Social Issues Questionnaire (SIQ); Miller et al., 2009) ushers in the potential for therapists to better serve the current public health needs of their clients.

While more attention has been given in recent years to the role of social justice in the therapy room, little is known about the training and practice of Couple and Family Therapists (CFTs) in this area. CFTs are trained to think systemically by focusing on relationships and context rather than individual pathology. This approach promotes second order change by working to change the system itself and not just attempting to "fix" the individual (Bertalanffy, 1968; Davey et al., 2012). However, unlike other counseling fields, the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics does not mention social justice,

systemic racism, or a duty to combat oppression. Recent CFT scholars urge therapists to interrogate their own social roles, privilege, and work to create third order change (McDowell et al., 2019). Knudson-Martin and colleagues' 2019 article asserts that "a shift to third order thinking enables therapists to integrate awareness of societal context and power processes into established family therapy models" (Knudson-Martin et al., 2019). This thinking creates room for larger social structures to be present in the therapy room and promotes consideration of the systemic influences beyond the family.

At the turn of the century, a debate among family therapists arose over the role of CFTs in addressing racial justice and human rights issues (Hardy, 2001; S. Johnson, 2001; McGoldrick, 2007; Sluzki, 2001). Johnson (2001) claimed that therapists seeking to address social injustices exhibited messianic tendencies, while Sluzki (2001) countered by asserting the need for therapists to continue to attend to social context in a changing world. Hardy (2001) took his stance a step further, promoting the need for family therapists to "transform the human condition" (p. 19) and take on the role of activist. Recent scholarship in the CFT field promotes the role of therapist as advocate and underscores the importance of weaving social justice into both the work and identity of CFTs (J. M. Goodman et al., 2018). Jordan and Seponski's 2018 survey of CFTs' engagement in political advocacy found that 86% of those surveyed believe that therapists have a role in political and policy processes, however 93% agreed that therapists should not engage in political discussions with clients (Jordan & Seponski, 2018b, 2018a). Their findings highlight the fragmentation of self as a social justice agent that some therapists faced. The authors concluded with a call to action for therapists to promote critical consciousness of key issues and "develop the skills to be politically active" (Jordan & Seponski, 2018b). Goodman, Morgan, and colleagues (2018) highlighted the importance of CFTs engaging in

advocacy given their expertise in systemic change. They introduced the concept of self-of-the-advocate, weaving advocacy into CFT identity, and discussed the need for more effective training around advocacy for CFTs (J. M. Goodman et al. 2018).

Advocacy in the CFT field should be considered on both the micro and the macro level. In fact, some argue that micro-level advocacy is a common process among CFTs, is client-centered, individually focused, and helps clients address systemic constraints that are impacting their daily lives (Gehart & Lucas, 2007; Holyoak et al., 2020). Holyoak and colleagues (2020) assert that micro-level advocacy can be as simple as advocating for a scapegoated family member or helping clients voice concerns in their families or in the workplace. Being an advocate involves recognizing the humanity of others and using empathy to promote social good for all at the systemic level. These elements are foundational to the work of CFTs and integrating advocacy into the identity of CFTs is paramount for the profession going forward (Holyoak et al., 2020).

Purpose of the Study

While research in the area of social justice counseling has advanced, few empirical studies focus on both multicultural competence (as defined by Sue et al., 1992) and social justice in counseling (Ratts et al., 2016). Further, this topic is extremely understudied in the CFT field, and few empirical studies measure multicultural competence among CFTs (Constantine et al., 2001; Murphy et al., 2006). CFTs are trained to use a systemic lens in their clinical work, yet little is known about how CFTs attend to broader contexts of privilege and power in the room, or how CFTs advocate outside of the therapy room.

The present study will utilize a cross-sectional mixed methods study design to assess CFTs self-report of multicultural competence, social justice commitment and self-efficacy, and advocacy competence. This study has three aims:

1. To assess the current level of multicultural competence, social justice commitment and self-efficacy, and advocacy competence in CFTs (quantitative).
2. To investigate the relationship between sociodemographic and professional factors and multicultural competence, social justice commitment and self-efficacy, and advocacy competence (quantitative).
3. To explore how CFTs develop multicultural and social justice counseling competencies and the processes by which they embody a critically conscious, social justice-oriented identity, both within and outside of the therapy room (qualitative).

Theoretical Frameworks

This study will be guided by three complementary frameworks: The Multicultural and Social Justice Counseling Competencies (MSJCC), critical consciousness, and Public Health Critical Race praxis.

Multicultural and Social Justice Counseling Competencies

The Multicultural and Social Justice Counseling Competencies (MSJCC) were ratified by the ACA in 2015 after a call by the Association for Multicultural Counseling and Development was put forth to update the 1992 Multicultural Counseling Competencies (MCC) developed by Sue, Arredondo, and McDavis (Ratts et al., 2016). The original 1992 MCC framework has guided counseling fields in the area of multicultural competence for decades. This framework operationalizes multicultural competence in terms of knowledge, beliefs and attitudes, and skills, and has had several instruments normed from its constructs. The updated MSJCC were developed with the intention to reflect a broader understanding of multiculturalism by noting the intersectionality of marginalized clients' identities and their influence on mental health. The MSJCC update the construct of multiculturalism from beyond studying discreet racial or cultural

groups and bringing more attention to intersectional identities (such as those of a black transgender woman). The MSJCC recognize the impact of oppression on health and well-being and considers individuals within their social contexts. As such, this framework includes individual counseling competencies and adds a focus on social justice (Ratts et al., 2016). This multilevel approach allows for counselors to both work with clients directly and also strive to address systemic oppression and barriers that their clients face through social justice advocacy.

The MSJCC are based on Bronfenbrenner's 1979 ecological model and contextual socioecological models. This model serves as a guidepost for therapists to balance individual work in the room with broader social justice advocacy and includes multiculturalism and social justice at its core (Ratts et al., 2016). The MSJCC incorporate power and oppression by including quadrants addressing the intersections of privileged and marginalized identities for both client and counselor. This is important as therapists must adapt to the status and the needs of the clients based on privileged or marginalized identities, especially at the current moment in time.

The model includes four developmental domains: (a) counselor self-awareness, (b) client worldview, (c) the counseling relationship, and (d) counseling and advocacy interventions. These domains are depicted as concentric circles representing contexts from the micro- to macro-level. Self-awareness involves self-reflection and understanding of privileged or marginalized identities as well as professional development to better serve clients. According to Ratts and colleagues (2016), "when counselors are aware of their values, beliefs, and biases, it allows them to be more attuned to clients' worldviews and experiences" (p. 39). Competence begins internally with the counselor's own self-awareness and moves gradually out to the systemic level to advocacy interventions. Therapists can help clients to understand their social locations and connect individual struggles to social contexts. This domain leads to the counseling relationship

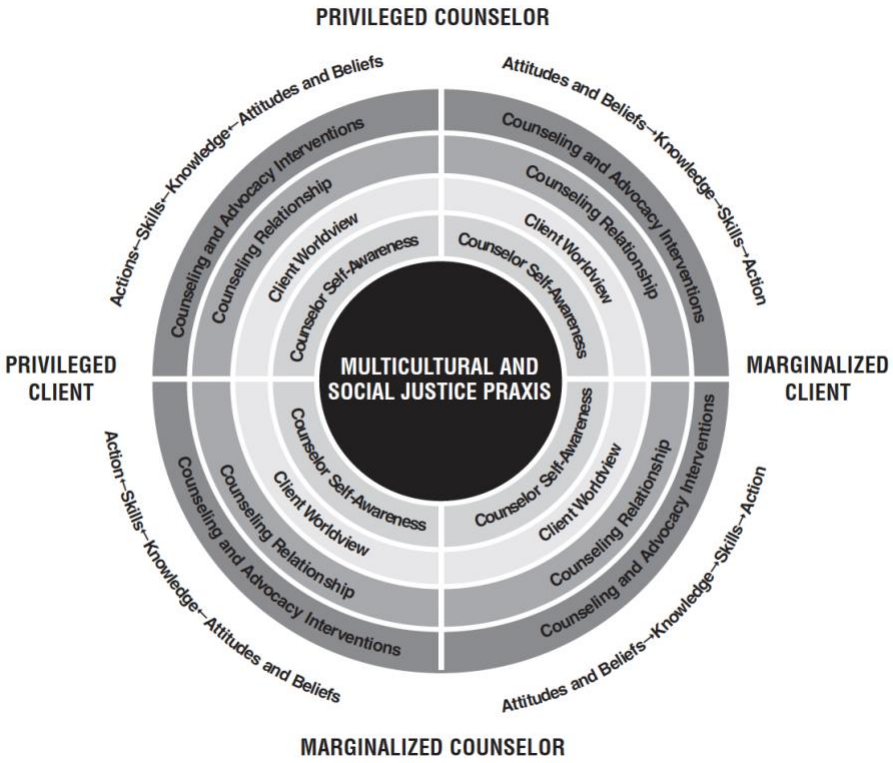
and an understanding about how privilege and oppression can influence the counseling relationship. Multicultural and social justice competent counselors should be able to discuss differences in power and privilege and how these may impact the therapeutic relationship (Ratts et al., 2016). Lastly, counseling and advocacy interventions follow from the first three developmental domains. Multicultural and social justice competent counselors and therapists are able to connect knowledge to practice to address change on the individual, community, and institutional levels (Ratts et al., 2016). Within each of these domains, four aspirational and developmental competences are embedded: (a) attitudes and beliefs, (b) knowledge, (c) skills, and (d) action. The first three competencies mirror the original MCC (Sue et al., 1992) and the fourth competency of action is added to reflect a commitment to social justice advocacy. This component is key to effective practice and allows therapists to create safe and culturally affirming services for their clients. This framework serves as the most comprehensive set of guidelines for therapists as human right activists and social justice change agents (Ratts et al., 2016).

The MSJCC will guide the present study in exploring multicultural and social justice counseling competencies among CFTs. This model provides a framework to investigate therapist multicultural and social justice competence, while also attending to the dynamics of power. This study assesses multicultural competence and social justice commitment and self-efficacy from therapist self-report, reflecting the innermost ring of counselor self-awareness. In addition, this study measures therapist privilege and oppression, noting whether the therapist is coming from a privilege or marginalized identity. To further assess social justice praxis, therapist advocacy competence is measured to create a comprehensive snapshot of multicultural and social justice competency. To create a deeper understand of CFT multicultural and social justice praxis,

qualitative interviews explored how therapists became effective social justice agents and how such therapists enact advocacy interventions.

Figure 1

Multicultural and Social Justice Counseling Competencies



Note. This figure demonstrates the MSJCC developed by M.J. Ratts, A.A. Singh, S. Nassar-McMillan, S.K. Butler, & J.R. McCullough in 2015.

Critical Consciousness

The second guiding framework of this dissertation is critical consciousness, originally conceptualized as *conscientização* by Paulo Freire in his 1970 book, *Pedagogy of the Oppressed*. Freire himself grew up in poverty and dedicated his life to education in Brazil's working-class communities. In this work, Freire focused on the conditions that lead to oppression and encouraged those who were oppressed to work to reclaim their humanity as a path to liberation.

Freire's original conceptualization of critical consciousness included two key pieces: critical reflection and critical action. *Critical reflection* involves an analysis of social inequities (including economic, racial, gendered, etc.) to understand how these conditions limit human agency (Watts et al., 2011). For both oppressors and the oppressed, Freire encouraged a process of constant self-reflection. Freire believed that this awareness of social position within the broader social context was essential to changing one's reality and working toward liberation (Freire, 1970). *Critical action* refers to the steps taken to address and remit oppressive social contexts, with a focus on structural change (Diemer et al., 2021). Freire's ideas provide a framework to understand oppression and marginalization and critically analyze social conditions. By combining critical reflection and critical action, critical consciousness provides individuals with the tools to understand social inequities and work to promote social justice (Diemer et al., 2015; Watts et al., 2011).

Freire's concept of critical consciousness has been applied widely in education and youth development scholarship (Diemer, 2020; Kumagai & Lypson, 2009; Rapa et al., 2020; Tyler et al., 2020). More recently, scholars have added a third component of *critical motivation* as a bridge between reflection and action (Diemer et al., 2015). *Critical motivation* refers to perceived efficacy in creating change as well as the moral commitment to act (Diemer et al., 2021). Diemer and colleagues (2021) stress the importance of all three components of critical consciousness working in tandem, likening the concept to striking a match. In their analogy, only focusing on reflection is similar to gathering wood but striking no matches and is insufficient to create true change (Diemer et al., 2021; Watts & Hipolito-Delgado, 2015). Therefore, promoting critical consciousness includes increasing knowledge and awareness of existing social inequities and having the motivation and skills to act combat them (Diemer et al., 2015).

The importance of critical consciousness is increasingly being recognized in counseling and other healthcare fields (Diemer et al., 2015; Hernández et al., 2005; Kumagai & Lypson, 2009). Garcia and colleagues (2009) define critical consciousness as "the ability to recognize and challenge oppressive and dehumanizing political, economic, and social systems." They discuss the importance of recognizing one's part in promoting inequity and upholding social justice within CFT therapy and supervision. Garcia and colleagues (2009) go on to assert that critical consciousness is an essential component of therapist competence in assessment and treatment, that contexts of oppression must be considered when working with individuals and families (M. Garcia et al., 2009). Discussion of critical consciousness in counseling and therapy has primarily been theory-based, and more research is needed to understand how critical consciousness is important to effective mental health care.

Critical consciousness may be an important mechanism by which therapists display multicultural competence. Developing a critical consciousness of various forms of oppression (such as racism, classism, and sexism) is an important way for therapists to develop awareness of their own privileges and their clients' privilege or marginalization (Shin et al., 2016; Vera & Speight, 2003). Critical consciousness can also be a way to uncover biases and assumptions about client experiences and may be essential for social justice praxis for therapists (Shin et al., 2016). This theory pairs well with the MSJCC while adding nuance and complexity to the by taking intersectionality into account. The theory was also created with liberation in mind and holds that awareness must be coupled with empowerment and action against social inequities (Shin, 2015).

Public Health Critical Race Praxis

Critical race theory has gained recent attention in the national news cycle, though is a paradigm that is still taking shape throughout different disciplines. It originated through collaboration between lawyers and activists on the heels of the civil rights movement in the 1970s. Delgado and Stefancic (2017) define critical race theory as a dedication to "studying and transforming the relationship among race, racism, and power" (p. 3). Ford and Airhihenbuwa (2010a) define critical race theory as "an iterative methodology for helping investigators remain attentive to equity while carrying out research, scholarship, and practice" (p. S31). With its roots in critical legal studies and feminism, critical race theory posits that racism is everyday and ordinary, that race is socially constructed, and that we live in a racialized society (Delgado & Stefancic, 2017). Critical race theorists also commit to creating more socially just societies by noting and resisting forms of oppression based on race, class, gender, religion, and nationality (McCoy & Rodricks, 2015; Solórzano & Yosso, 2016). Critical race theory has now been applied to the disciplines of education (Lynn et al., 2002; McCoy & Rodricks, 2015), nursing (Blanchet Garneau et al., 2018; Koschmann et al., 2020), mental health (Brown, 2003; Haskins & Singh, 2015; McDowell & Jeris, 2004), and public health (Ford & Airhihenbuwa, 2010b, 2010a, 2018; Thomas et al., 2011). It is evident that critical race theory is a lens through which many disciplines can look to improve their research and practice with diverse populations.

The Public Health Critical Race praxis was introduced in 2010 by Ford and Airhihenbuwa. This framework melds critical race theory and public health by developing a language for health disparities research and an outline for effective public health practice (Ford & Airhihenbuwa, 2018). The model includes four foci: contemporary patterns of racial relations, knowledge production, conceptualization and measurement, and action (Ford & Airhihenbuwa,

2010b). First, Ford and Airhihenbuwa (2010b) acknowledge that while racism has always been around, studies should consider how race operates in the current contexts of place and time. In terms of knowledge production, the authors encourage researchers to understand how scientific inquiry is a subjective enterprise and to interrogate existing knowledge on a topic to ensure it is free of bias. This focus works in tandem with conceptualization and measurement and encourages measures to be context-specific to promote racial equity. Ford and Airhihenbuwa (2010b) assert the need for qualitative methods and critical approaches to complement existing measurement tools. The final focus, action, completes the praxis component of the model and is necessary to combat inequity. This aim can be achieved through storytelling, through defining or naming terms that contribute to inequity, and by directly combatting injustice (Ford & Airhihenbuwa, 2010b).

In addition to its four foci, Public Health Critical Race praxis includes ten principles: race consciousness, the primacy of racialization, race as social construct, the ordinariness of racism, structural determinism, social construction of knowledge, critical approaches, intersectionality, disciplinary self-critique, and voice (Ford & Airhihenbuwa, 2010b). Race consciousness emphasizes that we live in a racialized society and, according to Ford and Airhihenbuwa (2010b), "is the lens through which all aspects of [Public Health Critical Race praxis] research occur" (p. 1393). The model posits that both racism and knowledge are socially constructed and are shaped by culture and power. Similarly, structural and systemic factors often perpetuated by dominant groups shape inequities (Ford & Airhihenbuwa, 2010b). As such, Public Health Critical Race praxis calls for critical approaches in which researchers and practitioners acknowledge and question assumptions, biases, and their own social location. This includes

attention to disciplinary self-critique, intersectionality, and giving voice to marginalized groups (Ford & Airhihenbuwa, 2010b).

Thomas and colleagues' 2011 article calls for Public Health Critical Race praxis to guide a new generation of health disparities research. Additionally, a growing body of research displays how Public Health Critical Race praxis can be used by public health practitioners to combat racial disparities in healthcare in areas such as gynecology (Doll, 2017), heart disease (Osuagwu et al., 2023), and COVID-19 vaccine uptake (Huffstetler et al., 2022). Thomas et al. (2011) encourage the use of mixed methods designs to fulfill the tenets of the framework, namely the social construction of knowledge, giving voice, and utilizing intersectional and critical approaches (Thomas et al., 2011). Similarly, Chapman and DeCuir-Gunby (2018) encourage those using critical race theories to move beyond traditional quantitative frameworks and incorporate qualitative components into their research (Chapman & DeCuir-Gunby, 2018). This dissertation utilizes a mixed method design to understand the processes by which CFTs enact social justice praxis in their clinical work. Attention is given to the history of the field and what underpinnings shape the convictions throughout each movement of counseling and through the field of couple and family therapy (focus 2: knowledge production of Public Health Critical Race praxis). Additionally, the qualitative interviews conducted build on the knowledge gained through survey measures and serve to give voice to participants about how they attend to oppression and marginalization in their practice of couple and family therapy. This dissertation also incorporates focus 4 (action) into its design by understanding the advocacy competence of therapists by directly measuring it and by getting an in depth understanding of practices around advocacy and social justice through interviews. Results of this inquiry can help to directly

influence the training and clinical practice of therapists to combat inequity and promote social justice.

Chapter 2: Review of the Literature

In 2019, nearly one in five Americans lived with a diagnosed mental health condition (Substance Abuse and Mental Health Services Administration, 2020). The COVID-19 pandemic has compounded mental health issues and has been linked to adverse mental health outcomes due to isolation, economic downturn, grief, and fear (Usher et al., 2020). A 2020 Centers for Disease Control and Prevention (CDC) report found that anxiety and depression symptoms increased significantly in adults between 2019 and 2020 (Czeilser et al., 2020). In June 2020, nearly 41% of respondents reported at least one mental or behavioral health condition, with 31% reporting depressive or anxiety symptoms and 26% reporting trauma and stressor related symptoms (Czeisler et al., 2020). For young adults, mental health symptoms were much more prevalent, with 75% of respondents aged 18-24 reporting at least one adverse mental health symptom (Czeilser et al., 2020). Another CDC report found that symptoms of depression or anxiety continued to increase significantly between August 2020 and February 2021 and that young adults reported the highest increases (49% to 57%) (Vahratian et al., 2021). The public health implications of the COVID-19 pandemic are vast and will likely impact Americans for generations to come.

Part of effective public health praxis is building awareness of the impacts of racial discrimination on health (Ford & Airhihenbuwa, 2010a). The COVID-19 pandemic has highlighted existing mental health disparities for Black and Brown Americans (Novacek et al., 2020). Scholars point to extant inequities, such as lack of access to healthcare and racism, as a cause for the compounding effects of the pandemic on mental health (Fortuna et al., 2020; Watson et al., 2020). Researchers urge a shift in delivery of mental health care given the adverse impacts of the pandemic. Novacek and colleagues (2020) call for comprehensive national

programs to provide insurance to all Americans and flexibility in delivery of services (such as telehealth) to promote access. Additionally, they encourage race-conscious interventions and research for scholars and practitioners (Novacek et al., 2020). Moreno and colleagues (2020) stress the need for collaboration and wraparound services in housing, education, and employment to bolster mental health services (Moreno et al., 2020). Fish and Mittal (2020) echo the need for public health and mental health services to be integrated in response to the COVID-19 pandemic and encourage clinical training to adapt to the current crisis, emphasizing alternate modes of treatment (Fish & Mittal, 2020, Mittal et al., 2022). Watson and colleagues (2020) urge family therapists to interrogate the ethical and moral responsibilities of care in the wake of the COVID-19 pandemic. They encourage family therapists to have a broad understanding of the systems that impact clients, and the "interconnectedness between inequity, trauma, and crisis" (Watson et al., 2020). The authors encourage clinicians to highlight interconnectedness and shared humanity to promote health equity and combat the forces of institutionalized racism and injustice (Watson et al., 2020).

Rates of mental health issues continue to increase and have been exacerbated by the stressors and isolation of the COVID-19 pandemic. Despite the recommendations provided throughout the last few years, there is little data on how competent mental health care professionals are in addressing the public health needs of Americans in a culturally competent and socially just way. The mental health field is being challenged to meet the current needs of the public, shepherding them through both a public health emergency and racial justice movement. The next section will provide an overview of the origins of the mental health field, focusing on both counseling and family therapy, to understand the need for social justice to be at the forefront of the next wave of mental health services.

Evolution of the Mental Health Field

The mental health field has gone through many iterations to reflect the changing dynamics of clients and the world around them. The counseling field has met the needs of the population through the development of five forces: psychoanalytic, cognitive-behavioral, existential-humanistic, multicultural, and social justice (Ratts, 2009). Each of these forces describes a paradigm of human development and connects theory to counseling practice (Ratts & Pederson, 2014). The first force, psychoanalytic, is grounded in Freud's idea of human behavior and focuses largely on individual factors. Today, it is seen by many as a pathologizing viewpoint and one that negates the influence of social factors (Ratts & Pedersen, 2014). The second force, cognitive-behavioral, relies on evidence-based practice and measurable outcomes. Beck (1976), a founder of the movement, focused on distorted thinking and helping clients to reframe negative experiences for themselves. The third force, existential-humanistic, questioned the previous paradigms and their focus exclusively on the individual. This paradigm is grounded in unconditional positive regard and helps clients to develop awareness and make meaning (Ratts & Pedersen, 2014).

The field of family therapy arose as a distinct discipline in the 1960s and expanded the first three counseling forces' focus on intrapsychic issues to systemic thinking (Kaslow, 2012). This served as a distinct paradigm shift from the "individual self" to the "relational self" and viewed individuals and their problems within the context of their family systems (Rasheed et al., 2010). Much of the groundwork for family therapy was laid by Gregory Bateson, Don Jackson, and Jay Haley of the Palo Alto group, whose family systems discoveries were made while working with family members with symptoms of schizophrenia (Nichols, 2013). Some of their ideas, such as family rules and scapegoating remain key concepts in family therapy practice. Murray Bowen's

work from the 1940s and 50s is still at the core of family systems theory. His work further confirms the notion of the relational self, in that individuals must be understood in the context of their family (Rasheed et al., 2010). The "Golden Age" of Family Therapy occurred between 1970 and 1985, with many centers opening and new models being developed. Experiential therapy, led by therapists such as Carl Whitaker and Virginia Satir, parallels the existential/humanistic movement, while cognitive behavioral family therapy mirrored the cognitive behavioral school of counseling (Bond, 2009; Nichols, 2013).

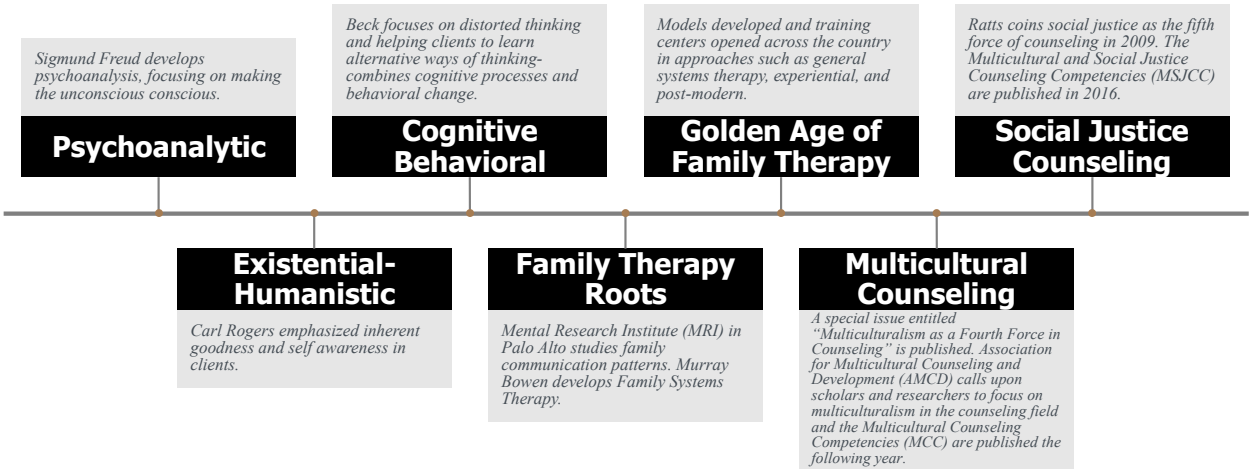
During the early 1990s, multiculturalism was coined as the fourth force of counseling (Pedersen, 1991); this paradigm considers sociological factors in addition to the individual factors of the first three forces (Essandoh, 1996; Pedersen, 1991). This movement stressed the importance of understanding how culture shapes clients' worldview and clinical practice (Ratts & Pedersen, 2014). Family therapy has been critiqued for not attending to social location or power and for failing to consider the influences of such factors on family functioning (M. Garcia & McDowell, 2010; McDowell et al., 2019; Rasheed et al., 2010). However, the shift to postmodern and feminist schools of thought in the CFT field addressed some of these concerns by bringing in the "narrative self," in addition to the "individual and relational selves," and positing that an individual must be considered in terms of their larger sociopolitical influences. Postmodern therapists (such as those practicing from narrative and feminist lenses) focus on meaning making and attend to the multiple contexts that their clients are embedded in, often seeking to change the oppressive structures that their client may be impacted by (Bond, 2009; Rasheed et al., 2010).

When multiculturalism was coined as the fourth force in counseling, it focused on meeting the needs of people from different cultures, though it did not necessarily consider how

counselors could help their marginalized clients consider or combat systems of oppression that they faced outside of the therapy room. Vera & Speight (2003) cite the importance of incorporating a social justice lens into clinical practice to balance individuals and their social contexts, and more importantly, to address systems that perpetuate inequity rather than simply to encourage individuals to adapt to oppressive contexts. In 2009, Ratts made the case to consider social justice the fifth force of counseling, highlighting the need for counselors to advocate to address social and economic inequities (Ratts, 2009). Ratts (2009) contended that the role of counselors must expand to meet the growing need and current understanding of mental health, and that counselors must be equipped to balance individual interventions with community or advocacy approaches. A decade later McDowell and colleagues (2019) made a similar call to the field of family therapy to "intentionally include the impact of societal systems and power dynamics" while working in the room with families (McDowell et al., 2019, p. 10). Their concept of the shift from second to third-order thinking allows for transformational change with families by attending to the impact of societal contexts in the room (McDowell et al., 2019).

Figure 2

Timeline of Key Moments in Counseling & Therapy



The first three waves of counseling- psychoanalytic, cognitive-behavioral, and existential-humanistic- focused on individuals and the best way to help them with their problems. With the advent of family therapy, systemic thinking broadened the lens of both problems and solutions for mental health challenges. In the 1990s, multiculturalism rose to prominence, acknowledging that mental health must be conceptualized not only from a White dominant lens but must also consider cultural diversity. This framework added a new layer to the field of mental health and serves as an important next step in ensuring the best care for clients.

Multicultural Competence

Discussions of multicultural competence in counseling and therapy began to take hold in the 1970s and 1980s, with most scholars focusing on the development of skills in multicultural competence for therapists in training (McRae & Johnson, 1991). The construct of multicultural competence has been conceptualized and defined in several different ways, making research on the topic challenging. While terms like cultural competence, intercultural competence, and cross-cultural competence have been used in the literature, this dissertation will use the term multicultural competence throughout. The first counseling training program that defined multicultural competence using the three tenets of knowledge, awareness, and skills was created in 1982 as part of a doctoral dissertation (S. D. Johnson, 1982). Since then, the definition and operationalization of multicultural competence has gone through a series of iterations to better reflect changing times.

In 1991, the *Journal of Counseling & Development (JCD)* came out with a special issue, "Multiculturalism as a Fourth Force in Counseling." This volume brought together scholars to define the construct of multiculturalism and promote its application in the field (Pedersen, 1991; Speight et al., 1991). Pedersen's article in this special issue framed multiculturalism as a

"generic" form of counseling and posited that it should be considered a fourth force in counseling, as all counseling relationships deal with culture. Pedersen's approach combined relativist and universalist thought, acknowledging that people must be viewed within both their shared and unique social contexts (Pedersen, 1991). He argued for a broad definition of culture, one that emphasized both between-group and within-group differences as well as factors such as socio-economic status, age, geographic location, race/ethnicity, and religion. He viewed a multicultural lens as both essential to the therapy process and complementary to other models of therapy (Pedersen, 1991). In another article in the special issue, Speight and colleagues highlighted that multicultural counseling involved the counselor being aware of bias and both their own and their clients' worldviews, emphasizing that achieving this awareness took "considerable introspection" (Speight et al., 1991, p. 35). The 1991 special issue also proposed various models for effective conceptualization and training of multiculturally competent mental health practitioners (D'Andrea & Daniels, 1991; Leong & Kim, 1991; McRae & Johnson, 1991; Sue, 1991).

In the same year, the Association for Multicultural Counseling and Development (AMCD) enlisted scholars and researchers to focus on multiculturalism in the counseling field. The call resulted in the development and publishing of the multicultural counseling competencies (MCC) to guide the field in multicultural practice (Sue et al., 1992). Sue, Arredondo, and McDavis (1992) provided a rationale for a multicultural perspective in counseling and outlined their tripartite model of multicultural counseling including three key tenets: beliefs/ attitudes, knowledge, and skills. The beliefs and attitudes dimension focuses on therapist awareness of their own biases and assumptions and the highlights the importance of therapists understanding their own culture (Sue et al., 1992). The knowledge dimension emphasizes counselor

understanding of their own worldview, their clients' worldview, and of the systems of oppression that influence each. Lastly, the skills dimension underscores that multiculturally competent therapists and counselors should seek out training and resources to promote their skills and actively work towards developing a non-racist identity (Sue et al., 1992). Sue and colleagues' 1992 work outlined the multicultural competencies associated with each of these domains and served as a call to action to endorse the competencies to move the profession forward. The authors highlighted the need for a multicultural approach given the changing nature of demographics in the United States and the growing recognition "that race, culture, and ethnicity are functions of each and every one of us and not limited to "just minorities"" (Sue et al., 1992, p. 478). Similar to Pedersen's 1991 article, Sue, Arredondo, and McDavis (1992) called for multicultural competence to be integrated into all counseling training and practice in an attempt to challenge the dominant discourse.

The Multicultural Counseling Competencies (MCC) were further expanded upon and operationalized by Arredondo and colleagues in 1996. They used the Dimensions of Personal Identity model (Arredondo & Glauner, 1992) to expound upon the MCC and illustrate how to put them into practice (Arredondo et al., 1996). The Dimensions of Personal Identity Model posits that people are multicultural individuals, people comprise of personal, political, and historical cultures, people are impacted by sociocultural, political, environmental, and historical events, and that to be multicultural is also a part of individual identity (Arredondo & Glauner, 1992). Arredondo and colleagues (1996) provided explanatory statements to illustrate specific processes that counselors need to go through in order to show multicultural competence across the domains of attitudes/ beliefs, knowledge, and skills. For example, counselors should specifically name and discuss privilege, address recent research on issues of racism, and be knowledgeable about

their social impact on others (Arredondo et al., 1996). These updates served as guideposts to shape research, theory, and practice and were suggested as competencies to guide the ACA's ethics and board certification (Arredondo et al., 1996).

Several instruments have been developed to measure the construct of multicultural counseling competence, the three most widely used are the Multicultural Awareness, Knowledge, and Skills Survey- Counselor Edition (MAKSS-CE, D'Andrea & Daniels, 1991), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS, Ponterotto, 1991), and the Multicultural Counseling Inventory (MCI, Sodowsky et al., 1994). These measures are based on Sue et al.'s tripartite model of multicultural competence along the dimensions of attitudes/ beliefs, knowledge, and skills (Sue et al., 1982; Sue et al., 1992). The MAKSS-CE was designed with 60 items across three subscales, awareness, knowledge, and skills. Early reviews found that the MAKSS-CE lacked rigor and validity and had a "rather unclear interpretive approach" (Dunn et al., 2006, p. 472). Despite this, the MAAKSS-CE has been widely used and was revised in 2003 to address these issues. The MCKAS was introduced in 1991 and has been revised several times. The current version has 32 items on two subscales, knowledge and awareness (Ponterotto & Potere, 2003). The MCI, another widely used scale, consists of 40 self-report items with four factors, awareness, knowledge, skills, and counseling relationship (Sodowsky, 1996). While the above measures have been frequently used, they are limited in scope to knowledge, awareness, and skills, and fail to assess the full spectrum of multicultural competencies in therapists.

More recently, instruments have been developed to assess multicultural competence with attention to social context. The Multicultural Competence Change Scale (MCCS, O'Neil, Caban & McWhirter, 2007) was created with the understanding that multicultural competence is developmental and fluid, rather than fixed (Caban, 2010). The MCCS was designed to measure

multicultural competence using the stages of change model (with scales: social acceptability, pre-contemplation, contemplation, preparation, action, and maintenance), commonly used in health promotion, and is the first measure of its kind to assess multicultural competence in this way (O'Neil, 2010). The Multicultural Competency Assessment (MCA), a 25-item measures was created to assess a) knowledge, skills and interventions, b) awareness of self, c) awareness of client worldview, and d) system and institutional structures (Mitchell, 2018). These measures add more depth to the measurement of multicultural competence by considering developmental contexts and moving beyond awareness, knowledge, and skills.

Multicultural competence being considered a fourth force of counseling represents an important step forward in effective mental health treatment. Its development aimed to bring more inclusivity to the practice and more attention to diverse client experiences. Incorporating multicultural competence helped to move beyond individual pathology by understanding the impact of culture on clients' lived experiences, opening the door for more accessible and culturally relevant services (Hays, 2008). However, the concept of multicultural competence has faced critiques for being reductionist and inadequate for addressing the needs of all clients and not attending to the intersectionality in clients' lives. Cultural competence frameworks, especially in their early development, were criticized for seeing culture as fixed and often conflating culture with race or ethnicity (Beagan, 2018; Carpenter-Song et al., 2007). Such frames emphasize knowledge and awareness over action and may lead to othering or stereotyping people by social or racial groups (Chao et al., 2011). While tools exist to measure this construct, they are limited in their scope and may not be adequately assessing whether therapists are enacting multiculturally competent practice.

In summary, while multicultural competence has brought the field forward, scholars argue that it must be accompanied by social justice in order to be effective (Ratts, 2009). In fact, Vera and Speight (2003) assert that if the mental health field "is to be committed to an agenda of multiculturalism… then the field must also be committed to social justice" (Vera & Speight, 2003, p. 254). They maintain that multicultural competence requires counselors to look beyond individual counseling interventions and think systemically to combat systems of oppression (Vera & Speight, 2003). Scholars urge the expansion of multicultural competence to be pluralistic and incorporate a critical lens that attends to power and privilege (Hays, 2008; Moodley, 2007).

Multicultural Competence and Social Justice

Calls to expand multicultural counseling to incorporate social justice have mounted over the last two decades. Vera and Speight (2003) emphasized that multicultural counseling should be grounded in the principles of social justice, but that it sometimes serves to perpetuate injustice by seeking to "change individuals rather than change the social context" (Vera & Speight, 2003, p. 258). In fact, Sue (1996) discussed how therapists can become remediation specialists, working with clients who exist in oppressive contexts, yet doing little to address these contexts themselves (Sue, 1996). Vera and Speight (2003) envisioned a new way to engage in clinical work, one that expands the scope of multicultural counseling and focuses on preventative services. Additionally, the authors suggested that multicultural competence should be reconceptualized to focus on macro-changes and leave room for counselors to incorporate systemic thinking into their work (Vera & Speight, 2003). Several scholars have also argued that taking action to combat oppressive systems is an essential component of socially justice clinical practice (Freire, 1970; Ratts et al., 2016; Vera & Speight, 2003).

Social justice is now considered to be the fifth force of counseling. Ratts (2009) deemed social justice a fifth force because of its paradigm shift to consider clients in the room as well as focus on the social contexts that they are embedded in. This framework further assists clinicians in determining whether the intervention should include individual/ relational counseling, social advocacy, or a combination of both (Ratts, 2009). Working from a social justice framework also involves giving more attention to how problems that show up in the therapy room are connected to oppressive social and environmental contexts. Despite the clear need for social justice advocacy to be part of effective counseling, scholars and practitioners have not agreed upon how to merge the two (Nassar & Singh, 2020).

The field of counseling has taken steps to codify social justice into clinical guidelines (Chang et al., 2010). The MCC were revised and updated to incorporate social justice in 2015 to promote more awareness and attention to context. The AMCD formed a committee to develop the revised competencies to include intersectionality and oppression and to help counselors to consider both individual- and advocacy-based interventions (Ratts et al., 2016). The revised Multicultural and Social Justice Competencies (MSJCC) incorporated social justice into the name highlighting the need to understand individuals within their social contexts and the importance of integrating social justice advocacy into client work (Ratts et al., 2016). The revised competencies also expanded the definition of culture, moving beyond race and ethnicity to consider other marginalized identities such as gender identity, SES, and disability, and their intersections.

Despite steps to include social justice in new frameworks and clinical guidelines, few research measures exist to operationalize the construct of social justice. The Social Issues Advocacy Scale (SIAS, Nilsson et al., 2011) includes 21 items and 4 subscales ranked on a scale

from 1 to 5 to measure political and social advocacy, political awareness, social issues awareness, and confronting discrimination (Nilsson et al., 2011). The team updated their measure in 2017, conducting an exploratory factor analysis that incorporated new scales relating to social identities, motivation, and relationship building (Marszalek et al., 2017). The Social Justice Scale (SJS, Torres-Harding et al., 2012) is a 24-item measure that is based in organizational and community psychology. It consists of 4 subscales, including attitudes, perceived behavior control, subjective norms, and behavioral intentions measured on a scale of 1 to 7 (Torres-Harding et al., 2012). Lastly, the Social Issues Questionnaire (SIQ, Miller, et al., 2009) is a 52 item scale that includes six subscales: social justice self-efficacy, social justice outcome expectations, social justice interest, social justice commitment, social justice supports, and social justice barriers (Miller et al., 2009). Fietzer and Ponterotto's 2015 review evaluates several instruments that measure social justice and advocacy. One of their main recommendations is for future inquiry into the discrepancies in mental health professionals' provision of socially just services to ultimately provide more equitable care.

Bringing the Field Beyond Multicultural Competence and Social Justice. Scholars who focus on social justice counseling have begun to move their practice beyond multicultural competence, which focuses on the knowledge, awareness, and skills of clinicians. Thomas and colleagues (2011) note a preference for the term "cultural confidence," stating that it is a "lifelong process based on the individual's self-reflection about their personal biases and prejudices" (Thomas et al., 2011, p. 10). Terms like cultural safety and cultural humility have been preferred over cultural competence in recent years because of their focus on power dynamics and imbalances inherent in healthcare fields. Kirmayer (2012) notes that cultural competence models have a one-size-fits-all approach and can further marginalize groups, while

the notion of cultural safety encourages an acknowledgement of difference and helps to build awareness that power imbalances exist in caregiver patient relationships (Curtis et al., 2019; Kirmayer, 2012). Similarly, Tervalon and Murray-Garcia (1998) make the distinction between cultural competence and cultural humility noting that the latter necessitates "a lifelong commitment to self-evaluation and self-critique" (p. 117) and an attention to inherent power imbalances (Tervalon & Murray-García, 1998). Foronda and colleagues (2016) similarly found that cultural humility was characterized by mutual respect and empowerment in patient caregiver relationships and a commitment to lifelong learning (Foronda et al., 2016). Foronda's (2020) theory of cultural humility prizes flexibility over the categorical nature of multicultural competence. By focusing on self-awareness, learning, and power dynamics, cultural safety helps lead to socially just clinical practice.

Additionally, the goal of many therapists' practice has moved beyond providing culturally competent services to providing anti-racist services or working to decolonize the field at large. A 2019 paper outlined a critical-conceptual framework to combat White supremacy and uphold anti-racist praxis through research, clinical practice, and advocacy (Grzanka et al., 2019). The authors discussed how to develop an anti-racist identity in detail, including building knowledge and awareness and exploring White racial identities and privilege. They outlined three practices for anti-racist work to combat White supremacy: (a) rejecting racial progress narratives, (b) conducting anti-racist clinical work with White people, and (c) identifying the structural dimensions of racism in institutions and practices that are not obviously racialized (Granzka et al., 2019, p. 503). This work emphasizes that, unlike multiculturalism which focused on clients of color, anti-racist work should focus on helping White people to recognize the role of White supremacy in their own and other people's lives. The authors encourage mental health therapists

to think systemically and to combat White supremacy through research, practice, and advocacy and to adopt an intersectional lens (Granzka et al., 2019). A recent article published in the Journal of Clinical Child and Adolescent Psychology summons the clinical world to take action on anti-racist science (Galán et al., 2021). The authors demonstrate how clinical fields perpetuate racial oppression and urge "the need for prompt and consistent efforts toward dismantling institutionalized racism and inequity in clinical science" (Galán et al., 2021, p. 13). This comprehensive paper outlines reform areas to target structural causes of racism in the field, and to focus on mental health needs, clinical training, curriculum, research methods, and hiring practices. Their call to action includes practices such as recruiting and hiring more students and faculty of color and reforming coursework and clinical training to include anti-racism.

To decolonize counseling practice, therapists must consider power structures that are embedded within our culture and work to change these systems (Gorski & Goodman, 2015). Singh, Appling, and Trepal (2020) discuss how the MSJCC can be used to decolonize counseling practice by highlighting contexts of power and oppression. They acknowledge that the counseling field often promotes Eurocentric ideas and attempts to "socialize and re-socialize those "at the margins" to fit into dominant cultural values and experiences" (Singh, Appling, et al., 2020, p. 262). The authors encourage counselors to consider other theories, such as critical consciousness (Freire, 1970), intersectionality (Crenshaw, 1989), and liberation psychology (Martín-Baró, 1994), to critically disrupt systems that maintain inequity and to promote social justice within the therapy room (Singh, Appling, et al., 2020).

The addition of social justice to multicultural counseling provides and integral step forward in the practice of psychotherapy. The MSJCC bring in contextual influences and attention to how social injustices contribute to adverse mental health outcomes. The frame can be utilized in

psychotherapy, supervision, and research to advance the profession forward and add dimension to the multicultural competence framework (Ratts et al., 2016). However, the MSJCC have not yet been fully operationalized and little empirical work has been done utilizing the competencies (Hays, 2020; Singh, Nassar, et al., 2020). Although the mental health field has evolved to include social justice within the scope of clinical practice, further research is needed on how clinicians enact social justice practice in order to meet the needs of the public and improve best practices in mental health care (Hays, 2020). Mental health scholars and practitioners continue to advance the profession and consider new paradigms to combat inequity and provide appropriate services to all people, especially those on the margins.

Therapists as Agents of Social Change

Social Justice in the Counseling Field

Increasingly, the role of mental health therapists is being expanded to move beyond the therapy room, and many scholars argue that counselors and therapists should be considered agents of social change (Chang et al., 2010; Crethar & Ratts, 2008; L. A. Goodman et al., 2004; Vera & Speight, 2003). In fact, more and more, a commitment to social justice is being seen as a moral imperative and an integral part of ethical clinical practice (Lee, 2007; Watson, 2019; Watts, 2004). At this point, several mental health professions have integrated a commitment to social justice into professional standards and ethical codes of practice. For example, the Council for Accreditation of Counseling and Related Education Programs (CACREP), the national accrediting board for counseling programs, considers social and cultural diversity among its core tenets of professional counseling and ethical practice (Council for Accreditation of Counseling and Related Education Programs, 2016). The National Association of Social Workers (NASW) has clearly outlined in their ethical codes a commitment to enhance human wellbeing, a focus on

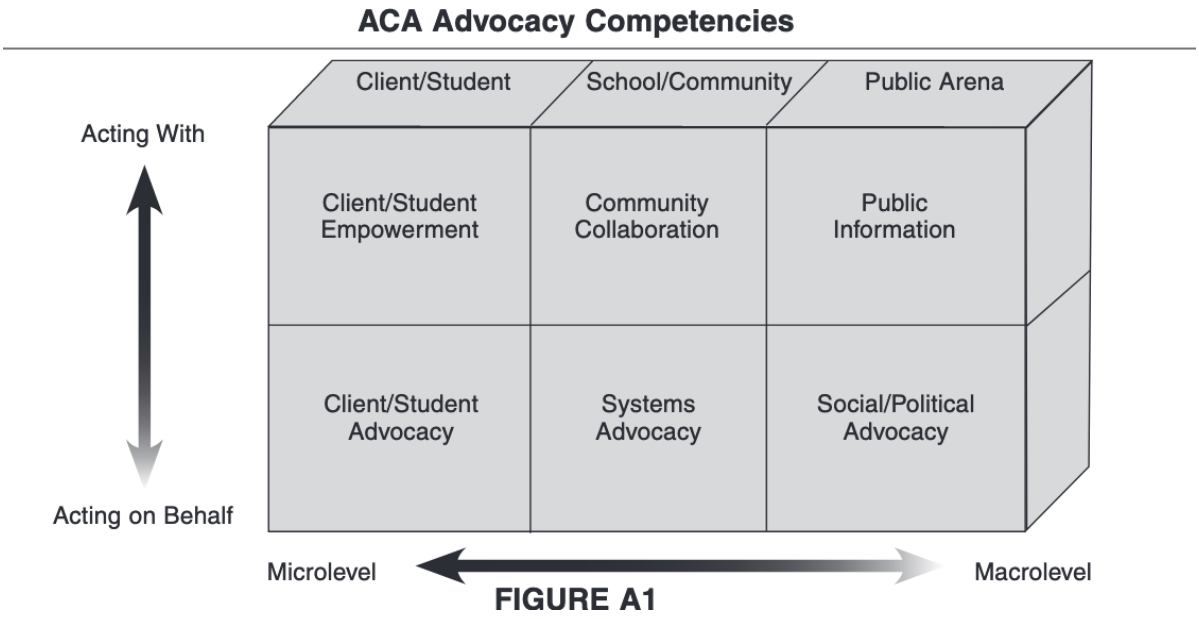
oppression, and understanding individuals within their contexts. The preamble of the NASW ethical code asserts "Social workers promote social justice and social change with and on behalf of clients" and its first two core values are service and social justice (National Association of Social Workers, 2017). The NASW website includes many social justice resources and outlines its social justice priorities as: voting rights, criminal and juvenile justice, environmental justice, immigration, and economic justice. The American Psychological Association (APA) developed their Guidelines on Multicultural Education, Training, Research, and Practice in 2002 and updated these guidelines in 2017. The 2017 version focuses on intersectionality and highlights the need for psychologists to understand power, privilege, and oppression and to address inequity (American Psychological Association, 2017). The APA also developed race and ethnicity guidelines in 2019 that encourage practitioners to build awareness of the influence of race, seek to understand their own positionality vis-à-vis race, and work to address bias and discrimination (American Psychological Association, 2019). These guidelines, designed for training, practice, and research, clearly outline the stance of the profession in promoting racial equity and social justice. In fact, over a decade ago, the APA's president, Melba J. T. Vasquez encouraged its members to be proactive in addressing critical social problems and continue their commitment to social justice (Munsey, 2011). Each of these therapy-allied professions has made a commitment to advancing equity and promoting social justice.

The American Counseling Association (ACA) has a longstanding commitment to social justice. The ACA Code of Ethics holds the promotion of social justice as one of its core professional values (American Counseling Association, 2014). Three additional statements on social justice and human rights focusing on immigrants and the LGBT community were added to their code of ethics in 2017. Social justice advocacy is highlighted as a key piece of counseling

practice by the ACA and touted as an effective way to promote systemic change (Toporek et al., 2009). The ACA Advocacy Competencies were developed in 2002 by Lewis, Arnold, House, and Toporek, and adopted by the ACA the following year. The ACA advocacy competencies were created to imbue counselors with the knowledge, skills, and behaviors to address systemic barriers and to distinguish when intervention is necessary at the individual level or at the community or policy level (Toporek et al., 2018). These competencies complement the MSJCC and were updated in 2018. The advocacy competencies help counselors to better address systemic barriers both within and outside of the therapy room (Toporek & Daniels, 2018). The competencies are operationalized in a multidimensional model from micro- to macro-level advocacy across two levels, acting with or acting on behalf of the client, with three domains: client/student, school/ community, and public arena.

Figure 3

ACA Advocacy Competencies



Note. Figure comes from American Counseling Association Advocacy Competencies developed by Lewis, Arnold, House & Toporek (2003) and updated by Toporek & Daniels (2018)

Toporek, Lewis, and Crethar (2009) acknowledge that counselors have long advocated for their clients and have worked to fight oppression, though only recently has advocacy been widely accepted as core to counselors' professional identity (Toporek, et al., 2009). The ACA advocacy competencies state that counselor-advocates should be able to recognize the impact of systems that clients are embedded within, increase client empowerment, and advocate for systemic change (Toporek et al, 2009). Ratts's Counselor-Advocate-Scholar model provides another framework to change the discourse for counselors to be able to hold each of these identities as central to their practice and consider themselves social change agents (Ratts & Greenleaf, 2018). A 2020 survey of professional counselors found that 74% of respondents participated in advocacy groups as part of a professional organization, 80% had contacted policymakers about a social justice issue, and 98% reported advocating for a client to receive services (Na & Fietzer, 2020). The results of this study provide an example of how advocacy can be integrated into and enacted within one's counseling practice. In fact, in 2004, Goodman and colleagues asserted that counseling "faculty members need to prioritize social justice work, making it integral to the curriculum and not just an appendage to traditional academic programs" (L. A. Goodman et al., 2004, p. 829). Arredondo and Perez suggest looking to social justice leaders like Martin Luther King Jr. and Rosa Parks to promote advocacy and activism within the field (Arredondo & Perez, 2003). A 2018 study explored how ten peer nominated "exemplar counselor advocates" developed their social justice interest. This study claimed to be the first to provide empirical evidence on the topic and found that these counselors often came to social justice at a young age and that their interest grew "from awareness of their own unmet needs" (Swartz et al., 2018). The results showed that exposure to injustice ignited an interest in social

justice for some, while a recognition of privilege spurred others to social justice (Swartz et al., 2018).

Many mental health disciplines prioritize social justice and a commitment to addressing systemic barriers that their clients face. The NASW, APA, and ACA are examples of associations that have focused on and codified a commitment to social justice, multicultural competence, and advocacy practice. The ACA created Advocacy Competencies to guide counselors in making decisions around advocating for their clients, whether on the micro- or macro-level, and acting on behalf of clients or with them. While the CFT field has a focus on systemic thinking, there is no iterated commitment to social justice or to combatting systems of inequality in the field's code of ethics or guiding principles.

Social Justice in the CFT Field

The CFT field has debated the role of therapists in promoting social justice for decades. Currently, the American Association for Marriage and Family Therapy (AAMFT) does not mention a commitment to social justice in its ethical code, though they state a commitment to service, advocacy, and public participation and "diversity, equity, and excellence in clinical practice, research, education, and administration" (American Association for Marriage and Family Therapy, 2015). Although CFTs are experts in systemic thinking, AAMFT does not specifically identify a need to combat systems of oppression or a commitment to social justice as central to its mission. AAMFT put forth a statement on countering racism in June of 2020, imploring professionals to stand against injustice and promote diversity, mentioning the need to advocate against societal inequalities and counter racism (American Association for Marriage and Family Therapy, 2020). The Commission on Accreditation for Marriage and Family Therapy (COAMFTE), the regulating board for CFTs, makes brief mention of the need for anti-racist

practice in its most recently updated accreditation standards (Commission on Accreditation for Marriage and Family Therapy, 2020). Efforts to advance the dialogue on the role of therapists in promoting social justice in the CFT field are present, but not unified.

According to a 2022 AAMFT report, the field is becoming more diverse and skewing younger, with 25% of study respondents self-identifying as people of color, compared to 17% in 2012 (American Association for Marriage and Family Therapy, 2022). With both the population at large and the CFT workforce becoming more diverse, more attention is needed to promote social justice and equity for all. Diversity was first mentioned in the COAMFTE accreditation standards in 2005 and a 2017 revision to the COAMFTE accreditation standards included a section devoted to diversity and inclusion efforts. This revision outlined the requirement for CFT curricula to include one course on diverse, multicultural, or underserved communities (Commission on Accreditation for Marriage and Family Therapy, 2017). Seven years before this mandate, Laszloffy and Habekost (2010) reported that approximately 60% of accredited CFT masters programs included one course on diversity and oppression (Laszloffy & Habekost, 2010). A decade later, Katafiasz and Patton (2021) note that there is still little guidance on how to include diversity and inclusion in CFT program curricula. The authors outlined their detailed process of reviewing and improving their CFT program's commitment to diversity, inclusion, and multicultural competence (Katafiasz & Patton, 2021).

Currently, 27 COAMFTE accredited programs advertise an explicit focus on social justice in their curriculum and training. Thirty-two additional programs make a reference to a commitment to cultural competence or diversity without mentioning social justice or an anti-oppressive lens. Adler University includes in its student learning outcomes a goal to "describe, understand, and identify issues of social justice, social responsibility, and oppression with

couples and families" (Adler University, n.d.). Antioch University Seattle states that its mission is "to prepare and train knowledgeable, skilled, self-aware, ethical, and anti-racist couple and family therapists in a learning environment that centers anti-white supremacy and social justice in its academic experience" (Antioch University, 2023). The Lewis and Clark Marriage, Couple, and Family Therapy program states in its program philosophy a commitment to "advocate for cultural democracy and social equity by infusing the curriculum with multiculturalism, highlighting issues of social justice, encouraging cultural immersion experiences, and promoting global citizenship in faculty, students, and supervisors" (Lewis & Clark Graduate School, n.d.). Programs such as these chart a course for other CFT programs across the nation to advance social justice through training, supervision, and clinical practice.

In 2001, several prominent scholars debated the role that CFTs should play in addressing oppression and other systemic contexts outside of the therapy room. Johnson (2001) discussed his observation that some therapists in the CFT field believed that "the mission of the clinical profession of Family Therapy [was to] solve national and international problems of conflict and bigotry" (S. Johnson, 2001, p. 3). Johnson critiqued the belief that family therapists should work to save a "sick society" and asserted that CFTs should only work to improve relationships among couples and families. He discussed the history of systemic therapy and his view that CFTs were prone to "messianic tendencies" by wanting to solve problems happening in contexts beyond the family system (S. Johnson, 2001). In response to the article, Sluzki (2001) explained how external contexts like politics and healthcare shape the therapy process and can serve to oppress families. He urged therapists to strive to "save the planet" and address contexts that help improve quality of life for their clients (Sluzki, 2001). In another response to Johnson's article, Hardy (2001) acknowledged the crisis that the CFT field was in and raised questions about its future

mission and purpose (Hardy, 2001). Hardy discussed the shortsightedness of promoting the wellbeing of couples and families without working to combat oppression due to societal forces. Hardy (2001) advocated for working to transform the human condition, and stated, "I should cease to serve as therapist when I become unwilling or unable to assume the position of activist" (Hardy, 2001, p. 19). Hardy asserted that family therapists must be willing to understand people within all the contexts they are embedded in and that sociocultural influences are an important component of what makes people who they are and what brings them to the therapy room (Hardy, 2001). Decades later, the CFT field still seems to be at a crossroads, unsure of the role of therapists in intervening in systems outside of the therapy room.

Despite a lack of a clear social justice identity in the field, there have been scholar practitioners who have consistently advocated for more attention to the contexts of oppression in the CFT field. In recent years, scholars have urged CFTs to work to promote human dignity and be willing to challenge oppressive structures that uphold injustice and to focus more on multicultural training (Dadras & Daneshpour, 2018; Watson, 2019). McGoldrick and colleagues (1999) discussed their social justice-informed training at the Family Institute of New Jersey. Informed by a feminist perspective, they attend to gender, race, class, and heterosexism by raising critical consciousness (McGoldrick et al., 1999). McGoldrick and colleagues (1999) discussed the importance of raising awareness of privilege and oppression and developing anti-racist consciousness. The first volume of *Re-Visioning Family Therapy: Race, Culture, and Gender in Clinical Practice* was published in 1998 and included chapters on culture, race, privilege, and oppression. This important volume has been revised twice, with the most recent edition published in 2019, bringing the CFT field forward in terms of its attention to race, gender, and multiculturalism. The book's second and third editions, edited by McGoldrick and

Hardy, include sections on racial identity, cultural legacies, and implications for clinical practice and training. In the most recent edition's introduction, McGoldrick and Hardy encourage CFTs to broaden their conceptualization of systemic therapy by including cultural contexts and re-visioning dominant discourses (McGoldrick & Hardy, 2019).

Over the past two decades, Teresa McDowell and colleagues have been a consistent voice in promoting social justice in the CFT field (M. Garcia et al., 2009; Knudson-Martin et al., 2019; McDowell et al., 2002, 2003, 2019; McDowell & Hernández, 2010; McDowell & Shelton, 2002; E. O. Parker & McDowell, 2017). In 2002, McDowell entered the debate over the professional identity and expectations of CFTs, stressing the importance of social justice and diversity in training programs (McDowell & Shelton, 2002; McDowell et al., 2002). McDowell and Shelton (2002) discussed the need to address oppression and inequity while working with families, to integrate social justice into foundational CFT courses and to apply a critical lens when evaluating therapy models and techniques (McDowell & Shelton, 2002). This critical multicultural lens allows for adaptation of traditional therapy models while attending to power and privilege and addressing social inequities that impact family systems (McDowell, 2005; E. O. Parker & McDowell, 2017). McDowell and colleagues (2002) asserted that "Marriage and family therapy educators must assume positions of leadership by transforming graduate programs to reflect a deep, active, systemic commitment to both diversity and social justice" (McDowell et al., 2002, p. 179). Garcia and colleagues brought these ideas to the supervisory system by highlighting critical consciousness as a key skill to address intersections of oppression and privilege in clinical supervision (M. Garcia et al., 2009). They suggest that supervisors devote time to promoting the development of critical consciousness and utilize tools such as a critical genogram, mapping social capital, or questionnaires to explore privilege (M. Garcia et al., 2009).

McDowell and colleagues' (2019) article introduced a paradigm shift and promoted third-order thinking as a way to encourage systemic change in families (McDowell et al., 2019). The advent of family therapy ushered in a wave of systemic thinking to the mental health field. First-order systems theory gradually transitioned to second-order thinking, wherein a therapist takes on a collaborative and nonjudgmental stance and recognizes the therapists' role in the system (Hoffman, 1985). While first order change focuses on symptom reduction for the individual and their presenting problem, second order change involves shifting the dynamics of the system itself (Davey et al., 2012). The shift to third-order thinking provides a meta-view of the family system by understanding the social contexts and power structures that families exist within. Additionally, it requires therapists to understand their own social location and understand relationships between the therapist, clients, and society (McDowell et al., 2019). This awareness and understanding ideally leads to efforts to change the unjust social systems at play for families. Adopting a meta-perspective allows for a nuanced understanding of the therapeutic work within systems of power and encourages therapists to help clients understand the impact of the multiple systemic influences in their lives (McDowell et al., 2019).

Two other models have been developed to help CFTs integrate social justice into their practice: The Cultural Context Model (Almeida et al., 1998) and Socioculturally Attuned Family Therapy (Knudson-Martin et al., 2019; McDowell et al., 2018). The Cultural Context Model (Almeida et al., 1998) is a social justice-based family therapy model that encourages the promotion of critical consciousness, accountability, and empowerment (Hernández et al., 2009). Originally developed for treating domestic violence in couples, the framework helps families to understand their situation in the broader contexts of society and retell their narratives (Almeida et al., 1998; Almeida & Durkin, 1999; Hernandez, 2004). Socioculturally Attuned Family Therapy

helps to ground presenting concerns that clients bring to the therapy room within the broader social systems and power dynamics in their lives. Therapists are encouraged to consider individual problems within the context of societal narratives such as capitalism and the patriarchy and recognize how such narratives impact clients' understanding of their own problems (Knudson-Martin et al.., 2019). Knudson-Martin and colleagues outline six guidelines for socioculturally attuned practice to move clinicians from awareness to transformation: attune to context and power, name injustice, value what is minimized, intervene in power dynamics, envision just alternatives, and transform to make the imagined a reality (Knudson-Martin et al., 2019). These guidelines help to make social justice practice clear by outlining steps of socially attuned practice with a focus on not only noticing power dynamics and imbalances but intervening in them and helping families to envision and enact equitable transformation (Knudson-Martin et al., 2019).

Two reviews of literature on diversity and social justice have also been published in the field of family therapy. Kosutic & McDowell (2008) reviewed five family therapy journals between 1995 and 2005 for articles on cultural identity, cultural competence, and social justice. While the scope of their review was large, only 27 (1.6%) of articles published between 1995 and 2005 focused on cultural competence in family therapists and less than 1% of articles (n=16) specifically mentioned social justice. The authors did, however, find an increase in articles that focused on diversity and social justice over time (Kosutic & McDowell, 2008). Seedall and colleagues' 2014 study reviewed articles published between 2004 and 2011 in three family therapy journals for focus on diversity, social justice, and intersectionality (Seedall et al., 2014). They used content analysis and found that 13.5% (*n*= 104) of articles published across the 8-year time period addressed at least one diversity issue from a social justice perspective. The authors

were encouraged by growing trends of scholarship on diversity, social justice, and intersectionality, and encourage future work to focus on systemic aspects of social inequality with more attention to power, oppression, and privilege (Seedall et al., 2014).

The importance of incorporating social justice into psychotherapy is increasingly being recognized. Unlike other mental health fields, the CFT field does not have social justice codified into its mission statement or ethical codes. Voices in the field have discussed the importance of social justice for decades (e.g. Hardy, McGoldrick, and McDowell) and highlighted how practicing with a systemic lens must incorporate a commitment to challenging social injustices. Despite a growing interest in the topic, very little empirical evidence of social justice practice in the CFT field exists. More research is needed on whether CFTs are currently integrating social justice into clinical practice and how this is being done.

Micro- and Macro-level advocacy in the CFT Field. Because of their systemic training, CFTs are uniquely poised to promote systemic change. While CFT scholars have been discussing how to integrate social justice into therapy for decades (see Almeida & Durkin, 1999; Beitin & Allen, 2005; McDowell & Shelton, 2002), more attention has been given in recent years to the ways that CFTs can and should be involved in creating systemic change and promoting social justice advocacy (J. M. Goodman et al., 2018). Despite recent efforts to encourage CFTs to integrate advocacy into their professional work, there is little empirical evidence on whether and how well CFTs are doing this. One qualitative study (n=11) explored therapist activism among postmodern therapists, aiming to understand how such therapists maintain multiple perspectives while attending to injustice and other sociocultural influences (D'Arrigo-Patrick et al., 2017). The authors found that both critical and postmodern therapists worked to "attend to and disrupt oppressive sociopolitical contexts and processes" and took on "therapeutic activism as their

ethical responsibility" as clinicians (D'Arrigo-Patrick et al., 2017, p. 580). These therapists struck a balance between attending to the needs of their clients in the room and bringing in outside contexts when warranted. CFTs should attend to both the micro-level, with clients in the room, and macro-level, advocating systemically or politically, advocacy (Holyoak et al., 2020; Toporek et al., 2009).

According to a 2020 article, micro-level advocacy, as opposed to macro-level advocacy, is commonly practiced by CFTs (Holyoak et al., 2020). Micro-level advocacy is a client-centered approach in which therapists help their clients to address institutional barriers and advocate for themselves (Gehart & Lucas, 2007; Ratts, 2009). While perceived barriers to larger-scale advocacy efforts exist for CFTs, micro-level advocacy occurs frequently within the therapy room when therapists help clients to understand their problems as being linked to larger societal contexts of oppression (Holyoak et al., 2020). Micro-level advocacy can include advocating for a client within the family system as well as advocating for clients in contexts outside of the therapy room such as within the medical system or with other providers.

In addition to considering social justice within the therapy room, CFTs should also consider how macro-level advocacy fits into their professional identity (J. M. Goodman et al., 2018; Jordan & Seponski, 2018b, 2018a). Micro-level advocacy may serve as a bridge between systems therapy and advocacy at the macro-level. Gehart and Lucas (2007) encouraged CFTs to move from awareness to action by implementing flexibility in how they deliver services in the room and collaborating with social services outside of the room. Goodman, Morgan, and colleagues (2018) highlighted the importance of social and political advocacy in the CFT field, noting that CFTs are well poised to use their systemic skills to advocate to improve family and community well-being. They discussed the need for advocacy training for CFTs and an

integration of the role advocate into their professional identity as therapists. Systemic therapy should not be limited to the systems present in the room. It must include larger societal systems and advocacy efforts at the state and national level. The self-of-the-advocate model is presented as a way to promote an understanding of one's own social location and potential for political self-efficacy (J. M. Goodman et al., 2018).

Jordan and Seponski (2018b) also assert that family therapists have an ethical duty to advocate, claiming that therapy is inherently political and that advocacy is necessary "to advance the family therapy profession and to promote human rights" (p. 5). The authors highlight the impact of policies on families and the need for family therapists to intervene in broader systems to promote justice and equity. Jordan and Seponski's study is the first to explore political engagement among family therapists (Jordan & Seponski, 2018b). They surveyed 174 family therapists across the country to understand the ways that therapists are politically engaged. From their survey and open text responses, the researchers found that over 86% of participants believe that therapists had a role in political and policy processes, however there were mixed results in terms of how therapists enacted their role as advocates. They found that nearly 94% of respondents had voted in the last national election and that 90.2% engaged in political discussion with family. However, only 35% of respondents had attended a political rally, 31% had worked to change a policy for a client, and 11.5% had organized a social action group. Jordan and Seponski (2018a) also explored therapists' barriers and beliefs to political action. They surveyed 174 family therapists and found that while 86% of therapists believed that they have a role in political and policy processes, that 93% did not believe political and policy issues should be discussed with clients (Jordan & Seponski, 2018a). The vast majority of clinicians surveyed voted in the last national election and two thirds had lobbied at the state level, but these efforts

were almost completely separate from their work within the therapy room. This important finding shows the need for a stronger emphasis on advocacy in CFT training, and an understanding that client wellbeing is embedded within sociopolitical contexts.

As systemic therapists, CFTs have expertise in understanding how contextual factors shape individual functioning. Many CFTs likely engage in micro-level advocacy in their day-to-day work by advocating for their clients with other family members or medical professionals (Holyoak et al., 2020). CFTs should also be aware of larger sociocultural and sociopolitical influences that impact clients' daily lives and strive to promote advocacy on the macro-level. Critical consciousness may be a key tool in building out awareness of and action toward social justice both within and outside of the therapy room (Shin, 2015). More information is needed to understand whether and how CFTs enact socially just clinical practice both within and outside of the therapy room.

Towards An Anti-Racist Praxis. In the last decade there has been a push in healthcare to focus efforts on anti-racism and infuse it into everyday practice. The fields of nursing and public health have recently made urgent appeals to prioritize anti-racism training, especially spurred by the health disparities seen throughout the COVID-19 pandemic (Blanchet Garneau et al., 2018; Essien & Ufomata, 2021; Hassen et al., 2021; Koschmann et al., 2020). In their 2022 paper, Huffstetler and colleagues put forth a call to action for practitioners to "explicitly address systems of oppression in their everyday praxis" (p. 21). Best practices in mental health care require attention to marginalized groups and an integration of anti-oppression and anti-racism into everyday care (Corneau & Stergiopoulos, 2012).

The field of Couple and Family Therapy remains at a crossroads. Traditional norms of the family and Eurocentric ideas still largely govern research and practice. However, scholars

continue to advocate for new research, practice, and policies to bring the field forward. For example, McDowell and Jeris (2004) stated, “There needs to be continued efforts made in MFT to develop anti-racist approaches to therapy, supervision, education and research to advocate actively for social justice” (McDowell & Jeris, 2004, p. 90). A 2013 dissertation highlighted the importance of programs creating an anti-racist environment and noted that student resistance and lack of instructor preparedness were barriers to fostering an anti-racist learning environment (Diggles, 2013). Family scholars have also used decolonizing frameworks to discuss ways that researchers and practitioners can dismantle the system of White supremacy through new approaches (Bermúdez et al., 2016; Jordan, 2022b, 2022a; McDowell & Hernández, 2010). Such approaches require reflexivity and accountability and can create space for inclusivity and intersectionality in training programs and in academia (Bermúdez et al., 2016; McDowell & Hernández, 2010).

Conclusion

Multicultural competence and social justice are now considered by many mental health fields as essential to the practice of psychotherapy. Recent scholars have noted that while multicultural competence has moved the field forward in an important way, it is insufficient to create lasting change for clients. Social justice awareness and advocacy are necessary to combat the systems of oppression that psychotherapy clients face and to create a more just world (Ratts, 2009; Vera & Speight, 2003). There has been much discussion in the fields of counseling and social work about how to best incorporate social justice into clinical work. While the CFT field emphasizes systems and systemic change, it does not prioritize social justice in its bylaws or guidelines for practice. Very little is known about competencies in the area of multicultural competence and social justice for CFTs. This dissertation utilizes both quantitative and

qualitative methods to explore multicultural competence, social justice, and advocacy in CFT clinical practice. Survey methods were used to understand the current competencies and practices of CFTs and determine what personal and professional factors are associated with higher levels of competence in these areas. Additionally, interviews were conducted with CFTs on their training and clinical practice in the area of multicultural competence and social justice. Interviews gave insight into the future of practice and training for CFTs to move the field forward and meet the current needs of the population.

Chapter 3: Methods

Methodological Approach and Study Design

This study utilized a cross-sectional mixed methods design to better understand the social justice practices of CFTs. The first aim of this study was to assess CFTs' current levels of multicultural competence, social justice commitment and self-efficacy, and advocacy competence. The second aim of this study was to determine the association between demographic and professional characteristics and multicultural competence, social justice commitment and self-efficacy, and advocacy competence. Both of these aims were assessed quantitatively. The final aim used qualitative methods to explore how CFTs develop multicultural and social justice counseling competencies and the processes by which they embody a critically conscious, social justice-oriented identity. In-depth, individual interviews were conducted to understand therapist social justice praxis both within and outside of the therapy room.

This study's use of mixed methods combines complementary methodologies to understand the phenomenon of socially just and multiculturally competent clinical practice. According to Creswell and colleagues (2003), mixed methods designs can strengthen research studies, especially in the social sciences. Ponterotto and colleagues (2013) echo this sentiment, claiming that "the flexibility inherent in mixed methods studies can result in a more holistic and accurate understanding of the phenomena under study" (Ponterotto et al., 2013, p. 47). At its basic level, mixed methods research combines both qualitative and quantitative data. Mixed methods research traditionally included three basic design options (exploratory sequential, explanatory sequential, and convergent) to describe the timing and order of data collection, yet

more recently additional advanced paradigms have been created to shape methods and analysis (Fetters et al., 2013).

Much discussion has been had over the last several decades of whether a researcher's philosophical orientation must match up with their research method, mostly spurred by the work of Lincoln and Guba. Guba and Lincoln (1988) outlined differences between the research processes of positivist researchers compared to constructivist researchers in terms of their epistemology, ontology, axiology, and methodology (Guba & Lincoln, 1988). This paradigm debate has led some researchers to believe that quantitative and qualitative frameworks were incompatible, however recent frameworks provide an overarching lens through which mixed methods researchers can approach their studies (Creswell et al., 2003). Creswell and Tashakkori (2007) expanded on the various perspectives that mixed methods scholars can take while approaching research design and data analysis. Their 2007 article outlined the method perspective, wherein data collection and analysis are focused on the questions involving qualitative and quantitative research, and are largely free of any philosophical paradigm (Creswell & Tashakkori, 2007). Many scholars, however, consider this approach to be incomplete. Mertens (2010) asserted, "If researchers do not acknowledge (or know) the philosophical assumptions that underlie their works, this does not mean that they have no philosophical assumptions. It merely means that they are operating with unexamined assumptions" (p. 9). In contrast, the paradigm perspective, often used in social research, outlines the philosophical assumptions that the researcher brings to the table, going beyond simply combining qualitative and quantitative data (Creswell & Tashakkori, 2007). Creswell and Tashakkori (2007) asserted that the paradigm perspective is not incompatible with combining methods that historically come from different perspectives (i.e. mixing quantitative methods

from a positivist tradition and qualitative methods from a constructivist tradition), but that it can, in fact, be a way to unify qualitative and quantitative through an overarching framework.

One paradigm utilized more in recent years is the transformative paradigm, often considered a critical or a participatory approach. Mertens (2007) called the approach a good fit for a researcher "who recognizes inequalities and injustices in society and strives to challenge the status quo" (p. 212). Creswell and colleagues concurred, saying of the paradigm, "The commonality across transformative studies is ideological, such that no matter what the domain of inquiry, the ultimate goal of the study is to advocate for change" (Creswell et al., 2003, p. 176). Mertens (2012) underscored how a transformative methodological approach has implications for each process of the research endeavor from study design to data collection to how the findings are used. In an earlier article, Mertens (2007) laid out the basic tenets of a transformative approach within the lens of Guba and Lincoln's four sets of philosophical assumptions: ontology, epistemology, methodology, and axiology (Guba & Lincoln, 2005; Mertens, 2007). Ontologically, the transformative paradigm supports the social construction of multiple realities, yet also acknowledges the role of sociopolitical and cultural influences that award differential levels of privilege to different groups based on social location. As such, the researcher must critically examine who has defined the current version of reality and determine whose voice is missing to promote social justice and equity in the research process (Mertens, 2007, 2012). Epistemologically, researchers and participants should work in collaboration when possible. Understanding power and privilege and the way that these dimensions operate is also important in this domain (Mertens, 2010). Methodologically, the transformative paradigm generally considers the inclusion of a qualitative component to be necessary and a good way to build trust with participants. It prizes mixed methods as a tool to increase social justice to be able to both

engage in a dialogue and supplement with quantitative findings (Mertens, 2012). Ponterotto and colleagues' 2013 article also underlined how mixed methods research can be a powerful tool to promote social justice and provide opportunities for social transformation. Finally, in terms of axiology, which focuses on ethics, the transformative paradigm prizes self-awareness, self-reflection, cultural competence, and social justice (Mertens, 2010). This paradigm does not prescribe specific methodological or analytic approaches, but is well suited to a mixed methods study focusing on social justice (Mertens, 2007; Ponterotto et al., 2013)

The current study employed a sequential transformative design with two phases; quantitative data were collected first and after preliminary data analysis, qualitative interviews were conducted (Creswell et al., 2007; Hanson et al., 2005). This design follows the same two prong approach of a sequential explanatory design; however, it also prioritizes a social justice lens. This two-phase approach allowed for qualitative data collection to build on the quantitative results, adding to the depth of understanding and contextualizing the descriptive findings. In this study, the preliminary quantitative results guided the purposeful sampling procedure for the qualitative study participants (Creswell et al., 2003).

The survey data were collected first to understand the current levels of social justice and multicultural competence, social justice commitment and self-efficacy, and advocacy competence among practicing CFTs. Following preliminary quantitative analyses, qualitative was collected in the form of individual interviews to further explain and explore the phenomenon of being a socially just and multiculturally competent therapist. Once preliminary quantitative results were obtained, exemplar therapists who scored above 100 on the Multicultural Competency Assessment (MCA) and indicated interest in participating in interviews were contacted to be interviewed on their social justice practices. While the assessment does not

provide cutoff scores, a score of 100 out of 25 indicated an average of 4 out of 5 on each likert scale question. This participant selection approach meant that participants for the qualitative component of the study were purposefully selected to participate in semi-structured interviews based on the results of the survey findings that they were practicing in a multiculturally competent way (Creswell & Plano Clark, 2007). Thereby, data were integrated by connecting the survey results with interviews through the sampling frame (Fetters et al., 2013).

Qualitative interviews were conducted to further elucidate the phenomenon of socially just clinical practice and explored what values, life experiences, and training influence clinical practice. These interviews explored topics such as what allows CFTs to take on the role of social change agent, how CFTs strive to advocate both inside and outside of the therapy room, and what models or frameworks multiculturally competent therapists utilize in their clinical practice. This multiprong approach adds a richer understanding of socially just clinical praxis in CFTs and aims to uncover both the *what* and the *how* of this process.

Interview participants were contacted later in the data analysis process to expand on quantitative findings through use of member checking. Participants were emailed to confirm that qualitative findings matched their experiences and asked if they had any other thoughts about how their social location influences their socially just clinical practice. Male participants were contacted and participated in a follow-up interview by phone or video to expand on their thoughts around how gender impacts socially just clinical practice and advocacy. These insights informed the discussion as the male participants described being unsure of their place in the current social justice movements and sometimes intentionally stepping back to leave space for others to participate. Two Black female participants provided additional insight into how social location shapes their social justice practices. These member checks provided additional insight to

integrate the quantitative results with qualitative findings in the interpretation phase (Creswell et al., 2003).

Figure 4

Sequential Transformative Design

Quantitative Component

Sample

Participants for this study were recruited nationally. To participate in this study, mental health practitioners must have graduated from a COAMFTE accredited program in the last 20 years with a masters or doctoral degree and be either a full licensed Marriage and Family Therapist or be in the process of gaining clinical licensure. According to the American Association for Marriage and Family Therapy (AAMFT), there are over 50,000 CFTs currently practicing in the US. Each of the fifty states and the District of Columbia has their own licensing board that regulates the practice of marriage and family therapy. Each board regulates the licensing type, from full clinical license to provisional license and includes categories such as Licensed Marriage and Family Therapist, Licensed Clinical Marriage and Family Therapist, Licensed Associate Marriage and Family Therapist, and Marriage and Family Therapist Intern. All license types, whether full or provisional will be included in the present study. According to Data USA, in 2020, females comprised approximately 77% of licensed marriage and family therapy professionals. According to 2020 data, almost 65% of CFTs are White and approximately 17% are Black. The average age of CFTs is 44 years old (Data USA, 2020).

AAMFT's 2022 workforce survey found that 76% of MFTs were White and 10% were Black with an average age of 45 years old. They also found that 77% of the MFT field identified as women (American Association for Marriage and Family Therapy, 2022).

Data Collection

Before data collection began, the University of Maryland Institutional Review Board (IRB) approved this study and all documents, including the recruitment scripts, survey, informed consent, and full research protocol. The research protocol and consent forms were found to provide adequate protections to the privacy and confidentiality of the research participants. Recruitment occurred using various strategies. Publicly available contact information was culled from statewide Marriage and Family Therapy board databases. National networks including the American Association for Marriage and Family Therapy (AAMFT) and the National Council on Family Relations (NCFR) were utilized to post to relevant listservs to recruit CFTs to participate in the study. I utilized social media groups and listservs such as DC Therapist Connect and MFTs for Social Change. I also contacted the department chair and/or clinical director of every COAMFTE accredited program in the nation by email to circulate the call to eligible participants. Lastly, I reached out to personal contacts via email and ask them to circulate the study announcement within their networks. Survey participation was incentivized by a donation of $1 for each survey completed up to 200 to So Others Might Eat (SOME), a Washington DC-based organization that works to break the cycle of homelessness through comprehensive services.

Participants were eligible to complete the survey if a) they had a full license (i.e. LMFT, LCMFT), were a provisionally licensed Couple and Family Therapist (i.e. LGMFT, LMFTA), or were in the process of gaining licensure, b) were currently practicing as a Couple and Family

Therapist (CFT), and c) had graduated from a COAMFTE accredited program within the last twenty years. Once screened for eligibility, all participants completed an informed consent document that included language recommended by the UMD IRB on the purpose of the study and its benefits and risks. Potential study participants were reminded at this stage that their participation in the research is completely voluntary. Eligible participants completed a survey that lasted approximately 20 minutes and was administered electronically through Qualtrics.

Confidentiality of participants was maintained by delinking survey data from any identifying information. The survey data is anonymous and is only identified through an IP address in the Qualtrics system that was only active while the survey was live to ensure that each participant only took the survey one time. At the end of the survey, participants were asked whether they would be interested in being contacted for a qualitative interview further exploring therapist beliefs about and participation in social change within and outside of the therapy room. If participants indicated interest in taking part in an interview, they were asked to provide their name, email address, and phone number. Because the survey responses had a direct impact on eligibility to complete an interview, a random ID was generated to link survey data with contact information for those who provided it.

Measures

Demographic Variables.

Age. Participants self-reported their current age in years.

Race. Participants self-reported their race by selecting Black or African American, White, Asian, American Indian, Native Hawaiian or Pacific Islander, bi-racial, multi-racial, or other (please specify). This variable was dummy coded into White, Black, and Other variables.

Ethnicity. Participants self-reported their ethnicity by selecting yes or no when asked "Are you of Hispanic or Latino descent?"

Gender Identity. Participants self-reported their gender identity by selecting male, female, non-binary/third gender, or prefer not to say. For analytic purposes, the variable was dummy coded into Female, Male, and Nonbinary variables.

Sexual Orientation. Participants self-reported their sexual orientation by selecting heterosexual, lesbian, gay, bisexual, asexual, or other (please specify). For analytic purposes, a dichotomous variable was created for heterosexual participants versus LGBQ participants given the cell size of each variable.

Religion. Participants answered whether they currently practice any religion, selecting 'yes' or 'no'. If yes, participants self-reported their religion by selecting Roman Catholicism, Christianity/Protestant, Mormonism, Judaism, Islam, Buddhism, Hinduism, or Other (please specify). For the purpose of analysis, religion was included as a dichotomous variable (yes/ no).

Education. Participants self-reported their highest education level attained by selecting from master's degree or doctoral degree.

Household Income. Participants self-reported their current household income by selecting from Less than $25,000, $25,000-$49,999, $50,000-$74,999, $75,000-$100,000, or over $100,000.

Relationship Status. Participants self-reported their relationship status, selecting Single, Married, Separated/ Divorced, Widowed, Cohabiting, or Dating but not living together.

Civic Engagement. Participants self-reported their level of civic engagement by answering one question: "I would consider myself to be committed to civic engagement (e.g. voting, volunteering in the community, advocating for causes I care about). Participants self-

reported their answer by selecting 1) strongly disagree, 2) disagree, 3) neutral, 4) agree, 5) strongly agree.

Privilege. Participants' self-reported level of privilege was measured using the Experiences with Cultural Identities Questionnaire privilege subscale (ECIQ) (Caban, 2010). Respondents indicated their perceived level of privilege across seven domains (ability/disability status, gender identity, nationality, sexual orientation, socioeconomic status, race/ethnicity, and religion) using a likert scale of 1-5. Participants responded to the question: "I am very privileged in terms of the following cultural identities" and answer choices included 1) this statement is not at all true for me, 2) this statement is not very true for me, 3) this statement is moderately true for me, 4) this statement is mostly true for me, or 5) this statement is very true for me. A composite measure of privilege was computed by using the mean score across each domain of privilege. A higher score indicated a higher level of privilege.

Oppression. Participants' self-reported level of oppression was measured using the Experiences with Cultural Identities Questionnaire oppression subscale (ECIQ). Respondents indicated their perceived level of oppression across seven domains (ability/disability status, gender identity, nationality, sexual orientation, socioeconomic status, race/ethnicity, and religion) using a likert scale of 1-5. Participants responded to the question: "I am very oppressed in terms of the following cultural identities" and answer choices included 1) this statement is not at all true for me, 2) this statement is not very true for me, 3) this statement is moderately true for me, 4) this statement is mostly true for me, or 5) this statement is very true for me. A composite measure of oppression was computed by using the mean score across each domain of oppression. A higher score indicated a higher level of oppression.

Professional Factors.

Years in Practice. Participants self-reported the number of years they have been in clinical practice.

Practice Setting. Participants self-reported the clinical setting that they currently practice in, selecting all that apply from private practice, agency, school, and other (please specify). Each setting was coded as a binary variable and for analysis purposes private practice was compared to all other settings and agency was compared to all other settings.

Geographic Location. Participants self-reported the state that they are currently practicing in, choosing from a list of the 50 states plus Washington DC. Additionally, participants selected whether the location that they practice from is located in an urban, suburban, or rural neighborhood.

Hours of Graduate Training. Participants reported the number of hours that they have spent during graduate training on diversity and multicultural competence in human service delivery (course work during masters or doctoral programs, independent study, discussion in supervision). To correct for skewness and remain more accurate to the self-report data, a categorical variable was created with three levels: 1) Some hours of graduate training (between 0 and 45 hours), 2) A moderate amount of hours of graduate training (46-100), and 3) Over 100 hours of graduate training. For the purpose of analysis, three dummy coded variables were created.

Hours of Additional Training. Participants reported the number of hours spent on additional training relevant to multicultural competence, social justice, advocacy, or anti-racism (continuing education through workshops, seminars, or conferences, independent research, other). To correct for skewness and remain more accurate to the self-report data, a categorical

variable was created with three levels: 1) Some hours of additional training (between 0 and 45 hours), 2) A moderate amount of hours of additional training (46-100), and 3) Over 100 hours of additional training. For the purpose of analysis, three dummy coded variables were created.

Dependent Variables.

Multicultural Competence. Participants' level of multicultural competence was measured using The Multicultural Competency Assessment (MCA) (Mitchell, 2018), at 25 item measure developed in 2018. This assessment has four subscales- knowledge, skills, and interventions; awareness of self; awareness of client worldview; and systemic and institutional structures- that map onto the Multicultural and Social Justice Competencies model. The self-report assessment is designed to measure therapist competence in their ability to provide relevant clinical services to clients and is scored with a rating scale of 1 through 5, with 1 being 'not competent in providing specified clinical task to 5 being 'very competent in providing specified clinical task.' Items include: "I am able to identify barriers that may impede clients' access to mental health services" and "I can tailor therapeutic interventions based on clients' cultural beliefs." Score were calculated by summing the items for each subscale and adding these to arrive at a total score. A higher score indicates a higher level of multicultural competence. The Cronbach's alpha for this 25-item revised measure (n=407) was reported to be .953 in the MCA training manual. In this study, Cronbach's alpha was found to be .958.

Social Justice Commitment and Self-Efficacy. The Social Issues Questionnaire (SIQ) (Miller et al., 2009) was used to measure social justice commitment and social justice self-efficacy. This 52-item measure contains six scales: social justice self-efficacy, social justice outcome expectations, social justice interest, social justice commitment, social justice supports, and social justice barriers (Fietzer & Ponterotto, 2015). Its social justice commitment scale has

four items including “I have a plan of action for ways I will remain or become involved in social justice activities over the next year.” Social justice commitment is rated on a scale of 0 to 9 indicating agreement with statement from “strongly disagree” to “strongly agree.” Its social justice self-efficacy scale has 20 items with four subscales rating confidence in abilities to complete activities. Sample items include “Examine your own worldview, biases, and prejudicial attitudes after witnessing or hearing about social injustice” and “Raise others’ awareness of the oppression and marginalization of minority groups.” Social justice self-efficacy is rated on a scale of 0 to 9 indicating confidence in the ability to complete a list of tasks ranging from “no confidence at all” to complete confidence.” A 2022 article found Cronbach’s alphas for both the social justice commitment and social justice self-efficacy scale to be .94 (Gushue et al., 2022). In this study, Cronbach’s alpha for social justice commitment was .944 and Cronbach’s alpha for social justice self-efficacy was .935.

Therapist Advocacy Competence. The Advocacy Competencies Self-Assessment (ACSA) Survey (Ratts & Ford, 2010) was used to measure therapist advocacy competence. This 30-item measure, based on the American Counseling Association’s Advocacy Competencies, assesses six domains: client/ student empowerment, community collaboration, public information, client/ student advocacy, systems advocacy, and social/political advocacy. Items include “I am able to identify barriers that impede the well-being of individuals and vulnerable groups” and “I am able to analyze the sources of political power and social systems that influence client development.” Response options include “almost always”, “sometimes”, or “almost never.” Items are summed for each domain and then added to find total advocacy score. A score from 100-120 indicates “You’re on the way to becoming a strong and effective social change agent.” A score of 70-99 indicates that “You’ve got some of the pieces in place.

However, you need to do some work to develop your competence in specific advocacy areas in order to be an effective social change agent." A score of 69 and below indicates that additional training can be helpful to improve effectiveness as a social justice change agent. A 2012 dissertation was the first to assess reliability for the scale and reported a Cronbach's alpha of .93 (Bvunzawabaya, 2012). The present study also found a Cronbach's alpha of .930. Recoding of items was completed on the Advocacy Competencies Self-Assessment Scale (ACSA) for reverse coded items 1, 7, and 13.

Data Analysis

Data were managed and analyzed using the IBM Statistical Package for Social Science (SPSS) Version 28. Little's MCAR test was performed to ensure that data were missing completely at random and failed to reject the null hypothesis that data were MCAR at sample size of 131 (p=.392). Listwise deletion of cases was done for survey respondents missing at least one survey measure for a final analytic sample of 101. A missing value analysis was done on the sample of 101 to reveal 17 missing values (.5% of the data). Given such a small amount of missing data, the expectation maximum (EM) algorithm method was used. This maximum-likelihood method estimates parameter based on the observed data is a more robust method than single imputation methods (Bennett, 2001; Dong & Peng, 2013).

Categorical variables (race, gender, sexual orientation, marital status, education, practice setting, hours of graduate training, and hours of additional training) were dummy coded to enter into the regression model. Scales and reliabilities were computed for all dependent variables. Then, frequencies and descriptive statistics of the data were performed. After that bivariate statistics were run, with ANOVAs run for each categorical variable and each outcome measure and Pearson Correlations run with continuous variables and each outcome measure. Finally, a

series of linear regressions were performed with relevant demographic and professional factors as independent variables. A separate regression was run for each dependent variable (multicultural competence, social justice commitment, social justice self-efficacy, and advocacy competence).

Qualitative Component

Methodological Approach

The second component of this study utilized a qualitative approach. This approach allowed for an exploration of how the phenomenon of interest was experienced by research participants and generated a richer understanding of the process of multiculturally competent and socially just clinical practice (Daly, 2007). This study explored the phenomenon of socially just clinical practice by investigating the common features and shared experiences of CFTs who enact such practice. A qualitative component was necessary in this study to further understand the ins and outs of socially just practice. This study utilized a sequential transformative design because of its focus on issues of social justice. This framework acknowledges multiple realities based on lived experiences with differential levels of privilege and oppression (Mertens, 2007). According to Creswell and colleagues, a transformative paradigm "is dedicated to promoting change at levels ranging from the personal to the political" (p. 171) and often has implications to promote social justice at a programmatic, practice, or policy level (Creswell et al., 2003).

Sample

A total of 22 people participated in in-depth, semi-structured interviews. At the end of the survey, 50 respondents indicated that they would be interested in participating in a qualitative interview to further explore CFTs' social justice practices. The survey (quantitative data) was connected with the interviews (qualitative data) through the sampling frame to work towards

integration of the data as suggested by Fetters and colleagues (2013). Purposeful sampling was used to select exemplar therapists who score high on multicultural competence to better understand how these therapists enacted multicultural competence and social justice in their clinical practice. This method tracks with scholars (Creswell et al., 2011; Palinkas et al., 2015) who state that utilizing purposeful sampling is a good way to select individuals who have experience with the phenomenon of interest, in this case, multicultural and socially just clinical practice. The MCA does not specify a cutoff score for multicultural competence, but states that the higher the score, the higher the multicultural competence (Mitchell, n.d.). A score of 100 was used as the cutoff point for multicultural competence, or an average of a score of 4 on a 5-point likert scale. Of the 50 who indicated interest in being contacted to participate in an interview, 31 scored 100 or more on the MCA. All 31 participants were contacted by email inviting them to take part in an interview, and a total of 22 people responded to the email, scheduled, and completed an interview. Creswell (1998) has deemed 20 to 30 interviews to be sufficient for most types of qualitative inquiry (Creswell, 1998). More recently, Braun and Clarke (2023) stated that 12-20 interviews are typically sufficient for a doctoral project. However, the authors caution against both strict sample size limits and the concept of saturation. Instead, they encourage researchers to stop collecting data when it provides sufficient information for the proposed analysis, or holds enough "information power" (Braun et al., 2023; Braun & Clarke, 2021b; Malterud et al., 2016).

Data Collection

In depth, semi-structured interviews were conducted with participants after scheduling via email. The semi-structured protocol ensured that the same questions were asked to each participant yet allowed for flexibility to expand or follow up on certain questions. A total of 22

interviews were conducted in June and July of 2022. Interviews were all conducted virtually via Zoom and lasted between 23 and 53 minutes, with an average of 36.5 minutes. Notes were taken throughout each interview as a form of memoing. All interviews were audio-recorded and transcribed automatically through Zoom. Transcripts were reviewed line by line with the recording for accuracy. Digital audio-recordings were stored on a password protected computer and identifiable information was removed from transcripts. Interview questions (found in Appendix C) explored CFTs' training in social justice and multicultural competence, their social justice practices within and outside of the therapy room, and how participants believe that the next generation should be trained as social justice agents. Sample questions include "How do you take into account the whole person (and all of the systems that they are embedded within) when working inside the therapy room?" and "How do you believe that therapists can be agents of systemic change? In what ways are systemic therapists uniquely poised to do this work?" Participation in interviews was incentivized by a drawing to win one of five $40 electronic Visa gift cards.

Data Analysis

Reflexive thematic analysis was used to analyze the qualitative data (Braun et al., 2023; Braun & Clarke, 2006, 2019, 2020, 2021a, 2021c). Thematic analysis has been applied by many researchers, though is not always clearly outlined and does not follow any one specific research tradition. Braun and Clarke's oft-cited 2006 article clearly outlines the procedures of rigorous thematic analysis and its common pitfalls. Since the publishing of this seminal piece, the authors have expanded their method and placed greater emphasis on the *reflexive* component of thematic analysis (see Braun et al., 2023; Braun & Clarke, 2019, 2021c). Braun and Clarke contend that no single method will be a perfect fit for a research project, and that there are many adequate

qualitative methods to choose from (Braun & Clarke, 2021c). According to the authors, thematic analysis comprises a "family of methods" with several different approaches to the same method (Braun & Clarke, 2023). While these methods share some similarities, they differ in their approaches to coding and theme development and perhaps, more importantly, the values underlying the research process (Braun & Clarke, 2023). Braun and Clarke's 2023 article outlines the differences in "small q" versus "Big Q" qualitative approaches, the former being borne out of positivist traditions. In contrast, "Big Q" approaches, such as reflexive thematic analysis, "emphasize researcher subjectivity as a resource for research, rather than a threat to be contained" (Braun & Clarke, 2023, p. 2). Braun and Clarke's reflexive thematic analysis process involves constant reflexivity on the researcher's part and the coding process is "unstructured and organic" ((Braun & Clarke, 2021c, p. 39). Themes do not simply emerge but are generated by the researcher with prolonged data engagement. This approach to data analysis can be used with a variety of different paradigmatic frameworks and epistemological assumptions, though the authors stress that these assumptions must be clear when utilizing this method (Braun & Clarke, 2020). Lastly, Braun and Clarke (2020) emphasize that reflexive thematic analysis is interpretive and not merely descriptive, it necessitates engaging with the data through an analytic process to generate multifaceted themes.

This project followed the six phases of reflexive thematic analysis as outlined by Braun, Clarke, and colleagues (2006, 2023): familiarization with the data; coding; generating initial themes; reviewing and developing themes; refining, defining, and naming themes; and producing the report. I approached phase one with the understanding that familiarizing myself with the data would lay the foundation for each of the next steps and took care to devote time to this process. I conducted all of the interviews myself and cleaned up the transcriptions for all participants.

During the first phase of familiarization, I listened to each of the audio-recorded interviews to ensure that all transcriptions were complete and correct. Through this process, I ensured that the transcripts were as accurate to the account as possible, noting emphasis through italics, and keeping utterances such as “um” or a laugh. I read each transcript all the way through and made notes of things that stood out in each interview as well as things that repeated or seemed familiar to myself as a CFT (Braun et al., 2023). During the process of data familiarization, I printed each transcript and read each one a few times, jotting down notes when I was done with each. This process of memoing allowed me to bracket my own insights and experiences reading the transcripts, noting when things stood out to me as the researcher.

I then began to transition the work into phase two: generating initial codes. This process was primarily done using pencil and paper, though Dedoose software was also used in the coding process. I began to code the data, bracketing and underlining segments of data and noting in the margins the relevant code, for example *definition of social justice*. This especially applied when seeing similarities in the data across cases. During this phase, I met twice with my advisor and an undergraduate research assistant (RA) who each completed coding with four interview transcripts. The research team met to discuss overall impressions of the data and worked collaboratively to generate initial codes. Examples of preliminary codes included: *role of therapist, involvement in social justice,* and *naming oppression in the room*. Phase three: initial theme generation began by collating the data across cases into meaningful patterns to begin to tell a story of the data. I, along with the help of an RA, began to cluster codes to generate an initial set of themes (Braun et al., 2023). At this phase, the research team met to discuss overall findings and how themes fit together to form a narrative. Examples of initial themes included *checking my bias, deconstructing societal discourses,* and *context is key*. In phase four, I

reviewed initial themes and continued to develop them. This process involved collapsing categories, creating a thematic map, and ensuring that this model fit the data well. Consultation was done between myself and the RA to come to a richer understanding of the data and its themes, and not to come to a consensus (Braun & Clarke, 2019). During phase five, I refined and defined themes, working to operationalize and dimensionalize each theme. Final theme names were developed at during this phase and writing began to best structure each theme within the narrative. The last phase of reflexive thematic analysis is producing the report. This phase involved telling the story of the findings by introducing each theme and illustrating them with participant quotes (Braun et al., 2023).

Data Quality

Data quality is important to ensure for any qualitative study. Braun and Clarke (2022) highlight the importance of generating rich and nuanced data from the outset by ensuring that data collection methods fit well with the research questions and theoretical frameworks. Lincoln and Guba's 1985 work outlines a comprehensive guide to establishing trustworthiness in qualitative research. Their conceptualization includes four components: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Strategies used to enhance credibility in this study included prolonged engagement, triangulation, peer debriefing, and member checking (Nowell et al., 2017). Through my insider status as a CFT, I have spent prolonged engagement in the field and have relationships with many others who are part of the "culture" of couple and family therapy. This was a way to build trust with my participants as we had shared statuses. I triangulated the data through the use of multiple methods and multiple team analysts (Lincoln & Guba, 1985). I occasionally utilized

peer debriefing by checking in with research and therapy colleagues about the research analysis process. This helped to shape and formulate ideas and refine the approach to my analysis.

Lastly, I engaged in the process of member checking with participants. For this study, the use of the term "member reflection" is preferred as a better with for a transformative paradigm and a reflexive thematic analysis approach (Braun & Clarke, 2023; Tracy, 2010). This process is done not to verify the truth or validity of the findings but to ensure that participants voice is well represented. This collaboration with participants was especially important in this study given its transformative mixed method design and intention to advance social justice in the field. Member checks were conducted after I completed the preliminary phase of quantitative and qualitative analysis. This served as a way to enhance trustworthiness and allowed interview participants to provide additional insight after reviewing the qualitative findings as well as some of the quantitative findings. I emailed all participants giving them the opportunity to reflect on preliminary themes to ensure that their voice was reflected and to see if they had additions or feedback. Each participant was given an option to simply review the themes, to receive a copy of their interview transcript in full, or to set up a time to speak further about the findings over Zoom. One participant requested to review their transcript for their own interest and six participants approved that preliminary findings accurately represented their voice. Two participants provided additional feedback expressing disappointment about CFT training and advocacy efforts concerning social justice. Participants were asked for follow up on how their identities shaped their social justice practices. Two additional brief follow-up member check interviews were done with male participants to further expand on the quantitative findings that men had lower levels of social justice commitment and advocacy competence. These interviews

provided additional insight into how men view their role in advocating for social causes when their gender identity comes with privilege.

In terms of establishing transferability, I employed thick description throughout the process of data analysis (Krefting, 1999; Lincoln & Guba, 1985). This was done to capture participant voice accurately and so that the findings could be transferable to different populations in subsequent studies. In this way, readers can themselves establish credibility by fully understanding the context through the use of direct quotes in the narrative (Creswell & Miller, 2000). Dependability involved clearly outlining each step of the research process along the way and following logical procedures (Nowell et al., 2017). I enhanced the confirmability of the study by employing triangulation and prizing reflexivity (outlined in more detail below). I triangulated the data by employing multiple methods in this study (both quantitative and qualitative). I also triangulated the data by reviewing the same transcripts as my RA and advisor to have multiple viewpoints on the data. Lastly, I utilized three complementary theoretical frameworks through which to view the data (Lincoln & Guba, 1985).

Reflexivity

Finally, it is imperative to regularly attend to reflexivity in the process of qualitative research. Given the paradigmatic and methodologic underpinnings of this study, reflexivity is arguably the most important aspect of trustworthiness for this inquiry. Feminist scholars built on the idea that social location and identities were relevant to social science research, and that the researcher was not invisible. While the importance of noting that the researcher shapes the research is paramount, a transformative approach also requires close attention to the primacy of participant voice (Daly, 2007; Mertens, 2007, 2012). Braun and colleagues (2023) stress that "reflexivity is an essential component of doing reflexive TA" (p. 3). This process entails that the

researcher is aware of their assumptions and decisions throughout the entire research process. Braun and colleagues (2023) consider reflexivity to serve as a sort of "quality control" to create a quality product while acknowledging how the researcher shapes the research (Braun et al., 2023). Bermudez, Muruthi, and Jordan's 2016 article urges all researchers to engage in reflexivity and to be clear about who the research is for, what difference it will make, who will conduct the study, and who might benefit from it (Bermúdez et al., 2016).

I came to this work with privilege, as an upper middle class White woman with a master's degree. I learned much about privilege, marginalization, and social justice during my undergraduate education at Georgetown through coursework, conversations with friends, and through my volunteer work at the Center for Social Justice on campus. Though I was not trained through a comprehensive social justice lens, I engaged in more work to promote justice and uncover my own unconscious biases during my CFT training. My work as a researcher has focused on individuals experiencing marginalization, from Black youth in Baltimore city to Asian Americans trying to discover their place in the Black Lives Matter conversation. The importance of research being a tool to advance social justice became especially clear to me during the summer of 2014 when Michael Brown was killed and when I was halfway through my master's degree. My identity as a privileged woman committed to enacting social justice continued to develop throughout my journey as a practitioner and as a scholar. I connected with other colleagues with similar commitments through my graduate programs, at conferences, and through social media, including a Facebook group called CFTs for Social Justice. Social justice, to me, at this time meant dedication toward equity and liberation for all, necessitating a commitment to amplify marginalized voices.

When beginning to formulate my dissertation topic, I realized that compared to other disciplines, the CFT field lagged behind in advocacy efforts and having a codified commitment to racial and social justice. At this time, I was navigating living through a pandemic and being with my clients as they navigated their own version of living through a pandemic. I was able to see these clients virtually from the home that I owned and most of my clients were in quite privileged positions with the ability to work from home as well. The events of 2020 and resultant civil unrest called me to question my role and if I was doing enough to combat racial and social inequality as a person with privilege. I did not always know whether or how to bring current events into the therapy room but understood that these events impacted my more marginalized clients differently than those with privilege. This dissertation became a way for me to avow the importance of multicultural competence, social justice, and advocacy to be part of the therapy process as I understood this in a new way. It allowed me to explore if and how we as CFTs are rising to the current moment and providing the necessary services to all clients.

The process of reflexivity throughout my dissertation process has necessitated continuous reflection on my own status as a CFT and a researcher. Throughout the process, I have reflected on how my social location shapes data collection and analysis, working to enhance the credibility of the research in doing so (Braun et al., 2023; Daly, 2007). My shared status with participants as a CFT may have added to the promotion of trust between research and participant (Goldberg & Allen, 2015). Additionally, I was able to utilize my skills as a therapist and a qualitative researcher to build rapport with interview participants through reflection and active listening. I also shared racial and gender identities with many of my participants, as the field is still overwhelmingly White and female. I, too, consider myself to be a therapist who is concerned with social justice and have undertaken much self-reflection and continuing education in this

area. I was intentional to hold space for those with both shared and different identities than myself. Finally, a few of the qualitative participants were colleagues with whom I already had some familiarity. This allowed for trust building, but I was thoughtful to maintain my role as researcher throughout the process.

Throughout the process of data collection, analysis, and writing, I regularly engaged in my own reflexive process to situate myself in the research process and to ensure that participant voice was paramount. Part of this strategy involved regular reflexive memoing to take note of my personal experiences and reactions throughout the research process. This included jotting down notes about the research process whenever they came to me and noting my own reactions after conducting interviews or re-reading transcripts for each interview. This process allowed for me to reflect on the self of the researcher throughout the process of data collection and analysis and helped me to notice my reactions to interview and what emerged from the data. I engaged in critical analysis of myself as a researcher and as a therapist at this time understanding how my experiences shaped the research process and how I was using myself as an instrument in the research process (Allen, 2000; Braun & Clarke, 2019).

Data Integration

A key decision in mixed methods research is the issue of how to integrate the quantitative and qualitive components of the study (Onwuegbuzie & Collins, 2007; Onwuegbuzie & Johnson, 2006). Creswell and colleagues' 2003 chapter outlined the types of mixed methods designs and explained how data is integrated within each approach. In sequential transformative designs, the transformative paradigm is used to unite both components of the study and the phases of quantitative and qualitative data collected are typically integrated most in the interpretation phase of the work (Creswell et al., 2003). Both quantitative and qualitative methods are necessary in

this study to create a complete picture of the social justice practices of CFTs. As such, the process is better understood, participant voice is prioritized, and there is greater opportunity to use the inquiry for advocacy (Creswell et al., 2003).

In 2015, Fetters and Freshwater called the mixed methods community to place even greater emphasis on "the integration challenge." Their editorial described the need for mixed methods studies to produce a product in which the sum is greater than each of the individual parts (Fetters & Freshwater, 2015). The authors urge mixed methods researchers to push the bounds and consider integration through theory, design, methods, and interpretation. Fetters and Freshwater (2015) reminded the readers of the utility of mixed methods designs to answer questions that are unanswerable through one approach alone. Plano Clark (2019) outlined meaningful integration strategies in mixed methods research, exploring why, what, when, and how to integrate data. She stressed the importance of integration being thought about from the outset of study design, through the development of research questions, and in the interpretation phase (Plano Clark, 2019). This study explored what factors shape a social justice identity both quantitatively and qualitatively. At the methods level, this study employed integration through connecting (Fetters et al., 2013). Connection occurred in this study with linking the quantitative data to the qualitative data through the sampling frame. In this case, participants who scored high on the multicultural competence survey measure were selected to participate in qualitative interviews expanding on their multicultural and social justice competence in clinical practice (Fetters et al., 2013). At the interpretive level, data were integrated in this study through integration of narrative (Fetter et al., 2013). The qualitative and quantitative findings are discussed in the same chapter in a contiguous manner wherein the quantitative results are presented and then the qualitative findings are expanded upon.

Chapter 4: Results

Introduction

This chapter presents the quantitative results and qualitative findings of the study. First, I will describe the sample and provide descriptive statistics for all the demographic and professional characteristics. Then I will provide summary statistics for the outcome variables – multicultural competence, social justice commitment and self-efficacy, and advocacy competency. Next, I will present the results of bivariate analyses, followed by the results of the linear regression models to address the relationship between demographic and professional characteristics and multicultural competence, social justice commitment and self-efficacy, and advocacy competency. Finally, I will describe the qualitative subsample characteristics and themes generated from the qualitative interviews.

Quantitative Results

Sample Characteristics

The final analytic sample consisted of 101 participants (see Table 1). The mean age of survey respondents was 37 years old (SD = 9.44) with participants ranging in age from 24 to 72 years old. Over three-quarters of the sample were White (*n* = 77, 76%) and 10% of participants were Black (*n* = 10). The remaining 14% (*n* = 14) of participants were combined into the Other racial group that comprised of three Asian participants (3%), one American Indian participant (1%), one Native Hawaiian or Pacific Islander participant (1%), four biracial or multiracial participants (4%), and five participants (5%) who self-identified in the other racial category, writing in responses of Iranian, Latino, Mestizo, and Jewish. Ninety three percent of the participants (*n* = 94) identified as non-Hispanic or non-Latino and 7% (*n* = 7) as Hispanic or Latino. Eighty three percent (*n* = 84) of the sample identified as women, with 12 participants

identifying as male (12%) and 4 participants (4%) identifying as non-binary. The sample was primarily heterosexual (72%, *n* = 73). The LGBQ group was comprised of participants who self-identified as bisexual (15%, *n* = 15) gay (3%, *n* = 3), lesbian (3%, *n* = 3), or other (6%, *n* = 6). Those who selected the 'other' category self-identified as queer or heteroflexible in a typed free response. This sample was overwhelmingly partnered and socio-economically well off, with 64% (*n* = 65) married, 9% (*n* = 9) cohabiting, and 11% (*n* = 11) dating but not living together. Almost sixty percent (*n* = 60) of respondents had a household income above $100,000 and 23 more participants (23%) had a household income between $75,000 and $100,000. Most participants had a master's degree (*n* = 80, 80%), while 21 participants had a doctoral degree (*n* = 21, 21%).

Civic engagement was high among study participants, with 88% (*n* = 89) noting that they somewhat agreed or strongly agreed that they were committed to civic engagement. Seven percent of participants (*n* = 7) disagreed with the statement and 5% (*n* = 5) neither agreed nor disagreed. Overall, this was a highly privileged sample. Measuring privilege across seven aspects of identity (ability/disability status, gender identity, nationality, sexual orientation, socioeconomic status, race/ethnicity, and religion) on a likert scale from 1 to 5, the average privilege score was 4.1 (SD = .7). Measuring oppression across seven aspects of identity (ability/disability status, gender identity, nationality, sexual orientation, socioeconomic status, race/ethnicity, and religion) on a likert scale from 1 to 5, the average score was 1.7 (SD = .7).

In terms of professional characteristics, the sample represented a range of experiences. Participants reported their time spent in clinical practice ranging from less than one year to twenty years with an average of 8 years (SD = 4.79) Most respondents worked in a private practice setting (*n* = 75, 75%), twenty-four participants (24%) worked in an agency setting, and

some respondents worked in multiple contexts. The majority of participants worked in either an urban (*n* = 49, 49%) or suburban (*n* = 47, 47%) setting. Survey respondents were from all across the country, representing 30 states and the District of Columbia. In terms of hours of graduate training completed in multicultural competence, social justice, and related topics, 51% (*n* = 51) received between 0 and 45 hours of training, 25% (*n* = 25) received between 46 and 100, and 25% (*n* = 25) received more than 100 hours of training. In terms of hours of additional training completed in multicultural competence, social justice, and related topics, 61% (*n* = 61) received between 0 and 45 hours of training, 28% (*n* = 28) received between 46 and 100, and 12% (*n* = 12) received more than 100 hours of training.

The first aim of this study was to assess the current level of multicultural competence, social justice commitment and self-efficacy, and advocacy competence in CFTs (See Table 4). Overall, this sample had high levels of multicultural competence, with scores ranging between 56 and 125 and a mean score of 99.9 (SD = 15.3). According the MCA, a higher score out of a possible 125 indicates a higher level of multicultural competence (Mitchell, n.d.). Social justice commitment and self-efficacy were measured on a likert scale from 0 to 9. The average social justice commitment score was 6.9 (SD = 2.2) and the average social justice self-efficacy score was 6.3 (SD = 1.5). Levels of advocacy competency overall were lower, with a mean score of 73.5 (range 18 to 120, SD = 22.2). According to Ratts and Ford (2010), a score of 69 or below warrants additional training, a score of 70 to 99 indicates having "some of the pieces in place" yet also benefitting from strengthening advocacy competencies, and a score between 100 and 120 indicates "you're on the way to becoming a strong and effective social change agent" (Ratts & Ford, 2010).

Bivariate Analyses

In order to examine bivariate relationships among study variables, Pearson correlation correlations were computed for all continuous variables with each dependent variable, ANOVAs were conducted for all categorical variables with more than two categories for each dependent variable, and independent samples t-tests were conducted for all categorical variables with two categories for each dependent variable.

Multicultural Competence. A one-way ANOVA revealed that there was a statistically significant difference in multicultural competence across racial groups ($F(2, 98) = 4.0$, $p = .021$). A Tukey post-hoc test revealed that Black participants (M = 111.70, SD = 11.41) scored significantly higher on multicultural competence than White participants (M = 97.93, SD = 15.52). A one-way ANOVA was performed to compare the effect of the level of additional training on multicultural competence. This test revealed that there was a statistically significant difference between groups ($F(2, 98) = 4.3$, $p = .016$). A Tukey post-hoc test revealed that those who had completed over 100 hours of additional training (M = 111.67, SD = 10.68) were significantly more likely to have higher levels of multicultural competence than those who completed 0-45 hours (M = 98.03, SD = 15.02) or 46-100 hours (M = 98.95, SD = 15.84). Results of an independent samples t-test showed that those with a doctoral degree (M = 106.68, SD = 14.27) had significantly higher levels of multicultural competence than those with a master's degree (M = 98.13, SD = 15.17), $t(99) = -2.322$, $p = .022$. An independent samples t-test also revealed that those who worked in an agency setting (M = 94.13, SD = 17.28) had a significantly lower level of multicultural competence than those who worked in any other setting (M = 101.71, SD = 14.30), $t(99) = 2.156$, $p = .033$. No demographic variables of interest significantly correlated with multicultural competence.

Social Justice Commitment. A one-way ANOVA revealed that there was a statistically significant difference in social justice commitment across gender ($F(2, 97) = 7.9$, $p < .001$). One participant who declined to provide their gender was removed so that a Tukey post-hoc test could be run. This test revealed that male respondents (M = 4.90, SD = 2.75) had significantly lower social justice commitment scores than both female (M = 7.04, SD = 2.00) and non-binary respondents (M = 9.00, SD = .00). There was a statistically significant difference in social justice commitment scores across hours of additional training ($F(2, 98) = 10.01$, $p < .001$). Because the assumption of homogeneity of variance failed as indicated by Levene's test of homogeneity of variances, $F(2, 98) = 6.94$, $p = .002$, Welch's test was conducted (Kim & Cribbie, 2018). This test confirmed that social justice commitment scores differed significantly across hours of additional training F_{Welch} $(2, 55.65) = 28.70$, $p < .001$. A Games-Howell test revealed that those who had 0-45 hours of additional training (M = 6.20, SD = 2.31) scored significantly lower than those with 46-100 hours of training (M = 7.61, SD = 1.71) and those who had completed over 100 hours of training (M = 8.69, SD = .53). Results of an independent samples t-test showed that those with a doctoral degree (M = 7.76, SD = 1.45) had significantly higher levels of social justice commitment than those with a master's degree (M = 6.66, SD = 2.31), $t(50.025) = -2.709$, $p = .009$. An independent samples t-test also showed that those who worked in private practice (M = 6.66, SD = 2.37) had significantly lower levels of social justice commitment than those working in any other clinical setting (M = 7.55, SD = 1.46), $t(71.33) = 2.25$, $p = .028$. Because the assumption of homogeneity of variance was violated, the Welch Satterthwaite method was used (Zimmerman, 2004). Among continuous variables, civic engagement ($r = .308$, $p = .002$) and oppression ($r = .295$, $p = .003$) were associated with higher levels of social justice

commitment. No demographic variables other than gender were associated with social justice commitment.

Social Justice Self-Efficacy. A one-way ANOVA revealed that there was a statistically significant difference in social justice self-efficacy across gender (F(2, 97) = 3.7, p = .029). One participant who declined to provide their gender was removed so that post-hoc tests could be run. Because the assumption of homogeneity of variance failed as indicated by Levene's test of homogeneity of variances, F(2, 97) = 5.57, p = .005, Welch's test was conducted (Kim & Cribbie, 2018). This test confirmed that social justice self-efficacy scores differed significantly across gender F_{Welch} (2, 8.3) = 13.63, p = .002. A Games-Howell test revealed that non-binary respondents (M = 8.15, SD = .66) had significantly higher social justice self-efficacy scores than both female (M = 6.21, SD = 1.33) and male respondents (M = 6.01, SD = 2.18). There was a statistically significant difference in social justice self-efficacy scores across hours of graduate training in multicultural competence and social justice (F(2, 98) = 4.7, p = .011). A Tukey post-hoc test revealed that those who had completed over 100 hours of graduate training (M = 7.04, SD = 1.14) were significantly more likely to have higher levels of social justice self-efficacy than those who completed 0-45 hours (M = 6.05, SD = 1.55) or 46-100 hours (M = 6.00, SD = 1.41). There was also a statistically significant difference in social justice self-efficacy scores for hours of additional training in multicultural competence and social justice (F(2, 98) = 8.5, p < .001). Because the assumption of homogeneity of variance failed as indicated by Levene's test of homogeneity of variances, F(2, 98) = 3.278, p = .042, Welch's test was conducted (Kim & Cribbie, 2018). This test confirmed that social justice self-efficacy scores differed significantly across hours of additional training F_{Welch} (2, 37.983) = 15.411, p < .001. A Games-Howell test revealed that those who had completed over 100 hours of additional training (M = 7.60, SD =

.81) were significantly more likely to have higher levels of social justice self-efficacy than those who completed 0-45 hours (M = 5.89, SD = 1.52) and those who completed 46-100 hours (M = 6.57, SD = 1.21). Results of an independent samples t-test showed that those with a doctoral degree (M = 7.03, SD = 1.12) had significantly higher levels of social justice commitment than those with a master's degree (M = 6.09, SD = 1.50), $t(41.102) = -3.176$, $p = .003$. Among continuous variables, age ($r = .276$, $p = .005$), years in clinical practice ($r = .232$, $p = .020$) and oppression ($r = .219$, $p = .028$) were associated with higher levels of social justice self-efficacy. No demographic variables besides gender were significantly associated with social justice self-efficacy.

Advocacy Competence. A one-way ANOVA revealed that there was a statistically significant difference in advocacy competence across gender ($F(2, 97) = 7.0$, $p = .001$). One participant who declined to provide their gender was removed so that a Tukey post-hoc test could be run. This test revealed that non-binary respondents (M = 107.00, SD = 5.03) had significantly higher advocacy competence scores than both female (M = 73.27, SD = 21.46) and male respondents (M = 61.92, SD = 19.16). There was also a statistically significant difference in advocacy competence scores for hours of additional training in multicultural competence and social justice ($F(2, 98) = 6.5$, $p = .002$). A Tukey post-hoc test revealed that those who had completed over 100 hours of additional training (M = 91.17, SD = 16.37) were significantly more likely to have higher levels of advocacy competence than those who completed 0-45 hours (M = 68.36, SD = 21.73) but not those who completed 46-100 hours (M = 77.29, SD = 21.27). Results of an independent samples t-test showed that those with a doctoral degree (M = 88.48, SD = 19.95) had significantly higher levels of advocacy competence than those with a master's degree (M = 69.63, SD = 21.17), $t(99) = -3.674$, $p < .001$. Among continuous variables, years in

clinical practice (r = .207, p = .038) and oppression (r = .396, p < .001) were associated with advocacy competence. No demographic variables besides gender were significantly associated with advocacy competence.

Linear Regression Results

The second aim of the study was to investigate the relationship between demographic and professional factors and multicultural competence, social justice commitment, social justice self-efficacy, and advocacy competence. Four linear regression models were computed, one for each of the outcome variables. Key demographic factors of race, gender, sexual orientation, and education were included in each model even though only gender was significantly associated with majority of the outcome variables in the bivariate analyses. In addition to these variables, demographic and professional factors that were associated with each outcome variable at the bivariate level were entered into that model. The results of each model are described below.

Multicultural Competence: Black participants had significantly higher levels of multicultural competence compared to White participants (β = .285, p = .004). Those who had completed over 100 hours of additional training in multicultural competence had higher levels of multicultural competence compared to those with 45 or fewer hours of training (β = .230, p = .032). Working in an agency setting compared to any other clinical setting was negatively associated with multicultural competence. In this sample, people who reported working in an agency setting had lower levels of multicultural competence compared to people working in other clinical settings (β = -.264, p = .005) (see Table 5).

Social Justice Commitment: Identifying as female was associated with higher levels of social justice commitment compared to identifying as male (β = .255, p = .011). Experiencing more oppression was associated with higher levels of social justice commitment (β = .273, p =

.005). Additionally, having a higher level of civic engagement was associated with higher levels of social justice commitment (β = .211, p = .020). Finally, both having between 46 and 100 hours (β = .306, p < .001) of additional training in multicultural competence and social justice and having over 100 hours of additional training in multicultural competence and social justice (β = .290, p = .003) were associated with higher social justice commitment than those with 45 or fewer additional hours of training (see Table 6).

Social Justice Self-Efficacy: Being older, (β = .270, p = .011), having 100 or more hours of additional training in multicultural competence and social justice (β = .220, p = .043), and experiencing more oppression (β = .212, p = .047) were all associated with social justice self-efficacy (see Table 7).

Advocacy Competence: Identifying as non-binary was associated with higher levels of advocacy competence compared to identifying as male (β = .225, p = .034). Completing between 46 and 100 hours of additional training in multicultural competence and social justice (β = .203, p = .031), completing over 100 hours of additional training in multicultural competence and social justice (β = .206, p = .035), and experiencing more oppression (β = .330, p = .001) were all associated with advocacy competence (see Table 8).

Qualitative Findings

Introduction

The aim of the qualitative component of this dissertation was to explore how CFTs develop multicultural and social justice counseling competencies and the processes by which they embody a critically conscious, social justice-oriented identity, both within and outside of the therapy room. It is important to note the context during which these interviews took place during the summer of 2022. On a global level, the COVID-19 pandemic had been part of everyday life

for more than two years and Russia had invaded Ukraine a few months prior. Political and social upheaval had marked the last few years in the United States, with the storming of the United States Capitol building the year prior in January of 2021 and protests advocating for racial justice happening since the murder of George Floyd in May of 2020. During the process of interviews being conducted, *Roe v. Wade* was overturned marking a monumental policy decision for health and human rights.

Sample Characteristics

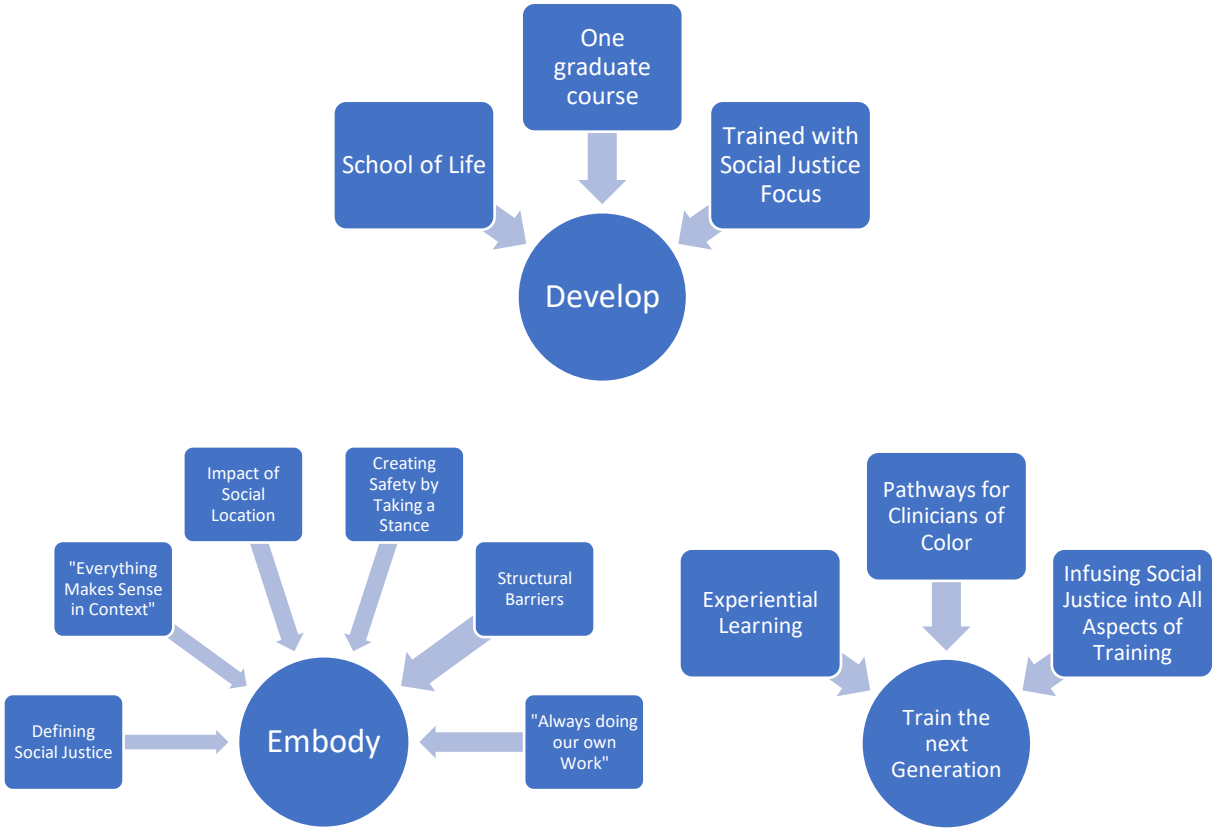
The 22 participants represented an array of ages, races, and geographic locations (see Table 3). Participants ranged in age from 24 to 72 years old, with a mean age of 38 years old. Participants skewed heavily female (n = 20, 90.0%), which is in line with gender representation of the field at large. Seventy three percent (n = 16) of the sample was White, 14% (n = 3) Black or African American, one participant identified as Asian, one Biracial, and one participant selected the other category and added the self-identification of Mestizo. Seventy three percent (n = 16) of participants identified as heterosexual and 18% (n = 4) of participants identified as bisexual with an additional two participants self-identifying as queer or heteroflexible. The sample was overall wealthy and married, with 69% (n = 15) of respondents reporting a household income of over $100,000 and 69% ($n$ = 15) reporting their marital status as married. More than half of the sample did not practice any religion (n = 13, 59%), but those who did reported a diversity in faith backgrounds, with Christianity (n = 5), Judaism (n = 2), Islam, (n = 1) and Paganism (n = 1) represented. Thirty-six percent (n = 8) of the sample had been in clinical practice between one and five years, 50% (n = 11) for 6-10 years, with two participants having 11-15 years of experience and one having between 16 and 20 years of experience. The vast majority of clinicians interviewed worked in private practice settings (n = 19, 86%), though

many also fulfilled roles in agency, non-profit, or academic settings. Interview participants came from 15 states across the nation, representing the east coast, west coast, midwest, south and southwest regions. Brief participant sketches can be found in Appendix D for more detail on the personal and professional experiences of those interviewed.

The findings were organized across three core areas (develop, embody, train the next generation) and themes are mapped below in Figure 5. The presentation of the qualitative findings will include a detailed description of themes and sub-themes along with quotes from participant interviews that exemplify each theme.

Figure 5

Thematic Coding Map



Developing a Multiculturally Competent and Socially Just Clinical Identity

Three themes emerged from the data that reflected the sample's development of a multiculturally competent and socially just clinical identity: *school of life, one graduate course, and trained with a focus on social justice*. The *school of life* theme describes formative life experiences that participants went through to develop their identities as multiculturally competent and socially just clinicians. The *one graduate course* theme describes the experiences of those who had one course in graduate school around diversity and/or social justice-related topics and their perception of its impact on their clinical practice. Lastly, the *trained with a focus on social justice* theme outlines the experiences of those who attended social justice focused graduate programs and how this impacted their clinical practice.

School of Life. Interviews explored how participants developed their identities as multiculturally competent therapists who strove towards social justice. A few participants described the strongest influences on their clinical practice as not coming from what they learned in graduate school but coming from what they had learned in their lives. When this was the case, participants typically spoke of a transformative moment or person that directly impacted their perception of the world. Those who had such experiences were confronted with injustices that drove them to combat inequities.

BJ, a White woman in her sixties, described growing up in a family that raised foster children. Because of this experience, she had a firsthand look at some of the systemic issues that she otherwise may have been unaware of. She explained:

> I grew up learning unjust systems, seeing them from the inside out, noticing that I could make a difference in oppression just by sharing my mom's lap with somebody… It's the

> only way I know how to think... I can't imagine any part of my life where [social justice] is not just central to how I see the world.

BJ repeated that her social justice lens was cultivated at a very early age and that she had a career in ministry before entering a graduate program as a second career later in her life. She viewed spirituality, her commitment to serving others, and social justice as all inextricably linked.

AK, a White man in his forties, similarly described entering the field of CFT as a second career. He described his career in fast food beginning in his teenage years and how that exposed him to people who were different from him. He noted how his family often discriminated against or stereotyped racial minorities in his small community growing up in the South. AK described how witnessing oppression and experiences of discrimination among his friends allowed him to understand injustice on a deeper level. He also discussed taking an undergraduate course where he learned more about oppression and the impact this course had on his development. In addition to understanding oppression through deep personal relationships, AK shared that learning about data and patterns in school impacted his understanding of social justice as well. He said:

> Even though I… worked in a job where I was working with people from other cultures and working for people from other backgrounds, I think reading those numbers really impacted me and I think kind of put it into perspective that I just didn't know. So that was probably more impactful than some of the other [graduate] classes and again it may be because I already had that information and had spent all those years thinking about it being aware of it and seeing it play out in society.

AK asserted that these experiences were foundational to his work and to his outlook on life. He acknowledged that with his privilege, he may not have been aware of social injustices in the same way. He spoke about his evolution as a therapist and how working with diverse clients

allowed him to build more competency and empathy. He described working with an undocumented family right after Donald Trump was elected president and stated:

> Working with this person, hearing her story really caused me to take a step back and rethink some of the ways that I was thinking about illegal immigrants. That was an evolution for me in my way of thinking and having that experience and being open to hear people's stories.

AK was up front in his interview about the ways that he has grown and unlearned things from his upbringing and about how he looked forward to continuing to sit with discomfort in order to grow as a personal and a professional.

MC, a Black woman in her thirties, shared about an influential class that she took at her predominantly White, private high school. This course, taught by a Black male teacher, left a profound impact on her. MC explained:

> He just made us read the good stuff… he was the first one that gently found a way to remind us that there was a lot to be done, there was a lot to talk about and we couldn't shy away from it, he didn't allow us to shy away from it.

MC noted that this experience in class had prepared her for conversations about oppression that she carried into her work. She spoke with passion about how special this experience was to her understanding her own identity and formulating her thoughts about the world. In addition to this pivotal moment, MC acknowledged how her own experiences in predominantly White spaces had shaped her lens on social justice. She also noted that processing experiences of oppression with her friends, who were also predominantly Black women, had given her a lens that no class could teach.

One Course in Graduate School. Half of the participants who were interviewed (*n* = 11) reported taking only one course that was focused on social justice and/or multicultural competence within their graduate school training. Of these 11, three spoke about this experience with positivity, four were neutral, and the remaining four participants expressed displeasure about their learning in this area.

Those with positive experiences talked about this graduate course helping them to understand systemic influences on their clients. AS, a White woman in her thirties, said:

> It taught me to really think about the different systems that [clients are] in whether it's race, gender, sexuality, romantic style, and to be curious about how those different parts of the person's system interact. [Noticing] which ones are pulling and which ones are really present in the forefront or which ones are being ignored and sort of help guide where we go next.

She noted that this course and learning about intersecting identities was directly beneficial to her work with clients in the room. NA, an Asian woman in her twenties, echoed this sentiment, noting how her program did a good job of educating students about systemic influences that impact clients' lives and mental health. She recalled learning about the wheel of privilege and intersecting identities and having to complete this in relation to her own identities. NA shared:

> I come back to that often because I think it just it's a good metaphor of [how] we are multifaceted, we have intersecting identities and in some spaces we are underprivileged and in some spaces we are privileged and that is the story of our lives.

This experience in her graduate training left an impact on NA in terms of thinking about her own identity as a human being and as a clinician. It gave her a tool to better understand the intersecting identities of her clients' lives as well. JM, a Black woman in her twenties, noted that

the course that she took on gender and ethnicity was “really helpful” to understand her own privileges and have tools to bring up identity-related topics in the therapy room.

The four participants who had neutral feelings about the course they took on multiculturalism while in graduate school shared some learnings that they took from it. However, they highlighted other experiences as more formative to their identity as a multicultural and social justice focused clinician. MC stated that the course made her more aware of people’s gender and sexual identities because as a cisgender heterosexual woman she had not thought much about these issues.

Four participants who took one graduate course on multicultural competence discussed their disappointment with their graduate programs for training them inadequately in the areas of multiculturalism and social justice. SA, a White man in his thirties, noted that while he took a course focused on gender and ethnicity, he had little additional formal training in the areas of intersectionality or identity. KS, a White woman in her forties, talked about a similar experience stating “you get a little scoop here and a little scoop there” but she did not feel as though she had comprehensive training on multiculturally competent practice, especially to use with clients in the therapy room. MH, a Mestizo woman in her thirties, noted she took a multicultural class while in graduate school but that it wasn’t until years later that she was able to integrate her learning about intersectionality and “fully understand what all of those terms mean[t] and how they play[ed] out in the therapy room.” She expressed that it was important for her to experience these things firsthand rather than just learn about them in a course in graduate school. AM, a White woman in her thirties, had one course on multiculturalism and one course on human sexuality. She noted how these courses were not necessarily comprehensive or inclusive of all identities.

> It's like, *hey let's have a chapter on LGBTQ and like two sentences on trans people*[2] and the multicultural counseling competency it's like, alright let's talk about privilege and race and racism and stuff like that, but… intersectionality wasn't really a big part of that. It was just like *hey, people are different from you, be cool about it.*

LG, a White woman in her forties, had a parallel experience. She says "I don't think I got very much from my master's degree" in terms of learning about social justice and intersectionality. She noted how the approach during her training in 2006 was to "learn about all these different races and what they're about so you can work with them in therapy," which often led to stereotyping rather than understanding clients' rich and unique lived experiences. She further shared that there was not much discussion of what cultural competency looked like or how to truly deeply engage with people different from oneself. AG, a White woman in her thirties, noted similar experiences, claiming that her graduate education introduced the conversation of multiculturalism but that there was "not necessarily a ton of discussion about the wide variety of ways that you can show up for clients and ways to talk about that that doesn't put a lot of work on the clients." She noted that the bulk of the way that she currently practiced, in a multiculturally competent way, was not because of her graduate training. Finally, RK, a White woman in her twenties, put it plainly saying that her graduate training in these areas was "mediocre at best." She expressed dissatisfaction with information being presented at a basic level and catered toward a White audience. She noted that much of the teaching was also done by White and privileged instructors and that "I think their privilege created a lot of our oppression in our learning environment."

[2] Italics added to denote participant speaking from another person's voice. In this instance, AM used a sarcastic tone.

Trained with a Focus on Social Justice. Seven participants completed their graduate training at a program that had an explicit focus on social justice. Most expressed how social justice was a part of all aspects of training, from course work to clinical work, to supervisory experiences. Each of these interviewees reported a positive experience with their graduate training. TR, a biracial Latina woman in her thirties, extolled her program, saying:

> I feel I went to a very, very good program. I've met other LMFTs, I've met a lot of people outside of the MFT discipline and they don't seem to have the capability to think about and conceptualize clients the way me and my friends did.

TR touted her training for its focus on systemic thinking and experiential learning techniques. She noted that she has met others who did not receive the same training and laughed when recalling a time she realized that this type of training was not the norm. LB, a White woman in her thirties, shared similar feelings about her graduate training.

> Feminism and queer affirmative social justice therapy was the core of our work. It wasn't, like tokenized, *we're going to talk about diversity today*. It was baked into everything that we did and so I really do appreciate that emphasis in my training program.

LB noted, as others did, that social justice was woven into all aspects of training, rather than just talked about in a single day or a single course. LH, a White woman in her sixties, was trained in a similar way in a program that had a clear mission statement around social justice and diversity. She outlined how each syllabus had to show how social justice was being addressed in the classroom. MP, White woman in her fifties, joked that social justice had such an emphasis in her training that it got "to the point where people were like, *why aren't we learning about therapy?"* CR, a White woman in her thirties, expressed appreciation for the mentorship that she received around cultural competence and cultural humility from "a superstar in the field." She explained

how this mentor was foundational to her training and how social justice was infused into all aspects of her training. She expanded on how this meant that the history of the models being taught was interrogated and looked at with a critical lens.

> We're looking at these therapeutic models through a decolonizing lens, through an understanding of how they were built, who built them, who they studied and trying to sort of dismantle that in ourselves and add our own cultural awareness and context.

CR explained that the process of combatting injustice began with working on the self and was paired with questioning societal and institutional norms. Her training gave her the foundation to do this work and set her on a path to be a socially just therapist.

Two participants spoke about intentionally choosing a master's program dedicated to social justice. KP, a White woman in her thirties, admitted "I think I had really exceptional training… I specifically was looking for places that had a social justice focus within their program that were very open about taking that into account within the clinical model or research model." KP described how her program excelled at teaching traditional therapy models within a social justice framework and appreciated how coursework and supervision was structured in this way. BJ, a White woman in her sixties, also selected a program based on its social justice lens, she stated:

> I chose the program that I chose because of its social justice influence. I knew that that would always be part of who I am but I needed to have colleagues around me who were also committed and learning along the same lines.

For BJ, a commitment to social justice was an important aspect of choosing a graduate program. She underscored how her training involved community work with a social justice organization, a curriculum that focused on the dynamics of oppression, and a cultural diversity class that was an

"amazing experience." BJ highlighted how important experiential learning and being in community with like-minded people was to her training experience and feeling competent to enact multiculturally competent clinical practice.

Embodying a Multiculturally Competent and Socially Just Clinical Identity

Six themes were identified to explore how multiculturally competent and socially just CFTs embodied these identities within and outside of the therapy room: defining social justice, "everything makes sense in context," impact of social location, creating safety, structural barriers, and "always doing our own work." Being a socially just therapist began with simply defining what social justice was and how it entered into the therapy room. Participants leaned on their systemic lenses to discuss how client experiences made sense in context. They reflected on how their social location impacted their clinical practice and how they worked to create safety by being up front about their beliefs and the promotion of equity. Participants named structural barriers to doing effective clinical work and noted how they continued to engage in self-reflection and seek out training to promote their own multicultural competence and social justice practice.

Defining Social Justice. A key challenge of enacting socially just clinical practice was actually defining social justice and understanding how this was relevant to therapists in the room. Most participants spoke passionately about the topic and how it was infused into everyday practice. Participants discussed examples of social justice on the micro-level in the room and the macro-level through advocacy, and the ways that they served as a bridge between those two in their role as therapists. Participants noted that social justice started with inner work, took place with clients one on one in the room, and also involved an awareness of systemic or oppressive contexts that their clients were embedded within.

Two participants defined social justice as awareness of privilege and bias. They expressed the necessity of creating welcoming spaces for clients by acknowledging differential levels of privilege and being willing to learn from other experiences. KP shared:

> When I hear social justice, some of what it means to me is being aware of my own privileges and often in the very first session... I try to acknowledge that… I have a lot of privileges and I want my clients to feel welcome, to acknowledge if there's something that I say or something I do that makes them feel like I don't understand or makes them feel like I don't have empathy for the situations that they're dealing with, that they can give me feedback about it and I try to open up that communication at the beginning.

A few more participants focused their definition of social justice on what they were doing in the therapy room, grappling with not always being able to enact macro-level change. AS, a White woman in her thirties, stated that before becoming a therapist, social justice meant going to protests and doing more outward advocacy, but that she has come to understand and appreciate social justice on the micro-level. She shared how things were different now, saying:

> But now as a therapist I am trying to be comfortable with [the fact that] I'm doing a lot of good work in the therapy room and that's where a lot of energy is going whereas I used to try to get out there in the world.

CR similarly noted how her shift from community work to private practice caused her to question what social justice meant to her. She brought up the need to reframe her thinking about her role as a social justice change agent to "helping people change their relationships and their individual lives and hoping that that trickles down to healthier generations of their children." AK, a White man in his forties, claimed that social justice was ensuring not to oppress in the

room by being intentional about the use of language and diagnosis. Each of these strategies represented different ways that therapists used micro-level advocacy with their clients.

Most of the participants linked their micro-level actions with macro-level advocacy in their definitions of social justice. SA, a White man in his thirties, noted how he practiced social justice in large and small ways by creating inclusive clinical forms, attuning to intersecting identities, and having discussions about how structural factors impact individuals in his therapy room. Many other participants talked about helping their clients to navigate oppressive systems, thereby serving as a bridge between their clients and larger structural forces that impact them. JS, a Black woman in her thirties, explained:

> Social justice, as I see it, is a goal, specifically in the therapy room, because I think social injustice has a huge part in affecting people's mental health. And so, in as much as I can affect social justice on a day to day basis I can at least at a minimum call out injustices that might help people feel understood and help them feel even better about themselves... Part of the reason social justice comes into the room for me is wanting to make sure that clients are giving themselves some grace when there are in fact larger systems at work that are impeding them or making things difficult for them. And for me, that may mean addressing income inequality or police brutality in the room, but it may also just mean talking about the ways in which a capitalist society makes you, as an employee, as a worker, somewhat against your employer at all times, you know.

JS noted how social injustice has a large impact on clients' mental health, so it was necessary for her to bring attention to these injustices. Most participants considered socially just clinical practice to include a recognition of systems of oppression and wove this into their therapeutic

work. This also included attention to power in the room. LG, a White woman in her forties, stated:

> It's really about centering and paying attention to these power dynamics, being aware of that on multiple levels… Just me being a therapist and my client a client and paying me for my services, right, my experience, my background, my education, and the roles that we inhabit so there's a power dynamic [there]. There are power dynamics within families, within relationships, within society as a whole. So, I think within the therapy room I can help to deconstruct for people how those things were created within them and within their relationships… and then I think I have a separate role and responsibility to try to make a more equitable and just society outside of that.

LG pointed out the possibility of multiple power imbalances in the therapy room and that this mirrors how clients may experience different levels of power within their families and society at large. While expanding on the concept of power, a few therapists shared that they addressed power or inequity with all clients while others discussed focusing on power under specific circumstances. Some discussed paying attention to the patriarchy and calling out gender imbalances. CR, a White woman in her thirties, echoed the need to attune to power dynamics, claiming that she named power whenever she saw it in the room. Regarding racial power imbalances, she said "I work with a few interracial couples and in those couples it's [a] really explicit conversation; we talk about racism, we talk about the power dynamics within the couple due to race."

Some participants defined social justice as honoring the humanity and dignity of all people. This included respecting people as individuals, promoting equity, and giving voice to marginalized groups. BJ, a White woman in her sixties, shared "Social justice is offering a sense

of wholeness, a sense that every person matters in the whole of who they are." She pointed out how people are afforded different levels of privilege and oppression and that she liked to discuss structural determinants of oppression and work with clients to begin to dismantle these structures internally. Participants highlighted that social justice meant prioritizing fairness and equity for all and creating a society where all had what they needed. AM, White woman in her thirties, explained:

> It's not about everybody having the same thing, it's about everybody having what they need and so for me social justice is like, let's give more to the people who have had less. Let's take people who've been stomped on and held down for so long and elevate them above ourselves and make them the priority for a little while, for a long while I mean, you know, let's do the opposite of what we've been doing. So, it's not so much about let's bring them up here with us, it's like let's center these people for a while because we've been doing the opposite for so long and that has led to so much oppression and so much generational trauma and, you know, spiritual trauma and all kinds of stuff.

MP, a White woman in her fifties, echoed this sentiment, boiling it down to "Social justice, to me, is [that we] don't stop until everybody is free."

Most participants spoke with hope and fervor and imagined the possibilities of creating a more just society However, two participants who were interviewed the week that *Roe v. Wade* was overturned expressed more cynical viewpoints of the idea of social justice. MC, a Black woman in her thirties, explained:

> I don't know social justice feels very… slippery these days… I just have a lot of I've lost a lot of faith and what social justice looks like, especially in America so I'm not sure

> what that means anymore. Sorry, I don't have a better answer. In therapy, I don't know what that means anymore either.

She discussed feeling disillusioned about what justice was and who it was for, noting that the United States did not seem to be currently operating from one shared moral code. LB, a White woman in her thirties, explained that social justice could be about noting what was not working and expressed a bit more hope about using accountability to create change. She defined social justice as "hold[ing] our country accountable to what we could be" and envisioning a more just future.

"Everything Makes Sense in Context." Many of those interviewed shared that considering their clients in context was important for them as therapists who valued systemic thinking and social justice. This meant understanding their clients in terms of their past experiences as well as the systems that they were currently embedded in. Moving beyond defining social justice, participants discussed how they enacted it in the room by weaving in systemic causes of oppression. Understanding things in context served to help educate clients as well as normalize and humanize their experiences. By doing this, therapists helped clients to build more awareness, more self-compassion, and empower them to make changes in their lives. AK, a White man in his forties, spoke to the importance of attending to context and people's intersecting identities. He said:

> So, for me again it comes back to that idea of context. Every person exists in a context and its multiple layers and they're sort of interconnected. So, there's the overarching social context, cultural context that we live in, and that is informed by so many different factors, you know, gender, race, sexuality, family of origin, religion, all of these things… [These contexts] put ideas about who we're supposed to be onto us.

He named context as being “hugely important” to his perspective as a narrative therapist and spoke how he calls attention to dominant societal discourses and the ways that they serve to oppress people. He also noted differential access to privilege based on intersecting identities and contextual factors. AK claimed that some clients were aware of how their social contexts affected them and others came in with less awareness around this. He brought up that building awareness of oppressive systems was essential to people living in a healthier way and that not taking context into account was missing a huge part of the picture in therapy. While NA, an Asian woman in her twenties, shared AK’s sentiments, she went a step further and described how neglecting to take context into account did clients a disservice. She stated:

> People don't exist in a vacuum… the things that they come into therapy with are compounded by or influenced by a lot of the systems that they're a part of in life, from micro to macro… To me it just feels like if we don't [use a systemic lens], we're ignoring a lot of the things that contribute to people's everyday issues and it's not really addressing the root cause of an issue.

AM, a White woman in her thirties, also highlighted the importance of understanding people in context and brought up the way that taking context into account can lead to greater understanding and empathy for client’s experiences.

> I think the key is that when we look at behaviors and the way people behave and the things that they do, a systemic perspective is just recognizing that those behaviors and beliefs make perfect sense when considered within the context of that person's life. So, if we were to live their life and experience their experiences, then we would act and believe in the exact same ways. So, it's just understanding that there's not a normal or abnormal,

> there's not a right or wrong, there's not one reality that is true: everything makes sense in context.

AM emphasized that she met clients where they were and normalized their current experiences based on contextual factors, including their family and childhood contexts. She brought context into the room to help her clients build greater awareness and empower them to make changes in their lives. AM explained this more and said:

> I think my main role is to… facilitate that discussion with the client or facilitate that connection so that they start to understand how their context influences their behavior and how their context influences their symptoms and so they can begin to make those changes within the system to yield the results that they want. So, it's just me saying, okay well let's look at this and how this impacts what you're doing right now and all that so that they start to put those things together and realize, okay here's how I need to get to where I need to be.

She explained that a key aspect of her role as a therapist was to help clients understand how oppressive systems were impacting them and to help them advocate for change. AM highlighted the importance of knowledge, awareness, and advocacy all working in tandem to provide the best services to clients.

Other participants also prioritized connecting individuals to broader relational and systemic contexts in their socially just clinical practice. KP, a White woman in her thirties, and KS, a White woman in her forties, both spoke about the iterative impact of systems on individuals and the individuals on their systems. KS said:

> It’s looking at the bigger surrounding factors in someone’s life… helping them see how their individual stuff shows up in their relationships and how they impact the world

around them, and the world around them impacts them, including the people in their lives.

SA, White man in his thirties, spoke to an evolution in his clinical work, claiming:

> Over the years, my systemic worldview has broadened to include systems beyond the family to structural systems and how systems differentially afford privilege and oppression to different people and how it might exacerbate a given presenting problem or maintain it.

He noted how important it is for therapists to understand and acknowledge the impact of systemic factors in their clients' lives. JS, a Black woman in her thirties, described her approach to looking at things contextually and holistically and shared that she tries to look at "a person's entire life and [tries] to think about how areas that maybe they hadn't considered might be affecting the problem that they're coming to talk about." For CR, a White woman in her thirties, often the systemic factors were the ones that caused the most difficulty for her clients. She stated:

> As I'm sitting with a client I can zoom out and out and out and understand all of these different layers of injustice or oppression within the systems that are outside of the clients… It's more of an understanding of the things that cause people the most pain are the systemic layers that are out of their control, that's my perspective.

Focusing on the connection between people and their contexts not only helped therapists to foster understanding and empathy for their clients but also helped clients connect to themselves and build greater understanding and empathy for their own experiences. Some study participants explained that making connections between the individual and their contexts was also a way of connecting clients to their humanity. AG, a White woman in her thirties, asserted

"it's always about the context and there's never a situation that's not about the context." She claimed that having an understanding of context "makes everyone safer" and humanizes people. She spoke of the importance of educating clients to think systemically to consider themselves and other people within their contexts. LG, a White woman in her forties, highlighted how understanding context can help to normalize difficult experiences.

> I think that's a very conscious part of my work, is that when people are bringing that up, I'm doing a lot of like, given your life experience, given what's going on in the world, given what you watched on the news last night, given all these things, it makes so much sense that you would feel this way. This is a very understandable response, right, like this is a terrible situation so [it's] a normal response to a crazy situation, an unhealthy situation.

Client contexts could include family and relational contexts, community contexts, and macro-systemic contexts that serve to privilege or marginalize such as the patriarchy and White supremacy. Context could also include past experiences and current events, which were quite relevant in the lives of participants and their clients at the time that the interviews took place. Understanding their clients in context was an essential part of multiculturally competent and socially just practice for those interviewed. It helped therapists to understand, empathize with, and empower clients to create change.

Impact of Social Location on Socially Just Practice. Similar to understanding external and systemic contexts, participants also recognized the impact of social location on the therapeutic process. This included the therapist's own social location as well as attending to their clients' social location and the similarities and differences between the two. What socially just practice looked like depended on therapist's intersectional identities such as race, gender, sexual

orientation, and geographic location and how these intersected with their clients' privileged and marginalized identities.

Many participants discussed the need to attend to clients' multiple intersecting identities. One of the first examples that MC, a Black woman in her thirties, brought up in her interview was working with a high powered Black female attorney who was dealing with challenging dynamics at work. MC noted how her client was one of the only Black women in her job. During their work together, MC shared with the client that her experiences and the perceptions of others might be contributing to her job satisfaction and job performance. MC framed this as holding up a mirror to identity within context. NA, an Asian woman in her twenties, echoed a similar sentiment, she said "I make a point to… [note] that or race or ethnicity can impact what you're experiencing as well." NA talked about this in the context of working with a couple and calling out the impact of race and gender on how her Black male client showed up in the room and in his relationship.

It was common for participants to admit that they discussed intersectionality more with minoritized clients than with their White or more privileged clients. NA stated, "I find myself probably doing that a lot with my more with ethnically diverse clients or ethnic minority clients a lot, um yeah I don't think with my White clients it comes up because I guess, I mean that's what's considered like the norm right that's like the baseline." NA talked about coming from a racial minority background herself and because of this, attuning more to clients who are racial minorities and how their identities intersected with what they were bringing into the room. For clinicians of color, normalizing clients' experiences was an important part of the therapy experience. This often was borne out of shared experiences with marginalized aspects of identity. NA talked about how she did this and shared:

> I'll say something to clients like *well yeah that makes sense that you feel this way*[3] or that you're experiencing this in this way and it's kind of almost like *oh,* like this realization that like oh, I guess, it is okay that it maybe doesn't feel normal to feel that way because of our intersecting identities, or something like that. But no, that makes absolute sense or maybe they're not around people who do validate that experience for them so I think having that experience is helpful.

NA expanded on this by sharing an example of a client who grew up in an immigrant family and did not have others in his life with similar experiences. She mentioned how important it was to normalize this experience for her client struggling with identity issues. She noted that when she normalized the client's experience, they expressed "oh I didn't realize [other] people also feel this way." NA was able to use her own experience as a child of immigrants to help her client build awareness and understanding. This experience of sharing minoritized statuses with clients came up throughout the interviews in terms of race, gender, or sexual orientation and the intersections between them.

MC, a Black woman in her thirties, shared that her Black female clients often bring up experiences of stereotyping or inequality and that she uses her shared status as a Black woman to empathize and to validate what her clients are going through.

> So, there's a lot of validation that happens of like *nope you are not crazy*[4]*,* like there is documented historical evidence of Black women having this experience or us being disenfranchised in this way or us being seen as, you know, these strong people in this way, or just these all these different stereotypes or characteristics that are just kind of

[3] Italics denote participant using a different voice, in this case to represent their conversation in the therapy room.
[4] Again, italics are used to denote participants speaking in a different voice, in this instance to their client in the therapy room.

> assigned to us without getting to know us or without getting to the core of who someone is.

MC noted how she is always attentive to intersecting identities in the room and often wonders with her clients about the role of identity in what they are going through. She shared examples of working with a Black man, an Asian woman, and a masculine presenting person who has a feminine name. MC discussed how she identifies the role of the patriarchy and racism in what her Black male clients are bringing into the therapy room. She said:

> [I'll speak to them] from a patriarchal perspective in terms of how crushing patriarchy is to them as well. In terms of expectations, a lot of Black men I work with talk about the stress of providing for their family and the stress of meeting their job demands or whatever it may be, in just these expectations, I feel really difficult to sustain sometimes, and so I just name it for them, like *yeah the Black man carries a lot on his back in almost all ways* and they're like *yes.* It's interesting that I have to name that for them, but as soon as I do, they lean into that.

She noted that many of her clients seemed to appreciate when aspects of identity were asked about and approached with curiosity rather than with avoidance or assumptions. JM, a Black woman in her twenties, similarly noted that as a Black woman, she often worked with Black women in therapy. She shared that she sometimes explicitly discussed their shared statuses while still being attentive that she and her clients may have different experiences. JM said, "I may check in and I'm like *hey this has been bothering me as a Black woman, has it brought up anything for you?* Because maybe it hasn't and I don't want to just assume that it has."

Several therapists who worked with clients in the LGBTQ community also identified as being members of the community. AM, a White woman in her thirties, noted that her shared

status with her clients helped her to empathize with some aspects of what they might be going through and to understand their intersecting identities. She discussed the fear that her LGBTQ clients and women experienced around policy decisions that could have a major impact on their lives. She normalized the fear and anger they experienced by sharing some of her own feelings around this with her clients. KM, a White woman in her forties, spoke about being part of the LGBTQIA+ community and how being embedded in the community helped her to serve her clients. She added that her membership in the community also spurred her to action and advocacy and said, “There are a lot of personal experiences that I’ve had and family members have had that I feel that it's my duty as an MFT to fight for these things.”

Female therapists similarly discussed what it was like to have shared statuses as women in an era where reproductive rights were in jeopardy. TR, a biracial Latina woman in her thirties, said “Anytime anything happens with women’s reproductive rights- over half of my clientele are women- that is something absolutely discussed and addressed.” She talked about how she addresses the importance of voting and other advocacy efforts with her clients to help empower them and encourage them that they have some agency even during difficult times. AM, a White woman in her thirties, was interviewed the week that *Roe v. Wade* was overturned and stated:

> I work with a lot of women and women right now are just feeling devastated and devalued. Women are starting to recognize that their position in society wasn't as firm as they thought and that it could be taken away really really easily, so there's a lot of people living in fear right now.

She continued, saying:

> This last week I've just spent a lot of time crying with clients and just sitting with them because there's nothing…there are going to be things that we can do and there are going to be things that we will do, but I think, right now, we just all need to feel it.

AM expressed a willingness to feel with her clients when they were all experiencing something that infringed upon their rights. JS, a Black woman in her thirties, also noted that it was important for her to hold space for her female clients experiencing oppression. She admitted that as a woman it was important for her to show up for other women the week *Roe v. Wade* was overturned, saying "I think for, for that sort of situation it's important to sort of show up and, you know, be a person in the room, rather than kind of falling back in a way that I think we are often trained to do." Both expressed a willingness to be full humans in the room standing up in the face of injustice, rather than lean solely on their role as a clinician.

Therapists with marginalized identities in terms of race or sexuality discussed some of the challenges they faced working with clients with privileged identities. MC, a Black woman in her thirties, spoke to difficulty, saying:

> I do not have many White clients, the few that I have, it has been a bit of a tight rope when it comes to discussing these things, because I have to make the choice of how direct do I want to be about challenging some things I hear that are, I feel are, very much so rooted in White supremacy… How much of that is really a part of the work and how much of that is my responsibility, like do I really feel like taking that on? Do I really feel like spending time arguing with somebody or you know going back and forth in some ways? Again, I think I have to remember I've created a safe space for them, I don't necessarily want to sully that space. At the same time, I've had White clients say some

things that are counter to who I am as a person and counter to the culture I love and I'm a part of so that's been that's been interesting it doesn't happen often, but it has happened. MC used this metaphor of a tightrope and then went on to say that it sometimes felt like she had to put a mask on in order to hold space for clients from different backgrounds or perspectives. She spoke to the difficulty of knowing what to take on in terms of speaking out against injustice and when to potentially jeopardize the safe space that she has created with her clients in therapy.

As Black women, both JM and MC brought up the experience of recent current events such as the storming of the Capitol building and racial justice movements (or what MC termed "The 2020 White People Wake Up") and having different experiences than their White clients. JM talked about a session during this time, reconciling "the different worldviews or how [her client] may have viewed America versus how I view America and being careful to not input my bias." Regarding confronting racial bias, JM shared that she "let[s] clients that are White do that themselves and not challenge it because I don't want them to feel like I'm doing it from a space of contention." JM used the same language as MC about wondering what her responsibility was in terms of shepherding her White clients to build more awareness of the systems of White supremacy versus letting them come to their own conclusions.

Therapists with privileged identities in terms of race, class, sexuality, etc. discussed ways that they attempted to promote social justice with other privileged clients or colleagues as well as the challenges they faced in doing so. KS, a White woman in her forties, talked about seeing mostly White clients but being open to and interested in working with a more diverse caseload. She stated, "I know people choose me because I am a blonde, blue eyed, White woman" and shared her discomfort around this. She talked about working in a conservative area and couples therapy being a way to get people in the door that would not otherwise access therapy services.

LH, a White woman in her sixties, discussed how politics impacted her practice and shared challenges of knowing when to speak out to combat injustice versus stay with the client. She stated, “I’ve had to make choices about whether to stop there and address that or serve client needs in the moment and what their treatment goals are.”

Two participants discussed their frustrations with trying to promote equity and justice within their White therapist circles. MP, a White woman in her fifties, discussed how her community expresses the desire to promote inclusivity and anti-racism but has a hard time doing the work to make it happen. She named how defensiveness and certain sentiments from fellow White therapists such as “no matter what I do I’ll get it wrong,” got in the way of doing anti-racist work. MP expanded on working with other White therapists in her community and said:

> I spent a lot of time doing anti-racist work and it's rough. It's um, it's disappointing. It's disappointing to me how hard it is to get; how hard it is for White people to get. [It’s] disappointing, the White fragility and White flammability that we come up against in our community.

CR, a White woman in her thirties, echoed a similar sentiment when talking about her conversations related to racial justice and creating space for diverse voices. She discussed how tiring the work was and said:

> I [have] dedicated a lot of energy over the last two years to try and stay at the table with other White folks in my couples therapy community and it's exhausting. I’m sick of it, but I keep showing up because, you know, it's my turn to be exhausted.

These two participants talked about how those with privilege and power in their communities were quick to acknowledge it but had difficulty with giving up power and knowing when to step back to create space for others’ voices.

Therapists with more privileged identities shared ways that they worked thoughtfully with clients with minoritized identities. This involved an acknowledgement of privilege or difference as well as an understanding of how different systems differentially impacted such clients. SA, a White man in his thirties, said:

> I am White, so clients who are not White sometimes I'll bring it up in the very first session of recognizing that I am not their race, and just having a sort of frank conversation about it, how they feel about it what it could mean for our work together and other times it'll come up earlier on in the therapy in a way that's related [to the] content at hand. For example, a Black couple that I'm working [with] who have two young children… were arguing over where to send their kid to school and I brought up the fact that their child is Black and [wondered], how much of your argument might be centered on their fears and have them to a predominantly White school?

BJ, a White woman in her sixties, spoke about her experience working in a school setting and how she gently encouraged conversation around race, oppression, and identity exploration. She noted

> Most of the kids and families that I'm dealing with in my schools are Latinx folk, so race is always a factor there. And what I'm discovering with people with a Hispanic background is that they are not always aware of how much oppression they have experienced or are experiencing. They see Black and White, they see places where they're left out, but they're not aware of systemic racial challenges and to be able to bring that up in ways that they can begin to hear oh, so I wonder how… race might impact these kinds of questions.

BJ was thoughtful about how she introduced conversations around oppression with her students and scaffolded their thinking about this by using groups and experiential activities.

Creating Safety in Therapy by Taking a Stance. While social location impacted how the therapists showed up in the room, most participants asserted that they needed to be up front about their values in order to create safety for their clients. For some therapists, this was done in the way they marketed themselves to potential clients and who they catered their work to. Participants also created safety by acknowledging differences between themselves and their clients. Finally, participants expressed that making their beliefs known was a way to provide socially just practice, even though many were trained not to do this.

Two Black female therapists (MC and JM) in the sample asserted that they were clear about who their work was for and why it was important. MC stated that it was important for her to "really work hard to have my practice a safe haven for Black and Brown people." She reflected:

> This work is hard, sometimes it feels very like, *oh my God why didn't I just get a job in IT programming computers*, but there's other moments, where people say things like *I couldn't wait to talk today, I really needed this space today.*

MC noted that moments like this reminded her how important the safe space she had created was. When asked about the evolution of her clinical practice, MC avowed, "I've become more unapologetic about who my work is for." Similarly, when asked about her role as an agent of change, JM stated, "The first thing that comes to mind is that my way of bringing change in this world is providing a safe space for healing." She noted how the murder of Michael Brown evoked such an emotional response in her that it spurred her to her career path and inspired the desire to want to "create space for people to talk about her feelings." She also brought up her

clients' reaction to the murder of George Floyd and how important it was for her to hold space for whatever clients were feeling in the moment and know that they were not alone.

While part of creating safety for minoritized therapists was a sense of shared understanding with their minoritized clients, therapists also discussed how they went about creating safety by being up front about their own potential differences and biases. AM, a White woman in her thirties, stated:

> One thing that I do and one thing that I teach new therapists to do is right up front, I acknowledge my differences. I acknowledge privilege and I acknowledge lack of experience things like that with clients who have a different experience from me.

KP, a White woman in her thirties, and JS, a Black woman in her thirties, also noted that they acknowledged their own identities irrespective of whether they were the same or different than that of their clients' during the first session. JS acknowledged that she was not "tabula rasa," and that she was a human with her own lived experience. She went on to say:

> I'll say it's important to me that I am aware of certain biases that I may have. And that I'll be working constantly to make sure that I am not putting those on you. That there are ways that I walk through the world that have affected the way that I see it and the way that I experience it, and that those differences, as I see them, are things that we should be aware of in the room, rather than pretending they don't exist.

JS shared setting expectations with her clients and telling them that she does a lot of reflecting to ensure that she has heard and understood their experience accurately. NA, an Asian woman in her twenties, also shared discussing difference with her clients, stressing that she has her "own personal worldview based off of my experiences and my identity and my upbringing and… as a result of that I'm not going to know everything and that's fine."

Finally, several therapists discussed creating safety by being up front about who they were and what they believed in. RK, a White woman in her twenties, asserted "I believe that as therapists we are not in a neutral position… [we] can take firm positive stances to create the social change that we want to see." She makes it clear on her website and throughout her therapy process where she stands on sociopolitical issues. RK noted how she believed that this created safety for her clients. She said:

> I take very firm stances on sociopolitical issues and make it very, very clear to people. I think a lot of people may say, *well I want to be more neutral on these things because perhaps then I'll have a wider client base potentially*. But to me, I think actually it's been quite the opposite, like why I think I tend to be as busy as I am and the waitlist looks like what it looks like for me is because people know actually exactly where I stand, and that makes them feel safe to come to therapy.

She continued saying that "I take a very firm unapologetic stance" and noted that she believed this stance advanced more equitable healthcare and got people in the door that may not have entered therapy otherwise. AM, a White woman in her thirties, acknowledged that advertising herself as LGBTQ attracted many LGBTQ clients. She discussed a shift from her training that therapists should be neutral to a belief that "I think a lot of times, it can be really helpful for your client to know those things about you, because they know that they're safe to talk about things with somebody who shares those beliefs." She shared that she told her clients that they could ask about her beliefs and that she would share them if it made her clients more comfortable. AG, a White woman in her thirties, stressed the importance of safety throughout her interview. She acknowledged that being up front about her beliefs was a way to create safety in the therapy process. AG pointed out that although her training taught her to not share her own beliefs, she

believed that this practice was paramount for client safety when it came to political, social, or human rights issues. AG noted how her training taught her to be wary if clients wondered about her beliefs and that "it took me some time to shake that off."

Structural Barriers. Those interviewed discussed the barriers that they faced on the path to promoting social justice through their therapeutic work, including experiencing systemic failures and encountering feelings of hopelessness among themselves and their clients. They focused on oppressive institutions, inadequate services for clients, and how sometimes even therapy itself could serve as an oppressive environment. Some participants spoke about systemic barriers in a matter-of-fact way while many acknowledged the difficulties of facing structural barriers and admitted how they often wrestled with this personally and professionally. Still other participants offered suggestions about the concrete ways that they address the challenges of facing structural barriers.

CR, a White woman in her thirties, shared the difficulties of bumping up against systemic failures in her work. She noted that the jobs where she felt as though she had the most impact on creating systemic change were the most demanding and led to burnout. She discussed her role as a therapist doing community and agency work, stating:

> The things that burned me out more than any of the trauma that I witnessed and experienced were watching the systemic failures and the ways that people were falling through the cracks. That's like my deepest vicarious trauma essentially in this work and so now I've had to really reframe that for myself and I think of myself as an agent of change in my work through changing, helping people change their relationships and their individual lives and hoping that that trickles down to healthier generations of their children.

CR, at the time she was interviewed, was still grappling with a shift into private practice from working in agency settings for several years. While she felt that her agency work was impactful, she faced more barriers in that setting. She noted that in private practice, “it's tricky because we never really see the fruits of that labor from this perspective, so I have to just hold true to the trust that it makes a difference.” SA, a White man in his thirties, spoke to a similar internal struggle of affecting change for people as a therapist in the room and said:

> It's something that is often on my mind, yeah, because in the therapy room, as we know, we can only do so much to change structures. In fact, arguably, we can't do very much at all because we're dealing with one client, one person, one couple, or family at a time and in the therapy room we don't have much power. I mean we might not have much power outside of the therapy room either to change some systems right, but certainly not in the therapy room, and so I think for me I’ve always tried to sort of straddle this duality between micro change and macro change.

For the therapists interviewed, striving toward social justice was important yet often difficult due to so many structural barriers out of their control. JS, a Black woman in her thirties, while sharing her frustrations about combatting structural inequality, stressed that she makes sure that clients don’t blame themselves for systemic barriers. She explained:

> I want to call out in the room that this is bigger than you. And that this is not just a matter of getting more sleep because part of the reason you can't get more sleep is because of your hours or because of the stress of the job. It's not going to be enough for you to go play squash on the weekend because, you know, that may help but… So sometimes it feels like I’m, yes, running up against a brick wall because oh my gosh, DC just feels like a rat race.

Participants noted the importance of being advocates in the face of structural barriers. KM, White woman in her forties, said:

> We have to be changing [the system] because, as we know, there are so many broken systems in our society. And nothing is going to change on its own. Our leaders definitely aren't going to voluntarily change things for the good. So we have to sign those petitions, we have to talk to our Congress people, we have to march, we have to educate our clients on how they can advocate for themselves. Because it's going to take all of us.

KM spoke with conviction about how it is the obligation of therapists to try and advocate for systemic change in the face of structural barriers even when it seems challenging.

MW, a White woman in her thirties, stood out as an outlier in terms of how she directly addressed structural and systemic barriers through comprehensive and wrap around services. She underscored the many barriers her clients faced and the ways she had attempted to address those barriers for clients. She noted barriers to accessing treatment like lack of translators for non-English speaking clients and prohibitive transportation costs. She spoke of a client living in poverty who had multiple diagnoses that made it difficult to fill out applications and make appointments. She acknowledged "it does take a toll on us as therapists not being able to change those things or to only do what we can with a lot of what the barriers that we see." Yet, MW also talked about providing wraparound services and often advocating for her clients who were interfacing with other agencies and systems like the criminal justice system. She noted how her practice was focused on working with clients that others would turn away and how important it is for her to reach the truly underserved, such as someone who had just been released from prison.

In addition to discussing structural barriers, participants highlighted that oppression and different forms of marginalization are also still perpetuated within the field of mental health by

therapists, supervisors, and professors. NA, an Asian woman in her twenties, brought up how therapists can create harm and how she has heard stories from many friends and family members recounting such experiences. She said:

> They've expressed sometimes they have therapists that really traumatize them because they say something offhandedly racist or things like that, or just don't understand them and don't handle it in a in a respectful way and I think that we are harming people more and turning them away from a place where they should be safe and vulnerable.

In an isomorphic way, MC, a Black woman in her thirties, noted that supervision experiences could also be a context where clients are oppressed rather than accepted. She recalled an experience in group supervision where a therapist's client was a Black single mother going through a very difficult time and the White therapist said, "I don't know if she even loves her kids" and the supervisor agreed. MC was disappointed to experience this lack of empathy and understanding for a woman facing many structural barriers. She summed it up saying, "talk about oppression in the therapy room." AG, a White woman in her thirties, similarly noted the limitations of supervision when supervisors and gatekeepers were not multiculturally competent. She brought up how this served as a barrier for therapists in training feeling safe and providing the best clinical services possible.

Lastly, participants discussed the toggle between hope and hopelessness that they and their clients faced when confronted with structural barriers. KP, a White woman in her thirties, noted that "in my professional role, I really help my clients by empowering them and giving them some hope that they can change, that things can be better" even in the face of structural barriers. AM was interviewed days after *Roe v. Wade* was overturned and spoke frankly about

the hopelessness she was feeling about structural barriers at the time. However, she noted some of the ways that she was using to help her clients shift out of this space and said:

> I like to help people become self-advocates and kindle that fire, you know, because I think that's the opposite of hopelessness. So, when I have people sitting in front of me that the world is just beating them down and taking their hope away, I'm like well, why don't we get mad about it. Let's do something.

Both AM, a White woman in her thirties, and TR, a biracial Latina woman in her thirties, elaborated on the role of advocacy in helping to combat the feeling of hopelessness. TR noted that with so many structural barriers and oppressive policies being put in place simply offering hope to clients was an important part of her work. She said:

> Hope is the best thing I can provide people, is just the ability to know that even if they do not see the big changes in their lifetime, that they can make strides towards that change. Especially when people have children, that's a really good way to talk about social justice.

She acknowledged that therapists sometimes get jaded by seeing slow progress in systemic change. She stated, "I think it does break you down over the years to experience that, especially when you're having those conversations with people and they're getting mad about the same things over and over again." She said that it could be defeating to not be able to control the systems, but that therapists can always provide hope for their clients. Discussing the current moment in time, TR said:

> That's why it's important for us to provide hope because when you think about it too much, it's very hopeless. So, the only way we can keep people continuing to make movement forward, in some way, is to provide hope and keep going.

"Always doing our own Work." The participants in this study were clear that enacting multiculturally competent and socially just clinical practice meant that they had to own their biases, sit with discomfort, and seek out opportunities to continue to learn and grow. Showing up to do the work often began with therapists understanding their own intersecting identities and associated experiences of privilege and oppression. NA, an Asian woman in her twenties, shared that in some spaces she was privileged and in others she was underprivileged. JM, a Black woman in her twenties, echoed similar sentiments, and highlighted the importance of building more awareness of her privileged identities and how they impacted her. JM noted that she entered her graduate training thinking that "Because my two main identities race and gender are the oppressed group, I assume I know all about oppression and it helped me realize [that] I'm also privileged in other areas." She described how learning more about intersectionality allowed her to be more thoughtful about how she recognizes privilege and uses language. JM explained how this intentionality led her to use the terms couple and family therapy rather than marriage and family therapy or partner instead of boyfriend to create more inclusive practice. This learning brought about ways to practicing in a more multiculturally competent way.

AS, a White woman in her thirties, pointed out how she utilized self-reflection as a therapist. She noted that she was a part of the systems that her clients may be weighed down by and that she was also affected by what was happening in the world. She expressed, "I'm also a person who has a particular point of view that I'm seeing and try to keep myself open and curious for stuff that I'm not seeing." This self-reflection happened both inside and outside of the therapy room for participants.

Part of the process of self-reflection was uncovering and interrogating internalized biases. MC, a Black woman in her thirties, noted the importance of therapists admitting their own biases

and also the importance of colleagues or supervisors helping therapists to grow in this area. She claimed that this process of uncovering bias was an important way to humanize clients and promote social justice rather than act "like you're looking at something at a zoo." AG, a White woman in her thirties, also echoed the necessity of therapists challenging themselves to look at their own biases to better serve their clients. She disclosed that she does her own research on what her clients might be experiencing and works hard on her own reactions to create safety for her clients. She said:

> If I'm not willing to learn about other people's experiences and challenge myself and my own internalized biases and do that work, then how am I helping people be safer? Because this world is hard enough and therapy should be one of the safest places.

AK, a White man in his forties, discussed checking his bias in an ongoing and developmental way. He said, "I want to make sure I'm doing that work, I'm checking how I'm doing and what I'm feeling and questioning some of the assumptions that I might be making." MP, a White woman in her fifties, noted that she was always evolving and always digging to uncover internalized biases and announced her disappointment that other therapists did not want to engage in this type of work. BJ, a White woman in her sixties, also emphasized that uncovering blind spots was a foundational part of therapeutic work. She asserted:

> I think the first, most important part is always doing our own work. Seeing, learning where our own blind spots are, having people around us who know us well enough to call us out when…. there are blind spots that we're carrying and perpetuating and know that it is alright with us to call us out even more when we're uncomfortable.

In addition to checking bias, participants discussed the need to sit with discomfort in order to grow as therapists. AG, a White woman in her thirties, shared that peer consultation and

seeking out additional resources and training could all be ways to foster a healthy level of discomfort. AG noted "I think our discomfort has to be normalized" and asserted that safety in supervisory experiences was an important ingredient in working with and not against discomfort. LG, a White woman in her forties, talked about ways that she fostered the ability to sit with discomfort in her students and supervisees. She discussed ways to "provide this scaffolding so that people can deeply engage in these uncomfortable conversations" by having direct conversations about it. She challenged her students to think about how they would be present with clients with different views than them. She also used the classroom learning environment to practice the skills of sitting with difference and discomfort.

Interviewees stressed that they were lifelong learners and they sought out learning and training opportunities around the areas of multicultural competence and social justice. KM, a White woman in her forties, offhandedly remarked during her interview "We're lifelong learners, right?" LG, a White woman in her forties, said "the more I learned, the more I knew I didn't know." She also identified additional areas of growth. A few participants spoke about trainings around social justice that they engaged in regularly. JM, a Black woman in her twenties, shared that she participates in the Black mental health symposium every year. CR, a White woman in her thirties, disclosed that she was starting a one-week training about racial trauma with Ken Hardy for the second time. Other participants spoke about getting trained in multiple modalities focused on their population of interest in order to increase the cultural competence of their services. LB, a White woman in her thirties, noted "I try to seek out training[s] that would fall under the social justice umbrella as often as possible…. I am trying to seek out training from the people who have the lived experience of what we're talking about as well."

Training the Next Generation

The final core area focused on how to bring the field forward to train the next generation of multiculturally competent and socially just therapists. Three themes are discussed below: experiential learning, creating pathways for clinicians of color, and infusing social justice into all aspects of training. Participants expressed how important it was for training programs to move beyond classroom learning and to include experiential learning. They also discussed the importance of creating pathways for clinicians of color by making training programs safer for BIPOC people. Finally, participants talked about the need to infuse social justice into all aspects of training, moving beyond the one diversity course model.

Experiential Learning. When asked about how to improve training for the next generation, respondents overwhelmingly advocated for experiential learning. They espoused the need for immersive learning experiences beyond their education in the classroom. Suggestions for training were to engage with those different than oneself, go beyond classroom learning, and be immersed in community work. Other innovative strategies to improve graduate training are presented.

Many participants highlighted the need to build relationships with people different than themselves on a personal and professional level. MC, a Black woman in her thirties, underscored the importance of this by saying:

> People have to build relationships with people different than them to understand and to really build cultural competence, it's more than just reading, it's more than just conversations around a table, it’s more than just reading research. It’s really about developing relationships with people, genuine relationships that I think you are able to

> better understand the systems around their world or how the systems in which you guys both exist could be impacting you all different.

For MC, building genuine relationships across difference was important to happen on a personal level first in order to humanize people that came from different backgrounds and build more competence in working with clients. LH, White woman in her sixties, brought up how this happened in her graduate program by engaging in difficult conversations and sharing deep relationships with those different than herself.

> So that in itself was an education for me. Just being in classroom, and discussions, and learning people's life experiences firsthand in relationship- that was huge for me and really helpful. Building relationships, and I got comfortable enough that… there was enough trust that we developed that some people could challenge me a little bit.

LH noted her own growth through the trusting relationships that she built with her cohort members. She developed more empathy for others' experiences and was also challenged to critically examine her own perspectives or actions and how they impacted those around her.

Most people interviewed described the need to have experiential rather than just didactic training. Participants described a variety of ideas about what this could look like and how it could happen. LH was clear that training should integrate social justice into all aspects, rather than just having one DEI (diversity, equity, and inclusion) course. MH, a Mestizo woman in her thirties, echoed this sentiment, saying:

> I do think that there has to be not just learning about [multiculturalism] but also doing projects that will help you have more of an immersion experience and so, and I do think that it's a continuing education on that, like I don't think that one course in graduate school will be enough.

MH also suggested moving beyond race and culture and focusing on internalized biases and immersion projects in different cultures. MW, a White woman in her thirties, emphasized anti-bias training and working with communities different than one's own as well. She focused on systemic training and how she would like "therapists to get more training on discrimination and get more comfortable with underserved populations."

Participants were clear about how getting out into the community and encountering difference is beneficial to learning. AS, a White woman in her thirties, said that graduate schools should promote "opportunities to get involved with social justice stuff that isn't just advocacy." AM, a White woman in her thirties, stated plainly, "we need to throw a lot more people into the fire." She expanded on this and stated:

> We need to have our trainees working with populations that are different from themselves. We need to as part of their coursework and assignments and things like that, they need to be going out and connecting with communities that they're not a part of.

She continued on to discuss the importance of cultural humility when going into someone else's community and eschewed the "savior idea." AM closed her thought saying, "We need to make sure that people are not graduating without some understanding of privilege, power, oppression, and social justice, and if they don't have that mindset then they don't need to be therapists."

A few participants espoused more innovative techniques to facilitate experiential learning in graduate training programs. AK, a White man in his forties, suggested using virtual reality exercises to help trainees become immersed in others' experiences. LG, a White woman in her forties, talked about utilizing mindfulness as a way to help those from privileged backgrounds to not react to their experiences and to help those from marginalized backgrounds feel an increased sense of safety. She shared that in her teaching she uses mindfulness as a tool to prepare students

to have difficult conversations. JS, a Black woman in her thirties, noted the importance of seeking knowledge from a variety of sources and voices, saying:

> I think one thing that will be really helpful would be more opportunities to seek out wisdom in non-traditional places and non-traditional voices. People that we don't think of as expert but might have important knowledge or things that we can glean.

For her, training the next generation in a socially just way meant giving voice to marginalized groups and prizing the wisdom of those who have not historically had power.

Creating Pathways for Clinicians of Color. In terms of promoting social justice in graduate clinical training programs, participants emphasized the importance of creating pathways for students and faculty of color. RK, a White woman in her twenties, noted the privilege of getting a graduate education, bringing up that "the very people we want in our field are the very people who do not have the opportunity to come sit in the seats that we were in." She encouraged a critical lens, questioning who was not in the room and whose voice was not being heard in clinical training programs. She named structural barriers that impeded equal access to graduate training programs and stated:

> I think we really need *radical radical*[5] change for what entering MFT looks like and who gets to be in those seats and who gets to lead these programs or these trainings or teach these classes to be a supervisor.

Participants talked about active recruitment of diverse cohorts and how this adds richness to the training and better serves the public. JM, a Black woman in her twenties, shared that having a really diverse cohort could be helpful in promoting social justice. LG, a White woman in her forties, agreed, adding that both diverse students and diverse faculty were necessary to the

[5] Italics added to denote participant's emphasis.

best training outcomes. This was important, she noted because “the makeup of our field and the people who are training the people who are in our field need to reflect our clients." MP, a White woman in her fifties, said “we have to make room for trainers of color” to effectively treat clients of color. She noted that this involved the dominant group giving up power and prizing voices of the marginalized who are not always heard.

CR stated, “If we don't have diverse graduate school faculties and safe places for them to work then, you know, it's never going to change.” She discussed the work of therapist scholars in the field and how Dr. Ken Hardy, a Black man, disclosed that he was trained to be a “good White therapist.” CR asserted that an important way for the field to move forward in its training was to both “support the White students to continue working from an antiracist, anti-oppressive lens” but to also move past the traditional multicultural methods of training White students to work with clients of color. CR shared that she felt it was critical to create pathways for clinicians of color to access higher education and become leaders in the field. NA, an Asian woman in her twenties, echoed this and emphasized the need for graduate faculty to be diverse. When asked about how to improve graduate training, NA stated, “Hiring a variety… of supervisors and professors…. so that we can have the best people to ask or to teach about different identities.” Other participants also noted the importance of having students, clinicians, supervisors, and faculty be of diverse backgrounds and lived experiences. Having a variety of perspectives in graduate training programs is what would be more likely to lead to multiculturally competent and socially just practice.

Infusing Social Justice into All Aspects of Training. Regardless of their own clinical training, participants talked about the importance of social justice being a focus of clinical training programs. SA, a White man in his thirties, asserted that social justice should be

integrated into training “literally every second of every day.” He claimed that every course should "acknowledge something about sociocultural, structural oppression, and privilege and how it interacts with whatever the topic is at hand." KP, a White woman in her thirties, concurred, explaining that “I really just can’t imagine doing training for MFTs without the social justice focus.” She emphasized that knowledge, such as understanding the intersections between poverty and mental health, was critical and that it could be damaging when therapists were not aware of such social justice matters. LH, a White woman in her sixties, also claimed that social justice should be a core feature of all MFT programs. LH expanded on this and shared:

> How can you train people to do systems work and work in a family if you don't have an awareness of the justice issues that are happening right in the home around culture and gender and age and sexuality, and all that, it’s like, to me you're missing a huge amount of what's happening there.

Participants also felt strongly about moving the field forward by updating the models and doing more as a profession to promote social justice and advocacy. AG, a White woman in her thirties, recommended that improvements to training include a “significant modernization of the models being taught” and more training around social justice. LB, a White woman in her thirties, noted the differences between clinical professions like LCSWs and LCPCs and MFTs and said that despite all of these clinicians being systemic mental health professionals, that MFTs have further to go in integrating social justice into practice. She spoke about the field did not have a unified voice and that there were viewpoints held by MFTs around social justice. She described how MFTs that value social justice are frustrated with the national organization for not prioritizing social justice matters or speaking out against injustice. LG, a White woman in her forties, also felt that the national organization for MFTs could do more to promote constructive

dialogue across difference. She noted the bifurcation of the field into those that want to protect the sanctity of marriage versus those that are welcoming of all couple types. LG stated:

> What I think we have to do is figure out a way to have real constructive dialogue across difference. And I think that that's the thing that's missing in AAMFT. That's the thing that's often missing in our society in general. But within our field… we need to have particular values related to non-discrimination, related to cultural competency, that everybody in our field is going to be on board for and agree to. We also need to make space for people who hold different beliefs and be able to disagree and be respectful and make space for that.

She expressed disappointment that the organization did not take a stand on recent human rights issues that had a significant impact on the public. LB, a White woman in her thirties, expanded on her thoughts around this in a written member check. She expressed her "frustration with AAMFT not taking a more progressive approach to their policies and ethics board." She also noted:

> For example, AAMFT still allows clinicians to practice Sexual Orientation Change Efforts and Gender Expression Change Efforts in therapy but also says as MFTs our therapy needs to be evidence-based. This feels fear-based (fear of losing members if the organization were to take a more social-justice, progressive, and evidence-based position) and does not reflect what I know MFT ethics to be based upon.

LB's statement highlights the need to bring the field forward to promote equity for all. Overall, participants felt that the national organization and field at large could be doing more to serve the needs of all clients and that practice of systemic therapy in a more socially just way.

Conclusion

Chapter 4 presented the quantitative and qualitative study findings. Regarding research question one, overall, study participants had high levels of multicultural competence, social justice commitment, and social justice self-efficacy. Advocacy competence was lower in the sample overall, with mean score in the middle scoring range, indicating having "some of the pieces in place" yet also benefitting from strengthening advocacy competencies (Ratts & Ford, 2010). Research question two was answered with bivariate associations as well as the linear regression models. Research question three was explored qualitatively through the presentation of qualitative themes across the three core domains of develop, embody, and train the next generation. Chapter 5 will discuss the findings and their implications and provide recommendations for future directions.

Chapter 5: Discussion

Introduction

This chapter summarizes the major findings of the study and contextualizes them within literature. The present study utilized a sequential transformative mixed methods design to explore multicultural competence, social justice commitment and self-efficacy, and advocacy competence among CFTs and understand how clinicians developed and embodied a social-justice oriented identity. The findings are also discussed within the complementary frameworks of the Multicultural and Social Justice Cultural Competencies (MSJCC), critical consciousness, and Public Health Critical Race praxis. Lastly, implications for research and practice are discussed along with limitations of the study and future directions for research.

Discussion of Findings

This study addressed a critical gap in literature regarding the practice of multiculturalism, social justice, and advocacy among CFTs. While multiculturalism and social justice are prioritized in the counseling and social work fields, little literature exists on theoretical or practical guidance for improving these outcomes in the CFT field (Ratts et al., 2016). Although a few scholars in the CFT field have discussed the importance of social justice (Beitin & Allen, 2005; Hardy, 2001; Knudson-Martin et al., 2019; McDowell et al., 2019; Watson, 2019), very few empirical studies have been done in this area and those that have tend to be very small qualitative studies (Esmiol et al., 2012; Morrison et al., 2022). While recent research has explored advocacy practices among CFTs (J. M. Goodman et al., 2018; Jordan & Seponski, 2018a, 2018b), there is a dearth of empirical research on multicultural competence and social justice among CFTs.

Multicultural Competence

To the best of my knowledge, only two studies have measured the level of multicultural competence quantitatively among CFTs (Constantine et al., 2001; Murphy et al., 2006). Constantine[6] and colleagues (2001) found that taking more multicultural courses was associated with greater multicultural knowledge but not with greater multicultural awareness. They also found that scoring higher on a racism scale and a White racial identity scale was associated with lower levels of multicultural knowledge and awareness. Murphy and colleagues' (2006) study included only 12 participants and compared pre and post-test results of students enrolled in a CFT multicultural course. They found that taking the multicultural course led to significantly higher rates of multicultural knowledge, awareness, and skills (Murphy et al., 2006). This finding, though important, is limited by the sample being so small and exclusively consisting of White females.

Findings from the present study indicated that study participants had high levels of multicultural competence, with scores ranging between 56 and 125 and a mean score of 99.9 out of a possible 125. Holcomb-McCoy and Myers (1999) similarly found high levels of multicultural competence among professional counselors (Holcomb-McCoy & Myers, 1999). A 2017 replication study of Holcomb and Myers' 1999 study also report high levels of perceived multicultural competence in a population of counselors (Barden et al., 2017). A more recent study found that self-report scores of multicultural competence among a sample of licensed psychologists and licensed professional counselors were high, however, participants scored low on cultural competence in a performance-based vignette (Wilcox et al., 2020). Both professionals and trainees failed to appropriately address cultural concerns in a case vignette, which is an

[6] Madonna G. Constantine was terminated from her faculty position at Columbia University in 2008 for plagiarism (Santora, 2008). Because of this, these findings should be interpreted with caution.

alarming and important finding (Wilcox et al., 2020). Recent scholars suggest that multicultural competence should be considered a common factor in therapy and that therapist multicultural competence has significant implications for the therapeutic relationship and therapeutic processes and outcomes (Bathje et al., 2022).

In the present study, Black participants scored significantly higher than White participants on multicultural competence. These findings support Holcomb and Myers (1999) and Barden and colleagues' 2017 findings that being a member of a racial/ethnic minority group was associated with higher levels of multicultural competence. Hill et al. (2013) also found that African American and Hispanic counselors scored significantly higher on multicultural competence than both their White and Asian counterparts. Having a minoritized racial ethnic identity likely makes it necessary to have awareness of multicultural issues in a way that being part of the dominant group does not. One Black interview participant echoed these sentiments by expressing how 2020 was the year that White people woke up, but that Black Americans had understood the harsh realities of racism and police brutality long before that.

Those who completed more hours of additional training in multicultural competence and social justice also had higher levels of multicultural competence compared to those with the lowest amount of training. More research has focused on graduate training rather than training outside of graduate school for counselors and therapists. Scholars have asserted the need for multicultural training to be infused into all parts of training (D'Andrea & Daniels, 1991; Pieterse et al., 2009). Recent studies have also found that more time in graduate school was associated with higher multicultural competence (Barden & Greene, 2015; Constantine et al., 2007; Gonzalez-Voller et al., 2020). Interestingly, Tummala-Nara et al. (2012) found that multicultural training at the graduate level was not associated with multicultural competence but that "the

extent to which ongoing multicultural (post-graduate training) was experienced as helpful" was significantly associated with higher levels of cultural competence (Tummala-Narra et al., 2012). They noted the importance of tailoring training and experiential learning to the individual. Qualitative participants in this study (high scorers in multicultural competence) echoed the need to be lifelong learners and frequently sought out additional training opportunities.

The study results also indicate that working in an agency setting is associated with lower levels of multicultural competence compared to working in any other clinical setting. This was an unexpected finding. It is possible that those working in an agency or community mental health setting might face some of the unique constraints and challenges. Tummala-Nara and colleagues (2012) investigated the relationship between access to institutional resources and cultural competence in a sample of 196 licensed clinicians working across various settings. They found that greater access to institutional resources was associated with higher levels of cultural competence. The researchers considered the possibility that meeting managed care requirements may limit time and access to quality multicultural competence training. They highlighted that lack of funding had plagued mental health agencies over the last several years (Tummala-Narra et al., 2012).

Additionally, higher caseloads and higher levels of burnout in agency settings may not leave time for training and a focus on multicultural competence. Mental health workers in agency settings are at higher risk of burnout which is known to also impact client care (Green et al., 2014). Those working in private practice settings report more control at work, a greater sense of personal accomplishment, more sources of satisfaction, and less emotional exhaustion than those working in agency settings (Rupert & Kent, 2007). Further, clinicians in private practice typically have the privilege of creating their own hours and rates, leading to more autonomy and

more financial freedom. Those working in agencies settings may be at more risk of secondary traumatic stress by working with clients with high levels of trauma, this can lead to burnout as well (Shoji et al., 2015). Interview participants spoke to the differences between agency and private practice work. One discussed burnout and deep vicarious trauma she experienced working with people who faced many systemic failures. Her transition into private practice left her with more space to take on advocacy roles and engage in her own training but left her wrestling with her role as a social change agent within the therapy room. Others also struggled with this privilege and ways to give back when not working directly with underserved populations. This finding is important and brings implications for agencies to improve work life balance for therapists by providing support for burnout and secondary traumatic stress and reducing caseloads. More funding should be allocated for agencies to benefit the public at large but also to support providers through professional and personal development. More research is needed to better understand how practice setting may have an impact on multicultural competence.

Social Justice Commitment and Social Justice Self-Efficacy

While the importance of multicultural competence has become increasingly clear in therapy and counseling fields, it should be coupled with social justice for the most effective outcomes (Ratts et al., 2016). In this study, participants' levels of both social justice commitment (M = 6.9) and self-efficacy (M = 6.3) scores were also on the higher side on a scale ranging from 0 to 9. Studies assessing social justice commitment and social justice self-efficacy have mostly focused on student and trainee populations, rather than practicing clinicians (Beer et al., 2012; Inman et al., 2015; Miller et al., 2009; Miller & Sendrowitz, 2011). Miller and Sendrowitz's 2011 study of counseling psychology trainees found that social justice self-efficacy had a direct

effect on the level of social justice commitment (Miller & Sendrowitz, 2011). Inman and colleagues (2015) found that counselors in training with more social support had more social justice self-efficacy and that counselors in training who perceived more social justice training supports reported greater social justice commitment (Inman et al., 2015). These findings echo the findings of the current study in that participants with more hours of additional training in social justice reported higher levels of both social justice commitment and social justice self-efficacy. Further, interview participants who had social justice infused throughout their graduate training spoke with confidence about their commitment to social justice and their perceived abilities to enact socially just clinical practice. A few participants explained their decision to seek out a social justice focused graduate program, displaying social justice commitment. Because of this, they may have gotten more training and better training around social justice, leading to more social justice self-efficacy.

Identifying as female and having higher levels of oppression were significantly associated with higher levels of social justice commitment. Overall, having a more marginalized identity was associated with higher social justice commitment. Research has shown that a commitment to social justice is often formed through exposure to injustice and oppression (Caldwell & Vera, 2010; Swartz et al., 2018). Beer and colleagues' (2012) mixed methods study also provides evidence that having a marginalized identity in terms of gender or race has an impact on social justice commitment and is associated with more empathy for others experiencing oppression (Beer et al., 2012). A 2017 article examines family schemas that serve to oppress those with marginalized identities and how infusing social justice into therapy can help to combat this (E. O. Parker & McDowell, 2017). Their article posits that familial and broader societal schemas can serve to oppress gender, racial, and sexual minorities. Interview

participants spoke about the strategies that they used to dismantle societal narratives in order to promote social justice in the therapy room.

Additionally, being more involved in civic engagement and having more hours of training in multicultural competence and social justice was associated with higher levels of social justice commitment. Other studies have also documented the relationship between interest in social justice and commitment to social justice (Miller et al., 2009; Miller & Sendrowitz, 2011). While it makes sense that those with an interest in social justice and political advocacy were more committed to practicing social justice, Jordan and Seponski (2018a) uncovered a disconnect between therapists' civic engagement and their social justice practices in the room. They found that 86% of CFTs surveyed in their study espoused a philosophy of civic engagement, believing that therapists should be involved in politics and policy, however, that less that 7% of participants believed that politics and policy should be discussed with clients. They noted the importance of training on social justice and advocacy efforts for CFTs and continuing to infuse public and political participation into CFT identity (Jordan & Seponski, 2018a).

Study results show that being older, experiencing more oppression, and completing over 100 hours of additional training in multicultural competence and social justice were significantly associated with higher social justice self-efficacy. Miller and Sendrowitz (2011) found that the training environment for counselors had an impact on their social justice self-efficacy. This finding mirrors the findings of the current study that completing more hours in social justice training would make one feel more confident in their ability to enact social change. Similar to social justice commitment, having exposure to oppression made it more likely that participants would be committed to social justice. One must have experience with and awareness of social

issues like racism and sexism in order to feel efficacious to enact social change (Clark-Taylor, 2017; Gushue et al., 2022). Gushue and colleagues' 2022 study found that having higher levels of critical awareness led to greater awareness of racism and was therefore associated with higher levels of social justice self-efficacy. Qualitative findings also spoke to the importance of exposure to oppression, whether that was through one's own lived experience or viewing how others were treated.

Advocacy Competence

Self-reported levels of advocacy competence were lower in the present study, with a mean score of 73.5 out of a possible 120. This score fell in the middle range of the ACSA's scoring scale, indicating that more work is needed to develop in advocacy competence. Advocacy work on behalf of clients is not highlighted as central to CFT professional identity in the same way that it is in fields like counseling and social work. A robust literature in counseling exists around advocacy, and social justice advocacy is highlighted as a core component of counseling and social work fields.

Although recent CFT scholars (see J. M. Goodman et al., 2018; Jordan & Seponski, 2018b, 2018a) highlight the importance of advocacy in the CFT field, it has mostly been explored on a small scale through the use of case study (Gehart & Lucas, 2007) or in terms of political advocacy rather than direct client work (Jordan & Seponski, 2018a, 2018b). Gehart and Lucas (2007) used case study with one teenaged client to understand her experiences around client advocacy. They found that human connection was an important part of client advocacy but that interfacing with client systems and thinking outside of the box was also key to effective advocacy (Gehart & Lucas, 2007). D'Arrigo-Patrick and colleagues (2017) interviewed 11 postmodern therapists and outlined the practice of therapeutic activism. In this process, therapists

"intentionally [sought] to attend to and disrupt oppressive sociopolitical contexts and processes" (D'Arrigo-Patrick et al., 2017, p. 580). They uncovered two strategies of therapeutic activism: collaborating and countering. Therapists who enacted activism through collaboration prioritized the therapeutic relationship and took the clients' lead preferring not to educate around issues of oppression. Those who enacted activism through countering prized consciousness raising and took clear sociopolitical stances (D'Arrigo-Patrick et al., 2017). In the present study, more therapists chose to use countering stance and discussed the importance of naming oppressive contexts in order to empower clients to advocate for themselves.

This study found that having more additional hours of training in multicultural competence and social justice and experiencing higher levels of oppression were significantly associated with higher advocacy competence. Having a non-binary gender identity was associated with higher levels of advocacy competence compared to identifying as male. Similar to the findings around social justice, this study reveals that having a more marginalized identity was associated with greater advocacy competence. Ratts and Hutchins's 2009 article emphasizes the importance of helping people understand their experiences within the context of an oppressive society. It is possible that CFTs with more marginalized identities have explored their own journeys to understand their experiences with oppression and therefore felt better equipped to advocate on behalf of clients with similar experiences. Such individuals may be more aware of the barriers that marginalized clients face and more aware of resources to help combat these barriers (Ratts & Hutchins, 2009). This was seen in the qualitative findings when Black female participants described being able to empathize with Black female clients and call out how oppression was impacting what they were experiencing. Additionally, women explained how they advocated for and with their female clients in the face of *Roe v. Wade* being overturned.

Sexual minority participants also shared how political decisions entered the therapy room often with their sexual minority clients. It seemed that having a shared status of marginalization sparked empathy and fueled greater drive to advocate for and with clients. Interestingly, in member checks, two White male interview participants expressed being unsure about where to fit in in terms of advocacy when gender or race issues were at the forefront.

Results from this study bolster Goodman, Morgan, and colleagues' (2018) suggestion that advocacy must be woven into MFT curriculum and continuing education opportunities. Jordan and Seponski (2018a) and Ratts and Hutchins (2009) also assert the importance of improved training and continued opportunities for professional development around the area of advocacy for mental health professionals. They suggest more continuing education opportunities and encourage state licensing board to require advocacy as part of their licensure renewal processes. Goodman, Morgan, and colleagues (2018) implore CFTs to engage in self-of-the-advocate work, seek out training opportunities, and engage in political activism to best advocate for their clients.

This study uncovered nuances around CFTs and advocacy by assessing advocacy competence quantitatively and exploring how therapists enact advocacy qualitatively. Findings from the present study echo Holyoak and colleagues' 2020 findings that CFTs often participate in micro-level advocacy practices, though they were sometimes unsure about their role in macro-level advocacy (Holyoak et al., 2020). Qualitative participants who worked in private practice discussed how they previously did more macro-level advocacy in the form of attending protests or linking clients to resources in agency settings. Those in private practice wrestled with wanting to enact social change on a broader scale yet not always knowing how to do this within the confines of therapy room. Holyoak and colleagues (2020) took a strengths-based approach to this

quandary, asserting that CFTs utilize their systemic skills to advocate for clients in the room often and that this micro-level advocacy can empower clients to seek out macro-level change. Jordan and Seponski (2018a) focus more on macro-level advocacy interventions and avow that CFTs have a duty to their clients to advocate and are uniquely poised to make significant contributions to social policy. The tension between micro- and macro-level advocacy interventions remains in the CFT field, with some considering macro-level advocacy work to be out of the scope of practice and others considering it to be an essential component of effective clinical work.

How CFTs Develop and Embody Multicultural and Social Justice Competencies

I also explored how CFTs develop multicultural and social justice counseling competencies and the processes by which they embody a critically conscious, social justice-oriented identity, both within and outside of the therapy room. Qualitative findings were grouped into three main areas: how therapists developed a social justice identity, how they embodied a social justice identity as a clinician, and recommendations to train the next generation of CFTs. Qualitative findings helped to support and expand on the quantitative study findings. The findings will be discussed through the lens of the study's three complementary theoretical lenses: the Multicultural and Social Justice Counseling Competencies (MSJCC), critical consciousness, and Public Health Critical Race praxis.

Multicultural and Social Justice Counseling Competencies (MSJCC). The MSJCC, ratified in 2015, call on counselors and therapists to pursue multicultural competence, social justice, and advocacy in their clinical work (Ratts et al., 2016). The model includes four developmental domains: (a) counselor self-awareness, (b) client worldview, (c) the counseling relationship, and (d) counseling and advocacy interventions. The MSJCC also incorporates

power and oppression by including quadrants addressing the intersections of privileged and marginalized identities for both client and counselor. Recent articles discuss how the MSJCC can be used in research, practice, and training (Hays, 2020; Nassar & Singh, 2020). However, a 2023 study found that only 38 articles have used the MSJCC as a concept or a variable and only 13 of these included empirical research. Additionally, none of these articles included the use of mixed methods research (Gantt-Howrey et al., 2023). This study attempts to operationalize and expand on some of the tenets of the MSJCC, three of its tenets are discussed below.

***Counselor Self-Awareness*.** Ratts and colleagues (2016) consider self-awareness to be the first step of multicultural and socially just clinical practice. The MSJCC note that multicultural and social justice competent counselors acknowledge levels of privilege and marginalization, are aware of their assumptions, worldviews, and biases, and are open to learning about both their own and others' cultural backgrounds and levels of privilege and marginalization. They work to build knowledge and skills in this area and take action for their own professional development and community work (Ratts et al., 2016). The findings from qualitative interviews confirm that participants emphasized the need to understand their own beliefs and biases as well as their privileged and marginalized statuses. Participants spoke about understanding where they fit into the systems and interrogating how their own social location impacted the way that they showed up with their clients. Several participants spoke with care about how they attended to their own biases and were often up front with their clients about them rather than pretending that they didn't exist. Doing the work of challenging one's own internalized biases was a way that participants created safety for their clients and enacted multiculturally competent and socially just practice. Both participants in this study and previous

research has acknowledged the need for a lifelong commitment to this work (Nassar & Singh, 2020).

***Counseling and Advocacy Interventions*.** The MSJCC acknowledge the importance of intervening with and on behalf of clients across several levels (Ratts et al., 2016). Advocacy can occur on behalf of or in collaboration with clients and can range from the individual to the community level through public participation (Toporek & Daniels, 2018). Participants spoke about how they enacted micro-level advocacy in the therapy room with their clients by calling out oppression or naming the impact of oppressive systems. Recognizing external factors or systems of oppression that impact clients is an important yet often overlooked form of advocacy (Ratts & Hutchins, 2009). Interviewees asserted the importance of these interventions, yet also saw them as an ordinary part of their everyday practice. Calling out systems of power may be something that CFTs do frequently, though it is not always considered to be advocacy (Esmiol et al., 2012; Holyoak et al., 2020; E. O. Parker & McDowell, 2017). Knudson-Martin and colleagues (2017) outline their process for socio-culturally attuned therapy, imploring CFTs to attune to context and power, name injustice, intervene in power dynamics, and promote equity. Many participants in this study employed these strategies, frequently attuning to context and naming power differentials in the room. They were clear about who the work was for and clear about their stances to promote equity.

Advocacy can also happen on a broader scale through macro-level interventions. Some interview participants noted how they owned non-profits, advocated for LGBTQ clients politically, or provided wraparound services connecting clients with other resources and systems. One participant stood out in terms of enacting macro-level advocacy by discussing several ways that they connected clients to resources like food or transportation and interfaced with systems,

like the criminal justice system, that their clients were embedded in. Other participants spoke about perceived barriers that they faced while attempting to create systemic change and noted the tension that they felt not being able to create change on a macro-level. They acknowledged that they could only do so much to intervene at the macro-level from their position in the therapy room. These participants held out hope that their intervention with clients one on one would have a positive impact for their children and generations to come. Participants spoke passionately about their intention to be a social justice change agent but noted the limitations enacting large scale change from the therapy room. Recent scholars assert that advocacy should be woven into the fabric of CFT identity and training should be enhanced to encourage CFTs that being a social justice change agent is an integral part of clinical practice (J. M. Goodman et al., 2018; Singh, Nassar, et al., 2020).

***Privilege and Marginalization*.** Attention to privilege and marginalization is woven throughout each of the MSJCC competencies. Ratts and Crethar (2008) argue that counselors hold a position of privilege and should use this position to amplify the voices of those who have been marginalized or oppressed. This study directly measured privilege and oppression and found that those with more oppressed identities scored higher on social justice and advocacy measures. Additionally, qualitative findings revealed how CFTs paid attention to privilege and oppression. Some discussed how their own marginalized identity impacted their work with clients, assisting therapists to better serve their clients. Others spoke about formative experiences that occurred in childhood, with peers, or through their graduate education that led to greater understanding of the intersections of privilege and oppression. It seemed that for participants with marginalized identities, attention to social justice was not a choice but a necessity. Many participants claimed that they could not be neutral in the face of oppression. This was especially

relevant in the current sociopolitical climate wherein rights for gender, sexual, and racial minorities were at risk.

However, both racial minority and White therapists expressed that they tended to discuss issues of social justice more with their racial minority clients and less with their White clients. Two White participants discussed their frustrations with doing anti-racist work in a circle of White therapists. These findings, coupled with the findings that oppression was associated with social justice and advocacy competence, show a great need for work to be done with White individuals in the areas of multicultural competence and social justice. According to Combs (2019), those with privilege should acknowledge and be willing to use it to speak up for others (Combs, 2019). Grzanka and colleagues' 2019 article explores social justice as an antidote to White supremacy in counseling psychology. Echoing Combs assertion, Grzanka and colleagues (2019) contend that White people should work to break down the systems that they benefit from but "must first increase their consciousness around White supremacy, race, and racism, and work alongside People of Color to confront and challenge structural racism" (p. 502). Recent research highlights the need for a focus on intersectionality when developing multicultural training programs that interrogate positions of privilege and oppression (Chan et al., 2018; Grzanka et al., 2019). McDowell and Shelton (2002) assert that CFT programs must "ensure that we create learning environments that allow students to freely explore the multifaceted aspects of privilege and oppression" (p. 330). A broader understanding of the dynamics of privilege and oppression would likely lead to greater multicultural and social justice competencies for therapists in training and practicing CFTs.

Critical Consciousness. Critical consciousness was originally conceptualized as *conscientização* by Paulo Freire in his 1970 book, *Pedagogy of the Oppressed* and used as a

framework to work towards liberation from oppression. Freire's conceptualization of critical consciousness included two key pieces: critical reflection and critical action. Scholars later added critical motivation as a bridge between critical reflection and critical action (Diemer et al., 2015).

Critical Reflection. Critical reflection focuses on analyzing social inequities (e.g. racial, gendered, socioeconomic) and understanding one's social position within the broader social context. According to Freire, this is essential for both oppressors and the oppressed and such reflection is necessary to change one's reality and working toward liberation (Freire, 1970). This tenet mirrors the MSJCC tenet of counselor self-awareness. Scholars cite this awareness as a key piece of critical consciousness including awareness of historical and sociopolitical contexts and awareness of self (Jemal, 2017; Shin et al., 2016; Watts et al., 2011). Participants in this study highlighted the importance of being aware of one's own privilege and bias. Gushue and colleagues (2022) found that critical reflection led to greater levels of racial awareness which thereby predicted social justice outcomes. They highlighted the importance of developing critical reflection on recognizing and combatting systemic inequity. Participants in this study spoke about the importance of promoting awareness of injustice for their clients. They pointed out systemic contexts that oppressed or marginalized their clients, like racism, capitalism, and the patriarchy. They promoted critical reflection in their clients and offered the possibility of creating change. Hernandez and colleagues (2005) assert that promoting critical consciousness in family therapy settings is a way to promote second order change. In this study, promoting critical reflection internally for therapists and with their clients was a way that participants worked toward equity and liberation.

Critical Motivation. Critical motivation, an understudied construct, refers to perceived efficacy in creating change as well as the moral commitment to act (Diemer et al., 2021). Critical

motivation seemed to be present for many of the participants in this study in both the quantitative and qualitative components. This study assessed the critical motivation to combat inequity with the social justice commitment and self-efficacy measures, with participants scoring high on each. Interview participants highlighted recent events (such as racial justice protests and the overturning of *Roe v. Wade*) as motivators to combat inequity. Results support Diemer and colleagues' (2016) assertion that people may develop greater critical consciousness and have more motivation to combat inequities in areas that they are more marginalized in. Qualitative participants also avowed the importance of social justice to their work and the importance of considering themselves to be change agents. However, qualitative participants also expressed some ambivalence about their ability to create change on a large scale. They discussed the perceived limitations of work in the therapy room to create large-scale systemic change, yet they framed their role as systemic therapists to focus on helping people change their relationships. Most who espoused this view kept their motivation by focusing on how their work with clients to lead to healthier generations of children. Participants who noted limitations in their perceived efficacy to create social change supplemented their work in the therapy room with other roles involved in creating systemic change such as teaching, supervising therapists in training, and advocating.

Critical Action. Critical action refers to the steps taken to address and remit oppressive social contexts, with a focus on structural change (Diemer et al., 2021). This can be done through individual action and collective action in order to combat the circumstances that lead to social injustice (Jemal, 2017). In this study, critical action was illustrated by measuring advocacy competence through survey methods and interviewing participants to understand how CFTs enacted advocacy interventions on behalf of their clients. Findings indicate that the social

location of the participants had an impact on critical action. Women who were interviewed the week that *Roe v. Wade* was overturned expressed an urgent need for critical action, seeming to understand their marginalized identities as women in a new way. Having a marginalized identity as the therapist, however, sometimes made critical action tricky when working with more privileged clients. Black female therapists spoke about feeling unsure about whether to intervene when confronted with injustice in the therapy room so as not to jeopardize the therapeutic relationship. Therapists also espoused critical action when working with minoritized clients and discussed these matters less when working with White clients. More attention should be given to critiquing and challenging systems of oppression with White individuals (Grzanka et al., 2019).

Similar to Jordan and Seponski's 2018 study of CFTs and political action, we found that advocacy competence in our quantitative was lower overall than multicultural competence or social justice commitment or self-efficacy. More training and higher levels of oppression were associated with advocacy. This speaks to the lack of training and focus on advocacy and critical action in the CFT field at large. Jordan and Seponski (2018) and Goodman and Morgan and colleagues (2018) urge more integration of advocacy into the training, continuing education, and personal practices of CFTs.

Public Health Critical Race Praxis. The Public Health Critical Race praxis was introduced in 2010 by Ford and Airhihenbuwa and melds critical race theory and public health to promote racial justice in public health practice. This framework has grown over the last decade to guide effective health disparities research and practice (Thomas et al., 2011).

***Contemporary Patterns of Race Relations*.** The first focus of Public Health Critical race praxis includes several tenets including race consciousness, race as a social construct, and structural determinism. This approach grounds research and practice in the understanding that

the significance of race is due to structural forces that perpetuate inequity. This study interviewed systemic therapists that prioritized context when working with their clients. This meant that they had a deep awareness of their own and their clients' racial position and racial stratification in society (Ford & Airhihenbuwa, 2010b). They attended to oppressive contexts and helped clients to build awareness of how forces like racism and sexism impacted their lives and clinical presenting problems. Researchers call attention to the need to use more innovative methods than quantitative studies to better understand complex phenomena (Hardeman & Karbeah, 2020). Additionally, we must move beyond interpreting findings by race devoid of other context. In this study, contexts of oppression were understood in an intersectional way and revealed that those with more marginalized identities tended to have higher levels of social justice and advocacy competence. Researchers urge greater use of critical race theory in mental health as a way to understand the experiences of people of color and work towards liberation (Mcgee & Stovall, 2015).

***Action*.** The action component of Public Health Critical Race praxis includes four principles: critical approaches, voice, disciplinary self-critique, and intersectionality. Public Health Critical Race praxis considers action to be inextricably linked with theory, research, and practice. This study also prioritized action by understanding how CFTs actively worked to promote social justice in their clinical practice and beyond. Participants espoused critical approaches to therapy, wherein they interrogated their own social positions and called out dominant discourses (Ford & Airhihenbuwa, 2010b). This study utilized the principle of giving voice through qualitative interviews and "privileged the experiential knowledge of outsiders within" (Ford & Airhihenbuwa, 2010b, p. 1394). The notion of outsiders within a field applies to study participants, as the CFT field does not as a whole have a dedicated commitment to social

justice. Several participants spoke about how they sought to combat injustice even when this went against how they were trained. Participants were quick to express their pride in being CFTs, but they were also willing to engage in disciplinary self-critique. They critically examined the ways that they were taught and who developed the clinical models that they learned. Participants talked about the importance of making space for more marginalized or non-traditional voices to move the field forward. Finally, participants were aware of their own intersectional identities and their clients' intersectional identities. Several discussed how their training and development as a therapist increased their awareness of intersectionality and allowed them to feel more prepared to bring this into the therapy room.

Implications for Practice and Training

As systemically trained mental health professionals, CFTs are uniquely poised to integrate multicultural competence, social justice, and advocacy to create systemic change. Systemic factors that impact social functioning and mental wellbeing include racism, poverty, and inequity in policy or healthcare (Vera & Speight, 2003). Negating such oppressive contexts is doing clients a disservice, especially those facing marginalization. Mental health fields still today fall victim to engaging in a problem-saturated narrative and working to change individuals rather than social contexts. Vera and Speight's landmark 2003 article describes how such remedial approaches to therapy are passive and encourage the status quo because they do not work to change oppressive contexts. Since this 2003 call to action, the field of counseling has made strides in infusing social justice and advocacy into everyday clinical practice and clinical identity. Much scholarship has been published on how to promote social justice and advocacy in the field of counseling (Paladino et al., 2011; Ratts & Hutchins, 2009; Toporek et al., 2009) and

calls to action have led to policy change and the codification of social justice and advocacy into guidelines from the ACA (Toporek & Daniels, 2018).

Unfortunately, in the CFT field, not much has changed in terms of "remedial therapy-based service delivery" (p. 258) since Vera and Speight (2003) implored the field of counseling to focus on social justice in addition to multicultural counseling. The field remains hamstrung by slow to act national organizations, licensing boards, and academic programs, and faces barriers from insurance companies. CFTs were only just included as Medicare-eligible providers and still face barriers to being recognized as mental health professionals who can provide supervision to other mental health practitioners on a state-by-state level. CFTs also lag behind all other major mental health fields in increasing client care across state lines through the provision of interstate compacts.

This study has notable implications for the training and practice of multiculturally competent and socially just CFTs. In this sample, self-reported levels of multicultural competence and social justice commitment and self-efficacy were on the higher side. However, this finding should be considered within the context of self-report, noting the limitations of this approach rather than experimental or client-reported data. Levels of self-reported advocacy were lower in this sample overall, mirroring current findings that advocacy in the CFT field should be strengthened (J. M. Goodman et al., 2018; Jordan & Seponski, 2018b, 2018a). Implications are presented below on ways to strengthen CFTs' multicultural competence, social justice, and advocacy competence through training, practice, and advocacy efforts.

Implications for Training

The quantitative findings of this study revealed the importance of training for multicultural competence, social justice commitment and self-efficacy, and advocacy

competence. More hours of training and more quality training in these areas are necessary to move the field forward (Mcdowell et al., 2007; McDowell & Shelton, 2002). Study results also revealed that Black participants had higher levels of multicultural competence than White participants. It is imperative to train White therapists to better serve the needs of diverse clients, helping them to build awareness of their own biases as well as how systemic racism impacts their clients. Hardy (2012), noted scholar and Black male CFT, discusses how he was trained to be a "good White therapist," pointing out the limitations of training for clinicians of color. It is clear that CFT programs must also recruit and cater to more diverse students and design more advanced curriculum in the areas of multicultural competence and social justice. Efforts should be made to create truly inclusive learning environments in CFT for all students (Mcdowell et al., 2007). It is also essential for CFT programs to recruit more diverse faculty and ensure that faculty and supervisors have adequate knowledge, awareness, and skills in these areas.

CFT programs should move beyond the traditional one multicultural course model and infuse social justice into all aspects of training. No longer should programs use the multicultural competencies devoid of social context, especially in a systemic field. Study participants highlighted a couple of CFT programs that could serve as exemplars for infusing social justice into all aspects of training. The goals of one such MCFT program include: "Students self-reflect on the implications of own and others' social location in clinical practice" and "Students' clinical practice demonstrates attention to social justice and cultural democracy." This program includes attention to sociopolitical context in each of its courses, considering such contexts in research methods and diagnosis with a critical approach. Another CFT program outlines its social justice focus on their homepage including an action orientation, a recognition of diversity of individuals and family structures, and attention to how political processes impact families. This program's

electives include a course on social justice and advocacy interventions in addictions counseling and four different electives on gender affirming clinical practice.

The counseling field has transformed clinical training and guidelines over the last two decades by putting forth calls to action (See Ratts, 2009; Toporek et al., 2009, Vera & Speight, 2003). As such, they have expanded what it means to be a counselor to include a focus on social justice and advocacy efforts. Experiential learning opportunities and community engagement should be prioritized over didactic learning in order for CFTs in training to build more competency. Participants asserted that therapists in training must build authentic relationships across difference and be immersed in community-based work. More opportunities should be built into training during and before internship experiences to do community work and engage with different communities. CFT training programs must work to enhance their multicultural and social justice competencies to lay the foundation for effective practice.

Implications for Practice

Though the CFT field is still overwhelmingly White, the U.S. grows more diverse each year and the need for multiculturally competent services is clear. This study revealed that those with marginalized identities in terms of gender or race practiced in a more multiculturally competent and socially just way. Participants with higher levels of oppression had higher scores in social justice commitment, social justice self-efficacy, and advocacy competence. Singh and colleagues (2020) assert the importance of acknowledging and moving away from a White, Western, male dominated lens in mental health fields. CFTs, especially those with privileged identities, need to be better trained to work with diverse clients. White therapists and male therapists should build understanding of their own areas of privilege and work to build awareness of oppression. This should involve building more awareness of social location and areas of

privilege but should also include integration of these concepts into clinical identity. Use of vignettes may help to enhance personal work done in these areas and clinical supervision is also a necessary part of developing a more socially just clinical identity (M. Garcia et al., 2009; Morrison et al., 2022). Beyond this, White therapist should use their privilege to dismantle systems of oppression (Combs, 2019; Grzanka et al., 2019). Participants in this study noted that they tended to focus more on social justice with marginalized clients. This work should also be done with privileged clients in order to dismantle oppressive systems.

The findings clearly pointed out the need for more post-graduate education in multicultural competence and social justice. Those with more hours of additional training scored higher on all measures. Training in these areas should be mandated by state boards in order to improve client services. Such trainings should be accessible and affordable to ensure that all therapists have access to them. Trainings should also incorporate self of therapist aspects wherein clinicians can interrogate their own biases and social locations.

Finally, support for therapists to combat burnout and structural barriers is paramount. This study found that those working in agency settings had lower multicultural competence compared to those working in other clinical settings. Studies have shown that agency settings often have high levels of burnout and stress and low levels of control (Green et al., 2014; Rupert & Kent, 2007). Qualitative participants also discussed their experience with burnout in agency settings and perceived limitations of doing their best work. Agencies should consider ways to combat burnout by focusing on employee wellness. Increasing funding for community care and wraparound services would also help to combat structural barriers faced by both therapist and client.

Implications for Advocacy

Findings of this study revealed the need to focus more on advocacy competence for CFTs. The CFT field prioritizes advocacy less than other mental health fields in its training, mission, and ethical codes, despite its systemic focus (J. M. Goodman et al., 2018). In fact, at the time of writing, social workers, psychologists, counselors, in addition to nurses and speech language pathologists have all pursued interstate compacts to increase access to clients across state lines. This innovative strategy to provide access to clients through teletherapy services is becoming best practice, thought AAMFT has not stated any intention to pursue a compact for CFTs. National organizations and state licensing boards play a large part in the success of advocacy efforts, though grassroots efforts have been most of how advocacy efforts in the CFT field has advanced. Toporek and colleagues (2009) point to "leadership from within" (p. 262) as a way that grassroots efforts have turned into policy for the counseling field. The counseling field has appointed task forces and commissioned special issues that served as touchpoints to ignite change in the field. Such advances could also help to move the CFT field forward.

Very little empirical evidence exists about CFTs advocacy efforts, and these studies tend to focus on advocacy in the room or on political participation rather than social justice advocacy efforts (Holyoak et al., 2020; Jordan & Seponski, 2018b, 2018a). According to Holyoak (2020), CFTs are commonly enacting micro-level advocacy by helping clients to recognize and address systems of oppression within the therapy room. More attention is needed to ways that CFTs can use systemic interventions to bridge micro- and macro-level advocacy interventions. Systemic thinking should be broadened to move beyond the family system to include community and policy as well as systems of oppression (Jordan & Seponski, 2018b). Systemic therapy interventions should target the social systems themselves rather than just the individuals (Ratts &

Hutchins, 2009). The ACA Advocacy competencies (Toporek & Daniels, 2018) provide implementable guidelines for the counseling field to enact advocacy efforts. Additionally, Ratts and Greenleaf (2018) encourage a paradigm shift for counselors to think of themselves as counselor-advocate-scholars. Adding the advocate component includes working with community leaders to create systemic change and combat systems of oppression (Ratts & Greenleaf, 2018). This model allows therapists to choose the appropriate interventions in the appropriate moment. CFTs work to involve as many parts of the system as possible, and incorporating advocacy is an important next step to advance the field. CFTs becoming more confident in an advocate role and more comfortable with connecting clients with resources will improve client care.

Strengths and Limitations

This study has several strengths. It provides an understanding of multicultural, social justice, and advocacy competence that has not been studied among CFTs yet. It is one of the first studies to comprehensive look at multicultural competence and social justice in CFTs, while other studies were limited in their scope or sample size. This study included a national sample, with participants from all across the country. Its sequential transformative mixed methods design provided a thorough look at whether and how CFTs were enacting multicultural competence, social justice, and advocacy in their clinical practice. This design allows for a more complete understanding of socially just clinical practice than using a single method and allowed for an explicit focus on creating social change (Mertens, 2012).

This study has a few limitations. The first limitation of this study is its cross-sectional design. Collecting data at one time point means that causal inferences cannot be drawn. It is possible that the therapists who completed the survey believe that they are effective at multicultural competence and social justice or that they inflated their answers due to the social

desirability bias. Additionally, the self-report nature of these measures may lead to slightly biased data. Sampling bias may have also been present, as those who were more interested in and well versed in multicultural competence and social justice may have completed the survey.

Limitations also occurred in measurement of variables. Notably, lessons were learned in creating numerical variables rather than fill in the blank options for hours of training. These answers spanned a large range and some participants wrote answers like "don't know" or "too many to count." In future designs, inputting a numerical value would be used instead.

Future Directions

This study provides a rich foundation for future research to build off of to understand multicultural competence and social justice practices in the CFT field. This field is at a crossroads and the need for competent services is higher than ever. CFTs bring a systemic lens to their work but are not always trained with a focus on understanding how oppressive symptoms impact their clients and the need to advocate to change these systems. Future studies could attempt to reach a larger sample size or collect data longitudinally to understand how social justice practice may occur over time. Attempts should be made to reach CFTs who are not necessarily passionate about social justice to understand their multicultural and social justice practices. Further research could also integrate data from clients to understand what multiculturally competent and socially just practice would look like to them. This would give a more comprehensive picture compared to therapist self-report data. Currently, we don't know if multicultural practice is actually improving client outcomes (Vera & Speight, 2003). Little data has been collected from clients directly, though Gehart & Lucas (2007) conducted a case study of one client concerning client advocacy. This study revealed the importance of human connection, collaboration with outside agencies, and creativity in service delivery. Clinical

vignettes, rather than self-report, could also be used to understand the decision-making practices of CFTs around multiculturalism and social justice. Ideally, future research efforts in this area would reach a more diverse population to hear from more marginalized voices in the field.

Conclusion

The purpose of this study was to understand the practices of CFTs in the areas of multicultural competence, social justice, and advocacy competence. This mixed methods study adds a greater understanding of where the field is and how the field can grow in these areas. Given the current sociohistorical context and the growing need for mental health services, CFTs are important public health practitioners and should ensure a health equity focus. Findings showed that CFTs self-reported higher levels of competence in multicultural and social justice praxis but have further to go in advocacy. Experiencing marginalization, having additional training, and working to uncover implicit biases all played an important role in socially just clinical practice. This study contributes important recommendations for training the next generation of socially just CFTs.

This project allowed me to explore a topic that I was passionate about and had a stake in. As I wrestled with how to deliver culturally competent services over the last few years, I got to speak to others passionate about this work. It helped me to understand how important community and conversation are to advancing the field and empowering clinicians to provide better services to their clients. I looked forward to continuing this work through collaboration with colleagues and through integrating research, practice, and policy.

Table 1: Sociodemographic Characteristics of Participants

Table 1

Sociodemographic Characteristics of Participants

Characteristic	n=101	%	Mean (SD
Age			37.43 (9.44)
18-24	1	1.0	
25-34	46	45.5	
35-44	35	34.7	
45-54	12	11.9	
55-64	5	5.0	
65-74	2	2.0	
Race			
Black or African American	10	9.9	
White	77	76.2	
Asian	3	3.0	
American Indian	1	1	
Native Hawaiian or Pacific Islander	1	1	
Biracial	2	2	
Multiracial	2	2	
Other	5	5	
Ethnicity			
Non-Hispanic or Latino	94	93.1	
Hispanic/Latino	7	6.9	
Gender			
Male	12	11.9	
Female	84	83.2	
Nonbinary	4	4.0	
Prefer not to say	1	1.0	
Sexual Orientation			
Heterosexual	73	72.3	
Lesbian	3	3.0	
Gay	3	3.0	
Bisexual	15	14.9	
Other	6	5.9	
Prefer Not to Say	1	1.0	
Currently Practicing a Religion			
Yes	43	42.6	
No	58	57.4	
Religion (n=43)			
Roman Catholicism	4	9.3	
Christianity/ Protestantism	16	37.2	
Mormonism	4	9.3	
Islam	2	4.7	
Buddhism	2	4.7	
Judaism	10	23.3	

Other	5	11.6	
Current Relationship Status			
Single	12	11.9	
Married	65	64.4	
Separated/Divorced	3	3.0	
Widowed	1	1	
Cohabiting	9	8.9	
Dating but not living together	11	10.9	
Current Household Income			
$25,000-49,999	5	5.0	
$50.000-74,999	13	12.9	
$75,000-100,000	23	22.8	
More than $100,000	60	59.4	
Education			
Master's degree	80	79.2	
Doctoral Degree	21	20.8	
Committed to Civic Engagement			4.18 (1.01)
Strongly Disagree	6	5.9	
Somewhat Disagree	1	1.0	
Neither Agree nor Disagree	5	5.0	
Somewhat Agree	46	45.5	
Strongly Agree	43	42.6	

Table 2: Professional Characteristics of Participants

Table 2

Professional Characteristics of Participants

Characteristic	n=101	%	Mean (SD)
Years in Clinical Practice			7.99 (4.79)
1-4	28	27.7	
5-10	48	47.5	
11-15	18	17.8	
16-20	7	6.9	
Practice Setting			
Private Practice	75	74.3	
Agency	24	23.8	
School	8	7.9	
Other	7	6.9	
State of Current Practice			
Alabama	2	2.0	
Alaska	1	1.0	
Arizona	1	1.0	
California	6	5.9	
Colorado	4	4.0	
Connecticut	1	1.0	
District of Columbia	4	4.0	
Florida	2	2.0	
Georgia	1	1.0	
Illinois	11	10.9	
Indiana	2	2.0	
Kansas	1	1.0	
Maryland	20	19.8	
Michigan	1	1.0	
Minnesota	3	3.0	
Missouri	1	1.0	
Nebraska	1	1.0	
New Hampshire	1	1.0	
New Jersey	1	1.0	
New Mexico	1	1.0	
New York	3	3.0	
North Carolina	1	1.0	
North Dakota	2	2.0	
Oregon	8	7.9	
Pennsylvania	3	3.0	
Tennessee	1	1.0	
Texas	5	5.0	
Utah	2	2.0	
Virginia	2	2.0	

Washington	1	1.0	
Wisconsin	8	7.9	
Geographic Location			
Urban	49	48.5	
Suburban	47	46.5	
Rural	5	5.0	
Hours of Graduate Training in Multicultural Competence			178.08 (482.59)
Some (0-45)	51	50.5	
A Moderate Amount (46-100)	25	24.8	
A Lot (More than 100)	25	24.8	
Hours of Additional Training in Multicultural Competence			81.06 (174.13)
Some (0-45)	61	60.4	
A Moderate Amount (46-100)	28	27.7	
A Lot (More than 100)	12	11.9	

Table 3: Sociodemographic and Professional Characteristics of Qualitative Participants

Table 3

Sociodemographic and Professional Characteristics of Qualitative Participants

Characteristic	n=22	%	Mean
Age			38.18
18-24	1	4.5	
25-34	9	40.9	
35-44	8	36.4	
45-54	2	9.1	
55-64	1	4.5	
65-74	1	4.5	
Race			
Black or African American	3	13.6	
White	16	72.7	
Asian	1	4.5	
Biracial	1	4.5	
Other (Mestizo)	1	4.5	
Gender			
Male	2	9.1	
Female	20	90.9	
Sexual Orientation			
Heterosexual	16	72.7	
Bisexual	4	18.2	
Queer	1	4.5	
Heteroflexible	1	4.5	
Religion			
None	13	59.1	
Christianity	5	22.7	
Judaism	2	9.1	
Islam	1	4.5	
Other (Paganism)	1	4.5	
Relationship Status			
Single	4	18.2	
Married	15	68.2	
Separated/Divorced	1	4.5	
Cohabiting	1	4.5	
Dating but not living together	1	4.5	
Current Household Income			
$25,000-49,999	1	4.5	
$50.000-74,999	3	13.6	
$75,000-100,000	3	13.6	
More than $100,000	15	68.2	
Education			

Master's degree	17	77.3	
Doctoral Degree	5	22.7	
Years Practicing			7.32
1-5	8	36.4	
6-10	11	50.0	
11-15	2	9.1	
16-20	1	4.5	
Location of Practice			
Urban	13	59.1	
Suburban	8	36.4	
Rural	1	4.5	
Practice Setting (some more than one)			
Private Practice	19	86.4	
Agency	1	4.5	
Non-Profit	1	4.5	
School	3	13.6	
State of Practice (some more than one)			
Arizona	1	4.5	
Colorado	1	4.5	
District of Columbia	1	4.5	
Georgia	1	4.5	
Illinois	3	13.6	
Maryland	6	27.3	
Minnesota	1	4.5	
Missouri	1	4.5	
New Hampshire	1	4.5	
North Dakota	1	4.5	
Oregon	2	9.1	
Texas	2	9.1	
Virginia	2	9.1	
Washington	1	4.5	
Wisconsin	1	4.5	

Table 4: Descriptive Statistics for Dependent Variables

Table 4

Descriptive Statistics for Dependent Variables

	N	Minimum	Maximum	Mean	Std. Deviation
Multicultural Competence	101	56.00	125.00	99.9070	15.31622
Social Justice Commitment	101	.00	9.00	6.8861	2.20043
Social Justice Self Efficacy	101	1.50	9.00	6.2822	1.47869
Advocacy Competence	101	18.00	120.00	73.5446	22.19528

Table 5: Multicultural Competence Linear Regression

Table 5

Multicultural Competence Linear Regression

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	94.166	4.494		20.956	<.001
Black	14.530	4.917	.285	2.955	.004
Other Race	6.761	4.116	.153	1.643	.104
Female	2.512	4.277	.062	.587	.559
Nonbinary	8.643	8.797	.111	.983	.328
LGBQ	3.544	3.291	.104	1.077	.284
Doctoral	3.004	3.900	.080	.770	.443
46-100 hours additional training	1.013	3.389	.030	.299	.766
Over 100 hours additional training	10.848	4.968	.230	2.184	.032
Agency setting	-9.440	3.291	-.264	-2.868	.005

Table 6: Social Justice Commitment Linear Regression

Table 6

Social Justice Commitment Linear Regression

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	1.724	.962		1.792	.076
Black	.631	.636	.086	.992	.324
Other Race	-.984	.558	-.155	-1.764	.081
Female	1.490	.575	.255	2.592	.011
Nonbinary	1.477	1.165	.132	1.269	.208
LGBQ	.561	.434	.115	1.293	.199
Doctoral	.108	.495	.020	.218	.828
46-100 hours additional training	1.498	.440	.306	3.409	<.001
Over 100 hours additional training	1.961	.632	.290	3.105	.003
Oppression	.894	.308	.273	2.900	.005
Civic engagement	.457	.193	.211	2.369	.020
Private practice setting	-.481	.439	-.096	-1.098	.275

Table 7: Social Justice Self-Efficacy Linear Regression

Table 7

Social Justice Self Efficacy Linear Regression

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	2.891	.805		3.592	<.001
How old are you?	.042	.016	.270	2.602	.011
Black	.844	.473	.171	1.783	.078
Other Race	.118	.412	.028	.287	.775
Female	.401	.422	.102	.949	.345
Nonbinary	1.348	.850	.179	1.586	.116
LGBQ	-.011	.339	-.003	-.032	.974
Doctoral	-.004	.390	-.001	-.010	.992
46-100 hours graduate training	-.053	.339	-.016	-.156	.876
Over 100 hours graduate training	.545	.398	.160	1.371	.174
46-100 hours additional training	.653	.349	.199	1.871	.065
Over 100 hours additional training	.999	.485	.220	2.058	.043
Oppression	.467	.232	.212	2.014	.047
Years in Clinical Practice	.012	.034	.037	.343	.732

Table 8: Advocacy Competence Linear Regression

Table 8

Advocacy Competence Linear Regression

	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	33.784	7.883		4.286	<.001
Black	11.018	6.691	.149	1.647	.103
Other Race	1.762	5.830	.028	.302	.763
Female	9.624	5.744	.163	1.675	.097
Nonbinary	25.470	11.805	.225	2.158	.034
LGBQ	2.656	4.526	.054	.587	.559
Doctoral	6.575	5.606	.121	1.173	.244
46-100 hours additional training	10.011	4.561	.203	2.195	.031
Over 100 hours additional training	14.062	6.572	.206	2.140	.035
Oppression	10.877	3.200	.330	3.398	.001
Years in Clinical Practice	.488	.433	.105	1.125	.263

Appendix A: Script for Recruitment

Dear Colleague,

My name is Laura Golojuch and I am a doctoral candidate in the Department of Family Science at the University of Maryland. I am doing a study on Couple and Family Therapists (CFTs) and their multicultural competence, social justice commitment and efficacy, and advocacy-related practices.

I am recruiting participants who have graduated from a COAMFTE accredited program within the last twenty years and are a currently practicing CFT who is fully licensed, provisionally licensed, or in the process of gaining licensure. You will be asked to complete a survey, which should last approximately 20 minutes. This study will help to better understand the practices around social justice in CFTs' clinical practice. If interested, please click on this link to complete informed consent and take part in the survey. For every survey completed up to 200, I will donate $1 to So Others Might Eat (SOME), a charity that focuses on fighting poverty and homelessness.

Additionally, I am looking for CFTs to participate in virtual interviews to better understand their practices around social justice. If interested in taking part in an individual interview, please indicate this while taking the survey. You may be selected based on your survey responses. Interviews are expected to take approximately one hour and will be video or audio recorded for all participants. For interview participation, respondents will enter a drawing to win one of five of $40 gift cards.

To participate in this study, please click the {link here}.

If you have any questions about this study, please contact me directly at lgolojuc@umd.edu. Please forward along to anyone who might be eligible and interested in taking part. Thank you for your contribution to the field and commitment to improving it!

Sincerely,

Laura Golojuch, LMFT

Appendix B: Survey Measures

Eligibility Criteria

Are you a fully licensed (i.e. LMFT, LCMFT) or provisionally licensed Couple and Family Therapist (i.e. LGMFT, LMFTA), or are you in the process of gaining licensure?

Are currently practicing as a Couple and Family Therapist (CFT)?

Did you graduate from a COAMFTE Accredited program?

Have you graduated from your clinical program in the last twenty (20) years?

Demographics

How old are you? _____

How do you self-identify your race?
- Black or African American
- White
- Asian
- American Indian
- Native Hawaiian or Pacific Islander
- Biracial
- Multiracial
- Other (please specify)

How do others in this country usually classify your race?
- Black or African American
- White
- Asian
- American Indian
- Native Hawaiian or Pacific Islander
- Biracial
- Multiracial
- Other (please specify)

What is your ethnicity?
- Hispanic or Latino
- Not Hispanic or Latino

What was your sex assigned at birth?
- Female
- Male
- Intersex

What is your gender identity?

- Cisgender
- Transgender
- Non-binary
- Other (please specify)

What is your sexual orientation?

- Heterosexual
- Lesbian
- Gay
- Bisexual
- Asexual
- Other (please specify)

Do you currently practice any religion?

- Yes
- No

If yes, please specify

- Roman Catholicism
- Protestantism
- Mormonism
- Islam
- Buddhism
- Hinduism
- Other (please specify)

Current Household Income

- Less than $25,000
- $25,000-$49,000
- $50,000-74,999
- $75,000-$100,000
- More than $100,000

Current Relationship Status

- Single
- Married
- Separated/ Divorced
- Widowed
- Cohabiting
- Dating, but not living together

I would consider myself to be committed to civic engagement (e.g. voting, volunteering in the community, advocating for causes I care about).

1) Strongly Disagree
2) Disagree

3) Neither agree nor disagree
4) Agree
5) Strongly Agree

Professional Factors

What is the highest level of education you have attained?
Master's degree
Doctoral Degree

How many years have you been in clinical practice? ____

What type of setting do you currently practice clinical work in? Select all that apply.
Private Practice
Agency
School
Other (please specify)

What state do you currently practice in?
[Select from 50 states or Washington, DC]

Is the location that you work in urban, suburban, or rural?
Urban
Suburban
Rural

How many hours of graduate training have you completed on diversity, social justice, or multicultural competence in human service delivery? Include formal coursework, independent, study, discussion in supervision, etc. _____

How many hours of additional training have you completed on topics relevant to multicultural competence, social justice, advocacy, or anti-racism. Include continuing education through workshops, seminars, or conferences, independent research, etc. _____

Privilege and Oppression

The following measure assesses self-reported level of privilege and oppression. It is rated on a scale from 1 (this statement is not at all true for me) to 5 (this statement is very true for me).

I would consider myself to be very privileged in terms of each of the following identities:
Ability/Disability Status
1) This statement is not at all true for me
2) This statement is not very true for me
3) This statement is moderately true for me
4) This statement is mostly true for me
5) This statement is very true for me

Gender Identity

1) This statement is not at all true for me
2) This statement is not very true for me
3) This statement is moderately true for me
4) This statement is mostly true for me
5) This statement is very true for me

Nationality

1) This statement is not at all true for me
2) This statement is not very true for me
3) This statement is moderately true for me
4) This statement is mostly true for me
5) This statement is very true for me

Sexual Orientation

1) This statement is not at all true for me
2) This statement is not very true for me
3) This statement is moderately true for me
4) This statement is mostly true for me
5) This statement is very true for me

Socioeconomic Status

1) This statement is not at all true for me
2) This statement is not very true for me
3) This statement is moderately true for me
4) This statement is mostly true for me
5) This statement is very true for me

Race/ethnicity

1) This statement is not at all true for me
2) This statement is not very true for me
3) This statement is moderately true for me
4) This statement is mostly true for me
5) This statement is very true for me

Religion

1) This statement is not at all true for me
2) This statement is not very true for me
3) This statement is moderately true for me
4) This statement is mostly true for me
5) This statement is very true for me

I would consider my client base to be very oppressed in terms of each of the following identities:

Ability/Disability Status

6) This statement is not at all true for me
7) This statement is not very true for me

8) This statement is moderately true for me
9) This statement is mostly true for me
10) This statement is very true for me

Gender Identity

6) This statement is not at all true for me
7) This statement is not very true for me
8) This statement is moderately true for me
9) This statement is mostly true for me
10) This statement is very true for me

Nationality

6) This statement is not at all true for me
7) This statement is not very true for me
8) This statement is moderately true for me
9) This statement is mostly true for me
10) This statement is very true for me

Sexual Orientation

6) This statement is not at all true for me
7) This statement is not very true for me
8) This statement is moderately true for me
9) This statement is mostly true for me
10) This statement is very true for me

Socioeconomic Status

6) This statement is not at all true for me
7) This statement is not very true for me
8) This statement is moderately true for me
9) This statement is mostly true for me
10) This statement is very true for me

Race/ethnicity

6) This statement is not at all true for me
7) This statement is not very true for me
8) This statement is moderately true for me
9) This statement is mostly true for me
10) This statement is very true for me

Religion

6) This statement is not at all true for me
7) This statement is not very true for me
8) This statement is moderately true for me
9) This statement is mostly true for me
10) This statement is very true for me

Multicultural Competence

This survey assesses competence in providing clinical services to clients. Please rate how confident you are in providing each of the following services to the best of your ability. This scale is rated from 1 (not competent in providing specified clinical task) to 5 (very competent in providing specified clinical task).

I can identify how clients' beliefs affect the therapeutic process

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I am able to recognize clients' cultural expectations of the therapeutic process

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can initiate discussions about cultural mores (e.g. roles expectations) when working with clients

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I am able to identify barriers that may impede clients' access to mental health services

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can describe elements of culture specific (e.g. faith, sexual orientation, race) developmental models during clinical practice

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can explain the implications of privilege as they relate to my clinical practice

1) Not Competent
2) Somewhat Competent

3) Moderately Competent
4) Competent
5) Very Competent

I can identify how my principles impact the therapeutic process

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can integrate clients' cultural heritage when implementing therapeutic techniques

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I am capable of connecting clients with culturally specific resources

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I am able to initiate dialogue about how social-political issues relate to my clients' mental health

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can pinpoint which cultural beliefs are most important to my clients

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I am able to conceptualize clients through culture specific developmental models in clinical practice

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can tailor therapeutic approaches based upon clients' cultural beliefs

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can identify how privilege may influence the therapeutic relationship

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can recognize how societal mistreatment of my clients may impact their self esteem

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I am able to recognize how my values may interfere with providing clients with therapeutic services

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can identify culturally appropriate resources for my clients

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I am capable of utilizing culture specific developmental models in my clinical practice

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can modify therapeutic strategies to honor the cultural identities of clients

1) Not Competent

2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I am able to articulate how cultural group membership impacts the lives of clients

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can convey the beliefs of my own cultural group to my clients

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can identify how my cultural identity impacts the therapeutic process

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can modify therapeutic interventions to meet the cultural needs of my clients

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I am able to recognize that my beliefs may create clinical limitations when working with clients

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

I can identify when clients from marginalized cultural groups experience the world differently than dominant cultural groups

1) Not Competent
2) Somewhat Competent
3) Moderately Competent
4) Competent
5) Very Competent

Social Justice Commitment

Please indicate your level of interest in social justice with the following statements on a scale ranging from 0 (strongly disagree) to 9 (strongly agree)

In the future I intend to participate in social justice activities. 0 1 2 3 4 5 6 7 8 9

I have a plan of action for ways I will remain or become involved in social justice activities over the next year 0 1 2 3 4 5 6 7 8 9

I think engaging in social justice activities is a realistic goal for me 0 1 2 3 4 5 6 7 8 9

I am fully committed to engaging in social justice activities 0 1 2 3 4 5 6 7 8 9

Social Justice Self Efficacy

Please rate how much confidence you have in your ability to complete the following activities on a scale from 0 (no confidence at all) to 9 (complete confidence)

Respond to social injustice (e.g., discrimination, racism, religious intolerance, etc.) with non-violent actions 0 1 2 3 4 5 6 7 8 9

Examine your own worldview, biases, and prejudicial attitudes after witnessing or hearing about social injustice 0 1 2 3 4 5 6 7 8 9

Actively support needs of marginalized social groups. 0 1 2 3 4 5 6 7 8 9

Assist members from marginalized groups create more opportunities for success (e.g., educational, career, etc.) by helping develop relevant skills 0 1 2 3 4 5 6 7 8 9

Raise others' awareness of the oppression and marginalization of minority groups
0 1 2 3 4 5 6 7 8 9

Confronting others that speak disparagingly about members of underprivileged groups
0 1 2 3 4 5 6 7 8 9

Challenge an individual who displays racial, ethnic, and/or religious intolerance
0 1 2 3 4 5 6 7 8 9

Convince others as to the importance of social justice 0 1 2 3 4 5 6 7 8 9

Discuss issues related to racism, classism, sexism, heterosexism and ableism with your friends
0 1 2 3 4 5 6 7 8 9

Volunteer as a tutor or mentor with youth from an underserved and underprivileged group
0 1 2 3 4 5 6 7 8 9

Support efforts to reduce social injustice through your own local fundraising efforts
0 1 2 3 4 5 6 7 8 9

Identify the unique social, economic, political, and/or cultural needs of a marginalized group in your own community 0 1 2 3 4 5 6 7 8 9

Encourage and convince others to participate in community-specific social issues
0 1 2 3 4 5 6 7 8 9

Develop and implement a solution to a community social issue such as unemployment, homelessness, racial tension, etc. 0 1 2 3 4 5 6 7 8 9

Challenge or address institutional policies that are covertly or overtly discriminatory
0 1 2 3 4 5 6 7 8 9

Leading a group of co-workers in an effort to eliminate workplace discrimination in your place of employment 0 1 2 3 4 5 6 7 8 9

Serve as a consultant for an institutional committee aimed at provided equal opportunities for underrepresented groups 0 1 2 3 4 5 6 7 8 9

Advocate for social justice issues by becoming involved in local government 0 1 2 3 4 5 6 7 8 9

Address structural inequalities and barriers facing racial and ethnic minorities by becoming politically active (e.g., helping to create government policy) 0 1 2 3 4 5 6 7 8 9

Raise awareness of social issues (e.g., inequality, discrimination, etc.) by engaging in political discussions 0 1 2 3 4 5 6 7 8 9

Advocacy Competence

This survey will assess your current perceived level of competence and effectiveness as a social justice change agent. Please answer questions honestly and to the best of your ability. Response options are: almost always, sometimes, and never.

It is difficult for me to identify client's strengths and resources.

Almost Always
Sometimes
Never

I am comfortable with negotiating for relevant services on behalf of clients.

Almost Always
Sometimes
Never

I alert community or school groups with concerns that I become aware of through my work with clients.

Almost Always
Sometimes
Never

I use data to demonstrate urgency for systemic change.

Almost Always
Sometimes
Never

I prepare written and multi-media materials that demonstrate how environmental barriers contribute to client development.

Almost Always
Sometimes
Never

I distinguish when problems need to be resolved through social advocacy.

Almost Always
Sometimes
Never

It is difficult for me to identify whether social, political and economic conditions affect client development.

Almost Always
Sometimes
Never

I am skilled at helping clients gain access to needed resources.

Almost Always
Sometimes
Never

I develop alliances with groups working for social change.

Almost Always
Sometimes
Never

I am able to analyze the sources of political power and social systems that influence client development.

Almost Always
Sometimes
Never

I am able to communicate in ways that are ethical and appropriate when taking on issues of oppression public.

Almost Always
Sometimes
Never

I seek out and join with potential allies to confront oppression.

Almost Always
Sometimes
Never

I find it difficult to recognize when client concerns reflect responses to systemic oppression.

Almost Always
Sometimes
Never

I am able to identify barriers that impede the well-being of individuals and vulnerable groups.

Almost Always
Sometimes
Never

I identify strengths and resources that community members bring to the process of systems change.

Almost Always
Sometimes
Never

I am comfortable developing an action plan to make systems changes.

Almost Always
Sometimes
Never

I disseminate information about oppression to media outlets.

Almost Always
Sometimes
Never

I support existing alliances and movements for social change.

Almost Always
Sometimes
Never

I help clients identify external barriers that affect their development.

Almost Always
Sometimes
Never

I am comfortable with developing a plan of action to confront barriers that impact clients/students.

Almost Always
Sometimes
Never

I assess my effectiveness when interacting with community and school groups.

Almost Always
Sometimes
Never

I am able to recognize and deal with resistance when involved with systems advocacy.

Almost Always
Sometimes
Never

I am able to identify and collaborate with other professionals who are involved with disseminating public information.

Almost Always
Sometimes
Never

I collaborate with allies in using data to promote social change.

Almost Always
Sometimes
Never

I assist clients with developing self-advocacy skills.

Almost Always
Sometimes
Never

I am able to identify allies who can help confront barriers that impact client development.

Almost Always
Sometimes
Never

I am comfortable collaborating with groups of varying size and backgrounds to make systems change.

Almost Always
Sometimes
Never

I assess the effectiveness of my advocacy efforts on systems and its constituents.

Almost Always
Sometimes

Never

I assess the influence of my efforts to awaken the general public about oppressive barriers that impact clients.

Almost Always
Sometimes
Never

I lobby legislators and policy makers to create social change.

Almost Always
Sometimes
Never

Thank you for your participation in this survey.

Are you interested in being contacted to participate in an interview to learn more about your practices as a socially just CFT?

Yes
No

If yes, please provide:

Name _____

Email address _____

Phone number _____

Appendix C: Qualitative Interview Protocol

Tell me a little bit about the work that you do as a therapist. What models do you practice in?

What does it mean to be a _____ [EFT/CBT/postmodern etc.] therapist?

What does it mean to you to be a "systems or a systemic therapist?" What does it mean to have a systemic lens?

How do you view your role as an agent of change? With individuals, families, what about the broader social system?

There's a lot happening in our society today- racial unrest, structural inequality, political upheaval- how much do current events enter into your therapy room?

In what ways have you been involved in social justice directly through your work as an MFT? Community work? Work with the court? Advocacy?

What does social justice mean to you and how does it enter the therapy room?

How do you take into account the whole person (and all of the systems that they are embedded within) when working inside the therapy room?

Are there any frameworks that you rely on for this?

Did your training involve attending to intersectionality or the broader systems and institutions that clients are embedded within?

Have you done additional trainings or do you have additional experience in this area (social justice, anti-racism, or intersectionality, etc.)?

How do you believe that therapists can be agents of systemic change? In what ways are systemic therapists uniquely poised to do this work?

How do you believe that we should integrate social justice into training for MFTs (curriculum, supervision, etc.)?

Appendix D: Qualitative Participant Profiles

TR is a 33-year-old biracial Latina woman who identifies as heteroflexible. She has been practicing for 10 years and currently works in a private practice and also owns a non-profit in Arizona. TR has her doctorate and supervises several interns and volunteers. She specializes in working with couples who practice polyamory and ethical nonmonogamy. In her interview, she highlighted the importance of instilling hope in her clients and promoting intergenerational healing. She also emphasized how she felt her graduate training prepared her to work in a multiculturally competent and socially just way.

JM is a 27-year-old Black woman who identifies as heterosexual. She works in private practice in Maryland and has been practicing for four years. In her interview she emphasized creating safe spaces for Black women to heal from oppressive social systems. She pointed out that today advocacy can also be done online through social media platforms.

AS is a 31-year-old White woman who identifies as heterosexual. She works in private practice in Maryland and has been practicing for one year. She often works with couples who practice kink, BDSM, and polyamory. She expressed focusing on micro-level advocacy in the room at the time but wanting to expand advocacy efforts to the community in the future.

MH is a 35-year-old Mestizo woman who identifies as heterosexual. She works in an agency setting in Virginia and has been practicing for eight years. Her role merges advocacy and therapy efforts in providing treatment to sexual assault survivors. She spoke about the importance of systemic and preventive work in schools and community organizations.

KM is a White woman in her forties who identifies as bisexual. She works in a private practice in Missouri and has been practicing for three years. She works with trans individuals and spoke about liaising with community resources to do so. Her interview focused on attending to clients'

intersectional identities. She also highlighted how being part of the LGBTQIA+ community helped her to connect with and deliver effective services to others who are part of the community.

MP is a 51-year-old White woman who identifies as heterosexual. She works in a private practice in Oregon and has been practicing for five years. She works with a lot of queer and polyamorous relationships. She noted resistance from White therapists in her community to show up to doing antiracist work, even in a progressive area. She also emphasized that therapy is not neutral and that her view is that therapists need to call out systems of oppression.

RK is a 26-year-old White woman who identifies as heterosexual. She has been practicing for three years and works in private practice in Virginia. She also facilitates workshops and trainings in diversity, equity, and inclusion and restorative justice. Her interview focuses on taking a stance and she markets herself leading with her stance on sociopolitical issues. She expressed strong feelings about her training lacking in the areas of multicultural competence and social justice.

AK is a 42-year-old White man who identifies as heterosexual. He works in a private practice in Georgia and has been practicing for seven years. He leans on his Narrative therapy lens to promote social justice. He discusses his conservative rural and family background and how experiences with friends of different backgrounds were formative in his journey to socially just practice.

CR is a 34-year-old White woman who identifies as heterosexual. She has been practicing for five years and recently transitioned to private practice in Oregon after spending years doing community work. She also teaches and works as a clinical supervisor in a marriage and family therapy graduate program. She touted her graduate training and being able to work with

superstars in the field of multicultural competence and cultural humility. She spoke of burnout as a barrier and the challenges of working with other White therapists to promote antiracism.

AM is a 38-year-old White woman who identifies as bisexual. She has been practicing for seven years and works in a private practice in Texas. She specializes in working with the LGBTQIA+ community and non-traditional relationships. She also runs a non-profit and LGBTQIA resource center and teaches marriage and family therapy graduate students. She spoke to the fear that marginalized communities were experiencing with recent legislation.

NA is a 24-year-old Asian woman who identifies as bisexual. She has been practicing for one year and works in private practice in Texas. She spoke about how Whiteness is considered the norm and so she focuses on working with ethnic minority clients to connect their individual experiences with systems of oppression. She also stressed the importance of graduate programs hiring diverse faculty and supervisors.

LH is a 69-year-old White woman who identifies as heterosexual. She works in a non-profit setting in New Hampshire and has been practicing for seven years. She also works in ministry and discusses how this works in tandem with her therapy. Additionally, she volunteers for a board and is on a diversity, equity, and inclusion committee of her non-profit. She noted political differences in the area that she practiced in and the struggle of promoting social justice while creating safe spaces for all of her clients.

KS is a 46-year-old White woman who identifies as heterosexual. She works in private practice in Maryland and has been practicing for 18 years. She spoke to the challenges of promoting social justice while working with a predominantly White client base in a conservative area.

MC is a 30-year-old Black woman who identifies as heterosexual. She has been practicing for seven years and works in private practice in Maryland. She highlighted how her experiences as a

minoritized person shaped her social justice and anti-oppressive lens. She spoke about creating safe spaces for Black clients and becoming more unapologetic about who her work is for.

LB is a 34-year-old White woman who identifies as heterosexual. She works in private practice in Colorado and has been practicing for nine years. She specializes in working with LGBTQ individuals and with healing professionals. She also teaches and provides clinical supervision in an MFT masters program. She spoke to the challenge of leading with the value of social justice and being able to still earn a living.

MW is a 39-year-old White woman who identifies as heterosexual. She works in Minnesota and has been practicing for ten years and supervises a team. She expressed the importance of wraparound services and interfacing with systems like the criminal justice system and addiction centers to provide the best client care. She talked about meeting clients where they are and sources resources and community partners to meet client needs.

KP is a 32-year-old White woman who identifies as heterosexual. She works in private practice in Illinois and has been practicing for eight years. She works with primarily LGBTQ clients and focuses on intersectionality. She stresses the importance of working with diverse colleagues and clients in order to grow in multicultural competence.

AG is a 38-year-old White woman who identifies as heterosexual. She works in private practice in Maryland and has been practicing for 15 years. AG highlighted the importance of safety in the therapy room and how that meant doing inner work and challenging oppressive systems in an overt way. She also talked about having to unlearn some of her training from graduate school in order to become a more socially just and multiculturally competent therapist.

JS is a 36-year-old Black woman who identifies as heterosexual. She works in private practice in Maryland and has been practicing for seven years. She brought up the importance of noting

differences in a first session with all clients. She also noted how she works toward liberatory practice with clients by pointing out how oppressive systems are influencing clients' day to day lives.

LG is a 41-year-old White woman who identifies as heterosexual. She has been practicing for 15 years and recently transitioned to working full time in private practice in Washington after teaching in an MFT program for a decade. She works primarily with couples and integrated mindfulness into her sessions. She noted how experiences of oppression can live in the body and that social justice should also involve a mind body connection. She touted the importance of constructive dialogues across difference and hiring diverse faculty members.

SA is a 32-year-old White male who identifies as queer. He has been practicing for seven years and works in private practice in Illinois. He is also a faculty member in a marriage and family therapy training program. He talked about straddling the line between micro and macro change. He underlined how his social justice lens is part of all aspects of his practice and should be infused into all aspects of clinical training.

BJ is a 62-year-old White woman who identifies as heterosexual. She has been practicing for four years and works in a school setting. She also works in a ministry setting and uses restorative justice processes to mitigate conflict. She avowed the importance of promoting each person's humanity. She talked about her upbringing and how social justice was primary in her household and influenced her lens on the world.

References

Adler University. (n.d.). *Student Outcomes*. Adler University. Retrieved November 11, 2022, from https://www.adler.edu/program/couple-and-family-therapy-chicago/#student-outcomes

Allen, K. R. (2000). A conscious and inclusive family studies. *Journal of Marriage and Family*, *62*(1), 4–17. https://doi.org/10.1111/j.1741-3737.2000.00004.x

Almeida, R., & Durkin, T. (1999). The cultural context model: Therapy for couples with domestic violence. *Journal of Marital and Family Therapy*, *25*(3), 313–324. https://doi.org/10.1111/j.1752-0606.1999.tb00250.x

Almeida, R., Woods, R., Messineo, T., & Font, R. (1998). Cultural context model. In M. McGoldrick (Ed.), *Re-Visioning family therapy: Race, culture, and gender in clinical practice* (pp. 404–432). Guilford.

American Association for Marriage and Family Therapy. (2015). *Code of ethics*. https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

American Association for Marriage and Family Therapy. (2020). *AAMFT statement on MFT responsibility to counter racism*. The AAMFT Blog. https://blog.aamft.org/2020/06/aamft-statement-on-mft-responsibility-to-counter-racism.html

American Association for Marriage and Family Therapy. (2022). *Marriage and family therapist workforce study 2022 introduction*.

American Counseling Association. (2014). *ACA code of ethics*.

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. https://www.apa.org/about/policy/multicultural-guidelines

American Psychological Association. (2019). *APA guidelines on race and ethnicity in psychology*. https://www.apa.org/about/policy/summary-guidelines-race-ethnicity

Antioch University. (2023). *Program overview*. Antioch University. https://www.antioch.edu/academics/counseling-therapy/couple-and-family-therapy-ma/

Arredondo, P., & Glauner, T. (1992). *Personal dimensions of identity model*.

Arredondo, P., & Perez, P. (2003). Expanding multicultural competence through social justice leadership. *The Counseing Psychologist*, *31*(3), 282–289. https://doi.org/10.1177/0011000003253155

Arredondo, P., Toporek, R. L., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, *24*(1), 42–78. https://doi.org/10.1002/j.2161-1912.1996.tb00288.x

Barden, S. M., & Greene, J. H. (2015). An Investigation of Multicultural Counseling Competence and Multicultural Counseling Self-Efficacy for Counselors-in-Training. *International Journal for the Advancement of Counselling*, *37*(1), 41–53. https://doi.org/10.1007/S10447-014-9224-1/METRICS

Barden, S. M., Sherrell, R. S., & Matthews, J. J. (2017). A national survey on multicultural competence for professional counselors: A replication study. *Journal of Counseling & Development*, *95*(2), 203–212. https://doi.org/10.1002/JCAD.12132

Bathje, G. J., Pillersdorf, D., & Eddir, H. (2022). Multicultural competence as a common factor in the process and outcome of counseling. *Journal of Humanistic Psychology*. https://doi.org/10.1177/00221678221099679/FORMAT/EPUB

Beagan, B. L. (2018). A critique of cultural competence: Assumptions, limitations, and

alternatives. In *Cultural competence in applied psychology: An evaluation of current status and future directions* (pp. 123–138). Springer International Publishing. https://doi.org/10.1007/978-3-319-78997-2_6

Beer, A. M., Spanierman, L. B., Greene, J. C., & Todd, N. R. (2012). Counseling psychology trainees' perceptions of training and commitments to social justice. *Journal of Counseling Psychology*, *59*(1), 120–133. https://doi.org/10.1037/A0026325

Beitin, B. K., & Allen, K. R. (2005). A multilevel approach to integrating social justice and family therapy. *Journal of Systemic Therapies*, *24*(1), 19–34.

Bennett, D. A. (2001). How can I deal with missing data in my study? *Australian and New Zealand Journal of Public Health*, *25*(5), 464–469. https://doi.org/10.1111/J.1467-842X.2001.TB00294.X

Bermúdez, J. M., Muruthi, B. A., & Jordan, L. S. (2016). Decolonizing research methods for family science: Creating space at the center. *Journal of Family Theory and Review*, *8*, 192–206. https://doi.org/10.1111/jftr.12139

Bertalanffy, L. (1968). *General system theory: Foundations, development, applications*. Braziller.

Biden, R. (2021). *Executive order on advancing racial equity and support for undeserved communities through the federal government*. The White House Briefing Room. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

Blanchet Garneau, A., Browne, A. J., & Varcoe, C. (2018). Drawing on antiracist approaches toward a critical antidiscriminatory pedagogy for nursing. *Nursing Inquiry*, *25*(1), 1–9.

https://doi.org/10.1111/nin.12211

Bond, S. (2009). Couple and family therapy: The evolution of the profession with social work at its core. *Intervention*, *131*, 128–138.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychologyychology*. https://doi.org/https://doi.org/10.1080/14780887.2020.1769238

Braun, V., & Clarke, V. (2021a). *Thematic analysis*. SAGE Publications Ltd (UK).

Braun, V., & Clarke, V. (2021b). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health*, *13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., & Clarke, V. (2021c). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. https://doi.org/10.1002/CAPR.12360

Braun, V., & Clarke, V. (2023). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health*, *24*(1), 1–6. https://doi.org/10.1080/26895269.2022.2129597

Braun, V., Clarke, V., Hayfield, N., Davey, L., & Jenkinson, E. (2023). Doing reflexive thematic analysis. In S. Bager-Charleson & A. McBeath (Eds.), *Supporting Research in Counselling and Psychotherapy* (pp. 19–38). Palgrave. https://doi.org/https://doi.org/10.1007/978-3-031-13942-0

Brown, T. N. (2003). Critical race theory speaks to the sociology of mental health: Mental health problems produced by racial stratification. *Journal of Health and Social Behavior*, *44*(3), 292–301. https://doi.org/10.2307/1519780

Buchanan, L., Bui, Q., & Patel J. K. (2020). Black Lives Matter may be the largest movement in U.S. history. *The New York Times*. https://www.nytimes.com/interactive/2020/07/03/us/george-floyd-protests-crowd-size.html

Bvunzawabaya, B. (2012). *Social justice counseling: Establishing psychometric properties for the Advocacy Competencies Self-Assessment Survey©*. [Doctoral dissertaiton, Auburn University].

Caban, A. R. (2010). *Development and initital validation of the Multicultural Competence Change Scale for psychology trainees* [Doctoral Dissertation, University of Oregon]. http://hdl.handle.net/1794/11143

Caldwell, J. C., & Vera, E. M. (2010). Critical incidents in counseling psychology professionals' and trainees' social justice orientation development. *Training and Education in Professional Psychology*, *4*(3), 163–176. https://doi.org/10.1037/A0019093

Carpenter-Song, E. A., Nordquest Schwallie, M., & Longhofer, J. (2007). Cultural competence reexamined: Critique and directions for the future. In *Psychiatric Services* (Vol. 58, Issue 10). https://doi.org/10.1176/ps.2007.58.10.1362

Chan, C. D., Cor, D. N., & Band, M. P. (2018). Privilege and oppression in counselor education:

An intersectionality framework. *Journal of Multicultural Counseling and Development*, *46*(1), 58–73. https://doi.org/10.1002/JMCD.12092

Chang, C., Crethar, H., & Ratts, M. J. (2010). Social justice: A national imperative for counselor education and supervision. *Counselor Education and Supervision*, *50*(2), 82–87. https://doi.org/10.1002/j.1556-6978.2010.tb00110.x

Chao, M. M., Okazaki, S., & Hong, Y. (2011). The quest for multicultural competence: Challenges and lessons learned from clinical and organizational research. *Social and Personality Psychology Compass*, *5*(5), 263–274. https://doi.org/10.1111/j.1751-9004.2011.00350.x

Chapman, T. K., & DeCuir-Gunby, J. T. (2018). " Where do we go from here?": A future agenda for understanding critical race research methods and methodologies. In *Understanding Critical Race Research Methods and Methodologies* (pp. 183–191). Routledge.

Clark-Taylor, A. (2017). Developing critical consciousness and social justice self-efficacy: Lessons from feminist community engagement student narratives. *Journal of Higher Education Outreach & Engagement*, *21*(4), 81–115. https://search.ebscohost.com/login.aspx?direct=true&db=eue&AN=126760515&site=ehost-live

Cohn, N., & Quealy, K. (2020). How public opinion has moved on Black Lives Matter. *New York Times*. https://www.nytimes.com/interactive/2020/06/10/upshot/black-lives-matter-attitudes.html

Combs, G. (2019). White privilege: What's a family therapist to do? *Journal of Marital and Family Therapy*, *45*(1), 61–75. https://doi.org/10.1111/jmft.12330

Commission on Accreditation for Marriage and Family Therapy. (2017). *Accreditation standards*

graduate & post-graduate marriage and family therapy training programs. https://www.coamfte.org/documents/COAMFTE/Accreditation Resources/2018 COAMFTE Accreditation Standards Version 12 May.pdf

Commission on Accreditation for Marriage and Family Therapy. (2020). *Accreditation standards*. https://coamfte.org/documents/COAMFTE/Accreditation Resources/COAMFTE Standards Version 12.5 - Published August 2021 - 8.26.21 (with links).pdf

Constantine, M. G., Hage, S. M., Kindaichi, M. M., & Bryant, R. M. (2007). Social justice and multicultural issues: Implications for the practice and training of counselors and counseling psychologists. *Journal of Counseling & Development*, *85*(1), 24–29. https://doi.org/10.1002/j.1556-6678.2007.tb00440.x

Constantine, M. G., Juby, H. L., & Liang, J. J.-C. (2001). Examining multicultural counseling competence and race-related attitudes among white marital and family therapists. *Journal of Marital and Family Therapy*, *01*(3), 353–362.

Corneau, S., & Stergiopoulos, V. (2012). More than being against it: Anti-racism and anti-oppression in mental health services. *Transcultural Psychiatry*, *49*(2). https://doi.org/10.1177/1363461512441594

Council for Accreditation of Counseling and Related Education Programs. (2016). *2016 CACREP standards*. https://www.cacrep.org/for-programs/2016-cacrep-standards/

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *1*. http://chicagounbound.uchicago.edu/uclfhttp://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. SAGE.

Creswell, J. W., Hanson, W. E., Clark, V. L. P., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseing Psychologist*, *35*(2), 236–264. https://doi.org/10.1177/0011000006287390

Creswell, J. W., Klassen, A. C., Plano Clark, V. L., & Smith, K. C. (2011). Best practices for mixed methods research in the health sciences. *Bethesda (Maryland): National Institutes of Health*, *2013*, 541–545.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, *39*(3), 124–130. https://doi.org/10.1207/S15430421TIP3903_2

Creswell, J. W., Plano-Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). An expanded typology for classifying mixed methods research into designs: Advanced mixed methods research designs. In A. Tashakkori & C. Teddlie (Eds.), *Handbook of mixed methods in social and behavioral research* (pp. 209–240). https://us.corwin.com/sites/default/files/upm-binaries/19291_Chapter_7.pdf

Creswell, J. W., & Tashakkori, A. (2007). Differing perspectives on mixed methods research. *Journal of Mixed Methods Research*, *1*(4), 303–308. https://doi.org/10.1177/1558689807306132

Crethar, H. C., & Ratts, M. J. (2008). Why social justice is a counseling concern. *Counseling Today*, *50*(12), 24–25.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health*

2019 18:1, *18*(1), 1–17. https://doi.org/10.1186/S12939-019-1082-3

Czeisler, M. E., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., Weaver, M. D., Robbins, R., Facer-Childs, E. R., Barger, L. K., Czeisler, C. A., Howard, M. E., & Rajaratnam, S. M. W. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic. In *Morbidity and Mortality Weekly Report* (Vol. 69, Issue 32). https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

D'Andrea, M. J., & Daniels, J. (1991). Exploring the different levels of multicultural counseling training in counselor education. *Journal of Counseling & Development*, *70*, 78–85. https://doi.org/10.1002/j.1556-6676.1991.tb01565.x

D'Arrigo-Patrick, J., Hoff, C., Knudson-Martin, C., & Tuttle, A. (2017). Navigating critical theory and postmodernism: Social justice and therapist power in family therapy. *Family Process*, *56*(3), 574–588. https://doi.org/10.1111/famp.12236

Dadras, I., & Daneshpour, M. (2018). Social justice implications for MFT: The need for cross-cultural responsiveness. In S. Singh Poulsen & R. Allan (Eds.), *The future of MFT: Clinical implications of cross-cultural responsiveness and social justice lens to the field* (pp. 1–20). Springer.

Daly, K. (2007). *Qualitative methods for family studies and human development*. SAGE.

Data USA. (2020). *Marriage and family therapists*. https://datausa.io/profile/soc/marriage-and-family-therapists

Davey, M. P., Davey, A., Tubbs, C., Savla, J., & Anderson, S. (2012). Second order change and evidence-based practice. *Journal of Family Therapy*, *34*(1), 72–90. https://doi.org/10.1111/j.1467-6427.2010.00499.x

Delgado, R., & Stefancic, J. (2017). Critical race theory: An introduction. In *New York*

University Press (Third). https://doi.org/10.4324/9781315778228-6

Diemer, M. A. (2020). Pushing the envelope: The who, what, when, and why of critical consciousness. *Journal of Applied Developmental Psychology*, *70*, 101192. https://doi.org/10.1016/j.appdev.2020.101192

Diemer, M. A., McWhirter, E. H., Ozer, E. J., & Rapa, L. J. (2015). Advances in the conceptualization and measurement of critical consciousness. *Urban Review*, *47*(5), 809–823. https://doi.org/10.1007/s11256-015-0336-7

Diemer, M. A., Pinedo, A., Bañales, J., Mathews, C. J., Frisby, M. B., Harris, E. M., & McAlister, S. (2021). Recentering action in critical consciousness. *Child Development Perspectives*, *15*(1), 12–17. https://doi.org/10.1111/cdep.12393

Diggles, K. R. (2013). *Factors associated with couples and family therapy students' racial awareness*. [Doctoral Dissertation, University of Minnesota].

Doll, K. M. (2017). *Investigating Black-White disparities in gynecologic oncology: Theories, conceptual models, and applications*. https://doi.org/10.1016/j.ygyno.2017.10.002

Dong, Y., & Peng, C. Y. J. (2013). Principled missing data methods for researchers. *SpringerPlus*, *2*(1), 1–17. https://doi.org/10.1186/2193-1801-2-222/TABLES/3

Dunn, T. W., Smith, T. B., & Montoya, J. A. (2006). Multicultural competency instrumentation: A review and analysis of reliability generalization. *Journal of Counseling & Development*, *84*(4), 471–482. https://doi.org/https://doi.org/10.1002/j.1556-6678.2006.tb00431.x

Esmiol, E. E., Knudson-Martin, C., & Delgado, S. (2012). Developing a contextual consciousness: Learning to address gender, societal power, and culture in clinical practice. *Journal of Marital and Family Therapy TA - TT -*, *38*(4), 573–588. https://doi.org/10.1111/j.1752-0606.2011.00232.x LK -

https://umaryland.on.worldcat.org/oclc/5155295022

Essandoh, P. K. (1996). Multicultural counseling as the “fourth force”: A call to arms. *The Counseling Psychologist*, *24*(1), 126–137.

Essien, U. R., & Ufomata, E. O. (2021). Adapting to a new normal: Antiracism as a core public health principle. *PLOS Global Public Health*, *1*(10), e0000037. https://doi.org/10.1371/journal.pgph.0000037

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs—Principles and practices. *Health Services Research*, *48*(6 Pt 2), 2134–2156. https://doi.org/10.1111/1475-6773.12117

Fetters, M. D., & Freshwater, D. (2015). The 1 + 1 = 3 integration challenge. *Journal of Mixed Methods Research*, *9*(2), 115–117. https://doi.org/10.1177/1558689815581222

Fietzer, A. W., & Ponterotto, J. G. (2015). A psychometric review of instruments for social justice and advocacy attitudes. *Journal for Social Action in Counseling & Psychology*, *7*(1), 19–40. https://doi.org/10.33043/jsacp.7.1.19-40

Fish, J. N., & Mittal, M. (2021). Mental health providers during COVID-19: Essential to the US public health workforce and in need of support. *Public Health Reports*, *136*(1), 14–17. https://doi.org/10.1177/0033354920965266

Fisher, D. (2020). *The diversity of the recent Black Lives Matter protests is a good sign for racial equity*. https://www.brookings.edu/blog/how-we-rise/2020/07/08/the-diversity-of-the-recent-black-lives-matter-protests-is-a-good-sign-for-racial-equity/

Ford, C. L., & Airhihenbuwa, C. O. (2010a). Critical race theory, race equity, and public health: Toward antiracism praxis. In *American Journal of Public Health* (Vol. 100, Issue SUPPL. 1, pp. 693–698). https://doi.org/10.2105/AJPH.2009.171058

Ford, C. L., & Airhihenbuwa, C. O. (2010b). The public health critical race methodology: Praxis for antiracism research. *Social Science and Medicine*, *71*(8), 1390–1398. https://doi.org/10.1016/j.socscimed.2010.07.030

Ford, C. L., & Airhihenbuwa, C. O. (2018). Commentary: Just what is critical race theory and what's it doing in a progressive field like public health? *Ethnicity and Disease*, *28*, 223–230. https://doi.org/10.18865/ed.28.S1.223

Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. *Journal of Transcultural Nursing*, *27*(3), 210–217. https://doi.org/10.1177/1043659615592677

Fortuna, L. R., Tolou-Shams, M., Robles-Ramamurthy, B., & Porche, M. V. (2020). Inequity and the disproportionate impact of COVID-19 on communities of color in the United States: The need for a trauma-informed social justice response. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(3), 443–445. https://doi.org/10.1037/tra0000889

Freire, P. (1970). *Pedagogy of the oppressed*. Herder & Herder.

Galán, C. A., Bekele, B., Boness, C., Bowdring, M., Call, C., Hails, K., McPhee, J., Mendes, S. H., Moses, J., Northrup, J., Rupert, P., Savell, S., Sequeira, S., Tervo-Clemmens, B., Tung, I., Vanwoerden, S., Womack, S., & Yilmaz, B. (2021). Editorial: A call to action for an antiracist clinical science. *Journal of Clinical Child and Adolescent Psychology*, *50*(1), 12–57. https://doi.org/10.1080/15374416.2020.1860066

Gantt-Howrey, A., Becnel, A., Shi, Y., & Lau, J. (2023). Use of the MSJCC: A content analysis of ACA journals. *Counselor Education and Supervision*, *62*(1), 40–51. https://doi.org/10.1002/CEAS.12259

Garcia, M. A., Homan, P. A., García, C., & Brown, T. H. (2020). The color of COVID-19:

Structural racism and the disproportionate impact of the pandemic on older Black and Latinx adults. *The Journals of Gerontology: Series B*, *XX*, 1–6. https://doi.org/10.1093/geronb/gbaa114

Garcia, M., Kosutic, I., Mcdowell, T., & Anderson, S. A. (2009). Raising critical consciousness in family therapy supervision. *Journal of Feminist Family Therapy*, *21*(1), 18–38. https://doi.org/10.1080/08952830802683673

Garcia, M., & McDowell, T. (2010). Mapping social capital: A critical contextual approach for working with low-status families. *Journal of Marital and Family Therapy*, *36*(1), 96–107. https://doi.org/10.1111/j.1752-0606.2009.00186.x

Gehart, D. R., & Lucas, B. M. (2007). Client advocacy in marriage and family therapy: A qualitative case study. *Journal of Family Psychotherapy*, *18*(1), 39–56. https://doi.org/10.1300/J085v18n01_04

Goldberg, A. E., & Allen, K. R. (2015). Communicating qualitative research: Some practical guideposts for scholars. *Journal of Marriage and Family*, *77*(1), 3–22. https://doi.org/10.1111/JOMF.12153

Gonzalez-Voller, J., Crunk, A. E., Barden, S. M., Harris, S., & Belser, C. T. (2020). A preliminary longitudinal study of multicultural competence in counselor education. *Journal of Counseling & Development*, *98*(3), 308–318. https://doi.org/10.1002/jcad.12325

Goodman, J. M., Morgan, A. A., Hodgson, J. L., & Caldwell, B. E. (2018). From private practice to academia: Integrating social and political advocacy into every MFT identity. *Journal of Marital and Family Therapy*, *44*(1), 32–45. https://doi.org/10.1111/jmft.12298

Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents. *The Counseling Psychologist*,

32(6), 793–836. https://doi.org/10.1177/0011000004268802

Gorski, P. C., & Goodman, R. D. (2015). Introduction: Toward a decolonized multicultural counseling and psychology. In R. D. Goodman & P. C. Gorski (Eds.), *Decolonizing "multicultural" counseling through social justice* (pp. 1–10). Springer New York. https://doi.org/10.1007/978-1-4939-1283-4_1

Green, A. E., Albanese, B. J., Shapiro, N. M., & Aarons, G. A. (2014). The roles of individual and organizational factors in burnout among community-based mental health service providers. *Psychological Services*, *11*(1), 41–49. https://doi.org/10.1037/A0035299

Grzanka, P. R., Gonzalez, K. A., & Spanierman, L. B. (2019). White supremacy and counseling psychology: A critical-conceptual framework. *The Counseling Psychologist*, *47*(4), 478–529. https://doi.org/10.1177/0011000019880843

Guba, E. G., & Lincoln, Y. S. (1988). Do inquiry paradigms imply inquiry methodologies. *Qualitative Approaches to Evaluation in Education*, *1*(1), 89–115.

Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In *The Sage handbook of qualitative research, 3rd ed.* (pp. 191–215). Sage Publications Ltd.

Gushue, G., Lee, T., & Postolache, N. (2022). Awareness, social cognition, and commitment: Developing a social justice orientation in psychology training programs. *Journal of Counseling Psychology*, *69*(3), 257–267. https://doi.org/10.1037/cou0000586

Hailes, H. P., Ceccolini, C. J., Gutowski, E., & Liang, B. (2021). Ethical guidelines for social justice in psychology. *Professional Psychology: Research and Practice*, *52*(1), 1–11. https://doi.org/10.1037/pro0000291

Hanson, W. E., Creswell, J. W., Plano Clark, V. L., Petska, K. S., & David Creswell, J. (2005).

Mixed methods research designs in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 224–235. https://doi.org/10.1037/0022-0167.52.2.224

Hardeman, R. R., & Karbeah, J. (2020). Examining racism in health services research: A disciplinary self-critique. In *Health Services Research* (Vol. 55, Issue S2, pp. 777–780). https://doi.org/10.1111/1475-6773.13558

Hardy, K. V. (2001). Healing the world in fifty-minute intervals: A response to "family therapy saves the planet." *Journal of Marital and Family Therapy*, *27*(1), 19–22. https://doi.org/10.1111/j.1752-0606.2001.tb01135.x

Haskins, N. H., & Singh, A. (2015). Critical race theory and counselor education pedagogy: Creating equitable training. *Counselor Education and Supervision*, *54*(4), 288–301. https://doi.org/10.1002/ceas.12027

Hassen, N., Lofters, A., Michael, S., Mall, A., Pinto, A. D., & Rackal, J. (2021). Implementing anti-racism interventions in healthcare settings: A scoping review. *International Journal of Environmental Research and Public Health*, *18*(6), 1–15. https://doi.org/10.3390/ijerph18062993

Hays, D. G. (2008). Assessing multicultural competence in counselor trainees: A review of instrumentation and future directions. *Journal of Counseling & Development*, *86*(1), 95–101. https://doi.org/10.1002/j.1556-6678.2008.tb00630.x

Hays, D. G. (2020). Multicultural and social justice counseling competency research: Opportunities for innovation. *Journal of Counseling & Development*, *98*(3), 331–344. https://doi.org/10.1002/jcad.12327

Hernandez, P. (2004). The cultural context model in supervision: An illustration. *Journal of Feminist Family Therapy*, *15*(4), 1–18. https://doi.org/10.1300/J086v15n04_01

Hernández, P., Almeida, R., & Dolan-Delvecchio, K. (2005). Critical consciousness, accountability, and empowerment: Key processes for helping families heal. *Family Process*, *44*(1), 105–119. https://doi.org/10.1111/j.1545-5300.2005.00045.x

Hocking, C., & Townsend, E. (2015). Driving social change: Occupational therapists' contributions to occupational justice. *World Federation of Occupational Therapists Bulletin, 71*(2), 1–4. https://doi.org/10.1179/2056607715y.0000000002

Hoffman, L. (1985). Beyond power and control: Toward a "second order" family systems therapy. *Family Systems Medicine, 3*(4), 381–396. https://doi.org/10.1037/h0089674

Holcomb-McCoy, C. C., & Myers, J. E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling & Development, 77*(3), 294–302. https://doi.org/10.1002/j.1556-6676.1999.tb02452.x

Holyoak, D., McPhee, D., Hall, G., & Fife, S. (2020). Microlevel advocacy: A common process in couple and family therapy. *Family Process*, *60*(2), 654–669. https://doi.org/10.1111/famp.12620

Horowitz, J. M., Parker, K., Brown, A., & Cox, K. (2020). *Amid national reckoning, Americans divided on whether increased focus on race will lead to major policy change*. https://www.pewresearch.org/social-trends/2020/10/06/amid-national-reckoning-americans-divided-on-whether-increased-focus-on-race-will-lead-to-major-policy-change/

Huffstetler, H. E., Boland, S. E., Williams, C. R., Rice, D. K., & Ramaswamy, R. (2022). Beyond virtue-signaling: Advancing equity through design justice and public health critical race praxis. *Health Equity, 6*(1), 21–26. https://doi.org/10.1089/HEQ.2021.0075

Inman, A. G., Luu, L. P., Pendse, A. C., & Caskie, G. I. L. (2015). Graduate trainees' social justice supports, beliefs, interest, and commitment. *The Counseling Psychologist*, *43*(6),

879–905. https://doi.org/10.1177/0011000015578932/FORMAT/EPUB

Jemal, A. (2017). Critical consciousness: A critique and critical analysis of the literature. *Urban Review*, *49*(4), 602–626. https://doi.org/10.1007/s11256-017-0411-3

Johnson, S. (2001). Family therapy saves the planet: Messianic tendencies in the family systems literature. *Journal of Marital and Family Therapy*, *27*(1), 3–11. https://doi.org/10.1111/j.1752-0606.2001.tb01132.x

Johnson, S. D. (1982). *The Minnesota multiethnic counselor curriculum: The design and evaluation of an intervention for cross-cultural counselor education*. [Doctoral dissertation, University of Minnesota].

Jordan, L. S. (2022a). Unsettling colonial mentalities in family therapy: Entering negotiated spaces. *Journal of Family Therapy*, *44*(1), 171–185. https://doi.org/10.1111/1467-6427.12374

Jordan, L. S. (2022b). Unsettling the family sciences: Introducing settler colonial theory through a theoretical analysis of the family and racialized injustice. *Journal of Family Theory and Review*, *14*, 463–481. https://doi.org/10.1111/jftr.12453

Jordan, L. S., & Seponski, D. M. (2018a). "Being a therapist doesn't exclude you from real life": Family therapists' beliefs and barriers to political action. *Journal of Marital and Family Therapy*, *44*(1), 19–31. https://doi.org/10.1111/jmft.12244

Jordan, L. S., & Seponski, D. M. (2018b). Public participation: Moving beyond the four walls of therapy. *Journal of Marital and Family Therapy*, *44*(1), 5–18. https://doi.org/10.1111/jmft.12240

Kaslow, F. W. (2012). A brief history of the field of family psychology and therapy. In *Handbook of EMDR and Family Therapy Processes* (pp. 438–454). John Wiley & Sons,

Inc. https://doi.org/10.1002/9781118269985.app4

Katafiasz, H., & Patton, R. (2021). Closing the loop: Addressing diversity in a COAMFTE-accredited MFT education program. *Contemporary Family Therapy*, *43*(1), 100–111. https://doi.org/10.1007/S10591-020-09558-2/FIGURES/2

Kelly, S., Jeremie-Brink, G., Chambers, A. L., & Smith-Bynum, M. A. (2020). The Black Lives Matter Movement: A call to action for couple and family therapists. *Family Process*, *59*(4), 1374–1388. https://doi.org/10.1111/famp.12614

Kim, Y. J., & Cribbie, R. A. (2018). ANOVA and the variance homogeneity assumption: Exploring a better gatekeeper. *British Journal of Mathematical and Statistical Psychology*, *71*(1), 1–12. https://doi.org/10.1111/BMSP.12103

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Knudson-Martin, C., McDowell, T., & Bermudez, J. M. (2019). From knowing to doing: Guidelines for socioculturally attuned family therapy. *Journal of Marital and Family Therapy*, *45*(1), 47–60. https://doi.org/10.1111/jmft.12299

Koschmann, K. S., Jeffers, N. K., & Heidari, O. (2020). "I can't breathe": A call for antiracist nursing practice. *Nursing Outlook*, *68*(January), 539–541. https://doi.org/https://doi.org/10.1016/j.outlook.2020.07.004

Kosutic, I., & McDowell, T. (2008). Diversity and social justice issues in family therapy literature: A decade review. *Journal of Feminist Family Therapy*, *20*(2), 142–165. https://doi.org/10.1080/08952830802023292

Krefting, L. (1999). Rigor in qualitative research: The assessment of trustworthiness. In A. Miliniki (Ed.), *Cases in qualitative research: Research reports for discussion and*

evaluation (pp. 173–181). Puscale Publications.

Kumagai, A. K., & Lypson, M. L. (2009). Beyond cultural competence: Critical consciousness, social justice, and multicultural education. *Academic Medicine*, *84*(6), 782–787. https://doi.org/10.1097/ACM.0b013e3181a42398

Laszloffy, T., & Habekost, J. (2010). Using experiential tasks to enhance cultural sensitivity among MFT trainees. *Journal of Marital and Family Therapy*, *36*(3), 333–346. https://doi.org/10.1111/J.1752-0606.2010.00213.X

Lee, C. C. (2007). Social justice: A moral imperative for counselors. *Professional Counseling Digest*, 1–2.

Leong, F. T. L., & Kim, H. H. W. (1991). Going beyond cultural sensitivity on the road to multiculturalism: Using the Intercultural Sensitizer as a counselor training tool. *Journal of Counseling & Development*, *70*, 112–118. https://doi.org/https://doi.org/10.1002/j.1556-6676.1991.tb01570.x

Lewis & Clark Graduate School. (n.d.). *Mission and student learning outcomes*. https://graduate.lclark.edu/departments/marriage-couple-and-family-therapy/mission/

Lincoln, Y., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publications.

Lynn, M., Yosso, T. J., Solórzano, D. G., & Parker, L. (2002). Critical race theory and education: Qualitative research in the new milennium. *Qualitative Health Research*, *8*(1), 3–6.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Marszalek, J. M., Barber, C., & Nilsson, J. E. (2017). Development of the Social Issues Advocacy Scale-2 (SIAS-2). *Social Justice Research*, *30*, 117–144.

https://doi.org/10.1007/s11211-017-0284-3

Martín-Baró, I. (1994). *Writings for a liberation psychology.* (A. Aron & S. Corne (Eds.)). Harvard University Press.

McCoy, D. L., & Rodricks, D. J. (2015). Critical race theory in higher education: 20 Years of theoretical and research innovations. *ASHE Higher Education Report*, *41*(3), 1–117. https://doi.org/10.1002/aehe.20021

McDowell, T. (2005). Practicing with a critical multicultural lens. *Journal of Systemic Therapies*, *24*(1), 1–4. https://doi.org/10.1521/jsyt.2005.24.1.1

McDowell, T., Fang, S. R., Brownlee, K., Young, C. G., & Khanna, A. (2002). Transforming an MFT program: A model for enhancing diversity. *Journal of Marital and Family Therapy*, *28*(2), 179–191. https://doi.org/10.1111/j.1752-0606.2002.tb00355.x

McDowell, T., Fang, S. R., Young, C. G., Khanna, A., Sherman, B., & Brownlee, K. (2003). Making space for racial dialogue: Our experience in a marriage and family therapy training program. *Journal of Marital and Family Therapy*, *29*(2), 179–194. https://doi.org/10.1111/j.1752-0606.2003.tb01199.x

McDowell, T., & Hernández, P. (2010). Decolonizing academia: Intersectionality, participation, and accountability in family therapy and counseling. *Journal of Feminist Family Therapy*, *22*(2), 93–111. https://doi.org/10.1080/08952831003787834

McDowell, T., & Jeris, L. (2004). Talking about race using critical race theory: Recent trends in the Journal of Marital and Family Therapy. *Journal of Marital and Family Therapy*, *30*(1), 81–94. https://doi.org/10.1111/j.1752-0606.2004.tb01224.x

McDowell, T., Knudson-Martin, C., & Bermudez, J. M. (2019). Third-order thinking in family therapy: Addressing social justice across family therapy practice. *Family Process*, *58*(1), 9–

22. https://doi.org/10.1111/famp.12383

McDowell, T., & Shelton, D. (2002). Valuing ideas of social justice in MFT curricula. *Contemporary Family Therapy*, *24*(2), 313–331. https://doi.org/10.1023/A:1015351408957

Mcdowell, T., Storm, C. L., & York, C. D. (2007). Multiculturalism in couple and family therapy education: Revisiting familiar struggles and facing new complexities. *Journal of Systemic Therapies*, *26*(4), 75–94. https://doi.org/10.1521/jsyt.2007.26.4.75

Mcgee, E. O., & Stovall, D. (2015). Reimagining critical race theory in education: Mental health, healing, and the pathway to liberatory praxis. *Educational Theory*, *65*(5), 491–511. https://doi.org/10.1111/EDTH.12129

McGoldrick, M. (2007). Response to "Family therapy saves the planet." *Journal of Marital and Family Therapy*, *27*(1), 17–18. https://doi.org/10.1111/j.1752-0606.2001.tb01134.x

McGoldrick, M., Almeida, R., Garcia Preto, N., Bibb, A., Sutton, C. E., Hudak, J., & Hines, P. M. (1999). Efforts to incorporate social justice perspectives into a family training program. *Journal of Marital and Family Therapy*, *25*(2), 191–209. https://doi.org/10.1111/j.1752-0606.1999.tb01122.x

McGoldrick, M., & Hardy, K. V. (Eds.). (2019). *Re-Visioning family therapy* (Third). Guilford.

McRae, M. B., & Johnson, S. D. (1991). Toward training for competence in multicultural counselor education. *Journal of Counseling & Development*, *70*(1), 131–135.

Mertens, D. (2007). Transformative paradigm: Mixed methods and social justice. *Journal of Mixed Methods Research*, *1*(3), 212–225. https://doi.org/10.1177/1558689807302811

Mertens, D. (2010). Philosophy in mixed methods teaching: The transformative paradigm as illustration. *International Journal of Multiple Research Approaches*, *4*(1), 9–18. https://doi.org/10.5172/mra.2010.4.1.009

Mertens, D. (2012). Transformative mixed methods: Addressing inequities. *American Behavioral Scientist*, *56*(6), 802–813. https://doi.org/10.1177/0002764211433797/FORMAT/EPUB

Miller, M. J., & Sendrowitz, K. (2011). Counseling psychology trainees' social justice interest and commitment. *Journal of Counseling Psychology*, *58*(2), 159–169. https://doi.org/10.1037/a0022663

Miller, M. J., Sendrowitz, K., Connacher, C., Blanco, S., de la Pena, C. M., Bernardi, S., & Morere, L. (2009). College students' social justice interest and commitment: A social-cognitive perspective. *Journal of Counseling*, *56*(4), 495–507. https://psycnet.apa.org/record/2009-18895-002

Mitchell, M. (n.d.). *The Multicultural Competency Assessment© (MCA©) training manual, theoretical framework and item development*.

Mitchell, M. (2018). *The development and validation of the Multicultural Competency Assessment© (MCA©)* [Doctoral dissertation, University of Central Florida]. https://stars.library.ecf.edu/etd/6375

Mittal, M., Morgan, A. A., Du, J., Jiang, J., Boekeloo, B., & Fish, J. N. (2022). "Each week feels like a mountain": The impact of COVID-19 on mental health providers' well-being and clinical work. *Professional Psychology: Research and Practice*. https://doi.org/https://dx.doi.org/10.1037/pro0000501

Moodley, R. (2007). (Re)placing multiculturalism in counselling and psychotherapy. *British Journal of Guidance and Counselling*, *35*(1), 1–22. https://doi.org/10.1080/03069880601106740

Moreno, C., Wykes, T., Galderisi, S., Nordentoft, M., Crossley, N., Jones, N., Cannon, M.,

Correll, C. U., Byrne, L., Carr, S., Chen, E. Y. H., Gorwood, P., Johnson, S., Kärkkäinen, H., Krystal, J. H., Lee, J., Lieberman, J., López-Jaramillo, C., Männikkö, M., … Arango, C. (2020). How mental health care should change as a consequence of the COVID-19 pandemic. *The Lancet Psychiatry*, *7*(9), 813–824. https://doi.org/10.1016/S2215-0366(20)30307-2

Morrison, T., Ferris Wayne, M., Harrison, T., Palmgren, E., & Knudson-Martin, C. (2022). Learning to embody a social justice perspective in Couple and Family Therapy: A grounded theory analysis of MFTs in training. *Contemporary Family Therapy*, *44*(4), 408–421. https://doi.org/10.1007/S10591-022-09635-8/TABLES/1

Munsey, C. (2011). And social justice for all. *Monitor on Psychology*, *42*(9), 30. https://www.apa.org/monitor/2011/10/vasquez

Murphy, M., Park, J., & Lonsdale, N. (2006). Marriage and family therapy students' change in multicultural counseling competencies after a diversity course. *Contemporary Family Therapy*, *28*(3), 303–311. https://doi.org/https://doi.org/10.1007/s10591-006-9009-8

Na, G., & Fietzer, A. W. (2020). A national survey of social justice engagement among professional counselors. *Journal of Counseling & Development*, *98*(3), 319–330. https://doi.org/10.1002/jcad.12326

Nassar, S. C., & Singh, A. A. (2020). Embodying the multicultural and social justice counseling competency movement: Voices from the field. *Journal of Counseling & Development*, *98*(3), 253–260. https://doi.org/10.1002/jcad.12320

National Association of Social Workers. (2016). *NASW sets social justice priorities for upcoming year*. https://www.socialworkers.org/News/News-Releases/ID/111/NASW-sets-social-justice-priorities-for-upcoming-year

National Association of Social Workers. (2017). *NASW code of ethics*. National Association of Social Workers. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

Nawaz, A., & Khan, S. (2020). How this year's antiracism protests differ from past social justice movements. *PBS*. https://www.pbs.org/newshour/show/what-is-unprecedented-about-this-years-racial-justice-protests

Nichols, N. P. (2013). *Family therapy concepts and methods* (Tenth). Pearson.

Nilsson, J. E., Marszalek, J. M., Linnemeyer, R. M., Bahner, A. D., & Misialek, L. H. (2011). Development and assessment of the social issues advocacy scale. *Educational and Psychological Measurement*, *71*(1), 258–275. https://doi.org/10.1177/0013164410391581

Novacek, D. M., Hampton-Anderson, J. N., Ebor, M. T., Loeb, T. B., & Wyatt, G. E. (2020). Mental health ramifications of the COVID-19 pandemic for Black Americans: Clinical and research recommendations. *Psychological Trauma: Theory, Research, Practice, and Policy*. https://doi.org/10.1037/tra0000796

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1609406917733847.

O'Neil, E. (2010). *Development and initial validation of a measure of multicultural competence stage of change*. [Doctoral dissertation, University of Oregon].

Onwuegbuzie, A. J., & Collins, K. M. T. (2007). A typology of mixed methods sampling designs in social science research. *The Qualitative Report, 12*(2), 281–316. http://www.nova.edu/ssss/QR/QR12-2/onwuegbuzie2.pdf

Onwuegbuzie, A. J., & Johnson, R. B. (2006). The validity issue in mixed research. *Research in*

the Schools, *13*(1), 48–63.

Osuagwu, C., Khinkar, R. M., Zheng, A., Wien, M., Decopain, J., Desai, S., McElrath, E., Hinchey, E., Mueller, S. K., Schnipper, J. L., Boxer, R., & Shannon, E. M. (2023). A public health critical race praxis informed congestive heart failure quality improvement initiative on inpatient general medicine. *Journal of General Internal Medicine*, 1–9. https://doi.org/10.1007/S11606-023-08086-7/TABLES/4

Paladino, D. A., Lewis, J. A., Ratts, M. J., & Toporek, R. L. (2011). Social justice counseling and advocacy: Developing new leadership roles and competencies. In *Journal for Social Action in Counseling and Psychology* (Vol. 3, Issue 1). http://scholarship.rollins.edu/as_facpub

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health*, *42*(5), 533. https://doi.org/10.1007/S10488-013-0528-Y

Paré, D. (2014). Social justice and the word: Keeping diversity alive in therapeutic conversations. *Canadian Journal of Counselling and Psychotherapy (Online)*, *48*(3), 206.

Parker, E. O., & McDowell, T. (2017). Integrating social justice into the practice of CBFT: A critical look at family schemas. *Journal of Marital and Family Therapy*, *43*(3), 502–513. https://doi.org/10.1111/jmft.12205

Parker, K., Horowitz, J. M., & Anderson, M. (2020). *Amid protests, majorities across racial, ethnic groups express support for the Black Lives Matter Movement*. https://www.pewresearch.org/social-trends/2020/06/12/amid-protests-majorities-across-racial-and-ethnic-groups-express-support-for-the-black-lives-matter-movement/

Parker, K., Minkin, R., & Bennett, J. (2020). *Economic fallout from COVID-19 continues to hit lower-income Americans the hardest*. https://www.pewresearch.org/social-trends/2020/09/24/economic-fallout-from-covid-19-continues-to-hit-lower-income-americans-the-hardest/

Pedersen, P. B. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling & Development, 70*(1), 6–12. https://doi.org/10.1002/j.1556-6676.1991.tb01555.x

Pieterse, A. L., Evans, S. A., Risner-Butner, A., Collins, N. M., & Mason, L. B. (2009). Multicultural competence and social justice training in counseling psychology and counselor education. *The Counseling Psychologist, 37*(1), 93–115. https://doi.org/10.1177/0011000008319986

Plano Clark, V. L. (2019). Meaningful integration within mixed methods studies: Identifying why, what, when, and how. *Contemporary Educational Psychology, 57*, 106–111. https://doi.org/10.1016/J.CEDPSYCH.2019.01.007

Ponterotto, J. G. (1991). The nature of prejudice revisited: Implications for counseling intervention. *Journal of Counseling & Development*, *70*(1), 216–224. https://doi.org/https://doi.org/10.1002/j.1556-6676.1991.tb01587.x

Ponterotto, J. G., Mathew, J. T., & Raughley, B. (2013). The value of mixed methods designs to social justice research in counseling and psychology. *Journal for Social Action in Counseling & Psychology*, *5*(2), 42–68. https://doi.org/10.33043/jsacp.5.2.42-68

Ponterotto, J. G., & Potere, J. C. (2003). The Multicultural Counseling Knowledge and Awareness Scale (MCKAS): Validity, reliability, and user guidelines. In *Handbook of Multicultural Competencies in Counseling & Psychology* (pp. 137–153). SAGE

Publications, Inc. : 2455 Teller Road, Thousand Oaks California 91320 United States. https://doi.org/10.4135/9781452231693.n9 LK - https://umaryland.on.worldcat.org/oclc/7385601540

Potash, J. (2011). Art therapists as intermediaries for social change. *Journal of Art for Life*, *2*(1), 48–58.

Rapa, L. J., Bolding, C. W., & Jamil, F. M. (2020). Development and initial validation of the Short Critical Consciousness Scale (CCS-S). *Journal of Applied Developmental Psychology*, *70*, 1–10. https://doi.org/10.1016/j.appdev.2020.101164

Rasheed, J. M., Rasheed, M. N., & Marley, J. A. (2010). The history of family therapy conceptual and clinical influences. In *Family Therapy Models and Techniques* (pp. 3–44). SAGE.

Ratts, M. J. (2009). Social justice counseling: Toward the development of a fifth force among counseling paradigms. *The Journal of Humanistic Counseling, Education and Development*, *48*(2), 160–172. https://doi.org/10.1002/j.2161-1939.2009.tb00076.x

Ratts, M. J., & Ford, A. (2010). Advocacy Competencies Self-Assessment Survey: A tool for measuring advocacy competence. In M. J. Ratts, R. L. Toporek, & J. A. Lewis (Eds.), *ACA Advocacy Competencies: A Social Justice Framework for Counselors* (pp. 21–26). American Counseling Association.

Ratts, M. J., & Greenleaf, A. T. (2018). Counselor–advocate–scholar model: Changing the dominant discourse in counseling. *Journal of Multicultural Counseling and Development*, *46*(2), 78–96. https://doi.org/10.1002/jmcd.12094

Ratts, M. J., & Hutchins, M. A. (2009). ACA advocacy competencies: Social justice advocacy at the client/student level. In *Journal of Counseling and Development* (Vol. 87, Issue 3).

https://doi.org/10.1002/j.1556-6678.2009.tb00106.x

Ratts, M. J., & Pedersen, P. B. (2014). Five forces in counseling and psychology. In Manivong J. Ratts & P. B. Pedersen (Eds.), *Counseling for Multiculturalism and Social Justice: Integration, Theory, and Application Theory, and Application* (Fourth, pp. 17–33). American Counseling Association.

Ratts, M. J., & Pederson, P. B. (2014). *Counseling for multiculturalism and social justice: Integration, theory, and application* (Manivong J. Ratts & P. B. Pederson (Eds.)). American Counseling Association.

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

Rupert, P. A., & Kent, J. S. (2007). Gender and work setting differences in career-sustaining behaviors and burnout among professional psychologists. *Professional Psychology: Research and Practiceesearch and Practice*, *38*(1), 88–96.

Santora, M. (2008, June 24). Columbia professor in noose case is fired on plagiarism charges. *The New York Times*. https://www.nytimes.com/2008/06/24/nyregion/24columbia.html

Seedall, R. B., Holtrop, K., & Parra-Cardona, J. R. (2014). Diversity, social justice, and intersectionality trends in C/MFT: A content analysis of three family therapy journals, 2004-2011. *Journal of Marital and Family Therapy*, *40*(2), 139–151. https://doi.org/10.1111/jmft.12015

Shin, R. Q. (2015). The application of critical consciousness and intersectionality as tools for decolonizing racial/ethnic identity development models in the fields of counseling and

psychology. In Goodman R. & Gorski P. (Eds.), *Decolonizing "Multicultural" Counseling through Social Justice* (pp. 11–22). Springer. https://doi.org/10.1007/978-1-4939-1283-4_2

Shin, R. Q., Ezeofor, I., Smith, L. C., Welch, J. C., & Goodrich, K. M. (2016). The development and validation of the Contemporary Critical Consciousness Measure. *Journal of Counseling Psychology*. http://dx.doi.org/10.1037/cou0000137

Shoji, K., Lesnierowska, M., Smoktunowicz, E., Bock, J., Luszczynska, A., Benight, C. C., & Cieslak, R. (2015). What comes first, job burnout or secondary traumatic stress? Findings from two longitudinal studies from the U.S. and Poland. *PLoS ONE, 10*(8), 1–15. https://doi.org/10.1371/journal.pone.0136730

Singh, A. A., Appling, B., & Trepal, H. (2020). Using the multicultural and social justice counseling competencies to decolonize counseling practice: The important roles of theory, power, and action. *Journal of Counseling and Development*, *98*(3), 261–271. https://doi.org/10.1002/jcad.12321

Singh, A. A., Nassar, S. C., Arredondo, P., & Toporek, R. L. (2020). The past guides the future: Implementing the multicultural and social justice counseling competencies. *Journal of Counseling & Development*, *98*(3), 238–252. https://doi.org/10.1002/jcad.12319

Sluzki, C. E. (2001). All those in favor of saving the planet, please raise your hand: A comment about "family therapy saves the planet." *Journal of Marital and Family Therapy*, *27*(1), 13–15. https://doi.org/10.1111/j.1752-0606.2001.tb01133.x

Sodowsky, G. R. (1996). The Multicultural Counseling Inventory: Validity and applications in multicultural training applications. In G. R. Sodowsky & J. C. Impara (Eds.), *Multicultural Assessment in Counseling and Clinical Psychology* (pp. 247–282). Buros Institute of Mental Measurements.

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

Solórzano, D. G., & Yosso, T. J. (2016). Critical race methodology: Counter-storytelling as an analytical framework for education research. *Qualitative Inquiry*, *8*(1), 23–44. https://doi.org/10.1177/107780040200800103

Speight, S. L., Myers, L. J., & Cox, C. I. (1991). A redefinition of multicultural counseling. *Journal of Counseling & Development*, *70*, 29–36. https://doi.org/https://doi.org/10.1002/j.1556-6676.1991.tb01558.x

Substance Abuse and Mental Health Services Administration. (2020). *Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*. https://www.samhsa.gov/data/

Sue, D. W. (1991). A model for cultural diversity training. *Journal of Counseling & Development*, *70*, 99–105. https://doi.org/https://doi.org/10.1002/j.1556-6676.1991.tb01568.x

Sue, D. W. (1996). Multicultural counseling: Models, methods, and actions. *The Counseling Psychologist*, *24*(2), 279–284. https://doi.org/https://doi.org/10.1177/0011000096242008

Sue, D. W., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, *70*(4), 477–486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Cross-cultural counseling competencies. *The Counseling Psychologist*,

10(2), 45–52. https://doi.org/10.1177/0011000082102008

Sugrue, T. J. (2020). 2020 is not 1968: To understand today's protests, you must look further back. *National Geographic*. https://www.nationalgeographic.com/history/article/2020-not-1968

Swartz, M. R., Limberg, D., & Gold, J. (2018). How exemplar counselor advocates develop social justice interest: A qualitative investigation. *Counselor Education and Supervision*, *57*(1), 18–33. https://doi.org/10.1002/ceas.12091

Tappe, A. (2021). America's inequality problem isn't new. The pandemic is just emphasizing it. *CNN*. https://www.cnn.com/2021/02/03/economy/k-shaped-us-economy/index.html

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

Thomas, S. B., Quinn, S. C., Butler, J., Fryer, C. S., & Garza, M. A. (2011). Toward a fourth generation of disparities research to achieve health equity. *Annual Review of Public Health*, *32*, 399–416. https://doi.org/10.1146/annurev-publhealth-031210-101136

Toporek, R. L., & Daniels, J. (2018). *American Counseling Association Advocacy Competencies*. https://www.counseling.org/docs/default-source/competencies/aca-2018-advocacy-%0Acompetencies.pdf?sfvrsn=1dca552c_6

Toporek, R. L., Lewis, J. A., & Crethar, H. C. (2009). Promoting systemic change through the ACA advocacy competencies. *Journal of Counseling & Development*, *87*(3), 260–268. https://doi.org/10.1002/j.1556-6678.2009.tb00105.x

Torres-Harding, S. R., Siers, B., & Olson, B. D. (2012). Development and psychometric

evaluation of the Social Justice Scale (SJS). *American Journal of Community Psychology*, *50*(1–2), 77–88. https://doi.org/10.1007/s10464-011-9478-2

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), 837–851. https://doi.org/10.1177/1077800410383121

Tummala-Narra, P., Singer, R., Li, Z., Esposito, J., & Ash, S. E. (2012). Individual and systemic factors in clinicians' self-perceived cultural competence. *Professional Psychology: Research and Practice*, *43*(3), 165–174. https://doi.org/10.1037/A0025783

Tyler, C. P., Olsen, S. G., Geldhof, G. J., & Bowers, E. P. (2020). Critical consciousness in late adolescence: Understanding if, how, and why youth act. *Journal of Applied Developmental Psychology*, *70*(January), 101165. https://doi.org/10.1016/j.appdev.2020.101165

Usher, K., Durkin, J., & Bhullar, N. (2020). The COVID-19 pandemic and mental health impacts. *International Journal of Mental Health Nursing*, *29*(3), 315–318. https://doi.org/10.1111/inm.12726

Vahratian, A., Blumberg, S. J., Terlizzi, E. P., & Schiller, J. S. (2021). *Symptoms of anxiety or depressive disorder and use of mental health care among adults during the COVID-19 pandemic- United States*. https://www.census.gov/data/experimental-data-products.html

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist*, *31*(3), 253–272. https://doi.org/10.1177/0011000003031003001

Villarreal, A. (2020). Coronavirus sharpens America's already stark economic inequalities. *The Guardian*. https://www.theguardian.com/us-news/2020/dec/29/coronavirus-sharpens-economic-inequalities-america

Watson, M. F. (2019). Social justice and race in the United States: Key issues and challenges for

couple and family therapy. *Family Process*, *58*(1), 23–33. https://doi.org/10.1111/famp.12427

Watson, M. F., Bacigalupe, G., Daneshpour, M., Han, W. J., & Parra-Cardona, R. (2020). COVID-19 interconnectedness: Health inequity, the climate crisis, and collective trauma. *Family Process*, *59*(3), 832–846. https://doi.org/10.1111/famp.12572

Watts, R. J. (2004). Integrating social justice and psychology. *The Counseling Psychologist*, *32*(6), 855–865. https://doi.org/10.1177/0011000004269274

Watts, R. J., Diemer, M. A., & Voight, A. M. (2011). Critical consciousness: Current status and future directions. *New Directions for Child and Adolescent Development*, *2011*(134), 43–57. https://doi.org/10.1002/cd.310

Watts, R. J., & Hipolito-Delgado, C. P. (2015). Thinking ourselves to liberation?: Advancing sociopolitical action in critical consciousness. *Urban Review*, *47*(5), 847–867. https://doi.org/10.1007/s11256-015-0341-x

Wilcox, M. M., Franks, D. N., Taylor, T. O., Monceaux, C. P., & Harris, K. (2020). Who's multiculturally competent? Everybody and nobody: A multimethod examination. *The Counseling Psychologist*, *48*(4), 466–497. https://doi.org/10.1177/0011000020904709

Wootson, C. R., & Jan, T. (2021). *Biden takes action on racial equity; civil rights groups expect more*. The Washington Post. https://www.washingtonpost.com/politics/biden-to-sign-executive-actions-on-equity/2021/01/26/3ffbcff6-5f8e-11eb-9430-e7c77b5b0297_story.html

Zimmerman, D. W. (2004). A note on preliminary tests of equality of variances. *British Journal of Mathematical and Statistical Psychology*, *57*(1), 173–181. https://doi.org/10.1348/000711004849222