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Mental Health Clinical Managers and Their Multicultural Leadership Practices

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MENTAL HEALTH CLINICAL MANAGERS AND THEIR MULTICULTURAL LEADERSHIP PRACTICES

by

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DEDICATION

I dedicate this dissertation first to the Lord of all nations, creeds, and cultures. I send my blessings for the opportunity to complete my doctorate. Through every moment of self-doubt, I felt Your Presence, pushing me forward and reminding me that I was indeed on the right path.

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Dorothy Ettling taught others to embrace the joy of living in a multicultural world!

MENTAL HEALTH CLINICAL MANAGERS AND THEIR MULTICULTURAL LEADERSHIP PRACTICES

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There is a general recognition that the United States has historically failed to provide adequate mental health services to ethnic minorities. The American Counseling Association has mandated multicultural competence of counseling professionals in today's context of dramatic demographic change. Despite numerous studies on practitioners, organizations, models, and interventions geared toward minorities, disparities in access, usage, and outcomes in still exist. Simultaneously, counseling fields have emphasized leadership development as a key factor in improving services, yet training or research on leadership remains scarce.

In response to these conditions, this basic interpretive qualitative study focused on exploring clinical managers' perceptions of their multicultural leadership practices in daily interactions in outpatient mental health settings. Bennett's (2003) Developmental Model of Intercultural Sensitivity was used as the study's guiding theoretical framework. Using face-to-face interviews with 10 licensed psychotherapists in positions of mental health leadership in the southwestern United States, data was collected about the participants' learning experiences and beliefs about how to relate to cultural difference as clinical managers. The constant comparison analysis indicated four major themes: culture as a complex concept, multicultural learning experiences outside of formal educational settings, leadership issues, and the recognition of organizational culture and its impact. The findings uncovered specific information about the

participants' self-identified multicultural leadership practices such as specific ways of handling human resource issues, shared decision making, and staffing and supervision strategies. The findings also spoke to the roles of the organization, executive leadership and the multiple cultural influences that impacted the multicultural leadership learning experiences and practices of the participants in the study. Original contributions of the research included the following: (a) the clinical managers in the study formulated their own unique multicultural leadership practices independent of organizational directives or formalized training; and (b) the organization can impact multicultural leadership practices through a variety of means. Future research should focus on clinical managers' cultural interactions in mental health, intercultural sensitivity at work, and organizational factors that affect multicultural leadership with the aim of creating multicultural leadership models to guide professional practice.

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Context of the Study

"To better serve the growing number of ethnic and culturally diverse people in the United States, the American Counseling Association (ACA) has mandated that counseling practitioners and counselor educators become multiculturally competent" (Dressel, Consoli, Kim, & Atkinson, 2007, p. 51). This directive is reasonable considering the anticipated growth of cultural diversity in the United States population. The United States Census Bureau's 2009 National Population Projections predicted that the United States will most likely experience increases in the populations of older adults as well as increased racial and ethnic diversity. Decreases in the White population will be accompanied by increases in the Asian population, and the country will also be affected greatly by international migration (U.S. Census Bureau, 2009). Members of minority racial and ethnic groups are predicted to make up 57% of the population by 2060, with Hispanics comprising 38% of this group (U.S. Census Bureau, 2012).

Arredondo, Tovar-Blank, and Parham (2008) spoke to the complexity of the role of the culturally competent counselor in today's climate of change. They considered cultural competency a must for the profession due to the anticipated rise of bicultural and multiracial children, the intersections of various cultural components that characterize human diversity, and global shifts within the next 2 decades. Arredondo et al. (2008) also urged counseling professionals to recognize that clients suffer due to environmental factors and to acknowledge that traditional interventions can still render clients vulnerable to negative influences on their mental health. Arredondo et al. (2008) insisted that placing attention on "the systemic elements of distress requires counselors to look at institutions and agencies as well as their own policies and practices when addressing the psychological needs of culturally different clients" (p. 266).

Professionals in the field of counseling no longer debate the importance of diversity-related research and are now emphasizing a call for practitioners to become more involved in efforts to best serve people from all backgrounds. The push for culturally competent mental health services has been ongoing over the past few decades and is believed to be essential to solving problems associated with service utilization and equity (Betancourt, Green, Carrillo, & Park, 2005; Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Whaley & Davis, 2007). This emphasis on cultural competence is not unique to mental health settings. Medical professionals also acknowledge the increasing importance of cultural competence in medical practice due to demographic changes, differences in doctor and patient concerns regarding illness, and cultural differences that affect interactions between physicians and patients (Altshuler, Sussman & Kachur, 2003; Bhui et al., 2007; McGuire & Miranda, 2008).

Researchers assert that historical, contextual, and socio-political factors affect quality of health care for minorities in the United States. There is also agreement that the design of health services, which favors values of the majority culture, contributes to the lower quality of health care for people of color in the United States (Kirmayer, 2012; Mwachofi & WaMwachofi, 2010). Furthermore, the underrepresentation of minority health care professionals and researchers further hinders efforts to better understand the health needs of minority groups and to promote commitment to justice and better outcomes (Association of American Medical Colleges, 2008; Crowley, Fuller, Law, McKeon, Ramirez, Trujillo, & Widerman, 2004; Jeste, Twamley, Cardenas, Lebowitz, Reynolds, 2009; McGuire & Miranda, 2008). It has become an issue of social justice to address the health and psychological needs of culturally diverse populations considering this legacy of unequal access to care and the conflicting American values of equality and human rights for all (Braveman et al., 2011; Higginbotham, 2012).

Cultural competence. Cross, Bazron, Dennis, and Isaacs (1989) defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13). Cross et al. (1989) also highlighted the ideal characteristics of mental health agencies that demonstrate cultural competence:

> A culturally competent system of care acknowledges and incorporates- at all levels--the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of cultural services to meet culturally-unique needs. (p. 13)

Cross et al.'s model is still highly influential today due to its clear focus on effectively serving diverse clients and because it approaches cultural competence at the individual, agency, and system levels (Fung, Lo, Srivastava, & Anderman, 2012; U.S. Department of Health and Human Services, 2014). The National Center for Cultural Competence, whose mission is to increase the capacity of health and mental health systems to accommodate the needs of culturally and linguistically diverse populations, bases its framework, models, guiding values and principles on the work of Cross et al. (1989).

Betancourt, Green, and Carrillo (2002) provided a definition of cultural competence based on a systems' abilities ''to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs'' (p. v). This definition later expanded to include the ability of a workforce capable of providing the best quality of care possible to all patients regardless of race, ethnicity, culture, or language (Betancourt et al., 2005). Kirmayer (2012), however, cautioned professionals to be vigilant in the acceptance of cultural competence as something that once attained, would forever, reduce health disparities. Kirmayer warned against the inclination to think of culture as fixed in nature and to engage in simply matching people of certain backgrounds to those of similar backgrounds in

behavioral health services. He also advised the public to take a contemporary view of culture with the peoples' identities continually being shaped by interactions with outside networks, and cultural groups' identities being shaped by what is going on in the world. Sanchez, Chapa, Ybarra, and Martinez (2012) noted that professionals must also not assume that ethnic groups are homogenous, because this too contributes to inequalities in services. Similarly, Thomas, Quinn, Butler, Fryer, and Garza (2011) challenged health professionals and researchers to adopt a practice to better develop cultural competence that moves beyond the finite limits of classroom instruction. They coined this term *cultural confidence.* This lifelong practice is described as one of reflection on the social construction of race, self-critique of biases, openness to directly discussing issues of race, and working against racism.

For years, the Association for Multicultural Development has emphasized the need for psychotherapists to develop skills as outlined in the Multicultural Counseling Competencies as defined by Arredondo et al. (1996). The competencies emphasize practitioners' need to develop awareness of personal values and biases, the worldview of the clients they serve, as well as the ability to provide culturally appropriate intervention strategies. The competencies emphasize the development of attitudes and beliefs, knowledge, and skills. Brady-Amoon (2011) reiterated this when specifying the long term responsibilities of counselors who wish to grow in their cultural competence throughout their careers:

> This includes working to become more (a) aware of oneself as a cultural being who operates from cultural biases and preferences; (b) knowledgeable about the impact of cultural and environmental factors (i.e., the impact of one's cultural values, worldviews, historical factors, and sociopolitical context) on one's own and other people's development; and (c) effective in working with people from diverse populations at the individual, group, institutional, and societal level. The last aspect of cultural competence refers to the need for counselors to develop a broad range of skills that enable them to implement different roles (e.g., educator, consultant, organizational development specialist, social change agent) to more effectively address the strengths and needs of persons in culturally different populations. (p. 140)

Historically, the roots of the multicultural movement in psychology and counseling began with the Civil Rights Act of 1964 which led to major shifts in access to services and opportunities for groups that were previously excluded. In the 1970s, there was recognition in the research literature that psychology was inherently biased and not suited to the needs of ethnic minority groups in the United States. In the 1980s and 1990s, much emphasis was placed on generating multicultural counseling competencies and standards for individuals and eventually organizations. Through the new millennium, professional chapters of the American Psychological Association (APA) and ACA were devoted to minority and cultural concerns, and both fields adopted support of multicultural populations as part of their ethical codes (Arredondo & Perez, 2006).

Mental health disparities. There has been a well-documented and ongoing legacy of health care disparities, or inequalities in access and treatment, in the United States despite numerous research efforts and interventions (Bediako & Griffith, 2007; Snowden, 2012). Various authors describe the problem as complex, with environmental, behavioral, sociocultural, biological, psychological, economic factors and access to care being important factors in the disparities puzzle (Chiao & Blizinsky, 2013; Dinwiddie, Gaskin, Chan, Norrington, & McCleary, 2013; Penner, Hagiwara, Eggly, Gaertner, Albrecht, & Dovidio, 2013; Satcher & Higginbotham, 2008; U.S. Department of Health and Human Services, 2014). This problem is not unique to the United States, however. Health and mental health care disparities in minority groups exist internationally and pose a serious threat to global well-being and economic development (Chiao & Blizinsky, 2013; Ngui, Khasakhala, Ndetei, & Roberts, 2010; Penner et al., 2013).

According to the Centers for Disease Control and the Office of Minority Health & Health Equity (2013), there is evidence that demonstrates a relationship between race/ethnicity and the

persistence and worsening of health disparities. Despite this evidence, the Office of Minority Health & Health Equity maintains that health disparities in the United States can and should be corrected through community involvement. Priority goals include reframing health disparities as achievable, the implementation of proven policies and strategies, advancing the science of health equity, and national and global collaboration.

Chin et al. (2012) discussed the need for researchers to move from attempting to study disparities, to studying community-based interventions aimed at tailoring treatment in the local context to the needs of ethnic minorities while taking into account the numerous influences on the health care experience. Social determinants of health such as neighborhood conditions, access to basic needs, educational level, employment opportunities and others should be factored into the health disparities equation since minorities are most likely to live in stressful conditions that affect their health in a negative manner (Sanchez et al., 2012). It is fundamental to address community needs related to employment, finances, and access to opportunities in order to improve the mental health of diverse populations (Power, 2010).

Yet others have posited that additional approaches offer more hope for understanding and potentially reducing disparities. Penner et al. (2013) highlighted empirical evidence that tied health care disparities to socioeconomic status, language proficiency, and health literacy in minorities, yet argued that these were not causal factors, but complex relationships with intricate solutions rooted in many systems. Penner et al. argued that applying social psychological approaches at the interpersonal and intrapersonal levels would more fully address disparities by working to improve interactions between patients and practitioners of different backgrounds by addressing issues of identity, discrimination, and communication challenges.

The concern about delivering effective mental health services to diverse populations is a serious one, and a challenge that the American mental health community has not yet risen to meet. Some studies from the 1990s into the millennium show that mental health disparities indicated no change or worsening despite attention (McGuire & Miranda, 2008). Despite the emphasis on this issue for decades, the mental health care industry is still in need of solutions to address the needs of racial and ethnic minority populations (Alegria, Vallas, & Pumariega, 2010).

The Department of Health and Human Services (2001) *Report on Mental Health: Culture, Race, and Ethnicity* stated that ethnic minorities have less access to mental health services, are less likely to receive needed services, receive a poorer quality of mental health care, and are underrepresented in mental health research. This lack of mental health treatment impacts educational and financial opportunities, length of lifespan, well-being, and involvement in the child welfare, justice and legal systems (Alegria et al., 2010; Alegria, Lin, Chih-Nan, Duan, Cook, & Meng, 2012).

Mental health disparity is defined depending on the interest of an organization or agency and usually falls under the broader definition of health disparities (McGuire & Miranda, 2008; Safran et al., 2009). The Substance Abuse and Mental Health Services Agency (SAMHSA) and the Centers for Disease Control attribute mental health disparities to numerous factors including lack of access to needed care, lack of diverse providers, a lack of information about services, and the lack of culturally and linguistically competent care. Both agencies' definitions of mental health disparities follow the *Healthy People 2020* report, are inclusive of populations beyond racial/ethnic minorities, and take into account the impact of group membership and inequities in power that affect issues of access and treatment (Centers for Disease Control, 2014; Safran et al.,

2009; Substance Abuse and Mental Health Services Administration, 2014, & U.S. Department of Health and Human Services, 2014).

Research has indicated that mental health services are underutilized by diverse peoples in the United States even when controlling for health insurance (Dobalian & Rivers, 2008; Thomas, Temple, Perez, & Rupp, 2011). Alegria et al. (2010) noted that despite data to support its efficacy, especially in combination with psychotropic medication, minorities are less likely to engage in psychotherapy than whites. Alegria et al. (2008) cited the following reasons for racial/ ethnic minorities having less access to mental health treatment in the United States for depression after controlling for social class related variables:

1. Problems with diagnosis due to clinician's inability to recognize symptoms;
2. Fear of lost wages from missed work;
3. Perceptions of mistreatment from providers;
4. Lack of family recognition of depression or lack of interest in formal care; and,
5. Lack of providers in safety net settings.

The underutilization of mental health services has been explained in several ways. Clinicians have been cited as not having the ability to interpret clients' experiences and to fulfill treatment needs. Therapists in general have been described as not being knowledgeable about how clients perceive mental illness and how they engage in help seeking behaviors (Roysircar, 2009). Researchers have also emphasized the need for professionals to understand the role of stigma and how it impacts help seeking (Alegria et al., 2010; Thomas, Temple, et al., 2011). Additionally, cultural mistrust for mental health services developed historically by diverse people has been another influential factor. Penner et al. (2013) emphasized the salience of historical racism and anticipation of discrimination and how this affects minorities' treatment

decisions. Comstock et al. (2008) explained that this anticipation of discrimination in counseling is often reasonable based on minorities' past experiences with oppression. Jimenez, Cook, Bartels, and Alegria (2013) added that past individual and group discrimination experiences must be taken into consideration when looking at cultural mistrust.

Roysircar (2009) also cited a lack of diverse staff and local services to meet the needs of clients of color. Alegria et al. (2012) agreed with this claim, and further accentuated the importance of the presence of local neighborhood clinics and partnerships with additional support services. Numerous issues of access also serve as barriers to use of mental health services (Roysircar, 2009; Thomas, Temple, et al., 2011). Penner et al. (2013) and Roysircar (2009) acknowledged socioeconomic challenges as a complicating factor in obtaining mental health care. While serving as a stressor, being of lower socioeconomic status can contribute to the worsening of overall health and mental health. It also contributes to provision of lower quality care from providers, further complicating the disparities situation.

Leadership and managed care. Leadership development and managed care are other major factors in mental health that affect service provision. The International Initiative for Mental Health Leadership (Beinecke & Spencer, 2007) produced a major report on mental health leadership training programs and competencies based on research conducted in eight primary English-speaking countries, including the United States. Beinecke and Spencer (2007) referred to the development of the future cohort of leaders as "a critical challenge in mental health as well as public and private administration" (p. 5). With regard to the United States, the report explained the lack of comprehensive leadership training to mental health professionals:

> Health agencies' resources are stretched by demands for training in other areas, for example information systems, learning the recovery paradigm of care, or evidence-based clinical practices. Budgets are very tight. The first thing to go is usually professional development and supervision. Pressures continue to grow to

> use one's time for direct service, not to go to conferences and seminars. Many agencies are struggling to keep up with the present, never mind prepare for the future. (p. 62)

Emphasizing the responsibility of counselors to recognize the role of organizational culture and to accept their role in influencing the organizational environment to promote positive change, Tatar and Bekerman (2002) assert that "professional counselors must become aware of how their own practices not only reflect the institution's culture but also help it take shape" (p. 382). Tatar and Bekerman advised counselors to become more involved in initiating movements within organizations to benefit all employees and consumers served by the organization. While this is a lofty ideal, it is not always possible due to time constraints, limitations on freedom in the workplace, and organizational values and climates that do not emphasize change or activism.

This is often considered the case in managed mental health care where institutional values shape the organization and the behaviors of its members. Wilcoxon, Magnuson, and Norem (2008) explained the character of organizational systems in terms of their motivation and rationale for operations as being "typically objective-driven entities or institutions, using policies and requirements founded on ideological missions that reflect the value placed on commodities, products, or outcomes essential to the success of that institution" (p. 145). Wilcoxon et al. (2008) reiterated the idea that managed mental health care programs promote values of efficiency and the avoidance of financial loss. These values may clash with the intentions of therapists and other health care providers who seek to provide optimal and culturally appropriate client care. Hansen et al. (2006) noted that clinicians may be affected by managed care mandates and may not believe that they can expend the extra effort needed to obtain guidance on culturally appropriate practices, create a professional development plan, or seek culture-specific consultation amongst

other efforts. Time and resources may not be dedicated to cultural competence training or resources if not deemed to be a good investment to the mental health organization.

Managed care has also meant huge shifts in the perceptions of psychotherapy, including the expectation that short-term therapy is the norm and best fit for all, and that the focus in treatment should be on behavioral symptoms instead of intrapsychic problems (Cantor & Fuentes, 2008). LaRoche and Turner (2008) provide three categorizations of the difficulties that ethnic minorities face due to the influence of financial interests from managed care: " (a) insufficient access to mental health providers, (b) inappropriate or culturally insensitive treatment, and (c) lack of consumer/ provider awareness" (p. 195). LaRoche and Turner argue that the focus on individualism and profit that has resulted from the managed care movement has the potential to increase health disparities and decrease the quality of psychological services.

Statement of the Problem

Mental health care is still wrestling the problem of disparities in access, service utilization, and quality of treatment with people of color in the United States. These problems exist even though counseling related fields have emphasized social justice efforts and produced a wealth of research on cultural competence in the provision of psychotherapy. Sanchez et al. (2012) asserted that there has been little success with disparities interventions for minority populations because organizational and institutional level factors have been ignored. To date, the majority of research on cultural competence has been conducted at the mental health practitioner level and has been focused on the delivery of therapeutic services, while leadership research in mental health has not been thoroughly addressed. To this end West, Bubenzer, Obsorn, Paez, & Desmond (2006) commented that "despite the importance of leadership in counseling, very little is addressed in the counseling literature, especially on leadership" (p. 2). Curtis and Sherlock

(2006) reported on the lack of leadership preparation in counseling graduate programs, the limitations on providing managerial training in human service settings, as well as the need for additional research to fill the gap in the literature.

"One approach in addressing the absence of attention to cultural competence and cultural training at the institutional level is to move beyond clinicians who exclusively provide direct services to administrators who are managers, supervisors, and clinical leaders" (Abernethy, 2005, p. 82). Abernethy further suggested that clinical managers can affect the cultural competence of their subordinates and the cultural organizations in which they work.

Toporek (2001) spoke about the need to acknowledge the different meanings of cultural competence based on level of leadership in an organization by stating that "the implications of being multiculturally competent are different when one is in a position of power institutionally (e. g. an administrative position)" (p. 20). Toporek noted that counseling professionals in administrative positions are able to make decisions and influence policy, which in turn affects clients of color. Following this logic, research involving clinical leadership in mental health has the potential to expose problems and to bridge the informational gaps between organizational functioning and the optimal delivery of culturally appropriate human services. However, there is currently a lack of research on mental health clinical managers' multicultural leadership practices, how they perceive multiculturalism, and how they learned and developed their multicultural leadership practices.

Purpose of the Study

The purpose of this qualitative study was to explore clinical managers' perceptions of their multicultural leadership practices in daily interactions in outpatient mental health settings. For this study, outpatient mental health settings refer to community clinics, private clinics, or

counseling centers in other organizational settings where mental health counseling and related services are provided where clients served do not have overnight visits or take up residence in the treatment facility or the part of the treatment facility where the outpatient service was provided. In this study, the term clinical manager refers to a leader who supervises licensed psychotherapists who provide therapeutic services to clients in outpatient mental health settings. Clinical managers may oversee other types of staff and can also be referred to as behavioral health managers, clinical leaders, or mental health supervisors in this study.

Research Question

The primary question that was used to guide this study was: How do clinical managers describe their multicultural leadership practices in daily interactions in outpatient mental health settings? Secondary questions inquired about how the participants in the study have learned about and developed their multicultural leadership practices as well as other factors they believe may influence these behaviors.

Theoretical Framework

Creswell (2008) acknowledged the use of theory in both quantitative and qualitative research as “a broad explanation for behavior and attitudes” (p. 61). In the context of qualitative research, Anfara and Mertz (2006) defined theoretical frameworks as “any empirical or quasi-empirical theory of social and/ or psychological processes at a variety of levels (e.g., grand, mid-range, and explanatory), that can be applied to the understanding of phenomena” (p. xxvii).

For this study, the Developmental Model of Intercultural Sensitivity (DMIS) was used to serve as an explanation of how individuals tend to progress in how they accommodate cultural difference. The DMIS was created as a framework to explain the observed and reported experience of people in intercultural situations (Bennett & Bennett, 2001). Sheffield (2007)

accentuated the difference between cultural knowledge and intercultural sensitivity, and noted that the latter "requires increasing experience of difference coupled with reflection and integration of insights" (p. 5). The following quote describes the nature of intercultural sensitivity from an evolutionary perspective.

> Intercultural sensitivity is not natural. It is not part of our primate past, nor has it characterized most of human history. Cross-cultural contact usually has been accompanied by bloodshed, oppression, or genocide. The continuation of this pattern in today's world of unimaginable interdependence is not just immoral or unprofitable—it is self-destructive. (Bennett, 2003, p. 21)

Culture, with its guiding principles that dictate appropriate behaviors for living and survival, was defined as "the collective programming of the mind that distinguishes one group or category of people from another" (Hofstede & McCrae, 2004, p. 58). Lunasco, Goodwin, Ozanian, and Loflin (2010) described culture as "the totality of ideals, beliefs, language, skills, practices, traditions, values, customs, and behaviors that are shared by a specific group" (p. 509). They further explained that these aspects of culture influence notions of individual identity and relationships. Endicott, Bock, and Narvaez (2003) underlined the notion that people hold memberships in different groups and that all individuals belong to multiple cultural frameworks. Whaley and Davis (2007) emphasized the importance of viewing culture as a "dynamic process that links the past to the present and is shaped in part by the social, historical, and political context" (p. 564). Today, culture is affected by globalization, travel and technology (Whaley & Davis, 2007). Johannes and Erwin (2004) referred to culture and how it provides its members with "schemas for understanding and navigating their multiple, interrelated realities" (p. 333).

"The set of distinctions that is appropriate to a particular culture is referred to a *cultural worldview*" (Hammer, Bennett, & Wiseman, 2003, p. 423). It is from this worldview or perspective that a person makes decisions about how to operate in the world and how to interact with others. Cultural practices affect psychological development, childrearing practices,

developmental norms, patterns of interpersonal communication, help-seeking behaviors as well as mental health-related behaviors and beliefs about illness (Pumariega, Rogers, & Rothe, 2005).

The DMIS "posits a continuum of increasing sophistication in dealing with cultural difference, moving from ethnocentrism through stages of greater recognition and acceptance of difference, here termed 'ethnorelativism'" (Bennett, 2003, p. 21). The model assumes the phenomenological nature of how people experience and make meaning of cultural differences and how they construct their reality as they become more capable of accommodating cultural differences (Bennett, 2003). Bennett summarized the role of self-reflection in becoming more efficient in dealing with cross-cultural differences by citing that "intercultural sensitivity is ultimately the development of consciousness and, through consciousness, developing a new 'natural' approach to cultural difference" (p. 26). The development of this consciousness takes place within the individual according to the meaning attributed to experiences with cultural difference.

Skilled professionals can provide guidance in the introduction of cultural differences and in facilitating the interpretation of these cultural differences and are thus able to influence learners to move along the continuum toward a greater acceptance of differences. It is important to note that although an individual may progress through each of the three stages on both halves of the model, reverse movement is also possible. In addition, some people, particularly those from oppressed backgrounds, may not experience a stage the same way others might.

As an individual develops his or her intercultural sensitivity according to the model, he or she operates from either an ethnocentric or an ethnorelative point of view. These perspectives divide the model into two halves, and are composed of three stages each. When people operate from an ethnocentric point of view, they assume that the worldview of their "own culture is

central to all reality" (Bennett, 2003, p. 30). This is essentially the starting point from which people experience or attribute meaning to cultural difference.

When operating from an ethnorelative point of view, "one's own culture is experienced in the context of other cultures" (Hammer et al., 2003, p. 425). This begins with an awareness of one's own culture and the understanding that cultural differences are important considerations in intercultural communication and that they affect human interactions. Culture is seen as neutral and the individual realizes that his or her cultural perspective is simply one of many that exist in the world.

The DMIS was developed in North America using a grounded theory approach and designed with the intention of explaining the reasons why some people improve and others do not improve in cross-cultural communications (Bennett, 2004). Intercultural competence encompasses the development of intercultural sensitivity along with more complex intercultural communication, cognitive complexity and a willingness to be more proficient in cross-cultural interactions. Thus intercultural competence is often the focus of organizational diversity initiatives and is believed to contribute to "effective recruitment and retention of members of underrepresented groups, management of a diverse workforce, productivity of multicultural teams, marketing across cultures, and to the development of a climate of respect for diversity in the organization" (Bennett & Bennett, 2001, p. 6).

In human services, research has been conducted using the DMIS to design and evaluate the Partners Reaching to Improve Multicultural Effectiveness (Bourjolly et al., 2005), a SAMHSA funded program designed to reduce mental health disparities based on culture. To analyze the qualitative component of the study, researchers focused on written reflection logs where participants reflected on cultural experiences between sessions over a 10 week training

span. Analysis of data supported that the stages of the DMIS were applicable to the participants' cultural experiences, but that forward progression along the model did not occur quickly or necessarily in a linear fashion. Insights gained from the study showed that some participants reverted to earlier stages of intercultural sensitivity when having difficulty processing information that challenged their current cultural beliefs at the time, and that more time was needed to integrate new information and process new skills. Variations in the process of intercultural sensitivity development, evidence of progression through stages toward the ethnorelative worldview were identified and were suggestive of possible helpful instructional techniques and timeframes (Bourjolly et al., 2005).

The Developmental Model of Intercultural Sensitivity as a theoretical framework provides a way of organizing how the clinical managers in this study perceived cultural differences, responded to these, and how these perceptions and responses may have evolved with time and experience. It is a particularly helpful model in dealing with individuals due to the assumptions about how to relate to other cultures that characterize each of the stages in the model and the communication-related behaviors that typically result from these assumptions. As clinical managers in outpatient mental health settings, the participants in this study were undoubtedly responsible for large volumes of communication in their daily work practices and were required to acknowledge to some degree and respond to cultural difference by the very nature of the human services that they and their staff members provided.

This model provided a foundation of beliefs and patterns related to intercultural development that was used to guide the language associated with the discussion of cultural difference in the analysis of the data. It also lent itself to explaining characteristics of perceived intercultural relations shared by each participant. Use of the model allowed for making

meaningful comparisons and contrasts amongst the perspectives of the participants when explaining the findings. Last but not least, the DMIS is predicated on the process of learning how to relate to cultural difference through life experience. This learning process is an important consideration in this study since little has been documented in the literature about how mental health professionals learn about how to relate to cultural difference in the context of leadership.

Definition of Terms

The following terms are defined in the context of the practice of mental health in the United States and represent overarching concepts in the field and working definitions for the purposes of this study.

Mental health. Mental health refers of the branch of health care that deals with the treatment of mental disorders, social-emotional problems, substance abuse, and abuse, trauma or neglect through psychiatric, psychotherapeutic, or other methods. According to the World Health Organization (2012), mental health is "related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders."

Culture. Culture in this study refers to "the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions" (American Psychological Association, 2003, p. 380).

Diversity. Diversity in this study refers to the existence of various cultures or belief systems that affect human interactions in mental health settings. The acknowledgement of diversity is based on the identification of group membership that provides people with a sense of identity. In mental health, special attention is given to meeting the needs of patients and clients who are considered "diverse" based on racial, ethnic or national affiliation, socioeconomic status, sexual identity or preference, along with other factors (Arredondo et al., 1996).

Intercultural competence. This term is defined as "the ability to communicate effectively in cross-cultural situations and to relate appropriately in a variety of cultural contexts" (Bennett & Bennett, 2001, p. 6). Intercultural competence is used interchangeably in the literature with intercultural communicative competence, transcultural communication, cross-cultural adaptation, global competence, multicultural competence and intercultural sensitivity (Fantini & Tirmizi, 2006; Sinicrope, Norris, & Watanabe, 2007). For the purposes of this study, and following United States mental health literature and the theoretical framework for this study, the terms intercultural competence, cultural competence, and multicultural competence will be used interchangeably.

Multiculturalism. This term refers to a pro-diversity perspective in the field of counseling consisting of attitudes and beliefs, knowledge, and skills with prescribed guidelines for psychotherapists' awareness of their own cultural values, clients' worldview, and the provision of culturally appropriate therapeutic interventions. This definition is based on the based on the Association for Multicultural Counseling and Development counseling competencies (Arredondo et al., 1996).

Outpatient settings. Outpatient settings refer to mental health settings in which clients or patients seek medical, counseling, psychoeducational, or referral services that allow them obtain time-limited services, set appointments, and leave the treatment setting after appointments and resume daily activities. Outpatient services do not require overnight stay (SAMHSA, 2012).

Clinical manager. A clinical manager in this study refers to a licensed psychotherapist in a supervisory position in a public, private, non-profit, or community-based organization who supervises other licensed psychotherapists, case managers, paraprofessionals, and other staff who work directly with mental health consumers. In this study, the term *clinical manager* may be

used interchangeably with clinic administrator or mental health supervisor (Abernethy, 2005).

Psychotherapy. This term refers to the therapeutic practice of counseling between a licensed professional and an individual, couple, family or group using dialogue or activities to increase mental well-being. Kaplan, Tarvydas, and Gladding (2014) stated that "counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (p. 366).

Overview of Research Design

This qualitative study was conducted using a basic interpretive methodology. Merriam (2002) notes "learning how individuals experience and interact with their social world, the meaning it has for them, is considered an interpretive qualitative approach" (p. 4). Merriam (2002) further stated that the aim of the basic qualitative study is "to discover and understand a phenomenon, a process, the perspectives and worldviews of the people involved, or a combination of these" (p. 6). This study focused on the perspectives of mental health clinical managers' everyday experiences in the workplace and understandings of multicultural leadership. Data collection emphasized the participants' understandings of their own multicultural leadership development, perceived influences on this development, and how their everyday leadership practices could be described in the context of mental health.

Data were collected through two primary means. Recorded, in-depth, individual, face to face interviews and the collection of data through the administration of open-ended demographic questionnaires were used with participants who were mental health clinical managers in the southwestern United States. Data from the interviews were transcribed verbatim and analyzed using constant comparison analysis. Themes were generated along with supporting information from the literature and quotations from the participants to describe concepts from their point of

view. Thick descriptions of each participant's leadership position, type of organization of employment, and demographic characteristics (including educational background and multicultural training, licensure), and other related characteristics that were pertinent to understanding their views on how they have developed and executed their multicultural leadership strategies were described.

Background of Researcher

I am a Licensed Professional Counselor (LPC) and supervisor who worked as a clinical manager in an outpatient mental health setting at the time of the data collection. My other professional behavioral health experiences include working as a clinical director of an outpatient counseling clinic and children's home, clinical manager of multiple mental health programs, and psychotherapist in for-profit, non-profit, private practice, and educational settings. Prior to entering the field of counseling, I completed my bachelor's degree in French and also studied Spanish. I pursued further study of both languages in both France and Spain, and worked as an English teaching assistant for National Education of France. This is important to note since immersion experiences are known to have a significant impact on the development of intercultural sensitivity and attention to cultural cues.

I also have a background in college teaching and consultation, and worked as the Associate Director for the McNair Scholars Program at a Catholic university in Texas. This professional experience opened my eyes to the lack of people of color in the United States with doctoral degrees and in leadership. In this work, I was able to help low income and minority undergraduate students to realize their potential as researchers and future scholars. As a first generation college student and woman of color, I saw myself in these students and decided to pursue my doctorate in education with the ultimate goal of becoming a consultant-researcher for

health care and helping organizations. I thought it wise to combine my counseling and education background for the benefit of others. I was compelled to navigate the culture of higher education in order to provide a voice for people from my culture as well as advocate for the at risk populations I had worked with in counseling, education, and higher education through scholarship on multicultural matters.

Understanding the unique needs of these groups and being energized by the idea of using my research to potentially better serve them has been a powerful motivator for me as a researcher. On a personal level, my everyday cultural learning experiences have also been rich and varied, as people have often misunderstood my ethnic background or communicated with me in local languages in the United States and abroad. Essentially, I have lived as a cultural chameleon of sorts and learned numerous intercultural lessons along the way.

"The participant's perspective on the phenomenon of interest should unfold as the participant views it (the emic perspective), not as the researcher views it (the etic perspective)" (Marshall & Rossman, 2006, p. 101). With this in mind, I was careful to interpret the data in the most neutral manner possible, try not to influence participant responses due to my personal life experience, and prior research experience in the field of mental health. Essentially, I used communication techniques during the interviews such as summarizing and reflection in an attempt to gauge my accuracy when interpreting information from the participants. I worked to be as transparent as possible throughout the study from transcription through data analysis. My reflections on experiences with the subject matter of inquiry were recorded as part of a journal and were used in reporting in different parts of the study.

Significance of Study

It should be noted that the qualitative research presented here is not generalizable to broad clinical manager populations in the United States. However, the study lends itself to transferability, or the potential to better understand similar issues in other mental health organizational settings (Schram, 2006). The inquiry is unique as it focuses on and combines mental health leadership and multiculturalism, which are two important and crucial topics that have not been thoroughly addressed in research.

This study is significant in that it sought to provide insight into mental health leaders' understandings of multicultural leadership practice and their behaviors that support multiculturalism in the organizational setting. The participants in the study were asked to provide data regarding their definitions of multiculturalism, ways that they demonstrate multicultural leadership practices, as well as information about the influences on their perceptions and learning about culture.

The data were a starting point for gathering information necessary to begin to formulate data to support future action research or optimal training programs to remediate the current problems associated with diversity and leadership in mental health outpatient settings. Researchers and practitioners in the helping professions can benefit from familiarity with this study to open their eyes to the multiple realities of the dimensions of culture that affect leadership practices in mental health. The data yielded information about complicated, problematic systemic and leadership issues in the mental health work setting as well as the current strategies used by the clinical managers represented in this study. The findings painted a picture of the behaviors, strengths, and self-identified needs and challenges of the clinical managers. This information can be used to formulate more concrete supervisory guidance for

clinical managers in mental health outpatient settings and lends itself to the design of highly specialized multicultural leadership training.

The data produced also introduces a more complete picture of the role of culture in service provision and management. The data further serve as a reminder to organizations to revisit their overall cultural competence strategies and to include new or modified considerations of ideal multicultural interactions and skills at the managerial level. The findings also provide some information about the perceived role of the organization and its influence on the clinical manager's multicultural leadership strategies.

At present there exists a gap in the literature with regard to actual mental health leadership practices that contribute positively to the nation's efforts to provide culturally competent services to consumers of mental health services. Moreover, there is a general lack of research on leadership in mental health. To date, the majority of multicultural research is centered at the clinical practitioner level in terms of desired knowledge, attitudes, and behaviors. General research is available at the organizational level where organizational mission, training, and checklists of diversity-friendly practices are observed and evaluated. Despite the availability of this research, there are still serious problems with disparities in service delivery in the United States. Little research actually looks at the level of the clinical manager where the intersections of individual learning about culture and leadership and personal interpretation of diversity-related behaviors, policies, organizational goals, financial considerations, and societal influences come together. Attention should be drawn to this area of research in order to discover missing data that can be used as a starting point to bridge the gaps between ideal multicultural mental health service delivery, leadership practices, and organizational process. Finally, data from this

study can be used to begin to formulate information that will lead to the development of criteria for best practices in leadership in mental health.

Limitations

This study was designed to provide a starting point for obtaining information about mental health clinical managers' understandings of multiculturalism and how they demonstrate multicultural leadership practices in outpatient settings. Limitations to this study include the fact that data were obtained through self-report and were dependent on the memory of the participants. In addition, the participants were allowed to choose the location of their interviews. The majority chose to be interviewed in their offices at work. Because of this there were numerous interruptions, distractions, and time limitations that affected interview answers and response time. In most cases, it was difficult to delve deeply into subtopics during the interviews.

Also, only half of the participants completed member checks. It should be noted that some participants admitted to being apprehensive about disclosing information related to their work due to their unfamiliarity with research processes even after being provided with full disclosure about the protection of human subjects. A few participants stated that they were simply not used to discussing multicultural issues on a daily basis and were concerned with giving the "right" answers. Again, it was explained to the participants that there was no right or wrong answer, and that the goal of inquiry was to learn from the participants' personal knowledge and experience. Still, this hesitation on the part of some participants to speak freely during the interviews due to feelings of uncertainty about their responses should be considered a limitation.

Summary

With the anticipation of major increases in the number of racial and ethnic minorities in the United States in the near future, health care professionals are increasingly more concerned about addressing the issue of health disparities. In the field of counseling, the ACA and the APA have both promoted cultural competence and social justice as fundamental to professional identity and professional practice. In addition, numerous studies have been conducted to identify best practices and evidenced based practices to be used with specific minority groups and at the organizational level. Yet complicating factors such as the influence of managed care, lack of leadership training, and lack of training and resources dedicated to cultural competence make it difficult to improve access and outcomes of mental health services for clients of color.

This study was designed to fill in part of the gap in behavioral health disparities research by focusing on the level of leadership. Most of the studies in the literature focus on culturally adapted interventions or organizational cultural competence as a means of reducing disparities. Ironically, despite this research and emphasis on cultural competence the problem still persists. The researcher chose to focus on the level of mid management with clinical managers who oversee counseling practitioners in outpatient settings. These individuals have traditionally been excluded from most multicultural and disparities research efforts despite the important role that they play in shaping mental health service provision. This descriptive interpretive study was conducted using face to face interviews with 10 clinical managers in the southwestern United States. The participants were asked about their multicultural learning experiences, understandings of their own multicultural leadership development, and how their everyday leadership practices could be described in the context of mental health.

Chapter 2: Review of the Literature

Introduction

The challenges of serving culturally diverse populations in mental health services in the United States are well-documented and have been approached in different ways in the literature. Rosenheck (2001) discussed the importance of organizational process and the need for research to address processes and to acknowledge the organizational context of the practice of mental health. Challenges in organizations affect the quality of clinical interventions, most notably the multiple influences on the decision-making process for those who work in these organizations. Rosenheck noted that decisions made by professionals working in multifaceted organizational contexts are not necessarily driven by empirical findings, but rather by "power structures, ingrained routines, and established resource configurations" (p. 1608). This study offered opportunities for participants to speak to daily decision making in the context of multicultural leadership in modern mental health outpatient settings.

There are also problems with a lack of culturally diverse representation in leadership in mental health research. With the increasing diversity in the United States, "recognition is growing that diversity in the research workforce is linked to improving health care quality and access for socially disadvantaged racial/ethnic populations" (Stoff, Forsyth, Marquez, & McClure, 2009, p. 8). As a researcher with African, European, Native American, and Hispanic heritages, I hoped to contribute to the fields of mental health and leadership by providing an innately multicultural perspective to guide the research, as well as the overt intention of supporting the communication of knowledge regarding the intersection of these two fields.

Due to the lack of research literature that focuses on mental health multicultural leadership, the literature review was designed using combined information obtained from the

fields of organizational science, various disciplines in mental health, leadership, public health, and multicultural studies from the United States and abroad to provide broad information to explain basic ideas related to the complexities imposed by culture for mental health leaders. The following literature review will elaborate on a) multiculturalism and social justice in mental health, b) cultural differences in conceptualizations of mental health, c) cultural competence at the organizational level, and d) clinical leadership in mental health settings. Each of these sections provides information about important aspects of organizational life that relate to mental health leadership with multicultural competence in mind.

Multiculturalism and Social Justice in Mental Health

The notion of social justice is often connected to multiculturalism in current mental health literature. Vera and Speight (2003) advised counselors to recognize oppression and to fight against it. Further, the authors also acknowledged how the multicultural counseling competencies mentioned the recognition of oppression "but say little specifically about ways to advocate for social justice" (Vera & Speight, p. 257). Oppression has been defined as "the systematic disadvantage of one group by other groups who hold more power in society" (Lopez-Baez & Paylo, 2009, p. 277). Counselors have also been asked to recognize the many societal influences on the mental health of their clients. Roysircar (2009) insisted that counselors work immediately to "understand the political and economic forces that cause so much of the alienation, depression, and self-hatred in their clients" (p. 289). Delphin and Rowe (2009) commented that having psychiatric illness contributes to stigma, and added that "membership in a historically oppressed, stigmatized, or underserved group can enhance a sense of marginalization for diverse populations" (p. 189).

Both the ACA and APA have included social advocacy as an important ethical imperative for practitioners (ACA, 2005; APA, 2002). Lewis, Arnold, House and Toporek (2003) wrote about advocacy competencies for counselors endorsed by the ACA. Counselors were advised to partner with or act on behalf of clients in the personal, school/ community, or public arenas in order to advocate for the needs of clients.

Overall, the advocacy competencies are based on counselors' recognition of social, political, economic, and cultural factors that affect clients' development in a negative manner, prevent clients from obtaining needed resources, or hinder clients' ability to reach personal goals. The following areas of competency are emphasized: client/student empowerment, client/student advocacy, community collaboration, systems advocacy, public information, and social/political advocacy (Lewis et al., 2003).

Toporek, Lewis, and Crethar (2009) noted that despite the adoption of the ACA's advocacy competencies which categorize advocating for clients as being at the heart of counselors' identities, more formal training is needed to address how counselors can successfully pursue advocacy roles at the systems level. Common roadblocks to implementing the ACA advocacy strategies were noted at the National Multicultural and Social Justice Leadership Academy in 2010 and included "(a) insurance and funding issues, (b) lack of community support, (c) unexpected resistance, (d) difficulty in building collaborative networks, (e) cultural and language biases, and (f) the counselor's own limited training in social justice advocacy" (Lewis, Ratts, Paladino, & Toporek, 2010, p. 11). Moreover, at the same conference, Ahmed, Wilson, Henriksen Jr., and Jones (2011) documented reactions from the professional audience as to why many clinicians choose not to implement advocacy strategies in the context of multicultural counseling including "(a) fear of isolation, (b) not knowing what to do to advocate,

and (c) a fear of lost wages, job, or both" (p. 21). Similarly, a study of psychologists and barriers to public policy advocacy by Heinowitz et al. (2012) suggested that psychologists have a lack of understanding and awareness of issues to advocate for along with a need for training. Future research in this area should be conducted since it is noted that psychologists participate in lower levels in advocacy efforts when compared to other helping professions (Heinowitz et al, 2007).

Constantine, Hage, Kindaichi, and Bryant (2007) acknowledged the various ways that counselors and counseling psychologists are attempting to promote social justice issues either in the international or domestic arenas. Constantine et al. (2007) noted that either level of social justice involvement is "critical in understanding the interdependence of macrosystems and microsystems in people's lives, especially in the lives of marginalized populations" (p. 24). Ratts (2009) spoke to the professional consensus that "social advocacy is a necessary step to address issues of equity for those who have been marginalized by society" (Ratts, 2009, p. 160). Ratts further argues that a social justice approach toward counseling helps counselors to make a connection between negative environmental factors or social injustices and issues with client growth and shapes the professional identity of the counselor.

Counselors for Social Justice (2011) a division of the ACA, provided the following definition of social justice in counseling:

> Social justice counseling represents a multifaceted approach to counseling in which practitioners strive to simultaneously promote human development and the common good through addressing challenges related to both individual and distributive justice. Social justice counseling includes empowerment of the individual as well as active confrontation of injustice and inequality in society as they impact clientele as well as those in their systemic contexts. In doing so, social justice counselors direct attention to the promotion of four critical principles that guide their work; equity, access, participation, and harmony. This work is done with a focus on the cultural, contextual, and individual needs of those served. (para. 3)

Ratts (2011) described the connection between multiculturalism and social justice in counseling as “seamless” (p. 24) and stated that both perspectives “acknowledge the importance of diversity and recognize that oppression has a debilitating effect on mental health” (p. 24). D’Andrea and Heckman (2008) advised on using the description of multicultural social justice work in recognition of how both of these movements are interrelated.

Roysircar (2008) noted that counselors are expected to demonstrate multicultural competence through recognizing and intervening in situations where social inequalities are promoted and to address these in the context of psychotherapy and at the organizational level. Ironically, Roysircar also admits that the influence of academic training, involvement in professional associations, and training on traditional psychotherapeutic theories can influence counselors to be biased in favor of middle class values. Sheely-Moore and Kooyman (2011) emphasized the promotion of multicultural social justice competencies through increasing counselors’ self-awareness using reflection and immersion activities, and by training on advocacy strategies through the use of broaching, role plays, interviews and social action plans. An example of a fairly new technique that supports social justice efforts is called *broaching* (Day-Vines et al., 2007) and involves counselors raising the subjects of race, ethnicity, and other aspects of culture in therapy and directly communicating to the client how one of these may be directly related to his or her presenting problem.

Along with the call to promote social justice action and advocacy, there is also a call for mental health professionals to take on leadership roles that go well beyond the scope of providing traditional therapeutic services in clinical settings. This section clearly focused on the need for mental health practitioners to take on leadership roles by learning about and concerning themselves with identifying and intervening with the social forces that negatively affect the lives

of clients of color that they serve. However, additional knowledge is necessary for counseling professionals to begin to comprehend and act according to the many considerations that influence the utilization of mental health services by different cultural groups. Professionals must acknowledge that several factors influence clients' mental health treatment choices including help seeking behaviors, conceptualizations of mental illness, preferred modes of healing, preventive/risk factors for certain types of mental illness, access to services, and attitudes toward systems of delivery and clinical practitioners themselves (Roysircar, 2009).

Cultural Differences in Conceptualizations of Mental Health

"Normal and abnormal behaviors are defined and differentiated by the society and culture, with the culture defining deviance—what is 'abnormal' versus what merely contravenes the norms of society" (Bhugra, Popelyuk, & McMullen, 2010, p. 242). Along the same lines, mental health can be understood as being defined and experienced differently based on cultural heritage and how identity is understood. How people regard the concept of "the self" becomes very important in understanding how mental health is perceived:

> The self in most collectivistic cultures is maintained and defined through active negotiation of facework or the ways we present ourselves to others and respond to others' presentations of themselves. By contrast, in Western societies the self is grounded intrapsychically in self-love, self-definition, and self-direction. In the solidarity of a collectivistic setting, the self is not free. It is bound by mutual role obligations and duties as it is structured and nurtured in an ongoing process of give-and-take in facework negotiations. In the West, there must be high consistency between public face and private self-image. In Asian cultures, the self is not an individual but a relational construct. (Pedersen, Crethar, & Carlson, 2008, p. 24)

Pedersen et al. (2008) drew attention to the numerous groups in the world that espouse philosophies that conflict with the values associated with Western Psychology. "Humanistic conceptions of self-realization are far more individualistic than Buddhists or Hindus could accept" (Pedersen et al., 2008, p. 31). McCarthy (2005) contrasted individualism with collectivism by stating that "emotional independence from in-groups, then has been one defining

characteristic" (p. 109). McCarthy (2005) provided a definition of collectivism that "involves subordinating one's goals to the goals of the larger organization or in-group" (p. 109). It is important to understand that individualism and collectivism exist on a continuum and influence the meaning that people attribute to relationships. These orientations can dictate behaviors in the context of relationships and inform ethics about how life decisions are made. Fundamental to the foundations of treatment in mental health in the United States, especially counseling and psychotherapy, is the development of a trusting relationship between the clinician and individual.

"Experiences of prejudice and discrimination are a social reality for many marginalized groups and affect their worldview of the helping professional who attempts to work in the multicultural arena" (Sue & Sue, 2008, p. 84). To complicate clients' reluctance to utilize mental health services, Tsang, Bogo, and George (2003) acknowledged that most researchers and practitioners in counseling "still consider ethnicity to be a client characteristic, instead of it being a dimension of identity and an experience shared by all" (p. 64). Quintero, Lilliott, and Willging (2007) argued that mental health professionals often have inaccurate views of ethnic cultures due to their misunderstanding of the interplay between actual cultural characteristics and everyday life. Kirmayer (2012) noted that the majority culture regulates the health care system as well as what problems and social or cultural differences are considered important. Behavioral health care practitioners are also lacking theoretical models that are sophisticated enough to help them successfully modify care to meet the cultural and health needs of their patients (Park, Chesla, Rehm, & Chun, 2011).

Throughout the research literature, it is clearly noted that the current training of mental health professionals and adherence to Western values are reflective of culture bound values. Western understanding of mental health and mental illness are based on foundations of

empiricism related to statistical occurrences of certain behaviors based on frequency of appearance in the population, humanistic beliefs that normality is equated with ideal mental health, and the identification of certain factors based on assessment or other identifiers agreed upon by researchers (Sue & Sue, 2008). Sue and Sue (2008) provided a summary of the culture bound values that underlie foundations of counseling practice in the United States; the individual as the unit of treatment, importance placed on high degrees of verbal/emotional/ behavioral expressiveness, insight-oriented treatment, expectation of self-disclosure, reliance on scientific empiricism, distinctions between mental and physical functioning, allowance of ambiguity in the counseling relationship, and the expectation of certain patterns of communication.

The Western and Eastern medical paradigms have been characterized by some as biomedical versus holism. The Western model is based on a biomedical paradigm that centrally acknowledges concepts like evidence and standardized treatments, whereas the Eastern model of healing takes into account factors outside of the body in healing such as spirituality, the environment, the mind, and individualized treatment (Hughner & Kleine, 2008).

Sue and Sue (2008) emphasized how mental health professionals, according to their standards and circumstances, have the ability to dictate the definitions associated with mental illness and mental health. However, in pursuit of the remediation of service utilization problems with racially and ethnically diverse populations, it is equally important to note the various definitions of mental health, treatment preferences, and other considerations. Due to the majority of mental health disparities research being conducted on the major racial/ethnic groups in the United States today, these groups are the main focus in the next few subsections.

Definitions of mental health. “Attributional beliefs about physical and mental illness are largely culturally determined, with illness viewed through Western biopsychosocial beliefs, or

through religious, spiritual, interpersonal, and/or supernatural beliefs." (Pumariega et al., 2005, p. 541-542). For example, in a study by Vera and Conner (2007), Latina mothers defined mental health in terms of "stability and happiness" (p. 235) and emphasized the "interpersonal nature of mental health," (p. 235) the relationship between their own mental health and the mental health of their children, and the influence of family and community resources. With regard to how Aboriginal and indigenous people around the world view concepts such as depression and substance abuse, Baskin (2007) stated that these "tend to be viewed as a state experienced by a person rather than a as a characteristic of the identity of that person" (p. 1).

"Healing and even the term 'medicine' from a Native American perspective are suggestive of a view of life that differs radically from the western medical model" (Rybak & Decker-Fitts, 2009, p. 334). Rybak and Decker-Fitts (2009) described how modern Native Americans conceptualize holistic health as being connected to spirituality and living in harmony with nature. Lokken and Twohey (2004) summarized the Native American view of how personal problems are conceptualized as being "seen from the perspective of the interrelatedness of the community" (p. 321). This is in stark contrast with the western medical model which uses a system of diagnosis and treatment of an individual's symptoms in order to eliminate disease.

In exploring definitions of mental health for African American cultures, Speight, Blackmon, Odugu and Steele (2009) emphasized the importance of recognizing the role of coping with racism and the historical context of the African American experience. Speight et al. (2009) asserted that African American models of behavioral health "must examine the oppressive social context of psychological development" (p. 364). The authors summarized the various theories of African American mental health and placed them into three categories in the context of the effects of racism on coping, Africentric models that purport that African heritage

is essential to mental health, and models that combine both (Speight et al., 2009). “The African worldview emphasizes the general guiding principles of survival of the tribe and being one with nature. The values and customs consistent with the African Worldview reflect a sense of cooperation, interdependence, and collective responsibility” (Speight et al., 2009, p. 366). Speight et al. (2009) accented how Western views of mental health of African Americans have neglected to incorporate psychological distress that has resulted from the stressful impact of racism and other oppressive experiences. Roysircar (2009) shared a similar view that “psychology is more symptom-focused than etiologically focused, which can discount the impact of context and social inequities on a client’s life” (p. 289).

Treatment preferences/ expectations. Culture has a major influence on human development processes as it impacts behaviors and skills of adaptation (Pumariega et al., 2005). Keeping this in mind, it is important to note that developmental practices vary with cultures, affect the foundations for understanding what is considered to be healthy psychological development, and are value laden and context driven. According to many researchers, the United States mental health system is not on par with what culturally diverse consumers want in services. Constantine, Myers, Kindaichi, and Moore (2004) commented that the preferred cultural components of the treatment experience for people of non-Western heritage are generally missing from the overall therapeutic experience, and this leads to a distrust of traditional mental health treatment. It has also been noted that “culture has a major influence on how we experience, understand, express, and address emotional, behavioral, and mental distress.” (Pumariega et al., 2005, p. 542).

Vera and Conner (2007) spoke to the need to understand the beliefs of mental health consumers to best serve them. One minority group in the United States who seeks out behavioral

health services at the lowest rate across the demographic are Asian Americans. (Sue, Cheng, Saad & Sue, 2012; U.S. Department of Health and Human Services, 2001). Ting and Hwang (2009) and the U.S. Department of Health and Human Services, (2001) cited that cultural factors such as stigma and shame influence Asian Americans' treatment choices. When seeking treatment for suicidal ideation, Asian Americans are more likely to seek out non mental health professionals (Chu, Hsieh, & Tokars, 2011).

Pedersen et al. (2008) wrote about Chinese children and the system for disciplining them which differs from the United States: "The Chinese child is taught to handle hostility without expressing anger. . .The handling of the child changes abruptly by about school age (6 years old), at which the teacher is expected to assume control over the child's discipline" (p. 33). Pedersen et al. explained the cultural values that underlie this practice such as respect for family and sharing is actually encouraged in Chinese culture above competition, and that children may internalize shame due to this. Teachers are also revered and respected, and sought out as mentors when children are experiencing personal problems.

Lokken and Twohey (2004) explained that there are therapeutic aspects of American Indian culture that include "mechanisms of social support, traditional healing rituals, or ceremonies" (p. 321). Talking circles, for example, serve as one therapeutic cultural practice and are infused in helping programs in the Native American community.

> Today, talking circles are used as a pantraditional healing intervention throughout the country in tribal inpatient and outpatient drug and alcohol centers, group homes, adolescent prevention and intervention programs, prayer circles, tribal and public schools, and college-based English as Second Language Programs. (Running Wolf & Rickard, 2003, p. 39)

These types of structured group activities help Native individuals explore themselves in environments that offer support and empathy (Running Wolf & Rickard, 2003). Rybak and

Decker-Fitts (2009) summarized the most common pan-Indian healing practices to include "powwow, music, smudging, storytelling, sweat lodge, pipe ceremony, and the use of herbs" (p. 336). Rybak and Decker-Fitts (2009) provided direction to counselors on how understand the importance of embracing traditional healing modalities to help American Indian clients to regain a sense of wholeness:

> Traditional Native American ceremonies can be an integral part of the process to help promote a greater sense of connection to deeper spiritual and emotional issues and contributing to the healing of significant wounds inflicted by traumatic and painful life experiences. (p. 339)

As is the case with African Americans, Rybak and Decker-Fitts (2009) also acknowledged the need to recognize the effects of discrimination on American Indians in the context of mental health.

In a study of Latino immigrants and their preferences for characteristics of parenting groups by Cardona et al. (2009), participants revealed that they wanted groups that were relevant to their cultural beliefs including acknowledging the importance of family cohesion, instilling values in children, using effective discipline, protecting children from drugs and alcohol, and being able to learn and help each other. One participant recalled her experience with parenting groups geared toward "gringos" and her dissatisfaction with the realization that the class was based on values that did not see people as interconnected.

Arredondo (2004) explained worldviews and values of importance to Chicanas that affect their behaviors and expectations in mental health settings. Concepts such as *familismo, personalismo,* and *respeto* are important to acknowledge with these consumers. Family, personalism, and demonstration of respect are culturally learned values that affect everyday behavior and exist on a continuum. Unlike United States mental health medical and counselor training that discourages clinician's self-disclosure, Chicanas, especially older ones, may

"inquire about the clinician's personal life" (Arredondo, 2004, p. 241) through a practice called *plática,* also known as small talk.

In addition to these interpersonal practices, Harris, Velasquez, White, and Renteria (2004) acknowledged the role of the of *curanderos* or folk healers in Chicano/a communities and the fact that these clients may choose not to admit certain beliefs and practices associated with these culturally relevant healers to medical mental health practitioners. Harris et al. stated that there are several healing concepts brought into psychotherapy by Chicanos. Curandero–based concepts appear to be known in the culture for the old and young to some degree, many clients consult with folk healers before engaging in Western mental health services because they may believe that they are experiencing spiritual problems. In addition, Chicanos incorporate indigenous treatments, culture-based theories about the development of illness, and healing rituals in their everyday lives. These clients may also incorporate talk of figures and concepts from Catholicism, and may actually be more open regarding their fundamental indigenous beliefs when speaking Spanish during services (Harris et al., 2004).

Other cultural models. Purnell posited that "cultural competence is the adaptation of care in a manner that is consistent with the culture of the client and is therefore a conscious process and nonlinear" (Purnell, 2002, p. 193). His model (Purnell Model for Cultural Competence) is based on the notion that healthcare workers will become more aware of cultural identity and beliefs within the healthcare environment and will still provide adequate treatment. In order to facilitate the process of service delivery, the healthcare professional is asked to address twelve domains, based on multiple theories, drawn from various academic fields that focus on primary and secondary characteristics of culture that affect people's health perspectives. The twelve interrelated domains include: overview/ heritage, communication, family roles and

organization, workforce issues, biocultural ecology, high risk behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health care practice, health care practitioner. The model encompasses all of these factors in the context of a global society, in the community, in the family, individual factors, as well as unknown factors about a person's culture, as well as varying levels of consciousness with regard to being culturally competent according to the model.

Although not a model, Gallegos, Tindall, and Gallegos (2008) argued that cultural competence is a "value-based perspective" (p. 52) rather than a theory. From this angle, cultural competence is an approach or social construct, consisting of the influence of multiple theories and values associated with respect for diversity and social justice.

Cultural Competence at the Organizational Level

General organizational cultural competence is associated with staff diversity, having a mission statement that addresses diversity, hiring and promotion practices that support diversity in the workforce, and the presence of a committee devoted to overseeing organizational policy and monitoring for fairness in diversity-related practices (Darnell & Kuperminc, 2008). Whealin and Ruzek (2008) referred to organizational cultural competency as "a dynamic, evolving, and ongoing endeavor" (p. 326).

Benton and Overtree (2012) made the argument that the physical space in which mental health services are provided be culturally appropriate and accessible to all, regardless of health needs. They emphasized the need to ensure clarity in advertising materials, paperwork, signage, and statements about the organization's commitment to fairness. Caldwell et al. (2008) emphasized the importance of cross-cultural communication training in all workers in counseling organizations, especially frontline service providers, who communicate with clients before they

come in contact with professionals. “If prospective clients from ethnically and racially underserved groups have a negative interaction and experience at the point of entry, that experience is likely to influence their decision regarding whether to continue seeking mental health services” (Caldwell et al., 2008, p. 89).

Additional care must be taken to address diverse needs in the healthcare industry. The Office of Minority Mental Health (2001) published *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which provided cultural competence guidelines that are specifically designed for human services. In summary, the standards advocated for care to be tailored to the needs of the consumers being served through respecting their cultural beliefs related to health and healing, and through providing consumers with mental health services that are linguistically appropriate. The standards also advocated for cultural competence and linguistic training for staff, collaboration with diverse communities, resolution of cultural related grievances, organizational strategic planning for providing culturally and linguistically appropriate services, organizational self-assessment related to cultural competence, and the collection and dissemination of data related to the diverse communities served by the organization as well as successes and innovations achieved. The standards were updated in 2013 based on advances in knowledge about cultural and linguistic competence (Bui & Dutta, 2014). The focus is on the elimination of health disparities, quality improvement, and the advancement of equity.

According to the National Center for Cultural Competence (n.d.), culturally competent organizations will keep in mind the following principles to guide organizational practices and the design of mental health services:

- Cultural competence is achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families.
- Culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and communities served.
- Practice is driven in service delivery systems by client preferred choices, not by culturally blind or culturally free interventions.
- Culturally competent organizations have a service delivery model that recognizes mental health as an integral and inseparable aspect of primary health care.

The aims of working toward cultural competence at the organizational level in health care organizations are broad and imbued with undertones of efficiency and social justice. LaVeist, Richardson, Richardson, Relosa, and Sawaya (2008) provided a concise rationale for these efforts:

> Conceptually, improving the cultural competency of a healthcare organization increases the likelihood that the staff can relate to the diverse patient population; lessens miscommunication between patients and providers; and heightens provider and staff sensitivity to the values, beliefs, and health-related practices of patients. All of these, in turn, lead to greater acceptance among patients of the organization's health education message, to improved accuracy of diagnoses and interventions, and to better patient adherence to prescribed treatment regimens. The ultimate results are higher patient satisfaction scores, more positive health outcomes, and the narrowing of health disparities. (p. 259)

The APA (2003) published Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists in response to societal changes and the changing needs of those served by psychologists. The purpose of the document was to provide guidance on the rationale, terminology, updated research and implementation of best practices to address the needs of United States racial/ethnic minorities and work with internationals in

education, training, research, practice, and organizational change. Six guidelines were provided, with Guideline 6 relating to Organizational Change and Policy Development. The APA (2003) noted that "psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices" (p. 392).

This guideline used information from contexts current in 2003 to educate readers about multiculturalism and its centrality to organizational structures and planning. The guideline also highlighted changes in policies and practices in Psychology. The following is a list of subtopics under Guideline 6:

a. The contemporary and future contexts that provide motivators for psychologists' proactive behavior with organizational processes;
b. Perspectives about psychologists in transition;
c. Frameworks and models to facilitate multicultural organizational development; and
d. Examples of processes and practices reflective of psychologists' leadership in the development of culture-centered organizations. (APA, 2003, p. 392)

In terms of context, the APA wrote about the influence of world events, demographic changes, advances in technology, the influence of other disciplines on the profession, and the push for psychologists to engage with other sectors of society to help with solving real world issues. Perspectives about psychologists in transition discussed recent policy and practice changes aimed at increasing service provision and recognition of underserved populations through changes in licensure laws, creation of guidelines for the treatment of specific underserved groups and the creation of divisions in APA focused on specific populations or cultural concerns. Psychologists were asked to anticipate trends in care and to be proactive in implementing needed organizational change. In addition, models for organizational multicultural development were provided to readers along with references for future reading, and examples of how the APA and the ACA have set examples for change through their professional

organizations that have been applied in real life employment settings and should be further applied to professional practice.

Finally, the APA encouraged psychologists under Guideline 6 to become agents of change and participate in changing policies to make them more inclusive to all. Psychologists were encouraged to become involved in legal and legislative issues involving ethnic/racial groups, to familiarize themselves with research on multicultural training, to engage in behavior in educational settings that is inclusive of people from diverse backgrounds, and to become acquainted with multicultural organizational enhancement strategies. Finally, psychologists were asked to read leadership literature. The document concluded with the acknowledgement that psychology has been historically based on "Western, Eurocentric, and biological perspectives and assumptions" (APA, 2003, p. 395) and has inherently been biased, sometimes harmful to the changing needs of clients and the public.

Sue (2001) proposed The Multiple Dimensions of Cultural Competence model as a conceptualization of cultural competence at the individual, professional, organizational, and societal levels, which is referred to as the foci of cultural competence. The framework includes three primary dimensions: "(a) specific racial/cultural group perspectives, (b) components of cultural competence, and (c) foci of cultural competence" (p. 791). The model appears visually like a cube as with a 3 x 4 x 5 design. "Each cell represents the confluence of these three major dimensions" (Sue, 2001, p.791). The components of cultural competence include beliefs/ attitudes, knowledge, and skills while the specific racial/cultural group perspectives speaks to African, Asian, Latino, Native and European American worldviews. Sue (2001) justified the development of the MDCC model in response to ongoing confusion about cultural competence, namely underestimation of the influence of race/culture/ethnicity on identity, the need for

psychologists to acknowledge levels other than the individual and assumed universal aspects of human experience, and as a reflection of social justice efforts following principles of a democracy, where ideally mental health care should be free of barriers and discrimination.

D'Andrea et al. (2001) wrote about the potential of the multicultural movement in counseling and psychology to "transcend their legacy of ethnocentrism, cultural oppression, and racism" (p. 224). D'Andrea et al. attempted to rally encouragement to take advantage of the opportunity to reinvent professional identity by moving beyond serving only individuals, by strengthening the role of professional organizations and divisions within dedicated to multicultural efforts, and contributing to research and the development of culturally inclusive psychological theories that drive mental health practice.

On the organizational level, Sue (2001) argued that all organizations, including mental health care and professional organizations should include the fair treatment of not only clients, but students and workers, and should look to models of multicultural organizational development (MOD) for guidance. Inclusive in Sue's recommendations is the push for psychologists to identify and actively intervene in organizational policies, practices, and subsystems that prevent multicultural development or access.

In Arredondo's (1996) *Successful Diversity Management Initiatives*, a wealth of information was provided about diversifying the organizational environment in response to inequalities in the United States workforce along with a diversity management model composed of eight assumptions about people, organizations, and society. Arredondo (1996) defined diversity management as "a strategic organizational approach to workforce diversity development, organizational culture change, and empowerment of the workforce" (p. 17). Arredondo (1996) emphasized the importance of placing people at the center of this change and

introduced basic principles of diversity management to educate those who will be involved in the planning process:

- Diversity management is the key to promoting dignity and respect in the workplace and a framework for positioning people as a necessary factor to organizational success.
- Diversity management is a strategic organizational goal.
- Diversity management requires a change in thinking.
- Diversity management requires a specific focus on personal and organizational culture, cultural differences, culture change, and cross-cultural relationships based on interdisciplinary knowledge.
- Diversity management requires broad-based, relationship-focused thinking.
- Diversity management focuses on critical business systems, policies, and practices.
- A diversity management approach promotes an examination of the relationship between systems, practices, and people.
- Diversity management requires and invites creativity, innovation, and risk taking.
- Risk taking is an asset in diversity management.
- Diversity management promotes approaching people as individuals rather than numbers of categories.

Arredondo (1996) led the reader through the stages of planning and implementing a diversity management initiative, while articulating the role of training and assessment. The following developmental stages of an organization during a diversity management process were explained: exploration, commitment, experimentation, redefinition, consolidation or integration, and regeneration. Attention was placed on issues of cognitive dissonance and resistance that occur in individuals and organizations going through this process of change (Arredondo, 1996).

Another important aspect of organizational multicultural competence is training, but issues abound in mental health organizations. Although cultural competence training is documented in the research literature as being effective (Delphin & Rowe, 2008), little research exists on the efficacy of specific training techniques (Dickson & Shumway, 2011). Rogers-Sirin (2008) called attention to the scarcity of research that addresses the multicultural training needs of practicing psychologists and the disproportionately small amount of literature aimed at helping professionals and mental health organizations to help them better serve multicultural populations using training. Park-Taylor et al. (2009) commented on the dearth of multicultural training models to be used with community mental health centers as well as barriers to training including managed care demands and missing supportive organizational structures.

Recommendations for cultural competence training in mental health agencies include planning for ongoing training, incorporating cultural competence strategic planning and research on clinical outcomes with diverse clients, training all levels of staff, using qualitative measures to encourage reflection, and including cross-cultural competency as part of staff evaluations (Delphin & Rowe, 2008; Whealin & Ruzek, 2008). Rogers-Sirin (2008) stated that "an organization must consider what populations they serve, how well they meet the needs of their clientele, what populations or individuals are not being served well, and what can be done to change that" (p. 313). The message is that organizations should have a clear motivation for engaging in and planning multicultural training.

Clinical Leadership

Callaly and Minas (2005) described leadership as a process that "involves intentionally influencing people" (p. 28) in contrast with management which focuses on stability and predictability in matters of the organization. Swanwick and McKimm (2011) clarified the complimentary and differing features of leadership and management and emphasized the need to

engage clinicians in both with the aim of improving health care in the midst of economic challenges. Swanwick and McKimm (2011) contrasted leadership and management with leadership: “being about setting direction, influencing others and managing change: with management concerned with the marshalling and organisation of resources and maintaining stability” (p. 23). They wrote adamantly about the professional responsibility and need for clinicians at every level of expertise to understand complex systems of care and to be willing to work to improve these systems on any scale possible for the benefit of patients.

The topic of clinical leadership in mental health settings has received increasingly more attention over the past few years due to national and international attention on the need to diversify and strengthen the skills of mental health administrators in hopes that the quality of mental health care will improve for clients of color. Rosenberg (2008) commented on this phenomenon:

> Not only are the mental health and addictions fields lacking in cultural competency, but there’s little diversity in our leadership ranks. Top administrators and executives in behavioral health today are overwhelmingly non-Hispanic whites. And as the population grows and becomes more diverse, this lack of cultural diversity among our leaders will lead to an ever-widening gap in the current chasm of racial and ethnic disparities in healthcare. (p. 126)

Lecca, Quervalu, Nunna, and Gonzales (1998) spoke to the need for multicultural leaders in human services due to the presence of ethnic minorities in the workplace who are either employees or patients. The understanding and acceptance of cultural differences and effective communication strategies are essential for multicultural leaders. Leaders in human services are also advised that they should be responsible for altering “their own qualities not only to better manage individuals of different ethnic and cultural backgrounds, but also to facilitate the same type of change in their organization and employees” (Lecca et al., 1998, p. 207).

The Annapolis Coalition established the aim to help remediate the problems in leadership in all segments of the mental health workforce through its publication titled *An action plan for behavioral health workforce development: A framework for discussion* (Hoge et. al, 2007). The non-profit organization dedicated to promoting quality mental health services in the United States, is actively committed to fostering leadership development in the mental health workforce in order to shape organizational environments in hopes that they will begin to better meet the needs of the clients they serve. Hoge et al. (2007) encouraged professionals to broaden the definition of leadership "to encompass not only organizational and change management, but also coalition and community building, team and program management, and the provision of supervision" (Hoge et al., 2007, p. 19). This issue of leadership and management, according to the Annapolis Coalition, is a serious area of focus and concern. Numerous improvements to the recruitment, development, and management of the mental health workforce need to be pursued. These include but are not limited to remediating the performance issues associated with lack of proper preparation for real world work in graduate programs, improvements in policy and licensure/ certification, the development of specialists in mental health fields with critical shortages such as gerontology, work with rural populations, substance abuse, and children's mental health. The organization's recommendation was that skill sets for leaders be developed as well as quality training to enforce these skill sets. Further, the action plan acknowledges the ongoing challenges to these leadership efforts which include systemic factors, high rates of turnover, and a lack of culturally and linguistically diverse workers amongst other challenges (Stuart, Hoge, Morris, Adams, & Daniels, 2009).

Curtis and Sherlock (2006) illustrated the leadership dilemma that exists with most counselors who become managerial leaders in agencies and schools. They summarized that

although counselors may have effective leadership with clients, they seldom have the training to handle real life leadership tasks that occur in the work environment, may not be as enthusiastic about leadership as much as providing therapy, but are still held responsible for ensuring successful program and service delivery. Similarly, Callaly and Minas (2005) also agreed with the notion that management and leadership skills are missing from mental health clinical training for psychiatrists. They acknowledged that the flexibility needed for leadership effectiveness is often not cultivated in clinician-managers nor understood by them due to intensive medical training that emphasizes right versus wrong ways of practicing.

Reif, Horgan, Torres, and Johnson (2011) conducted a qualitative study using face to face interviews of front-line substance abuse program directors in Massachusetts to ask about their perspectives on areas of concern in management and to ask about potential areas of future training. This study was conducted in the context of the use of evidenced-based practices with clients, and the identified potential to yet improve treatment outcomes. Findings indicated that the participants expressed difficulty accessing management training beyond when they initially assumed their positions, yet all had the desire to create optimal environments for both employees and clients. Reif et al. (2011) asserted that their findings were necessary in identifying the needs of these managers in order to better inform administrators and policy-makers about how to better support the managers in improving care for the clients they serve.

Regarding cultural competence skills in clinical leaders, Abernethy (2005) offered the following dimensions to be offered in cultural competency training for clinical managers:

> (a) specific opportunities to enhance managers' cultured competency skills (skills); (b) discussion of key processes, ways of thinking rather than content, that may be imparted to staff (processes); and (c) strategies that increase a health care system's ability to support culturally competent care (system). (p. 83-84)

Limited research literature focuses on the need for clinical managers or leaders in mental health settings to look beyond training needs for clinical practitioners. A study by Caldwell et al. (2008) looked at the training experiences and understandings of cultural competence for human service providers of front line service providers working in mental health settings. Findings showed that the majority of participants were Caucasian and reported a moderate level of training in working with diverse people and moderate exposure to working with diverse people. Through a thematic analysis of understandings of cultural competence, the following themes were discovered: color blindness, client focused, acknowledgement of cultural differences, textbook consistent, resource-driven, skills-based, and self-integration. The study emphasized that it is important for leaders to pay more attention to the interpretations of front line service providers in human service settings since they set the tone and serve as the gatekeepers for access to mental health services. Further, the research called attention to the need for assessment to determine relationships between training and multicultural competence development in all staff.

Summary

There is currently a paucity of research studies and literature that focus on mental health leadership and even fewer that focus on the multicultural aspects of mental health leadership. Related literature was used in an attempt to explain current findings and movements in mental health that directly relate to the background and aims of this study.

Each of the sections of the literature review shed light on important aspects of the overarching issue of mental health disparities in the United States. Even with such emphasis on multiculturalism and social justice, counseling practitioners are unprepared to advocate in organizations and in the public on behalf of their clients of color who are disadvantaged because

of cultural reasons. Research has also produced vast knowledge about the varying mental health beliefs of people of color in the United States, yet there are still serious problems with access and service delivery to these populations. Furthermore, the recommendations for mental health organizations to continually work on cultural competence are noble, yet not always followed due to lack of interest, funding or necessary training and assessment resources. In clinical leadership, serious problems are present including lack of leadership training, overemphasis on management versus leadership, and lack of diversity in leadership ranks.

Considering the information highlighted in the literature review, it is clear that new data are needed to help add to the understanding of the mental health disparities conundrum. Moreover, there is a significant lack of literature on mental health leadership, so little is known about the learning and lived experiences of leaders' multicultural practices in mental health settings. Clinical managers supervise clinical staff and have the ability to influence the work environment, staffing patterns, processes, and training by the nature of their jobs. This is especially true in outpatient settings where more flexibility is allowed due to the non-emergency nature of services. Bearing in mind that little research has been conducted on clinical managers, this qualitative study focused on clinical managers and their multicultural leadership practices in outpatient mental health settings. Information from the literature review was used to shape the design of the study and the interview protocol. Participants were asked questions about their multicultural learning experiences, understandings of multiculturalism, their role as a supervisor, orientation toward cultural difference, and questions about self-assessment of and influences on their multicultural leadership practices.

Chapter 3: Methodology

Introduction

The purpose of this study was to explore clinical managers' perceptions of their multicultural leadership practices in daily interactions in outpatient mental health settings. The primary question that was used to guide this study was: How do clinical managers describe their multicultural leadership practices in daily interactions in outpatient mental health settings? Through this qualitative inquiry, the aim was to describe clinical managers' understandings of multiculturalism and how their leadership behaviors reflect their understanding of this concept. Ponterotto (2005) promoted the use of qualitative methods in counseling psychology in order to help the profession to advance as a scientific field. Likewise, Pope-Davis, Liu, Toporek, and Brittan-Powell (2001) encouraged the use of qualitative methods in multicultural counseling research as it allows for a more thorough study of political factors, personal agendas, meaning, and context.

As the data collection focused on daily interactions in the mental health outpatient setting, there was an attempt to capture a snapshot in time of the perspective of the participants who are in the unique position to interpret organizational directives and policies and to direct psychotherapists and other employees through their leadership practices. Merriam (2002) stated that in order to "understand a phenomenon, uncover the meaning a situation has for those involved, or delineate process (how things happen), then a qualitative design would be the most appropriate" (p. 11). In this study, the participants were asked to explain their understandings of multicultural leadership in mental health settings. This study allowed another perspective in multicultural mental health service delivery to be voiced and represented in research that has

previously been neglected. Morrow, Rakhsha, and Castaneda (2001) acknowledged the utility of qualitative methods when researching certain issues in multicultural counseling:

> Qualitative methods are particularly suited to the study of individual meanings in social context and to research on phenomena and experiences that previously have not been investigated, about which there is little research, or where there are contradictory findings in the literature. (p. 577)

The profession has now acknowledged the importance of understanding leadership practice as one of the possible keys to solving problems associated with mental health disparities. While this is acknowledged through commentary in the literature, research associated with leadership in mental health is still scant, and research that combines multiculturalism and leadership is scarcely found.

Research Design

Because the interest of the study was to explore the perceptions of the participants as they relate to clinical managers' multicultural leadership practices in everyday staff interactions in outpatient mental health settings, a basic interpretive qualitative research design (Merriam, 2002) was implemented and allowed for the participants to freely construct the meaning of their multicultural leadership experiences.

Intercultural learning is abstract in nature and involves the use of dialogue and the interpretation of belief systems. Mezirow (2003) stated that in order "to understand communicative learning, qualitative methods are often more appropriate" (p. 59). Marshall and Rossman (2006) support the use of qualitative methods when studying an individual's lived experience and provided the rationale that "human actions cannot be understood unless the meaning that humans assign to them is understood" (p. 53).

Merriam (2002) provided a summary of the characteristics of qualitative research, including the basic interpretive approach. These characteristics include researcher interest in

participants' meaning-making strategies, how researchers serve as instruments and mediate meanings, and the fact that inductive strategies as well as descriptive outcomes are part of the research process. In order to distinguish between other qualitative designs and the basic interpretive design, Merriam provided three criteria:

- How people interpret their experiences
- How they construct their worlds
- What meaning they attribute to their experiences. (p. 38)

Merriam (2002) cited that the aim of the basic interpretive approach "is to understand how people make sense of their lives and experiences" (p. 38). Data collection included primarily the use of in-depth interviews, along with open ended demographic questionnaires, and the use of the researcher's journal to note observations. According to Merriam (2002), qualitative studies typically draw from three data sources which are "interviews, observations, and documents" (p. 13).

"*Interviews* yield direct quotations from people about their experiences, opinions, feelings, and knowledge" (Patton, 2002, p. 4). As such, the interview was used as the primary method of data collection in this study since the researcher was interested in acquiring data related to the clinical managers' personal experiences in positions of leadership in mental health. "To achieve richness and depth of understanding, those engaged in qualitative interviews listen for and then explore key words, ideas, and themes using follow-up questions to encourage the interviewee to expand on what he or she has said that the researcher feels is important to the research" (Rubin & Rubin, 2005, p. 13). Rubin and Rubin (2005) also emphasized the need for researchers to pay careful attention to the interaction during the interview between the qualitative

researcher and interviewee, and to focus not only on “learning about a topic, but also learning what is important to those being studied” (p. 15).

Seeing as how the aim of the study was to identify the participants’ understanding of their multicultural learning experiences and connection to leadership behaviors in the mental health organizational setting, a basic interpretive methodological design seemed appropriate for this study.

The methodology for this proposed study was shaped by a previous pilot study conducted by Melonson (2011) on mental health professionals and their multicultural leadership practices using a similar basic interpretive design. The findings of the pilot study contributed to this study by providing data to help refine the targeted population and the interview protocol. In the pilot, participants ranged from team leaders to executive leaders in mental health settings. For this study, it was determined that clinical managers would be appropriate participants since these individuals directly supervise employees who provide mental health services directly to consumers and also participate in organizational planning activities. The nature of the work of clinical managers is diverse and thus the participants were expected to provide rich information through the interviews.

Secondly, additions were made to the interview protocol based on the themes that emerged during the pilot study. Additions to the refined interview protocol include questions about personal strengths and weaknesses in self-assessment of multicultural leadership, descriptions of daily situations at work where culture comes into play, how the organization affects the understanding of multicultural leadership practice, and how staff members affect the individual’s views of multiculturalism.

Setting

The setting for the study was the southwestern United States where there is a large population of Hispanic/ Latino Americans. The participants represented in this study were considered clinical practitioners as well as leaders in the field of mental health and will be referred to mainly as clinical managers. In this dual role they are required to meet organizational demands related to culturally competent practice, handle various administrative concerns, and to manage subordinates and trainees who provide professional counseling and other mental health services in outpatient settings. For this particular study, the fact that the clinical practitioners were employed in positions of leadership allowed for valuable opportunities to inquire about their cultural learning experiences and how they have been able to develop their multicultural leadership philosophies and current practices.

Participants

A total of 10 participants agreed to participate in this study. Participants were required to be employed in positions of leadership in outpatient mental health organizations during the time the research was conducted. Criterion and snowball sampling were used to recruit and select participants from various outpatient mental health organizations including public, for-profit, community-based and non-profit agencies. Patton (2002) explained that the reasoning behind criterion sampling "is to review and study all cases that meet some predetermined criterion of importance" (p. 238). For this study, it was important to identify participants with the necessary professional training and supervisory experience in order to obtain the data needed for the study which is directly related to first hand, specialized experience. All participants selected for interviewing met the following specifications:

1. Employed full time in a mental health-related position;

2. Employed in a position of leadership in an outpatient or non-residential mental health setting where he or she supervised at least one staff member who provided psychotherapy/ counseling;

3. The participant must have had a master's degree in one of the following disciplines: clinical psychology, counseling psychology, counseling, marriage and family therapy, clinical social work, or school psychology;

4. The participant must have held a current license to practice psychotherapy in his/ her state of residence; and,

5. The participant must have held employment in his or her position as a clinical manager for at least 6 months at the time of the study.

Further, since the population was small and difficult to identify, snowball sampling was utilized by encouraging past pilot study participants, professional mental health colleagues, and participants to recommend others who met the stated criteria (Creswell, 2005). An introductory letter (Appendix C) was also forwarded to these parties, and outpatient mental health agencies were contacted directly to obtain possible participants.

Data Collection Procedures

In the initial proposal of this research, institutional review board (IRB) approval was granted to collect data through demographic questionnaires, face to face interviews, and the collection of documents that included the participants' job descriptions and organizational charts. However, after careful consideration regarding the use of the information from these documents, the researcher determined that incorporating too much data from these sources might put the confidentiality of the participants at risk. Therefore, only the demographic questionnaires and interviews were used directly with participants as primary data collection measures.

Demographic questionnaire. Before the interview and after receiving information about informed consent, each participant was asked to complete a demographic questionnaire (Appendix A). Each questionnaire asked about mental health leadership experience, job descriptions, multicultural training experiences, multicultural researcher experiences, and educational background as well as current mental health licensure.

Interviews. Potential participants were identified and screened using the approved eligibility criteria. Upon demonstrating that they met the criteria stated above, 10 eligible participants were scheduled for 1 hour, in-depth, face to face interviews. Interviews took place at the workplace of the participants or in another location of their choice and were digitally audio-recorded. Prior to starting the actual research interviews, participants received explanations of the purposes of the research, were informed of their rights, were asked to sign consent forms, and were administered a brief demographic questionnaire. The researcher continued with the set of guiding interview questions and adjusted the inquiry as needed in order to better understand the ideas expressed by the participants and to draw more detail out of their descriptions. “The purpose of guided interviews is to elicit the participant’s worldview. The researcher develops categories or topics to explore but remains open to pursuing topics that the participant brings up” (Rossman & Rallis, 2003, p. 181). The interview guide was used flexibly, according to the flow of the interview based on the participant’s thoughts and information provided. All interviews were transcribed verbatim without the use of participants’ names by the researcher.

Interview protocol. The guiding question for this study was “How do clinical managers describe their multicultural leadership practices in daily interactions in outpatient mental health settings?” To explore participants’ perceptions related to this fundamental question, the

following main questions and potential sub-questions were used to guide the individual interviews:

1. Can you tell me about your current position of leadership in the field of mental health? (job description)
2. How do you see your role as a supervisor? (point of entry)
3. What do you do when you work with people who are different from you? (orientation toward cultural difference)
4. How do you define culture?
5. What were some formative or noteworthy multicultural learning experiences for you? (learning experiences)
    a. What were some significant moments in your life when you realized or learned something about culture?
    b. Can you describe any formal multicultural learning experiences?
    c. Have you ever taught any multicultural training or classes? If so, please describe these.
6. What have you learned about yourself from your multicultural learning experiences? (self-assessment in multicultural leadership)
    a. Would you describe any weaknesses or biases that you believe affect your ability to lead mental health staff in the context of diversity?
    b. What do you perceive are your strengths?
7. Can you describe your definition or understanding of multiculturalism?
    a. What is your approach to dealing with diversity today?

   b. How can you connect what you've learned about diversity to the world of mental health?
   c. How has your perspective on diversity affected your role as a leader in your current job?
   d. Would you describe any situations in your daily work where cultural diversity seems to really come into play?
   e. How would you describe your current multicultural leadership practice in mental health?
8. Has anyone influenced your views on multiculturalism? If so, how?
   a. Would you describe how your organization affects your multicultural leadership practice?
   b. How have your staff or other you work with affected your views on multiculturalism?

Researcher's journal. Observations, interpretations of the participants' emotional reactions to questions, and non-verbal behaviors were recorded in the researcher's journal during and after each interview. Rossman and Rallis (2003) provide reasons why qualitative researchers should observe research participants:

- to understand the context;
- to see tacit patterns;
- to see patterns people are unwilling to talk about;
- to provide personal experience and knowledge; and
- to move beyond the selective perceptions of both researcher and participants. (p.194)

Field notes are considered important in qualitative research and capture the researcher's process of analysis (Brodsky, 2008). Rossman and Rallis (2003) encourage researchers to write field notes in order to "systematically record your impressions, insights, and emerging hypotheses" (p. 195). They divide these into the *running record*, which consists of detailed descriptions of observations, on data, and on the research project, and *observer comments*, which include the researcher's "emotional reactions to events, analytic insights, questions about meaning, and thoughts for modifying your design"(Rossman & Rallis, 2003, p. 196). Together these types of field notes were contained within the researcher's journal, which was ultimately used to expose potential biases and to provide thick descriptions, which were necessary for interpreting data.

Protection of Human Subjects

"Ethical practice is a moral stance that involves conducting research to achieve not just high professional standards of technical procedures, but also respect for the people actually consenting to be studied" (Payne & Payne, 2004, p. 66). Prior to interviewing, participants received explanations about the type of study being conducted, the purpose of the study, and why they were asked to engage in the interview process. Informed consent document (Appendix D), follow up procedures, how confidentiality would be maintained, use of findings, and requested written consent were reviewed with all participants. Participants were then asked to complete a written demographic questionnaire (Appendix B). Being mindful of the need to build rapport and demonstrate respect for participants, the researcher attempted to create an atmosphere where the participant was fully aware of his or her rights, and felt comfortable asking questions during or after the interview. Participants were also advised that they would not be asked to violate any laws associated with the Health Insurance Portability and Accountability Act.

All foreseeable risks or discomforts were explained to the participants, including the possibility of discomfort due to the content of the interview protocol, as well as what would be done to minimize any risks. For the participants in this study, there was a mild risk of emotional sensitivity to questions about culture, especially if these questions provoke memories of discrimination or difficult past experiences. Participants were offered momentary breaks and the opportunity to stop the interview in order to lessen any discomfort due to significant emotional distress.

Data Analysis Procedures

Participants' demographic information, job descriptions, and type of organization were summarized and appear in the findings. After transcribing the interviews verbatim, pseudonyms were put in place of participants' names and the names of their organizations. The next step was immersion in the data by reviewing the transcriptions multiple times, recording thoughts, and consulting research journal as needed along with the appropriate literature.

Merriam (2002) explained that the data analysis process "is *simultaneous* with data collection" (p. 14), actually starts with data collection, and informs the researcher regarding how data collection should be modified as research continues. With this flexibility in mind, the researcher adjusted her views and data collection as appropriate through the duration of the study. Merriam (2002) also stated:

> Data analysis is essentially an inductive strategy. One begins with a unit of data (any meaningful word, phrase, narrative, etc.) and compares it to another unit of data, and so on, all the while looking for common patterns across the data. These patterns are given names (codes) and are refined and adjusted as the analysis proceeds. (p. 14)

"Many qualitative researchers have adopted the constant comparative method, originally used for developing grounded theory, whether or not they are seeking to build substantive theory" (Merriam, 2002, p. 14). The constant comparative method combines inductive and

deductive methods (Payne & Payne, 2004). To summarize, inductive methods are used toward the beginning of the analysis to identify patterns and explore meaning in data, while later, deductive methods are used to test the initial patterns or relationships acknowledged by the researcher. Payne and Payne (2004) elaborated on three steps in the analysis process:

1. Open coding: beginning phase where researchers examine written data line by line, sentence, or paragraph to grasp overall significance. Researcher will make notes and highlight items that are considered important;
2. Axial coding: researcher compares and groups data, reorganizing when necessary, to identify concepts or patterns. Deduction is used to re-test through validating or negating evolving ideas; and
3. Selective coding: final stage where central or core categories are refined, relationships to sub-categories are clearly stated, and gaps and variability are identified. Each core category should be theoretically dense and fully refined. (pp. 100-102)

This process was continued until categories and themes emerged from the data yielded by the participants. “The procedure is completed when *theoretical saturation* is achieved. New data no longer add to conceptual density” (Payne & Payne, 2004, p. 102).

The focus of this study was on the perceptions of mental health clinical managers, their understanding of diversity, and their interpretations of how they demonstrate multicultural leadership practices in the context of everyday work experiences in outpatient mental health settings. The researcher was interested in generating themes related to the participants’ perceptions that were supported by the data and triangulation methods. After the point of saturation was achieved, the researcher then explained the findings using quotations from the

participants and a thorough explanation of the context. Table 1 illustrates the main themes that emerged in the analysis along with examples of participants' quotations.

Table 1

Main Study Themes and Participant Quotes

Themes	Participant Quotes
1. Culture is a Complex Concept	John stated: "The definition that works for me best is culture is everything about a person that makes them who they are. So it's more than skin color, it's more than language… it's everything."
2. Multicultural Learning Outside of Formal Educational Settings	Marcus noted substantial learning about culture in his previous work in the military. He explained to the researcher that he was from a small town in a southern state where he had only encountered Black and White people. When I joined the military I was exposed to people from different parts of the U.S., even people from different countries that were American citizens. The job that I had in the military—and I guess when we talk about culture we have to include education as well, but that brings a whole new culture, also."
3. Leadership Issues	Valeria described her role as helping everyone to reach their professional potential in her agency, but also emphasized the importance of communicating, whether verbally or in writing, according to the needs of her staff: …and how I communicate with someone, even emails, how we address emails to someone may come across defensively and the other one is just tell me up front, don't skirt around the issue. So its learning that even within our own agency and even with my mental health providers that, diversity is among us and I need to be able to flip from one to the next. So it definitely helped me grow.
4. Recognition of Organizational Culture and Its Impact	Steve's experience with organizational culture clashes occurs frequently in the emergency room setting where he provides consultative services. He noted that there are distinctive differences between him and the medical staff he works alongside. "There's a certain culture with doctors. I've worked in ERs for 25 years…there's a big power differential and it's very difficult sometimes."

Attention was given to explaining how the data were interpreted along with the acknowledgement of sub themes. Anomalies in participants' experiences and interpretations of experience were also acknowledged in the reporting of the research. Moreover, in the final chapter of the study, the primary and secondary research questions were answered using data from the themes. The guiding theoretical framework, explanatory theories and concepts, and research literature were used to explain the findings, and original contributions of the research were explained. At the end of the study, implications for future research and professional practice were also noted.

Role of the Researcher

"The personal biography of the researcher and the roles she takes influence the research—both the sense she makes of the setting and how people she studies make sense of her" (Rossman & Rallis, 2003, p. 49). As the researcher in this study, my role was to provide clear information to the participants about the study design and the potential use of the findings. In addition, I used my professional stance as an LPC to uphold the ethics promoted by my profession, and worked to ensure that the participants felt comfortable during the interviews. I did my best to take a non-judgmental stance as they discussed the concept of multicultural leadership and was careful to safeguard them from emotional distress from the topic of conversation by allowing them breaks or the permission to not discuss certain ideas that came up during the interviews.

Schram (2006) warned qualitative researchers to remain neutral in their stance as they pursue research and not to interpret findings in a way that merely pushes forward a personal agenda. He further recommended that researchers become aware of their own beliefs and behaviors as a researcher and that they seek to uncover potential biases. Similarly, Rubin and Rubin (2005) suggested that followers of the interpretive approach in qualitative research recognize the role of any cultural assumptions that may influence the questions they ask in interviews and their interpretations of what is heard during interviews.

> Interpretive researchers do not need to drop their cultural assumptions and assume those of the conversations partners, but researchers do need to be cautious lest they fail to hear the meaning of what the interviewees have said because their cultural assumptions get in the way. (Rubin & Rubin, 2005, p. 29)

In the role of the researcher, I was responsible for monitoring my own research tendencies, beliefs, and continually questioning and reflecting on my work. I was also open to obtaining guidance from other research professionals.

Trustworthiness and Credibility

> Data gathering is a deliberate, conscious, systematic process that entails both the products—the data—and the processes of the research activities so that others may understand how the study was performed and can judge its adequacy, strength, and ethics. (Marshall & Rossman, 2003, p. 179)

In qualitative research, researchers serve as instruments in the collection and analysis of the data (Schram, 2006). Qualitative researchers bring along perceptions, emotions, and past experiences that affect the research from design, to data collection, to interpretation of data and reporting of findings. To counteract any potential researcher bias, additional measures were taken and are described in detail in the following sections. Moreover, assumptions are clearly stated throughout the duration of the study. Guidance from the dissertation committee and reflective strategies were employed to monitor for potential biases in the interpretation of the findings.

Credibility. In order to establish the believability of the findings of a qualitative study, efforts must be made to help outsiders understand the research design. According to Jensen (2008), credibility is "the methodological procedures and sources used to establish a high level of harmony between the participants' expressions and the researcher's interpretations of them" (p. 3). Patton (2002) stated that a qualitative study's credibility depends on the following: "rigorous methods, the credibility of the researcher" and the "philosophical belief in the value of qualitative inquiry" (p. 553). Methods used to establish credibility in this study include triangulation, member checks, working closely with dissertation committee/ peers, development of a pilot study prior to this inquiry, immersion in the data, provision of detail about study context, and examination of data from various angles.

Triangulation. Triangulation, according to Patton (2002) "is based on the premise that no single method ever adequately solves the problem of rival explanations" (p. 555). Patton

explained that different methods of data collection and analysis yield different perspectives on reality, and that using multiple methods can help reduce errors linked to researcher bias. The data from the researcher's journal was used during the analysis process to compare with transcribed data when there was confusion about possible interpretations of participants' statements that were unclear or ambiguous. The journal served as a data source for non-verbal information that was recorded during the interviews, observations of participants' reactions to questions, interpretations of spoken and unspoken responses to questions, and data that was shared after the interview but not recorded. In addition, pertinent research literature was also used in the triangulation process.

Reflexivity. Schram (2006) spoke of the need for qualitative researchers to develop "a simultaneous awareness of self and other and of the interplay between the two" and further stated that this ability, also known as "reflexivity", actually "serves to inform, not undermine, a study's credibility" (p. 9). Attention to reflexivity was crucial during the interview process and during the data analysis. Select insights were highlighted in chapter 5.

Member checks. The researcher also used member checks which entailed asking participants to comment on the accuracy of the interpretation of the data by the researcher (Jensen, 2008; Merriam, 2002). For convenience purposes, participants were emailed their interview transcription data and were asked for feedback related to the accuracy of the data.

Audit trail. In qualitative research, the audit trail "describes in detail how data were collected, how categories were derived, and how decisions were made throughout the inquiry" (Merriam, 2002, p. 27). The audit trail provides documentation of all aspects of the research and the data analysis process. Keeping an audit trail supports the rigor of the research and the trustworthiness of the findings (Rodgers, 2008). For this inquiry, the most common strategies

were used to support the audit trail: notes related to data collection, the documentation of changes in the research design, data analysis notes, and notes from the researcher's journal.

Thick, rich description. Patton (2002) described thick, rich description as providing "the foundation for qualitative analysis and reporting" (p. 437). To ensure the use of thick, rich description, the reporting of the themes included as much information as possible about the nature of the situations, environments, organizations, scenarios, and other details shared that support the participants' quotations in the presentation of the themes. In addition, participant profiles were created to provide background information to help the reader better understand the perspectives of the clinical managers interviewed in the study.

Summary

A basic interpretive qualitative research design was used to explore clinical managers' perceptions of their multicultural leadership practices in daily interactions in outpatient mental health settings. The setting for this study was the southwestern United States. Criterion and snowball sampling were used to recruit the 10 participants in this study who met criteria to be classified as clinical managers. Informed consent was provided to the study participants. The clinical managers in the study were also explained confidentiality measures, use of findings, conditions of participation, and asked to complete IRB approved consent forms. Data were collected through administration of demographic questionnaires, face to face recorded interviews and observation in a place chosen by each participant. Interview protocol included a series of open ended questions related to the main question of the research study: "How do clinical managers describe their multicultural leadership practices in daily interactions in outpatient mental health settings?" Participants were asked questions about their leadership roles, how they

understand and relate to cultural difference, their multicultural learning experiences, self-assessment in cultural competence, and influences on their multicultural leadership practices.

The data were transcribed verbatim and pseudonyms assigned to each participant. Data were analyzed using the constant comparative method, using inductive means to theorize patterns and later using deductive means to test these patterns until theoretical density was achieved. Themes and sub themes were developed. These findings were explained using participant quotations and thick, rich descriptions of context. In addition, participant profiles were provided to introduce relevant background information. Inconsistencies in participants' experiences were noted as well as implications for future research and professional practice.

Various methods were employed to ensure the trustworthiness and credibility of the study. Triangulation with research literature and the researcher's journal were used during data analysis to clarify understanding of participants' explanations. Assumptions were clearly stated, guidance was obtained from faculty and peers, and reflexivity was practiced. Member checks, audit trails, and thick, rich descriptions were also used to support the study's credibility.

Chapter 4: Findings

Introduction

The purpose of this qualitative study was to explore clinical managers' perceptions of their multicultural leadership practices in daily interactions in outpatient mental health settings. To date, few research studies have focused on the topic of leadership in the counseling field. Even fewer studies have addressed how leaders in mental health understand the concept of multiculturalism as it applies to leadership. The research focused on clinical managers' perceptions of their multicultural leadership practices in order to help fill this gap in the literature, and to produce data to contribute to the understanding of the larger issue of health disparities in mental health service provision in the United States.

For this study, clinical managers, or licensed psychotherapists who serve as supervisors for other psychotherapists and additional staff in outpatient mental health settings, were recruited from public, private, non-profit, and community-based organizations in the southwestern United States using the criteria and strategies outlined in Chapter 3. This level of leadership in outpatient settings was selected as opposed to inpatient settings due to the flexibility of these roles to plan programs and shape counseling and mental health service provision. Outpatient settings also offered more variety in terms of targeted clients, types of services provided, and program structures and funding sources, adding to the concept of diversity and context which are important considerations in this study.

The primary question that was used to guide this study was: How do clinical managers describe their multicultural leadership practices in daily interactions in outpatient mental health settings? Secondary questions inquired about how the participants in the study learned about and developed their multicultural leadership practices as well as other factors they believe may

influence these behaviors. The research was designed to gathering data from the participants that would provide insight into their leadership responsibilities, multicultural learning experiences, understandings of culture and multiculturalism, orientation toward cultural difference, influences on their understandings of multiculturalism, perceived strengths and weaknesses in dealing with cultural difference, situations where they believe culture really affects their daily work, and their overall approach toward leadership with multiculturalism in mind.

A qualitative mode of inquiry was chosen in order to allow the participants to explain the meaning of their multicultural leadership experiences as clinical managers in mental health outpatient settings. Attention was given to participants' understanding of the intercultural learning process in their personal and professional lives and how they understood these learning experiences have affected their leadership practices in the outpatient mental health setting. It was relevant to this study to expose information about learning experiences that were catalysts to growth and changes in thoughts about culture, detailed explanations of participants' thoughts related to cultural concepts, and perceptions of bias, strength, and innovation in cultural understanding and leadership practice. Moreover, participants were asked about the perceived influence of the organization on multicultural leadership practice.

Participants were provided with informed consent, asked to sign relevant forms, and asked to complete demographic questionnaires. During the digitally recorded, semi-structured interviews, all participants were asked to respond freely, ask questions and provide examples as to how they understood the concepts inquired about based on the interview protocol. The interview strategy was focused on the use of conversation, asking probing questions to elicit more detailed information and examples that illustrated participants' responses to the interview

protocol, and reflection and asking for clarification to ensure a more accurate understanding of the participants' responses.

Upon completion of the interviews, each interview was transcribed verbatim, participants were each provided with pseudonyms, and overly detailed information from each transcript that would potentially identify each participant was removed. Immersion in the transcribed data took place next, and the steps of the constant comparative/ descriptive interpretive data analysis method outlined in Chapter 3 were followed. Lastly, themes were identified that emerged from the participants' experience and were organized based on the aims of the study. The participants were viewed as the experts of their own experiences. Findings were based on the interpretation of the participants' explanations of lived experience, learning and understandings of multicultural concepts and the connection of these to their leadership practices in the world of mental health.

In the following sections, basic demographic data and general organizational information will be presented to provide a snapshot of the variety of individual differences represented by the participants in the study along with a glimpse of the variety of the types of mental health programs represented in the study. Next, individual profiles were included for each participant to highlight leadership responsibilities in the workplace and other relevant professional information and program specific information. The next part and the bulk of the chapter provides in-depth information about the themes and sub themes that emerged during the descriptive interpretive analysis. Explanations of the themes and sub themes are provided, and supported with quotes from the participants along with thick descriptions of context. Any data that would be considered outliers or anomalies compared to the responses of the other participants were also noted.

Demographic Data

A total of 10 participants were successfully recruited and participated in this study. All participants were interviewed in their offices at work, with the exception of John who chose to be interviewed at Starbucks. The majority of the participants held the LPC credential, with one who held the title of Licensed Marriage and Family Therapist. All had earned a master's degree in a counseling related field, and two of the 10 had completed a doctorate.

The participant pool provided diversity in years of experience, ethnicity, age, and in the types of programs represented. Half of the participants in this study were female and the other half male, ranging from 34 to 54 years of age with 6 to 28 total years of experience working in mental health and 2 to 15 years in mental health leadership. Participants self-identified their ethnic and cultural backgrounds through the interviews, and these included the broad racial/ethnic categories of White/Anglo, Hispanic/Latina, Black/African American, and Asian/Pacific Islander.

The varying nature of the organizations and programs represented by the participants in the study also added diversity to the findings. Eight organizations, both public and private were represented in this study. The counseling programs led by the participants focused on serving distinctly different clients with five providing services to adults only, four providing services to children only, and three programs providing services to clients of all ages. Moreover, the specialties of the counseling programs led by the participants included domestic violence and sexual abuse/ assault counseling, juvenile justice and jail diversion, crisis intervention, and general mental health outpatient services. Table 2 provides a summary of the participants' demographic data.

Table 2

Demographic Data of Study Participants

Pseudonym	Self-Identified Ethnic/ Racial Background	Years of Experience	Years in Leadership	Highest Degree	License Type	Multicultural Research (Y/N)
John	White	17	15	Master's	LPC	Yes
Andy	Hispanic	17	8	Master's	LPC	No
Felicia	African-American	22	7	Master's	LMFT	No
Marcus	Black	10	8	Master's	LPC	No
Emily	Asian/Pacific Islander/ Multiracial	16	3	Master's	LPC	Yes
Estrella	Hispanic	10	5	Master's	LPC	No
Valeria	Latina (Cuban-Bolivian)	6	4	Master's	LPC	No
Steve	Anglo/Middle European	12	2	Ph.D.	LPC	Yes
Gunther	White	25	15	Ph.D.	LPC	No
Josie	Hispanic	28	8	Master's	LPC	No

Note. LMFT = Licensed Marriage and Family Therapist.

Participant Profiles

All participants in the study self-identified as clinical managers in one or more mental health organizations with at least six months of experience in their current position(s) of leadership at the time the data was collected and met the other criteria outlined in Chapter 3. Relevant data collected through the open ended questionnaire were reviewed along with data collected through the interview to produce each participant profile. In order to protect the identity of the participants, each was given a pseudonym in the participant profile section. All profiles serve as a brief introduction into the professional backgrounds and current work contexts

of the participants. Select demographic and training information, basic descriptions of the leadership positions and mental health programs of the participants are included in the profiles.

John. John, who was interviewed on May, 22, 2013, has 17 years of experience in the mental health field and 15 years of leadership experience and described himself as white. He holds a Master of Educational Science and is an LPC supervisor. John received some formal training in multicultural diversity issues beyond graduate school through conferences and training programs in the areas of lesbian, gay, bisexual, transgender issues, immigration, SES and race. In addition, he has taught multicultural seminars to professionals on working with mental health clients with HIV and has conducted research on lesbian, gay, bisexual, transgender issues issues.

John shared that he is a clinical manager for a non-profit agency that provides counseling and additional programming and services to survivors of domestic violence or child abuse. He stated that his agency serves about 2,400 clients a year, mainly Hispanic females between the ages of 20 to 29 who are low income. In his leadership role, John provides clinical and administrative supervision to staff counselors, graduate counseling interns and supervises a few administrative staff. Additional job duties include providing clinical direction to the agency, providing expert witness service, representing the agency in the larger social service community at events, and participating in leadership activities with programs that partner with the agency.

Andy. Andy, who interviewed on May 29, 2013, self-identified as a Hispanic male with 17 years in the field of mental health and eight years in leadership. Andy has earned a master degree in counseling and is an LPC. He shared that other than one graduate course in multicultural counseling he has had a few brief training experiences for continuing education, but

could not recall details of these trainings at the time of the interview. He has not conducted research or taught on multicultural issues.

Andy stated that he is a manager for a child advocacy center that also provides trauma specific counseling and forensic interviewing for child victims of sexual assault. The majority of clients served by the agency are Hispanic females between the ages of 6 to 9. In this role he is responsible for supervising three full time counseling clinicians, three part time clinicians, and two counseling interns. Andy also provides quality assurance and administrative leadership to the clinicians, while monitoring budgets and serving as a leader in meetings and relationships with partnering organizations.

Felicia. Felicia was interviewed on June 21, 2013. She is a self-identified African-American female, has worked in mental health for 22 years and has seven years of leadership experience. She holds a master's degree in marriage and family therapy and is a Licensed Marriage and Family Therapist. Felicia previously worked as a diversity trainer and routinely taught a 40 hour course to mental health professionals in another region of the country for several years. She stated that she has no multicultural research experience.

Felicia is a manager who oversees three juvenile justice based programs associated with a public mental health organization with majority probation youth who have mental health and legal issues. The first program she oversees is for children with both mental health and legal issues, while the second program she oversees serves children with severe diagnoses who have gotten in trouble in school or in the community due to issues with their diagnoses. The third program Felicia leads is a substance abuse risk reduction program for youth. Her staff members consist of licensed therapists, probation officers, and substance abuse counselors.

Marcus. Marcus identified himself as a Black male with 10 years of experience in mental health and 8 years in leadership and was interviewed on June 21, 2013. He has a master's degree in counseling and is an LPC supervisor. Marcus denied any formal training in multicultural issues outside of a course in graduate school. He also stated that he has no research or teaching experience in this area.

Marcus is a manager for a jail diversion program with approximately 300 mentally impaired offenders that provides outpatient and residential treatment, case management services, benefit services to assist the clients in graduating from parole or probation with the final aim of reducing recidivism. He is responsible for managing the contract that guides the program, including creating goals and objectives for staff, writing job descriptions, and creating relationships with other agencies. He oversees a psychiatrist, a nurse practitioner, additional nursing staff, a few licensed professional counselors and clinical social workers, some bachelor level case managers and some PhD level psychotherapists.

Emily. Emily self-identified as an Asian/Pacific islander first and second as multiracial (due to being half Japanese/Hawaiian and German) with 16 years in mental health, three of which is in leadership. She was interviewed on June 21, 2013. She holds a master's degree in counseling psychology and is an LPC. She stated that she has received formalized training in multicultural issues, specifically on working with lesbian, gay, bisexual, transgendered, queer, and two spirit populations and cultural disparities in foster care. Emily has assisted with a research project on heterosexism in counseling and has led some training with mental health staff on working with gay and lesbian youth.

Emily stated that she is a clinical manager over four children's mental health programs at a public mental health agency. These programs serve regular outpatient children in need of

psychiatric and counseling services, children needing early intervention to address mental health issues, children's who have been hospitalized numerous times due to psychiatric illness, and a clinic that provides crisis triage for children who may need psychiatric hospitalization. Emily oversees the behavioral health staff members that are composed of LPCs, Licensed Master Social Workers, bachelor and master's level clinicians, and family partners. She is responsible for the administrative and clinical supervision of her employees, managing the flow of the clinics, and handling client concerns.

Estrella. Estrella, a Hispanic female, has 10 years of mental health experience and 5 years of leadership experience. She was interviewed on June 24, 2013. Her graduate degree is in counseling psychology and she is an LPC. Outside of a required graduate course, she denied any formal multicultural training and has not participated in multicultural research.

Estrella is a manager of a mental health program that provides outpatient services to adults with severe mental illness who are functioning at a variety of levels. She provides oversight for the clinical practitioners who provide field based rehab services and the licensed clinicians who provide therapy in her clinic. She also supervises support staff, monitors budget, and manages client concerns.

Valeria. Valeria was interviewed on June 24, 2013. She described herself as Latina (Cuban-Bolivian) and has 6 years in mental health along with four years in leadership. Her master's degree is in counseling psychology and she is an LPC. She stated that she has attended numerous trainings at conferences on various diversity related topics but does not have any certifications. She has not conducted research on multiculturalism, but teaches a required 1 hour 30 minute training at her organization that is required for new employees and interns that focuses on culture and working with military, men, and Hispanic populations.

Valeria serves as a clinical manager for a non-profit organization and supervises the part of the agency that provides counseling, telephone assistance, advocacy services and crisis intervention for individuals and families of individuals who have experienced sexual assault. She oversees all of the mental health service providers ranging from graduate and PhD level interns to licensed mental health staff.

Steve. Steve identified as an Anglo male with 12 years of experience in mental health and two years in leadership. He was interviewed on June 25, 2013. Steve has a PhD in counseling and is an LPC supervisor. Steve has taught graduate level counseling courses on diversity topics and has conducted research on counseling deaf clients. He did not specific other areas of specialty training in multiculturalism.

Steve mentioned multiple mental health positions where he plays a leadership role. He is part of a psychiatric team in a hospital and serves as a consultant as part of a larger team of medical professionals to determine if individual clients need to be hospitalized for psychiatric reasons. Second, he serves as clinical manager in a graduate counseling program and is also a professor. As the manager he is responsible for locating clinical sites for the graduate students and supervising interactions between the sites and the university program. Third, he is also the supervisor for the university counseling clinic. In these roles, he oversees other faculty, graduate students, clinicians, and administrative staff.

Gunther. Gunther interviewed on June 25, 2013. He self-identified as white with 25 years of mental health experience and 15 years of leadership experience. He holds a master's degree in counseling and a PhD in education and is an LPC supervisor. Gunther denied having research experience or specialized training in multiculturalism but explained that he has taught multicultural counseling at the graduate level.

Gunther described to positions he currently holds in mental health leadership. In the first, he provides counseling services, peer counseling and consultation to other counseling professionals in an educational setting. He is also the manager of a private practice, faith-based counseling group that focuses on adolescents and marriage and family work. In this capacity he supervises two licensed counselors, two interns, and administrative staff.

Josie. Josie described herself as Hispanic, with 28 years of mental health experience and 8 years of leadership experience. Her interview took place on June 28, 2013. She has a master's degree in counseling and is a Licensed Professional Counselor. She is also working on earning an MBA in health care management. She stated that she has not received any formalized training on multicultural topics outside of graduate courses and has not conducted research on this topic.

Josie is the manager of a large outpatient mental health clinic for adults with various service needs that consist of two programs, one that is more generalized and one that requires specific criteria for clients to participate in services. The populations served by her clinic are adults with severe and persistent mental illness and they receive psychiatric, counseling, rehab skills, case management and benefit services. She is responsible for overseeing the business support staff, case managers, physicians, and team leaders who provide clinical supervision to case managers.

Themes

Despite the variety in the demographic variables, training and professional background of the participants, four major themes were identified, along with sub themes that emerged during the descriptive interpretive analysis of the participants' responses. A three step coding was used process to analyze the transcribed data from the participant interviews. First, in the open coding phase, data were examined line by line, and overall significance and important items were noted.

Second, in the axial coding phase, data were grouped and reorganized as needed to identify concepts and patterns. In the final phase, selective coding, core categories were refined and relationships to sub-categories fully explained. Chapter 3 provides a complete explanation about the data analysis process. Detailed descriptions of the themes, sub categories of themes, explanations of both, along with quotations from the participants and descriptions of context will be presented in this section.

Culture is a complex concept. The first theme that emerged from the analysis was the idea that culture is a complex concept. Participants provided a description of culture beyond race or ethnicity and expressed an understanding that people define culture in different ways. The belief that culture is complex was also conveyed through all of the participants' hesitation and long pauses when contemplating the answer to questions about culture. All of the participants in the study were able to define culture and multiculturalism using descriptions of multiple cultures, in terms of a person's identity being dependent on these cultural memberships, and various elements of culture including language, communication preferences, and the importance of context or location.

When asked about his understanding of culture, John stated: "The definition that works for me best is culture is everything about a person that makes them who they are. So it's more than skin color, it's more than language… it's everything." When asked about his understanding of multiculturalism, John provided an example from his organization of what he perceived to be an inaccurate and limited example of multicultural understanding based on a required multicultural training within his organization:

> This may not be socially acceptable to say, but every time we have a multicultural training at the agency, it essentially boils down to be nice to Black people, and there really isn't a multicultural training. It's generally based on skin color and just be sure you're nice to everybody. And that doesn't account for all the elements of culture like

> immigration status, race, ethnicity, SES, religiosity or non-religiosity. Of course the list goes on and on, LGBT issues, etc. So multiculturalism to me, would mean an openness to working with people from all of those backgrounds, all of those elements combined, and an openness to being told that you're wrong.

John actually made reference to this required multicultural training from his agency three times during his interview thus indicating his sense of disappointment with the situation. He actually went on to say that the leader of this training was another staff member at his agency with no formalized training, best practices or research to back up the material she would generally present to the audience. John surmised that she was merely stating her opinion and indicated that he thought that this type of training was ineffective at best and not comprehensive enough to meet the needs of the agency.

Andy communicated his understanding of diversity more in terms of organizational context and individual preferences. When asked about his understanding of culture, he responded: "That's a loaded question because I think there's a multitude of cultures. It depends on the setting that you're talking about." In response to being questioned about his understanding of multiculturalism as a manager, he responded by accentuating the role of communication and describing the process as iterative and ever changing:

> I have to have a clear understanding and be empathetic to various cultures to put it simply. I have to understand that certain cultures don't respond to somebody who is really hard lined. A hard line person. Somebody who comes at you and is a little more direct. Certain cultures do respond better to that, you know. So to me it's an evolving thing, it's an ever evolving thing and it's not linear. I don't think it is anyway.

Felicia described her understanding of culture in terms of tradition and family relationships. "Culture is who your family is, how long they've been in the states, how they celebrate, how they communicate." When expressing her understanding of multiculturalism, she shared her that she was not in agreement with the theory of the melting pot that is popular in the United States:

> Being truly respectful of multiculturalism is taking that kind of wherever people are, and understanding that their practices and holidays and religious practices *make* them who they are, and instead of trying to take that away from them, accepting that and *embracing* them and giving yourself the opportunity to learn.

Marcus spoke about his understanding of culture and expressed some uncertainty in his response.

> That's a hard thing to define, but I guess its values, upbringing, language, its dialect, its location, its belief system, its morals. I guess I would define it as that. It's really hard to define what culture is, but, you know? Location is probably a big factor. Location and race are probably some of the biggest factors.

When asked about his understanding of multiculturalism, Marcus said:

> Multiculturalism, I would say it has a lot to do with having an open mind and a willingness to see things from a different cultural perspective. To take somebody as to what they bring and be open to that and accepting of that and understanding of that. And not being, I guess *centered* by your own culture and to be willing to look at and experience and learn from other cultures.

Marcus added another element to his definition that was distinct from other participants insomuch as he described the process and importance of seeing beyond one's personal cultural perspective and symbolically stepping into the shoes of someone who is from a different culture in order to learn about that perspective. His explanation was indicative of a deeper understanding of the intercultural learning process and an appreciation for experience in that learning process.

Emily shared her thoughts on culture from the perspective of social systems, commonly shared characteristics, and how we can describe culture from different perspectives.

> I believe that not only is culture how you were raised, but also I believe that we build a culture within ourselves, within our friends, within the people that we hang out with. I think at work you can also have a different culture depending on the individuals that you work alongside. So culture can really be divided among ethnic grounds or religious background, so it can be defined in many different aspects.

Emily also mentioned the influence of an assessment training she had recently attended when she was asked about her understanding of multiculturalism. She shared that she was

excited when she recently learned about “cultural humility” from the creator of the assessment who educated the audience about the term. She explained her understanding of the meaning of this term. “This allows you to have individuals teach you about their culture. Whether it’s based on religious, ethnic, you know, or just their background and the way they were raised.

Estrella explained her understanding of culture using a multidimensional view with an acknowledgement of organizational culture:

> Culture is everything that makes up who you are, or the existence that we live in. Culture has to do with beliefs, practices, ideas, trends even, that becomes a culture somewhere, something that continues to happen that becomes a culture of your environment, of your clinic, we talk a lot about that.

In explaining her view of multiculturalism, Estrella highlighted different belief systems and practices. “My understanding would be, you know, having people from different backgrounds, who have different ideas about how to approach things, have different practices and different rituals about how they live.”

Valeria’s views on culture and multiculturalism were explained from a first person perspective. She added insight as to how cultural membership is complex, comes together from seeing various angles of a person’s life, and affects her decisions and behaviors.

> A set of beliefs that help me, that guide me to make decisions in my life whether its spiritually, my culture spiritually, my culture from my background, my family of origin culture, being first generation, that culture, having a household half Spanish, half English, that culture, There’s just so many. I think it’s just a set of beliefs, a set of experiences, that guide me to make my decisions every day or guide me to form certain types of relationships, seek certain types of support and so it’s such a multidimensional definition. I think it’s probably that. Knowing that it’s a multidimensional thing. That there’s not just one linear definition of. Let’s say, I’m Cuban, so this is my one line of culture and my one line of experiences, but it’s knowing that multiculturalism is this one thing that has experiences from my father’s side, my mother’s side, my husband’s side, my children’s side, me as a new mom, me as a professional, and that’s what makes this. That’s what makes me, me. It’s just all of these dimensions.

When asked about his understanding of culture, Steve responded that culture is "so nebulous and abstract." After a moment, he continued by stating the following and incorporating the aspect of societal pressure in deciphering the meaning of culture along with his interest in people's strengths in the midst of cultural factors:

> I think culture is just the collection of family values, family rituals, kind of juxtaposing with whatever is going on in that society at that time. The influences and the pressures of that society just from the social construction perspective. Just the pressures of society, the expectations of society, kind of again, keeping in mind each person's culture and values and ethics and expectations of what society wants from them as well as what they want from society. What they bring to the table. I'm always interested in what people bring to the table.

As far as his understanding of multiculturalism, Steve responded by saying "multiculturalism is just kind of previously what I said with layers." Steve's response with the use of theory, namely the social construction perspective, being able to name a theory that corresponds with his beliefs, reflects the culture of his membership in academia as well as his theoretical background as a therapist trained in narrative therapy. He confirms this throughout the interview.

Gunther's response to the cultural question was similar to Steve's with regard to the use of stories to define who people are culturally. Additionally, he added his thought about the negative repercussions of emphasizing any singular story of a people over the story of an individual person when attempting to understand culture.

> I guess to me, culture is a mix of our personal history, our family history and our life experience. I think culture is very individual. I do not think that culture works well as a broad term. I think it gets us into a *lot* of trouble. When you walked in I was watching Ted Talks and one of them was a young lady from Nigeria and she talked about the danger in life as accepting one story as the definition of a people. And talking about how we are made up of multiple stories, not a single story. Well, culture is that way. Every one of us has different stories.

Despite a dislike for the word *multicultural* due to its association with an emphasis on cultural differences rather than similarities amongst people, Gunther also acknowledged and emphasized the role of communication in bridging the gaps between clinician and client who may have outward differences, but can connect based on commonalities as illustrated in the statement below.

> Kid walks into my office, Hispanic, 15 years old, comes from a lower socioeconomic standing, he immediately assumes that I have no understanding of his life. And when we begin to talk, he begins to realize that we have a lot of commonalities. He is the only boy with sisters with a very chauvinistic father. I'm an only boy with sisters and a very chauvinistic father. I carry the burden of the family and I'm the third child. He complains 'cause his older sisters don't have to do anything and he does. We have many commonalities and we assume the differences and multiculturalism assumes the differences not the commonalities. You do have to be aware of the differences, absolutely. But I think sometimes we give the differences too much power when we should give more power to the commonalities.

Josie's understanding of culture incorporated the role of education and experience. "It's just the differences. Like I said the different things, the education, the ethnic background, the knowledge that we have, our life experiences, all of that combined." Her understanding of multiculturalism was stated with the explanation that our reality is devised by the presence of a world that consists of people with a variety of individual and group membership differences.

> It's what makes up our world. Its people that are from different backgrounds and at different levels of education, people with different abilities, whether it be individuals who are handicapped, individuals who are fully able…handicapped is not the best word, I guess—differently-abled. And so I think it's all of those. It's looking at the diversification amongst our population.

Moreover, most of the participants shared the common philosophy of learning from others about their cultural backgrounds, and being open to this learning process. The word openness was used by multiple participants throughout the length of the interviews. Although not always overtly stated, other participants acknowledged the variations in different levels of

culture and implied embracing openness to understanding the different factors that help people define cultural memberships.

Despite similar licensure and educational experiences, there were marked variations in the participants' expressions of the meaning culture and related terms. None of the participants referred to one singular definition of culture or multiculturalism, and all seemed to define these based not on formal training or theory alone but on their understandings stemming from life experiences. None of the participants referenced popular multicultural theorists from the counseling field, with the exception of Steve who ultimately praised the role of life experience or experiential learning and discounted the usefulness of popular theoretical explanations of culture by saying "I don't put a lot of stock in people like Sue and Sue."

Another point of variation in this theme revolved around what aspects of culture were accentuated by whom. The African American participants accentuated race as part of their definitions, while the Hispanic/Latino and Asian participants emphasized the interrelatedness of individuals with various differences. The two participants with membership in the lesbian, gay, transgender, queer, and two spirit communities emphasized the importance of acknowledging sexual orientation as part of understanding cultural difference.

Multicultural learning outside of formal educational settings. All of the participants shared impactful multicultural learning experiences that took place outside of formal educational settings. Two sub themes that emerged within this category were learning experiences that took place in family relationships and in work experiences the participants had before they entered the counseling field. Throughout all of the learning experiences featured under this theme, the participants experienced cultural lessons that affected their core beliefs about how to relate to cultural difference.

Family and personal experiences. John recalled a powerful experience involving his mother where he remembered being a young child and making a visit to a local park. When he tried to climb the ladder for a second time to slide down a spiral slide, a young African American girl stopped him from doing so by hitting him.

> My mother came over and told me to hit her because she had been hitting me. I don't think that my mother meant for me to learn that White people are more powerful, whatever, than Black people, or African Americans now, but there's a strong message in that that isn't very good. So I don't see myself as doing that.

John went on to say that he did not hit the girl. He also shared that his father, who is a professor, was secretly racist and that he remembers the irony of his behaviors. "In the classroom he would say all of the nice, appropriate things, but at home or in the car it would be this stream of garbage coming out of his mouth, which was really unpleasant to listen to." Despite these early learning experiences, John explained that he makes a conscious effort to focus on staff or clients as individuals: "I take them more as a whole person and who they are and what we can do to advance whatever our cause is together."

Andy's multicultural learning experiences from family were rooted in his dual cultural heritage and upbringing. However, he admitted that he did not consciously think about cultural differences until later in life. "Wasn't until college until I went to school, graduate school in college that I really kind of found really paid attention to--you gain this sense of insight into it all." Andy explained the region of the United States where he grew up was very segregated and that the families of his parents literally lived on different sides of the tracks. "So I was raised in that environment, you know, it was like this dichotomy of my mom being from this kind of poor, Hispanic background, and my dad being kind of from this middle class." Andy explained that one grandmother lived by fruit factories, while the other lived in an upscale retirement

community. “One Saturday I’d be at one grandmother’s house and the next Saturday I’d be at another grandmother’s house by the fruit factory. And you smell the rot of fruit.”

When asked about how this experience has affected him today, he shared his philosophy of the impact of that life situation: “I think it’s grounded me, somewhat, if anything.” Andy explained that while he identifies himself as a Hispanic male, he also understands that people may view him as Anglo. He elaborated on his perspective of this multicultural learning experience:

> And that’s impacted me in terms of like, there’s not an Anglo male out there who’s better than me, but I’m not better than any Anglo male. There’s not a Hispanic male out there who’s any better than me, but I’m not any better than any Hispanic male.

Felicia noted multiple memorable experiences of multicultural lessons stemming from family relationships. She explained that she came from a military family who accepted friends and family from any background. “I think in a lot of ways they set me up to be very open-minded about multiculturalism so in that way, I think they did me a huge service by raising me the way that they did.”

Felicia fondly recalled having a best friend who was blonde haired and blue eyed from her early childhood days. She explained that she and her friend were extremely close and got along well. She remembered her friend coming to school one day very distraught. As Felicia approached the girl and asked why she was upset, the girl told Felicia that her mom told her they couldn’t be friends anymore because Felicia was Black. “And so that was the first time I really realized that not everybody’s parents taught their kids the way that my parents had.”

Marcus explained that the fact that he was raised in a single parent household by his mother has impacted his view of gender roles. Before he came to live in his current city of

residence, he was unaware of the importance of being aware of the power of gender roles in certain cultural communities and how those beliefs might impact his work:

> Here in this city— and this is just one sub segment of the population but— you got a lot of Hispanic families where you've got multi-generations that live either really close by or in the same household and so forth, lots of kids, grandparents and so forth, and with that there's roles. Males do this, females do this. That wasn't something that I knew about or understood because when I grew up all we had was mom and that was it and she was everything, so when we have patients that talk about, well, you know guys don't do that, or women do this and that's all new to me, but some of my staff that grew up in the same type of environment understand that. They don't agree with it, not necessarily, but they understand it. And that's more important than agreeing with it. So, I'm willing to learn from that, and that's how we balance it out. If they're more familiar with something they can teach me, that's good. Vice versa it works just as well.

Emily shared a few different learning experiences centered on concepts of cultural beliefs about families. She first shared that she had a good friend in college who was African American who announced that his sister was in town. Emily was at her friend's home with his roommate and had met his sister, but was still wondering where his sister was. She failed to consider that the other girl present was his sister because she was white. "That was one of the first times when I was like. . . oh, ok, so families come in all different ways." She went on the learn that her friend and his siblings were from African American, Anglo, and Filipino backgrounds, lived in a Hispanic neighborhood, were adopted, and had been featured on the Oprah show because of the diversity within their family.

Emily also admitted to doing a lot of religious stereotyping of families in her youth due to being raised in a sheltered environment. She stated: "I was raised in a very religious home with a lot of—and this is gonna sound really bad considering the topic that I'm talking about—with a lot of 'whiteys.'" It wasn't until college that she began to learn that people of different ethnicities participated in the same religious practices. "I know that for the longest time whenever I'd hear Hispanic because all the Hispanic kids I knew were all Catholic and all the Black kids I knew

were all Baptist." This was her belief until a white family that happened to be Catholic moved across the street from Emily and her family.

> This family moved in, they had four kids and she was pregnant with her fifth. My parents said something about them being Catholic. I had always assumed that Catholics were Hispanic, and so when I had this white, uh Anglo family that was Catholic, I was like I don't know. And the other assumption is that if you're Catholic then you have a bunch of kids. So kind of getting back to that stereotype of what a Catholic is and kind of what religious culture means in society. I guess that was another big thing.

Valeria attributed learning about multiculturalism to a few key events in her life involving family and her identity. First, she mentioned that her mom is Cuban and her dad Bolivian, and that the family learned some major lessons about their language when the family relocated from Miami to their current state, where Spanish is also widely spoken.

> That was huge because we used words in Florida that are really bad words here. I remember saying something at school when I was corrected and it was just. I was so taken back, because I was a good girl and I didn't want to get in trouble, and to get in trouble that way was a slap in the face that I was somewhere different. And even if the people looked like me, spoke Spanish like me, had the same hair color as me, that they were *very* different. So that has been an adjustment for us, being Cubans and living in Miami and coming to this state has been very different.

Valeria went on to mention that she is conscious about how she raised her children, which contrasts with her own upbringing. She explained that her parents were strict Baptist, that she is not, and that she rejects traditional views about race and the anti-homosexual view she was taught by her parents. She further explained that the view of the agency where she works has affected her profoundly since the views she have chosen represent the values of her agency. "Being here for the last 8 years, being in this state, I think it's just kind of taken my beliefs apart in a very positive way."

Josie explained that she also had some profound discrimination related learning experiences in the context of family. She stated that while her entire biological family is Hispanic with Native American heritage, she is the only sibling who has a dark complexion and

really did not pay attention to this until she experienced an incident crossing the United States-Mexican border coming into the United States after visiting family:

> I was in the back of the station wagon and I remember the border patrol guy turning to me and in Spanish asking what nationality was I. He didn't ask any of my other siblings but he asked me. And that was like…what? And I answered him in English and I said "what?" And he asked me again in Spanish. And I told him, I said "really? I'm American!" He thought I was a Mexican national.

Josie questioned her family as to why she was the only one singled out by border patrol. She explained that this was the first time she ever felt different from her family members. "It was very impactful. I was upset by it for a long time. I was just like, how dare he? I'm not a Mexican!" Her family was honest with her about how her appearance was different than the others. Today, it does not bother her so much if someone asks or assumes that she is Mexican.

As she got older and began dating, Josie had another impactful experience when she dated a man outside of her race. "I went to a family function with him and his cousins and other family members came to me and basically told me, hands off, stick to your own kind, kind of thing." Josie explained that she remembered these experiences most due to them being unpleasant, and was really surprised that her date's family would not accept her dating him. She believes that although the incident occurred some time ago, the time in which the incident occurred indicated that people were outwardly accepting of interracial dating.

Prior work experiences outside of the counseling field. Marcus noted substantial learning about culture in his previous work in the military. He explained that he was from a small town in a southern state where he had only encountered Black and White people.

> When I joined the military I was exposed to people from different parts of the U.S., even people from different countries that were American citizens. The job that I had in the military—and I guess when we talk about culture we have to include education as well, but that brings a whole new culture, also.

Marcus explained that he had a career in meteorology when he was in the military. He was one of the few black men in that field and that most of the other black males were in positions that did not require strict training. In the beginning, he even questioned whether or not he should be in that field due to the absence of people from his ethnic background.

> I kinda wondered, should I be there or should I be here? You know? So that was a learning experience, I guess because of the schooling that I was able to take advantage of, that put me in a different category, in a different perspective, in a different culture, even on board the ship that I was on.

Initially, Marcus was concerned about not fitting in with the other non-black men in his career. However, he soon realized that he had a lot in common with them, became part of the meteorology team, and was very successful in his job. He explained that he and the other men happened to get along well and he was accepted despite the difference in their ethnic backgrounds.

Estrella noted a powerful learning experience working alongside a Muslim colleague when she was a resident assistant in graduate school. She explained that the young lady would have lunch with her and she would eat in different ways and would explain her customs to Estrella. Estrella smiled as she remembered the girl's openness and willingness to answer questions about her cultural background.

> And we worked as RA's together and so we had to walk the floors together, so I'd go get her sometimes and I'd knock on the door and she'd say some in and she'd have her cloth on the floor … because she just finished doing her prayer so that was really interesting and something different than I'd ever seen and she was really a very kind girl and very open and understanding that other people didn't know what she was doing. She was very open to telling you anything you wanted to know.

Steve described a cultural learning experience that took place in his previous, 10 year career as a firefighter in another city. He explained that this city up north was extremely diverse,

but also very segregated. Steve described an incident that occurred when he was working in an all-White firehouse in the housing projects.

> I sat there one day, and the firemen, when I was upstairs in the bunkroom, I was making my bed, it was in the middle of the wintertime, all the windows were closed. It was nice in there. It was very warm in there. And one of the firemen who had been assigned to the house gave me like two extra blankets. And I said, I got a blanket. He goes, you'll need 'em. So guys get detailed, they get sent from other firehouses there, so a couple of Black guys got detailed to the firehouse. When night came, the fireman nailed all the windows open. And the thought for them was, these assholes, was that Blacks didn't like the cold, so they were trying to keep Blacks out of the firehouse. So it was a very big, big, big cultural.

Steve offered another example of a cultural lesson that took place during his work as a fireman. During his work at a certain firehouse, it was brought to his attention that he was the only non-Irish, non-Catholic, by his peers who referred to him as "The Heathen." He shared additional information about how he was addressed by his peers:

> Here comes Steve the German. You know how we feel about Germans. It was kind of, and I think on some level I laughed it off. But I could see now looking back and just pretty offensive and it was. But these were guys I cared about and they cared about me and that was another one. A real interesting thing.

Gunther explained that he spent most of his life as a young man in Asian countries and did not encounter many people of Hispanic heritage until moving to his current city. He obtained a special education teaching position at a school for students who were emotionally disturbed. He noted that the majority of the students were Black or Hispanic and were of lower socioeconomic status. Gunther emphasized his accomplishment of being able to build good relationships with these students and what that process looked like for him.

> And they just got such a kick out of me and they would look at me and go 'you're just so White!' I'd go, and that means? And they began to teach me. They began to talk to me and some would use words. I came from a conservative, Christian perspective and have served on church staff and there were curse words I didn't have a clue what they meant. I'd be cursed at and I'd look at one of the boys and go 'Am I offended or what? What do I do?' And they just thought that was so interesting that they became transparent with me. And so I got a crash course on probably more honesty and culture than anyplace else I could have gotten. They felt no need to protect themselves against me and I felt no need

> to pry into their lives and they just began opening up and sharing so I learned a great deal in that context.

In this study, all 10 participants stated that they had taken at least one required multicultural course in graduate school, yet eight of the participants admitted to not actually remembering anything that they learned from the course. Two of the participants, Gunther and Emily, admitted remembering heated discussions and having some type of learning experience from that. In Emily's case, she spoke fondly of her multicultural counseling professor, but could not recall any specific learning activities that took place in the course other than interesting conversations. Gunther recalled one emotional learning experience that was actually an argument that ensued between African American students sitting in the back of the classroom who accused White males in leadership of several negative accusations. When Gunther attempted to intervene with a bit of humor to break the tension, the professor introduced the idea to the class that Gunther was actually going through an experience of discrimination. This is the only formal learning experience of any sort that he could recall. Steve described his graduate training as "superficial" and recalled that many of the cultural exposure activities in his courses were guest speakers or field trips. In his opinion, these activities would never be as powerful as his own lived experience living alongside people from different cultural backgrounds.

Leadership issues. All of the participants in this study were asked about everyday situations where culture really seems to come into play in their roles as leaders. Each described an interest and willingness to learn about the cultural needs of their staff as well as the clients served by their agencies. The participants provided clear examples of how they have understood and responded to differences of culture in the workplace. Within these themes, three sub themes emerged: Human Resource Issues, Shared Decision Making, and Staffing and Supervision Strategies.

Human resource issues. John shared that some of his staff are from other countries and "sometimes the cultural needs are a little different and being willing to be flexible with policies and procedures so they can work the schedule more pleasing to them or more relevant to their needs." When asked to provide an example, he stated that he has had issues with a certain childcare provider in his agency who has numerous children and is from a lower socioeconomic status. John shared that because of the children's health needs and doctor's appointments, the employee often has trouble keeping a consistent work schedule. He described his perspective on this situation:

> I could be difficult about it and say, you have to go and I'll find somebody who can work the schedule, or I can flex a little bit and say, as long as it doesn't conflict with--unless of course it's an emergency, with the times that the children are here, why can't we just flex around that? Much more realistic thing to do.

Andy described an experience where the age and ethnicity of an employee were brought to his attention as the reason why he gave a specific individual a directive to stay and clean up after a community luncheon. Andy asserted that he was challenged by a female, Hispanic employee in her 50s who verbally confronted him with the accusation that he asked to stay and clean up based on her age and the color of her skin. Andy shared that the employee's response caught him off guard, especially since he provided the directive that anyone who was not going to court with the group and would remain behind would need to clean up after luncheon. He shared the following about the experience:

> It put me on my toes. I'm sorry, that was not the intent. Is this something you want to take to HR [human resources]? My apologies. And I explained to her and we talked and hugged and she knew it wasn't--that's not what it was about. It was about, if you're gonna be a part of this team then be a part of this team. You're not just gonna not do something we asked you to do as a team, and if you are, then you're going to help the team out in terms of picking this mess up.

Andy admitted to going back and questioning himself about the experience and reflecting internally to see if there was something he might have done to contribute to the employee's perception of the situation even though there were no negative intentions on his part. Andy spoke of the need to reflect on that particular situation: "that's a heavy accusation to lay on someone. And as a director and a manager and a leader inside the organization, you have to do that. *A*, because there's lawsuits! Age discrimination or cultural discrimination." He further stated that he was not interested in creating an organizational environment where people feel that they are discriminated against based on any demographic factors.

Along the same lines, Valeria has admitted to growing on the job with regard to understanding the diversity in her staff and potential human resource issues. She acknowledged that within her staff there are numerous personalities represented along with different meanings that her employees attribute to their work. Valeria described her role as helping everyone to reach their professional potential in her agency, but also emphasized the importance of communicating, whether verbally or in writing, according to the needs of her staff:

> And how I communicate with someone, even emails, how we address emails to someone may come across defensively and the other one is just tell me up front, don't skirt around the issue. So its learning that even within our own agency and even with my mental health providers that, diversity is among us and I need to be able to flip from one to the next. So it definitely helped me grow.

Valeria referred to a specific example where she learned about the importance of tailoring communication when a staff member became very defensive with her after receiving an email directive. She explained that one of her staff scheduled a tour of her clinic for an outside group, and that the person who does this is asked to inform the front office so that the clinic will be closed for a while so as not to upset any clients in the waiting areas. The employee failed to warn the front office of the tour and a client was in crisis during the time of the tour. In response,

Valeria emailed the employee of the proper procedure for scheduling tours. She said that the employee became defensive and somewhat condescending toward her. Upon scheduling a meeting with the staff member and asking about why she had such a reaction, the employee responded that she felt as if she were being treated like a child and scolded for her actions. Valeria shared her reaction and insight into the situation:

> And I thought, wow! Because that was not my intent, I didn't read it that way. I thought it was brief, short, hey remember this, and she took it so defensively that I was really surprised and so it helps remind me that email and texting and things like that just--you have to be--you have to take one step further into making sure that its very general, the mood and the tone is very balanced out, so that would be an example of HR issues, even how we address, how we respond to emails and how I send reminders out.

Shared decision making. John described himself as fair when making decisions in his agency. He admitted to favoring making decisions with the other staff members in his agency on important matters, especially those that affect the clients served. He also acknowledged that group decision making can be a lengthy process, but is important for the success of his agency:

> I could just do it myself, but then that's just some White guy's perspective on how things should be done. That may work fine for me, but guess what? We don't serve a lot of White men in my program so more people need to be involved in those decisions.

John admitted to being flexible in his decision making approach. He stated that he generally makes decisions on his own about matters that are administrative in nature and not likely to impact clients. Further, he shared that he tends to involve his children's counselors in decision making processes for his adult programs since "all adults were children once."

Josie succinctly described her multicultural leadership philosophy: "I'm democratic. I'm for the people, by the people." When asked to elaborate, she added "I believe in the process of having people contribute and thinking about what's best—again, not only for my consumers, for my patients, but what's best for my staff, what's best for the organization."

Josie also shared that she has staff members of different ethnic backgrounds and levels of experience whose opinions she values. She described her approach to decision-making:

> …so when we're sitting down and we're making decisions about things, I like to take the approach where-sort of democratic—where I get their input and we get ideas. I think that this opens up the opportunities for us to get ideas from different people from the experiences that they bring to the table and how they view whatever it is that we're talking about. And I think that that helps us to have a broader perspective or a broader look at what the situation is and how and help us to find the best solution to whatever it is going on.

Josie expressed that she intentionally looks at the differences of the staff who work for her and attempts to figure out which of the differences are actually strengths. Her goal is to play to the strengths of her staff members.

Staffing and supervision strategies. Felicia explained that she makes deliberate attempts several times a week to learn from her staff about work situations where they are experiencing difficulty and what they need from her to improve their work performance. "I really try and have them educate me more on what their experience is as opposed to making the assumption." Felicia shared that she tries not to make judgments about what her staff are doing and not doing in their work.

She also tries to learn about her staff and who they are as individuals outside of the workplace. She stated: "I want to get to know them outside of their resume." This helps her get a better of picture of who her employees are and helps her identify their strengths better. She does this by checking in with her staff and asking about their hobbies and things that they like. Felicia stated that she writes this information down and references it at times. The ultimate goal of approaching her staff in this manner, according to Felicia, is to improve her performance as a manager. "What's the best way for me to approach you if I have to give you constructive criticism? Do you want that in writing? Do you want it in an email? That sort of thing."

For Marcus, it is an imperative that he maintains staff members who represent the backgrounds of the clients served by his program. “I try to keep a diverse staff that’s as diverse as the people we treat.” He admitted that this task is easier said than done, but that he makes a genuine effort. In addition, he shared that his background as a clinician affects his staffing strategies since he believes in making clients’ needs the focus of supervision. Marcus summarized his focus on awareness of clients’ diverse needs:

> I’m making sure that staff are aware of differences in the people that we serve and that we’re willing to look at those differences and be willing to tailor treatment based on the culture that’s brought to us working with them in a fashion that’s conducive to their benefit and stability and so forth.

He provided some examples of common scenarios in his clinic that highlight client needs and preferences when it comes to culture. “Sometimes we have patients that have issues with certain races or genders. Gender more than race.” Marcus elaborated by saying that criminal history of patients plays a part in staff members’ comfort level in providing treatment across genders due to concerns of potential threat. He also stated that language barriers have occasionally arisen and patients have been uncomfortable with their providers due to this.

Moreover, Marcus explained that beyond ethnicity, the culture of criminal life plays a part in managing staff interactions with patients. He stated that patients will sometimes complain that they cannot effectively work with certain staff members. Marcus attempts to keep an open mind when managing complaints about staff. “With the population I work with there is a lot of manipulation as well. So I have to really kind of vet it and see if there are true issues there or is this a tactic to manipulate.”

On the other hand, Marcus admitted that he suspects that cultural differences are at the root of patient concerns about working with certain providers. Patients will complain that they are unable to work with clinicians due to what side of town they are from, or their perceived

belief systems, or just the belief that they are very different and unable to relate to the needs of the patient. Marcus explained his beliefs about these situations:

> I think in most cases it probably, really come out that it might be the underlying issue of culture thing, but they frame it as something else. I just don't like this person. I don't get along with this person. I can't work with this person.

Emily expressed several staffing and supervision strategies that she actively uses with her staff. First, she stated that she aims to hire an ethnically, linguistically, and gender diverse staff to meet the diverse needs of the clients that her agency serves. She shared that it is often difficult to achieve diverse staffing when it comes to gender. "I've always looked to make sure as I'm hiring that there is not only ethnic diversity. The hardest part has been gender diversity in the mental health field."

Emily added that another factor she takes into consideration when hiring employees is professional background and work experience. She stated: "But I also look as diversity as in experience." Emily explained that employees who have worked in different types of agencies such as child welfare, probation, inpatient settings, etc. have different perspectives on clients' treatment needs. Keeping these factors in mind, Emily has aimed to create diverse clinical teams in her programs. "So I've really tried to put together groups of teams that really have that diversity amongst themselves."

Emily explained that having groups of clinicians with diverse mental health related work experience are especially useful during group staffing sessions. Having staff with a variety of background experiences helps other members of the team to solve questions associated with proper treatment for clients and to gain knowledge about the most common systems that are intertwined with mental health systems. She explained how the staffing process works:

> Whenever they meet and they say ok, I have this kid, this is what's happening, we look over at that person and say what do we need to do about this? And so it's not one person

> having to know everything about every other system. But it's having everybody be able to collaborate together so they can share that information and share their experiences with each other.

Emily also explained that staff members who have different professional backgrounds tend to use different terminology and conceptualize cases differently. She elaborated on how this affects her communication with her individual team members. "So sometimes the approach you have with one staff member may be different than the way you need to explain or approach it with another staff member." Further, Emily believes that her supervisees have combinations of diverse experiences and characteristics that equate to strengths that are most beneficial to clients in certain mental health programs. She described that her approach is to learn about these strengths through observing her staff members' work with clients and to listen to what their professional interests are. With this information, she sometimes moves employees to more appropriate positions. "I have moved people from one program to another just because it was a better fit for them."

When asked about their multicultural leadership practices, staffing of ethnically and gender diverse individuals came up for many participants. Some managers admitted to hiring for diverse background experience from different areas of mental health or related professions. However, no one spoke to theory, best practices, or organizational recommendations or requirements.

Estrella recognizes the diversity of her staff members on her leadership behaviors and the impact of culture on employee relationships. "They have all different backgrounds and some of them have similar backgrounds with each other so I can see them gravitate to one another." She also shared that this diverse group of employees keeps her on her toes. She added that she works hard to build a sense of community with her staff members: "So I really try to bring them all

together so they can all bring whatever they have with them to the table." By using team building activities that get her employees to disclose personal information about their interests and backgrounds, Estrella believes that her team members are able to bond and learn about each other. In turn, she feels that this process helps them to connect in the workplace for the benefit of learning about different ways to help clients. "People from different backgrounds, I try to bring that out of them so they can share it with the other members of their team because I think it's all an enhancement to have people who are different."

Estrella also mentioned that there exist certain cultural characteristics of employees under her supervision who have chosen to pursue a second career in mental health. She noted that this affects her placement of these employees. "I find that personality type or that particular person where they're at to be more suitable for different types of jobs. I consider that when I'm considering what type of position to put them in." Estrella elaborated on her perspective by saying that it was not a matter of age, but rather a matter of "being at a different state in life." She explained that she does have a bias toward employees entering her supervision who bring significant work experience in other fields. "I've found that people are more challenged when they're coming in with a lifetime of experience, to come in at that entry level I find that--they're not as successful with it in general, that's been my experience."

Valeria described her leadership strategy as "collaborative" and stated "I'm a very collectivistic kind of person. The more that I know I like to share it with someone else." She explained her opinion that the field of mental health does not have many therapists who are adequately trained to provide sexual assault counseling, so she is especially motivated to share any professional knowledge she obtains with her staff members. She stated "I really feel that part of my leadership is to help other people professionally grow and take my position." Valeria also

explained that the collaboration she engages in with employees helps to eliminate the fear of asking questions and promotes a positive work environment.

Another aspect of Valeria's supervision strategy is her openness to receiving feedback from her employees about how she provides leadership. She shared: "If they feel that we're to chit chatty or they are not getting enough structure, they are very comfortable telling me because I don't take it personally because I think that's part of the diversity part." Valeria takes the stance that her employees are responsible for providing feedback to her to direct her supervision strategies to meet the employee's individual needs. She explained how she implements this philosophy with employees: "That's part of my interview, too. Tell me what you need from a supervisor. I look at their files and I try to remind myself that this person needs this and this person needs this."

Steve acknowledged the reality of encountering cultural differences in his work in daily interactions and shared that his approach is "to be able to just say, that's where you're at and that's who you are and that's fine with me." When asked about his specific strategies in handling cultural differences at work, he described a few behaviors that he employs as a leader. First, Steve stated that his tendency is to "eliminate power differentials." He described himself as "very much an egalitarian" and expressed that he tries to establish relationships with other staff he works alongside, regardless of their rank or position.

> In the ER, I have the same level of engagement with the nurses as I do with the tech, as well as the radiologist, as well as the doctor and the psychiatrist. Makes no difference to me their level of education, or their culture, or their background or their station in life.

Ironically, Steve also admitted that he has learned to reflect on the importance of people calling him sir, even though he still works diligently to eliminate power differentials. Steve spoke of the difficulty he had in getting his female, Hispanic administrative assistant in his

university position to refrain from calling him sir or doctor. He spoke briefly about his thoughts on why he believes it was difficult to do in this situation "I've found at least to some extent in the Hispanic community, titles are very important. I come from the polar opposite."

Another tendency that Steve has is that he communicates a sense of empathy or wondering what it is like to be in the other person's shoes to other professionals he collaborates with for the benefit of the client's care. In his leadership role in the emergency room, he believes that this message is worthwhile even though it may not immediately register upon communication or in a logical or predictable manner. He provided his opinion on his communication tactic:

> I think sometimes it may not make a whole lot of difference, but I'm a big fan of sleeper effect, so you say something, they may not remember it today, but two weeks, two months—oh I remember what Steve said! I think a big part of it is that.

In addition, Steve considers the professional culture that the other professional he is working with is from as he tries to model empathy for clients. He makes it a point to extend a sense of empathy for the medical professionals he works with who are under a different set of ethical and organizational pressures. Steve acknowledged that promoting an understanding of all parties involved is not an easy task.

> I also look at the culture which they come from, the doctors. They see emergencies. Is this real? Is this faking? Is this malingering? Is this just whining? Versus hey, I see people come in that are dying. So that's another thing. So one, I try to get them to say I wonder what it's like to be that client right now, in that room, by themselves, under a fluorescent light, saying they want to die. And I also try to look at it from their perspective of the nurse and doctor. This is the tenth patient they've had in an hour.

Steve further shared that he actively uses his narrative therapy orientation to understand how people establish their identity and tries his best to be respectful of this. For him specifically, his experience conducting research on counseling with the deaf community has taught him about labels that establish identity. He spoke of this lesson, "The deaf community say I'm a deaf

person. So their identity is tied into their hearing impairment of deafness. So that's one of the big changes for me because you know in counseling you don't label."

As a graduate counseling supervisor, Steve tries to promote acceptance of certain groups based on openly expressing why they engage in certain behaviors. He stated that he is very open when discussing issues that affect counseling practice and provided an example of explaining sexual practices and matters of sexual orientation to what he considers to be a conservative audience whose cultural values make such a discussion difficult. He explained that he tries to promote a sense of empathy for these groups using scientific rationale to explain the behaviors of counseling populations. Steve provided the following example:

> Some people engage in certain behaviors, example is someone who will perform oral sex in the park to get methamphetamine and to get some people to understand that that's what they do, it is objectifying, its denigrating, its dehumanizing but the brain craves dopamine and methamphetamine gets you dopamine. So trying to get people to understand that. You're not in their shoes.

Gunther spoke briefly about how the discussion of cultural difference fits into his clinical supervision strategies. He warns the counselors under his supervision that there is always a temptation for therapists to impose their cultural values on their clients unknowingly. Gunther described how this inclination affects the focus of his supervision: "And so we have to become aware of that and how we do that. So we talk about that a lot in supervision, particularly when there is a difference of culture."

John mentioned during the interview that he had just recently attended his first leadership training after being with his agency for 15 years. Ironically, it wasn't geared toward mental health leaders, but he stated that he was thankful for the experience nonetheless. He stated:

> Just two or three weeks ago, I was allowed to go to a managers and supervisors' conference, introductory level. And it was about things like managing difficult employees, customer service. It wasn't specifically about non-profit. It was about

> management and leadership in a global sense, in a generic sense. And that's the first time I've ever had any formal training in leadership.

John mentioned his initiation into his position of leadership as being "backwards" due to both a lack of preparation in his graduate program and a lack of training on the part of his agency. "I think the assumption sometimes is, well, you've been to graduate school, you must know how to run a program. And unless you went to graduate school in leadership, I don't know that that's always necessarily the case." Interestingly enough, John was the only participant who mentioned ever receiving formal leadership training.

Recognition of organizational culture and its impact. All of the participants in this study discussed elements of organizational culture and how one or more organizational cultures affect their roles as leaders and working conditions in mental health. Interestingly enough, the topic of organizational culture was not specifically mentioned in the interview protocol. Within this theme three sub themes emerged: Clashes in Organizational Cultures, Influence of Organizational Culture, and the Culture of Counseling. Also, it is important to note that participants who were part of the same organization provided varying perspectives on the nature of the influence of their organization on their multicultural leadership practices.

Clashes in organizational cultures. Andy's focus on culture during data collection centered on the various organizational cultures that come together on his organizational turf on a daily basis in his work as a clinical manager. He explained that in addition to managing psychotherapists, he also oversees the forensic interviewing component of the agency and the family specialists who build relationships with families to educate them on how the sexual abuse investigation process works. Andy asserted that the employees under these and other titles who work under his umbrella have varying cultures within their work. According to Andy, the binding factor within his organization is one of trauma informed culture. He stated: "We try to

create an organization that's trauma informed top down from the CEO to the people who are greeting our clients that come through the door." Andy spoke more specifically about the culture he and others in his organization are trying to create. "We're trying to create one that families feel comfortable in and that they wanna return to and that's a culture within itself that we're trying to create."

He also shared that his situation is unique and poses challenges for his employees and the clients served that are not easily overcome. Andy explained that a multidisciplinary team works at his organization and that each component of this disciplinary team operates by a different set of rules and is guided with different end goals in mind. These competing organizational values amongst the different groups coming together can clash with one another and the professionals operating within these cultures are not necessarily interested in trauma informed care.

> I have a multidisciplinary team that works here, I have the district attorney's office. They don't care about trauma. They don't care about the impact of the experience on the child. They wanna get the perpetrator and they want to put him behind bars. They want to get a successful conviction. Police is the same way. They don't care that the question they are gonna ask you it might hurt your feelings a little bit. I have to ask this question now if I'm going to get this guy. Child Services has a goal in mind and that goal is to protect that child and to do everything they can to protect that child and there are very difficult families out there so they have to have their own culture as well in the way that they interact with families.

Andy expressed his frustration and the efforts that he has made to try to provide training on trauma to the different organizational members who share his workspace. He admits that he cannot hold these other entities responsible for the standards of his organization and that these efforts have been met with resistance. "I can ask and we can work as a team to try to get them trained, but some of them think its complete bullshit and they don't want to even hear about it."

For John, clashes in organizational interests have occurred internally at his agency between he and his front line staff's efforts to accommodate client needs based on cultural

diversity and executive leadership. When asked about how he believed his organization affected his multicultural leadership practice, he responded, “I don’t know if we necessarily have the best example of a leader at our organization in that regard.” He elaborated on this view by saying: “I think the person who leads our organization makes a lot of choices willy-nilly and not culturally based.” John explained a particular situation where a client was removed from services due to what he believed was a misunderstanding about reasons for the client’s behaviors. He added that in that situation, he would have taken into account the cultural variables that explained the client’s behavior, which in his opinion, would have made the situation to be perceived less as a conflict and more as a matter of cultural difference. John summarized his view of the situation. “And if you understood the culture, you would see the situation in context, and you would make a different decision. Looking at behavior out of context, meaning out of culture, isn’t very helpful.”

John emphasized the difference in his view and the view of executive leadership at his organization with another example. He shared that he currently has a staff member of Asian ancestry who is working on networking with the local community in hopes of attracting more clients of Southeast Asian heritage since they agency is currently not reaching these clients. “For example, our idea of a support group isn’t it, but maybe coming for tea ***is*** it.” John said that he is planning on attending a technical assistance seminar in another part of the country in order to learn about how to make his agency’s services “more appealing and more welcoming” to this population. He shared that his agency is even planning to change the internal décor to be more attractive toward this group of potential clients. When asked about the perspective of the agency on this effort he expressed his opinion that he believes the front line staff members are

supportive whereas the higher levels of leadership are not interested. “I think from above it doesn’t necessarily generate significant numbers or money so it doesn’t matter.”

Valeria’s brush with organizational culture clashes was actually experienced during an international training where she learned about the differences between sexual assault counseling services in the United States and a few other countries. She provided a synopsis of the training.

> We went to Monterrey and we went to Nicaragua and that was really important to us because it helped us understand that we may be able to provide these types of services, but other countries don’t have the luxury of unlimited therapy sessions or the fact that the therapists themselves are afraid of retaliation and they have to have undisclosed locations for even their mental health.

Valeria expressed her gratitude for attending this training and the fact that she was able to collaborate with the mental health professionals abroad to focus on potential solutions to their obstacles to providing needed services to clients. She spoke about the lasting effect of those trainings: “That preparing for those trainings with my colleagues, being there and then when we came back and debriefed about those trainings, has opened up my perception, my experience of the importance of multiculturalism.”

Valeria explained that she also does educational presentations to different audiences that represent different belief systems, and that she must be careful how she presents sexual assault information in order to avoid clashes in organizational cultures. To accommodate the needs of various groups, she consciously tailors the information she speaks about to appeal to her audience. Valeria expressed that activists in the sexual assault world are very straightforward with how they deliver information, but she chooses not to operate that way because does not want people to miss the message that she is trying to get across about her clinical services. “Some activists would not agree with that but I think that’s a part of my trying to be multicultural.” She provided an example of how she tailors her presentations for a church setting.

> I know I'm going to church so I can't really talk about pro-choice too much. Doesn't mean that I don't believe that, it just means that I want them to meet me where I'm at and give as much information as possible so I'm going to talk about *this*.

Steve's experience with organizational culture clashes occurs frequently in the emergency room setting where he provides consultative services. He noted that there are distinctive differences between him and the medical staff he works alongside. "There's a certain culture with doctors. I've worked in ERs for 25 years. There's a big power differential and it's very difficult sometimes." Steve recognizes that the physicians he works with have more education than he does and added that "a lot of times it takes a while to get them to understand that you know what you're doing so it's taken several years." Steve illustrated the difference between his perspective and the perspective of the physicians: "Their job is to clear the ER out. My job is to help the client which they call a patient. So there's kind of a different understanding of what constitutes this individual we're seeing."

Steve explained that there is a significant difference in the wellness-based model he was trained on, and the pathology-based model under which the doctors operate. A few differences in patient treatment preferences between himself and the doctors include the doctors' hastiness to prescribe medication and opinions on whether a patient is a danger to others. Steve elaborated on the latter by saying "their job is to keep the patient and the rest of the other people in the ER safe."

Culture clashes also occasionally take place between the influence of Steve's cultural background and the beliefs of the clients he works with in his consultation role. His response to this challenge is to acknowledge his bias and to find a middle ground in treatment that meets the needs of the client. He explained that this process has become easier for him over time, but he still must work continuously at it.

According to Steve, his middle European background espouses a perspective of self-sufficiency and not asking for help. Ironically, he works with individuals in extreme distress. He addressed his approach: “So it’s a real bridge between empowering them, not enabling them, and keeping my biases. You know, someone becomes suicidal because their girlfriend broke up with them. The devastating emotional pain. But coming to understand that that’s where they’re at.”

In his supervision of clinical sites, Steve explained that he works alongside other mental health professionals with different views on mental health treatment. These professionals include psychologists, social workers, marriage and family therapists and licensed chemical dependency counselors. His approach to diffusing conflict is to first listen to where the professional is coming from. Steve highlighted the rest of his strategy in these situations. “So a lot of it is kind of bridge building, finding a common denominator, which again tends to be the client. And then taking account into the differences. And then of course, the clients themselves.”

Influence of organizational culture. Marcus noted that there is one culture that superimposes itself over other cultural elements in the mental health workplace. For him that is the culture of higher education and it affects his perspective of his employees. He elaborated by saying “I think because… probably 95% of the people I have are bachelor’s and master’s level people so I think you’ve got that educational culture overlay and that kind of blinds you to their original culture.” Marcus presented an example using himself as a basis for his belief. He does not believe that others are able to see elements of his cultural background very often at play in his work.

Understanding the operations and the influence of multiple organizations has been part of Marcus’s adjustment to his leadership position. He shared that there is something to learn from all of the organizations he routinely collaborates with.

> Just learning the area and the people and the way of the city I think has opened my eyes and I think I've learned a lot in dealing with how parole deals with this type of thing, or probation, or juvenile justice and different things like that I think all of those things influence me when it comes to multiculturalism.

Emily expressed her observation of how her staff members' past work in certain organizations affects their current work, and in turn affects her management with these employees. She stated that she has some staff "that because of their history and their backgrounds they approach clients differently." She elaborated that this background influence necessitates changing her approach with employees based on their past experiences. Emily gave an example of a staff member who used to be a probation officer. She stated that this employee expects total compliance from clients. At one point this employee was working with a family and advising them on steps to take to avoid a child services report. The employee presented the concern to Emily that the family did not follow her advice. Emily got involved and realized that the family wanted to care for their child but the information was presented in a negative manner and was not fully explained. Emily explained the employee's reaction to this supervision. "So when we talked about that, she was like, oh, I need to explain it more clearly. It's not just a,b,c. This next step is because this will happen, and the family just wasn't understanding that." According to Emily, the employee was working from the former belief system from probation where if clients did not comply with directives, then the final result would end in handcuffs. Through the supervision session, Emily shared that the employee was able to realize this unacknowledged belief and to approach the family in a different manner.

Estrella believes her past experience of counseling prisoners profoundly affected her as a leader in her current position. Through working with that population in the past, she stated that she learned "how to accept the language, the lifestyle, the differences in choices and access to jobs and resources." She admitted that it was tough working in the prison environment at first but

she was able to become accustomed to the sights, sounds, and routines. Furthermore, she learned to better handle client differences because she has grown a "thick skin" so not much surprises her anymore. "I think it's easier for me to provide leadership when I'm not rattled by something that's different."

Her knowledge and understanding of prison populations proved to be helpful when she first moved into her current leadership position. Estrella described the situation that occurred: "there was a patient X who the case managers were nervous about serving because they came across information that he had a criminal background and I just thought, lots of people have criminal backgrounds." She shared that part of her leadership philosophy is to provide the best care to all clients regardless of their criminal history.

Estrella explained that luckily she had a physician on staff who had worked in the same prison she had prior to working in this position. They were able to work together to role model for the staff how to serve the client with no less quality of care than other clients without criminal records.

Josie noted that recently there has been an element of organizational influence that she finds particularly positive. She shared that within her organization, there have been leadership changes that have left her more optimistic about her potential to climb the career ladder in her organization. According to Josie, for the longest time, the majority of the executive level leaders in her organization were male. Now, Josie believes that the glass ceiling has been broken:

> If you think about the organizational structure now, we have one male vice president and the rest are female. Our CEO is male, and I see that as breaking the glass ceiling because before the restructuring of our organization, all the people in power were males.

Before this organizational change, Josie decided to begin working on an additional master's degree in health care administration. She was doubtful that there would be true

opportunities for her own advancement prior to the structural change in her agency. “I really thought that I was going to have to leave the organization in order to continue advancing in my career.”

None of the participants stated that multicultural competence was an imperative in their respective organizations. Moreover, none of the participants shared information about required practices or organizational initiatives geared toward cultural competence. Even participants affiliated with the same organization had varying perceptions about the core beliefs of the organization when it came to diversity and multiculturalism as well as the influence of the organization on their multicultural leadership practices.

Culture of counseling. Felicia acknowledged how what she called the culture of counseling influences her employees. It has been her experience that the preference in mental health counseling is to have a private practice mentality. For her, this means that her staff would prefer in many cases to work with clients who have less intensive mental health needs. Felicia explained that some of her employees complain that their clients are not interested in working hard to get better. She provided an example of factors that staff do not always consider when coming up with judgments such as these.

> They haven’t taken the time to find out that client X is a single mom with four kids and its gonna be difficult for her to make sessions in the middle of the day because she doesn’t have insurance at work.

Another element of the culture of counseling according to Felicia is the unfair relationship between clients and counselors. She spoke of the one sidedness of the counseling relationship by referring to her past experiences with clients in therapy by explaining that “the expectation is that they were supposed to be vulnerable, honest, and in some cases tell me things that they really never told anyone else and they really didn’t get to know a lot about who I was.”

Gunther also spoke to a different aspect of the culture of counseling. Gunther acknowledged that there is a lack of ethnic diversity in the field as well as individuals who come from non-middle class backgrounds. This presents an issue with new clients who are attempting to enter his private practice. “We’re in an upper socioeconomic area and so people come in and they’re like ‘Do I fit here?’ ‘Sure you do! Come on in!’” He explained that he has to work to reduce clients’ hesitation to seek services through his practice in the church which is largely White and affluent.

His emphasis was also on financial challenges that occur in the profession. “We have created a culture around counseling that says there’s not much money in it so you have to have another income. Well that eliminates, culturally, an entire class of people that would be phenomenal therapists.” Gunther insisted that a therapist must accept a lower socioeconomic lifestyle to work full time in the field of counseling. The lack of income in the field is frustrating to him.

One additional aspect of the culture of counseling sub theme was the evolution of learned bias to one of tolerance for people from diverse backgrounds. Many participants admitted that they were raised by parents who were prejudiced against certain cultural groups. However, their current beliefs point to the culture of counseling, which teaches that counselors have an ethical obligation to accommodate cultural differences and take a non-judgmental stance when working with clients. The only exception in the group was Gunther who stated: “I am a very conservative Christian. I have a problem with the concept of homosexuality as a lifestyle. I think it’s more of a mental health issue than a lifestyle.” Gunther consistently identified himself more strongly with his religious beliefs than any of the other participants in the study. He was also the only participant who admitted to being an ordained minister and a Christian counselor.

Summary

In summary, the constant comparison data analysis produced four major themes. The clinical managers in the study described culture as a complex concept with many dimensions for the first theme. Second, they shared having significant multicultural learning experiences outside of educational settings with family and friends, and in prior work settings before entering the counseling field. Third, leadership issues emerged as a theme. The sub themes under this theme included human resource issues, shared decision making, and staffing/ supervision issues. The final theme that emerged was the recognition of organizational culture and its impact. The three sub themes under this theme were clashes in organizational culture, the influence of organizational culture, and the culture of counseling.

Through the analysis, it was discovered that the participants expressed shared multicultural leadership practices and learning experiences in the workplace, despite individual and organizational differences. The study was able to address the primary research question as evidenced by the theme of Leadership Issues, which speaks to the participants' descriptions of their multicultural leadership practices in daily interactions in outpatient settings. Further, this theme also speaks to how the clinical managers in the study learned through experience to adapt their leadership practices at work.

The data analysis also produced helpful information about how the participants learned about multiculturalism and diversity, and their perceptions of what learning experiences were most valuable and least valuable. Likewise, the clinical managers were able to speak about influences on their multicultural leadership practices and transformative experiences that were catalysts to change. The next chapter continues with a discussion of original research contributions from this study, along with additional data considerations and recommendations.

Chapter 5: Discussion and Recommendations

Introduction

This study was developed in an attempt to contribute data to begin to fill the gaps in the United States mental health disparities puzzle by addressing the level of leadership. Despite the proliferation of research at the practitioner level that addresses best practices in serving culturally diverse clients and organizational prescriptions for cultural competence, problems with access, utilization, and outcomes in mental health services persist in the United States. This study was designed with the understanding that leadership at the level of ground floor clinic management could be the possible "missing link" between the practitioner and organizational levels. Through inquiring about the lived experiences of the 10 professionals in the study, the study sought to shed light on how these counselor-leaders described their multicultural leadership practices.

The purpose of this basic interpretive qualitative study was to explore clinical managers' perceptions of their multicultural leadership practices in daily interactions in outpatient mental health settings. The primary research question used to guide the study was: How do clinical managers describe their multicultural leadership practices in daily interactions in outpatient mental health settings? The research was also designed to address secondary research questions as to how the clinical managers learned about and developed their multicultural leadership practices as well as other factors they believed may have influenced these behaviors.

To answer the research questions, data were collected primarily through face to face interviews with 10 licensed psychotherapists who met the criteria as clinical managers working in outpatient mental health settings. The leaders in the study represented diverse cultural backgrounds, organizational settings, and training backgrounds. In spite of the individual and

work-related differences amongst the participants, four major and unified themes were produced through the constant comparison analysis:

- culture is a complex concept;
- multicultural learning outside of formal educational settings;
- leadership issues; and
- recognition of organizational culture and its impact.

These themes were further categorized into sub themes and supported with detailed contextual information to provide the reader a more in-depth understanding of the meaning of the participants' perspectives.

The remainder of this chapter will present the answers to the research questions while integrating the theoretical framework and connecting insights obtained through the study back to the research literature where possible. In addition, this chapter will also explain how the gap in the literature was filled through the inquiry and how the original contributions of the research produced valuable data that can be used to formulate future studies and recommendations to various organizations. Overall, this chapter presents a deeper level of analysis of the findings, connects the findings to current research literature, and presents applications to real life. Following is a sequential overview of the major sections in this chapter.

First, an in-depth discussion of the findings from the constant comparative analysis will be presented. The discussion will explicate how the overall research question and secondary questions were answered according to the findings. This section will integrate the theoretical framework, explanatory theories, and related concepts. The last part of the discussion includes the original contributions of the research. Second, recommendations for mental health organizations will be thoroughly discussed. In the third section, recommendations will be

provided for training professionals, faculty, and professional associations affiliated with mental health organizations. Fourth, implications for future research will be stated. And in the final section, the chapter will close with the final reflection of the study.

Discussion of the Findings

Through the themes that emerged in the data analysis, the main research question and the secondary research questions were thoroughly addressed and added meaningful information to the body of mental health leadership as it relates to multiculturalism. The inquiry was focused on learning about what specific behavioral practices the clinical managers routinely employed as multicultural leaders in outpatient mental health settings. In addition, the research also sought to explain the reasons behind these behaviors. Data related to the participants' rationale for their multicultural leadership behaviors came from the third theme of Leadership Issues as well as the corresponding sub themes of Human Resource Issues, Shared Decision Making, and Staffing and Supervision Strategies. Moving beyond the limitations of the previous chapter, Chapter 5 will speak more in-depth to leadership practices of the participants in the study, the rationale for these behaviors, and to other contextual factors that are important considerations.

Answering the research question. The broad theme of *Leadership Issues* was a key theme that essentially answered the central research question of the study. The clinical managers provided specific examples of how they address the needs of the culturally diverse clients served by their clinics and the culturally-influenced needs of their staff members. All participants indicated an interest in accommodating the cultural needs of others in some form or fashion with the majority of participants employing multiple methods. The sub themes speak more precisely to the specific area of clinical management where the participants have intentionally planned or tailored their leadership based on multicultural needs. Across the participants, some of the

common concepts that are particularly significant included commentary on multicultural leadership practices related to communication, flexibility, and working with their staff members to reach programmatic goals. The following sections provide a synopsis of the multicultural leadership practices cited by the participants.

The participants' multicultural leadership practices and explanations of these practices are explained in detail in the previous chapter, but it is important to examine the assumptions upon which these practices are based. Chapter 5 will highlight the leadership practices and how the participants were able to justify their behaviors using their examples and rationale. Chapter 5 will also compare the insights gleaned about these practices with mainstream research literature where possible.

Human resource issues. This sub theme emerged to capture leadership issues that were a result of conflicts, potential complaints, or issues of fairness that could be considered the domain of human resources. In this sub theme, the participants found themselves in challenging situations in their work settings and formulated ways of handling dilemmas with subordinate staff members. These difficult situations involved differences of opinion or perspective that the participants attributed to cultural misunderstandings. They also involved extreme frustration and emotion for all involved. To resolve these dilemmas, the participants learned to take an action or formulate a way of approaching the specific work situation in an attempt to avoid future problems. The behaviors described under this sub theme were (a) the practice of demonstrating flexibility with policies and procedures; (b) tailoring communication to meet staff members' needs; (c) creating consistent rules and enforcing them with all staff; and (d) carefully reflecting on accusations of discrimination.

Figure 1. Participants' multicultural leadership practices in everyday outpatient settings categorized by four aspects of the supervisory role.

In reference to being flexible with policies and procedures, John provided the example of how one of his employees is from another country, has several children, and needs flexibility to attend to her children's needs during work hours. This has been noted especially in the case of working mothers in the United States who may face challenges with regular business hour schedules when children are under their care (Fondas, 2013). Similarly, people from different backgrounds may have different perspectives on the meaning of their work, as Valeria noted. Indeed, values about the importance and meaning of work vary based on one's country of origin and in many Latin American countries, there is much less distinction between work and personal life than with people from the United States (Stewart & Bennett, 1991). She explained that this is why she works diligently to tailor communication style to the needs of her employees. She

learned early as a clinical manager that not all employees interpret the same types of emails or verbal messages the exact same way, and that the subtleties in her communications were important to pay attention to.

Interestingly enough, practices (a) demonstrating flexibility with policies and procedures and (c) creating consistent rules and enforcing them with all staff may appear to be contrary, but the rationale for both as explained by the participants was to be equitable to staff members and to treat all of them with respect. Reflecting on accusations of discrimination was the final behavior noted under this sub theme. Participants explained that despite the initial shock of being accused of discriminating against staff, they did go back and take time to reflect on their role in the conflict. A few participants explained how they made amends with staff and worked moving forward, to attempt to create a more harmonious and non-discriminatory work environment through their leadership efforts.

Shared decision making. The sub theme of shared decision making refers to the idea of including staff in the process of making programmatic decisions that affect clients or the mental health organization itself. Two participants were adamant about utilizing this practice. These clinical managers freely explained that the benefit of making decisions with their employees was well worth the effort involved. Specifically, this effort entailed lengthy amounts of time and figuring out how staff members' differences can be understood as strengths in the decision making process. The rationale provided by both of the participants was that they were each limited in their professional perspective and contributions, largely in part due to cultural reasons. Therefore, involving staff members in decision making processes afforded them the chance to make better leadership decisions and to learn from additional viewpoints.

Shared decision making is one technique for creating a culture of collaboration that is associated with the practice of *shared governance*. According to Scott and Caress (2005), shared governance is a type of leadership and management that promotes collaboration and learning amongst staff and leaders, with the final aim of improving clinical practice for patients. This approach moves away from the top down decision making historically used in health care. Stemming from governmental mandates for changes to modernize the health care workforce in the United Kingdom, shared governance is a means by which organizations can "reflect the diversity of the workforce and the community it serves" (Scott and Caress, 2005, p. 4). Lamont, Walker, and Brunero (2009) discussed the concept of *practice development* under which shared governance falls, as a way of achieving an ongoing quality improvement health care culture that values the contributions of teams. Lamont et al. (2009) speak to their use of shared governance and practice development in inpatient mental health in Australia. Practice development has the potential to affect positive change in the workplace but comes with issues such as resistance from senior leadership, lack of clear strategies, and unknown outcomes with patients until services are rendered (Lamont et al., 2009).

Staffing and supervision strategies. The staffing of employees was a key area that was mentioned by the participants throughout the data collection. For this section, staffing will refer to hiring and placement of employees. The majority of the participants made claims that they viewed diversity related characteristics of employees as assets for clients served in their clinics. Meeting the needs of the clients was the driving force for creating diverse clinical teams for the clinical managers in this study. Linguistic and gender diversity are other types of diversity that the managers looked for when hiring and filling certain positions. The participants explained that they believed it helpful to have clinicians who were able to mirror the cultural characteristics of

the populations served in their clinics since clients' culture affects treatment preferences. Marcus stated that he believes that client complaints are sometimes attributed to differences in culture, particularly when there are differences in cultural perspectives.

The participants' definition of diversity also extended to past professional work experience. Emily was particularly adamant about hiring clinicians with a variety of professional experiences. She believes the knowledge these employees bring to the table is helpful in providing more comprehensive approaches to treatment for clients. The staff members are able to contribute a wide array of perspectives about systems that intersect with mental health and other human services that may benefit clients. The downside of this type of staffing pattern is that much debate ensues during the clinical supervision process about how to understand the treatment needs of a client and employees must interpret each other's jargon. For teams such as Emily's where her team members consist of individuals of varied cultural and professional backgrounds, research has noted that multicultural teams face a multitude of challenges and communication problems are not uncommon (Ramthun & Matkin, 2012).

Sanchez et al. (2012) stated: "Key to the delivery of culturally and linguistically competent care is a diverse workforce that also represents the population" (p. 18). However, most participants acknowledged that it is indeed challenging to hire a workforce that culturally mirrors their clients. Hoge et al. (2013) commented on the crisis level shortage in the mental health and addiction workforce in the United States by stating that high turnover, a lack of diversity, and concerns about effectiveness are major issues. Hoge et al. (2013) also noted that the United States does not keep systematic data on the size or demographics of the mental health workforce, but the general belief is that it is not sufficient to support the current needs for services, let alone to address the needs of minority populations. "Only 6.2 percent of

psychologists, 5.6 percent of advanced practice psychiatric nurses, 12.6 percent of social workers, and 21.3 percent of psychiatrists are members of minority groups" (SAMHSA as cited in Hoge et al., 2013, p. 2007). The Sullivan Commission (2004) emphasized the idea that minorities can feel ostracized from the health care system since providers do not resemble them, and called attention to the discriminatory practices that continue in health care institutions.

As for supervision strategies, the clinical managers presented a variety of practices that can be further subdivided into groupings of techniques. Figure 2 visually displays the groupings and subgroupings of multicultural supervisory techniques.

Figure 2. Study participants' multicultural supervision strategies.

According to the clinical managers in this study, all of the multicultural supervision techniques they use contribute either directly or indirectly to the provision of more culturally competent services for clients. The managers believe that building relationships with and amongst employees is fundamental to promoting cohesion in teams as well as multicultural competence. According to them, this works by using team building strategies, including planned activities like games and discussion to eliminate staff members' self-imposed segregation based on perceived differences. The clinical managers also noted that they work on building relationships with staff at all levels, and working to get to know staff for who they are outside of the workplace. Steve referred to eliminating power differentials in his leadership practice.

The premise behind the relationship building is to interrupt the unconscious staff patterns that mimic the traditional hierarchical structures that contribute to the perpetuation of racism, classism, and division in society. Second, relationship building enables the clinical staff to work better together during other work processes, such as clinical supervision. Third, this strategy helps the leaders in the study to better understand the uniqueness and strengths of each of their employees. Schein (1993) explained that dialogue within groups in organizations is essential to building teams that are able to think as creatively and generatively. Schein also explained the cultural concept of saving *face*, or the culturally engrained tendency of people to resist threatening the social order. This leads to withholding information and therefore a lack of communication. For Schein, the end result of effective dialogue is clear communication across subcultures within the organization and ultimately organizational effectiveness.

To facilitate communication processes, the clinical managers worked on creating a collaborative learning environment and obtaining feedback from supervisees about how to improve the supervision process. Valeria explained that developing an open learning environment for staff

helps eliminate the fear of asking questions and communicating concerns related to work performance. It also encourages staff to share pertinent clinical information that could help work performance with the team. A few of the participants were also adamant about gathering input directly from staff about supervisory needs and preferences to improve their management skills. Felicia recognized that without seeking input directly from staff, she may only be able to assume or make speculative judgments about needs for performance coaching. She expressed that she uses the technique of making her staff members responsible for asking for what they need. Valeria maintains objectivity when receiving feedback on her leadership strategies, and has learned not to take criticism personally. From the perspective of the clinical managers, leadership is an ongoing and iterative process. The one sized approach does not fit all.

During the clinical supervision process, where clinical cases are discussed and treatment options and advice are explored, the participants shared that they employ both group clinical supervision and the intentional emphasis on cultural differences between the therapist and client. In the case of group clinical supervision, working together as a group poses benefit to planning the treatment of the client since several staff members can contribute expertise based on cultural perspectives and differences in professional background experience.

Also during the clinical supervision process, the leader can bring cultural value differences to therapists' conscious awareness and educate them on how they may unknowingly impose their values on clients. Psychotherapists tend to have the inclination to work from perspective of their own culture and Eurocentric training in therapy. However, they can be trained to explore *culturally sensitive empathy,* which is more consistent with the diverse client's cultural reality. This requires obtaining information to understand the cultural perspective and reality of the client (Chung & Bemak, 2002). In addition, using broaching techniques, or

addressing salient issues of culture and how they affect clients during counseling, contributes to counselor credibility and strengthens the relationship (Sheely-Moore & Kooyman, 2011). Although broaching was not explicitly mentioned by the participants, it holds promise according to research, for bridging the gap between therapists and clients of different cultural backgrounds.

Language in supervision and clinical practice is another factor. There is research evidence that speaks to the importance of the use of clients' native language in mental health assessment and services for more accurate diagnosis and treatment (Sanchez et al., 2012; Verdinelli & Biever, 2013). Unfortunately, Latinos only account for less than 3% of the total psychology and counseling professionals in mental health, and there are no clear statistics on the number of bilingual individuals (Verdinelli & Biever, 2013). The issue of language for the participants in the study was important considering the location of the study in the southwestern United States. Qualitative research has shown that any training or supervision of psychotherapists is potentially beneficial due to lack of training on how to translate clinical vocabulary and navigate variations in the Spanish language. There are also different linguistic training needs with native and heritage speakers (Verdinelli & Biever, 2009).

Last but not least, the final category under supervision strategies, *advocacy*, was mentioned by some of the clinical managers in the study. Steve was adamant about using educational strategies to combat negative stereotypes about commonly misunderstood populations that are served in mental health. Four of the participants mentioned providing training to their staff and organizations on specialized diversity topics. Amongst the participants, there was mention about the taboo associated with the open discussion of certain topics such as sexuality and more specifically, non-traditional practices related to sexuality. One participant mentioned the conservative nature of the region of the country in which this study took place and

how peoples' attitudes restrict their willingness to engage in critical discussion about stereotypes. This should also be considered an important factor in disparities as researchers and practitioners work to improve cultural competence.

Strengths and other considerations. Playing to the strengths of the employees was mentioned by a few participants but was not elaborated on in detail during the interviews. Participants also stated that throughout the use of supervision strategies that they were interested in identifying the strengths of their employees based on different characteristics associated with diversity. Williams (2001) noted that understanding the cultural lenses of employees can help managers "to recognize and develop these strengths across diverse populations" (p. 6), thus serving as a benefit to the development of the organization. However, there was no mention of exactly how this was accomplished, ideal strengths or desired characteristics in staff based on cultural difference, nor how these are used by the clinical managers in the workplace.

Participative management. The clinical managers in this study demonstrated characteristics of participative management strategies in their descriptions of their multicultural leadership behaviors. Participative management can be traced back to Likert's (1967) typology of organizations, based on an organization's use of authoritative or participative management techniques. Participative leadership includes extensive participation, group decision making, communication with employees at all levels, and focus on improvement and appraisal (Likert, 1967). A study by Angermeier, Dunford, Boss, and Boss (2009) indicated that employees in health care organizations who perceived working in highly participative work environments provided better customer service, committed fewer clinical errors, demonstrated less burnout, and had a lower likelihood of leaving the organization than employees in more authoritarian settings. While effectiveness of leadership is not the focus of this study, it is important to note

that the participatory techniques mentioned by the participants affect employee attrition and performance. These leadership techniques could be built upon and considered as potentially powerful in helping improve retention of minority employees and mental health services for diverse clients.

Application of the DMIS. An understanding of mental health leadership cannot occur without consideration of each of the participants' beliefs about cultural difference. The rationale that each provided for their choices of pro-diversity behaviors and the management of work issues around cultural difference speaks to their perceptions about how they and others should relate to cultural difference at work. It must be noted that the intention of this study was not to categorize the participants in terms of their orientations toward cultural difference; however, certain conclusions can be logically drawn about the participants' orientations based on their justifications for their multicultural leadership behaviors. The DMIS provides a way of interpreting, and understanding the leaders' perceived understandings of how to relate to cultural difference in the behavioral health setting. Across the participants in this study, multicultural leadership practices indicative of individuals in the stages across the spectrum of the DMIS, from minimization onward were noted.

Hernandez and Kose (2012) emphasized the developmental differences that occur when applying the DMIS to members of the dominant culture and minority groups in educational leadership. They also accentuated the importance of factoring background, education, and work context when considering the nuances of cultural competence of these leaders. When applied to this study, for example, statements made by the two white, doctoral level participants demonstrate ambivalence about acknowledging and accommodating cultural difference and point to the stage of minimization, or the colorblind outlook, in mental health leadership. In the state of

minimization, individuals assert that they should be themselves, will often correct the behavior of others to match their own, and believe that people are basically all the same (Hernandez & Kose, 2012). While they each acknowledged cultural differences, both participants expressed not only discomfort with terms associated with multiculturalism, but also downplayed the importance of addressing cultural differences as part of culturally competent service provision. Gunther explicitly stated that he did not like the word multiculturalism, and expressed that he thought people tended to focus too much on cultural difference and not enough on commonalities. At the same time, he did admit to providing intentional focus on client and counselor differences in clinical supervision.

Along the same lines, Steve spoke adamantly about how psychiatric illnesses are perceived very differently in countries outside of the United States thus demonstrating knowledge of international understandings of behavioral health. Ironically, he also stated that he doesn't put stock in researchers like Sue, who historically and currently is regarded as a well-respected researcher in multicultural counseling. Moreover, he acknowledged some importance in understanding the culturally influenced perspectives of others through empathizing with a suicidal client who was distraught over the loss of a relationship, yet he maintains that he pushes to eliminate power differentials through not allowing people to call him sir. Steve maintains this practice even though he realizes that participation in these power differentials, or use of formal communication behaviors with people in leadership, are part of the cultural practices and beliefs of minority ethnic groups around him.

In contrast, with individuals from the non-dominant culture, such as Andy, minimization takes on a different form and tends to show as an expression of "melting pot" (Bennett, 2004, p. 68) beliefs about how people should think and behave in the mental health organization.

Universal standards are applied to all people regardless of cultural background (Bennett, 2004). Andy's explanation of how he holds all of his staff to consistent rules for behavior in the attempt to be fair is indicative of minimization. Also, Andy minimized the importance of the presence of cultural differences amongst his staff members and the clients his agency serves. When describing clients, he emphasized their universal need for sexual assault counseling and advocacy. Most of his focus during the interview was on differences between values in his agency and those of outside organizations. He described the influence of outside, collaborating organizations as interfering with the values in his organization, so awareness of organizational culture was present. However, when describing employees, Andy did not make statements that were indicative of his awareness of how his employees' cultural backgrounds might impact their interactions at work and his approach to employee management could be conceptualized as being universal in nature, with much emphasis on enforcing compliance with his rules. Bennett (2004) suggested that to move someone from minimization to acceptance of cultural difference, awareness of one's own culture is required. It is only when people can accept the idea that all of their values and behaviors have been influenced by the contexts they have been exposed to that they can move forward with intercultural development (Bennett, 2004).

The move from the ethnocentric worldview into the worldview of ethnorelativism is a needed shift and highly desired in behavioral health. According to Bennett (2004), "the DMIS is not a model of knowledge, attitude, or skills" (p. 69). In behavioral health, for example, knowledge of a cultural group or language is not enough to speak to one's ability to understand the appropriateness of how to tailor services or communication to meet the needs of the cultural group as the disparities research over the past two decades has clearly demonstrated. One example of how this plays out in mental health leadership might involve a clinical manager's

general recognition of a local market of Spanish speaking clients, but not having a sense of urgency or any follow through when it comes to hiring Native Spanish speaking therapists or working to translate forms and marketing materials into Spanish. This is because in the minimization stage, there is no personal investment in addressing differences.

Furthermore, acceptance, the first stage on the ethnorelative end of the DMIS, is accompanied with a positive view of cultural difference and the acknowledgement and understanding of the presence of multiple ways of perceiving situations through a cultural lens. Felicia demonstrated aspects of acceptance through her statements about cultural memberships define and affect the needs of each individual, especially when it comes to relationships. Moreover, her solicitation of her employees' personal characteristics and preferences on their supervisory needs indicated a positive view of their individualized needs and perspectives.

John also acknowledged the importance of cultural difference in light of his self-proclaimed limited view as a white male, to justify his group decision making strategies. Further, he was eager to move forward with seeking out Asian clients by working alongside an Asian staff member. His investment in this strategy indicates his adaptation to cultural difference when working with staff and clients. Regarding people from the dominant culture in domestic contexts who are in the stage of adaptation: "they seek the other cultural perspectives represented in groups and attempt to learn how to act in ways that are to some extent appropriate in those cultural contexts" (Bennett, 2004, p. 71).

Also with adaptation, there is more of a shift into the type of empathy that Bennett (2004) described as "the ability to take perspective or shift frame of reference vis-à-vis other cultures" (p. 70). This shift involves changes in cognition, affect, behavior and the understanding of lived experience. In other words, individuals are able to feel and function in the context of the other

culture. With this stage there is an accompanying sense of flexibility that could be highly beneficial in the fight against disparities if applied in behavioral health leadership. In this study, clinical managers such as Valeria demonstrated aspects of adaptation thoughts and leadership behaviors through how she tailors her sexual assault education with religious organizations, how she responds to the needs of diverse employees by adjusting her communication strategies, and how she uses participatory strategies and adjusts to the needs of her employees.

By applying the stages of the DMIS to behavioral health leadership, researchers can begin to conceptualize cases in leadership and match multicultural leadership practices. Researchers and professionals can also create hypothetical examples of thoughts, behaviors, and potential organizational impact associated with each DMIS orientation to begin to create informational models for understanding clinical managers' multicultural leadership in behavioral health. Table 3 provides an overview this concept.

Table 3

Hypothetical Application of the Developmental Model of Intercultural Sensitivity to Mental Health Clinical Managers' Thoughts and Leadership Behaviors with Organizational Impact

	DMIS Orientation	Thoughts	Leadership Behaviors	Organizational Impact
- Complexity in relating to cultural difference +	<<<*Ethnocentric Worldview that Perpetuates Mental Health Disparities*>>>			
	Denial	Decline in use of behavioral services has nothing to do with race, ethnicity or culture.	CM makes clinic changes to increase use of services without considering the influence of race, ethnicity, culture or consulting staff members.	Changes are not impactful. Revenue and time are lost. Staff members view CM as disconnected and uninformed.
	Defense	Substance abuse in the African American community is a sign of weakness.	CM makes derogatory comments about African American population. Prohibits black heritage celebrations, client outreach, or tailoring services to meet the needs of this population.	Hostile work environment, increased turnover, lack of staff diversity, client dissatisfaction, legal problems, and stigmatization of African Americans.
	Reversal of Defense	The counseling center is too Eurocentric. We should redesign our services around the needs of the Latino/a community.	CM decides to market only to Latino/a populations, hires Spanish speaking clinical staff, changes office décor to be more Latino/a friendly, requires staff to participate in only Latino/a celebrations at work, and tells counselors to always overtly address issues of racism with their clients in session.	Extreme changes promote discomfort in clients and staff who feel forced to engage in mandatory activities. Stereotyping is promoted. Client dissatisfaction and turnover increase. Revenue is lost.
	Minimization	If immigrant clients riding the bus tried harder to get to their appointments on time, we wouldn't have to cancel them.	CM reinforces late policies with staff to "teach" clients to follow clinic rules. CM denies suggestions to accommodate clients' needs for flexible scheduling and will not consider the financial and cultural considerations that might explain the immigrant bus riders' tardiness.	Clients become frustrated and terminate services. Revenue is lost. Staff lose morale from not being heard when advocating for clients. Cultural distrust of services is perpetuated.
	<<<*Ethnorelative Worldview Leading to Culturally Responsive Clinical Practice*>>>			
	Acceptance/ Adaptation*	The agency should respect cultural differences, learn about clients' cultural strengths, and respond* to their service needs accordingly.	CM addresses client culture with staff in all supervisory processes. CM uses shared governance, client, and local community data to make culturally informed leadership decisions. Multicultural training is responsive to staff need. Outreach to underserved populations is conducted. Staff diversity is sought out. CM also advocates within organization when needed.	Respect for cultural differences, learning, and critical thinking is cultivated. Policies, marketing, access, community education, and clinical services become more responsive to cultural needs of clients. Revenues increase.

Note. Adapted from Bennett, M. J. (2003). Towards Ethnorelativism: A Developmental Model of Intercultural Sensitivity. In R. Paige (Ed.), Education for the Intercultural Experience: Second Edition (pp. 22-71). Yarmouth, ME: Intercultural Press.

In addition, formalized assessment can also be used to understand where leaders lie on an abbreviated version of the DMIS continuum and to formulate training strategies. The Intercultural Development Inventory (IDI) is a 50 item self-administered questionnaire developed by Hammer based on the DMIS that can be used to measure the mindset and behavior that influences individuals' work, education, and leadership toward others. The instrument can be administered to individuals, groups, and organizations for training, research, and program evaluation purposes (Zhang, 2014).

According to Hammer (2015), the IDI is used extensively for leadership training and has been adapted for use in general organizational settings and in education. The instrument is purported to be free of cultural bias, with high cross-cultural validity, high reliability in the United States and abroad, and with strong predictive validity in organizations. The IDI measures five core mindsets that correspond to specific diversity related behaviors in the workplace. Furthermore, managers in the adaptation mindset prove to be more effective leaders and mentors, utilize diverse resources that enhance team performance, and help create a more inclusive workplace culture. Moreover, those in adaptation demonstrate responsiveness to the needs of those who are culturally different (Hammer, 2015). IDI, LLC (2015) provides consultation to organizations seeking to improve intercultural competence, as do other consultants who are trained to administer the instrument.

Though there currently is no evidence of a health care adaptation of the IDI, this assessment might be helpful to more accurately categorize clinical managers' intercultural sensitivity development and to develop training that helps these leaders move further along the developmental continuum toward ethnorelativism**.** At the very least, the IDI could be used to help foster self-awareness of clinical managers' perceptions about how to relate to cultural

difference. Assessment is often used and valued in health care, however, rarely with leadership. Assessment should become part of building an evidenced based culture around leadership in health care, especially since leadership has not been fully addressed as a means to help remedy the problem of disparities.

Answering secondary research questions. Secondary questions in the study focused on how the participants learned about and developed their multicultural leadership practices and other factors they believe may influence these behaviors. The secondary questions used to guide the study are important because they helped identify participants' learning experiences along with people and environmental factors involved in the development of their leadership practices. This is imperative since little is known about multicultural leadership learning processes or contexts in mental health.

Moreover, the secondary questions in the study pick up where the primary research question leaves off in conjunction with the use of the study's guiding theoretical framework. According to the DMIS, beliefs about how to relate to cultural difference and the resulting accompanying behaviors are shaped through life experience and interactions with people who are culturally different. Therefore, it made sense for the participants to share learning experiences from professional and personal settings they believed influenced their multicultural leadership development. In addition, participants were asked to identify people and influences on their multicultural leadership practices to get more of a complete picture about the role of relationships and milieu in this learning process.

The learning that occurs in the intercultural interaction that leads to movement along with DMIS continuum changes the perception of the person engaged in the learning process about how to relate to cultural difference. Essentially, progression or regression in intercultural

sensitivity relies on a learning process that fundamentally alters one's assumptions, perceptions, and behaviors. Along these lines, the qualitative shift in the individual's thoughts leading to changes in how to interact with those who are culturally different closely resembles the process of Transformative Learning (Mezirow, 2000).

Since little is known about these powerful types of learning experiences with clinical managers in mental health, close attention was given to data produced through the interviews where participants identified events that challenged their multicultural leadership behaviors. Thoughts or beliefs that resulted from participants' intercultural learning experiences were also highlighted.

To respond to the secondary questions in this study, it was important to pay attention to the specific learning experiences and influences that arose from the analysis of the themes, most notably the themes of *Leadership Issues* and *the Recognition of Organizational Culture and Its Impact*, and secondarily from unique and powerful learning experiences identified by the participants themselves. The discussion of how the inquiry addressed the secondary research questions will include brief examples of the most common and noteworthy experiences of learning and multicultural leadership development for the clinical managers in the study. Careful attention was given to identify factors that impacted the learning experience.

Multicultural leadership learning and development. Throughout the data collection, it was noted that for eight out of 10 participants, graduate level training in multiculturalism was not memorable, and according to them, had little to no impact on their multicultural learning. This is a powerful statement considering the fact that many programs in counseling and related fields now require at least one course in Multicultural Issues for the completion of the graduate degree. Most of the participants remembered little about the course they took and explained that when

they did remember, it was fairly superficial in nature, with teaching activities revolving around broad knowledge about typical ethnic groups and other specialized populations, and activities involving some exposure to cultural difference. The most memorable moments in the graduate classroom were those interactions with faculty and students that involved intense emotion and confrontation. And when the participants did note having powerful learning experiences, the content of the education or training was not the focus of their recollections. Specialized multicultural training was only mentioned by one participant, and he could not remember any of the details.

The clinical managers spoke more to the feelings associated with the impact of their multicultural learning experiences, and gave more recognition of learning that occurred during the course of their personal lives and in their professional work as leaders. Relationships with friends, family, and colleagues were perceived to be the most powerful cultural learning experiences along with on the job learning experiences. Participants' experienced what Mezirow (2000) called a *disorienting dilemma,* or an event that impacted their beliefs about cultural differences in the context of personal or professional relationships. This is turn led to the examination of old beliefs, and eventually changes in perceptions and practices related to cultural difference, and for some, development along the continuum of the DMIS.

One promising element of the learning experiences for the clinical managers, however, was the impact of past participation in research. Three of 10 participants noted that their research experiences with diverse populations in mental health had last impressions on them. At the time of the study, two participants admitted to still using the knowledge from their prior research in their current jobs, either in training or in professional leadership practice. And the third

participant, Steve, spoke adamantly about the lessons he has learned from conducting research with the deaf community about culture.

On the culture of counseling. Gunther was particularly adamant about the issue of compensation being a factor in limiting diversity within the field. And even though other participants did not speak passionately on the topic, others did mention the fact that they hold multiple jobs. Hoge et al. (2013) summarized the financial dilemma in behavioral health by saying that employers struggle with financial viability, and therefore place more demands on workers while offering lower wages than in other health professions and in business. Gunther's comment about how limited wages serve to exclude a large number of culturally diverse people who would make excellent psychotherapists was a valid one. Behavioral health organizations should consider the impact that wage has on their ability to attract minority practitioners and to reduce turnover.

Original contributions of the research. There are two major contributions to the research literature that came out of this study. *First, clinical managers in this study independently formulated their own multicultural leadership practices separate from training, internalization of knowledge on best practices in mental health multicultural leadership strategies, or organizational directives.* This finding supports what is cited in the mainstream research literature about the lack of attention to leadership training in mental health. The finding also highlights the resourcefulness and creativity of the leaders in the study who have essentially learned in response to life and professional conditions about how to lead in the context of cultural difference in mental health.

Although it was beyond the scope of this study, the interview data suggest that very different leadership styles represented in this study. Some of the participants likened their

leadership to leading a family, replete with sibling rivalry, while others mentioned “coaching up and coaching out”, therefore indicating a more transactional approach. Yet another participant mentioned learning from staff after having a difficult time adjusting to her role as she transitioned from clinician to leader during a time of organizational turbulence and change. Staff challenged her authority and she realized she wasn’t listening to them so she changed her approach to be more participatory. This participant also indicated not having any internal support, and felt she had to seek outside consultation to help with her leadership problems. There was a wide range of confidence, too, when it came to the participants’ perceptions about the quality of their leadership skills. However, what the participants have in common is that none mentioned organizational standards for leadership or internal training. In fact, only one mentioned attending general leadership training after many years of working as a director at his agency. Because of this, it is reasonable to assume that the leadership practices described by the participants to accommodate cultural differences with staff and clients were not attributed to organizational directives or training.

From most of the participants there seems to be a feel good mentality about cultural differences and openness to learning, but there is difficulty articulating how these differences concretely affect clients’ use of services except some examples given about language and education level. The examples of group staffing strategies, asking staff members directly for leadership feedback, and group decision making are a little more concrete in illustrating how managers accommodate staff diversity. It was noted that the participants did not go into the specifics of managerial strategies they use to help their staff clinicians accommodate cultural differences when working with clients. This could be due to a lack of understanding about all of the scenarios their staff members face when dealing with multicultural issues when working with

clients. It could also be attributed to the lack of organizational directives that emphasize focusing on the cultural differences and needs of the clients being served.

Only one participant mentioned receiving leadership training on the job but others did not. In the case of John, the leadership training he received was many years after he was hired, took place at a conference outside of his organization, and it was neither specific to the mental health environment nor to issues of multiculturalism. Through his interview, he commented that it would have been helpful to have had this type of training much earlier in his career. Morino (2011) spoke to the norm in non-profit agencies such as John's, where leadership development is neglected and training is virtually non-existent. Morino (2011) asserted that non-profits tend to select managers and promote them based on their dedication and success in service to others, but fail to train them in management or leadership techniques. These practices are explained largely due to how non-profits are funded, and because of grantors' wishes for the use of funding to go directly toward project goals. Morino (2011) argued that in order to move non-profits toward addressing better managing outcomes, organizations and grantors alike need to be better educated about the returns on investing in leadership training.

The second major contribution of the research is the idea that *the organization has the potential to influence multicultural leadership practices.* Ironically, most described the organization they worked for as being neutral or hands off when it comes to issues of multiculturalism in the clinical setting. For example, when asked about their multicultural leadership practices, staffing of ethnically and gender diverse individuals came up for many participants. Some managers admitted to hiring for diverse background experience from different areas of mental health or related professions. However, no one spoke to theory, best practices, or organizational recommendations or requirements.

John and other participants made comments about executive leadership not caring if an action doesn't bring in funding or substantial income. Organizational culture, or the way people are treated and the way things are done, is largely affected by senior leadership. Further, for an organization to successfully cope with change, leadership competency should be high and goal-directed, with built in mechanisms to allow teams to reach mutually agreed upon goals (Alimo-Metcalfe & Alban-Metcalfe, 2005). In John's case and with other participants in the study, the lack of senior leadership support in managing issues of diversity is perceived as problematic, and rightfully so. Alimo-Metcalfe and Alban-Metcalfe (2005) asserted that attempts to change organizational cultures can actually be damaging without the support of senior leaders and can lead to cynicism with staff below them, as was the case with John. With regard to cultural competence and disparities in behavioral health, organizational change and internal cohesion are definitely needed to produce environments that are conducive to adapting to the needs of diverse consumers.

However, cultural competence goes beyond the ethical; there is a practical business and competitive need to provide better behavioral health services to people of diverse backgrounds in the United States. Also, prevention efforts and diverting emergency room costs are directly tied into funding for health services. Traditionally, people of color in the United States use primary medical services such as check-ups and outpatient counseling at significantly lower rates and engage in emergency care at higher rates than whites. In a nutshell, there is a financial incentive to organizations to incorporate serious efforts toward cultural competence and community involvement in long term planning.

Measuring cultural competence. When Marcus was asked about how his perspectives on multiculturalism and diversity have affected his leadership in the workplace, he admitted that he

was unsure. He stated that there were “no metrics in place” to capture that. This was a very specific and candid statement that speaks to his perceptions of both the culture of his organization and how he operates in the context of leadership. According to Marcus, a metric tool to collect data is essential to measure cultural competence with employees. This comment was very striking considering the fact that the question asked of the participant was intentionally geared toward eliciting a response that was personal in nature. His perspective is shared not only with managed care organizations, but with the dominant type of thinking that pervades American society. Stewart and Bennett (1991) noted that the middle class American perspective on thinking is highly analytical, and this is reflected in the workplace in various ways. In general, Americans place much emphasis on rationality, efficiency, observation and measurement, action orientation, and adherence to procedures. Moreover, United States culture is very focused on achievement. According to Stewart and Bennett (1991) “achievement has to be visible and measurable” to be valid in United States culture (p. 79).

In addition to these cultural values that explain Marcus’s response to the interview question, Stewart and Bennett (1991) emphasized that through the American analytical perspective that there is an objective reality that allows for the observation and measurement of results. This is how people in the United States understand what is factual. This type of thinking mirrors the scientific process that guides quantitative research, as well as the development of metrics used in the workplace that Marcus mentioned in his comment. Unfortunately, the analytical type of thinking associated with the general “American” way does not recognize perception as an important part of measurement or evaluation. Nor does it belong to all Americans, especially those of color from lower income backgrounds (Stewart & Bennett, 1991).

Moreover, the response provided by Marcus also speaks to a lack of understanding and exposure to organizational tools that are available and in use that address cultural competence throughout the mental health care organization. Referring to several studies published from 1997 to 2009, Fung et al. (2012, p. 169) affirm that organizational cultural competence assessment should ideally address

> key areas such as: organizational commitment, values, governance and leadership; community partnerships; ability to tailor services to meet the needs of specific populations; workforce development through recruitment and training; and integration of diversity initiatives within the organizational infrastructure including how success or quality is measured and reported.

Socioeconomic status as cultural difference. Many participants discussed the importance of looking at socioeconomic status as part of cultural difference. Some data were shared that illustrated how managers would tailor communication strategies to meet the needs of clients, but no information was presented as to how they were able to put in place systemic changes to accommodate the needs of their low income clients. This is interesting considering the bureaucratic nature of managed care and funding that affects many organizations. Quintero et al. (2007) discussed how in their qualitative participants in New Mexico that socioeconomic status was seen as important consideration in help seeking and potential barrier to accessing services. With providers there can be a tendency to separate the two and attribute problems with access or service use to membership in low socioeconomic or in a certain minority group. Quintero et al. (2007) explained that it's important for clinicians to understand the underlying patterns and structures that contribute to the connection of the two. The participants in this study alluded to socioeconomic status, but did not make distinctions between the influence of culture and SES or the intersection of the two.

Lack of organizational diversity directives. In the case of the participants at the same organization, the organization's view on diversity was not made explicit to the clinical managers. They were not able to state clear goals expressed by the organization when it came to addressing diversity. There were no clear procedures or written protocols in place to ensure cultural competence, inclusion, or equity. Josie, for example, described the organization as detached. Participants from the same organization provided different understandings and perceptions of the organization's stance toward cultural difference. Some mentioned examples in leadership while others said benefits for same sex partners and perceived equity in sexual orientation for higher level leaders in the organization, or encouraging them to work to help people of lower socioeconomic status.

Organizational culture clashes. There was recognition by many of the participants of the presence of multiple organizational cultures that come together in the mental health environment. Because of these they had to modify their leadership strategies or expectations of workplace processes, sometimes to the detriment of the clients being served. These organizational culture clashes were also viewed as frustrating or irritating by many of the participants since the interfering organizations were perceived to espouse or promote values that were in opposition of the clinical managers' goals for their teams or agencies. It's important to acknowledge that behavioral health leadership is influenced by the intersection of many organizational cultures. This in turn affects the treatment of the consumers being served. For the participants in the study, organizational cultural influences included legal entities, justice systems, child welfare agencies, hospital/ medical services, religious organizations, financial/ funding organizations, and educational institutions/ professional associations. To truly

understand the participants' leadership strategies, these organizational influences should be taken into consideration.

Melonson model for understanding clinical managers' multicultural leadership. It is important to acknowledge that clinical managers are subject to the influence of the people around them, including superiors, peers, subordinates and others. The exchanges in these professional relationships provide opportunities for powerful learning experiences that shape their multicultural leadership beliefs and practices. Clinical managers are also affected by previous learning experiences, intercultural development, and their ability to apply this understanding to their leadership practices in conjunction with the influence of other organizational systems and cultures. Clinical managers also take on many work-related roles in the mental health setting. This is important because behaviors and learning do not exist in isolation; they are affected by peoples' sense of identity in the context of social interactions, which are uniquely situated in a given context (Bennett, 2004). However, due to the current lack of research outside of this study, there aren't any comprehensive models that speak to this combination of factors to help researchers and professionals understand the profile and multicultural leadership development of clinical managers in behavioral health settings.

Recommended components for building a model of multicultural leadership for mental health professionals include:

- Measure of intercultural sensitivity (preferably the Intercultural Development Inventory with an adaptation for leadership in behavioral health care settings) along with statement of philosophy on multicultural leadership;

- Profile of consistent leadership practices related to supervision of employees and program management along with analysis of degree of participative management strategies used;
- Documentation of Current Organizational Influences (outside organizations, funding influences, contractual obligations, etc…);
- Clinical Program Description;
- Organizational Cultural Competence Disposition (directives, policies, mandates on cultural competence and diversity inclusion—rating/ categorization would be needed based on DMIS orientation, Cross Model, or other relevant model that speaks to organizational cultural competence);
- Geographical & Regional Considerations; and
- Diverse populations to be served.

Figure 3 provides a visual representation of the Melonson model.

Rich contextual information is important for understanding the position of clinical managers and determining the multicultural leadership skills they need to be effective in meeting the needs of culturally diverse populations of staff and clients through their leadership efforts. The idea is to put together a profile to help describe the orientation and influences on the multicultural leader within the local and organizational context. Such a model could also be used to determine how clinical mangers can best focus their multicultural leadership development moving forward.

Implications for Mental Health Organizations

While the findings of the study are not generalizable as is the case with quantitative research, readers may make extrapolations, or conjectures, about how the findings might be

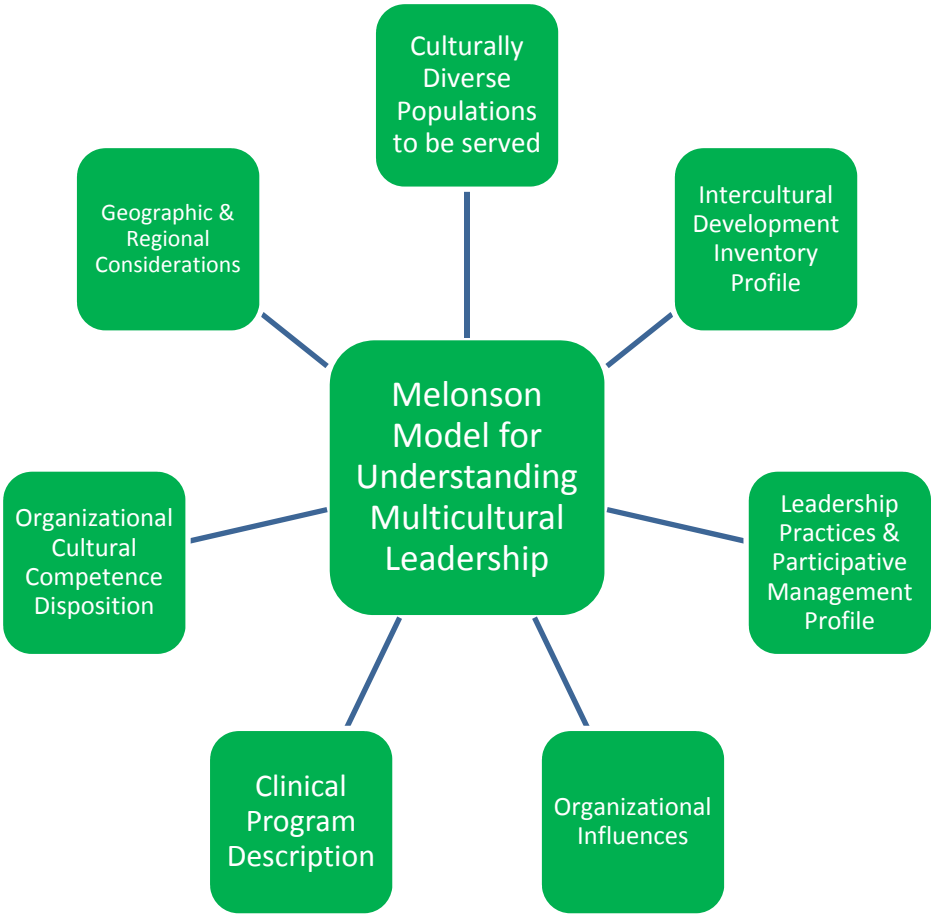

Figure 3. Melonson model for understanding multicultural leadership in clinical managers.

applicable to similar settings (Patton, 2002). In terms of transferability, the data and related insights produced through this inquiry merit special consideration in light of their concordance with the current research literature and current problems with mental health disparities and lack of leadership development in mental health.

Organizations should be clear about standards for cultural competence. This study speaks to the need for executive leaders to be explicit in providing directives toward managers and supervisors about cultural competence in the organization. It would be helpful to provide definitions and to identify variables associated with the various cultures of the clients served, the organization itself and any additional entities with which the organization works in conjunction

with federally recognized standards in conjunction with organizations such as SAMHSA or the U.S. Department of Health and Human Services. It is not enough for an organization to say that it is multicultural considering the persistence of the disparities problem. The participants in this study have clearly demonstrated that there is no single definition of what it means to practice multiculturalism in leadership. With emphasis on managed care and its focus on numbers, it is important to have specific directives that combine all of these factors and make clear statements to clearly articulate where the organization stands when it comes to cultural competence.

Cultural competence practices should be embedded in organizational processes. "Cultural competence at the organisational level must be embedded in the infrastructure and ethos of any service provider" (Bhui et al., 2007, Organizational Cultural competence, para. 1). It is also recommended that organizations design services in response to the needs of their clients (Bhui et al., 2007; Chin et al., 2012). The mental health organization's commitment to cultural competence and valuing diversity should be clear in its mission and vision and efforts should be built into strategic planning. The organization should consider hiring consultants if needed. Schein (1993) made a strong argument that outside consultants working with clinical organizations should contribute to the development of internal process consultants who are able to diagnose and solve problems that exist within their own organizational cultures. Such an approach is worth considering as the field of mental health has struggled to meet the needs of diverse populations using blanket strategies about dealing with cultural difference, and also since many cultural issues are locally defined. Ideally, an organization with a continuous learning orientation and effective internal structures would be able to self-monitor and creatively problem solve issues around disparities. However, research is needed to ensure that efforts are effective, especially if improved access or treatment outcomes are the focus.

Community involvement is needed. Ironically, it could be considered unjust or unethical not to try respond to the needs of diverse clients, but with continuous feedback mechanisms and the use of modern qualitative research approaches like focus groups and community based participatory research, clients' voices can be heard and this information that can be used to improve clinical services. Bediako and Griffith (2007) wrote about the importance of community involvement in resolving the legacy of health disparities. Mwachofi and WaMwachofi (2010) also emphasized how cultural strengths that contribute to health have been traditionally ignored along with historical inequalities by people trying to solve the health disparities puzzle. Solutions must be sought out using the support of the local community with the involvement of leaders such as clinical managers.

Participatory management strategies should be used. Following the logic of Bhui et al. (2007), it's important to have a flexible organization that responds to the needs of diverse populations. Naturally, this requires the availability of skilled and flexible managers who are willing and open to learning and responding to needs of employees and clients alike. In addition, organizational priorities must be in alignment with supporting time for problem solving, innovation, and creativity to accommodate diversity needs. *Practice Development* in health care holds promise for United States mental health settings because of the collaborative strategies, focus on consistently improving the quality of health services, and the democratic foundations involved. Practice Development is a collaborative endeavor that involves using leaders as consultants who engage and encourage employees to build goals for services based on a shared vision and values. It is described as an ongoing pursuit of innovation for excellence and involves the transformation of individuals and groups. The culture of PD is person-centered, and both

processes and outcomes are embedded in the organization's strategy (Atter, 2008; Boomer & McCormack, 2008).

Clinical managers should be empowered within mental health organizations. Clinical managers work with staff members who provide direct therapeutic services, so they often advise staff on how to improve their services. Working on front lines with clinical staff gives them a completely different perspective from executive leadership who generally obtain information about performance and financials through data or reports. Managers' creativity and initiative can be harnessed and shared with others in the organization and in the field of behavioral health through undertakings such as interagency collaboration, internal interdepartmental training, or presentation at conferences.

Fung et al. (2012) spoke about mid management and how valuable they are at leading cultural competence initiatives within the organization. In this study, some of the participants developed their own ideas about how to improve cultural competence with ethnic groups: (a) providing clinical supervision in Spanish; (b) self-selecting training and developing tea time to attract Southeast Asian clients and; (c) starting a clinic in the black church and having white clinicians provide services. Park et al. (2011) discussed the concept of cultural brokering in the mental health environment, which entails helping clients and/ or their loved ones to negotiate cultural norms to better understand options in clinical care. The three ideas presented above are good examples of creative efforts to enhance cultural competence, and are all backed by rationale from the research literature. It was interesting that the managers initiated these efforts, not the organization's executive leadership. These efforts were not based on the organization's written philosophies or best practices in the field. John commented that working on attracting more of the Asian population was not of interest to higher ups due to a significant lack of

increased funding, but that it was still an ethical imperative for him. In all of these cases, the aim was to attract a wider client base and/ or to provide a better service to clients. Organizations should encourage clinical managers to facilitate work groups, share information about successful diversity initiatives and share knowledge with other parts of the mental health organization.

Divisions should be created within the mental health organization to focus on addressing cultural competence. This includes serving clients, but also fostering a commitment to honoring organizational diversity to better serve both staff and clients. The issue of health disparities desperately needs to be addressed for ethical reasons and for financial reasons. There is also the issue of institutional discrimination and the traditionally disproportionate numbers of Caucasian males in leadership in behavioral health organizations (Chin et al., 2012). Moreover, the overwhelming number of white, female psychotherapists in mental health and addictions fields who are practitioners is also an issue.

Organizations should provide training to clinical managers on engaging leadership or transformational leadership strategies. Unfortunately, as the Annapolis report and others mention, mental health leadership training is rarely provided to leaders in mental health organizations in the United States. Transformational leadership is the only type of leadership that is empirically connected to improvements in patient outcomes in the United States literature. Abroad in the United Kingdom and Australia, engaging leadership has gained recognition along with practice development for contributions to addressing diversity and recovery in mental health. This type of leadership has been researched longitudinally in conjunction with the National Health Service in the United Kingdom to reach outcomes through the creation of engaging cultures where leaders relinquish their expert status in favor of a team problem solving approach (Alban-Metcalfe & Black, 2013). Engaging leadership helps employees successfully

cope with the demands and impact of continuous change (Alimo-Metcalfe & Alban-Metcalfe, 2005). The engaging leadership model is characterized by leaders who demonstrate transparency, respect and interest in the development of others, use of empowering delegation of tasks, and facilitation of constructive critical thinking (Alimo-Metcalfe, Alban-Metcalfe, Bradley, Mariathasan, & Samele, 2008).

Focus on solutions and take action. Chin et al. (2012) summarized a formula to make the paradigm shift in research from focusing on disparities to solutions to disparities:

1. Recognize disparities and commit to reducing them;
2. Implement a basic quality improvement structure and process;
3. Make equity an integral component of quality improvement efforts;
4. Design the interventions— Consider 6 levels of influence: patient, provider, microsystem, organization, community, policy;
5. Implement, evaluate, and adjust the interventions; and
6. Sustain the interventions.

This requires organizations to adopt and believe in the value of assessment and attention to continuous quality improvement in order to help the disparities situation. Creativity and flexibility should be employed to focus on practical solutions that work in the midst of multiple organizational influences. The role of the local community should be taken into consideration, and policies and practices should be adjusted as appropriate to meet the needs of diverse populations. Overall, this approach requires vigilance and open mindedness for all in the mental health organization, and unfortunately is contrary to current practices in the United States.

Make cultural competence part of employee evaluations. The field can no longer rely on the assumption that individuals are motivated to achieve cultural competence or that it cannot

be measured. The behavioral aspects of cultural competence and its goals should be made tangible and understandable in the context of the organization. These should be tied in to larger organizational goals and reinforced by clinical managers and other leadership in the organization. Making cultural competence part of performance evaluations gives it a definite priority, even only if for the purposes of the individual employee's professional evaluation.

Implications for Training Professionals

Multicultural training leading to intercultural competence is not a one-time event, but an ongoing process that involves professionals' ability to adequately respond to the behavioral health needs of those who are culturally and linguistically diverse, from entrance to exit of services. Individuals at all levels of the mental health organization should be trained in cultural competence regardless of rank. Training should be tailored for the position and should be tied to performance and problem solving goals. Munoz, DoBroka, and Mohammad (2009) noted that minorities often use mental health services as a last resort for a variety of reasons. It is important that all professional training be focused on working against the perpetuation of negative beliefs about outpatient mental health services.

Thomas, Quinn, et al. (2011) coined the term cultural confidence and this should be considered when planning professional development. It is characterized by the use of reflection, acknowledging and confronting the social construction of race. Thomas, Quinn, et al. (2011) also stated that this concept included asking questions about culture when practitioners don't know the answers, discussing uncomfortable issues of race, and admitting bias. These ideals are by no means easy to achieve. Cultural confidence is much akin to intercultural development in that it is a lifelong process for researchers and health professionals. Both require personal commitment in one's orientation toward cultural difference and for learners to take action beyond sitting in a

classroom. Moreover, complexity in cognitive development is needed for such growth. This is tied to movement through the developmental model of intercultural sensitivity through profound transformative learning processes.

Didactic methods alone such as lectures or power point presentations which are extremely common in many organizations are insufficient for fostering cultural competence and intercultural sensitivity development. Exposure to cultural difference, explanation of differences in modern context and dialogue, and experiential activities should be used with reflective writing and creative activities in order to help learners integrate new insights. Training should be multifaceted and should involve pre and post training assessment using both qualitative and quantitative measures. Trainers should be able to clearly teach terminology relevant to cultural competence and how what is learned can be directly applied to the learners' jobs. Quintero et al. (2007) emphasized the need to help providers consciously identify any views of aspects of their clients' cultural identity as negative in any way, and to change their perceptions of these views to see them as a factor of resilience. Since clinical managers and other leaders are also trained as practitioners, it's important for all who are involved in treatment to engage in active, ongoing and transformative educational training activities that help change any negative views of aspects of minority cultures as being deficits. Moving to a strengths perspective is important in gearing leaders and psychotherapists to focus on solutions when it comes to providing responsive services to diverse populations. Training must move from the view of culture as static and same across the board, to include the notion that all people have multiple cultural members, and all of these cultural groups are constantly affected by what is going on locally and in the world. Culture should be defined as something local. Taking this stance in the mental health environment helps ground clinical managers, leaders, and practitioners in training to focus on the

practicality of the training and how it directly connects to their professional work in their unique organizational setting.

Implications for Universities and Faculty

Specialized coursework, student research, and experiential learning on behavioral health leadership and disparities is needed to promote cultural competence in graduate students. Bemak, Chung, Talleyrand, Jones, and Daquin (2011) provided a thorough description of their graduate program and how faculty have been able to take the learning out of the classroom into the diverse communities surrounding the university. The program also worked at changing admission standards and working with students of color to increase retention. Finally, they increased recruitment of ethnically diverse faculty to attract and retain more students of color.

When using the DMIS to guide university coursework in health care professions, it has been suggested that faculty work together cross departmentally and explicitly state how the DMIS and related cultural competence models directly apply to health care. Reflective activities, guest speakers, panels, and field experience have been viewed as promoting intercultural competence with graduate students in health related programs (Munoz et al., 2009).

Mahoney and Schamber (2004) emphasized the importance of helping university students to understand the nature of cultural difference and likened learning that leads to movement through the DMIS to various theories of affective learning and cognitive development. They argued that both elements are needed in teaching and that the end result should be improvement in communication and relationship behaviors. They demonstrated empirical evidence for success of diversity curricula infused with analysis and evaluation activities to promote developmental sensitivity with undergraduate students. Techniques such as discussion, role play, research,

group work, creating an atmosphere of interest in intercultural sensitivity development and having the professor set goals for students' achievement were also noted as helpful.

The majority of the participants in this study did not retain any information from required graduate courses in multiculturalism. Of those who did remember, the consensus was that their required course was superficial in nature, meaning cultural difference was approached from only the view of observation and exposure to cultural difference. The participants recalled professors dividing people into groups by race or disability and teaching about their preferences in counseling through lecture, having guest speakers on different topics, and having them engage in exposure to cultural difference through visiting a place of worship different from their own.

Manis (2012) stressed the importance of using critical theory to ground teaching for social justice advocacy in counseling education programs. Consistent with other sources, the learning experiences needed to accommodate this type of teaching entail largely experiential and reflective activities that are akin to transformative learning (Mezirow, 2000). This work entails the development of critical consciousness and the exploration of social privilege. It is therefore a type of education that requires planning and anticipation of resistance and uncomfortable conversations. This was a type of multicultural education not afforded the participants in this study.

Care should also be taken to learn from the failures of intercultural education in other health professions. Boggis (2012) reported on the lack of success in a study of Occupational Therapy students who were assessed pre and post as part of a three year professional program cohort with a curriculum guided by intercultural competence using the Intercultural Development Inventory to measure intercultural progression. With no statistically significant results other than the identification of students progressing beyond the point of polarization to

the point of minimization on the Intercultural Development Continuum, Boggis concluded that the students could have been overwhelmed by the massive amounts of health information they were learning. Counseling and psychology programs should consider the influence of the medical model and its cultural implications when interpreting the results of studies such as this one.

West et al. (2006) referenced the Council for Accreditation of Counseling and Related Educational Programs' call for counseling programs to prepare doctoral students for positions of leadership; however, the reality in many outpatient mental health settings is that master's level practitioners often hold positions of leadership. Therefore, faculty should create dual master's degree programs that focus on behavioral health and diversity management to equip clinicians for becoming managers in diverse counseling environments.

Clinical practica and internships should be expanded to include required consultation on multicultural topics, creating, participating and leading professional development that is focused on the local populations being served, and should include an element of multicultural research with the organization. Graduate students need to get a practical feel for diversity in practice in the mental health outpatient setting. The reality is that leadership in an academic or university counseling center teaching setting is notably different from the organizational settings represented in this study. Because of this, consideration should be given in re-evaluating counseling program's priorities when it comes to leadership and clinical supervision training.

Professionals in the counseling field have provided much commentary on between academic programs and graduates' preparation to handle real world mental health performance and leadership situations. Interestingly enough, the participants in the study who did engage in research on topics of multiculturalism in their graduate studies spoke highly of the practical

knowledge they amassed about these populations. They were also able to articulate how they still use that information today in professional practice.

University research should focus on the development of desirable multicultural performance outcomes for frontline staff, support staff, managers, human resources, and executive leadership in mental health organizations. Scholars should begin to create a roadmap of how these different types of employees can come together to work with diversity friendly policies within the mental health organization.

Implications for the American Counseling Association/ American Psychological Association

Professional associations in counseling and psychology should begin efforts to focus on leadership and create chapters devoted to leadership development with focus on health disparities. It is also advised to sponsor fellowships for researchers to focus on issues of leadership and multiculturalism and organizational cultural competence in behavioral health. The ACA and APA should begin a long term plan to research and articulate best practices and training that promote effective multicultural leadership in behavioral health. The operational definition of effective multicultural leadership should include ethical considerations and improved outcomes for diverse populations and retention and promotion of diverse staff. Finally, as a long term goal, specific best practices should be added under multicultural leadership to ethical codes.

Recommendations for Future Research

Large professional organizations like the APA and the ACA amongst others provide broad statements related to multicultural competence/ social justice advocacy, and fewer about leadership. Governmental organizations and other governing bodies and managed care organizations have provided guidelines for cultural and linguistic competence. Ironically, the

good intentions of providing standardized strategies, especially without thorough and ongoing training and technical assistance, assessment and mentoring, may not be enough as the general research in the United States has indicated through documentation of ongoing mental health disparities. Therefore, extensive research still needs to be conducted to truly understand the problem at hand.

These research efforts represent a tremendous undertaking; however, it is very important for standards to be clarified and raised in leadership, and for more data to be produced to help professionals better understand cultural competence and leadership. Too much pressure has been placed on practitioners to make services and unresponsive mental health systems work for the consumers who have had virtually no voice in services that don't always meet their needs or expectations.

All areas of mental health leadership still need to be thoroughly researched. It is recommended to continue qualitative research with clinical managers to learn more about their work experiences with cultural diversity and multicultural leadership practices. This type of research should lead to the development of models that speak to mental health clinical managers' position, leadership development, multicultural development, and degree of power/influence in the workplace. Specifically, models should visually represent the position of the clinical manager in the midst of the numerous cultural influences in the behavioral health environment and should include measures that speak to the managers' cultural competence and leadership. Comprehensive models to be developed through research should include the following: employee cultural differences, organizational influences outside of mental health, funding/ managed care influences, neighborhood/ regional cultural influences, leader's leadership style/ competencies, DMIS/ Intercultural Development Inventory scoring, and awareness of bias.

- More information is needed about the range of actual organizational practices in mental health when it comes to multiculturalism and leadership. It would be helpful to obtain data on diversity/ inclusion efforts that affect hiring of diverse individuals (through human resources), mentoring of diverse professionals to be groomed for leadership, and training quality and protocols.
- Based on the diversity of counseling related programs and services that exist in various environments in the United States, more should be researched and documented about the organizational structures, ethnic compositions of clients served, and multicultural leadership expectations of clinical managers. Case studies and other qualitative inquiries should seek to answer questions such as: Are multicultural expectations written into job descriptions? Infused into values & mission? To what extent are clinical managers able to influence factors that they believe benefit diverse clients? What training to clinical managers think would be helpful to benefit their clients? Their employees? Their organization?
- More research should be conducted on training that contributes to cultural competence with practitioners and leaders. Research efforts should include training that incorporates how mental health organizations can best implement and direct such training programs with evidence of improved multicultural leadership processes and client outcomes.
- Research should be conducted on best practices for local community involvement in planning culturally responsive and flexible services, and what the optimal role of leadership is in the process. Community based participatory research, focus groups, and modern qualitative methods using media and technology should be explored to give communities a voice in order to educate mental health organizations about community

needs and expectations of treatment. Universities should assist local mental health organizations in conducting community assessments and research projects.

- Professional organizations should consider funding a serious of studies to begin to develop a working set of best practices in multicultural mental health leadership and how it fits into the bigger picture of cultural competence within organizations. Eventually, comprehensive models of multicultural leadership practices in mental health for clinical managers and other leaders should be fully investigated using quantitative methods and tied to access, usage, outcomes, and customer service ratings in mental health organizations.

Reflection on the Research

> For every one of you have We designed a law and a way of life. And if God had so willed, He could surely have made you all one single community: But he willed it otherwise in order to test you by means of what He has bestowed on you. Strive, then, with one another in doing good! Your goal is God; and then, He will make you understand the truth of everything in which you have differed. (Quran 5:48)

As I reflect on the completion of this research project, several thoughts come to mind about the nature of this endeavor. First, as a researcher I have enjoyed the challenge of researching such a complex topic that is so meaningful and relevant to the fields of health care and behavioral health. On a personal level, I have come to see my research and other work in cultural competence as a professional and spiritual calling, especially at a time when behavioral health has come into the forefront of media attention, and advances in clinical research have established a connection between behavioral and physical health. As a therapist, leader, professor and doctor, I am fully committed to contributing knowledge to the intersections of organizational leadership, cultural competence, and mental health for the purpose of working toward the improvement of services for people of all backgrounds.

It is sometimes perplexing, however, why the health care industry in the United States still appears to carry stigma about mental health services and why so little time and effort is spent in improving leadership, cultural competence, and workforce development in behavioral health with the dramatic changes in our nation's demographic composition. The numerous commentaries and research articles I consulted during this project speak to the need for improvement, yet the research methods and areas of inquiry under behavioral health disparities remain traditional in nature; quantitatively focused, driven by numbers, and not at all focused on understanding the expectations of diverse groups in their local contexts. Where are the research projects that highlight the strengths of diverse cultural communities and how these contribute to behavioral health? Where is the marriage between the medical model of mental health and respect for traditions in cultural communities? My belief is that if we in the profession are truly invested in respecting diverse cultural groups, we should honor and incorporate strategies that are meaningful and relevant to these groups into research and solutions to improve access, use, and outcomes in mental health services. However, we can only do this by partnering with the staff and the individuals who are part of these communities in the research process.

For an industry that writes so adamantly about equity and injustice in serving populations of color and other marginalized groups, little has been done in the way of research or leadership development to change the future trajectory of behavioral health. Our health systems have failed people of color from entry way to exit and our educational and legal systems have done the same. The faculty in our programs that prepare the next generations of psychotherapists bear little resemblance to the people of our diverse nation, and we have made careers in mental health and related fields unprofitable, lack prestige, and irrelevant to the lives of many people of color. In other words, if we talk the talk, we must walk the walk to improve services for all. And like

most institutions in the United States, there are obviously engrained elements of discrimination and lack of opportunity for all. The participants' post interview comments about the topic of inquiry stood out in my mind and validated my concerns about the lack of attention given to cultural matters in behavioral health leadership. Figure 4 shows some of the most impactful after interview comments.

Figure 4. Participants' after interview comments recorded in researcher's journal.

As a qualitative researcher, I have gained a new appreciation for the potential benefit of the use of emancipatory approaches, like community based participatory research, as part of the possible solution for helping mental health professionals really understand the types of changes that need to take place to remedy some of the current disparities problems. In addition, as a clinical manager, I have personally experienced many of the struggles and frustrations noted by the participants. I have dealt with the lack of senior leadership support for process improvement endeavors and community outreach, the lack of support for giving the clients a voice through

collection of open ended data, and the lack of interest for more than the one hour of mandatory cultural competence training that exists in many organizations. What is more disturbing is the fact that many of the executive level leaders I have worked with in my career have been people of color— people who have forgotten how minority groups have struggled in this country, whose focus is now solely on profits or other political motives.

What has become clear to me through this research is that internal cooperation and harmony are crucial when it comes to implementing any work to improve cultural competence. This focus on improving cultural competence must be clear from the top down in leadership, and organizations and individuals must be personally invested for improvement efforts to work. Structures must be put into place to allow time for assessment, planning, and problem solving. Cultural and local community involvement is also crucial. Organizations must take ownership of cultural competence efforts and begin to invest in leadership development, especially with clinical managers who have the ability to contribute solutions to real life service-related problems since they work at the intersection of the providers and the organizational structures under which services are provided.

I will freely admit that as a woman of color, I am personally invested in conducting innovative research to inform the understanding of disparities in behavioral health for a variety of reasons. Interestingly enough, I was very transparent before each of the participant interviews about my motivation in pursuing this project. Nine of the 10 participants responded in a positive manner, yet one response struck me as odd. I was questioned by one participant about why I believed it was important to mention my cultural background and lifelong interest in studying culture. Considering the topic of this research, I would have never expected such a reaction. So I would like to explain.

My parents and grandparents attended segregated schools and have suffered emotionally due to the trauma of racism. I, too, have been the object of discrimination at times in professional and educational settings. Moreover, I have witnessed leadership in behavioral health organizations consciously choose to not accommodate the needs of culturally diverse populations, even when only small efforts were called for. Racism and discrimination have been an authentic part of my experience as a human being and as a professional.

Ingrained beliefs about right and wrong are part of culture, but they are also the things that contribute to the development of world wars and destroy lives. Consequently, untreated mental illness also has the potential to end many lives through suicide and homicide, and to destroy others through grief and suffering. My sincere hope through this and other research efforts is that my work will contribute toward solutions to help reduce suffering attributed to a lack of cultural competence in mental health.

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Appendices

Appendix A: Demographic Questionnaire

Date/ time of Interview _____

Age _____

Highest degree earned _____

Degrees in Progress _____

Type of mental health license currently held _____

Number of years worked in mental health field _____

Number of years worked in positions of leadership in mental health _____

Description of current position(s) of leadership in mental health (Title and duties)

_____

_____

Formal Training in Multiculturalism/ Diversity Issues (List topics)

_____

_____

Research Experience in Multiculturalism/ Diversity Issues (List topics)

_____

_____

Appendix B: Invitation to Participate in Research

LETTER TO POTENTIAL SUBJECTS FOR A STUDY OF MENTAL HEALTH CLINICAL MANAGERS AND THEIR MULTICULTURAL LEADERSHIP PRACTICES

University of the Incarnate Word

Dear Prospective Participant:

My name is Christie Melonson, M.A., LPC and I am a graduate student at the University of the Incarnate Word working towards a doctorate degree in Education with a concentration in Organizational Leadership. You are being asked to participate in a qualitative research study titled Mental Health Clinical Managers and their Multicultural Leadership Practices. We want to learn and explore mental health clinical managers' perceptions of multiculturalism and how this understanding influences their roles, identities, attitudes, and behaviors as leaders in the field. I am working with Dorothy Ettling, Ph.D., C.C.V.I, my dissertation chair, and other dissertation committee members Ozman Ozturgut, Ph.D., Audra Skukauskaite, Ph.D., and John Velasquez, Ph.D. to conduct this research. I am looking to conduct an interview and obtain a job description, a copy of your organizational chart, and a completed demographic questionnaire to gather data on this topic with you since you meet the following criteria:

1. The subject/ participant must be employed full time in a mental health-related position
2. The subject/ participant must be employed in a position of leadership in an outpatient or non-residential mental health setting where he or she is responsible for at least one staff member who provides psychotherapy
3. The subject/ participant must have at least a completed master's degree in one of the following disciplines: clinical psychology, counseling psychology, counseling, marriage and family therapy, clinical social work, or school psychology
4. The subject/participant must have a current license to practice psychotherapy in his/ her state of residence
5. The subject/participant must have held employment in his or her position as a clinical manager for at least 6 months

If you decide to take part in this study, we will ask you to provide a copy of your current job description, a copy of your organizational chart, to complete a demographic questionnaire, and to participate in a face to face interview with the researcher that will last between 45 minutes to 1.25 hours. The purpose of this is to gather information about your organization, your current work position, basic demographic data related to your work experience and multicultural learning experiences. The interview will provide more insight about how you have learned about multiculturalism in your career as a clinical manager in mental health.

As this study will include questions about diversity and various multicultural concepts and learning experience, there may be a potential for increased stress if any of the interview questions make the interviewee uncomfortable. If this happens, the interviewee will be encouraged to take a break from the interview and to reconvene when he or she is ready. We do not guarantee that you will benefit from taking part in this study, as no money or other incentives will be provided. However, the research may benefit human and scientific knowledge by contributing information about multicultural learning experiences, diversity-related leadership beliefs, and organizational factors that influence leadership practices.

Everything we learn from you in this study will be confidential and cannot be identified with you. If we publish the findings of the study, you will not be identified in any way. Your decision to take part in the study is voluntary. You are free to choose not to take part in the study or to stop taking part at any time. If you choose not to take part or to stop at any time, it will not affect your future status at UIW.

If you have questions now, feel free to ask us. If you have additional questions later or you wish to report a problem that may be related to this study, contact Dorothy Ettling, Ph.D. @ 210-829-6000. Also, the University of the Incarnate Word committee that reviews research on human subjects, Institutional Review Board, specifically the Dean of Graduate Studies and Research @ 210-829-2759 with any questions about your rights.

You will be given a copy of this letter to keep.

Thank you in advance for your cooperation and support.

Sincerely,

Christie Melonson, M.A., LPC

PhD Student

Phone number: 832-236-8776

Appendix C: Consent Form

SUBJECT CONSENT TO TAKE PART IN A STUDY OF MENTAL HEALTH CLINICAL MANAGERS AND THEIR MULTICULTURAL LEADERSHIP PRACTICES

University of the Incarnate Word

My name is Christie Melonson, M.A., LPC and I am a graduate student at the University of the Incarnate Word working towards a doctorate degree in Education with a concentration in Organizational Leadership. You are being asked to participate in a qualitative research study titled Mental Health Clinical Managers and their Multicultural Leadership Practices. We want to learn and explore mental health clinical managers' perceptions of multiculturalism and how this understanding influences their roles, identities, attitudes, and behaviors as leaders in the field. I am working with Dorothy Ettling, Ph.D., C.C.V.I, my dissertation chair, and other dissertation committee members Ozman Ozturgut, Ph.D., Audra Skukauskaite, Ph.D. and John Velasquez, Ph.D. to conduct this research. I am looking to conduct an interview and obtain a job description, a copy of your organizational chart, and a completed demographic questionnaire to gather data on this topic with you since you meet the following criteria:

1. The subject/ participant must be employed full time in a mental health-related position
2. The subject/ participant must be employed in a position of leadership in an outpatient or non-residential mental health setting where he or she is responsible for at least one staff member who provides psychotherapy
3. The subject/ participant must have at least a completed master's degree in one of the following disciplines: clinical psychology, counseling psychology, counseling, marriage and family therapy, clinical social work, or school psychology
4. The subject/participant must have a current license to practice psychotherapy in his/ her state of residence
5. The subject/participant must have held employment in his or her position as a clinical manager for at least 6 months

Please note that IRB approval has been obtained prior to the initiation of this study. Your decision to take part in this study is strictly voluntary. You are free to choose not to take part in

this study or to stop taking part at any time. Participation poses no benefit to the participant, and involves no financial cost. You may choose not to participate at any time without penalty or loss of any kind. If you decide not to participate in this study, it will not adversely prejudice future interactions with the institution or your current and future status with UIW. In addition, you will not be asked to violate HIPAA restrictions at any time during your interview.

Participation will consist of one personal interview with the researcher that will be recorded using a digital voice recorder, the completion of a demographic questionnaire, and each participant will be asked to provide a copy of his or her job description and organizational chart. This information will be kept confidential and kept in a secure, locked location and will be destroyed in a reasonable period of time upon completion of the study, not to exceed 5 years. Pseudonyms will be used instead of names to report the findings. The findings will also add to the general understanding of multicultural leadership processes, especially in the field of mental health. The findings may also be presented to academic audiences, to audiences in the profession of mental health/ social services, and submitted for publication in major academic journals. If we present or publish the findings of this study, you will not be identified in any way.

As a participant in this project, you also have the right to contact the principal investigator, Christie Melonson, @ melonson@student.uiwtx.edu or by phone @ 832-236-8776, anytime, 24 hours a day, or the University of the Incarnate Word committee that reviews research on human subjects, the Institutional Review Board, specifically the Dean of Graduate Studies and Research @ 210-829-2759 with any questions about your rights. If you have questions now, feel free to ask us. If you have additional questions later or you wish to report a problem that may be related to this study, contact Dorothy Ettling, Ph.D. @ 210-829-6000.

Your signature indicates that you (1) consent to take part in this research study, (2) that you have read and understand the information given above, and (3) that the information above was explained to you. You will be given a copy of this form to keep.

_____ _____

Signature of Subject Signature of Witness

_____

Signature of Investigator

_____/_____

Date (Time)