WHITE THERAPIST-TRAINEE RACIAL IDENTITY DEVELOPMENT, SELF-REPORTED BROACHING STYLES, AND OBSERVED BROACHING

by

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ABSTRACT

WHITE THERAPIST-TRAINEE RACIAL IDENTITY DEVELOPMENT, SELF-REPORTED BROACHING STYLES, AND OBSERVED BROACHING

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George Mason University, 2022

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In order to provide culturally competent and responsive care, therapists must demonstrate the ability to initiate conversations about race and ethnicity with clients. However, White therapists often report that they do not broach race with clients of color. White Racial Identity Development (WRID) offers a theoretical framework for anticipating and identifying how White therapist-trainees vary in their broaching behaviors. The relationships between WRID, reported broaching styles, and observed broaching behaviors have not yet been examined empirically. The current study tested the hypotheses that more advanced WRID would be associated with more advanced self-reported broaching styles and higher frequencies of observed broaching. Exploratory analyses examined the hypothesis that more advanced self-reported broaching styles would be associated with higher frequencies of observed broaching behavior. The sample consisted of 46 White-identifying therapist-trainees currently or recently enrolled in

graduate school. Participants completed self-report measures and submitted audio-recorded responses for one “easier” and one “harder” video of a Black mock therapy client describing experiences of racism. Responses were transcribed and coded for explicit references to race, ethnicity, or culture. Results demonstrated that more advanced WRID was generally associated with more advanced self-reported broaching but had minimal association with observed broaching. Self-reported beliefs that broaching was unnecessary were lower for those who did not broach in the “easier” scenario, and self-reported anxiety about broaching was higher for those who did not broach in the “harder” scenario. Training implications include greater focus on facilitating White therapist-trainees to explicitly learn and practice broaching behavior with clients of color.

INTRODUCTION

The American Psychological Association's Multicultural Guidelines (APA, 2017) emphasize the importance of psychologists developing multicultural competence in all aspects of their work. The guidelines call on psychologists to engage in lifelong learning regarding how individuals' experiences are shaped by their multiple social identities, contexts, and differential experiences of power, oppression, and privilege. They also encourage psychologists to actively combat oppressive systems and empower marginalized communities through avenues such as advocacy, research, and clinical work. In 2022, these guidelines are especially relevant in light of the APA's formal apology to Racial and Ethnic Minority (REM) individuals regarding its role in perpetuating systems of oppression (APA, 2021). It is possible for psychologists of all identities to perpetuate systems of oppression. However, the APA's recent historical chronology of these patterns makes the outsized role of White psychologists in perpetuating racism clear (APA, 2022).

In the context of mental health treatment, White therapists in particular have enacted harm when working with racial and ethnic minority (REM) clients (Wendt et al., 2015; Baima & Sude, 2020; APA, 2022). Thus, while all mental health professionals must develop competence in serving clients of all identities, there is a particular need to ensure the competence of White therapists in working with REM clients. This study

focuses on one foundational clinical skill for White therapist-trainees in this vein: In order to reduce harm and facilitate racial healing in their work with REM clients, White therapist-trainees must develop effective broaching skills. That is, they must be able to explicitly initiate and invite conversations about race, ethnicity, and culture in order to fully see, connect with, and support REM clients (Day-Vines et al., 2013; Pettyjohn et al., 2020).

Dissertation Structure

In the first part of my dissertation (See Appendix B) I reviewed literature detailing how White therapist-trainees' White Racial Identity Development (i.e., WRID; Helms, 2008) affects the ways they go about broaching race when working with REM clients. Moreover, I provided a novel set of training recommendations for improving White therapist-trainees' broaching behavior based on their current WRID. In this second part of my dissertation, I have added to the small body of theoretical and empirical research regarding the relationship between WRID and broaching. That is, this study examined the relationship between WRID and self-reported broaching styles in a sample of White therapist-trainees. This study also analyzed the relationship between White therapist-trainees' self-reported broaching styles and observed broaching behaviors in a novel broaching task paradigm.

LITERATURE REVIEW

Broaching Behavior Defined

General Description of Broaching

Broaching has been defined as a therapist's "deliberate and intentional efforts to discuss those racial, ethnic, and cultural (REC) concerns that may impact the client's presenting concerns" (Day-Vines et al., 2020, p. 1). Supporting the importance of this skill, one study found that when White therapists broached race during the course of therapy, REM clients reported higher therapeutic alliances and rated their therapists as more credible and competent (Zhang & Burkard, 2008). In another study, undergraduate students were randomly assigned to view one of four different videos of mock therapy intake sessions, some of which included broaching (King & Borders, 2019). Their results revealed that both White and REM participants rated therapists who broached as more culturally competent and culturally humble. While broaching is an important skill, developing broaching skills alone does not adequately prepare therapists to provide culturally appropriate interventions, such as facilitating healing from racial trauma or strengthening ethnic identity (Comas-Diaz, 2016). Rather, broaching is one essential relational skill for therapists to develop in order to provide these interventions effectively (Malott & Schaefle, 2015).

In a recent literature review, King (2021) identified five core tenets of broaching upon which scholars across the counseling fields have agreed. First, therapists must actively broach the topic of race rather than wait for their clients to do so. Within every

therapist-client dyad exist certain power dynamics based on each individual's social location (Pettyjohn et al., 2020). Due to their professional status, therapists are in positions of relative power when interacting with clients. These power differentials are compounded further when the therapist holds other dominant social identities. In addition, therapists provide direct and indirect cues to their clients regarding appropriate topics of conversation in sessions. As a result of these relational dynamics, clients look to therapists for cues regarding appropriate content of therapy sessions. In the absence of cues that race is acceptable and safe to discuss, REM clients often refrain from discussing race in counseling, and such cultural concealment has been linked to negative outcomes (Drinane et al., 2018). Moreover, a culture of silence around race has socially conditioned many REM individuals to avoid mentioning race in different spaces in order to remain safe (Day-Vines et al., 2018).

Second, broaching must occur consistently over the course of therapy as an "ongoing attitude of openness with a genuine commitment by the [therapist] to continually invite the client to explore issues of diversity" (Day-Vines et al., 2007, p. 2). Therapists should begin broaching early on during the therapy process, including the first session, in order to set the stage for ongoing conversations about race over the course of therapy (Day-Vines et al., 2007; Jones & Welfare, 2017; Knox et al., 2003; Zhang & McCoy, 2008; Day-Vines et al., 2018). Therapists' ongoing broaching efforts involve identifying and capitalizing on cultural opportunities, or "markers or moments in therapy where the therapist and client can engage in purposeful and meaningful dialogue about the clients' cultural identity" (Owen et al., 2016, p. 31). These opportunities are always

present, but occur most frequently when a client mentions a salient identity, and when a therapist believes a client's identity may be related to a presenting problem (Davis et al., 2018).

Two related core tenets of broaching are that therapists must address the dynamic identities that both they and clients hold, as well as conceptualize identity on multiple levels (King, 2021). These two tenets are outlined further in the Multidimensional Model of Broaching Behavior (Day-Vines et al., 2020), which recommends four specific dimensions of cultural opportunities that therapists must be able to recognize and broach. The four broaching contexts include the cultural dynamics within the therapeutic relationship, clients' experiences as individuals holding multiple social identities, clients' salient within-group experiences, and clients' experiences of racism, oppression, and discrimination.

A final core tenet of broaching involves adopting a flexible and open stance that allows clients to feel in control of how discussions of race and other salient identities unfold (King, 2021). For example, Day-Vines et al. (2021) proposes a step-by-step broaching process in which therapists begin by utilizing the client-centered helping skill of joining. This involves therapists developing rapport with REM clients by expressing interest, validating their experiences and worldviews, and exploring more personal topics (i.e., including race) as clients demonstrate increased comfort in the therapeutic relationship. This tenet of broaching also includes therapists asking about the salience of clients' various identities during cultural opportunities rather than assuming them. Lastly, therapists can demonstrate openness by allowing REM clients to control the pace and

checking in on their comfort while broaching - especially when discussing experiences of oppression.

Specific Therapist Broaching Styles and Dimensions

Clinicians across racial identities vary in their general approaches to broaching race in therapy with REM clients. Several studies utilizing the Broaching Attitudes and Behaviors Scale (e.g., Day-Vines et al., 2013; Day-Vines et al., 2022a; Day-Vines et al., 2022b) have demonstrated that therapists report attitudes and behaviors consistent with four distinct broaching styles: Avoidant, Continuing/Incongruent, Integrated/Congruent, and Infusing (Day-Vines et al., 2007). *Avoidant* therapists are unlikely to initiate conversations about race, and may avoid responding directly to client's comments about race. *Isolating* therapists may broach race with clients sporadically, but are likely to do so in a shallow way that quickly pivots to less race-related topics. These therapists implicitly signal to REM clients that they are unaware of race-related issues and/or they are unwilling to talk about them in any meaningful way. *Continuing/Incongruent* therapists broach race more frequently and attempt to do so with more depth, but they have difficulty demonstrating warmth and empathy in their broaching attempts. These therapists may possess an intellectual understanding of racism without having connected emotionally to the experiences of REM individuals related to racism. Thus, Continuing/Incongruent therapists are likely to come off as uncomfortable and mechanical in their broaching efforts. *Integrated/Congruent* therapists broach race frequently in a way that demonstrates cultural self-awareness and socio-political awareness, and thus they are able to enact more culturally effective therapeutic

interventions. In comparison to therapists utilizing the three less advanced broaching styles, Integrated/Congruent therapists are better able to recognize and explicitly validate clients' experiences of racism. *Infusing* therapists demonstrate the same qualities as those using the Integrated/Congruent style, but they also think about and work towards reducing racial/ethnic injustice at the systemic level. For example, Infusing therapists may participate actively in local and national racial justice initiatives that move beyond advocating for clients solely inside the therapy room. To date, no empirical studies have examined whether therapists enact these four broaching styles when working with clients.

Broaching among White Therapist-Trainees

Rationale for Focus on white Therapist-Trainee Broaching

While talking about race is an important skill set for every therapist, the need is particularly acute when the therapist is White. White individuals currently make up the majority of therapists in practice and training (APA, 2018). Many White therapists do not broach the topic of race with racial and ethnic minority (REM) clients (e.g., Day-Vines et al., 2022a; Pettyjohn et al., 2020; Lee & Horvath, 2013), thus missing out on or mishandling a potential source of both distress and healing. Of course, White therapists' social locations are complex and consist of many other social identities—both privileged and marginalized—and willingness to broach may be influenced by social context (e.g., institutional climate regarding race, racial composition of clientele and peers). Research supports the importance of focusing on whiteness, notwithstanding these complexities. For example, analyses from a panel of 20 experts in diversity training yielded 20 agreed-upon items regarding aspects of whiteness that may affect how White therapists enact

essential clinical skills (Baima & Sude, 2020). For example, "When white people have internalized white supremacy and a sense of white being normal, it is difficult for them to truly appreciate their clients' ways of being and join with them" (Baima et al., 2020, p. 13). Additionally, Grzanka and Spanierman (2019) outline a critical-conceptual framework that emphasizes studying whiteness as a method of dismantling white supremacy in psychotherapy. This study adds to this knowledge base by empirically examining the extent to which whiteness influences therapist-trainees' broaching behaviors.

The Connection Between White Racial Identity Development and Broaching

Just as White therapists vary in terms of social locations, they also vary in terms of how they think, feel, and act related to race. For example, across various studies White clinicians have endorsed color-blind attitudes as well as more actively anti-racist attitudes about race (e.g., Morales et al., 2018; Stone, 2013). White racial identity development (WRID) theory offers an organizing framework that may illustrate how White individuals experience, think about, and discuss race (Helms, 2008). For example, a recent study found that for a sample of White clinical, counseling, and school psychology doctoral students, higher racial identity statuses predicted higher self-reported levels of multicultural competence (Johnson & Jackson Williams, 2015).

While multiple models of WRID exist, scholars exploring broaching have largely relied on Helms' model (1990) as a theoretical basis. In foundational work articulating the process of broaching, Day-Vines (2007) notes that the unfolding of broaching attitudes 'parallels' therapists' WRID. In this article, she describes the expected

counselor attitudes regarding broaching that occur during each status of Helms' model of WRID. According to Helms' WRID theory, White individuals move through six developmental "statuses" (2008). These statuses detail how White individuals generally think and feel about race, as well as how they process and behaviorally respond to racial information. Broadly, the first three statuses of Helms' WRID model (i.e., Contact, Disintegration, and Reintegration) represent a phase marked by recognition and initial steps towards abandonment of racism. White individuals in the Contact status deny racial prejudice and believe race is unimportant. The Disintegration status involves a White person experiencing internal distress after becoming aware that race is more important than they had originally realized. During the Reintegration phase White individuals endorse more explicitly racist attitudes, which function to reduce their feelings of guilt during the previous WRID phase. The second three statuses (i.e., Pseudo-Independence, Immersion/Emersion, and Autonomy) denote a phase in which an individual works to create a nonracist White identity. During Pseudo-Independence White individuals gain understanding about ways that racism negatively impacts people of color, and they are able to identify a few ways that White privilege benefits them. It is not until Immersion/Emersion, however, that White individuals feel emotionally affected enough by the realities of racism that they begin to relinquish some of the benefits of White privilege. Finally, the Autonomy status occurs when White individuals develop a positive White racial identity and they are engaged in antiracist actions with other White individuals. The six statuses are not mutually exclusive, and thus White individuals often operate in multiple statuses at once. Progression through these statuses is bi-directional

and context-dependent. For example, White individuals may be presented with new racial stimuli that disorients their current understanding of the self and others in terms of race. Such experiences may cause a White individual to regress towards an earlier WRID status, remain in the current status, or move towards a more advanced status. Their current status depends on situational factors (e.g., social pressure) as well as personal factors (e.g., fatigue). However, a person tends to predominantly operate in the single WRID status that is most effective in their current environments.

Although no studies to date have directly examined the connection between therapist WRID and broaching, some indirect empirical evidence exists. For example, Burkard and Knox (2004) demonstrated that more color-blind White therapists reported lower empathy towards and tended to hold Black clients as more responsible for solving their problems than White clients. In addition, King and Summers (2020) found that White therapists who endorsed higher levels of race neutrality or "color-blindness," a marked feature of several WRID statuses, reported lower rates of broaching behavior. Additionally, Day-Vines and colleagues (2022b) recently demonstrated a connection between racial identity functioning and reported broaching styles for both White and REM school counselors. Specifically, they found that heightened racial identity functioning was related to more advanced self-reported broaching intentions and attitudes.

While this literature indicates a connection between therapists' White racial identity development and broaching behaviors, it is limited in that past studies have primarily relied on self-report measures of therapist broaching skills (e.g., King et al.,

2020; Jones & Welfare, 2017). In addition, prior broaching literature has called for future studies to examine social desirability and general counseling skills self-efficacy as potential covariates of therapists' self-reported broaching styles (Day-Vines et al., 2018). Moreover, there is a need for behavioral measures in order to advance our understanding of White therapists' broaching skills. In summary, there is solid theoretical ground demonstrating that White therapists' approaches to broaching are informed by their racial identity development; however, there is a dearth of direct empirical support (Day-Vines et al., 2021b). Such information would help point to specific identity characteristics that graduate training programs can use to determine White trainees' levels of readiness to work effectively with REM clients, as well as identity characteristics to focus on to increase readiness levels.

CURRENT STUDY

The current study's primary aim is to fill this gap in the literature by examining whether therapist-trainees' WRID is associated with their self-reported broaching styles and observed broaching behaviors. A secondary, exploratory aim of this study involves examining the relationship between White therapists' self-reported and observed broaching behaviors. Previous research has demonstrated that clinicians often report higher propensity to enact multicultural skills than they actually demonstrate in practice (e.g., Guzmán et al., 2013; Sehgal et al., 2011; Hansen et al., 2006). However, to date no studies have examined how therapists' self-reported and observed broaching attitudes and behaviors relate to one another. Understanding this relationship can help inform future methods of training therapists to better translate their intentions to broach into meaningful attempts to actually do so. Building on the literature just reviewed, the study explores the following hypotheses and exploratory questions.

Hypothesis 1

We predict that scores on the four White racial identity development statuses will align with participants' endorsements on the four broaching styles, such that:

Hypothesis 1a

Higher endorsement of the Contact status (i.e., lack of exposure to Black individuals) will be related to higher scores on the two least advanced broaching styles and lower scores on the two most advanced broaching styles.

Hypothesis 1b

Higher endorsement of the Reintegration status (i.e., racist attitudes) will be related to higher scores on the two least advanced broaching styles and lower scores on the two most advanced broaching styles.

Hypothesis 1c

Higher endorsement of the Pseudo-Independence status (i.e., White shame/guilt about racism) will be related to higher scores on the two most advanced broaching styles and lower scores on the two least advanced broaching styles.

Hypothesis 1d

Higher endorsement of the Autonomy status (i.e., antiracist actions) will be related to higher scores on the two most advanced broaching styles and lower scores on the two least advanced broaching styles.

Hypothesis 2

We predict that scores on the four White racial identity development statuses will align with the frequency of participants' observed broaching when responding aloud to two mock therapy client videos, such that:

Hypothesis 2a

Higher endorsement of the Contact status (i.e., lack of exposure to Black individuals) will be related to less frequent observed broaching.

Hypothesis 2b

Higher endorsement of the Reintegration status (i.e., racist attitudes) will be related to less frequent observed broaching.

Hypothesis 2c

Higher endorsement of the Pseudo-Independence (i.e., White shame/guilt about racism) status will be related to more frequent observed broaching.

Hypothesis 2d

Higher endorsement of the Autonomy status (i.e., antiracist actions) will be related to more frequent observed broaching.

Exploratory Hypothesis 3

Hypothesis 3a

We predict that, after accounting for hypothesized covariates (i.e., counseling skills self-efficacy and social desirability), higher scores on more advanced self-reported broaching styles (i.e., Integrated/Congruent and Infusing) will predict higher frequency of observed broaching when responding aloud to two mock therapy client videos.

Hypothesis 3b

We predict that, after accounting for hypothesized covariates (i.e., counseling skills self-efficacy and social desirability), higher scores on less advanced broaching styles (i.e., Avoidant and Continuing/Incongruent) will predict lower observed broaching when responding aloud to two mock therapy client videos.

METHOD

Participants

Participants were adults living in the United States who were enrolled in, or had completed within the last year, a graduate-level program for clinical psychology, counseling psychology, school psychology, or social work. All participants reported that they actively work with individual clients for counseling/psychotherapy as part of their clinical placement or occupation. Sixty-one participants completed the study, and 15 individuals were not included in analyses because they did not identify as White. The final sample consisted of 46 individuals ranging in age from 22 to 45 (Table 1). All participants identified as White, including 5 participants who identified as biracial (i.e., White and another non-Black race). Biracial participants were included in the sample because they did not differ from White participants on any key study variables. Individuals who racially identified as both Black and White were not included because the WRID measure selected is not relevant to individuals who identify as Black. The majority of participants (84.8%) identified as cisgender women. Participants reported living in various regions of the United States, with a slight majority (32.7%) residing in western states. The modal graduate program and degree types reported by participants were clinical psychology (71.7%) and doctoral (60.9%). The modal number of Black therapy clients participants worked with per week was zero (43.5%). The modal number of diversity-related graduate-level courses taken was one (52.2%).

Procedure

Recruitment for this study occurred during May-November 2021 via physical flyers posted in a university outpatient mental health clinic, and through various online channels such as graduate program email listservs, local and national professional organization email listservs, and social media platforms. In order to mask the study purpose of exploring White therapists' WRID and broaching behaviors, participants were told that the aim of the study was to explore various aspects of therapists' identities, their self-efficacy in treating therapy clients, and their use of basic helping skills. After providing informed consent, participants completed the 30-minute study via *Qualtrics*. The first 22 participants earned a $5.00 *Amazon* digital gift card for their participation in the study. In order to increase the pace of recruitment, we received IRB approval to increase participant compensation to $10.00 for all subsequent participants. All participants were entered into a raffle to win one of two bonus $50.00 *Amazon* gift cards.

During the first part of the study participants provided informed consent and completed a brief eligibility questionnaire. Eligible participants then engaged in a process of recording themselves responding aloud to two mock therapy client videos. Prior to each video, they were presented with the following instructions:

> You are about to watch a 2-minute video of an individual talking about a personal issue. Please imagine that you are currently meeting with this person as your therapy/counseling client. After watching the video, you will be instructed to record your response out loud as the therapist/counselor.

Participants were then shown the first of two 90-second video clips of a mock therapy client discussing a personal life experience. We received permission to use two videos from the "Multicultural Orientation Deliberate Practice" series, which was developed by psychologists at Sentio University for the purpose of training mental health providers to discuss culture in therapy/counseling. Each video portrayed the same Black/Ethiopian American, cisgender, male mock therapy client. This individual was an actor performing scripted versions of his own real-life experiences of racism. The first several seconds of each video provided participants with the following information: "The client is a cis, straight, Black/Ethiopian-American male who came to therapy for help with anxiety symptoms. This is your 3rd session of therapy" (Deliberate Practice Institute, 2021).

In the first video, the actor described repeatedly needing to prove to his co-workers that racism exists, despite their company's recent commitment to various social justice initiatives (i.e., racial discrimination at work). Participants then received instructions on how to begin, stop, and submit their first audio-recorded response. After receiving these instructions participants recorded and submitted their first responses out loud. They then repeated the same process (i.e., watch a mock therapy client video, receive recording instructions, submit a recorded response) for a second video. In the second video, the client shares an experience of having a panic attack in front of his son while at a shopping mall. He adds that he doesn't want his son to see him feel scared, and he asks how he can raise his son to not live in fear (i.e., fear about safety in public due to racism).

Of note, 13 out of 46 participants did not provide recorded data for both of the two mock therapy client videos. This included ten individuals who did not record a response for the second video and three individuals who did not record a response for either video. These individuals completed all of the questionnaires prior to and following the videos and did not drop out, so they were provided compensation and included in all analyses for which they did provide responses. One of these individuals misunderstood the instructions and responded by describing how they would respond to the client rather than actually responding to the client. We do not have information regarding why the remaining participants did not record data for both responses. Analyses revealed that these individuals did not significantly differ from those who responded to both client videos on any study variables.

After submitting audio-recorded responses to the two mock therapy client videos, participants completed a questionnaire that included the key study variables of interest (i.e., broaching styles and WRID statuses) and the proposed covariates (i.e., counseling skills self-efficacy and social desirability). Participants then read a debriefing statement which explained the true purpose of the study, and they provided their email addresses in order to be sent their monetary reward.

Research Team Positionality Statements

I am a White, queer, cis-gender man who is writing this dissertation in order to achieve my doctoral degree in clinical psychology. This research topic reflects my passion for continuously growing in terms of my own cultural self-awareness, how I show up as a cultural being in my personal and professional roles, and the actions I take

to create positive social change at various levels. I am also a White therapist-trainee who has worked with REM therapy clients and has attended workshops aimed at advancing my White racial identity development. These aspects of my identity and experiences are highly likely to have influenced the way I coded instances of broaching. That is, when evaluating whether participants in this study explicitly acknowledged aspects related to race, I could not stop myself from imagining what I would mean if I had spoken their statements when working with a REM client. In addition, my positionality likely affected the conclusions I have drawn from the results of this study. In particular, I have received similar types and amounts of multicultural training as the participants in this study. I therefore know that before reviewing literature for - let alone conducting - this study I was inclined to recommend greater attention to broaching skills training. Due to my positionality, it was important to consult often with members of my research team throughout the process of designing, implementing, and writing up results from this study.

The second member of the research team is a Black, cis-gender woman who was previously an undergraduate research assistant in the lab with the graduate student leading this project. She recently received her bachelor's degree in psychology, and is now pursuing graduate-level education in applied developmental psychology. Her research focuses on how intersectional identity and perceived discrimination play a role in the experiences of Black women's lives. The third member of the research team is a Black, cis-gender man who is a graduate student pursuing his doctoral degree in clinical psychology. His research focuses on identifying, addressing, and removing structural

barriers to health equity in diverse communities. These two individuals coded participants' transcribed audio-responses for multicultural verbal content. In coding responses, both the second and third members of the research team were able to reflect on their own experiences in conversations about racism with people who are White. Therefore, their perspectives often added a very different angle to my initial perceptions of participants' responses. The fourth member of the research team is the advisor for the graduate student leading the project. She is a White, cis-gender woman with a doctorate in clinical/community psychology and a tenured position on the faculty of a clinical psychology program. Her work focuses on the ways psychology can facilitate movement toward a more just society, including culturally relevant approaches to mental healthcare.

Measures

Demographics

For descriptive purposes, participants reported their age, gender, race, current U.S. region, type of graduate program (i.e., clinical psychology, counseling psychology, social work, or school psychology), type of graduate degree (i.e., Master's, Ph.D., or Psy.D), number of Black/African American therapy clients seen per week, and number of courses taken related to multicultural competence, diversity, and/or antiracist practice.

White Racial Identity Development (WRID)

Participants completed the 40-item White Racial Consciousness Development Scale – Revised (WRCDS – R; Lee et al, 2007), which measures the extent to which White individuals hold beliefs and feelings about race that are indicative of four of Helms' (1984) original six WRID statuses. The WRCDS – R was developed in response

to several reports that Helms' measure of WRID (i.e., White Racial Identity and Attitudes Scale – WRIAS; Helms & Carter, 1993) demonstrated poor internal consistencies (e.g., Behrens, 1997; Pope-Davis et al., 1999). The WRCDS – R has been recommended as a reliable and valid alternative measure of WRID (e.g., Schooley et al., 2019; Paone et al., 2015). Lee et al. (2007) found evidence for a four-factor model of WRID (i.e., excluding the Disintegration and Immersion/Emersion statuses) with alpha coefficients ranging from .78-.89, including the following subscales: Contact (8 items), Reintegration (14 items), Pseudo-Independence (9 items), and Autonomy (9 items). Several studies have implemented the WRCDS – R and also demonstrated high internal consistencies for each of the four subscales (e.g., Peters et al., 2016; Paone et al., 2015).

Reliability coefficients found in this sample for the WRCDS-R subscales were as follows: Contact ($\alpha = .82$), Reintegration ($\alpha = .85$), Pseudo-independence ($\alpha = .83$), and Autonomy ($\alpha = .59$). Upon observing the low reliability of the autonomy scale in comparison to the others, we first examined the content of the scale's nine items. In doing so we determined that three of the nine items appeared to lack face validity. Specifically, six Autonomy items assess White individuals' engagement in antiracist actions (e.g., "When I hear a racist joke, I say something to show my disapproval"). Three additional items examine how White individuals' families and friends would respond if they were romantically involved with a Black individual (e.g., "My family would disown me if I married a Black person"). We decided to drop these latter three items in order to more cleanly interpret higher scores on this subscale as indicative of greater engagement in antiracist actions. Doing so also increased the reliability of the Autonomy scale from .59

to .69. For ease of interpretation, the four WRID statuses measured by the WRCDS-R will be referred to throughout this study as follows: Contact (i.e., lack of exposure to Black individuals), Reintegration (i.e., racist attitudes), Pseudo-Independence (i.e., White shame/guilt about racism), and Autonomy (i.e., antiracist actions). Items on the WRCDS-R are measured using a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). An example item from the Contact subscale is "I have lived in close proximity to black people." An example item from the Reintegration subscale is "Black people have brought many of their problems on themselves." An example item from the Pseudo-Independence subscale is "White people think they are better than everyone else just because they are White."

Broaching Attitudes and Behaviors

The Broaching Attitudes and Behaviors Survey (BABS; Day-Vines et al., 2013) assessed participants' feelings and beliefs about broaching race in the therapeutic context. BABS items were rated on a five-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). Day-Vines et al. (2013) reported alpha coefficients of .88 for the 14-item Avoidant subscale, .88 for the 10-item Continuing/Incongruent subscale, .80 for the 10-item Integrated/Congruent subscale, and .78 for the 9-item Infusing subscale. Reliability coefficients found in this sample for the BABS subscales were as follows: Avoidant ($\alpha = .87$), Continuing/Incongruent ($\alpha = .80$), Integrated/Congruent ($\alpha = .80$), and Infusing ($\alpha = .75$).

Counseling Skills Self-Efficacy

The 41-item Counselor Activities Self-Efficacy Scale assesses self-perceived capabilities of enacting basic helping skills (CASES; Lent et al., 2003). Lent et al. (2003) reported alpha coefficients of .79-.94 for its six subscales. Reliability coefficients found in this sample for the CASES subscales were as follows: Insight (α = .82), Exploration (α = .89), Action (α = .79), Session Management (α = .93), Relationship Conflict (α = .88), and Client Distress (α = .93). Participants were instructed to "Indicate how confident you are in your ability to use each of the following helping skills effectively, over the next week, in counseling most clients" using a ten-point scale ranging from zero (no confidence) to nine (complete confidence). The six-item Insight scale measured skills in facilitating awareness of specific problems (e.g., "Immediacy - disclose immediate feelings you have about the client, the therapeutic relationship, or yourself in relation to the client"). The five-item Exploration scale measured basic communication skills (e.g., "Open questions - ask questions that help clients to clarify or explore their thoughts or feelings"). The four-item Action scale assessed skills in implementing structured interventions (e.g., "Homework - develop and prescribe therapeutic assignments for clients to try out between sessions"). The ten-item Session Management scale measured skills in keeping sessions focused (e.g., "Respond with the best helping skill, depending on what your client needs at a given moment"). The ten-item Relationship Conflict scale measured skills in navigating difficult interpersonal situations (e.g., "How confident are you in your ability to work effectively, over the next week with a client who is dealing with issues that you personally find difficult to handle?"). The six-item Client Distress

scale assessed skills in navigating challenging therapy situations (e.g., "How confident are you in your ability to work effectively, over the next week with a client who is clinically depressed?").

Social Desirability

The Socially Desirable Response Set-5 Scale (SDRS-5; Hays et al., 1989) measured participants' propensities to respond to survey items in a socially desirable way. The SDRS-5 includes five items rated on a Likert-type scale ranging from zero (Definitely True) to five (Definitely False). Hays et al. (1989) reported internal consistencies of .64-.66 for the SDRS-5. The reliability coefficient found in this sample was .59. Each individual item has a specific "extreme response" indicating especially high social desirability. An example item is "I am always courteous even to people who are disagreeable," and its extreme response is "Definitely True." Scoring the SDRS-5 involves rating each participant response as zero if it did not match the extreme response or as one if it did match the extreme response. The number of extreme responses were summed for each participant to create a total scale score variable that was used in analyses.

Observed Broaching – Multicultural Verbal Content

In order to quantify participants' observed broaching behavior, we initially aimed to follow an established coding scheme used in previous research (Worthington et al., 2000). However, several adaptations were made to the original coding scheme in order to address issues that arose throughout the process. The following section describes the

original coding scheme, as well as alterations made to better quantify observed broaching behavior in the current study.

The original coding scheme involved training study personnel to count the number of times participants exhibited multicultural verbal content (MVC), or "explicit verbal reference[s] to culture, race, ethnicity, minority status, cultural values, cultural differences, cultural conflict, racial-cultural identity, and environmental, geographical, or social conditions arising from any of the above factors" (Worthington et al., 2000, p.463). While we did not identify previous work that specifically coded therapist responses for broaching statements, this definition of MVC aligns well with the most commonly used definition of broaching (e.g., Day-Vines et al., 2020). In order to capture participants' audio recordings, an audio recorder was embedded into *Qualtrics* by using an integration feature from the video and audio research platform *Phonic*. The audio-recorded responses on *Phonic* were linked to participants' *Qualtrics* data using a common response ID variable. *Phonic* provided transcripts of all participant responses, which an undergraduate research assistant reviewed and corrected for accuracy. The first author then introduced two additional raters to the definition of MVC and outlined the coding process and timeline for them. The two additional raters were an undergraduate research assistant and a graduate student. At the time of coding, all raters were blinded to participants' other questionnaire responses and scores, including their scores on measures of WRID and broaching attitudes and behaviors.

After each rater independently coded all transcripts from the two mock therapy client videos, a Fleiss' kappa statistic was calculated to assess agreement among the three

raters. Applying the coding system described above resulted in poor agreement between the three raters for both the first video ($\kappa = .16$, $p < .001$) and the second video ($\kappa = .17$, $p < .001$). Since the goal of the coding paradigm is to reach consensus on all MVC counts, the first author and the faculty member on the team then reviewed ten responses for which each of the three coders had provided different MVC counts. Using these responses, the two of us identified common reasons for disagreement among raters. The first author then discussed the new coding guidelines with the other two coders, both of whom agreed with incorporating them into the next steps of the coding process. The first author and the two coders then re-coded ten more participant responses while utilizing the new guidelines. Afterwards, the three of us met to compare MVC codes and discuss discrepancies. Re-coding this batch of responses resulted in much higher agreement among raters ($\kappa = .70$, $p < .001$) than when we had originally coded the same ten responses without the two added guidelines. No new reasons for disagreement were identified during this process. Therefore, we continued to code and discuss batches of 10-15 responses per week using the two added guidelines until we had finished re-coding all responses. As recommended by Worthington et al. (2000), responses that the three coders still did not agree on after these discussions were brought to the lead researcher on the team who made a final decision on MVC count.

The two most common reasons for disagreement that led to adding new coding guidelines included the level of “explicitness” necessary to count a statement as MVC, and whether more implicit references to multicultural content should count as MVC if preceded by a statement explicitly containing MVC. A frequent example of the

disagreement among coders in terms of level of "explicitness" surrounded participants referencing some iteration of "everything going on in the world" in response to the second mock therapy client video. The first author discussed with the faculty member on the research team and the three coders what participants could have meant by such statements in the context of this video. We all agreed that participants were likely referencing the recent increase in awareness and distress related to police brutality towards people of color (Mattingly et al., 2022). For example, during the video the black actor emotionally asked "is [my son] supposed to walk around scared all the time?" We believe that participants who brought up "everything going on in the world" were picking up on the client's fear for his son's safety in a world where Black individuals are shot by the police every day. However, all members of the research team felt that this type of statement was too vague – given the timing of the study it could also refer to the man's fear that his son will contract Covid-19 – and thus is not explicit enough to be considered broaching or coded as MVC. Therefore, we set forth a new guideline that statements including ambiguous reference to a current event or social identity do not count as MVC. The second new guideline the research team agreed on was that if participants made a statement that counted as MVC, later statements that were ambiguous on their own could count as MVC so long as they added something novel directly related to the participants' first broaching statement. For example, if a participant explicitly mentioned the client's identity as a Black man, we would later consider the statement "I can understand your fear given what we see on the news these days happening to Black men" as MVC. In this example, we view the first instance of MVC as functioning to explicitly acknowledge the

client's identity as a black man. The second instance of MVC adds to this acknowledgement by validating his fear and potentially inviting discussion on police brutality against Black individuals.

Following completion of counting instances of MVC, the next step in the original coding scheme involved calculating the proportion of each response's MVC count to its total number of sentences. The purpose of this step was to account for the fact that therapists are likely to vary in their level of verbosity when responding to clients (Worthington et al., 2000; Hill, 1978). Accordingly, the first author unitized participant responses first by examining the transcripts, and then confirming these initial ratings by listening to the audio recordings. Once all responses had been unitized into sentences and tallied for MVC, a new variable was calculated by dividing each participant response's MVC count by its number of sentences. Each responses' resultant score thus reflected the proportion of MVC to the total number of sentences spoken by participants. These scores were multiplied by 100 in order to be more easily interpreted as the percentage of MVC evident in each response, with higher scores indicating more instances of participants broaching race.

Analysis Plan

In order to reflect Helms' theory that White individuals operate in multiple statuses of WRID concurrently (i.e., Helms, 1984), we intended to operationalize participants' WRID as profile scores (Carter et al., 2020; Parigoris, 2021). Specifically, we had planned to identify WRID profile scores and use these as independent variables in multivariate analyses predicting the broaching outcome variables. However, due to the

small sample size and low variance we found for multiple WRID statuses (i.e., Reintegration and Autonomy), we lacked sufficient statistical power to render multivariate analyses a viable option. Therefore, we designed an analysis plan that tests study hypotheses with bivariate analyses. That is, for all hypotheses involving the WRID construct, we analyzed the bivariate relationship between each of the four WRID mean status scores and each of the broaching outcome variables. Prior studies have utilized WRID scales separately in this way as continuous predictor and outcome variables to answer similar research questions (e.g., Johnson et al., 2015; Paone et al., 2015).

In order to examine Hypotheses 2a-2d – that self-reported WRID statuses are associated with observed broaching behavior – we intended to operationalize observed broaching behavior as participants' MVC proportion scores in line with the original coding scheme. However, coding participant responses in this way resulted in extremely low variance—in fact, the majority of responses contained zero instances of MVC (see Tables 3-4). Therefore, we conducted t-tests that examined whether each WRID status mean score differed among participants who broached versus did not broach in response to the two separate videos. That is, for each of the two mock therapy client videos, participants' responses were rated as "broached" if their response contained at least one instance of MVC, and they were rated as "did not broach" if their response contained no instances of MVC. Due to the difference in content between the questions (i.e., racial discrimination at work vs. fear of safety in public due to racism), we examined the questions both separately and jointly. Joint analyses involved coding participant responses as either "broached neither time," "broached one time," or "broached both

times” across the two videos. Then, we ran one-way analyses of variance (i.e., ANOVAs) in order to test whether each WRID status mean scores differed among participants who demonstrated the three levels of broaching.

Given the limitations described above, we were unable to examine hypotheses 3a-3b using multivariate analyses as originally intended. Instead, we conducted one-way ANOVAs to compare average scores on the four self-reported broaching styles among participants who broached at various levels. We ran a one-way ANOVA comparing each BABS mean scale score among participants who broached versus those who did not broach, and then repeated the process for the second video. For joint analyses, we ran one-way ANOVAs comparing each of the four mean WRID status scores across the same three levels of broaching described above (i.e., “ broached neither time,” “broached one time,” or “broached both times”). In order to inform future studies in selecting variables to include in multivariate analyses that predict observed broaching behavior, we also ran these analyses comparing the hypothesized covariates across different levels of broaching (i.e., counseling skills self-efficacy and social desirability).

RESULTS

Sample Description

Several details of the sample offer important context for interpreting results. In terms of White racial identity development, the current sample is not characteristic of the samples of White individuals included in prior studies (Table 2). That is, this sample is uncharacteristically advanced in their WRID compared to White individuals in other studies. Specifically, this sample reported higher mean scores for the Pseudo-Independence (i.e., White shame/guilt about racism) and Autonomy (i.e., antiracist actions) statuses and lower mean scores for the Contact (i.e., lack of exposure to Black individuals) and Reintegration (i.e., racist attitudes) statuses compared to a sample of school counseling students (Malott et al., 2022) and preservice teachers (Peters et al., 2016). We also observed extremely small ranges on both the Reintegration (i.e., racist attitudes) and Autonomy statuses (i.e., antiracist actions), with all average scores on these scales falling within 1.5 points of each other on a 5-point scale. Due to the restricted range of these variables, correlation coefficients that include the Reintegration and Autonomy statuses may be lower than expected (Goodwin & Leech, 2006). In addition, analyses that compare means on the Reintegration and Autonomy scales should be interpreted to reflect very small differences between effectively homogenous groups. Notably, the self-reported broaching style rated highest on average by participants was the Infusing style (i.e., broaching comfortably and engaged in advocacy) and the lowest was the Avoidant style (i.e., viewing broaching as unnecessary). Taken together, all

subsequent results should be interpreted as occurring in a sample characterized by White – or biracial, including White – therapist-trainees who reported especially advanced White racial identity development and broaching styles.

Another important consideration in this sample is that participants broached minimally across the two mock therapy client videos (see Tables 3-4). Less than half of all participants broached at all in response to the first video (i.e., racial discrimination at work), less than a third of participants broached in response to the second video (i.e., fear of safety in public due to racism), and only 4 out of 33 participants broached in response to both client videos. Thus, these results should be interpreted cautiously given the small sample sizes in the "broached" comparison groups in all analyses.

H1

Hypotheses 1a-1d examined the extent to which participants' scores on the four WRID statuses were related to their self-reported broaching styles (Table 2). Scores on the Contact status (i.e., lack of exposure to Black individuals) were positively correlated with the Continuing/Incongruent broaching style (i.e., "I feel uncomfortable and am bad at broaching") and negatively correlated with the Integrated/Congruent broaching style (i.e., "I make attempts to broach effectively"). Scores on the Reintegration status (i.e., racist attitudes) were positively correlated with the Avoidant broaching style (i.e., "I think broaching is unnecessary") and positively correlated with the Continuing/Incongruent broaching style (i.e., "I feel uncomfortable and am bad at broaching"). Scores on the Pseudo-Independence status (i.e., White shame/guilt about racism) were negatively correlated with the Avoidant broaching style (i.e., "I think

broaching is unnecessary"), positively correlated with the Integrated/Congruent broaching style (i.e., "I make attempts to broach effectively"), and positively correlated with the Infusing broaching style (i.e., "I broach and do advocacy"). Scores on the Autonomy status were negatively correlated with the Avoidant broaching style (i.e., "I think broaching is unnecessary"), negatively correlated with the Continuing/Incongruent broaching style, (i.e., "I feel uncomfortable and am bad at broaching"), positively correlated with the Integrated/Congruent broaching style (i.e., "I make attempts to broach effectively"), and positively correlated with the Infusing broaching style (i.e., "I broach and do advocacy").

H2

Results from this study largely did not support hypotheses 2a-2d, which examined whether higher scores on the more advanced WRID statuses would be related to greater frequency of broaching when responding aloud to two mock therapy client videos (see Tables 3-5). No significant differences in average WRID status scores were observed between individuals who did and did not broach for the first video (i.e., racial discrimination at work). In response to the second video (i.e., fear of safety in public due to racism), the 8 participants who did broach (M = 1.12, SD = 0.07) reported significantly lower average scores on the Reintegration status (i.e., racist attitudes) compared to the 26 participants who did not broach (M = 1.36, SD = 0.36). One-way ANOVA results comparing mean WRID status scores between individuals who broached in response to neither, one, or both client videos did not yield significant results. Overall, these results indicated that WRID status scores largely did not differ among individuals who broached

or did not broach. The one significant finding suggests that White therapist-trainees who report more racist attitudes may be less likely to broach in more "difficult" broaching contexts.

H3

We found some support for Hypotheses 3a-3b, which examined whether more advanced self-reported broaching styles would be related to higher frequency of broaching in response to two mock therapy client videos (see Tables 3-5). In response to the first video (i.e., racial discrimination at work), the 18 participants who did broach compared to the 25 participants who did not broach reported significantly lower average scores on the Avoidant broaching style (i.e., "I think broaching is unnecessary) as well as significantly higher average scores on the Integrated/Congruent broaching style (i.e., "I make attempts to broach effectively"). In response to the second video (i.e., fear of safety in public due to racism), the 8 participants who did broach compared to the 26 participants who did not broach reported significantly lower average scores on the Continuing/Incongruent broaching style (i.e., "I feel uncomfortable and am bad at broaching"). A one-way ANOVA revealed that there was a significant difference in scores on the Continuing/Incongruent broaching style (i.e., "I feel uncomfortable and am bad at broaching") between at least two levels of broaching frequency. Tukey's HSD test for multiple comparisons revealed that the mean value for the Continuing/Incongruent broaching style was significantly higher for individuals who broached in response to both videos in comparison to those who broached in response to one video and those who did not broach in response to either video.

The remaining analyses examined relationships between the hypothesized covariates (i.e., counseling skills self-efficacy and social desirability) and both self-reported broaching styles and observed broaching behaviors (see Tables 2-4). An interesting pattern of correlations emerged such that scores on all of the counseling skills self-efficacy subscales were negatively correlated with the Continuing/Incongruent self-reported broaching style (i.e., "I feel uncomfortable and am bad at broaching") and positively correlated with the Integrated/Congruent self-reported broaching style (i.e., "I make attempts to broach effectively"). These correlations were significant for five of the six types of helping skills, with the Action subscale approaching significance. These results suggest that for participants in this study, feelings of self-efficacy may cut across most of their clinical skills, as opposed to feelings of self-efficacy varying among specific skill sets such as broaching versus keeping sessions focused. The only other significant correlations for the counseling skills self-efficacy revealed that scores on the Avoidant self-reported broaching style (i.e., "I think broaching is unnecessary") were significantly negatively correlated with the Relationship Conflict and Client Distress-related helping skills. Similarly, social desirability was significantly negatively correlated with the Avoidant self-reported broaching style (i.e., "I think broaching is unnecessary"). These findings related to the Avoidant broaching style suggest that participants who believe broaching is less necessary may have a general desire to "keep the peace" with therapy clients by not talking about more difficult or "taboo" subjects.

In response to the first video (i.e., racial discrimination at work) no significant differences emerged in terms of counseling skills self-efficacy. In response to the second

video (i.e., fear of safety in public due to racism), the 8 participants who did broach compared to the 26 participants who did not broach reported higher average scores on all subscales of the counseling skills self-efficacy measure, though this difference was only statistically significant for the Exploration and Insight subscales. These results indicated that participants who broached in the “harder” video” felt more self-efficacious with regard to their helping skills in general. These results also provide additional support to the significant correlations between therapists reporting higher comfort broaching and enacting various other basic helping skills. That is, these findings suggest that participants’ general feelings of self-efficacy may be most related to their in-the-moment broaching decisions during more “difficult” broaching contexts. Average scores on the SDRS-5 (i.e., social desirability) revealed no significant differences between those who did or did not broach for either video.

DISCUSSION

The purpose of this study was to gain a better understanding of the relationships between White racial identity development, self-reported broaching styles, and observed broaching behaviors in a sample of White therapist-trainees. To our knowledge, this is the first study to examine therapist-trainees' observed broaching behaviors by implementing an action-based broaching task. Therefore, in addition to exploring the aforementioned relationships between constructs of interest, descriptive statistics revealed interesting aspects of this population that warrant additional research on White racial identity development and broaching behaviors.

First, this sample of White therapist-trainees reported particularly advanced White racial identity development. Namely, these individuals reported moderate-high exposure to Black individuals, low racist attitudes, high experiences of White shame and guilt related to racism, and high commitment to antiracism. Similarly, participants reported quite advanced broaching styles—they believe broaching is necessary, report low discomfort with broaching, report frequent attempts to broach effectively, and consider themselves to be advocates for REM individuals inside and outside the therapy room. However, the majority of participants did not broach in response to two mock therapy videos of a Black client describing issues related to racism. The small number of individuals who broached in the current study emphasizes previous results demonstrating that White clinicians seldom broach race (e.g., Day-Vines et al., 2022a; Pettyjohn et al.,

2020; Lee & Horvath, 2013), and underscores the possibility that self-report may be of limited use in evaluating this tendency.

White Racial Identity Development and Self-Reported Broaching Styles

There are four sets of key findings of the present research (see Table 6). First, our hypothesis that more advanced WRID would be associated with more advanced self-reported broaching styles was largely supported. That is, scores on the two least advanced WRID statuses were positively correlated with at least one of the two least advanced broaching styles, and scores on the two most advanced WRID statuses were positively correlated with both of the two most advanced broaching styles. These results add to the small body of empirical and theoretical research detailing the relationship between therapists' WRID and self-reported broaching styles. In particular, our results were consistent with findings from a recent empirical study which found a significant positive relationship between therapist-trainees' racial identity functioning and self-reported broaching styles (i.e., Day-Vines et al., 2022b).

In addition, these results provide additional nuance to the theory that White therapist-trainees' WRID parallels their development of broaching attitudes and behaviors (i.e., Day-Vines et al., 2007). Our results suggest that White therapist-trainees' attitudes that are in line with each of the four WRID statuses offer distinct information regarding their self-reported broaching styles. For example, we found support for our hypothesis that that therapist-trainees with less exposure to Black individuals (i.e., least advanced WRID status) would also report higher self-reported discomfort related to broaching (i.e., the second least advanced broaching style). It is thus evident that WRID

statuses and self- reported broaching styles were related for this sample of participants; however, these relationships may have minimal practical significance given that WRID was not related to participants' observed broaching behaviors as measured in this study (detailed further below).

White Racial Identity Development and Observed Broaching Behavior

The second set of findings generally did not support our hypothesis that more advanced WRID would be associated with more observed broaching behavior. When comparing those who broached and those who did not broach in response to the mock therapy client video describing racial discrimination at work, no significant differences were detected in terms of WRID. When responding to the video of a Black mock therapy client describing his fear of safety in public due to racism, participants who broached reported significantly less racist attitudes than those that did not. However, this significant result reflects a less than 0.25-point difference in racist attitudes on a 5-point scale, and thus does not seem meaningfully significant. When looking at broaching behavior across the two videos, we did not find any significant differences in WRID between those who broached neither, one, or both times.

Taken together, this set of results suggests that while WRID statuses are associated with therapist-trainees' self-reported broaching styles, they appear to be unrelated to their actual broaching behaviors. To our knowledge, this is the first study to examine the relationship between White therapist-trainees' WRID and observed broaching behaviors. An important takeaway is that for White therapist-trainees who report advanced WRID, there are likely factors other than WRID that are more related to

whether or not they broach when working with REM clients; based on the results discussed below, anxiety and self-efficacy may be more pertinent therapist-trainee variables.

Self-Reported Broaching Styles and Observed Broaching Behavior

The third set of key findings somewhat supported our hypothesis that more advanced self-reported broaching styles would be associated with more frequent observed broaching behavior. When comparing those who broached and those who did not broach when responding to the "easier" video (i.e., one in which racism is explicitly mentioned by a client) participants who broached believed broaching was more necessary to do and they reported that they frequently attempt to broach effectively with REM clients. Interestingly, when responding to the "harder" video (i.e., one in which racism is less explicitly mentioned by a client), participants who broached only reported greater comfort and self-efficacy when broaching compared to participants who did not broach. Their beliefs about the importance of broaching and how often they claim to broach were not predictive of their actual behavior. These results are in line with a large body of literature that suggests that clinicians overestimate their competencies in delivering various interventions when compared to their observed behaviors (e.g., Becker-Haimes et al., 2022; Hogue et al., 2015). In addition, these results suggest that when responding to a "harder" scenario it is White therapist-trainees' distress levels, not their attitudes about broaching or even their attitudes about race that differentiates who will or will not broach. In essence, White therapist-trainees can recognize the importance of broaching

and intend to facilitate meaningful discussions about race, but may experience too much distress in the moment to actually broach in more difficult broaching contexts.

Since there are no empirical studies to which we might compare these specific results, it is helpful to interpret them in relation to the *Five Areas* model of White therapists interacting with clients of color (i.e., Naz et al., 2019). Applying this model to less explicit, more emotionally heavy broaching contexts (e.g., fear of safety in public due to racism) begins with the moment a White therapist first hypothesizes that a broaching context may be relevant in therapy. Next, they have an intent to broach alongside a stream of cognitions such as “I’m probably just making this about racism when it really isn’t for this person” or “How could I possibly say anything helpful if I haven’t lived this experience myself?”. These cognitions lead to emotions such as shame, anxiety, and guilt, as well as physiological changes such as increased heart rate and muscle tension. As a result of these internal sensations, White therapists avoid broaching despite their initial desire to do so. When recognizing opportunities to broach more obvious, less emotionally heavy contexts in sessions (e.g., racial discrimination at work), White therapists may experience less internal distress which they are better able to overcome and thus they engage in broaching.

Counseling Skills Self-Efficacy, Self-Reported Broaching, and Observed Broaching Behavior

The fourth and final set of key findings provided information regarding how counseling skills self-efficacy related to White therapist-trainees’ broaching. The results indicated that participants who reported feeling more self-efficacious and less nervous when

broaching also reported similarly high levels of comfort and self-efficacy related to nearly every other basic helping skill. Moreover, participants who broached in response to the more "difficult" video (i.e., fear of safety in public due to racism) also reported more confidence when enacting a host of basic helping skills—including broaching. We did not find this same relationship when comparing participants who did and did not broach in response to the "easier" video. In essence, although participants in general reported that they broach often, the small group of participants who actually did broach in a challenging task also reported being more effective at other counseling skills more broadly. It thus may be that White therapist-trainees who consistently broach with REM clients represent a different level of trainee compared to those who broach less often—that is, one who feels more competent as a therapist across the board.

Limitations and Future Directions

One limitation noted throughout the current paper involves the small sample size of White – and biracial, including White – therapist-trainees. It is important that future studies observe the relationships between WRID, self-reported broaching styles, and observed broaching behaviors in larger samples. In addition, the current sample was largely homogenous in terms of gender, graduate program type, and graduate degree. We did not find a difference in self-reported broaching styles between participants enrolled in different types of graduate programs (i.e., clinical, counseling, other) or degrees (i.e., Ph.D., Psy.D., Master's). However, given the small number of participants in this sample not enrolled in clinical psychology Ph.D. programs, these results should be interpreted cautiously. We were also unable to test for differences in observed broaching between

participants enrolled in different types of graduate programs and seeking different degrees due to sample size limitations. Broaching differences in these populations should be examined in future research, as at least one prior study has demonstrated a difference in self-reported broaching styles between different types of mental health professionals (i.e., Day-Vines et al., 2022a).

We have also touched on several important measurement and methodology-related limitations of the current study. As previously mentioned, there is currently no consensus on how to best measure WRID. We chose to use the WRCDS-R because several studies have reported higher reliabilities for its subscales compared to other measures of WRID, yet we still ended up observing poor reliability for the Autonomy (i.e., antiracist actions) scale in this study. We also found low variance in responses for the Reintegration (i.e., racist attitudes) and Autonomy (i.e., antiracist actions) scales; however, this may not be a measurement issue and simply reflect that sample is truly high in WRID. Future research can address these potential measurement issues by gathering larger samples and conducting cluster analyses to identify different patterns of WRID among White therapist-trainees (Carter et al., 2020). Alternatively, based on the current results it could just be that WRID is simply more associated with self-reported broaching than with observed broaching. Therefore, future studies might instead examine the relationship between therapist-trainee WRID and less interaction-based skills such as multicultural case conceptualization and developing cultural humility.

Another important measurement-related consideration is that we selected mock therapy client videos of a Black individual to align with the WRCDS-R, which measures

White individuals' attitudes and beliefs regarding Black individuals specifically. Just as there are unique types of prejudice that White individuals hold and enact against Black individuals specifically, this is also true about other racially minoritized groups (Pierson et al., 2021). It is thus important to follow up the current study by examining White therapist-trainees' broaching behaviors when working with clients of various other racial and ethnic identities. These studies can explore questions such as whether there is something about working with Black clients that is particularly anxiety-provoking, or whether broaching race is equally difficult for White-therapist trainees to do when working with all REM clients. In addition, future studies can apply a more intersectional lens by examining whether White therapist-trainees' broaching behaviors vary when working with REM clients who hold other minoritized social identities. Additionally, although this study provides rationale for examining how whiteness affects counselors' broaching behaviors, additional research is needed regarding the unique experiences of REM therapists broaching race. There is some theoretical and qualitative research that describes how REM therapists' broaching decisions differ from White therapists', including the need to consider one's own experiences of racial trauma, and the potentially negative perceptions clients hold about REM therapists when they discuss race (e.g., Branco & Jones, 2021; Moon & Sandage, 2019; Bayne & Branco, 2018). However, similar to the literature on White therapists broaching race, there is a lack of empirical studies examining REM therapists' observed broaching behaviors.

Another limitation of the current study involves how we operationalized observed broaching behavior. That is, no coding scheme for broaching existed, so we adapted the

non-validated MVC coding system (i.e., Worthington et al., 2000) to meet our needs. One limitation that arose is that there were no example cases that we could use to train the coders with before they began coding real cases. Instead, all raters simply read the definition of MVC and then began coding responses for MVC. Future studies may use the responses from the current study to train coders with example cases prior to coding new therapist responses for MVC. In addition, future research should examine how results may vary with different coding systems.

Finally, the results of this study suggest that White therapist-trainees who report that they frequently make attempts to broach and actually do so in challenging broaching contexts may represent an overall different, more confident level of trainee (i.e., compared to White therapist-trainees who report attempts to broach but do not do so in challenging contexts). This finding raises the question of how White therapist-trainees develop this overall higher level of confidence, including teasing apart how developing the particular skill of broaching is similar to or different from learning other challenging skills (e.g., suicide risk assessment). That is, is it basically the same as learning how to ask clients about suicide that with increased broaching practice White therapist-trainees will feel more confident to broach and thus broach more often, or is some additional aspect of training needed? Future research should also examine how White therapist-trainees' internal experiences affect their in-the-moment broaching decisions when working with REM clients. For example, future studies might gather physiological and self-report measures of stress (e.g., heart rate variability, subjective units of distress) from White therapist-trainees as they listen and respond to REM clients' experiences of

racism. Moreover, future studies should compare the effectiveness of various training interventions aimed at improving White therapist-trainees' abilities to manage anxiety in different broaching contexts (e.g., emotion regulation skills training; mindfulness skills training; gradual exposure). Lastly, although it is important to examine broaching frequency, it is not necessarily the case that broaching more often is more effective. Therefore, it is important that future studies include measures of broaching effectiveness as well. For example, future research could incorporate REM individuals rating the quality of White participants' broaching statements via the Client Assessment of Multiculturally Competent Behavior (CAMCB; Oh & Shillingford-Butler, 2020).

Training Implications

Despite the aforementioned limitations, these results offer several practical implications related to training White therapists to broach more effectively. First and foremost, our results suggest that White therapist-trainees who endorse antiracist beliefs and report that they broach often and effectively may be broaching with REM clients (i.e., especially Black clients) infrequently. As a result, clinical supervisors cannot presume their trainees' actual broaching behavior with REM clients based on their reported beliefs about Whiteness, race, racism, or even the necessity of broaching. Instead, supervisors must observe White therapist-trainees in action (i.e., via live supervision or review of video-recorded session content) in order to ascertain their broaching behaviors. By doing so, supervisors will be able to provide more accurate feedback and guidance to trainees regarding all aspects of their broaching attempts with REM client. When supervisors identify in-session moments during which trainees do not broach despite a broaching

context being relevant, they can provide a developmentally appropriate supervisory intervention such as role-play or self-reflection (Borders, 2014).

A second important practical application of these results is that greater attention needs to be paid to reducing White trainees' distress related to broaching in the therapy room. Our results suggest that neither having high exposure to Black individuals nor engaging in racial justice advocacy sufficiently prepares White trainees to feel comfortable broaching race in more difficult broaching contexts. Rather, lower feelings of distress and more self-efficacious beliefs during broaching attempts differentiated those who broached and those who did not. Training programs and clinical supervisors can thus draw on exposure principles to increase White trainees' management of anxiety during sessions with clients of color (e.g., Abramowitz et al. 2019). This should include providing opportunities for White trainees to intentionally practice responding to REM clients in broaching contexts of various levels of difficulty. For example, the videos used in the current study were part of Sentio University's publicly available "Multicultural Orientation Deliberate Practice" online training series (Deliberate Practice Institute, 2021). Their website offers a collection of scripted client videos alongside instructions that guide trainees to practice broaching in response to gradually more difficult scenarios related to race and racism. After responding to each video, trainees reflect on whether their cognitions and body sensations indicate that the video was an appropriate challenge or too difficult. Based on this self-assessment, they continue either by repeating the current video until their anxious thoughts and feelings reduce, proceeding to the next video if minimal anxious thoughts and feelings arose, or going back to an easier video if

their anxiety was too overwhelming. Supervisors can supplement trainees' deliberate practice with broaching in several ways. First, as White trainees progress through these videos, supervisors can help them identify in-session broaching opportunities similar in difficulty to the videos they have already "mastered." They can also work with trainees who are "stuck" in their progression towards more anxiety-inducing videos. This may involve identifying specific emotions, cognitions, and/or physical sensations that are most getting in the way, as well as targeted interventions to practice as they continue with exposure.

APPENDIX A: TABLES

Table 1

Sample Description

Variable	Mean/Median (SD) or *n* (%)
Demographics	
Age	27.5/27 (3.7) (*n* = 46)
Gender	
Woman/Female	39 (84.8)
Man/Male	5 (10.9)
Non-Binary/Genderqueer	2 (4.4)
Race	
White	41 (89.1)
Bi/Multi-Racial	5 (10.9)
U.S. Region	
West	15(32.6)
Northeast	12 (26.1)
Southeast	10 (21.7)
Midwest	8 (17.4)
Southwest	1 (2.2)
Clinical Experience	
Grad Program – Type	
Clinical Psychology	33 (71.7)
Counseling Psychology	9 (19.6)
Social Work	3 (6.5)
School Psychology	1 (2.2)
Grad Program – Degree	
Ph.D.	28 (60.9)
Master’s	10 (21.7)
Psy.D.	8 (17.4)
Grad Program – Years Enrolled	3.1/3.0 (1.5)
Clinical Training Experiences	
Black Therapy Clients/Week	1.5/1.0 (3.8)
Multicultural Courses Taken	1.4/1.0 (1.0)

Table 2

Bivariate Correlations among Study Variables

Measure	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
WRCDS-R															
1. Contact	1														
2. Reintegration	.26	1													
3. Pseudo-Independence	-.27	-.58**	1												
4. Autonomy	-.61**	-.39**	.42*	1											
BABS															
5. Avoidant	.16	.58**	-.29*	-.33*	1										
6. Continuing/Incongruent	.41**	.37*	-.25	-.51**	.32*	1									
7. Integrated/Congruent	-.48**	-.20	.37*	.57**	-.32*	-.62**	1								
8. Infusing	-.22	-.15	.36*	.37*	-.43**	-.01	.40**	1							
SDRS-5															
9. Extreme Responses	-.17	.03	-.12	.04	-.31*	-.13	.02	.11	1						
CASES															
10. Exploration	-.44**	-.45**	.29	.30*	-.22	-.42**	.40**	.21	.17	1					
11. Insight	-.43**	-.24	.26	.27	-.09	-.45**	.31*	.06	.12	.63**	1				
12. Action	-.41**	-.09	.20	.19	-.10	-.25	.25	.15	.11	.62**	.59**	1			
13. Session Management	-.33*	-.19	.21	.20	-.22	-.33*	.37*	.25	.20	.64**	.78**	.70**	1		
14. Relationship Conflict	-.37*	-.39**	.29*	.30*	-.36*	-.43**	.44**	.14	.22	.65**	.71**	.62**	.73**	1	
15. Client Distress	-.28	-.24	.21	.21	-.38*	-.37*	.36*	.27	.35*	.51**	.62**	.63**	.74**	.67**	1

Note. WRCDS-R= White Racial Consciousness Development Scale – Revised; BABS = Broaching Attitudes and Behaviors Survey; SDRS-5 = Socially Desirable Response Set Five Item Survey; CASES = Counselor Activities Self-Efficacy Scales

$^{*}p < 0.05$

$^{**}p < 0.01$

Table 3

Independent Samples T-Test Results – Observed Broaching During "Easier" Workplace Racism Video

Measure	All Respondents (n = 43)		Broached (n = 18)		Did Not Broach (n = 25)		$t(41)$	p
	Mean	SD	Mean	SD	Mean	SD		
WRCDS-R								
Contact	1.90	0.67	2.00	0.70	1.82	0.64	-0.87	.39
Reintegration	1.29	0.32	1.27	0.31	1.30	0.33	0.27	.79
Pseudo-Independence	3.78	0.57	3.81	0.74	3.76	0.43	-0.27	.79
Autonomy	4.24	0.41	4.32	0.33	4.18	0.46	-1.13	.27
BABS								
Avoidant	1.55	0.42	1.39	0.34	1.67	0.43	2.27	.03*
Continuing/Incongruent	3.32	0.59	3.22	0.68	3.39	0.52	0.90	.37
Integrated/Congruent	3.50	0.46	3.50	0.48	3.20	0.41	-2.26	.03*
Infusing	3.95	0.48	4.03	0.42	3.90	0.53	-.93	.36
SDRS-5								
Extreme Responses	0.81	1.03	0.94	1.00	0.72	1.06	-0.70	.49
CASES								
Exploration	7.29	1.25	7.30	1.21	7.28	1.39	-0.05	.96
Insight	5.61	1.30	5.56	1.17	5.65	1.33	0.20	.84
Action	5.55	1.53	5.17	1.52	5.82	1.51	1.39	.17
Session Management	6.19	1.21	6.21	1.18	6.17	1.26	-0.11	.91
Relationship Conflict	5.43	1.20	5.35	1.24	5.48	1.20	0.35	.73
Client Distress	6.10	1.64	6.04	1.62	6.15	1.68	0.23	.82

Note. WRCDS-R= White Racial Consciousness Development Scale – Revised; BABS = Broaching Attitudes and Behaviors Survey; SDRS-5 = Socially Desirable Response Set Five Item Survey; CASES = Counselor Activities Self-Efficacy Scales
* $p < 0.05$
** $p < 0.01$

Table 4

Independent Samples T-Test Results – Observed Broaching During "Harder" Fear of Safety in Public Video

	All Respondents (n = 34)		Broached (n = 8)		Did Not Broach (n = 26)		$t(32)$	p
Measure	Mean	SD	Mean	SD	Mean	SD		
WRCDS-R								
Contact	1.95	0.60	1.78	0.50	2.00	0.62	0.91	.37
Reintegration	1.30	0.33	1.12	0.07	1.36	0.36	3.25	$.00^{**}$
Pseudo-Independence	3.81	0.62	4.04	0.58	3.74	0.62	-1.21	.24
Autonomy	4.25	0.40	4.42	0.35	4.21	0.41	-1.31	.20
BABS								
Avoidant	1.52	0.40	1.29	0.24	1.59	0.41	1.97	.06
Continuing/Incongruent	3.25	0.57	2.67	0.46	3.43	0.48	4.00	$.00^{**}$
Integrated/Congruent	3.40	0.42	3.60	0.48	3.34	0.39	-1.60	.12
Infusing	3.99	0.45	4.22	0.56	3.92	0.40	-1.65	.11
SDRS-5								
Extreme Responses	0.85	1.16	0.94	1.00	0.73	1.19	-1.11	.27
CASES								
Exploration	7.26	1.30	7.83	0.51	7.09	1.42	-2.21	$.04^{*}$
Insight	5.62	1.24	6.58	0.45	5.33	1.27	-2.73	$.01^{*}$
Action	5.65	1.47	6.44	0.82	5.41	1.55	-1.78	.08
Session Management	6.19	1.31	6.94	0.55	5.97	1.40	-1.91	.07
Relationship Conflict	5.40	1.30	6.00	0.83	5.21	1.35	-1.56	.13
Client Distress	6.28	1.78	7.31	1.00	5.96	1.86	-1.95	.06

Note. WRCDS-R= White Racial Consciousness Development Scale – Revised; BABS = Broaching Attitudes and Behaviors Survey; SDRS-5 = Socially Desirable Response Set Five Item Survey; CASES = Counselor Activities Self-Efficacy Scales
$^{*}p < 0.05$
$^{**}p < 0.01$

Table 5

Means, Standard Deviations, and One-Way Analyses of Variance – Observed Broaching Frequency Across "Easier" and "Harder" Videos

	All Respondents (n = 33)		Broached Both Videos (n = 4)		Broached One Video (n = 14)		Broached Neither Video (n =15)		F(2,30)	p	Partial η^2
Measure	Mean	SD	Mean	SD	Mean	SD	Mean	SD			
WRCDS-R											
Contact	1.95	0.60	1.78	0.60	2.18	0.65	1.78	0.53	1.82	.18	.11
Reintegration	1.31	0.34	1.13	0.09	1.32	0.33	1.33	0.38	0.65	.53	.04
Pseudo-Independence	3.79	0.61	4.19	0.55	3.63	0.75	3.84	0.45	1.46	.25	.09
Autonomy	4.25	0.41	4.58	0.29	4.18	0.28	4.23	0.51	1.60	.22	.10
BABS											
Avoidant	1.52	0.40	1.21	0.27	1.48	0,33	1.64	0.45	2.06	.15	.12
Continuing/Incongruent	3.26	0.58	2.33	0.18	3.43	0.57	3.35	0.42	8.80	.00**	.37
Integrated/Congruent	3.38	0.40	3.73	0.46	3.33	0.41	3.32	0.34	1.90	.17	.11
Infusing	3.97	0.44	4.19	0.55	3.92	0.32	3.96	0.51	0.57	.57	.04

Note. WRCDS-R= White Racial Consciousness Development Scale – Revised; BABS = Broaching Attitudes and Behaviors Survey

** $p < 0.01$

Table 6

Summary of Main Findings

Variable	Observed Broaching – "Easier" Workplace Racism Video		Observed Broaching – "Harder" Fear of Safety Video		Observed Broaching Across "Easier" and "Harder" Videos		
	Broached	Did Not Broach	Broached	Did Not Broach	Broached Both Videos	Broached One Video	Broached Neither
White Racial Identity Development							
Contact (i.e., lack exposure to Black people)	X	X	X	X	X	X	X
Reintegration (i.e., endorse White supremacist/racist beliefs	X	X	Lower	Higher	X	X	X
Pseudo-Independence (i.e., experience White shame/guilt)	X	X	X	X	X	X	X
Autonomy (i.e., endorse antiracist beliefs and actions)	X	X	X	X	X	X	X

Self-Reported Broaching							
Avoidant (i.e., "I think broaching is unnecessary)	Lower	Higher	X	X	X	X	X
Continuing/Incongruent (i.e., "I feel uncomfortable and bad at broaching")	X	X	Lower	Higher	Lower	Higher	Higher
Integrated/Congruent (i.e., "I make attempts to broach effectively")	Higher	Lower	X	X	X	X	X
Infusing (i.e., I broach and do advocacy"	X	X	X	X	X	X	X

APPENDIX B: DISSERTATION STUDY 1- WHITE RACIAL IDENTITY DEVELOPMENT: IMPLICATIONS & RECOMMENDATIONS TO FACILITATE GROWTH IN WHITE THERAPIST-TRAINEE BROACHING BEHAVIOR

The American Psychological Association's *Multicultural Guidelines* (2017) emphasize multicultural competence as an important aspect of psychologists' clinical training. More specifically, the guidelines suggest that psychologists must understand that all individuals' experiences are shaped by their multiple social identities, as well as how these are related to systems that differentially confer power, oppression, and privilege. They also encourage psychologists to actively combat oppressive systems and empower marginalized communities in all aspects of their work. Therefore, one critical skill set for psychologists is broaching—the ability to explicitly initiate and invite conversations about race, ethnicity, and/or culture— in order to fully see, connect with, and support clients of color (Day-Vines, Bryan, & Griffin, 2013; Pettyjohn et al., 2019).

While talking about race is an important skill set for every therapist, the need is particularly acute when the therapist is White. White individuals currently make up the majority of therapists in practice and training (APA, 2016), and many of them report that they do not broach the topic of race with their racial and ethnic minority (REM) clients (Pettyjohn et al., 2019; Lee & Horvath, 2013), thus missing out on or mishandling a potential source of both distress and healing. Although there are guidelines for training White therapists to broach race and racism, their effectiveness has not been examined. Additionally, these guidelines do not adequately address the fact that White individuals

enter psychology graduate programs with different personal experiences and understandings of race, power, oppression, and privilege. Some White students enter graduate school endorsing colorblind attitudes about race (Morales et al., 2018). Other White trainees enter these programs having much greater understanding about the effects of race and racism, and may be actively working on anti-racist practices (Stone, 2013). Helms (2008) outlines several "statuses" of White racial identity development (WRID) that may illustrate how White individuals experience, think about, and discuss race as they begin their graduate-level training in psychology. Moreover, a recent study found that for a sample of White clinical, counseling, and school psychology doctoral students, lower racial identity statuses predicted lower self-reported levels of multicultural competence (Johnson and Jackson Williams, 2015).

Taking a developmental approach to training novice psychologists (i.e., meeting trainees where they are) is considered the gold standard (Falender & Shafranske, 2012). Accordingly, White trainees at different stages of WRID require different training experiences in order to improve their ability to broach race and racism with REM clients. Existing MCC training models do not adequately address which training components can be implemented with students at various stages of WRID, especially for building the specific skill of talking about race with REM clients (i.e., broaching behavior). Moreover, graduate students in counseling and clinical psychology often report that their graduate education failed to adequately teach them a host of multicultural skills (D'Andrea et al., 2008; Sammons & Speight, 2007). Therefore, the current paper will review literature on

White racial identity development and provide a set of recommendations for tailoring MCC training approaches for broaching based on this literature.

Broaching Behavior

Therapists—both directly and indirectly— provide cues to their clients regarding appropriate topics of conversation in sessions. Within every therapist-client dyad exists certain power dynamics based on each individual's social location, or intersection of multiple social identities (Pettyjohn et al., 2019). Due to their professional status, therapists are in a position of relative power when interacting with clients, which is compounded further when the therapist holds other dominant social identities in relation to clients. For example, a White, male therapist working with a Black, female client is multiply empowered in terms of professional identity, race, and gender. As a result of such power dynamics, clients look to therapists for cues regarding appropriate content of therapy sessions. In the absence of cues that race is acceptable and safe to discuss, clients of color often refrain from discussing race in therapy, and such cultural concealment has been linked to negative therapy outcomes (Drinane, Owen, & Tao, 2018). Moreover, a culture of silence around race has socially conditioned many people of color (POC) to avoid mentioning race in different spaces in order to preserve their own safety (Day-Vines et al., 2018). Therefore, therapists must be willing and able to actively broach the topic of race rather than waiting for their clients to do so (Day-Vines et al., 2018). When therapists have actively acknowledged race in therapy, clients of color have rated them as

more credible and competent, and they were less likely to drop out of treatment (Zhang & McCoy, 2009; Knox, et al., 2003)

Broaching has been defined as a therapist's "deliberate and intentional efforts to discuss those racial, ethnic, and cultural (REC) concerns that may impact the client's presenting concerns." (Day-Vines et al., 2020). Broaching is not considered a single event, but rather a "consistent and ongoing attitude of openness with a genuine commitment by the counselor to continually invite the client to explore issues of diversity" (Day-Vines et al., 2007). Importantly, broaching skills alone do not adequately prepare therapists to provide culturally appropriate interventions, such as facilitating healing from racial traumas (Comas-Diaz, 2016). However, broaching is an essential relational skill for therapists to develop in order to provide these interventions effectively (Malott & Schaefle, 2015).

Several scholars have suggested likely timing and contexts under which therapists can broach race during the course of therapy. In terms of timing, there has been general consensus that therapists can begin broaching race early on during the therapy process (Day-Vines et al., 2007; Fuertes et al., 2002; Jones & Welfare, 2017; Knox et al., 2003; Zhang & McCoy, 2009). Doing so sets the stage for ongoing conversations about race over the course of therapy, especially if broached effectively. It may even be beneficial to broach race during the initial intake session with clients of color (Day-Vines et al., 2018; Choi et al., 2015). In a recent study, a sample of racially and ethnically diverse participants were randomly assigned to watch one of four video-recorded, scripted therapy intake sessions between a White female therapist and a Black female client (King

& Borders, 2019). In three of the video conditions the therapist engaged in different types of explicit broaching behavior, and in the fourth they did not engage in any broaching behavior. Their results demonstrated that participants across all races rated broaching therapists as higher in cultural humility, cultural competence, and cultural opportunities than therapists who did not broach.

Another common recommendation for when therapists should broach race in therapy involves therapists identifying and capitalizing on cultural opportunities, or "markers that occur in therapy in which the client's cultural beliefs, values, or other aspects of the client's cultural identity could be explored" (Owen et al., 2016, p. 31). In other words, cultural opportunities are times when a therapist needs to further explore a client's salient social identity. Davis et al. (2018) described that these opportunities are always present, but occur most frequently in two circumstances: 1) when a client explicitly mentions a salient identity, and 2) when a therapist believes a client's identity may be related to a presenting problem. On the other hand, cultural opportunities do not include spontaneous or abrupt discussions about social identities just for the sake of having them (Davis et al., 2018). Additionally, a therapist's decision to broach should center around their clients' needs rather than their own feelings of discomfort (Pettyjohn et al., 2019). For example, a therapist should not ask about their client's race if the primary reason is to avoid appearing racist by not asking about it.

In addition to the timing of broaching race in therapy, therapists must recognize the various contexts under which race is likely to become relevant in sessions with clients of color. The Multidimensional Model of Broaching Behavior (MMBB; Day-Vines et al.,

2020) offers the most comprehensive guidelines for broaching contexts. The MMBB outlines four types of situations that arise for clients of color, and refers to each of these as a therapist broaching dimension. As previously mentioned, therapists must be alert for cultural opportunities within these dimensions, and broach them as early as they become relevant. The Intra-counseling dimension involves the therapist's acknowledgement of cultural dynamics within the therapeutic relationship. Here, therapists share their own positionality, as well as invite clients to share their social identities. Therapists may also explore clients' feelings about working with someone with their named social identities. The main intents of broaching Intra-counseling dynamics are to name and reduce the power imbalance in the therapeutic relationship, and to relay to clients that race is an acceptable topic to discuss in therapy. The Intra-individual dimension involves the therapist's deeper exploration of clients' experiences as individuals holding multiple social identities. They also acknowledge the intersectional systems of oppression that function for clients with multiple marginalized identities. In doing so, therapists convey their acceptance of a client's full humanity, rather than mistakenly assuming the salience of any one of a client's singular identities. Intra-REC dimensions involve the therapist's acknowledgement of a clients' salient within-group experiences. Therapists must recognize that there is variability in the values, beliefs, and behaviors within a group. When relevant, they must acknowledge how their clients' experiences (mis)align with those of other group members. These include clients' positive and negative within-group experiences, both of which may heavily impact their psychological functioning (Day-Vines et al., 2020). Finally, Inter-REC dimensions involve the therapist's

acknowledgement of clients' experiences of racism, oppression, and discrimination. Therapists must address how these experiences affect clients' lives, as well as assist them in identifying and implementing tools to combat and advocate against these oppressive systems.

In sum, broaching race with REM clients is a necessary component of therapists' multicultural competence. Cultural opportunities arise at various points throughout the course of therapy, and these relate to factors both inside and outside of the therapeutic relationship. Therapists must develop an ongoing orientation towards race, as well as a willingness to explicitly name race as it becomes relevant in the moment.

White Racial Identity Development and Broaching

White therapists' racial identities can provide useful context for understanding how they go about broaching race with clients of color (Day-Vines et al., 2007). Racial identity refers to one's: 1) understanding of the self as having a race (i.e., a socio-politically constructed classification based on biological characteristics), 2) awareness of being a member of a racial group and that such membership is perceived by others, and 3) internalization of the socialization processes that occur as a result of one's racial group membership (Helms, 2007). Helms (1984) introduced one of the earliest and arguably the most influential models of adult white racial identity development (WRID). Helms (2014) described that she developed this theory in the context of the American Psychological Association's growing interest in multicultural counseling competencies. Her theory has been used widely, and is largely credited with stimulating discussion and research on the racial socialization processes of White individuals (Helms, 2014).

In its current form, Helms' WRID theory explains that White individuals move through six developmental "statuses" (2008). These statuses detail how White individuals generally think and feel about race, as well as how they process and behaviorally respond to racial information. Statuses are not mutually exclusive, and thus White individuals often operate in multiple statuses at any given time. Moreover, progression through the six statuses may be bi-directional and context-dependent. For example, White individuals may be presented with new racial stimuli that disorients their current understanding of the self and others in terms of race. Such experiences may cause a White individual to regress towards an earlier WRID status, remain in the current status, or begin moving towards a more advanced status. Their current status may depend on situational factors (e.g., social pressure) as well as personal factors (e.g., fatigue). However, a person tends to predominantly operate in the single WRID status that is most effective in their current environments.

Broadly, the first three statuses of Helms' WRID model (i.e., Contact, Disintegration, and Reintegration) represent a phase marked by internalized racism. The second three statuses (i.e., Pseudo-Independence, Immersion/Emersion, and Autonomy) denote a phase in which an individual begins to abandon racism and create a nonracist White identity. A typical progression in terms of improving broaching behavior involves: 1) increasing knowledge about race, racism, and the importance of broaching race in therapy, 2) increasing self-awareness of race, racial identity development, and how these may affect broaching efforts, 3) developing the ability to recognize and seize broaching opportunities during sessions, 4) learning to recognize internal discomfort as it arises

while broaching and how it affects interactions, and 5) develop ability to regulate internal discomfort and refocus attention towards listening deeply and responding appropriately to clients (Lenes et al., 2020). For White therapists, however, these general recommendations can be adapted to meet the developmental needs in different WRID statuses.

The following six sections will define each of Helms' WRID statuses, and will draw on previous theoretical work to describe the expected broaching behavior of White therapists operating in a given status. In order to inform training and supervision, each section will then present a novel set of training recommendations for improving White therapists' current broaching behavior with clients of color. These recommendations are important both in the interest of growth, and in the interest of competent care: clinical training happens while trainees are actively seeing clients. Although more advanced stages of White racial identity development have been associated with higher multicultural competence (Jackson & Johnson, 2015; Middleton et al., 2005), many White trainees will begin seeing therapy clients of color when they are at lower WRID statuses (Middleton et al., 2005). The recommendations are meant to support both therapist growth and competent practice in the context of their current stage of development.

Status 1 - Contact

Definition

A White person in the Contact status does not think that race is an important factor in their own or others' lives. They may consider themselves simply part of the "human

race," and consider themselves as simply "normal." Whites in this status deny having any bias or prejudice towards other racial groups. This racial identity status has been noted elsewhere as commonly held among White individuals, and is often referred to as colorblind racial ideology (Johnson et al., 2015).

Broaching Behavior

Given their colorblind attitudes about race, White therapists operating in the Contact status are unlikely to broach the topic of race with clients of color (Day-Vines et al., 2007). When engaging in case conceptualization and treatment planning, they do not consider their client's race relevant. In terms of thinking about how they interact with clients, they are likely to believe that they see and treat clients of all races equally. When clients of color initiate conversations about race, White therapists in the Contact status will likely miss, ignore, and/or invalidate their experiences. These therapists only pick up and respond to the aspects of a client's racial experience that they see as "universal." Whites in this status may explicitly minimize the importance of race for clients of color by openly stating that race is not pertinent in the context of therapy (Constantine, 2007). White therapists in the Contact status may also overidentify with clients of color, thus invalidating REM clients' unique experiences (Constantine, 2007). For example, a Black female client may reveal that she was fired by her White boss at work for appearing too "angry." The White female therapist in the Contact status may respond by stating that she can empathize with the client because she has been called "dramatic" by her male co-workers. This is considered a microaggression because the White therapist invalidates the distinct form of discrimination her client faces due to being both Black and female.

Growth in Broaching Behavior

The primary training objectives for improving White therapist broaching behavior during this status are to increase their understanding of race as an important identity to explore with clients, and to provide them with explicit language to use during initial broaching efforts. Therapists are trained to explore and conceptualize clients' sources of both distress and healing (e.g., relationships, occupation, education). However, White therapists in the Contact status do not tend to think of racial identity as one of these sources for themselves or for their clients (Miller, 2017).

In order to begin to learn about the importance of racial identity for themselves and their clients, exercises for White trainees in this status can focus on general ideas about social identity and privilege. Therapists can complete a self-awareness-raising activity such as a Social Identity Wheel (e.g., Chow et al., 2019). The goal of this activity is for therapists to acknowledge each of their multiple social identities, how salient each one is for them personally, and how each identity may be perceived by others. A helpful mnemonic tool for teaching White therapists to recognize various social identities is the ADDrESSing framework, which stands for: Age and generational influences, Developmental or other Disability, Religion and spirituality, Ethnic and racial identity, Socioeconomic status, Sexual orientation, Indigenous heritage, National origin, and Gender (Hays, 2016a). Hays (2019) offers a list of simple questions therapists can use to begin exploring these identities – first with peers in a training setting, and then with therapy clients. The aforementioned training activities function to plant the seed that race and other social identities are important to recognize and broach in therapy.

Moving from recognizing identities to understand that there are different levels of privilege associated with them, the "Counseling Privilege Scenarios Group Assignment" (Case, 2015) begins with an example of privilege associated with not having a disability. For White therapists in the Contact status, first learning about a privileged social identity other than Whiteness may make them more open to the idea that people have different experiences based on their race as well (Case, 2015). For example, the instructor may read a vignette about an individual with a physical disability that is suffering from depression. They learn that this individual has contacted several local therapists and cannot find one that provides the necessary accommodations for them to be able to attend therapy sessions. The leader can then ask trainees if they have ever experienced a similar problem (either as individuals with or without physical disabilities), and whether they have ever considered the extent to which their current place of employment provides accommodations for differently-abled clients. Trainees are then split into small groups to discuss a vignette about another privileged social identity such as high socioeconomic status. Trainees then read and discuss a vignette about White privilege in their small groups before having a full-group discussion about White privilege that is moderated by the group instructor.

When training White therapists in the Contact status to begin thinking about and broaching the topic of race, it is important to also demonstrate how racial identity can be a positive aspect of people's lives. Iwamasa and Hays (2019) suggested that positive aspects of a client's "cultural background"—or in this case, racial identity—can be categorized into environmental conditions, interpersonal supports, and personal strengths.

Trainees can be given examples from each of these categories in order to demonstrate how one's race creates a nuanced experience for every individual.

In addition to training exercises, supervision with White therapists in the Contact status can also emphasize the importance of thinking and talking about race. As with the therapist-client relationship, the supervisor holds a position of relative power and thus must initiate broaching behavior with supervisees (Falender et al., 2013). When working with White supervisees operating in the Contact status, supervisors should model broaching behavior early on in supervision (Iwamasa et al., 2019). For example, they may first share with supervisees why doing so is important, their own comfort level with broaching race, and what training experiences they have had regarding broaching. Supervisors must recognize that White trainees in the Contact status likely will not expect the topic of race to come up in clinical supervision. They may either discount discussions on race, or feel a sense of shame for having not thought about it up until this point. Given their subordinate status as supervisees, they may feel uncomfortable acknowledging either of these experiences. Supervisors can normalize these reactions by emphasizing their own journey towards learning to broach race even when society largely encourages avoidance of such discussions (Hays, 2016a). In addition to normalizing initial discussions of race in the supervisory context, supervisors can discuss race and other social identities as they become relevant during joint review of recorded therapy sessions (Hays, 2016a). Supervisors of White trainees operating in the Contact status will likely need to call attention to cultural opportunities that occur in sessions. Rather than criticizing, supervisors can simply point out that these moments occur more often than

one may expect. Supervisors can suggest an effective broaching statement and then role-play the therapeutic interaction so that the supervisee gains practice broaching.

Status 2 - Disintegration

Definition

The next status, Disintegration, occurs when a White individual encounters racial stimuli that contradict their colorblindness or denial about race and racism. For example, they may learn about institutional racism or become aware of their own internal racism. Disintegration is marked by newly confused thoughts and distressing emotions (e.g., guilt, shame, helplessness) regarding what it means to be White or a person of color. During this status, White individuals often face competing desires to feel like they are not racist, and to simultaneously remain committed to their own racial group (Helms, 2014). White folks in this status may try to suppress such discomfort by discounting racist events as anomalies, or by denying that anything can be done about racism.

Broaching Behavior

White therapists in the Disintegration status are more likely to think about their clients of color in racial terms, and may even engage in broaching behavior. When doing so, these therapists initiate dialogue about race at a superficial level. They may broach with clients of color more out of a desire to appear non-racist rather than to fully explore their clients' experiences. After initially broaching race with clients of color, White therapists in the Disintegration status may feel they have "checked the race box" and are unlikely to demonstrate ongoing broaching behaviors. When treating clients of color, White therapists may experience in-session shame and guilt when recognizing their own

privilege, ways their racial group has harmed people of color, and ways they have personally enacted racial discrimination or microaggressions (Naz et al., 2019). If clients of color point out racist or discriminatory comments they make in therapy, these White therapists are likely to become extremely defensive (e.g., "I didn't mean to say something racist" or "I'm not racist, I have lots of friends who aren't White"). White therapists may become so visibly distressed that clients of color end up taking on the role of consoling them during these interactions (Naz et al., 2019).

Growth in Broaching Behavior

The goal for improving broaching behavior during the Disintegration status is to increase White therapists' ability to tolerate discomfort and remain empathetic when discussing race with clients of color. The ultimate risks for White therapists in this status are that they will experience such intense discomfort that they end up invalidating or insulting clients of color, and/or they feel so uncomfortable that they no longer wish to work with clients of color (Naz et al., 2019). These trainees need to learn to recognize feelings of discomfort and use effective emotion regulation skills during these interactions (Naz et al., 2019).

Teaching trainees to use mindfulness techniques while learning about and discussing race can enhance therapists' ability to recognize and tolerate such discomfort (Perera-Diltz & Greenidge, 2018; Fisher, 2020; Davis et al., 2020). Indeed, mindfulness techniques have been found to increase therapists' self-reported levels of multicultural competence (Ivers et al., 2016; Campbell et al., 2018). Trainees in this status can first learn how to engage in basic mindfulness practices such as focusing on the breath,

completing a body scan, and simply noting thoughts and emotions without engaging them (Hilert & Tirado, 2019). Trainees may practice using these mindfulness skills individually before using them to engage in *insight dialogue* (ID) with peers (Kramer, 2007). Trainees can use the following guidelines of ID while practicing broaching race with their peers, potentially using the ADDrESSing framework questions mentioned above.

Implementing ID involves the following six steps: Pause, Relax, Open, Trust Emergence, Listen Deeply, and Speak the Truth. Before broaching race with a conversation partner, trainees Pause to observe their inner experiences without judgment. White trainees in this status are likely to notice discomfort in their bodies, such as muscle tension and shallow breathing. During the Relax step, trainees are encouraged to invite their minds and bodies to rest in order to increase a sense of acceptance and equanimity. Some trainees may relax effectively with this simple invitation, while others may need to use more explicit self-soothing skills such as deep breathing. Trainees are then instructed to Open, or broaden their mindful attention to their conversation partner and the social context. When broadening their attention outwards, trainees engage in Trust Emergence by recognizing and accepting that the following conversation can proceed in many different, constantly changing ways. White trainees in this status may be additionally reminded at this point that their discomfort may rise and fall, and that it is important to allow such experiences to occur without prematurely ending the conversation. Trainees are then instructed to Listen Deeply to their conversation partner, remaining fully present and attentive as they speak. Trainees can be reminded to demonstrate helping skills such

as maintaining eye contact, nodding, and using reflections. Finally, trainees are instructed to Speak the Truth by sharing their authentic subjective experiences and reactions during the conversation. Trainees in the Disintegration status need to learn to share their inner reactions while remaining equanimous and avoiding burdening clients of color with the task of holding or soothing their therapist's discomfort.

As previously mentioned, White therapists in the Disintegration status are likely to apologize profusely if clients of color acknowledge that they have made a race-related offense or misstep. Beyond managing their discomfort, White therapists in this status can benefit from proactively preparing a mental script for an effective apology to use when cultural ruptures occur (Hook et al., 2017). An effective apology following a rupture includes six elements: 1) explicitly stating an apology, 2) acknowledging the specific offense enacted, 3) taking personal responsibility for the offense, 4) sharing your feelings regarding what happened, 5) discussing your client's emotions, and 6) committing to doing better in the future (Kirchhoff et al., 2012). Trainees can practice making effective apologies with their peers and supervisors so that these steps become easy to implement when needed. Trainees should be reminded that uncomfortable emotions may compel them to repeat and emphasize their apology in the moment, thus necessitating the use of mindfulness skills in order to recognize these urges and calm the mind.

Clinical supervisors of White trainees in the Disintegration status can acknowledge the importance of managing in-session discomfort early on in the supervisory relationship. Supervisors may provide trainees with examples of topics other than race that may engender therapist discomfort but are still critical to ask about. For example,

many novice therapists feel nervous when first asking clients about suicidal ideation. Nonetheless, they are encouraged to ask about suicide directly, and to respond with empathy rather than surprise, judgment, or fear (Cramer et al., 2013). Most importantly, trainees learn to continue collecting all necessary information despite any internal discomfort they experience. Supervisors can convey to White trainees in the Disintegration status that broaching race may be a similar experience for them. Supervisors can work with trainees to set individualized goals related to maintaining composure while broaching race in sessions. For example, when reviewing video recordings, supervisors can provide specific feedback regarding how well supervisees demonstrated equanimity and empathy via their nonverbal behaviors and their responses to the client. By doing so, they can identify specific behavioral goals for trainees to work towards in future broaching efforts.

Status 3 - Reintegration

Definition

The Reintegration phase occurs when White individuals are no longer able to consciously suppress their distress regarding the realities of racism and White privilege. Instead, Whites in this status begin to justify these realities in a way that denigrates people of color, and idolizes Whites (Helms, 2008). White individuals in Reintegration endorse common negative stereotypes about POC that help them reconcile the guilt associated with benefiting from White privilege and racial inequality. They may hold the essentialist belief that people of color are inherently different or inferior in comparison to Whites (Mandalaywala et al., 2019). It is common for White individuals in Reintegration

to believe that POC would experience less racism and discrimination if they adopted White cultural values. Relatedly, they are likely to espouse the meritocratic belief in the American Dream, or that one can achieve anything if they "pull themselves up by their bootstraps". White individuals in this status believe that racial inequities are not a result of systemic and institutional racism, but rather a result of individual inadequacies of POC. This mindset allows White individuals to feel absolved of experiencing any guilt or personal responsibility for racial inequity (Helms, 2008). Therefore, Reintegration is considered a very comfortable status that White individuals can remain in for a significant amount of their lives (Helms, 2008).

Broaching Behavior

During the Reintegration phase, White therapists will continue to broach race in a minimal, shallow fashion. They feel obligated to acknowledge race with clients of color, and will consider themselves culturally competent as long as they broach race at least once. Whites operating in the Reintegration status endorse common stereotypes about people of color, and thus are likely to commit several types of microaggressions when broaching race. Therefore, this is a status during which White therapists are at high risk of harming clients of color in their broaching efforts. In particular, they may over-emphasize positive qualities that Black clients possess, and even point them out as racial anomalies (Constantine, 2007). For example, a White therapist in Reintegration may tell a Black client that she speaks much more proper English than any other Black person she has met. If clients of color point out instances of racism that have occurred, White therapists in this status may respond in more explicitly offensive or accusatory ways than

in the Disintegration status (Helms, 2008). More specifically, they might accuse clients of color of being overly sensitive regarding race, or even go on to blame clients of color for their experiences of racism (Constantine, 2007). For example, consider a Black client stating that they continue to be overlooked for promotions that their White co-workers ultimately receive. A White therapist in the Reintegration status might respond by suggesting that the promotion process is normally color-neutral, and that they might have more success if they improved their job performance. Alternatively, they might acknowledge that the promotion process can be discriminatory, and thus suggest that the Black client should act more White – without actually using those words (e.g., "Have you tried a different hairstyle/outfit/manner of speaking?"). Either way, White therapists in this status are likely to encourage clients of color to "fix" themselves to fit the system, rather than to join these clients in articulating the ways systems and institutions that perpetuate racism.

Growth in Broaching Behavior

During the Reintegration status, the primary growth area is in displaying cultural humility when broaching race. A cornerstone of cultural humility is the belief that one's own cultural worldview is one of many equally valid ways of viewing the world (Mosher et al., 2017). This poses two important goals for White therapists in the Reintegration status – 1) recognizing that their social identities (i.e., Whiteness in this case) affect their beliefs, values, and attitudes; 2) learning to explore and value REM clients' worldviews (Mosher et al., 2017).

White trainees in this status can practice recognizing how Whiteness shows up in their personal worldviews with a structured journaling and reflection exercise (e.g., Hook et al., 2017b). First, trainees are instructed to write down their most central beliefs, values, and attitudes, and where these came from. For example, they can identify what messages they have learned and internalized regarding topics such as family, romantic relationships, work, crisis, health, and money. Next, trainees can be introduced to a list of beliefs, values, and attitudes commonly held by White people. For example, Katz (1985) outlines components of White culture such as the importance of individual autonomy and control, an emphasis on the 'Protestant work ethic' as the primary path to success, and an orientation towards thinking and planning for the future. Trainees can then think, journal, and discuss regarding how similar or different their own beliefs, values, and attitudes are to those associated with Whiteness. Additionally, trainees can complete a similar exercise to identify their behaviors and preferences that are typical of White individuals by completing the White Racial Identity Scale (WRIS; Miller, 2017). The WRIS indicated eight aspects of White racial identity, including being American (i.e., celebrating American holidays, having pride in America, speaking 'proper' English, and participating in politics), endorsing trust in institutions (i.e., political systems, doctors), and enjoying specific music and foods (i.e., White musicians, potlucks, casseroles).

After positioning their own personal beliefs, values, attitudes, and behaviors in the context of Whiteness, trainees can learn how to broach race in a way that centers and embraces their clients' worldviews. Opportunities to center clients' worldviews often present themselves when therapists recognize a values conflict (DeBlaere et al., 2018).

White therapists who have participated in the aforementioned journaling exercises will likely be able to recognize when their values conflict with a client's. When this occurs, therapists can use an intra-counseling broaching statement – that is, they can explicitly address that their worldview and experiences as a White person might be different from their clients' (Day-Vines et al., 2020). They can then demonstrate openness and curiosity by expressing their desire to better understand their client's perspective (Hook et al., 2017c). White therapists can then proceed to discuss how the values conflict might affect the course of therapy, as well as how they can navigate the conflict in order to work collaboratively towards the client's goals.

Another approach White therapists can use during the Reintegration status is ethical bracketing (Hook et al., 2017c). Ethical bracketing is a simple, actionable approach that involves White therapists internally setting aside their own values in order to simply listen to and empathize with their client's experiences. This can be helpful when a White therapist notices a difference in values in the moment, but holds onto this value so strongly that they are not prepared to engage in collaborative values discussions. Following the use of ethical bracketing, therapists must take steps to understand the values difference and prepare to address it effectively with clients. These steps may include self-reflection, education, consultation, supervision, and personal therapy.

Clinical supervisors can help White therapists in the Reintegration status develop cultural humility through modeling and role-plays in supervision. Hook and colleagues (2016) recommend that clinical supervisors utilize an "initiate-invite-instill" approach for fostering cultural humility. That is, supervisors can initiate early conversations about race

and other social identities with supervisees, continue to invite dialogue about social identities throughout the course of supervision, and instill the importance of considering social identities in every aspect of therapy (Hook et al., 2016). Clinical supervisors can also share with trainees when they notice their own cultural worldviews are different from their supervisee's, and then proceed to model effective navigation of the value conflict . In addition to modeling cultural humility, clinical supervisors should look for opportunities to point out moments in supervisees' therapy sessions when they could have responded to REM clients in a more culturally humble manner. Supervisors should praise the trainee's efforts at broaching race, point out how the trainee mis-stepped, and then have them role-play a more culturally humble response.

Another essential training goal for White therapists in the Reintegration status is learning how to broach REM client's experiences of racism without assigning individual blame. It is likely that trainees in this status will not understand how racism is perpetrated at the institutional and systemic levels. Gaining this understanding is critical for therapists in this status to be able to discuss clients' experiences of racism effectively. In addition to learning about racism through didactic lessons, trainees may use the "5 Why's" exercise to better see how clients' individual problems can be related to higher-level inequities (Cattaneo et al., 2019). In this exercise, trainees are presented with an individual's problem (e.g., a Black parent was reprimanded for not getting their child to school on time). The instructor then asks trainees to provide reasons why the parent was unable to do so. After some suggestions, the instructor picks one explanation and then asks "why?" until they have asked this question a total of 5 times. Generally, trainees'

responses will advance from individual to systemic and institutional reasons for the situation. Clinical supervisors should be vigilant for opportunities to practice this exercise with White trainees in this status who are treating REM clients.

Status 4 – Pseudo-Independence

Definition

Pseudo-independence is the first status in Phase 2 (i.e., Abandoning Racism) of Helms' White racial identity development model. White individuals often progress towards Pseudo-Independence after encountering an indisputably racist event that defies their essentialist beliefs about race. Such an event propels them to question their understanding of race and how a person's race affects their position in society. They may start to identify ways in which they benefit from White privilege, but they do not feel required to give up these benefits. At this point, a White individual has a more intellectual than emotional understanding of racism and of their own race. Moreover, they believe that racial inequalities are the fault of "other White people" (e.g., White supremacists, Ku Klux Klan members) and environmental conditions (e.g., "broken homes," inferior education). Whites operating in Pseudo-Independence often feel compelled to "help" people of color work to become "equal" to Whites. At the same time, they fail to take a serious look at how they personally perpetuate and benefit from racist systems. Relatedly, they commonly look to the people of color in their lives for validation that they are not racist.

Broaching Behavior

When operating primarily in the Pseudo-independence status, White therapists may broach the topic of race with REM clients during the course of therapy (Day-Vines et al., 2007). However, due to their more intellectual understanding of race, their broaching efforts lack depth and likely will not facilitate deeper connections with REM clients. Their approach to broaching may involve overly frequent questions about race, to the point where they assume every aspect of a client's life is related to their race (Hays, 2016). They might ask race-related questions out of genuine interest to connect and understand, but these questions can function to tokenize and exoticize clients of color (Sue et al., 2008). Whites in this status may validate REM clients' experiences of oppression and discrimination, but they might do so in a way that demonstrates pity rather than empathy (Davis et al., 2020). They are also likely to focus heavily on clients' negative experiences regarding race, thus exhibiting a deficit rather than strengths-mindset with REM clients (Sue et al., 2008). Therapists with this mindset are likely to treat REM clients as victims of racism rather than as resilient individuals with many strengths related to their racial identities (Hays, 2016). As such, they may attempt to act as saviors or "fixers", which is likely to be interpreted as paternalistic and demeaning (Davis et al., 2020). Additionally, when discussing clients' experiences of racism, they are likely to blame broken systems and "other" White folks, without addressing their own White privilege. In doing so, White therapists in this status are often indirectly asking clients of color to validate their view of themselves as "good White people."

Growth in Broaching Behavior

White therapists in the Pseudo-Independence status must learn how to talk about race with REM clients without attempting to "fix" them. It is important that educators and clinical supervisors validate and work with-rather than against-White therapists' desires to help REM clients with issues related to racial injustice. They can normalize this experience by introducing trainees to the concept of White Savior Industrial Complex (WSIC; Cole, 2012). Deznin (2014) outlines a compelling socio-political history of how WSIC developed in the United States, which may help trainees understand the concept. Trainees can practice identifying WSIC behavior by watching clips from White savior films such as *The Help*, *Freedom Writers*, and *The Blind Side* (Deznin, 2014). Educators and clinical supervisors can then provide examples of how WSIC might occur in the therapeutic context. Normalizing the desire of White trainees to help or fix POC sets the stage for them to adopt a more effective role in their work with REM clients. A guiding philosophy is that "the role of White allies has nothing to do with helping people of color to survive in a system of White dominance. Rather, ally work involves transforming systems of White dominance to be equitable, fair, and just." (Spanierman and Smith, 2017, p. 609). That is, White trainees must learn that the best way they can support REM clients is by demonstrating allyship rather than heroism. Case (2015) introduced a framework for White therapists to create "therapeutic ally-ances" with REM clients that may be helpful during this WRID status. This model involves White therapists engaging in more in-depth analysis of their experiences of White privilege, as well as steps for engaging in social action to dismantle oppressive systems. Enhancing White trainees'

awareness of such a model can also function to motivate them to progress towards more advanced WRID statuses.

After learning about the ways that efforts to "fix" REM clients are problematic, these therapists can begin to use mindfulness skills in order to recognize the internal (i.e., thoughts and feelings) and external (i.e., behaviors) clues that they are experiencing that urge, and then make choices about how to respond. For example, self-conscious emotions such as guilt and shame, and even feelings of sympathy can prompt paternalistic behaviors (Grzanka et al., 2019; Langhout, 2015). Externally, urges to fix REM clients may take the form of making suggestions for coping and navigating experiences of racism, or even asking "What can I do to fix this?". Clinical supervisors can work with each trainee individually to determine their unique set of internal and external clues that indicate a desire to fix REM clients.

White therapists in the Pseudo-Independence status also need a framework for what to do when they recognize an urge to "fix" REM clients. Rather than suggesting any form of coping, support, or action, trainees can explore how their clients already successfully exist within and even resist oppressive individuals, institutions, and systems. Trainees must learn that, in general, REM clients are highly likely to already be engaging in effective methods of survival and resistance against oppression. For example, Johnson and Carter (2019) found support for a five-factor model of Black Cultural Strengths, which predicted Black adults' psychosocial well-being. One of these factors involved various methods of Effective Racism-Related Coping (i.e., Constrained Resistance, Empowered Action, Confrontation, and Spirituality). White therapists can use similar

models to hypothesize about which methods of racism-related coping their REM clients are likely to be enacting. Then, when they notice an urge to "fix" an REM client, they can instead inquire about how this client engages in the hypothesized methods. By doing so, White therapists' broaching efforts serve to acknowledge and encourage REM clients' strengths, rather than to position White therapists as saviors or experts.

Status 5 – Immersion/Emersion

Definition

During the Immersion/Emersion status, White individuals engage with race and racism at a more personal and emotional level (Helms, 2008). They actively recognize ways in which they and other Whites enact and benefit from racism. Whites in this status frequently feel angry about racial inequity, and are driven to work towards social justice. When Whites in this status perceive others' actions or statements as racist, they often attempt to criticize and educate them. This happens often for White individuals, as their thinking regarding racism during this status tends to be dichotomous – a person or action is considered racist or not racist, rather than somewhere in between. Demonstrating little empathy or patience towards other Whites may lead to rejection from a White individual's family and friends. Whites who remain in this status may therefore begin to feel isolated and struggle to maintain their commitment to anti-racist actions (Helms, 2008). As a result, Whites in the Immersion/Emersion status may begin to search for ways to develop a more positive White racial identity. For example, Whites in Immersion/Emersion may seek out books, podcasts, and other forms of media in which other Whites talk about Whiteness and anti-racism. White individuals can learn from

these resources that successful advocacy and social justice efforts require collaboration with other individuals and organizations.

Broaching Behavior

During the Immersion/Emersion status, White therapists understand the importance of broaching race with REM clients (Day-Vines et al., 2007). They have gained a better understanding of Whiteness and are eager to address clients' racial experiences. These therapists have multicultural self-awareness and knowledge, and thus their broaching efforts can function to create more open, trusting spaces for REM clients. White therapists in the Immersion/Emersion status may misstep in their broaching efforts by assuming or imposing specific cultural narratives for their REM clients (Sue et al., 2008). Whereas White therapists in earlier WRID statuses have difficulty zooming out to see the effects of systemic racism, these therapists may have trouble zooming in to see their clients' experiences as individuals. Additionally, White therapists in the Immersion/Emersion status may unintentionally direct their ire about racial inequality towards REM clients who demonstrate internalized racism (Steele, 2020). Doing so might prevent these therapists from effectively helping their REM clients recognize and challenge internalized racist beliefs and attitudes.

Growth in Broaching Behavior

An area of growth for White therapists in the Immersion/Emersion Status is to increase their flexibility when broaching race with REM clients. To this end, White trainees in this status must practice applying an intersectional framework in their broaching efforts (Day-Vines et al., 2020). White therapists in this status may already

demonstrate comfort asking and commenting about REM clients' experiences of power, privilege, and oppression related to their race. However, by focusing on any one of a clients' social identities in isolation, these therapists will necessarily fail to understand their clients' full experiences (Case, 2015).

Educators and clinical supervisors should begin by teaching these trainees about intersectional theory through didactic lessons and experiential exercises (Nnawulezi et al., 2020). For the purpose of fostering growth in trainees' current broaching behavior with REM clients, clinical supervisors can ask intersectional questions about supervisees' ongoing client case conceptualizations. Supervisors can adapt the questions provided by Dessel and Corvidae (2017) to facilitate White trainees' use of intersectional approaches when broaching race with REM clients. For example, consider a White trainee treating a Latinx cisgender female client. A clinical supervisor *not* applying an intersectional framework might ask the following questions - "How are your clients' experiences shaped by her female identity?" and "How are your clients' experiences shaped by her Latinx identity?" Alternatively, a supervisor who *is* applying an intersectional framework would additionally ask "How do your clients' gender and racial identities interact to affect her experiences?" and "How does your clients' social location within structures of power, privilege, and oppression affect her experiences?" This second approach leads the supervisee to think in a more complex way about their clients' social identities. Most importantly, supervisors can encourage these trainees to translate this thinking into more probing questions when broaching race with their REM clients.

Status 6 - Autonomy

Definition

During the last status, Autonomy, White individuals form a more stable and assured sense of what it means to be White (Helms, 2008). They have generally come to form a schema of a self-affirming, positive White racial identity. White folks operating in the Autonomy stage may identify as practicing what scholars have termed White allyship, and/or antiracist practices (Sue, 2017). Whites in this status make conscious decisions to reject White privilege, and to actively pursue interracial experiences. White individuals in the Autonomy status have fostered the mindset, stamina, and support systems necessary to engage in ongoing efforts towards racial justice.

Broaching Behavior

White therapists in the Autonomy status view broaching efforts as necessary when working with clients of color (Day-Vines et al., 2007) . They both respond to and seek out opportunities to discuss race and other social identities with REM clients. They consistently initiate meaningful conversations about race and other social identities, identify culturally competent interventions, and can work towards implementing them effectively with REM clients.

Growth in Broaching Behavior

The primary goal for White therapists in the Autonomy status is to develop long-term strategies for continued growth in their broaching behavior with REM clients. One effective strategy they can implement is committing to ongoing peer consultation regarding their work with REM clients (Kirmayer et al., 2014). These therapists should

actively seek out opportunities to learn from peers with diverse cultural backgrounds, vantage points, and experiences. On a larger scale, graduate programs can develop and implement structured multicultural peer consultation teams using the guidelines suggested and implemented by Duke University Medical Center (i.e., Nagy et al., 2019). Multicultural consultation team meetings should involve both a didactic component with pre-selected multicultural topics, and a consultation component aimed at enhancing therapists' multicultural competence, cultural humility, and broaching behavior (Nagy et al., 2019). White therapists in the Autonomy status can also identify opportunities outside of their graduate programs to engage in routine multicultural consultation meetings. These meetings can be client-centered (i.e., the goal is to learn how to best broach race with specific clients), consultee-centered (i.e., the goal is to improve the therapists' overall broaching efforts and other multicultural skills), or a combination of both (e.g., Ingraham, 2017; Jones et al., 2016). Clinical supervisors should support these trainees' decisions to engage in consultation, as well as help connect them with any necessary resources to do so.

Conclusion

Graduate training in clinical and counseling psychology represents a unique opportunity and an ethical imperative for therapists-to-be to understand the meaning of multicultural competence, and to begin a career-long trajectory of growth. Graduate students in these disciplines are also seeing clients as part of their training. The majority of psychologists—both in training and in practice—are White, and often report that they do not broach the topic of race. This review has applied White Racial Identity Development

Theory (Helms, 2008) as a framework for understanding how White therapists go about broaching—and not broaching—race in therapy with REM clients. While there is strong theoretical support for the link between therapist WRID and broaching behavior (e.g., Day-Vines et al., 2007; Jones & Welfare, 2017; Sue et al., 2010) and in some cases general empirical support (e.g., King & Summers, 2019; Day-Vines et al., 2018), there remains a need to further examine this relationship through empirical studies. The recently developed Broaching Attitudes and Behaviors (BABS; Day-Vines et al., 2018)—which measures therapists' feelings and approaches regarding discussions about race with therapy clients—will facilitate this line of research. In particular, future studies should test whether therapist WRID statuses (i.e., as measured by the WRIAS) are associated with their broaching styles (as measured by the BABS) in the ways proposed in the current literature review. Furthermore, past research studies have almost exclusively reported therapists' self-reported multicultural competence and broaching skills. Future research should implement more objective measures to explore how therapist WRID statuses relate to their in-session broaching behaviors (Davis et al., 2018; Day-Vines et al., 2018). For example, future studies may use coding schemes to examine therapists' in-session verbal content that indicates broaching behavior (Worthington et al., 2000). Future research should also use client-reported measures of therapist broaching behavior, such as the recently developed Client Assessment of Multicultural Competent Behavior (CAMCB; Oh & Shillingford-Butler, 2020), in which clients indicate whether therapists have asked specific questions about race and other social identities during therapy sessions.

In addition to presenting WRID as a framework for understanding White therapists' broaching behaviors, we have made suggestions about specific strategies in each status to facilitate White trainees' growth, and to improve the quality of their client care during each of Helms' (2008) proposed WRID statuses. Importantly, there is a need for empirical research to add to the knowledge base about effective training methods for broaching behaviors. Future studies can test the effectiveness of the aforementioned training recommendations with White students in graduate-level psychology, counseling, and social work programs. None the less, these training recommendations are actionable for graduate-level training programs and clinical supervisors. A simple first step that educators and supervisors can take is to have White trainees complete the White Racial Identity Attitudes Scale (WRIAS; Helms & Carter, 1999). Based on their responses, they can then adapt trainees' group-level and individual training experiences according to the aforementioned recommendations.

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BIOGRAPHY

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