DEVELOPING THE DIVERSITY, EQUITY, INCLUSION, POWER, AND PRIVILEGE ASSESSMENT IN CFT/MFT: A DELPHI STUDY

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ABSTRACT

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A DELPHI STUDY

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Marriage and Family Therapists (MFTs) and Couple and Family Therapists (CFTs) engage in clinical practice from a systemic framework. This framework positions MFTs to consider the impact of social systems on the MFT/CFT field and their clients. Issues related to diversity, equity, inclusion, power, and privilege (DEIPP) impact all of the systems in which we operate. Currently, there is no consensus on a tool measuring training clinicians' competencies related to DEIPP beyond self-report. There is a need for a DEIPP competency measure because, currently, the most widely used measure is self or observer report, which may not provide a complete picture of a training clinician's competencies. This study utilized Critical Race Theory (CRT) and Feminist Family Therapy (FFT) to guide a thorough review of the literature. This process solidified domain and construct generation and then further synthesized item generation. This Delphi study was used to reach a consensus on item reduction. The survey contained 322 questions related to DEIPP. These questions were divided into three domains, attitudes self-report, multicultural knowledge questions, and clinical application vignettes. Specifically, this study's goal was to reach a consensus on item generation through two rounds of Delphi surveys sent to each participant; thus, establishing content validity. Five experts provided insight and feedback to address the domain definitions and items generated. The major contribution of this research is the completion of stage 1 for developing a measure that will address DEIPP

competencies in MFT/CFT. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: feminist family therapy (FFT), critical race theory (CRT), diversity, equity, inclusion, power, privilege, competency-based learning

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DEDICATION

This dissertation is dedicated to my nuclear family, my two children, Sophia and Peter, and my partner, Jonathan. You three have been my strongest support throughout my entire journey, and I am my best self because I am loved by you three.

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CHAPTER I: INTRODUCTION

Quiet isn't always peace, and the norms and notions of what just is, isn't always justice.

—Amanda Gorman, *The Hill We Climb*

For the Marriage and Family Therapy (MFT) field to thrive, it must continually work to support clinicians-in-training so that they can serve diverse populations. The American Association for Marriage and Family Therapy (AAMFT, 2015) and the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE; Commission on Accreditation for Marriage and Family therapy, 2020) have made a call for action for clinically competent therapists pertaining to diversity-related topics. One current challenge toward fulfilling this call to action is that the MFT field has very few measures that assess clinicians' attitudes, knowledge, and clinical application related to diversity, equity, inclusion, power, and privilege (DEIPP) competencies. The most commonly used measures rely on self- and observer reports. These are helpful but can also be fraught with error (Cates et al., 2007).

MFTs are at the crux of activism (Ventres et al., 2018) through the systems vantage point and relational understanding. It is this researcher's belief that MFT clinical training programs must acknowledge their own systemic history of white supremacy, make efforts to be culturally competent, antiracists, and ensure that graduation from clinical programs and licensure is dependent on measurable knowledge relating to DEIPP competencies. Training clinicians are humans who live in a society that promotes colorblindness, whitewashes history, and whose systems perpetuate the success of the majority at the expense of individuals of minority status. Cognitive dissonance and pathology often follow when one's identities are constantly up for political debate (Lee et al., 2018), and this is important for clinicians to understand. Having

DEIPP competent clinicians is important to the field because it is a move from allyship to activism.

Past research in the MFT field has demonstrated equivocal competency standards of cognitive performance in DEIPP competencies (Sue et al., 1992). In COAMFTE accredited programs, each MFT training program is tasked with establishing its own way to measure this competency; no consistently used measure exists (COAMFTE, 2020). COAMFTE has favored an outcome-based education philosophy in which university programs assess various competencies as evidenced by measurable student learning competencies in the most current Accreditation Standards, Version 12.5 (COAMFTE, 2020).

Creation of a DEIPP assessment that is informed by feminist family theory (FFT) and critical race theory (CRT) as a movement towards a critical, action-oriented praxis is important. Both FFT and CRT consider the consequence of prescribed societal rules and norms and provide a clear path to empowerment and equity. Currently, there is a movement trying to stifle the use of CRT and other antiracist education in our nation (The White House, 2020). As a field of mental health practitioners, this political rhetoric can either foster compliance or provide the fuel necessary to change the subjective oppressive narrative of white supremacy and encourage efficacious and empirically validated practices within the field. Since these racist structures are in place, the MFT field must actively think about race, privilege, and discrimination, and earnestly engage in practices that promote equity, working to dispel the negative impacts caused by political and social disparities.

The development of the DEIPP assessment is an attempt to fill the need for a psychometrically sound instrument to assess for MFT training clinicians' DEIPP competencies and as an activist approach to creating systemic change within the MFT field by effecting justice

for those that these training clinicians serve. This assessment tool is intended to be a catalyst for MFT education to foster critical thinking skills about multiculturalism, diversity, and marginalization and helping ensure that therapists are trained to view clients in a more multifaceted way instead of examining clients' identities as silos. The present research is innovative because it endeavors to measure the elusive and the tangible by assessing a student's self-assessment, cognitive knowledge, and clinical application. Based on an extensive literature review, a unified set of competencies was identified. The identified competencies that were focused on are diversity, equity, inclusion, power, and privilege. The assessment's domains and items generated were developed to measure these competencies through the liberatory FFT and CRT lenses. As no such scale exists in the MFT field, several competency measures were borrowed from other mental health disciplines to inform the construction of this instrument.

FFT (Dankoski, 2000) and CRT (Volpe et al., 2019) are the catalysts for change. In the space of the problem, and through the lens of these theories, the DEIPP domains were defined. Diversity is defined as the embodiment of the difference between groups present in families, communities, and institutions that are categorical in nature (Frisby & O'Donohue, 2018) regarding age, class, sex, sexual orientation, disability, education, race, etc. Equity is defined as acknowledgment and awareness of the historical inequalities and disparities of the culturally diverse that result in a disregard of unbalanced and unequal opportunities to all groups of people (Adams et al., 2016): by affirming and eliminating barriers that prevent or make it difficult for some groups of people to participate in personal well-being. Inclusion denotes social categories and individuals' interdiscursive history as part of the shared cultural world where difference is respected and valued (Adams et al., 2016). Inclusion is the act of having social and personal entities structured in a way that all personhood is seen, voices are heard and valued, with the

power to make changes to shape policies and institutions (Frisby & O'Donohue, 2018). Power is the ability to shape relationships and the ability to influence the social world. Power also has the opportunity to exercises the oppression of others and regulates, "In whose interest systems operate" (Adams et al., 2016, p. 18). Power is exercised by control over others and deciding what is best for them by implementing policies that define who will or will not have access to resources. Privilege is defined as an unearned advantage with access to resources based on identification and membership to a dominant social group. This research focused on the item development phase of scale development, supporting the creation of a critical multicultural awareness within training clinicians by addressing the intersection between multicultural competence and social justice in the MFT field. The Delphi method was used for the item development phase. Item generation was the result of expert consensus with two rounds of collecting expert feedback.

Ultimately, the DEIPP assessment is a tool that can be used to assess if the efforts of competent clinicians are effective because there is a charge from the field to graduate DEIPP competent clinicians. The DEIPP assessment will further be developed to address and capture the sophistication of understanding DEIPP core competencies in three different domains: attitudes self-report, multicultural knowledge questions, and clinical application of constructs related to diversity, equity, inclusion, power, and privilege. This measure is intended to move beyond self-report to generalized assessment and application of these competencies. This measurement will assist in identifying areas of growth when utilized as a standardized evaluation. This research study aims to address the current problem that no DEIPP measurement tool exists in the MFT field that goes beyond self-assessment. As evidenced by the literature, self-reports may not provide a complete picture of an individual's competencies (Kuncel et al., 2005). This study

focused on the first phase of scale development, item development which assessed for content validity and gained expert consensus for domain definitions and goodness of fit for item questions developed.

CHAPTER II: REVIEW OF THE LITERATURE

> The license never requires a measure of competency. It requires a measure of how long you went to school. And therefore, I think it's a deception really, you have to be pretty sure that the licensing is based on competence, or you're sending incompetent people out.
>
> —Jay Haley (1990), *AAMFT Masters Series*

Throughout time, philosophers have sought understanding of the human condition and the components of life that comprise our existence; to find the similarities between linear growth, the commonality of emotions, and the ultimate sameness—death. Perhaps philosophers are missing the mark. Perhaps the understanding of the human condition is not in the sameness and common experience of human existence but rather in the diversity of the human condition. Historically, society has valued sameness, yet it also seems important to acknowledge differences; the diverse sequences of individual thoughts and experiences that determine aspects like communication, collaboration, opportunity, and understanding. Acknowledgment of difference is important in life, education, and in the mental health field. As systemic thinkers, if we fail to acknowledge differences, we risk missing the injustices that are present in society, including mental health disparities and other inequities that people may bring into the therapy room. Thus, it is our duty as Marriage and Family Therapists (MFTs) to acknowledge disparities and advocate for equity.

From their inception, MFTs were seen as a radical group of mental health providers because they looked at pathology through a systems lens, invited multiple people into the therapy process, and considered the contexts in which people lived (Nelson & Smock, 2005). Throughout the years, MFTs have gained legitimacy as a distinct mental health field. With this new power,

the profession can capitalize on being a radical group that does progressive things in the therapeutic space, thus affecting the field in positive ways. MFTs need to be blatant and open about the impact intersectionality has on their clients' lives and in our clinical spaces (Ababio & Littlewood, 2019). Every human needs to know about diversity; every therapist needs to be proficiently trained to actively think about race, privilege, and discrimination in order to train people who can support marginalized voices (Killian, 2013). Culturally competent and humble practice needs to be valued in all professions; MFTs can lead the charge and have begun to do so through establishing educational and national organizational standards (Bussema & Nemec, 2006) that include looking at DEIPP competencies. Yet there is more to be done.

The COAMFTE is the accrediting body for MFT training programs (COAMFTE, 2020). COAMFTE provides teaching and student competency standards as a method of promoting evidence-based practices in accredited MFT programs. COAMFTE provides guidance for training programs by stating that training in DEIPP competencies is important and requiring accredited programs to measure the DEIPP competencies of their students. AAMFT establishes the professional code of ethics and promotes rules, laws, and guidelines for the practice of marriage and family therapy throughout the United States and several countries. AAMFT lobbies to promote the field and for family policies that will impact clients. Both COAMFTE and AAMFT agree that it is important for therapists to have systemic therapeutic skills, practice in a competent manner, and serve all clientele in a non-racist manner, thus improving the overall quality and availability of mental healthcare. AAMFT's CEO, Tracy Todd, in his message titled, "Conversations Must Lead to Action" in *Family Therapy Magazine*, suggested next steps for antiracist research, including "assessing effectiveness, areas of compliance and noncompliance, and areas within the policies and procedures needing more attention" (Todd, 2020, p. 3).

However, there are two distinct disconnects between the value placed by AAMFT and COAMFTE on DEIPP competencies and whether practitioners actually know how to practice in culturally competent ways: there are no standardized ways to measure DEIPP competencies and there is no evaluation of DEIPP competency standards on a national level within the MFT field.

The Association of Marital and Family Therapy Regulatory Boards (AMFTRB) governs the regulation of licensed MFTs and coordinates with state licensing boards to establish rules and laws associated with licensing requirements. One of the most important gatekeeping roles associated with the AMFTRB is the development and administration of the national MFT licensing exam. AMFTRB publishes the national exam test specifications, indicating specific areas of clinical competency, which do not include DEIPP competencies as stand-alone competencies, but rather, embedded within other competencies (AMFTRB, 2019). AAMFT and COAMFTE value both diversity and outcome measures which are in place to ensure that diversity-related topics are addressed in MFT educational programs. However, AMFTRB does not test for DEIPP competencies at the national level as a criterion for licensure. This is a glaring example of where the field falls short in promoting culturally competent practice for MFTs.

Critical race theory (CRT), in tandem with feminist family therapy (FFT), is the beacon in which the consequences of mental health disparities produced by psychosocial and political stratification can be understood, and consciousness raised (Delgado & Stefancic, 2017; Hare-Mustin, 1978). Critical Race Theory is a lens for examining how power structures maintain and reinforce racial disparities (Volpe et al., 2019). Feminist family therapy focuses on how individuals face stressors as a result of bias and discrimination (Hare-Mustin, 1978). Both CRT and FFT self-impose strategies for action-oriented change and are logical lenses to examine the process and purpose of DEIPP measurement development and implementation. DEIPP

competencies should be embedded throughout the MFT curriculum as a means of implementing action-oriented change. We need a way to measure whether practitioners are absorbing and applying this knowledge. There is no standardized measurement except for program self-report on DEIPP competency for MFTs. Without a standardized measure, how can the field say that we are doing a consistent job in educating our members and addressing the disparities of the people with whom we work?

The explorations made in the literature review aim to provide an avenue for an altruistic understanding of ways the MFT field can raise critical consciousness and receptivity towards multicultural process and engagement for social justice within training programs. Doing so provides a clear path to the research inquiry, a process geared toward creating social and systemic change. This literature review aims to provide a background into the research that has been produced to date addressing the need for a competency driven DEIPP measurement that can be used within the field of marriage and family therapy and its training programs to measure knowledge and application of DEIPP competencies. There are five focused sections most relevant to the study: marriage and family therapy as a profession, accreditation and training, measurement development of DEIPP competencies, systems of oppression, and theory. Because this study focuses on the development of a competency measure, discussions on theory, how theory informs the questions asked, and how information is privileged are included. All of these areas will culminate in an argument as to why there is a need for a DEIPP measure to assess the competency of MFT clinicians. This measure was designed to offer MFT educational programs and clinicians a standardized method to evaluate DEIPP competencies and application effectiveness when working with clients.

Marriage and Family Therapy as a Profession

Having a national professional organization and national recognition within the mental health field is vital for MFT clinicians. Without national recognition as a valid and vibrant mental health field, MFT clinicians could lose their ability to diagnose, to be credentialed on insurance panels, and to practice mental health services. The American Association for Marriage and Family Therapy (AAMFT) was founded in 1979 as a seminal organization for those who practice systemic therapy. This organization provides a code of ethics for therapists and guidelines for clinical practice. AAMFT has historically engaged in policymaking and promoted professional development for the profession and the organization (AAMFT, 2022). AAMFT houses a prominent professional academic journal focused on systemic practice, the *Journal of Marital and Family Therapy* (JMFT). *Family Therapy Magazine* (FTM) is AAMFT's flagship publication for the field that updates members on family policy and advancements in the field. Currently, AAMFT has over 24,000 members (AAMFT, 2022), and supports the MFT education accreditation body, COAMFTE, that sets the standards for MFT educational programs (Northey, 2009).

Marriage and family therapy is a distinct form of clinical practice, which is steeped in systemic theory. Mental health professionals across disciplines engage in couple, marital, and family therapy; however, people trained as marriage and family therapists view the human condition through not only the relational context, but also through the social context in which humans live (Nichols, 2012). Traditionally, mental health treatment has been provided from a linear, content-focused lens; MFTs are process-oriented practitioners who take into consideration the circular causality of problem treatment, focusing on patterns of binding mutual influence (Nichols, 2012). An MFT will view clients' presenting issues through the lens of relationships,

focusing on the problem's function rather than something inherently wrong or pathological within an individual.

Marriage and family therapists are systemic practitioners who view the individual within the context of their relationships. Located in the family are dominant relational patterns that influence each individual. Roles in the family system often reinforce these patterns creating dominant family traits and problematic dynamics. Because of this, individual pathology is viewed as a symptom of the larger family system. MFTs view the pathologized individual as the one who is personifying the familial dysfunction (Smith & Hamon, 2012). A phenomenon resulting from individual therapy is when an individual member in the family heals, and then other asymptomatic individuals in the family get worse as a result. Family therapists assume that change within an individual enacts changes in the family, and work to break generational patterning, regardless of who is in the room. The systems approach is purposeful in positioning the problem not only as possible psychological pathology but locating it in the context of relationships. Understanding that contextual complexity is crucial for therapists.

MFTs are in a prime position to see clients' many identities and the intersections of these identities within the world in which they live. As MFTs pay close attention to the family system and context of relationships, they have the responsibility to widen the systemic lens in order to consider those systems outside of the family that have direct influence on the family members. The systems in which people live influence the quality of life for families and individuals (Cloete & Manona, 2007). The context of many people's lives is harmful due to systems of oppression in which they must operate (Rastogi et al., 2020). Lyness (2020) offers an important perspective about the importance of not just recognizing the characteristics of systems of oppression that clients live, but also the importance of training clinicians to provide trustworthy services to the

general public. MFT training focuses on seeing where there may be dysfunctions in the structural family patterning and relational dynamics that are often influenced and reinforced by the larger societal discourse and systems of oppression. These structural roles are demonstrated through the functioning of the larger systems, down to each individual (Bertalanffy 1969).

Education on intersectionality and systems of oppression is important for MFT training clinicians, so that they can better understand their clients. If there is not a quantifiable, minimal level of competence on diversity-related topics, there is a risk of harm. Because of this risk, it is imperative that clinicians be assessed for DEIPP competencies. We need the ability to gauge if clinicians have absorbed this information and can apply it in the therapy room in order to minimize the therapeutic risk of harm to marginalized clients.

Rooted in Activism

Systemic work of MFTs is rooted in radical assumptions and approaches to therapy that are entrenched in activism. Therapists bear the responsibility of working competently and advocating for their clients (Hodgson et al,, 2020). MFTs are ethically obligated to be involved in antiracist practices and advocacy work. The AAMFT Code of Ethics (2015) states the following:

> Marriage and family therapists are defined by an enduring dedication to professional and ethical excellence, as well as the commitment to service, advocacy, and public participation. The areas of service, advocacy, and public participation are recognized as responsibilities to the profession equal in importance to all other aspects. Additionally, marriage and family therapists are concerned with developing laws and regulations pertaining to marriage and family therapy that serve the public interest, and with altering such laws and regulations that are not in the public interest. Marriage and family

> therapists also encourage public participation in the design and delivery of professional services and in the regulation of practitioners. Professional competence in these areas is essential to the character of the field, and to the well-being of clients and their communities. (p. 1)

Researchers across health disciplines urge mental healthcare providers to engage in advocacy, stating that it is an ethical obligation to be involved in activism as part of the professional organization's identity and to assess the effectiveness of global antiracist and anti-discriminatory endeavors (Ventres et al., 2018). Some MFT programs are changing their names from Marriage and Family Therapy to Couple and Family Therapy to be more inclusive and deconstructing the dominant discourse through acknowledging the shift from preconceived notions of what a family is and how it is comprised. Thirty six of the 123 COAMFTE accredited programs have made the change from MFT to CFT (COAMFTE, 2020). As the field of marriage and family therapy evolves, it flourishes through political advocacy; such activism is at the root of the field (Goodman et al., 2017).

MFTs engage in activism in and out of the therapeutic space. Activism is rooted in therapeutic practice by embodying both countering and collaboration with clients as a route to activism (D'Arrigo-Patrick et al., 2017). Activism in the field does not look the same for every practitioner. Because activism is embedded within the field's structure, it can range from policy reform (Heidemann et al., 2013) to the accountability of personal growth, and by learning about diverse communities and ethical practices.

Research suggests that social policy and access significantly impact the experience and effects of psychopathology (Jordan & Seponski, 2017). The systemic framework is an avenue for activism by acknowledging and understanding how DEIPP disparities influence clients'

everyday lives within the familial and social context. The client's problems and pathology are seen through the context of the many systems in which they are involved and MFTs glean insight into how societal messages and policies directly influence an individual or family's context (Jordan & Seponski, 2017). This systemic view is necessary for creating all systemic change, from individual to institutional change.

Close examination of the field's overt and subtle processes that communicate the values of the field is imperative. Supporting institutional change from within the MFT profession is an important piece of social activism. Measuring DEIPP competencies in beginning clinicians is one way to measure culturally competent practices and can help improve systemic education. Without committing to finding effective and reliable measurement tools, the field of marriage and family therapy will reinforce the historical narrative that the DEIPP skills are not as highly valued.

Accreditation and Training Programs

Accreditation of graduate level educational programs is the first step in a field's ability to be recognized as distinct and separate from one another (Northey, 2009). Accreditation is vital to a profession because it establishes educational quality standards for clinical training programs and drives the field in determining educational content for training competent therapists. Accreditation bodies function to regulate standards for teaching and learning outcomes in academia. When MFT education was first forming and licensing was being established, there was some debate on whether MFTs should be considered a subspecialty or an independent field of study (Keller et al., 1988). Keller and colleagues (1988) posed a survey aimed at collecting opinions from AAMFT members about their preferences regarding training and accreditation. The survey data indicated that professionals felt accreditation was useful and would hold training

programs to high standards. It is through establishment of rigorous accreditation standards and compliance of these standards at the university level that MFTs remain a distinct mental health field, not a subspecialty of another mental health field (Lyness, 2020).

Although COAMFTE provides guidance for training programs in DEIPP competencies, there is no standardized way of measuring proficiencies. Historically, MFT training programs have struggled with expressing compliance in teaching and measuring student learning goals for diversity-related topics (Winston & Piercy 2010). Nelson and Smock (2005) suggested that an essential aspect of clinical training is to stay up to date with research and the current political trends. This is important because DEIPP topics are often in the foreground of family policy and political debate. In 2005, COAMFTE redesigned its standards with the implementation of outcome-based-education-models (Lyness, 2020), influenced by the competency movement (Nelson & Smock, 2005). Lyness (2020) suggested that a primary difficulty in implementing a competency-based movement was a "lack of valid and clear measures of outcomes" (p. 559). This movement is powerful; however, the definition of competency is not consistent. Although this gives programs tremendous autonomy and educational decision-making, there is no objective way of measuring if what they are doing is effective for the clinician and their clients.

COAMFTE is currently on Version 12.5 of the accreditation standards (COAMFTE, 2017). This update to Version 12 stepped further away from the focus on a commitment to diversity and inclusion, in some ways. Version 12 included five accreditation standards: outcome-based education, commitment to diversity and inclusion, infrastructure and environmental supports, curriculum, and program effectiveness and improvement. The Commission on Accreditation for Marriage and Family Therapy (2017) defined Standard II in Version 12 as the following:

> Programs demonstrate their commitment throughout the program to diversity and inclusion. This includes providing a multiculturally-informed education that addresses a range of diversity; a safe, respectful, inclusive learning climate; student experience with diverse, marginalized, and/or underserved communities; and a commitment to the ethical and social responsibility to diverse, marginalized, and/or underserved communities. (p. 23)

In Version 12, COAMFTE stated that training programs must have explicit goals that reflect diversity and inclusion, a definition of diversity, and evidence that the program's curriculum demonstrates the implementation of diversity and inclusion (COAMFTE, 2020). COAMFTE first introduced these training goals in 2004. With the newly updated standard, version 12.5, Standard II is no longer a standalone standard (COAMFTE, 2020). Version 12.5's accreditation standards are outcome-based education, program leadership, curriculum, and program effectiveness and improvement. Though Standard II is not currently listed as an accreditation standard, it is embedded throughout accreditation with the COAMFTE (2020) commitment to education that aligns with diversity and inclusion through the use of what COAMFTE calls "developmental competency components" (p. 36). Though not a stand-alone standard, diversity is also embedded within the eligibility criteria for programs seeking accreditation. Examples of the current approach to diversity are found throughout the handbook released by the COAMFTE (2020): Students are required to demonstrate awareness of diversity if they are involved in teaching, they must also demonstrate sensitivity to diversity, programs must have student learning outcomes that address human diversity and social structures, and lastly, all students must have experience working with diverse populations. COAMFTE requires that programs provide documents and supporting evidence that they are operating through

policies that reflect diversity and inclusion within their training programs. Each training program has its own way of assessing DEIPP competencies. Documents that universities must provide for accreditation include a list of how students gain experience with diversity as training clinicians and self or supervisor evaluations. Accredited MFT programs address multicultural training in various ways, some of which include a multicultural course, weaving multiculturalism and diversity throughout every course, or a combination of the two.

How the Field Measures Student Learning Competencies

There are several ways in which accredited MFT programs measure student competencies. The most common measures are student self-evaluations, supervisor rating scales of students, role plays, comprehensive tests, the MFT Internship Evaluation Instrument, skills rating forms (Perosa & Perosa, 2010), and objective structured clinical exercises (Miller, 2010). Accredited MFT training programs seek to evaluate students on four levels of conceptual skills. The first is measuring student understanding and perceptual competencies, that is, the students' thought process, which is measured through self-reporting (Nelson et al., 2007). The second is evaluating students' executive skills which are exhibited by how they facilitate therapy sessions (Perosa & Perosa, 2010). Third, students are assessed on their evaluative skills which is evaluated by self-report or observer reporting (Perosa & Perosa, 2010). Lastly, training clinicians are evaluated on their ability to build therapeutic relationships and rapport building, often referred to as the therapeutic alliance (Marrelli et al., 2005). Students are assessed on their ability to ask open-ended and circular questions, reframing the clients' problematic narratives, reflecting back on the client's emotional experiences and expressions, and challenging clients' complex and often problematic patterning and cognitive assumptions by providing alternative constructs (Perosa & Perosa, 2010). Although these methods of measuring student learning competencies

are valuable and necessary for evaluating more than theoretical knowledge, more needs to be known about clinician's DEIPP competence.

AMFTRB (2014), the organization that administers the national MFT licensing exam, requires that MFTs demonstrate a minimal level of competency through national or state testing that covers six core competency areas: treatment, assessment/diagnosis, treatment planning, theory-based interventions, legal/ethical, and research/ program evaluation. AMFTRB competencies directly mirror the COAMFTE competencies except for one glaring exception: the competence related to diversity, inclusion, equity, power, and privilege. The system is structured to perpetuate white privilege by treating the six-core competencies as core curriculum while diversity, equity, inclusion, power, and privilege are treated as an elective or as a subsection to be measured within the other domains. This is one way that the system perpetuates the marginalization of Black, Indigenous, and People of Color (BIPOC; The BIPOC Project, 2016) clients and families and perpetuates white privilege. White privilege denotes a notion of unfairness that is often hard for the white American psyche to conceptualize (McIntosh, 1988; McIntosh & ZAPP Zine Project, 2000). White privilege is maintained when white students' and clinicians' uncomfortableness is protected and, therefore, is not assessed adequately. White training clinicians then benefit from maintaining the status quo of not evaluating DEIPP competencies, while BIPOC clinicians and clients are discounted, or worse, harmed. White privilege will continue if we remain stagnant; the field must actively think about race, privilege, and discrimination, and disassemble the structures that perpetuate white privilege in the field. The hegemonic limitations for clinicians are that they are not currently being tested for their minimal level of competence on a stand-alone basis for DEIPP competencies. DEIPP topics should be central to the education, testing, and competencies of MFT clinicians because each

form of oppression directly impacts the clinicians, the mental health of clientele, and the MFT field. These various forms of oppression are laden with social legacies. Making DEIPP competency central to outcome-based education and evaluation is of critical importance for the trajectory of training programs.

Cultural Competency as a Core Competency

Culturally competent therapy mends the crisis of competence in treatment with clients who are different than the clinician (DeAngelis, 2015). Cultural competency is a measurable clinical capacity (White-Means, 2009). Clinical training programs must make perpetual endeavors in outlining normalcy that culturally competent mental health care is ethical mental health care. Regardless of a person's reason for seeking care, mental health professionals should act with appropriate cultural competence and exhibit sensitivity in providing care. This can be attained by considering and implementing efficacious measures that dismantle the current centripetal trend of relying on self-reporting measures and move toward a centrifugal approach of quantitative competency measures.

In 2004, AAMFT published a set of core competencies (AAMFT, 2004). These core competencies were developed as a set of skills comprised of minimum competencies that all clinicians in the field must possess. These competencies were established as a way of implementing the practice of improving the mental health field. The six core values stated, "safety, person-centered, efficient, effective, timely, and equitable," are the gold standard for mental health services (AAMFT, 2004, p. 1).

The present study focuses on the core value of equality. Each of the six core values include five separate domains, and within the domains are several secondary domains with accompanied competencies. Domain 4 of AAMFT (2004) core competencies is Therapeutic

Interventions, and item 4.4.2 states that the therapist in training must exhibit executive functioning in "delivering interventions in a way that is sensitive to special needs of clients (e.g., gender, age, socioeconomic status, culture/race, ethnicity, sexual orientation, disability, personal history, larger system issues of the client" (p. 4). Cultural competency is also listed under eight AAMFT core competencies. The first competency, 1.2.1, states that the clinician must "recognize contextual and systemic dynamics (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, spirituality, religion, larger systems, social context)" (p. 2). Core competency 1.3.1 indicates that clinicians must "Gather and review intake information, giving balanced attention to individual, family, community, cultural, and contextual factors" (p. 2). The third core competency that addresses cultural competency, 2.1.4, stipulates that MFTs must have an ability to "Comprehend individual, marital, couple and family assessment instruments appropriate to presenting problem, practice setting, and cultural context" (p. 2). The importance of understanding "the strengths and limitations of the models of assessment and diagnosis, especially as they relate to different cultural, economic, and ethnic groups" (p. 3) is the focus of core competency 2.1.6. Core competency 4.1.1 urges clinicians to "comprehend a variety of individual and systemic therapeutic models and their application, including evidence-based therapies and culturally sensitive approaches" (p. 4). Recognizing the "strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit" (p. 4) is the focus of 4.1.2. The seventh core competency, 4.3.2, urges clinicians to be competent by delivering "interventions in a way that is sensitive to special needs of clients (e.g., Gender, age, socioeconomic status, culture/race, ethnicity, sexual orientation, disability, personal history, and larger systems issues of the client)" (p. 4). The final core competency,

4.4.1, indicates that clinicians must "Evaluate interventions for consistency, congruency with model of therapy and theory of change, cultural and contextual relevance, and goals of the treatment plan" (p. 5). As these directives represent the gold standard of treatment for clients, it is imperative to be able to measure how clinicians fare in operating in a culturally competent manner; a standardized consistent measurement tool would be a step toward equitable education and treatment of clients.

Diversity, Equity, Inclusion, Power, and Privilege

DEIPP represents diversity, equity, inclusion, power, and privilege. DEIPP-competent work is guided by the understanding that every human has unique experiences, and through these experiences, we relate to others. Diversity is defined as the difference between groups that are categorical in nature (Frisby & O'Donohue, 2018), for example, race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, etc. These differences can be seen within historical experiences and within an individual's heritage. Adams et al. (2016) described equity as the state of creating access for equal opportunities through acknowledging the disparities in appropriate mental health treatments for the culturally diverse. Inclusion is defined as having social and person entities structured in a way that all people's personhood is seen, and their voices are heard and valued (Frisby & O'Donohue, 2018). Inclusion denotes social categories and an individual's interdiscursive history as part of the shared cultural world (Adams et al., 2016). Privilege, as defined by Adams et al. (2016), has unearned advantages. Power is the oppression of others and regulates, "In who's interest systems operate" (Adams et al., 2016, p. 18). Power is defined by who has access to resources. Power and privilege are something that many clinicians are taught to pay attention to during the therapeutic process.

Clinicians can unintentionally reinforce harmful stereotypes and contribute to mental health disparities by not addressing power dynamics in and out of the therapy room (Burgess et al., 2004). Burgess et al. (2004) found that clinicians who were made aware of their unconscious biases were less likely to display automatic stereotyping of their clients. Because the current cultural systems are still in place to support the dominant white majority, racial categories confer advantage and access, thus, privilege is denied to other groups (Adams et al., 2016). These power hierarchies create a system of oppression and disadvantage. In the clinical setting, therapists are inherently viewed as being in a position of power because clients are seeking mental health professionals' help. This inherent position of power may not be the only position of power a clinician holds. Other possible positions of inherent power may be through their race, gender, education, sexual identity, physical abilities, or socioeconomic status. It is imperative that therapists understand their own power and privilege in society and in the therapy room so that they can recognize how they may contribute to the disparities of others, and better understand how power and privilege might be affecting their clients. This awareness offers insight into their clients' intersectionality. Clinicians should not be surprised that disparities exist for their clients.

When clinicians are trained to see and consider their own power and privilege, they can then move into the space of recognizing and exploring the advantages and disadvantages attached to others, namely, their therapeutic clients (Kosutic, 2009). In the simplest understanding, privilege can be framed as advantages that are both earned and unearned (McIntosh, 1988). Cultural codes, or subculture, play a role in how individuals interact and move within the world, which is guided by societal paradigm (Ayon & Ausenberg, 2010) and social capital, meaning that society places expectations that are relevant and defined to members of different groups. Power and privilege are defined through the "power with us versus the power

over" (Adams et al., 2016, p. 26). If clinicians are unable to recognize disparities, they will be implementing a blind approach to whatever clinical work they implore. Both clients and therapists are affected by their experiences with diversity, equity, inclusion, power, and privilege. MFTs benefit from valuing diversity and inviting conversations about it into the therapy room. Because MFTs are being trained and have participated in the self of the therapist work which includes cultural responsibility, when clients come into the therapeutic space, they should not have to explain and educate their therapists on their identities. This is the work of collective liberation for disenfranchised, minoritized, and oppressed people both in and out of the therapeutic space.

Measuring DEIPP Competencies

A thorough search of the literature did not yield any results for an empirically validated measurement tool to assess for therapist/student competencies in their understanding of DEIPP. In the absence of a testing measure of DEIPP competencies, self-reporting measures are often used as a substitute. Self-reporting measures can be helpful but may not be enough, as the literature suggests that self-reporting measures are often an inaccurate representation of student competencies. Kuncel et al. (2005) ascertained that students are often inaccurate when self-reporting their grades. A study conducted by Maxwell and Lopus (1994) suggested that students at risk for lower grades were likely to misreport their competencies by over inflating their competence in a positive direction. Cassady (2001) found similar results in their study as well; low-performing college students were deficient at accurate self-reporting and disproportionately overreported their competency.

Self-reporting measures may not be enough at capturing DEIPP competencies because they do not account for the unconscious attitudes and beliefs of those reporting. Clinicians are

not immune from over and underinflated self-reporting of their skills. Burgess and colleagues (2004) found that clinicians' self-report about their DEIPP related competencies were directly related to their verbal communication with racial minorities. Those clinicians who reported themselves more positively on their DEIPP related skills, also reported high levels of friendliness toward clients of color. In that study, white clinicians' unconscious biases and attitudes were seen as unfriendly by observers and perceived by their BIPOC clients as unfriendly. This therapeutic double bind is a result of verbal communication that is different than their nonverbal communication because of underdeveloped DEIPP competencies (Blair et al,, 2013). In these cases, the mental health professional could unknowingly be causing unjust and undue harm to their clients.

Several studies have used self-reporting measures with some success. There are a variety of measurement tools that capture some DEIPP competencies and measure a variety of clinical competencies. Self-reporting is an important skill because self-awareness is an integral aspect of doing effective therapy (Aponte & Kissil, 2016). Self-awareness is integral, yet there is also a need for a more robust measure of both awareness of DEIPP topics and standardized DEIPP competencies. Four measurements widely utilized by the mental health field for DEIPP competencies are self-report. The Multicultural Counseling Inventory (MCI) developed by Sodowsky (1996) assesses counselors on four domains: multicultural counseling skills, multicultural awareness, multicultural counseling knowledge, and the multicultural counseling relationship. The MCI addresses issues of power and privilege but does not address diversity, equity, and inclusion. The Cross-Cultural Counseling Inventory (CCCI) developed by LaFromboise et al. (1991) assesses counselors on three domains: cross-cultural counseling skills, socio-political awareness, and cultural sensitivity. The CCCI addresses awareness of diversity

and power but does not address equity, inclusion, and privilege. The Multicultural Counseling Awareness Scale (MCAS) developed by Ponterotto et al. (1996) assesses aspects of multicultural competency of counselors. The CCCI addresses issues of diversity, power, and privilege but does not address equity and inclusion. Lastly, the Multicultural Awareness-Knowledge-and Skills Survey (MAKSS) developed by D'Andrea et al. (1991) assesses counselors on four domains: perceived skills, perceived awareness, perceived therapeutic relationship, and perceived knowledge. The MAKSS addresses self-reported attitudes towards diversity, power, and privilege. One additional way to assess student self-awareness measure is through the exploration process of the master's degree theory of therapy or theory of change paper (Nelson & Prior, 2003). However, it should only be used as a portion of the training clinicians' overall DEIPP competency. These measures are a great foundation yet do not meet the criteria of evaluating more than clinicians' assessment of self. It is hoped that the Diversity, Equity, Inclusion, Power, and Privilege Assessment will assess a clinicians competency related to DEIPP and to be used to determine growth areas for training clinicians.

MFT program research and the development of core competencies by the American Association for Marriage and Family Therapy (AAMFT) advocates for the use of psychometrically sound measures for outcome-based learning and student outcomes (Perosa & Perosa, 2010). Yet, one does not exist in the MFT field. Perosa and Perosa (2010) suggested that three curricula domains are assessed in outcome-based education, and future measurement assessments are needed to evaluate attitudes, knowledge, and clinical application for training clinicians (p. 126). The authors call on researchers in the MFT field to utilize empirically validated measures produced by other mental health fields to create new measures for MFT training programs to develop efficacious measures to complement the competency-driven and

outcome-based standards (Perosa & Perosa, 2010). A measurement tool of such magnitude would need to assess for both DEIPP knowledge and general skills; this is the intent of the DEIPP assessment.

Theory

It is important to study and transform the relationships among diversity, equity, inclusion, power, privilege, and mental health. The theories that are utilized in this study are critical race theory (CRT) and feminist family theory (FFT). More traditional MFT systems theories were considered, but more radical theories were chosen since radical changes are needed to promote movement toward a more competency-driven field. FFT intends to bring a feminist voice into the systemic therapy process to develop equality within the context of gender, power, and oppression; and to voice issues of privilege and oppression (Silverstein & Goodrich, 2003). CRT is the basis for exploration of how race-related inequalities affect the psychosocial health of clientele (Carbado & Roithmayr, 2014). Together, these theories create a critical framework for understanding how the MFT field can implement a competency-based outcome measure. They also inform the construction of such a measure. CRT and FFT are not just an epistemological standpoint but are utilized throughout the study to inform the questions that will be asked for evaluating student competency and the DEIPP construct definitions.

Critical Race Theory

CRT examines how individuals are affected by structural racism and partake in efforts to seek liberation from the forms of systemic racism that are affecting the emotional wellbeing of minority groups (Delgado & Stefancic, 2017). CRT was developed by legal scholars such as Kimberle Crenshaw, Derrick Bell, Mari Matsuda, Richard Delgado, Gloria Ladson-Billings, Patricia Williams, and Jean Stefancic in efforts to frame higher education scholarship through a

liberatory jurisprudence (Delgado & Stefancic, 2017). These scholars provided a framework for addressing multiple levels of consciousness as a way to language our categories of existence (Ross, 2017). CRT is vital because of the focus on culture and experiences of race, law, and power challenges. It offers a critique of hierarchies that mask the perpetuation of power, privilege, and white supremacy, helping to deconstruct racist structures in today's modern society. CRT views both race and gender as social constructs and examines how White supremacy and patriarchy take part in the domination of minority groups (Ross, 2017).

Tenets of CRT are a purposeful articulation between race, the experiences of racism, and its effects on the psychological sequelae (Brown, 2008). MFTs can be guided by CRT as they delve deep into the social roots of the struggles that many clients present in the clinical setting. This aids in dismantling oppressive discourses around the cultural norms of the dominant culture. When the therapist takes an activist stance, CRT can be utilized in therapeutic work, focusing on "interrupting socio-cultural-based inequality by naming implicit power process" (Knudson-Martin & Huenergardt, 2010, p. 381). CRT challenges racist hegemonic rhetoric that can guide therapists' movement toward becoming more critically informed therapists and scholars. An emphasis is placed on reconstructing societal norms and social action in a way that promotes structural and societal change (D'Arrigo-Patrick et al., 2017). The use of CRT in this research study aims to make structural changes in the way in which DIEPP competencies should be privileged and assessed in MFT clinical training programs. Currently, they are avoided; white-washed to not make white people uncomfortable by not making them accountable for competent practice (Brown, 2008). Much of the education that focuses on DEIPP competencies is through the lens of defects within minority groups, for example, labeling minority groups as underprivileged, yet programs need more consistency in address the silent cultural attitudes

within the clinician and the ego functioning of the positions of power they hold in the clinical space (McDowell, 2012). It seems imperative that educational programs and clinicians need to understand their knowledge and attitudes about DEIPP.

Feminist Family Theory

FFT grew out of the social feminist movement and the shift toward consciousness-raising (Hare-Mustin, 1978). Feminism, at its fundamental core, is a movement to end sexist oppression, with the central theme of the feminist movement being that all women are oppressed (hooks, 2015). Hooks (2015) suggested that through societal prescriptions, women are oppressed and through their oppression is the "absence of choice" (p. 5). Feminism also has roots in the fight for equality. Feminist theory is structured around the discourse toward an understanding of gender inequality. FFT is predicated on the activation of the socio-political rights of all people, not just those identifying as a woman. Under capitalism, patriarchy is structured so that women are restricted. Feminism is a political and social perspective that is independent of sex or gender. FFT bridges the gap between the person and the political, bringing the therapy work in the office to politics and the systems to which we belong (Silverstein & Goodrich, 2003). Through the poststructuralist feminist praxis, Alexander-Floyd (2012) suggested that humans, through their complexities, are kept into the categories in which society puts them. Feminist research is dedicated to questioning whose interests are served when asking research questions (Chan & Ma Ma, 2006) which is an essential component to this research study.

Feminist research aims to transform traditional MFT academic disciplines which is "an understanding that many aspects of women's experience have not yet been articulated or conceptualized within social science" (Jayaratne & Stewart, 1991, p. 89). FFT is critical in the MFT field because women's perspectives are of high value. After all, researchers and clinicians

who do not identify as women may misrepresent women's lived experiences (Mercier & Harold, 2008), and this is most likely also true of other marginalized groups of people.

FFT is utilized by MFTs as an avenue for propelling forward-thinking and social change (Dankoski, 2000). FFT clinicians see and critique how families are defined, and how subjugated family roles and rules are maintained and structured. FFT shares the postmodern perspective of the epistemology of knowledge as socially constructed (Gosling & Zangari, 1996). FFT stresses the postmodern stance of the equality of women, the equality of the therapist-client relationship, and mutual respect (Hare-Mustin, 1978). Feminist family therapists are active in recognizing their own power and privilege and acknowledging the disparities of the clients in which they serve (Prouty Lyness & Lyness, 2007). Szymanski (2005), working with internalized heterosexism, found that there were three tenants of the FFT that were consistent across her research inquiry: the person as political, recognizing oppression, and holding an egalitarian view. This egalitarian view was the vehicle for reducing the power and hierarchy of the clinician.

Feminist research requires a more nuanced approach and has to be intentional and methodological. Throughout the years, feminist research has been employed mainly by qualitative researchers as it was deemed the only proper way to do feminist research (Harnois, 2013). FFT is political action. From a feminist standpoint, any theory of family or therapy has to be measured against the case of power. FFT teaches therapists to address issues of race, sex, gender, power, privilege, and oppression and make them explicit to the family (Tiefer, 2001). Therapists are the entity of power in the therapy room with clients. Creating systemic change within the MFT field requires looking at the current systems that are in place for training clinicians (Hare-Mustin, 1978), not in efforts to tell the MFT field that it is not competent, but to explicitly explore if MFTs are DIEPP competent. Typically, this is viewed through diagnosing

and a non-pathologizing stance. This research inquiry views relabeling deviance as a habitual attribute of the MFT field by stating the importance of a competency-driven field while masking DEIPP competency's relevance and not considering the consequences. FFT is a theory of consciousness-raising which emphasizes social context. FFT stands with the awareness of the oppressiveness of androgynous, traditional roles within society, while also focusing on the awareness of our own biases and changing patterns and changing the structure of historical boundaries. This research inquiry lends primacy to the interests of underserved and marginalized communities and the liberatory practice of growth in the mental health field, specifically of training clinicians in MFT training programs.

The Present Study

Because MFTs are systemic thinkers, they are primed to view how systems, including the field of MFT, perpetuate systems of racism and the nuanced conflation of race, ethnicity, and clinical competencies with the perceived discrimination of race-related stress. "Critical race theory framework may further strengthen psychological science's ability to orient towards equitable practices in the reduction and prevention of racial health disparities" (Volpe et al., 2019, p. 1). The field of MFT is rooted in activism and in systems thinking. DEIPP topics are woven throughout coursework and are woven throughout the national licensing exam (Association of Marital and Family Therapy Regulatory Boards, 2014). The present study endeavors to answer the call to action to make progressive change in the field's current state of stagnancy by dismantling the system of oppression and placing a high value on DEIPP competencies by exploring the steps for developing quantifiable competency measures. MFT clinical training programs teach whiteness and then test on white theories on a national level, either disregarding DEIPP competencies all together or watering them down as part of other

tested skills. The MFT field may not be testing for DEIPP competencies because there is not an existing measure.

The current study takes an activist approach to social justice. The activist stance of making movement in the field of MFT turning social justice, the noun, into social justice, the verb. As a field of systemic thinkers, MFTs are compelled to dismantle systemic racism and to be groundbreakers of change. McGoldrick and Hardy (2019) pointed out that "whiteness comes with comfortable ignorance of itself and its privilege" (p. 238). The gap that will be filled by creating a critical testing practice for MFTs is that DEIPP competencies will no longer be freely disparaged, with the hope of closing the chasm between outcome-based learning and evidenced-based cultural competency measures.

The present study aimed to complete the first step in creating a measurement tool, with item generation and defining domains through reliability testing with expert judges. This first step towards creating a standardized measurement tool is a necessary next step because critique has been made on the effectiveness of self-report measures for assessing clinical competence in the mental health field (Perosa & Perosa, 2010). This measure will echo McIntosh's (1988) practice of creating lists with specific instances or examples of what privileges look like in action while asking clinicians to question why they know what they know and to challenge the construction of knowledge nuanced perspective. The DEIPP measurement tool will assess based on the three different domains suggested by Perosa and Perosa (2010): attitudes, knowledge, and clinical application. This researcher intends to advocate activism within a liberatory teaching praxis.

CHAPTER III: RESEARCH DESIGN AND METHODS

> In a well-established scientific endeavor, the foundation is made explicit so that one is able to recognize when the resulting structure can no longer be properly supported and reexamination of the fundamentals is in order.
>
> —Linstone & Turoff (2002)

The current study is an exploratory design employing the Delphi technique (Linstone & Turoff, 2002) as a way to develop an expert consensus for the development of an assessment intended to measure attitudes self-report, multicultural knowledge questions, and clinical application vignettes of constructs related to DEIPP competencies. The Delphi method was used to reach a reliable consensus regarding the definitions of domains and questions to be asked on the measurement tool. To conceptualize the specificity of the DEIPP constructs being measured, FFT and CRT was applied to the competency measures. Through the theoretical framework, the three domains, attitudes, knowledge, and clinical application and five latent constructs, diversity, equity, inclusion, power, and privilege, were established as meaningful. The domains and constructs were based on the accumulated knowledge through the literature review, and through the CRT and FFT lens. Content analysis of the literature and existing competency measures delineated items and unique factors related to competency standards. Chapter three contains four sections: item development, participants, statistical analysis, and limitations.

Item Development

Scale development is both nuanced and technical. Boateng and colleagues (2018) produced a straightforward and concrete review of steps needed for developing and producing psychometrically sound scales and measurement tools for the social sciences. They outlined the following steps for validating and developing measures in the social sciences. As outlined, scale

development and validation consist of three phases that can be broken down into nine distinct steps. Phase one, item development, is divided into domain and construct development, and item generation. Phase two, scale development, consists of four steps: question pre-testing, survey sampling, item reduction, and factor extraction. Lastly, phase three, scale evaluation, consists of dimensionality testing, reliability testing, and validity testing. This exploratory research inquiry is focused on the first phase of scale development, the item development phase, which aims to develop questions and to assess content validity of the questionnaire. Content validity is defined as "the degree to which elements of an assessment instrument are relevant to a representative of the targeted construct for a particular assessment purpose" (Haynes et al., 1995, p. 238). Measuring latent constructs, which is a factor that cannot be easily measured or observed, is done by capturing indicators representing the underlying constructs through scale items. Content validity will be assessed by assembling a large group of questions that relate to the three domains, attitudes self-report, multicultural knowledge questions, and clinical application vignettes. Content validity will be established through asking a panel of experts to judge how well the questions measure the constructs. This process is called the Delphi method (Stone Fish & Busby, 2005).

The Delphi method has four phases, as Stone Fish and Busby (2005) outlined. These phases are as follows: phase one is the initial evaluation of experts. For this research inquiry, the experts evaluated the definitions of constructs related to DEIPP and the items generated to assess DEIPP constructs within the three domains. This initial step is crucial for exploring the item constructs generated. Phase two is compiling responses and feedback. This step involved pulling the information together from the expert judges and looking for measured tendencies in the group responses. Phase three makes sense of the discrepancies between the experts. This is done

by calculating the median and the interquartile range for each item. The third phase complied the results and presented them back to the expert judges. The results indicate how each item scored within the group compared to their response and the group means, and other statistical outcomes. Phase four sent the modified survey back to the panelists for a final review. Participants provided their final feedback as influenced by the group statistics that compared their initial indications with the group's responses. The last phase allowed the participants to see the modified assessments and provide any last remarks and evaluations. The experts were asked to reconsider their initial responses carefully.

I compiled a substantial list of questions from existing instruments that I believe measure the DEIPP constructs, as described below. The question sets were sent out to the panel of experts to determine if a consensus could be found among them regarding the construct I hoped to measure. The scales sent to the expert judges were a rating system for items to assess the importance of characteristics, symptoms, or items for a target construct of interest. The resulting data of the scaled items produced an evaluation with face validity. Stone Fish and Busby (1996) suggested that the experts participate in two rounds of evaluating the question sets and that any more than two rounds can result in participants changing their answers based on other experts opinions, rather than just providing their honest feedback.

The literature review identified five latent constructs: diversity, equity, inclusion, power, and privilege. These characteristics were organized tri-dimensionally according to attitudes self-report, multicultural knowledge questions, and clinical application vignettes of constructs related to DEIPP knowledge as domains, as evidenced by Perosa and Perosa (2010). Each domain sought to assess the same five latent constructs through differing assessment strategies. The DEIPP assessment comprises modified questions borrowed from various measurement tools

utilized by the counseling field because there is no comparable measure for MFTs. As the counseling field and MFT are closely related, the questions seem appropriate for both populations, and the language was modified to reflect nuances in training and professional identity. An example of how the questions were modified was, changing the word “counselor” to “therapist” or “counseling” to “therapy.” The narrative words on each Likert-type scale were modified as needed to the aforementioned parameters to unify the borrowed measurements. Items from each inventory were selected as they related to three different DEIPP competency domains: attitudes self-report, multicultural knowledge questions, and clinical application vignettes of general clinical skills. These three domains were suggested by Sue and Sue (1982) as the tenets of an effective measurement tool, and general clinical skills were changed to the application of DEIPP constructs to reflect better the application of skills, rather than the development of skills.

The proposed DEIPP measurement tool is divided into three sections, each measuring a different aspect of DEIPP competence: attitudes self-report, multicultural knowledge questions, and clinical application vignettes. Each of the latent constructs, diversity, equity, inclusion, power, and privilege, is reflected in the questions contained in each section. The item development aimed at gleaning at least 100 items to reflect 20 observations per five latent variables for each of the three sections, with over 300 items. The large item generation is purposefully large, and not all items will be retained as part of item reduction with the Delphi technique. Domain development and preliminary item generation were identified by deductive methods via the literature review and assessment of existing scales and modified for section one. In the construction of section 1, affective development, a pool of 100 self-assessment items was modified from four existing self-assessment tools identified as measuring each of the

characteristics of DEIPP latent constructs. These tools are: Multicultural Counseling Inventory (MCI; Sodowsky, 1996), Cross-Cultural Counseling Inventory (CCCI; LaFromboise et al., 1991), Multicultural Awareness-Knowledge-and Skills Survey (MAKSS; D'Andrea et al., 1991), and the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996). These measurement tools and the process for item development are addressed in detail in the next section. Section two builds off section one by supplementing the previous self-assessment questions with questions and definitions from the literature. These questions aim to capture participants' working knowledge. Item generation for section three builds off the previous two sections with clinical vignettes that I wrote to capture the behaviors of competent implementation of training clinicians' perceived and actual knowledge. A more detailed description of this process is discussed further in the next section. These three sections capture the latent constructs through the harmonious sequence of item questions. In the DEIPP assessment, each section builds off the section it precedes. Each section was intentionally designed to mirror the content of the sections that comes before it. Section 1 measures perceived knowledge. Section 2 part 1 tests for actual knowledge pertaining to the items in section 1. Part 2 of section 2 is designed to measure the application of the exact same constructs. In essence, this assessment allows the user to really see if what they believe is reflected in what they know and if they are applying what they believe and know in a competent manner.

Questions Derived From Other Measures

Questions were derived from the MCI, CCCI, MAKSS, and the MCAS as each of these tools measures some aspect of the DEIPP competencies. Because of Copywrite laws, the questions utilized in the proposed DEIPP measurement tool are not provided in the appendices. However, each assessment is available for reference in the reference section of this manuscript

and via a google search, as these measures are open access. The original MCI (Sodowsky, 1996) is a 40-item self-reporting scale that has participants rate answers on a 4-point Likert scale from very inaccurate to very accurate. This scale is unique because it measures a respondent's multicultural counseling relationship, including how identity and culture impacts and influences the client's relationship with therapy and mental health in general (Ponterotto et al., 1994). The coefficient of factor congruence ranged from .75 and .87 (Ponterotto et al., 1994). The factor congruence suggests that the sample can be relatively generalizable.

The CCCI was developed for the counseling field to meet the needs of clients from more diverse backgrounds than the therapists. The CCCI (LaFromboise et al., 1991) consists of 20 items utilizing a 6-point Likert scale ranging from strongly disagree to strongly agree. This inventory assesses for the clinician's cultural awareness. The measure demonstrates a good validity of 0.89 and a reliability of 0.96 (LaFromboisee et al., 1991). Statements were adapted from the CCCI because it measures sociopolitical awareness. Sociopolitical awareness directly relates to inclusion (United Nations, 2016). While some statements intend to measure therapists' cultural sensitivity. Cultural sensitivity is directly related to the diversity component and supports the use in the item development and statements directly related to the inclusion factor of the DEIPP phase one, item development.

The third scale utilized is the MAKSS developed by D'Andrea et al. (1991). The validity of the total scale was not analyzed, although the authors suggested that there was independence between the different subscales (Ponterotto et al., 1994). This multidimensional assessment measures an individual's level of competency by eliciting responses evoked by stimulus questions. This measure is intended to elicit representative samplings of the phenomena of construct intelligence that is not ordinarily directly observable. The MAKSS consists of 60 items

in which participants choose from strongly disagree, disagree, agree, and strongly agree. The MAKSS scale was developed to gain insight into a respondent's current level of cultural competence and is intended to be used as a base for identifying growth areas, multicultural awareness, knowledge, and skills.

The MCAS developed by Ponterotto et al. (1996) was modified and utilized in the development of the DEIPP. The MCAS intends to measure concrete operational knowledge of multicultural competencies. The MCAS was critically revised in terms of reliability, validity, and methods for instrument development in creating the DEIPP, item development. The MCAS has 45 questions and a 7-point Likert scale ranging from 1–7; not at all true to totally true. Validity is reported as 0.89; reliability 0.92 (Ponterotto et al., 1996). Table 3.1 provides a brief indication of the measures used in this section.

Table 3.1

Measures, Item Response Format, and Focus

Measure	Item Format	Focus	Number of Items Used
Multicultural Counseling Inventory (MCI) Sodowsky, 1996	4-point Likert scale 1 = very inaccurate; 4 = very accurate	Self-Report	19
Cross-Cultural Counseling Inventory (CCCI) LaFromboise, 1991	6-point Likert scale 1 = strongly disagree; 6 = strongly agree	Self-Report	19
Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) D'Andrea et al., 1991	4-point Likert scale 1 = strongly disagree; 4 = strongly agree	Self-Report	55
Multicultural Counseling Awareness Scale (MCAS) Ponterotto et al., 1996	7- point Likert Scale 1 = not at all true; 7 = totally true	Self-Report	30

Section 2 of the DEIPP Assessment

Section 2 of the DEIPP assessment addressed domains two and three, multicultural knowledge and clinical application. Section 2 measures cognitive development in DEIPP competencies. Cognitive development is considered an evaluation of self-awareness, knowledge, and clinical skills (Sue et al., 1982). Section 2 is an expansion of the perceived knowledge and affective development (Lyons & Hazler, 2002), defined as trait-based attitudes (Mayes et al., 2016), as well as attitudes, self-awareness, and advocacy work in section 1 by testing for actual knowledge of the competencies from the earlier section. Section 2 of the DEIPP assessment is subdivided into two distinct parts: multiple-choice questions, which capture multicultural knowledge, and questions based on vignettes that assess the application of knowledge. Section 2 will be analyzed with the exam item analysis lens in mind. The assumption of exam item analysis is synonymous with item reliability which is congruent with section 3 of scale development (Boateng et al., 2018).

> Item analysis data are not synonymous with item validity. An external criterion is required to accurately judge the validity of test items. By using the internal criterion of the total test score, item analyses reflect internal consistency of items rather than validity. (University of Washington, 2022, A Caution in Interpreting Item Analysis Results, bullet 1).

Because this research inquiry is exploratory and assessing for content validity, the same method of expert testing will be used, but exploratory factor analysis (EFA) will be saved for future use.

Section 2 part 1

Section 2 part 1 consists of 100 multiple-choice questions. These questions mirror the self-assessment questions asked in section 1. They are structured as multiple-choice to capture multicultural knowledge. Section 1 assesses attitudes via self-assessment. This part of section 2

assesses the knowledge base of the same DIEPP competencies in section 1, thus building off the baseline of self-reporting through a series of multiple-choice questions.

Since the MFT/CFT field has no existing measure, the multiple-choice questions had to be designed using varying strategies. There were three different methods for item development for this section. The first method was taking the self-assessment questions and asking them differently that produced a right or wrong, more dichotomous type of response. The second method employed searching the literature for any multiple-choice questions related to DEIPP constructs, inside and outside the mental health field. The third method of multiple-choice question development was by looking to clinical books often used in MFT/CFT training programs to find the end of chapter questions relating to DEIPP constructs.

DEIPP related assessments and quizzes include the following. The multicultural education quiz by Heinzep (2022) is a 32-question exam made for K–12 teachers to test their fluency on multiculturalism. This measurement tool has no research backing. These questions were used because they asked DEIPP related multiple-choice questions. DEIPP related books and end of chapter assessments include the following: *The Socio-Emotional Relationship Therapy: Bridging Emotion Societal Context, and Couple Interaction* (Kundson-Martin et al., 2015); *Teaching for Diversity and Social Justice* (Adams et al., 2016); *Readings for Diversity and Social Justice* (Adams et al., 2010); *Psychology Express: Educational Psychology: Undergraduate Revision Guide* (Taylor, 2014); *Feminist Measures in Survey Research* (Harnois, 2013); *The Ethical and Professional Practice of Counseling and Psychotherapy* (Sperry, 2007); *Diversity in Couple and Family Therapy* (Kelly, 2017); *Addressing Cultural Complexities in Practice: A Framework for Clinicians and Counselors* (Hays, 2001); *Eliminating Race-Based Mental Health Disparities* (Arredondo, 2019); *Mastering the National Counselor Examination*

and the Counselor Preparation Comprehensive Examination: and Substance Abuse and Mental Health Services Administration Treatment Improvement Protocol (Erford et al., 2015).

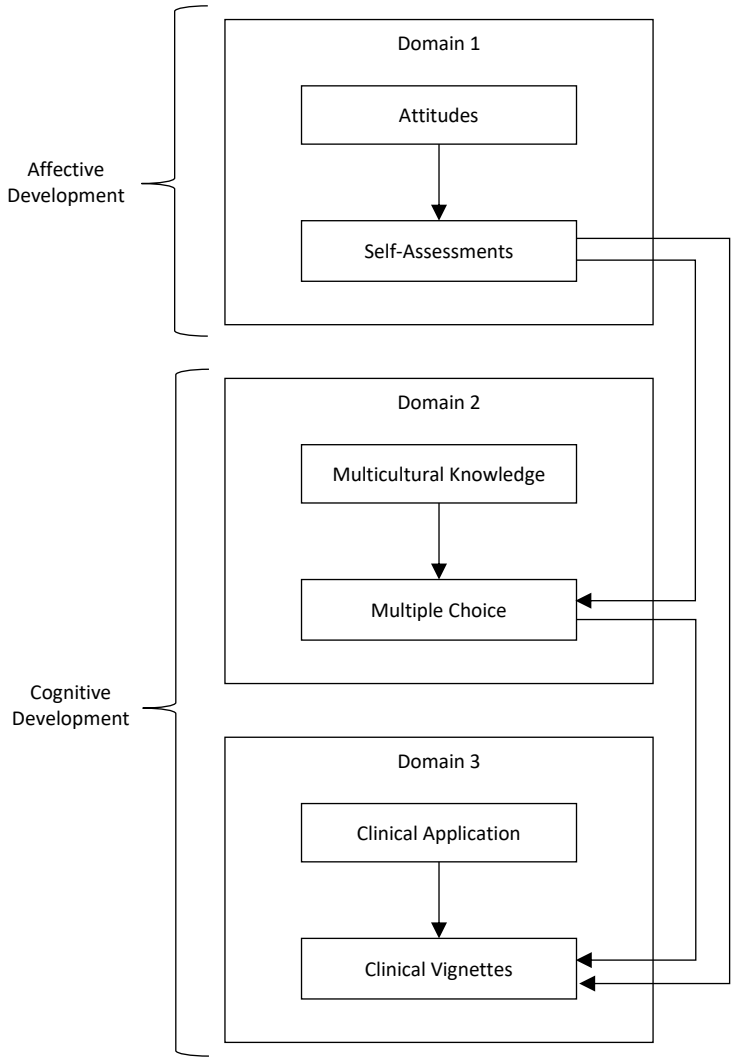
Section 2 part 2

Section 2 part 2 consists of 100 vignettes assessing the application of the constructs, which is defined as a working knowledge and skills, or complex structures (Lyons & Hazler, 2002) related to DEIPP. These vignettes test whether the attitudes and knowledge base of DEIPP competencies can be applied to clinical practice. In developing the clinical vignettes, MFT textbooks such as Volini's (2018), *The National Licensing Exam for Marriage and Family Therapy: A Comprehensive Practice Exam and Solutions Institute's Study Guide for the Marriage and Family Therapy National Licensing Examination*, were utilized. Vignettes created were modeled after the examples in the textbooks, which followed a pattern of an introduction of the client(s), a brief description of the problem, and an inquiry of the reader as to what they would do next. Similarly, the method of structured clinical vignettes is outlined by both Peabody and colleagues (2004) and Lawton and colleagues (2010) for assessing clinical judgment. The vignettes were structured according to the chief complaint, history, and assessment. Then, the trainee was instructed to indicate how they would proceed based on a list of multiple-choice questions. The themes for the vignettes were designed to capture the same concepts from Section 1 and Section 2 part 1 in an attempt to determine if the training clinician can apply their attitudes towards multicultural awareness and knowledge into the therapeutic space with clients in a competent manner. Historically, vignettes have been used in the training of mental health clinicians because they offer a non-maleficent outcome of care (Lawton et al., 2010) approach to observing therapeutic skills without practicing on live clients (Hecker & Wetchler, 2003).

Figure 3.1 presents a flow chart illustrating the intricate process and flow of how the questions from each section build off the section it proceeds.

Figure 3.1

Competency Measure Flowchart



Participants, Recruitment, and Procedures

Before implementing this study, approval from Antioch University New England's Institutional Review Board (IRB) was obtained. Content validity was assessed through expert evaluation; because of this, the targeted population consisted of expert judges. Experts were

defined as professionals who met the first criteria; identify as highly knowledgeable in diversity, equity, inclusion, power, and privilege (DEIPP) constructs, and at least two of the following four criteria: Criteria 2, they identified as highly knowledgeable in the three domains: training clinicians attitudes self-report, multicultural knowledge questions, and clinical application vignettes of DEIPP constructs; Criteria 3, they identified as having expertise in social justice: Criteria 4, they are involved in training MFT/CFT students; Lastly, criteria 5, they have expertise in COAMFTE accreditation. Two hundred and seventy-nine professionals were contacted, yielding five expert participants.

The group of experts rated the pool of items for appropriateness (content validity) and clarity (wording; DeVellis, 2012). These experts were asked to "rate how relevant they think each item is to what it is intended to measure" (DeVellis, 2012, p. 135), and if the items that are asked in the measurement tool are related to the constructs indicated. The expert judges scored items for appropriateness on a 7-point scale, with 1 indicating strongly disagree and 7 indicating strongly agree (DeVellis, 2012). They were also be encouraged to give feedback on each individual item.

Experts were found by going to COAMFTE's website to find a listing of accreditation reviewers and COAMFTE's directory of accredited program directors. These two listings on COAMFTE's website provided experts on teaching and accreditation. Snowball sampling was also utilized by asking for materials to be forwarded to others in the filed who met the expert criteria. I contacted experts I referenced in the literature review who have expertise in DEIPP constructs, the three domains, and self-identify as having expertise in social justice. The experts were contacted directly via an email invitation for stage one of employing the Delphi method. The email requested their participation and contained a link to SurveyMonkey, where the

informed consent, the items developed, and a critical appraisal form to rate questions were located. Then, a second email was sent out with stage 4 of the Delphi method containing the revised Delphi questionnaire. Stone Fish and Busby (2005) suggested that experts' initial evaluation and data collection consist of four phases. There was a narrative portion of the statistical analysis for each question that indicated the interquartile and median for each item and is compared to each of the participant's responses to the item. The experts were asked to "reconsider each item carefully and present new ratings in the scale under Delphi Questionnaire II" (Stone Fish & Busby, 2005, p. 246).

Data Analysis

This Delphi study was an exploratory-sequential approach which means that the qualitative nature of the expert panelists responses were analyzed through quantitative analysis (Edmonds & Kennedy, 2017). This initial content validity check was essential for creating a homogeneous scale that reflects the latent variables underlying the constructs measured. Stone Fish and Busby (2005) reviewed MFT literature and compiled steps for using the four-step Delphi method in social sciences research. In these steps, expert judges participate in providing as much input for the original question sets as possible. The expert judges scored items for appropriateness on a 7-point scale, with 1 indicating strongly disagree, 2 indicating disagree, 3 indicating somewhat disagree, 4 indicating neither agree nor disagree, 5 indicating somewhat agree, six indicating agree, and 7 indicating strongly agree. This initial step was crucial for exploring the item constructs generated.

The data collected during phases 1 and 4 were analyzed following the protocol outlined by Stone Fish and Busby (2005). The authors suggested calculating both the median and the interquartile ranges of the feedback from the expert judges. The medians and interquartile ranges

were calculated to identify the rates of group agreement and consensus for each item. The median indicated the central tendency of the feedback scales, which is calculated and displayed as the 50th percentile, representing the distribution of responses toward agreement or disagreement. The Delphi Questionnaire provided nominal indicators for each question, including the mean, median (50th percentile), 25th percentile, 75th percentile, and interquartile range. Stone Fish and Busby (2005) further prescribed methods for interpreting the data. The interquartile range indicates how well the experts agreed on item appropriateness. A consensus on items is considered reached when items reach at least the desired 50th percentile. The final report formalized content validity, and this report refined the original complexity of item generation. The final report was a refined set of data questions that accurately reflect the measured DEIPP constructs, as evidenced by the group consensus.

After the data was collected from the first survey, it was exported from SurveyMonkey into an SPSS formatted document. This document was then uploaded into SPSS, where the data was cleaned and organized. The cleaning process consisted of removing responses from potential participants who did not complete the entire survey and changing all the variable types and value labels. Once the data was cleaned and organized, descriptive statistics were run for each item using SPSS descriptive statistics, which provides the mean, median, mode, and interquartile range (IQR). After participants completed the second Delphi survey, the same method was used to collect the descriptive statistics for each item. The median is an indicator of each item's central tendency. The IQR is the statistical dispersion of the middle 50% of responses. The IQR is another indicator of group consensus because it accounts for how wide the response range differed between the group members.

Each item was assessed to determine retention status. If items were retained, content validity was assumed. The median and IQR were utilized for item retention purposes. The mean and mode were calculated to provide a complete picture of the central tendencies of each scored item (Linstone & Turoff, 2002). The mean was calculated and shared with all participants during completion of the second-round survey, so the participants had an idea of the average on each response item. The mode was calculated and provided to the participants to indicate if more than one participant rated the questions the same. The mean, median, mode, and IQR were utilized to describe how each item was perceived by the individual and the group as a whole.

During the first survey, some participants provided written feedback. The written feedback received for items was helpful in general but did not aid in the reconstruction of questions. Delphi studies often rely heavily on qualitative data as well, but as seen in Kraines and colleagues' (2020) Delphi study centered around mindfulness, they focused on the quantitative data for similar circumstances as mine. The researchers stated explicitly that panelists were not provided with the comment or feedback of responses from the first survey because the feedback did not elevate the discussion. For the second survey, the participants were provided with the original survey plus the addition of the descriptive statistics. After survey 1 was complete, a collection of qualitative responses were compiled for each participant. Few questions had written feedback, and the feedback given was, "I don't like the way this question reads," "I'm confused as to what this question is asking," and the most common response, "I don't like questions that have a right or wrong answer." Because the feedback did not focus on the reconstruction of questions or DEIPP definitions, and did not influence the survey construction, the qualitative data was not used beyond this exploration. There were no comments or feedback on survey

two—because the feedback could not be used to enhance the questions, only descriptive statistics were sent out in the revised Delphi survey to participants.

CHAPTER IV: RESULTS

> In what ways do you fulfill your moral obligation to correct current social inequities? Are these ways meaningful to those who have been wronged or just meaningful to you?
>
> —Kosutic et al. (2009)

The purpose of this quantitative research study was to complete step one for developing a measurement tool which is the item development phase, following Boateng and colleagues' (2018) work on scale development. This is the first step towards creating a comprehensive measure for DEIPP competencies to enhance the evaluation of DEIPP competencies in training programs and their training clinicians. The DEIPP competency measure is intentionally being designed to move beyond a self-report skills-based measure to generalized assessment and application of DEIPP competencies. The study utilized the Delphi technique to gain expert consensus on items that were generated to measure training clinicians' DEIPP competencies. This research focused on refining competency-based outcomes; the Delphi study was employed in order to gain expert feedback. This feedback was used to help determine consensus on the DEIPP definitions and validity of measurement items. A sample of expert participants completed two rounds of Delphi surveys that aimed to capture the expert's options on items that were generated to assess a training clinician's DEIPP competencies. The use of multiple surveys attempt consensus on survey items. After the first Delphi survey, the responses were aggregated and shared with the group for the opportunity to reconsider their initial reactions and opinions in light of the contribution and options of expert peers. The final survey results retained 82% of the total question items.

Participants and Demographics

Experts in DEIPP competencies were defined as professionals who met three out of the five expert criteria, which are: Criteria 1, identify as highly knowledgeable in diversity, equity, inclusion, power, and privilege (DEIPP) constructs, and at least two of the following four criteria; Criteria 2, they identified as highly knowledgeable in the three domains: training clinicians attitudes self-report, multicultural knowledge questions, and clinical application vignettes of DEIPP constructs; Criteria 3, they identified as having expertise in social justice; Criteria 4, they are involved in training MFT/CFT students; and lastly, criteria 5, they have expertise in COAMFTE accreditation. An initial recruitment email was sent to 100 professionals in the MFT field who most likely met the expert criteria for participation. Snowball sampling was also used during the initial recruitment that resulted in an additional 179 more recruitment emails being sent to potential participants. Twenty-five people signed the consent form and filled out the demographic questionnaire. Of the 25 people, five fully responded by completing both surveys in their entirety. The sample size of five is considered sufficient because a Delphi study is limited to 5–7 participants (Boateng et al., 2018).

Participant 1 met expert criteria 1, 3, and 4 and identified as a Black or African American female. Participant 2 met all five expert criteria and identified as a white or Caucasian non-binary individual. Participant 3 met all five expert criteria and identified as a White or Caucasian female. Participant 4 met expert criteria 1, 2, 4, and 5 and identified as an Asian or Asian American male. Participant 5 met all five expert criteria and identified as a White or Caucasian female. Table 4.1 illustrates the participant demographics.

Table 4.1

Participant Demographics

Question	Options	Responses				
		Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Experts are defined as professionals who meet three of the five criteria.	You identify as highly knowledgeable in diversity, equity, inclusion, power, and privilege (DIEPP) constructs.	X	X	X	X	X
	You identify as highly knowledgeable in the three domains: attitudes, multicultural knowledge, and clinical application.		X	X	X	X
	You identify as having expertise in social justice.	X	X	X		X
	You are involved in training MFT/CFT students.	X	X	X	X	X
	You have expertise in COAMFTE accreditation.		X	X	X	X

Question	Options	Responses				
		Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Gender: How do you identify?	Non-Binary		X			
	Female	X		X		X
	Male				X	
What is your racial background?	White or Caucasian		X	X		X
	Black or African American	X				
	Hispanic or Latino					
	Asian or Asian American				X	
	American Indian or Alaskan Native					
	Native Hawaiian or other Pacific Islander					
	Another race/prefer to describe					

Data Analysis Procedures

Participants were asked to complete two rounds of surveys. The surveys contained 322 questions related to diversity, equity, inclusion, power, and privilege. These questions were divided between three domains: attitudes self-report, multicultural knowledge questions, and clinical application vignettes of DEIPP constructs. The participants were asked to rate each item for content, clarity, and appropriateness on a 7-point Likert scale. The data were examined by computing the mean, median, mode, and IQR as a way to indicate the group's level of consensus on the appropriateness of each item and how well it defined the DEIPP constructs.

Once round one surveys were complete, descriptive statistics were run for each item (Stone Fish & Busby, 2005). The original Delphi survey was duplicated by utilizing the same item questions and revised by adding in descriptive statistics for each item. This revised survey was sent back to the original participants for additional feedback. The revised survey included the mean, median, mode, and IQR so that the participants were informed by the first survey results. Figure 4.1 is an example of how questions were presented in the "Delphi Survey 1."

Figure 4.1

Example of Delphi Survey 1

Privilege is defined as an unearned advantage with access to resources based on identification and membership to a dominant social group whose policies exercise control over others (Adams et al., 2016).

Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7
○	○	○	○	○	○	○

Feedback related to content and clarity.

The experts were asked to review their original answer considering the group statistics. They were also asked to reconsider each item carefully, considering their initial response to the overall group statistics. And lastly, to rate the item on the 7-point Likert scale. The group statistics were added to influence participants. Figure 4.2 is an example of how the questions were asked in the "Revised Delphi Survey."

Figure 4.2

Example of Revised Delphi Survey

Privilege is defined as an unearned advantage with access to resources based on identification and membership to a dominant social group whose policies exercise control over others (Adams et al., 2016).

Strongly Disagree	Disagree	Somewhat Disagree	Neither Agree or Disagree	Somewhat Agree	Agree	Strongly Agree
1	2	3	4	5	6	7
○	○	○	○	○	○	○

Group Statistics: Individual Response: 6

Mean: 5.8

Median: 6

Mode: 6

IQR: 0

Feedback related to content and clarity.

The Delphi method is structured so that changes in the way that the expert individually responds to items are not influenced by other participant variables, such as perceived expert status. During the first survey, some participants provided written feedback. The feedback did not focus on the reconstruction of questions or DEIPP definitions, so it did not influence the survey construction. Because the written feedback could not be used to enhance the questions, just the descriptive statistics were sent out in the revised Delphi survey to participants.

Retention of items is based on the expert's consensus of two criteria: the item's median score is 6 or higher and the IQR of no higher than a score of 1.5 (Stone Fish & Busby, 2005). In Table 4.2, the items that met the median of 6 or above and IQR of 1.5 or below are marked with an asterisk. The items that became part of the final profile are marked in the results column as "retained." These items indicate that the questions are consistent with the DEIPP competency and DEIPP constructs by the panel of experts, as evidenced by the group statistics, indicating that these questions were selected for the final survey result. Content validity was assessed through expert evaluation via the Delphi method. Content validity is the degree of consensus among the experts on each item matching the retention criteria. When an item meets retention status, content validity for that item is the result.

Statistical Analysis and Results

Table 4.3 contains the results of both rounds of surveys. The initial survey is indicated on the table as "Delphi Survey 1" and includes the mean, median, mode, and IQR for each item question. The second survey is indicated on the table as the "Revised Delphi Survey" and also includes the same descriptive statistics for each item. Stone Fish and Busby (2005) suggested that items with a median of at least 6 and an IQR of less than 1.5 be retained. The Likert scale limits are, 1 = strongly disagree; 2 = disagree; 3 = somewhat disagree; 4 = either agree or disagree; 5 = somewhat agree, 6 = agree, and 7 = strongly agree. After the final Revised Delphi Survey group statistics were run, 264 items were retained and 68 items were discarded.

Table 4.2

Survey Results: Defining DEIPP Constructs

	Descriptive statistics results for Delphi Survey 1				Descriptive statistics results for Revised Delphi Survey				
Question	Mean	Median	Mode	IQR	Mean	Median	Mode	IQR	Result
1	4.60	5.00	6.00	2.00	6.00	*6.00	6.00	*0.00	RETAINED
2	5.60	6.00	6.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
3	5.80	6.00	5.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
4	5.40	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
5	5.80	6.00	6.00	0.00	6.00	*6.00	6.00	*0.00	RETAINED

Table 4.2 illustrates the results of the first five questions which were defining the DEIPP constructs. All of the DEIPP construct definitions were retained. In survey 1, question 1, defining the DEIPP construct, diversity, initially scored low on the median and too high of an IQR. These initial scores indicate that some participants initially did not favor this definition. After being presented with the group statistics in the second survey, the group as a whole indicated significant consensus in this item's score.

Table 4.3

Survey Results: Diversity Question Sets

	Descriptive statistics results for Delphi Survey 1				Descriptive statistics results for Revised Delphi Survey				
Question	Mean	Median	Mode	IQR	Mean	Median	Mode	IQR	Result
				Self-Assessment					
6	5.20	6.00	6.00	2.00	5.00	5.00	5.00	*1.00	
7	5.40	5.00	7.00	3.00	5.20	5.00	4.00	2.00	
8	5.80	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
9	6.20	7.00	7.00	1.00	6.20	*7.00	7.00	*1.00	RETAINED
10	6.00	6.00	6.00	0.00	6.00	*6.00	6.00	*0.00	RETAINED
11	4.40	6.00	6.00	4.00	4.00	5.00	6.00	4.00	
12	4.40	4.00		3.00	4.40	4.00	4.00	2.00	
13	5.00	6.00	6.00	1.00	4.80	*6.00	6.00	*1.00	RETAINED
14	4.40	6.00	6.00	4.00	4.80	5.00	6.00	*1.00	

15	5.80	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
16	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
17	5.20	5.00	5.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
18	4.80	5.00	5.00	1.00	4.80	5.00	5.00	*1.00	
19	5.60	6.00	6.00	1.00	5.20	5.00	6.00	*1.00	
20	5.40	5.00	5.00	1.00	5.20	5.00	6.00	*1.00	
21	5.60	6.00	6.00	1.00	5.00	5.00	5.00	*0.00	
22	5.60	6.00	6.00	1.00	5.20	5.00	5.00	*1.00	
23	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
24	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
25	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
26	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
27	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
28	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
29	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
30	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
31	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
32	5.00	5.00	5.00	0.00	4.40	5.00	5.00	*0.00	
33	4.20	5.00	6.00	3.00	5.20	5.00	5.00	*1.00	
34	6.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
35	5.40	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
36	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
37	5.80	6.00	6.00	0.00	6.00	*6.00	6.00	*0.00	RETAINED
38	6.20	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
39	5.20	5.00	5.00	1.00	5.00	5.00	5.00	*0.00	
40	6.00	6.00	6.00	0.00	6.00	*6.00	6.00	*0.00	RETAINED
41	5.80	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED

Multicultural Knowledge

42	5.20	6.00	6.00	2.00	6.00	*6.00	6.00	*0.00	RETAINED
43	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	2.00	
44	4.20	6.00	6.00	4.00	4.40	*6.00	6.00	4.00	
45	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
46	5.20	6.00	6.00	2.00	6.00	*6.00	6.00	*0.00	RETAINED
47	5.20	6.00	6.00	2.00	5.20	5.00	6.00	*1.00	
48	5.40	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
49	5.00	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
50	5.20	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
51	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
52	5.20	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	

53	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	2.00	
54	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	2.00	
55	4.80	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
56	5.40	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
57	5.20	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
58	4.80	6.00	6.00	2.00	4.80	*6.00	6.00	2.00	
59	4.20	4.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
60	5.40	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
61	5.40	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
				Clinical Application					
62	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
63	5.60	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED
64	5.20	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
65	5.80	6.00	6.00	0.00	6.20	*6.00	6.00	*0.00	RETAINED
66	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
67	5.80	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED
68	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
69	5.60	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
70	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
71	5.80	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
72	5.60	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED
73	5.40	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
74	5.80	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
75	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
76	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
77	5.60	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED
78	5.40	6.00	6.00	1.00	5.20	*6.00	6.00	2.00	
79	5.20	6.00	6.00	2.00	4.60	5.00	6.00	2.00	
80	4.60	5.00	6.00	2.00	4.40	5.00	5.00	*1.00	
81	4.60	5.00	6.00	2.00	5.00	5.00	5.00	*0.00	

Table 4.3 illustrates the results of the 76 diversity-related questions. The first section was the self-assessment portion which contained 36 questions, of which 23 were retained, and 13 were not. Of the 13 questions not retained, two (questions number 6 and 7) were from the CCCS-R (LaFromboise, et a., 1991). Ten questions from the MCKAS (Ponterotto et al., 1996) questionnaire were not retained; two (questions 11 and 14) were

reversed scored. Nine MCKAS (Ponterotto et al., 1996) questions asked clinicians to rate themselves as “highly competent” in understanding DEIPP terms, which was in questions 11, 12, 18, 19, 20, 21, 22, 32, and 33. Lastly, one of the MCKAS (Ponterotto et al., 1996) questions (question 7) asked about providing referrals based on cultural identity. The one MCI (Sodowsky, 1996) question, number 39, that was not retained also asked clinicians about providing referrals for minority clients.

The second section was the multicultural knowledge-based questions. This section had the most questions not retained. Of the 20 multicultural knowledge-based questions, 9 were retained and 11 were not. The questions not retained were 43, 44, 47, 48, 49, 50, 52, 53, 54, and 58. The 11 questions not retained consisted of one question (number 43) related to defining culture. One question that was not retained was reversed scored. This group of experts did not favor the reverse-scored questions, 80% were not retained, question 44. Lastly, there were eight questions that aimed at defining diversity, social class, minority, bias, microaggression, and culture, which were questions 47, 48, 49, 50, 52, 53, 54, and 58. The third section was the clinical application questions. Of the 20 clinical application vignettes, 16 were retained, and four were not—vignette numbers 78, 79, 80, and 81. The four vignettes not retained consisted of ones that all had a similar undertone of assuming that the client was at a disadvantage because of their minority status.

Table 4.4

Survey Results: Equity Question Sets

	Descriptive statistics results for Delphi Survey 1				Descriptive statistics results for Revised Delphi Survey				
Question	Mean	Median	Mode	IQR	Mean	Median	Mode	IQR	Result
				Self-Assessment					
82	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
83	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
84	6.40	6.00	6.00	1.00	6.40	*6.00	6.00	*1.00	RETAINED
85	6.40	6.00	6.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
86	5.20	6.00	6.00	0.00	5.20	*6.00	6.00	*0.00	RETAINED
87	6.00	6.00	6.00	0.00	6.00	*6.00	6.00	*0.00	RETAINED
88	6.20	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
89	4.40	6.00	6.00	4.00	5.20	*6.00	6.00	*0.00	RETAINED
90	6.40	6.00	6.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
91	4.20	6.00	6.00	5.00	4.60	*6.00	6.00	2.00	
92	5.80	6.00	6.00	1.00	6.20	*6.00	6.00	*0.00	RETAINED
93	6.40	6.00	6.00	1.00	6.40	*6.00	6.00	*1.00	RETAINED
94	6.20	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
95	4.80	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
96	5.80	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
97	6.20	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
98	6.40	6.00	6.00	1.00	6.40	*6.00	6.00	*1.00	RETAINED
99	5.80	6.00	6.00	0.00	5.60	*6.00	6.00	*1.00	RETAINED
100	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*1.00	RETAINED
101	6.00	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
				Multicultural Knowledge					
102	5.20	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
103	5.20	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
104	5.20	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
105	5.00	5.00	6.00	2.00	5.00	5.00	5.00	*0.00	
106	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
107	5.60	6.00	6.00	1.00	5.20	*6.00	6.00	2.00	
108	5.00	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
109	5.00	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
110	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
111	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED

112	5.80	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED
113	5.60	6.00	6.00	1.00	5.20	*6.00	6.00	2.00	
114	5.20	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
115	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
116	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
117	5.60	6.00	6.00	1.00	4.80	*6.00	6.00	2.00	
118	4.40	5.00	6.00	2.00	5.20	*6.00	6.00	2.00	
119	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
120	5.40	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
121	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
				Clinical Application					
122	5.40	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
123	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
124	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
125	5.40	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
126	5.40	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
127	5.00	5.00	6.00	2.00	5.20	5.00	6.00	*1.00	
128	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
129	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
130	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
131	5.00	5.00	6.00	2.00	5.20	5.00	6.00	*1.00	
132	5.00	5.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
133	5.00	5.00	6.00	2.00	5.20	*6.00	6.00	2.00	
134	5.00	5.00	6.00	2.00	5.20	5.00	6.00	*1.00	
135	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
136	5.20	6.00	6.00	2.00	5.80	*6.00	6.00	*0.00	RETAINED
137	5.60	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
138	5.60	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
139	5.60	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
140	5.20	6.00	6.00	2.00	5.80	*6.00	6.00	*0.00	RETAINED
141	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED

Table 4.4 shows the equity question sets. This section contained 60 questions: 20 self-assessment questions, 20 multicultural knowledge-based questions, and 20 clinical application questions. The self-assessment portion retained 19 questions; the only question that was not retained was a MCKAS (Ponterotto et al., 1996) question, number 91, that was reversed

scored. Within the second section, multicultural knowledge, 11 questions were retained, and 9 were not (questions 102, 103, 104, 105, 107, 108, 113, 117, and 118). This section had the highest number of non-retained questions. Of the items not retained, seven were questions that asked for definitions of racism, race, health disparities, race equality, and implicit racial bias (questions 102, 103, 104, 107, 113, 117, and 118). Two additional questions were not retained (questions 105 and 108), and both asked about cultural responsiveness. Lastly, of the clinical application questions (which consisted of the 20 clinical application vignettes), 16 were retained, and 4 were not (questions 127, 131, 133, and 134).

Table 4.5

Survey Results: Inclusion Question Sets

	Descriptive statistics results for Delphi Survey 1				Descriptive statistics results for Revised Delphi Survey				
Question	Mean	Median	Mode	IQR	Mean	Median	Mode	IQR	Result
				Self-Assessment					
142	6.20	7.00	7.00	1.00	6.20	*6.00	6.00	*1.00	RETAINED
143	6.40	7.00	7.00	0.00	6.40	*7.00	7.00	*1.00	RETAINED
144	5.40	6.00	6.00	0.00	5.40	*6.00	6.00	*0.00	RETAINED
145	5.40	6.00	7.00	2.00	4.60	*6.00	6.00	3.00	
146	5.40	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
147	5.80	6.00	7.00	2.00	5.60	*6.00	6.00	*1.00	RETAINED
148	6.00	6.00	6.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
149	6.20	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
150	5.20	6.00	7.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
151	5.60	6.00	7.00	3.00	5.40	*6.00	6.00	2.00	
152	4.80	5.00	7.00	3.00	5.40	5.00	7.00	3.00	
153	5.40	5.00	5.00	2.00	5.80	*6.00	6.00	*0.00	RETAINED
154	6.00	6.00	6.00	1.00	5.00	*6.00	6.00	2.00	
155	5.00	6.00	7.00	3.00	5.60	*6.00	6.00	*0.00	RETAINED
156	6.00	6.00	6.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
157	5.40	5.00	5.00	1.00	5.60	*6.00	6.00	*1.00	RETAINED
158	5.80	6.00	7.00	2.00	5.60	*6.00	6.00	*1.00	RETAINED
159	5.80	6.00	6.00	1.00	6.40	*6.00	6.00	*1.00	RETAINED

160	6.40	7.00	7.00	1.00	6.60	*7.00	7.00	*1.00	RETAINED
161	6.00	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
				Multicultural Knowledge					
162	5.20	6.00	6.00	2.00	5.00	5.00	6.00	2.00	
163	4.80	4.00	4.00	2.00	5.20	5.00	6.00	*1.00	
164	4.40	4.00	6.00	2.00	5.20	5.00	6.00	*1.00	
165	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
166	5.60	6.00	6.00	1.00	5.40	5.00	5.00	*1.00	
167	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
168	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
169	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
170	5.80	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
171	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
172	6.00	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
173	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
174	5.80	6.00	7.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
175	5.60	6.00	7.00	3.00	5.20	*6.00	6.00	2.00	
176	5.20	6.00	7.00	3.00	5.20	*6.00	6.00	2.00	
177	5.00	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
178	5.40	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
179	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
180	5.60	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
				Clinical Application					
181	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
182	5.60	6.00	6.00	1.00	5.20	*6.00	6.00	2.00	
183	5.20	6.00	6.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
184	5.80	6.00	6.00	0.00	6.20	*6.00	6.00	*0.00	RETAINED
185	5.40	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
186	5.40	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
187	5.80	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED
188	5.00	5.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
189	5.60	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
190	5.60	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
191	5.40	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
192	5.80	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
193	5.60	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED
194	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
195	5.60	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED

196	5.00	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
197	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
198	5.60	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
199	5.60	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
200	5.60	6.00	6.00	0.00	5.20	*6.00	6.00	2.00	

Table 4.5 shows the results of the inclusion questions. There were 59 inclusion questions in total. The self-assessment portion contained 20 questions, of which 16 were retained and four were not. Of those four, one question from the CCCS-R (LaFromboise, et al., 1991), question 144, and one from the MAKSS (D'Andrea et al., 1991), question 151, were not retained. One question from the MAKSS (D'Andrea et al., 1991) about understanding the awareness of self and how it impacts clients, number 154, was discarded. One other MAKSS (D'Andrea et al., 1991) question (number 152) was discarded and reversed scored. There were 19 multicultural knowledge-based questions, of which 13 were retained and six were not. All questions that were not retained asked about defining terms such as inculturation, multiculturalism, ethnicity, cultural identity, and discrimination. These questions are 162, 163, 164, 166, 175, and 176. The clinical application contained 20 questions, of which 18 were retained and two were not.

Table 4.6

Survey Results: Power Question Sets

	Descriptive statistics results for Delphi Survey 1				Descriptive statistics results for Revised Delphi Survey				
Question	Mean	Median	Mode	IQR	Mean	Median	Mode	IQR	Result
				Self-Assessment					
201	5.00	6.00	6.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
202	5.60	6.00	6.00	1.00	5.40	5.00	5.00	*1.00	
203	5.40	6.00	6.00	0.00	6.00	*6.00	6.00	*0.00	RETAINED
204	4.20	6.00	6.00	5.00	5.80	*6.00	6.00	*0.00	RETAINED
205	4.20	6.00	6.00	5.00	6.20	*6.00	6.00	*0.00	RETAINED
206	5.40	6.00	7.00	2.00	6.20	*6.00	6.00	*1.00	RETAINED

207	6.40	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
208	5.60	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
209	4.40	6.00	6.00	4.00	5.00	*6.00	6.00	*1.00	RETAINED
210	4.00	5.00	6.00	4.00	5.40	*6.00	6.00	*0.00	RETAINED
211	5.00	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
212	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
213	6.20	6.00	6.00	1.00	6.20	*6.00	6.00	*1.00	RETAINED
214	6.00	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
215	4.20	6.00	6.00	4.00	4.80	*6.00	6.00	2.00	
216	4.40	4.00		3.00	5.20	*6.00	6.00	2.00	
217	4.80	6.00	6.00	2.00	5.00	5.00	6.00	2.00	
218	5.80	6.00	6.00	0.00	6.00	*6.00	6.00	*0.00	RETAINED
219	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*1.00	RETAINED
220	5.20	5.00	5.00	1.00	5.20	*6.00	6.00	2.00	
221	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*1.00	RETAINED
222	5.80	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
223	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*1.00	RETAINED
224	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
225	5.60	6.00	6.00	1.00	5.20	5.00	4.00	2.00	
226	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
227	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
228	5.80	6.00	6.00	0.00	6.00	*6.00	6.00	*0.00	RETAINED
229	5.80	6.00	6.00	1.00	5.60	5.00	5.00	*1.00	
230	5.20	6.00	6.00	2.00	5.80	*6.00	6.00	*0.00	RETAINED
231	6.40	6.00	6.00	1.00	6.60	*7.00	7.00	*1.00	RETAINED
232	6.60	7.00	7.00	1.00	6.00	*6.00	6.00	*1.00	RETAINED

Multicultural Knowledge

233	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
234	4.80	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
235	4.80	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
236	4.80	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
237	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
238	5.40	6.00	6.00	2.00	5.80	*6.00	6.00	*0.00	RETAINED
239	6.00	6.00	6.00	1.00	6.00	*6.00	6.00	*1.00	RETAINED
240	5.60	6.00	7.00	3.00	5.80	*6.00	6.00	*0.00	RETAINED
241	5.60	6.00	7.00	3.00	5.80	*6.00	7.00	2.00	
242	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
243	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	2.00	
244	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED

245	5.40	6.00	6.00	2.00	5.40	5.00	5.00	*1.00	
246	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
247	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
248	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	2.00	
249	5.60	6.00	7.00	3.00	5.80	*6.00	6.00	*0.00	RETAINED
250	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
251	5.60	6.00	7.00	3.00	5.60	*6.00	6.00	*0.00	RETAINED
252	5.40	6.00	6.00	2.00	5.80	*6.00	6.00	*0.00	RETAINED
				Clinical Application					
253	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
254	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
255	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
256	5.40	6.00	6.00	2.00	5.80	*6.00	7.00	2.00	
257	5.20	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
258	5.20	6.00	6.00	2.00	5.80	*6.00	6.00	*0.00	RETAINED
259	5.00	5.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
260	5.20	6.00	6.00	2.00	5.60	*6.00	6.00	*1.00	RETAINED
261	4.80	5.00	6.00	2.00	5.40	*6.00	6.00	2.00	
262	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	2.00	
263	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
264	5.20	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
265	5.40	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
266	5.60	6.00	7.00	3.00	5.60	*6.00	6.00	*1.00	RETAINED
267	4.80	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
268	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
269	5.00	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
270	5.40	6.00	7.00	3.00	5.60	*6.00	6.00	*1.00	RETAINED
271	5.20	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
272	5.40	6.00	6.00	2.00	5.60	*6.00	6.00	*1.00	RETAINED

Table 4.6 displays the power-related questions. There was a total of 72 power questions. The first section was the self-assessment portion which contained 32 questions; 25 were retained and seven were not. Question number 202 from the CCCS-R was reversed scored. Question numbers 216 and 217 were reversed scored. Two questions, number 220 and 225, were worded with asking the person to rate if they have a "strong ability." Question number 229 from the MCI

scale was aimed at case conceptualization. Of the 20 multicultural knowledge-based questions, 16 were retained and four were not. Question 241 asked for "truth" about power dynamics was not retained. Three questions aimed at defining power and power over structures, numbers 243, 245, and 248, were not retained. Of the 20 clinical application questions, 17 were retained and three were not. One question, number 256, was reversed scored.

Table 4.7

Survey Results: Privilege Question Sets

	Descriptive statistics results for Delphi Survey 1				Descriptive statistics results for Revised Delphi Survey				
Question	Mean	Median	Mode	IQR	Mean	Median	Mode	IQR	Result
				Self-Assessment					
273	6.00	7.00	7.00	1.00	6.60	*7.00	7.00	*1.00	RETAINED
274	6.60	7.00	7.00	1.00	6.60	*7.00	7.00	*1.00	RETAINED
275	5.00	6.00	6.00	1.00	5.40	*6.00	6.00	*0.00	RETAINED
276	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
277	4.40	6.00	7.00	6.00	5.40	*6.00	6.00	*1.00	RETAINED
278	6.40	6.00	6.00	1.00	6.60	*7.00	7.00	*1.00	RETAINED
279	6.60	7.00	7.00	1.00	6.60	*7.00	7.00	*1.00	RETAINED
280	6.00	6.00	6.00	1.00	6.60	*7.00	7.00	*1.00	RETAINED
281	6.20	6.00	6.00	1.00	6.40	*6.00	6.00	*1.00	RETAINED
282	6.00	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
283	5.80	6.00	6.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
284	4.60	6.00	6.00	3.00	5.60	*6.00	6.00	*0.00	RETAINED
285	4.40	4.00	6.00	2.00	4.80	*6.00	6.00	2.00	
286	4.40	4.00	6.00	2.00	4.80	*6.00	6.00	2.00	
287	5.40	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
288	5.00	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
289	4.20	5.00		4.00	5.40	*6.00	6.00	*0.00	RETAINED
290	5.80	6.00	6.00	1.00	6.00	*6.00	6.00	*0.00	RETAINED
291	5.00	6.00	7.00	3.00	5.40	*6.00	6.00	*1.00	RETAINED
292	5.80	6.00	6.00	0.00	6.20	*6.00	6.00	*0.00	RETAINED
293	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED

Multicultural Knowledge

294	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
295	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
296	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
297	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
298	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
299	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
300	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
301	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
302	5.60	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
303	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
304	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
305	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
306	5.80	6.00	6.00	0.00	5.40	*6.00	6.00	2.00	
307	5.40	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
308	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
309	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
310	5.60	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
311	5.80	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED
312	5.60	6.00	6.00	1.00	5.40	*6.00	6.00	2.00	

Clinical Application

313	5.40	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
314	5.20	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
315	5.20	6.00	6.00	2.00	5.60	*6.00	6.00	*0.00	RETAINED
316	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
317	5.60	6.00	6.00	1.00	5.80	*6.00	6.00	*0.00	RETAINED
318	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
319	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
320	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
321	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
322	5.80	6.00	6.00	0.00	5.80	*6.00	6.00	*0.00	RETAINED
323	5.80	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
324	5.60	6.00	6.00	0.00	5.60	*6.00	6.00	*0.00	RETAINED
325	5.80	6.00	6.00	0.00	5.40	*6.00	6.00	2.00	
326	5.40	6.00	6.00	1.00	5.60	*6.00	6.00	*0.00	RETAINED
327	5.60	6.00	6.00	0.00	5.40	*6.00	6.00	*1.00	RETAINED
328	5.20	6.00	6.00	2.00	5.20	*6.00	6.00	2.00	
329	5.20	5.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED
330	5.40	6.00	6.00	2.00	5.20	5.00	4.00	2.00	

331	5.20	6.00	6.00	2.00	5.40	*6.00	6.00	*1.00	RETAINED
332	5.40	6.00	6.00	1.00	5.40	*6.00	6.00	*1.00	RETAINED

Table 4.7 illustrates the 60 original questions focused on privilege. There are 21 self-assessment questions; 18 were retained and three were not. The three questions that were not retained, numbers 285, 286, and 287, came from the MAKSS questionnaire. One question, number 285, is worded in such a way that assumes that ethnic minority students do not receive a quality education, whereas White students do. The second question, number 286, alludes to males achieving more in school than females. The third question, number 287, asks about other countries and how immigrant families are treated in those countries compared to the U.S. The multicultural knowledge section contains 19 questions, of which 17 were retained and two were not. Both questions, number 306 and 312, asked about the definition of privilege. Lastly, there were 20 clinical application vignettes, of which 17 were retained and three were not.

The Delphi survey was divided into five different domains: diversity, equity, inclusion, power, and privilege. Each domain was then subdivided into three sections representing the three domains attitudes self-report, multicultural knowledge questions, and clinical application vignettes aimed at capturing clinical application. The cumulative results for the three domains were as follows: Self-assessment questions contained 129 questions, 78% were retained, and 22% were not retained. Multicultural knowledge-based questions aimed at capturing an individual's knowledge base of DEIPP, 67% were retained and 33% were not retained. Of the clinical application questions, 84% were retained and 16% were not retained. The cumulative results for the five DEIPP constructs were as follows: There were 76 diversity-related questions, 63% of the total questions were retained. There were 60 equity questions, of which 76% were retained. Of the 59 inclusion questions, 79% were retained, while 80% of the 72 power questions were retained. Lastly, the privilege questions yielded the highest percentage of retained items at

86%. The initial survey contained 332 questions, and after two rounds of Delphi surveys, 253 questions were retained. See Appendix A for a listing of all the initial survey questions. Survey questions not retained are indicated with a strike through the text.

CHAPTER V: DISCUSSION

The first resistance to social change is to say it's not necessary.

—Gloria Steinem (2003)

Overview

This chapter provides an overall summary of the current study. The results will be discussed, along with implications and recommendations for future studies to further the understanding and implications of the continued development of a competency-based measurement tool for DEIPP competencies. This research study was designed based on the idea that student competencies in diversity-related topics should go beyond self-report measures. MFT is a competency-driven field that favors outcome-based education. Yet, there is no universal measure for DEIPP and no competency-based standard, leaving training programs to establish their own ways to measure DEIPP competencies. This research aimed to fill a research gap and the charge from the field (COAMFTE and AAMFT) to graduate competent training clinicians and to assess effectiveness in antiracist practices (Todd, 2020). MFTs have a systems perspective, which helps us not only view systems of oppression but also allows us to acknowledge the MFT field's own systemic history of oppression and offer ways in which training programs can evaluate their students' DEIPP competencies as it relates to their work with clients. With topics such as DEIPP competencies, consciousness-raising of training clinicians has to be tackled from several different angles. A current challenge is that few measures assess clinicians on more than self and observer reports. To date, there is no comprehensive measure that relies on attitudes self-report, multicultural knowledge questions, and clinical application vignettes of DEIPP constructs.

This study focused on the initial phase of developing a DEIPP measurement that intends to assist in identifying areas of growth when utilized as a standardized evaluation. This study utilized the Delphi method. The Delphi method is used for achieving consensus where previously none existed (Keeney et al., 2006), and in this case, experts came to consensus on which of the questions in the DEIPP competency tool best measure the concepts. Linstone and Turoff (1975) suggested that the Delphi method be applied to both curriculum and measurement development. The results indicated a final consensus on item retention, and these reduced sets of questions will be the base for future research and measurement development.

Although self-report items were generated from existing measures and modified to reflect the MFT field, the remaining two sections of the assessment, including both the multicultural knowledge (multiple choice questions) and clinical application questions (vignettes), were guided by Feminist Family Theory (FFT) and Critical Race Theory (CRT). The present research aimed to take the first step toward designing an instrument to measure DEIPP competencies through obtaining content validity for each item question.

Feminist research is dedicated to questioning whose interests are served when asking research questions (Chan & Ma Ma, 2006). The feminist family therapy approach focuses not only on patriarchy but on how social contexts such as cultural, political, individual, and familial experiences influence the behaviors and development of both people and institutions. This epistemological stance guided the generation of the initial questions aimed at capturing DEIPP competencies. FFT aided in identifying the gaps in the literature around student learning competencies related to DEIPP. CRT is the practice of investigating the role of race and racism in academia and provided “the how” for determining how to address the gap once it was found. CRT guided the idea of creating a competency measure. CRT requires the acknowledgement of

institutionalized racism and how racism is perpetuated through social construction. Because CRT is an action verb, this call-to-action states, “CRT observes that scholarship that ignores race is not demonstrating ‘neutrality’ but adhering to the existing racial hierarchy” (George, 2021, Principles of the CRT Practice, para. 2). FFT is similar in nature to CRT in that it is politically positioned within the cultural context as a method of empowerment for those seeking treatment. FFT makes a call for action through the commitment to social change with the recognition of all types of change. These guiding theories pushed and guided this research because both FFT and CRT are theories that call for action as not having a DEIPP measure is a racist practice and hurts students, clinicians, and their clients.

Summary of Findings

Responses were collected from participants who self-identified as experts and who met three out of the five expert criteria. Utilizing CRT and FFT, the item questions and domain definitions were created through various means, such as modifying existing DEIPP self-report measures, questions asked in chapter summaries throughout the existing literature (Adams et al., 2016; Adams et al., 2010; Arredondo, 2019; Erford et al., 2015; Harnois, 2013; Hays, 2001; Kelly, 2017; Kundson-Martin et al., 2015; Sperry, 2007; Taylor, 2014), and items generated by this researcher as informed by the literature. Domains were determined a priori (Linstone et al., 2002) through the established theoretical framework of CRT and FFT. A priori is a method for item generation where the theoretical framework influences and guides the literature review. The literature review accounted for the item generation portion of scale development, domain identification, and item generation. The literature review showed that the MFT/CFT field is competency driven. The national organization for MFT professionals, AAMFT, and training programs accreditation body, COAMFTE, have all pushed for the

importance of the inclusion of DEIPP-related competencies in training programs and have made efforts to regulate DEIPP competencies in training programs. Despite the talk about DEIPP competency's importance, there remains a gap between what is being asked and what is implemented in training programs. This gap of not having a competency measure for training clinicians to assess effectiveness in antiracist practices was understood and conceptualized through FFT and CRT frameworks.

Implementing a standardized measure can be seen as equalizing power over structures by graduating training clinicians with an adequate understanding of DEIPP-related competencies. Through the FFT lens, graduating DEIPP competent therapists directly addresses justice and moves towards equalizing power over structures (Goodrich et al., 1991). By implementing a standardized measure, the MFT/CFT field can directly address its own system of power inadequacies. By doing so, there is a potential for immediate results to manifest in the clinical system with clients.

The results reflected what the current literature suggests: self-assessment-based questions (Aponte & Kissil, 2016) and clinical vignettes (Lawton et al., 2010; Peabody et al., 2004) are favored. The self-report and vignette-based items were retained more often than the knowledge-based multiple choice questions. These findings make sense because these question types are more broadly used for training clinicians (Nelson et al., 2007; Perosa & Perosa, 2010). The results indicated that 78% of the self-assessment questions and 84% of the clinical application results were retained, while only 67% of the multicultural knowledge-based questions were retained. There seems to be an overwhelming acceptance of self-assessment and vignette-based assessments and an underrepresentation in the literature for knowledge-based assessments. It is unclear why the multicultural knowledge-based section would be less favored,

but it is important to acknowledge that participants favored open-ended questions over multiple choice questions. One hypothesis is that multicultural knowledge-based questions related to DEIPP competencies may be less used and preferred by training programs. Gillem and colleagues (2016) infer that the addition of knowledge-based questions is imperative, albeit less favored, because there is a lack of evidence-based standardized measures. Another possibility is that the item questions generated may not have been the right questions to ask to capture the nuances of DEIPP competencies.

There were connections between the item questions that were not retained. Thirty percent of the overall questions that were not retained came from the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 1996). The MCKAS (Ponterotto et al., 1996) assessment domain is consistent with the counselor's ability to be aware of their individual biases (Lu, 2017). Many of the items that this group of experts did not retain were the questions related to referring clients to other therapists based on their identity and questions directed at asking if the mental health practitioner considers themselves "highly knowledgeable" in various ways. Ponterotto et al. (2002) discussed the discrepancy with the initial validation of the MCKAS (Ponterotto et al., 1996) in that training clinicians were not a part of the original sampling of participants. It makes sense that questions such as "do you consider yourself as highly knowledgeable in" might have been disregarded in the present study because the current aim is to capture the attitudes, knowledge, and application of training clinicians, who may not be at the level of "highly knowledgeable."

A significant portion, 25%, of the questions not retained aimed to capture training clinicians' ability to define bias, culture, cultural identity, discrimination, diversity, ethnicity, health disparities, inculturation, implicit racial bias, microaggressions, minority,

multiculturalism, privilege, race, race equality, racism, and social class. One expert participant expressed their distaste for definition-based questions that inferred there was a right and wrong answer. The post-modern approaches to therapy suggest more collaborative and introspective epistemologies and often stray away from the assumption of absolute truth. Lastly, all reversed-scored questions were not retained by the group.

The Delphi method was helpful in reaching a consensus on item questions because it helped to clarify if the definitions accurately defined the DEIPP constructs and if the item questions generated were accurately assessed for the DEIPP constructs. The Delphi method facilitated opinions and anonymous interactions among the group experts, and these controlled interactions led to a level of consensus about the DEIPP constructs and items generated. This method enabled discourse between experts without needing to meet in person (Stone Fish & Busby, 1996), which happened through the controlled feedback process.

Social Justice and Clinical Implications

This study is important because it transcends beyond the training clinician and translates into the therapy room with clients. This study is also important to the field because it has the potential to add to the vault of MFT-born measures, one that includes a more comprehensive look at how clinicians apply DEIPP competencies. The future of this tool has the potential to not just be used in MFT training programs, but it will also prompt growth in other behavioral health disciplines. The major contribution of this research is to further MFT/CFT training and learning outcomes. It is a significant development in recognizing the gap between what topics are privileged in training programs, which often emphasize and highlight white theories and western narratives around mental health and wellness. MFTs have been seen as a radical group doing radical things in therapy, and as such, moving towards doing radical things in our teaching and

educational standards via social justice remains the consistent aim of the field. The research findings will be an addition to the existing works of literature claims, which suggest that training programs need to spend time being up to date with current political rhetoric (Nelson & Smock, 2005) and the need for valid measures for learning outcomes (Lyness, 2020). As a field we have a duty to implement equitable competency standards for both the training clinicians and the clients served.

This research will provide a framework for deepening the epistemology and theories of MFT teaching and learning through an action-oriented lens of competency-based learning outcomes. A significant implication of this project is to contribute to very limited research of furthering competency-based learning. There was some important anecdotal information that I gleaned from the project that implied interest and need. Despite the difficulties in recruitment, I received several emails from experts stating that they could not commit to the time restraints of the study but that this research was compelling and needed. Nine potential participants responded to the initial call for participants. They stated that they scanned the survey, were proud of the research's direction, and asked me to send them the dissertation once completed because they were excited to read the results. Two published authors in the field responded, stating that they could not participate because of time restraints, but wrote, "This is exactly what the field needs."

The results and findings are understood and interpreted through a social justice action-oriented lens. This research can promote awareness of growth areas in DEIPP competencies for training clinicians, which, if implemented, can impact the clinical settings because clinicians are aware of their growth. When clinicians make efforts to grow in their DEIPP competencies, that can lead to clients feeling supported in therapy. This study's results retained a significant portion of the questions, and this retention suggests a consensus from

experts on the importance of such a measurement tool. These findings are hopeful because they can potentially provide an avenue for programs to assess clinicians in training more comprehensively. As marriage and family therapists, we must elevate our expectations for training programs and their training clinicians.

Limitations

As is common in research, limitations exist. One barrier for this project was expert participation. Experts are often busy conducting the professional lives that make them experts. Because of the nature of a Delphi study, professionals in the MFT/CFT field were contacted to participate in the study. All of the potential participants were full-time university faculty, practicing clinicians, scholars, or a mixture. Many MFT/CFT faculty were not in the office; out-of-office responses were received to 32 recruitment emails. Some potential participants responded to the initial call for participants stating that they were already stretched for time and could not participate. Eighteen of the potential participants stated they could not participate because they could not take on more tasks on top of their already heavy load at their universities. Another barrier to recruitment was the time that was expected of participants. There were two surveys, and each survey took two hours to complete.

Another limitation of the study is simply the nature of a Delphi study. Delphi studies do not produce a dichotomous, right or a wrong answer, and a group consensus does not necessarily mean that the outcome is correct (Linstone & Turoff, 2002). It is difficult to know if the same results could be replicated with a different group of experts. The data collected was from experts who may not end up fully representing the field. A Delphi study as a whole lacks strict methodology. For instance, Vogel and colleagues' (2019) study in epidemiology stated that the correct sample size for a Delphi study should be 12. In contrast, several Delphi studies in the

MFT field (Doerries & Foster, 2005; Stone Fish & Busby, 2005) suggest a sample size between five and seven. There is no agreed-upon standard. Because the sample size was limited to five experts, more voices might have brought forth different items from the surveys.

Another limitation is that the Delphi technique was slow (Linstone & Turoff, 2022), and the data collection process took a total of 11 weeks between the two surveys. Because of this, there is a potential that the experts can become disconnected from the Delphi survey and may have difficulty connecting to their initial responses. One of the Delphi technique's strengths is anonymity because it offers a space to compare your answers to the group without feeling pressure to give into the group. Anonymity can also be seen as a limitation of this study because there is less ownership for the responses provided by each participant (Iqbal & Pipon-Young, 2009).

Because of the sampling techniques used, such as snowball sampling and searching the experts referenced in the literature review as well as COAMFTE's website, diversity within the sampling is a slight limitation of the study. Another limitation of the study is that little literature was found that comprehensively explores MFT clinical training clinicians' DIEPP competencies, which may have resulted in potential gaps missed during the initial instrument development phase. Responder fatigue could also be viewed as a limitation of the study because this researcher was transparent from the beginning that participants should expect to spend a significant amount of time completing the survey. These limitations indicate the hopeful nature of research that more progress can be made in the MFT field and investigate future research directions.

Future Direction

Scale development of the DEIPP competency measure was modeled after Boateng and colleagues (2018) published work on best practices for developing and validating scales for health, social, and behavioral research. The authors postulated that there are three phases to developing a measurement tool. The first phase is the item and domain development phase which aims to ultimately obtain content validity. The second phase is the scale development phase, which consists of pre-testing of questions, survey administration, item reduction, and extraction of factors. Phase three is scale evaluation, which includes dimensionality, reliability, and validity tests. This study fulfilled all the steps in phase one, item development. A series of questions were obtained and created to measure DEIPP competencies in three domains: attitudes self-report, multicultural knowledge questions, and clinical application vignettes. Five experts in the MFT/CFT field participated in two Delphi surveys to reach a consensus on which items captured DEIPP domains and competencies. Through future research and further scale development, this measure can be used to evaluate the impact of specific training within training programs and to see training clinicians' growth over time. Over time, the measure has the potential to be refined using the second and third phases of scale development which are the scale development phase and the scale evaluation phase (Boateng et al., 2018). Ultimately, the goal is to have a final psychometrically sound measure that will tri-dimentionally evaluate clinicians' DEIPP competency. The measure is intended to be used in MFT/CFT training programs as a demonstration of implementing competency-based measures and learning for more than just theories. Viewing aggregated results has the potential to be impactful and insightful.

Because this is the beginning phase of scale development, the current research opens doors to many possibilities for future research. The next steps in this research are to continue

with the subsequent two phases in scale development and to ultimately create a psychometrically sound measurement tool that will tri-dimensionally assess if what clinicians know about DEIPP is what they believe they know and if they are implementing what they believe and know in a competent manner. This research can be applied within training programs as a consideration for improving training of clinicians, with a growth mindset. This measure, once complete, has the potential to foster interpersonal growth for clinicians. A tenet of DEIPP competency-driven tools is that training clinicians would have an avenue to identify areas of growth and development to become more culturally competent with their training experience. With the potential for a standardized measurement tool, the field has the opportunity to converge with the aim of graduating accomplished DEIPP-competent therapists. As a field, we have been suppressing practitioners and clients through our educational practices by remaining stagnant in our competency-based standards. There is a potential for harm because as a field, we are not evaluating if what we think we know as therapists can be clinically applied in competent practice. This awareness has the potential of a trickle-down effect on the clients that are served.

Readers can use this information to determine if there are other ways to incorporate more than self-assessments to measure DEIPP competencies when assessing training clinicians. Future directions might include acknowledging that there are other ways to measure DEIPP constructs beyond the three domains identified in this study. The results indicated that experts agreed to retain the self-assessments and the multicultural knowledge-based and application-based vignette questions. Ultimately, the future direction of this research is to facilitate efforts in future work toward action-oriented social justice in clinical training programs and competency measures and for professionals in the field to duplicate this study with more experts to see if the results are consistent.

Conclusion

For the MFT field to thrive, we must continue to work toward implementing changes that support marginalized populations. The current study answers the call to action from Tracy Todd in his message titled, “Conversations Must Lead to Action” in *Family Therapy Magazine* (Todd, 2020, p. 3). He suggested the next steps for antiracist research include “assessing effectiveness, areas of compliance and noncompliance, and areas within the policies and procedures needing more attention” (p. 3). Though this research is still in its infancy, and the present research endeavored to complete just the item development phase, the future of this measure is that it can be utilized to assess if our efforts in training DEIPP competent clinicians are effective. This study gives value to the field by providing a path towards consciousness-raising for clinicians in training; and actively valuing DEIPP-related competencies. This is a continuation of MFTs ethical duty to be trained in DEIPP competencies. Education in clinical programs is not just for the therapists in training, but for also for the clients served. This study is one way to change and influence the rhetoric of academic echo chambers of being a place where training clinicians only encounter education that reinforce their own personal narratives and lived experiences. MFT training programs have a unique opportunity to amplify and reinforce social justice, the verb.

MFT training programs have been tasked with demonstrating student learning outcomes as part of maintaining program accreditation. In lieu of a universal, standardized measure, programs demonstrate student learning outcomes in numerous ways. The most common way is through self-report measures, which some research suggests may not be enough. Though this measurement tool is in its infancy, ultimately, though work continues, the potential of a

measurement tool could be utilized as a measure that goes beyond self-report and can provide a deeper insight into the therapist's DEIPP competencies.

There have been calls for action in the field. This study is novel because it endeavors to fill the gap by developing a measure to assess training clinicians' DEIPP competencies tri-dimensionally according to attitudes, multicultural knowledge, and clinical application. Sue and colleagues (1982) provided a cognitive development framework for measuring student learning outcomes. These outcomes were more specifically measured through students' attitudes and judgments about the self.

This study will contribute to the MFT/CFT field by promoting action oriented social justice practices in MFT training programs. I hope these findings inspire further research into identifying best practices for student learning outcomes. Because, after all, "Education is the practice of freedom" (hooks, 1994).

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APPENDIX A: DEFINING DEIPP CONSTRUCTS

1. Diversity is defined as the embodiment of the difference between groups present in families, communities, and institutions that are categorical in nature (Frisby & O'Donohue, 2018) regarding age, class, sex, sexual orientation, disability, education, race, ect.
2. Equity is defined as acknowledgment and awareness of the historical inequalities and disparities of the culturally diverse that result in a disregard of unbalanced and unequal opportunities to all groups of people (Adams et al., 2016): by affirming and eliminating barriers that prevent or make it difficult for some groups of people to participate in personal well-being.
3. Inclusion denotes social categories and individuals' interdiscursive history as part of the shared cultural world where difference is respected and valued (Adams et al., 2016). Inclusion is the act of having social and personal entities structured in a way that all personhood is seen, voices are heard and valued, with the power to make changes to shape policies and institutions (Frisby & O'Donohue, 2018).
4. Power is the ability to shape relationships and the ability to influence the social world. Power also has the opportunity to exercises the oppression of others and regulates “In whose interest systems operate” (Adams, Bell, & Griffin, 2016, p. 18). Power is exercised by control over others and deciding what is best for them by implementing policies that define who will or will not have access to resources.
5. Privilege is defined as an unearned advantage with access to resources based on identification and membership to a dominant social group.

APPENDIX B: DIVERSITY QUESTION SET

Self-Report, Questions 6-41

Table A.1

Diversity Self-Report Questions

Measure	Original Item Number	DEIPP Item Number
Multicultural Counseling Inventory (MCI) Sodowsky, 1996	4	*36*
	6	*37*
	13	*38*
	14	39, *40*
	17	*41*
Cross-Cultural Counseling Inventory (CCCI) LaFromboise, 1991	4	6
	5	7
	18	*8*
	17	*9*
Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) D'Andrea et al., 1991	10	18
	21	19, 22, *23, *24, *25, *28, *29, *30
	22	20
	23	21
	25	*26
	27	*27
	30	*31
	32	32
	38	33
	39	*34
	45	*35
Multicultural Counseling Awareness Scale (MCAS) Ponterotto et al., 1996	12	*10
	15	11
	21	12
	24	*13
	26	14
	27	*15
	29	*16
	44	*17

* Indicates the item was retained

Multicultural Knowledge

42. What is the most accurate definition of a stereotype?
~~43. What is the most accurate definition of culture?~~
~~44. Traits such as being highly competitive and achievement oriented are goals that all clients should aim for in their therapeutic work.~~
45. Which answer best describes implicit racial bias.
46. Cross-cultural therapy (NCE practice test question 8):
~~47. Which of the following is true about therapy within a cultural context (NCE practice test question 10)?~~
~~48. Which of the following factors would come under the term of "diversity" (Upton & Taylor, 2014, question 1)?~~
~~49. Which of the following lists contains an item that would not be used to define social class (Upton & Taylor, 2014, question 6)?~~
50. ~~Omitted for copyright~~
51. Omitted for copyright
~~52. Omitted for copyright~~
~~53. Omitted for copyright~~
~~54. Omitted for copyright~~
~~55. Omitted for copyright~~
~~56. Omitted for copyright~~
57. Omitted for copyright
~~58. Omitted for copyright~~
59. Omitted for copyright
60. Omitted for copyright
61. What is the role culture plays in the treatment process, both generally and with reference to specific cultural groups (Center for Substance Abuse Treatment, 2006, pg. 27)?

Clinical Application

62. D and Z are a biracial couple who present for couples therapy with complaints that D's family doesn't accept Z. This has caused a lot of contention in their marriage. As the therapist, what best reflects your assumptions?
63. A new family presented to their first therapy session with you. This family is comprised of a young mom and her two daughters, a 9 and 12-year-old. The family seemed to display what you know to be enmeshment. During your genogram interview, the family reported that they all had "great relationships with each other" and stated that they were comfortable with the amount of closeness. What thoughts might you have about how to proceed with this family?
64. You received a referral for an individual client seeking services for her feelings of depression. During the intake interview, you find out that the client was born and raised in a culture and country where mental health has historically had high prejudice and stigma. You assume that therapy might be complex because the client might have difficulty opening up about their struggles because of their upbringing.
65. You have seen a high school student for individual therapy who has a high trauma history related to their sexual and gender identity. You keep hearing the client's stories of instances of low self-esteem and feelings of not good enough. Recently, they said, "I tell people at school that I'm straight." As the therapist, what might you be concerned about for this client?

66. You received a phone call from a client seeking therapeutic services to elevate their experience and symptoms of depression. On the day of their appointment, you were about to mark them as a no-show when you received a phone call from them stating that your office wasn't wheelchair accessible, and they couldn't make it into your office. What would be the next steps you take?
67. After several sessions with the same client, you noticed that they rode their bike to the appointment for the first time, and they seemed extremely exhausted. After further investigation, you find out that they live 20 miles from your office and have no other forms of transportation and that coming to appointments with you is at a great cost to them. The client stated that you were the therapist recommended to them by a friend and that they were unaware of other therapists in the area but would have gone to a different therapist if there was one in closer proximity. What would be the next steps you take?
68. You have worked hard to advertise yourself as a highly trained and competent therapist specializing in faith-based therapy. You received a phone call from an individual who states that they are seeking treatment because they have recently left their religion and are struggling with feelings of isolation. When the client showed up to their appointment, you had difficulty engaging with them, and you could sense that there was a conflict between how you viewed the problem-saturated story differently than they were. You start to think that perhaps you might not be the best fit for this client. What would be the next steps you take?
69. Living in a major metropolitan area, you have a lot of experience working with diverse communities different from your own. You have been working with a hard-of-hearing client and require a sign language interpreter during the session. You sense that there are times in which the client feels that they have to teach you about deaf culture and that there are times where having an interpreter leaves both of you feeling disconnected. What would be your next steps?
70. You have worked hard to advertise yourself as a highly trained and competent therapist specializing in trauma. You received a phone call from an individual who is the survivor of a violent hate crime. When the client showed up to their appointment, you had difficulty connecting with them, and you could sense that they felt uncomfortable. Partway through the session, they stated that you couldn't be their therapist because you looked and sounded like the person who assaulted them. What would be the next steps you take?
71. During a therapy session with a child, they state that they are sad and scared all the time because of their immigrant status and how their culture is portrayed in the media. What is a good first step in talking about diversity and intersectionality with this client?
72. Living in a major metropolitan area, you have a lot of experience working with diverse communities different from your own. You have been working with a client who speaks a different language than you and require an interpreter during the sessions. After speaking with the client, you find out that they feel that the use of an interpreter leaves them feeling disconnected. What would be your next steps?
73. You have a family who are seeking services because their eleven-year-old child is "always pushing back on rules," and they are hoping you can "fix" them. After four sessions, you observe that the parents repeatedly edit their child's reality and judgments by saying their experiences are wrong. The parents talk over their child and often use phrases like, "boys behave this way" or "boys should like sports." During your last

session, you asked the child what they think it means to be a boy, and their response was, “I'm not a boy, and my parents won't listen to me.”

74. You have been seeing a couple in therapy for several weeks, working on their sexual and intimacy issues. Partner A states that they want to have an open relationship during a session. What is likely to be a direction you might take with this new information?
75. In your private practice, you offer two pro bono slots per week for clients that cannot afford therapy otherwise. You have one pro bono slot available and receive two voicemails from prospective clients looking to fill your pro bono slot. How would you make the decision as to who gets the space?
76. In your private practice, you offer a few pro bono slots per week for clients that cannot afford your private pay cost since you do not take insurance. You have one pro bono slot available and receive two voicemails from prospective clients looking to fill your pro bono slot. How would you make the decision as to who gets the space? The first client is still living at home and has their family support but does not bring in any money themselves. The second client is a single parent living under the poverty line with no resources.
77. You have a client who has overcome many challenges and obstacles in their life, despite being only 18 years old. They say that people often say, “Wow, you are so mature for your age.” Or others try to minimize what they went through because, “Kids are resilient.” They talk a lot about how it feels so condescending when people talk that way to them. What might these comments have demonstrated to them?
~~78. You have a client who is the only person in their social circle who has not received a college education. They say that when they are out with their friends, they often assume that they can't pay their share of the bill when they are out. Recently they have noticed that their friends will start to explain things that they never asked to be explained. What might these comments from friends have demonstrated to them?~~
~~79. You have a client who relayed a story to you about their experience of growing up biracial in their family. They stated that their grandfather loved them and always wanted them around, and at the same time, they had nicknames that felt like a mockery of their race and cultural background based on a stereotype that grandpa had. This mockery and stereotyping from grandpa is an example of what.~~
~~80. As a therapist working at a domestic violence shelter, you hear of experiences of abuse every day. When clients present to the session, you feel that it is your job to __.~~
~~81. One of your clients often struggles with a lack of motivation, goals, hopes, and dreams for their life. Part of wellness is ____.~~

APPENDIX C: EQUITY QUESTION SET

Self-Assessment, Questions 82-101

Table A.2

Equity Self-Report Questions

Measure	Original Item Number	DEIPP Item Number
Multicultural Counseling Inventory (MCI) Sodowsky, 1996	23	*100
	27	*101
Cross-Cultural Counseling Inventory (CCCI) LaFromboise, 1991	19	*82
	20	*83
	6	*84
	9	*85
Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) D'Andrea et al., 1991	5	*96
	4	*97
	40	*98
	47	*99
Multicultural Counseling Awareness Scale (MCAS) Ponterotto et al., 1996	2	*86
	9	*87
	13	*88
	14	*89
	25	*90
	28	91
	31	*92
	32	*93
	41	*94
	43	*95

* Indicates the item was retained

Multicultural Knowledge

~~102. Which answer best describes the definition of race.~~

~~103. Structural racism is:~~

~~104. According to the center for social justice, what are the four levels of racism?~~

~~105. Omitted for copyright~~

106. Which of the following obstacles is often encountered by school children who are living in poverty (Upton & Taylor, 2014, question 7).

~~107. Omitted for copyright~~

~~108. Omitted for copyright~~
109. Omitted for copyright
110. Omitted for copyright
111. Omitted for copyright
112. Omitted for copyright
~~113. Omitted for copyright~~
114. On a self-assessment you indicated that you feel uncomfortable working with clients who are sexual minorities. Your attitudes are biases are:
115. Why is it important to understand our biases?
116. Which is an examples of institutional barriers that affect my clients.
~~117. Omitted for copyright~~
~~118. The best path to creating and maintaining good mental health is:~~
119. What is the difference between equality and equity?
120. As the therapist what is the best way to talk about cultural differences in the therapy room?
121. As the therapist what is the best way to address systemic oppression in the therapy room?

Clinical Application

122. You have chosen a theory of therapy model that aligns with your personal world views and your theory of change. In the therapy room, the techniques from your therapy model makes you feel comfortable and competent. An individual presents to their seventh session feeling overwhelmed due to chronic and persistent political rhetoric that promotes shame and guilt related to your client's identity. The client expresses thoughts and feelings associated with depression and anxiety. Your client states, “why is my identity political?” You feel conflicted because going down this path with the client goes against your treatment plan, and this is a topic you are unsure how to navigate. What would be the sentence that best represents what you would say to your client?
123. Client I is seeking individual therapy because they are unhappy, which is a stark difference from how they typically experience themselves. They strongly identify as “a happy person.” Recently, the weight of consistent microaggressions that they face “everywhere they go” is heavy. What should you do as the therapist?
124. You are a busy clinician and work as an outpatient therapist at a hospital and are starting a private practice. You accept most insurances through the outpatient clinic but do not accept insurance at your private practice. A new client calls to make an appointment at your private practice who has insurance you take through the hospital. How do you navigate this situation?
125. You were contacted by a client seeking therapy to address their feelings of guilt and shame around their work as a superintendent for a local builder whose current work includes gentrifying the downtown area. As a white person growing up, they were told they could get out of poverty if they just worked hard enough. Despite being a person who grew up downtown, privately, they experience beliefs and shame around the poverty of their upbringing and feelings of disgust when faced with the poverty-stricken area. What might you notice about this client's experience of shame and disgust?
126. You were contacted by a client seeking therapy to address their feelings of guilt and shame around their work as a superintendent for a local builder whose current work includes gentrifying the downtown area. During the building planning meetings, there were comments of it being a “dicey neighborhood,” a “dangerous neighborhood,” with

"scary people ."As the one person of color on the project, they decided to stay quiet when these remarks were made, all while experiencing feelings of guilt about the work because of how the gentrification will affect and displace lower-income people of color. Their experience of stress has gotten to be so much that they thought about quitting their job.

~~127. You just graduated from grad school and procured a community mental health center job. You are excited about this new opportunity because you assume you will have a diverse caseload and will be able to interact with all mental health diagnoses. After several weeks you notice that the waitlists primarily consist of people of color, and most therapists' caseloads are overwhelmingly white. This is an example of what?~~

128. You live in a rural small town where there are few mental health professionals. The local police department contacted you to contract with them to provide fit-for-duties. Your most recent fit-for-duty was a young officer awaiting disciplinary action because of accusations of excessive force. During the appointment, you explored the officer's racial bias towards persons of color and their personal racial beliefs. The officer admitted that these beliefs affected their public interactions. This is an example of what?

129. A family that recently immigrated to the US presented to a therapy session with you because their youngest child's school insisted that the family receive therapy. The family reports that their nine-year-old has been experiencing difficulty at school with getting into fights with other kids, grades slipping, and truancy. During their first session, you notice that the family is reluctant to talk to you, and you notice that one parent seems to be demonstrating symptoms of paranoia.

130. You are a private practice clinician who, up until recently, only accepted private pay clients because you heard that insurance companies were too difficult to work with. You have lately felt that this is an inequitable practice because it sets up barriers for those who lack financial support. Which best describes this new thought process.

~~131. You are a private practice clinician who only accepts private pay clients because you heard that insurance companies were too difficult to work with. You have felt lucky because you just increased your hourly rate. Which best describes your thought process.~~

132. During post-graduate supervision, you tell your supervisor that there aren't any cases that you necessarily need help with. Rather, you are seeking help with some self of the therapist issues that are coming up. You have a couple system that you are struggling to work with because it is hard to connect with the female partner because she demands and expects a lot from the male partner. The female partner seemed to take up a lot of verbal and emotional space during the sessions while the male partner sat in silence. When reflecting on this couple with your supervisor, they ask you if this frustration is coming from wanting to reengage the male partner in session, and you said no. You said that it is just uncomfortable because you feel that he should hold the most power in the relationship as a man. What answer best makes sense of where the uncomfortable feeling may be coming from?

~~133. A therapist has been seeing a young, 16- year- old, heterosexual, transmasculine individual in therapy for the past three months. They have endeavored to strengthen the client's relationship with their family of origin during this time. But, the client has focused on building connections with people in their community for support. They have begun to feel like perhaps the client would be better served by a therapist who has similar views as the clients about family and support. What best describes how the therapist perceives the family unit?~~

~~134. A therapist has been in practice for fifteen years, and they pride themselves on their ability to emotionally dig deep with clients as a verbal processing master. They recently had an experience during a first session where the client wanted to work towards making active behavioral changes in their lives. This therapist felt like they were in a bind because their training and therapy theory were telling them to process verbally and explore attachments. Still, the client voiced dissatisfaction and asked again for help with behavioral modifications.~~

135. During a therapy session with a client, the client states that they feel worn down by the weight of taking care of their aging parents. They say that their culture has taught them that their responsibility is to care for their aging parents. Yet, because of the social structures in place, your client makes $0.60 on the dollar of white males and is struggling to take care of themselves and their parents. Which below best describes what is going on for your client.
136. As part of your clinical assessment with children, you have them engage in Kinetic family drawings. This is utilized as a way to begin talking about family dynamics and relationships within the family. During a Kenetic Family drawing with a nine-year-old Latinx male, you begin to hear stories of identity tangled with political rhetoric such as "I'm an alien." Which best describes your understanding of this child's identity development?
137. During a therapy session, a client states that they feel a lot of pressure to do well in college because they are a first-generation graduate in their family. They also said that they feel a lot of responsibility to complete college because many people in their community did not have the opportunity to go to college as well. What is something that you should address during this session?
138. A female client presents to their therapy session wanting to process through her experiences from the past week's job interviews. During the past week, they were turned down for six different positions. She noted that several instances of discrimination during her interviews ranging from interviewers asking if she will need to take a lot of time off to take care of her kids to seeing male interviewees leaving their interviews with praises of, "you will fit in nicely here, all the guys go out on Fridays." What is at the forefront of your mind as you facilitate the session?
139. A female client presents to their therapy session wanting to process through their experiences from the past week's job interviews. During the past week, she was turned down for six different positions. She noted that several instances of discrimination during her interviews ranging from interviewers asking if she will need to take a lot of time off to take care of her kids to seeing male interviewees leaving their interviews with praises of, "you will fit in nicely here, all the guys go out on Fridays." What are you aware of as you facilitate the session?
140. You have a colleague that has been a practicing MFT for the past fifteen years. During an impromptu consultation, your colleague states that they just raised their rates and stopped taking Medicaid (the highest insurance payer in your area) because they are "sick of having those people in sessions. I want clients who work hard." Your colleague then began to talk about how Medicaid clients don't have any buying-in for therapy because the services are free. What might you do or think as you are listening to this?
141. You have a colleague that has been a practicing MFT for the past fifteen years. During an impromptu consultation, your colleague states that they have a difficult time working

with the culturally diverse and that they like working with clients with a similar background as themselves. They say they are “sick of having crazy unrelatable people in sessions, and I want clients who work hard.” What might you do or think as you are listening to this?

APPENDIX D: INCLUSION QUESTION SET

Self-Assessment, Questions 142-161

Table A.3

Inclusion Self-Report Questions

Measure	Original Item Number	DEIPP Item Number
Multicultural Counseling Inventory (MCI) Sodowsky, 1996	20	*159
	30	*160
	31	*161
Cross-Cultural Counseling Inventory (CCCI) LaFromboise, 1991	16	*142
	2	*143
	13	*144
	11	145
	10	*146
	7	*147
Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) D'Andrea et al., 1991	1	150
	3	151
	15	152
	16	*153
	17	154
	19	*155
	41	*156
	49	*157
	50	*158
Multicultural Counseling Awareness Scale (MCAS) Ponterotto et al., 1996	19	*148
	40	*149

* Indicates the item was retained

Multicultural Knowledge

~~162. Omitted for copyright~~

~~163. Which of the following terms is consistent with the definition "integration is managed differently for different groups" (Upton & Taylor, 2014, question 3).~~

~~164. Which definition best fits your current understanding of the term ethnicity?~~

165. Omitted for copyright

~~166. Omitted for copyright~~

167. Omitted for copyright

168. Which of the below are options that can help foster behaviors of inclusion in your work as a therapist?
169. I can advocate for diverse perspectives by.
170. When reading about therapeutic techniques and models, what should you consider if you were being inclusion minded?
171. Omitted for copyright
172. Larger society forces inequality by restricting the voices of whom?
173. Which answer below best fits your understanding of sexuality?
174. Individuals belonging to minority groups often experience which of the following?
~~175. Discrimination is defined as.~~
176. The four types of discrimination are:
177. What is an example of positive discrimination?
178. Which of the following is needed to achieve gender equality?
179. What are challenges faced by same sex couples with adoption?
180. What are some potential barriers for undocumented immigrants for receiving equitable mental health care?

Clinical Application

181. You have seen F, a racial minority identifying with "culture Z," in therapy for several sessions. During your sessions together, you have focused on F's experience of anxiety and depression, and often, F states that "most of my extended family members feel this way too. There's just something wrong with my family". During the treatment process, F, recognized how they and their parents were historically victimized socially and politically. And past generations in their family were victimized as well. In recognizing this, they began to see their family in a different light. They began to see themself and familial struggles with mental health as something other than intrinsic pathology within themselves. As a result, this client asks you, as their therapist, if you could recommend a therapist that identifies as "culture Z." You find yourself thinking that if a white client asked only to see a white therapist, this would be seen as racist. Does this mean that F is racist too?
~~182. You have worked hard to advertise yourself as a highly trained and competent therapist specializing in trauma. You received a phone call from a parent making an appointment for their teen who had recently experienced a sexual assault. When the client showed up to their appointment, you had difficulty engaging with them, and you could sense that they felt uncomfortable. Partway through the session, they stated that you couldn't be their therapist because you looked and sounded like the person who assaulted them. They said that some of your mannerisms reminded them of their abuser as well. What would be the next steps you take?~~
183. In the second session with a heterosexual racial minority couple identifying as belonging to "culture Z," you turn to the female client and ask if they would like to set up another appointment with you next week. She turns to her husband, and he answers yes. You then proceed to set up an appointment with the male partner. After they leave, a colleague states that they identify as belonging to "culture Z" too and that it is considered respectful to speak directly to the male partner when making appointments for both of them. Using the above vignette, fill in the blank: Because _____.
184. Please fill in the blank: By attending CEU's, panels, webinars, and trainings that have more than just white, heteronormative, and cisgender voices, I am ____.

185. You attended an ethics CEU and have felt inspired by the lecturer to go back to your practice to identify blind spots and areas in which your biases are displayed in your practice. The first thing you explored was your intake paperwork and changed the demographics page from asking about gender in binary ways to including other gender identities. What does this change demonstrate?
186. You attended an ethics CEU and have felt inspired by the lecturer to go back to your practice to identify blind spots and areas in which your biases are displayed in your practice. As a result, you place flyers on the front desk where clients check-in, asking them to provide feedback on your practice so that you can implement client feedback. What does this change demonstrate?
187. A female-identifying client is seeking therapy because of her symptoms of depression that are fueled by her negative cognition of "not good enough." Upon further exploration of the belief of not being good enough, you ask her about times in which this story of hers has been reinforced by society and others in her life. She then retells stories about how "women should" be and do certain things and stories of how she is not living up to her role of being a woman. What is a thought you have that may help your client restorying the narrative about gender?
188. You have been seeing F in therapy for over a year. F initially was seeking therapy because they were feeling isolated and lonely since immigrating to this country. During your latest session, F states that they are no longer dreaming in their native language, and their internal thoughts are not in their native language as well. They also stated that their parents were upset because they didn't want to participate in a celebration of their country of origin because they were embarrassed about what the neighbors might think. What best describes what this client is going through?
189. A female client presented to their therapy session expressing frustration and fatigue from the way in which she is treated in society. Her family is from the Dominican Republic, and she is often asked about her race and culture by individuals asking, "what are you." What represents your present understanding of culture, given this current situation?
190. A female client presented to their therapy session expressing frustration and fatigue from the way in which she is treated in society. Her family is from the Dominican Republic, and she is often asked about her race and culture by individuals asking, "what are you." People also attribute her physical characteristics to her ethnicity. What represents your present understanding of culture and ethnicity?
191. A colleague of yours has just left their job in community mental health to begin their endeavors as a private practice clinician. They were nervous at first because they heard that it is difficult to build a caseload. To their surprise, they were fully booked after six months. They attribute this to the many different websites that they advertise on. One website that tends to pull in 80% of their caseload is from a well-recognized and respected therapeutic models' website where they took all their trainings. This is the method of therapy that they utilize during all of their therapy sessions "because it works for everyone!" What is something you notice about the vignette above?
192. A female-identifying client is seeking therapy because of her symptoms of depression that are fueled by her negative cognition of "not good enough." Upon further exploration of the belief of not being good enough, you ask her about times in which this story of hers has been reinforced by society and others in her life. She then talks about how "women should be" and "should do" certain things. And many stories of how she is not

living up to her role of being a woman. While exploring these narratives, the client became upset and said, “No, this is just the way it is in my culture, and my culture isn't the problem, it’s me.” In a therapy session with you, what might happen next?

193. You are a private practice clinician who is considered an expert in couples work because of your training through the ABC Institute. And this is the method of therapy that you utilize for the majority of your sessions. You've seen success with most of your clients, but through reading recent research, you realize that the majority of the clients that were studied with this method were white, middle-class heterosexual couples. You know that this does not represent the general population, so you cannot assume that this method will be effective with every couple. What this kind of thinking demonstrate?
194. At the end of the second session with a heterosexual racial minority couple identifying as belonging to “culture Z,” you turn to the female client and put your hand out to shake hands while saying it was nice to meet you and thank you for coming today. With a measure of hesitancy, she reaches out to shake your hand. You then turn to the male partner to do the same, but he is more receptive to your handshake. They then no-showed on their second appointment, and when you called the couple, they said they felt more comfortable seeing someone else. Without having more information on the subject, what is something that you could assume about the interaction?
195. As a clinician, you pride yourself on working well and effectively with couples. You are a heterosexual person in a monogamous relationship with your partner of fifteen years and tend to draw in couples of a similar background as yourself. During an initial therapy session with a new same sex couple, they state that they are in a polyamory relationship, and they are curious if you have experience working with couples in relationships similar to theirs. You are open about the couples that typically come to see you, and then you ask the couple if they would like to talk openly about their expectations and hopes for therapy. What does this type of interaction represent?
196. As a clinician, you spend a lot of time exploring your theory of therapy and your epistemology of change. Your theory of therapy is mainly developed around being a cheerleader who cheers their clients on. You also utilize metaphors in sessions as a way for clients to view their problem-saturated stories differently. One client seems to never connect with your metaphors and zones out. Aside from checking in with the client, what hypothesis might you have about this client?
197. As a clinician, you spend a lot of time exploring your theory of therapy and your epistemology of change. Your theory of therapy is mainly developed around attachment theory. You often use humor as a way to connect with clients. A parent has reached out to you because they seek attachment-based therapy between them and their six-year-old neurodivergent child. You are finding it difficult to assess their attachment because the child does not want to be touched by their parent, does not accept influence from them, and when you try to engage the child through laughter, it falls short. What assumption do you have about therapy with this client?
198. As a clinician, you spend a lot of time exploring your theory of therapy and your epistemology of change. Your theory of therapy is mainly developed around attachment theory. You often use humor as a way to connect with them. A parent has reached out to you because they seek attachment-based therapy between them and their six-year-old neurodivergent child. You are finding it difficult to assess their attachment because the child does not want to be touched by their parent, does not accept influence from them,

and when you try to engage the child through laughter, it falls short. Your assessment would suggest that the parent and child have an insufficient level of attachment. What assumption do you have about therapy with this client?

199. In the second session with a heterosexual racial minority couple identifying as belonging to "culture Z," you turn to the female client and ask if they would like to set up another appointment with you next week. She turns to her husband, and he answers yes. You then proceed to set up an appointment with the male partner. After they leave, a colleague states that they identify as "culture Z" and that it is considered respectful to speak directly to the male partner when making appointments for both of them. You addressed this during your next appointment with this couple. They affirmed that they found the encounter initially very disrespectful, and they both felt respected when you corrected the situation. In your opinion, what did you demonstrate in this interaction?

~~200. In the second session with a heterosexual racial minority couple identifying as belonging to "culture Z," you turn to the female client and ask if they would like to set up another appointment with you next week. She turns to her husband, and he answers yes. You then proceed to set up an appointment with the male partner. After they leave, a colleague states that they identify as "culture Z" and that it is considered respectful to speak directly to the male partner when making appointments for both of them. This leaves you feeling uneasy during the week because your work with clients is typically around toxic masculinity and elevating the female voice. During your next appointment, you address the toxic masculinity in the relationship to elevate the female voice. In your opinion, what did you demonstrate in this interaction?~~

APPENDIX E: POWER QUESTION SET

Self-Assessment Questions 201-232

Table A.4

Power Self-Report Questions

Measure	Original Item Number	DEIPP Item Number
Multicultural Counseling Inventory (MCI) Sodowsky, 1996	3	229
	5	*230
	9	*231
	38	*232
Cross-Cultural Counseling Inventory (CCCI) LaFromboise, 1991	8	*201
	14	202
Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) D'Andrea et al., 1991	2	*211
	7	*212
	4	*213
	11	*214
	12	215
	14	216
	18	217
	20	*218
	34	*219
	54	220, *221, *222
	55	*223
	56	*224
	57	225
	58	*226
	59	*227
	60	*228
Multicultural Counseling Awareness Scale (MCAS) Ponterotto et al., 1996	3	*203
	6	*204
	7	*205
	20	*206
	23	*207
	34	*208
	36	*209

45 *210

* Indicates the item was retained

Multicultural Knowledge

233. What are the four levels of racism?
234. What is the most accurate definition of a prejudice?
235. What is the most accurate definition of discrimination?
236. When a client does not discuss intimate aspects of their lives what is the best assumption I take as their therapist.
237. Omitted for copyright
238. Which of the following is the best definition of oppression (defined by Adam et al., 2016).
239. Which answer best completes the following statement, based on Adams, Bell, Goodman, and Joshi's published work? Social groups are sorted into a hierarchy that confers advantages, status, resources, access, and privilege.
240. According to Kundson-Martin, Wells, and Samman's (2015) SERT model, the reasons why power is so difficult to recognize is because of:
~~241. Omitted for copyright~~
242. The concept of boundaries in therapy includes which of the following clinical or ethical ideas(Sperry, 2007)?
~~243. _____ occur as a result of exploitation of clients, abuse of power, coercion, deception, or misrepresentation.~~
244. Any concurrent or sequential relationship between a therapist and client that is distinct from the therapeutic relationship can be defined as.
~~245. The therapist being in a position of privileged knower having expert knowledge contributes to the ____ in the therapeutic relationship.~~
246. Self-disclosure of details of the therapist's personal life or thoughts and feelings unrelated to the therapeutic need and for the primary benefit of the therapist is an example of.
247. Omitted for copyright
~~248. Omitted for copyright~~
249. Omitted for copyright
250. At the interpersonal level ____ is the process through which people are able to influence a relationship toward their "own goals, interests, and well-being" (Kelly 2017 pg. 155).
251. What is a good representation of power in a relationship (Kelly 2017 pg. 155)?
252. What is a good representation of power in a relationship (Kelly 2017 pg. 155)?

Clinical Application

253. You have seen E in therapy for eight sessions and feel that you have built a strong therapeutic alliance. At the beginning of your ninth session, you ask E how their week was and if there had been any changes in their expression of anger. They laugh and then begin to retell a story that made them feel proud. During the story's telling, they use derogatory, blatant, and explicit racial biases regarding their neighbor. How do you effectively deal with this situation as the therapist?
254. You are working for a child psychiatric hospital and over half of your caseload is children and adolescents experiencing gender dysphoria. Though this is not a diagnosis you have worked with before, you take on the clients, assuming that your models and theories will be sufficient for these youth. Your supervisor encourages you to attend

training dedicated to transgender and gender nonconforming health during supervision. What might you do in this situation?

255. You are working for a child psychiatric hospital and over half of your caseload is children and adolescents experiencing gender dysphoria. Though this is not a diagnosis you have worked with before, you take on the clients because no one in the area specializes in gender dysphoria, and these kids are in need of services. What might you realize through your work with this population?

~~256. You are a sex therapist who typically works with couples experiencing sexual difficulties, and occasionally, you work with victims of sexual abuse. During an initial therapy appointment, you experience difficulty because your client is staying very surface level and deflecting the conversation towards different topics, and you find yourself becoming continually frustrated. What is the most inaccurate assumption listed?~~

257. You're beginning to build a great reputation for working well with children in foster care and adoption through your work with clients. Professionals in the area often refer their foster and adoption families to you. Lately, you have been receiving referrals for non-traditional families such as single parents adopting children and same-sex couples who are fostering or adopting kids. What is the most harmful assumption listed?

258. You specialize in family therapy in your private practice. The J family is of undocumented status and is seeking therapy because the family as a whole is experiencing significant levels of stress that are impacting their overall wellbeing. The family is cautious about what they talk about in therapy, and it seems like there is an agreement amongst the family members that there are rules about what can and cannot be said in therapy. What is a hypothesis you might make about this family?

259. You specialize in family therapy in your private practice. The J family is of undocumented status and is seeking therapy because the family as a whole is experiencing significant levels of stress that are impacting their overall wellbeing. The family is cautious about what they talk about in therapy, and it seems like there is an agreement amongst the family members that there are rules about what can and cannot be said in therapy. You state, “I don't know how to help if I don't know what is going on with the family.” What does this demonstrate?

260. You specialize in family therapy in your private practice. The J family is of undocumented status and is seeking therapy because the family as a whole is experiencing significant levels of stress that are impacting their overall wellbeing. The family is cautious about what they talk about in therapy, and it seems like there is an agreement amongst the family members that there are rules about what can and cannot be said in therapy. You state, “you are free to talk about anything in therapy without any repercussions.” This is an example of?

~~261. You have been seeing A in therapy for the past several months regarding her experience of leaving an abusive relationship. During your appointment this week, you can tell that A is sad and that something is weighing on her. You ask her how her week was, and when you inquire about her low mood A states, “I just read a statistic that one in three black men will spend time in prison in their lifetime. I have three black sons; which one will it be?” This story from A is an example of what?~~

~~262. You have been seeing a family system for the past several weeks. The family initially presented to sessions stating that the identified patient was their twelve-year-old child, P, who “acts out and is defiant all the time.” The family stated that they need help “fixing”~~

~~their child. You respond with, "well, I wanted to thank P for being so dedicated to their family's wellness that they took on the responsibility of being the problem." Which of the following helps you make sense of this response?~~

263. As a new graduate, you are eager to build your practice. Your first client is a transmasculine individual who is seeking therapy as a way to heal their past trauma from their forced experience in conversion therapy. They ask you if you have experience with religious trauma and with helping clients through their social transition. You say, "yes, I have a lot of experience in this area, and it is my area of specialty." You say that because, during your internship, you saw clients who experienced childhood trauma, and you also saw clients who had poor experiences and relationships with religion. This vignette demonstrates what?
264. As a new graduate, you are eager to build your practice. Your first client is a transmasculine individual who is seeking therapy as a way to heal their past trauma from their forced experience in conversion therapy. They ask you if you have experience with religious trauma and with helping clients through their social transition. You say, " I am a new graduate, but during my internship, I saw clients who experienced childhood trauma, and I also saw clients who had poor experiences and relationships with religion. I want to specialize in gender dysphoria and religious trauma down the road." Saying this, you know that there is a significant possibility the client will choose a more knowledgeable clinician and that you may lose out on booking your first client. This vignette demonstrates what?
265. During the check-in at the beginning of a session with a client who is a racial minority, and single parent who lives below the poverty line says to you that "it is so hard sometimes, paying the bills and putting food on the table. It's my fault; I should have gone to school to get a better job. I've done this to myself" This is an example of what?
266. Towards the end of an initial intake session with a 16-year-old client seeking therapy to address their experience of anxiety, asks if there is anything they can do this week to help them feel relief from their symptoms. Because of this inquiry, you gave the client homework to practice mindfulness for two minutes every day. And then, you taught the client the proper way to engage in mindfulness. During the next several appointments, you checked in on your client's progress with mindfulness activities at home. Each time they report that they did the homework. After four weeks, you notice that the client reports a higher frequency of anxiety symptoms and even had a panic attack during the session. When the client was able to reengage in therapy, they tell you that mindfulness doesn't work, and all the other homework assignments made things worse and that they have been blaming themselves thinking that they must be damaged because you know how to help people, but what you are offering wasn't helping. Which of the following displays an accurate understanding of what happened during this session?
267. J is a young female who just graduated from medical school. She is seeking therapy because of her preoccupation with her concern regarding her family of origin. She experiences shame and guilt because her father is incarcerated and is worried about her younger siblings because they aren't doing well in school. She sometimes can't sleep at night because of her experience of loneliness because she feels that her income has created a divide between her and her family. Thus, her experiences embody the results of the interlocking forces that create and sustain injustices. What word best describes J's current experience?

268. J is a young female who just graduated from medical school. She is seeking therapy because of her preoccupation with her concern regarding her family of origin. She experiences shame and guilt because her father is incarcerated and is worried about her younger siblings because they aren't doing well in school. Recently, a young, African American 16-year-old male came in with a gunshot wound during her ER rotation. He had been shot by an officer while climbing through his window, and the police thought he was breaking into someone's house. J reports that it was difficult to focus for the rest of her shift, and she experienced a panic attack because of her racing thoughts that "that could have been my brother." As you are processing through this recent incident with her, you define this experience with the young man in the ER as...
269. A young father named D is seeking therapy because of his preoccupation with his concern regarding his son. He experiences shame and guilt because he doesn't "make enough money and can't move his small family to the better side of town" and is worried about his son because he isn't doing well in school. He was recounting his latest experience to you because he said that he doesn't have anyone in his life that he can process through "these things" with. Last week, his son was called into the principal's office for "gang-related activity." When D arrived at the school, the principal stated that his son was fist-bumping in the halls and throwing gang signs. D's son said, "no, dad, we were just fist-bumping and telling jokes." Through verbally processing, D concluded that the principles views were fueled by ignorance, fear, and hatred. You define this as which of the following?
270. A white therapist is providing therapy for a racial minority client. This client stated that she is having a tough week and is feeling run down. She said that her white colleagues often discriminate against her. And that when she told her primary care physician that she was having feelings of worthlessness and self-doubt, she felt like they weren't hearing her, and she was prescribed medication for her "symptoms of depression." Because of these events, she has begun to experience feelings of low self-worth and feelings of less than. The therapist states that it does sound like the client is experiencing depression and that medication might help. What best describes the therapists' response?
271. A white, middle-aged woman contacted you in hopes of setting up a one-time appointment. Over the phone, she stated that she was experiencing difficulty with one of her best friends, and she needed a place to process "what to do next." The client presented to the session in tears, saying that she was concerned about her friendship and don't know what went wrong and want to talk to you to find where things went wrong. The client began telling a story about how it all started when she put a bumper sticker on her car that said, "all lives matter." She was quite proud of her sticker because she was always taught that everyone is the same. She said that the two of them got in an argument and her friend hasn't talked to her since. You reflected back on the client's emotions and began exploring the meaning the client makes of an "all lives matter sticker" and what meaning her friend might make of an "all lives matter sticker." You were helping the client move from a place of color blindness to a place of recognizing her friend's perspective. This initial reaction of the client is an example of what?
272. An African American woman is presenting to therapy to address her feelings of self-worth. During the initial evaluation, she states that her white colleagues often discriminate against her. And that when she told her primary care physician that she was having feelings of worthlessness and self-doubt, she felt like they weren't hearing her,

and she was prescribed medication for her “symptoms of depression.” Because of these events, she has begun to experience feelings of low self-worth and less than. What is this a result of?

APPENDIX F: PRIVELEGE QUESTION SET

Self-Assessment Questions 273- 292

Table A.5

Privilege Self-Report Questions

Measure	Original Item Number	DEIPP Item Number
Multicultural Counseling Inventory (MCI) Sodowsky, 1996	2	*288
	15	*289
	16	*290
	19	*291
Cross-Cultural Counseling Inventory (CCCI) LaFromboise, 1991	1	*273
	3	*274
	15	*275
Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) D'Andrea et al., 1991	3	*280
	4	*281, *282
	8	*283
	13	*284
	35	285
	36	286
	37	287
	44	*292
Multicultural Counseling Awareness Scale (MCAS) Ponterotto et al., 1996	5	*276
	11	*277
	37	*278
	42	*279

* Indicates the item was retained

Multicultural Knowledge

293. Which answer best completes the following statement. Societies dominant gender narratives about what it means to be a "woman" or a "man" (Kundson-Martin, Wells, & Samman, 2015).

294. Whites are less likely than blacks to be arrested: once arrested, they are less likely to be convicted and, once convicted, less likely to go to prison, regardless of the crime or circumstances. Whites, for example, constitute 85 percent of those who use illegal drugs, but less than half of those in prison on drug use charges are white (Adams et al., 2016). This is an example of what?

295. Whites can reasonably expect that if they work hard and "play by the rules," they'll get what they deserve, and they feel justified in complaining if they don't. It is something other racial groups cannot realistically expect (Adams et al., 2016). This is an example of what?
296. Whites are more likely to control conversations and be allowed to get away with it and to have their ideas and contributions taken seriously, including those that were suggesting previously by a person of color and ignored or dismissed (Adams et al., 2016). This is an example of what?
297. Most whites are not segregated into communities that isolate them from the best jobs, opportunities, schools, and community services (Adams et al., 2016). This is an example of what?
298. If men do poorly at something or make a mistake or commit a crime, they cab generally assume that people won't attribute the failure to their gender. The kids who shoot teachers and schoolmates are almost always boys, but rarely is the fact that all this violence is being done by males raised as an important issue (Adams et al., 2016). This is an example of what?
299. Men can generally assume that when they go out in public, they won't be sexually harassed or assaulted just because they're male, and if they are victimized, they won't be asked to explain what they were doing there (Adams et al., 2016). This is an example of what?
300. Male representation in government and the ruling circles of corporations and other organizations is disproportionately high (Adams et al., 2016). This is an example of what?
301. Men don't have to deal with an endless and exhausting stream of attention drawn to their gender (for example, to how sexually attractive they are) (Adams et al., 2016). This is an example of what?
302. Most men can assume that their gender won't be used to determine whether they'll fit in at work or whether teammates will feel comfortable working with them (Adams et al., 2016). This is an example of what?
303. Heterosexuals are free to revel and live their intimate relationships openly- by referring to their partners names, recounting experiences, going out in public together, displaying pictures on their desk at work- without being accused of "flaunting" their sexuality or risking discrimination (Adams et al., 2016). This is an example of what?
304. Heterosexuals can move about in public without fear of being harassed or physically attacked because of their sexual orientation (Adams et al., 2016). This is an example of what?
305. Heterosexuals don't run the risk of being reduced to a single aspect of their lives, as if being heterosexual summed up the kind of person they are. Instead, they can be viewed and treated as complex human beings who happen to be heterosexual (Adams et al., 2016). This is an example of what?
~~306. Heterosexuals can live where they want without having to worry about neighbors who disapprove of their sexual orientation (Adams et al., 2016). This is an example of what?~~
307. Heterosexuals can live in the comfort of knowing that other people's assumptions about their sexual orientation are correct (Adams et al., 2016). This is an example of what?

308. Nondisabled people can choose whether to be conscious of their disability status or to ignore it an regard themselves simply as human beings (Adams et al., 2016). This is an example of what?
309. Nondisabled people can live secure in other people's assumption that they are sexual beings capable of an active sex life, including the potential to have children's and be parents (Adams et al., 2016). This is an example of what?
310. Nondisabled people can ask for help without having to worry that people will assume they need help with everything (Adams et al., 2016). This is an example of what?
311. Nondisabled people can generally assume that when they go out in public, they won't be looked at as odd or out of place or not belonging. They can also assume that most buildings and other structures will not be designed in ways that limit their access (Adams et al., 2016). This is an example of what?
312. Nondisabled people can count on being taken seriously and not treated as children (Adams et al., 2016). This is an example of what?

Clinical Application

313. Mr. G and his partner Mr. H are in a committed open relationship. They are seeking therapy because of Mr. G's "on and off again" dependence to alcohol. Initially, Mr. H loved partying with his partner, but it became a source of contention for the couple when partying always resulted in Mr. G drinking too much. You are newly licensed and are trying to start your private practice and are in the "I'll take anyone and everyone" mindset. The only experience you have with couples is with heterosexual monogamous couples, and you have never worked with addictions. But you decide to take them on as clients so that you can "learn to work with this population."
314. You have a heterosexual couple that is struggling with intimacy. The female client states that she has a low sex drive and a low desire to be with her husband. The couple states that they were both part of a religion that dictated gender roles and regulated identity and expression of gender when they first met. Once they left their religion, they began exploring who they were and their identities. The female client stated that she identifies as a woman, but all the rigidity around what femininity looks like is something that she has left behind. Her husband says that he is in love with her, regardless of how she expresses her gender. Still, she states that she is having a hard time with her identity because there is a feeling that the more she tries to be herself, the feeling of not being good enough gets even stronger. As the therapist, you hypothesize what?
315. You work as a therapist on a college campus where you provide therapeutic services for college students. One student presents to each session feeling exhausted and emotionally worn down because, on a daily basis, they are met with microaggressions. Yesterday they went on a date with another student at the university. As an individual with a physical disability, they state that they always have to do a lot of planning to make sure that the venue for their date is wheelchair accessible. They showed up to their date, and the restaurant wasn't wheelchair accessible. The client turned around, went home, and did not go on their date. The client states that they couldn't ask for help in the restaurant because if they were to ask for help, people would assume that they need help with everything. What is an appropriate thing to bring to the forefront of reprocessing?
316. You work as a therapist on a college campus where you provide therapeutic services for college students. A student named A, presents to each session feeling exhausted and emotionally worn down because, on a daily basis, they are met with microaggressions.

Yesterday they went on a date with another student at the university. As an individual with a physical disability, they state that these dates require a lot of planning because they have to go places that are wheelchair accessible. After a very successful first date, A led in to kiss their date, and they pulled away and said, “I don't want to be rude, but are you even able to have sex?” The client was upset about this encounter and believes that they will be romantically alone forever. What is an appropriate thing to bring to the forefront of reprocessing?

317. A couple presents to the therapy session stating that they are having a hard time in their marriage. They aren't sexually intimate anymore, and everything turns into an argument. They are both grad students who are under significant pressure to finish school. They have little support from their families of origin because both of their families disapproved of their marriage, stating that homosexuality is a sin. When exploring with the clients the current stressors in their life, the couple states that they are struggling in their neighborhood because they feel that their neighbors disapprove of their sexual orientation. What is an appropriate thing to bring to the forefront of reprocessing?
318. A couple presents to the therapy session stating that they are having a hard time in their marriage. They aren't sexually intimate anymore, and everything turns into an argument. They are both grad students who are under significant pressure to finish school. They have little support from their families of origin because both of their families disapproved of their marriage, stating that homosexuality is a sin. When exploring with the clients the current stressors in their life, the couple states that they are struggling in their neighborhood because they feel that their neighbors disapprove of their sexual orientation. They state that they have a neighbor that during a neighborhood party, they were having a good time and shared a kiss (as a married couple do), and a neighbor started yelling, saying, “stop doing that around the children, keep your perversions inside your own home.” What is an appropriate thing to bring to the forefront of reprocessing?
319. A couple named G and C presents to the therapy session stating that they are having a hard time in their marriage. They aren't sexually intimate anymore, and everything turns into an argument. They are both grad students who are under significant pressure to finish school. They have little support from their families of origin because both of their families disapproved of their marriage, stating that homosexuality is a sin. When exploring with the clients the current stressors in their life, one of the partners named G states that they are struggling at work because their coworkers have been treating them poorly since they realized that they were gay. One day, C came to G's work and dropped off their favorite lunch before kissing goodbye. A few colleagues asked how sex works in their relationship. Another colleague stated that it was inappropriate to bring their perversions to the workplace. What is an appropriate thing to bring to the forefront of reprocessing?
320. A female client presents to their therapy session wanting to process through her experiences from the past week's job interviews. During the past week, she was turned down for six different positions. She noted several instances of discrimination during her interviews ranging from interviewers asking if she will need to take a lot of time off to take care of her kids to seeing male interviewees leaving their interviews with praises of, “you will fit in nicely here, all the guys go out on Fridays.” What is at the forefront of your mind as you facilitate the session?

321. You work as a therapist on a college campus where you provide therapeutic services for college students. A female student named A presents to each session feeling exhausted and emotionally worn down because, on a daily basis, she is met with exhausting streams of attention drawn to her gender at work. She said that yesterday while she was at work, a coworker said, “wow, I didn't realize pretty girls were smart too.” A was upset about this encounter and all the other encounters she has of a similar nature. What is an appropriate thing to bring to the forefront of reprocessing?
322. An individual presents to the therapy session stating that they are having a hard time recently because they are under a lot of stress. They are a grad student who is under significant pressure to finish school, and they have little support from their families of origin. When exploring the client's current stressors in life, they become embarrassed and say that it sounds ridiculous, but it is even stressful going out into public alone. They said that when they walked from their car into the grocery store, someone walked up to them and began sexually harassing them. And the client spent a good portion of the rest of the session talking about how they can't get away from all the feelings of stress. What is an appropriate thing to bring to the forefront of reprocessing?
323. You work as a therapist on a college campus where you provide therapeutic services for college students. One cisgender, heterosexual, white female student presented to their therapy session feeling overwhelmed and depressed because they didn't understand why they were getting a B in one of their classes that they “worked really hard in.” She said, “I worked hard in class, and I deserve an A.” As the clinician, you steered the session towards exploring the clients' expectations and definition of fairness. And the student stated that “people deserve to get what they want if they try hard enough to get it.” This client was so dysregulated that she experienced difficulty engaging in the session. What informs how you conceptualize this case?
324. During a therapy session with a couple you have been working with for the past six months, one partner turns to you and says, “okay, no offense, but until you've been married for 20 years and have five kids, you can't possibly be able to help us. How old are you even? Twelve?” This has happened a few times during sessions, and you find that the first few times it happened, you felt disorganized and confused. Still, now you intuitively smile and say, “is it my age and marital status that is causing the rift in your relationship, or is it the cycle that you two are in. Let me worry about me, and we are here for you two.” How was this situation handled by the therapist?
~~325. During a therapy session with a couple the therapist has been working with for the past six months, one partner turns to the therapist and says, “okay, no offense, but until you've been married for 20 years and have five kids, you can't possibly be able to help us. How old are you even? Twelve?” They sat stunned and didn't know how to respond. The rest of the session was a blur. What is your hypothesis as to what was going on for the therapist?~~
326. A client that you have been seeing in therapy for almost a year now presented to their therapy session with a different dispensation than is common for them. When you asked how their week was, they stated, “fine” and then said, “I'm not upset about my week. I'm upset about last week in a session with you. Last week you made a homophobic comment.” You are shocked and become nervous. You say with a lot of excitement, “oh my gosh, that was a joke! I'm sorry, I thought it was funny.” Then when the client

became silent, you started crying, and you said, “I'm not sure where these tears are coming from. I'm sorry, I really didn't mean to offend you.”

327. You just received initial intake paperwork for a seven-year-old racial minority male who was described as an “angry kid, who gets into trouble at school.” During the appointment, mom stated that her son, who is in the second grade, has gone to two different schools because the first school couldn't handle his behaviors. And now this second school is saying he can't stay at school unless they get him outside help because his aggression is so frequent at school. This mom states that she doesn't understand where his aggression at school comes from because he is polite and non-aggressive at home. With this limited information that you have, what are some initial thoughts you have.

~~328. You work at a community mental health center. A family that recently immigrated to the US presented to a therapy session with you because their youngest child's school insisted that the family receive therapy. The family reports that their nine-year-old has been experiencing difficulty at school with getting into fights with other kids, grades slipping, and truancy. During their first session, you noticed that mom had a limp as they walked into the session, and she said that she hurt it at work. When you asked her if she's gone to the doctor to get it checked out, she said she couldn't because the family doesn't have insurance. The family states that there is a lot of tension at home because they struggle to pay food and bills.~~

329. A white therapist work at a community mental health center. A family that recently immigrated to the US presented to a therapy session with them because their youngest child's school insisted that the family receive therapy. The family reports that their nine-year-old has been experiencing difficulty at school with getting into fights with other kids, grades slipping, and truancy. During their first session, the therapist noticed that mom had a limp as they walked into the session, and she said that she hurt it at work. When the therapist asked her if she's gone to the doctor to get it checked out, she said she couldn't because the family doesn't have insurance. The family states that there is a lot of tension at home because they struggle to pay food and bills. This reminds the therapist of when they were growing up, and their parents struggled with money too. And so the therapist said to the family, “I know how hard it is to get the things you need in life when money is tight.” Have you considered entering into the community work program to help find higher-paying jobs?”

~~330. A therapist prides themself on working well and effectively with couples. They are a Christian counselor and tend to see a lot of couples looking for Christian counseling. During an initial therapy session with a new couple, they state that they are Islamic and are curious if the therapist has experience working with Islamic couples. The therapist is open about the couples that typically come to see them and then asks them if they would like to talk openly about their expectations and hopes for therapy. What does this type of interaction represent?~~

331. A therapist prides themself on working well and effectively with couples. They are a Christian counselor and only provide Christian counseling. Lately, this therapist has been experiencing a lot of backlash from the mental health community in their area, saying that their practice is not inclusive. What does this complaint from the community represent?

332. A therapist who works in a small-town pride themself on working well and effectively with couples. They are the only couples counselor in their county, and they are a

Christian counselor and only provide Christian counseling. Lately, this therapist has been experiencing a lot of backlash from the mental health community in their area, saying that their practice is not inclusive. What does this complaint from the community represent?

APPENDIX G: INITIAL EMAIL TO PANEL OF EXPERTS

Hello,

Hello! My name is Carrie Hatch, LCMFT. I am a doctoral candidate in the Couple and Family Therapy program at Antioch University New England. You are invited to participate in an exciting research study employing the Delphi method. I recently received approval from the IRB to conduct my dissertation research. I am in the beginning stages of scale development and am endeavoring to build an assessment tool beyond self-assessment to measure student competencies related to diversity, equity, inclusion, power, and privilege (DEIPP). The Delphi method will be used to reach a consensus regarding the definitions of domains and questions being asked on the measurement. With your help, this research will formalize content validity and refine item generation. The final report will be a refined set of data questions that accurately reflect the measured DEIPP constructs.

I have chosen you as a content expert because you self-identify as having expertise in social justice-related topics, involvement in training MFT/CFT students, or experience COAMFTE accreditation. I would be grateful if you would consider being a content expert. The Delphi method requires expert participants like yourself. As an expert, your participation is vital to my success as a doctoral student and is greatly appreciated. Your contribution aids in my growth and development as both a clinician and scholar dedicated to social justice.

Should you agree to contribute to my research in this manner, I invite you to click this link **https://www.surveymonkey.com/r/LDXJVVB** to the survey. Should you opt to participate in my dissertation research, you will be asked to complete a brief demographic questionnaire prior to starting the survey. Participation will take approximately 2.5 hours to complete. After the survey closes date, I will assess all the expert responses to understand the group's consensus. Then, I will send you the survey information again so you can view your response compared to other participants' responses for one last evaluation.

Because of the timely nature of research, I ask for your thoughtful responses by _____.

The research has been approved by Antioch University New England’s Institutional Review Board (IRB).

I look forward to working with you.

Warmly,
Carrie Hatch, LCMFT

APPENDIX H: DELPHI SURVEY #2 EMAIL TO PANEL OF EXPERTS

Hello,

Welcome to the final phase of the Delphi study. Thank you for your continued participation in my research! Your participation is vital to my success as a doctoral student and is greatly appreciated.

The following attachment contains a modified questionnaire containing a narrative portion of the statistical analysis for each question that indicates the interquartile range and the median for each item. In this last phase you will view the modified assessments and provide any last remarks and evaluations. In this phase will provide your final feedback as influenced by the group statistics to compare your initial indications with the group's responses. You will be asked to reconsider your initial responses carefully.

Should you agree to contribute to my research in this final phase of the study, I invite you to click this link _____ to the survey.

Because of the timely nature of the research, I ask for your thoughtful responses by _____.

The research has been approved by Antioch University New England's Institutional Review Board (IRB).

I look forward to working with you.

Warmly,
Carrie Hatch, LCMFT

APPENDIX I: INFORMED CONSENT

Dear Content Expert,

This research is intended to support training programs and clinicians by building an assessment tool that goes beyond self-assessment to measure student competencies related to diversity, equity, inclusion, power, and privilege (DEIPP). Utilizing the Delphi method, this research will formalize content validity and refine item generation. The final report will be a refined set of data questions that accurately reflect the measured DEIPP constructs.

Both surveys will take approximately 2.5 hours to complete. Your responses will help determine content validity.

There are minimal, if any, risks from participating. You will not be asked for your name, and all demographic data being collected will be reported as aggregated information. No personally identifiable information will be associated with your responses to these data reports, and no additional information will be requested.

This survey is part of my dissertation research at Antioch University New England in the Department of Applied Psychology's Ph.D. in Couple and Family Therapy Program. The information may be used for future research without additional consent.

Your participation is voluntary, and you may elect to discontinue your participation at any time. If you have any questions about the survey or the research study, please contact me.

The Institutional Review Board has approved this project at Antioch University. If you have any questions about your rights as a research participant, please contact Kevin Lyness, the local IRB chair. Or Shawn Fitzgerald, the provost.

I have read and understood the above information. By clicking “Next” below, I indicate that I have read and understood this consent form and agree to participate in this research study.

Please print a copy of this page for your records. Thank you for your participation!