RELATIONSHIPS BETWEEN WHITE PSYCHOLOGY TRAINEES' MULTICULTURAL COMPETENCE AND RACIAL AFFECT IN THE PANDEMIC

A Dissertation

Presented to the Faculty of

Antioch University New England

In partial fulfillment for the degree of

DOCTOR OF PSYCHOLOGY

by

Daniella L. Colb

ORCID Scholar No. 0009-0005-5887-9411

April 2024

RELATIONSHIPS BETWEEN WHITE PSYCHOLOGY TRAINEES' MULTICULTURAL COMPETENCE AND RACIAL AFFECT IN THE PANDEMIC

This dissertation, by Daniella Colb, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of
Antioch University New England
in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

Dissertation Committee:

Martha B. Straus, PhD, Chairperson

Karen Meteyer, PhD

Paige Shaw, PsyD

ABSTRACT

RELATIONSHIPS BETWEEN WHITE PSYCHOLOGY TRAINEES' MULTICULTURAL COMPETENCE AND RACIAL AFFECT IN THE PANDEMIC

Daniella Colb

Antioch University New England

Keene, NH

In this dissertation, I used an exploratory research approach to examine White psychology trainees' affective responses to race-related material and how they relate to trainees' self-perceived levels of multicultural competence amidst the COVID-19 pandemic and the rise of the Black Lives Matter movement. Participants completed self-report instruments about their experiences and identities, their affective responses to racial content, and their grasp of facets of multicultural competence. Significant correlations were found between affective responses—specifically White guilt and negation—and multicultural competence. The relationship found between White guilt and multicultural competence may speak to the power of guilt to motivate trainees' pursuit of insight and knowledge and may also reflect attunement to relevant issues given participants' choice of profession and depth of training. Negation's relationship to multicutural competence was also significant; the role that avoidance plays in negation may also lead trainees to avoid the implications of race in their multicultural training. I delve into other significant findings in the paper's discussion. While statistically non-significant findings cannot yield definitive insights, I speculate about factors that possibly contribute to the weakness of some predicted associations. Relationships found in this study suggest the importance of exploring White guilt and negation during professional training, while non-findings offer opportunities for future studies on how racial affect may (or may not) relate to trainees' grasp of

material pertaining to their education and careers. This dissertation is available in open access at AURA (https://aura.antioch.edu) and OhioLINK ETD Center (https://etd.ohiolink.edu).

Keywords: race, affect, guilt, shame, negation, multiculturalism, COVID-19

ACKNOWLEDGEMENTS

I would like to thank my advisor, Dr. Martha Straus, who anchored and supported me throughout this dissertation. Ever since I first pumped myself up to speak to you in your office, I have been so grateful for you. I would also like to thank Dr. Karen Meteyer and Dr. Paige Shaw for being part of my dissertation committee. Thank you all for your patience and support!

I would like to thank my husband Craig, who has been my steadfast source of encouragement, support, and love throughout a degree and project that encompassed years of our lives. You are the most wonderful husband that an anxiety-riddled graduate student could ask for. Thank you for believing in me, hugging me whenever I need it, making me laugh, and bringing me two kinds of coffee when I can't decide on one. I love you and I like you. (And thank you to your family, who have given me a lot of love, joy, and Grateful Dead merchandise.)

I want to thank our beautiful son, Jackson, who was born smack dab in the middle of this dissertation and who generously shared his Mommy with the computer so that she could finish it. Jackson Bear—I love you more than anything in the world.

I would like to thank Maria Niitepold, who was always available for a quick question or pep talk, and Becca Butler, who patiently assisted me with data input and compilation.

I would like to thank my older sisters, Ora, Sara, and Adina, and my little brother / statistics consultant, Ben. A shoutout to your spouses and all your kiddos too, who make life more chaotic and wonderful for all of us. I love you all very much.

Finally, I want to thank my mother and father for babysitting Jackson—and listening to "Diamonds on the Soles of her Shoes" three thousand times—while I completed this dissertation. (Tip of the iceberg.) I could not have done this degree at all without your love and support in its myriad forms. Thank you for keeping me going. I love you and I am so very lucky to have you.

Table of Contents

List of Tables

CHAPTER I: INTRODUCTION AND LITERATURE REVIEW

In this dissertation, I examine the relationship between affective responses to race-related topics and multicultural competence (MCC) for psychology trainees during the first years of the coronavirus pandemic. Utilizing Joseph Ponterotto's (1988) Stage Model of White Racial Consciousness Development among White counselor trainees, I explore trainees' affective responses to race-related material and the impact their responses have on their self-perceived level of MCC. The term "trainee" is used throughout the dissertation as an umbrella term for graduate students pursuing psychology degrees. The term "COVID-19" is also used throughout the paper to refer to the coronavirus pandemic from its onset in 2020 through the paper's completion in early 2024. Since the assessment tool chosen for this study centers on racism toward Black people, this project focuses on how White trainees respond to discussions of race and racism as they pertain to the Black community.

While doctoral training for psychologists is rigorous and multifaceted, one area of particular importance is trainees' awareness and understanding of sociocultural factors that inform both their own identities, and those of their clients. Included among these factors is race, a construct "determined by socially defined inclusion criteria (e.g., skin color)" (Helms, 1995, p. 181) with profound social implications for members of different groups, including the power and opportunities afforded to them within their social context (Helms, 1995). As an emotionally charged topic across identities and contexts, engaging with issues pertaining to race and racism elicits a range of emotional reactions in White trainees, particularly as they become more enlightened about the social advantages that their White identity and racial background has afforded them. Social advantage and oppression based on race were further exacerbated by COVID-19, as the emergence of new infectious diseases have historically contributed to

increased racial discrimination (White, 2020). As COVID-19 has spread throughout the United States, it shone a brighter light on the institutional racism embedded within the country's social systems. The systemic racism underscored by the pandemic, as well as increased attention to acts of racial violence (i.e., police brutality, the murders of George Floyd, Breonna Taylor, and Ahmaud Arbery) that became the focus of worldwide attention, sparked national outrage and gave substantial power to social movements like Black Lives Matter. The historical moment highlighted drawing the nation's attention to the racial discrimination and oppression nationally and around the globe.

Psychology trainees were similarly impacted by these worldwide events. Indeed, the COVID-19 pandemic transformed academic and clinical training, leading, for example, to evolving standards of safety and competency providing teletherapy. Of particular note during this historical moment, and against the backdrop of a country that is publicly and actively grappling with its historically unjust (and violent) treatment of Black people, White trainees are endeavoring to develop MCC. There is growing evidence that trainees' interaction with racial topics provokes strong affective responses, including White guilt and White shame (Ancis & Szymanski, 2001; Spanierman et al., 2008; Utsey et al., 2005). Since these affective responses may play a role in trainees' professional development, they warrant attention and exploration.

Racial Terminology

While formulating this dissertation, I grappled with appropriate terms to use when referencing individuals from different racial identities—an important question given the emotional valence of the topic at hand. Racial labels vary considerably within the literature—including use of "Black," "White," "African American," "European American," and more. When moving into descriptions of my own project, I use the terms "Black" and "White"—the two

racial groups that are the focal point of my project. To echo Lynn M. Jacobs, PhD, PsyD, in her 2014 article on White shame and White guilt: "I prefer the terms, 'White' and 'Black,' because, aside from ethnic heritage, class etc., racialized skin color does matter in this country" (p. 298). I fully acknowledge that there are limitations associated with use of the terms I have chosen, but feel that they better encapsulate the socially constructed identities discussed in this dissertation than other considered alternatives.

I also wish to acknowledge that COVID-19—and the subsequent rise in attention to a range of social movements—raised awareness not only about racial injustice toward Black people, but people with other marginalized racial identities. For instance, the COVID-19 pandemic has been linked to increased incidents of discrimination and violence against Asians, Asian Americans, and Pacific Islanders (Litam, 2020). While a valuable area of focus for future research, the limits of the project and available assessment tools made it necessary to focus specifically on racism that impacts White trainees working with Black individuals and communities.

Author's Racial Background

Given the content of this dissertation and the topics it explores, it is necessary that I share my own racial and cultural background so that readers may consider it within the context of my project. I identify as a White Jewish cisgender female, as well as a mother and a graduate student within a clinical psychology doctoral program. As such, the topics discussed in this dissertation pertain to me directly. I have personally experienced affective responses (e.g., White guilt) discussed in the project over the course of my training, particularly since the onset of COVID-19. As such, I must acknowledge the possibility that my personal experience of these emotions may impact my interpretation of the findings and the conclusions I draw from them.

With the support of my advisor, my clinical supervisors, and my peers, I approached this project with open acknowledgement and discussion of my own cognitive and affective responses to my interpretation of the data I collected.

Multicultural Competence (MCC)

As the field of psychology has developed and adapted over time, psychologists have placed increased emphasis on fostering MCC to meet the needs of an increasingly diverse society (Abreu et al., 2000; Sabnani et al., 1991). Dating back to the Vail conference in 1973, the summary statement from the conference emphasized cultural competence as a crucial element of ethical training and practice and called for culturally diverse and relevant issues to be integrated into psychological education and training (Abreu et al., 2000). Following the Vail conference, the American Psychological Association (APA) started to establish entities for individuals from marginalized cultural and racial identities, including the Office of Ethnic Minority Affairs (OEMA) in 1979 and the Division of Ethnic Minority Affairs (Division 45) in 1986 (Abreu et al., 2000). Over time, multicultural competence has increasingly been considered foundational for effective and ethical training and practice (Collins & Arthur, 2010).

Hansen et al. (2000) offered a two-part definition of the concept of MCC that is as follows:

> a) awareness and knowledge of how age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language, and socioeconomic status are crucial dimensions to an informed professional understanding of human behavior and b) clinical skills necessary to work effectively and ethically with culturally diverse individuals, groups, and communities. (p. 653)

Encapsulating a range of sociocultural factors, this definition of MCC urges psychologists to balance unique identifying characteristics and underlying sociocultural identities in their conceptualizations and interventions (Hansen et al., 2000). The development of MCC charges all trainees with the task of acquiring racially, ethnically, and culturally relevant knowledge and skills, while also requiring them to reflect on the sociocultural contexts and beliefs that have shaped their own identities and worldviews (Carter & Johnson, 2019; Collins & Arthur, 2010).

Among the most salient social identities that can shape trainees' experiences—internal and external—is race, a construct with profound implications for individuals and communities that must be part of every trainee's self-exploration and MCC. Race is a relevant construct for all racial groups; however, this dissertation centers on the White racial identities of White trainees. In acknowledgement of race's pivotal role in social contexts and psychosocial development, scholars have formulated a variety of theoretical models that delineate how individuals progress in acknowledging and integrating race into their sense of self (Helms, 1995; Ponterotto, 1988).

Some of these models identify an objective of "racial identity," which refers to the idea that all people "ascribe different psychological meanings to their race" (Carter & Johnson, 2019, p. 43). Other models emphasize "racial consciousness"; for White-identifying people, this racial consciousness can be defined as awareness of one's Whiteness and its implications relative to those who do not share their racial background (Rowe et al., 1994). Racial consciousness may be experienced as a clear and significant identifying feature for some, while less defined or significant for others (Rowe et al., 1994). Joseph Ponterotto's (1988) model of White racial consciousness attempts to outline the process by which White-identifying counselors "come to

know and accept their racial identity as well as that of U.S. minority groups" (Ponterotto, 1988, p. 153). This racial consciousness model provides the theoretical framework for this study.

Joseph Ponterotto's (1988) Stage Model of White Racial Consciousness Development Among White Counselor Trainees

Derived from several preceding racial identity theories and his experiences teaching students in a multicultural counseling class, Ponterotto (1988) developed a four-stage model—*Pre-exposure*, *Exposure*, *Zealot-Defensive*, and *Integration*— outlining racial consciousness development among White counseling trainees. In this model, Ponterotto (1988) asserts that White counseling student's awareness and acceptance of their racial identity—facilitated in part by contact with multicultural topics—occurs through a "systematic behavioral, cognitive, and emotional process" (p. 154).

The first stage, *Pre-Exposure*, describes the initial stage in which trainees may have not paid much attention to multicultural or racial issues, and are often oblivious to their role as a White person in a social context characterized by racism and oppression (Ponterotto, 1988). During the second stage, *Exposure*, counseling students encounter the realities of racism and prejudice, drawing their attention to their role as a White individual in their social context. Given the racial introspection that occurs during *Exposure*, this stage is often characterized by trainees' affective responses of guilt and anger (Ponterotto, 1988).

The third stage, *Zealot-Defensive*, addresses the affective responses that students have to confronting their racial identity and privilege (Ponterotto, 1988). Ponterotto (1988) places these responses into two categories; some trainees may become very adamant about MCC, actively committing to fostering a "pro-minority perspective" (p. 152). Ponterotto posits that this channeling of energy may serve to help students cope with the guilt they experience over

receiving unearned race-based advantage within a White-dominant society. In contrast, after the *Exposure* stage and the self-examination that it encourages, some White trainees internalize criticisms associated with the systemic inequities that favor Whiteness. These trainees may retreat from MCC-related issues, becoming more passive in their learning style. Ponterotto (1988) notes that total withdrawal from MCC is not possible and his students in the *Zealot-Defensive* stage must process their feelings in some capacity, as they have to continue their coursework. During the fourth and final stage of the model, *Integration*, the severity of students' zealotry and defensiveness in the previous stage both subside; that is, students who gravitated toward zealotry become more subdued in their multiculturally-based efforts, and students who became passive in their engagement with course material process their reactions and "return" to the class with a renewed interest and appreciation for MCC. It is noteworthy that students do not move through these stages in unison, vary in their depth and breadth of engagement, and some do not reach the *Integration* stage by the end of the training experience (Ponterotto, 1988).

Construct of Race

While based on "apparent" physical characteristics (i.e., skin color), race is a socially constructed identity that is not based in biological traits (Altman, 2000). Rather, the categorization of racial groups served, and continues to serve, the purpose of creating a hierarchical system by which one racial group, White people, can assert control over others. By couching these racial distinctions within attributes that "appear to innocently mirror nature," race can be rationalized as a readily apparent and neutral system of differentiation, rather than the power-based and discriminatory system that it is (Altman, 2000, p. 590). These racial divides contributed to the pervasive and systemic racism that defines America's history (e.g., slavery,

Jim Crow laws) and shaped its social systems, including education, law enforcement, and health care (Altman, 2000).

Race has had a similarly influential role in the study of psychology; many psychological theories and practices have developed from a predominantly Euro-American perspective (Abreu et al., 2000; Sue, 2001). Reflecting monocultural experiences and worldviews, many psychological approaches have often been applied to clients of color with no modification or adjustment, leaving those clients vulnerable to the presumption of psychopathology when and if the therapeutic supports do not align with their needs (Abreu et al., 2000). As such, it is not only the psychologists and trainees themselves that are susceptible to racism, but the tools they learn and apply may also be inherently racist and inadequate for addressing the needs of diverse clients. Furthermore, while the United States continues to become more culturally diverse, the field of psychology continues to be composed predominantly of White-identifying psychologists; among active psychologists in the United States in 2018, 83.8% were shown to be White, 6.7% identified as Hispanic, 4.39% as Black/African American, and 3.35% as Asian (APA, 2019). Furthermore, the racial and ethnic diversity of the United States continues to increase, with some predicting that White-identifying people will become a minority in the United States by 2045 (Sáenz & Poston, 2021). The increasingly diverse population of the country has made cross-cultural interactions within a therapeutic context more and more common (Chang & Berk, 2009), increasing the need for an emphasis on MCC during clinical training.

Race and Psychology Trainees

As a topic characterized by structural discrimination, systemic oppression, and inestimable violence, racism evokes strong cognitive, affective, and behavioral reactions from individuals across racial backgrounds (Branscombe et al., 2007; Estrada & Matthews, 2016;

Spanierman et al., 2012; Spanierman & Heppner, 2004). These difficulties may be even greater during cross-racial interactions, in which lack of a common racial identity may evoke responses from both parties, including for example, anxiety, a sense of vulnerability, concern of causing offense, and overall emotional discomfort. Sue (2001) asserts that people have historically been reticent to explore racial topics due to the fact that it is a "hot button issue" (p. 795); people prefer not to be reminded of the oppression and personal biases that continue to wield profound influence over their lives. While race-related issues have always been salient to American culture, the COVID-19 pandemic and the rise of Black Lives Matter have greatly magnified the significance of the racial divide for all.

For those training to be mental health professionals, avoidance of racial topics cannot be an option; in addition to understanding the integral role of race within MCC, trainees who want to develop safe, trusting therapeutic relationships with diverse clients must be ready and able to engage with clients on race-related issues (Utsey et al., 2005). White trainees are likely to encounter race-related social tension in the classroom and in clinical settings through practicum and externship placements. Avoidance of conversations about race with clients, peers, supervisors, and professors may impede trainees' cross-cultural work with clients and their overall professional development.

Trainees' Affective Responses to Race

A survey of the scholarship over the last several decades reveals growing acknowledgement of the role of affect in the development of racial awareness overall. In her adapted model, Helms (1995) punctuates her identified racial identity statuses with associated cognitive-emotional processes (e.g., denial, confusion, distortion of information), denoting the role of both cognitive and affective processes in developing racial identity. Ponterotto (1988)

similarly articulates affective processes (e.g., anger and guilt) that accompany stages of racial consciousness development for White counselors.

Over time, the burgeoning research literature reflects the clear role of affective processes for White trainees has been reflected, giving rise to both quantitative and qualitative studies examining what trainees feel when interacting with race-related material. Studies to date have shown trainees' cognitive and affective reactions to racial issues to include anxiety (Sue et al., 2010; Utsey et al., 2005), anger and defensiveness (Ancis & Szymanski, 2001), sadness and disgust (Ancis & Szymanski, 2001), guilt (Spanierman & Heppner, 2004), and denial (Utsey & Gernat, 2002). In an effort to further explore the impact of affect on professional development (specifically MCC), this dissertation focused predominantly on White trainees' experiences of White guilt, White shame, and negation—three prominent reactions to White privilege, racial injustice, and other race-related topics.

White Privilege

Meaningful discussions of racism, racial identity, and racial affect among White trainees begin with an exploration of White privilege. According to McIntosh (1998), White privilege can be defined as an unearned series of societal assets or rewards that White people receive merely because of their race. White people do not overtly request these rewards, and are often socialized to be unaware of how they have benefitted from them (McIntosh, 1998). Nevertheless these "invisible" assets contribute to the perpetuation of a racist society. In Ponterotto's (1988) model of racial consciousness development, trainees at the *Pre-Exposure* stage may be unaware of White privilege; they gain such awareness during the *Exposure* phase and integrate it into their professional knowledge as they continue to develop.

While arguably, awareness of White privilege has increased substantially since Helms (1995) and Ponterotto (1988) shared their insights into race, conversations about White privilege are still not a universal component of psychology training programs. Indeed, in "The Unbearable Lightness of Being White," Diane M. Adams (2015) wrote that in her experience, "contemporary doctoral trainees are unfamiliar with the concept of White Privilege and have never thought of social injustices as privileging them but only in terms of it disadvantaging others" (p. 328). It is significant that MCC, a core component of psychology training, might exclude exploration of White privilege and its role in perpetuating systemic racism.

White Guilt

White guilt, sometimes referred to as "White collective guilt" (Chudy et al., 2019), describes the feelings of remorse or regret that White individuals can experience when they become aware of racism and the unearned race-based privilege that they receive (Spanierman & Heppner, 2004; Swim & Miller, 1999). Unlike individual guilt, which can arise from a discrepancy between an individual's values and their own personal behavior, White guilt can be an emotional response to the behavior and history associated with White people as a whole (Doosje et al., 1998). Exploration of the concept of White guilt became prominent during the 1960s, when race-related social movements (e.g., civil rights, Black power) illuminated discrepancies between treatment of White and Black individuals in America and forced White-identifying Americans to acknowledge their culpability for perpetuating existent power imbalances between White and Black people in America (Steele, 1990). Ponterotto (1988) notes the prevalence of guilt among White students during the *Exposure* stage, during which trainees' increasing awareness of racial issues forces them to acknowledge their role in perpetuating

racism. While White guilt is not always felt, it is a racial vulnerability that has the potential to evoke regret and remorse in a White individual (Steele, 1990).

Findings on the manifestations of White guilt vary. On one hand, a White individual's experience of guilt about their racial identity can be healthy and positive. For example, Jacobs (2014) and Adams (2015) both identified the experience of guilt as key to acknowledging White privilege and extricating oneself from a White-centered social and professional context. Adams (2015) noted that White guilt can alert individuals to racial injustice, and act as "a pathway for White individuals in developing a sense of connection, accountability, and responsibility around issues of social justice and equity" (p. 330). In a similar vein, some studies offer evidence for a relationship between White guilt and awareness of White privilege, making guilt a valuable tool in acknowledging the systemic injustices that impact the trainee and client alike (Iyer et al., 2003; Spanierman & Heppner, 2004; Swim & Miller, 1999).

However, some research also indicates that the self-focused nature of guilt can urge White people to act out of selfishness, focusing on the alleviation of their own emotional distress rather than motivation to help those who have been wronged (Iyer et al., 2003). For instance, in a study conducted by Iyer et al. (2003), White guilt was a predictor of support for compensatory policy such as affirmative action, but was not a reliable predictor for other noncompensatory programs that would also promote equality. Findings from Iyer et al. (2003) suggest that there may be limited benefits and utility associated with White guilt.

This complex expression of guilt is reflected in the *Zealot-Defensive* third stage of Ponterotto's (1988) racial consciousness development model; in this stage of racial consciousness, White trainees may advocate on behalf of racial minorities in order to alleviate their own White guilt. Steele (1990) also speaks to this self-focused nature of guilt:

> Guilt makes us afraid for ourselves, and thus generates as much self-preoccupation as concern for others. The nature of this preoccupation is always the redemption of innocence, the re-establishment of good feeling about oneself. In this sense, the fear for the self that is buried in all guilt is a pressure toward selfishness. (pp. 501–502)

Steele's (1990) insights reflect the threat to one's sense of self that guilt can pose. This can be particularly true if the guilt becomes pathological, and the individual starts to feel "bad" or "inferior," which may provoke defensiveness and block authentic remorse or regret (Shelby, 2019).

Guilt versus Shame

While guilt and shame are both self-focused emotions (Tangney et al., 1996), it is important to distinguish between the two constructs. In his exploration of the distinction, Shelby (2019) noted that while guilt is an emotional reaction to what we do, shame is "a feeling about who we are as people" (p. 291). In a piece discussing the development of the White Racial Affect Scale (WRAS)—an instrument I administered to my project's participants—Grzanka et al. (2020) offered a similar example to differentiate guilt from shame: "When contrasting guilt and shame, these primary differences in degree and target can be characterized as: 'I feel bad about what I did' versus 'I hate myself'" (p. 50). While guilt can cause an individual to focus on a negative act or failure, shame causes them to negatively evaluate their entire self (Estrada & Matthews, 2016). These negative self-evaluations can cause emotional pain that may range from unpleasant to debilitating (Benetti-McQuoid & Bursik, 2005; Tangney et al., 1996). Unlike guilt, shame does not serve an adaptive function, and is positively associated with poorer mental health and psychological maladjustments (Benetti-McQuoid & Bursik, 2005).

White Shame

When referenced in existing literature, White guilt and White shame are often grouped together (Estrada & Matthews, 2016; Jacobs, 2014; Spanierman & Heppner, 2004), possibly obscuring the differences between these two self-conscious emotions. Some research has offered insight into potential differences between guilt and shame; in their study exploring the impact of White guilt and White shame in college students, Estrada and Matthews (2016) observed that White guilt, but not White shame, predicted better performance on a brief quiz about structural racism, potentially supporting claims from Benetti-McQuid and Bursik (2005) about shame's apparent lack of adaptive functioning. Offering a possible explanation for their findings, Estrada and Matthews (2016) posited that since shame is believed to be more painful than guilt, the anxiety associated with shame might negate beneficial properties of other self-conscious emotions (such as guilt). In developing the White Racial Affect Scale (WRAS), Grzanka et al. (2020) also found that while White shame was positively correlated with White guilt, it is a separate construct with distinctive indicators (e.g., a weaker negative correlation with racism than White guilt). Beyond these findings, limited research reflects different manifestations of White guilt and White shame. As such, White shame warrants further research in order to better grasp its unique manifestations and its interactions with other affective experiences.

Negation

Negation describes "cognitive and affective strategies taken to deny the potential for feeling White guilt, much less White shame" (Grzanka et al., 2020, p. 70). In formulating the WRAS, Grzanka et al. (2020) initially conceptualized negation as two separate constructs, "externalization" and "detachment," but combined them after discovering that the two constructs loaded onto the same factor. Strategies of negation center on externalizing blame for White

privilege, detaching from racial conflict, and trivializing the role that race plays within social interactions (Grzanka et al., 2020). By denying the existence of systemic oppression or acknowledging that they benefit from it, White individuals can not only avoid experiencing guilt, but also avoid responsibility or accountability for any unearned race-based advantage that they have received (Adams, 2015).

Earlier studies have explored defensive cognitive and affective strategies that may relate to the construct of negation. For example, in 2002, Utsey and Gernat conducted an exploratory study examining the relationship between racial identity status and the use of ego defense mechanisms in White counseling trainees. These defense mechanisms may enable the White trainee to detach from race-related anxiety (and other emotions, such as guilt) and externalize responsibility for racism. Findings indicated that "psychological defense mechanisms that focus outward" (p. 480)—similar to "externalization" and its role within negation—were associated with less mature racial identity statuses among White participants (Utsey & Gernat, 2002).

Color-blind racial attitudes, another race-based response, can also be characterized as negation strategies due to their minimization of the role of race within social interactions. Color-blind racial attitudes are defined as "cognitive schema with affective correlates for processing racial material" (Utsey et al., 2005, p. 454). These cognitive and affective strategies may include denying the existence of White privilege, claiming that racism no longer exists, or strictly adhering to notions of individuality and egalitarianism (Ponterotto et al., 2006).

Recent backlash to the racial justice movement offers a further vivid example of individuals grappling within the defensive third stage of Ponterotto's (1988) model. In response to the rise of "Black Lives Matter," some White-identifying people rallied around the slogan "All

Lives Matter." This ostensibly color-blind racial attitude may claim to be rooted in egalitarianism while in reality it masks racist ideology (Burke, 2017; Tawa et al., 2016).

Color-blind racial attitudes may have significant implications for those training and working within mental health professions. For example, while exploring color-blind racial attitudes among applied psychology students and mental health workers, Neville et al. (2006) found that that color-blind racial ideology was related to lower levels of MCC, as well as lower case conceptualization ability. Consistent with this research, a 2008 study indicated that lower levels of color blind racial attitudes were associated with higher levels of multicultural knowledge (Spanierman et al., 2008). Trainees' inclination to engage in color-blind racial attitudes and other forms of negation may impact their awareness of and sensitivity to multicultural issues that arise in their training. As such, attending to negation in White-identifying trainees is important to assuring their professional competence.

MCC and Trainees' Affective Responses to Race

The ability of trainees, and those involved in their professional growth—supervisors, professors, colleagues—to address White trainees' affective reactions to racial issues is key to guiding professional development. If trainees can openly identify and process such reactions, they will be able to better understand the privilege and power associated with their racial background, as well as begin to extricate themselves from a power-based oppressive social system. While potentially evoking discomfort and reticence, it is imperative that the affective responses discussed in this literature review—White guilt, White shame, and negation—act as a topic of discussion and exploration within professional contexts, so that trainees have a safe environment in which to acknowledge, process, and address those responses as budding professionals. If trainees and their professors and supervisors ignore or mismanage explorations

of race and racism, the intricate affective responses of White trainees—guilt, shame, denial, anger – may give rise to an "ugly and self-defeating combination" (Jacobs, 2014, pp. 303–304), impeding trainees' ability to work confidently and ethically in cross-racial interactions.

There is substantial literature exploring the types of emotional reactions elicited from trainees when confronted with race-related materials (Abreu et al., 2000; Ancis & Szymanski, 2001; Neville et al., 1996; Utsey et al., 2002; Utsey et al., 2005); however, only a few studies focus on the relationship between those emotional responses and the trainees' MCC (Spanierman et al., 2008). In a publication that discusses trainee resistance to multicultural learning, Abreu et al. (2000) acknowledged the obstructive role that defensiveness and apathy can play in multicultural training. These researchers offered support for the third stage of Ponterotto's (1988) model when discussing the defensiveness that race-related materials can evoke in White trainees and obstruct their engagement in multicultural material (Abreu et al., 2000).

In a related exploratory study, Spanierman et al. (2008) used several psychological measurement tools—including the Psychosocial Cost of Racism to Whites (PCRW) and the Multicultural Counseling Knowledge and Awareness Scale (MCKAS)—to examine the role of racial affect in predicting different dimensions of MCC for White trainees. Findings from the study supported the crucial role of affective responses in MCC, with lower levels of White fear predicting higher levels of multicultural counseling knowledge. Trainees in the study with lower levels of color-blind racial attitudes—as measured by the Color-blind Racial Attitude Scale (CoBRAS)—experienced higher levels of White empathy and White guilt, which in turn predicted higher levels of multicultural counseling knowledge. Overall, the study's results offered support for understanding the role of racial affect (e.g., White empathy, White guilt, and White fear) in trainees' development of MCC.

This literature contributes to our understanding of the role of affect in White trainees' acquisition of multicultural knowledge and awareness (Spanierman et al., 2008). Since its publication, the disruption fostered by the COVID-19 pandemic magnified issues of racial injustice, discrepancies in access to healthcare, including mental healthcare, and vulnerabilities in MCC training for psychology graduate students. This dissertation builds upon earlier explorations to consider the impact of dramatic cultural shifts occuring with the COVID-19 pandemic on the affective experience of trainees engaging with racial material as they develop multicultural competence.

COVID-19: Providing Social Context

In order to appropriately contextualize my dissertation questions, it is crucial to understand how the past several years, characterized by the onset and spread of COVID-19, have both changed America and highlighted its existing systemic injustices. To this end, the following section offers a brief look at the observed impact—economic, medical, and social—of the COVID-19 pandemic in the United States with a focus both on the general population and on individuals and communities of color.

Advent of COVID

In December 2019, an outbreak of COVID-19, a novel and highly transmissible coronavirus, was identified in Wuhan, China after health officials noted a trend of pneumonia whose origin was unknown (Laurencin & McClinton, 2020; Paules et al., 2020). A novel virus from the same viral family as Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS), COVID-19 was noted to be highly transmissible and to typically manifest in symptoms such as fever, cough, myalgia, and fatigue (Paules et al., 2020; Xiang et al., 2020). COVID-19 spread outward from China, affecting over 114 countries and more than

118,000 people by March 11, 2020—at which point the World Health Organization (WHO) declared the spread of COVID-19 to be a global pandemic (Shah et al., 2020). On March 17th, 2020, the COVID-19 outbreak was declared a national emergency in the United States, infecting over 4,226 citizens and claiming about 75 lives (Shah et al., 2020). The United States was unprepared for the magnitude of the COVID-19 pandemic, and as a result, experienced profound interruptions in all aspects of life.

Economic Impact

The onset of the COVID-19 pandemic devastated the economies of nations around the world, including that of the United States (Laurencin & McClinton, 2020; Pfefferbaum & North, 2020). Apprehension about community spread of COVID-19 caused the U.S. government to implement social distancing measures, ranging from mass home-confinement directives to the temporary shutdown of factories and businesses nationwide (Choi et al., 2020; Sim, 2020). Many of the businesses affected by these orders never recovered and were forced to close their doors permanently. Others scrambled to change their existing service models in order to stay open (e.g., dine-in restaurants pivoting to a takeout/delivery model), reducing their workforce and resulting in massive unemployment (Sim, 2020). By July 2020, more than 40 million people in the United States had filed for unemployment, approaching numbers not seen since the Great Depression of the 1930s (Galea & Abdalla, 2020).

Three years after its initial disruptions, the impact of COVID-19 on the United States economy continues; Hlávka and Rose (2023) estimated that the pandemic would exact a toll of $14 trillion in the United States by the end of 2023. In a review of data from 2022, two years after the onset of COVID-19, Berdan et al. (2023) found that COVID-19 continued to have a detrimental impact on the U.S. economy through such factors as “productive workdays lost to

worker illness, caregivers' responsibilities for children and seniors, and compliance with isolation guidelines" (p. 2). Other costs, such as learning loss experienced by students during the pandemic, are also significant, and their full consequences for the economy have yet to be determined (Hlávka & Rose, 2023). While the passage of time and various adaptations have contributed to COVID-19 becoming "part of the US landscape" (Berdan et al., 2023, p. 2), its impact on the U.S. economy continues to evolve.

Social and Academic Impact

In February and March 2020, as major American cities started to see rapid increases in COVID-19 infections and deaths, schools and universities closed their buildings and followed Center for Disease Control and Prevention's recommendation to shift classes online (Noel, 2020). In similar efforts to contain infection and promote "social distancing," major restrictions were placed on social events and gatherings (e.g., concerts, movies, graduation ceremonies), drastically limiting opportunities for shared social experiences (Choi et al., 2020).

The shift of many experiences—academic, professional, and recreational activities—to an online setting was fairly abrupt and stressful, changing the landscape of social interaction. Furthermore, the lack of face-to-face contact that accompanied the shift to online settings caused many to experience an increased sense of isolation and stress. Individuals whose jobs required them to have continued contact with the public—including those in emergency services (i.e., police and fire), those in the cleaning or hospitality industry, those in childcare or education, those in transportation, or those working in elder care—were at higher risk of infection due to proximity to others, making them susceptible to additional stress and anxiety (Sim, 2020).

The observed impact of COVID-19 on academic life has been extensive since its onset. The need that COVID-19 placed on teachers, students, and parents to adopt distance learning as

an educational format gave rise to a series of shifts and challenges. First and foremost, in the wake of the pandemic, "school districts created policies and repurposed technology to facilitate remote learning" (Camp & Zamarro, 2022, p. 6). This "digitalization of education" (Goudeau et al., 2021, p. 1273) did not have a uniform impact on families. Access and connectivity to remote learning varied considerably based on numerous factors, including household income and race (Ong, 2020). The pivot to distance learning that occurred during the COVID-19 pandemic also placed a new level of emphasis on parental involvement to support children's completion of their academic responsibilities (Goudeau et al., 2021). This increased parental role in children's schoolwork understandably gave rise to additional stressors for many parents, including struggles to balance professional and personal responsibilities, and managing feelings of being overwhelmed (Garbe et al., 2020). Other challenges included barriers to meeting the learning needs of children (e.g., fulfillment of IEPs), unmet need for communication with teachers, and inadequate technological resources (Garbe et al., 2020).

Medical Impact

The healthcare system in the United States was ill-equipped for and quickly overwhelmed by the spread of COVID-19. Given the novel nature of the virus, healthcare providers could not offer sufficient testing or treatment options when the virus began to spread (Pfefferbaum & North, 2020). Infected patients quickly outpaced medical resources—testing kits, personal protective equipment, ventilators, even personnel—making it impossible to appropriately protect healthcare workers or treat infected patients (Laurencin & McClinton, 2020; Pfefferbaum & North, 2020). Healthcare workers were unable to keep pace with the demand for testing and treating COVID-19 patients (Neto et al., 2020). Demands including long work hours, prolonged exposure to stressful settings, and high exposure risk due to proximity to infected patients

characterized the daily lives of many healthcare workers (Choi et al., 2020; Pfefferbaum & North, 2020). As the number of patients infected with COVID-19 increased, so did the number of exposed healthcare workers who were under self-quarantine due either to becoming infected or possibly exposed to the virus (Sim, 2020). This shrinking workforce overextended the remaining healthcare workers and the services they were able to provide, placing additional strain on medical settings and the healthcare system overall (Sim, 2020).

Mental Health Impact

While most pandemic-related efforts centered on the containment of the virus itself, there was growing concern for the emotional and psychological issues that arose in reaction to COVID-19 across the lifespan (Choi et al., 2020; Novacek et al., 2020). While emotional and psychological implications of the pandemic initially received less attention than the viral outbreak itself, the emotional impact on individuals, communities, and families has proven to be profound (APA, 2023; Wan, 2020). As the pandemic has progressed, researchers have documented trends in the country's deteriorating mental health; in 2021, Vahratian et al. used data collected from the Household Pulse Survey (HPS)—an online survey conducted collectively by the CDC and the U.S. Census Bureau—whose purpose was to "monitor changes in mental health status and access to care" (p. 490). Data from the HPS used in this study showed a significant increase in anxiety and depressive symptoms—from 36.4% to 41.5%—from August 2020 to February 2021 (Vahratian et al., 2021). In 2022, HPS data was used again to "track mental health … on over three million people between April 2020 and April 2022" (Blanchflower & Bryson, 2022, p. 7). Notably, findings from Blanchflower and Bryson (2022) indicate that at points during the pandemic, rises in COVID-19 cases were related to reported mental health symptoms; in their words, "as [COVID-19] cases peaked and troughed, well-being

followed" (p. 22), speaking to a relationship between mental health in America and the ebb and flow of COVID-19 cases.

As time has passed and Americans have begun to reclaim their routines, underlying concerns about the country's mental health persist (Gramlich, 2023). Psychologists affiliated with the APA have reported concern about the experience of collective trauma in America resulting from the pandemic, stating that "a superficial characterization of day-to-day life being more normal is obscuring the posttraumatic effects that have altered our mental and physical health" (APA, 2023, para. 1). In the 2023 Stress in America™ survey, conducted by The Harris Poll on behalf of the APA, results indicated that more than one third (37%) of surveyed adults—5 percentage points higher than in prepandemic surveys—report a diagnosed mental health condition (APA, 2023). Struggles with stress were also a focal point of the survey; nearly half of the survey's respondents (47%) reported that they wished they had someone to help them manage their stress (APA, 2023). When respondents were asked to rank their overall stress level from 1 to 10 (where 1 is "little to no stress" and 10 is a "great deal of stress"), a quarter of adults (24%) ranked their stress level between an 8 and a 10—up from 19% in 2019 before the onset of the pandemic (APA, 2023). These studies point to a national struggle to manage emotional and psychological stressors that have been introduced or intensified by COVID-19.

Fear of Contraction. Numerous safety directives about masks, handwashing, and social distancing serve both to educate a vulnerable public and to increase anxiety. The highly transmissible nature of COVID-19 from person to person, and its association with high morbidity, intensified the sense of fear and personal danger for all (Neto et al., 2020). Recent research confirms growing mental health concerns due to the pandemic. For example, in a year-long study initially begun in March 2020, researchers began to explore the diffusion of

mental health symptoms and pandemic-related fear throughout the United States (Fitzpatrick et al., 2020). Early findings from the study indicated an elevated level of fear about COVID-19, with higher concentrations of fear in more densely populated and urban regions of the country (Fitzpatrick et al., 2020). Early findings from Fitzpatrick et al. (2020) illustrated a significant relationship between COVID-19 fear and mental health symptomatology, particularly anxiety and depression.

Economic Fallout and Mental Health. The devastating economic impact from COVID-19 in the United States has significant implications for the mental health of the general population, as evidenced by the strong historical link between economic upheaval and suicide risk (Wan, 2020). With the rampant job loss and business shutdowns ushered in by COVID-19, many individuals and families were faced with the stressors associated not only with unemployment, but also food insecurity and housing instability (Choi et al., 2020). For many in the United States, job loss also eliminated their mental health benefits, denying them access to psychological support (Fitzpatrick et al., 2020). For those who kept their jobs, work-related changes (i.e., the shift to an online platform, juggling personal and professional responsibilities) also caused mental health challenges, due to factors such as lack of workplace, Zoom fatigue, and social isolation (Shklarski et al., 2021; Sim, 2020). The economic impact of COVID-19 continues to be a significant stressor for Americans: a 2023 survey of American adults showed that the economy was among respondents' most significant sources of daily stress (APA, 2023).

Social Distancing and Mental Health. Confinement at home for long periods of time—whether due to exposure, fear of exposure, or a shift in work setting—led to a rise to a range of psychological reactions, including stress depression, insomnia, anger, and anxiety (Pfefferbaum & North, 2020). For those with children, school closures and online classes intensified

caregiving responsibilities, which in turn contributed to psychological reactions such as stress, anxiety, and guilt (Choi et al., 2020). In homes where domestic abuse or other forms of violence occur, individuals—both as witnesses and victims—were exposed to increased trauma (Choi et al., 2020). Indeed, an emerging body of research describes a pandemic of family violence within the COVID-19 pandemic (e.g., Xue et al., 2020) suggesting that social isolation may have offered substantial health benefits but had significant costs for vulnerable women and children.

Healthcare System and Mental Health. Apart from risk of infection resulting from close contact with patients or infectious coworkers, early evidence showed that healthcare workers—including mental healthcare workers—were also at increased risk for stress and mental health challenges due to COVID-19 (Haller et al., 2020; Sim, 2020). Anxiety, depression, and other symptomatology arose due to inability to save patients' lives, risk of exposing their loved ones through close contact, and other stressors related to the healthcare work environment (Haller et al., 2020).

The emotional and psychological stress ushered in by COVID-19 also had professional and personal implications for mental health providers. For example, in a study conducted by Fish and Mittal (2020) exploring the impact of COVID-19 on mental health providers, participating providers noted a range of negative professional consequences from the pandemic, including teletherapy fatigue and dissatisfaction with work (Fish & Mittal, 2020). Respondents also reported a range of negative affective experiences associated with administering therapeutic supports during COVID-19, including anxiety, fearfulness, depression, distress, and a sense of isolation (Fish & Mittal, 2020).

In a 2020 Italian study investigating experiences of stress, burnout, and compassion fatigue among different types of healthcare workers, Franza et al. found that reported

compassion fatigue was higher among psychiatric health workers than other providers. Psychiatric nurses in the study reported highest mean results in burnout, and psychologists and therapists reported highest scores in hopelessness, indicating a trend of emotional and psychological stress among mental health providers during COVID-19 (Franza et al., 2020).

As time has marched on, the COVID-19 pandemic has "constrained therapists in ways that no one could have predicted and has required significant adjustments to be made" (Shklarski et al., 2021, p. 55). Litam et al. (2021) noted the potential hardships for counselors navigating pandemic-related stressors including "increasingly difficult client concerns, navigation of telehealth practices, difficulties related to online confidentiality, ethical obligations, and personal experiences related to COVID-19" (p. 385). As the pandemic progressed, COVID-19 had a particular impact on the well-being—emotional and physical—of mental health professionals (Byrne et al., 2021). For example, in a 2023 study exploring COVID-19's impact on the well-being of mental health providers, respondents reported "feeling lost, vulnerable, stressed, overwhelmed, and emotionally burned out" (Mittal et al., 2023, p. 107). These enduring emotional responses echo those of a 2020 survey in which respondents reported experiences of depression, fear, anxiety, and isolation in the early wake of the COVID-19 pandemic (Fish & Mittal, 2020). Negative overall health symptoms have also been a source of concern. In Mittal et al.'s (2023) study, physical symptoms reported by clinicians included "headaches, trouble sleeping, poor appetite, back pain [and] eye strain" (p. 108). Concerns and challenges for psychology graduate students during COVID-19, including increased levels of stress, have also been a focus of research (Geary et al., 2023).

Concerns about high rates of burnout have also proved relevant in the months and years since March 2020. For example, in a 2022 COVID-19 Practitioner Impact survey conducted by

the APA, almost half of the survey's respondents reported that they could not meet their patients' demands. The same survey found that 45% of responding practitioners either agreed or strongly agreed that they were were feeling burnt out—higher than the 41% of practitioners who reported burnout in 2020 (APA, 2022). In another study exploring the impact of COVID-19 on mental health clinicians in long term care facilities, researchers found that "more then half (67.5%) of the clinicians surveyed reported experiencing burnout during the COVID-19 pandemic" (Lind et al., 2023, p. 98).

Identified challenges of COVID-19 for the mental health community are myriad. For one, due to the pandemic impacting people worldwide, mental health professionals found themselves facing the same challenges as their clients (Mittal et al., 2023; Shklarski et al., 2021). This overlap in experience between provider and client was, on one hand, identified as a means of therapeutic bonding (Shklarski et al., 2021), but also as a possible hindrance to maintaining effective therapeutic boundaries (Mittal et al., 2023). Another significant challenge for mental health providers has been the blurring of personal and professional spaces; with the shift to telehealth and with many providers working from home, boundaries—both physical and psychological—between work life and home life have been compromised (Shklarski et al., 2021). As stated by Shklarski et al. (2021), "this lack of separation between [providers'] work life and their personal life has sabotaged therapists' ability to process and 'decompress' in between or after sessions and made it difficult to establish boundaries" (p. 64).

Another common complaint that has been reported among mental health professionals during COVID-19 has been "Zoom fatigue" (Shklarski et al., 2021). This phenomenon, also referred to as "Zoom gloom," is characterized by Mamtani et al. (2022) as the "mental tiredness and anxiety" (p. 1) that can result from excessive use of videoconferencing applications. These

varied challenges for mental health providers associated with the pandemic have proven to be sources of substantial difficulty and distress.

COVID-19 and Systemic Racism

Although COVID-19 disrupted lives throughout America, the range and severity of those disruptions has not been uniform. In the United States, widespread disasters such as the COVID-19 pandemic typically cause the highest level of disruption—physical, economic, emotional, and social—to the most disenfranchised portions of the population (Fortuna et al., 2020). Pre-existing inequities in the United States in income, education, and healthcare have contributed to the disproportionate impact of COVID-19 on all racial minorities (Fortuna et al., 2020). Since this study explores affective responses to race during the pandemic, COVID-19's discrepant impact on different racial groups provides valuable context.

Healthcare and Rate of Contraction

Multiple studies have noted that the pandemic illuminated and exacerbated a longstanding history of racial discrimination in the United States healthcare system (Fairchild et al., 2020; Hooper et al., 2020; Kantamneni, 2020; Laurencin & McClinton, 2020). If infected with COVID-19 and seeking treatment, Black individuals were more likely to have to secure services at institutions with (1) lower quality of care due to lower budgets and lack of resources, (2) shortage of critical care physicians, and (3) inadequate numbers of medical supplies and equipment (Louis-Jean et al., 2020). Furthermore, the disproportionate rates of underlying comorbid disorders among racial minority groups (including Black individuals) may increase the level of risk associated with COVID-19 contraction (Hooper et al., 2020; Lund, 2020). Once hospitalized, implicit and explicit biases of healthcare providers were more likely to affect decision-making during times of emotional stress and may have negatively impacted provider

support for Black patients (Kirksey et al., 2021), further causing Black patients to mistrust both the provider and their recommendations (Laurencin & Walker, 2020). These social vulnerabilities may contribute to the fact that COVID-19 infections have had a disproportionate rate of contagion and fatality among Black individuals in America (Fortuna et al., 2020), fueling what has been described as "a moment of ethical reckoning" (Yancy, 2020, p. 1892) for the country's inequitable healthcare system.

COVID-19 Vaccination

Additional racial disparities during the COVID-19 pandemic arose following vaccination development and dispersal. Announcements of effective COVID-19 vaccines began in November 2020, and their distribution in the United States under emergency use authorization began in January 2021 (Diamond et al., 2022; Dong et al., 2022). Since the availability of COVID-19 vaccinations, research identified lower rates of vaccination among Black Americans than White Americans (Dong et al., 2022; Siegel et al., 2022). One contributing factor mentioned in existing research is higher rates of "vaccine hesitancy"—which can be defined as "delay in acceptance or refusal of vaccination despite availability of vaccination services" (MacDonald & SAGE Working Group on Vaccine Hesitancy, 2015, p. 4163)—among Black individuals than White individuals during the COVID-19 pandemic (Khubchandani & Macias, 2021). This hesitancy is linked to—among other things—longstanding systems of racial discrimination embedded into numerous institutions in the United States, including its healthcare system (Dong et al., 2022). The mistrust born out of these discriminatory systems assumes myriad forms; in a qualitative study by Dong et al. (2022) exploring "barriers to and facilitators of COVID-19 vaccination" (p. 3), this included mistrust of healthcare providers, of healthcare systems, and of the vaccinations themselves. As stated by Giselle Corbie-Smith, MD, MSc, in her 2021 article,

the Black community's "lack of faith in a system that has so consistently demonstrated little or no regard for their well-being should come as no surprise" (p. 1). Other factors that have been identified as barriers to vaccination for Black individuals include limited access to transportation, limited vaccination sites that are publicly accessible, inability to afford childcare, difficulty taking time off work, and lack of health insurance coverage (Dong et al., 2022; Siegel et al., 2022).

Employment

Businesses most profoundly impacted by social distancing protocols in the United States, including restaurants, bars, travel and transportation, entertainment, personal services, and certain types of manufacturing and retail, employ a higher percentage of individuals from racial minority groups (Kantamneni, 2020). Consequently, social distancing measures implemented in these businesses, many of which have implications for employment opportunities, most profoundly impacted individuals and communities of color, resulting in higher rates of unemployment among Black workers than White workers (Galea & Abdalla, 2020; Sobo et al., 2020). These race-related trends in unemployment have shown signs of continuing over time. For instance, a 2022 survey that examined trends in employment loss in Saint Louis County, Missouri, concluded that "Black adult residents were disproportionately affected, compared with White adults" (Coats et al., 2022, p. 5). Black individuals were also highly represented among emergency workers and "essential workers" in the transportation and delivery sectors in the United States (Sobo et al., 2020), resulting in frequent interactions with the public and thus higher risk of COVID-19 exposure. By being asked to remain on the job, often without sufficient protective equipment, these individuals were exposed to greater physical risks and higher rates of stress when the pandemic began (Sobo et al., 2020).

Social Disparities

Social Distancing. While social distancing was considered integral in the prevention of COVID-19 transmission and contraction, the ability to maintain adequate social distance is a privilege not afforded to all (Yancy, 2020). Some studies indicate that due to increased rates of poverty and social oppression, higher numbers of individuals from racial minority backgrounds live in settings that made it difficult to implement social distancing measures (Cole et al., 2021). Characteristics of those settings include multi-family homes include crowded, smaller spaces with higher concentrations of people and poor ventilation systems, all of which are conducive to the spread of infectious diseases such as COVID-19 (Cole et al., 2021; Lund, 2020). Individuals living in such settings may also have limited or unreliable access to the internet, thwarting their access to accurate COVID-19-related information in a timely manner (Cole et al., 2021). During the height of the pandemic, our understanding of best practice changed rapidly. Those who had timely and accurate information were better equipped to take proper precautions and protect both themselves and their families (Lund, 2020).

Education. At all levels of education, COVID-19 had a profound impact on student learning. However, while all students were affected by lockdown and its aftermath, some students' learning experiences were disrupted more than others (Haderlein et al., 2021). Among other disparities, research indicates that pandemic-related shifts in education had a disproportionately negative impact on students of color (including Black students).

The nationwide pivot to distance learning, for instance, amplified existing racial disparities through unequal access to technological resources—an issue predating the pandemic that is known as the "digital divide" (Golden et al., 2023). In addition to computer ownership and internet subscription, the digital divide refers to the source and quality of the technological

access (e.g., quality of internet connection, shared use of computers and other devices; Golden et al., 2023). In a study that used data collected from school-age children in American households between April 2020 and March 2021, Haderlein et al. (2021) reported that "Black students were least likely to have internet and computer for learning and most likely to have no devices in the fall" (p. 17). Francis and Weller (2022) reported similar technological disparities, noting less availability of technological supports (e.g., reliable internet access) for educational purposes for "Black, Latinx, Native American, and Asian American families" (p. 42) than for White families. This limited access to technological resources at home means a greater need for public resources that support remote learning; however, "schools and school districts serving Black and Latinx families may have fewer resources to meet those needs" (Francis & Weller, 2022, p. 52).

Rates of return to in-person schooling in the United States also revealed racial discrepancies. In fall of 2020, schools reopened in various modes—utilizing in-person, remote, and hybrid approaches—and in some cases moved between modes over the course of the academic year (Haderlein et al., 2021; Jack & Oster, 2023). The inconsistent approach to this transition created unequal academic opportunities for students, including access to in-person learning (Camp & Zamarro, 2022). Camp and Zamarro (2022) found that in 2020–2021, while most parents reported their children using fully a remote or hybrid approach to learning, higher rates of remote or hybrid learning were reported among Black and Hispanic families than White families. Haderlein et al. (2021) had similar findings, reporting that "Black students were … least likely to have access to in-person learning throughout the spring of 2021" (p. 17). Attitudes about in-person learning may play a role in these race-related discrepancies; Haderlein et al. (2021) notes that in planning for the fall of 2021, "Black families expressed the least certainty about sending their children back in person" (p. 17). Possible explanations for this hesitation

include the disproportionate impact of COVID-19 on communities of color (Camp & Zamarro, 2022) and familial concerns about Black children resuming their exposure to racial discrimination—both individual and systemic—in the classroom (Wright et al., 2023).

Studies on academic achievement over the course of the pandemic have also illuminated significant racial disparities. While systemic inequities in education have long impacted students of color—well before the onset of the COVID-19 pandemic—these disparities have deepened as the pandemic has progressed (U.S. Department of Education's Office for Civil Rights, 2021). Multiple studies point to an uneven impact of the pandemic on the academic achievement of school-age children across racial groups, with many students of color (e.g., Black, Hispanic, AI/AN) and students from high-poverty schools exhibiting disproportionately large achievement declines in math and reading (Kuhfeld & Lewis, 2022; Kuhfeld et al., 2023). Researchers also note the role of racial trauma in the education of students of color during COVID-19; as stated by Francis and Weller (2022), "Black and Hispanic/Latinx children likely experienced worse trauma during the pandemic, which can impede their ability to learn" (p. 56).

Racist Beliefs. Long-standing social prejudices and racist beliefs have further contributed to how COVID-19 has impacted Black individuals in America. For instance, for Black male individuals, wearing a facemask in public—a standard protective measure during COVID-19—may trigger racist stereotypes from White people about Black men being likely to be criminals, putting Black men at risk for racist attacks ranging from microaggressions to physical violence (Lund, 2020). The need to weigh compliance with public health measures (e.g., wearing facemasks) against the potential for racist attacks was yet another cause of stress for members of the Black community during the pandemic (Lund, 2020).

Racial Injustice and the Black Lives Matter Movement

The timeline for the pandemic coincided with a national (and global) movement sparked by racial violence and civil unrest. Millions of people who had been suddenly confined to their homes by the COVID-19 pandemic united in their focus on the tragic deaths of numerous unarmed Black men and women in 2020 including, for example, Ahmaud Arbery, Breonna Taylor, and George Floyd. The outrage about these deaths combined with the rapidly increasing awareness of the institutional racism laid bare by COVID-19 for a population increasingly feeling the devastating social, economic, and health effects of the pandemic. The result: racial injustice became an area of intense national focus across the U.S. and around the world. One important reason for this impassioned focus on racial oppression in the United States was increased national awareness of the Black Lives Matter (BLM) movement.

The Black Lives Matter movement was founded in 2013 after the death of Trayvon Martin and acquittal of George Zimmerman (Holt & Sweitzer, 2020). Following the deaths of George Floyd and Breonna Taylor (among others) in 2020, an estimated 15 to 26 million people in the United States participated in demonstrations to advocate for Black lives, making these protests the largest movement in the history of the U.S. (Arora, 2020; Buchanan et al., 2020). Widespread protests and demonstrations flooded the country. Signs that read “Stop Killing Us,” “Let Us Breathe,” and “Not One More” (McDonald et al., 2020) were waved at protests and displayed outside people’s homes and businesses, reflecting the pain, fury, and other strong affective responses that the movement had elicited in both dominant and nondominant racial groups. Country-wide protests and demonstrations, a strong presence on social media (e.g., twitter hashtags including #saytheirnames and #blacklivesmatter), increased media coverage (Sobo et al., 2020), and public support from prominent organizations like the National Football

League (Arora, 2020), prompted large shifts toward favorable public opinion about BLM, further pushing racial injustice to the forefront of national attention.

The BLM movement, and the social and political events surrounding it, figured prominently in the social context for this project. The ubiquity of race as a topic of consideration during these years of the pandemic—in the news, on social media, through signs on people's lawns, as well as the classroom and clinic—may make it harder for trainees to stay long in early stages of White racial consciousness. The BLM movement may have also played a role in the cognitive and emotional strategies that trainees employ to cope with race-related realities encountered in training—and in life.

Knowledge Gap and Research Questions

White psychology trainees engaging in classes on MCC and gaining clinical experience with diverse clients during the pandemic are inevitably grappling with their privilege at a critical juncture in the history of race, privilege, and systemic inequality in the United States. As trainees consider the implications of their Whiteness for their lives and vocation, it is likely they will experience strong affective reactions, including White guilt, White shame, and negation. Their active engagement with these powerful feelings may help them develop the MCC necessary to face White privilege and institutional racism and become more effective psychologists for the new, changed world that awaits them.

Although a substantial body of research explores how White psychology trainees respond affectively to race-related material, just a few studies investigate how these emotional responses may be associated with their sense of their MCC—their capacity to attune to the needs of clients from different racial, ethnic, and sociocultural background. In a moment defined by social and racial inequities, this dissertation examined trainees' powerful race-related emotions and

self-perceived grasp of MCC. As a related area of inquiry, I also explored how the nature and intensity of certain affective responses to race might be related to how trainees perceive their own level of MCC.

Hypotheses

Based on this review of the literature, the following relationships were hypothesized between self-perceived MCC and affect for this study:

1. Higher scores on White guilt will be associated with higher overall MCC scores.

   Rationale: White guilt has been identified as an affect that can have both positive and negative implications for White trainees. According to Ponterotto's (1988) model, the desire to alleviate experiences of White guilt can fuel trainees' adoption of a zealous stance and motivate them to explore multicultural issues in great depth.

2. Higher scores on negation will be associated with lower overall MCC scores.

   Rationale: Strategies aligned with negation can be characterized as defensive, as they serve to protect White individuals from unpleasant race-related cognitive and affective experiences (e.g., White guilt and White shame). Trainees who frequently utilize negation strategies may be in the *Defensive* stage of Ponterotto's (1988) model, causing them to withdraw from MCC training.

3. Higher scores on White shame will be associated with lower overall MCC scores.

   Rationale: White shame has been characterized in the literature as profoundly unpleasant and lacking in adaptive purpose (Benetti-McQuoid & Bursik, 2005; Tangney et al., 1996).

Additional hypotheses were made regarding subscales within the MCKAS and WRAS. Those hypotheses were as follows:

4. Within the MCKAS, higher scores on multicultural knowledge will be associated with higher scores on the multicultural awareness subscale.

Rationale: According to Ponterotto (1988), exposure to the realities of race and racism can propel students toward one of two extremes: immersion in the subject, or avoidance of it. I predict that students who devote their energy to MCC gain multicultural knowledge and multicultural awareness in tandem.

5. Within the WRAS, higher scores on the White guilt subscale will be associated with higher scores on the White shame subscale.

Rationale: The tendency of both affective responses to cause a focus on the "self" may result in an overlap in those who are vulnerable to them; those who are prone to judging their actions may also be prone to judging their whole selves.

CHAPTER II: METHODS

Quantitative Design

This project was conducted as a quantitative study using two existing psychological assessment tools. An exploratory research approach was used to look at associations between variables measured by two different psychological instruments. For this project, the variables of interest were the participants' reported affective experiences—White guilt, White shame, and negation—as measured by the White Racial Affect Scale (WRAS) and participants' self-perceived level of MCC, as measured by the Multicultural Counseling Knowledge and Awareness Scale (MCKAS).

Participants

Participants for this project self-identified as White and were currently enrolled in doctoral programs in counseling or clinical psychology within the United States. They could hold a master's degree, but all were currently in pursuit of a doctoral degree. In order to recruit participants, I obtained contact information (i.e., email addresses) for the directors of doctoral psychology programs throughout the United States. I composed an email to the directors that includes an explanation of my project and its objectives (Appendix D). The email explained that my project is seeking participants who are White-identifying, as the project centers on affective experiences of White trainees during COVID and ongoing issues pertaining to racial injustice.

Included in the email was a link to Google Survey where interested students found an informed consent form (Appendix B), a demographic questionnaire (Appendix C), and the two existing measurement tools incorporated into this study: the MCKAS and the WRAS. The email included a request that the directors forward this email to their enrolled students, who could elect to participate. In order to provide students with an incentive to participate, the informed consent

form explained that students could send me their email to enter a raffle to win a $20 gift card. The informed consent also specified that students could send their email addresses to me in order to receive the study's results once they are complete. This email was also sent to the director of my own program at Antioch University New England (AUNE), as students training within AUNE's clinical psychology doctoral program could be eligible for inclusion. In addition to contacting program directors, social media (i.e., Reddit, Facebook, Instagram, LinkedIn) was used to recruit participants. I created a social media post (Appendix E) with largely the same content as the program director's email (e.g., a brief explanation of the study and a link to the online survey) in order to recruit eligible participants.

Measures

The survey for this study was created online in Google Survey. It included an informed consent form (Appendix B), a demographic questionnaire (Appendix C), the MCKAS, and the WRAS. Permission to use the WRAS for this project was received through email from Patrick R. Grzanka, PhD, on August 26, 2020. Permission to use the MCKAS for this project was received through email from Joseph G. Ponterotto, PhD, on September 15, 2020.

Demographic Questionnaire

The demographic questionnaire constructed for this study included questions about age, gender, graduate program, years of practicum experiences, location of practicum placements (e.g., urban, suburban, rural), and number of clients—both overall and Black-identifying—seen within past two weeks. The demographic questionnaire was completed by survey participants after the informed consent form, and before the WRAS and MCKAS.

Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto & Potere, 2003)

The MCKAS is a 32-item self-report scale that consists of two subscales: knowledge and awareness. The MCKAS includes 20 Knowledge items (e.g., "I check up on my minority/cultural counseling skills by monitoring my functioning—via consultation, supervision, and continuing education") and 12 Awareness items (e.g., "I think that being highly competitive and achievement oriented are traits that all clients should work towards"). Each of the MCKAS item responses is measured on a 7-point Likert scale, ranging from 1 (not at all true) to 7 (totally true). The two factors represented in the MCKAS subscales will be measured separately, as research supports that they are two independently measured constructs (Ponterotto & Potere, 2003). The study will also include participants' overall MCKAS scores, as done in other studies that employed use of the MCKAS (Triplett et al., 2023).

All items included within the Knowledge subscale of the MCKAS are worded positively, such that higher scores indicate higher levels of perceived multicultural knowledge. Scores on the Knowledge scale range from 20 to 140 with aggregate scoring, and from 1 to 7 with mean scoring. Ten of the twelve items within the Awareness Scale are reverse-scored, with lower numbers indicating higher self-perceived multicultural awareness. After reverse-scoring, the total score range for the Awareness scale ranges from 12 to 84 for aggregate scoring, and from 1 to 7 with mean scoring. Ponterotto et al. (2002) reported the internal consistency of the instrument's subscales as 0.85 for Knowledge and 0.85 for Awareness.

Coefficient alphas were calculated for the MCKAS subscales in the present study as a means of measuring internal consistency. Verbal ratings for these coefficient alphas were then determined based on a table created by Ponterotto and Ruckdeschel (2007) that offers guidelines

for "considering the adequacy of magnitudes for coefficient alpha in light of item count and sample size" (p. 1002). For the MCKAS, the coefficient alpha of the Multicultural Knowledge subscale in this study was .933, a score rated as "excellent" according to the table created by Ponterotto and Ruckdeschel (2007). The coefficient alpha for the Multicultural Awareness subscale was calculated as .778, falling between "moderate" and "good" on the same table (Ponterotto & Ruckdeschel, 2007). Further discussion of the internal consistency of the MCKAS in this study—and comparisons to earlier studies—can be found in Appendix F.

White Racial Affect Scale (WRAS; Grzanka et al., 2020)

The WRAS is an 18-item self-report scale based on six separate scenarios introduced to the participant (e.g., "You read a news story about White students at a large private university dressing in 'Blackface' for a theme party"). Participants offer responses based on a 5-point Likert scale, ranking their likeliness to experience a particular response to each scenario (e.g., "You would think: 'I'm sure the students didn't mean any harm'"). Likert scale responses on the WRAS range from 1 (not likely) to 5 (very likely). Higher scores on the WRAS indicate greater proneness to the factor being measured (i.e., higher scores on White guilt indicate a participant's greater proneness to experiencing White guilt). One item on the WRAS is reverse coded, with higher scores indicating less proneness to the specified affect. Although four subscales were expected when formulating the WRAS, the empirical testing revealed three identified factors: White guilt, White shame, and negation (Grzanka et al., 2020). Since "findings regarding fit were mixed" (Grzanka, 2020, p. 71) for the WRAS's factor structure, both the measure's subscales and its total scores were calculated in this study.

As a fairly new measure, limited research is available on the WRAS. In a pilot that set out to "examine the basic psychometric properties of the [WRAS]" (p. 55), Grzanka et al. (2020)

reported coefficient alphas associated with three studies conducted within the pilot on the WRAS. For the first study, an exploratory factor analysis, the coefficient alphas were reported to be .79 for White guilt, .70 for White shame, and .71 for Negation. The second test, a confirmatory factor analysis, yielded coefficient alphas of 0.79 for White guilt, 0.62 for White shame, and 0.67 for Negation. The third test—a test-retest reliability analysis—yielded two coefficient alpha scores for each subscale, associated with time 1 and time 2 of the study. Coefficient alphas were calculated to be .76 and .82 for White guilt, .68 and .72 for White shame, and .68 and .73 for Negation. Grzanka et al. (2020) reported that these "subtoptimal alphas" were "consistent with existing measures of White racial affect" and were attributable to the few items in the WRAS subscales as well as the "scenario format of the measure, which introduces additional points of interpretation for each respondent" (pp. 68–69).

Coefficient alphas were also calculated in the present study for the three WRAS subscales. Verbal ratings for these coefficient alphas were then determined based on the table created by Ponterotto and Ruckdeschel (2007) that was similarly used for the study's MCKAS subscales. The coefficient alpha for the White guilt subscale was calculated to be 0.828, which would be ranked "excellent' by Ponterotto and Ruckdeschel (2007). The coefficient alpha for the White shame subscale was calculated to be 0.509, falling below the standard for "fair" and therefore would be characterized as "unsatisfactory." Finally, the coefficient alpha for the Negation subscale was calculated to be 0.734, ranking between "moderate" and "good" (Ponterotto & Ruckdeschel, 2007). These scores suggest that White guilt subscale is composed of items consistently measuring the same construct, as are the items in the negation subscale. Scores for the White shame subscale point to low levels of consistency between the subscale's

items, indicating that these items may be measuring different things. Further discussion of the internal consistency of the WRAS can be found in Appendix F.

Procedure

Participants for this study were recruited through the use of an explanatory email (Appendix D) that was sent to clinical directors and administrators of doctoral psychology programs throughout the United States, requesting that they send along the email to their students. Posts on social media (Appendix E) with the same information were used to recruit additional participants that were eligible for inclusion. Additional recruitment also occurred via snowball sampling (e.g., reaching out to supervisors from past practica and encouraging them to forward the email along to their colleagues).

My introductory email to doctoral programs provided both program directors and participants with a written explanation of my project and its aims, as well as a link to the online survey. Participants who chose to click on the survey link were taken to an informed consent form that they had to sign before proceeding to the survey itself. The informed consent form reiterated the project's goals and the confidentiality of the information that respondents offer. The form identified areas of anticipated discomfort (i.e., engaging with material pertaining to race and racism) that the respondent might experience while completing the survey. The informed consent also included an invitation for the participant to send along the survey to other eligible psychology trainees, and invited participants to send an email requesting the project's findings (once completed). My email address was provided, should any director or participant wish to clarify any component of the project or its purpose. The informed consent prompted the respondent to click a box agreeing to the terms outlined in the form. After they did so, the survey took them automatically to the demographic questionnaire, the MCKAS, and the WRAS.

In order to reduce the risk of Type II error, according to Cohen (1992), I initially sought to recruit 85 participants in order to obtain 0.8 probability of detecting a medium effect size at the 0.05 level of statistical significance. Due to challenges with recruitment, I requested and secured permission to close my survey after 67 responses had been recorded. I kept recruiting and collecting responses over a period of 17 months (November 2021 to April 2023). Once the survey was closed, I began the input and analysis of data using SPSS and with the help of an assistant.

Upon closing my survey, I also completed the raffle and sent via email $20 gift certificates to the six winning participants. These individuals' email addresses were placed in a password-protected document on my personal computer. Survey data was downloaded and stored on my computer, in a password protected document, while I completed the data analyses portion of this project.

Data Analysis

Data collected for this study was analyzed using the Statistical Package for the Social Sciences (SPSS) software. Input of collected data into SPSS was completed with the help of an assistant. After data was entered into SPSS, participants' agreement with the study's inclusion criteria was reviewed and the data was "cleaned" by looking for missing values (e.g., unanswered questions).

Descriptive statistics about trainee characteristics including gender, age, and program year, were computed and reported (Table 1). Descriptive statistics (e.g., means, standards deviations) for each WRAS factor and both MCKAS factors were calculated and reported (Table 2), and Pearson correlations were conducted to determine if each of the three subscales on the WRAS (White guilt, White shame, and negation) were significantly correlated with the two

subscales of the MCKAS (Table 3). Additional Pearson correlations were conducted to look at relationships between each instruments' own subscales (e.g., a relationship between multicultural awareness and multicultural knowledge). Internal consistency measures (i.e., coefficient alpha) were calculated for the WRAS and the MCKAS, and verbal ratings for the quality of these alphas were offered based on a table created by Ponterotto and Ruckdeschel (2007).

CHAPTER III: RESULTS

Subscale Intercorrelations

Pearson correlations were conducted on the MCKAS to look at the association between its two subscales: multicultural awareness and multicultural knowledge. No significant relationship was found between the two MCKAS subscales [r(57) = .233, p = 0.75]. Pearson correlations were also conducted between the three WRAS subscales—White guilt, White shame, and negation—and revealed a positive correlation between the White guilt and the White shame subscales [r(55) = .40, p = .002]. This finding could point to overlap between the two constructs, or how they are operationalized. It could also indicate that an individual's increased vulnerability to one is linked to increased vulnerability to the other. No significant correlations were found between negation and the two other WRAS subscales.

Demographic Information

Two respondents were found not to meet the criteria stated in the project description and consent form (i.e., respondents indicated that they do not identify as White); consequently, those responses were removed from the collected data. While cleaning the data, six additional respondents were found not to have completed any of the scales included in the survey and were therefore omitted from the data analysis as well. A total of 59 participants and responses remained and were used in the data analysis portion of this project.

Of these 59 participants, 79.7% (n = 47) reported that they identified as female, 11.9% (n = 7) as male, and 6.8% (n = 4) as nonbinary. Age of the participants ranged from 23 to 45, with the mean age of 28.95 and a standard deviation of 5.03 years. In terms of education, 28.8% (n = 17) of participants reported a bachelor's degree as their highest completed degree, while 71.2% (n = 42) of participants indicated that they already held a master's degree. While all

participants indicated pursuit of a doctoral degree (as this was a requirement for participation in the study), 57.6% (*n* = 34) reported pursuit of a PsyD while 42.4% (*n* = 25) reported pursuit of a PhD. Participants reported different stages within their doctoral programs; 16.9% (*n* = 10) in their first year, 22% (*n* = 13) in their second year, 16.9% (*n* = 10) in their third year, 11.9% (*n* = 7) in their fourth year, 27.1% (*n* = 16) in their fifth year, and 5.1% (*n* = 3) in their sixth year. In reports about practicum, 89.8% (*n* = 53) reported current involvement in a practicum while 8.4% (*n* = 5) of participants reported that they did not have a practicum at that time. In questions about client caseloads, participants' reports of clients seen in the past two weeks ranged from 0 to 40 individuals (M = 10.15, SD = 8.90). When asked about the percentage of clients participants had seen in those two weeks that identified as Black, participant responses ranged from 0 to 100 (*M* =16.03, *SD* = 24.47). Of respondents who addressed in the demographic questionnaire where they had learned MCC (*n* = 58), 44.8% (*n* = 26) indicated they had learned "in classes/activities/events directly associated with my doctoral program," 41.4% (*n* = 24) indicated that they had learned "in classes/activities/events not directly associated with my doctoral program," and 13.8% (*n* = 8) indicated that they were "not sure." Of respondents who answered question about how many hours they spent learning MCC from different possible sources, the mode number of different sources endorsed was 11, with a range of 2–15 different sources. (See Table 1 for additional demographic information on the study's sample.)

The mean of participants' scores on the MCKAS was calculated (Table 2). Total scores on the MCKAS were calculated to be 5.53 with a standard deviation of 0.69 (*M* = 5.53, *SD* = 0.69). The mean of participants' scores on the multicultural awareness subscale were calculated to be 6.22, with a standard deviation of 0.62 (*M* = 6.22, *SD* = 0.62). On the

multicultural knowledge subscale, the mean of participants' scores was calculated to be 5.11, with a standard deviation of 0.95 ($M = 5.11$, $SD = 0.95$).

Mean subscale scores and total scores for the WRAS were also calculated (Table 2). The mean of participants' total scores on the WRAS was 2.55 with a standard deviation of 0.36 ($M = 2.55$, $SD = 0.36$). The mean score for the White guilt subscale was 4.04 with a standard deviation of 0.79 ($M = 4.04$, $SD = 0.79$). For the White shame subscale, the mean score was 2.27 with a standard deviation of 0.67 ($M = 2.27$, $SD = 0.67$). Finally, the mean score for the negation subscale was 1.28 with a standard deviation of 0.38 ($M = 1.28$, $SD = 0.38$).

White Guilt and MCC

It was hypothesized that high scores on the White guilt subscale of the WRAS would be associated with higher overall MCC scores. Consistent with this hypothesis, higher scores on the White guilt subscale of the MCKAS were found to be associated with higher scores on the multicultural knowledge subscale [$r(55) = .54$, $p < .001$], the multicultural awareness subscale [$r(55) = .42$, $p=.001$] and total MCKAS scores [$r(55) = .60$, $p < .001$]. These findings suggest that participants who experience more White guilt have more—or perceive that they have more—multicultural knowledge and awareness than participants who experience less White guilt.

Negation and MCC

It was hypothesized that high scores on negation would be associated with lower overall MCC scores. Consistent with this hypothesis, higher scores on the negation subscale of the WRAS were associated with lower scores on the multicultural awareness subscale of the MCKAS [$r (54) = -.49$, $p < .001$] and lower total scores on the MCKAS [$r(56) = -.34$, $p = .010$]. This indicates that participants who experience more negation have less—or perceive that they

have less—multicultural awareness and overall MCC than participants who experience less negation. Negation was not significantly correlated with scores on the multicultural knowledge subscale of the MCKAS [r(54) = -0.225, p = .095]. This suggests that for the participants, there is not a significant relationship betweeen negation and self-perceived level of multicultural knowledge.

White Shame and MCC

It was hypothesized that high scores on White shame would be associated with lower overall MCC scores. In contrast to this hypothesis, no significant relationship was found between the WRAS White shame subscale and the MCKAS multicultural knowledge subscale [r(57) = 0.226, p = .090], the MCKAS multicultural awareness subscale [r(57) = 0.049, p = .716], or the MCKAS total score [r(57) = 0.212, p =.113].

Additional Findings

A closer examination of the data yielded additional information. Notably, higher total scores on the WRAS correlated with higher scores on the multicutural knowledge subscale of the MCKAS [r(54) = .51, p < .001] and higher total scores on the MCKAS [r(54) = .49, p < .001]. This finding suggests that participants with higher levels of racial affect perceive themselves to have a stronger grasp of multicultural knowledge, and MCC overall, than participants with lower levels of racial affect.

I also looked more closely at information collected in the demographic questionnaire to find possible correlations to the MCKAS and WRAS subscales. Neither total hours spent learning MCC nor percentage of client caseload that is Black-identifying were found to be significantly correlated with any of the MCKAS or WRAS subscales. Additionally, no

significant differences in MCKAS or WRAS scores were found between participants pursuing a PsyD and those pursuing a PhD.

CHAPTER IV: DISCUSSION

The aim of this study was to explore the relationship between the self-perceived MCC of doctoral-level psychology students, and their experiences of race-related affect. The social backdrop for this study—specifically the COVID-19 pandemic—was highly significant, as racial discrimination and racial discrepancies exacerbated by the pandemic's onset and spread were topics of national focus while the study's data collection took place. To consider my first question, I had hypothesized that participants' experiences of White guilt would be associated with higher levels of MCC, while their experiences of White shame and negation would be associated with lower levels of MCC. Existing instruments were used to measure both racial affect (the WRAS) and MCC (the MCKAS).

Findings provided partial support for the study's hypotheses. As predicted in the first hypothesis, higher reported scores on White guilt were found to be associated with higher levels of MCC. In support of this study's second hypothesis, higher reported experiences of negation were correlated with lower MCC scores—specifically lower scores in multicultural awareness and total MCKAS scores. Inconsistent with the study's third hypothesis, no relationship was found between White shame and MCC in the study's sample.

Two additional hypotheses were made regarding the MCKAS and WRAS: I predicted that for the MCKAS, higher scores on multicultural knowledge would correlate significantly with higher scores on multicultural awareness. This fourth hypothesis was not supported by the study's data. In contrast, findings did support my fifth and final hypothesis regarding the WRAS: higher scores on the White guilt subscale correlated significantly with higher scores on the White shame subscale.

Closer exploration of the data revealed additional information. For instance, overall WRAS scores were found to be significantly correlated with higher scores on the MCKAS total score and multicultural knowledge subscale. However, other details collected in the demographic questionnaire believed to have bearing on the study's focus—specifically percentage of client caseload that identifies as Black and number of hours spent learning MCC—were not found to have a significant relationship with the participants' scores on the two measures.

White Guilt and MCC

This study's findings on the positive relationship between White guilt and higher scores on MCC is consistent with Spanierman et al.'s (2008) study that identified White guilt as a predictor of demonstrated MCC. The relationship between White guilt and MCC supported in this study is also consistent with literature that endorses the utility and adaptive dimension of guilt (Adams, 2015; Benetti-Quoid & Bursik, 2005; Jacobs, 2014). In their discussion of differences between shame and guilt, for example, Benetti-Quoid and Burski (2005) note that "a change in behavior" (p. 134) can often be a response to the experience of guilt. For students of psychology, this behavioral change may include increased focus on how race impacts identity and perspective. This response to guilt would be consistent with the *Zealot-Defensive* stage of Ponterotto's (1988) model, which asserts that race-related guilt can fuel some White students' impassioned pursuit of multicultural knowledge and understanding.

It is also reasonable to infer that these are the same students that would elect to participate in a study such as this one, willing to engage in work that furthers understanding of how White individuals respond to race-related situations. Dedication to this type of learning may foster a deeper understanding of race and other sociocultural factors that shape the world, ultimately leading to a stronger grasp of concepts central to MCC. In this sense the experience of

guilt may be galvanizing, driving these individuals to better understand the dynamics that give rise to their distressing emotional experiences. As Adams (2015) stated, “White guilt, although an emotionally painful experience, is arguably a good thing, indicating acceptance of personal responsibility and connection” (p. 330).

The pandemic’s illumination and exacerbation of White privilege may also have fueled participants’ experience of White guilt. Trainees who elected to participate—showing a readiness if not eagerness to reflect on their race—were likely aware that their Whiteness has disproportionately granted them access to the resources that enabled them to navigate the pandemic with more ease than many other individuals and communities. (This understanding of race-based privilege may stem in part from training in MCC that participants had undergone prior to or during the pandemic.) Awareness of unearned White privilege and its protections in the face of a pandemic that has altered and claimed countless lives is likely to elicit emotional reactions, including White guilt. In this respect, the significant correlation between White guilt and MCC points to the role that COVID-19 played in “setting the stage” for this study.

Negation and MCC

The significant relationship found between higher negation and lower scores on multicultural competence (specifically lower total MCC scores and lower scores on multicultural awareness) was consistent with several studies’ findings on the relationship between color-blind racial ideologies—a form of negation—and facets of MCC (Neville et al., 2006; Spanierman et al., 2008). Negation encompasses strategies that center on avoiding responsibility for issues pertaining to White privilege and racial conflict, therefore guarding the individual against White guilt or White shame (Grzanka et al., 2020). By failing to acknowledge the role of race in their social contexts, individuals who employ strategies of negation cannot wholly engage with the

issues of prejudice, discrimination, and power that are linked with race. They avoid the full scope of implications of a construct that has shaped the country and those who inhabit it, including those that they hope to serve as mental health professionals.

This finding has important implications for MCC training. Indeed, explicit mention of race in the definition for MCC offered by Hansen et al. (2000) speaks to its unavoidability as a dimension of the human experience that must be acknowledged, studied, and integrated into one's professional lens. Therefore, it stands to reason that those who indicate more extensive use of negation do not harness the same understanding of MCC as those who engage fully with the topic of race in both personal and professional areas of their lives.

In my study, negation was associated with lower multicultural awareness but not with multicultural knowledge. Together, these interesting findings underscore the independence of the two constructs—knowledge and awareness. Strategies of negation serve to protect individuals against their own distressing emotions, presumably doing so at times at the cost of objectivity. However, the self-report nature of this survey requires objectivity, placing the burden of honest self-assessment on the respondent. It is possible that students accustomed to using strategies of negation (e.g., externalizing blame or responsibility, detaching from conflict) to spare themselves emotional discomfort in certain situations—such as racially-charged interactions—may also call upon them elsewhere. For instance, use of negation may protect students against acknowledging deficits in their knowledge and understanding of topics relevant to their education.

The lack of a correlation between negation and MCC knowledge specifically is hard to understand. It might be useful in future studies to include additional measures that extend beyond self-report—for instance, reports completed by academic and clinical supervisors. Other

objective data might offer perspective on the student that is not subject to mechanisms the students may use to protect their self-image.

Finally, "negation" as defined and operationalized by Grzanka et al. (2020) for the WRAS, is a fairly young construct. While studies centered on strategies that align with criteria for negation were reviewed in this study, research that explicitly makes use of the instrument is limited at present. Future research that employs use of the WRAS will aid understanding of the full range of cognitive and affective strategies that negation encompasses, and how they interact with learning processes, including both awareness and knowledge, for psychology students.

White Shame and MCC

The lack of a relationship found between White shame and MCC—an outcome that contrasted with the study's hypotheses—aligns with findings reported by Estrada and Matthews, (2016). These authors, who looked at how White guilt and White shame in White college students are associated with racial prejudice and anti-racist knowledge, also found that White shame did not have a relationship with demonstrated anti-racist knowledge (Estrada & Matthews, 2016).

There are a couple possible explanations for the lack of a relationship found between MCC and White shame in my study. For one, it is important to bear in mind the limited sample size in this study; it is possible that a larger sample would have yielded a clearer connection between the affective experience of shame and MCC. As such, further research on the relationship between these constructs is warranted to clarify any relationship that may (or may not) exist between them.

The study's findings also compel a return to what differentiates shame from guilt: while guilt is directed outward at an occurrence, behavior or action, shame is directed inward at the self

(Benetti-McQuoid & Bursik, 2005; Tangney et al., 1996). According to Tangney et al. (1996), in instances of shame, "the self is impaired" (p. 798). Such impairment of—or even alienation from—the self may cause the individual's response to the affective experience of shame to be unpredictable. In a similar vein, Estrada and Matthews (2016) posited, "the link between affect and outcome is not always straightforward" (p. 316). With self-reproach that damages self-image, behavior may be erratic and "inconsistent" with the individual's typical behavior. For psychology students, this unpredictability may extend to its relationship with their education and professional development. For some, shame may imitate guilt in having an adaptive dimension to it, making it possible for students to use their affective experience to drive their studies forward. For others, the distressing threat to their identity that shame can pose may impair their absorption of course material—including MCC—and their ability to incorporate it into their professional perspective.

The insignificance of the relationship found between these two factors in my study limits meaningful interpretation of the outcome. My results prohibit any conclusions about how these two factors do (or do not) relate to one another. However, the question of the relationship between White shame and various facets of mental health training—including MCC—merits further exploration and research.

Subscale Intercorrelations

Multicultural Knowledge and Multicultural Awareness Subscales

The lack of a significant correlation found in this study between the two subscales of the MCKAS, knowledge and awareness, aligns with Ponterotto and Potere's (2003) findings that there were "lower to moderate intercorrelations" (p. 148) between the two subscales of the MCKAS. Ponterotto and Potere (2003) asserted that the low intercorrelations between these two

subscales supported the notion that "the two constructs are fairly independent and should be analyzed separately in research studies" (p. 148). Notably, the lack of a significant correlation found between the two subscales in this study both supports their independence and underscores the difference in relationships that they had with the negation subscale on the WRAS.

The lack of a significant correlation between multicultural knowledge and awareness may possibly reflect a more complicated relationship between students' multicultural knowledge and multicultural awareness than initially anticipated. These two domains may not increase in tandem as I predicted; instead, students may notice a divergence between their own knowledge of different sociocultural identities, and their overall attentiveness to the sociocultural landscape in which they study and practice. This divergence may be attributable to these skills being acquired through different facets of training; for instance, students with a strong academic background in multiculturalism but limited clinical experience (e.g., first or second year students) may report lower levels of awareness, as many of the questions in the multicultural awareness subscale are client-centered in their phrasing.

For a better understanding of different facets of White students' MCC, further studies might expand on my initial findings about how affective processes impact students' grasp of MCC. Additionally, because MCC learning is dynamic and relational, research on this topic may benefit from incorporating measures completed by third parties (e.g., supervisors, professors) and through qualitative conversations that delve more deeply into a student's lived emotional experience of White privilege in clinical work with Black clients.

White Guilt and White Shame Subscales

The significant relationship found between the White guilt and White shame subscales of the WRAS supports the fifth and final hypothesis made by this study. The finding echos Grzanka

et al.'s (2020) findings that "White guilt-proneness was significantly correlated with proneness to White shame" (p. 69). Based on these findings, participants who are susceptible to White guilt may be similarly susceptible to White shame. This vulnerability to both White guilt and White shame is echoed by the aforementioned tendency in some academic literature (Jacobs, 2014; Spanierman & Heppner, 2004) to bulk the two emotions together. The designation of both constructs as self-conscious emotions that elicit distress may make it difficult to identify how their impact on internal processes and observable behavior differ.

Additional Findings

The correlation between higher total scores on the WRAS with both higher scores on the total MCKAS and on the multicultural knowledge subscale is an interesting finding. When considering its implications, it is important to bear in mind that the study's sample was composed of individuals who are pursuing a doctoral-level degree in psychology. Some studies indicate that people who are skilled in mental health work are highly reflective and self-aware (Jennings & Skovholt, 1999). Many within the discipline would posit that psychology requires its professionals to foster insight into their emotions, including those that are unpleasant or socially undesirable, and use it to inform their interactions with those around them (including their clients). As such, experiences of race-related affect—as indicated by high scores on the WRAS—may afford students of psychology the opportunity to reflect on the roots of their affective experiences. Given that all students participating in this study identify as White, their emotional responses may include awareness of unearned race-based privilege, and their place within a system that offers them unearned advantages while encountering others facing greater adversity and discrimination. Students who can identify these emotions can create space from

them, and harness them to peer under the surface at dynamics in society that are crucial to psychological work.

The lack of a relationship found between MCC and the number of hours dedicated to MCC is another intriguing result from this study. The absence of this relationship aligns with the results of another study which found that the number of muticultural counseling courses participants took did not significantly predict self-reported levels of multicultural awareness (Constantine et al., 2001). When considering possible explanations, it is important to consider to bear sample size in mind and the possibility that a larger sample would have yielded a stronger relationship between the relevant variables.

Furthermore, student's self-report of time spent on MCC learning may not be an accurate estimate of actual engagement. It may be difficult for students to recall the exact the full scope of experiences—academic and otherwise—that taught them about MCC, let alone offer a true estimate of total time spent engaged in these experiences. For these reasons, limitations caused by the study may have impacted the accuracy of these relationships. Additionally, as noted by Constantine et al. (2001), coursework—along with other media for exploring MCC—may cover different materials and at different depths.

The lack of a relationship in this study between MCC and hours spent engaged in MCC-based activities may also underlie distinctions between exposure to and absorption of material. Engagement with the activities named in the study (e.g., conversations with peers, with professors, televised news, interest groups, movies) would seem consistent with individuals attuning to the myriad differences (e.g., race, gender, age, socioeconomic status, etc.) that compose the individuals and communities around them. However, the process of internalizing knowledge and awareness may not yield a clear, direct relationship between hours devoted to

MCC and actual grasp of MCC. Instead, students' paths to absorption, retention, and implementation of MCC in everyday life may be subject to additional factors that vary from student to student (e.g., personal belief systems, quality of relationships with mentors, opportunities afforded to them by their traning programs). The lack of relationship illustrated here may help doctoral-level programs to appreciate the difference between the opportunity for growth and growth itself.

The lack of a clear relationship between MCC and the percentage of Black-identifying clients seen by the participants is another interesting outcome of the study, and likely attributable to myriad factors. For one, client sessions may appear very different across different settings and modalities (e.g., in an integrated health setting, in a group therapy context, college counseling, intensive in-patient work). Without a more accurate understanding of the racial composition of a student's caseload, it is harder to discern the relationship to MCC. In addition, MCC addresses all forms of intersectionality and identity, not just race. Attending to and addressing race in academic and clinical contexts is necessary but not sufficient for the development of MCC in psychology trainees.

The lack of relationship between MCC and the percentage of Black-identifying clients found in this study may also illustrate the difference between acquiring knowledge and implementing it in a clinical setting. Psychology students are often taught that it is their responsibility to pursue multicultural knowledge outside of their client-facing hours, so as to avoid making any client a "teacher" about some facet of their personal identity (e.g., race, religion, sexuality, nationality). No matter the racial composition of a student's caseload, they cannot harness and implement understanding and clinical skills that they have not gained in training outside of the therapy room.

When speculating about non-significant findings, it is crucial to bear in mind the impossibility of drawing any solid conclusions; non-significant relationships cannot offer information about the topic at hand. However, thinking about the factors that may possibly impact a study's results can offer direction to future studies.

Limitations

When exploring the outcomes of this study, it is important to bear its limitations in mind. First and foremost, the self-report nature of this study limits the objectivity of participants' responses. Self-reporting on a culturally sensitive topic such as race may create a reluctance to share reactions that are considered socially undesirable, such as experiences of racial judgment or bias. Fear of judgement, or resistance to acknowledging a reaction that illicits discomfort or distress may have impacted responses offered by the study's participants.

This study is also subject to volunteer bias. Those who elected to report on their experiences of racial affect may experience more comfort and confidence with the topic than those who declined participation.

The cross-sectional nature of this study is another limitation of this study; without the ability to observe the chosen variables over a period of time, it is impossible to conclude any directionality within the relationships found in this study. Therefore, while these relationships can be explored and explanations can be speculated about, the data collected for this study does not offer directionality to any of the relationships that it has found. Further research and data collection would help to illuminate not only the strength of the relationship between these variables, but how they influence one another.

The data collection involved in this study may also yield limitations. For instance, while the two subscales of the MCKAS operate independently of one another, this study included

participants' combined MCKAS scores in its data analysis. By using and interpreting the combined score of two subscales that can function as separate constructs, results may at times misrepresent the collected data—in this case MCC—and its relationship to other factors.

For the sake of sharpening the focus of the project, participants had to be enrolled in a doctoral-level psychology program in order to qualify. These fairly specific inclusion criteria make it likely that participants—depending on stage of training—have been exposed to a certain amount of material pertaining to race, muticulturalism, and diversity through their training to date. Furthermore, as students of psychology, participants may demonstrate a propensity to reflect thoughtfully on matters pertaining to identity (including race), skills that are important features of their future careers. As such, it is important not to generalize the results of this study to individuals who may demonstrate a wider range of personal and professional characteristics.

Difficulty with recruitment—and subsequently a smaller number of responses than initially anticipated—is another important limitation of this study. Numerous factors may have contributed to the struggle to recruit larger numbers of respondents; for one, the COVID-19 pandemic—and subsequent increase in remote, computer-based activities for many—may have reduced people's desire to dedicate attentions to another remote task. Additionally, the highly sensitive nature of the study's topic may have caused some to be reluctant to engage with it—a possibility that would certainly be important to consider within the mental health community, given the importance of engaging openly with the topics raised in this study.

The instruments used in this study also merit additional scrutiny. For instance, the study is limited to the affective experiences explored in the WRAS—emotions that while crucial to the topic, do not cover the entire spectrum of emotions elicited by discussions of race. The omission of other salient emotional responses—such as White fear and White empathy (Spanierman et al.,

2008)—from this study emphasizes the need for further research to understand the range of emotional responses elicited by this sensitive topic, and how they manifest in professional training and clinical encounters.

The demographic questionnaire written for this study could also have been designed for greater accuracy. For instance, a few participants wrote that they were uncertain about how to quantify hours spent engaged in MCC-related activities. More precise wording might have reduced confusion and led to more precise calculations.

Implications

In spite of these limitations, the outcomes of the current study still have significant implications for understanding the relationship between racial affect and MCC among doctoral-level psychology students and perhaps for a wider range of students training for careers in mental health. The four most notable implications taken from this study are the significant relationships that negation and White guilt both have with MCC, and the lack of significant findings between MCC and each of the three following factors: White shame, hours spent engaged in MCC-related tasks, and percentage of client caseload that identifies as Black.

MCC, Negation, and White Guilt

The significant statistical relationship between strategies of negation and lower levels of multicultural awareness and overall MCC suggests that psychology programs should dedicate time and resources to addressing negation with their students. Similarly, the relationship this study found between White guilt and higher levels of MCC raises important questions about the salience of guilt for motivation to learn about and attend to race. As an emotion with complex implications, White guilt ought to be "unpacked" in both classrooms and clinical settings so that it can be better understood by those experiencing it. It is important that negation and White guilt

be addressed within a safe environment, as they may play a significant role in trainees' professional growth and therapeutic alliances.

Trainings and open discussions centered on experiences of negation and White guilt may help students to reflect on these emotions without judgement, and under the guidance of professionals who have navigated those internal processes themselves. In creating a well-bounded environment for such exploration, programs may better equip their students to handle race-related affects responsibly and professionally when they arise in therapeutic contexts.

MCC and White Shame

Of note, the lack of a significant statistical relationship between the experience of White shame and MCC should not necessarily be interpreted to mean that shame bears no relationship to students' cultivation of MCC, although that is one possible explanation. However, taken together with previous research and the other results from this study, it seems that more attention ought to be dedicated to understanding the role of White shame in developing MCC because it is a powerful and disconnecting affective experience that likely interacts with the emotional, behavioral, and learning processes of future psychologists. Devoting more resources to the understanding of affect, including shame, in MCC can be accomplished on both a training-based level and a research-based level.

MCC and Time Dedicated to MCC-Related Tasks

The lack of relationship found between MCC and the number of hours spent engaged in MCC-related tasks may speak to the fact that different media for content—lectures, conversations, books, articles, podcasts, and films—may "reach" students to varied degrees. As the identities of students differ, so do the processes that help them to make sense of and absorb

material relevant to their degrees. As such, it may be important for programs to consider a variety of approaches to learning and exploring MCC. By using a range of methods and media for exploring a crucial topic, programs may offer students more individualized and effective paths to incorporating MCC into their professional identities. In so doing, programs will not only produce graduates who are better equipped to begin their careers, but the educational tools themselves that they use will demonstrate the respect for individual differences that programs hope to instill in their students.

MCC and Racial Composition of Client Caseload

As discussed, the lack of a relationship found between student's level of MCC and the percentage of their caseload that identifies as Black may speak to the distinctions between learning processes that take place in a clinical context and those that occur in an academic setting. While learning and reflection on racial identity takes place face-to-face with clients, there is no replacement for the acquisition of knowledge and development of insight on racial identity that occurs in a safe environment where the well-being of the students—and not the clients—is the primary focus. This nonfinding also draws to attention that MCC encompasses a wide range of sociocultural identities, not simply race. (Furthermore, within the topic of race, there are numerous racial identities not represented within this study.) The breadth and depth of the topic of MCC, when compared to this study's narrow glimpse at identities represented within a trainee's caseload, may contribute to the lack of a significant finding in this study between trainees' MCC and the Black-identifying percentage of their clients.

Future Directions

Findings from this study can be used to inform the curricula and overall practices of doctoral-level psychology programs throughout the country. Charged with the task of attending

to students' emotional and professional development, psychology programs can gain valuable insight from studies like this one that illuminate the relationship between emotional and professional growth. By learning more about the emotions that may inform students' exploration of their own identities, biases and assumptions, programs do well to integrate discussion of emotions—and associated cognitive and behavioral processes—into their MCC training and coursework. Professors will need to do their own work, too, so they can create space for internal processes that students might otherwise be wary of discussing, de-stigmatizing them and empowering students to process them together. In so doing, programs have the opportunity to approach the issue of race, and the role it plays in the academic and professional journey of their students, in a more direct and comprehensive manner.

Previous studies over the years have made similar calls for programs to create safe environments for students to explore race. For example, while discussing their study's findings, Utsey and Gernat (2002) emphasized the need to normalize defenses that arise among White counselor trainees during racial identity development "so they can be recognized, acknowledged, and eventually relinquished" (p. 481). Similarly, Spanierman et al. (2008) emphasized a need for "training opportunities through which White students feel encouraged and empowered to process their own emotional responses to racism" (p. 86). Estrada and Matthews (2016) also reported the need for educators to "enhance the learning environment for their students to consider working pedagogically with race-informed feelings such as White guilt and shame" (p. 321).

Findings from this study can also inform more research centered on psychology students' emotional processes concerning race. For instance, qualitative research on psychology students' experience of racial affect (e.g., offering students the opportunity to describe their feelings in their own words) would add further dimension and breadth to existing understanding of these

emotions, and how they interact with professional and academic endeavors. More quantitative research—with a larger sample of participants—would also yield valuable information on the complex relationship between experience and awareness of the impact of the range of racial affects and the development of MCC.

Finally, the cohort of psychology trainees who pursued their degree during COVID-19's onset and progression experienced a profound and unique convergence of factors; these include the collective trauma of COVID-19, the abrupt pivot to remote learning (in academic and clinical settings) and associated challenges, the increased reliance on technology as a means of social connection, and as discussed in this paper, witnessing a rise in national attention to racial discrimination and inequity. Training in a moment like no other, it seems likely that the cohort of psychologists targeted by this study are distinct from past cohorts in a multitude of ways—perhaps including their absorption and retention of MCC-related content. A closer look at what trainees were able to retain about MCC while simultaneously contending with a new (and evolving) social landscape, may yield valuable insights into how this historically singular moment shaped those who will one day practice, teach, and supervise as psychologists. In a world forever changed by COVID-19, psychologists must strive to understand how our profession—and its future practitioners—were changed as well.

Conclusion

As a discipline that requires individuals to integrate personal identity and experience into their academic journey, psychology is a field that arguably demands more emotional reflection alongside professional development than many other disciplines. Students are inevitably asked to identify, access, and share parts of themselves with their peers, their teachers, and their clinical supervisors as they complete their course of study. Nowhere are these self-disclosures and

reflections more important than on topics that elicit emotional distress, including race and racial discrimination. While the urge may be to avoid these topics on both an individual and discipline-wide level, the cost for such avoidance is significant for the psychologist's personal and professional well-being.

As the long shadow of the COVID-19 pandemic continues to illuminate the deep-seated flaws and inequities in our social systems, students must move toward their discomfort, rather than away from it, for their clients' sake and their own. Emotionally sensitive racial content should be explored early and often not only to de-stigmatize and to invite dialogue, but to encourage the learning and self-reflection over time that produces more thoughtful and capable professionals.

References

Abreu, J. M., Chung, R. H. G., & Atkinson, D. R. (2000). Multicultural counseling training. *The Counseling Psychologist*, *28*(5), 641–656. https://doi.org/10.1177/0011000000285003

Adams, D. M. (2015). The unbearable lightness of being white. *Women & Therapy*, *38*(3–4), 327–340. https://doi.org/10.1080/02703149.2015.1059215

Altman, N. (2000). Black and White thinking: A psychoanalyst reconsiders race. *Psychoanalytic Dialogues*, *10*(4), 589–605. https://doi.org/10.1080/10481881009348569

American Psychological Association. (2019). Demographics of U.S. Psychology Workforce [Interactive data tool]. https://www.apa.org/workforce/data-tools/demographics

American Psychological Association. (2022). *2022 COVID-19 practitioner impact survey.* https://www.apa.org/pubs/reports/practitioner/2022-covid-psychologist-workload

American Psychological Association. (2023, November). *Stress in America 2023: A nation recovering from collective trauma.* https://www.apa.org/news/press/releases/stress/2023/collective-trauma-recovery

Ancis, J. R., & Szymanski, D. M. (2001). Awareness of White privilege among White counseling trainees. *The Counseling Psychologist*, *29*(4), 548–569. https://doi.org/10.1177/0011000001294005

Arora, M. (2020). How the coronavirus pandemic helped the Floyd protests become the biggest in U.S. history. *The Washington Post*. https://www.washingtonpost.com/politics/2020/08/05/how-coronavirus-pandemic-helped-floyd-protests-become-biggest-us-history/

Benetti-McQuoid, J., & Bursik, K. (2005). Individual differences in experiences of and responses to guilt and shame: examining the lenses of gender and gender role. *Sex Roles*, 53(1–2), 133–142. https://doi.org/10.1007/s11199-005-4287-4

Berdan, C., Charumilind, S., Craven, M., Lamb, J., & Singhal, S. (2023, January 9). *One billion days lost: How COVID-19 is hurting the US workforce*. McKinsey & Company. https://www.mckinsey.com/industries/healthcare/our-insights/one-billion-days-lost-how-covid-19-is-hurting-the-us-workforce#/

Blanchflower, D. G., & Bryson, A. (2022). Covid and mental health in America. *PloS ONE*, *17*(7), e0269855. https://doi.org/10.1371/journal.pone.0269855

Branscombe, N. R., Schmitt, M. T., & Schiffhauer, K. (2007). Racial attitudes in response to thoughts of white privilege. *European Journal of Social Psychology*, *37*(2), 203–215. https://doi.org/10.1002/ejsp.348

Buchanan, L., Bui, Q., & Patel, J. (2020, July 3). Black Lives Matter may be the largest movement in U.S. history. *The New York Times*. https://www.nytimes.com/interactive/2020/07/03/us/george-floyd-protests-crowd-size.html

Burke, M. A. (2017). Colorblind racism: Identities, ideologies, and shifting subjectivities. *Sociological Perspectives*, *60*(5), 857–865. https://doi.org/10.1177/0731121417723827

Byrne, A., Barber, R., & Lim, C. H. (2021). Impact of the COVID-19 pandemic–A mental health service perspective. *Progress in Neurology and Psychiatry*, *25*(2), 27–33b. https://doi.org/10.1002/pnp.708

Camp, A. M., & Zamarro, G. (2022). Determinants of ethnic differences in school modality choices during the COVID-19 crisis. *Educational Researcher*, *51*(1), 6–16. https://doi.org/10.3102/0013189X211057562

Carter, R. T., & Johnson, V. E. (2019). Racial identity statuses: Applications to practice. *Practice Innovations*, *4*(1), 42–58. https://doi.org/10.1037/pri0000082

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*(4), 521–536. https://doi.org/10.1037/a0016905

Choi, K., Heilemann, M., Fauer, A., & Mead, M. (2020). A second pandemic: Mental health spillover from the novel coronavirus (COVID-19). *Journal of the American Psychiatric Nurses Association*, *26*(4), 340–343. https://doi.org/10.1177/1078390320919803

Chudy, J., Piston, S., & Shipper, J. (2019). Guilt by association: White collective guilt in American politics. *The Journal of Politics*, *81*(3), 968–981. https://doi.org/10.1086/703207

Coats, J. V., Humble, S., Johnson, K. J., Pedamallu, H., Drake, B. F., Geng, E., Goss, C. W., & Davis, K. L. (2022). Employment loss and food insecurity—Race and sex disparities in the context of COVID-19. *Preventing Chronic Disease*, *19*, 1–11. https://doi.org/10.5888/pcd19.220024

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112(1),* 155–159. https://doi.org/10.1037/0033-2909.112.1.155

Cole, H., Anguelovski, I., Baró, F., García-Lamarca, M., Kotsila, P., Pérez del Pulgar, C., Shokry, G., & Triguero-Mas, M. (2021). The COVID-19 pandemic: Power and privilege, gentrification, and urban environmental justice in the global north. *Cities & Health*, 5(Sup 1), S71–S75. https://doi.org/10.1080/23748834.2020.1785176

Collins, S., & Arthur, N. (2010). Culture-infused counselling: A fresh look at a classic framework of multicultural counselling competencies. *Counselling Psychology Quarterly*, *23*(2), 203–216. https://doi.org/10.1080/09515071003798204

Constantine, M. G., Gloria, A. M., & Ladany, N. (2002). The factor structure underlying three self-report Multicultural Counseling Competence Scales. *Cultural Diversity and Ethnic Minority Psychology*, *8*(4), 334–345. https://doi.org/10.1037/1099-9809.8.4.335

Constantine, M. G., Juby, H. L., & Liang, J. J-C. (2001). Examining multicultural counseling competence and race-related attitudes among White marital and family therapists. *Journal of Marital and Family Therapy*, *27*(3), 353–362. https://doi.org/10.1111/j.1752-0606.2001.tb00330.x

Corbie-Smith, G. (2021). Vaccine hesitancy is a scapegoat for structural racism. *JAMA Health Forum*, *2*(3), e210434. https://doi.org/10.1001/jamahealthforum.2021.0434

Diamond, L. L., Batan, H., Anderson, J., & Palen, L. (2022). The polyvocality of online COVID-19 vaccine narratives that invoke medical racism. *CHI Conference on Human Factors in Computing Systems*, *145*, 1–21. https://doi.org/10.1145/3491102.3501892

Doosje, B., Branscombe, N. R., Spears, R., & Manstead, A. S. R. (1998). Guilty by association: When One's group has a negative history. *Journal of Personality and Social Psychology*, *75*(4), 872–886. https://doi.org/10.1037/0022-3514.75.4.872

Dong, L., Bogart, L. M., Gandhi, P., Aboagye, J. B., Ryan, S., Serwanga, R., & Ojikutu, B. O. (2022). A qualitative study of COVID-19 vaccine intentions and mistrust in Black Americans: Recommendations for vaccine dissemination and uptake. *PLoS ONE*, *17*(5), e0268020. https://doi.org/10.1371/journal.pone.0268020

Estrada, F., & Matthews, G. (2016). Perceived culpability in critical multicultural education: Understanding and responding to race informed guilt and shame to further learning outcomes among White American college students. *International Journal of Teaching and Learning in Higher Education, 28*(3), 314–325.

Fairchild, A., Gostin, L., & Bayer, R. (2020). Vexing, veiled, and inequitable: Social distancing and the "rights" divide in the age of COVID-19. *The American Journal of Bioethics*, *20*(7), 55–61. https://doi.org/10.1080/15265161.2020.1764142

Fish, J. N., & Mittal, M. (2020). Mental health providers during COVID-19. *Public Health Reports*, *136*(1), 14–17. https://doi.org/10.1177/0033354920965266

Fitzpatrick, K., Harris, C., & Drawve, G. (2020). Fear of COVID-19 and the mental health consequences in America. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S17–S21. https://doi.org/10.1037/tra0000924

Fortuna, L., Tolou-Shams, M., Robles-Ramamurthy, B., & Porche, M. (2020). Inequity and the disproportionate impact of COVID-19 on communities of color in the United States: The need for a trauma-informed social justice response. *Psychological Trauma: Theory, Research, Practice, And Policy*, *12*(5), 443–445. https://doi.org/10.1037/tra0000889

Francis, D. V., & Weller, C. E. (2022). Economic inequality, the digital divide, and remote learning during COVID-19. *The Review of Black Political Economy*, *49*(1), 41–60. https://doi.org/10.1177/00346446211017797

Franza, F., Pellegrino, F., Del Buono, G., Solomita, B., & Fasano, V. (2020). Compassion fatigue, burnout and hopelessness of the health workers in COVID-19 pandemic emergency. *European Neuropsychopharmacology*, *40*, S476–S477. doi: 10.1016/j.euroneuro.2020.09.619

Galea, S., & Abdalla, S. (2020). COVID-19 pandemic, unemployment, and civil unrest. *JAMA*, *324*(3), 227–228. https://doi.org/10.1001/jama.2020.11132

Garbe, A., Ogurlu, U., Logan, N., & Cook, P. (2020). COVID-19 and remote learning: Experiences of parents with children during the pandemic. *American Journal of Qualitative Research, 4*(3), 45–65. https://doi.org/10.29333/ajqr/8471

Geary, M. R., Shortway, K. M., Marks, D. R., & Block-Lerner, J. (2023). Psychology doctoral students' self-care during the COVID-19 pandemic: Relationships among satisfaction with life, stress levels, and self-compassion. *Training and Education in Professional Psychology*, *17*(4), 323–330. https://doi.org/10.1037/tep0000444

Golden, A. R., Srisarajivakul, E. N., Hasselle, A. J., Pfund, R. A., & Knox, J. (2023). What was a gap is now a chasm: Remote schooling, the digital divide, and educational inequities resulting from the COVID-19 pandemic. *Current Opinion in Psychology*, *52*, 101632. https://doi.org/10.1016/j.copsyc.2023.101632

Goudeau, S., Sanrey, C., Stanczak, A., Manstead, A., & Darnon, C. (2021). Why lockdown and distance learning during the COVID-19 pandemic are likely to increase the social class achievement gap. *Nature Human Behaviour*, *5*(10), 1273–1281. https://doi.org/10.1038/s41562-021-01212-7

Gramlich, J. (2023, March 2). *Mental health and the pandemic: What U.S. surveys have found*. Pew Research Center. https://www.pewresearch.org/short-reads/2023/03/02/mental-health-and-the-pandemic-what-u-s-surveys-have-found/

Grzanka, P. R., Frantell, K. A., & Fassinger, R. E. (2020). The White Racial Affect Scale (WRAS): A measure of White guilt, shame, and negation. *The Counseling Psychologist*, *48*(1), 47–77. https://doi.org/10.1177/0011000019878808

Haderlein S. K., Saavedra, A. R., Polikoff, M. S., Silver, D., Rapaport, A., & Garland, M. (2021). Disparities in educational access in the time of COVID: Evidence from a nationally representative panel of American families. *AERA Open*, 7(1), 1–21. https://doi.org/10.1177/23328584211041350

Haller, M., Norman, S., Davis, B., Capone, C., Browne, K., & Allard, C. (2020). A model for treating COVID-19–related guilt, shame, and moral injury. *Psychological Trauma: Theory, Research, Practice, and Policy*, *12*(S1), S174–S176. https://doi.org/10.1037/tra0000742

Hansen, N., Pepitone-Arreola-Rockwell, F., & Greene, A. (2000). Multicultural competence: Criteria and case examples. *Professional Psychology: Research and Practice*, *31*(6), 652–660. https://doi.org/10.1037/0735-7028.31.6.652

Helms, J. E. (1995). An update of Helms's white and people of color racial identity models. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 23–37). Sage.

Hlávka, J., & Rose, A. (2023, May 16). *COVID-19's total cost to the U.S. economy will reach $14 trillion by the end of 2023*. Leonard D. Schaffer Center for Health Policy & Economics. https://healthpolicy.usc.edu/article/covid-19s-total-cost-to-the-economy-in-us-will-reach-14-trillion-by-end-of-2023-new-research/#:~:text=The%20big%20idea,and%20other%20experts%20have%20estimated.

Holt, L. F., & Sweitzer M. D. (2020). More than a black and white issue: Ethnic identity, social dominance orientation, and support for the Black Lives Matter movement. *Self and Identity, 19*(1), 16–31. https://doi.org /10.1080/15298868.2018.1524788

Hooper, M., Nápoles, A., & Pérez-Stable, E. (2020). COVID-19 and racial/ethnic disparities. *JAMA*, *323*(24), 2466–2467. https://doi.org/10.1001/jama.2020.8598

Iyer, A., Leach, C., & Crosby, F. (2003). White guilt and racial compensation: The benefits and limits of self-focus. *Personality and Social Psychology Bulletin*, *29*(1), 117–129. https://doi.org/10.1177/0146167202238377

Jack, R., & Oster, E. (2023). COVID-19, School closures, and outcomes. *Journal of Economic Perspectives*, *37*(4), 51–70. https://doi.org/10.1257/jep.37.4.51

Jacobs, L. (2014). Learning to love White shame and guilt: Skills for working as a White therapist in a racially divided country. *International Journal of Psychoanalytic Self Psychology*, *9*(4), 297–312. https://doi.org/10.1080/15551024.2014.948365

Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional, and relational characteristics of master therapists. *Journal of Counseling Psychology*, *46*(1), 3–11. https://doi.org/10.1037/0022-0167.46.1.3

Kantamneni, N. (2020). The impact of the COVID-19 pandemic on marginalized populations in the United States: A research agenda. *Journal of Vocational Behavior*, *119*, 103439. https://doi.org/10.1016/j.jvb.2020.103439

Khubchandani, J., & Macias, Y. (2021). COVID-19 vaccination hesitancy in Hispanics and African-Americans: A review and recommendations for practice. *Brain, Behavior, & Immunity - Health*, *15*, 100277. https://doi.org/10.1016/j.bbih.2021.100277

Kirksey, L., Tucker, D., Taylor, E., Jr., White Solaru, K., & Modlin, C. S., Jr. (2021). Pandemic superimposed on epidemic: COVID-19 disparities in Black Americans. *Journal of the National Medical Association*, *113*(1), 39–42. https://doi.org/10.1016/j.jnma.2020.07.003

Kocarek, C. E., Talbot, D. M., Batka, J. C., & Anderson, M. Z. (2001). Reliability and validity of three measures of multicultural competency. *Journal of Counseling & Development*, *79*(4), 486–496. https://doi.org/10.1002/j.1556-6676.2001.tb01996.x

Kuhfeld, M., & Lewis, K. (2022). Student achievement in 2021–22: Cause for hope and continued urgency. NWEA. https:// www.nwea.org/research/publication/student-achievement-in2021-22-cause-for-hope-and-continued-urgency

Kuhfeld, M., Lewis, K., & Peltier, T. (2023). Reading achievement declines during the COVID-19 pandemic: Evidence from 5 million U.S. students in grades 3–8. *Reading and Writing*, *36*(2), 245–261. https://doi.org/10.1007/s11145-022-10345-8

Laurencin, C., & McClinton, A. (2020). The COVID-19 pandemic: A call to action to identify and address racial and ethnic disparities. *Journal of Racial and Ethnic Health Disparities*, *7*(3), 398–402. https://doi.org/10.1007/s40615-020-00756-0

Laurencin, C., & Walker, J. (2020). A pandemic on a pandemic: Racism and COVID-19 in Blacks. *Cell Systems*, *11*(1), 9–10. https://doi.org/10.1016/j.cels.2020.07.002

Lind, L. M., Ward, R. N., Rose, S. G., & Brown, L. M. (2023). The impact of the COVID-19 pandemic on psychological service provision, mental health practitioners, and patients in long-term care settings: Results from a rapid response survey. *Professional Psychology: Research and Practice*, *54*(1), 93–102. https://doi.org/10.1037/pro0000486

Litam, S. (2020). "Take your Kung-flu back to Wuhan": Counseling Asians, Asian Americans, and Pacific Islanders with race-based trauma related to COVID-19. *The Professional Counselor*, *10*(2), 144–156. https://doi.org/10.15241/sdal.10.2.144

Litam, S. D. A., Ausloos, C. D., & Harrichand, J. J. (2021). Stress and resilience among professional counselors during the COVID-19 pandemic. *Journal of Counseling & Development*, *99*(4), 384–395. https://doi.org/10.1002/jcad.12391

Louis-Jean, J., Cenat, K., Njoku, C., Angelo, J., & Sanon, D. (2020). Coronavirus (COVID-19) and racial disparities: A perspective analysis. *Journal of Racial and Ethnic Health Disparities*, *7*(6), 1039–1045. https://doi.org/10.1007/s40615-020-00879-4

Lund, E. (2020). Even more to handle: Additional sources of stress and trauma for clients from marginalized racial and ethnic groups in the United States during the COVID-19 pandemic. *Counselling Psychology Quarterly*, 34(1), 321–330. https://doi.org/10.1080/09515070.2020.1766420

MacDonald, N. E., & SAGE Working Group on Vaccine Hesitancy. (2015). Vaccine hesitancy: Definition, scope and determinants. *Vaccine*, *33*(34), 4161–4164. https://doi.org/10.1016/j.vaccine.2015.04.036

Mamtani, H., Karaliuniene, R., de Filippis, R., & Nagendrappa, S. (2022). Impact of videoconferencing applications on mental health. *BJPsych International*, *19*(1),1–2. https://doi.org/10.1192/bji.2021.40

McDonald, D., Adams, D., Ebbert, S., & Fernandes, D. (2020, June 13). Thousands march against racism as protests continue around the region. *Boston Globe*. https://www.bostonglobe.com/2020/06/13/metro/scores-show-east-boston-demonstration-march-against-racism/

McIntosh, P. (1998). White privilege: Unpacking the invisible knapsack. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, culture, and gender in clinical practice* (pp. 147–152). The Guilford Press.

Mittal, M., Morgan, A. A., Du, J., Jiang, J., Boekeloo, B., & Fish, J. N. (2023). "Each week feels like a mountain": The impact of COVID-19 on mental health providers' well-being and clinical work. *Professional Psychology: Research and Practice*, *54*(1),103–113. https://doi.org/10.1037/pro0000501

Neto, M. L. R., Oliveira Araújo, F., de Souza, R., Rolim Lima, N., & Lima da Silva, C. (2020). When health professionals look death in the eye: The mental health of professionals who deal daily with the new coronavirus outbreak of 2019. *Frontiers in Medical Case Reports*, *01*(02). https://doi.org/10.47746/fmcr.2020.1205

Neville, H. A., Heppner, M. J., Louie, C. E., Thompson, C. E., Brooks, L., & Baker, C. E. (1996). The impact of multicultural training on White racial identity attitudes and therapy Competencies. *Professional Psychology: Research and Practice*, *27*(1), 83–89. https://doi.org/10.1037/0735-7028.27.1.83

Neville, H., Spanierman, L., & Doan, B. (2006). Exploring the association between color-blind racial ideology and multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology*, *12*(2), 275–290. https://doi.org/10.1037/1099-9809.12.2.275

Noel, T. K. (2020). Conflating culture with COVID-19: Xenophobic repercussions of a global pandemic. *Social Sciences & Humanities Open*, *2*(1), 100044. https://doi.org/10.1016/j.ssaho.2020.100044

Novacek, D., Hampton-Anderson, J., Ebor, M., Loeb, T., & Wyatt, G. (2020). Mental health ramifications of the COVID-19 pandemic for Black Americans: Clinical and research recommendations. *Psychological Trauma: Theory, Research, Practice, And Policy*, *12*(5), 449–451. https://doi.org/10.1037/tra0000796

Ong, P. M. (2020, December 9). COVID-19 and the digital divide in virtual learning. UCLA Center for Neighborhood Knowledge. https://knowledge.luskin.ucla.edu/wp-content/uploads/2020/12/Digital-Divide-Phase2_brief_release_v01.pdf

Paules, C., Marston, H., & Fauci, A. (2020). Coronavirus infections—More than just the common cold. *JAMA*, *323*(8), 707–708. https://doi.org/10.1001/jama.2020.0757

Pfefferbaum, B., & North, C. (2020). Mental health and the COVID-19 Pandemic. *New England Journal of Medicine*, *383*(6), 510–512. https://doi.org/10.1056/nejmp2008017

Ponterotto, J. (1988). Racial consciousness development among White counselor trainees: A stage model. *Journal of Multicultural Counseling and Development*, *16*(4), 146–156. https://doi.org/10.1002/j.2161-1912.1988.tb00405.x

Ponterotto, J. G., & Potere, J. C. (2003). The Multicultural Counseling Knowledge and Awareness Scale (MCKAS): Validity, reliability, and user guidelines. In D. P. Pope-Davis, H. L. K. Coleman, W. M. Liu, & R. Toporek (Eds.), *Handbook of multicultural competencies in counseling and psychology* (pp. 137–153). Sage.

Ponterotto, J. G., & Ruckdeschel, D. E. (2007). An overview of coefficient alpha and a reliability matrix for estimating adequacy of internal consistency coefficients with psychological research measures. *Perceptual and Motor Skills*, *105*(3), 997–1014. https://doi.org/10.2466/pms.105.3.997-1014

Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). A revision of the Multicultural Counseling Awareness Scale. *Journal of Multicultural Counseling and Development, 30*(3), 153–180. https://doi.org/10.1002/j.2161-1912.2002.tb00489.x

Ponterotto, J. G., Rieger, B. P., Barrett, A., Harris, G., & Sparks, R. (1996). Development and initial validation of the Multicultural Counseling Awareness Scale. In G. R. Sodowsky & J. C. Impara (Eds.), *Multicultural assessment in counseling and clinical psychology* (pp. 247–282). Buros Institute of Mental Measurements.

Ponterotto, J. G., Utsey, S., & Pedersen, P. (2006). *Preventing prejudice*. SAGE.

Rowe, W., Bennett, S., & Atkinson, D. (1994). White racial identity models. *The Counseling Psychologist*, *22*(1), 129–146. https://doi.org/10.1177/0011000094221009

Sabnani, H. B., Ponterotto, J. G., & Borodovsky, L. G. (1991). White racial identity development and cross-cultural counselor training: A stage model. *The Counseling Psychologist*, *19*(1), 76–102. https://doi.org/10.1177/0011000091191007

Sáenz, R., & Poston, D. L. (2020, January 17). Big number: the year 2045. *Boston Globe*. https://www.bostonglobe.com/2020/01/17/opinion/big-number-year-2045/

Shah, K., Kamrai, D., Mekala, H., Mann, B., Desai, K., & Patel, R. (2020). Focus on mental health during the coronavirus (COVID-19) pandemic: Applying learnings from the past outbreaks. *Cureus*. https://doi.org/10.7759/cureus.7405

Shelby, R. (2019). White privilege, pathological shame and guilt, and the perversion of morality. In M. McGoldrick & K. V. Hardy (Eds.), *Re-visioning family therapy: Addressing diversity in clinical practice*. Guilford Publications.

Shklarski, L., Abrams, A., & Bakst, E. (2021). Navigating changes in the physical and psychological spaces of psychotherapists during COVID-19: When home becomes the office. *Practice Innovations*, *6*(1), 55–66. https://doi.org/10.1037/pri0000138

Siegel, M., Critchfield-Jain, I., Boykin, M., Owens, A., Muratore, R., Nunn, T., & Oh, J. (2022). Racial/ethnic disparities in state-level COVID-19 vaccination rates and their association with structural racism. *Journal of Racial and Ethnic Health Disparities*, *9*(6), 2361–2374. https://doi.org/10.1007/s40615-021-01173-7

Sim, M. (2020). The COVID-19 pandemic: Major risks to healthcare and other workers on the front line. *Occupational and Environmental Medicine*, *77*(5), 281–282. https://doi.org/10.1136/oemed-2020-106567

Sobo, E., Lambert, H., & Heath, C. (2020). More than a teachable moment: Black lives matter. *Anthropology & Medicine*, *27*(3), 243–248. https://doi.org/10.1080/13648470.2020.1783054

Spanierman, L. B., & Heppner, M. (2004). Psychosocial costs of racism to whites scale (PCRW): Construction and initial validation. *Journal of Counseling Psychology*, *51*(2), 249–262. https://doi.org/10.1037/0022-0167.51.2.249

Spanierman, L. B., Beard, J. C., & Todd, N. R. (2012). White men's fears, white women's tears: Examining gender differences in racial affect types. *Sex Roles*, 67, 174–186. https://doi.org/10.1007/s11199-012-0162-2

Spanierman, L. B., Poteat, V., Wang, Y., & Oh, E. (2008). Psychosocial costs of racism to white counselors: Predicting various dimensions of multicultural counseling competence. *Journal of Counseling Psychology*, *55*(1), 75–88. https://doi.org/10.1037/0022-0167.55.1.75

Steele, S. (1990). White guilt. *The American Scholar*, *59*(4), 497–506.

Sue, D. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, *29*(6), 790–821. https://doi.org/10.1177/0011000001296002

Sue, D., Rivera, D., Capodilupo, C., Lin, A., & Torino, G. (2010). Racial dialogues and White trainee fears: Implications for education and training. *Cultural Diversity And Ethnic Minority Psychology*, *16*(2), 206–214. https://doi.org/10.1037/a0016112

Swim, J. K., & Miller, D. L. (1999). White guilt: Its antecedents and consequences for attitudes toward affirmative action. *Personality and Social Psychology Bulletin*, *25*(4), 500–514. https://doi.org/10.1177/0146167299025004008

Tangney, J., Wagner, P., Hill-Barlow, D., Marschall, D., & Gramzow, R. (1996). Relation of shame and guilt to constructive versus destructive responses to anger across the lifespan. *Journal of Personality and Social Psychology*, *70*(4), 797–809. https://doi.org/10.1037/0022-3514.70.4.797

Tawa, J., Ma, R., & Katsumoto, S. (2016). "All Lives Matter": The cost of colorblind racial attitudes in diverse social networks. *Race And Social Problems*, *8*(2), 196–208. https://doi.org/10.1007/s12552-016-9171-z

Triplett, N. S., Blanks Jones, J. L., Garfias, Y., Williams, N. D., & Dorsey, S. (2023). Policy for equity: Associations between community mental health agency policies and clinicians' cultural competence. *Health Promotion Practice*, 15248399231208422. Advance online publication. https://doi.org/10.1177/15248399231208422

U.S. Department of Education's Office for Civil Rights (OCR). (2021). *Education in a pandemic: The disparate impacts of COVID-19 on America's students*. https://www2.ed.gov/about/offices/list/ocr/docs/20210608-impacts-of-covid19.pdf

Utsey, S., & Gernat, C. (2002). White racial identity attitudes and the ego defense mechanisms used by White counselor trainees in racially provocative counseling situations. *Journal of Counseling & Development*, *80*(4), 475–483. https://doi.org/10.1002/j.1556-6678.2002.tb00214.x

Utsey, S., Gernat, C., & Hammar, L. (2005). Examining White counselor trainees' reactions to racial issues in counseling and supervision dyads. *The Counseling Psychologist*, *33*(4), 449–478. https://doi.org/10.1177/0011000004269058

Vahratian, A., Blumberg, S. J., Terlizzi, E. P., & Schiller, J. S. (2021). Symptoms of anxiety or depressive disorder and use of mental health care among adults during the COVID-19 pandemic—United States, August 2020–February 2021. *Morbidity and Mortality Weekly Report*, *70*(13), 490–494. https://doi.org/10.15585/mmwr.mm7013e2

Wan, W. (2020, May 4). The coronavirus pandemic is pushing America into a mental health crisis. *The Washington Post*. https://www.washingtonpost.com/health/2020/05/04/mental-health-coronavirus/

White, A. I. R. (2020). Historical linkages: epidemic threat, economic risk, and xenophobia. *Lancet (London, England)*, *395*(10232), 1250–1251. https://doi.org/10.1016/S0140-6736(20)30737-6

Wright, B. L., Cross, B. E., Ford, D. Y., & Tyson, C. (2023). When I think of home: Black families supporting their children during the COVID-19 pandemic. *Education and Urban Society*, *55*(5), 515–532. https://doi.org/10.1177/00131245211065415

Yancy, C. W. (2020). COVID-19 and African Americans. *JAMA, 323*(19), 1891–1892. https://doi.org/10.1001/jama.2020.6548

Xiang, Y., Yang, Y., Li, W., Zhang, L., Zhang, Q., Cheung, T., & Ng, C. (2020). Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. *The Lancet Psychiatry*, *7*(3), 228–229. https://doi.org/10.1016/s2215-0366(20)30046-8

Xue, J., Chen, J., Chen, C., Hu, R., & Zhu, T. (2020). The hidden pandemic of family violence during COVID-19: Unsupervised learning of tweets. *Journal of Medical Internet Research*, *22*(11), e24361. https://doi.org/10.2196/24361

APPENDIX A: TABLES

Table 1

Demographic Characteristics of Participants (n= 59)

Characteristic	n	Frequency %
	Gender	
Female	47	79.7%
Male	7	11.9%
Non-Binary	4	6.8%
	Age	
22-25	13	22.0%
26-28	21	35.6%
29-31	16	27.1%
32-34	2	3.4%
35-37	0	0%
38-40	2	3.4%
41-43	2	3.4%
44-46	2	3.4%
	Academic Degree	
Bachelor's	17	28.8%
Master's	42	71.2%
	Doctoral Program Type	
Clinical Psychology	54	91.5%
Counseling Psychology	3	5.1%
School Psychology	1	1.7%
Cognitive Psychology	1	1.7%
Psy.D. / Ph.D.		
Psy.D.	34	57.6%
Ph.D.	25	42.4%
	Program Year	
First	10	16.9%
Second	13	22.0%
Third	10	16.9%
Fourth	7	11.9%
Fifth	16	27.1%
Sixth	3	5.1%
	Currently in Practicum	
Yes	53	89.8%

No	5	8.5%
	Practicum Setting	
Urban	35	59.3%
Suburban	12	20.3%
Rural	5	8.5%
Other	1	1.7%
Not in Practicum	5	8.5%
	Practicum Setting Type	
Forensic	2	3.4%
Behavioral Health	6	10.2%
Inpatient	2	3.4%
Outpatient	16	27.1%
College Counseling	9	15.3%
School	6	10.2%
Veterans Affairs	2	3.4%
Private Practice	2	3.4%
Other	8	13.6%
Not in Practicum	5	8.5%
	Where MCC Learned	
Classes/Activities/Events Associated with Program	26	44.1%
Classes/Activities/Events Not Associated with Program	24	40.7%
Not sure	8	13.6%

Table 2

Participant Scores on WRAS and MCKAS

Instrument/Subscale	*n*	*M*	*SD*
		MCKAS	
Multicultural Knowledge	59	5.11	.95
Multicultural Awareness	59	6.22	.62
Total	59	5.53	.69
		WRAS	
White Guilt	57	4.04	.79
White Shame	57	2.27	.67
Negation	56	1.28	.38
Total	56	2.55	.36

n = Sample size. M = Mean. SD = Standard Deviation.

Table 3

Correlations between Subscales of WRAS and MCKAS

Variable	WRAS-White Guilt	WRAS-White Shame	WRAS-Negation	WRAS – Total
Multicultural Knowledge	.541**	0.226	-0.225	.505**
Multicultural Awareness	.415**	0.049	-.485**	0.176
MCKAS – Total	.597**	0.212	-.343**	.493**

** Correlation is significant at the 0.01 level (2-tailed)

APPENDIX B: INFORMED CONSENT FORM

My name is Daniella Colb – I am a doctoral student in the clinical psychology program at Antioch University New England. I hope you will take part in a research study about the relationship between emotional responses to race-related topics and self-perceived multicultural competence.

The purpose of this study is to explore White psychology trainees' affective responses to race-related material —specifically White guilt, White shame, and negation—and how they relate to trainees' self-perceived levels of multicultural competence (MCC). The information obtained will inform how best to support both the training and emotional needs of future psychologists as they navigate their academic and professional growth.

If you agree to participate, you will be asked to complete a total of three questionnaires – a demographic questionnaire, a questionnaire about multicultural competence and awareness, and a questionnaire about racial affect – that will take a total of approximately 15-20 minutes of your time. The questionnaires includes questions about your practicum setting, your client caseload, classes you have taken in your training, and your responses to hypothetical situations pertaining to racial identity.

The information you provide will be combined with information provided by other participants in the study. No personally identifying information will be gathered and the survey is anonymous.

By participating in the study, you will be providing valuable information about the experiences of psychology trainees during this unprecedented historical moment. Additionally, you will be helping to explore how racial identity can impact trainees both emotionally and professionally.

After participating in the study, you will have the option to send me an email to be entered into a raffle to win a $20 gift card. If interested, you may also email me to request the de-identified results from this project once the data has become available.

Given the sensitive nature of race-related topics for many individuals, there is a small possibility that you may experience emotional and psychological discomfort when reading and responding to some of the survey questions. Resources for those who experience psychological distress resulting from this study will be provided after you sign this consent form. I will also recommend some resources for participants who wish to learn more about racial injustice.)

Aside from potential discomfort from answering questions pertaining to race and racism, we do not anticipate that participation in this project poses any risk to you. If you experience items

within the questionnaire as too stressful, you are free to skip them or to stop filling out the questionnaire. You will not be penalized in any way for choosing not to participate or to stop participating.

Your participation in this survey is entirely voluntary, and will remain confidential. Your name will not appear on any form you complete. If you choose to send me an email to participate in the gift card raffle, just send me an email with the word "raffle" on the subject line. Your email address will remain on a password-protected document and will be deleted following the raffle. If you choose to send me an email to receive the project's final results, please send an email with the word "results" on the subject line. Your email address will remain on a separate password-protected document and will be deleted after I send you the results.

If you have any questions about the project, please contact Daniella Colb at xxxxxx@xxxxx.edu. Please put "Race and COVID Study" in the subject line of any email that you send regarding this project.

If you have any questions about your rights as a research partcipant, please contact Dr. Kevin Lyness, Chair of the Antioch University New England Institutional Review Board at XXXXX@XXXXXX.edu or XXX-XXX-XXXX. You can also contact Dr. Shawn Fitzgerald, Provost and Campus Chief Executive Officer (CEO) at Antioch University New England, at XXXXXXX@XXXXX.edu or XXX-XXX-XXXX.

Thank you for helping us to explore psychology trainees' affective responses to race, and their self-perceived multicultural competence, during the COVID-19 pandemic.

****

By clicking "I Agree," I confirm that a) I am at least 18 years of age, c) I identify as White, c) I am currently enrolled in a doctoral-level psychology program, and d) I agree to take part in this study about the relationship between affective responses to racial topics, and self-perceived levels of multicultural competence, during the COVID-19 pandemic.

- I Agree
- I Do Not Agree

APPENDIX C: DEMOGRAPHIC QUESTIONNAIRE

1. **What is your current age (in years)?**

2. **Gender: how do you identify? (Please choose only one.)**
   Male
   Female
   Transgender
   Non-Binary
   I Would Rather Not Say
   Other

3. **Do you identify as White?**
   Yes
   No
   Other

4. **What is the highest academic degree you currently hold?**
   Bachelor's Degree
   Master's Degree

5. **If you hold a master's degree, what field is it in? (If you hold multiple master's degrees, please include them all.)**

6. **In which of the following fields are you currently pursuing a doctoral degree:**

   Clinical Psychology
   Counseling Psychology
   School Psychology
   Child Psychology
   Other:

7. **What kind of program are you currently in?**

   Ph.D.
   Psy.D.
   Ed.D.

8. **In what state did you grow up? (If more than one, please put the state in which you have spent the majority of your life.)**

9. **If answered "Other" above, please specify:**

10. **In what state are you pursuing your doctorate degree? (If you are currently attending classes remotely, please choose the state in which your program is located, not the state in which you reside.)'**

11. **If answered "Other" above, please specify:**

12. **Please select the number "3" from the following list:**

1
2
3
4
5

13. **What year of your program are you?**

1
2
3
4
5
6
7

14. **How many credits from courses centered on multicultural competence have you taken in your doctoral program so far?**

1
2
3
4
5
…
100 or more

15. **How many practicum/externship placements have you completed (please include any ongoing practicum/externship placement in your total)?**

0

1
2
3
4
5
6
7
8
9
10 or more

16. Do you currently have a practicum/externship placement?
Yes
No

17. What geographical setting is your practicum located in?
Urban
Suburban
Exurban
Rural
I do not currently have a practicum/externship placement
Other

18. What setting type is your current practicum located in?
Behavioral Health/Integrated Care
College Counseling
Forensic
Inpatient
Outpatient Community Mental Health Center
Private Practice
School
I do not currently have a practicum/externship placement
Other

19. OVER THE PAST TWO WEEKS, how many clients did you see (either in person or remotely)?
0
1
2
3
4
5

…
100 or more

20. **OVER THE PAST TWO WEEKS, what percentage of the clients you saw identify as Black (e.g., 10%, 15%, 20%, etc.)?**
0%
1%
2%
3%
4%
5%
…
100%

18. To date, where would you say that you have learned more about multicultural competence?

- In classes/activities/events directly associated with my doctoral program.
- In classes/activities/events not directly associated with my doctoral program.
- I am not sure.

20. Next to each activity, please enter an approximate amount of time IN HOURS (e.g., 1 hour, 2 hours, etc.) that you have spent learning about multicultural competence within each of these activities. If none, please write "N/A."

- Practicum (e.g., clinical supervision, conversations with clients, etc.)
- Employment outside of practicum
- Volunteer work outside of practicum
- Conversations that take place during classes that are not specifically centered on multicultural competence (e.g., during case conference)
- Conversations that take place outside of class-time/practicum with professional/academic contacts (e.g., professors, clinicians, other students)
- Conversations with personal contacts (e.g., friends, family members, etc.)
- Voluntary trainings/courses outside of doctoral program
- TV programs / movies / documentaries
- Televised news
- In-person interest groups
- Online interest groups
- Attended academic events (e.g., presentations, poster sessions)

- Attended political events (e.g., rallies, protests)
- Podcasts
- Travel (personal or professional)
- Other (please specify)

APPENDIX D: EMAIL TO DOCTORAL PROGRAMS AND POTENTIAL PARTICIPANTS

Hello,

My name is Daniella Colb, and I am a fifth year doctoral student in the Clinical Psychology program at Antioch University New England. If you are able, I would greatly appreciate you forwarding the following email—including this brief description of my dissertation topic—to your students:

I am currently seeking participants for my dissertation exploring relationships between affective responses to race-related material, and self-perceived multicultural competence, among White-identifying psychology trainees. I am sending emails to doctoral-level training programs throughout the country to recruit participants.

Are you:

- 18 years or older?
- An individual who identifies as White?
- Currently enrolled in a doctoral-level psychology training program?

If so, please consider completing the survey and brief demographic questionnaire attached to the link below. Completing the questionnaire will likely take less than 20 minutes and you could win one of four gift cards for your time.

The survey is anonymous and voluntary, and this study has secured received IRB approval. If you have any questions or concerns about your rights as a research participant, please contact Dr. Kevin Lyness, Chair of the Antioch University New England Institutional Review Board at XXXXX@XXXXX.edu or XXX-XXX-XXXX. You can also contact Dr. Shawn Fitzgerald, Provost and Campus Chief Executive Officer (CEO) at Antioch University New England, at XXXXX@XXXXX.edu or XXX-XXX-XXXX.

I very much appreciate you taking the time to consider and complete this survey. Please feel free to distribute this email to your fellow trainees.

Sincerely,
Daniella Colb

APPENDIX E: SOCIAL MEDIA POST

Hello,
My name is Daniella and I am a fifth year doctoral candidate in the clinical psychology program at Antioch University New England. **I am conducting a study to learn about the relationship between emotional responses to race-related material, and self-perceived multicultural competence, among White-identifying psychology trainees.** This study has received IRB approval. If you have any questions or concerns about your rights as a research participant, please contact Dr. Kevin Lyness, Chair of the Antioch University New England Institutional Review Board at XXXXX@XXXXX.edu or XXX-XXX-XXXX. You can also contact Dr. Shawn Fitzgerald, Provost and Campus Chief Executive Officer (CEO) at Antioch University New England, at XXXXX@XXXXX.edu or XXX-XXX-XXXX.

Are you:

- 18 years or older?
- An individual who identifies as White?
- Currently enrolled in a doctoral-level psychology training program?

If you answered yes to all three questions, then you qualify for participation in this study!

Your participation in this research would help us better understand how to address and explore race-related topics during the professional development of future psychologists. It would involve completion of several questionnaires that will likely take 15- 20 minutes and, to thank you for your time, you can participate in a raffle to win one of four gift cards. Participation is anonymous, and no personally identifying information will be collected.

Are you interested in participating? If so, please read and sign the informed consent form:

https://docs.google.com/forms/d/e/1FAIpQLScM3Cbq2JdOPKWpZ2YZGW4j198apIsFpKehYnuDPaRagORFWg/viewform?usp=sf_link

This document will give you more information about the nature and purpose of the study, including your rights as a participant and any potential risks and benefits you may receive through your participation. Once you have electronically signed the informed consent form, you will then be redirected to fill out the relevant questionnaires.

Thank you so much for your consideration! If you have any questions or concerns, please feel free to contact me via email at XXXXX@XXXXX.edu.

APPENDIX F: INTERNAL CONSISTENCY OF MCKAS AND WRAS

It is worthwhile to compare coefficient alphas for the MCKAS calculated in this study to those of other studies that employed use of the MCKAS to provide further context for these findings. My data yielded .933 for the Knowledge subscale and .778 for the Awareness subscale. In a study conducted by Constantine et al. (2002) which assessed three different self-report multicultural scales, including the MCKAS, a coefficient alpha of .90 was reported for the multicultural knowledge subscale—also "excellent" according to Ponterotto and Ruckdeschel's (2007) table—and a coefficient alpha of .89 was reported for the multicultural awareness subscale, falling between "good" and "excellent" on the same table (Ponterotto & Ruckdeschel, 2007).

Looking further back, a 2001 study conducted by Kocarek et al. sought to examine the reliability and validity of three measures of multicultural competency—one of which was the Multicultural Counseling Awareness Scale: Form B (MCAS:B), a precursor to the MCKAS (Ponterotto & Potere, 2003). The MCAS:B consisted of 28 Knowledge/Skill items, 14 Awareness items, and 3 Social Desirability items (Ponterotto et al., 1996). In this study, the two factors that became subscales for the MCAS:B were named Knowledge/Skills and Awareness (Kocarek et al., 2001). After being completed by 79 participants, coefficient alphas for the MCAS were calculated to be .91 for the Knowledge subscale and .83 for the Awareness subscale (Kocarek et al., 2001). Based on the table created by Ponterotto & Ruckdeschel (2007), these coefficient alphas would be characterized as "excellent" for Knowledge/Skills subscale and would fall between "good" and "excellent" for the Awareness subscale – similar to that of the Awareness subscale in Constantine et al.'s 2002 study.

The coefficient alphas for all three studies—my dissertation, Constantine et al.'s (2002) study and Kocarek et al.'s (2001) study—all produced coefficient alphas for the Knowledge subscale that would fall within the "excellent" range on Ponterotto & Ruckdeschel's (2007) table. For the Awareness subscale, however, my study's coefficient alpha yielded a somewhat lower score than the two earlier studies, falling between "moderate" and "good" (Ponterotto & Ruckdeschel, 2007). Factors that may have contributed to differences in internal reliability include total number of respondents used in the analyses (59 participants for current study, 259 participants for main analyses in Constantine et al.'s 2002 study, and 79 in Kocarek et al.'s 2001 study) and targeted population (the current study surveyed strictly doctoral-level students while the 2002 study surveyed practicing psychologists at the doctoral, master's, and bachelor's level, and the 2001 study surveyed master's level students). It may also be relevant to consider that in their chapter on MCKAS validity, reliability, and user guidelines, Ponterotto & Potere (2003) posited that "the pattern of coefficient alphas across the subscales indicates that the Knowledge subscale is more reliable (internally consistent) than the Awareness subscale" (Ponterotto & Potere, 2003, p. 148). Nevertheless, coefficient alpha values found for the MCKAS subscales in all three studies indicate adequate levels of internal reliability (Ponterotto & Ruckdeschel, 2007).

The coefficient alphas obtained in this study for the WRAS subscales—.828 for the White guilt subscale, .509 for the White shame subscale, and .734 for the Negation subscale—appear to be aligned with the "adequate to less-than-adequate levels of internal consistency" (p. 68) described in Grzanka et al.'s 2020 studies on the psychometric properties of the WRAS. According to the ratings system created by Ponterotto & Ruckdeschel (2007), my study offered "excellent" internal reliability for White guilt, "moderate" to "good" internal reliability for negation, and "unsatisfactory" internal reliability for White shame. The low internal reliability

reported for White shame—relative to the other two subscales—may speak to the fact that Grzanka et al.'s (2020) studies are self-described as the "first empirical attempt to distinguish White shame psychometrically from White guilt" (Grzanka et al., 2020, p. 72). More research is needed to effectively understand and measure these two affective experiences.