COUNSELING AT THE INTERSECTIONS: COMPARING TRAINEE MULTICULTURAL COMPETENCY

by

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Abstract

This study addressed facets of counselor trainee cultural competency (e.g., perceived attractiveness, assessments of clinical severity and treatment planning, self-efficacy) when working with Black bisexual clients as compared to White bisexual or Black or White heterosexual clients. Due to a paucity of literature addressing Black bisexual clients (Ghabrial & Ross, 2018; Muñoz-Laboy, 2019), complexity of client needs due to balancing intersecting identities (Mays et. al, 2002), and the discrimination clients with multiple diverse identities encounter (Castro & Carnassale, 2019), it is important to assess counselor trainees’ multicultural counseling competence with Black bisexual clients to increase the likelihood they receive competent care. Participants were 151 mental health trainees from graduate counseling, psychology, and related programs in the U.S. who responded to one of four clinical vignettes portraying a cisgender woman, which varied by race (Black/White) and sexual orientation (bisexual/heterosexual). Major findings indicated a significant difference in clinical attractiveness with the Black and bisexual vignette clients perceived as being more attractive clients. No significant differences were found in trainees’ perception of psychological distress, and personal clinical expectations regarding client concerns and identities between vignettes. When identifying top three most salient presenting concerns, depression and academic concerns were appropriately identified for all vignettes, however both the Black and White bisexual clients were identified as having specific relationship concerns as a top salient concern more often than the heterosexual client vignettes. Implications, limitations, and recommendations for future research are discussed.
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Introduction

Both the American Psychological Association (APA, 2017) and the American Counseling Association (ACA, 2014) provide standards and guidelines for multicultural competency. According to Sue et al. (1992) multicultural competency is the knowledge, awareness, and skills necessary for therapists to provide effective counseling services to individuals from diverse racial, ethnic, and cultural backgrounds. Mental health professionals are expected to gain awareness of personal and societal prejudicial attitudes and biases; develop appropriate clinical skills via relevant experience; and gain working knowledge of client needs and issues (ACA, 2014; APA, 2017). However, discrimination and disparities confronted by marginalized populations can be perpetuated within counseling, suggesting that practitioners continue to struggle with meeting these standards (Hays, 2008). In counseling, these disparities become evident in misdiagnosis, biased attitudes, or differing treatment recommendations (Eliason & Hughes, 2004; Garb, 1997; Mohr et al., 2009; Shelton & Delgado-Romero, 2011). The issues with multicultural competency become more complex when working with clients with multiple minority identities – for whom counselors might even be less prepared.

While there are substantial bodies of literature focusing on competence with racially diverse clients and lesbian and gay clients, less literature addresses bisexual clients and very little literature addresses competence with clients who hold multiple minority identities. Additionally, the assessment of cultural competence is often based on counselors’ ratings of their knowledge, skills, and/or awareness for working with the relevant cultural group and these self-assessments are subject to social desirability influences (Barden & Greene, 2015; Constantine & Ladany, 2000). While still based in
the clinician’s own estimate, self-efficacy has been shown to be a reliable indicator of a trainee’s perception of counseling competence (Larson, 1998) and an appropriate alternative (Worthington et al., 2007) to more face valid measures of cultural competence. In order to address a gap in the literature on multicultural competence with clients with multiple diverse identities and shift away from relying on assessments of cultural knowledge, awareness or skills, this study examined the self-efficacy and diagnostic impressions of counselor trainees when working with vignettes of clients with intersecting identities (Black and bisexual) compared to clients identified as bisexual, but not Black, or Black or White heterosexual clients.

**Multicultural Competence and Self-Efficacy**

Sue et al. (1992) defined multicultural competency as having three parts: knowledge, skills, and awareness. Research indicates that multicultural counseling courses significantly increase both the skills and knowledge components of multicultural competency of counselors and trainees, but not always awareness (Manese et al., 2001; Tomlinson-Clarke, 2000); though the literature on coursework and MCC development is mixed (Killian & Floren, 2020). In comparison, personal experience has been shown to be one of the strongest predictors in developing therapist multicultural competency (Hansen et al., 2006; Knox et al., 2003; Tummala-Narra et al., 2012). In a study exploring how Black and White therapists addressed race in psychotherapy, several White therapists reported feeling as though their graduate training did not adequately aid in developing necessary skills to work with clients who were racially different from themselves (Knox et al., 2003). However, Black psychologists’ personal experiences with oppression and diversity, as opposed to knowledge gained from academic settings,
increased their comfort and openness to work with diverse clients and explore cultural discussions (Knox et al., 2003). This indicates that personal experiences, in addition to multicultural coursework, are an important component to developing trainees’ multicultural competency.

Clinicians are more likely to experience warm feelings and positive regard for a client that is viewed as more similar to themselves (Feeser, 1998), potentially impacting their clinical judgments. Additionally, clinicians may indicate an inappropriate diagnosis based upon their comfort level in working with or beliefs about someone from a different racial or ethnic background (Lopez, 1989). The current study assessed whether clinical judgments and attitudes trainees have towards their clients (via measuring client attractiveness) differ based on clinical vignettes of clients with differing identities.

Multicultural counseling competence is often assessed from one of three perspectives: self-assessment by the counselor, assessment by the client, or assessment by a third party (e.g., supervisor; Dunn et al., 2006; Worthington et al., 2007). Research has suggested that common multicultural competency measures, such as the Multicultural Awareness-Knowledge-Skills Survey (MAKSS; D’Andrea et al., 1991) and the Multicultural Counseling Inventory (MCI; Sodowsky et al., 1998), are subject to social desirability influences (Barden & Greene, 2015; Constantine & Ladany, 2000). Measures of counseling self-efficacy have been proposed as an appropriate alternative to self-reports of cultural competence (Worthington et al., 2007). Self-efficacy has been shown to be a reliable indicator of a trainee’s perception of general counseling competence (Larson, 1998). Counseling self-efficacy (CSE) includes counselors’ confidence in being
able to effectively work with a client (Larson et al., 1992) and their perception of their own competence to engage in counseling (Barnes, 2004).

Barden and Greene (2015) asserted that self-efficacy measures are likely to have strong content validity since participants may be less biased when rating perceived confidence with specific skills compared to their overall perceived multicultural competence. Additionally, amount of graduate level multicultural training significantly correlated with school counselors’ levels of multicultural CSE (Holcomb-McCoy et al., 2008). Barden and Greene (2015) identified a positive relationship between self-reported multicultural counseling competency and CSE and suggested that future research either replace existing self-report competency measures and focus more on CSE or measure CSE alongside tools examining competency in counseling trainees. This study used counselor self-efficacy as one aspect of multicultural competency.

**Black Individuals and Mental Health Services**

Research on the experiences of Black clients show they experience discrimination and disparities when seeking and utilizing counseling. When White and Black adults present with the same symptoms, Black clients are more likely to be diagnosed with schizophrenia compared to White clients who are diagnosed with a mood disorder (e.g., depression; Bell et al., 2015; Garb, 1997). This misdiagnosis has lasting impact when one considers that Black individuals diagnosed with schizophrenia are more commonly incarcerated than other racial groups (Hawthorne et al., 2012). Black clients are at greater risk of premature termination from counseling compared to other racial minorities (Trahan & Goodrich, 2015) and statistically underutilize mental health services (Taylor & Kuo, 2019). Several interconnecting factors may help explain this underutilization, such
as perceived stigma, social pressure against attending counseling services, as well as barriers to and difficulties with attaining needed help (e.g., financial concerns and microaggressions by counselors; Taylor & Kuo, 2019). Black individuals also experience higher discrimination in both personal and group counseling modalities compared to White and Latinx individuals (Levin et al., 2002).

**LGBTQ+ Populations and Mental Health**

Homosexuality was removed as a mental illness from diagnostic manuals in 1973, a move supported by the APA (Conger, 1975) and guidelines have been created to recommend best practices for working with sexual minority individuals (ALGBTIC LGBQQIA Competencies Taskforce et al., 2013; APA, 2012, 2015). Heterosexual discrimination and internalized heterosexism (Brewster et al., 2016), struggles with issues related to coming out (Legate et al., 2017), and conflict between their identity and belief systems (Wood & Conley, 2014) are all issues that can negatively impact the mental and physical health of LGBTQ+ individuals as well as their social relationships. Sexual minorities often draw upon personal and community-level coping mechanisms and resources to develop resilience, coping, and hardiness (Meyer, 2003); and individuals who adopt a strong sexual minority identity may be better equipped to manage minority stressors while affirming a positive self-evaluation (Herek & Garnets, 2007). Knowledgeable counselors can assist with the development of important resiliencies; however, they must have the training and competence to work effectively with this population (Rimes et al., 2019).

Unfortunately, members of the LGBTQ+ population often face discrimination and bias in their mental health care as well. Shelton and Delgado-Romero (2011) listed seven
common microaggression themes found in the therapy experiences of LGBQ individuals: assumptions that sexual orientation is the cause of all presenting issues; avoidance and minimizing of sexual orientation; attempts to over-identify with LGBQ clients; making stereotypical assumptions about LGBQ clients; expressions of heteronormative bias; the assumption that LGBQ individuals need psychotherapeutic treatment; and warnings about the dangers of identifying as LGBQ. Encountering these microaggressions in counseling has led to experiencing negative emotional responses, decreased belief in the effectiveness of therapy, and lowered retention within therapy with that therapist (Shelton & Delgado-Romero, 2011). Due to findings such as these, researchers assert a continued need for additional research with sexual minority groups (Meyer et al., 2008), particularly with individuals of color, disability, or low socioeconomic status (Szymanski & Gupta, 2009).

**Bisexual Specific Experiences**

The various sexual and gender minority identities are commonly grouped together within the LGBTQ+ literature; however, research indicates that bisexual individuals’ experiences differ from those of other sexual minority persons (Chan et al., 2020; Firestein, 1996). Specifically, they encounter stigma separate from other sexual minority identities, such as the belief that they are more promiscuous or more confused in their identity than other sexual minority individuals (Alarie & Gaudet, 2013; Rodríguez Rust, 2000). According to the Human Rights Campaign (HRC, n.d.), 50% of the LGB population identify as bisexual, making them the largest sexual minority group within the LGBTQ+ community. Although definitions of bisexuality differ within research (Scherrer, 2013), bisexuality includes those who are emotionally, romantically, or
sexually attracted to more than one sex, gender or gender identity, though not necessarily simultaneously, in the same way, or to the same degree (HRC, n.d.); and may be considered an umbrella term for any polysexual identities including pansexual, sexually fluid, and queer.

Bisexual people may have adverse experiences within both heterosexual and gay communities (Mulick & Wright, 2002), including experiences of biphobia as well as bi-erasure (Hertlein et al., 2016; McLean, 2008; Ochs, 1996). Bi-erasure refers to the omission of bisexuality or claims that bisexuality does not exist (Eisner, 2013) and biphobia is based on negative stereotypes and irrational fears regarding bisexual individuals (Ochs, 1996). When people assume or assert that a bisexually identifying individual is heterosexual or gay, they are practicing bi-erasure (Eisner, 2013). These experiences may be overt or might be experienced in the form of multiple, repeated microaggressions. Either way, they contribute to experiences of minority stress (Sarno & Wright, 2013).

Research indicates that bisexual individuals experience depression, anxiety, mood disorders, PTSD, heavy drinking, domestic violence, sexual assault, and poverty at higher rates than other cisgender populations (Alessi et al., 2013; HRC, n.d.; la Roi et al., 2019; Pakula et al., 2016). Bisexual women have indicated lower identity centrality, lower levels of being “out,” and higher identity uncertainty compared to lesbian peers (Dyar et al., 2015). Bisexual individuals have also reported lower levels of identity valence, less integration of sexual identity into their self-concepts (Lambe et al., 2017), less self-disclosure, lower community connection (Balsam & Mohr, 2007; Kertzner et al., 2009), and a higher frequency of need for community contact to buffer the relationship between
depression and bi-negativity relative to their lesbian/gay peers (Lambe et al., 2017). The number of bisexual individuals and their unique identity-based experiences underscore the importance of understanding their unique needs and ensuring that clinicians are trained to work with them (Dyar & London, 2018; Hertlein et al., 2016).

**Bisexual Experiences with Mental Health Services**

In addition to having higher rates of mental health struggles, Page (2004) found that bisexual individuals report discriminatory experiences within counseling settings, such as invalidation of bisexuality, lack of knowledge and skills working in bisexual issues, and pathologizing bisexual attractions or behaviors. Therefore, it is possible that even when bisexual individuals seek counseling to counteract negative impact of discrimination, they are still subjected to discriminatory experiences that can decrease their overall well-being.

Research examining practitioners’ attitudes towards sexual minorities rarely explores attitudes towards bisexual individuals separate from gay and/or lesbian individuals (Mohr et al., 2009). However, studies have found that counselors’ attitudes about bisexuality generally coincide with biphobic stereotypes and are more negative toward bisexual than lesbian/gay clients (Eliason & Hughes, 2004; Mohr et al., 2009). Research indicates that stereotypes about bisexuality negatively impact counselors’ perceptions about their clients’ overall functioning, feelings about treating the client, and assessment of the seriousness of their problems (Mohr et al., 2009). However, counselors who were affirming of bisexual identities were less likely to perceive the bisexual client as having issues related to bisexual stereotypes than those who did not perceive
bisexuality as a legitimate identity (Mohr et al., 2001); this indicates that negative attitudes and perceptions of bisexual clients can impact clinical judgment.

Intersectionality Theory

Intersectionality theory has been applied to research that focuses specifically on intersections of minority identities. Intersectionality is the term originally coined by Black feminist legal scholar Kimberlé Crenshaw (1989); however, the concept underlying intersectionality dates back further than that, to Sojourner Truth’s 1851 speech at the Women’s Convention in Akron, Ohio. Both Kimberlé Crenshaw and Sojourner Truth laid the foundations of this theoretical perspective by describing how Black women have discriminatory experiences that cannot be simply explained by being a woman or being Black, but whose explanation requires consideration of the intersection of both identities.

From this foundation, intersectionality evolved into a theoretical framework that explains how interlocking systems of oppression create unique experiences for individuals as a result of their multiple marginalized identities (Cole, 2009). This framework is often cited when discussing any intersecting minority identities (Cor et al., 2018). Due to intersectionality’s original focus on Black women, much of the research has centered on the intersections of gender and race, which have been used to address the multitude of health disparities related to intersecting systemic oppressions (Egede, 2006; Lewis et al., 2017). Recently, intersectionality research has broadened to include LGBTQ+ identities as they intersect with race, gender, and socioeconomic class (Dyar et al., 2015; Gates & Newport, 2012; Gates, 2013; Grzanka & Miles, 2016). The synergistic effect of multiple marginalized identities means that mental health practitioners must
consider additional factors (e.g., systemic barriers, protective factors, stigma) when working with LGBTQ+ clients of color or others with multiple identities (Bowleg, 2012; Cole, 2009; Crenshaw, 1989).

**LGBTQ+ Black, Indigenous, People of Color (BIPOC)**

Current evidence suggests that multiply oppressed groups exhibit higher risk for some mental health problems, particularly depression symptoms (Vargas et al., 2020). LGBTQ+ BIPOC individuals can experience different forms of discrimination within the LGBTQ+ community (i.e., being fetishized; Sung et al., 2015) based on their racial/ethnic identity (Kulick et al., 2017). LGBTQ+ BIPOC individuals are exposed to excess stress through combinations of homophobia, transphobia, and racism (Cyrus, 2017; Walsh, 2016); at times confronting homophobia within their own racial/ethnic community, experiencing alienation from the LGBTQ+ community, and simultaneously managing their own internalized homophobia (Diaz et al., 2001).

Trahan and Goodrich (2015) focused on the process of disclosing an LGBT status with families in the Black community, finding that the context of the Black Baptist church heavily influenced participants’ perception of their sexual identity, disclosure patterns, and led to perceiving an implied need to adopt a heterosexual identity. Participants also noted strict social codes within Black communities that lead to a need to appear heterosexual while privately engaging in same-sex relationships (Trahan & Goodrich, 2015). Trahan and Goodrich (2015) also indicated that LGBTQ+ BIPOC individuals indicated feeling neglected or left out of PRIDE events and social settings, which can negatively impact physical and mental health. Research has also indicated that
Black LGBTQ+ individuals face microaggressions and sexual objectification from within the LGBTQ+ community (Teunis, 2007).

While Black bisexual and lesbian individuals often face greater health risks, Ejaife and Ho (2019) found there was a tendency to avoid or delay healthcare in addition to having lower rates of self-disclosure to their physicians than their White counterparts. Mays et al. (2002) found that Black and Hispanic sexual minority women reported lower rates of receiving preventive care, less healthcare coverage, and less access to healthcare than their Black and Hispanic heterosexual counterparts. Within a national sample, a majority of LGB participants identified experiencing discrimination based on their gender, racial or ethnic, or sexual orientation identities (Bostwick et al., 2014). Although research into LGBTQ+ BIPOC experiences and needs has increased within and outside the field of counseling, researchers still frequently study combined samples of LGBTQ+ and BIPOC persons without attending to important subgroups such as Black bisexual clients.

**Bisexual Black Individuals**

According to the Williams Institute, there are more than one million LGBTQ+ Black individuals currently living in the United States. English et al. (2018) found that it is critical for researchers and clinicians to consider the effects of intersecting racial and sexual minority stigma on emotion regulation in the persistence of psychological and behavioral health inequities facing Black sexual minorities. Additionally, research indicates that Black lesbians and bisexual women have higher rates of tobacco use and heavy alcohol consumption, in addition to frequently lacking insurance and regular sources of healthcare (Mays et al., 2002). Mays et al. (2002) suggested that the greater
risk to the health of Black bisexual and lesbian women is underestimated and noted this would indicate that the needs and issues of Black bisexual and lesbian women may be more complicated due to balancing multiple minority identities. Ghabrial and Ross (2018) found that there are very few studies in the counseling field that focused on bisexual BIPOC and that the lack of racially diverse samples in research results in perpetuating the stereotype that LGBTQ+ individuals are White. Additionally, Trahan and Goodrich (2015) called for training programs to continue increasing the emphasis of LGBTQ+ individuals living with racial disparities.

**Purpose of Study**

Research shows that LGBTQ+ and BIPOC individuals often experience discrimination in counseling (Bell et al., 2015; Shelton & Delgado-Romero, 2011), impacting clinical judgments regarding clients’ presenting concerns and perceived need for psychotherapy (Shelton & Delgado-Romero, 2011), with bisexual individuals experiencing a potentially higher level discrimination from their mental health clinicians (Page, 2004; Shelton & Delgado-Romero, 2011). Historically, early career counselors have reported feeling unprepared to work with culturally diverse clients (Holcomb-McCoy & Myers, 1999), highlighting the need to ensure mental health trainees have the knowledge, skills, and an awareness of the relevant identity factors to provide effective services to clients holding multiple minority identities as indicated in the APA multicultural guidelines (APA, 2017).

Considering the paucity of literature with Black bisexual clients (Ghabrial & Ross, 2018; Muñoz-Laboy, 2019), complexity of needs due to balancing multiple identities (Mays et.al, 2002), and the discrimination they encounter (Castro & Carnassale,
2019), it is important to assess counselor trainees’ multicultural counseling competence with Black bisexual clients to help increase the likelihood that clients receive multiculturally competent care. The present study extends the understanding of counselor trainee cultural competency levels when working with Black bisexual clients as compared to White bisexual or Black or White heterosexual clients. Participants responded to one of four clinical vignettes, varying only by race (Black/White) and sexual orientation (bisexual/heterosexual). All vignettes portrayed a cisgender woman since women seek counseling at higher rates than men (Terlizzi & Zablotsky, 2020).

**Research Question 1**

Will counselor trainees display lower cultural competency with vignettes of Black bisexual clients compared to the other three vignettes when lower cultural competency is defined as assessments of greater client psychological distress and clinical severity, less knowledge/comfort, lower perceived client attractiveness, and lower clinician self-efficacy? Perceived level of multicultural coverage in counseling courses, personal experiences with Black or bisexual individuals, and social desirability will be included as statistical controls in relevant analyses.

**Hypothesis 1a.** Counselor trainees will perceive vignettes of Black bisexual clients as having more psychological distress, (e.g., lower Global Assessment of Functioning (GAF) scores), when compared to vignettes of White bisexual or Black or White heterosexual clients.

**Hypothesis 1b.** Counselor trainees will demonstrate less clinical competence when viewing vignettes of Black bisexual clients, (e.g., higher scores on measures of clinical severity and perceived difficulty, lower ratings of clinical
knowledge/comfort) when compared to vignettes of White bisexual or Black or White heterosexual clients.

**Hypothesis 1c.** Counselor trainees will perceive the vignette of the Black bisexual client as less attractive, (e.g., lower scores on the TPRQ (Therapist Personal Reaction Questionnaire)), when compared to vignettes of White bisexual or Black or White heterosexual clients.

**Hypothesis 1d.** Counselor trainees will have higher counseling self-efficacy based on working with White bisexual or Black or White heterosexual clients (vignettes) than with the Black bisexual client.

**Research Question 2**

Will differences exist in which clinical issues are identified as relevant based on the client presented in the vignette?

**Hypothesis 2.** Participants who receive vignettes of Black bisexual, Black, or White bisexual clients are more likely to rank clinical issues related to minority identities as important concerns when compared to the vignette of the White heterosexual client even though no vignette will specifically mention minority identities as clinically relevant.
Method

Participants

The study sample consisted of 151 graduate-level mental health trainees from training programs (Counseling Psychology, Clinical Psychology, School Psychology, and Counselor Education) within the U.S. Participants ranged in age from 22 to 66 ($M = 27.73$, $SD = 5.29$). The sample included 126 (83.4%) White/Caucasian identifying participants, 10 (6.6%) Black/African American identifying participants, 16 (10.6%) Hispanic/Latinx identifying participants, 9 (6.0%) Asian/Asian American identifying participants, 1 (0.7%) Hawaiian or other Pacific Islander identifying participant, and 1 (0.7%) Middle Eastern identifying participant. Four participants (2.6%) identified as multiracial or biracial. The majority of the sample (82.8%) identified as cisgender women, 12.6% identified as cisgender men, 0.7% identified as transgender men, 4.0% identified as genderqueer/gender non-binary. Participants identified their sexual orientation as heterosexual (64.9%), bisexual (17.9%), pansexual (4.6%), lesbian (4.0%), queer (3.3%), asexual (2.0%), gay (1.3%), questioning (0.7%), and 1.3% preferred not to identify their sexual orientation.

This study sample appears to be representative of current U.S. mental health professionals and psychologists both racially and gender-wise, with recent estimates of the field comprising approximately 80-83.0% White, 1-4.0% Asian/Asian American, 3-6.7% Black/African American, 7-9.0% Latinx/Hispanic, and the other racial identities comprising about 2.0% of the psychologist field. Estimates of gender frequently appear to be along binary lines, with estimates of 70-76.7% of current U.S. mental health
professionals and psychologists identifying as women, and 23.3-30% identifying as men (APA, 2020; “Mental health worker demographics..,” 2022).

The sample included 72 (47.7%) Ph.D. students, 31 (20.5%) Psy.D. students, 23 (15.2%) M.A. students, 15 (9.9%) M.S. students, 5 (3.3%) M.Ed students, 4 (2.6%) MSW students, and 1 (0.7%) Ed.S. student. Fields of study included: counseling psychology (37.7%); clinical psychology (25.8%), school psychology (3.3%); counselor education (25.8%); art therapy (0.7%); clinical and school psychology (1.3%); clinical and community psychology (0.7%); clinical and counseling psychology (0.7%); counseling and school psychology (0.7%); marriage and family therapy (0.7%); and social work (2.0%). Participants were able to identify on a ladder, what they perceived their SES to be compared to others and values ranged from 1-10 (M = 6.03, SD = 1.51). Other demographic variables included number of diversity courses completed (range 0 - 6, M = 1.99, SD = 1.34) and number of completed supervised graduate practicum/internship semesters (range 1-7+, M = 4.07, SD = 2.27).

Materials

Materials used for this study included four vignettes (one for each experimental condition), questions measuring personal experiences of contact and quality of contact with Black and bisexual individuals, the Marlowe-Crowne Social Desirability Scale (MCSDS) Form-C, the Global Assessment of Functioning (GAF), Clinical Scales (questions asking case conceptualization-type questions), the Therapist Personal Reaction Questionnaire (TPRQ), the Counseling Self-Estimate Inventory (COSE), a list of possible presenting concerns taken from the Clinician Index of Client Concerns (CLICC; Center for Collegiate Mental Health [CCMH], 2013), and 5 manipulation and attention check
items that were integrated throughout the survey. The questionnaires were created and data collected using Qualtrics, an online survey platform.

**Measures of Descriptive and Control Variables**

**Demographic questionnaire.** The demographic questionnaire collected information regarding participants’ age, gender, race/ethnicity, sexual orientation, socioeconomic status, program type (area in the field of counseling/psychology, doctoral versus masters), number of semesters in a supervised graduate practicum, number of multicultural courses, and length of time as an employed mental health practitioner (if applicable). In addition, to determine perceived quality of multicultural graduate training, participants reported on 5-point Likert scales (1 “Strongly Disagree” to 5 “Strongly Agree”) if they perceived BIPOC and LGBTQ+ issues to have been adequately covered in their graduate experiences and whether they felt they had been trained to work with these client populations. These last four questions addressing training were averaged together to indicate quality of multicultural training. The alpha coefficient for this set of training quality questions was .85.

**Personal Contact.** Participants were questioned about their level of experience interacting with bisexual and Black individuals. To measure interaction experiences with bisexual individuals, respondents were asked to identify if they had a family member, close friend, or personal acquaintance who identifies as bisexual, have worked with a bisexual client, or have seen bisexual individuals represented in the media. They were able to choose as many of the relationships as applied to them and this question was used to assess quantity of contact. Participants were then asked to indicate their overall perception of their past interactions with bisexual individuals (quality of contact). The
contact quality questioned used a 6-point Likert scale that ranges from 1 “very negative” to 6 “very positive” with an option for not applicable/no interaction. Participants then responded to the same above questions, with wording changed by replacing “bisexual” with “Black.” The two items measuring quantity of contact were summed for a quantity of contact with Black and bisexual individuals score; higher scores indicate greater level of contact. The two quality of contact questions were summed to provide a quality of contact with Black and bisexual individuals score; higher scores indicate more positive contact. Internal consistency was examined for the Black and bisexual quantity of contact (2 items; $\alpha = .69$) and quality of contact (2 items; $\alpha = .77$) scores.

The Marlowe-Crowne Social Desirability Scale (MCSDS) Form-C (Crowne & Marlowe, 1960; Reynolds, 1982). This instrument was originally a 33-item scale (Crowne & Marlowe, 1960), but was shortened to 13 items (Reynolds, 1982). The 13-item instrument assesses participants’ tendency to answer questions in a manner that portrays themselves in highly favorable ways. The items are answered as either true or false and are summed for a total score of 13 to 26 (e.g., "I am always willing to admit it when I make a mistake"). The internal consistency reliability for scores on this scale has been shown to be .78 with undergraduate students (Reynolds, 1982). The 13-item questionnaire was administered in this study to control for participants’ social desirability when answering questions about their perceived cultural competence for working with clients portrayed in the vignettes. The alpha coefficient for this sample was .74.

Measures of Clinical Functioning Assessing Cultural Competency

The Global Assessment of Functioning (GAF). The GAF is a numeric scale used by mental health clinicians and physicians to rate the social, occupational, and
psychological functioning of an individual (e.g., how well one is meeting various problems in living). The GAF was originally introduced as Axis V of the Diagnostic and Statistical Manual, 3rd edition (DSM-III; American Psychiatric Association, 1980), eventually evolving to be a diagnostic axis in the DSM-IV (American Psychiatric Association, 1994). It is presented as a 100-point scale, with 1 representing lowest possible functioning and 100 representing highest overall adaptive functioning (Mossbarger, 2005).

**Clinical Scales.** Clinical judgments (i.e., diagnosis, symptom severity, prognosis, treatment approach, length of therapy, and therapy outcome) have been used to measure bias in previous psychotherapy research (Garb, 1997). To determine the skill component of multicultural competency, four clinical judgment ratings were included in the present study. Participants were asked to rate the client along the following clinical judgments (similar to those previously utilized by Dougall & Schwartz, 2011) using a 5-point Likert-type scale: perceived difficulty working with the client (1 = “Very Easy” to 5 = “Very Difficult”), likelihood of treatment success with the vignette client (1 = “Very Likely” to 5 = “Very Unlikely”); and rating the severity of the clients presenting problems (1 = “Mild Problems”, 3 = “Moderate Problems”, and 5 = “Severe/Crisis Problems”). These answers were summed to create a clinical judgment scale with higher scores indicating greater difficulty/clinical severity. Preliminary EFA analyses were conducted to evaluate the created clinical judgment scale; information on the EFA is presented in the Results. Additionally, clients were asked about anticipated length of treatment recommended (1 = “No Treatment Needed”, 2 = “Brief Counseling or 1-3 sessions”, 3 = “Short-Term Counseling or 4 - 10 sessions”, 4 = “Longer-Term
Counseling or 10-15 sessions”, and 5 = Long-term Counseling or 16 or more sessions”) and were also be asked whether they would more likely refer this client to a practicum student (coded as 1), an intern (coded as 2), or senior staff member (coded as 3) to determine their perception of how complex the case is. As the data from these questions were nominal/categorical, these items were examined separately rather than combined with the other judgment items.

Additionally, participants were asked to rate how knowledgeable they felt about the client’s concerns, how knowledgeable they were about the clients’ identities, how comfortable they believed they would be in working with the client, and how well they felt their training had prepared them for working with their client. These items are answered on a 5-point Likert-type scale ranging from 1 (very knowledgeable, comfortable, or prepared) to 5 (not at all knowledgeable, comfortable, or prepared). These four questions were combined to create a comfort/knowledge scale with higher scores indicating less knowledge/comfort working with the client. Preliminary EFA analyses were conducted to evaluate the created clinical knowledge/comfort scale; information on the EFA is presented in the Results.

**Therapist Personal Reaction Questionnaire (TPRQ; Davis et al., 1977; Tryon, 1989).** The TPRQ is a 15-item instrument used to measure mental health trainees’ anticipated feelings about working with the vignette client (Tryon, 1989). The full scale is a measure of overall attractiveness of a client from the perspective of the clinician, with higher scores reflecting more attractiveness (Tryon, 1989). According to Tryon (1989), the TPRQ is an appropriate measure to measure a therapist’s attitude towards their client during the therapy process; in this study it will help examine the trainees’ attitude
towards their vignette client. In a cluster analysis, Tryon (1989) found two clusters. Cluster one has seven items assessing the attractiveness of the client as a psychotherapy candidate after one session (e.g., “I have a warmer, friendlier reaction to this client than to others”). Cluster two has eight items assessing how well the session went (Tryon, 1992). An example items is, “It was hard to know how to respond to this client in a helpful way.” Adequate internal consistency was established as evidenced by a Cronbach’s alpha of .89 for cluster one and of .82 for cluster two. The 15 items are rated on a 5-point Likert-type scale from 1 (“strongly disagree”) to 5 (“strongly agree”), with six items negatively scored and all items summed for a total score. Some items were altered to reflect that the participants have not worked with the client in the vignette (e.g., changing “I felt ineffective with this client” to “I would feel ineffective with this client”). Similar changes were made in a study by Mohr et al. (2009). Internal consistency reliabilities greater than .80 have been reported for scores on the scale (Tryon, 1989) and were .75 for the altered items in the study done by Mohr et al. (2009). In this study with graduate mental health trainees internal consistency reliabilities for the full scale, cluster one, and cluster two were .71, .74, and .62 respectively.

Counseling Self-Estimate Inventory (COSE; Larson et al., 1992). Larson et al. (1992) developed the COSE to determine counselors’ self-efficacy. Counseling self-efficacy is defined as a counselor’s perception of his or her ability to effectively counsel a client. The COSE is a 37-item scale with five factors that reflect counselor trainees' confidence in using microskills (12 items), attending to process (10 items), dealing with difficult client behaviors (7 items), behaving in a culturally competent way (4 items), and being aware of one's values (4 items). Items are rated on a 6-point Likert-type scale,
ranging from 1 ("Strongly Disagree") to 6 ("Strongly Agree)." Some items were slightly altered to reflect that the participants would not actually work with the client in the vignette (e.g., changing “I feel confident that I will appear competent and earn the respect of my client.” to “I feel confident that I would appear competent and earn the respect of my client.”). The total score range represents the trainee’s’ level of self-efficacy beliefs; scores may range from 37 to 222, with higher scores representing higher levels of self-efficacy.

Internal consistencies among counselor trainees enrolled in introductory pre-practicum courses range from $\alpha = .93$ (COSE total) to $\alpha = .62$ (Awareness of Values). Test-retest reliability coefficients for COSE total and subscale scores appear adequate over a 3-week test-retest period with counselor trainees, ranging from $r = .87$ (COSE total) to $r = .68$ (Microskills). Larson and Daniels (1998) asserted that the COSE appears to be the most widely used of the common self-efficacy measures and has the most adequate psychometric properties. The COSE is positively related to counselor performance, self-concept, problem-solving appraisal, and performance expectations and has been indicated as sensitive to change over the course of a master's practicum and across different counselors with different training levels (Larson et al., 1992). The total scale score was used within this study. Internal consistency reliability for the full COSE scale was .92.

**The Clinician Index of Client Concerns (CLICC; Center for Collegiate Mental Health [CCMH], 2013).** The CLICC was developed by CCMH’s Advisory Board, comprised of approximately 12 counseling center professionals who represent diverse college and university counseling centers, to assist with reporting on the most
common presenting concerns of counseling center clients. The CLICC is a checklist of 44 client concerns that clinicians use following an initial appointment with a new client. Clinicians indicate all the concerns applicable to the client and identify the “top concern” of all those selected. The two-part approach was intended to encapsulate the complexity of each client, while highlighting each individual client’s primary concern. For the purposes of the present study, only 20 of the client concerns that are most pertinent to the issues in the vignettes were included. For example, “discrimination” was retained, but “stalking” was not. Participants were asked to identify whether they perceive items to be a presenting concern for the fictional client (Yes = 1, No = 0). Participants were then also asked to identify the three most salient presenting concerns to the client and rank order them (1-3).

**Manipulation/Attention check items.** Five items were used to assess whether participants attended to the sexual orientation and race of the vignette client (manipulation checks) and followed the survey instructions. Two items asked participants to indicate their client’s sexual orientation (heterosexual, bisexual) and their race (Black, White). Three other items asked participants to either leave specific items blank or identify a particular answer for that question. Data were not analyzed from participants whose responses did not correctly identify the client’s identities or correctly follow the instructions.

**Client Vignettes.** Participants were randomly assigned to receive one of the four vignettes depicting a client presenting to counseling with concerns of mild depression and asked to picture themselves as the counselors for the client. In their role as counselors, they were told they would be completing questionnaires regarding diagnostic
impressions, symptom severity, and treatment assignment for this client. The vignettes featured a cisgender woman client who identified as either Black and heterosexual, White and bisexual, White and heterosexual, or Black and bisexual (Appendix A). Other than race and sexual orientation, the four vignettes were identical. The presenting concern of depression was chosen based on a study using the Clinician Index of Client Concerns (CLICC) with a sample of 1308 clinicians rating the presenting concerns of 53,194 clients after an initial session. When divided by sexual orientation and race, both bisexual clients and Black clients were identified as having depression ranked as their second most common primary concern (Pérez-Rojas et al., 2017). After reading the vignette, participants completed the instruments in relation to the client in the vignette. The vignettes were constructed by the primary investigator and reviewed by graduate-level trainees and faculty, encompassing varying racial, ethnic, and sexual orientations.

**Procedure**

The study was approved by the University of Memphis IRB. Participants in the current sample were recruited from the target population using snowball sampling and convenience sampling methods. Specifically, electronic recruitment included sending recruitment requests through professional and academic email listservs (e.g., APA Division 17 Student listserv - SAS), emailing recruitment requests to professors/training directors/department chairs of APA and Master-level accredited programs (e.g., CCPTP listserv, Division 17 listserv), and dissemination of survey links using social media platforms (e.g., Facebook, Reddit). Individuals who completed the survey were asked to pass the information about the study to appropriate peers and colleagues. Upon receipt of
the recruitment email/message, participants were asked to participate in a study focused on trainee clinical decision making with various clients.

Following acknowledgment of the informed consent, participants were directed to the survey items. The survey pages were locked so that participants were unable to return to previously completed questions or skip ahead to other scales, in order to prevent hypothesis guessing. Data collection utilized Qualtrics survey platform. Participants were not compensated for their participation.
Results

Preliminary Analysis

Following the completion of the collection process data were screened to ensure validity of responses, identify outliers, test assumptions, and establish that using ANCOVA analyses was appropriate. The full dataset included responses from 283 graduate-level trainees. The data were first screened for participants who did not respond accurately to the attention check items included in the survey. Of the 26 participants who did not pass the attention checks, 10 identified the incorrect sexual orientation for their vignette (notably nine thought their bisexual client was heterosexual), two identified the incorrect race for their vignette, and 14 failed attention checks within the surveys asking participants to identify specific answer options. Next, 61 participants were excluded due to stopping the survey after being assigned to a vignette condition and having more than 5% data (Schafer, 1999), 29 were excluded for stopping the survey prior to being assigned a vignette, and 10 participants were excluded for not meeting the practicum requirement for participation. Subsequent missing data analyses indicated two participants each had one missing item on the TPRQ (each was one item offset from the attention check); these were replaced with the series mean. Less than 3% missing data was observed on descriptive variables relative to the participant demographic data. Analyses focused on participants with less than 5% missing data on all predictor and outcome measures (\(N = 157\)).

To ascertain normality of the distributions, scatterplots, kurtosis, and skewness were examined; kurtosis and skewness between -2 and +2 were deemed as acceptable (Bryne, 2010; George & Mallery, 2010; Hair et al., 2010). Only the GAF variable
violated the normality assumption, and was examined using non-parametric tests. In order to assess for univariate outliers, standardized versions of each variable were created and examined against a criterion of \( z < +/- 3 \). Any identified score exceeding this univariate outlier criterion was deleted from the participants’ overall data, this included data points from the following scales/variables: the TPRQ cluster 2 variable (one data point); the total TPRQ scale variable (one data point); quantity of contact variable (one data point); the quality of contact variable (two data points); the total COSE scale variable (one data point); the Clinical scale skill variable (two data points), and the clinical scale knowledge and comfort variable (one data point). The original data set was also examined for multivariate outliers using a threshold of \( \chi^2 = 43.32 \) (\( p = .001, df = 20 \)) for the Mahalanobis distance (Kleinbaum et al., 2013), identifying six multivariate outliers, and a threshold of one for Cook’s distance (Cook & Weisburg, 1982; Tabachnick & Fidell, 2012), identifying no multivariate outliers. According to Kleinbaum et al. (2013), using more than one method of outlier identification is recommended since relying on one method may not detect all possible outliers. The total response sets from the six participants identified with multivariate outliers were removed from further analysis, leaving a final data set of 151 participants.

Participants were randomly assigned to one of four vignette conditions (Black bisexual, \( n = 39 \); Black heterosexual, \( n = 31 \); White bisexual, \( n = 38 \); White heterosexual, \( n = 43 \)). Group equivalence was assessed by conducting ANOVA procedures comparing demographic variables between groups. No significant differences were observed in number of practicum experiences (\( F (3, 136) = 0.75, p = .53, \eta^2 = .016 \)); employment history (\( F (3, 136) = 0.06, p = .98, \eta^2 = .001 \)); number of diversity courses (\( F (3, 136) = \))
average perceived training quality \((F(3, 136) = 1.41, p = .24, \eta^2 = .030)\); total quantity of contact with Black and bisexual individuals \((F(3, 136) = 0.93, p = .43, \eta^2 = .020)\); total quality of contact with Black and bisexual individuals \((F(3, 136) = 0.94, p = .43, \eta^2 = .020)\); or in social desirability \((F(3, 136) = 0.22, p = .80, \eta^2 = .007)\) by vignette. Additionally, a chi-square analysis indicated there were no significant associations between type of degree being sought \((X^2(6, N = 151) = 5.57, p = .473)\) and vignette type.

**Clinical Scale Exploratory Factor Analysis**

Due to the clinical scales being developed for the study, exploratory factor analysis (EFA) was conducted to determine whether the items grouped together and meaningfully represented an underlying factor. Principal Axis Factoring (PAF) with a non-orthogonal rotation (Promax) was chosen due to possibility factors would be correlated. Initially, the factorability of all seven (three clinical judgement items and four clinical knowledge scale items) continuous clinical scale items was examined. The Kaiser-Meyer-Olkin measure of sampling adequacy was .73, above the commonly recommended value of .6, and Bartlett’s test of sphericity was significant \((\chi^2 (21) = 230.10, p \leq .001)\). Following the recommendations of Worthington and Whittaker (2006), an item was assigned to a factor if its loading was greater than or equal to .32 on that factor and did not cross-load within an absolute value of .15 on any other factor. While the initial two-factor structure was affirmed, using the scree plot; one item had low loading and was deleted. Table 1 presents the initial factor loadings.

A final EFA of the remaining six items suggested no items to delete based on factor loadings (see Table 2). The Kaiser-Meyer-Olkin measure of sampling adequacy
was .76, and Bartlett’s test of sphericity was significant ($\chi^2 (15) = 193.84, p \leq .001$). The 2-factor structure continued to be indicated by the scree plot with Factor 1 including three items assessing knowledge and severity. Factor 2 had three items and was named personal clinical expectations instead of clinical judgment, to better reflect item content.

Table 1

*Initial Factor Loadings for Promax Rotated Two-Factor Solution*

<table>
<thead>
<tr>
<th>Item</th>
<th>Factor Loading Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>How comfortable would you be in having Kimberly as your client?</td>
<td>.93  -.18</td>
</tr>
<tr>
<td>How prepared do you believe you are to work with a client like Kimberly based upon your graduate training?</td>
<td>.72  -.05</td>
</tr>
<tr>
<td>How challenging do you think it would be for you to work with this client?</td>
<td>.51  -.01</td>
</tr>
<tr>
<td>How likely do you think it is that the client will be successful in therapy (i.e., make progress towards goals, decrease symptom severity, etc.)?</td>
<td>.27  .13</td>
</tr>
<tr>
<td>How knowledgeable did you feel about the concerns Kimberly brought up?</td>
<td>.30  .55</td>
</tr>
<tr>
<td>How knowledgeable are you about Kimberly’s identities?</td>
<td>.21  .49</td>
</tr>
<tr>
<td>How would you rate the severity of the Kimberly’s presenting problems?</td>
<td>-.20  .46</td>
</tr>
</tbody>
</table>

*Note.* Bold items indicate loading onto a factor without low loading or cross-loading onto more than one factor within .15.
Table 2

Final Factor Loadings for Promax Rotated Two-Factor Solution

<table>
<thead>
<tr>
<th></th>
<th>Factor Loading Final</th>
</tr>
</thead>
<tbody>
<tr>
<td>How comfortable would you be in having Kimberly as your client?</td>
<td>0.90 -0.16</td>
</tr>
<tr>
<td>How prepared do you believe you are to work with a client like</td>
<td>0.76 -0.06</td>
</tr>
<tr>
<td>Kimberly based upon your graduate training?</td>
<td></td>
</tr>
<tr>
<td>How challenging do you think it would be for you to work with</td>
<td>0.48 -0.01</td>
</tr>
<tr>
<td>this client?</td>
<td></td>
</tr>
<tr>
<td>How knowledgeable are you about Kimberly’s identities?</td>
<td>0.13 0.64</td>
</tr>
<tr>
<td>How knowledgeable did you feel about the concerns Kimberly</td>
<td>0.30 0.51</td>
</tr>
<tr>
<td>brought up?</td>
<td></td>
</tr>
<tr>
<td>How would you rate the severity of the Kimberly’s presenting</td>
<td>-0.21 0.42</td>
</tr>
<tr>
<td>problems?</td>
<td></td>
</tr>
</tbody>
</table>

Note. Bold items indicate loading onto a factor without low loading or cross-loading onto more than one factor within .15.

Determining Analyses Covariates

Based on possibility that trainees’ program coverage of BIPOC and LGBTQIA+ issues, socially desirable responses, and quantity and quality of contact with Black and Bisexual individuals could impact trainees’ conceptualization of the vignette client ‘Kimberly,’ each was examined using Pearson correlations for use as a possible covariate. As presented in Table 3, several descriptor variables correlated with personal clinical expectations (perceived level of multicultural coverage in counseling courses, social desirability, contact quality and quantity) and the COSE total score (social desirability and contact quality) but none of the variables correlated with GAF and the clinical knowledge scale. Therefore, when running analyses for hypotheses 1a through
Id, no covariates were used when examining mean differences in GAF scores or clinical knowledge scores by vignette but social desirability, contact quality, contact quality, and perceived level of multicultural coverage in counseling courses were used as covariates in an ANCOVA when examining differences in personal clinical expectations by vignette. Social desirability and contact quality were used as covariates in an ANCOVA when examining mean differences in counseling self-efficacy of participants by vignette type.

Table 3

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Social Desirability</td>
<td>18.91</td>
<td>2.99</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Contact Quantity</td>
<td>6.92</td>
<td>2.05</td>
<td>-.12</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Contact Quality</td>
<td>11.13</td>
<td>1.03</td>
<td>.19*</td>
<td>.13</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Multicultural coverage</td>
<td>3.19</td>
<td>.93</td>
<td>.14</td>
<td>-.06</td>
<td>.16*</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. COSE</td>
<td>4.78</td>
<td>.49</td>
<td>.33**</td>
<td>.14</td>
<td>.29**</td>
<td>.16</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Client attractiveness</td>
<td>15.46</td>
<td>4.43</td>
<td>.01</td>
<td>.05</td>
<td>-.05</td>
<td>.07</td>
<td>.06</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Clinical knowledge</td>
<td>7.17</td>
<td>1.56</td>
<td>-.14</td>
<td>-.10</td>
<td>-.11</td>
<td>-.00</td>
<td>-.36**</td>
<td>-.17*</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>8. Personal clinical expectations</td>
<td>5.15</td>
<td>1.52</td>
<td>-.25**</td>
<td>-.17*</td>
<td>-.26**</td>
<td>-.17*</td>
<td>-.63**</td>
<td>-.05</td>
<td>.45**</td>
<td>-</td>
</tr>
<tr>
<td>9. GAF</td>
<td>65.55</td>
<td>7.57</td>
<td>.03</td>
<td>.12</td>
<td>.02</td>
<td>-.05</td>
<td>.05</td>
<td>.31**</td>
<td>-.21**</td>
<td>-.05</td>
</tr>
</tbody>
</table>

Note. COSE = Counselor Self-Efficacy total score.
*p < .05 (two-tailed). **p < .01 (two-tailed).
**Question 1**

The initial question explored whether counselor trainees would display lower cultural competency with vignettes of Black bisexual clients compared to the other three vignettes when lower cultural competency is defined as assessments of greater client psychological distress and clinical severity, less knowledge, lower perceived client attractiveness, and lower clinician self-efficacy.

**Hypothesis 1a**

The first hypothesis proposed that counselor trainees would perceive vignettes of Black bisexual clients as having more psychological distress, (e.g., lower GAF scores), when compared to vignettes of White bisexual or Black or White heterosexual clients. Kruskal-Wallis Test was conducted to examine the differences on how client’s intersecting identities impacted trainee perception of severity. Significant differences were found between vignette clients on GAF scores ($H (3) = 8.18$, $p = .042$). A Dunn-Bonferroni post hoc analysis indicated that there was a difference between medians of the Black bisexual vignette (86.45) and the White heterosexual vignette (60.67) on GAF scores (see Table 4). No other significant differences were found between vignette groups GAF median scores (Black heterosexual = 78.31; White bisexual = 80.74). This indicates that in this sample of trainees, Black bisexual clients were viewed as less severe than the White heterosexual clients. Although there was a significant difference in perceived severity by vignette, it was not in the expected direction and Hypothesis 1a was not supported.
Table 4

Summary of the Kruskal-Wallis Vignette Pairwise Comparisons on GAF scores

<table>
<thead>
<tr>
<th>Vignette Comparisons</th>
<th>H</th>
<th>Std. error</th>
<th>Standardized H</th>
<th>p</th>
<th>Adjusted p</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Heterosexual - Black Heterosexual</td>
<td>17.63</td>
<td>10.21</td>
<td>-1.726</td>
<td>.084</td>
<td>.506</td>
</tr>
<tr>
<td>White Heterosexual - White Bisexual</td>
<td>20.06</td>
<td>9.65</td>
<td>2.08</td>
<td>.038</td>
<td>.226</td>
</tr>
<tr>
<td>White Heterosexual – Black Bisexual</td>
<td>-25.77</td>
<td>9.59</td>
<td>-2.69</td>
<td>.007</td>
<td>.043</td>
</tr>
<tr>
<td>Black Heterosexual - White Bisexual</td>
<td>2.43</td>
<td>10.49</td>
<td>0.23</td>
<td>.817</td>
<td>1.000</td>
</tr>
<tr>
<td>Black Heterosexual - Black Bisexual</td>
<td>8.14</td>
<td>10.43</td>
<td>0.78</td>
<td>.435</td>
<td>1.000</td>
</tr>
<tr>
<td>White Bisexual - Black Bisexual</td>
<td>5.71</td>
<td>9.88</td>
<td>-0.58</td>
<td>.563</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Note. Significance values have been adjusted by the Bonferroni correction for multiple tests.
*p < .05. **p < .001.

Hypothesis 1b

The second hypothesis posited that trainees would demonstrate less clinical competence (e.g., lower scores on clinical scales of knowledge and higher scores on clinical severity/perceived difficulty) when considering vignettes of Black bisexual clients, when compared to vignettes of White bisexual or Black or White heterosexual clients. Responses for three of the clinical judgment/severity scale items were categorical and differences on these aspects of clinical judgment were tested using chi-square tests of independence. Results showed that there were no significant associations between clinician referral level ($\chi^2 (6, N = 151) = 9.52, p = .147$), recommended length of counseling ($\chi^2 (9, N = 151) = 10.18, p = .336$), or likelihood of client success ($\chi^2 (6, N = 151) = 7.43, p = .283$) and vignette condition.

A one-way ANCOVA was used to determine differences between vignettes based on participants’ personal clinical expectations working with their client (see Table 5). Based
on preliminary analyses examining possible covariates, perceived level of multicultural coverage in counseling courses, personal contact quality and quantity experiences with Black or bisexual individuals, and social desirability were included as statistical controls. The assumption of homogeneity of variance was assessed using Levene’s Test of Equality of Variance ($p < .05$) and met. Homogeneity of regression slopes was assessed and demonstrated due to an absence of interactions between the covariates (perceived level of multicultural coverage in counseling courses, personal contact quality and quantity experiences with Black or bisexual individuals, social desirability) and vignette condition on the personal clinical expectations variable ($p = .65, .41, .08, \text{ and } .09$ respectively). No main effect was found on vignette type with the personal clinical expectations scale ($F (3, 141) = 0.62, p = .602, \eta^2 = 0.01$). These findings indicate there were no significant differences found in trainee expectations in working with the client based on her demographic differences.

**Table 5**

*Summary of the ANCOVA Analyses of Personal Clinical Expectations by Vignette*

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>$\eta^2$</th>
<th>Observed power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette Type</td>
<td>3</td>
<td>1.23</td>
<td>0.62</td>
<td>.13</td>
<td>.177</td>
</tr>
<tr>
<td>Multicultural Coverage</td>
<td>1</td>
<td>4.27</td>
<td>2.15</td>
<td>.015</td>
<td>.308</td>
</tr>
<tr>
<td>Contact Quality</td>
<td>1</td>
<td>8.09</td>
<td>4.08*</td>
<td>.028</td>
<td>.518</td>
</tr>
<tr>
<td>Contact Quantity</td>
<td>1</td>
<td>12.72</td>
<td>6.42*</td>
<td>.044</td>
<td>.711</td>
</tr>
<tr>
<td>Social Desirability</td>
<td>1</td>
<td>17.59</td>
<td>8.87*</td>
<td>.059</td>
<td>.841</td>
</tr>
</tbody>
</table>

*Note. Covariates included perceived level of multicultural coverage in coursework, personal contact quality and quantity experiences with Black or bisexual individuals, and social desirability.  
$p < .05$. **$p < .001$.***
An ANOVA was used to examine differences between vignettes based on clinical knowledge. The assumption of homogeneity of variance was met using Levene’s Test of Equality of Variance ($p < .05$). The ANOVA indicated a main effect for vignette type on the clinical knowledge scale ($F(3, 147) = 2.68, p = 0.049, \eta^2 = 0.05$), however the effect size was in the small to medium range. Results of the ANOVA are presented in Table 6. Tukey’s HSD Test for multiple comparisons did not find any statistically significant differences among vignette means, potentially indicating there was not enough power to identify significant differences between specific group means. These results show that in this sample of mental health trainees, there is a significant, but small, difference in level of perceived knowledge based on client demographics, however it is unclear where those differences lie. Hypothesis 2a was partially supported for knowledge, but not for personal clinical expectations regarding client severity and likelihood of treatment success.

Table 6

ANOVA Analyses of Clinical Knowledge and Client Attractiveness by Vignette

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>df</th>
<th>Mean Square</th>
<th>$F$</th>
<th>$\eta^2$</th>
<th>Observed power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Knowledge</td>
<td>3</td>
<td>6.34</td>
<td>2.68*</td>
<td>.052</td>
<td>.643</td>
</tr>
<tr>
<td>TPRQ-Attractive</td>
<td>3</td>
<td>121.89</td>
<td>6.95**</td>
<td>.124</td>
<td>.977</td>
</tr>
</tbody>
</table>

Note. TPRQ-Attractive = Perceived attractiveness of the vignette client.

* $p < .05$. ** $p < .001$.

**Hypothesis 1c**

Counselor trainees were also hypothesized to perceive the vignette of the Black bisexual client as a less attractive client to work with, (e.g., lower scores on the TPRQ),
when compared to vignettes of White bisexual or Black or White heterosexual clients. An ANOVA was calculated on Cluster 1 of the TPRQ, which focuses on the perceived attractiveness of the client as a psychotherapy candidate (in contrast to Cluster 2, which addresses elements of the session). The assumption of homogeneity of variance was met using Levene’s Test of Equality of Variance ($p = .21$). The vignettes showed a main effect with the TPRQ attractiveness cluster 1, $F (3, 147) = 6.95, p \leq .001, \eta^2 = 0.124$, indicating a medium effect size (see Table 6). Tukey HSD post-hoc comparisons indicated that there was a difference between means of the Black bisexual vignette ($M = 17.36, SD = 3.47$) and the White heterosexual vignette ($M = 13.39, SD = 4.65$). There was also a significant difference between the means of the Black heterosexual vignette ($M = 16.48, SD = 4.37$) and the White heterosexual vignette ($M = 13.39, SD = 4.65$). These results indicate that in this sample of mental health trainees, individuals perceived the Black bisexual vignette as more attractive than the White heterosexual clients. Additionally in this sample of trainees, individuals who received the Black heterosexual client perceived her to be a more attractive client than did those who received the White heterosexual client. This finding was not in the hypothesized direction and Hypothesis 1c was not supported.

**Hypothesis 1d**

Counselor trainees were hypothesized to have higher counseling self-efficacy based on working with White bisexual or Black or White heterosexual clients (vignettes) than with the Black bisexual client. An ANCOVA was calculated using the total COSE scale, with personal contact quality of experiences with Black or bisexual individuals, and social desirability as statistical controls (see Table 7). The assumption of
homogeneity of variance was assessed and met using Levene’s Test of Equality of Variance ($p = .24$). Homogeneity of regression slopes was assessed and demonstrated due to an absence of interactions between the covariates (personal contact quality of experiences with Black or bisexual individuals, social desirability) and vignette condition on the COSE variable ($p = .43$, and $p = .53$ respectively). No main effect was found on vignette type with the full COSE measure, $F(3, 143) = 1.38$, $p = .253$, $\eta^2_p = .03$, indicating that there was no significant difference in trainees’ reported level of self-efficacy between type of vignette. Hypothesis 1d was not supported.

Table 7

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>$df$</th>
<th>Mean Square</th>
<th>$F$</th>
<th>$\eta^2_p$</th>
<th>Observed power</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vignette Type</td>
<td>3</td>
<td>0.28</td>
<td>1.38</td>
<td>.03</td>
<td>.360</td>
</tr>
<tr>
<td>Contact Quality</td>
<td>1</td>
<td>2.08</td>
<td>10.30*</td>
<td>.07</td>
<td>.890</td>
</tr>
<tr>
<td>Social Desirability</td>
<td>1</td>
<td>2.90</td>
<td>14.36**</td>
<td>.09</td>
<td>.964</td>
</tr>
</tbody>
</table>

*Note. Covariates included personal contact quality experiences with Black or bisexual individuals, and social desirability. *$p < .05$. **$p < .001$. |

Question 2

The second question explored whether there were differences by vignette in which clinical issues are identified as relevant. It was hypothesized that those participants who received vignettes of Black bisexual, Black heterosexual, or White bisexual clients would be more likely to rank clinical issues related to minority identities as important concerns when compared to the vignette of the White heterosexual client even though no
vignette specifically mentioned minority identities as clinically relevant. Frequencies of all identified presenting concerns were calculated for each vignette and are presented in Table 8.

Depression was identified by 94% of all the participants across vignette type, correctly identifying the intended presenting concern for the vignette client “Kimberly.” Anxiety was identified for the White bisexual client by 10.5% of the participants, whereas anxiety was identified as a presenting concern by approximately twice that percentage for the White heterosexual (18.6%) and Black bisexual (20.5%) and approximately three times that percentage of participants identified the Black heterosexual client as having a presenting concern of anxiety (29.0%). Trainees with the Black heterosexual vignette identified sleep as a concern at a higher percentage (80.6%) than did any of the other vignettes. Academic performance also appeared to have differences in percentage of endorsement; endorsed by 80.6% of participants with the Black heterosexual vignette and 78.9% of trainees with the White bisexual vignette, compared to slightly lower endorsements from participants with the White heterosexual vignette (72.1%) and those with the Black bisexual vignette (71.8%).

Discrimination was identified for the Black heterosexual client (16.1%) more frequently than it was identified as a concern for Black bisexual vignette (5.1%) and compared to white bisexual (2.6%) and white heterosexual (2.6%) clients. Racial/ethnic/cultural concerns were identified as comparably relevant to the Black bisexual (23.1%) and Black heterosexual vignettes (22.6%), and indicated at higher percentages as a concern when compared to the White bisexual (5.3%) and White heterosexual (0%) vignettes. There was no mention of either sexual concern or gender
identity in the vignette, but a small number of participants identified them as concerns for all vignettes except for the White heterosexual vignette. Additionally, relationship concern (specific) was identified at a higher rate for those with marginalized identities with the highest percent participants endorsing this concern for White bisexual vignettes (73.7%), then Black bisexual vignettes (69.2%), then Black heterosexual vignette (61.3%), with the lowest percentage of participants endorsing this presenting concern from the White heterosexual vignette (53.5%).

Trainees were also requested to identify the top three concerns for their clients; frequencies were calculated by vignette type (see Table 9). The concerns identified at the highest frequencies for the White bisexual vignette were depression (81.6%), relationship problem-specific (47.4%), and academic performance (47.4%). The same three concerns of depression (87.2%), relationship problem-specific (43.6%), and academic performance (33.3%) were the most frequently identified for the Black bisexual vignette. For the White heterosexual vignette the most frequently identified top three concerns were depression (90.7%), academic performance (34.9%), and stress (34.9%). Participants with the Black heterosexual vignette most frequently identified depression (80.6%), social isolation (32.3%), and academic performance (32.3%) as the top three presenting concerns. Hypothesis 2 that concerns related to race or ethnicity would be indicated more frequently for the two Black vignettes was supported. Although not hypothesized, participants identified relationship problems as an important clinical issue more often for the bisexual vignettes.
Table 8

Presenting Concerns by Vignette

<table>
<thead>
<tr>
<th>Presenting Concerns</th>
<th>White bisexual</th>
<th>White heterosexual</th>
<th>Black bisexual</th>
<th>Black heterosexual</th>
<th>Full Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Self-Esteem/Confidence</td>
<td>9</td>
<td>23.7%</td>
<td>7</td>
<td>16.3%</td>
<td>12</td>
</tr>
<tr>
<td>Family</td>
<td>20</td>
<td>52.6%</td>
<td>17</td>
<td>39.5%</td>
<td>16</td>
</tr>
<tr>
<td>Stress</td>
<td>27</td>
<td>71.1%</td>
<td>27</td>
<td>62.8%</td>
<td>23</td>
</tr>
<tr>
<td>Depression</td>
<td>36</td>
<td>94.7%</td>
<td>41</td>
<td>95.3%</td>
<td>36</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4</td>
<td>10.5%</td>
<td>8</td>
<td>18.6%</td>
<td>8</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>1</td>
<td>2.6%</td>
<td>0</td>
<td>0.0%</td>
<td>5</td>
</tr>
<tr>
<td>Discrimination</td>
<td>1</td>
<td>2.6%</td>
<td>1</td>
<td>2.3%</td>
<td>2</td>
</tr>
<tr>
<td>Religion/Spirituality</td>
<td>1</td>
<td>2.6%</td>
<td>1</td>
<td>2.3%</td>
<td>1</td>
</tr>
<tr>
<td>Racial/Ethnic/Cultural concerns</td>
<td>2</td>
<td>5.3%</td>
<td>0</td>
<td>0.0%</td>
<td>9</td>
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<tr>
<td>Self-injurious thoughts/behaviors</td>
<td>1</td>
<td>2.6%</td>
<td>1</td>
<td>2.3%</td>
<td>1</td>
</tr>
<tr>
<td>Trauma</td>
<td>1</td>
<td>2.6%</td>
<td>2</td>
<td>4.7%</td>
<td>1</td>
</tr>
<tr>
<td>Identity development</td>
<td>8</td>
<td>21.1%</td>
<td>7</td>
<td>16.3%</td>
<td>10</td>
</tr>
<tr>
<td>Social isolation</td>
<td>21</td>
<td>55.3%</td>
<td>22</td>
<td>51.2%</td>
<td>20</td>
</tr>
<tr>
<td>Sexual concern</td>
<td>4</td>
<td>10.5%</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
</tr>
<tr>
<td>Suicidality</td>
<td>1</td>
<td>2.6%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
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<tr>
<td>Attention difficulties</td>
<td>16</td>
<td>42.1%</td>
<td>15</td>
<td>34.9%</td>
<td>18</td>
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<tr>
<td>Sleep</td>
<td>24</td>
<td>63.2%</td>
<td>25</td>
<td>58.1%</td>
<td>21</td>
</tr>
<tr>
<td>Relationship Problem (specific)</td>
<td>28</td>
<td>73.7%</td>
<td>23</td>
<td>53.5%</td>
<td>27</td>
</tr>
<tr>
<td>Academic performance</td>
<td>30</td>
<td>78.9%</td>
<td>31</td>
<td>72.1%</td>
<td>28</td>
</tr>
</tbody>
</table>
Table 9

*Top Three Presenting Concerns by Vignette*

<table>
<thead>
<tr>
<th>Presenting Concerns</th>
<th>White bisexual</th>
<th>White heterosexual</th>
<th>Black bisexual</th>
<th>Black heterosexual</th>
<th>Full Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Self-Esteem/Confidence</td>
<td>3</td>
<td>7.9%</td>
<td>1</td>
<td>2.3%</td>
<td>7</td>
</tr>
<tr>
<td>Family</td>
<td>3</td>
<td>7.9%</td>
<td>4</td>
<td>9.3%</td>
<td>6</td>
</tr>
<tr>
<td>Stress</td>
<td>13</td>
<td>34.2%</td>
<td>15</td>
<td>34.9%</td>
<td>8</td>
</tr>
<tr>
<td>Depression</td>
<td>31</td>
<td>81.6%</td>
<td>39</td>
<td>90.7%</td>
<td>34</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1</td>
<td>2.6%</td>
<td>5</td>
<td>11.6%</td>
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</tr>
<tr>
<td>Gender Identity</td>
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<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Discrimination</td>
<td>1</td>
<td>2.6%</td>
<td>1</td>
<td>2.3%</td>
<td>0</td>
</tr>
<tr>
<td>Religion/Spirituality</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Racial/Ethnic/Cultural concerns</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
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<tr>
<td>Self-injurious thoughts/behaviors</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>2.3%</td>
<td>0</td>
</tr>
<tr>
<td>Trauma</td>
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<td>0.0%</td>
<td>1</td>
<td>2.3%</td>
<td>0</td>
</tr>
<tr>
<td>Identity development</td>
<td>5</td>
<td>13.2%</td>
<td>3</td>
<td>7.0%</td>
<td>6</td>
</tr>
<tr>
<td>Social isolation</td>
<td>10</td>
<td>26.3%</td>
<td>13</td>
<td>30.2%</td>
<td>12</td>
</tr>
<tr>
<td>Sexual concern</td>
<td>2</td>
<td>5.3%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Suicidality</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Attention difficulties</td>
<td>2</td>
<td>5.3%</td>
<td>7</td>
<td>16.3%</td>
<td>3</td>
</tr>
<tr>
<td>Sleep</td>
<td>6</td>
<td>15.8%</td>
<td>7</td>
<td>16.3%</td>
<td>4</td>
</tr>
<tr>
<td>Relationship Problem (specific)</td>
<td>18</td>
<td>47.4%</td>
<td>10</td>
<td>23.3%</td>
<td>17</td>
</tr>
<tr>
<td>Academic performance</td>
<td>18</td>
<td>47.4%</td>
<td>15</td>
<td>34.9%</td>
<td>13</td>
</tr>
</tbody>
</table>
Post-hoc Exploration of Race and Sexual Orientation

While examining the differences on clinical scales by vignette, results appeared to be reflecting the effect of race more strongly than the interaction of race and sexual orientation. Therefore, it was decided to run a follow-up 2 (race) x 2 (orientation) ANOVAs on dependent variables of clinical knowledge, and TPRQ attractiveness. Follow-up 2 (race) x 2 (orientation) ANCOVAs were used with dependent variables of personal clinical expectations, and the total counseling self-efficacy scale.

The assumption of homogeneity of variance for these analyses were assessed and met using Levene’s Test of Equality of Variance \( (p > .05) \). The ANCOVA assumption of homogeneity of regression slopes was assessed and demonstrated due to an absence of interactions between the covariates (perceived level of multicultural coverage in counseling courses, personal contact quality and quantity experiences with Black or bisexual individuals, social desirability) and either vignette race \( (p = .71, .29, .78, \text{ and } .31 \text{ respectively}) \) or vignette sexual orientation on the personal clinical expectations variable \( (p = .48, .40, .91, \text{ and } .67 \text{ respectively}) \). There were also no interactions between the covariates (personal contact quality and social desirability) and either vignette race \( (p = .53, \text{ and } p = .55 \text{ respectively}) \) or vignette sexual orientation on the COSE variable \( (p = .62, \text{ and } p = .39 \text{ respectively}) \).

A significant main effect was found on the race of the vignette client with the clinical scale of knowledge \( (F (1, 149) = 7.33, p = .008, \eta^2 = .047) \). While this is a small effect size, it indicated a difference between means of the vignettes with a Black client \( (M = 7.54, SD = 1.45) \) and the vignettes with a White client \( (M = 6.86, SD = 1.60) \). This suggests trainees perceived themselves to be more knowledgeable regarding working
with the Black client than with White client. No significant difference was found by sexual orientation of the vignette on the clinical knowledge scale ($F (1, 147) = .00, p = .97, \eta^2 = 0.000$). No significant main effects were found on personal clinical expectations scale, by vignette race ($F (1, 143) = 0.53, p = .47, \eta^2 = 0.004$), or sexual orientation ($F (1, 143) = 0.76, p = .386, \eta^2 = .005$).

The 2 (race) x 2 (orientation) ANOVA on TPRQ attractiveness indicated a significant main effect for vignette race ($F (1, 149) = 16.90, p \leq .001, \eta^2 = 0.102$), showing a medium effect size, and for vignette sexual orientation ($F (1, 149) = 4.49, p = .036, \eta^2 = 0.029$), showing a small effect size. Participants rated the Black client vignette as more attractive ($M = 16.97, SD = 3.89$) than the White client vignette ($M = 14.15, SD = 4.47$). Participants also rated the bisexual vignette as more attractive ($M = 16.20, SD = 3.98$) than the heterosexual vignette ($M = 14.69, SD = 4.76$).

Additionally, two follow-up Kruskal-Wallis analyses were run on the GAF dependent variable. No significant differences were found on the GAF by vignette race ($H (1) = 3.25, p = .071$), however there was a significant difference in group median by vignette sexual orientation ($H (1) = 4.87, p = .027$). This indicates that while GAF scores did not significantly differ based on race of the client, participants viewed the bisexual clients as having less clinical severity than their heterosexual vignette counterparts. No significant main effects were found on the COSE, by vignette race ($F (1, 142) = .518, p = .473, \eta^2 = 0.004$), or by vignette sexual orientation ($F (1, 143) = .22, p = .639, \eta^2 = 0.002$).
Discussion

This study originated from a intersectional framework and examined counselor trainee cultural competency levels when working with Black bisexual clients as compared to White bisexual or Black heterosexual or White heterosexual clients. The initial hypothesis posited that trainees would assess the Black bisexual vignette as having more psychological distress and severity than the Black heterosexual, White bisexual, and White heterosexual vignettes. However, with this sample of trainees, the opposite was found to be the case, such that the vignette for the Black bisexual client was perceived as having less psychological distress than the White heterosexual vignette. Furthermore, when examined by sexual orientation, it appears participants viewed the bisexual clients as having less clinical severity than their heterosexual vignette counterparts, regardless of race. It is possible that the GAF rating of distress was not as familiar to these trainees, as it has become much less commonly utilized, or perhaps trainees were mindful that marginalized clients have historically been over-diagnosed (Bell et al., 2015; Garb, 1997; Mohr et al., 2009) and compensated for this history by decreasing the level of distress assigned to the Black bisexual vignette. If this is the case, then this would be a positive movement away from a pattern of biased clinical judgments and might indicate that years of increased focus on multicultural competency within graduate programs is having a positive effect (Grzanka et. al., 2019). On the other hand, this compensation could become problematic if client distress is not accurately identified and Black bisexual women are under-diagnosed and not referred for appropriate treatment. This would parallel problems in emergency medical settings when Black
women’s pain is under-diagnosed and they are not provided similar levels of treatment as White women (Lee et al., 2019).

Furthermore, it was posited that trainees would show less knowledge with the Black bisexual vignette compared to the other three vignettes, however while there was a significant overall difference identified, the lack of significant comparisons among the vignettes made it difficult to ascertain between which vignettes this difference existed. However, upon further examination it appeared that this sample of trainees perceived themselves to be more knowledgeable on the vignettes with Black clients compared to the vignettes with White clients. Once again, the results were in the opposite direction than what was hypothesized. It is possible that trainees feel more knowledgeable about Black client identities and concerns within counseling since the past two years have had several high-profile killings of individuals within the Black community as well as the increased emergence of the Black Lives Matter (BLM) movement, which are likely to have filtered into discussions in training programs.

Additionally, participants were aware that the study was on decision-making and counseling diverse clients and this knowledge might have biased their responses. Based on social desirability being a significant covariate for trainee’s counseling self-efficacy scores, it does appear that participants had some motivation to present themselves in a socially desirable manner. Trainees are often evaluated on areas of knowledge and awareness around concepts of diversity and diverse identities, thus, a tendency to appear socially desirable may have translated into responses indicating greater awareness and knowledge when working with individuals with marginalized identities. A similar phenomenon has been reported within trainee supervisory relationships where supervisee
disclosure is impacted by fear of being perceived as incompetent and being judged (Backlund, 2017).

It was also hypothesized that trainees would perceive the vignette with the Black bisexual client as being lower in client attractiveness as compared to the other vignettes. In this study, vignette type was shown to have an impact on trainee perceptions of their clients, which was expected. However, contrary to the hypothesis, it appeared that trainees in this sample reported having more positive perceptions of Black bisexual and Black heterosexual clients than they did the White heterosexual clients. This contradicted hypothesis 1b, and appears inconsistent with previous findings (Dodge et al., 2016).

Considering the sample was predominantly White heterosexual cisgender women, it is interesting that they identified Black and bisexual clients to be more attractive, compared to prior research that indicates more positive perceptions of clients exist when they are similar to the counselor (Feeser, 1998).

In a recent study on implicit bias in counselor trainees, Egwu (2021) found that participants indicated empathy as a significant factor in deciding to confront their biases. Frequently, this empathy was based on seeing the suffering of another person as well as the unique oppressions they encountered. Sawyer and Gampa (2018) found that implicit attitudes held by White individuals became increasingly less pro-White during times of higher BLM activity. Therefore, it is possible that after the shift in national attention to social injustice related to the murders of George Floyd and Breonna Taylor, increased conversations within graduate programs resulted in trainees’ increased awareness of diversity and potential overestimates of how they view themselves working with clients with marginalized identities. Egwu’s (2021) findings that White trainees had more
frequent and novel conversations around racism and their own biases after these high-profile events offer some support for this idea.

It was additionally posited that there would be differences in clinician self-efficacy based on which vignette trainees received, however this was not seen in the results even when examining by race or sexual orientation alone. It is possible that trainees were overestimating their self-efficacy as their mean score was 4.77, which is slightly higher than what Li et al. (2018) found to be a normative mean for masters level counseling students ($M = 4.46$). In providing psychometric information on the COSE for clinicians, NovoPsych (2021) reported that scores above 5 on the COSE may be interpreted as a sign of overconfidence, defensiveness, or concern that the scale is being used as a measure of professional competence. Therefore, trainee suspicions on the purpose of the study may have led to increased stated levels of self-efficacy that masked any vignette-specific differences in self-efficacy. This is especially possible if the study participants assumed their competency was being evaluated, or if participants were able to guess the purpose of the study.

Alternatively, this could be indicative of programs being more intentional regarding discourse around client identities, how to incorporate these into case conceptualization, and educating trainees on the historically discriminative patterns the mental health field has had with BIPOC and LGBTQ+ clients. Tummala-Narra et al. (2012) found a positive association between having access to institutional resources and self-perceived cultural competence among licensed clinicians. With increased conversations around racial injustice (Egwu, 2021) and increased attention to multicultural competency (APA, 2017) within graduate programs, it is possible that
increased resources on how to best work with clients holding marginalized identities may have contributed to the lack of significant differences in self-efficacy. It is also worth noting that in this study, trainees were asked to project their self-efficacy in working with a vignette client (rather than responding to work that they had done) and this may not have been a viable approach.

The second hypothesis that participants who received vignettes of Black bisexual, Black, or White bisexual clients were more likely to rank clinical issues related to minority identities as important concerns when compared to the vignette of the White heterosexual client even though no vignette specifically mentioned minority identities as clinically relevant, did appear to be supported in a limited fashion. When examining the presenting concerns identified by this sample, several findings stand out. First, the vignettes with Black clients were identified as having racial/ethnic/cultural concerns as a presenting concern at a much higher rate than the White client vignettes, with no participants identifying this as a concern for the White heterosexual vignette. This may be due to awareness of how these concerns may come into the room when working with these clients going forward – even though it wasn’t mentioned in the vignette. On the other hand, it could indicate counselors making assumptions about racial concerns being relevant to the presenting issues even when they are not.

Additionally, while all vignette clients were cisgender women, and no concerns around gender identity or sexual concerns were written into the vignettes, there were a small number of participants who identified gender identity concerns for the Black bisexual vignette at a higher rate than any of the other three vignettes. Sexual concern was identified as a presenting concern for the White bisexual and Black bisexual
vignettes at higher frequencies than the heterosexual vignettes, with no participant identifying it as a concern for the White heterosexual vignette. While these concerns were infrequently endorsed, it does raise the question whether, despite few differences in perceptions of working with clients based on intersecting or individually held Black and bisexual identities, there are some trainees who perceive Black bisexual clients as either not adhering to normative gender identity behaviors or holding misunderstandings about how these identities intersect. Considering the client’s sexual history was not included in the vignettes, this could indicate potential assumptions that bisexual clients may inherently be presenting with sexual concerns as compared to their heterosexual counterparts.

Additionally, while not an identity specific concern, Black heterosexual vignettes were identified as presenting with stress at the highest rates, while the Black bisexual vignettes had the lowest rates of having stress endorsed as a presenting concern. This is in direct contradiction to minority stress theory (Meyer, 2003) as well as what would be likely based upon their intersecting identities leading to increased systemic oppression. Similar points exist for Black heterosexual vignettes also having higher percentage of participants identifying discrimination as a presenting concern compared to Black bisexual clients. This is a possible indicator of bi-erasure as bisexual individuals might be seen as experiencing fewer instances of discrimination.

On a positive note, when asked to identify the top three salient concerns for their vignettes, depression was accurately identified more frequently for all four vignettes. Additionally, academic performance was another shared presenting concerns most commonly identified in the most salient concerns for all four vignettes. As these were
clinical issues suggested in the vignettes, the findings provide evidence that mental health trainees are able to accurately identify salient clinical concerns.

However, when looking at the other frequently identified top concerns, participants with the bisexual vignettes rated relationship problem-specific concerns as the second most identified presenting concern. When taking into consideration that this concern was identified at approximately twice the frequency compared to the heterosexual vignettes, it indicates a possibility that bisexual individuals are assumed to have more specific relational concerns compared to their heterosexual peers. This may be indicative that while sexual orientation did not seem to impact how trainees indicated that they would perceive their clients, there are negative assumptions being made about bisexual clients’ relational abilities or relationship health that are not based on actual clinical presentation. Inquiring about presenting concerns could be a more subtle way to detect bias than directly asking about attractiveness or clinical prognosis. It might be that trainees are overestimating their cultural competency even when they are still falling prey to bias.

Black heterosexual clients were identified as having social isolation as their third top presenting concern. While the vignette did suggest this concern (the client was described as no longer socially engaging and decreasing communication with family), it is interesting that it was not listed as an important concern in the other vignettes. One possible explanation might be cultural considerations around importance of community for many Black individuals, or it could indicate a focus on external concerns rather than the immediate concerns that the client was bringing in. In conclusion, while trainees were able to accurately identify depression and academic performance as two of the primary
concerns their vignette clients were presenting with, there were identity-based differences that might imply trainees’ conceptualizations of their clients are being impacted by covert biases that were not captured by the other self-report measures.

**Limitations**

Study limitations include the use of self-report questionnaires that could be subject to responding in expected or desirable ways. Additionally, although the vignette was reviewed by individuals providing clinical services, it may have been overly simple, such that the nuances that arise with real clients were not included to the degree that might have been reflected in trainees’ rating of severity, prognosis, clinical work, and self-efficacy. Another potential limitation with using a vignette approach is that trainees may have struggled to fully envision themselves as working with the presented client, leading them to report anticipated versus actual behavior. Furthermore, while we identified differences in top-ranked presenting concerns by vignette, we are not able to fully explore the clinical reasoning behind these choices and so are limited in conclusions we can make. Lastly, the participant sample was predominantly comprised of White cisgender heterosexual women, thus limiting generalizability and also creating the possibility of missing valuable perspectives that could have been gathered from a more diverse sample.

**Future Research**

This study did have some significant and interesting results that could be extended in future research. A qualitative approach may be better suited to identify nuanced reasons behind perceived clinical presenting concerns and could also allow for follow-up case conceptualization questions using a format trainees may be more familiar with from
their graduate programs. Using a more complex vignette may better capture differences in how trainees conceptualize working with their clients. Future research may also benefit from conducting research with mental health professionals instead of students for several reasons. First, students might have been more strongly impacted by concerns of their competency being questioned or evaluated and motivated to overstate their competency levels. Second, students might be more likely to overestimate competency levels in general since they have not encountered as many challenging or difficult situations that provide a reminder about how much more can be learned. Finally, while established professionals have more experience working with diverse clients, many might have been trained when there was less emphasis on diversity and cultural considerations in counseling and it would be interesting to ascertain whether there were cohort differences based on the emphasis on multicultural training over time.

Despite the study limitations, this research was intended to increase the focus on multicultural competency when working with clients with intersecting identities. The unexpected results of trainees viewing the Black and bisexual clients more positively (rather than less) warrants further exploration especially considering the increased dialogue around racial injustice within the U.S. as well as increased visibility of bisexual individuals.
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Appendix A.

Client Vignette

As you read this vignette of a client seeking counseling, picture yourself as the counselor for the client. You have obtained this information during an initial intake session. Afterwards you will be asked to conceptualize her treatment. Please read this vignette carefully.

Kimberly is a 21-year-old [insert race] cisgender woman currently attending college for an undergraduate degree in communications. She has never been in counseling before and appears mildly apprehensive during the initial interview. Her presenting complaint is that she is having difficulty “focusing on my coursework,” feels sad most days, and is sleeping “a lot more than usual.” She’s confused that even though she is sleeping more than typical, she feels very tired throughout the day and does not even have the energy or interest in going for her morning run. She has missed a few classes as well and is concerned that if she doesn’t “get over this funk” then her grades may be impacted since it has been going on for “about two months.”

The one thing she is interested in is eating junk food, and a lot of it. Kimberly says this is unusual considering that eating healthily is important to her, even though it wasn’t modeled in her family growing up. She was raised by her parents who are still married, and they live in a town an hour away. She visits sometimes, but finds that she enjoys the larger city she moved to for college, saying that there are more things to do here. Kimberly’s sister lives in a different state, but they are close. She was even a bridesmaid at her sister’s wedding last year, and they are supposed to go on a trip over the upcoming school break together!

Kimberly tells you that her partner recently broke up with her after a 1.5 year-long relationship, and she often finds herself feeling guilty that she did not have enough time for “relationship things” due to her school and work schedules. She states that she identifies as [insert sexual orientation] and that prior to this relationship, she had 2 steady relationships. Her first was with someone she met in her high school debate class, but they broke-up when they both left for college. Her second relationship was with a former co-worker, but they broke up when she quit her job because of the work environment. She had been casually dating prior to this most recent relationship and tells you that she just isn’t ready to “get back out there.”

Kimberly says she has a few good friends at school with her. She is typically involved in campus organizations as well, but she has missed a few recent events that she was excited about. While she is not one for sports, she does enjoy the tailgating before games as she can wander and meet new people around campus. Kimberly has a strong relationship with her sister and parents, but has not wanted to respond to their text messages in the last couple of weeks because she doesn’t want them to worry about her. She says that her family believes in hard work and would not understand her lack of motivation right now.

*Race was either Black or White; sexual orientation was either heterosexual or bisexual.*