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Cognitive and Behavioral Practice 26 (2019) 656–675

Cognitive and Behavioral Practice

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Development and Implementation of a Multicultural Consultation Service Within an Academic Medical Center

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A major challenge for our field is to ensure we meet the growing demand for culturally sensitive and responsive evidence-based practices to keep up with changing demographics in the U.S. as well as calls to action by our field. To address the mental health imperative to improve the multicultural competence of clinicians and to provide appropriate care, it is important to create opportunities for clinicians to receive training in this area. One route to meet these demands is to provide ongoing multicultural peer consultation to clinical providers. This model also facilitates direct application to clinical work. To that end, we present herein a model for developing and implementing a multicultural peer consultation team. In our implementation, our consultation team aimed to function as therapy for therapists in the context of provision of empirically supported, principle-driven cognitive and behavioral therapies, with a consultation focus on multicultural perspectives and multicultural competence. We demarcate consultation needs within an academic medical center, identify facilitators and barriers to implementation of the service, and provide recommendations for future directions. Moreover, herein we present a case study to demonstrate the process of multicultural peer consultation.

Culture Matters

The field of psychology had long held the premise that our treatments, assessments, and research findings were noncultural, free of culture, or universally valid as evidenced by lack of discussion of culture until the recent decades (Lonner & Adamopoulos, 1997). However, it is now accepted that psychologists and clients are shaped by their context (e.g., identity development, socialization, socioeconomic experiences) and therefore culture. Moreover, it has been widely established that all humans are multicultural beings (e.g., Arredondo et al., 1996; Brewer & Brown, 1998; Fiske et al., 1998; Fouad & Brown, 2000; Markus & Kitayama, 1991; Pedersen, 2000; Sue et al., 1982; 1992; Sue, Ivey, & Pedersen, 1996). Thus, it logically follows that our treatments and assessments are susceptible to biases, assumptions, and narrowed perspectives (Naidoo, 1996). Current and projected increases in racial and ethnic minority and immigrant populations in the United States (Passel & Cohn, 2008) have further highlighted discrepancies among groups (predominantly shaped by race, ethnicity, and socioeconomic status), as have significant barriers to mental health services that disproportionately affect disenfranchised communities (e.g., Alegria et al., 2002; Alegría et al., 2008; Chow, Jaffee, & Snowden, 2003; Merikangas et al., 2011; Wells, Klap, Koike, & Sherbourne, 2001). Further, those with disadvantaged social status have a heightened propensity for mental health problems due to challenges associated with their sociocultural context, including poverty (e.g., Lorant et al., 2007; Murali & Oyebode, 2004; Schilling, Aseltine, & Gore, 2007) and discrimination (e.g., Kessler, Mickelson, & Williams, 1999; Mays & Cochran, 2001; Williams, Yu, Jackson, & Anderson, 1997). Moreover, cultural processes impact mechanisms of disease, ways in which distress is conveyed, and help-seeking attitudes and behaviors (Kirmayer, 2005).

The zeitgeist of clinical and counseling psychology presently centers on multiculturalism and the idea that culture matters. In recent decades, the mental health field has taken notable steps to increase its focus on multicultural issues in research, teaching, and clinical care (for an elaborate discussion, refer to APA, 2003, and APA, 2017), as documented in the 2001 Surgeon General's report (U.S. Department of Health and Human Services, 2001) and multicultural guidelines for psychologists (APA, 2003, APA, 2017). Specifically, the Surgeon General argued that the most pressing challenge in mental health is the disproportionately high rates of mental health concerns that affect low-income, racial and ethnic communities of color (U.S. Department of Health and Human Services, 2001). The 2003 multicultural guidelines demarcated

Keywords: multicultural consultation; multicultural competence; multicultural humility; multiculturally competent treatment

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multicultural best practices in the mental health field, especially as it relates to historically disadvantaged groups (primarily shaped by race and ethnicity) and the 2017 updated guidelines emphasized intersectionality of identities and placing the individual in an ecological framework. Of importance, these documents underscore the need for including formal training of a multicultural perspective in psychology training (APA, 2003, 2017).

The implications of these calls to action for practitioners manifest at two levels. First, as mental health providers, we have an ethical responsibility to be multiculturally sensitive to all patients and especially toward those who have been underrepresented and/or historically harmed by our field in all stages of clinical care (e.g., assessment, therapy). Second, we are responsive by ensuring our treatments meaningfully consider multicultural content to meet the needs of diverse populations (e.g., culturally adapted treatments). One route to training multiculturally competent[1] providers is through supervision and consultation, which is most often available through clinical training. In fact, for graduate programs to receive APA accreditation, they must demonstrate a plan for providing trainees with knowledge about the influence of diversity on human experience (APA, 1994). Despite this mandate, it is not uncommon for graduate students and trainees to report perceiving that they are inadequately trained to effectively work with diverse populations (e.g., Dillon et al., 2004; Sherry, Whilde, & Patton, 2005). Further, research suggests that licensed and student clinicians desire more training than they receive in working with diverse individuals and skills related to integrating advocacy or social justice work into their education (Miller & Sendrowitz, 2011; Singh et al., 2010). Nonetheless, it appears existing training in this area is generally effective. For example, a meta-analytic review that set out to quantitatively summarize the existing research literature regarding the effectiveness of multicultural education found that there is a positive overall effect of multicultural education; however, these results were derived primarily from subjective self-report questionnaires rather than objective ratings of multicultural competence skills (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006).

[1] There is debate in the field about appropriate terminology regarding processes by which clinicians, educators, and researchers provide care that is sensitive and responsive to all clients, especially those from marginalized, vulnerable, socially disadvantaged, underrepresented, and/or traditionally harmed backgrounds. Two major terms often used are *(multi)cultural competence* and *(multi)cultural humility*. We acknowledge the debate, and understand the benefits and shortcomings of each of these operationalizations. In this manuscript, we choose to utilize the term *multicultural competence*.

Multicultural Integration into Cognitive-Behavioral Assessment and Treatment

An important consideration when treating clients from underrepresented and minority backgrounds is the unique and additive impact of multicultural (e.g., ethnic identity, acculturation) and sociocultural factors (e.g., socioeconomic status, life stress, age cohort) on psychopathology, which may have implications for the assessment and treatment approach utilized (e.g., Chapman, DeLapp, & Williams, 2014; Williams, Malcoun, & Bahojb Nouri, 2015). It has been proposed that optimal clinical care of minorities integrates multiculturally salient values, ideologies, and behaviors for the goal of diagnostic clarity and treatment that appropriately and sensitively targets key clinical areas (Chapman et al., 2014). For example, in considering the case of ethnic identity development, findings are mixed with regards to its influence on psychopathology. Namely, a strong ethnic identity (characterized by acceptance, integration, and a strong sense of belonging to one's ethnic group) has been linked to high levels of self-esteem and coping mechanisms, which may serve as protective factor toward the development of psychopathology for minority individuals (e.g., "the buffering hypothesis"; Williams, Chapman, Wong, & Turkheimer, 2012; Yip, Gee, & Takeuchi, 2008). Alternatively, however, having a strong ethnic identity could potentially amplify multicultural stressors such as discrimination and appraisal of social inequalities (i.e., increased focus on the difference in levels of privilege and inequality between majority and minority groups), which could have adverse consequences on psychological well-being (e.g., "the exacerbating hypothesis"; Yip et al., 2008). This reality is further complicated when considering how ethnic identity development functions in cases when there is acculturative stress and socioeconomic disadvantage (e.g., Schwartz et al., 2013). In sum, multiculturally competent clinical care engenders an appreciation for the nuanced intersection of multicultural factors, as those described above.

In the pursuit of multicultural integration into sensitive and responsive clinical care, it is equally important to appreciate the transactional nature of psychotherapy. Not only must we consider the impact of clients' multicultural and sociocultural factors on psychopathology, but we must also be aware of our own set of cultural factors' potential influence on the clinical encounter. For example, prior research has indicated even well-intentioned clinicians are at risk for committing microaggressions (e.g., Shelton & Delgado-Romero, 2011), and hold preconceived notions, implicit and explicit biases, and stereotypes of specific cultural groups (e.g., Blair et al., 2013). The implications of these phenomena are significant on the working alliance, perceived general

and multicultural competence of clinicians, and satisfaction in treatment (Constantine, 2007) and clients' perceived quality of care (e.g., Blair et al., 2013). Additionally, they may lead to worse adherence (e.g., Sirey et al., 2001), retention and clinical outcomes (e.g., Guerrero & Andrews, 2011), and misdiagnosis of clients (e.g., Snowden & Pingitore, 2002). Taken together, these experiences may contribute to mental health care disparities disproportionately affecting disenfranchised and vulnerable groups.

Multicultural Peer Consultation

Multicultural peer consultation serves as a route to increasing multicultural competence and supporting clinicians in providing multiculturally sensitive and responsive care (Kirmayer, Groleau, & Rousseau, 2014), building upon formal coursework and prior training experiences. As multicultural competence is an aspirational path rather than a finite achievable goal, ongoing consultation allows for continued growth and development over time, well beyond what any individual class or workshop can offer. Further, multicultural peer consultation teams facilitate the application of multiculturally sensitive and responsive care to particular clients, providing training in the consideration of client-specific idiographic and contextual elements. Thus, in recent years, the concept of multicultural peer consultation has gained momentum. The goal of multicultural peer consultation is to give or expand attention to social and cultural factors that may be missing or not emphasized in traditional mental health care provision (Kirmayer, Guzder, & Rousseau, 2013). Given that many supervisors were trained at a time when multicultural competence was not included in training programs, multicultural peer consultation allows trainees to receive additional consultation on cases that might otherwise not be discussed through a multiculturally sensitive lens. Additionally, there may be a multitude of factors that make discussing multicultural issues challenging, which may include aversive emotions (e.g., anxiety, shame), skills deficits (i.e., not knowing how to talk about the topic), and lack of training in this area, to name a few. Despite these challenges, it is worthwhile to engage in such dialogue as there is compelling evidence to suggest clinicians who demonstrate higher multicultural competence may also demonstrate improved clinical outcomes (Betancourt & Green, 2010). To that end, multicultural peer consultation holds the promise of contributing to the reduction of mental health disparities (Betancourt & Green, 2010). Despite the hope of enacting widespread improvements in multicultural competence, the empirical and theoretical literature in this area is nascent (Betancourt & Green, 2010).

Aims of Paper

In the present study, we sought to (a) present a model for developing and implementing a multicultural peer consultation team within an academic medical center (AMC), (b) demarcate consultation needs within an AMC, (c) identify facilitators and barriers to implementation of the service, and (d) develop recommendations for future directions. Additionally, we present a case study to demonstrate the process of multicultural peer consultation. The results contained herein represent preliminary outcomes from a consultation team developed within a large AMC. While there are unique factors associated with this setting that have both facilitated and posed barriers for development of such a service, we believe that our model is applicable to diverse settings (e.g., graduate training programs, community health centers, private practice, private or governmental hospitals).

Method

Peer Consultation Service Development Procedures

The process to develop a multicultural peer consultation service at an AMC was iterative and informed by continuous assessment of needs. Below, we outline the process we underwent to reach that goal (refer to Figure 1). The multicultural peer consultation service was developed within a clinic that specializes in contemporary cognitive-behavioral therapies (CBTs). This clinic is the highest-volume adult outpatient therapy clinic at this AMC. This clinic is a part of the Department of Psychiatry and Behavioral Sciences (a department with approximately 500 faculty members, 130 of which provide clinical care). This clinic is comprised of 26 faculty, staff, and training clinicians with backgrounds in both psychology and social work. Clinic clients primarily come from the "Triangle Region" (i.e., Durham–Raleigh–Chapel Hill in North Carolina), an area with rapid population growth (32.9% increase from 2000 to 2010), including a large increase in minority populations (e.g., 128.5% increase among Hispanic populations, 108.5% increase among Asian populations, 29.1% increase in African-American populations; Triangle J Council of Governments, 2011). Additionally, 12.3% of individuals in the Triangle Region live below the poverty line, 15.1% speak a language other than English in the home, and 11.3% were born outside of the U.S. (U.S. Census Bureau, 2016). While these data only represent a few categories of multiculturalism, they highlight the diversity of the Triangle Region and a snapshot of the population that this clinic serves. Consistent with national patterns and growing need, the Department of Psychiatry and Behavioral Sciences at this AMC has had an increased focus on providing multiculturally sensitive and responsive

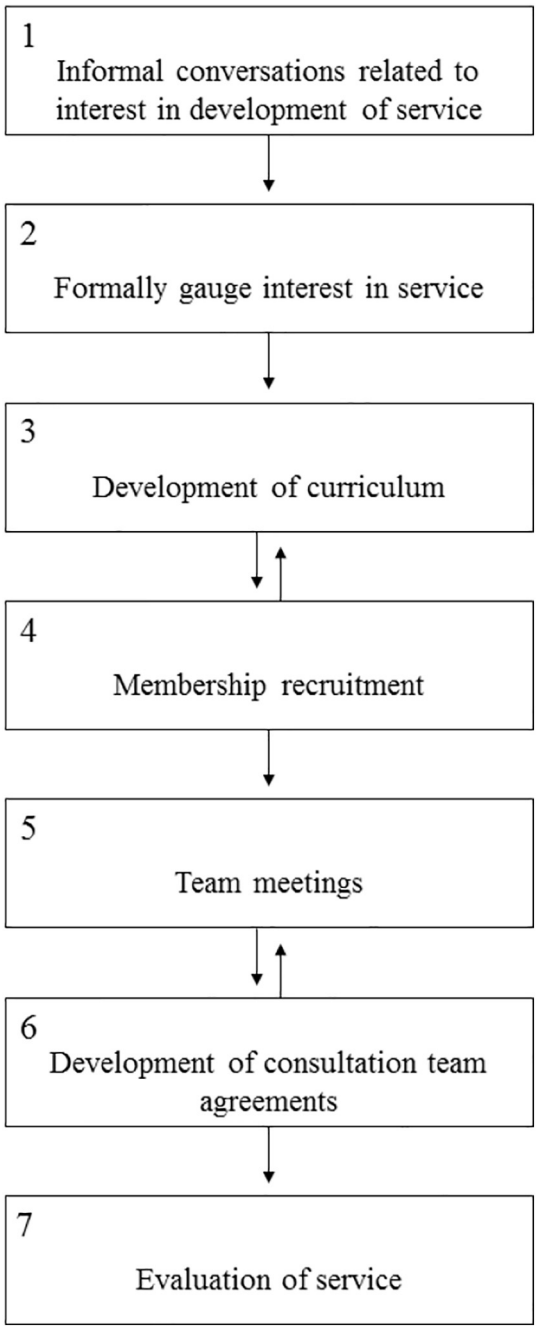

Figure 1. Process of development of the consultation service

services. Within this clinic, creating a multicultural peer consultation team has aided with that goal.

Informal Conversations Related to Interest in Service (Step 1)

The idea to develop a multicultural peer consultation team initially arose from several members (i.e., predoctoral clinical psychology interns at the time, authors GN and KL) informally stating a desire for such a service. These members consulted with several faculty members to determine the feasibility of starting such a service. Faculty were supportive and recommended assessment of interest among clinic members.

Formally Gauging Interest in Service (Step 2)

Next, we formally assessed interest within the clinic using a brief electronic survey that was sent to all members of our program (n = 26; explained in "Evaluation of the Service" section). Overall, results indicated many providers within the clinic could identify a need for and stated a commitment to joining such a service and that many members of the clinic stated that further building their multicultural competence skills was consistent with their personal and professional values. The tone of the responses we received was enthusiastic. Importantly, due to the anonymity of this survey, we were unable to conduct analyses to determine the sociodemographic composition of the survey completers versus noncompleters, thereby precluding us from identifying apparent differences between those who were and were not interested in participating in the team.

Development of Curriculum (Step 3)

With the overwhelmingly positive response, we proceeded with curriculum development, being that a primary aim (as informed by the aforementioned survey) was to increase knowledge of specific multicultural issues. The second aim was to enhance multicultural competence through applying a multiculturally sensitive and responsive lens to discussion of specific clients. To these ends, we opted to include two components in our curriculum—didactic and consultation. The process of development of these components is outlined under Step 5.

Membership Recruitment (Step 4)

An iterative process in our development of this service was recruitment of consultation team members. We emailed providers and had face-to-face discussions with other providers in our clinic. These conversations centered on weighing pros and cons of joining the team and to what extent members felt they could actively participate.

Team Meetings (Step 5)

As previously mentioned, our team meetings oscillated between consultation and didactic sessions. For all team meetings, we began with setting an agenda wherein team members could collaboratively add items to discuss with the group. Consultation team meetings were then followed by reading a team agreement and each member requesting consultation presenting their consultation request. For didactic team meetings, following setting the agenda, the member leading the didactic would present didactic information and/or engage participants in an experiential exercise, followed by debriefing and/or

discussion. Refer to Table 1 for a schedule of team meetings.

Didactic Sessions

To generate didactic topics, several members from the consultation team created an *a priori* list of didactic topics, drawn from prior experience with multicultural training and lived experiences, which was then sent to team members (in the survey described in Step 2 to gauge interest in the service). A free-text response item was also included requesting all team members to suggest additional topics. The didactic series spanned a large array of topics, with the aim of increasing broad training in multicultural psychology. See Table 2 for a complete list of *a priori* and *post-hoc* topics identified, along with interest levels.

Both didactic and experiential training components have shown to significantly increase knowledge, and experiential exercises positively increase clinician behaviors (i.e., in-session skills; Beidas, Edmunds, Marcus, & Kendall, 2012). As such, we privileged active learning components (e.g., experiential exercises) versus passive learning (e.g., one member lecturing on a topic) in our didactic sessions. Experiential exercises have demonstrated promise as a particularly useful tool for training multicultural content (e.g., Kim & Lyons, 2003). For example, one experiential exercise was intended to highlight differences in unearned privilege (Meeting 1), leading to insight and discussion related to this topic. In this exercise, participants line up against a wall and listened to a series of statements. Sample statements included, "If English is your first language, take one step forward" and "If you were ever uncomfortable about a joke related to your race, religion, ethnicity, gender, disability, or sexual orientation but felt unsafe to confront the situation, take one step back." Participants moved forward and backward throughout the exercise, demonstrating how privilege was distributed inequitably. Participants also reflected on aspects of privilege that they took for granted (e.g., growing up in a home with books or a computer).

Another experiential activity related to asking clients about their religious or spiritual beliefs and how these beliefs may relate to treatment (Meeting 15)—a topic that is infrequently addressed in psychotherapy. Group members were asked to use imagery techniques to imagine that they were meeting with a mental health professional for the first time. They were asked to think about an aspect of their identity that is meaningful to their sense of self, life, and values. Group members were then instructed to imagine (and experience) how they would feel if the mental health professional never asked about this important aspect of their identity. Next, they were asked to imagine (and experience) if they would

Table 1
Multicultural Consultation Team Schedule

#	Type	Topic
1	D	Unearned privilege and oppression *(Leaders: 3 clinical psychology pre-doctoral interns)*
2	C	Multicultural action plan development and consultation *(Leader: 1 clinical psychology pre-doctoral intern)*
3	D	Clinician microaggressions, prejudice, and bias *(Leader: 1 clinical psychology pre-doctoral intern)*
4	C	All team members *(Leader: 1 pre-doctoral clinical psychology intern)*
5	D	In-session cultural competence skills *(Leader: 1 clinical psychology pre-doctoral intern)*
6	C	All team members *(Leader: 1 clinical psychology pre-doctoral intern)*
7	D	Barriers to access to care and community resources for underserved groups *(Leader: 1 faculty member [licensed clinical social worker])*
8	C	All team members *(Leader: 1 clinical psychology pre-doctoral intern)*
9	D	Psychological impacts and unique challenges of immigration of families *(Leader: 1 clinical psychology post-doctoral trainee)*
10	C	All team members *(Leader: 1 clinical psychology pre-doctoral intern)*
11	D	How global mental health research can inform our clinical practice in the US *(Leader: 1 advanced graduate trainee in clinical psychology)*
12	C	All team members *(Leader: 1 clinical psychology pre-doctoral intern)*
13	C	All team members *(Leader: 1 clinical psychology pre-doctoral intern)*
14	C	All team members *(Leader: 1 clinical psychology pre-doctoral intern)*
15	D	Incorporating spirituality and religion into clinical care *(Leader: 1 faculty member [licensed clinical psychologist])*
16	C	All team members *(Leader: 1 clinical psychology pre-doctoral intern)*
17	D	Considerations for working with African-American/Black clients and the cross-cultural therapeutic relationship *(Leader: 1 clinical psychology post-doctoral trainee)*
18	D	Creating LGBTQ safe spaces *(Leader: 1 clinical psychology pre-doctoral intern)*

Note. Type refers to either didactic (D) or consultation (C).

Table 2
Topics of Interest for Didactic Series

Respondents interested (*N* = 12)	Topic
42% (*n* = 5)	All topics listed
42% (*n* = 5)	In-session multicultural competence skills
33% (*n* = 4)	Prejudice and bias as it relates to clinical work
33% (*n* = 4)	Adaptations and modifications to evidence-based treatments
33% (*n* = 4)	Decreasing barriers to access for underserved groups (e.g., Medicaid, Charity Care patients)
33% (*n* = 4)	Building on strengths of cultural norms in therapy (e.g., prayer, close-knit family connections)
33% (*n* = 4)	Orientation to community resources and cultural support organizations (for our clients)
33% (*n* = 4)	Increasing awareness about frequent clinician microaggressions
33% (*n* = 4)	Education about cultural norms that might be pathologized (e.g., hexes)
25% (*n* = 3)	Increasing our awareness of unearned privilege and oppression
25% (*n* = 3)	Maintaining respect when therapist and patient values conflict
25% (*n* = 3)	Allied mental health professional training (e.g., LGBTQ safe spaces),
25% (*n* = 3)	Discussing operational definitions of culture, multicultural competence, multicultural sensitivity, etc,
17% (*n* = 2)	Increasing group-specific knowledge (e.g., group norms)
8.3% (*n* = 1)	Incorporating religion/spirituality into clinical work

Note. We provided a free text response option and requested respondents suggest topics in which they were interested. This table is inclusive of those responses. Some respondents selected multiple answers.

voluntarily mention this important aspect of identity to the mental health professional and to notice how they would feel if they chose to approach the topic. Finally, group members were asked to imagine (and experience) what they would think and feel if the mental health professional appeared uncomfortable when they mentioned this important aspect of their identity. Following this experiential imagery exercise, group members were invited to notice and describe their experiences. We noted differences in which aspects of identity were held as important (e.g., sexual orientation, trauma survivor status, religion and spirituality), and we discussed similarities in experiences (e.g., sadness, shame, fear) if those aspects of identity were ignored by a mental health professional. We then related our own experiences during the exercise to enhancing clinical practice with our own clients, including discussion of initial paperwork, language on forms, questions that we may ask in intake assessments, and safety symbols within the clinic.

Additionally, we wanted to promote a sense of shared ownership over this group and tap into the prior experiences with and knowledge of multiculturalism of different members. Thus, we asked team members to volunteer to lead the different didactic topics. We were fortunate enough to have several members of the team with previous research and/or clinical experience in relevant domains, and these individuals were able to facilitate didactic discussions drawing upon their existing knowledge. In many instances, individuals leading the didactic discussion incorporated their own empirical work or review of relevant literature into the didactic. Some didactic facilitators chose to send out articles for the team to read prior to the didactic discussion (e.g., Saunders, Miller, & Bright, 2010 as reading for the discussion about incorporating spirituality and religion into clinical care). During several team meetings, team members remarked that having readings to support didactic sessions was helpful.

Clinical Peer Consultation Process

The other half of the meetings comprised consultation regarding multicultural factors associated with client care, brought by members of the team. Research has indicated that ongoing consultation can be a valuable supplement to didactic trainings (e.g., Beidas & Kendall, 2010; Herschell, Kolko, Baumann, & Davis, 2010). Consultation form and function were heavily inspired by dialectical behavior therapy (DBT) consultation team (Linehan, 1993), as many founding members participate in the AMC's long-established DBT consultation team, which we have found to be a highly effective and efficient form of consultation. As such, the function of multicultural peer consultation team was to provide therapy for the therapist, and to promote provision of effective empirically supported, principle-driven treatment. Some of the key elements of DBT consultation team that we utilized were balancing acceptance and change, participating with a spirit of vulnerability, and utilizing a structured agenda (for additional reading about DBT consultation team, please see Koerner, 2012). Given our consultation team's central aim of increasing competence around multicultural elements, special attention was paid to helping one another implement multiculturally sensitive, responsive, and competent therapy.

Consultation meetings were structured to facilitate addressing the consultation needs of multiple members, the clarity of consultation needs, and the team meeting those needs. Each consultation session began with setting an agenda, in which each team member would indicate their consultation needs, with a time estimate, and priority level to allow for efficient and effective time management. When a team member sought consultation, they presented the team with a request (e.g., "I would like help thinking through how sexual orientation and internalized homophobia may influence the client's engagement in target behavior X. Both problem-solving and validation would be helpful."). The consulting team member provided relevant background and contextual information, with particular attention to multiculturally relevant facets. Team members then asked additional assessment questions as needed and attempted to respond to the consulting member's question, with attention to treating the therapist. Team members provided validation, resources, alternate perspectives, and problem solving as needed. Those seeking consultation were asked if their needs were met with each individual consultation before moving on to the next consultation. If a team member's needs had not been met, the team would either extend time or offer additional consultation outside of team.

Development of Consultation Team Agreements (Step 6)

In the spirit of DBT and to maintain the culture of vulnerability, cohesiveness, curiosity, nonjudgment, and commitment to empirically informed practice, members collaboratively generated consultation team agreements in the first few team meetings. Some of these were adapted from DBT, while we developed others specific to the objectives for multicultural peer consultation team. These agreements were utilized to promote attention and awareness to these principles relevant to team process and culture. Members endeavored to observe instances in which an agreement had been violated. While all agreements are integral to the spirit of the team, the fallibility agreement is worthy of emphasis. Refer to Table 3 for a list of consultation agreements.

Evaluation of Service (Step 7)

The study team collected data at various stages for the purposes of evaluating the effectiveness of our development and implementation of this service. Specifically, we collected data before developing the service, throughout implementation of the service, and at the end of the academic year. These data were used to inform further development and implementation of this service. These are outlined below.

Data Collection Procedures

Assessment for the Need of the Peer Consultation Service

Consultation needs were initially assessed to determine the utility in our setting. As outlined above, we developed and distributed an electronic survey that encompassed the following questions: level of interest in the service, preferences about frequency and length of team meetings, components of the service (e.g., didactic, consultation, journal club, case presentations), and topics for didactic series. During the first meeting, we assessed members' reasons for joining the team and what they hoped to get out of the team, with the goal of being able

Table 3
Consultation Agreements

Agreement	Description
Dialectical Agreement	We agree to balance being gentle with ourselves and colleagues, while also helping each other identify "blind spots." We agree to not hold on to one position as presumed fact, but rather as personal perspectives nuanced by our learning history and contexts.
Phenomenological Empathy Agreement	We agree to be mindful of assumptions we may make about our patients. We will strive to use non-judgmental and non-pejorative language when discussing clients' or each other's culture (see domains under Diversity Agreement). We strive to not over-pathologize behaviors, belief systems, or practices that may have a cultural basis.
Fallibility Agreement	We understand that we are humans existing in contexts shaped by our culture. To that end, we agree to strive to have a deeper understand of our clients' behaviors, belief systems, or practices and see that validity in them. We will aim to not hold our perspectives as presumed fact, but rather as an alternative viewpoint.
Continuous Growth Agreement	We acknowledge that we can never fully achieve multicultural competence, as it is an aspirational goal. Instead, we will strive towards continuously growing in this area.
Safe Space Agreement	We agree to create a space that is safe and explorative. Doing so will allow us to feel safe in sharing our backgrounds and challenges, which, in turn, will help us have effective consultation.
Diversity Agreement	We strive to be inclusive in our conceptualization of diversity, such that it will encompass, but not be limited to, race, ethnicity, age, gender identity, sexual orientation, socioeconomic status, ability, spirituality/religion, rituals/traditions, ideologies, communication, family structure/roles, and health-care practitioners/practices.

to adapt the peer consultation service to meet those needs.

Group Membership

We thoughtfully considered team composition and invitations to join, as detailed in Steps 2 and 4. The peer consultation service was developed by several members of a CBT clinic within a large psychiatry department, comprising pre-doctoral interns, postdoctoral trainees, practicum students (i.e., graduate students), and faculty members trained in clinical psychology and clinical social work. We considered inviting other department members (e.g., medical students, psychiatry residents, other psychiatry faculty members and clinicians) and evaluated the pros and cons of expanding group membership versus maintaining the group size (as detailed above). To make a collaborative decision, we developed and distributed an electronic questionnaire sent to group members, outlining pros and cons identified and asking for impressions related to possible solutions. Results were discussed in subsequent meetings.

Peer Consultation Requests

During each team meeting that centered on consultation, team members requesting consultation were asked to complete a paper-and-pencil questionnaire concerning the nature of their consultation request and their subsequent satisfaction with the recommendations they received.

Nature of peer consultation requests. To characterize the consultation requests made, we developed paper-and-pencil questionnaires during consultation meetings, informed by Kirmayer et al. (2014). We collected sociodemographic information related to the clients featured in each consultation, including: age, gender, sexual orientation, country of origin, marital status, education level, employment, religion, immigration status, and clinical diagnoses. Furthermore, to identify the nature of each consultation request, we asked team members requesting consultation to identify the category(ies) in which their request fell, including: family systems issues; exposure to trauma and violence; migration issues; cultural identity, acculturation, and adjustment; cultural models of illness and healing; other social, economic, and structural issues; and other (for which we included a free-response space).

Satisfaction with consultation received. We were interested in assessing the extent to which team members found recommendations made by the team during consultation meetings helpful. To that end, we evaluated the outcomes of consultations across three domains using a Likert scale that ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). Specifically, we assessed the effectiveness of recommendations (e.g., clear, feasible), impact (e.g., adherence, clinician-client relationship), and satisfaction (e.g., would recommend service to colleague, would use service again). As it was our goal to improve client outcomes, we assessed the degree to which clinicians implemented recommendations with their clients and their perspectives regarding its helpfulness. Additionally, when applicable, we asked clinicians to document the primary reason for not implementing recommendations.

Overall Satisfaction with Multicultural Peer Consultation Service

We sought to conduct an overall program evaluation at the end of the academic year to identify components that worked well in the team as well as areas for improvement. To that end, we circulated an electronic survey to team members that comprised quantitative items and qualitative items. Quantitative items comprised satisfaction ratings for various team components (i.e., range of didactic topics, quality of didactic presentations, frequency of didactic presentations, frequency of consultation, quality of consultation, organization, time management, safety in the team, ability to add items to the agenda, and consultation team agreements), utilizing a 5-point Likert type scale ranging from 1 (*extremely dissatisfied*) to 5 (*extremely satisfied*). Qualitative items comprised free-text response questions regarding "what worked well" and "areas for growth."

Meeting Attendance

To evaluate the feasibility of implementing a multicultural peer consultation service, we tracked meeting attendance for each meeting. Given this was the first stage of development for this group, we did not make a mandatory attendance policy. Rather, we were interested in evaluating the rate of attendance to inform development of such a policy in the future. Additionally, we were interested in assessing factors that interfered with group attendance. To this end, we provided an *a priori* list of possible barriers (e.g., competing demands for time, schedule did not permit attendance, attendance not incentivized by the clinic) as well as a free-text response option.

Results

Assessment of the Need for the Peer Consultation Service

An initial step of developing this service was to gauge the level of interest within the clinic through an electronic survey. The survey was distributed to 26 providers, 12 of whom completed it. Regarding level of interest in the service, 67% ($n = 8$) reported "I am very interested, and will try to find the time to participate in the consultation team" and 33% ($n = 4$) reported "I am interested in participating, but do not have the time to commit to the consultation team." Fifty-eight percent ($n = 7$) of

members reported wanting to meet monthly, 33% ($n = 4$) twice a month, and 8.33% ($n = 1$) reported a preference for "a few didactic trainings for those who cannot commit." Concerning length of meetings, 67% ($n = 8$) reported a preference for 45-60 minutes, 8.33% ($n = 1$) for 90 minutes, 8.33% ($n = 1$) for "recurrently up to one hour, if longer trainings offered," and 8.33% ($n = 1$) "45-60 minutes if bi-weekly; 90 minutes if monthly." Respondents indicated components they would like included in the service were: didactic series (75%; $n = 9$), consultation time (67%; $n = 8$), case presentations (67%; $n = 8$), and a journal club (50%, $n = 6$).

Reasons for Joining the Peer Consultation Service

During our first meeting, we asked members to reflect on the reasons for which they joined the multicultural peer consultation team. We found several themes, including a need to increase knowledge in the area of multicultural issues (e.g., "Continued growth in multicultural issues"; "To have a reparative experience of multicultural training"), a desire to have a supportive, safe space to discuss multicultural issues (e.g., "To have the support to talk about difficult situations with clients"; "To have a space to discuss the intersection of professional and personal, as they relate to multicultural issues"), a desire for personal growth (e.g., "To increase comfort in asking tough questions"; "To challenge assumptions of coworkers"), a need for direct application of material discussed (e.g., "To increase our effectiveness as advocates on behalf of our clients"; "To engage in experiential exercises"), and several team members noted that participating in the consultation team was consistent with professional values (e.g., "[I] Value the space and time [for enhancing multicultural competence]"; "It's important from a social justice perspective").

Group Membership

There were 15 team members on the multicultural peer consultation service including faculty members ($n = 4$; 26.7%), postdoctoral trainees ($n = 5$; 33.33%), predoctoral clinical psychology interns ($n = 3$; 20%), clinical psychology graduate students ($n = 2$; 13.3%), and a social work intern ($n = 1$; 6.67%). To that end, years of clinical experience varied widely. All members of the team primarily practiced contemporary CBTs, primarily DBT. In regard to multicultural identities, 14 (93.3%) members identified as female and 1 (6.67%) as male; 1 member (6.7%) identified as Hispanic and 14 (93.3%) as non-Hispanic White; 14 (93.3%) were born in the U.S.; 5 (33.3%) have parents who are immigrants to the U.S.; and 3 (20%) self-identify as members of the LGBTQ community. Additionally, experience with multiculturalism varied widely member to member. For example, some members reported not having much formal training in this area (e.g., graduate students) while for others topics related to multiculturalism is a primary research area (e.g., pre-doctoral clinical psychology interns who led the development of the team). Importantly, all authors of this paper were members of the consultation team.

As previously mentioned, early in the development of the peer consultation service we debated in our group whether to include additional members or keep group membership to our established group. We took a poll through an electronic survey. Four (26.7%) members completed this survey. Solutions identified were: maintain group membership and empower other providers to start their own multicultural peer consultation team (50%); maintain group membership for consultation meetings and invite additional members to didactic sessions only (50%); maintain group membership as is (25%); broaden group but only if additional members can commit to attending half of meetings (25%); and maintain group membership and invite other providers to Action Committee meetings (i.e., outside of peer consultation service; 25%; committee detailed in our discussion). We brought these results back to the group and had a larger discussion. Ultimately, we opted to maintain membership to our established group without inviting additional members.

Demarcating Peer Consultation Needs

Nature of Peer Consultation Requests

We kept track of the types of consultation requests via paper-and-pencil questionnaires to be completed by each team member requesting consultation, which team members were asked to bring back to the subsequent meeting. However, a major challenge in our assessment of consultation requests was a low return rate of evaluation forms. Specifically, we estimated during the period of data collection, our team had approximately between 3 and 5 consultation requests per meeting for a total of approximately 27 to 45. However, we present data on a total of 13 forms returned. As we reflected on factors that interfered with data collection at this stage, we hypothesize that it could be due to competing demands (e.g., many team members often left immediately after meetings for a session with a client and many were not able to attend every week). Additionally, in some instances, there were multiple forms for the same client when the team member requested consultation more than one time. Thus, the results contained herein are presented cautiously, and recommendations to enhance future data collection are offered. Table 4 presents the demographic characteristics of the clients featured in consultation, for the consultation team members that returned the form.

A portion of the form that we asked consultation team members to complete for each consultation request

Table 4
Sociodemographic Characteristics of Cases Presented ($N = 13$)

Characteristic	n (%)	M (SD)	Range
Age		28.15 (11.75)	9 - 51
Gender			
Woman	8 (62%)		
Man	5 (38%)		
Sexual orientation			
Heterosexual	10 (77%)		
Other/Unknown	2 (15%)		
Bisexual	1 (8%)		
Marital status			
Never married	8 (62%)		
Married	3 (23%)		
Co-habitating	1 (8%)		
Separated	1 (8%)		
Widowed	1 (8%)		
Education level			
BS/BA	7 (54%)		
Elementary or Secondary School	2 (15%)		
HS diploma/GED	2 (15%)		
Unknown	1 (8%)		
Employment			
Student	5 (39%)		
Employed/full time	5 (39%)		
Employed/part time	3 (23%)		
Countries of origin (other than USA)			
Yemen	3 (8%)		
St. Thomas, US Virgin Islands	1 (8%)		
Korea	1 (8%)		
Religion			
Christianity	5 (39%)		
Islam	3 (23%)		
None	3 (23%)		
Judaism	1 (8%)		
Other	1 (8%)		
Immigration status			
Citizen	12 (92%)		
Immigrant/permanent resident	1 (8%)		
Diagnoses			
Affective disorder	8 (62%)		
Anxiety disorder	7 (54%)		
PTSD	4 (31%)		
Eating disorder	4 (31%)		
Personality disorder	3 (23%)		
Other disorder	2 (15%)		
Sleep disorder	1 (8%)		

Note: Some cases were presented multiple times, thus results may be an overrepresentation of some demographic characteristics in cases when consultation was requested multiple times for the same case. These data do not include all consultation requests, only the ones for whom team members completed a follow-up questionnaire. This table only includes responses for which data was presented, and does not represent all categories that were provided as choices.

concerned the primary foci of their consultation requests, which are presented in Table 5. The most common requests concerned stereotyping, prejudice, and discrimination ($n = 6$; 46%); family honor and obligations ($n = 5$; 39%); family and couple conflict ($n = 4$; 31%); intergenerational issues ($n = 4$; 31%); and posttraumatic stress disorder (PTSD), depression, and other symptoms ($n = 4$; 31%).

Satisfaction with Peer Consultation Received

Overall, results indicated participants found recommendations very feasible ($M = 4.92$, $SD = 0.29$) and very clear ($M = 4.75$, $SD = 0.45$). Additionally, members generally were satisfied with the service, as indicated by willingness to recommend service to colleague ($M = 4.88$, $SD = 0.35$), planning on using service again ($M = 4.88$, $SD = 0.35$), general satisfaction with consultation ($M = 4.50$, $SD = 0.76$), and perceived help with the client's problems ($M = 4.50$, $SD = 0.54$). With regards to the impact of consultation, members thought the consultation improved the clinician–client relationship ($M = 4.50$, $SD =$

Table 5
Consultation Requests ($N = 13$)

Consultation Topics	n (%)
Other social, economic, and structural issues	
Stereotyping, prejudice, and discrimination	6 (46%)
Social isolation, marginalization	2 (15%)
Poverty, socioeconomic uncertainty	1 (8%)
Unemployment or underemployment	0 (0%)
Family systems issues	
Family honor and obligations	5 (39%)
Family and couple conflict	4 (31%)
Intergenerational issues	4 (31%)
Changes in configuration of extended family	1 (8%)
Exposure to trauma and violence	
PTSD, depression, and other sequelae	4 (31%)
Domestic violence	1 (8%)
Effects of violence on development	1 (8%)
Impact of war, torture, and organized violence	0 (0%)
Cultural models of illness and healing	
Illness explanatory models and causal attributions	1 (8%)
Cultural influences on social determinants of health	1 (8%)
Treatment choice and expectations for care	1 (8%)
Modes of symptom expression and idioms of distress	0 (0%)
Migration issues	
Stresses and losses on migration trajectory	0 (0%)
Uncertainty of refugee or immigration status	0 (0%)
Family separation and reunification	0 (0%)
Homesickness and mourning for culture	0 (0%)
Cultural identity, acculturation, and adjustment	
Adjusting to life in host country	0 (0%)
Shifting/hybrid cultural identity	0 (0%)
Changing gender roles and relations	0 (0%)
Changing social roles and community	0 (0%)

1.00), influenced the client keeping appointments more regularly ($M = 4.33$, $SD = 0.58$), and influenced the client's treatment adherence ($M = 4.20$, $SD = 0.45$). We assessed whether the consultation influenced the use of other services, which was rated neutrally ($M = 3.00$, $SD = 0.00$). This may be due to applicability of this question to our clinic. It is also possible participants were confused by this question.

Overall Satisfaction with Multicultural Peer Consultation Service

Quantitative Feedback Regarding the Peer Consultation Service

In a final attempt to gauge the value and effectiveness of this peer consultation service, we asked consultation team members to provide feedback with regards to their satisfaction with various components of peer consultation service. Thus, following completion of the academic year, a total of eight (53.3%) team members responded to our request, the results of which indicated on average team members were either extremely satisfied or moderately satisfied with the multicultural peer consultation team overall. Namely, they provided high ratings for: satisfaction for the range of didactic topics ($M = 4.71$, $SD = 0.49$), the quality of these didactic topics ($M = 4.67$, $SD = 0.52$), the frequency of the didactic series ($M = 4.17$, $SD = 0.98$), the quality of consultation and feedback ($M = 4.71$, $SD = 0.49$), frequency of consultation and feedback ($M = 3.80$, $SD = 0.84$), the organization of the team ($M = 4.00$, $SD = 1.10$), time management of sessions ($M = 4.33$, $SD = 0.87$), safety in the team ($M = 4.86$, $SD = 0.38$), team members' ability to add items to the agenda ($M = 4.83$, $SD = 0.41$), and the team consultation agreements ($M = 4.67$, $SD = 0.82$). It is noteworthy that zero participants endorsed being either extremely dissatisfied (= 1) or moderately dissatisfied (= 2) for any of the aforementioned components.

Qualitative Feedback Regarding the Peer Consultation Service

We included a free-text response option to allow for feedback on the most helpful and valuable components, as well as suggestions for improvement. Team members reported the following components were helpful or valuable: the environment (e.g., "The creation of a safe environment is hard to achieve with these topics and was done well by the group as a collective"), didactics and consultation (e.g., "I thought the didactics were varied and helpful. Consultation was great—I wish we had more"), that the service leveraged team member's own experience with multiculturalism (e.g., "Ability to leverage knowledge of our team's members in sharing their experience with multiculturalism and promoting learning within our group to improve patient care"), and the structure and flexibility (e.g., "Having a plan/agenda and also having flexibility worked well"). Suggestions for improving the team included: prioritizing consultation over didactic sessions (e.g., "I would also do didactic every third meeting rather than every other"), working with administration to facilitate ease of attending (e.g., "Work with leadership to address barriers to provider involvement"), sending reminders about group *attending* (e.g., "I would suggest sending out reminder emails to those who want to participate on teams about meetings"), increasing the diversity of group membership (e.g., "I think the group could be enhanced by being more diverse itself"), and removing attendance of supervisors on team (e.g., "I'm curious to see if the students/interns/post docs like having the attendings [faculty] in there or not. I could make an argument either way").

Meeting Attendance

In line with our efforts to evaluate feasibility of this service, we examined attendance at all meetings. Attendance rates varied from 13% to 67% per meeting and attendance rates varied from 6% to 100% per person. Additionally, didactic meetings were attended on average by 45% of participants, in comparison to 33% of consultation meetings. Another interesting factor is that four (27%) members attended at least half of meetings, thus indicating there were significant barriers to team attendance for other team members.

Given some challenges with regular attendance, we sought to identify what factors interfered with members being able to attend team meetings. Results indicated the most common identified barriers to attendance included: competing demands for time (87.5% endorsed this barrier), schedule did not permit it (62.5%), attendance in the consultation team was not incentivized by clinic (37.5%), and sick/FMLA/vacation leave (37.5%). Moreover, other respondents also indicated they prioritized attending consultation meetings (25%), prioritized attending didactic meetings (12.5%), and that they had too many other nonoptional consultation teams and education hours (12.5%). Team members did not endorse any of the following barriers: the environment did not feel safe, the team felt evaluative, the consultation team did not meaningfully add to my knowledge, the content was not applicable or relevant, no longer at the clinic (i.e., practicum ended). Results overall lead us to believe that for an organization to successfully implement such a service, there needs to be institution/systems-level support for such a service. We discuss recommendations for developing systems-level support in our discussion.

Case Study to Demonstrate Consultation Process

In line with our efforts to provide a model that may be useful for other providers to implement in their clinics, we outline the process of consultation utilizing a case that was brought to the multicultural peer consultation team

several times. Herein, we present relevant sociodemographic characteristics, our case conceptualization (as well as the client's and her family's), the consultation requests made to the team, and suggestions made by team members.

Client Information

Fatima[2] was a 21-year-old female who was born in the U.S. and whose family immigrated from a country in the Middle East. She identified culturally as Arabic and her religion as Muslim. She was originally referred to our clinic for "treatment of anxiety." At the time of intake, she was living at home with her family (i.e., mother, father, three siblings, four cousins). In the context of several sessions, she shared with the therapist that her family had arranged her upcoming marriage, about which she reported being ambivalent. Fatima was a full-time college student and was completely financially reliant on her parents. Fatima reported that most of her family members were overtly critical of her and would often call her "crazy," especially during moments of dysregulated emotion.

Presenting Problem and Case Conceptualization

Fatima's family originally sought treatment for help reducing her behaviors violating the family structure and cultural norms (e.g., "talking back to family," "disobeying her elders [parents, older sister] by arguing"). Her mother stated to the therapist in the clinic's waiting area: "She's crazy. Fix her." From Fatima's perspective, she understood the reason for treatment was "to be fixed" because she was "not normal" and as a result "did not fit in" with her family. After assessment, the therapist's conceptualization (in line with DBT conceptualization) was that the client was exquisitely sensitive and reactive to emotion, was living in a chronically invalidating environment (e.g., continuously received messages "she is crazy"), and as a result had significant skills deficits with regards to emotion regulation and interpersonal effectiveness. It is noteworthy that the client, the family, and the therapist each had divergent conceptualizations of the presenting problem.

Treatment Approach Selected

Based on conversations with Fatima and her family, the therapist developed a treatment plan for the client to engage in weekly CBT focused on enhancing emotion regulation and interpersonal effectiveness. Family therapy was also recommended and referrals were provided; however, the family was unwilling to pursue this option. Despite the therapist believing the client could benefit from a comprehensive DBT program, there were major barriers that prevented the client's ability to participate in such a program (e.g., time commitment, homework compliance, irregular attendance due to relying on her family members to bring her to appointments, not sharing the therapist's conceptualization).

[2] We have changed identifying information to protect the client's identity. To that end, Fatima is a pseudonym for this client.

Peer Consultation Requests to Team

It is beyond the scope of this article to outline all clinical consultation questions that were present through the course of treatment. Instead, we limit our discussion to relevant multicultural peer consultation requests that were presented to the team. The therapist presented Fatima to the team three times, for the following consultation requests: (a) considerations and feedback regarding Fatima's request that the therapist intervene on the environment to help her address discrimination that she was experiencing in a class; (b) recommendations about how and to what degree to incorporate Fatima's family into treatment; and (c) help identifying and conceptualizing primary targets and developing a case conceptualization, and how to prioritize and structure treatment.

Recommendations

The first consultation request was related to Fatima's request for the therapist to intervene to help her with discrimination that she was experiencing (i.e., other students taunting her in class for being Muslim, and in particular for wearing a hijab). Some team members suggested that the therapist coach Fatima on how she might intervene herself, using interpersonal effectiveness skills to assertively request support from faculty and college administration. Other team members recommended that given the extensiveness of the discrimination Fatima was experiencing, as well as the academic impact of her associated anxiety, it would be appropriate for the therapist to advocate for Fatima by directly contacting the class professor (with a signed release of information form). The team explored the notion that this would allow the therapist to use her privilege as a psychologist to speak to the damaging mental health effects of discrimination as well as to demand action from the professor, who was currently acting as a bystander despite his position of power in the classroom. A synthesis of these options was to call the professor while in session with Fatima. This synthesis would allow Fatima to practice interpersonal effectiveness skills and the therapist to provide instrumental and emotional support at the same time.

The second consultation discussion involved how and to what degree to incorporate Fatima's family into

treatment. The therapist felt constrained by the family's blaming and judgmental statements in session and lack of receptiveness to corrective feedback and consideration of family therapy. Therefore, having them in session was, in fact, increasing emotion dysregulation, and was not conducive to addressing intergenerational issues or teaching family skills, while also interfering with the therapist's ability to teach Fatima emotion regulation skills to help her more effectively manage her emotions (consistent with treatment plan). The therapist was also aware of her own reactions to the expectation that Fatima maintain a deferential and respectful stance while experiencing profound invalidation. However, Fatima's ultimate objective was to simultaneously maintain connection to while also getting independence from her family. This included goals of "fitting in" with her family and abiding by cultural norms. The team emphasized that this was particularly important given her financial reliance on her family and the distress caused for her by viewing herself as a "misfit." The team also highlighted the interdependent cultural context in contrast to Western ideals of autonomy and independence. Team members validated the challenge of supporting Fatima in balancing acculturation with honoring her traditional culture, particularly given Fatima's own ambivalence about cultural norms (e.g., arranged marriage). The team problem-solved the various challenges of addressing intergenerational issues. Discussion focused on balancing the communication of respect for family honor and involvement with an emphasis on Fatima's need for individual therapy and the importance of providing her with skills. The team also offered the dialectical synthesis that as Fatima becomes more equipped with emotion regulation skills, she will likely become a more functional family member within their system.

The third consultation focused on conceptualizing primary targets, case conceptualization, and how to prioritize and structure treatment. The therapist particularly emphasized the need to distinguish between psychopathology and breaking cultural norms, which she perceived the family as conflating. It is important to note, when the family was brought into treatment, they often asked the therapist whether medications "could fix" Fatima and inquired as to the process of getting the client started on medications. However, Fatima expressed repeatedly she did not want to be on medications. The therapist requested input from the team related to the most effective way of honoring Fatima's request (and advocating on behalf of the client) as well as providing psychoeducation (related to distinguishing emotion dysregulation from anxiety and prolonged mood disruption, which were also present) to her family members. Moreover, as previously mentioned, the therapist believed Fatima might benefit from a comprehensive DBT program given the client's skills deficits, particularly in the areas of emotion dysregulation and interpersonal effectiveness, which were at odds with the family's preference for treatment frequency (twice per month) and length (several weeks to months, which is in contrast with 1-year commitment required by DBT). The consultation team helped the therapist think through a treatment plan that honored and balanced the clinical targets, the barriers, and Fatima's and her family's preferences.

Implementation of Recommendations

The consulting therapist integrated the multicultural team consultation into her clinical work by discussing the concept of dialectics with the client. First, she discussed with the client the balance between empowering her to practice interpersonal effectiveness (in a way that is culturally appropriate) and advocating on behalf of the client by calling the professor in-session. Ultimately, they collaboratively decided to focus on learning interpersonal effectiveness skills so that she could talk with her professor and thereby increase self-respect skills (e.g., per DBT handouts). Second, they discussed the balance between "keeping the peace" at home by keeping in line with traditional norms and her family's wishes, and at the same time increasing use of interpersonal effectiveness skills. For example, the consulting therapist and client decided to collaboratively find ways in which she could practice physiological and emotional arousal reduction strategies (e.g., politely excusing herself to go to the bathroom to do deep breathing) and practice interpersonal effectiveness skills in a way that would be in line with traditional norms (i.e., not becoming dysregulated and yelling) while still prioritizing self-respect.

Additionally, regarding subjective impressions of recommendations from team members, the consulting therapist indicated that the team was constructive in helping her think through different perspectives, holding the other side of her perspective, and bringing in awareness of cultural practices via different team member backgrounds and multicultural knowledge. She also noted that the consultation process was helpful in empowering her to be an advocate against discrimination for Fatima. Finally, she expressed that the team helped her to increase awareness of her own reactions to cultural practices that are distinct from her own, and nonjudgmentally supported her in managing her reactions.

Post-Hoc Assessment of Facilitators of and Barriers to Implementation of the Multicultural Peer Consultation Service

In line with calls to incorporate theoretical frameworks into implementation initiatives (e.g., Kirk et al., 2016; McEvoy et al., 2014), we conducted a post-hoc evaluation

of the process of implementation of the multicultural peer consultation service to increase its generalizability to other contexts (i.e., the set of circumstances or unique factors that surround a particular implementation effort). Namely, we elected to rely on the Consolidated Framework for Implementation Research (CFIR), which provides a comprehensive listing of constructs thought to influence implementation, namely the intervention, inner and outer setting, the individuals involved, and the process by which implementation is accomplished (Damschroder et al., 2009). To this end, we delineate these facets of the context in which we implemented our service. Importantly, we also identify facilitators and barriers to implementation of our service.

Intervention (Peer Consultation Service)

The core components of the peer consultation service comprised didactic and consultation components. The service entailed collaboratively developed didactic series wherein team members took turns leading a didactic topic. Regarding consultation, an essential component was the development of mutually agreed-upon consultation agreements. Consultation comprised a process in which team members self-identified a need for multicultural peer consultation to obtain validation and/or problem-solving from team members. Lastly, we identified a need to develop an action committee that would target organizational-level factors to make our clinic more multiculturally competent.

Outer Setting

Our clinic is located within a geographic area in the U.S. Southern region, which has a complicated social history of marginalization and maltreatment of people of color and other minority groups. Moreover, empirical exploration into the health care of marginalized groups in this region highlights several factors that contribute to health care disparities, including limited transportation, low socioeconomic status, and limited health care access (e.g., Lesane, 2013). Moreover, recent demographic shifts have now led this region to be more diverse (Triangle J Council of Governments, 2011), thereby highlighting the need for increased attention to multiculturalism.

Inner Setting

In recent decades, our institution has led several efforts to repair strained racial relations, with an aspirational goal of meeting the needs of vulnerable, disenfranchised, and underserved populations in our region. Indicators of this commitment are visible at the institutional, departmental, and clinic levels. For example, at the institutional level, this has taken the form of messaging from institutional leaders regarding commitment to diversity and inclusion, the development of the institutional offices (e.g., Office for Diversity and Inclusion) and committees centered on increasing attention to this area, and intentional training and education about the history of the institution. At the departmental level, members of the faculty have developed partnerships with community agencies to increase access to care for uninsured and underinsured individuals, increased attention on recruitment and retention of underrepresented trainees and faculty, and the development of committees focused on multicultural competence. At the clinic level, the majority of our team members share a passion for multicultural psychology and for providing optimal care to diverse populations. In fact, for many team members this is a clinical and research area of expertise. In this way, our clinic holds a culture of providing sensitive and responsive care to all patients. This is evident through inclusion of multicultural topics in training and education efforts delivered by our clinic members to other members of the institution and wider community, providing training opportunities for trainees to increase their skillsets in multicultural competence, and partnerships with community agencies that do work with underserved populations.

Individuals Involved

Development and implementation of our peer consultation service was carried out by faculty members, postdoctoral trainees, pre-doctoral clinical psychology interns, and graduate students (i.e., clinical psychology, social work). We elected to pull together a team with members with differing levels of power and during the course of the overall evaluation this was identified as a strength as it elevated the importance of such a service. Alternatively, we can appreciate in some settings this may make the team feel evaluative and therefore not safe and thus this is a level of consideration for individuals hoping to create such a service in their setting. Additionally, we set out to develop an interdisciplinary team comprised of clinical psychology and clinical social work practitioners. Lastly, all members of the team were practitioners of CBTs primarily. This allowed us to deepen our consultation and to be targeted in our recommendations. We encourage others to consider these factors as there are associated benefits and drawbacks to the choices that we selected through this process.

Process

The development of the peer consultation service was one that utilized a hybrid approach in that it was both developed from the ground-up (by the members and for the members derived from an identified need), and it was also top-down in that we relied on theories and existing frameworks to shape the process in which we engaged. From the beginning, our process was collaborative, data-driven, and iterative, considering perspectives from all members at various choice points (e.g., who to invite to be members, topics for didactics). Ultimately, we were able to

foster an environment where members felt a sense of shared ownership, safety, and pride in the service. Additionally, there was a high degree of commitment from team members to continue having the team and attend when they were able to, despite many demands on their schedule.

Facilitators of Implementation

We identified facilitators of the peer consultation service at various levels. At the community-wide level, the area in which the clinic resides has been drastically and rapidly changing in recent years, thereby diversifying our client population and increasing the need for attention in this area. At the institutional level, our AMC has demonstrated commitment to diversity and serving the surrounding the community. On a departmental level, there have been numerous initiatives developed aimed at improving multicultural education for trainees as well as care to underserved populations. At our clinic, the developers of the peer consultation service have been involved in leading efforts to provide evidence-based practice in a sensitive, responsive, and flexible manner when working with clients with many social stressors (e.g., not able to afford weekly therapy) and problem-solving barriers to engagement in care. It was also helpful that the team members shared values around increasing access to care for vulnerable and underserved populations, and ensuring a baseline level of comfort, attention, training in multicultural competence in clinical care. Moreover, it was helpful that some team members were very knowledgeable about multiculturalism and were able to lead discussions on select topics. Importantly, a major facilitator of the service was that the service itself increased a sense of cohesion and community by bringing clinic members together who have shared values in this area. In sum, our environment encouraged the development of the multicultural peer consultation team which contributed to the success of the service.

Barriers to Implementation

Despite many factors that contributed to the development and implementation of the peer consultation service, we encountered some barriers to implementation. Providing this type of service is challenging due to the competing demands that are present in AMCs (e.g., clinical care, care coordination, administrative responsibilities, educational opportunities, research tasks, supervision and other consultation teams, institutional and departmental events). In this setting, it is often difficult to prioritize all valued activities with limited time. In function, this was a factor that prevented many of our members from regularly attending team meetings, despite a strong commitment and desire to be present. Relatedly, high demands on the time of team members also posed a challenge with regards to collecting outcome data (which team members were asked to bring to the following session). Through qualitative feedback, many team members reported that in the future, they would like for the clinic to further support this team by reducing workload (e.g., requiring one less clinical session per week). Another barrier to providing this service is that our clinic is housed within a large department (i.e., over 500 members) at a large AMC, and therefore many of our team members have clinical, research, and educational responsibilities spread across many locations, which posed challenges for finding a time and location that would maximize attendance.

Lessons Learned and Recommendations for Starting a Multicultural Peer Consultation Service

We learned many lessons from our first attempt at developing and implementing a multicultural peer consultation team at a large AMC. In line with our mission of continuous assessment to guide our decision-making, we, the authors of this paper, reflected on the most salient lessons learned to make recommendations to other clinicians with the aim of empowering them to create their own multicultural peer consultation teams.

1. Develop and Implement in an Iterative, Data-Driven Process

The team development occurred iteratively and collaboratively, utilizing data to guide decision-making. At various stages of development, we collected data to guide our subsequent steps. This process allowed team members to provide their perspectives and for us to maintain a collaborative spirit. For example, we altered the frequency and content of the meetings over time in response to feedback received from the members (e.g., monthly to biweekly, and ultimately, weekly meetings). To maximize the value to team members, we developed and altered the format as opportunities and needs arose. We recommend that similar teams assess their own functioning regularly and modify the content and process of the team to serve the changing needs of the members.

2. Have a Specific Process for Collecting Follow-Up Data

We easily collected data on initial consultation requests; however, we were not able to collect any follow-up data (despite our intention and effort to do so). Likely contributing variables include: lack of incentives for providing data, too much time passing between consultation and implementation of the strategies discussed, irregular team attendance, time commitment required to provide accurate feedback, or simply forgetting. We recommend that similar teams develop and implement a specific process for collecting follow-up data to track the helpfulness and effectiveness of consultation. Teams are encouraged to assess the need for and utility of the data, establish commitment and accountability from

members, make the process as simple as possible, and provide feedback about how the data are useful or other incentives.

3. Elicit Buy-in from Stakeholders

Through our efforts, we found it is essential that the administration of an organization is in support of new initiatives. The most prevalent impediments to regular attendance included lack of time or competing commitments. Regular attendance would likely be enhanced if time was protected to allow attendance or practical incentives were offered (e.g., reducing caseload to allow time to attend team meetings). These types of encouragement would require investment from leadership and administrative support.

4. Meaningfully Tap into Each Member's Prior Experiences with Multiculturalism

Many members had previous training, clinical experience, or research expertise in relevant domains, and we could assemble a didactic curriculum that spanned many topics related to multiculturally competent practice. The diversity of training, academic field, and prior experiences with multiculturalism created opportunities for learning from one another and greater involvement in the team. We found that team members effectively balanced leveraging and sharing their experience and also remaining open to feedback, suggestions, and alternative perspectives. Developing multicultural peer consultation is still possible without members who have expertise in relevant areas (see Hill et al., 2017 for an elaborated discussion on what constitutes clinical expertise). Teams with less multicultural training may leverage speakers within their institution or community, online training courses, or journal articles to help provide didactic information. Members can still consult about multicultural issues relevant to clinical work, support each other, and learn together. We recommend that others considering implementing a similar consultation service leveraging the skills members within their groups possess by inviting them to lead didactic presentations and to meaningfully engage in peer consultation that allows for all members to participate (not only those who posees a very high level of knowledge in this area).

5. Include an Action Steps Component

Early in the team's development, it became apparent that there were ways that the clinic could be improved outside of offering ongoing consultation. For example, members noted a lack of gender-neutral restrooms and a desire for safety symbols to be placed in the clinic. The team discussed whether these tasks were appropriate to address within a consultation team, and ultimately decided to form a separate action committee (further detailed in the discussion) to tend to these needs. We recommend to others that they engage in a process of determining ways in which the peer consultation team can also address organizational in addition to individual-level factors that may enhance the clinic's ability to be sensitive and responsive to all clients.

6. Invite Experts to Join the Team

Our team was largely comprised of trainees, thereby potentially limiting the breadth and depth of didactic topics and consultations provided. While each member of the consultation team may have incredible experience in certain multicultural topics, we nonetheless recommend that other teams invite internal and external experts to join the team to either lead didactic presentations and/or to be members of the team to scaffold peer consultation provided. We acknowledge, however, that doing so may necessitate additional funding, which may pose a particular challenge in some settings.

7. Incorporate an a Priori Implementation Science Framework

The nature of our peer consultation service was such that it was developed organically, in response to a stated need within our clinic, and driven by the passions and interests of our founding members. We believe these factors represent particular strengths of our service. In order to encourage others to develop similar peer consultation services, we present herein a *post-hoc* evaluation of facilitators and barriers that may affect implementation of such a service. It is possible that the model we present may be developed and implemented similarly in other clinics; however, it may also be the case that the context in which we developed our peer consultation service was unique. To this end, we recommend incorporation of an *a priori* implementation science framework to guide the development and implementation of a peer consultation service that will be responsive to the unique contextual factors present across a wide array of settings.

8. Acknowledge and Address Power Structures

Our team comprised four faculty members and 11 trainees of various levels, which we view as a strength of the peer consultation model we present herein. Specifically, it demonstrated that we could have a peer consultation group in a hierarchical system. We posit that attention to these dynamics is crucial in order to have an optimally functioning team. We found that an effective way to have peer consultation in a hierarchical system such as ours was to uphold the spirit of the team and to remind ourselves of at least one team agreement at the start of each consultation meeting. Furthermore, we encourage other teams to have open and candid conversations regarding power differentials and the develop a mutually-agreed-upon intention for the team.

Discussion

One route to increasing multicultural competence of providers is to provide ongoing consultation that centers on multicultural factors that impact the clinical presentation and affect treatment engagement. In this article, we outlined the initial process we underwent to develop and implement a multicultural peer consultation team for our clinic, housed within a psychiatry department at an AMC. To that end, this paper centers on the lessons we learned through that process so that other groups may develop and implement a similar peer consultation service in their setting.

In our opinion, a primary strength of this service is that we engaged in an iterative and informed decision-making process that worked well for our clinic. This allowed us to get a beneficial level of buy-in from many members of our clinic to be able to develop and maintain this service. In fact, this grassroots effort to develop this service was a response to clinic providers stating a need for the service. Consultation team members named numerous reasons for joining the team, including to increase their knowledge base, to help their work with their clients, for personal growth, because it was values-consistent, and to be able to have a supportive and safe space to discuss multicultural topics.

Overall, results revealed that the peer consultation service was acceptable to team members, as evidenced by high satisfaction ratings with regards to different components of the peer consultation service, such as the quality and frequency of didactic and consultation meetings, organization, time management, and shared ownership (e.g., ability to add items to the agenda). Moreover, qualitative feedback revealed that members appreciated the environment of the team, found the meetings helpful, that the team leveraged team members' prior experiences with multiculturalism, and liked the balance of structure and flexibility. We found that one of the biggest pieces of feedback we received was that regular attendance was challenging and that one strategy to address this is to work with the administration to facilitate ease of attending. The members of this group chose to attend the group over and above their existing workloads. A related difficulty was that it was challenging for group members to complete questionnaires both related to the group generally as well as on the outcomes of specific consultation requests. It appears that this was primarily due to many demands placed on clinicians. It is possible participation might be improved if administration better supported clinicians participating in this group by reducing client load. It may be more likely to get stakeholder backing by providing support for improved client outcomes connected with the consultation team.

We valued data collection throughout development and implementation, and we also found that this was challenging to execute (particularly to collect follow-up data about consultations). We suggest that it may also be useful for other teams attempting to develop a similar service to determine a simple, yet informative, way to collect data about the effectiveness of the consultation team. This will not only give members valuable information about how to improve and maintain a team that is most beneficial to its members, but also allow potential stakeholders to assess the importance and utility of the team.

It is noteworthy that the consultation team was comprised primarily of women (only one man attended). Although our clinic is comprised of more women than men overall, proportionally, fewer men participated in the consultation team. This gender gap was notable, especially during discussions of privilege and gender. It is possible that there may have been an interaction of privilege and interest in the multicultural peer consultation group. Consistent with that hypothesis, the one man who did participate identifies as gay (i.e., holds a marginalized group identity). Research suggests that those with more privilege may view multicultural issues as less important or not relevant to them (McFalls & Cobb-Roberts, 2001). Organizations may consider how to engage a broad audience in multicultural peer consultation and training, especially those who may benefit most by learning about diverse experiences and perspectives (e.g., trainees, those who hold socially advantaged identities).

The team considered team size and membership both at the onset of the team and mid-way through the academic year. A larger team holds the possibility of numerous benefits including allowing more members of the institution to benefit from consultation, increasing the diversity of viewpoints and expertise, and a larger support system. However, with a larger team, members may have more difficulty being vulnerable and have less opportunity to get consultation needs met (i.e., more members, more consultation items in total). Further, it is likely with increased membership that less time would be allocated to each consultation item. In contrast, with a smaller team, each member may have a sense of increased responsibility, ownership, and control of the team. More in-depth and frequent discussions of particular cases/issues are possible. Keeping the team small, however, allows for fewer people to benefit from the service and limits group diversity and the size of the support system.

It became clear in early discussions in the multicultural team that there were ways the department and clinic could be improved with respect to embracing multicultural competence outside of clinical consultation and didactic training. A smaller team who felt passionate about these issues and were able to dedicate time to them formed a separate action committee. The action

committee was comprised of six individuals (faculty, postdoctoral trainees, pre-doctoral interns, and graduate students) who were all part of the multicultural team. The action committee met once per month and took on tasks such as crafting a diversity commitment statement for the website; creating and disseminating multiculturally sensitive clinic forms, clinical interviews, and case conceptualization forms for clinicians to use with clients; and developing and disseminating safety symbols for clinicians (e.g., stickers, buttons for lanyards). It is likely that most clinical settings may identify areas for growth. It may be appropriate to develop a separate action committee to address these areas or integrate identified tasks into the work of the multicultural peer consultation team.

The findings contained herein are presented in light of significant limitations. First, though there was some representation of multicultural identities held by the members of the peer consultation service, the sociodemographic composition of our team overall is limited. Second, the majority of our consultation team members were not able to make at least half of the team meetings, primarily due to competing demands for time and their schedules did not permit it. These data speak to the fact that members wanted to attend regularly, but environmental barriers were present. Third, we had a large amount of data lost to follow-up, for reasons previously mentioned. It is possible challenges with attendance may have had important implications for our ability to collect quality improvement data (e.g., satisfaction with specific peer consultation requests) and surveys (e.g., group membership expansion survey), which may ultimately limit our ability to make generalizations regarding the efficacy, acceptability, and feasibility of our peer consultation service. Fourth, though we conducted a post-hoc evaluation of facilitators and barriers of implementation utilizing the CFIR (Damschroder et al., 2009), we acknowledge the development and implementation of our peer consultation service could have been enhanced had we done so in an *a priori* manner. Doing so may have increased our ability to make generalizations regarding an appropriate implementation strategy that could be easily translatable to a wide array of settings.

This paper documents our iterative and collaborative efforts to develop and implement this sort of service within a large AMC. In spite of the aforementioned limitations, we strongly believe this service enhanced the multicultural competence of many clinicians within our clinic. Anecdotally, we have had many members express gratitude for the presence of the team. We hope that our sharing the operationalization of this framework and preliminary results empowers other providers to develop similar consultation teams in their respective settings.

There are important future directions to take into account. First, in this study we did not capture consumer satisfaction data from clients themselves, which would have allowed us to assess another dimension of efficacy of this team. Moreover, there may be other client-related outcomes that may aid in evaluation of the service, such as retention in treatment, attendance, homework completion, treatment adherence, and working alliance. Ultimately, these data may make a compelling case to the departmental administration to facilitate attendance by clinicians. Second, future studies ought to consider assessing outcomes via subjective (e.g., self-report measures) and objective ratings (e.g., role-play assessments with standardize clients) of multicultural competence. Lastly, our service was housed within a clinic of CBT practitioners. It is likely other disciplines (e.g., psychiatry, community and family medicine) or practitioners from other theoretical orientations (e.g., psychodynamic) could benefit from participation in this service. Thus, we recommend future studies consider expanding team membership.

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The authors declare that there are no conflicts of interest.

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Received: February 12, 2018
Accepted: February 17, 2019
Available online 14 March 2019