RQ5: Do service providers more appreciate the need for cultural self-awareness to help take responsibility for racial power?

Background and rationale

Fundamental Attribution Error (FAE) and white privilege

Service providers may believe that most or all barriers to disclosure and uptake of formal services among CALD victims/survivors of child sexual abuse are ‘cultural’ (and so belong to the group), rather than also taking into account ‘non-cultural’ factors (which are shared cross-culturally), or confusing cultural factors with ‘migratory’ ones (which occur for CALD groups but only after migration, including racism). Failing to take into account cross-cultural similarities (which should neither be over- nor under-stated), or understanding racialised power dynamics in broader white-majority society (in which a CALD individual exists and manages pressures to assimilate and cede authentic identity), carry the effect of localising understanding of the client to the client; ‘everything about CALD groups is cultural, so it is something about them that explains them’.

This cognitive bias reflects the fundamental attribution error (FAE; Ross, 1977), in which causal reasoning for a behaviour is tipped toward dispositional factors (i.e. characteristics of the person) even when situational factors in the external environment are clear causal contenders (Vaughan & Hogg, 2002). Research has long ago also shown that the FAE is more prevalent in Western/individualistic societies (Miller, 1984), because of the personal agency (valued and) bestowed with having the right and responsibility to be independent, autonomous, and self-sufficient.

Thus, if Anglo Australian service providers fail to appreciate that in the dyadic clinical relationship, the CALD client is seeking and receiving services from a perceived representative (consciously or otherwise) of that white-majority society in which their ethnic group has lower power (social, cultural, economic, and political; Giddens 1997), then there is a risk that those professionals may not be aware of and therefore take responsibility for their racial power inherited from Anglo Australian group membership. That is, if a professionals’ understanding of Australian racial politics excludes the role of group-level power, solely focuses on individual prejudices as the cause of racism, makes every effort to work with all clients in a non-racist way, and therefore believes that race is not really a critical variable to
be aware of in the clinical setting, then an unintended abuse of racial power could occur. As Fontes and Plummer (2010) write, “cultural humility refers to self-awareness and habits of self-reflection (Tervalon & Murray-García, 1998) … (that are critical for good practice because) even when professionals are unaware of (racial) biases and assumptions, clients often perceive them (Perez Foster, 1999)” (p. 509).

**Professional differences, client differences, and ethnic-matching**

Social workers receive education in their curricular on social justice and therefore sociological conceptualisations of racism. Within the discipline of sociology, racism is defined as the combination of prejudice plus power and therefore does not only discuss prejudicial cognition the way the discipline of psychology does. Thus, there is a risk that psychologists miss vital education on understanding CALD clients as ‘ethnic minorities’ in Australia. Medical practitioners such as GPs and psychiatrists may also miss the vital education psychologists receive about cognitive errors that lead to racial prejudice.

At the same time, CALD client victims/survivors may be seeking Anglo Australian service providers precisely for their assumed lack of cultural knowledge and self-awareness; it could be perceived as the vehicle to being treated as just a person like any other, with no special knowledge or accommodations required or wanted. Indeed, with greater knowledge come more questions, so lack of racial awareness can also simplify the clinical setting rendering it more effective.

CALD client victims/survivors, like any other group of clients, will be diverse in their needs and expectations about services. For this reason, racial self-awareness by virtue of being critically reflective on one’s own cultural norms, traditions, values, and beliefs, as well as group-level power inherited from group membership and therefore independent of personal cognitions, was seen in this project to enhance the quality of services but not essential for them to meet basic needs in the clinical setting with CALD victims/survivors.

Research has shown that there is a tendency for CALD service providers to be seen as best placed to engage with CALD clients because they will have tacit cultural knowledge that allows them to better understand ‘where they are coming from’ (Sawrikar, 2013). While racial similarity does increase empathy because of biased stereotypes socialised for different others (Xu, Zuo, Wang, & Han, 2009), it can also increase judgement or risk of harm. For example, (especially male) interpreters may abuse their power and tell (especially female) victims of DFV to return to their spouse and spare family shame (Sawrikar, 2015). Feared breaches of confidentiality with CALD service providers, in turn threatening community standing, are a substantial barrier to service uptake, and can lead CALD victims/survivors to seek what they see as a culturally neutral and therefore safe space with an Anglo Australian. Thus, CALD clients will not necessarily want an ethnically-matched service provider, leading
to an onus for the whole Australian mental health and sexual assault workforce to be trained in cultural competency and not just leave ‘CALD matters’ to CALD workers.

In short, all service providers have different and expert knowledge that together allows them to meet the diverse range of needs CALD victims/survivors may present with. Those that are clinically unwell can benefit from liaising with a psychiatrist with the professional power to administer appropriate medications. GPs are an appropriate point of referral to psychiatrists, psychologists, social workers, and counselors, all of whom work to talk through and share trauma with the aim of reducing the symptoms of emotional distress. Good engagement with a GP also has the power to act as a sign of good engagement with other professionals whose work encompasses recovery from sexual assault. All services providers differ in the extent to which they receive education in social justice, and this may sometimes be of benefit to CALD victims/survivors and at other times not. However, this project errs on the side that while ‘ignorance may be bliss’ it is also dangerous; it is better to have cultural and racial self-awareness and use it accordingly than to not have it and risk adding to abuses of power already incurred by the victim and therefore good clinical outcomes. As the education program was not centrally about ‘white privilege’\(^1\), it only aimed to examine change over time in the number of service providers who were now aware of the concept after having taken part in the program.

**Measures**

Program attendees were asked two questions in relation to RQ5. The first was, *B.3* – ‘How self-aware of your own cultural background do you feel you are?’ with options varying from 1 = Not at all to 5 = Completely. The second question was, *B.5* – ‘Have you ever heard of the phrase ‘white privilege’?’ with options Yes or No.

**Changes over time**

**Cultural self-awareness**

**By cultural background of service provider**

As can be seen from Table 14, scores on cultural self-awareness only marginally increased for CALD service providers from T1 (M = 4.2) to T2 (M = 4.4), and for Anglo service providers from T1 (M = 3.9) to T2 (M = 4.1). These lack of substantial changes over time

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\(^1\) In the literature, ‘white privilege’ can sometimes be capitalised and an author’s choice warrants consideration and explanation. In this project, the lower case ‘w’ has been selected to denote skin colour not race. By analogy, ‘Black’ is not a race, ‘black’ is a skin colour. It also works within a decolonial framework, removing the power of a capital letter.

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indicate that cultural self-awareness is already high among all relevant service providers, and therefore that the program was not likely to be effective in improving it. Indeed, scores were significantly lower for Anglo than CALD service providers at T1 ($t(109) = 2.82, p < 0.01$) but not by a great margin, and not significantly different at T2 ($t(42) = 1.56, p > 0.05$).

On the other hand, had medical practitioners such as GPs and psychiatrists been involved in the evaluation study, differences between service provider types (‘medicos’ cf. ‘non-medicos’) may have been observed. Specifically, improvements in cultural self-awareness may have been observed among medicos as a result of taking part in the program, thereby demonstrating its effectiveness on this necessary component of being able to provide services in ways that responsibly use racial power. Arguably, counselors and social workers, and then psychologists or other indirectly related professionals, are likely to receive training in social justice in their curricular and/or daily work practice and therefore their need of exposure to such information is lower than for medical practitioners.

**Table 14: Descriptive data on cultural self-awareness by cultural background of service provider (T1 and T2)**

<table>
<thead>
<tr>
<th>Cultural self-awareness (B.3)</th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>CALD</td>
<td>4.2</td>
<td>0.7</td>
</tr>
<tr>
<td>Anglo</td>
<td>3.9</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>4.1</td>
<td>0.7</td>
</tr>
</tbody>
</table>

**Relationship with cultural self-efficacy**

The correlations between cultural self-awareness and cultural self-efficacy (knowledge, confidence, and sensitivity) are in Table 15. They show that for both CALD and Anglo service providers, the correlations were moderate and positive (if not significant) at both T1 ($0.13 < r < 0.45^{***}$) and T2 ($0.18 < r < 0.53^{***}$). Thus, independent of the program but as expected, service providers increased on their self-rated cultural self-awareness as they increased on their self-rated cultural knowledge, confidence, and sensitivity. Importantly, it is not clear if or to what extent cultural self-awareness reflects racial self-awareness.
Qualitative data

Qualitative data about the program promoting cultural self-awareness was not extensive, perhaps because it is already high among this service provider group. Still, important and relevant comments were obtained:

*Excellent information re importance of family reputation and racism to disclosing CSA (Satisfaction Survey_15).*

*Great opportunity to reflect about my own understanding (of) cultural competency and racism (Satisfaction Survey_61).*

*(Liked best?) Awareness and reflection of white privilege and power, important to reflect on this (Satisfaction Survey_99).*

*Excellent to see sociological approach to working with CALD communities, revisiting and highlighting the importance of white privilege. Thanks very much for valuable and needed contributions to practice in this field (Satisfaction Survey_88).*

*Great presentation, glad to see patriarchy in the mix and mention of feminism/intersectionality/social justice in service delivery. Raising awareness of white privilege is a good starting point to develop cultural competency (Satisfaction Survey_64).*

Thus, the program was seen to promote self-reflection, which in turn is a critical component of self-awareness. However, further research would be required to examine what exactly constitutes as cultural self-awareness for Anglo and CALD service providers, and how this translates to better self-understanding and engagement with clients of all backgrounds, and appreciation of cross-cultural similarities and differences in daily work practice.

In comparison, much more qualitative data was generated on the issue of racism itself – as opposed to the role it plays for CALD victims/survivors in disclosing abuse and accessing clinical services, which was the primary aim of RQ5 (this discussion is documented in the following section on ‘white privilege’). Only one such relevant comment was made:

*I learnt the importance of understanding how cultural norms can influence the ability for child’s sexual abuse victims’ to report the perpetrator(s). The most interesting learning for me was about groups and sub groups and how they like to protect their own, which then explains why most victims or victim’s parent do not report sexual abuse to protect either the victim or perpetrator. This has given me space to be impartial when dealing with CALD victims of child sexual abuse or their families (Follow up Survey_5).*
Finally, a discussion between two colleagues demonstrated the preference for a non-ethnically matched service provider, and therefore the need for a fully trained workforce rather than one in which ‘CALD matters’ are left to ‘CALD workers’. One practitioner sought further clarification on how to implement confidentiality in a statutory setting, and the other provided that clarification by pointing out that it is not confidentiality from other workers but from other members of their CALD community that is sought:

*I’m from the Department of Child Protection, and you were talking about confidentiality and how crucial that is for clients. That can be really difficult for us. Confidentiality with who? We might have to tell the Court, we have to report to our supervisors and our seniors on certain points, so confidentiality in a statutory organisation can be very blurred* (Q&A Forum_Adel).

*I work for the Department of Child Protection, within a team called Multicultural Services. I think communities are mainly concerned around confidentiality within their community, so they don’t really mind us talking to police or to doctors, but their fears are ‘don’t tell the pastor at my church’, or ‘what if they tell my sister or my cousin?’* (Q&A Forum_Adel).
Table 15: Correlations between cultural self-awareness and cultural self-efficacy by cultural background of service provider (T1 and T2)

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th>T2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cultural knowledge</td>
<td>Cultural confidence</td>
</tr>
<tr>
<td><strong>CALD</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural self-awareness</td>
<td>0.45***</td>
<td>0.13</td>
</tr>
<tr>
<td><strong>Anglo</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural self-awareness</td>
<td>0.32*</td>
<td>0.32*</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural self-awareness</td>
<td>0.45***</td>
<td>0.26**</td>
</tr>
</tbody>
</table>

*p < 0.05, ** p < 0.01, *** p < 0.001; a – T1 n = 58, T2 n = 23; b – T1 50 < n < 53, T2 n = 21; c – T1 108 < n < 111, T2 n = 44.
White privilege

All but one service provider reported being aware of the phrase ‘white privilege’ at T1 (n = 111/112; 99%); herself of CALD background. As mentioned previously, had medical practitioners (GPs and psychiatrists) been involved in the evaluation study, more substantial differences between service provider types and therefore change over time may have been observed, thus demonstrating the effectiveness of the program in promoting self-awareness and therefore responsible use of racial power in professional settings. Such differences, if they were to occur, would likely be the result of curricular on social justice and daily work practice reflecting its pursuit. Three themes related to ‘white privilege’ – terminology, skin colour, and intersectionality – are discussed below.

The term ‘CALD’

During the Introduction, an explanation of the use of the term ‘CALD’ in the program and project was provided; namely, that it is only being used for consistency with terminology used by Australian governments, but that it suffers two critical issues: (i) while it celebrates ‘the diverse’ it hides that it is really about ‘the different’, and (ii) it does not allow discussion and therefore recognise a fundamental experience for those who belong in this group – racism.

This discussion was seen favourably by many of the participants (n = 30), and none reported unfavourable responses or saw it as redundant. As examples, they said:

Diverse -> different (CALD) (Satisfaction Survey_3).

Loved challenging term “CALD” (Satisfaction Survey_51).

Also liked the discussion re CALD title (Satisfaction Survey_32).

(Liked best?) CALD – explanation (cause division) (Satisfaction Survey_42).

I also feel that the term CALD is not useful – and is othering (Satisfaction Survey_34).

Wonderful work you are doing! Well done and loved your critic of the word “CALD” (Baseline Survey_79).

(Liked best?) The initial talk about the CALD acronym and its lack of transparency (Satisfaction Survey_6).

The “D” stands for ‘different’ rather than diverse was great – I'll use that! (Satisfaction Survey_93).
Really got a huge amount out of the critique of CALD terminology and appreciate the invitation to think about this differently (Satisfaction Survey_66).

CALD – D = different; this is a great way to think about this and something I will explore with my team and pose as a discussion point in training (Satisfaction Survey_7).

Racism is so important to mention, we need to name it. You were clear you were talking about clinical settings (Q&A Forum_Bris).

You discussed with us the inappropriateness of the term CALD, and how it reasserts to further marginalise. I’d love to know your thoughts on what you propose would be a more equitable term (Q&A Forum_Bris).

If you talk about CALD communities, where to draw the line? Because the second generation or third generation may not want to consider them [as CALD], see my daughter, she’ll say, ‘I’m Australian’, whereas I consider myself Sri Lankan even though I’m an Australian citizen. There is a barrier between a migrant and a second and third generation, that’s an issue as well (Q&A Forum_Syd).

CALD is a term developed by government. To make it easier we use NESB. But that (still) excludes international students, women on tourist visas, women on temporary visas whose children have been sexually assaulted or in situations of domestic violence. So how we name people, I guess a name is a name, but who we include and who we exclude for supports because of their immigration status, that shouldn’t happen (Q&A Forum_Bris).

I think the term ethnicity is really limited. When we talk about culture, we define that in the context of ethnicity, language, and faith. We did some consultation with kids, and many of them identify themselves as Australian-Vietnamese, Australian-Greek, Australian-Turkish, and I think for me CALD is relevant and ‘ethnic minority’ doesn’t do it to me, I’m from a CALD background, I’m second generation, my kids are third generation, and they identify themselves as CALD, so there’s a sense of the breadth and depth of the migration experience in this term (Q&A Forum_Syd).

Thanks so much. I have been thinking lots about your intro and the discussion about the term CALD. I was impressed with the idea of D as different not diverse and carrying a negative judgement. I wonder what difference it makes to your intro now that, for young people in Victoria, we now have more than 50% with one or both parents born overseas? That first large circle becomes a nonsense and is the first part of the deceit. That and the fact that there were 75 different cultures on the first boats coming over from England 200 years ago also mask the idea that ‘we were all
white(right) until the ‘foreigners’ started coming. I have decided to revamp my training intro based on these ideas. Thanks for the inspiration (T1_Email).

Two participants noted that while the discussion on the limitations of the term CALD were good, they still required further thinking through. Specifically, the role of religion needs to not always be subsumed within the role of culture, and the false synonymous use of culture and ethnicity needs to be called out:

- Would have been good if culture and religion we’re not group together all the time as it can be really powerful to be able to understand that some things are not the same as each other (Satisfaction Survey_25).

- The concept of CALD is diverse/not one group – references to migration etc. but I think is an issue if not unpacked further. Reference to ethnicity which captures culture, and inference that culture is part of ethnicity – yet term culture used more generally (Satisfaction Survey_45).

Discussions about terminology were only a ‘foreword’ to the program, but research centred on language for ‘racial others’ and on child sexual abuse in minority groups, are inextricably linked. Thus, these comments are seen as useful suggestions, and further research can progress such goals.

**Skin colour**

Throughout the program, skin colour – namely, white, black, and brown – was used to talk about racial diversity. It was anticipated that this would cause discomfort for some people, and was therefore acknowledged and encouraged to be shared on the Program Satisfaction Survey. Three participants took this encouragement up, saying:

- I believe you assume racism is only between whites and non-whites when there is also between us, brown to brown (Satisfaction Survey_75).

- The use of black and white would have been said differently. The speaker identified herself as brown and the session seems to refer to white or black when referring to racism (Satisfaction Survey_11).

- Talking in reference to “brown” woman is almost suggesting the issues are only for people with brown skin. This is not an issue of skin it’s a cultural issue which goes beyond colour (Satisfaction Survey_6).

There is indeed validity in all three comments, which primarily serve to highlight the complexity of the issue of racism. Nevertheless, more attendees appreciated and were comfortable with the use of this language (n = 6). They said:
Less PC which was very refreshing (Satisfaction Survey_21).

Excellent presenter from ‘CALD’ community (Satisfaction Survey_67).

I appreciated the “openness” of the conversation (Satisfaction Survey_76).

(Liked best?) The instructor was very honest in the way she addressed the issues of concern (Satisfaction Survey_59).

I could sense the brown comment made some uneasy, but I personally had no issue and agree that colour is the first thing people see and then make a judgment on (Satisfaction Survey_7).

I enjoyed hearing about the concerns that CALD members face. As a white Australian, I do my best to acknowledge the cultural differences but I will never really know so seeing that and hearing that makes a difference (Satisfaction Survey_24).

**Intersectionality**

Many participants appreciated the intersectional approach of the program. They said:

(Liked best?) Unpacking the complexity (Satisfaction Survey_18).

(Liked best?) Exploration around power (Satisfaction Survey_25).

(Anything else?) Introduction to the term of ‘misogynoir’ (Satisfaction Survey_82).

(Liked best?) Intersectionality – culture, gender, person, trauma (Satisfaction Survey_54).

(Liked best?) Thoughtful. Talked about racism and feminism – and still culturally appropriate (Satisfaction Survey_67).

Engaging talk and nuanced discussion about racism, intersectionality, sexism, and survivor experiences (Satisfaction Survey_48).

I came across the word intersectionality only a couple of months ago listening to a Ted Talk. Thanks, great presentation with excellence and knowledge (Satisfaction Survey_97).

In comparison, one participant did not appreciate the intersectional approach of the program. They said:

A fair bit of intersectional-focused material seemed unhelpful in terms of supporting individuals. ‘White privilege’, ‘patriarchy’ are such fuzzy ideas (you could substitute
‘evil’ and not lose much information). I’m not sure these concepts help clients, and the presentation wasn’t persuasive with regards to this (Satisfaction Survey_14).

The relevance of intersectionality became manifest in several comments made by program attendees. For example, one noted that ‘white feminism’ is not the same as ‘brown feminism’; calling for responsible use of language and (an inexplicit) reminder of the need for and importance of self-determination:

I think we have to be very sensitive when we’re trying to educate people on feminist language, that we’re not imposing our own ideology on them, because it’s important to us I think, but it might not be important to them. Some of them want to adhere to their own version of feminism, and that will also take them out of their community (Q&A Forum_Adel).

Another participant extended this point, saying:

I think the reality is that for a lot of women, they do stand up, because they have to, to survive, not be murdered, whether that’s around domestic violence or sexual assault that sits within that, the fact that they leave that relationship and get help, that can ostracise them completely, so they’ve already made a statement and stood up to stuff. And then learnt that sexual assault is against the law here in Australia, but they didn’t know that through their marriage, and can’t cope with it anymore … (Q&A Forum_Adel).

The discussion then swung back to a reminder that although some women do break from tradition, the social expectations are nevertheless strong and pervasive:

... But often they don’t leave their marriages, and they won’t disclose to be honest, they’re so afraid of organisations (Q&A Forum_Adel).

The issue of legal rights is really important. All the CALD women I’ve worked with, either they don’t believe they have the same rights as other white people or they believe if they exercise their rights, their partners or the abuser will actually put them down. I have heard dozens of times, “my husband said if I go to the police, the police will lock me up because I’m complaining about my husband. If I go to a housing estate, they will throw me out because the lease is in his name”. Even really well educated European women have extensive legal battles in family court because they don’t understand our system, or they don’t have confidence that our system will treat them the same and respect their rights. So there’s a lot of work to actually build up their understanding and esteem, to say, ‘we will work with you, the community legal system will support you, will walk you through it’ (Q&A Forum_Adel).
Two opposing but equally valid comments offered by white women perhaps best demonstrate the need for an intersectional lens. One made the point that the same cultural beliefs that contribute to difficulties for victims/survivors of sexual assault in accessing services can be held by workers within multicultural organisations, undermining the quality of the support they might offer. The other made the point that sometimes no matter how much training white service providers receive they cannot really understand ‘the lot’ of a woman of colour, who navigates two systems of oppression (race and gender), and due to the FAE is at risk of being labelled as ‘behaving badly’ and without genteele the way passive feminine women ‘should’ when she expresses and experiences rage at their combined injustice.

That is, lack of institutional safety can come from both white and brown spaces; white feminists may not have solidarity with CALD women because of an inability to understand and relate to the experience of racism, and CALD feminists still operate within patriarchal cultural norms that can be suffocating. The dialogue was a reminder that ‘safety’ from a good service worker cannot ultimately or wholly be predicted by her (or his) skin colour, and why all service providers require training:

I just wanted to make mention, particularly for mainstream services, risk around connecting with culturally diverse service providers, particularly sexual assault specialist organisations. The risk for those organisations where they also hold those myths, those values, the trauma of the people that we work with, is because they have tried their faith leader, they’ve tried their migrant service, they’ve tried bilingual workers, and it’s that additional trauma that the service system has given, so there is a risk in saying, ‘please connect with cultural community groups’. We very much need to respect that, but we then also need to challenge our colleagues, our co-workers, and other organisations that are faith-based, community-based, religious-based, to then highlight child sexual abuse as an issue, that is an issue across the board. So I just wanted to put that out there, because I do want people to be mindful that when they run to their local CALD services, they’re going to be hit with this, because they are also part of the community. That it’s not just the clients that hold these views, the service system holds these views (Q&A Forum_Syd).

One of the concerns I have, working on the [name of not diverse local area], is that I work a lot with [CALD] women who go through domestic abuse, and it’s really hard the way they are treated in refuges. They tend to get a different treatment to what other people might have, and that causes me great concern. We need cultural awareness training to understand cultural differences, however what we still are up against is that, still those individuals have their own belief systems, and you can’t change that, it’s just embedded, and that does still come out in the services they provide. So I think that’s difficult. It doesn’t matter how much training they might get,
that does not mean they will see things differently. Maybe at the surface, but there are other issues (Q&A Forum_Syd).
Summary

- CALD client victims/survivors of child sexual abuse are diverse in their needs and expectations about services. Some will want services that appear to have cultural knowledge, sensitivity, and regard for cultural safety, whereas others will want a ‘colour blind’ service that appears to make no accommodations for their cultural differences from the mainstream and treats them ‘like any other’.

- This diversity is not seen to justify lack of cultural knowledge among service providers, but rather an onus for them to have cultural and racial self-awareness and use it according to an individual’s emerging preferences. This is because lack of such knowledge could lead to an unintended abuse of racial power, which then adds to the abuses of power the victim/survivor of sexual abuse has already incurred, and alienates them from accessing services that could be highly beneficial for their mental well-being.

- Awareness of racial power takes the form of understanding that white practitioners benefit from white group membership by virtue of their higher social power in broader society, which then impacts on power dynamics in the clinical setting. This further assists with understanding that not all barriers experienced by CALD victims/survivors are due to ‘their own culture’, as if they are responsible for all parts of their needs and barriers (the fundamental attribution error).

- As the education program was not centrally about ‘white privilege’, RQ5 only aimed to examine change over time in the number of service providers who were now aware of the concept after having taken part in the program. It was predicted that more counselors and social workers would have heard of this phrase than psychologists due to social justice curricular, who in turn would be more aware of it than medical practitioners due to daily clinical work in which the relevance of at least cognitive errors underpinning racial prejudice would be apparent. Support for this hypothesis could not be found as there were an insufficient number of psychologists to compare with counselors and social workers, and no medical practitioners, in the sample. Thus, almost the entire sample had heard of white privilege, and so the program was not going to be effective in providing this knowledge.

- Nevertheless, the qualitative data did show that participants appreciated the discussions on white privilege and saw them as useful for framing how best to understand and engage with this client group. In particular, the program was seen to promote self-reflection which in turn is a critical component of self-awareness. Terminology when talking about ethnic minorities, acknowledging the role of skin colour in racism, and identifying its complex intersecting role with other structural disadvantages were also
seen as fruitful for service providers working in this space (especially differentiating ‘white feminism’ from ‘brown feminism’).

• It was also found that cultural self-awareness was high for both CALD and Anglo service providers at both T1 and T2. However, further research is required to examine what exactly constitutes as cultural self-awareness for each of them, and how it translates to better self-understanding and engagement with clients of all backgrounds, and appreciation of cross-cultural similarities and differences in daily work practice.

• Correlational data showed that as service providers increase on cultural self-awareness, they increase on cultural knowledge, confidence, and sensitivity, but that these correlations did not strengthen after the program. It is also unclear if or to what extent cultural self-awareness reflects racial self-awareness.

• Overall, racial self-awareness – by virtue of being critically reflective on one’s own cultural norms, traditions, values, and beliefs, as well as group-level power inherited from group membership and therefore independent of personal cognitions – is not seen as essential for meeting basic needs in the clinical setting, but is seen to enhance the quality of services for CALD victims/survivors.

• Moreover, the need to develop this cultural competency and racial self-awareness is growing with Australia’s expanding diversity. Combined with a fear of breached confidentiality and therefore preference for a non-ethnically matched worker, as well as risk for increasing harm from judgmental CALD workers or interpreters, there is a rising onus for the whole Australian mental health and sexual assault workforce to be appropriately trained and not just leave ‘CALD matters’ to CALD workers.

• Given that psychiatrists can assist clinically unwell victims/survivors, GPs can model good engagement with other professionals and provide referrals, and psychologists, social workers, and counselors can talk through and share trauma with the aim of reducing the symptoms of emotional distress, the relevant workforce is as diverse as the client group.