

The MECA model: A culturally and structurally responsive approach to the training of health service psychotherapists

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Abstract

Culturally and structurally responsive healthcare psychology requires psychologists and supervisors to acknowledge their cultural experiences, values, views, and positions of power or privilege, or lack thereof. The Multidimensional Ecosystemic Comparative Approach (MECA) (Falicov, 1995, 2017) provides a methodology for psychologists, trainees, and supervisors to engender the cultural and structural self-awareness necessary to engage in decolonizing and liberatory intersectional practices. This paper applies the MECA framework to three aspects of healthcare psychology training: a) a theoretical foundation for understanding intersecting identities and clinical conceptualization of self and clients, b) a pedagogical tool for improving diversity, equity, and inclusion in trainee education, c) a framework for understanding multicultural and multisystemic interpersonal interactions among supervisors, trainees, and clients. Testimonies from supervisors and trainees trained in MECA illustrate its impact on psychotherapy training and practice.

Keywords: Culturally responsive training; decolonization; supervision; counselor education

Public Significance Statement: The present article contributes a theoretical perspective and related supervision intervention to enhance the training of psychologists. The described theory and training intervention focus on decolonization of psychology and empowerment of marginalized individuals through a comparative and collaborative approach to psychotherapy.

CLINICAL VIGNETTE

Laurel is a cisgender, heterosexual woman and international psychology trainee from China, completing her internship at a large urban public hospital. English is her second language. She grew up as an only child with her parents and grandparents in a family that highly valued education, doing the “right” things, respecting elders and authority, and filial piety. Gender norms were communicated through messages such as, “A girl should behave like a girl.” Through her family upbringing and education, Laurel learned the importance of working hard, contributing to the larger collective, and maintaining group harmony.

Laurel co-facilitates a Pride psychotherapy group for LGBTQIA+ individuals under the supervision of Dr. Lancaster, a second-generation caucasian lesbian woman of Polish background who grew up in a non-English-speaking immigrant community. Raised in a large, close-knit family, Dr. Lancaster learned to value openness, taking initiative in decision-making, direct communication, and active problem-solving, despite differences in gender, age, or the potential for interpersonal conflict.

Laurel’s and Dr. Lancaster’s positionalities intersect within their supervisory relationship, as well as in their respective interactions with patients in the Pride group, all situated within the broader hierarchy of a city hospital system. In co-facilitating the group and reflecting on group dynamics in supervision, Laurel and Dr. Lancaster navigated multilayered power dynamics related to their respective positions as supervisee and supervisor, trainee and department director, immigrant visa holder and U.S. citizen, and members of sexual majority and minority groups. Their differing cultural experiences also shape their approaches to communication, authority, conflict, and clinical decision-making. For example, Laurel may be more inclined to observe and

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consider multiple perspectives before intervening, particularly when Dr. Lancaster is present, whereas Dr. Lancaster may favor more direct intervention and active problem-solving.

These differences manifested specifically in the clinicians' work with one transgender group member, who exhibited a pattern of self-deprecating and self-focused communication, frequently returning to negative experiences and ruminating on them. When other group members or facilitators offered alternative perspectives or suggestions, he often responded with counterarguments and, at times, returned to his concerns even after the group had shifted to another topic. In supervision, Dr. Lancaster reflected on her frustration with the patient and how it might relate to her upbringing, values, and working style. She disclosed to Laurel, "This patient really gets on my nerves. Please keep an eye on me and let me know if you think I'm reacting too strongly," inviting Laurel to intervene if her frustration appeared to interfere with the therapeutic process.

This openness created space for mutual reflection on how cultural, familial, and social backgrounds influenced their work and empowered Laurel, as a supervisee, trainee, and younger clinician, to speak from a position that might otherwise have felt subordinate within cultural and institutional hierarchies. Discussion of the patient's transgender identity and gender expression also invited Laurel to reflect on her position as a member of the sexual-orientation majority and how this position, alongside her orientation toward interpersonal harmony, might shape what she noticed, questioned, or chose not to confront. At the same time, areas of commonality emerged between Laurel and Dr. Lancaster, including a strong work ethic and a shared commitment to meaningful clinical work, providing common ground for their collaboration despite differences in their identities, cultural backgrounds, communication styles, and positions within the hospital hierarchy.

KEY BACKGROUND

Culturally and structurally responsive training in health service psychology requires acknowledgment of the colonization of our field and a need for active decolonization of theories, training, and practice. Colonizing practices in counseling and psychology training are those that replicate existing conditions of oppression by failing to challenge the hegemonic views that marginalize groups of people, perpetuate deficit-based ideologies founded upon racism, and continue to disenfranchise the diverse communities that trainees come from, and with whom our trainees will work (Metzl & Hansen, 2014; Goodman et al, 2015). Psychotherapists are often trained with polarized colonial notions of either the universality of psychotherapy-related concepts, or with “cultural competence” or literacy in stereotyped categories for various ethnic groups such as Latinx, Black or Asian individuals. Issues of power are increasingly being considered conceptually, but less so in actual training and practice. Training practices that result in cultural and structural competency in psychotherapists, and the ability to understand how symptoms, attitudes, or disorders may represent other sociopolitical conditions (Metzl & Hansen, 2014) are vital for the decolonization of psychotherapy.

This leads us to the dominant questions of this paper: What tools are needed to decolonize education and training in clinical psychology?; how do we interlace cultural and sociopolitical considerations in the training of future psychotherapists?; how do we instill tenets of systemic accountability and cultural humility in our trainees, and how do we ensure the integration of these issues and values in the therapeutic encounter?

The Multidimensional Ecosystemic Comparative Approach (MECA) (Falicov, 1995, 2014a, 2014b; 2017) provides a structure for trainees and supervisors to engender the self-awareness necessary for engaging in decolonized and liberatory intersectional practices. Culturally

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and structurally responsive training redistributes power in both training and clinical practice through the empowerment of the diverse identities of trainees and their respective clients, thus creating opportunities to safely share their backgrounds, beliefs, and values, fostering a sense of belonging (Masked et al., 2023). When trainees feel valued, respected by supervisors and peers, and confident that they belong in a learning community, they can participate more fully, build important relationships, increase thresholds for vulnerability, be open to constructive feedback, and be more likely to persevere in difficult situations.

Theoretical Underpinnings of the MECA Model

The multicultural guidelines developed by the American Psychological Association (APA) over two decades ago call for viewing the individual holistically and within social, cultural, and historical contexts. The MECA Model is based on two conceptual tenets: 1) Ecosystemic Theory and 2) Collaborative Practices.

1. MECA is based in ecosystemic theory (Bronfenbrenner, 2005) by highlighting the interaction of the individual and family within larger systems and their social and cultural environments. In MECA, everyone occupies their own “ecological niche,” a concept that refers to their societal participation and exclusion based on the multidimensionality of race, ethnicity, social class, religion, sexual identity, migration history, occupation, education, etc. MECA’s intersectional approach in viewing the client, extends to the trainee and to the supervisor, by focusing on both similar and different experiences within these sociocultural contexts, and how they unfold in the therapeutic process. MECA is anchored in social constructionist and postmodern approaches (Falicov, 2014a, 2017) that question fixed and stereotyped categories and grand narratives of cultural diversity imposed top-down; instead, it honors the importance of local and indigenous knowledge from the ground-up.

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2. At the level of practice, MECA promotes collaborative approaches by centering the voice of clients as their own sociocultural experts, which in turn facilitates cultural humility on the part of practitioners. Cultural humility encourages an approach of curiosity and unknowingness to reduce biases, mitigate power imbalances, and engage in a more authentic understanding of others; it requires intentionally honoring the experiences, beliefs, values, and customs of others as defined by them rather than our own preconceived notions of who they are based on their identity (Falicov, 2021). Supervisors encourage trainees to be client focused, allowing for more client-led interactions, rather imposing perspectives of the clinician as “expert.”

The MECA model domains of inquiry

The four domains identified in MECA are ecological context, migration and dislocations, family organization, and family life cycle (Falicov, 2017). These domains are considered across a cultural and sociopolitical spectrum to help understand and mitigate the impact of power dynamics. Cultural diversity focuses on the recognition and appreciation of variety in meaning and belief systems amongst social groups based on demographic variables. Social justice focuses on the impact of power differentials and related sociopolitical stressors often related to one’s demographic variables. The MECA domains help outline cultural diversity such as background, communication styles, and traditions, yet we are careful to also understand the social inequalities that result in mental health disparities. For our focus on the training, we will concentrate our description of the C in MECA that stands for a Comparative approach rather than detailing the learning of the strategies mentioned. The MECA domains provide a baseline of where to begin the examination of cultural and structural similarities or differences among supervisors, trainees, and their clients. Trainees are then encouraged to consider MECA in clinical training or internships where they continue to learn specific clinical interventions.

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The Ecological Context domain focuses on the individual's interaction with or exclusion from societal institutions, neighborhood/community, cultural connections, school, work, and health systems. This domain highlights concepts, such as sociopolitical inequity, particularly salient in understanding interpersonal interactions in training and clinical work. Training programs often encourage trainees to examine the systemic and structural factors that contribute to health disparities of clients without recognizing that trainees also have their own lived experiences with these factors that result in power differentials and limited social and economic opportunities particularly for minoritized trainees. The MECA model encourages trainees to reflect on the impact of these factors on themselves and their clients. The *Migration and other Dislocations* domain encourages curiosity and understanding of an individual's migration story and experience inclusive of losses, family fragmentation, traumatic experiences. This domain also addresses experiences of injustice and inequity, marginalization, and changes in family roles that are the result of incarceration or other forms of systemic violence. The *Family Life Cycle* details family stages, family transitions and timings including major life transitions, such as birth, marriage or death, and other age-related milestones. This domain includes identification of cultural values and norms, family rituals, and religious beliefs. The *Family Organization* domain identifies relational connectedness; hierarchies and power-dynamics in familial gender or generational roles, and cultural methods of conflict resolution.

CLINICAL AND ETHICAL CONSIDERATIONS

Applying MECA within healthcare psychology requires attention to how cultural, structural, and relational factors influence psychologists' work with clients and the training of future psychologists to provide culturally and structurally responsive care. In healthcare settings, psychologists work within systems that influence access to services, treatment expectations,

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diagnostic practices, and relationships between clinicians and clients. These systems may create unequal access to psychological services and differences in the quality of care, particularly for clients from underserved or marginalized groups. MECA provides a framework for examining these influences while also encouraging psychologists to consider how their own identities, assumptions, and positions of authority shape clinical interactions. Since these skills are developed through training and supervision, the ethical application of MECA involves attention to both the client and psychologist relationship and the supervisor and trainee relationship, as demonstrated in the clinical vignette.

Power and Positionality

Psychologists working in healthcare settings occupy positions of professional authority that may influence how clients communicate their experiences, understand their symptoms, and participate in treatment. This clinical encounter is shaped by differences in authority, as psychologists have the power to interpret clients' experiences and determine how those experiences are understood diagnostically (Aggarwal, 2023). These power differences may become more pronounced when clients experience marginalization. This client centered stance is especially important when intersectionality increases the unequal relational power inherent in the client and psychologist positioning and interaction (Guilfoyle, 2018). Clients from socioeconomically disadvantaged and racially marginalized groups may be more inhibited or intimidated to advance their needs for the session or question the statements of the psychologist.

In practice, psychologists can address these dynamics by reflecting on their own positions, asking patients how they understand their experiences, and being aware of differences in authority and how that may affect communication, clinical participation, and shared decision-making. Similarly, supervisors hold evaluative and institutional authority over trainees, creating

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a power differential that can impact what trainees feel comfortable disclosing or bringing to supervision sessions. Therefore, MECA encourages supervisors and trainees to examine their own positionality and consider how shared or differing identities may influence the supervisory relationship and, ultimately, clinical decision making (Aviles-Acosta et al., 2025; Falicov, 2017). This was evident when Dr. Lancaster disclosed how her upbringing contributed to an active problem-solving stance and direct communication style, which she recognized may not always be well received by patients with personality pathology, and invited Laurel to intervene when appropriate. Dr. Lancaster's disclosure that English is her second language, along with her use of humor about her own grammatical errors, also empowered Laurel to communicate more comfortably and authentically. Moreover, her openness provided Laurel with a meaningful model of how a psychologist can navigate professional practice and communication while working in a second language. Developing these skills and awareness during training can help prepare psychologists to recognize and navigate power dynamics in their clinical relationships.

Cultural Assumptions and Clinical Formulation

A culturally and structurally responsive approach also has implications for clinical assessment and case conceptualization. In healthcare settings, psychologists may risk overlooking important contextual factors when psychological symptoms are understood primarily as individual pathology. The DSM-5-TR emphasizes that sociocultural contexts shape individuals' experiences and that psychologists should consider how a person's position within social structures and hierarchies may influence exposure to adversity and access to resources (American Psychiatric Association, 2022, as cited in Aggarwal, 2023). Experiences such as racism, discrimination, socioeconomic inequity, migration-related stress, family separation, and other forms of systemic marginalization may contribute to psychological distress and should be

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considered as part of a client's broader ecological environment (Falicov, 2017). At the same time, psychologists should avoid replacing one form of reductionism with another by assuming that every psychological concern is caused by a sociopolitical condition. MECA instead encourages a comparative and contextual process in which psychologists remain curious about how clients themselves understand the relationship between their identities, experiences, environments, and presenting concerns. This approach is consistent with the APA Multicultural Guidelines' emphasis on considering the multiple and intersecting contexts in which individuals live and develop (APA, 2017). By incorporating these factors into assessment and treatment planning, psychologists can avoid reducing complex experiences to either individual pathology or broad cultural explanations.

To achieve this, conversations in supervision that explore both the psychologist's and trainee's cultural backgrounds are critical not only for raising awareness of each clinician's own ecological niche, but also for modeling a comparative stance toward how their respective positionalities interact, highlighting both differences and shared borders. As demonstrated in the clinical vignette, Dr. Lancaster's and Laurel's different immigration experiences and experiences of community while growing up influenced their clinical formulations and communication styles with patients in the group. Their different sexual identities also prompted Laurel to reflect on how her own sexuality and positionality shaped her interactions with the LGBTQIA+ population, while allowing her to learn from Dr. Lancaster's insider perspective. At the same time, their shared collectivistic values and commitment to hard work provided a foundation for deeper collaboration. By applying the MECA model to systematically explore these different dimensions of their cultural backgrounds and positionalities, the supervisory relationship was

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strengthened on both professional and personal levels, contributing to a deeper understanding of the dynamics among supervisor, supervisee, and patients.

Client Autonomy and Cultural Humility

Positioning clients as experts of their own cultural and lived experiences can help psychologists avoid assumptions based on identification in a particular cultural or identity group. In practice, cultural humility requires psychologists to remain curious about how clients understand their own identities, experiences, and treatment needs rather than presuming that a particular identity determines an individual's beliefs or behavior (Falicov, 2021). This can include asking how clients understand their concerns, identities, and treatment preferences, and how their cultural or personal factors may be relevant to their care. This perspective supports viewing identity as an intersubjective process, meaning that identity and culture are shaped through interactions between clients and psychologists rather than residing solely within the client (Aggarwal, 2023). MECA supports this process by encouraging psychologists and trainees to identify both differences and areas of similarity between themselves and their clients (Falicov, 1995, 2014). These comparisons are intended to facilitate understanding rather than to establish assumptions about the client.

Implications for Supervision and Clinical Practice

These clinical and ethical considerations suggest that MECA should be understood as an ongoing process rather than a one-time cultural assessment. Supervisors can return to the MECA framework during supervision to examine how trainees' positionality and assumptions may influence their work with particular clients. In turn, trainees can use the framework to consider how clients' ecological contexts may inform clinical formulation and treatment. Within healthcare settings, this process can help trainees integrate cultural and structural considerations

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into routine assessment, communication, treatment planning, and collaboration with other healthcare providers rather than treating them as an additional component of multicultural training.

MECA also provides a mechanism for connecting self-reflection in supervision to culturally and structurally responsive clinical practice. Supervisors and trainees can examine not only the client's cultural and structural context but also how their own identities, assumptions, and positions within healthcare institutions shape the clinical encounter, as highlighted in the supervision between Dr. Lancaster and Laurel. In this way, MECA encourages psychologists to approach cultural humility as an ongoing practice of reflection. Ultimately, culturally and structurally responsive supervision requires attention to both the clinical needs and autonomy of clients and the ethical responsibilities of psychologists to practice with humility, competence, and awareness of the power relationships embedded within healthcare and training contexts (American Psychological Association, 2017).

PRACTICE CONSIDERATIONS IN TRAINING AND SUPERVISION

MECA Mapping

In preparation for the training exercise, trainees are introduced to Falicov's MECA model through didactic discussion, including a presentation of its four domains and illustrations of its application to clinical encounters. As clinicians and supervisors, we typically begin the exercise by discussing applied case studies and presenting our own MECA maps. This serves two purposes: (a) modeling the assignment, including the vulnerability involved in self-awareness and self-disclosure while acknowledging layers of power, privilege, and positionality; and (b) reducing the power differential between supervisor and trainee by explicitly acknowledging the identities and

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positionalities of all parties within the clinical encounter. This increased level of disclosure and transparency can serve as a bridge toward a more collaborative supervisor–supervisee relationship.

This exercise can be particularly powerful when supervisors with marginalized identities share their cultural maps, as their narratives can provide representation and model the presence of individuals with marginalized identities in positions of professional authority. At the same time, it is important to recognize that all supervisors, including those from racial, ethnic, or other marginalized backgrounds, hold institutional and relational power within the supervisor–supervisee relationship. Supervisors who hold privileged identities are likewise encouraged to share their cultural and structural maps, as doing so creates an opportunity to acknowledge and critically examine the societal and systemic structures that may position them within systems of power and privilege.

Doctoral- and master's-level clinical psychology and counseling trainees, inclusive of individuals from the global majority, sexual and gender minorities, and those holding privileged identities, are tasked with creating their own cultural and structural maps within the MECA framework. These maps explore the values, beliefs, positionalities, social contexts, and lived experiences that shape trainees' cultural identities and clinical perspectives. Trainees then share their MECA maps either individually with their supervisor or within a group of peers. Embedded within this self-reflective activity is an emphasis on increasing awareness of one's own positionality, including experiences of power, privilege, and marginalization.

Following completion of the MECA map, trainees can debrief through one-on-one discussions with their supervisor or in small groups with other trainees. Trainees who do not wish to share their maps with the group are not required to do so. The debriefing process allows trainees to make meaningful connections between what they learn from their peers and their developing

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understanding of themselves and their clients. Trainees are encouraged to identify their own positionalities and explore cultural and structural identity “borderlands”, areas of similarity, overlap, or shared experience (Falicov, 1995, 2014), between themselves and others across multiple levels of the clinical encounter, including clients, supervisors, and peers. Subsequent supervision sessions can build upon this exercise through continued reflection on trainees’ positionalities across these domains and consideration of how their cultural maps intersect with, diverge from, and map onto those of their clients and supervisors.

Table 1. Description of components of the MECA mapping training exercise and their contribution to decolonization of training.

Component	Description	Contribution to Decolonization of Training
Didactic detailing MECA	Describe the tenets of the MECA model, focusing on the impact of boarderlands between client , trainee and supervisee, using applied case examples to detail.	Theory; Multicultural understanding; Intersectionality; Cultural Humility; Power and privilege principals
Sharing of supervisors own MECA model	Supervisor describes personal MECA model (aspects of identity or history they are comfortable sharing) with trainee.	Modeling self-awareness; Humanizing; Equal vulnerability in the room; Creating safe space for supervision; Sharing of power in the room; Applied cultural humility
Sharing of trainee MECA model	Trainee describes personal MECA model (aspects of their identity or history they are comfortable sharing) with supervisor.	Empowerment; Self reflection; Humanizing; Equal vulnerability in the room; Creating safe space for supervision; Applied cultural humility
Sharing with peers	Trainee describes personal MECA model (aspects of their identity or history they are comfortable sharing) with other trainees or members of the training system.	Emic learning; Cultural awareness; Intersectionality; Enhancing belonging; Empowerment; Self reflection; Humanizing; Decolonizing; Equal vulnerability in the room; Creating safe space for supervision; Applied cultural humility
Group Debrief	Trainees and supervisors process the experience of reflecting on their identity in the context of MECA, and sharing their MECA models with members of the training system.	Processing of vulnerability; Bulding community; Ehnancing belonging

As demonstrated in the supervision between Laurel and Dr. Lancaster, discussion of the multidimensional and intersecting dimensions of diversity embedded within the MECA framework can help trainees develop a critical consciousness of intersectionality, particularly with regard to experiences of privilege and oppression, as they come to recognize the complex positionalities of every individual, including themselves. Establishing MECA as a pedagogical foundation to which trainees can continually return helps integrate diversity and multicultural perspectives into subsequent clinical and supervisory discussions.

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Importantly, the assignment can empower trainees with marginalized identities to share their lived experiences through an emic rather than an etic perspective, creating opportunities for reciprocal learning among all members of the training context. For example, Laurel's experiences of immigration and navigating visa-related challenges provided a point of connection for understanding patients' experiences of displacement, not belonging, and existential uncertainty, thereby enriching the supervisory dialogue and contributing to shared learning between trainee and supervisor. We also have witnessed trainees from disadvantaged educational backgrounds proudly share personal narratives of overcoming adversity to enter privileged educational spaces, while also reflecting on ongoing challenges, such as navigating supervisory relationships in which systems of oppression may be intentionally or unintentionally reenacted, or experiencing the discomfort of being the "only" or "token" individual holding a particular identity within a broader sociopolitical context of educational reform (e.g., resistance to affirmative action or diversity initiatives in education). The MECA model provides a framework through which these experiences can be articulated, contextualized, and critically examined, thereby facilitating the development of critical consciousness among trainees and supervisors alike.

MECA for Comparative Reflection

By utilizing the same four domains of comparison, Ecological Context, Migration and Other Dislocations, Family Life Cycle, and Family Organization, MECA engages trainees in reflecting on and identifying overlapping and differing identity factors within the trainee–client dyad during clinical encounters. Similarly, supervisors reflect on areas of consonance and divergence between themselves and the trainees they supervise, as well as between themselves and the clients or clinical cases being discussed. Rather than examining cultural and sociopolitical features as disparate or isolated domains, MECA provides a shared framework for systematic

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comparison across the same dimensions. In doing so, it encourages all parties within the training system to consider how their own cultural and sociopolitical identities and lived experiences may shape their understanding of presenting concerns, clinical formulations, and interpersonal interactions. Figure 1 presents a comparative MECA mapping of Laurel and Dr. Lancaster.

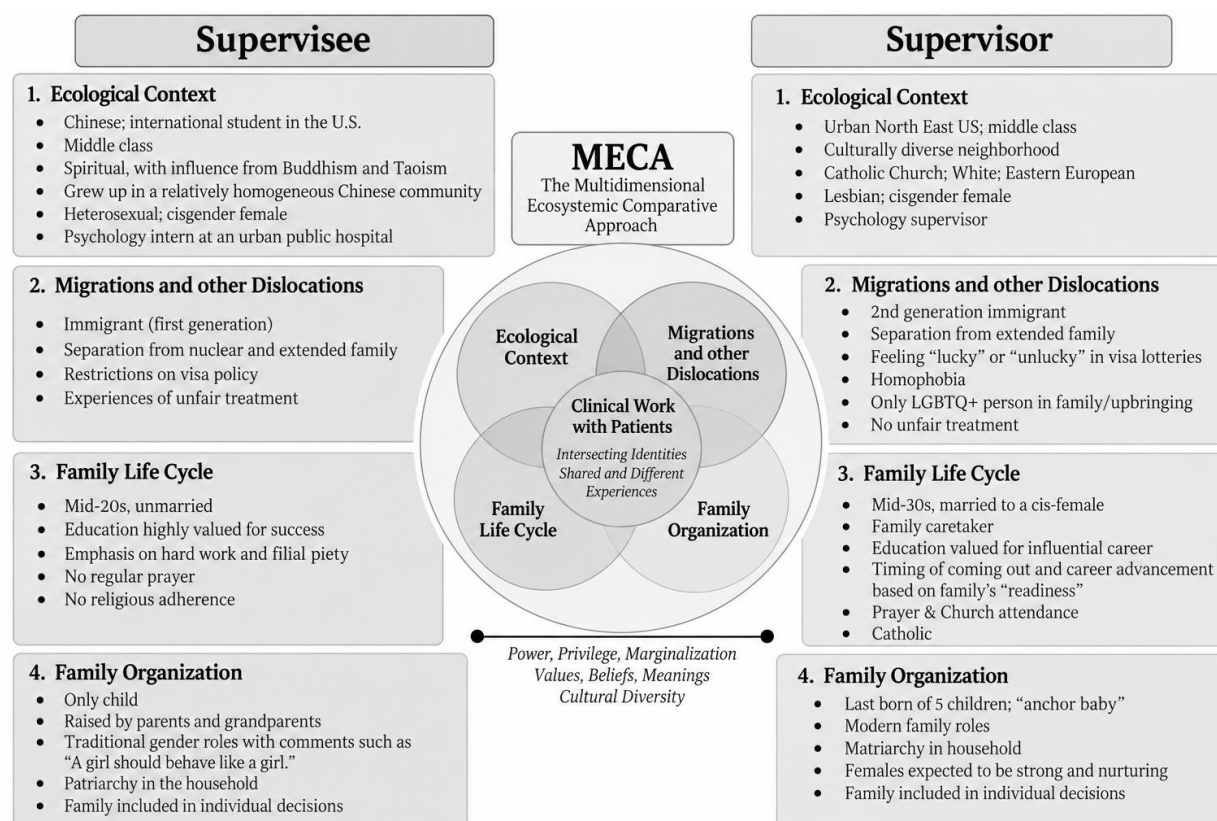


Figure 1. Example of a supervisee and supervisor maps detailing the four domains of Multidimensional Ecosystemic Comparative Approach (MECA).

Differences in identity (e.g., race, sexuality, religion, family hierarchies, and family values) can easily be identified in the comparative diagram, yet similarities or "borderlands" in experiences (e.g., immigration, religiosity, ostracism or discrimination based on identity, collectivistic decision making) are also denoted. While the example showcases the cultural landscape of the trainee and supervisor relationship, trainees and supervisors always incorporate

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the MECA maps of clients in their training as their central concern to learn and to offer culturally and structurally responsive psychotherapy treatment.

Using the MECA model's focus on integration across constructs of culture and social justice in the education and training of psychologists helps increase awareness and empowerment of individuals of both privileged and marginalized identities within the educational system (e.g., educators, supervisors, trainees, and clients). As reflected in the clinical vignette, the MECA framework also helped strengthen the supervisee's sense of autonomy and agency within a hospital setting that placed strong emphasis on institutional hierarchy. MECA supports the notion that everyone has culture, therefore, it encourages cultural humility as a continuous process of self-reflection about personal identities, theoretical and personal preferences, and biases by all members of the training system. It is common practice in training of psychologists to facilitate self-reflection of positionality and historical context in trainees to improve clinical practice and decrease possible harm to clients related to unconscious bias. However, it is much less common to encourage cultural humility by asking supervisors and trainees to consider the intersections/layers of their positionality and historical context, along with their client's positionality and historical context. Our method of concretely applying the MECA framework includes review of the model in supervision and assigning the comparative training exercise of creating and reflecting on the trainee's MECA map. Templates of MECA to be filled for the three levels of the treatment system (supervisor, trainee, and client) are graphic aids to this comparative approach. Additionally, there is a list of questions available to facilitate filling in the templates for each one of the domains (Templates and Questions are available upon request).

The Impact of the MECA Mapping Exercise in Clinical Training

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Beyond the clinical vignette presented here, accounts from other trainees have similarly indicated that completing the MECA self-reflection task increased their self-awareness and strengthened their connection to their own identities. For example, one Latino, gay, cisgendered male stated, “I never really thought about my life in this way, and when I do think about it through this lens, who I am and how I behave makes so much more sense.” White-identified trainees express the impact of increased awareness facilitated by the training exercise: “I had previously believed that I did not “have” a culture, but the MECA model has helped me confront that false belief about myself.” Additionally, trainees in a culturally, religiously, and sexually diverse cohort attending graduate courses in a private urban university observed a deeper understanding of how their “cultural identities impact [their] clinical practice” and “how to conceptualize cultural borderlands between [themselves] and clients”. One multiracial, religious, sexually diverse trainee noted “I often consider this model when trying to better understand clients' whose values or experiences do not exactly match my own” highlighting how MECA provides a tool for understanding clients and self.

The modeling of supervisors' own MECA maps also appears to be particularly impactful. A racially and culturally diverse group of master's-level graduate students reflected, “getting the perspective of the supervisor's own MECA domains was very eye-opening to how our lived experiences can influence our clinical perspective and practice” and “as clinicians, it is important for us to be vulnerable not only with our clients but also with our supervisors and faculty, and I found this was a fun way to facilitate that.” As supervisors, it is our role to model vulnerability and trust, which may serve as a parallel process for trainees in their relationships with their own clients. One East Asian, cisgender male international student shared, “It was a liberating feeling to know that my supervisor was willing to be vulnerable and disclose personal information and

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experiences [in relation to their clinical work]. I think it leveled the power dynamic to some extent... it was valuable that the supervisor shared first and then subsequently demonstrated how one's MECA frame influences clinical practice such as having more insight towards personal biases and how to use this insight effectively in clinical work.”

Trainees also noted a community-building outcome of increased sense of belonging amongst their peers, approaching each other with a sense of warmth, connection, and deepened understanding. Specifically, trainees have stated that they “never have an opportunity to learn about their peers on such a personal and close level and doing so provides a newfound sense of community within their learning environment.” The activity helps to integrate the notion that trainees and supervisors alike can bring their full selves into different contexts (e.g., educational, organizational, workplace, etc.) and still be considered professional.

CONCLUSIONS AND LESSONS LEARNED

The MECA framework and training exercise contextualize several goals of decolonization of training of psychology. The supervisory space between the supervisor and trainee is a parallel process of the space held between the trainee and their client. Given that supervisors innately hold evaluative and institutional power within the supervisory relationship, they are afforded the opportunity to model a continual process of self-reflection, cultural humility, and transparency. As illustrated in the clinical vignette, the application of the MECA framework, alongside intentional discussion of institutional racism, privilege, positionality, and structural inequities, can enable supervisors to create greater psychological safety for trainees while modeling practices that trainees can carry into their relationships with clients. In this way, MECA provides a mechanism for moving conversations about culture, identity, and power from abstract principles of multicultural competence into everyday practice of training and clinical care. Finally, supervisors

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must be willing to participate in this work. Modeling vulnerability and examining their own positionality helps dismantle supervisor-trainee hierarchies, fosters supervisee reflections, and frames cultural humility and an ongoing practice, which in turn, increases self-awareness, helps develop greater insight into how cultural identity affects clinical care, and creates a stronger sense of belonging.

Our application of the MECA model in training has yielded several valuable lessons. First, culturally and structurally responsive practices have to begin with the recognition that everyone has culture, therefore, cultural self-reflection is relevant to trainees and supervisors across privileged and marginalized identities. Second, rather than focusing on specific cultural knowledge, to be culturally humble is to commit to a continuous journey of self-reflection and curiosity. It requires ongoing examination of one's unique identities, biases, and privilege when engaging and treating others.

Insights gained from the MECA model carry significant implications for broader healthcare environments. Healthcare encounters occur within systems characterized by multiple and intersecting levels of authority, including relationships among patients, psychologists, physicians, trainees, supervisors, interdisciplinary teams, and healthcare institutions. These relationships inherently influence whose knowledge is privileged, how symptoms are interpreted, how diagnoses and treatment recommendations are formulated, and how this information is shared with patients. The MECA model offers a structured way of making these dynamics visible by asking all healthcare professionals to consider the ecological contexts, migration and dislocation experiences, family life-cycle factors, and family organization of the patient while simultaneously reflecting on their own cultural and structural locations.

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While the testimonials of trainees and supervisors support the usefulness of MECA as a training approach, future directions for the use of MECA should evaluate these applications systematically, including the voices of clients in the treatment outcomes and on the impact of MECA on therapeutic and supervisory relationship. Additionally, it would be beneficial to study the use of MECA as compared to other multicultural and structural competency approaches and explore its application across healthcare disciplines and organizational systems. Such research would help determine whether the self-reflection, cultural humility, and attention to power fostered through the MECA training model translate into meaningful changes not only in how clinicians are trained, but also in how healthcare is conceptualized, delivered, and experienced by clients.

KEY CLINICAL CONSIDERATIONS

- MECA provides a theoretical foundation for healthcare psychology supervisors to continually reflect on how their identities, cultural backgrounds, privileges, and positions of authority shape supervisory relationships, and ultimately, influence trainee's clinical decision making.
- MECA mapping provides a pedagogical tool for modeling cultural humility, vulnerability, and transparency between supervisor and trainees, while fostering psychological safety, diversity, equity, inclusion, and belonging within healthcare psychology training.
- MECA encourages supervisors and trainees to examine both differences and areas of similarity in their cultural and structural experiences, using these comparisons to strengthen understanding of themselves, their clients, and the clinical encounter rather than relying on assumed similarities or culturally stereotyped categories.

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