

MULTICULTURAL COMPETENCE AND THE PROCESS AND OUTCOME OF  
COUNSELING

by

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(Under the Direction of Alan E. Stewart)

ABSTRACT

Historically, cultural variables and macrosystemic issues have not been sufficiently addressed in psychological theory, practice, and research. In response, an effort to define and operationalize multicultural competencies emerged (Arredondo et al, 1996; Sue, Arredondo, & McDavis, 1992; Sue et al, 1982). Much research has been conducted on multicultural competence (MCC) over the past three decades, though there is still a need to conduct further research of the role of multicultural competence within actual counseling relationships.

The present study was designed to better elaborate the relationship between MCC and several common factor therapy and outcome variables within actual cross-cultural counseling relationships. Participants rated several variables related to their present or most recent counseling experience, including therapist variables (MCC and counselor credibility), therapeutic process variables (working alliance, therapeutic relationship, social provisions, and hope/expectancy), and therapeutic outcomes (termination status, satisfaction with counseling, and perceived change).

Findings indicated that MCC was significantly more strongly correlated with all measured variables (except perceived change) within cross-cultural counseling relationships than in culture-matched relationships, though MCC was significantly positively correlated with each variable regardless of cultural match. Through a two-way ANOVA, MCC was found to be associated with higher ratings on the other measured variables whether the relationship was cross-cultural or culture-matched. Only the therapeutic relationship was significantly impacted by the interaction of counselor's level of MCC within cross-cultural dyads. One-way ANOVA analysis revealed lower ratings of MCC to have a large effect (.383) on premature termination within cross-cultural relationships, and a small but significant effect (.083) in culture-matched relationships. Lastly, path analysis supported a model where MCC was treated as a therapist factor influencing process factors, which in turn influenced therapeutic outcomes. Similar models fit the data for culture-matched and cross-cultural relationships, though the strength and number of significant paths leading from MCC were greater in the cross-cultural model. The findings provide support for the importance of multicultural competence to the process and outcome of counseling, particularly within cross-cultural counseling relationships.

**INDEX WORDS:** Multicultural competence, therapeutic process, outcome research, therapeutic relationship, working alliance, cross-cultural counseling, therapy, common factors, empathy, congruence, CCCI-R, CRF-S, BLRI, CSQ-S, Hope, SPS, WAI

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A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial  
Fulfillment of the Requirements for the Degree

DOCTOR OF PHILOSOPHY

ATHENS, GEORGIA

2010

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## DEDICATION

This dissertation is dedicated to my parents, Richard Bathje and Doris (Poleck) Bathje. Thank you for always being supportive and for giving me the freedom to pursue my interests and make my own choices. The older I get, the more I appreciate how you raised me. The compassion and idealism I learned from you is what led me to psychology. More specifically, I don't know that I would have ended up focusing on diversity and multiculturalism without your influence. You modeled nonjudgmental attitudes, anti-racist beliefs, respect rather than fear of differences, open-mindedness, and skepticism toward the status quo. Thank you for never being afraid to discuss race and privilege and for making sure I was always surrounded by diversity. I know how fortunate I am to have been raised in that environment.

## ACKNOWLEDGEMENTS

I would like to acknowledge my mentors and advisors. My first mentor in psychology was my high school psychology teacher, Raymond Price, who to this day is the best teacher I've ever had and the person who had the biggest impact on me at a time when I had little direction. I have had too many other mentors and supportive people to mention, but would like to specifically acknowledge my dissertation committee. Dr. Stewart, thank you for your humor, kindness, and the consistent support you have provided. You provided me with much needed encouragement and expertise. Dr. Delgado-Romero, I appreciate how responsive and thoughtful you have been. I hope to incorporate your student-centered style into my own teaching and advising. Dr. Phelps, thank you for your guidance on professional issues and your contributions towards my development as an instructor. Dr. Singh, I appreciate your passion for social justice and your ability to challenge me. I would also like to thank all of the other faculty members who provided me with the training experiences, research opportunities, support, and advice I needed to succeed.

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## CHAPTER I

### INTRODUCTION

#### Therapy Research and Multicultural Competence

Research on the effectiveness of psychotherapy has long shown disparate outcomes for racial and ethnic minority clients in comparison to European American clients. This is true in terms of availability and utilization of services (O'Sullivan & Lasso, 1992; Solomon, 1988; Watts, Scheffler, & Jewell, 1986), premature termination rates (Baekeland & Lundwall, 1975; Wierzbicki & Pekarik, 1993), and treatment outcome (Jerrell & Wilson, 1996; Rosenheck, Leda, Frisman, & Gallup, 1997; Zane, Enomoto, & Chun, 1994). There are many possible explanations for these discrepancies including, but not limited to, inadequate access to and availability of services, lack of culturally appropriate services and treatment modalities, cultural mistrust, and lack of diversity among service providers and service providing organizations.

Despite these disparities, cultural variables and macrosystemic issues have historically not been sufficiently addressed in the theory, practice, and research of psychotherapy. In response to this longstanding neglect and the lack of guidance in working with diverse populations, an effort to define and operationalize multicultural competencies emerged (Arredondo et al, 1996; Sue, Arredondo, & McDavis, 1992; Sue et al, 1982). The emergence of the multicultural competencies also marked a path by which all mental health providers could become more effective with culturally different clients. Prior to the emergence of the multicultural competencies, matching client and counselor on race/ethnicity was one of the few means of increasing the effectiveness of services for racial/ethnic minorities. While has been strong evidence that clients show a

preference for counselors of the same race/ethnicity (Atkinson & Lowe, 1995), a meta-analysis of ethnic matching revealed only a small positive effect in reducing premature termination and increasing treatment utilization (Maramba & Hall, 2002). As a result, researchers have explored the impact of individual differences beyond race/ethnicity in relation to therapeutic process and outcome, such as level of counselor multicultural competence (Constantine, 2002a; Fuertes & Brobst, 2002; Fuertes et al., 2006), racial identity (Utsey & Gernat, 2002), acculturation (Ramos-Sanchez, Atkinson, & Fraga, 1999), worldview (Kim, Ng, & Ahn, 2005), and cognitive match (Zane et al., 2005).

Clearly, diversity and multicultural issues have gained significant momentum in research, theory, and practice of psychology over the past few decades, though the multicultural perspective continues to be marginalized and ignored in many areas of psychology (Ponterotto, 2008). It is particularly troublesome that the multicultural competencies have been largely ignored in psychotherapy research, as the majority of the competencies specifically address being multiculturally competent in providing psychological services. Much of the research on the psychotherapeutic process provides an emphasis on competence in providing interventions, so the multicultural competencies should be seen as highly relevant to this area of research. However, culture and diversity variables have been largely neglected in the broader context of therapeutic intervention competence. In a comprehensive review of the available measures, it was noted that cultural competence and diversity are largely ignored in all of the popular intervention competence measures (Barber, Sharpless, Klostermann, & McCarthy, 2007).

Fortunately, the existing measures of intervention competence have been developed to assess particular treatments (e.g. cognitive-behavioral therapy), and

therefore more work is needed to create measures of global intervention competence that can be applied across theories (Barber et al., 2007). Because measures of global competence have not yet been developed, there remains an opportunity for the inclusion multicultural competencies. This is important as competence is increasingly being used as a metric for determining the efficacy of treatments through clinical research, and particularly in randomized clinical trials (Barber et al.). Some research is available to identify which multicultural competencies are most important from the client's perspective (Pope-Davis et al., 2002; Fraga, Atkinson, & Wampold, 2004) and from the counselor's perspective (Hansen et al., 2006), though more work is needed in this area.

Beyond the inclusion of MCC in general competence measures, it will be necessary to conduct more research on the relationship between multicultural competence and the process and outcome of therapy as a means of advocating for inclusion of cultural variables in therapeutic all therapeutic process and outcome research. This can be accomplished by directly examining the therapeutic process or by measuring the predictive ability of MCC on outcomes. This area of research might also be advanced by examining the relationship between MCC and variables known to facilitate the therapeutic process and positive therapeutic outcomes. In particular, the relationship between MCC and therapeutic common factors remains relatively unexamined.

Common factors are components that exist in many or all theories of psychotherapy and influence the process or outcome of treatment (Garfield, 1995). Similarly, the multicultural competencies are conceptualized as a set of competencies that all clinicians should seek to attain regardless of theoretical orientation. There is strong evidence that common factors, rather than specific techniques, are primarily responsible

for treatment gains (Wampold, 2001). By examining the nature and extent of the relationship between MCC and common factors known to facilitate the process and positive outcome of psychotherapy, additional evidence may be generated regarding the value of MCC.

### Purpose of the Study

The current study was designed to explore the relationship between client perceptions of counselor MCC and several common factor variables within the context of the therapeutic process. This was accomplished by asking participants who have been in counseling to retrospectively rate the counselor, counseling relationship, and outcome of counseling. Because the emphasis of the study is on MCC, cross-cultural counseling relationships were of particular interest (as defined by racial/ethnic difference between the counselor and client). Variables included in the current study that have been measured in previous multicultural process/outcome studies include working alliance, counselor empathy, counselor credibility, premature termination, and client satisfaction with counseling. Common factor variables included in the current study that appear not to have been previously assessed in relation to MCC include counselor supportiveness and counselor facilitation of hope/expectancy. Each of these variables was rated from the client's perspective as no data was collected from counselors. The client's perspective of common factors has not been researched as thoroughly as the clinician's or objective observer's perspective in psychotherapy research (Thomas, 2006).

The current study has several specific purposes. First, this study contributes to the small but growing number of studies on the relationship between MCC and therapeutic process and outcome. Thus, the present study seeks to help clarify this relationship and

contribute more evidence about how MCC impacts the therapeutic process and outcome. Second, the current study seeks to explore variables that have not yet been examined in relation to MCC. Thus, the study has the potential to reveal additional variables of importance for future research on MCC. In this sense, the present study has the potential to provide direction for future process and outcome studies. Third, the current study seeks to understand MCC within a common factors framework. Conceptualizing MCC in this way may be an effective way to build the case for MCC as a transtheoretical concept for those psychologists who have been more resistant to recognizing the importance of being multiculturally competent.

#### Statement of Problem

Though several process studies and a few outcome studies have been published with regard to MCC, the research base is still relatively small. Additional studies are needed to build upon the current understanding of MCC as it relates to therapeutic process and outcome. Unfortunately, most researchers who are studying the therapeutic process and outcome of therapy do not include multicultural or diversity variables, or racially and ethnically diverse clients, in their studies. Therefore it is important to build the research base and continue to make the case that MCC and cultural factors are important to both the process and outcome of psychotherapy.

The existing research on the impact of MCC on the therapeutic process has been encouraging. All of the published studies have revealed significant relationships between MCC and process variables that are known to facilitate positive outcomes. The small amount of research that has explored the impact of MCC on therapeutic outcome has been equally encouraging. However, the range of variables that have been studied in



relation to process and outcome is still relatively narrow. Examining a broader range of variables would promote a greater appreciation for the scope of impact of MCC on the process and outcome of counseling.

There are several potential areas in need of further exploration in relation to multicultural competence and common factors research, and in particular the overlap between the two. Common factors research has had a significant impact on process and outcome research in general. Though much process and outcome research continues to be comparative in nature, exploring the relative efficacy of different treatments, there has also been an emphasis on identifying and examining variables that impact therapeutic process and outcome across theories and specific treatments. To date, MCC has been largely neglected in both common factor and specific intervention research (Barber et al., 2007). Similarly, MCC has not been researched within a common factors framework, despite the fact that MCC has long been described as a superordinate competency that all mental health providers need to develop across all types of interventions, including career counseling, psychotherapy, consultation, assessment, teaching, and research (Sue, 2001).

To date, studies that have examined the impact of MCC on the therapeutic process have included some common factor variables, but the range of variables have been limited and the studies have not been described within a common factors framework. Recently, a few researchers have proposed that therapist factors mediate the relationship between common factors and outcome (Sexton, 2007; Sprenkle & Blow, 2007). Using this framework, it is possible to view MCC as a therapist common factor and explore its relation to other common factors and outcome.

## Hypotheses

The hypotheses of the current study were derived from the literature on multicultural competence, the literature on common factors, and on the theoretical relationship between these two areas. A review of the literature did not reveal any studies that specifically explored MCC from a common factors perspective, though there are studies that have examined the relationship between MCC and variables that have been identified as common factors. Further, the present study examined several common factor process variables that have not been researched previously in relation to MCC. Outcome was evaluated by multiple indicators, including satisfaction, premature termination, and perceived symptom change. The hypotheses of the present study are stated as follows:

- Hypothesis 1: Ratings on each measured common factor process variable and outcome variable (satisfaction, symptom reduction, and premature termination) will be significantly correlated with MCC in cross-cultural dyads.
- Hypothesis 2: Overall, clients from cross-cultural dyads will report a higher rate of premature termination, lower satisfaction ratings, less symptom reduction, and lower common factor variable ratings than those in culture-matched dyads.
- Hypothesis 3: Clients from cross-cultural dyads who had particularly multiculturally competent counselors (defined by MCC scores in the upper 33% of the sample) will report premature termination, satisfaction, symptom reduction and

common factor variable ratings that do not differ significantly from those in culture-matched dyads.

Hypothesis 4: Clients who terminated counseling prematurely will rate their counselors significantly lower in MCC than those who completed successfully, particularly within cross-cultural dyads.

Hypothesis 5: In cross-cultural dyads, MCC will fit into a common factors model as a therapist factor. The therapist factors will influence the process factors, which will influence outcomes (See Figure 1).

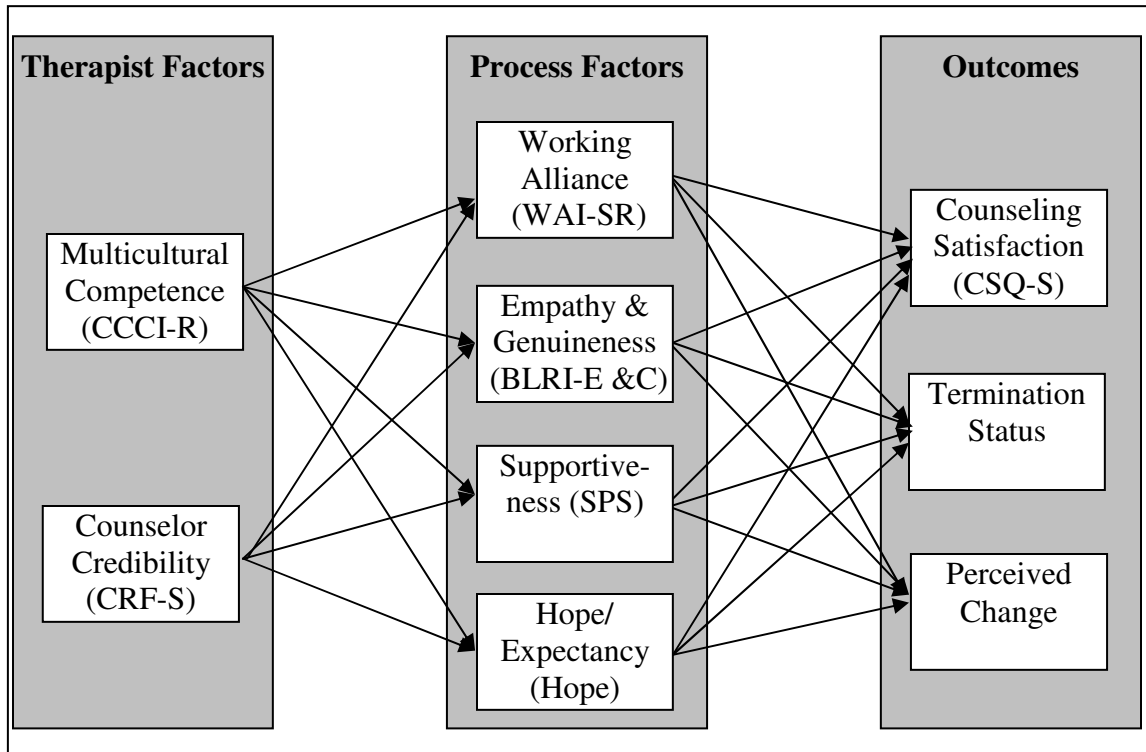


Figure 1

*The Hypothesized Model*

## Definition and Operationalization of Terms

### *Multicultural competence*

The term multicultural competence, or multicultural counseling competence, refers to the recognition that mental health providers need certain skills to competently provide services to diverse groups. The present study focuses primarily on racial and ethnic groups, though multicultural competence is also applied to other aspects of diversity, such as language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions (Sue, 2001).

### *Multicultural competencies*

The multicultural competencies are a set of 31 competencies developed by Sue and colleagues (Arredondo et al, 1996; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982). The competencies are organized into three categories: awareness (of one's own culture, worldviews, biases, and limitations), knowledge (and appreciation for other cultural groups and differences), and skills (to work with individuals who differ from oneself in one or more aspect of diversity; Sue et al., 1982).

### *Intervention competence/general competence*

Each term refers to competency in providing mental health services. Intervention competency typically refers to competency in using a particular intervention (e.g. cognitive-behavioral therapy for depression), while general competence can be independent of any particular theory and typically refers to the ability to work effectively with a range of presenting clients (Barber et al., 2007). Notably, multicultural competence is rarely addressed when researchers speak about general competence or intervention competence.

### *Cross-cultural dyads/relationships*

Cross-cultural dyads/relationships refer to therapeutic relationships where the client is a racial/ethnic minority or where the client and counselors are from different racial/ethnic groups. Relationships where the client and counselor are of the same minority racial/ethnic group are also considered to be cross-cultural counseling relationships in the present study, as the multicultural competencies are designed to be utilized with such clients regardless of the race/ethnicity of the counselor. In the broadest sense, “cross-cultural” might include variation on any one or more of several important diversity variables, such as race/ethnicity, gender, disability status, or sexual orientation (Arredondo et al, 1996). For the purposes of the present study, “cross-cultural” refers only to race/ethnicity.

### *Culture-matched dyads/relationships*

Culture-matched dyads/relationships refer to therapeutic relationships where both the client and counselor are European American. As stated above, matched minority race/ethnicity dyads (e.g. African American client and counselor) are not defined as culture-matched for the purpose of the present study.

### *Premature termination*

Premature termination occurs when a client terminates counseling in an unplanned manner or before significant improvement is made (Baekland and Lundwall, 1975). Premature termination is defined in different ways in different studies, such as by client report, by counselor judgment, or by any unplanned discontinuation of treatment (Wierzbicki & Pekarik, 1993).

### *Successful termination*

Successful termination occurs when a client has made progress in treatment or when the counselor is accepting or supportive of the client terminating counseling.

### *Common factors*

Common factors refer to aspects of the client, counselor, or therapeutic relationship that exist in all or most theories, whether specified or unspecified, and that impact treatment across a broad range of clinical issues and client populations (Garfield, 1995).

### *Therapeutic relationship*

The therapeutic relationship (also working alliance, therapeutic alliance) is a particularly important and well researched common factor. Though the important components of the therapeutic alliance have been a source of debate, the alliance is a means of engaging with and effecting change in a client (Wampold, 2001). Therapeutic relationship is typically the broadest term, while therapeutic alliance often refers to the specific therapeutic aspects, such as tasks, bonds, and goals (Horvath and Greenberg, 1989).

### *Therapeutic process*

Although the therapeutic process differs with each therapist and each client depending on a host of factors, the term refers to the actual course of therapy or treatment. Therapeutic process research is concerned with observing and/or measuring what happens during the course of therapy, often for the purpose of identifying or studying variables that predict positive change.

### *Therapeutic outcome*

Therapeutic outcome is simply the end result of a therapeutic intervention. However, there has been significant debate over which variables are the most important indicators of outcome. Therapeutic outcome research is generally concerned with either measuring the impact of a therapeutic intervention or with evaluating variables that impact outcome for better or worse.

## CHAPTER II

### REVIEW OF THE LITERATURE

#### The Multicultural Competence Movement

Attention to issues in multiculturalism has grown since the cross-cultural counseling competencies were first proposed by Sue et al. (1982). Coupled with early research on racial identity (e.g. Helms, 1984) and a shift toward within-group differences, the multicultural movement gained theoretical and empirical momentum (Ponterotto, 2008). The multicultural counseling movement matured into a specialty during the 1990's and has grown into an international, multidisciplinary movement over the past decade (Ponterotto). Surveys of psychologists suggest that issues related to diversity and multiculturalism are likely to be prominent in the field over the next decade. In a Delphi poll of counseling psychologists, "commitment to issues of diversity" received the highest rating among 11 core areas in terms of anticipated emphasis and growth (Neimeyer & Diamond, 2001). In a Delphi poll of prominent and experienced mental health professionals, "culture-sensitive/multicultural theories" were ranked second among 29 theoretical orientations (behind cognitive-behavioral therapies) in terms of its anticipated popularity over the next decade (Norcross, Hedges, & Prochaska, 2002).

Despite the increasing enthusiasm for multiculturalism, there has been resistance to incorporating multicultural competence into ethical codes, guidelines, and practice. This resistance has stemmed primarily from persistent beliefs in the universality of psychological laws and theories (thus portraying multiculturalism as unnecessary) and the invisibility of monoculturalism (which denies the reality that theories, techniques, and research tend to be Eurocentric; Sue, 2001). There have been problems implementing the



competencies even among those who support the idea, resulting from disagreements in defining MCC and lack of a conceptual framework to guide practice, training, and research, though a framework has since been provided by Sue.

There has not been a single approach to incorporating multicultural competence into professional standards for counselors and psychologists. For example, the American Counseling Association (ACA) has made a stronger commitment to the competencies than has the American Psychological Association (APA). While ACA has formally endorsed the multicultural competencies, APA has established nonbinding guidelines for multicultural competence (Ridley & Kleiner, 2003). Nevertheless, the publication of the “Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists” (American Psychological Association [APA], 2003) represented a significant moment of progress in terms of collaboration among multicultural advocates and for the greater integration of multiculturalism into the field of psychology as a whole, and in particular for APA divisions 17 and 45 who led the effort (Arredondo & Perez, 2006).

In the broad scope of “diversity issues” there are many areas of research, such as racial/cultural identity, acculturation, multicultural competence, specific demographics and populations (e.g. gender, sexual orientation, and socioeconomic status), etc., and the relationship between these constructs and nearly every area of psychological research. This literature review is primarily concerned with the counselor’s level of MCC and its interaction with therapeutic process variables (and common factors in particular) that are known to be associated with therapeutic outcome (e.g. client perceptions of therapist empathy and therapeutic alliance).

## Defining and Operationalizing Multicultural Competence

There is not a consensus on the definition of “multicultural” or “multicultural competence” (APA, 2003). Multiculturalism has sometimes been defined broadly and equated with diversity, which includes dimensions race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions (APA). More narrowly, multiculturalism has been used to refer to the five largest cultural groups in the United States: African/Black, Asian, Caucasian/European, Hispanic/Latino/a, and Native American/Indigenous (Arrendondo et al., 1996). There has been controversy regarding whether MCC should be defined broadly to be inclusive to multiple aspects of identity (e.g. gender, sexual orientation, age, etc.) or whether it should focus on race, ethnicity, and culture (Sue, Arredondo, & McDavis, 1992). One criticism is that the focus on race and ethnicity may lead to neglect of diversity factors (e.g. sexual orientation, age, gender, etc.) if the multicultural competencies are incorporated into ethical codes (Weinrach & Thomas, 2002). In response, Coleman (2004) contends that the field of psychology has historically neglected macrosystem (cultural) factors, and that the competencies serve to promote greater integration of these factors into case conceptualization and treatment. The competencies thus facilitate understanding emotional disturbance as a byproduct of complex interactions of personal, social, and cultural factors, which allows for the consideration of all aspects of diversity and not just individual differences.

The multicultural competencies do, in fact, focus on race, ethnicity, and culture, but recognize the importance of multiple identities. Multiple aspects of diversity have been categorized into three dimensions (see Sue et al., 1992). The “A” dimensions,

considered to be relatively fixed, include age, culture, ethnicity, gender, language, physical/mental health, race, sexual orientation, and social class. The “B” dimensions, considered to be more fluid, include educational background, geographic location, relationship status, health care practices/beliefs, work experience, military experience, interests, and hobbies/recreational interests. The “C” dimensions include sociopolitical and contextual factors, such as historical events and eras. The multicultural competencies recognize that we are all influenced by sociocultural, political, environmental, and historical events and that multiculturalism intersects with individual diversity to create each individual’s personal identity.

The multicultural counseling competencies originally consisted of 11 competency statements (Sue et al., 1982). The Association of Multicultural Counseling and Development (AMCD) expanded the list to 31 competencies (Sue et al., 1992) and an additional 119 explanatory statements were later added (Arredondo et al, 1996). The multicultural counseling competencies are divided into areas of awareness (sometime referred to as attitudes), knowledge, and skills. “Awareness” refers to recognition of self as an ethnic, racial, and cultural being, possessing an awareness and knowledge of one’s own cultural heritage and the ways it impacts worldview and biases, and the ability to recognize one’s own limitations with regard to MCC. “Knowledge” encompasses being able to appreciate diverse beliefs and values in a nonjudgmental way, possessing specific knowledge about the cultural heritage, historical context, and life experiences of culturally different clients, and familiarity with the latest research regarding mental health of various racial and ethnic groups. “Skills” refers to the ability to respect diverse spiritual and religious beliefs, ability to recognize aspects of therapy that may clash with

cultural values and utilize culturally appropriate treatments, and the ability to send and receive verbal and nonverbal messages accurately and appropriately with clients from various racial and ethnic groups. Sue (2001) developed a multidimensional model to organize the competencies. The three dimensional model defines MCC as possessing the requisite a) beliefs/attitudes, knowledge, and skills to provide services at the b) individual, professional, organizational, and societal levels with c) each of the five major racial/ethnic groups in the United States (Sue).

Of course, there are some criticisms of this model, and some failures in the application of the model into training. One frequent criticism is that training programs focus primarily on the knowledge and awareness aspects of the model, and neglect the skills dimension (Arredondo & Arciniega, 2001; Daniels, Roysircar, Abeles, & Boyd, 2004). There also appears to be a disconnect in practice, as practicing psychologists show a discrepancy between their perceptions of the importance of the competencies and their application of the competencies in their clinical work (Hansen et al., 2006). In fact, for 86% of 52 multicultural competencies, there was a significant discrepancy between psychologists' perceived importance of each competency and use of those competencies practice.

#### Common Factors

At the broadest level, the active ingredients of therapy can be described as *specific* and *nonspecific* factors (Garfield, 1995). The term *specific* refers to those aspects of therapy that are theoretically specified as having an effect on the treatment, while the term *nonspecific* refers to aspects of therapy that are either theoretically unspecified or not unique to a particular theory or set of problems (Garfield). Specific (common) factors

are conceptualized as existing in all or most theories, whether specified or not, and as active in treatment across a broad range of clinical issues and client populations.

### *Support for Common Factors*

There is a compelling case that common factors, rather than specific aspects of treatment, are primarily responsible for treatment gains. Imel and Wampold (2008) reason that if specific aspects of treatment were responsible for change in psychotherapy, then research should reveal differences among treatments based on their specific attributes. However, meta-analyses have consistently failed to reveal evidence that outcomes are significantly different among treatments (Shapiro & Shapiro, 1982; Smith & Glass, 1977; Wampold et al, 1997; as cited in Imel & Wampold). Thus, at the broadest level, it appears that no particular theoretic orientation is superior to others. Further, some authors argue that there is little evidence that specific treatments are more effective than others for specific problems or disorders (Wampold, 2006; Westen, Novotny, & Thompson-Brenner, 2004; as cited in Imel & Wampold).

The common factors model suggests that there are common therapeutic mechanisms across treatments that are responsible for change. Wampold (2001) found that 70% of the benefits of psychotherapy resulted from common factors, 8% from specific factors (i.e. specific theories and techniques), and 22% undetermined. Lambert (1992), estimated 30% of variance in outcome to be due to common factors, with 15% due to specific factors, 15% due to expectation, and 40% due to extra-therapeutic factors, though his estimates were not mathematically derived. Note that these authors also created different classifications of “common factors.” Wampold classifies expectation as

a common factor, while Lambert does not. The common factors are conceptualized and organized in different ways by different authors.

Though common factors are often discussed in absence of a theoretical framework, a common factors approach does not advocate for atheoretical practice. The contextual model is one description that views coherent theory and treatment as providing the necessary context for the effective delivery of common factors (Wampold, 2001). Thus, coherent theory and practice are practical ways of taking full advantage of the common factors. Further, the contextual approach has multicultural implications, through a shift in emphasis from *what* treatment is provided to *how* treatment is provided (Imel & Wampold, 2008). Thus, a treatment and rationale that do not fit the client's worldview might not be viewed as legitimate (negatively impacting hope and expectancy) and may fail to facilitate the interpersonal aspects of treatment (formation of the therapeutic alliance and client perceptions of the counselor). This conclusion is slightly more controversial, as it suggests that dogmatic use of one treatment cannot sufficiently provide the most appropriate context for every client (Imel & Wampold).

On the surface, it is surprising that few studies have found significant differences between theoretically divergent treatments. Jørgensen (2004) emphasizes two points to explain this finding. The first is that although therapists may endorse a particular theory, most therapists tend to be eclectic in practice. Thus, there is more difference between therapists in theory than in practice. Secondly, therapy is not homogenous. Even when treatment is manualized, therapist factors and the complexities of the therapeutic encounter will impact the process and outcome of treatment.

### *Identifying the Common Factors*

Because different authors have developed different lists of common factors, and because researchers are continually proposing new common factors, it is difficult to compile a definitive list of these variables. Further, the common factor model is sometimes reduced to focusing on the therapeutic alliance, which is the most reliable predictor of psychotherapy outcome, but not the only common factor (Imel & Wampold, 2008). Two conceptualizations of common factors that are often cited in the literature are those by Grencavage and Norcross (1990) and by Lambert (1992).

The common factors identified by Grencavage and Norcross (1990) were derived from 50 publications from different authors that proposed commonalities between therapies. The frequency of each common factor was computed and they were organized into five categories: client characteristics, therapist qualities, change processes, treatment structure, and relationship elements. This categorization was used in Wampold's (2001) influential metaanalysis on the relative contribution of common factors to therapeutic outcome. Alternatively, Lambert (1992) identified common factors that are associated with positive therapeutic outcomes. He organized these common factors into three categories: support factors, learning factors, and action factors. Contrary to Grencavage and Norcross, Lambert conceptualized hope/expectancy as a placebo effect and did not include extratherapeutic factors as common factors. Extratherapeutic factors include client factors (e.g. ego strength and psychological-mindedness) and environment (e.g. social support and fortuitous events). Despite different methods there is significant overlap between the two lists of common factors (See Table 1), with the biggest

difference being the organization of the factors and Lambert's exclusion of hope/expectancy and client factors.

Therapist factors have largely been ignored in psychotherapy process research, particularly in research that seeks to compare treatments. Sprenkle & Blow (2007) used the analogy that researchers act as if treatments are like pills, capable of curing clients without being affected by the person administering them. As a result, counselor differences are treated as nuisance variables, to be minimized through strict adherence to a treatment manual. This perspective is quite contrary to common factor and multicultural research where counselor attributes are of central importance both in terms of direct impact on clients and on the relationship between the counselor and client.



Table 1

*Popular Categorizations of the Common Factors*

<b>Grencavage &amp; Norcross (1990)</b>	<b>Lambert (1992)</b>
Client Characteristics	Support Factors
Hope/expectation	Therapist warmth, empathy, respect, acceptance, genuineness, expertness
Actively seeks help	catharsis
Distressed or incongruent	identification with therapist
Therapist Qualities	mitigation of isolation
General positive descriptors	reassurance
Facilitates hope/ expectancy	release of tension
Warmth/positive regard	structure
Empathy	therapeutic alliance
Acceptance	trust
Socially sanctioned	Learning Factors
Change Processes	Advice
Opportunity for catharsis	Affective experiencing
Acquisition and practice of new behaviors	Assimilation of problematic experiences
Provision of rationale	Realizing personal effectiveness
Insight/Awareness	Cognitive learning
Emotional/interpersonal learning	Corrective emotional experience
Feedback	Exploration of internal frame of reference
Suggestion	Feedback
Success/mastery experiences	Insight
Persuasion	Rationale
Identification with therapist	Action Factors
Modeling	Behavioral regulation
Desensitization	Cognitive mastery
Education/information	Encouragement of facing fears, taking risks, mastery efforts
Relationship Elements	Modeling
Development of alliance-relationship	Practice
Engagement	Reality testing
Transference	Success experience
Treatment Structure	Working through
	<i>*Therapeutic factors not defined as common factors: extratherapeutic change (client and environment factors), expectancy/placebo effects, and techniques</i>

## Multicultural Competence Research

Much empirical research has been conducted in the area of MCC. The first measures of MCC were developed almost 20 years ago. As such, there is a substantial body of research available, much of it relying on counselor self-reports measures. Issues related to the measurement of MCC and research findings are discussed below.

### *Measuring Multicultural Competence*

Several popular measures of MCC exist, each based wholly or partially on the multicultural competencies outlined by D.W. Sue and colleagues (Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982). The most frequently used measures of MCC in the literature are the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991), Multicultural Awareness Knowledge Skills Scale (MAKSS; D'Andrea, Daniels, & Heck, 1991), Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996); and Multicultural Counseling Inventory (MCI; Sadowsky, Taffe, Gutkin, & Wise, 1994). Two of these measures have been revised since the most recent publication of the multicultural competencies in 1996. The Multicultural Counseling Knowledge and Awareness Scale (MCKAS) is a revision of the MCAS (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002) and the MAKSS-Counselor Edition Revised (MAKSS-CE-R) is a revision of the original MAKSS (Kim, Cartwright, Asay, & D'Andrea, 2003). Of the four most popular measures, three are counselor self-report measures (MCI, MAKSS-CE-R, and MCKAS) and one (CCCI-R) was developed to be used by observers, such as supervisors or other outside raters. The CCCI-R has also been adapted to be used by clients to rate their counselors (Ramos-Sanchez et al., 1999) and as a self-report measure (Constantine & Ladney, 2000).

### *Instruments*

The MCI, MAKSS-CE-R, MCKAS, and CCCI-R are each described briefly below. Several authors have written in-depth reviews of these measures (see Hays, 2008; Ponterotto, Rieger, Barrett, & Sparks, 1994; Pope-Davis & Dings, 1995) and conducted empirical investigations of their psychometric properties (see Constantine & Ladany, 2000; Dunn, Smith, & Montoya, 2006).

*Cross-Cultural Counseling Inventory-Revised (CCCI-R)*. The CCCI-R is a 20-item measure designed to allow observers to assess a counselor's cultural awareness and beliefs, cultural knowledge, and flexibility in counseling skills (LaFromboise, Coleman, & Hernandez, 1991). The items were based on the 11 original multicultural competencies (Sue et al., 1982) but have not been revised since 20 additional competencies were added (Arredondo et al., 1996). This may be viewed as a limitation of the measure, though none of the four most popular measures aligns perfectly with the competencies or capture all 31 competencies. The CCCI-R yields a single score, unlike the other three MCC measures that also yield subscale scores. Although the CCCI-R contains items related to the competency areas of knowledge, skills, and awareness, factor analysis has revealed a one-factor solution (LaFromboise et al., Ponterotto & Alexander, 1996). In a meta-analysis, the CCCI-R had the highest internal consistency (.91) of any of the four most popular MCC measures (Dunn et al, 2006). The CCCI-R has been noted to have a few items that appear related to general therapist competency (e.g. "Counselor has a clear understanding of counseling and therapy process" and "Counselor is aware of the professional and ethical responsibilities of a counselor."); (Dunn et al). Like several other MCC measures, the self-report version of the CCCI-R has been found to be significantly

correlated with social desirability (Constantine & Ladney, 2000), leading to the recommendation that social desirability be measured along with self-reported MCC to account for inflated self ratings.

*Multicultural Counseling Knowledge and Awareness Scale (MCKAS)*. The MCKAS is a 32-item measure that yields a total score and two subscale scores of multicultural “knowledge” and “awareness” (Ponterotto et al., 2002). Notably absent is a “skills” dimension. The original version of the scale contained a combined knowledge/skills subscale, though some items were removed and the subscale was renamed when the scale was revised because most of the items were related to knowledge and factor analysis was most consistent with a two-factor (knowledge and awareness) structure (Ponterotto et al.). Interestingly, the MCKAS is the only one of the four popular measures that has been found not to correlate significantly with social desirability across several studies. In fact, the MCKAS awareness scale has been found to be negatively correlated with social desirability, possibly because increased multicultural awareness reduces the need to present oneself in a socially desirable way (Constantine & Ladney, 2000; Kim et al., 2003). The same was true of the MAKSS-CE-R awareness scale (Kim et al.). Across several studies, the MCKAS was found to have good internal consistency (.88) averaged across several studies (Dunn et al., 2006). The knowledge (.89) and awareness (.80) subscales were also found to have acceptable consistency across several studies.

*Multicultural Counseling Inventory (MCI)*. The MCI is a 40-item scale that yields a total score and four subscale scores: Multicultural Knowledge, Skills, Awareness, and Relationship (Sodowski et al., 1994). The relationship subscale is unique to the MCI.

This subscale could be problematic if used in studies that include other measures of the therapeutic relationship, as similar items across scales may create artificially inflated correlations between the measures. The relationship subscale has also been found to be significantly correlated with social desirability (Constantine & Ladney, 2000). The MCI has not been revised for the most recent update of the multicultural competencies. The average internal consistency of the full scale MCI has been found to be good (.86) across several studies (Dunn et al., 2006), while the knowledge (.76), skills (.79), and awareness (.78) subscales were found to have acceptable internal consistency. The relationship subscale does not appear to have adequate internal consistency (.65).

*Multicultural Awareness Knowledge Skills Scale – Counselor Edition - Revised (MAKSS-CE-R)*. The MAKSS-CE-R is a 33-item measure that yields a total score and subscales of Knowledge, Skills, and Awareness (Kim et al., 2003). Thus, the MAKSS-CE-R conforms most closely to the organization of the multicultural competencies, at least in terms of its factor structure. The scale was found to have good internal consistency (.89) for the full scale, though it has shown varying degrees of consistency (Dunn et al., 2006). The knowledge (.78) and skills (.91) subscales were found to have adequate internal consistency across several studies, but the awareness subscale (.64) was not. Higher scores on the knowledge subscale have been found to be correlated with social desirability (Constantine & Ladney, 2000; Kim et al.).

#### *Limitations of MCC Instruments*

One limitation of the existing measures of MCC is that there is a limited amount of psychometric data available (Hays, 2008). The validity of self-report measures of MCC has also been called into question. Researcher has shown weak correlations

(Worthington et al, 2000) or nonsignificant correlations between self and other/observer ratings of MCC (Constantine, 2001b; Constantine & Ladney, 2000). It has been suggested that self and other rated MCC may be theoretically divergent constructs, with self-reported MCC being more representative of social desirability and multicultural self-efficacy than competency (Constantine et al.; Ponterotto et al., 2002).

Constantine (2001b) has suggested using observer ratings of MCC, or more behaviorally-based measures of MCC, to tap actual abilities and practice rather than beliefs and attitudes. Only one behaviorally based self-report measure of MCC was identified in the literature (Multicultural Practices and Beliefs Questionnaire) and it has only been used in one study to date (Hansen et al., 2006). Two potential problems with observer ratings of MCC is that the rater must be multiculturally competent (Constantine & Ladany, 2001) and that observer ratings have typically been based on single sessions, which can be heavily influenced by client factors or absence of particular information/content in any given session (Constantine). Thus, observer ratings would likely be most valuable if assigned by multiculturally competent supervisors who are familiar with a supervisee's work across multiple sessions, with multiple clients. Along these lines, a portfolio approach has also been proposed to more thoroughly evaluate multicultural competence (Coleman, 1996).

A third option in measuring MCC is to utilize client ratings of their counselors. Therapeutic process research has long shown that therapists and clients typically have very different perceptions across a range of variables, with the client's perceptions being most consistent predictor of outcome (Gurman, 1977). Rather than viewing counselor and client ratings of MCC as different constructs, it may be that clients and counselors have

different perceptions of what is important in terms of competence. Further, competence as assessed by expert raters is a poor predictor of outcome (Wampold, 2001). It seems the client's own perceptions of a counselor (and the counseling process) are the most relevant perceptions in relation to outcome. Of course, client reported measures also have limitations (Bachelor and Horvath, 1999). The client's rating is necessarily limited by the fact that a client can only evaluate their own therapeutic relationship with their counselor, rather than the counselor's MCC in general. However, this might also be viewed as a strength, as ratings from multiple clients may be useful in providing a profile of a counselor's MCC. MCC with one group (e.g. African American clients) does not guarantee competence with another group (e.g. Latina/o clients or LGBT clients), so ratings from a diverse range of clients may provide the clearest picture of a counselor's MCC. The major limitation of client ratings is that no measures of MCC have been developed from the client's perspective and only one qualitative study has been conducted to examine client perspectives of MCC (Pope-Davis et al., 2002). Instead, researchers have had to rely on rewording existing measures of MCC that may contain technical language that is unfamiliar to clients and that may overlook aspects of competence that are important from the client's perspective.

### *Research Findings*

Much empirical research has been conducted in the area of multicultural competence over the past 20 years. The majority of the empirical research has been quantitative, with only about 5% being qualitative (Worthington, Soth-McNett, Moreno, 2007). Still, a ten year review of the *Journal of Counseling and Development* revealed

that only about half of the research on MCC has been empirical, with the other half being conceptual or theoretical (Arredondo et al., 2005).

Worthington et al. (2007) conducted a 20-year content analysis of the empirical research on MCC and identified 81 empirical studies (qualitative, quantitative, and mixed methods). They found that the majority of research has utilized counselor self-report measures of MCC. Only 21% of the studies utilized “client” reports of counselor MCC, with only three studies collecting data from actual clients and the rest using data from pseudo-clients (typically college students recruited into experimental conditions). This content analysis further revealed that the majority of empirical studies (57%) have explored correlates of counselors’ multicultural competence, while only four studies have explored the counseling process. In light of these findings and the limitations associated with self-reported MCC, there appears to be a need for alternate measures of MCC, such as client reports, supervisor reports, and observer ratings. Further, several authors have cited the need for greater emphasis on therapeutic process and outcome research (Constantine, 2002a; Fuertes et al, 2006; Worthington et al.)

Aside from scale development and instrumentation validity (discussed previously), the empirical research on MCC can be organized into the following topical categories: multicultural training, interpersonal correlates of counselor MCC, therapeutic process (including common factors), and therapeutic outcome.

#### *Correlates of Counselor Multicultural Competence and Impact of Training*

Much of the early research on multicultural competency focused on identifying correlates of MCC and the impact of multicultural training. In their content analysis, Worthington et al. (2007) found that the majority of the empirical research on MCC



utilized self-report measures of MCC and explored their relationship to interpersonal variables. Research on multicultural training has consistently shown that having more multicultural training is associated with higher levels of multicultural competence (Boyson & Vogel, 2008; Constantine, 2001a; Sadowsky et al., 1998; Toporek & Pope-Davis, 2005). There are many ways of implementing multicultural training, though metaanalysis has revealed that programs that base their interventions in theory and research yielded outcomes nearly twice as programs that did not (Smith et al., 2006). Further, it is clear that multiculturalism should be integrated into programs rather than treated as a special topic (Fouad, 2006). Though comprehensive training is the ideal way to build MCC in trainees, a host of individual variables related to attitudes and beliefs about multiculturalism, racism, and culture mediate the impact of training and are also impacted by training, such as racial identity, racial prejudice, and demographic variables (Smith et al.). Clinical experience is also a critical component of training. Experience in cross-cultural counseling relationships has been shown to contribute to the development of MCC in trainees (Ottavi, Pope-Davis, and Dings, 1994).

At the demographic level, several studies have found ethnic minority counselors to be higher in MCC than their White peers. Sadowsky et al. (1998) found that among university counseling center staff, Hispanic counselors and psychologists rated themselves higher in MCC than did White counselors and psychologists. In a study of White, Black, and Latino/a counselor trainees working with racial/ethnic minority clients, observers rated transcribed counseling sessions that concealed the race/ethnicity of the counselor and client (Constantine, 2001b). Again, the ethnic minority counselors were rated higher in MCC than the White trainees, providing support to previous studies where

counselors of color rated themselves higher in MCC than did White counselors (Pope-Davis et al., 1995). Constantine hypothesized that counselors of color may be more multiculturally competent because of the salience of race and culture in their own lives. In terms of the relationship between gender and MCC similar results might be expected, as gender discrimination in the lives of women and might allow them to better empathize with and understand racial and cultural issues. However, most research has not revealed any significant gender differences in self-reported MCC (e.g. Neville, Spanierman, & Doan, 2006; Ottavi et al., 1994; Pope-Davis & Dings, 1995). Though one study utilized observer ratings of counselor multicultural case conceptualization ability and found that although there was no self-reported gender difference in MCC, observers rated female counselors as significantly more multiculturally competent (Worthington et al., 2000). Another study found that while female counselors were rated higher in multicultural case conceptualization ability, the effect was mediated by their affective reactions to racism (Constantine, 2001a). Thus it would appear that male counselors overestimate their level of MCC and/or female counselors underestimate the level of MCC and that gender differences may be attributable to empathy regarding racism.

Moving beyond race, there has been an interest in understanding within-group differences in relation to MCC. The majority of this research has focused on White counselors providing services to racial/ethnic minority clients. Ottavi et al. (1994) found that for White counseling graduate students, White racial identity attitudes significantly predicted attainment of MCC beyond demographic variables (age and gender), amount of prior multicultural training, and amount of clinical experience. Subsequent studies have consistently shown higher levels of White racial identity attitudes to be associated with

prior multicultural training and current MCC (Constantine, 2002b, Evans & Foster, 2000; Neville et al., 1996). Research has also revealed that White counselors in less mature stages of racial identity development tend to rely on more primitive ego defenses (e.g. identification with the aggressor or projection) when confronted with racially provocative counseling situations (Utsey & Gernat, 2002). In a study of racial identity of both White and racial/ethnic minority counselor trainees, higher levels of racial identity development were associated with higher ratings of MCC for both groups (Ladany, Inman, Constantine, & Hofheinz, 1997).

Additional constructs related to racial attitudes and beliefs have also been measured in MCC studies, including affective reactions to racism, color-blind racial attitudes, and locus of control racial ideology. Along with the importance of racial identity in promoting development of counselor MCC, affective responses to racism appear important in facilitating commitment to multiculturalism and MCC in White counselors. Empathy has been found to be a significant predictor of self-reported MCC (Constantine, 2000). Across two studies, White counselor trainees' affective reactions to racism (i.e. White guilt, White empathy, and White fear of people of other races) were predictive of self-reported, demonstrated (through case conceptualization), and supervisor rated MCC (Spanierman, Poteat, Wang, and Oh, 2008). White fear was found to predict the Knowledge component of self-reported MCC, while White guilt predicted demonstrated MCC, and White empathy predicted supervisor rated MCC. Further, color-blind racial attitudes were negatively correlated to MCC and positive affective responses, which extended upon earlier research showing color-blind racial attitudes predictive of lower levels of self-reported MCC and lower multicultural case conceptualization ability

(Neville et al., 2006). Lastly, beliefs about locus of control regarding racial issues have been shown to be associated with MCC. Specifically, the tendency to use more external or sociocultural causal attributions for culture-related problems was predictive of self-reported MCC (Sodowsky et al., 1998) and multicultural case conceptualization ability (Worthington et al., 2000).

### *Therapeutic Process and Common Factor Studies*

Therapeutic process/common factor studies that have included client or pseudo-client participants have most typically utilized the CCCI-R as the measure of MCC, as it is the only measure that was designed to be used by observers (i.e. not a counselor self-report measure). These studies have typically measured a limited range of client-reported common factors (working alliance, credibility [defined as expertness, attractiveness, utility, and trustworthiness], and empathy) and process/outcome variables (session depth and satisfaction with counseling). In addition, a few studies have collected data from client-counselor dyads and therefore also measured counselor-rated variables such as multicultural training, working alliance, and counselor satisfaction.

Several process-like studies have been conducted with participant-observers (typically undergraduate student volunteers) viewing a videotape of a mock counseling session and rating the multicultural competence of the counselor. These studies have revealed that individuals without psychological training rate counselors higher in MCC when the counselor explicitly acknowledges the importance of culture (Atkinson, Casas, & Abreu, 1992) or addresses culture within the context of the client's presenting problem (Coleman, 1998). Gim et al. (1991) found that counselors who actively acknowledged the importance of culture were perceived as more credible by Asian American participants.

Further, in a study with Asian American participant-observers, counselors who expressed cultural values inconsistent with Asian culture were viewed more favorably if they first specifically acknowledged cultural differences than when they did not acknowledge differences (Li & Kim, 2007). These studies also provide evidence for the importance of “broaching” the topics of race and culture as an important multicultural skill (Day-Vines et al., 2007), though qualitative research has found that White therapists often avoid bringing up race out of discomfort or wait for the client to broach the topic (Knox et al., 2003). Level of acculturation also affects the way multicultural competence is viewed by participant-observers. For Asian clients, racial match with the counselor was found to be more important in terms of ratings of MCC and counselor credibility for less acculturated clients (Gim, et al.). Similar results were obtained among Mexican American participants, with counselor language proficiency being an important predictor of primarily Spanish speaking participants’ ratings of MCC and counselor credibility, but not for the primarily English speaking participants (Ramos-Sanchez, et al., 1999). Thus, it appears that racial match may be a more important indicator of cultural similarity and MCC for less acculturated clients.

Relatively fewer studies have examined the perceptions of clients or pseudo-clients following direct interaction with a counselor. In a study with Asian students who were recruited as clients for a single career counseling session, their ratings of the counselor’s MCC were significantly correlated with their ratings of the working alliance, session depth, and the counselor’s credibility and empathy (Li & Kim, 2004). In a similar study, with graduate student participants who had been in counseling, client-rated MCC was significantly predictive of client perceptions of credibility, empathy, and satisfaction

with counseling (Fuentes & Brobst, 2002). Further, the clients' ratings of MCC were predictive of satisfaction above and beyond the impact of credibility and empathy for racial/ethnic minority clients. In a follow-up study with client-counselor dyads, Fuentes et al. (2006) found that counselors' satisfaction with counseling was predicted by their ratings of the working alliance and the clients' ratings of the counselor's credibility, but it was not associated with MCC. For clients, their ratings of their counselor's MCC were predictive of their ratings of counselor empathy and uniquely predicted their satisfaction with counseling. One limitation of these two studies is that some clients had been in cross-cultural counseling relationships and others had not, with the majority of White participants being in same race counseling relationships. In a study of students of color who had sought and terminated therapy in a university counseling center, client-rated MCC mediated the relationship between counselor credibility and satisfaction with counseling (Constantine, 2002a). One qualitative study has explored client perceptions of MCC, using grounded theory methodology (Pope-Davis et al., 2002). The results revealed that clients who did not perceive culture as important to their interpersonal relationships placed less importance on MCC (possibly relevant to client racial identity), and that MCC appeared to influence several common factors, such as the therapeutic alliance, agreement on goals/client needs, shared worldview, and expectations for positive change. Fraga, Atkinson, and Wampold (2004) analyzed the preferences for the 31 multicultural competencies (Sue et al., 1992) among prospective Caucasian, Asian American, and Latino clients and found significant agreement among the groups for most and least preferred competencies. Among the most preferred competencies were knowledge about institutional barriers, aware of their own cultural heritage, awareness of

personal stereotypes, and being able to intervene at the institutional level on behalf of minority clients.

Though only a few studies have examined the relationship between MCC and common factors in relation to the therapeutic process with actual clients, the results have consistently shown that higher ratings of MCC are associated with increased ratings on common factors that have been shown to be associated with positive therapeutic outcomes. However, only a narrow range of common factors have been explored in these studies and the research base can be expanded by examining the relationship between MCC and other important common factors. For example, three common factors shown to be associated with positive therapeutic outcome that have not yet been measured in relation to MCC are hope/expectancy (e.g. Expectation for Counseling Success; Kim et al, 2005), supportiveness (e.g. Social Provisions Scale; Cutrona & Russell, 1987), and genuineness (e.g. Barrett-Lennard Relationship Inventory; Barrett-Lennard, 1962). Qualitative research suggests that clients would rate the multiculturally competent counselor higher than the less competent counselor on each of these dimensions (Pope-Davis et al., 2002).

#### *Research Direction*

More work is needed to provide evidence for the nature of the role of MCC in process and outcome research, and in relation to common factors. It is possible that MCC acts as a mediator or moderator to influence the therapeutic process and outcomes, particularly in cross-cultural counseling relationships. This hypothesis has clearly guided recent research on MCC and the therapeutic process. MCC has also been discussed as a mediator in forming and maintaining the therapeutic alliance in cross-cultural counseling

relationships (Vasquez, 2007). More generally, some common factors researchers have recently hypothesized that the counselor (or therapist common factors) may be a mediator between common factors and therapeutic outcome (Sexton, 2007; Sprenkle & Blow, 2007).

MCC might be viewed as a therapist common factor, in that it can be implemented across theoretic orientations, appears to interact with a host of important common factors, and has a unique effect on therapeutic outcome. Paul Pedersen (1991) appears to have been advocating for a similar position, though without using the term “common factor”, when he advocated for multiculturalism as a fourth force that has influenced the way we look at psychology across theories and disciplines. Additionally, seminal research on common factors identified therapist “attitudes about culture” as a therapist common factor (Lambert, 1992), though this factor appears to have been neglected due to a lack of research tying it to therapeutic process or outcome at that time, and possibly due to miscategorization as a situational variable (e.g. relevant only to cross-cultural counseling relationships). Sprenkle and Blow (2004) advocate for viewing the counselor and their level of competence as a common factor (in a broad sense), while viewing the counselor as someone who activates common factor mechanism of change (in a more narrow sense). Whether MCC is viewed as a common factor, as a mediator of the common factors, or both, there is much opportunity to expand the multicultural research base by including a broader range of common factors in process research that explores the role of MCC.



## CHAPTER III

### RESEARCH METHODOLOGY

#### Participants

Participants were recruited from undergraduate, elective courses at the University of Georgia, two technical colleges in the state of Georgia, and graduate programs in counseling and psychology. There were 231 participants in total, with 118 being UGA undergraduate students, 38 being technical college students, and 75 being graduate students in counseling and psychology. Descriptive statistics of the participants are provided in the results chapter.

#### Selection and Recruitment

Selection of participants was based on enrollment in one of several elective, undergraduate courses or enrollment in a PhD program in counseling or psychology. These courses included choosing a major and career, drug and alcohol issues, introduction to helping professions, and introductory psychology. Courses were both lower level and upper level undergraduate courses. Counseling and psychology graduate students were solicited to participate through their training directors, who were contacted through a training director list-serve.

Exclusion criteria for the study included having never been in counseling. Students under the age of 18 were excluded from the study in order to avoid the necessity of obtaining parent/guardian consent. Otherwise, all students who were currently or had previously been in counseling were eligible to participate

## Procedures

Participants completed the research survey online. Instructors and training directors were asked to forward links to the survey to their students. An alternative survey, which is not part of the present study, was available for participants who had never been in counseling. The request explained the voluntary nature of the study and how much extra credit, if any, was offered. Each instructor was allowed to decide whether or not to offer extra credit for participation in his/her course. For courses where extra credit was offered, those who did not wish to participate were offered the alternative activity of completing the online “Equity and Diversity Quiz” at <http://www.edchange.org/multicultural/quiz/quiz1.htm> and submitting a one-page reaction paper to the researcher to obtain an equivalent amount of extra credit. Once participants clicked the link to access the survey, they were presented with an online informed consent document. After reading the document, participants clicked a link at the bottom of the webpage to begin the survey.

Once the survey was closed, the instructors who offered extra credit were notified by the researcher about which of their students participated. Instructors were not informed about which of the two activities their students participated in, but only whether they participated. Disclosing the activity in which they participated would disclose whether the student had been in counseling. During the time the survey was open, the researcher downloaded survey results at least weekly and immediately replaced participant names with participant numbers. A list linking participant names and numbers was stored separately from the dataset in the event that a participant would contact the researcher to request that their data removed from the study. No participants asked to

have their data removed and the list linking participant numbers to participant names was deleted once data analysis began.

### Measures

Participants completed a demographic and counseling history form, and several measures related to common factors, multicultural competence, and outcome. The common factor measures include the Working Alliance Inventory – Short Revised (WAI-SR), Barrett-Lennard Relationship Inventory – Empathetic Understanding and Congruence Scales, Counselor Rating Form – Short Form (CRF-S), Social Provisions Scale (SPS), and Hope/Expectancy measure. The measure of multicultural competence is the Cross Cultural Counseling Inventory – Revised (CCCI-R) and the outcome measure is the Client Satisfaction Rating Scale (CSQ-S).

#### *Demographics Counseling History Questionnaire*

The demographics questionnaire asked briefly about participant demographic information, including gender, race/ethnicity, and age. The remainder of the questionnaire contained questions about the participant's most recent counseling experience. Items included length of treatment, approximate date of termination, approximate number of total sessions, modality of treatment (e.g. individual, group, etc.), cause and nature of termination, perceived impact of treatment, and counselor demographics (race/ethnicity, gender, and degree/license). Race/ethnicity was reported using a text box rather than discrete categories to allow for the capture of a wider range of cross-cultural relationships. Using discrete categories would not have captured some cross-cultural relationships because some counselors and clients would have been

grouped in the same category (e.g. “African American” counselor and “Black, Kenyan” client).

Two outcome measures were derived from this data. *Client perceived change* was measured by a single item that states, “Please choose the statement that best describes the outcome of your therapy/counseling.” The item was rated on a 5-point scale ranging from “I stopped attending because I felt worse than when I started” to “I stopped attending after my concerns were completely or almost completely resolved.” The second outcome measure, *termination status*, was derived from two questions. The first question captured cause of termination (i.e. outside factors, counselor encouraged, client decided, or mutual client-counselor agreement). The second question captured the nature of termination (i.e. stopped attending without notice or discussion, stopped against counselor’s advice, stopped after counselor expressed neutrality about termination, and stopped after counselor gave support/encouragement).

Premature termination is most broadly defined as a client ending counseling without the agreement of the counselor or before the presenting concerns are sufficiently resolved (Baekland and Lundwall, 1975). Premature termination has been operationalized in a number of ways, with client perceptions and client reports being one method of identification (Wierzbicki & Pekarik, 1993). In the present study, type of termination was categorized as premature termination, mutual planned termination, or other termination. “Premature termination” was defined by a participant response that they decided on termination themselves (question one) and terminated without notifying the counselor or against the counselor’s advice (question two). “Successful termination” was defined by a participant response that termination resulted from counselor encouragement or mutual

agreement (question one) and that the counselor was supportive or neutral about termination (question two). All other responses to these two questions were categorized as “other termination.”

*Working Alliance Inventory – Short Revised (WAI-SR)*

The WAI is the most widely used measure of therapeutic alliance (Hatcher & Gillaspay, 2006). The measure was designed by Horvath and Greenberg (1989) based on Bordin’s (1980) transtheoretical, tripartite conceptualization of alliance that includes bonds, goals, and tasks. Bordin conceptualized the working alliance as counselor-client agreement on the goals of therapy, agreement on the tasks that will address the client’s presenting problems, and the quality of the interpersonal bond between the client and counselor. A particular strength of the WAI is that it was developed to be transtheoretical, with experts from various theoretical backgrounds involved in screening the original pool of 91 potential items (Horvath & Greenberg).

The full-scale WAI consists of 36 items that are rated on a 7-point Likert scale. There are three versions: client rating, counselor rating, and observer rating of alliance. The WAI-S, was later designed as a brief 12-item version of the WAI (Tracey & Kokotovic, 1989). Despite adequate reliability of the WAI and WAI-S, a later study failed to confirm the factor structure of the WAI-S and so a revised short-form (WAI-SR) was developed based on the original WAI items (Hatcher & Gillaspay). The Likert scale was changed to a 5-point scale for the WAI-SR after it was determined that clients were not differentiating well between the items on a 7-point scale. The WAI-SR was found to better differentiate the bond, goal, and task dimensions in a factor analysis, correlates significantly with the full scale WAI and other working alliance measures, and shows

reliability in the range of .85 to .92 for each subscale across two studies (Hatcher & Gillaspy).

The reliability of the WAI-SR was found to be .983 in the present study, however there was a measurement problem with the scale due to the liker-scale being backwards compared to each other measure in the study. It appears that many participants did not notice that the scale was backwards and responded inaccurately as a result. This issue is discussed further in the results section

#### *The Barrett-Lennard Relationship Inventory – Client Form*

Two scales were used from the short version of the Barrett-Lennard Relationship Inventory (BLRI-S-40; Barrett-Lennard, 1973). The BLRI uses a 6-point rating scale ranging from -3 (I strongly feel that it is not true) to +3 (I strongly feel that it is true), though Barrett-Lennard (1986) reports that a 1 to 6 scale may be used in place of the original scale. The BLRI-S-40 includes four 10-item subscales related to empathetic understanding, positive regard, unconditionality, and congruence/genuineness. The empathetic understanding (BLRI-E) and congruence/genuineness (BLRI-C) subscales were used in the present study. Empathetic understanding is defined as the ability to accurately understand the experience of another and congruence/genuineness is defined as being honest, sincere, and open in relationships (Barrett-Lennard, 1962). The BLRI was developed to measure important relationship constructs from the perspective of person-centered theory and was based on the work of Carl Rogers (1957). As a result, the items on the BLRI are significantly different from those on the WAI-SR, which are focused on bonds, goals, and tasks within the therapeutic relationship.

Many previous studies have omitted one or more BLRI subscales rather than using the full, four-subscale measure (e.g. Arachtingi & Lichtenberg, 1998; Barkham & Shapiro, 1986; Ganley, 1989; Horvath & Greenberg, 1989; Zuroff & Blatts, 2006). The BLRI-empathy scale has often been used as a stand-alone measure and is the most widely used client-rated measure of empathy (Greenberg, Elliott, Watson, and Bohart, 2001).

The BLRI has demonstrated test-retest reliability, split-half reliability, and internal consistency across several studies. The average internal consistency across 14 studies was found to be .84 (with a range of .64 to .92) for the BLRI-E scale and .88 (with a range of .80 to .92) for the BLRI-C scale (Gurman & Razin, 1977). The same study found mean test-retest reliabilities of .83 for the empathetic understanding scale and .85 for the congruence scale across 10 prior studies. The internal consistency of the BLRI-E and BLRI-C were .932 and .860 in the present study.

#### *Counselor Rating Form – Short Form*

The CRF-S is a 12-item version of the original 36-item CRF (Barak & LaCrosse, 1975). Both versions contain a list of adjectives (e.g. Warm, Skillful, Sincere, etc.) and the client is asked to rate the extent to which each adjective describes their counselor on a 7-point Likert-scale ranging from “very” to “not very”. The CRF is designed to measure attractiveness, expertness, and trustworthiness (Corrigan & Schmidt, 1983). Because the three subscales show high intercorrelations, it has been suggested that the scale is measuring a single construct best labeled as counselor credibility (Ponterotto & Furlong, 1985) or interpersonal perceptions (Tracey, Glidden, & Kokotovic, 1988).

Other researchers have used the CRF as a measure of general counseling competence (see Constantine, 2002a), though the CRF is likely too specific to serve as a

measure of general competence. Further, a comprehensive review of general competency measures highlighted the difficulty of developing a general, transtheoretical measure of competence (Barber, Sharpless, Klostermann, & McCarthy, 2007). That review failed to identify any measures of general competency designed for use across psychotherapeutic theories, with the majority of measures focusing on a single presenting concern (e.g. depression) within a specific theory of practice. Further evidence against using the CRF as a measure of general competency and in favor of using it as a measure of counselor credibility can be found in a study by Heppner and Heesacker (1982), where little difference was found in client ratings of beginning practicum, advanced practicum, and predoctoral interns on the CRF. If the CRF were a measure of general competence, different ratings would be expected for students at different levels of training.

The CRF and CRF-S have been found to have adequate split-half reliability (Corrigan & Schmidt, 1983; LaCrosse & Barak, 1976). A strength of the CRF-S is that all of the items that were retained require no higher than a 9<sup>th</sup> grade reading level, making the measure more accessible than the full-scale version (Corrigan & Schmidt). Additionally, the items that were retained were those with the highest factor loadings in prior factor analyses, and thus the CRF-S has lower subscale intercorrelations than the CRF (Corrigan & Schmidt). There is some evidence of construct validity, as Atkinson and Wampold (1982) found the CRF to be highly correlated to a similar measure of counselor attractiveness, expertness, and trustworthiness (Counselor Effectiveness Rating Scale; Atkinson, & Carskaddon, 1975). Further, the CRF-S has been found to be highly correlated with the CRF and possess similar internal consistency in the range of .87 to .91



(Ponterotto & Furlong, 1985). The internal consistency of the CRF-S was found to be .963 in the present study.

### *Social Provisions Scale*

The Social Provisions Scale (SPS) is a widely used measure of perceived social support (Cutrona & Russell, 1987). Responses are given on a 4-point Likert scale.

Multiple versions of the measure have been developed from the full scale, including measures of general social support, social support from friends, and social support from specific others. Different versions include differing numbers of items, ranging from a 6-item brief scale to the 24-item full scale. The SPS contains six dimensions, with four items per dimension, related to the extent to which an individual's current relationships or a specific relationship are currently supplying guidance, reliable alliance, reassurance of worth, social integration, attachment, and opportunity to provide nurturance. The four items that make up the opportunity to provide nurturance scale was omitted in the present study, consistent with prior psychotherapy studies (Lakey et al., 1996), as the items are not applicable to therapeutic relationships (e.g. "I feel personally responsible for the well-being of \_\_\_\_\_").

With regard to psychometric properties, the internal consistency of the full-scale SPS has been found to be .92 (Cutrona & Russell, 1987) and the internal consistency of the 20-item scale has been found to be .94 (Lakey et al., 2008). Reliabilities of the subscales range from .76 to .84 (Cutrona & Russell). Discriminant validity has been shown in relation to depression and introversion-extroversion, which convergent validity has been shown in relation to its high correlation with number of supportive others and loneliness (Cutrona & Russell). Confirmatory factor analysis has confirmed a six-factor

structure consistent with the six social provision scales (Cutrona & Russell, 1990). The SPS was found to have an internal consistency of .937 in the present study.

### *Hope/Expectancy*

No suitable measures of the counselor's contribution to the client's hope and expectancy for a positive outcome or successful resolution of problems was identified. Snyder (1989) developed a hope scale, but it purports to measure dispositional (trait-like) hope, not hope as facilitated by the counselor. Kim et al. (2005) also developed a 5-item measure of client expectations of counseling success, but the items are only related to expectations and cannot be easily reworded for retrospective reporting (e.g. "I do not expect my life will get better with counseling").

Hope/expectancy has been identified as potentially one of the most important client variables by the APA Division 29 taskforce on empirically supported therapy relationships (Ackerman et al., 2001). However, little investigation has been done on the relational aspect or counselor's contribution to client hope/expectancy. Hope/expectancy has also been identified as a common factor that accounts for an estimated 15% of variance in outcome (Lambert, 1992). Because no suitable measures of counselor contribution to hope/expectancy were identified, two items were developed to measure the counselor's contribution in facilitating client hope/expectancy. The two items were worded as "My counselor made me more hopeful that I could overcome my problems" and "My counselor raised my expectations that counseling would be helpful for me." These items were rated on a four-point Likert scale, ranging from 1 (strongly disagree) to 4 (strongly agree). Because the items were developed for the current study, no

psychometric data was available for the scale. The Hope/Expectancy scale was found to have an internal consistency of .838 in the present study.

#### *Client Satisfaction Questionnaire - Short*

The Client Satisfaction Questionnaire - Short (CSQ-S) is a 3-item measure of client satisfaction (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). The three items were derived from the 8-item Client Satisfaction Questionnaire-8 (CSQ-8; Larsen et al.). In contrast to the CSQ-8, which contains questions about the counselor, agency, support staff, and facilities (e.g. “When you first came to our program, did the receptionists and secretaries seem friendly and make you feel comfortable?”), the CSQ-S contains questions about counseling services only. In this respect, the CSQ-S is a more direct measure of satisfaction with the process and outcome of counseling, while the CSQ-8 is a more general measure of satisfaction with multiple aspects of the counseling experience.

Some authors have criticized the use of client satisfaction as an outcome measure (Lunnen, Ogles, & Pappas, 2008), as satisfaction does not always correlate significantly with symptom change (Tetzlaff et al., 2005). However, this finding might also suggest that symptom change, rather than satisfaction, is the inadequate indicator of outcome. This point appears particularly relevant to situations where the counselor fails to address the presenting problem as the client sees it or in the manner that the client would prefer (e.g. overemphasis on individualism may lead to symptom reduction at the individual level while failing adequately address family or systemic issues). Perhaps for this reason, client satisfaction has been one of the most frequently used measures of outcome in multicultural process/outcome research (see Constantine, 2002a; Fuertes & Brobst, 2002; Fuertes et al., 2006).

Despite any criticisms of client satisfaction as a measure of outcome, the CSQ is one of the most widely used measures of outcome and has shown predictive validity in relation to premature termination (Kokotovic & Tracey, 1987) and client perceptions of change (Lunnen, Ogles, & Pappas, 2008). The CSQ-S has been found to have an internal consistency of .89 to .93 in prior research (Hasler et al., 2004; Kokotovic & Tracey). The three items on the CSQ-S have been shown to correlate highly with the full-scale CSQ-8, and factor analysis has revealed a single factor underlying the items (Larsen et al., 1979). The internal consistency of the CSQ-S was found to be .898 in the present study.

#### *Cross Cultural Counseling Inventory*

As detailed previously, the CCCI-R is a 20-item measure designed to allow observers to assess a counselor's cultural awareness and beliefs, cultural knowledge, and flexibility in counseling skills (LaFromboise, Coleman, & Hernandez, 1991). The items were derived from the multicultural competencies (Sue et al., 1982). Like several other MCC measures, the self-report version of the CCCI-R has been found to be significantly correlated with social desirability (Constantine & Ladney, 2000), leading to the recommendation that social desirability be measured along with self-reported MCC to account for inflated self ratings. The CCCI-R was not used as a self-report measure in the present study, so social desirability was not measured. The version of the CCCI-R used in the present study has been adapted to be used by clients to rate their counselors (Ramos-Sanchez et al., 1999).

Although the CCCI-R contains items related to the competency areas of knowledge, skills, and awareness, factor analysis has revealed a one-factor solution (LaFromboise et al., 1991, Ponterotto & Alexander, 1996). In a meta-analysis, the CCCI-

R had the highest internal consistency (.91) of any of the four most popular MCC measures (Dunn et al, 2006). In the present study the internal consistency was .954. Nearly all studies that require client or observer ratings of counselor MCC utilize the CCCI-R.

### Research Design

The current study was designed as a correlational study, as there are is no experimental component. The methodology and design of this study is similar to a prior study by Fuertes & Brobst (2002). Participants were asked to respond to questions about their most recent (past or present) counselor and counseling experience. All participants had received the treatment of counseling, though they differed in terms of whether they were in a cross-cultural or culture-matched counseling relationship. Participants were compared based on this difference, in contrast to the Fuertes and Brobst study which compared the experiences of Caucasian and racial/ethnic minority participants regardless of whether or not their counseling relationships were cross-cultural or culture-matched.

### Statistical Procedures

Prior to analysis of the data, alpha coefficients were calculated for each of the scales used in the study. This was done to ensure that each measure had sufficient reliability to be used in further analysis. Robinson, Shaver, and Wrightsman (1991) suggest that for the purpose of research, measures should have an alpha coefficient of at least .70 to be considered internally consistent. Descriptive statistics were generated so numbers and percentages of participants may be reported by gender, race/ethnicity, and age. Descriptive statistics were also generated in regard to therapy history, including averages and standard deviations for number of sessions completed, duration of

counseling, and reason for termination. Next, a correlation matrix, with average scores and standard deviations, was created to compare each of the variables measured in the study.

### Limitations

There are several limitations to this study associated with the research design. First, the sample was not randomly selected, but was one of convenience. As a result, participants likely differ from nonparticipants. Because the order of the scales in the scale was not varied across participants, it is not possible to rule out any ordering effects. Because the design of the study was correlational and measurements were only collected at one point in time, it is not possible to establish causal relationships. The study can only provide direction for future studies that are designed to capture the causal nature of any relationships identified in the present study.

Additionally, because all participants are college students, the generalizability of the findings will be limited. College students are on average more educated, less racially/ethnically diverse, younger, and of higher socioeconomic status than the general population. Despite this limitation, the results should be highly relevant to university counseling centers. In addition, because most of the participants were recruited from general elective courses, they are more representative of typical college students than many other studies where the participants are all enrolled in psychology courses or are all graduate students in counseling and psychology programs.

Another limitation of the study is that a large percentage of participants were not currently involved in counseling and therefore rated past counseling relationships. It may be that the longer it has been since the counseling relationship has ended, the less reliable

the report. Including participants who are currently in counseling may weaken the statistical power of the study as they may rate their counselor and counseling relationship significantly differently than those who are rating past counseling relationships. The presence of such an effect can be tested prior to analysis by examining correlations between time since termination or past/current counseling and other variables in the study.

Another potential limitation of the study may be a disproportionate number of European American counselors. In prior MCC research, the majority of cross-cultural dyads have been racial/ethnic minority clients with European American counselors (e.g. Fuertes & Brobst, 2002). However, it appears that there were a sufficient number of racial/ethnic minority counselors in the cross-cultural dyads so that the results of the study can be generalized to all cross-cultural relationships and not just cross-cultural counseling relationships with European American counselors. The sample was also adequately racially/ethnically diverse, as additional participants were recruited until there were a sufficient number of cross-cultural dyads for analysis.

## CHAPTER IV

### RESULTS

#### Preliminary Analysis

Preliminary analyses were performed to calculate descriptive statistics, produce correlation matrices, and produce reliability estimates for all measures included in the study. Analysis of missing data and data replacement were also performed.

##### *Missing Data*

The dataset was first analyzed for missing data. Nine participants did not complete the survey, but completed a sufficient number of the measures to be kept in the dataset. Because SPSS uses listwise (also called casewise) deletion by default for cases with missing data, participants who did not complete all of the measures were automatically excluded by SPSS from any analysis involving a measure to which they did not respond. Data replacement was utilized for all cases where a participant completed at least 80% of the items on a scale to allow for computation of total scores for the scale. For cases where a participant did not respond to at least 80% of the items, no total score was computed for that scale. 28.6% of participants left at least one survey item blank, 10.0% left two or more items blank, and 5.6% left three or more items blank. Data replacement is preferred to deletion when more than 5% of the cases are missing at least one data point, as case deletion makes the assumption that data is missing at random and that participants who skipped items do not differ from those who completed all items, which may not be true (Little and Rubin, 1987). No individual survey item had more than 3.4% missing data across all participants and most items had less than 1% missing data.



Missing data is often replaced with a value representing the mean of the other items of the scale or by the mean of nearby data points. These methods are problematic because they reduce the variance of a variable. Even the more complex methods that are supported by SPSS, such as replacement by multiple regression or maximum likelihood estimation (MLE) have limitations in that they assume that data is missing at random and that the model that explains the data for nonmissing cases is the same for missing cases (Garson, 2008). Multiple imputation is the preferred method of data replacement, and is the method that was used in the present study (Schafer, 1999). Multiple imputation uses Monte Carlo methods to generate multiple simulated values for each missing value, then iteratively analyzes the dataset to compare the fit of each simulated value. This method generates estimates that better reflect true variability in data than do other methods of data replacement (Garson). The program used for data replacement in the present study was NORM v2.03. NORM is a free, standalone multiple imputation program developed by Joe Schafer and is available on his website (<http://www.stat.psu.edu/~jls/misoftwa.html>). Correlation matrices were created to compare correlations between variables after using replacement by scale mean values and after replacement by data imputation. The two methods resulted in similar correlations between variables (differing by 0 to .01), which is likely reflective of the small amount of missing data. The dataset that was completed using multiple imputation was utilized for all subsequent analysis.

#### *Demographics and Participant Characteristics*

There were 231 participants in total, with 118 being UGA undergraduate students, 38 being technical college students, and 75 being graduate students in counseling and

psychology. The mean age of participants was 26.13 (SD=8.47), with a range of 18 to 63. With regard to gender, 78.4% of participants were female and 21.6% were male. Participants reported their race/ethnicity and their counselor's race/ethnicity through a text box to provide for maximum flexibility in capturing cross-cultural relationships. The primary investigator then coded the responses in to racial/ethnic categories to provide demographic statistics. The coding was repeated by a second counseling psychology PhD student to ensure consistency. With regard to race/ethnicity, 77.9% of participants identified as White/European American, 8.2% African/African American, 5.6% Latina/o, 3.0% Asian/Asian American, 2.6% Native American/American Indian, 1.7% Biracial, and 0.9% Arab/Arab American. Participants reported their counselors' race/ethnicity as 86.1% White/European American, 6.1% African/African American, 4.3% Latina/o, 1.7% Asian/Asian American, 0.9% Jewish/Israeli, 0.4% Native American/American Indian, and 0.4% Biracial.

With regard to the counseling experience being reported, 25.1% of participants described a current therapeutic relationship, while 74.9% described a previous counseling relationship. Of those describing a previous counseling relationship, participants terminated counseling an average of 47 months (SD = 51.9 months) prior to participation, with a median time since termination of 33 months. The length of time since termination ranged from 1 month to 338 months. Participants who were currently in counseling reported attending an average of 41.5 sessions (SD = 53.5; median = 19.5), while those who had terminated reported attending an average of 29.8 sessions (SD = 51.3; median = 12.0). The number of sessions attended ranged from 1 to 400.

With regard to the modality of counseling, 88.9% reported being in individual counseling, 4.3% in family counseling, 3.7% in couples counseling, and 3.1% in group counseling. Six participants were excluded due to reporting a non-counseling relationship (e.g. physical therapy) or treatment by multiple counselors where it was unclear which counselor they were responding about (e.g. group counseling with co-leaders or inpatient psychiatric treatment with multiple providers). Participants also reported their counselor's level of training. 40.5% reported receiving counseling from psychologists, 29.7% from master's level counselors, 16.4% from psychiatrists, and 9.5% from social workers. 3.9% of participants were unsure of their counselor's level of training. Four participants were excluded for reporting a relationship with a psychiatrist where they received only medication and not counseling.

Categorization of cross-cultural vs. culture-matched relationships was coded by the primary investigator and recoded by a second counseling psychology PhD student to ensure consistency. There was disagreement in only one case (where the client was European and the counselor was European American) and the decision was made to consider that relationship to be cross-cultural based on the ethnic difference and on the fact that the participant identified the difference. The multicultural competencies are considered to be essential when working with racial/ethnic minority clients (Arredondo et al, 1996), and in the present study, European American clients in cross-cultural relationships were also of interest. Thus, the culture-matched group included only European American counselors working with European American clients.

Of the 231 participants, 162 were European American participants who reported culture-matched relationships with European American counselors, while five were

racial/ethnic minority participants reported being in relationships with a counselor of the same racial/ethnic minority group. Of the remaining 64 participants who reported being in cross-cultural relationships, nine were racial/ethnic minority participants with a counselor of a different racial/ethnic minority group, 36 were racial/ethnic minority participants with a European American counselor, 18 were European American participants with a racial/ethnic minority counselor, and one was a European client with a European American counselor.

An attempt was made to provide empirical support for including European American clients in the cross-cultural group. While the numbers of participants in each group were too small to perform a Fisher's test to compare correlations between the CCCI-R and other measures, an informal evaluation of correlations with the CCCI-R shows that European American participants in cross-cultural relationships responded more similarly to racial/ethnic minority participants than to European Americans in culture-matched relationships on all measures (See Table 2).

### *Measures*

Robinson, Shaver, and Wrightsman (1991) suggested that measures should have a reliability of at least .70 to be considered internally consistent. Based on this standard, each measure in the study was found to have acceptable internal consistency in the present study. The reliabilities were as follows: CCCI-R (.954), CRF-S (.963), SPS (.937), Hope (.838), BLRI-E (.932), BLRI-C (.860), and CSQ-S (.898). Reliability could not be computed for the Termination Status variable, which was derived from categorical responses, or for the single item Perceived Change measure.

Table 2

*Correlations between CCCI-R and Other Measures across Different Cultural-Matches*

	CCCI-R		
	Euro Matched	Euro CC	Minority CC
CRF-S	.63	.74	.82
Hope	.44	.74	.70
SPS	.56	.79	.78
BLRI-E	.63	.84	.85
BLRI-C	.50	.67	.80
CSQ-S	.57	.67	.76
Change	.41	.58	.60
Termination	.29	.80	.63

*Note.* Euro Matched=Euro American counselor and client; Euro CC=Euro American client with racial/ethnic minority counselor; Minority CC=Racial/ethnic minority client with any counselor.

The Working Alliance Inventory (WAI-SR) was excluded from analysis due to a measurement problem. The likert scale for the WAI-SR was backwards compared to every other measure in the study (i.e. 1 = strongly agree). It appears that some participants noticed that the scale was reversed but that most did not, which resulted in the measure being uncorrelated or negatively correlated with most measures in the study. This finding would be highly inconsistent with any previously reported research using the WAI-SR. It was not possible to determine the intention of many of the participants, so the measure had to be excluded from further analysis. Instead, the BLRI was used as the primary measure of the therapeutic relationship.

Because the cross-cultural and culture-matched groups were analyzed separately, separate correlation matrices were produced for each group (see Tables 3 and 4).

Demographic variables, including participant age, participant gender, counselor gender,

number of sessions attended, and time since termination were also included in the correlation matrices.

### Hypotheses

Five research questions were designed to be tested in the present study. The first hypothesis stated that multicultural competence would be significantly correlated with all of the other measured process and outcome variables, with higher correlations in cross-cultural relationships. The second hypothesis predicted that individuals in cross-cultural relationships would have a less positive experience in counseling than those in culture-matched relationships, as indicated by lower ratings on process and outcome variables. The third hypothesis was dependent on confirmation of the second hypothesis and was designed to explore whether being in a cross-cultural relationship with a highly multiculturally competent counselor would eliminate any discrepancy in quality of counseling as compared to participants in culturally-matched relationships. The fourth hypothesis was concerned with whether there would be mean differences in participant ratings of counselors' level of multicultural competence between those who terminated prematurely or appropriately, taking into account whether the relationship was cross-cultural or culture-matched. The fifth hypothesis stated that multicultural competence would strengthen the fit of the path model when included for participants in cross-cultural relationships.

Table 3

*Correlation Matrix for Cross-Cultural Participants (n = 69)*

Variable	M	SD	2	3	4	5	6	7	8
1. P Age	28.68	9.46	0.09	0.14	0.13	0.28*	-0.04	0.04	-0.03
2. P Gender	-	-	-	-0.34**	0.12	0.25	0.02	-0.02	-0.06
3. C Gender	-	-	-	-	-0.17	-0.15	0.1	0.15	0.05
4. Sessions	38.88	57.16	-	-	-	0.46**	-0.06	0.02	-0.03
5. Term Time	36.9	39.48	-	-	-	-	-0.24	-0.14	-0.26
6. CCCI-R	93	20.29	-	-	-	-	-	0.81**	0.77**
7. BLRI-E	44.59	10.96	-	-	-	-	-	-	0.84**
8. BLRI-C	43.43	10.03	-	-	-	-	-	-	-
9. BLRI-Total	88.01	20.13	-	-	-	-	-	-	-
10. CRF-S	70.75	15.17	-	-	-	-	-	-	-
11. SPS	60.52	11.53	-	-	-	-	-	-	-
12. Hope	6.42	1.53	-	-	-	-	-	-	-
13. CSQ-S	11.49	3.41	-	-	-	-	-	-	-
14. Change	3.34	0.92	-	-	-	-	-	-	-
15. Term Status	1.76	0.44	-	-	-	-	-	-	-

Variable	M	SD	9	10	11	12	13	14	15
1. P Age	28.68	9.46	0.01	-0.04	0.12	-0.08	-0.05	-0.03	-0.02
2. P Gender	-	-	-0.04	-0.11	0.01	-0.15	-0.05	0.18	-0.08
3. C Gender	-	-	0.11	0.17	0.14	0.1	0.09	0.02	0.32
4. Sessions	38.88	57.16	0	-0.11	0.07	-0.1	-0.05	-0.03	-0.07
5. Term Time	36.9	39.48	-0.21	-0.34*	-0.13	-0.23	-0.22	-0.03	-0.23
6. CCCI-R	93	20.29	0.82**	0.80**	0.75**	0.69**	0.72**	0.57**	0.62**
7. BLRI-E	44.59	10.96	0.96**	0.81**	0.82**	0.69**	0.79**	0.64**	0.74**
8. BLRI-C	43.43	10.03	0.95**	0.77**	0.75**	0.70**	0.73**	0.44**	0.59**
9. BLRI-Total	88.01	20.13	-	0.82**	0.82**	0.73**	0.80**	0.57**	0.70**
10. CRF-S	70.75	15.17	-	-	0.75**	0.74**	0.83**	0.55**	0.74**
11. SPS	60.52	11.53	-	-	-	0.75**	0.80**	0.49**	0.61**
12. Hope	6.42	1.53	-	-	-	-	0.77**	0.50**	0.68**
13. CSQ-S	11.49	3.41	-	-	-	-	-	0.65**	0.67**
14. Change	3.34	0.92	-	-	-	-	-	-	0.80**
15. Term Status	1.76	0.44	-	-	-	-	-	-	-

*Note.* P = Participant; C = Counselor; Sessions = Number of sessions; Term Time = Time (in months) since termination; Term Status = Termination Status. \* $p < .05$ . \*\* $p < .01$ .

Table 4

*Correlation Matrix for Culture-Matched Participants (n = 162)*

Variable	M	SD	2	3	4	5	6	7	8
1. P Age	25.06	7.81	-0.07	0.1	0	0.43**	0.01	0.1	0.11
2. P Gender	-	-	-	-0.26**	0.09	-0.22*	0.07	0.17*	0.05
3. C Gender	-	-	-	-	-0.15	0.21*	0.05	-0.06	-0.02
4. Sessions	30.24	49.66			-	-0.01	0.1	0.13	0.12
5. Term Time	51.26	56.27				-	-0.04	-0.15	-0.12
6. CCCI-R	95.85	14.91					-	0.63**	0.50**
7. BLRI-E	45.03	10.15						-	0.79**
8. BLRI-C	44.6	7.98							-
9. BLRI-Total	89.63	17.17							
10. CRF-S	71.19	12.63							
11. SPS	61.05	11.38							
12. Hope	6.42	1.53							
13. CSQ-S	11.56	3.35							
14. Change	3.4	0.96							
15. Term Status	1.7	4.61							

Variable	M	SD	9	10	11	12	13	14	15
1. P Age	25.06	7.81	0.11	0.01	0.06	0	0.02	-0.03	0
2. P Gender	-	-	0.12	0	0.08	0.08	0.04	0.14	0.09
3. C Gender	-	-	-0.05	0	-0.14	-0.12	-0.16	-0.14	-0.13
4. Sessions	30.24	49.66	0.13	0.13	0.18*	0.12	0.16*	0.18*	0.19
5. Term Time	51.26	56.27	-0.15	-0.08	-0.20*	-0.19*	-0.25**	-0.15	-0.05
6. CCCI-R	95.85	14.91	0.61**	0.63**	0.56**	0.44**	0.57**	0.41**	0.29**
7. BLRI-E	45.03	10.15	0.96**	0.80**	0.84**	0.77**	0.82**	0.60**	0.51**
8. BLRI-C	44.6	7.98	0.93**	0.69**	0.72**	0.65**	0.67**	0.43**	0.32**
9. BLRI-Total	89.63	17.17	-	0.79**	0.83**	0.76**	0.80**	0.56**	0.45**
10. CRF-S	71.19	12.63		-	0.78**	0.71**	0.81**	0.46**	0.41**
11. SPS	61.05	11.38			-	0.81**	0.84**	0.51**	0.35**
12. Hope	6.42	1.53				-	0.82**	0.60**	0.43**
13. CSQ-S	11.56	3.35					-	0.61**	0.56**
14. Change	3.4	0.96						-	0.62**
15. Term Status	1.7	4.61							-

*Note.* P = Participant; C = Counselor; Sessions = Number of sessions; Term Time = Time (in months) since termination; Term Status = Termination Status. \* $p < .05$ . \*\* $p < .01$ .



### *Hypothesis 1*

The first hypothesis was that ratings on each measured process and outcome variable would be significantly correlated with the CCCI-R in cross-cultural dyads. No hypothesis was made about whether those correlations would be significant in culture-matched dyads, though it was expected that the correlations would be significantly stronger in the cross-cultural dyads. All process and outcome variables were found to be significantly correlated with the CCCI-R in both cross-cultural and culture-matched dyads. To determine whether the CCCI-R was significantly more strongly correlated with the other measures within cross-cultural dyads, Fisher's Z test was utilized to compare the correlations for each measure across the two cultural match groups (Fisher, 1921). The hypothesis was supported as all variables except Perceived Change were significantly more highly correlated with the CCCI-R in cross-cultural relationships than in culture-matched relationships (See Table 5).

Table 5

#### *Comparison of Correlations with CCCI-R between Cross-Cultural and Culture-Matched Participants*

	Cross-Cultural		CCCI-R		Z
	Correlation	n	Culture-Matched	n	
CRF-S	0.803	69	0.632	162	2.474**
Hope	0.690	66	0.444	155	2.474**
SPS	0.747	66	0.561	155	2.215*
BLRI-E	0.810	68	0.627	155	2.635**
BLRI-C	0.768	68	0.505	155	3.100**
CSQ-S	0.721	67	0.566	155	1.799*
Change	0.569	56	0.413	129	1.263
Termination	0.619	37	0.288	93	2.121*

*Note.* \*p < .05. \*\*p < .01.

## *Hypothesis 2*

The second hypothesis, that clients from cross-cultural dyads would report a higher rate of premature termination, lower satisfaction ratings, less symptom reduction, and lower common factor variable ratings than those in culture-matched dyads was not supported. An ANOVA was performed with cultural match (cross-cultural vs. culture-matched) entered as the factor and all of the measured variables entered as the DVs. As can be seen in Table 6, there were no significant mean differences based on cultural match for any of the measured process or outcome variables. As can be seen in the descriptive statistics, sample size does not appear to be an issue, as the mean differences for most measures were less than one point between the cross-cultural and culture-matched groups. A second ANOVA was computed, removing European American clients in cross-cultural relationships, to determine whether there were any significant differences between European American clients in culture-matched relationships and racial/ethnic minority clients in cross-cultural relationships. No significant mean differences were found on any variable in that analysis either.

Table 6

### *One-Way ANOVA of Process and Outcome Variables by Cultural-Match*

Variable	<i>df</i>	<i>F</i>	<i>p</i>
CCCI-R	1	1.41	.23
CRF-S	1	0.05	.82
Hope	1	0.00	.98
SPS	1	0.10	.75
BLRI-E	1	0.08	.77
BLRI-C	1	0.87	.35
CSQ-S	1	0.02	.89
Perceived Change	1	0.18	.67
Termination Status	1	0.43	.51

*Note.* \* $p < .05$ . \*\* $p < .01$ .

### *Hypothesis 3*

The third hypothesis was dependent upon confirmation of the second hypothesis. It stated that lower ratings in process and outcome variables in cross-cultural relationships would not be present when comparing only the 50% most multiculturally competent counselors in cross-cultural relationships to all counselors in culture-matched relationships. Due to lack of support for hypothesis two, the third hypothesis was modified to explore whether there were any differences on mean levels of process and outcome measures based on cultural match, level of counselor MCC, or the interaction between the two variables. A MANOVA was performed to compare the means of process and outcome variables with counselor level of MCC (top 50% vs. bottom 50% of CCCI-R ratings) and cultural match (cross-cultural vs. culture-matched) entered as factors. There were no significant differences on the process and outcome variables by type of cultural match [ $F(1, 123) = 0.40, p = .92$ ] or by the cultural match by level of multicultural competence interaction [ $F(1, 123) = 1.64, p = .12$ ], though there were significant differences by level of counselor multicultural competence [ $F(1, 123) = 14.07, p < .001$ ]. While the model overall did not show a significant interaction, there was a significant difference on the BLRI-Congruence subscale [ $F(1, 123) = 6.35, p = .01$ ] based on the interaction between type of cultural match and level of MCC. The BLRI-Empathy scale was the only other measure that approached significance [ $F(1, 123) = 3.16, p = .08$ ] based on this interaction. These findings suggest that counselor level of MCC is associated with higher ratings on the other measured variables whether the relationship is cross-cultural or culture-matched. However, the therapeutic relationship was particularly impacted by the counselor's level of MCC within cross-cultural dyads.

#### *Hypothesis 4*

The hypothesis that participants who terminated counseling prematurely would rate their counselors significantly lower in MCC than those who completed successfully, particularly within cross-cultural dyads was supported using a one-way ANOVA. Termination status (premature vs. successful termination) was entered as the factor and CCCI-R score was entered as the DV. There was a significant difference in the counselor's mean level of multicultural competence between those who terminated prematurely in both the cross-cultural ( $F(1, 35) = 21.77, p < .01$ ) and culture-matched groups ( $F(1, 91) = 8.21, p < .01$ ). The effect size was much larger for the cross-cultural group (.383) as compared to the culture-matched group (.083). According to Cohen (1992), an effect size between .10 and .23 is small, .24 to .36 is medium, and .37 or higher is large.

The descriptive statistics reveal that the difference in effect size appears to be accounted for by the presence of lower multicultural competence of counselors in cross-cultural relationships where termination was premature. Participants who terminated successfully rated their counselors similarly in multicultural competence regardless of the type of cultural match ( $M=98.2$  for the cross-cultural group and  $M=97.1$  for the culture-matched group). On the other hand, participants in cross-cultural relationships who terminated prematurely rated their counselors much lower in multicultural competence than those in culture-matched relationships ( $M=65.0$  vs.  $M=88.4$ ).

#### *Hypothesis 5*

The fifth hypothesis was that MCC would act as a therapist factor to influence the measured therapeutic process variables, which would in turn influence the outcomes. No

hypothesis was made regarding whether MCC would influence the therapeutic process in culture-matched relationships, though the same model was tested for both populations of participants. The fifth hypothesis was supported through the results of a path analysis using AMOS, version 17.0. The analysis was conducted separately for the cross-cultural and culture-matched groups. The initial model included paths between each therapist variable to each therapeutic process variable and from each therapeutic process variable to each outcome variable. Paths were not included from the therapist variables to outcome variables (see Figures 1 and 2). The premature termination variable was not included in the path model due to the large number of participants (43.5%) who had not yet terminated or whose termination status could not be classified as either successful or premature. Instead, premature termination was analyzed separately in the fourth hypothesis so as not to reduce the power of the path analysis.

As recommended by Kahn (2006), two fit indices that are not influenced by sample size, the Tucker-Lewis Index (TLI) and comparative fit index (CFI), were computed in addition to chi-square, which is influenced by sample size. Values of .95 or higher on the TLI and CFI indicate good model fit (Hu & Bentler, 1999). With regard to chi-square, a statistically nonsignificant value is desired as it indicates that there is no difference between the hypothesized model and the data. In addition, the Root Mean Square Error of Approximation (RMSEA) was computed. The RMSEA is a measure of fit between the actual and model-implied covariance matrices, adjusting for model complexity. An RMSEA value below .08 indicates adequate model fit and below .05 indicates good model fit, while it is recommended that a model with an RMSEA greater than .10 should not be employed (Browne & Cudeck, 1993).

The initial model was run and fit statistics were computed for the cross-cultural group ( $\chi^2(4, N = 69) = 10.97, p = .03, CFI = .98, TLI = .89, RMSEA = .18, 95\%$  confidence interval (CI) = .06 – .31) and for the culture-matched group ( $\chi^2(4, N = 162) = 20.04, p = .00, CFI = .98, TLI = .89, RMSEA = .18, 95\%$  CI = .11 – .26). The fit statistics indicated that the initial model was not an adequate fit for the data. Modification indices were run for each group and in each case indicated that one path should be added. For the culture-matched group, modification indices indicated that model fit would be improved by adding a path from CRF-S to CSQ-S. For the cross-cultural group, modification indices indicated that model fit would be improved by adding a path from CRF-S to the error term for CSQ-S. Because each model suggested an association between the CRF-S and CSQ-S, that path was added for both groups before trimming nonsignificant paths. After adding the path, the fit statistics indicated that the model was a good fit for both the cross-cultural ( $\chi^2(3, N = 69) = 2.24, p = .52, CFI = 1.00, TLI = 1.02, RMSEA = .00, 95\%$  CI = .00 – .18) and culture-matched models ( $\chi^2(3, N = 162) = 1.46, p = .69, CFI = 1.00, TLI = 1.02, RMSEA = .00, 95\%$  CI = .00 – .10).

The model was next trimmed to remove nonsignificant paths. There were initially four nonsignificant paths ( $>.05$ ) in the model for both the cross-cultural and culture-matched groups. Modification to each model was performed separately. A conservative approach was taken to trimming nonsignificant paths from the model. The least significant path was deleted first, the model was rerun, and fit statistics were recomputed to ensure that model fit was not significantly reduced by removing the path before the next least significant path was removed. Beginning with the culture-matched model, the least significant path was deleted (CCCI-R to Hope = .83). After verifying that the fit

statistics were not significantly reduced by deleting the path, the model was rerun, deleting one path at a time, then rerunning until two additional paths were deleted: SPS to Perceived Change (.34), and BLRI to CSQ-S (.20). There were no additional nonsignificant paths and the model fit was improved compared to the unmodified model ( $\chi^2(6, N = 162) = 4.03, p = .67, CFI = 1.00, TLI = 1.01, RMSEA = .00, 95\% CI = 0.00 - 0.08$ ).

Modification was then performed for the cross-cultural group, which resulted in two paths being deleted: SPS to Perceived Change (.89) and BLRI to CSQ-S (.15). The path from Hope to Perceived Change remained nonsignificant (.07), but when deleted the model fit was significantly reduced ( $\chi^2(6, N = 69) = 7.82, p = .25, CFI = .99, TLI = .98, RMSEA = .07, 95\% CI = 0.00 - 0.18$ ). Because the path from Hope to Perceived Change approached significance and deletion reduced the fit of the model, the path was added back in ( $\chi^2(5, N = 69) = 4.36, p = .50, CFI = 1.00, TLI = 1.01, RMSEA = .00, 95\% CI = 0.00 - 0.16$ ). After modification, the two models were identical with the exception of the deletion of the path from CCCI-R to Hope in the culture-matched model (see Figures 2 and 3). Fit statistics for the initial, modified, and reduced models can be seen in Table 7.

Similar models fit the data for both the cross-cultural and culture-matched groups, though there are some differences in the strengths of the paths. Comparison of the two path models reveals that the paths from the CCCI-R to the therapeutic process variables are stronger in the cross-cultural model than in the culture-matched model, though those paths are still important to the overall model fit for both groups. Within the cross-cultural model, the paths from the CCCI-R to the SPS and BLRI are nearly equally as strong as the paths from the CRF to those variables. The relationship between the process and

outcome variables appears similar between the two models. Hope and SPS were similarly predictive of Client Satisfaction for both groups. For the culture-matched group, the strongest path to Perceived Change comes from Hope. For the cross-cultural group, the strongest path to Perceived Change comes from the BLRI. Overall, very similar models fit the data for each group, with the most notable differences found in relation to the CCCI-R.

Table 7

*Fit Statistics for Path Analysis of the Hypothesized Model*

<i>Model</i>	Culture-Matched Participants						
	$\chi^2$	<i>df</i>	<i>p</i>	<i>TLI</i>	<i>CFI</i>	<i>RMSEA</i>	<i>RMSEA 95% CI</i>
Hypothesized model	20.04	4	.00	0.89	0.98	0.18	.11-.26
Model plus CRF-CSQ path	1.46	3	.69	1.02	1.00	0.00	.00-.10
Reduced model	4.03	6	.67	1.01	1.00	0.00	.00-.08

<i>Model</i>	Cross-Cultural Participants						
	$\chi^2$	<i>df</i>	<i>p</i>	<i>TLI</i>	<i>CFI</i>	<i>RMSEA</i>	<i>RMSEA 95% CI</i>
Hypothesized model	10.97	4	.03	0.89	0.98	0.18	.06-.31
Model plus CRF-CSQ path	2.24	3	.52	1.02	1.00	0.00	.00-.18
Reduced model	4.36	5	.50	1.01	1.00	0.00	.00-.16

*Note.* CFI = Comparative Fit Index; RMSEA = Root Mean Square Error of Approximation; TLI = Tucker-Lewis Index. \**p* < .05. \*\**p* < .01.



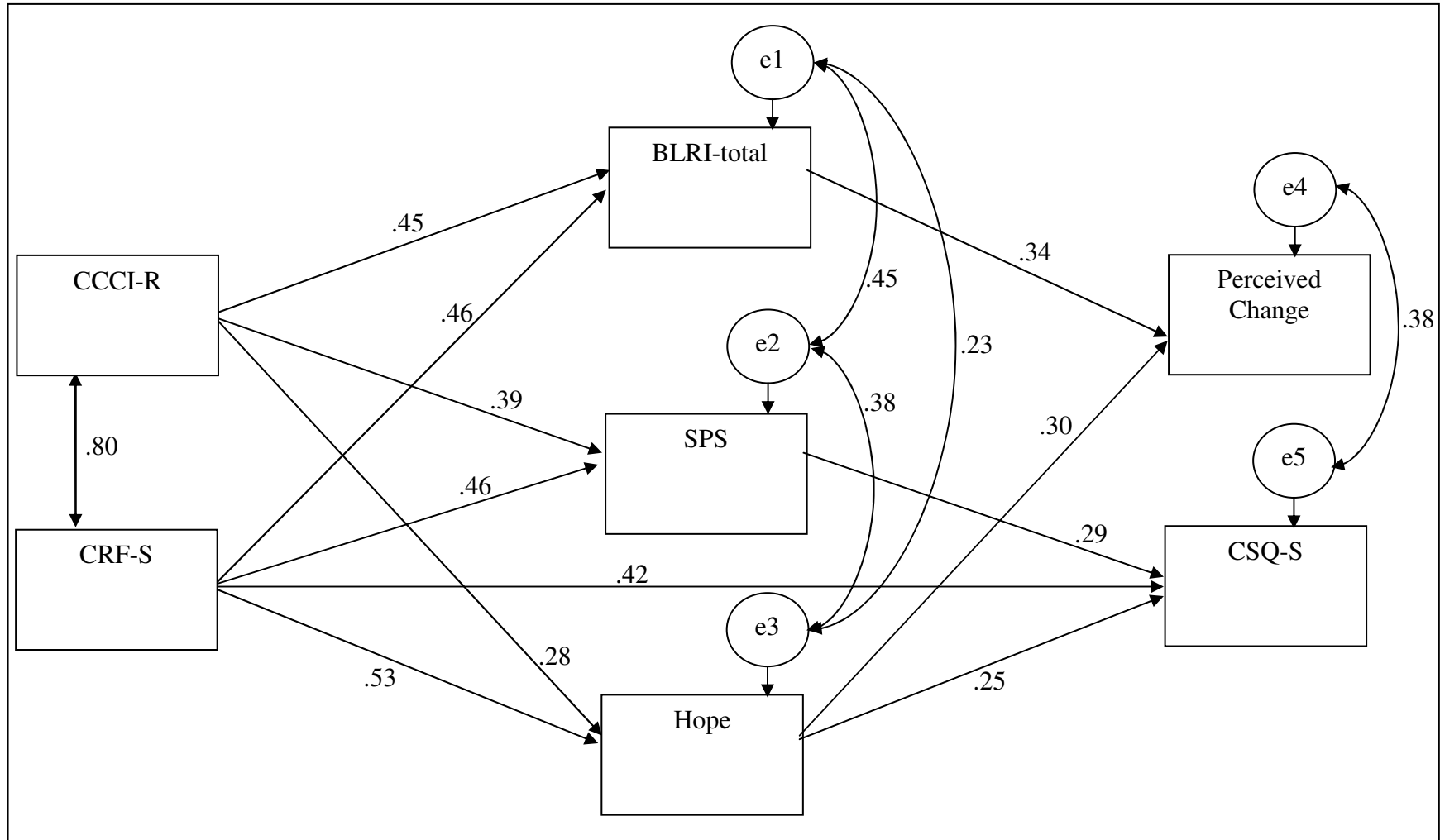


Figure 2

*Path Model for Cross-Cultural Counseling Relationships*

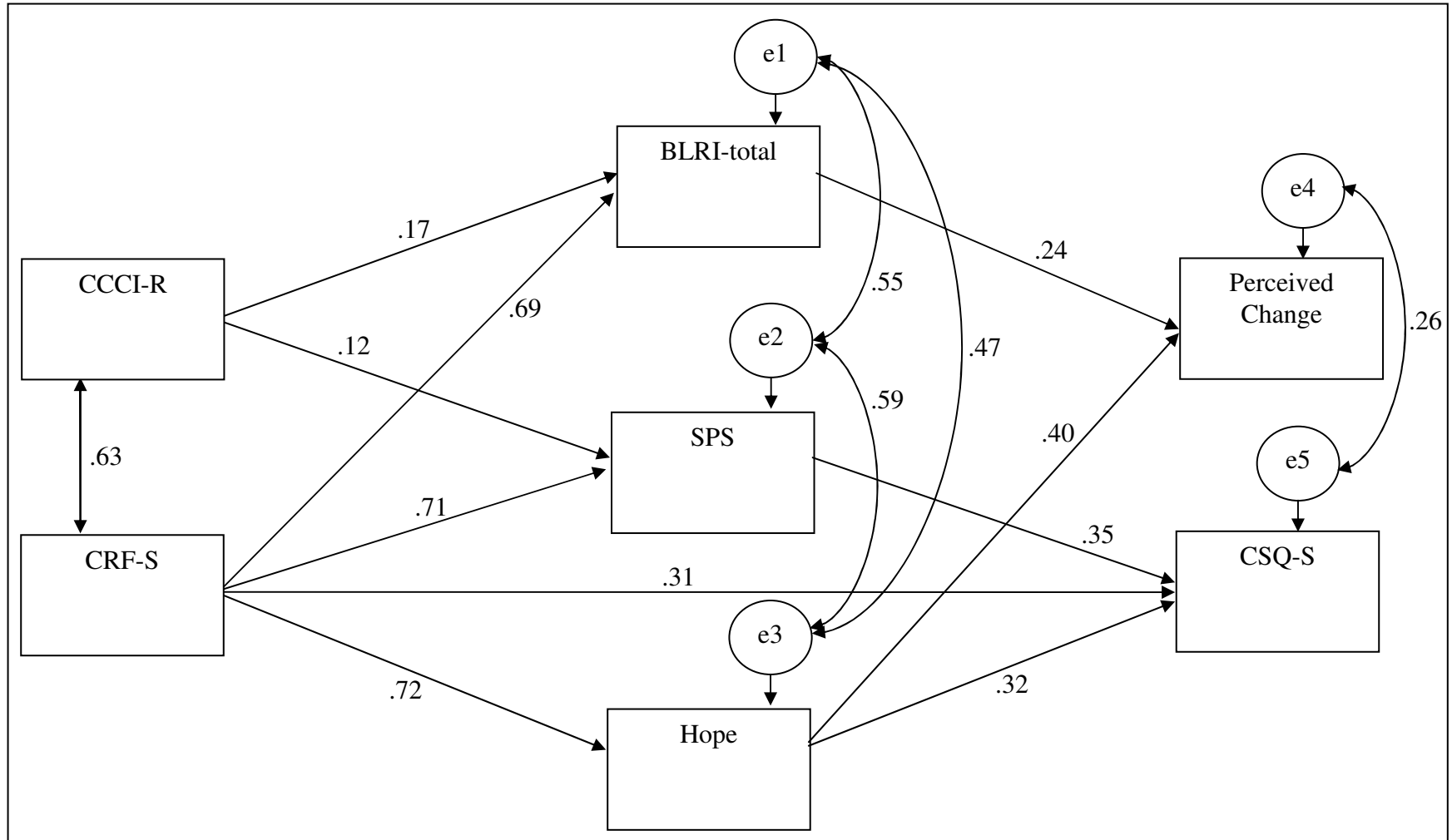


Figure 3

*Path Model for Culture-Matched Counseling Relationships*

## CHAPTER V

### DISCUSSION

#### Summary of the Study

Much research has been conducted over the past few decades on the topic of multicultural competence (MCC). The existing research has largely examined correlates of MCC (Worthington, Soth-McNett, Moreno, 2007), which has provided valuable information about counselor attributes that contribute to MCC. There has also been a significant amount of research focused on pseudo-client reactions to experimental situations where cultural variables or multicultural competence are manipulated. This research has provided valuable evidence that clients can perceive and rate a counselor's level of MCC, and that they prefer a more multiculturally competent counselor. However, relatively little research has been conducted to examine the role and impact of MCC on the process and outcome of counseling with actual clients (Worthington et al.).

The present study was designed to examine multicultural competence within a common factors framework. Furthermore, the purpose was to better elaborate the relationship between MCC and several process and outcome variables within actual cross-cultural counseling relationships. Data was collected entirely from the client's perspective as client ratings of therapeutic variables are typically much more predictive of outcomes than are observer ratings or counselor ratings (Gurman, 1977; Wampold, 2001). Participants who were presently or had previously been in counseling were asked to complete a survey related to their experiences in counseling. The survey included demographic questions and measures of therapist variables (MCC and counselor credibility), therapeutic process variables (working alliance, therapeutic relationship,

social provisions, and hope/expectancy), and therapeutic outcomes (termination status, satisfaction with counseling, and perceived change).

## Conclusions

### *Findings of Research Hypotheses*

*Hypothesis One.* The first hypothesis stated that multicultural competence would be significantly correlated with the other measured process and outcome variables, and that the correlations would be significantly stronger in the cross-cultural relationships. This hypothesis was supported, which provides evidence that multicultural competence is important to the process and outcome of counseling, and particularly so in cross-cultural relationships. The most significant correlational differences between the cross-cultural and culture-matched groups were noted for the therapeutic relationship subscales. This provides initial evidence that the therapeutic relationship is particularly sensitive to multicultural competence in cross-cultural relationships. The least significant correlational differences were found with regard to the outcome measures, which may simply reflect the smaller sample size available for that comparison because not all participants completed the outcome measures. Alternatively, this finding could mean that multicultural competence is similarly important to outcomes for both the cross-cultural and culture-matched groups or that multicultural competence primarily impacts outcomes through therapeutic process variables.

*Hypothesis Two.* The second hypothesis stated that clients in cross-cultural relationships would report lower ratings on all measures and poorer outcomes than clients in culture-matched relationships. This hypothesis was not supported, which means that in the present study, participants rated their counselors similarly whether they were in cross-

cultural or culture-matched relationships. The data was also analyzed to determine whether European American clients in culture-matched relationships rated their counselors more favorably than racial/ethnic minority clients in cross-cultural relationships, and no differences were found. This finding does not support prior research showing that racial/ethnic minority clients tend to experience less positive outcomes in counseling (Baekeland & Lundwall, 1975; Wierzbicki & Pekarik, 1993). Taken alone, this finding could be interpreted to mean that culture did not influence the counseling process in the present study. An alternate interpretation is that although cultural matching did not appear to impact the process or outcome of counseling, the impact of cultural differences may have been moderated by level of counselor multicultural competence. Prior researchers have proposed that cognitive match (e.g. attitudes, beliefs, and expectations) is more important than racial match, which is a distal demographic variable that may not result in a cognitive match (Zane et al., 2005).

*Hypothesis Three.* The third hypothesis was that there would be mean differences on process and outcome variables based on cultural match, level of counselor MCC (highest 50% vs. lowest 50%), or the interaction between these two variables. Results showed that there were significant mean differences by level of counselor multicultural competence, but not by cultural match. These findings suggest that counselor level of MCC is important to the process and outcome of counseling regardless of whether the relationship is cross-cultural or culture-matched. This finding might appear surprising, but within the broader context of diversity many relationships can be considered to be cross-cultural based on ethnic differences within racial groups, sexual orientation,

disability status, socioeconomic status, gender, spiritual/religious beliefs, and a number of other variables (Sue, 2001).

Analysis further revealed that the interaction effect for cultural match and level of multicultural competence was not significant overall, but was significant for the BLRI-Congruence scale and approached significance for the BLRI-Empathy scale (i.e. therapeutic relationship variables). Thus, the therapeutic relationship appears to be the variable that is most sensitive to the counselor's level of MCC within cross-cultural relationships. Multicultural researchers have previously stated that MCC is crucial to forming relationships in cross-cultural counseling relationships (Sodowsky, Taffe, Gutkin, & Wise, 1994; Vasquez, 2007).

*Hypothesis Four.* The fourth hypothesis stated that clients who terminated counseling prematurely would rate their counselors lower in MCC than those who completed successfully, and that the effect would be stronger in cross-cultural relationships. This hypothesis was supported with level of MCC having a small, but significant, effect on termination status in culture-matched relationship and a large effect on termination status in cross-cultural relationships. It has long been known that there is a disparity in the rate of premature termination among racial/ethnic minority clients (Baekeland & Lundwall, 1975; Wierzbicki & Pekarik, 1993). However, this finding suggests that counselor MCC impacts more than just the termination status of racial/ethnic minority clients. Higher levels of MCC also predict lower levels of premature termination for European American clients in cross-cultural relationships and, to a lesser degree, European American clients in culture-matched relationships.

Further analysis revealed that the difference in effect size between the culture-matched and cross-cultural relationships was attributable to the least multiculturally competent counselors. Clients who terminated successfully did not rate their counselors significantly differently on MCC based on cultural match. However, clients in cross-cultural relationships who terminated prematurely rated their counselors significantly lower in MCC than those in culture-matched relationships. This finding suggests that with regard to premature termination, highly multiculturally competent counselors were similarly effective whether working with clients of their same racial/ethnic group or in cross-cultural relationships. However, the least multiculturally competent counselors experienced fewer successful terminations regardless of cultural match, but were particularly less successful in cross-cultural relationships.

*Hypothesis Five.* The fifth hypothesis was that MCC would fit into a common factor path model with the other measured variables. The model was designed with the therapist factors (MCC and counselor credibility) influencing the therapeutic process variables (therapeutic relationship, social provisions, and facilitation of hope), which would in turn influence the therapeutic outcome variables (satisfaction with counseling and perceived change). The structure of the model was supported, though a few paths between variables were removed during modification and one path was added. Path analysis confirmed that similar models fit the data for both cross-cultural and culture-matched participants. The only difference between the models was that the path between multicultural competence and hope was trimmed from the culture-matched model. Modification indices suggested that the therapist factor of counselor credibility directly influenced the outcome of satisfaction with counseling. This path was not included in the

original model, though previous research has shown that counselor credibility (CRF-S) is predictive of satisfaction with counseling (CSQ-S; Heppner & Heesacker, 1983).

As expected, the paths between MCC and the process variables were strong within cross-cultural relationships. Two of three paths between MCC and the process variables remained significant for the culture-matched group as well, though the strength of the path coefficients was not as strong. It was anticipated that MCC would be important to the therapeutic process in cross-cultural relationships. Multiple authors have cited the importance of MCC within the therapeutic relationship (Sodowsky, Taffe, Gutkin, & Wise, 1994; Vasquez, 2007), but the therapeutic relationship is not the only therapeutic process variable. The findings of the present study suggest that counselor MCC impacts other aspects of the therapeutic process as well, including the facilitation of hope and client perceptions of social provisions. Furthermore, the paths between MCC and the process variables were nearly as strong as the paths between counselor credibility and the process variables. Thus, in cross-cultural relationships, it appears that multicultural competence is almost as important to the therapeutic process as the counselor's credibility (which is operationalized as a counselor's expertness, attractiveness, utility, and trustworthiness).

No hypotheses were made about whether MCC would fit into the model for culture-matched participants, as the measure of MCC used in the study was designed to be relevant to racial/ethnic differences between the counselor and client. MCC was found to fit in the model and there are several possible explanations that might account for the finding. One explanation might be that clients had negative experiences related to working with counselors who were in a lower stage of racial identity. Literature on



clinical supervision suggests that development is impeded and the supervisory alliance is weakened when a supervisor is in a lower stage of racial identity development than the supervisee (Ladany, Brittan-Powell, & Pannu, 1997). The fact that the therapeutic relationship was the process variable most strongly influenced by MCC in culture-matched relationships lends support the hypothesis that a related effect may be present in counseling. So, for example, a client in a higher stage of racial identity who values multiculturalism may feel less connected to a counselor in a lower stage who demonstrates racial insensitivity. An alternate explanation might be that the majority of the items on the CCCI-R are worded generally enough that they could be interpreted to refer to areas of difference beyond race/ethnicity (e.g. “Counselor is comfortable with differences between counselor and client.”). Thus, participants in “culture-matched” relationships may have focused on other areas of cultural difference, such as sexual orientation or spiritual/religious beliefs, when responding to several of the items. In other words, some of the culture-matched relationships were likely cross-cultural along dimensions other than race/ethnicity, though the CCCI-R can only partially capture other areas of difference.

### *Limitations*

In addition to the findings and implications, it is important to address the limitations of the present study. First, the high positive correlations between the measured variables may indicate a halo effect (Thorndike, 1920). The halo effect may be present if when the counselor is rated highly on one variable, they are also rated highly on all other variables. Similarly, there may be a reverse halo effect where if the counselor is rated poorly on one variable, they are rated poorly on the other variables. Correlations might

also become higher as time passes and a client has difficulty remembering specifics about the counselor and the counseling relationship. In the present study, time since termination was negatively correlated with each of the measured variables, though the correlations were only significant for one variable among the cross-cultural participants and three variables among the culture-matched participants. Thus, time since termination does not appear to have had a significant negative impact on the participants' ability to self-report their counseling experiences.

There are also strengths and weaknesses of measuring clients who are currently in counseling or who have already terminated. Constructs may be inherently different depending on whether a person is in counseling or has already terminated. For example, ratings of the therapeutic relationship are likely to reflect a snapshot of the relationship at the time of measurement, while the relationship measured after termination may reflect a more integrated view of the overall experience of the therapeutic relationship. In the future, it would be valuable to gather data from the same participants during and after termination of counseling to capture the formation and fluctuation in process variables, in addition to outcomes, such as premature termination, that can only be measured once counseling is completed.

Another potential limitation is that data was gathered only from the client's perspective. With regard to demographics, the participants were only able to directly report their own race/ethnicity and there would likely be some error in reporting their counselor's race/ethnicity. However, the client's perspective was important to obtain, in order to determine whether they perceived their counselor as being of a different race/ethnicity. It is also likely that the counselors or outside observers would have

provided different ratings on the measured variables (e.g. therapeutic relationship). However, client ratings of variables are typically the best predictors of outcomes (Gurman, 1977; Wampold, 2001). With regard to MCC, it is well-known that counselor self-reports of competence are correlated with social desirability (Constantine & Ladney, 2000) and that observer ratings are of limited utility because observers view only snapshots of counseling (Constantine & Ladany, 2001). Lastly, the present study was correlational and thus, the findings cannot prove the causal relationship between the measured variables.

### Implications

The present study has several implications that are important for practitioners and researchers. First, the findings provide evidence that multicultural competence makes an important contribution to the therapeutic process, and through those variables, effects outcomes. MCC is particularly important to relationships that are cross-cultural with regard to race/ethnicity, but also appears to play a role in relationships among racial majority clients and counselors. Thus, the present study provides further evidence that multicultural competence is an essential component of therapeutic competence in general, and particularly when working with clients of a different culture. As previous authors have stated, if multicultural competence is an essential competence, then it becomes an ethical necessity as well (Sue & Sue, 2003). Yet, the American Psychological Association has yet to formally endorse multicultural competence as an ethical mandate, as has been done by the American Counseling Association (Ridley & Kleiner, 2003). This failure to endorse specific multicultural competencies, or even multicultural competence in general, has allowed psychologists to deemphasize multicultural

competence as little more than a “nondiscrimination” policy. The findings of the present study provide further support for the multicultural competencies that were first operationalized by Sue et al. (1982) and later expanded (Arredondo et al, 1996; Sue, Arredondo, & McDavis, 1992), as the items from each popular measure of MCC have been drawn from these competencies. With almost 30 years of research supporting the multicultural competencies, it is time for APA to formally endorse them in the next update of the Ethical Principles of Psychologists and Code of Conduct (APA; 2002).

The present study also has implications for researchers. With regard to therapy research, the present study highlights the importance of recording not just client demographic, but also the counselor’s demographic information to identify important areas of difference that will be impacted by the counselor’s level of MCC. The present study also provides support for recent calls to include more therapist variables in counseling (Sexton, 2007; Sprenkle & Blow, 2007). MCC is a therapist factor that is unaccounted for in most process and outcome studies, and likely accounts for a significant amount of variance, especially within cross-cultural relationships. The present study clearly shows that process and outcome studies that do not include measures of counselor MCC cannot accurately capture the impact of the counselor on the process and outcome of counseling, particularly within cross-cultural dyads. Furthermore, studies that do not include a sufficient number of cross-cultural dyads may underestimate the importance of the therapeutic relationship and the contribution of multicultural competence to the relationship.

While similar models fit the data for both cross-cultural and culture-matched participants in the present study, it is important to recognize that MCC played a stronger

role for the cross-cultural participants. This provides evidence that there are some inherent differences between cross-cultural counseling and culture-matched counseling, which may be attributed to a lack of cultural awareness among European American clients and the perception that culture is not salient when they are working with European American counselors. The multicultural competencies call for some specific behaviors in cross-cultural relationships, such as demonstrating comfort with cultural differences, discussing cultural differences, assessing the client's sociopolitical context, addressing institutional barriers, and accommodating different verbal and nonverbal communication styles (Arredondo et al, 1996). Thus, studies that rely too heavily on European American, culture-matched client-counselor dyads or fail to take into account the counselor's level of multicultural competence should not be generalized to cross-cultural relationships or racial/ethnic minority clients.

With regard to research on multicultural competence, the present study shows that client ratings of MCC can yield meaningful results in process and outcome research while avoiding some of the limitations of self-reported or observer-rated MCC. The findings also support conceptualizing MCC as a common factor, and specifically as a therapist factor. This conceptualization may promote the inclusion of MCC in studies that measure other common factor variables, while still allowing MCC to be viewed as a transtheoretical construct. Lastly, the present study provides support for applying the multicultural competencies to all racially/ethnically cross-cultural relationships, in contrast to prior research that has primarily focused on European American counselors working with racial/ethnic minority clients.

The present study also has implications for counseling psychology. The findings of the study provide support for the multicultural competence movement, a pursuit to which the contributions of counseling psychologists have been central (Ponterotto, 2008). As research supporting the multicultural competencies accumulates, the legitimacy and importance of this movement will continue to build. It is important that multicultural competence become broadly embraced within the field of psychology, and that counseling psychology be recognized for its contributions and leadership in this area. It will also be important for counseling psychologists to remain at the forefront of the multicultural competence movement and embrace this valuable legacy as a central aspect of their professional identity.

#### Recommendations for Further Research

When considering recommendations for future research in this area, there are several potential directions. First, it is important that multicultural competence be part of the movement to identify general therapeutic competencies. Currently, measures of therapeutic competence are typically theory specific, though there is movement toward developing more general measures that can be used transtheoretically. As measures of general therapeutic competence are developed, it is essential that researchers not neglect issues of diversity and multicultural competence. These dimensions of competence have been entirely excluded from the popular existing measures of therapeutic competence despite the fact that the multicultural competencies are well established and supported by nearly 30 years of research (Barber, Sharpless, Klostermann, & McCarthy, 2007).

While the multicultural competencies are well-established, there is a need to develop additional measures and conduct research to address competence in working

with other aspects of cultural difference such as sexual orientation, socioeconomic status, and disability status to name a few. Once additional measures have been developed, it will be possible to examine multiple aspects of identity within the therapeutic process. It will also be possible to examine the impact of having multiple areas of difference or having varying levels of competence across several areas of difference.

It would also be valuable to conduct more research on client perceptions of multicultural competence. This should include conducting more studies where clients rate their counselor's level of MCC, and also studies of client preferences for multicultural competencies and client perceptions of what constitutes multicultural competence. There is relatively little research on within group and between group differences in client attitudes about and preferences for the multicultural competencies. There is also a need for research to explore how the competencies differ based on other racial/ethnic cultural matches. Without this research, training programs might assume that racial/ethnic minority counselors should apply the competencies in the same way with a European American client as a European American counselor would apply them with a racial/ethnic minority client, even though there are different sociopolitical issues and power dynamics depending on the demographics of different counselor-client dyads.

More detailed research on the role of MCC within the therapeutic process is needed. This research will require data collection from clients and counselors while counseling is ongoing. For example, it will be important to understand how multicultural competence contributes to the formation of the therapeutic relationship or the facilitation of hope/positive expectations. It will be valuable to include an increased number of individual difference variables that may influence a client's perceptions of MCC (e.g.

racial identity status or cognitive match). There is also a need to examine how in-session events (e.g. microaggressions) contribute to client perceptions of counselor MCC.

Inclusion of additional diversity-related variables will continue to clarify best practices within and between various cultural groups.

It will be important to conduct more studies that include measurement while counseling is ongoing and after termination. The present study suggests that MCC primarily influences outcomes through process variables. While studies with different methodology or different client populations may still find a direct impact on outcomes, it appears that the effect will be at least partially mediated by process variables. Studies that focus only on outcomes may overlook important indirect effects.

Finally, it will be important for therapy researchers to include more diversity variables in their research to more fully capture the dynamics that exist in cross-cultural counseling relationships, broadly defined. Conversely, it will also be important for multicultural competence researchers to conduct more studies of the process and outcome of counseling. Ideally, each area of expertise can be taken advantage of through collaboration between researchers. Further research in this area can only serve to benefit clients and practitioners, each of whom will be more likely to participate in cross-cultural counseling as the United States becomes more diverse.



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## APPENDICES

### APPENDIX A

#### Consent Form

Dear Participant,

By clicking the link below you are agreeing to participate in a research study titled, “The relationship between multicultural competence and therapeutic common factors”, that seeks to examine factors associated with effective counseling and the decision to enter into counseling. You must be at least 18 years of age to complete this survey. If you have been in counseling in the past, you will be asked to rate your most recent counselor and respond to questions related to the process of therapy. If you have never been in counseling, you will be asked to respond to questions about your preferences for various counseling competencies and your opinions about other social issues. The potential benefits of participation include gaining a greater awareness and appreciation of multiculturalism or cultural differences. The scientific and societal benefits of the study include identifying factors that may make counseling/therapy more effective. The study is being conducted by Geoff Bathje, a doctoral student in Counseling Psychology, under the supervision of Dr. Alan E. Stewart in the Department of Counseling and Human Development Services, The University of Georgia, 402 Aderhold Hall, (706) 542-1263.

It will take approximately 20-30 minutes to complete the survey. At the discretion of your instructor, you may be entitled to extra credit in an ECHD course for participation in this study. If you do not wish to participate in this study, you may complete the alternative activity of reviewing a multicultural website

(<http://www.edchange.org/multicultural/quiz/quiz1.htm>) and writing a one-page reaction paper for an equal amount of extra credit, which is to be submitted to [bathje@uga.edu](mailto:bathje@uga.edu). The survey or alternative activity must be completed no later than 5pm on MM/DD/YY to receive extra credit. It is not anticipated that you will experience any psychological, social, legal, economic or physical discomfort, stress, or harm as a result of participation in this study. Your participation in this study is voluntary. In the event that you find it uncomfortable to respond to questions about your experiences with counseling or social issues you may discontinue participation at any point, skip particular questions, or withdraw your data from the study up to one month after completing the survey by contacting Geoff Bathje at (###) ###-#### or [bathje@uga.edu](mailto:bathje@uga.edu). You will not be penalized or lose any extra credit for withdrawing from the study. By completing the survey online, you are reminded that Internet communications are insecure and there is a limit to the confidentiality that can be guaranteed due to the technology itself. However, once the completed survey is received by the investigator standard confidentiality procedures will be employed. Data from the survey will be stored in a data file to which only the principal investigator and other members of the research team will have access and any identifying information will be removed from your survey results as soon as the data is downloaded. The results of this study may be published in aggregate form at some point, but individual information will not be shared, published, or presented.

If you have any questions or concerns about this study, please do not hesitate to contact Geoff Bathje at (###) ###-#### or [bathje@uga.edu](mailto:bathje@uga.edu).

Additional questions or problems regarding your rights as a research participant should be addressed to The Chairperson, Institutional Review Board, University of Georgia, 612 Boyd

Graduate Studies Research Center, Athens, Georgia 30602-7411; Telephone (706) 542-3199; E-Mail Address IRB@uga.edu.

Thank you for your participation!

Sincerely,

Geoff J. Bathje, M.S.  
Counseling Psychology Ph.D. Candidate  
Department of Counseling and Human Development

## APPENDIX B

### Demographic and Counseling History Questionnaire

1. What is your gender?

- (1) Female
- (2) Male
- (3) Transgender

2. How old are you?

\_\_\_\_\_

3. What is your sexual orientation?

- (1) Heterosexual
- (2) Homosexual (includes gay/lesbian)
- (3) Bisexual
- (4) Other (write in): \_\_\_\_\_

4. Please specify your race/ethnicity in the box below:

Examples include Asian American/Asian, Black/African American, White/Caucasian, Native American/American Indian, Hispanic/Latino/a, Biracial, etc. If born outside of the United States or if you identify based on nationality, you may also specify your nationality or country of origin, but please also specify race/ethnicity (e.g. "Asian American, Chinese"; "African, born in Kenya"; "Mexican American"; or "White, born in Australia").

\_\_\_\_\_

Please answer all of the questions in this survey in response to YOUR MOST RECENT (OR CURRENT) EXPERIENCE IN COUNSELING.

1. Approximately how long were you in therapy/counseling? (if more than one year, please convert to months – e.g. 2 years = 24 months)

# of Months \_\_\_\_\_

2. Approximately what date did you complete or stop attending therapy/counseling?

Month \_\_\_\_\_ Year \_\_\_\_\_

I am still in therapy/counseling \_\_\_\_\_

3. Approximately how many sessions of therapy/counseling did you complete?

\_\_\_\_\_

4. The counseling/therapy experience you are describing is best described as:

- (1) Individual counseling/therapy (you saw a counselor/therapist individually)
- (2) Group counseling/therapy (multiple nonrelative clients in sessions)
- (3) Couples counseling/therapy (your partner/spouse attended most or all sessions)
- (4) Family counseling/therapy (members of your family attended most or all sessions)

5. Please choose the statement that best describes the cause of your completing or stopping therapy/counseling:
- (1) Outside factors forced me to stop counseling (e.g. moved out of the area, reached the maximum number of sessions allowed by insurance or agency, etc.)
  - (2) My therapist encouraged me to cease counseling
  - (3) The decision to cease counseling was primarily my decision
  - (4) My therapist and I mutually agreed I was ready to cease counseling
6. Please choose the statement that best describes the circumstances surrounding you completing or stopping therapy/counseling:
- (1) I stopped attending sessions without seeking my counselor's opinion or without notifying my counselor ahead of time
  - (2) After discussing it with my counselor, I stopped attending sessions against his/her advice
  - (3) After discussing it with my counselor, he/she was neutral about my decision to cease counseling
  - (4) After discussing it with my counselor, he/she supported my decision to cease counseling
7. Please choose the statement that best describes the outcome of your therapy/counseling:
- (1) I stopped attending because I felt worse than when I started
  - (2) I stopped attending without seeing much or any improvement
  - (3) I stopped attending after making some progress
  - (4) I stopped attending after making significant progress
  - (5) I stopped attending after my concerns were completely or almost completely resolved
8. What was your counselor/therapist's gender?
- (1) Female
  - (2) Male
  - (3) Transgender
9. What was your counselor/therapist's race/ethnicity?  
(Examples include Asian American/Asian, Black/African American, White/Caucasian, Native American/American Indian, Hispanic/Latino/a, Biracial, etc.)
- 
10. What license/degree did your therapist/counselor hold?
- (1) Social worker
  - (2) Counselor (Master's degree in counseling or psychology)
  - (3) Psychologist (PhD or PsyD)
  - (4) Psychiatrist (M.D.)
  - (5) Other (write in): \_\_\_\_\_