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**Client and Practitioner Perspectives on Multicultural Counseling
Competence**

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Competence**

by

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Report

Presented to the Faculty of the Graduate School
of the University of Texas at Austin
in Partial Fulfillment
of the Requirements
for the Degree of
Master of Arts

The University of Texas at Austin

May 2012

Client and Practitioner Perspectives on Multicultural Counseling Competence

by

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The University of Texas at Austin, 2012

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Abstract: As the population of the United States becomes more diverse, it is important that research be done to inform the implementation of psychological services that meet the needs of a wide variety of ethnic and socioeconomic groups. Research suggests that minority and low-SES clients with mental health disorders are underserved and receive inferior care when they do receive treatment. Although a large body of theory on multicultural counseling competence (MCC) has been developed over the last 30 years, little empirical research has been done in this area. This research proposal reviews the current research and theory and proposes the development and norming of a consumer measure of MCC.

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Introduction

The United States Census Bureau estimates that ethnic and cultural minorities currently make up one third of the total population of the U.S., and predicts that minorities will become a majority by 2042 and will make up 54% of the population by 2050 (U.S. Census Bureau, 2001). National surveys also show that approximately 21% of adults have a diagnosable mental health or addictive disorder and up to 9% of adults suffer from functional impairment as a result of mental illness (U.S. Department of Health and Human Services [USDHHS], 1999). Ethnic and cultural minorities experience mental health disorders at the same rate as the general population, yet research suggests that minorities with mental health disorders are underserved and receive inferior care when they do receive treatment (Constantine, 2007; Davis, 2007; Hernandez & Issacs, 1998; Knitzer, 1982; Roizner, 1996; Smedley, Stith, & Nelson, 2002; Sue, Arredondo, & McDavis, 1992; USDHHS, 2008). The current disparities in mental health care are troubling, and with the increasing diversification of the United States, it appears that they may grow more problematic with time. Thus, it is essential that research be done to inform and assist the creation and implementation of effective services that meet the needs of a wide variety of ethnic and cultural groups. If psychologists wish to remain a viable resource to the communities they serve, they must possess the skills to work effectively with diverse minority populations.

Professional organizations have also acknowledged the need for mental health practitioners who can work successfully with diverse clientele. The American Psychological Association's 2003 *Guidelines on Multicultural Education, Training,*

Research, Practice, and Organizational Change for Psychologists and the American Counseling Association's 2005 revised *ACA Code of Ethics* both highlight the importance of understanding and addressing multiculturalism in the therapeutic relationship. Although multicultural counseling competence is seen by many as central to the effectiveness of practitioners in an increasingly diverse society, little empirical research exists to inform best practice in this area (Fuentes, Bartolomeo, & Nichols, 2001; Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001). The importance of examining the role of multicultural counseling competence when working with clients has been noted in the research (Constantine & Ladany, 2001).

One hindrance to research in multicultural competence is a lack of viable assessment options; it will be difficult to improve the effectiveness of psychological practices until researchers can be sure that they are measuring those practices in a reliable and valid manner. The bulk of the standardized measures currently available are self-report measures that are completed by practitioners regarding their own perceived multicultural competence (e.g., D'Andrea, Daniels, & Heck, 1991; Gamst et al., 2004; Holcomb-McCoy & Meyers, 1999; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; Sadowsky, Taffe, Gutkin, & Wise, 1994). The practitioner self-report measures are based largely on the well-regarded multicultural competence guidelines set forth by D. W. Sue, P. Arredondo, and R. McDavis (1992). Unfortunately, subsequent research has found no significant relation between scores on practitioner self-report measures and other accepted measures of cultural competence, such as multicultural case conceptualization ability (Constantine & Ladany, 2000; Ladany, Inman, Constantine, & Hofheinz, 1997).

Practitioner self-report measures also present an incomplete (and possibly erroneous) representation of multicultural competence as experienced by the client. The need to obtain a consumer perspective on the multicultural counseling competence of practitioners is well-documented in the literature (e.g., Fuertes et al., 2001; Fuertes & Brobst, 2002; Gamst et al., 2004; Pope-Davis et al., 2001). An understanding of how consumer perspectives relate to existing practitioner self-assessments is crucial to developing a more complete picture of multicultural competence and the manner in which it is measured.

Recent efforts to create new instrumentation have made it possible to incorporate the client's perspective, a step that has long been anticipated by researchers in the field (e.g., Fuertes et al., 2001; Fuertes & Brobst, 2002; Gamst, Dana, Der-Karabetian, Aragon et al., 2004; Pope-Davis et al., 2001); however, these client measures are not founded in solid theory, and have either poor psychometric properties or have not been tested on an appropriate, diverse client population. In addition, the ways in which client perceptions compare to self-report measures of multicultural counseling competence have not yet been determined. The purpose of this study will be to develop and norm a client measure of multicultural counseling competence. For this measure, the results of Davis' 2003 study will be integrated with Sue et al.'s theory (1982, 1992, 1998) to create items that assess the cultural competence of mental health services from the client's perspective. The reliability and the content and construct validity of the instrument will be established in order to determine the viability of its use in community health settings, as well as in subsequent research. The present study will also examine the constructs measured by

client assessments of multicultural counseling competence and how those constructs relate to the constructs measured by practitioner self-assessments.

Literature Review

The following literature review presents an overview of the literature on practitioner multicultural competence in the mental health fields. Because multicultural competence cannot be understood fully without context, this analysis will provide a brief summary of the history of the multicultural competence movement in psychology, including discussion of the most prevalent controversies within the field. There is currently a lack of expert agreement on a singular definition of multicultural competence, so this analysis will describe the most widely accepted theories, and discuss the implications that this lack of agreement has on the available research. This analysis will also review the available methods and instruments for measuring the construct, including the strengths and weaknesses of each approach, and discuss the most prevalent themes throughout the research.

History

The American Psychological Association (APA) published its *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (2003) with the goal of guiding current and future psychological practice, as well as training, education, and research. Though relatively new, these guidelines were preceded by more than 40 years of attention to multicultural issues in applied psychology and were in the process of development for 22 years before they were finally approved. An appreciation of the history of the multicultural movement in applied psychology, as

well as past and present controversies surrounding the movement, is integral to understanding research in this area.

Attention to multicultural issues in applied psychology is a relatively new development; it is only within the last 60 years that leaders in the field of psychology have begun to acknowledge the need for an expanded understanding of multicultural issues and an increased awareness of the importance of this understanding to working with clients. The Civil Rights movements of the 1950s and 1960s jumpstarted these changes by creating forums for political activism and subsequent public policy initiatives that began the conversation about multicultural competence in earnest (Constantine & Sue, 2008). By the late 1960s and early 1970s, the Association of Black Psychologists (ABP) and the Asian American Psychological Association (AAPA) were formed to work toward the elimination of racially biased research and establish training programs in which cultural issues were included (Robinson & Morris, 2000). Greater visibility of psychologists of color in the profession led to the development and spread of research related to racial and ethnic minorities during this period as well (American Psychological Association [APA], 2003). For example, in 1971 the National Institute of Mental Health (NIMH) established an Office of Minority Research. The historic 1973 Vail Conference on Professional Training in Psychology also addressed the lack of attention paid to diversity in psychology (Korman, 1974), and in the same year, the APA began to create formal structures to research and discuss mental health and equity issues as they pertained to minorities (Constantine & Sue, 2008). The APA's Office of Ethnic Minority Affairs was formally established in 1979 (APA, 2003). In spite of these changes, few

psychologists at that time viewed racial and ethnic minority concerns as a priority (Robinson & Morris, 2000), and many others were resistant to change in this area. These problems have persisted to the present day (Sue, et al., 1998; Sue & Sue, 2008).

Today, there still exists some controversy surrounding the importance of multicultural counseling competence, and many well-respected psychologists in the field also take issue with aspects of the movement. In some factions, there is disagreement about the need to study multicultural counseling competence at all. Arguments in this vein are centered on the idea that solid, research-based techniques are universally effective and equally applicable, that “good counseling is good counseling” (Sue et al., 1998, p. 28). This viewpoint, referred to as “ethnocentric monoculturalism” by Sue and colleagues (1998, p. 28), has been the source of substantial controversy in recent years. Proponents of multicultural competence assert that this view is oppressive and culturally racist (Sue et al., 1998), while opponents argue that a universal perspective is central to the practice of psychology, and that within-group differences are as large or larger than between-group differences (Weinrach & Thomas, 1996).

In addition, there is disagreement regarding the shape that the multicultural counseling movement has taken over the years. Much of the most prominent research in the area has been focused primarily on the four major racial/ethnic groups in the United States (African Americans, Asian Americans, Hispanics/Latinos, and Native Americans), and critics have raised concerns about the ethics of focusing on such a narrow group when studying diversity (Weinrach & Thomas, 1996). In response, while acknowledging that the issue is a valid concern, proponents of an increased focus on cultural

competence argue that change must begin somewhere, and that waiting for perfection is the more grievous error (Sue et al., 1998).

Though key points have been made by both sides in this discussion, these arguments continue to be primarily philosophical and rhetorical, as minimal empirical research has been done to support either viewpoint. In spite of this, the APA and other major organizations have begun to officially recognize the importance of culturally competent practice, and the increased focus on appropriate practices and adequate training highlight the value of further research in this area.

Defining Multicultural Counseling Competence

Beginning with *Position Paper: Cross-Cultural Counseling Competencies*, the 1982 paper written by Sue et al., the field of applied psychology began to produce a number of important and influential works on the topic of multicultural competence. In this groundbreaking paper, Sue et al. presented the tripartite model of multicultural counseling competency that still forms the basis of most research and theory in this area today. Sue and colleagues defined multicultural counseling competency as counselors' ability to (1) recognize their personal attitudes and values around race and ethnicity, (2) develop their knowledge of diverse cultural worldviews and experiences, and (3) identify effective skills in working with clients of color. The group also defined 11 specific competencies within these three categories and recommended that the APA and graduate programs for mental health professionals adopt these competencies as minimal standards.

This framework has guided training, research, and education in the area of multicultural counseling competence since its creation (Fuentes et al., 2001).

In 1992, the Professional Standards Committee of the Association for Multicultural Counseling and Development (AMCD) expanded this tripartite model to a 3x3 matrix model that crossed the original three dimensions of competence with three new counselor characteristics (Sue et al., 1992). The three desired characteristics of multiculturally competent counselors included (1) awareness of personal assumptions, biases, and values; (2) understanding the worldviews of culturally diverse clients; and (3) developing abilities to use and create culturally appropriate intervention strategies (Sue et al., 1992). The original 11 specific competencies were expanded to include 31 total statements across the nine competency areas. The authors of this revision also clarified their intent by noting that these competencies were created primarily for the four major ethnic and racial minority populations in the U.S.: African Americans, Asian Americans, American Indians, and Hispanics and Latinos, a decision that has since been used by opponents of the multicultural competence movement to discredit its principles (Sue et al., 1998). Shortly after the publication of Sue et al.'s paper, one of the authors produced a supplemental paper that formally defined and operationalized the constructs and competencies from the 1982 version of the model that had proved confusing (Arredondo et al., 1996).

In 1998, the third major revision to Sue et al.'s multicultural counseling competencies was published (see Appendix A). Changes made to the competencies in this revision reflected emerging research in racial and ethnic identity models and

expanded the definition of a counselor's role in working with minority populations (Constantine & Sue, 2008); the "identifying effective skills in working with clients of color" dimension was expanded to include three new competencies in this area. In addition, the characteristics of multiculturally competent organizations were described and operationalized (Sue et al., 1998). In general, the 1998 revision of the multicultural counseling competencies underscored the need to incorporate change at the systemic and mesocosmic levels, as well as at the individual level (Constantine & Sue, 2008). In 1999, Arredondo published another response paper to address confusion and criticisms surrounding this model (Arredondo, 1999). In this paper, she further emphasized the primary importance of race and ethnicity in creating these guidelines, while noting that other dimensions of identity (sexuality, gender, religion, etc.) are also important.

In 1990, the Board of Ethnic Minority Affairs approved the APA's first set of guidelines for multicultural counseling competence. The APA's *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (1993) emphasized the importance of knowledge and skills in working with diverse clients, categories similar to two of the three ability categories named in Sue et al.'s 1982 position paper, though the document is not based on Sue et al.'s work. In particular, the African American population is conspicuously absent from the APA's definition of "ethnic, linguistic, and culturally diverse populations": in the introduction to the document, the APA stated, "Populations of concern include, but are not limited to, the following groups: American Indians/Alaska Natives, Asian Americans, and Hispanics/Latinos. For example, populations also include recently arrived refugee and

immigrant groups and established U. S. subcultures such as Amish, Hasidic Jewish, and rural Appalachian people” (p. 2). The APA’s definition of diverse populations thus appeared to be less focused on race than the definition assumed by Sue et al. (1982) and more focused on other aspects of identity.

Based on this definition of diverse populations, the APA Board of Ethnic Minority Affairs (1993) set forth four important abilities for multicultural assessment and intervention: (1) recognizing cultural diversity, (2) understanding the role that culture and ethnicity/race play in the sociopsychological and economic development of ethnic and culturally diverse populations, (3) understanding that socioeconomic and political factors significantly affect the psychosocial, political, and economic development of ethnic and culturally diverse groups, and (4) helping clients to understand/maintain/resolve their own sociocultural identification; and understand the interaction of culture, gender, and sexual orientation on behavior and needs. Using these guiding principles, they then detailed 25 guidelines for working with diverse populations. In contrast to the minimum standards set forth by Sue et al. (1982), the APA intended their 1993 guidelines to be “aspirational in nature” (p. 2).

In 2003, the APA published its *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA Multicultural Guidelines), building on the evolving guidelines for multicultural counseling competence outlined by Sue et al. (1982, 1992, 1998) and the supplemental response papers written by Arredondo and colleagues (1996, 1999). The APA Multicultural Guidelines are grounded in six foundational principles that are meant to “articulate respect and

inclusiveness for the national heritage of all groups, recognition of cultural contexts as defining forces for individuals' and groups' lived experiences, and the role of external forces such as historical, economic, and socio-political events" (APA, 2003, p. 382). The six guidelines are:

Guideline #1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.

Guideline #2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.

Guideline #3: As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.

Guideline # 4: Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.

Guideline #5: Psychologists strive to apply culturally appropriate skills in clinical and other applied psychological practices.

Guideline #6: Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices (APA, 2003).

The APA Multicultural Guidelines "represent a hallmark in the movement toward including multicultural initiatives in the field of psychology. These multicultural guidelines imply that all psychologists should engage in culturally relevant education, training, research, practice and organizational development" (Constantine & Sue, 2008, p. 98). Though nearly 40 years in the making, with the creation of the APA Multicultural Guidelines, the greater psychological community has taken steps to offer strong support

to issues of multicultural counseling competence and to encourage further research in the area. The authors of the APA Multicultural Guidelines also intended for the document to change as new research emerged, and assigned the guidelines an expiration date of 2009 to ensure that this would happen (APA, 2003).

The APA Multicultural Guidelines also acknowledged the ambiguity and controversy surrounding the language used to discuss multicultural counseling competence, and offer definitions of some of the most contested and commonly confused terms (APA, 2003). The APA's definitions are those used in this review:

Culture is “the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, care taking practices, media, educational systems) and organizations” (APA, 2003, p. 7)

Race is “the category to which others assign individuals on the basis of physical characteristics, such as skin color or hair type, and the generalizations and stereotypes made as a result” (APA, 2003, p. 8).

Ethnicity is “the acceptance of the group mores and practices of one's culture of origin and the concomitant sense of belonging” (APA, 2003, p. 9).

Multiculturalism and **Diversity** are used interchangeably. They are defined as “dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions” (APA, 2001, p. 10).

In 2008, the APA published the *Report of the APA Task Force on the Implementation of the Multicultural Guidelines* (APA, 2008). In this report, the task force acknowledged that “diversity issues are addressed in a very disparate and uncoordinated manner that undermines the stated goal of the association to enhance diversity across

APA” (p. 6). Among their recommendations were the creation of an Office on Diversity Enhancement and the hiring of a Chief Diversity Officer who would coordinate and lead all APA efforts to improve the way that issues of diversity are addressed within the organization. The task force also made a number of recommendations for how trainers and researchers can improve the ways in which they address multicultural issues. In April 2011, the APA announced that the Multicultural Guidelines were under review, and the expiration date for this document, originally set for 2009, had been extended to 2012 (APA, 2011).

Measuring Cultural Competence

In spite of the rich history of theory in multicultural counseling competence, little empirical research has been done in the field (Gamst et al., 2004). This dearth of research may be due in part to a lack of appropriate instrumentation; most of the multicultural counseling competence measures currently available are self-report measures to be completed by practitioners. The most widely researched of these self-report measures are based on Sue et al.’s 1982 tripartite model of cultural competence. These scales include the Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D’Andrea et al., 1991), the Multicultural Counseling Inventory (MCI; Sadowsky et al., 1994), the Multicultural Competency and Training Survey (MCCTS; Holcomb-McCoy & Myers, 1999), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002), and the California Brief Multicultural Competence Scale (CBSMCS; Gamst et al., 2004). The primary use of these measures in the current literature is to evaluate the effectiveness of training programs in providing multicultural competence training.

The Multicultural Awareness/Knowledge/Skills Survey (D'Andrea et al., 1991) is a 60-item, 4-point Likert-type self-report scale consisting of three subscales measuring Awareness, Knowledge, and Skills. The MAKSS was designed to be given before and after training to assess students' development in key areas of multicultural counseling competence. The authors of the scale demonstrated acceptable construct and criterion-related validity, as well as good reliability in a sample of 90 graduate students from a large Western university (D'Andrea et al., 1991).

The Multicultural Counseling Inventory (Sodowsky et al., 1994) is a 40-item, 4-point Likert-type self-report scale consisting of four subscales measuring Multicultural Counseling Awareness, Multicultural Counseling Knowledge, Multicultural Counseling Skills, and Multicultural Counseling Relationship. The authors of the MCI chose to expand Sue et al.'s 1982 tripartite model by including a relationship dimension; they hoped that the addition of the fourth scale would improve the instrument's ability to accurately measure an aspect of multicultural counseling competence that they believed had been neglected in previous instrumentation. Psychometric properties of the MCI were obtained in a series of studies using graduate students, counselors, and psychologists from a Midwestern university. Estimates of content validity, criterion-related validity, and reliability have supported the reliability and validity of the MCI (Sodowsky et al., 1994; Ponterotto & Alexander, 1996).

The Multicultural Competency and Training Survey (Holcomb-McCoy & Myers, 1999) is a 61-item, 4-point Likert-type self-report survey consisting of five scales, including Knowledge, Awareness, Definitions (the ability to define multicultural

counseling terms the authors deemed important), Racial Identity Development, and Skills. The MCCTS was developed to determine professional counselors' perceptions of their multicultural counseling competence, as well as the adequacy of their training (Holcomb-McCoy & Myers, 1999). Because the authors' intent was to survey attitudes for their study and not to create a measure, validity and reliability have not been estimated for the MCCTS.

The Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002) is a 32-item, 7-point Likert-type scale consisting of only two scales: Knowledge and Awareness. The MCKAS is a revised version of an earlier scale (Multicultural Counseling Awareness Scale–Form B, MCAS-B) created by the same primary author, and that measured only Awareness. The authors of the scale demonstrated good content, criterion-related, and construct validity, and good reliability in a pair of large studies using samples of students and professionals in counseling and counseling psychology in the Northeast (Ponterotto et al., 2002).

The California Brief Multicultural Competence Scale (Gamst et al., 2004) is a 21-item, 4-point Likert-type scale that assesses multicultural competence in four areas: Nonethnic Ability, Sensitivity to Consumers, Multicultural Knowledge, and Awareness of Cultural Barriers. The CBMCS was developed from four pre-existing multicultural counseling competency measures (the CCCI-R, MAKSS, MCAS-B, and MCCTS) to address some of the concerns that had been raised in the literature regarding these scales. The CBMCS has shown good content validity, criterion-related validity, and reliability in

a series of large (n = 415) studies done using responses from mental health providers practicing in Southern California (Gamst et al., 2004).

Self-report multicultural counseling competence measures have been used to some extent in counseling research, and they have provided an important first step in assessing multicultural counseling competence (Constantine & Ladany, 2001). However, several concerns have been raised about the limitations of these measures. Social desirability contamination is one potential limitation of these self-report rating scales (Constantine & Ladany, 2001; Fuertes et al., 2001; Pope-Davis & Dings, 1995; Pope-Davis et al., 2001; Sue, 1996). This possible contamination has been studied extensively, although contradictory results have emerged. Gamst et al. (2004), Ponterotto et al., (1996), and Sadowsky et al. (1994) reported nonsignificant correlations between a measure of social desirability and their self-report measures of multicultural counseling competence. In contrast, Sadowsky, Kuo-Jackson, Richardson, & Corey (1998) and Worthington et al. (2000) found a significant positive relation between self-report scores on the MCI and a measure of social desirability. Constantine and Ladany (2000) also found a significant positive relationship between social desirability and certain subscales of multicultural counseling competence inventories.

Researchers have also noted that there appears to be a lack of clarity and agreement about what these self-report measures actually assess (Pope-Davis & Dings, 1995; Sue, 1996). Although all these measures are based on Sue et al.'s 1982 tripartite model, factor analyses performed on the scales reveal that they vary in the number of factors they actually assess. For example, the CBMCS and MCI have both shown four

factors (Gamst et al., 2004; Sadowsky et al., 1994), the MAKSS has three (D'Andrea et al., 1991), the MCCTS has five (Holcomb-McCoy & Myers, 1999), and the MCKAS has only two (Ponterotto et al., 2000). The differing numbers of factors that have emerged from these scales may indicate that the theoretical orientation on which they are based does not really assess three underlying constructs. In spite of these findings, Sue et al.'s 1982 conceptualization of multicultural counseling competence has gone mostly unchallenged by other scholars, a limitation noted by some researchers in the field (Constantine & Ladany, 2000).

Another commonly cited concern is that these inventories “measure anticipated rather than actual behaviors or attitudes correlated with multicultural competence” (Constantine & Ladany, 2001, p. 485; see also Constantine, Gloria, & Ladany, 2002; Fuertes et al., 2001; Pope-Davis & Dings, 1995; Pope-Davis et al., 2001; Sue, 1996). Indeed, findings suggest no statistically significant relation between self-reported multicultural competence and written multicultural case conceptualization ability, a measure of demonstrated multicultural competence (Constantine & Ladany, 2000; Ladany et al., 1997) or observer ratings of multicultural competence (Worthington, Mobley, Franks, & Tan, 2000). Such concerns have raised questions about the completeness and accuracy of current models and have led to suggestions that client input may also play an important role in furthering understanding of multicultural counseling competence (Fuertes et al., 2001; Pope-Davis et al., 2001).

The Cross-Cultural Counseling Inventory–Revised (CCCI-R; LaFramboise, Coleman, & Hernandez, 1991) is an instrument that addresses some of the issues raised

by self-report measures. The CCCI-R is 20-item, 6-point Likert-type instrument designed for use by a supervisor in evaluating the competency of a practicing counselor during observation of a cross-cultural counseling session (LaFramboise et al., 1991). The CCCI-R is also based on Sue et al.'s 1982 tripartite model. However, although it contains questions in three areas (Cross-Cultural Counseling Skill, Sociopolitical Awareness, and Cultural Sensitivity), factor analysis suggests that it measures only one factor (LaFramboise et al., 1991). Scale authors verified psychometric properties using a sample of 86 university students; the scale is reported to demonstrate good content, construct, and criterion-related validity (Sabnani & Ponterotto, 1992), as well as good reliability (LaFramboise et al., 1991). One of the limitations of the CCCI-R is that the rater must have a good understanding of cultural competence, which is not a possibility in many situations (Constantine & Ladany, 2001).

Though the CCCI-R solves some of the limitations of self-report measures, when used properly, it still does not allow client input regarding a practitioner's multicultural counseling competence. Many theorists in the field have called attention to the need for consumer input when determining the components of cultural competence (e.g. Fuertes et al., 2001; Pope-Davis et al., 2001). In this vein, recent attempts have been made by some researchers to incorporate client perceptions of multicultural competence into assessment of practitioner's abilities in this area (Cornelius, Booker, Arthur, Reeves, & Morgan, 2004; Davis, 2007). Though no psychometrically sound client measures are currently available, there are instruments-in-progress and unvalidated instruments being used in some settings.

In spite of the fact that the above-mentioned CCCI-R has never been appropriately normed on a client population, it has been modified for use in research as a client measure. In 2002, Constantine used a modified version of the CCCI-R to assess the perceptions of 112 students of color at Columbia University regarding their counselor's multicultural counseling competence. Setting aside potential issues stemming from a lack of client norms, in this case the CCCI-R was used as a client measure with students seeking mental health services at a major research university—an extremely well-educated population that is not representative of most clients seeking mental health services at a community mental health center.

Attempts have also been made to create and norm a client measure for use in a community setting. In 1997, the state of Maryland reworked its mental health care system, naming consumer satisfaction, evaluation, and cultural competence as high priorities for the new system (Arthur et al., 2005). The Maryland Mental Hygiene Administration/Maryland Health Partners (MMH/MHP) was unable to find a validated, reliable, normed measure to assess client perceptions of multicultural counseling competence, so they developed a consumer assessment tool for measuring cultural competence (Arthur et al., 2005). The result of this effort, the Cultural Competency Inventory (CCI; Cornelius et al., 2004), is a 52-item, dichotomous consumer feedback instrument measuring the cultural competence of mental health providers. After testing the psychometric properties of the scale, the authors acknowledged that “more work is needed to fine tune the scale” (Cornelius et al., 2004, p. 201). Limitations of the scale mentioned by the authors include its length—which they believe could be shortened—

and the small sample size of clients of Asian American and Native American descent included in their study (Cornelius et al., 2004).

The authors claim that they have established good content and construct validity, as well as good reliability (Cornelius et al., 2004); their statements regarding content validity are reasonable, but the construct validity and reliability of the scale are questionable. The scale's theoretical basis is in unidentified social work literature on cultural competence; although some social work theories of cultural competence are similar to Sue et al.'s 1982 tripartite model, they do differ in some aspects. The authors of the CCI named eight aspects of multicultural counseling competence in the social work literature which they used to create items for the CCI: (1) communication ability/access to interpreters, (2) understanding of indigenous practices, (3) acceptance of cultural difference, (4) awareness of patient's culture, (5) respectful behaviors, (6) awareness of patient and provider values, (7) consumer involvement, and (8) community outreach (Cornelius et al., 2004). Principal components analysis (PCA) performed on the CCI indicated that the scale likely measures four components (Cornelius et al., 2004), with the majority of the items written in the eight areas loading significantly on one of these four components. Items from the eight scales are divided between the components, however, without a clear pattern. From this research Cornelius and colleagues (2004) concluded that their arrangement of subscales needs improvement, although they offered no interpretation of these four components and made no attempt to calculate reliability estimates for the rearranged scale.

In addition, the use of PCA is questionable in this case. It appears that the authors intended to look at the underlying factor structure of the measure in order to explain common variance; they repeatedly refer to the four components as “factors” (Cornelius et al., 2004). Factor analysis, which uses the common variances on the diagonal in the analyzed matrix, is a more appropriate method of analysis for this task. PCA, which uses the value 1 on the diagonal in the analyzed matrix, creates summaries of observed variables to explain total variance. The authors of the CCI also chose to use a more liberal estimate of sufficient sample size when using PCA to examine the psychometric properties of their measure. Their sample size of $N = 238$ for a measure containing 52 questions is large enough using the rule of thumb that a minimum of 100 is sufficient for factor analysis (e.g., Sapnas & Zeller, 2002), but is not sufficient for more conservative estimates that a minimum of 5 cases per variable is necessary. The failure of the instrument’s authors to interpret the components, the questionable use of PCA, and the smaller sample size call into question the construct validity of the measure and indicate that further investigation is needed.

Reliability claims for the CCI are also questionable. For the overall measure, the investigators found that Cronbach’s $\alpha = 0.92$, which is acceptable, but the coefficient alpha values for the eight individual subscales were all lower than acceptable minimums, ranging from 0.08 to 0.69 (Cornelius et al., 2004). No attempt was made to calculate reliability estimates for the measure using a four- factor structure. This is an indicator that work needs to be done to refine these scales before reliability can comfortably be assumed.

Given the poor psychometric properties of the CCI and the fact that all widely available practitioner self-report measures are based on Sue et al.'s model, it would be difficult to effectively compare client and practitioner conceptions of multicultural competence using the CCI.

A second attempt at creating a client measure of multicultural counseling competence was begun by Davis in her 2007 mixed-methods study investigating clients' conceptions of multicultural counseling competence. Taking a systems of care lens and focusing primarily on agencies' work with children and their families, Davis used concept mapping to organize the results from a large qualitative study examining clients', practitioners', and administrators' views of what multicultural counseling competence meant to participants in a community health setting. Her sample consisted of 186 diverse adult subjects from four community health sites across Texas, in both rural and urban areas. Davis performed a cluster analysis using responses to a questionnaire created using qualitative data from focus group discussions about cultural competence. In this analysis, Davis was able to identify 15 groups of statements that reflect the perceptions of clients, practitioners, and administrators who receive mental health services (see Appendix B). These 15 categories include some categories and statements that apply only to agencies or practitioners, but also include a number of statements that directly reflect the views of typical consumers of community mental health services. Unfortunately, Davis did not continue with this project, and has never created a client measure using the results from her qualitative study.

Other Research in Multicultural Counseling Competence

Because the field lacks adequate instrumentation, most of the research in multicultural counseling competence has focused on creating and examining measures that can be used to assess the construct. However, a few researchers have also investigated tangentially related aspects of multicultural competence that do not require the use of a psychometrically validated measure. This research does not directly assess multicultural counseling competence, but has looked at issues that may inform a better understanding of what multicultural competence means. It may also offer insight into why cultural competence is important: if better outcomes result from counseling situations that are assumed to be culturally competent, this finding provides evidence of the importance of culturally competent counseling.

Much of this related research has been done in the area of client-practitioner racial/ethnic match, with the assumption that cultural competence is inherent in this situation. Unfortunately, results in this research are mixed, so no definite conclusions can be reached. Some researchers have found that ethnic match does not result in a significant difference in outcomes (Global Assessment of Functioning scores [GAF] and recurring need for treatment) for children or adolescents in counseling situations, regardless of race (Gamst, Dana, Der-Karabetian, & Kramer, 2004). Other researchers have found that there *are* significant differences in adolescent outcomes, including higher GAF scores and a lower dropout rate, for ethnically matched client-practitioner pairs, and that this difference did not vary across races (Yeh, Eastman, & Cheung, 1994). Still others have found significant differences in outcomes (GAF and recurring need for treatment) for

some groups of matched vs. nonmatched adult and older adolescent clients, though this varied by race (Gamst, Dana, Der-Karabetian, & Kramer, 2000).

These inconclusive results clearly indicate that more research needs to be done in this area, and may also point to problems with research design of such studies. The link between cultural competence and shared racial background has not yet been empirically established, and seems assumptive at best. None of these research groups used an index of multicultural competence or a measure of overall counseling ability as covariates in their research, which may have contributed to the variability in their results.

Proposed Research Study

Statement of Problem

With the increasing diversification of the US population, multicultural counseling competence has become an important focus for many mental health providers, but little research exists to inform best practice in this area. Issues in multicultural counseling competence are particularly salient for those who work with children and families, as even less research has been done on cultural competence with these groups; families from diverse backgrounds form the bulk of those seeking services in many areas of the country. Current research in multicultural counseling competence has failed to take into account client perspectives of practitioner's abilities in this area, and has relied almost exclusively on self-report measures to determine competence. Attempts to measure the effects of cultural competence without adequate instrumentation have been inconclusive, and have further illustrated the need to improve the way in which cultural competence is measured (Gamst, Dana, Der-Karabetian & Kramer, 2000, 2004; Yeh, et al., 1994). Recent efforts to create new instruments have made it possible to incorporate the client's perspective, a step that has long been anticipated by researchers in the field (e.g. Fuertes et al., 2001; Fuertes & Brobst, 2002; Gamst, Dana, Der-Karabetian, Aragon et al., 2004; Pope-Davis et al., 2001); however, these measures are still under development and have not yet been incorporated into the existing psychology research on multicultural counseling competence. Perhaps most importantly, the ways in which client perceptions compare to self-report measures of multicultural counseling competence have not yet been determined.

The purpose of this study will be to compare family therapists' self-ratings and parent ratings of multicultural counseling competence. This study will first examine the psychometric properties of an existing measure to ensure its viability for use in research. The study will also provide clarity about the relations between practitioner self-report ratings of cultural competence and parent-client ratings of cultural competence. Finally, it will examine how race and SES affect parent-client ratings of practitioners' cultural competence.

Research Questions and Hypotheses

Research Question 1

Is the structure of the Cultural Competency Inventory proposed by Cornelius et al. (2004) reasonable?

Hypothesis 1

It is expected that the four-component structure of the CCI proposed by Cornelius and colleagues (2004) will be replicated.

Rationale

Principal components analysis on the measure revealed that the majority of the items loaded significantly onto one of four components (Cornelius et al., 2004), and these components appear to be interpretable. Although PCA was not an ideal method of analysis, and the sample size used was slightly too small by more conservative estimates, it is expected that Cornelius et al.'s proposed structure is a reasonable approximation that simply needs to be verified.

Research Question 2

When rearranged in accordance with a more appropriate factor structure, do the subscales of the Cultural Competency Inventory meet acceptable minimums for instrument reliability?

Hypothesis 2

It is expected that the subscales of the CCI will meet acceptable minimums for reliability after being rearranged and edited to remove poorly written and construct-irrelevant questions.

Rationale

The overall measure has shown good reliability, with Cronbach's $\alpha = .92$ for the measure as a whole (Cornelius et al., 2004). The eight individual scales need to be rearranged into subscales corresponding with the four indicated components, and a number of questions need to be removed, but it seems reasonable that the individual scales will demonstrate acceptable reliability after these changes have been made.

Research Question 3

Do self-reports and client ratings assess the same constructs, or are the constructs being measured specific to the instrument?

Hypothesis 3

It is expected that self-report measures and client rating scales will assess the same constructs, but that a methods factor will emerge, indicating that the method of measurement (i.e. the respondent) affects scores.

Rationale

Both the CCI and the CBMCS have been influenced by the APA's Multicultural Guidelines and by the guidelines set forth by Sue and colleagues. Though the authors of the CCI have yet effectively to establish reliability and validity for their measure, the instrument is promising and this study should help to demonstrate that the measure is both valid and reliable. The CBMCS has been shown to have acceptable reliability and validity for measuring the constructs it purports to measure. In addition, both teams of researchers have found four factors represented on their respective questionnaires, and it appears that these factors can be paired across measures. Though both instruments appear to measure the same constructs, respondent differences have been noted in the past. Research has shown that self-ratings on multicultural competence scales do not correlate with observer measures of cultural competence (Worthington et al., 2000) or with multicultural case conceptualization ability (Constantine & Ladany, 2000; Ladany et al., 1997). Although minimal research has been done in this area, self-report measures have not been found to correlate with any other measures of multicultural counseling competence currently available, indicating that the constructs assessed through these measures differ by respondent.

Research Question 4

Do parent ratings of therapists' multicultural counseling competence vary by race and/or by SES?

Hypothesis 4

It is hypothesized that parent ratings of multicultural counseling competence will vary by race and by SES.

Rationale

A literature review showed that no studies have been done to assess how client satisfaction with practitioner multicultural counseling competence varies by race of the client. Although general measures of satisfaction have been shown not to correlate with demographics (e.g. Gerkenmeyer, Austin & Miller, 2006), these studies have not focused specifically on the question of satisfaction as it pertains to multicultural counseling competence. Because race and SES are not the focus of their inquiry, researchers often take minimal steps to ensure adequate participation from diverse groups, which results in extremely small sample sizes of minority clients and reduces their power to detect differences. The proposed study places a large focus on ensuring adequate representation from all groups, and will thus have sufficient power to find these differences, should they exist. In addition, a 1999 study by Holcomb-McCoy and Myers found that practitioner self-report measures of cultural competence vary by race, which may translate to differences in client perceptions.

Method

Participants

Participants will be the parents/ guardians of families who receive family therapy services, and the practitioners who work with them. Practitioner participants will be

randomly selected using a mailing list obtained from one of the major professional psychology or counseling organizations. In order to ensure geographical and cultural diversity, a minimum of fifty sites will be chosen to participate. The sites will include at least twenty urban and twenty rural settings, and will be asked to participate based on the diversity of the population served. Racial and cultural diversity of the sites is paramount, as the study will need sufficient representation from a wide variety of groups to determine whether socio-economic or racial differences exist in perceptions of practitioners' cultural competence. Sites will be chosen to ensure that no single race forms a majority of the respondents, and that there are respondents from across the SES spectrum. A G*Power analysis, assuming a medium effect size, indicated that a sample size of 535 practitioner-client pairs would produce a minimum power of 0.95 for all analyses.

Instrumentation

The California Brief Multicultural Competence Scale (CBMCS; Gamst, Dana, Der-Karabetian, Aragon, Arellano, Morrow & Martenson, 2004; Appendix A): The CBMCS is designed to assess practitioners' perceptions of their own multicultural counseling competency. The CBMCS is a brief self-report instrument, developed from four pre-existing multicultural counseling competency measures (the CCCI-R, MAKSS, MCAS-B, and MCCTS). Theoretically, the CBMCS is based on D. H. Sue's 1982 tripartite model of multicultural counseling competency, although factor analysis performed on the measure by its authors suggests a four-factor model to be most appropriate. Thus, the measure consists of 21 Likert scale items that assess multicultural competence in four

areas: Nonethnic Ability, Sensitivity to Consumers, Multicultural Knowledge, and Awareness of Cultural Barriers. These four underlying factors were found to account for 59% of the total variance in a large ($N=415$) study of practitioners in Southern California. The measure has shown good internal consistency, criterion-related validity, and reliability (Gamst, Dana, Der-Karabetian, Aragon et al., 2004). Cronbach's alpha for the entire measure was 0.89, and alphas for each of the individual scales were 0.75 or higher. Criterion-related validity was demonstrated through the expected correlations with another, similar measure: the MCI. Scores on the CBMCS also do not appear to correlate significantly with measures of social-desirability (Gamst, Dana, Der-Karabetian, Aragon et al., 2004), a criticism leveled against other, similar instruments (Worthington, Mobley, Franks, & Tan, 2000).

Cultural Competency Inventory (CCI; Cornelius, Booker, Arthur, Reeves & Morgan, 2004; Appendix B): The CCI is a consumer assessment instrument designed to assess the cultural competency of mental health providers. It is a 52-item measure, consisting of 8 subscales (Awareness of Patients' Culture, Respectful Behaviors, Language Interpreter Issues, Understanding of Indigenous Practices, Consumer Involvement, Acceptance of Cultural Differences, Community Outreach, and Patient-Provider-Organization Interactions), which load on four un-named components (Cornelius, et al., 2004). The four un-named components correspond roughly to the four factors found on the CBMCS: Component 1 appears to correspond to the CBMCS Sensitivity to Consumers scale; Component 2 is similar to the Non-Ethnic Ability scale on the CBMCS; Component 3 consists of questions similar to those on the Awareness of Barriers scale; and Component

4 consists of questions similar to those on the CBMCS Multicultural Knowledge scale. The measure's creators reported good content validity, and reliability for the measure as a whole (Cronbach's $\alpha = .92$) with a diverse sample of 238 adult consumers who received mental health care across the state of Maryland, but failed to effectively establish construct validity or reliability for the individual subscales. Additionally, the authors of the scale provided no psychometric analysis of the measure as a four-factor scale, and have not yet taken steps to remove poor questions from the measure; this is of particular concern because many of the questions on the measure failed to load on any of the four components.

Demographics Form: Parents or guardians will fill out a demographic form with information including child age, diagnosis, gender, race(s), relationship to child, highest level of education, income, number of contact hours, etc. The practitioner working with the family will also fill out a similar form (See Appendix D).

Procedure

After receiving University IRB approval and confirming the participation of practitioners, research will begin. Parents or guardians will be asked to complete the CCI and a demographic form as a check out procedure after their first meeting with the practitioner, and will also complete the CCI after the fifth session, or after planned termination of therapy, should planned termination occur before five sessions. Unless the client terminates therapy unexpectedly before five sessions, the CCI completed after the fifth session will be the one used for this research. A local research assistant not involved

in providing services to the families will maintain confidentiality. Practitioners will be asked to complete the CBMCS and a demographic form after the first session, as well.

Analysis and Expected Results

First, the demographics of the sample will be checked to ensure that there is adequate representation across demographic groups (race and SES). Parent education level will be used as an approximation of SES, and the distribution will be checked to ensure that it is approximately normal. Chi-square analysis will be used to check for over- or under- representation of participants from each of the five primary racial groups in the United States (Caucasian, Asian American, African American, Native American/Alaskan Native, and Hispanic/Latino). All analyses will use a 0.05 significance level.

Hypothesis 1

It is hypothesized that the four-component structure of the CCI proposed by Cornelius and colleagues (2004) will prove accurate. In order to assess this hypothesis, confirmatory factor analysis (CFA) will be performed to assess the model. Results from CFA should indicate that a four-factor model yields interpretable factors similar to the components proposed by Cornelius and colleagues (2004).

Hypothesis 2

It is expected that the subscales of the CCI will meet acceptable minimums for reliability after being rearranged and edited to remove poorly written and construct-irrelevant questions. To assess this hypothesis, Cronbach's alphas will be calculated on the

individual subscales, as well as on the measure as a whole. In addition, alpha values will be calculated as if each question was removed, and questions that are not found to contribute to the overall reliability of the measure will be removed.

Hypothesis 3

It is expected that self-report measures and client rating scales will assess the same constructs, but that a methods factor will emerge. To assess this hypothesis, a Multitrait Multimethod Matrix (Campbell & Fiske, 1959) will be computed and analyzed to assess the convergent and discriminant validity of the subtests for each of the two measures. Reliability coefficients along the main diagonal (monotrait- monomethod values) should consistently be the highest values in the matrix, indicating that the measures both have acceptable reliability. It is expected that coefficients in the validity diagonals (monotrait- heteromethod values) will be significantly different from zero, indicating evidence of convergent validity, and will be higher than the other values in the corresponding row and column in the same heteromethod block, indicating discriminant validity. Values in the heterotrait-monomethod triangles should be moderate because moderate correlations between the factors measured within each of the scales have previously been found (Cornelius et al., 2004; Gamst et al., 2004). Because it is expected that a methods factor will emerge, coefficients in the heterotrait-monomethod triangles should be higher than the validity coefficients, indicating that methods factors are stronger than trait factors. Finally, the same pattern of trait interrelationship should be seen in all triangles.

Hypothesis 4

It is expected that significant differences will emerge in parent-client ratings based on the race of the respondent. To determine whether differences in ratings by race exist, responses on the CCI will be separated by race and compared using ANOVA. Post hoc tests will be used as necessary to further refine findings. It is also expected that differences will emerge based on SES; for this analysis, the correlation between parent education and measure scores will be examined. Post hoc tests will be used as necessary to further refine findings.

Discussion

Summary

With the growing ethnic and racial diversity of the United States, multicultural counseling competence becomes increasingly important for mental health practitioners, particularly those who work with children and families. Though the APA has acknowledged the importance of multiculturally competent practice since 1973, little empirical research has been done in this area.

There has also been some research done on client- therapist ethnic match, with the assumption that this match inherently creates cultural competence in therapy, though results are mixed. Some researchers have found no significant differences in outcomes for children or adolescents (Gamst, et al., 2004), while others have found that there are significant differences in adolescent outcomes for ethnically matched client-practitioner pairs (Yeh, et al., 1994). The mixed results from research in this area may indicate that research in ethnic match does not offer the insight into multicultural counseling competence that these researchers had hoped.

In 1982, D.W. Sue, et al. established their first framework of multicultural competency that has guided training, research, and education in this area since that time (Fuentes et al., 2001). Sue et al. (1982) defined multicultural counseling competency as counselors' ability to (1) recognize their personal attitudes and values around race and ethnicity, (2) develop their knowledge of diverse cultural worldviews and experiences, and (3) identify effective skills in working with clients of color. This framework was

revised and expanded in 1992 and again in 1998; the most recent version of this model is a 3x3 matrix model that crosses the original three dimensions of competence with three new counselor characteristics, including (1) awareness of personal assumptions, biases, and values, (2) understanding the worldviews of culturally diverse clients, and (3) developing abilities to use and create culturally appropriate intervention strategies (Sue et al., 1992).

As an outgrowth of this framework, a number of measures assessing multicultural counseling competence have been created, though most are self-report measures to be completed by practitioners (e.g. the California Brief Multicultural Competence Scale, the Multicultural Awareness, Skills, and Knowledge Scale, the Multicultural Counseling Knowledge and Awareness Scale, the Multicultural Counseling Inventory, and the Multicultural Competency and Training Survey). Though these measures have enjoyed moderate use in the literature, they are not free from flaws, and many theorists in the field have also called attention to the need for consumer input when determining the components of multicultural counseling competence (e.g. Fuertes et al., 2001; Pope-Davis et al., 2001). In this vein, an attempt has been made by some researchers to incorporate client ideas of multicultural competence to create self-report measures for ethnically diverse consumers (Cornelius et al., 2004; Davis, 2007), though these measures have not been used in psychology research to date.

This study proposes that examining the relationship between practitioner self-report measures and consumer perceptions of multicultural counseling competence can help practitioners to better understand multicultural counseling competence and the

respectful, inclusive practice that counselors hope to achieve as a result of developing skills in this area. In order to examine this relationship, this study will first establish the validity and reliability of a client-response measure. This measure will then be used to investigate the relation between family therapist self-report ratings and parent ratings of multicultural counseling competence, as well as the similarities and differences in what is assessed by the available measurement tools for practitioners and patients. The study will also examine how race and SES affect parent-client ratings of cultural competence. To do this, the study would include administering the CBMCS to family practitioners and the CCI to the parents of the families they serve. In addition, both would fill out a demographic form to allow the study of how race and SES affect responses.

It is anticipated that the construct assessed by the each of the two measures will be the same, but that a methods factor will be found, indicating that scores of cultural competence vary by respondent. The results would also be expected to show that parent ratings vary based on race and SES. These results would indicate that, though the currently available client and practitioner measures are assessing the same set of multicultural counseling competencies, practitioners and clients see multicultural counseling competence in different ways. These results would also indicate that multicultural counseling competence, as viewed by the client, is related to a variety of individual factors, such as race and SES.

Limitations

Although the proposed study seeks to investigate multicultural counseling competence, it would focus specifically on issues of race and ethnicity, and would not include a study of other forms of diversity, such as gender, sexuality, disability status, or religion. Most multicultural counseling competencies have been developed specifically with racial/ ethnic minorities as the focus, as well, and this has been the basis for much of the criticism that has been leveled against research in this area (Sue et al., 1998). Because of this decision, the study will inform only a small portion of true multicultural counseling competence, and cannot be said to generalize to other forms of diversity.

The lack of well-developed instrumentation could be problematic, as well. The CBMCS self-report measure was compiled from scales that were created to assess multicultural counseling competence in a training setting, not in a practice setting. Although the authors have administered the finished measure to practitioners and believe that it is appropriate for practical use, differences exist between these two settings, and some of the questions may be less applicable to licensed professionals. Furthermore, the items on the CBMCS are based on a three-factor model, as were most of the measures that it was created from. Factor analysis has revealed four factors on the CBMCS, and a number of factors ranging from one to four on the other measures. This finding calls into question the validity of the supposed three-factor model on which these instruments are based, yet the Sue et al. model (1982, 1992, 1998) remains mostly unchallenged in the research literature. The CCI is problematic in some ways, as well. Foremost, the CCI is an admitted “work in progress” (Cornelius et al., 2004) and a confirmatory factor analysis

has not yet been performed on the measure. The four factors are as yet unnamed by the creators of the measure, and no psychometrics have been computed for the CCI as a four factor measure, though this study hopes to show that the measure has acceptable validity and reliability. Additionally, the theoretical basis for the CCI (in the Social Work literature) is less cohesive than the Sue et al. theory (1982) behind the self-report measures created in the counseling psychology research; the theories included in the creation of the CCI were decided upon by a committee formed to choose the most important pieces from this literature (Arthur, 2005). The absence of a perfect theoretical match between the two instruments is also a limitation, as it increases the likelihood that the instruments are measuring different constructs entirely.

Additionally, no measure of racial identity development for either consumers or practitioners is included in this study, which may affect ratings. For example, people who are at more basic levels of racial identity development may rate themselves or their practitioners as having a higher level of multicultural counseling competence, simply because they lack a full understanding of what could be possible with truly respectful and competent practice.

Finally, there is no discussion of treatment outcomes in this proposed study. To a certain extent, research in multicultural counseling competence is based on the assumption that a practitioner who is multiculturally competent is more effective than one who lacks skills in this area. No research to date has effectively made the connection between multicultural counseling competence and tangible improvements in client outcomes, however. Although this research is designed to test the relation between client

and practitioner assessments of cultural competence, neither client satisfaction nor practitioner self-assessment is an indicator of actual, positive change in a client's life.

Implications

Research in the area of multicultural counseling competence has been limited thus far, in part by a lack of appropriate instrumentation, and a lack of agreement about what the available scales are actually measuring. The proposed study would contribute to a better understanding of what self-report measures (the dominant form of assessment available in the field) are able to tell us about multicultural counseling competence, and may also show that the Cultural Competency Inventory is a viable, client-centered alternative to these practitioner measures. Furthermore, if a methods factor is discovered, thus differentiating client and practitioner responses, these practitioner self-report measures may have limited utility – an important factor to consider when designing research in this area, particularly because research has already shown that these measures do not correlate with other methods of assessing multicultural counseling competence (i.e. case conceptualization ability and observer ratings). Additionally, the proposed study may offer an alternative that lessens the role of social desirability in self-report measures. If psychologists know they are being evaluated by clients, socially desirable responses are automatically checked by the reality that any inaccuracies may present themselves in the clients' ratings.

Many theorists and researchers in the field have called attention to the lack of client input in multicultural counseling competence research, and this study would take

initial steps in including this valuable input. If the expected results occur, it would serve to further highlight the importance of including client feedback in research done in this area. The relationship (or lack thereof) between these two methods of measuring multicultural counseling competence would create further discussion around how researchers choose to use client input in studies and would emphasize the importance of giving clients a voice in their treatment. Furthermore, the proposed study will offer insight into how aspects of race and SES affect consumer perspectives. Increasing the general understanding of client ratings may make future researchers more likely to incorporate client feedback in future research.

Research on multicultural counseling competence and its effects on families and children is scant in the literature, though its importance to creating a complete understanding of multicultural competence has been noted (Constantine & Ladany, 2001). The proposed study would offer insight into how multicultural counseling competence is viewed by families, and will create a starting point for future research in this area. In order to maximize the potential of mental health services, early intervention is important, and service providers and researchers must begin by meeting the needs of families and children. Multicultural counseling competence is a key part of meeting these needs.

Appendices

Appendix A

California Brief Multicultural Competence Scale

Please circle your response.

1. I have an excellent ability to assess accurately the mental health needs of gay men.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
2. I have an excellent ability to assess accurately the mental health needs of lesbians.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
3. I have an excellent ability to assess accurately the mental health needs of persons with disabilities.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
4. I have an excellent ability to assess accurately the mental health needs of older adults.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
5. I have an excellent ability to assess accurately the mental health needs of men.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
6. I have an excellent ability to assess accurately the mental health needs of persons who come from very poor socioeconomic backgrounds.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
7. I have an excellent ability to assess accurately the mental health needs of women.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
8. I am aware that counselors frequently impose their own cultural values on minority clients.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
9. I am aware that being born a White person in this society carries with it certain advantages.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
10. I am aware of institutional barriers which may inhibit minorities from using mental health services.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

11. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
12. I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
13. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
14. I have an excellent ability to critique multicultural research.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
15. I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons with different cultural/ racial/ethnic backgrounds.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
16. I can discuss within group differences among ethnic groups (e.g., low socioeconomic status [SES] Puerto Rican client vs. high SES Puerto Rican client).
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
17. I can discuss research regarding mental health issues and culturally different populations.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
18. I am knowledgeable of acculturation models for various minority groups.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
19. My communication is appropriate for my clients.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
20. I am aware of institutional barriers that affect the client.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*
21. I am aware of how my own values might affect my client.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

Appendix B

Cultural Competency Inventory

Please circle your response.

1) When I first called or came here, it was easy to talk to the staff	Yes	No
2) This place is easy to get to from where I live.	Yes	No
3) The waiting room has pictures or reading material that show people from my racial or ethnic group.	Yes	No
4) The waiting room has brochures or handouts that tell me about services I can get here.	Yes	No
5) These brochures and other handouts are in other languages as well as English.	Yes	No
6) The reading materials are not in the language that my family and I usually speak at home.	Yes	No
7) Some of the staff here are from my racial or ethnic group.	Yes	No
8) Some of the office and support staff are from my racial or ethnic group.	Yes	No
9) Some of the mental health staff are from my racial or ethnic group.	Yes	No
10) Some of the mental health providers are from my racial or ethnic group.	Yes	No
11) My family or friends are included in discussions about the mental health help I need.	Yes	No
12) The staff here listen to me and my family when we talk to them.	Yes	No
13) The staff here do not ask me what I think about the mental health services I can get here.	Yes	No
14) The staff here do not ask my family what they think about the mental health services I can get here.	Yes	No
15) The staff here ask me, my family, or others close to me to fill out forms that tell them what we think of the place and services.	Yes	No
16) Some of the staff at the clinic speak the language I usually speak at home.	Yes	No
17) If I need it, there are translators or interpreters easily available to assist me and/or my family.	Yes	No
18) The staff here treat me with respect.	Yes	No
19) The staff here think less of me because of the way I talk.	Yes	No
20) The staff here think less of me because of the color of my skin.	Yes	No
21) The staff here respect my religious or spiritual beliefs.	Yes	No
22) If I complain, the staff here try to help me with my complaint.	Yes	No
23) The staff here hold it against me if I complain about things that I am not happy with.	Yes	No
24) If I show anger about something the staff here think the worst right	Yes	No

away.		
25) The staff here understand some of the different ideas that I, my family, and others from my racial or ethnic group may have about mental illness.	Yes	No
26) The staff here understand that I might want to talk to a person from my own racial or ethnic group about getting the mental health help I want.	Yes	No
27) The staff seem to understand that I might feel more comfortable working with someone who is the same sex I am.	Yes	No
28) The mental health staff here seem to understand the experiences and problems I have in my past life.	Yes	No
29) The mental health staff here know how to use this knowledge to help me address my current day-to-day needs.	Yes	No
30) Staff are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.	Yes	No
31) The staff who work directly with me on my mental health needs respect my belief in God, a supreme being, or higher power.	Yes	No
32) The staff here are not willing to allow me to use my spiritual beliefs and practices as a way of addressing my mental health needs.	Yes	No
33) If I want, the people who work here will help me get folk or healing remedies or services that are used in my culture to deal with mental health needs.	Yes	No
34) If I want, the mental health staff will help me get services from clergy or spiritual leaders.	Yes	No
35) The staff who work here do not talk to other people about my problems or treatment without asking me first.	Yes	No
36) Most of the time, I feel I can trust the staff here who work with me.	Yes	No
37) The staff here talk to me about the medications they will give me to help me.	Yes	No
38) The staff here who work with me pay attention to what I say about how the medications make me feel.	Yes	No
39) The directions for the medications are easy to follow.	Yes	No
40) The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, and so forth.	Yes	No
41) The services I get here really help me work toward things such as getting a job, taking care of my family, going to school, and being active with my friends, family, and community.	Yes	No
42) The people who work here do not try to help me to be on my own as much as I can.	Yes	No
43) Some of the staff here understand the difference between their culture and mine.	Yes	No
44) Staff here acknowledge the importance of my cultural beliefs in my treatment process.	Yes	No

45) Staff here understand that people of my racial or ethnic group are not all alike.	Yes	No
46) Staff here generally assume they know enough about my personal cultural beliefs without asking me.	Yes	No
47) I do not see staff here taking time to understand a person's culture.	Yes	No
48) Staff here treat me as if my culture is not important for them to consider in planning my treatment.	Yes	No
49) This program advertises on television stations I and/or my family watch, radio stations we listen to, or in magazines and/or newspapers we read.	Yes	No
50) Information about this program can be found at the shopping malls, neighborhood stores, community centers, and other places where people from my racial or ethnic group go.	Yes	No
51) It was easy to get information I need about housing, food, clothing, and other social services from this place.	Yes	No
52) Staff from this program came to my community to let people like me and others know about the services they offer and how to get them.	Yes	No

Appendix C

Cultural Competency Inventory – Proposed Subscales and Proposed Factors

Proposed Subscales

(Values in superscript are subscale numbers)

Awareness of Patients Culture subscale¹

- 3) The waiting room has pictures or reading material that show people from my racial or ethnic group.
- 4) The waiting room has brochures or handouts that tell me about services I can get here.
- 7) Some of the staff here are from my racial or ethnic group.
- 8) Some of the office and support staff are from my racial or ethnic group.
- 9) Some of the mental health staff are from my racial or ethnic group.
- 10) Some of the mental health providers are from my racial or ethnic group.
- 11) My family or friends are included in discussions about the mental health help I need.
- 12) The staff here listen to me and my family when we talk to them.
- 13) The staff here do not ask me what I think about the mental health services I can get here.
- 14) The staff here do not ask my family what they think about the mental health services I can get here.
- 25) The staff here understand some of the different ideas that I, my family, and others from my racial or ethnic group may have about mental illness.
- 32) The staff here are not willing to allow me to use my spiritual beliefs and practices as a way of addressing my mental health needs.
- 42) The people who work here do not try to help me to be on my own as much as I can.

Respectful Behaviors subscale²

- 15) The staff here ask me, my family, or others close to me to fill out forms that tell them what we think of the place and services.
- 18) The staff here treat me with respect.
- 19) The staff here think less of me because of the way I talk.
- 20) The staff here think less of me because of the color of my skin.
- 21) The staff here respect my religious or spiritual beliefs.
- 22) If I complain, the staff here try to help me with my complaint.
- 23) The staff here hold it against me if I complain about things that I am not happy with.
- 24) If I show anger about something the staff here think the worst right away.

Language Interpreter Issues subscale³

- 5) These brochures and other handouts are in other languages as well as English.
- 6) The reading materials are not in the language that my family and I usually speak at home.
- 16) Some of the staff at the clinic speak the language I usually speak at home.
- 17) If I need it, there are translators or interpreters easily available to assist me and/or my

family.

Understanding of Indigenous Practices subscale⁴

- 30) Staff are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.
- 31) The staff who work directly with me on my mental health needs respect my belief in God, a supreme being, or higher power.
- 33) If I want, the people who work here will help me get folk or healing remedies or services that are used in my culture to deal with mental health needs.
- 34) If I want, the mental health staff will help me get services from clergy or spiritual leaders.

Consumer Involvement subscale⁵

- 26) The staff here understand that I might want to talk to a person from my own racial or ethnic group about getting the mental health help I want.
- 27) The staff seem to understand that I might feel more comfortable working with someone who is the same sex I am.
- 35) The staff who work here do not talk to other people about my problems or treatment without asking me first.
- 40) The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, and so forth.
- 41) The services I get here really help me work toward things such as getting a job, taking care of my family, going to school, and being active with my friends, family, and community.

Acceptance of Cultural Differences subscale⁶

- 43) Some of the staff here understand the difference between their culture and mine.
- 44) Staff here acknowledge the importance of my cultural beliefs in my treatment process.
- 45) Staff here understand that people of my racial or ethnic group are not all alike.
- 46) Staff here generally assume they know enough about my personal cultural beliefs without asking me.
- 47) I do not see staff here taking time to understand a person's culture.
- 48) Staff here treat me as if my culture is not important for them to consider in planning my treatment.

Community Outreach subscale⁷

- 49) This program advertises on television stations I and/or my family watch, radio stations we listen to, or in magazines and/or newspapers we read.
- 50) Information about this program can be found at the shopping malls, neighborhood stores, community centers, and other places where people from my racial or ethnic group go.
- 51) It was easy to get information I need about housing, food, clothing, and other social services from this place.

52) Staff from this program came to my community to let people like me and others know about the services they offer and how to get them.

Patient-Provider-Organization Interactions subscale⁸

- 1) When I first called or came here, it was easy to talk to the staff.
- 2) This place is easy to get to from where I live.
- 28) The mental health staff here seem to understand the experiences and problems I have in my past life.
- 29) The mental health staff here know how to use this knowledge to help me address my current day-to-day needs.
- 36) Most of the time, I feel I can trust the staff here who work with me.
- 37) The staff here talk to me about the medications they will give me to help me.
- 38) The staff here who work with me pay attention to what I say about how the medications make me feel.
- 39) The directions for the medications are easy to follow.

Proposed Factors

** = negative load

(Values in superscript correspond to subscale numbers)

Factor 1

- 9) Some of the mental health staff are from my racial or ethnic group.¹
- 10) Some of the mental health providers are from my racial or ethnic group.¹
- 12) The staff here listen to me and my family when we talk to them.¹
- 18) The staff here treat me with respect.²
- 21) The staff here respect my religious or spiritual beliefs.²
- 31) The staff who work directly with me on my mental health needs respect my belief in God, a supreme being, or higher power.⁴
- 35) The staff who work here do not talk to other people about my problems or treatment without asking me first.⁵
- 43) Some of the staff here understand the difference between their culture and mine.⁶
- 44) Staff here acknowledge the importance of my cultural beliefs in my treatment process.⁶
- 45) Staff here understand that people of my racial or ethnic group are not all alike.⁶
- 51) It was easy to get information I need about housing, food, clothing, and other social services from this place.⁷
- 1) When I first called or came here, it was easy to talk to the staff.⁸
- 2) This place is easy to get to from where I live.⁸
- 36) Most of the time, I feel I can trust the staff here who work with me.⁸
- 37) The staff here talk to me about the medications they will give me to help me.⁸
- 39) The directions for the medications are easy to follow.⁸

Factor 2

- 25) The staff here understand some of the different ideas that I, my family, and others

from my racial or ethnic group may have about mental illness.¹

30) Staff are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.⁴

34) If I want, the mental health staff will help me get services from clergy or spiritual leaders.⁴

26) The staff here understand that I might want to talk to a person from my own racial or ethnic group about getting the mental health help I want.⁵

40) The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, and so forth.⁵

41) The services I get here really help me work toward things such as getting a job, taking care of my family, going to school, and being active with my friends, family, and community.⁵

28) The mental health staff here seem to understand the experiences and problems I have in my past life.⁸

29) The mental health staff here know how to use this knowledge to help me address my current day-to-day needs.⁸

38) The staff here who work with me pay attention to what I say about how the medications make me feel.⁸

Factor 3

4) The waiting room has brochures or handouts that tell me about services I can get here.^{1**}

15) The staff here ask me, my family, or others close to me to fill out forms that tell them what we think of the place and services.²

19) The staff here think less of me because of the way I talk.^{2**}

20) The staff here think less of me because of the color of my skin.^{2**}

22) If I complain, the staff here try to help me with my complaint.²

23) The staff here hold it against me if I complain about things that I am not happy with.^{2**}

5) These brochures and other handouts are in other languages as well as English.³

6) The reading materials are not in the language that my family and I usually speak at home.^{3**}

17) If I need it, there are translators or interpreters easily available to assist me and/or my family.³

49) This program advertises on television stations I and/or my family watch, radio stations we listen to, or in magazines and/or newspapers we read.⁷

50) Information about this program can be found at the shopping malls, neighborhood stores, community centers, and other places where people from my racial or ethnic group go.⁷

52) Staff from this program came to my community to let people like me and others know about the services they offer and how to get them.⁷

Factor 4

8) Some of the office and support staff are from my racial or ethnic group.^{1**}

- 13) The staff here do not ask me what I think about the mental health services I can get here.¹
- 14) The staff here do not ask my family what they think about the mental health services I can get here.¹
- 42) The people who work here do not try to help me to be on my own as much as I can.¹
- 24) If I show anger about something the staff here think the worst right away.²
- 47) I do not see staff here taking time to understand a person's culture.⁶
- 48) Staff here treat me as if my culture is not important for them to consider in planning my treatment.⁶

Do not load on any proposed factor

- 3) The waiting room has pictures or reading material that show people from my racial or ethnic group.¹
- 7) Some of the staff here are from my racial or ethnic group.¹
- 11) My family or friends are included in discussions about the mental health help I need.¹
- 32) The staff here are not willing to allow me to use my spiritual beliefs and practices as a way of addressing my mental health needs.¹
- 16) Some of the staff at the clinic speak the language I usually speak at home.³
- 33) If I want, the people who work here will help me get folk or healing remedies or services that are used in my culture to deal with mental health needs.⁴
- 27) The staff seem to understand that I might feel more comfortable working with someone who is the same sex I am.⁵
- 46) Staff here generally assume they know enough about my personal cultural beliefs without asking me.⁶

Appendix D

Demographic Form – Case Information Sheet

Date:

To be filled out by client:

Parent/Guardian Name	
Parent/Guardian Gender	
Parent Race/Ethnicity	
Highest Grade Completed (Parent)	
Household Monthly Income	
Relationship to Child	
Child's Name	
Child's Gender	
Child's Date of Birth	
Child's Race/Ethnicity	

To be filled out by practitioner:

Case ID Number	
Name of Facility	
Practitioner's Name	
Practitioner's Gender	
Practitioner's Race/Ethnicity	
Start date of Sessions	
End date of Sessions	
Number of Sessions	
Number of Hours of Client Contact	
Diagnosis (if any)	

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