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Client Perceptions of

Community Mental Health Providers'

Multicultural Counseling Competence

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Client Perceptions of Community Mental Health Providers' Multicultural Counseling Competence

by

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Client Perceptions of Community Mental Health Providers' Multicultural Counseling Competence

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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. One current limitation to research in multicultural counseling competence (MCC) is the lack of reliable and valid measures that consider the perspectives of the client. The standardized measures currently available are self-report measures completed by practitioners regarding their own perceived competence. These self-report measures are based largely on the well-regarded MCC guidelines set forth by Sue and colleagues (1992). Unfortunately, these measures present an incomplete (and possibly erroneous) representation of MCC as experienced by the client.

The current study outlines the development of a measure meant to meet this need—the Client Experience of Provider Cultural Competence (CEPCCI) —and investigates the relationship between provider and client perceptions of the providers' abilities in this area. The CEPCCI is anchored in Sue et al.'s (1992) well-regarded theory on cultural competence and a qualitative study of client perceptions of multicultural counseling competence (Davis, 2007). The

resulting scale consists of 38 items loading on one subscale with demonstrated content and construct validity and good reliability. A significant correlation between provider and client perceptions of the providers' multicultural counseling competence was also found.

The need to obtain a consumer perspective on practitioner MCC is well-documented in the literature, and the present study has created a measure to fill this gap. This measure will open up a wider range of possibilities for research in MCC, as well as allowing providers of mental health services a way to assess their performance and progress in this area.

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Chapter I: 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 (Fuertes, 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; Sodowsky, 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 had not yet been determined. The primary purpose of this study was to develop and norm a client measure of multicultural counseling competence. For this measure, the results of Davis' 2007 study were 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. Factor analysis was used to establish the content validity, and Cronbach's alpha used to determine the reliability of the measure. The present study also used Pearson correlation to examine the constructs measured by client assessments of multicultural counseling competence and how those constructs relate to the constructs measured by practitioner self-assessments.

Chapter II: 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 focused 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 (Fuertes 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 ways 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). As of March 2013, the APA website indicates that "the process has begun for a thorough review" of the guidelines, but a new version of the guidelines has not yet been completed (APA, 2013).

Measuring Cultural Competence

Provider Self Report

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-repot 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; Sodowsky 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 Sodowsy et al. (1994) reported nonsignificant correlations between a measure of social desirability and their self-report measures of multicultural counseling competence. In contrast, Sodowsky, 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; Sodowsky 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 CCCI-R

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). 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. One of the limitations of the CCCI-R is that the rater must have a solid understanding of the elements that comprise cultural competence, which is not a possibility in many situations (Constantine & Ladany, 2001); this is particularly problematic when the CCCI-R is used as a client measure. In spite of the fact that the 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. Study results showed that these students' perceptions of their counselors' multicultural competence accounted for significant variance in their satisfaction with counseling. In addition, results revealed that client's rating of their counselor's multicultural counseling competence partially mediated the relationship between general counseling competence ratings and satisfaction with counseling. In addition to 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.

A more recent study by Owen, Tao, Leach, & Rodolfa (2011) also used the CCCI-R as a client measure, and found results that appear to partially support those of Constantine (2002). The Owen et al. (2011) study examined whether clients' perceptions of their therapists' multicultural counseling competence were associated with their psychological functioning and satisfaction with the client-therapist relationship. The results showed that clients' perceptions of their therapists' cultural competence were positively related to working alliance, real relationship, and psychological functioning. Unfortunately, this study's results are questionable and its utility limited – in addition to using an improperly normed measure (the CCCI-R), the sample that was primarily White, female, and highly educated (more than half were graduate students). Again, this population is not representative of most clients seeking mental health services and the results do not speak to the experience of ethnic and racial minorities.

A second study by the same research group investigated whether therapists who were rated as exhibiting more multicultural counseling competence (as measured by the CCCI-R, modified to be completed by clients) also had clients with better therapy outcomes (Owen, Leach, Wampold, & Rodolfa, 2011). Results of this study showed that multicultural counseling competence did not account for the variability in therapy outcomes that were attributed to that therapist. Additionally, clients' race/ethnicity, therapists' race/ethnicity, or the interaction of clients' and therapists' race/ethnicity were not significantly associated with clients' perceptions of their therapists' multicultural counseling competence. This study also used a primarily White, female, and highly educated sample, and has the same issues as the previous two studies, in addition to other, serious methodological issues. These issues include problems with the conceptual underpinnings of their research and the authors' interpretation of the findings (Ridley & Shaw-Ridley, 2011).

While the researchers in these three studies chose to investigate important aspects of multicultural counseling competence, their results cannot be generalized, and the validity of the results is questionable, because of limitations to their methodologies and assumptions. Though the CCCI-R solves some of the problems presented by practitioner self-report measures, when used properly, it still does not allow client input regarding a practitioner's multicultural counseling competence. Furthermore, research on multicultural counseling competence is useless if participants are not representative of the socioeconomically, racially, and ethnically diverse populations that many therapists serve.

Attempts at Client Measures

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 (e.g. Constantine, 2002; Cornelius et al., 2004; Owen, Tao, Leach, & Rodolfa, 2011).

The Cultural Competency Inventory (CCI; Cornelius et al., 2004), is the product of one such attempt 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, 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 weak 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.

Beyond Measurement: 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, a measure of racial identity development, or a measure of overall counseling ability as covariates in their research, which may have contributed to the variability in their results.

Summary and Statement of Problem

With the increasing diversification of the U.S. 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. 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 et al., 2000, 2004; Yeh et al., 1994). 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 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 was to develop and norm a client measure of multicultural counseling competence. For this measure, the results of Davis' 2007 study were 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 created instrument (the Client Experience of Provider Cultural Competence Inventory; CEPCCI) were established in order to determine the viability of its use in community health settings as well as in subsequent research. The present study also examined the constructs measured by client assessments of multicultural counseling competence and how those constructs relate to the constructs measured by practitioner self-assessments.

The following research questions were proposed:

1) What constructs underlying the client experience of multicultural counseling competence can be identified? Are these constructs measured in a reliable and valid manner by the CEPCCI?

2) How do these client constructs relate to the constructs underlying the provider's experience of their own multicultural counseling competence?

3) What is the nature of the relationship between client perceptions of their provider's multicultural counseling competence, and the provider's own self-perception of their ability in this area?

Chapter III: Method

The dissertation study consisted of two phases. The first phase entailed the development of the Client Experience of Provider Cultural Competence Inventory (CEPCCI; Appendix D), an instrument that measures clients' perspectives on their providers' multicultural counseling competence. The second phase consisted of data collected at two community mental health centers in order to establish the psychomentric properties of the CEPCCI and to determine the relationship between client and provider perceptions of the providers' multicultural counseling competence.

Instrument Development

A group of 12 mental health professionals and graduate students who had received training in culturally competent counseling practices participated in a instrument development panel to combine and sort statements from Davis' (2003) study (see Appendix A) and the guidelines for culturally competent practice established and revised by Sue et al. (1998; see Appendix B). The group met three times over the course of one week to sort through the two sets of potential statements and use these to draft items for the measure.

As many of the statements/guidelines were written from a provider's perspective and reference a provider's internal states (e.g., "Culturally skilled counselors are aware of how their own cultural background and experiences, attitudes, and values and biases influence psychological processes"; Sue et al., 1998) the panel first reviewed both lists to determine which aspects of items, if any, could not reasonably be assessed by a client. After all such components had been removed, the instrument development panel sorted the remaining statements from both sources into conceptually related groups. The panel reviewed each of these concept groups, combined or eliminated any redundancies, and created a bank of potential measurable concepts.

Finally, the panel rewrote each of these concepts into a brief statement using simple, natural language that could easily be read and understood by clients. In order to determine whether the set of statements adequately assessed the domain, the items were then cross-checked with both Sue et al.'s 1998 guidelines and with the categories determined by Davis's 2007 qualitative study. These final statements were then used to generate Likert-scale (1–4) response items.

A small focus group was also conducted to determine the validity and ease of use of the compiled measure. The focus group members were asked to review the 38 items that resulted from the instrument development panel, and to make comments and suggestions about content, ease of readability, scale format, and organization.

Convenience sampling was used to obtain participants in this focus group; friends and family members of the principal investigator who approximated the education and demographics of clients at the participating community mental health centers were asked to assist in measure development. Five volunteers reviewed the measure and offered feedback on the instrument. Of these volunteers, three participants had a high school diploma, one had a GED, and one had completed no schooling past the 9th grade; one participant identified as White, one participant identified as Hispanic, and three of the participants indicated that they were of a mixed racial background. They ranged in age from 27 to 63 years old. None of the participants work in a mental health field, but all have received mental health services in the past, or are receiving mental health services at this time.

Focus group members generally indicated that the measure was easy to understand and appeared to address all areas of cultural competence that they felt were important. Requests were made for a few small changes to the wording of some items, as well as for more space between scale items.

After these changes were made, the Flesch-Kincaid reading level (Kincaid, Fishburn, Rogers, & Chissom, 1975) of the measure was calculated. The Flesch–Kincaid readability tests are designed to indicate comprehension difficulty of a passage in English (Kincaid et al., 1975), and are widely available in word processing programs. Analysis using Microsoft Word indicated that the Flesch-Kincaid reading level of the measure is 7.1, meaning that an average 7th grader could read the text. A 9th grade reading level is the maximum reading level allowed by many government agencies for their documents and forms (Si & Callan, 2001); a reading level of 7.1 is well below this limit.

The community in which the research was conducted has a number of Spanish-speaking members, so a Spanish-language version of the measure was created. The principal investigator and another school psychology graduate student who was a native speaker of Spanish created a Spanish version of the scale. Instead of exact translation, transadaptation was used to preserve the meaning of the statements on the measure. Another graduate student who was a native Spanish speaker and a representative from the University of Texas IRB checked the translation for errors and suggested changes as needed.

Research Study

Overview

The second phase of the dissertation study entailed the administration of the Client Experience of Provider Counseling Competence Inventory (CEPCCI) to clients at two community mental health clinics, as well as administration of the California Brief Multicultural Competence Scale (CBMCS) to their mental health providers. The client responses on the CEPCCI were used to identify an appropriate factor structure for this instrument and to provide the information necessary to determine which items should be retained in the final version of the

measure. The provider responses on the CBMCS were used in conjunction with client responses on the CEPCCI to determine the nature of the relation between client and provider perceptions of the providers' cultural competence.

Procedure

All participants were adult clients who receive mental health services from one of two large community mental health organizations, and the practitioners who work with them. Although the clients, providers, and administration at both of the organizations participating in this research were supportive, the nature of the organizations necessitated persistence and frequent innovation to ensure successful data collection. Neither organization has a substantial, continuous affiliation with the university conducting the research. Both organizations had large, complex administrative structures with multiple loosely related satellite clinics and a complex web of managers, administrators, and office staffs, making both gaining entry and continued communication exceptionally difficult. At Organization A, entry was made into eight different satellite sites, each with their own manager(s), office staff, and providers. At Organization B, four separate sites participated.

The researchers secured permission and presented the research project proposal at multiple organization-wide meetings to network with staff and administrators and generate interest in the study. Entry into individual sites was gained either by email and/or phone solicitation of administrators and managers at the site, or by in-person visits to the site to request a brief, future meeting with the site's manager. In many cases, managers and administrators who were familiar with the research (because of previous participation, presentations at organization-wide meetings, etc.) helped facilitate the introduction of the researchers to leadership at new sites within the organizations.

Because of staff turnover and an email screening system that automatically sent emails from outside addresses to a quarantine area, communication with sites was often difficult. Managers and providers also indicated that the pressure of working with high-needs clients on a tight budget made responding to researchers a lower priority. Because of this, the principal investigator and a research assistant used hands-on data collection methods and did much of the communication legwork through brief, in-person meetings.

Participation in the study was voluntary, and all participants were told that the purpose of this research study was to better understand how organizations can provide respectful and culturally sensitive mental health services to their clients. The ethical guidelines put forth by the American Psychological Association and the University of Texas' "Policies and Procedures Governing Research with Human Subjects" were strictly adhered to in order to ensure the ethical treatment of all participants. Ethics board approval was also obtained from the research boards at each of the community mental health clinics that participated in the study, and the researchers adhered to the ethical guidelines of each of the participating organizations, as well.

Clients at each of the sites were asked to complete the Client Multicultural Competency Inventory and a demographic form (see Appendices D and E). The specific methods used for data collection were developed collaboratively with administrators and staff at the individual sites within each of the organizations. At some sites, clients were approached by one of the researchers in the waiting room of the clinic. At others, they were asked by the front desk staff to complete the forms when they checked in for their appointment. At some sites, the researcher was given permission to approach clients at the end of a group therapy or support meeting to solicit their participation.

The researchers explained the purpose of the study to all potential participants. Clients were also informed that their participation in the study was entirely voluntary, and were told that their responses were confidential and private. The researcher explained that they could choose to complete as much or as little of the requested information as they felt comfortable sharing, and that questions or comments about the research measures and the nature of the study were welcome. Clients were given the choice to complete the forms in Spanish or in English. While a number of clients requested forms in both Spanish and English, and some appeared to reference the Spanish language forms while completing the measures, no completed Spanish language forms were submitted by participants in this study.

Clients gave their completed forms directly to the principal investigator or a research assistant not involved in providing services to the clients, or placed their completed forms in a sealed envelope, which they deposited in a box at the front desk of the community mental health center. The principal investigator collected forms from the boxes at each of the sites twice a week during data collection. Due to the nature of the research collection, exact numbers are not available, but it is estimated that approximately 90% of clients who were approached agreed to participate in the research study.

Practitioners at all sites were approached during staff meetings. The research project was explained to the potential participants, and they were encouraged to ask questions about the nature of the research and how the results would be used. For purposes of analysis, practitioner and client forms were linked using an identification number assigned to the provider, but all practitioner and client responses were be kept confidential and de-identified to the greatest extent possible. Providers were asked to complete the California Brief Multicultural Competence Scale (CBMCS; Gamst et al., 2004) and a demographic form (Appendix C); for providers, these forms

were offered only in English. Providers gave their completed forms directly to the principal investigator or a research assistant not involved in providing services to the clients. All providers who were approached agreed to participate in the research study.

Additional Instrumentation

The California Brief Multicultural Competence Scale (CBMCS; Gamst, Dana, Der-Karabetian, Aragon, Arellano, Morrow & Martenson, 2004; Appendix C)**.** 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 Sue et al.'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. 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 criterion-related validity and reliability (Gamst et al., 2004). In the sample of 415 practitioners, Cronbach's alpha for the entire measure was 0.89 and alphas for each of the individual scales were 0.75 or higher (Gamst et al., 2004). 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 et al., 2004), a criticism leveled against other, similar instruments (Worthington, Mobley, Franks, & Tan, 2000).

Demographic forms (Appendices C, D, and E). The client demographic form collected data on the following variables: identification number, number of sessions with counselor, gender, age, highest grade completed in school, sexual orientation, type of service, diagnosis, and site. The provider demographic forms collected data on the following variables: identification number, gender, age, race/ethnicity, sexual orientation, degree type, licensure type, and site. Initially, sexual orientation was not included on the demographic form; one of the first groups of clients approached about participation in the study collectively requested that the principal investigator include a question about this on the demographic form, so an item was added requesting this information.

Participants

All participants were adult clients who receive mental health services from one of two large community mental health organizations, and the practitioners who work with them. A total of 187 clients and 56 providers participated by completing at least part of the survey protocol. Of the client protocols, 52% were collected at Organization A and 48% were collected at Organization B. Of the provider protocols, 68% were collected at Organization A and 32% were collected at Organization B. A summary of Organization Characteristics can be found in Table 1. Data collection methods are explained in greater detail in the Procedures section.

The provision of demographic information was presented to participants as being optional, but many client respondents chose not to provide some or all of this information. A summary of this information can be found in Table 2.

Between the two organizations, a total of 187 clients completed at least part of the research protocol. Client respondents included both men and women, with 40.1% indicating that they were male, 48.1% indicating that they were female, and 11.8% choosing not to disclose

Table 1

Organization Characteristics

	Organization A	Organization B
Description	Local Authority providing community-based behavioral health and developmental disabilities services to high need individuals	Nonprofit, Federally Qualified Community Health Center providing health care for uninsured and underinsured clients
Collection Method	For clients: Distribution by front desk administration; individual collection by researcher at group therapy meetings and in waiting room	For clients: Individual collection by researcher in waiting room
	For providers: Collection at staff meetings	For providers: Collection at staff meetings
Number of Clients Participating	97	90
Number of Providers Participating	38	18

their gender. Descriptions of sexual orientation included: 54.0% heterosexual/straight, 8.6% gay or lesbian, 3.2% bisexual. Client respondents ranged in age from 18 years to 81 years, with a mean age of 42.16 years and a standard deviation of 12.61 years. Clients' races/ethnicities included: 1.1% Asian, 16.6% Black, 16.0% Hispanic, 49.7% White, 1.6% Other Race, and 2.1% Multiracial.

The level of educational attainment of client respondents ranged from one client who indicated that their highest grade completed was 3rd grade, to those who indicated they had completed some graduate-level coursework. Sixteen participants indicated that they had earned a

Table 2

Client Characteristics

	Organization A		Organization B		Full Sample	
Characteristic	N	%	N	%	N	%
Gender						
Female	32	33.0	58	34.4	90	48.1
Male	44	45.4	31	64.4	75	40.1
No Response	21	21.6	1	1.1	22	11.8
Sexual Orientation						
Bisexual	3	3.1	3	3.3	6	3.2
Heterosexual	31	32.0	80	88.9	101	54.0
Homosexual	12	12.4	4	4.4	16	8.6
No Response	61	62.9	3	3.3	64	34.2
Race/Ethnicity						
Asian	0	0	2	2.2	2	1.1
Black	19	19.6	12	13.3	31	16.6
Hispanic/ Latino	17	17.5	13	14.4	30	16.0
White	33	34.0	60	66.7	93	49.7
Other	2	2.1	1	1.1	3	1.6
Multiracial	2	2.1	2	2.2	4	2.1
No Response	24	24.7	0	0	24	12.8
Educational Attainment						
Did Not Complete High School	19	19.6	14	15.6	33	17.6
High School Diploma	20	20.6	30	33.3	50	26.7
GED	12	12.4	4	4.4	16	8.6
Some College/Associate Degree	14	14.4	22	24.4	36	19.3
Bachelor's Degree	5	5.2	15	16.7	20	10.7
Graduate Degree	1	1.0	4	4.4	5	2.7
No response	26	26.8	1	1.1	27	14.4
Number of Sessions with Provider						
More than 5	38	39.2	55	38.9	93	49.7
Less than 5	6	6.2	35	61.1	41	21.9
No Response or Unsure	53	54.6	0	0	53	28.3

GED. The mean educational attainment of client participants was 11.43 years with *SD* = 2.38 years of schooling. Both the median and mode educational attainment of the client sample was

12 years (i.e., the completion of 12th grade). As with the other demographic questions, many clients chose not to provide a response to this item; 14.4% of client participants did not disclose the highest grade they completed.

The most common client diagnoses included Anxiety, Bipolar Disorder, Depression, Schizoaffective Disorder, and Posttraumatic Stress Disorder; 21% of respondents reported multiple diagnoses. The services most frequently sought by participants included Behavioral Health, Individual Counseling, Psychiatry Services, and Substance Abuse Services; many clients received assistance from the organization in multiple areas.

A total of 56 providers across the two organizations participated in the research protocol. Most providers chose to share their demographic information. A summary of this information can be found in Table 3.

Providers who participated included both men and women, with 39.5% indicating that they were male, 57.1% indicating that they were female, and 3.6% choosing not to disclose their gender. Because of the late addition of the question about sexual orientation to the demographic form, the providers from Organization A did not have the opportunity to share this information. Of those who were able to respond, the overwhelming majority (94.4%) indicated that they were heterosexual. Providers ranged in age from 23 years to 68 years, with a mean age of 36.26 years and a standard deviation of 11.30 years. Providers' races/ethnicities included: 1.8% Asian, 8.9% Black, 14.3% Hispanic, 69.6% White, and 1.8% Multiracial.

Most participating mental health providers had earned a master's degree (62.5%), though a substantial minority (23.2%) held bachelor's degrees. A few held PhD/PsyD (5.4%) or MD (3.6%) degrees, and one held an associate degree (1.8%). Most providers were licensed professional counselors (21.4%) or licensed clinical social workers (28.6%).

Table 3

Provider Characteristics

	Organization A		Organization B		Full Sample	
Characteristic	N	%	N	%	N	%
Gender						
Female	19	50.0	13	72.2	32	57.1
Male	17	44.7	5	27.8	22	39.3
No Response	2	5.3	0	0	2	3.6
Sexual Orientation						
Bisexual	--	--	0	0	0	0
Heterosexual	--	--	17	94.4	17	30.4
Homosexual	--	--	1	5.6	1	1.8
No Response	--	--	0	0	38*	68*
Race/Ethnicity						
Asian	1	2.6	0	0	1	1.8
Black	3	7.9	2	11.1	5	8.9
Hispanic/ Latino	6	15.8	2	11.1	8	14.3
White	26	68.4	13	72.2	39	69.6
Other	0	0	0	0	0	0
Multiracial	0	0	1	5.6	1	1.8
No Response	2	5.3	0	0	2	3.6
Licensure Type						
Clinical Social Worker (LCSW)	10	26.3	7	38.9	17	30.4
Chemical Dependency Counselor (LCDC)	2	5.3	0	0	2	3.6
Marriage and Family Therapist (LMFT)	2	5.3	0	0	2	3.6
Professional Counselor (LPC)	11	28.9	3	16.7	14	25.0
Medical	0	0	2	11.1	2	3.6
Peer Specialist	1	2.6	0	0	1	1.8
Psychologist	0	0	3	16.7	3	5.4
Psychology and Mental Health Nurse Practitioner	0	0	1	5.6	1	1.8
Qualified Mental Health Professional (QMHP)	2	5.3	0	0	2	3.6
No License	1	2.6	2	11.1	3	5.4
No Response	9	23.7	0	0	9	16.1

*These numbers are inflated because information on sexual orientation was not collected from providers at Organization A.

Research Questions and Hypotheses

Research Question #1: What constructs underlying the client experience of multicultural counseling competence can be identified? Are these constructs measured in a reliable and valid manner by the CEPCCI?

Hypothesis #1a: When items from the CEPCCI are factor analyzed, it is expected that three factors will emerge, corresponding to Sue et al.'s (1998) theory of multicultural counseling competence.

Rationale: Though existing measures of multicultural counseling competence have been demonstrated to vary in the number of factors they assess, the theory on which they are based (Sue et al., 1982) posits three distinct factors. Thus, it is expected that the current measure will contain three distinct factors as well

Hypothesis #1b: It is expected that the factors/subscales of the CEPCCI will meet acceptable minimums for reliability after being rearranged and edited to remove poorly written and construct-irrelevant questions.

Rationale: All other measures of multicultural counseling competence based on Sue et al.'s (1998) theory that have been normed using appropriate samples and sufficiently large sample sizes have been demonstrated to have good reliability, both for individual subscales and for the measure as a whole (e.g., Gamst et al., 2004; Sodowsky et al., 1994). As the present measure is based in part on the same theory, it seems reasonable to conclude that the individual scales and the measure as a whole will be able to demonstrate acceptable reliability after appropriate changes have been made to the measure.

Research Question #2: How do the client constructs assessed by the CEPCCI relate to the constructs underlying the providers' experience of their own multicultural counseling competence?

Hypothesis #2a: It is expected that the CEPCCI will have three factors, whereas the most psychometrically sound provider self-report measure of multicultural counseling competence, the CBMCS, has been demonstrated to assess four distinct factors. Thus, it is expected that the CEPCCI will assess a subset of the constructs assessed by the CBMCS

Hypothesis #2b: It is expected that the three factors making up the CEPCCI will be interpretable and able to be matched with subscales/factors from the CBMCS.

Rationale: Both the CEPCCI and the CBMCS have been influenced by the APA's Multicultural Guidelines (1993) and by the guidelines set forth by Sue and colleagues (1982, 1992, 1998). The CBMCS has been shown to have acceptable reliability and validity for measuring the four constructs it purports to measure. It is expected that the CEPCCI will also be shown to have acceptable reliability and validity and to demonstrate three distinct factors. Because of their common origins, it is expected that items on each of the measures will be closely related, and thus, when the proposed measure is completed by a provider, the constructs assessed by each of the measures should overlap substantially in a way that would allow them to be matched across assessments.

Research Question #3: What is the nature of the relationship between client perceptions of their providers' multicultural counseling competence, and the providers' self-perception of their ability in this area?

Hypothesis #3: It is expected that there will be a significant, positive relationship between provider-reported scores on the CBMCS and client-reported scores on the CEPCCI, but that only

a small portion of the variance in client-reported scores will be accounted for by provider self-report scores.

Rationale: Because mental health practitioners at both participating organizations have been trained to understand and use culturally competent techniques in their practice, it is expected that provider and client responses will be roughly similar. Though both sets of responses are expected to demonstrate the same general pattern of responses, 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 some other measures of multicultural counseling competence currently available, indicating that the constructs assessed through these measures differ by respondent.

Chapter IV: Results

The purpose of this chapter is to explain the psychometric properties of the instrument created to measure client perceptions of mental health providers' multicultural counseling competence, and to present the results of the exploration of the relationship between provider and client perceptions of providers' multicultural counseling competence.

Analysis and Results for Research Question #1

What constructs underlying the client experience of multicultural counseling competence can be identified? Are these constructs measured in a reliable and valid manner by the CEPCCI?

An exploratory factor analysis was conducted on the Client Experience of Provider Cultural Competence Inventory (CEPCCI) in order to determine an appropriate and interpretable factor structure underlying the measure items. In addition, all 38 individual items, as well as the scale as a whole, were evaluated for normality and reliability.

Preliminary Analyses

Before conducting a factor analysis, the characteristics of each of the 38 items were reviewed for skewness and kurtosis, both of which are indicators of a nonnormal distribution of responses. In general, skewness values having an absolute value greater than two, and kurtosis values greater than seven are considered indicative of nonnormality (Curran, West, and Finch, 1996); as seen in Table 4, all of the items on the CEPCCI have skewness and kurtosis values within these limits, indicating that analyses assuming univariate normality are appropriate for this data set.

Item means ranged from 3.08 to 3.49, and item standard deviations ranged from .577 to .780 (see Table 4). For every scale item, the skewness values were negative and the mean

Table 4

Item Characteristics

Item Number	Mean Item Score	Standard Deviation	Skewness	Kurtosis
1	3.49	.651	−1.265	1.941
2	3.46	.698	−1.308	1.752
3	3.31	.691	−.805	.623
4	3.27	.755	−.959	.836
5	3.27	.698	−.927	1.347
6	3.33	.737	−1.029	1.002
7	3.35	.726	−1.001	.826
8	3.30	.689	−.875	1.102
9	3.47	.590	−.919	1.578
10	3.28	.698	−.835	.901
11	3.41	.577	−.537	.389
12	3.33	.755	−1.160	1.413
13	3.31	.708	−.904	.885
14	3.22	.686	−.417	−.420
15	3.41	.603	−.626	.296
16	3.13	.729	−.459	−.177
17	3.07	.780	−.479	−.282
18	3.42	.641	−.789	.202
19	3.30	.697	−.875	.989
20	3.31	.716	−.995	1.208
21	3.42	.633	−.898	1.026
22	3.48	.679	−1.385	2.246
23	3.08	.727	−.476	.049
24	3.14	.655	−.268	−.204
25	3.37	.683	−.935	.934
26	3.40	.703	−1.219	1.842
27	3.36	.687	−1.006	1.346
28	3.38	.660	−.711	−.018
29	3.13	.668	−.269	−.327
30	3.35	.694	−.987	1.220
31	3.42	.698	−1.080	.986
32	3.37	.690	−.947	.851
33	3.37	.666	−.929	1.136
34	3.38	.677	−.959	1.050
35	3.46	.693	−1.321	1.874

Table 4, continued

36	3.23	.666	−.526	.243
37	3.23	.674	−.532	.158
38	3.45	.685	−1.387	2.512

Note. Items were scored on a scale from 1 (Strongly Disagree) to 4 (Strongly Agree).

score was greater than three, indicating that clients tended to respond positively about their provider's multicultural counseling competence.

Factor Analysis

Bartlett's Test of Sphericity (Bartlett, 1937) and the Kaiser-Meyer-Olkin Measure of Sampling Adequacy (KMO; Kaiser & Rice, 1974) were used to determine if factor analysis was an appropriate form of data reduction. The KMO estimates the proportion of variance that is caused by underlying factors; in general, samples with values greater than 0.8 are considered to be good candidates for factor analysis (Dziuban & Shirkey, 1974). For this data set, the KMO was 0.957, indicating that factor analysis was appropriate. Bartlett's Test of Sphericity tests the hypothesis that the population correlation matrix between the items is equivalent to the identity matrix, meaning that the variables are uncorrelated. This test was statistically significant (χ^2 = 7087.504, df = 703, $p < .0001$), indicating that linear relationships exist among the items on the CEPCCI, and again supporting factor analysis as an appropriate form of dimension reduction.

The factor analysis was conducted using SPSS version 20. Maximum-likelihood was used as the extraction method, per Costello & Osborne's (2005) recommendation that maximum-likelihood be used when data are generally normally distributed, as is the case with this data set. Kaiser's rule, Cattell's scree test, and parallel analysis were used to assist in the decision about how many factors to retain. Kaiser's rule produced three factors with eigenvalues greater than 1.0 (23.4, 1.4, and 1.1; see Appendix F); however, the scree plot (see Appendix F) showed a flattening at the second factor, indicating a one-factor solution. Parallel analysis, which is

considered by some to be the most accurate method for deciding how many factors to retain (Zwick & Velicer, 1986), confirmed that a one-factor solution is most appropriate (see Table 5), as only one factor had an eigenvalue that was statistically significant at the $\alpha = .05$ level. Many experts also agree that Kasier's rule tends to retain too many factors and is a less accurate method of selecting an appropriate factor structure (e.g., Costello & Osborne, 2005; Velicer & Jackson, 1990). This single factor explained 61.69% of the total variance in the measure items.

A factor loading greater than .5 can be considered a strong loading, and .32 is recommended as the minimum loading for an item to be considered for retention (Costello & Osborne, 2005). With a one-factor solution, factor loadings for scale items ranged from .626 to .880 (see Table 6), meaning that all items load strongly on the one retained factor. Costello & Osborne (2005) state that an ideal factor will have five or more strongly loading items; the retained factor in this study has 38 items with strong loadings.

There are a number of different guidelines in the literature dictating adequate sample size for factor analysis. There were a total of 184 clients who turned in a survey; of these, 182 of the surveys had all 38 items completed, and only two surveys were incomplete. These two incomplete surveys were excluded from analysis. As the study had a total of 182 client surveys that were retained, there were just fewer than five participants per variable. Most recommendations for adequate subject-to-variable ratio indicate that five participants per variable is an acceptable minimum (e.g., Gorsuch, 1983; Tinsley & Tinsley, 1987). Other researchers have found that total sample size is more important than this ratio; Comrey (1988) stated that a sample size of approximately 200 is acceptable in most cases of factor analysis involving no more than 40 items.

Table 5

Parallel Analysis Eigenvalues

Factor	Raw Data Eigenvalue	95th Percentile Criterion Eigenvalue
1	23.32**	1.37
2	1.14	1.22
3	0.79	1.10

**= statistically significant at $\alpha = .05$

However, more recent studies have indicated that appropriate sample size is (at least in part) determined by the nature of the data, and that accurate analysis is also a function of the strength of the data (Costello & Osborne, 2005; MacCallum, Widaman, Zhang, & Hong, 1999). Two attributes are considered indicative of strong data: high communalities (i.e., a high proportion of each variable's variance that can be explained by the extracted factors), and a large number of variables having high loadings on each factor (Costello & Osbourne, 2005). MacCallum et al. (1999) found that a sample size of 100–200 will still allow for accurate factor extraction in cases where there are more than six indicators per factor and communalities are approximately .5. The mean communality for a one-factor solution including all 38 variables was calculated to be .61 (see Table 7), indicating that the achieved sample size of 182 is adequate. A one-factor solution accounted for less than 40% of the variance in only one of the 38 variables [Item 10: My counselor is aware of the barriers (money, transportation, child care, language, schedule, etc.) I may have faced to participate in treatment here]. A total of seven variables (Items 1, 2, 3, 4, 10, 23, and 29) had a communality value less than .5, indicating that less than half of the variance in these items was accounted for by the extracted factor.

Table 6

Factor Loadings for One-Factor Solution

Item Number	Factor Loading	Item Number	Factor Loading
1	.660	20	.858
2	.669	21	.804
3	.642	22	.849
4	.661	23	.674
5	.728	24	.710
6	.800	25	.758
7	.795	26	.858
8	.767	27	.785
9	.751	28	.811
10	.626	29	.645
11	.782	30	.859
12	.743	31	.880
13	.771	32	.893
14	.769	33	.754
15	.837	34	.853
16	.771	35	.878
17	.717	36	.768
18	.848	37	.761
19	.848	38	.857

Cronbach's alpha was calculated to assess the reliability of the measure as a whole. For the entire scale (including all 38 items), alpha was 0.98; values greater than 0.9 are considered indicative of excellent internal consistency (Kline, 1999).

Though it was hypothesized that three factors would emerge, all of the items on the CEPCCI were found to load on one factor, meaning that they all assess the clients' general perception of their providers' multicultural counseling competence. As hypothesized, the CEPCCI demonstrated good reliability in the study sample, as demonstrated by the high level of internal consistency between the items on the measure. In general, the CEPCCI appears to have acceptable psychometric properties for use in research.

Table 7

Extraction Communalities for One-Factor Solution

Item Number	Extraction Communality	Item Number	Extraction Communality
1	.435	20	.736
2	.448	21	.646
3	.413	22	.721
4	.437	23	.454
5	.529	24	.505
6	.640	25	.575
7	.632	26	.737
8	.589	27	.616
9	.564	28	.658
10	.392	29	.416
11	.612	30	.738
12	.552	31	.774
13	.594	32	.798
14	.592	33	.568
15	.700	34	.728
16	.595	35	.770
17	.514	36	.590
18	.720	37	.579
19	.718	38	.734
		Mean	.606

Analysis and Results for Research Question #2

How do the client constructs assessed by the CEPCCI relate to the constructs underlying the providers' experience of their own multicultural counseling competence?

The items and factors of the California Brief Multicultural Competence Scale (CBMCS) were examined to determine a qualitative fit between the client perception construct assessed by the CEPCCI and a subset of the provider perception constructs assessed by the CBMCS.

The four factors of the CBMCS include: Nonethnic Ability, Awareness of Cultural Barriers, Multicultural Knowledge, and Sensitivity to Consumers (see Appendix D). An

examination of the items loading on each of these factors indicated that the "Sensitivity to Consumers" factor appears to ask questions similar to those posed by the CEPCCI (see Table 8). The "Sensitivity to Consumers" is the subscale on the CBMCS most likely to measure a construct that is closely related to the single construct assessed by the CEPCCI. This qualitative analysis was also supported by the results of the computed Pearson correlations between scores on the subscales of the CBMCS and scores on the CEPCCI (see below).

In summary, both parts of the second hypothesis were supported, as the CEPCCI does appear to assess a subset of the constructs measured by the CBMCS, and the construct assessed by the CEPCCI can be matched to the "Sensitivity to Consumers" factor from the CBMCS.

Analysis and Results for Research Question #3

What is the nature of the relationship between client perceptions of their providers' multicultural counseling competence, and the providers' self-perception of their ability in this area?

As the CEPCCI was found to assess only one factor, correlation was used to determine the nature of the relationship between client perceptions of their providers' multicultural counseling competence, and providers' own self-perception of their ability in this area. Due to the nature of the analytic methods available given the single-factor solution, the role of a methods factor could not be precisely determined. Client perceptions were measured by computing the sum of the scores for the items on the CEPCCI, and provider perceptions were measured by computing the sum of the scores for the items on the Sensitivity to Consumers subscale of the CBMCS. Further exploration into the nature of this relationship was conducted by examining the correlation between the client's CEPCCI sum score and the total sum score for the providers' responses on the CBMCS.

Table 8

Comparison of CBMCS and CEPCCI items

CBMCS "Sensitivity to Consumers" Items	CEPCCI Items
My communication is appropriate for my clients	My counselor speaks in a way that I understand.
	My counselor uses the language I am most comfortable with.
I am aware of institutional barriers that affect the client	My counselor considers how discrimination might affect me (e.g. racial, ethnic, language, immigration status, sexuality, economic, political, etc.).
	My counselor is aware of the barriers (money, transportation, child care, language, schedule, etc.) I may have faced to participate in treatment here.
I am aware of how my own values might affect my client	My counselor doesn't impose his/her own values and beliefs on me.
	My counselor respects my values and beliefs.

Some providers had multiple clients who participated in this study, so a random number generator from the website www.random.org was used to determine which client response would be retained for each provider. A total of 34 provider–client pairs were used for this analysis

Preliminary Analyses

Normality. The variables used in a Pearson correlation must be approximately normally distributed, though the statistic has been found to be fairly robust against some violations of this assumption (e.g., Havlicek & Peterson, 1976). This distribution can be determined by a visual analysis of histograms that plot frequencies of the variable values and by computing the Shapiro-Wilk statistic. An examination of the histogram for the Provider CBMCS Sum Score showed that the variable appeared to be normally distributed, and the Shapiro-Wilk statistic indicated that the variable's distribution is not significantly different from a normal distribution (see Appendix G).

The histograms for the variables Client CEPCCI Sum Score and Provider "Sensitivity" Scale Sum Score appear to have a somewhat nonnormal distribution, so a more precise method of assessing normality was also used. The Shapiro-Wilk statistic indicated that both distributions were significantly different from a normal distribution (see Appendix G). *Z*-scores were then calculated for the skew and kurtosis statistics for each of these variables, to determine the nature of their distributions. *Z*-score calculations showed that the skew and kurtosis of the Client CEPCCI score distribution were nonsignificantly different from a normal distribution by this metric. Provider "Sensitivity" subscale scores were found to have acceptable kurtosis, but to be moderately, positively skewed (Skew = .991, $z = 2.46$, $p < .05$). This determination is based on the rule-of-thumb that skew statistics with an absolute greater than 0.5 and less than 1 are moderately skewed (Bulmer, 1979).

Linearity and outliers. The Pearson product-moment correlation also assumes that there is a linear relationship between the variables and that there are no outliers. An examination of the scatterplots indicated that there is a linear relationship between the variables and that there are no outliers in the data set. An examination of standard deviation scores for each of the data points confirmed that there are no outliers for either of the variables (see Appendix G).

Pearson Correlation

The sum of provider self-report scores on the Sensitivity to Clients subscale of the CBMCS was correlated with the sum of client response scores on the CEPCCI using a Pearson product-moment correlation. The correlation was statistically significant [$r = .385$, $p = 0.025$, n=34], indicating that there is a significant, positive relationship between one aspect of provider self-perception and client perception of their providers cultural counseling competence. With $r^2 = .148$, approximately 15% of the variability in the client's perception could be accounted for by

providers' self-perception of their sensitivity to clients. A scatterplot for this relationship can be seen in Figure 5.

Pearson product-moment correlations between the sum of client response scores on the CEPCCI and provider self-report sum scores for the other three subscales of the CBMCS (Nonethnic Ability, Awareness of Cultural Barriers, and Multicultural Knowledge) were not significant at the $\alpha = .05$ level.

The sum of provider self-report scores on the full CBMCS was correlated with the sum of client response scores on the CEPCCI using a Pearson product-moment correlation. The correlation was statistically significant [$r = .378$, $p = 0.028$, $n = 34$], indicating that there is a significant, positive relationship between provider self-perception and client perception of their providers' cultural counseling competence. With $r^2 = .143$, approximately 14% of the variability in client perception could be accounted for by providers' self-perception of their ability. A scatterplot for this relationship can be seen in Figure 6.

Achieved power of the analyses were calculated using the G*Power program, version 3.1. With $N = 34$, $\alpha = .05$, and the observed r-values for the five analyses performed , G*Power indicated that achieved power for the analyses ranged from .70 to .74. This means that there was a 70-74% chance that the analyses performed would detect a relationship, if the relationship actually existed.

In summary, there is a significant, positive relationship between mental health providers' self-perception of their sensitivity toward their clients and the clients' perception of their providers' cultural counseling competence. There is also a significant, positive relationship between mental health provider's overall self-perception and the clients' perception of their providers' multicultural counseling competence. It appears that hypothesis #3 was supported by

the data, as clients and providers have roughly similar perceptions of the providers' multicultural counseling competence abilities and only a small portion (14-15%) of the variance in client perception could be accounted for by providers' self-perception of their abilities.

Chapter V: Discussion

The purpose of this dissertation study was to create an instrument that could assess the cultural competence of mental health services from the client's perspective, determine how the constructs underlying client perceptions relate to those underlying provider perceptions, and explore the relationship between provider and client perceptions of the providers' ability. Though it was expected that three factors would emerge from the measure, the research demonstrated that only a single factor was assessed by the Client Experience of Provider Cultural Competence Inventory (CEPCCI). As predicted, this factor could be interpreted and mapped to a construct assessed by the California Brief Multicultural Competence Scale (CBMCS), a psychometrically sound instrument that measures the providers' assessment of their own abilities. Specifically, the CEPCCI mapped onto the "Sensitivity to Consumers" CBMCS subscale. It was also hypothesized that the CEPCCI would have acceptable reliability, and it did exceed established minimums for this psychometric property. The prediction that there would be a significant relationship between provider and client perceptions was also supported by this research. The results of this study provide strong preliminary support for the psychometric quality of a measure of client-reported evaluation of provider cultural competence when no such measure has previously existed.

The main focus of this study was to create a psychometrically sound instrument that could give voice to client perceptions of their providers' cultural counseling competence. Through this research, good content validity, reliability, and construct validity were established for the CEPCCI as an instrument with a single factor. The items for the measure were selected from well-established theory and research, and were deemed by content experts—including people with graduate training in cultural competence and experience working in community

mental health settings, as well as a group of community mental health clients—to appropriately assess cultural competence from the consumer's perspective. The overall reliability of the measure, as determined by Cronbach's alpha, exceeded the acceptable minimum. When a factor analysis was computed, one strong factor emerged from the measure items, indicating that the CEPCCI measures a single concept. This single factor maps to the "Sensitivity to Consumers" subscale on the CBMCS, a provider self-report measure of multicultural counseling competence.

Although the reliability and validity of the measure were correctly predicted by the hypotheses, the number of factors assessed by the CEPCCI was not. It was hypothesized that three constructs would emerge from the CEPCCI because the guidelines set forth by Sue and colleagues (1982, 1992, 1998) propose three distinct components of multicultural counseling competence (attitudes, knowledge, and skills), and it was initially believed that clients could provide insight into their providers' competence in each of these areas. When the measure creation group met to combine the statements from Sue et al. (1998) and Davis (2007) to generate items for the measure, however, the items that were deemed inappropriate for client response were most frequently from the attitudes and knowledge categories. Though many knowledge and awareness items were reworded for inclusion in the administered measure, the extensive discussion around "What can a client reasonably provide comment on?" made it evident that the nature of the construct(s) underlying client perceptions were different from those underlying their providers' self-perceptions.

Given that only one factor emerged on the CEPCCI, it appears that clients may not differentiate among the provider's knowledge, attitudes, and skills relating to cultural competence. Rather the client is sensitive to the provider's integration of these components into a single, interrelated construct of cultural competence. For example, a client may not be able to

articulate her counselor's "knowledge of models of minority and majority identity, and understand[ing of] how these models relate to the counseling relationship and the counseling process" (Sue et al, 1992, pp. 88) but she will be able to discuss the results of this knowledge as reflected in her provider's empathy (or lack thereof) when issues of identity come up. Conversely, it is also possible clients would have been able to distinguish between these attributes, but the panel creating the measure underestimated a client's ability to offer insight into their providers' knowledge and attitudes and deemed too many of these items inappropriate for inclusion in a client measure. In this case, the client participants may not have been given sufficient opportunity to demonstrate their ability to distinguish between the attributes underlying their provider's cultural competence abilities.

The factor structure of the CBMCS also offers insight into the nature of the construct underlying the client's experience and how those relate to the constructs that have been established as part of the provider's experience. The CBMCS is the provider measure used in this research, and it has been shown to assess four constructs: Nonethnic Ability, Awareness of Cultural Barriers, Multicultural Knowledge, and Sensitivity to Consumers. The Sensitivity to Consumers subscale measures the providers' perceptions of the way in which the other factors underlying their multicultural counseling competence play out in their relationship with their clients, and it is conceptually distinct from the provider competence constructs that explicitly assess ability/skills, awareness, and knowledge. Since the questions on the Sensitivity to Consumers subscale are those that most closely map to the items on the CEPCCI, it supports the idea that the CEPCCI functions in a similar way: it assesses the way that providers' ability, awareness, and skills express themselves within the counseling relationship.

The single factor structure of the CEPCCI contrasts with a previous attempt to create a

client measure, the Cultural Competency Inventory (CCI; Cornelius et al., 2004). These authors found four components underlying their conceptualization of cultural competence from the consumer's perspective. There are a number of possible explanations for this disagreement, including the difference in the psychometric properties, structure, and theoretical underpinnings of the two measures. The authors of the CCI were unable to demonstrate acceptable reliability and construct validity for the components of their scale, as alpha estimates for the subscales were not all above acceptable minimums, and principal components analysis did not yield interpretable components. Fortunately, the researchers creating the CEPCCI were able to take into account the limitations of the CCI when designing this study; the CEPCCI used a 1–4 Likert scale instead of dichotomous items, factor analysis instead of principal components analysis to determine an appropriate factor structure, and used well-regarded theory to develop the scale: Sue et al.'s highly regarded tripartite model (1982, 1992, 1998) and Davis' 2007 mixed methods study investigating client perceptions of providers' multicultural counseling competence within a systems of care framework.

The single-construct conceptualization of provider cultural competence from the client's perspective is also supported by the research conducted on the only other psychometrically validated observer measure, the Cross-Cultural Counseling Inventory–Revised (CCCI-R; LaFramboise et al., 1991). The CCCI-R is also based on Sue et al.'s 1982 tripartite model, and although it contains questions in three areas (Cross-Cultural Counseling Skill, Sociopolitical Awareness, and Cultural Sensitivity), factor analysis suggested that it measures only one factor (LaFramboise et al., 1991). This single-construct model was also verified in a second study on the psychometric properties of the measure (Sabnani & Ponterotto, 1992). Though the CCCI-R was created for and normed on university supervisors evaluating the competency of a practicing

counselor during observation of a counseling session, there is a conceptual link between what a client and a trained observer could be expected to understand about a provider's abilities after a counseling session. Like a client, a supervisor cannot determine exactly what awareness, knowledge, and skills a provider possesses; a supervisor can only assess the way that these attributes express themselves within the counseling relationship that he or she is observing. This single construct is related to, but distinct from, the knowledge, awareness, and skills that make up a provider's multicultural counseling competence ability.

Researchers in the field have often noted the lack of viable options for assessing the client's perspective of their provider's cultural competence (e.g., Constantine & Ladany, 2001; Gamst, Dana, Der-Karabetian, Aragon et al., 2004) and 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). The CEPCCI shows promise as a psychometrically solid instrument that can meet this demonstrated need and assist the development of a more complete picture of multicultural counseling competence and its impact on clients.

A secondary purpose of this study was to determine the relationship between client and provider perceptions of the providers' multicultural counseling competence. As predicted, there was a positive relation between client responses on the CEPCCI and provider responses on the CBMCS, a provider self-report measure with established psychometric properties, meaning that providers are relatively accurate when assessing their own cultural competence. In particular, there was a significant correlation between the sum of provider self-report scores on the Sensitivity to Clients subscale of the CBMCS and the sum of client response scores on the CEPCCI, as well as significant correlation between the sum of the provider self-report scores for

all items on the CBMCS and the sum of the client response scores on the CEPCCI. The Sensitivity to Clients subscale assesses the provider's understanding of his or her impact on the client, whereas the total score for the CBMCS is representative of the provider's overall multicultural counseling competence ability.

This is a noteworthy finding as no previous research has examined the relationship between provider self-reported and client-reported multicultural counseling competence. Both of these findings could have significant implications for the way that researchers, practitioners, and teachers understand and assess multicultural counseling competence, as they provide preliminary evidence that clients and providers tend to view the providers' cultural competence in a similar way. Furthermore, these findings verify that providers can be relatively accurate judges of their own abilities in this area, in contrast to previous research, which has found no relationship between scores on practitioner self-report measures and other accepted measures of cultural competence, such as multicultural case conceptualization ability (Constantine & Ladany, 2000; Ladany et al., 1997).

Limitations

One of the most significant limitations of the study is the failure to fully take into account the client's thoughts on cultural competence in the process of measure development. As the purpose of creating a client measure was to give clients a voice, it seems important that the client should have significant input in how culturally competent practice is defined. Unfortunately, there have been few qualitative, theory-building studies on multicultural counseling competence from the client's perspective. While Sue et al.'s (1982, 1992, 1998) theory is well-regarded and widely accepted, it was conceived and created by academics, with a focus on what counseling professionals believe that other professionals should consider in their practice. Davis' (2007)

mixed-methods study incorporated client perspective into a broader discussion with providers, administrators, and organizations. No studies were found that look specifically and exclusively at the client's conception of what cultural competence means in this context, and it is possible that the available research and theory does not adequately express the client's definition of cultural competence.

As with many satisfaction measures, there also appears to be a ceiling effect with client-reported scores on the CEPCCI. In general, clients liked their providers and gave them high scores; the mean score for every item on the measure was over 3, out of a possible 4 points, and every item has a negative skew statistic, indicating that the responses tended to be higher scores, and only a few responses, in the tail of the distribution, were lower. A similar pattern was observed in the CEPCCI scale sum scores. This restriction of variance impacts the validity of the findings and could be an alternate explanation for the single-factor structure of the CEPCCI.

Unique characteristics of the participants are another study limitation. Because of the nature of the two organizations that participated in this study, the clients served by Organization A and Organization B were almost exclusively low-income and high-need clients, many having multiple serious, chronic physical and mental health issues. Though this group is representative of many clients seeking community mental health care, their experiences and worldviews are likely different from clients who need lower levels of care or who have a higher socioeconomic status. In a similar vein, although ethnic and racial minorities are overrepresented in the community behavioral health population, the majority of study participants indicated they were White. While approximately 13% of participants chose not to disclose demographic information, the racial and ethnic breakdown of the participants who did respond was representative of the region in which the research was conducted, and it is likely that those who did not respond would

break down similarly. As the measure's specific goal is assessing cultural competence with regard to race and ethnicity, the limited diversity of the norming sample—particularly the underrepresentation of Asian and Native American respondents—is a substantial limitation. The nature of cultural competence, and the perspectives of clients and providers, may vary across setting, region, culture, race, and ethnicity, and the size and diversity of the sample used in the present study did not allow for the exploration of this possibility. The factor structure that emerged with this population may not be stable across populations that vary.

The nature of the services provided by the participating organizations is another limitation of the study, as the client participants were receiving a wide variety of mental health services provided by a range of professionals. Given the realities of government-funded managed mental health care for high-risk and high-need populations, traditional counseling was not the service being evaluated for many of the client-provider pairs in the study. Though all client participants considered the mental health professional in question to be a "counselor," what that meant within the context of each provider-client relationship varied. Some providers were Licensed Professional Counselors providing more traditional therapy; others were Social Workers serving in a case-management role, in addition to providing some counseling and direction to their clients; still others were Chemical Dependency Counselors, providing support through a rehabilitation plan, which was, in some cases, court-mandated. While Davis' (2007) study was based in a systems of care framework, which includes a wider variety of services, Sue et al.'s (1982, 1992, 1998) theory is conceptually rooted in the client-provider relationship in a more traditional therapeutic context. This mismatch between the reality of mental health care as provided at the sites, and the assumptions of one of the theories used to create the measure is a limitation of the study.

Finally, a limitation of this study related to the observed relationship between client- and provider-reported multicultural counseling competence is the failure to control for any of the many related variables that could have contributed to the correlation, including racial/ethnic match of clients and providers, the general counseling ability of the providers, and the racial identity development of all participants. The impact of these variables on both the provider's self-assessment of his or her own cultural competence and the client's assessment of the provider's abilities is currently unknown.

Directions for Future Research

The present study was an exploratory analysis of the CEPCCI, and further work can be done to strengthen the psychometric claims of the measure. A confirmatory factor analysis should be conducted to confirm that a one-factor solution is the appropriate structure of the instrument. In addition, the CEPCCI currently contains 38 questions that load on only one factor. Factors are generally considered to be "strong" if they contain 5 or more items with high loadings (Costello & Osborne, 2005), so the measure can likely be shortened significantly without sacrificing validity. A shorter administration time would make using the survey in an applied context much easier.

An investigation into the factor structure across racial/ethnic and socioeconomic groups is another area for further research. It is possible that consumers from different groups have different conceptions of what it means for a mental health provider to practice in a culturally competent way; if so, the factor structure of the CEPCCI would vary across these groups. A stable factor structure would indicate that the concept of cultural competence is universal across different client groups, and provide support for Sue et al.'s (1982, 1992, 1998) theory of multicultural counseling competence, which assumes racial invariance.

Though a significant relationship was observed between client and provider scores on measures of the providers' cultural competence, much more research can be done to examine the nature of this relationship. More research should be done to explore the variables (such as racial identity development, racial/ethnic match of client and provider, and the overall counseling ability of the provider) that may mediate or moderate the relationship between client and provider perceptions. In addition, cultural competence depends, at least in part, on the provider's familiarity with the client's culture, and the perceived level of competence of a single provider may vary depending on the race and ethnicity of the client. Use of hierarchical linear modeling could allow for a better understanding of how client perceptions for a single provider vary across clients from different backgrounds. Further study in this area would further the field's understanding of the nature of cultural competence and help establish a research-based foundation for more effective training and, ultimately, more respectful and inclusive practice.

In addition to these areas of research, a number of studies would represent a natural outgrowth of the present findings, given the substantial gaps in the multicultural counseling competence literature. Perhaps the most important of these are further studies investigating the outcomes associated with varying levels of provider multicultural counseling competence. In recent years, the groups that govern the ethics and standards of practice for mental health professionals, including the American Psychological Association (1993, 2003) and the American Counseling Association (2005), have taken significant steps to ensure that practitioners understand the importance of inclusive and respectful practice. During this same period, there has also been an increased emphasis on the importance of using evidence-based practices in the treatment of mental health problems. Establishing criterion validity, such as improved therapeutic outcomes, is essential to ensuring that groups such as the APA continue to emphasize

the importance of training mental health professionals in equitable practices that take into account the diversity of clients. If research is not conducted that bears out the clinical effectiveness of culturally competent practice, this focus may shift as time passes, effectively reversing the significant improvements made in these areas in recent decades. In fact, recent research conducted using client measures that had not been properly normed found that better therapeutic outcomes were not associated with counselors who were rated by their clients as having a higher level of cultural competence (Owen, Leach et al., 2011). It would be a grave disservice to mental health consumers to allow this finding to go unchallenged, when the measure used to obtain this outcome was administered in a manner inconsistent with its intended use.

In a similar vein, given the increasing emphasis on evidence-based practice, further investigation into the cultural appropriateness of various forms of therapy should be conducted. The evidence basis of many methods has been established on a highly educated and largely White slice of the population, and the assumption is often made that these results are generalizable to the population as a whole, and that race and ethnicity do not or should not play a role in the effectiveness of these treatments. There has been minimal research to determine whether these assumptions are justified, in part because of a lack of appropriate instrumentation (Fuertes et al., 2001). The CEPCCI will allow researchers to incorporate the client's perspective on the role of race, ethnicity, and culture in effective mental health treatment.

Summary

The purpose of this study was to use established and research-based theory to develop and norm a client measure of multicultural counseling competence and to compare client and provider perceptions of the provider's multicultural counseling competence. The reliability and

the content and construct validity of the created instrument (the Client Experience of Provider Cultural Competence Inventory; CEPCCI) were established in order to determine the viability of its use in community health settings as well as in subsequent research, and a significant relationship between provider and client perceptions of providers' multicultural counseling ability was observed.

The findings of the current study have the potential to advance the area of multicultural counseling competence by providing a psychometrically sound way to incorporate the consumer perspective into the assessment of this construct, an advancement that has been long anticipated by researchers (e.g., Fuertes et al., 2001; Fuertes & Brobst, 2002; Gamst, Dana, Der-Karabetian, Aragon et al., 2004; Pope-Davis et al., 2001). Substantial research is needed in the area of multicultural counseling competence to verify the intuitive beliefs and opinions of researchers in this field; now that there is a way to measure this, the more difficult work of developing a research-based understanding of the impact of culturally competent practice can begin.

Appendix A: Sue et al.'s 1998 Multicultural Counseling Competencies

COUNSELOR AWARENESS OF OWN ASSUMPTIONS, VALUES, AND BIASES

Beliefs and Attitudes

1. Culturally skilled counselors have moved from being culturally unaware to being aware and sensitive to their own cultural heritage and to valuing and respecting differences.
2. Culturally skilled counselors are aware of how their own cultural background and experiences, attitudes, and values and biases influence psychological processes.
3. Culturally skilled counselors are able to recognize the limits of their competencies and expertise.
4. Culturally skilled counselors are comfortable with differences that exist between themselves and clients in terms of race, ethnicity, culture, and beliefs.

Knowledge

1. Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of normality-abnormality and the process of counseling.
2. Culturally skilled counselors possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows them to acknowledge their own racist attitudes, beliefs, and feelings. Although this standard applies to all groups, for White counselors it may mean that they understand how they may have directly or indirectly benefitted from individual, institutional, and cultural racism (White identity development models).
3. Culturally skilled counselors possess knowledge about their social impact upon others. They are knowledgeable about communication style differences, how their style may clash or facilitate the counseling process with minority clients, and how to anticipate the impact it may have on others.

Skills

1. Culturally skilled counselors seek out educational, consultative, and training experiences to enrich their understanding and effectiveness in working with culturally different

populations. Being able to recognize the limits of their competencies, they (a) seek consultation, (b) seek further training or education, (c) refer out to more qualified individuals or resources, or (d) engage in a combination of these.

2. Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a nonracist identity.

UNDERSTANDING THE WORLDVIEW OF THE CULTURALLY DIFFERENT CLIENT

Beliefs and Attitudes

1. Culturally skilled counselors are aware of their negative emotional reactions toward other racial and ethnic groups that may prove detrimental to their clients in counseling. They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion.
2. Culturally skilled counselors are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups.

Knowledge

1. Culturally skilled counselors possess specific knowledge and information about the particular group that they are working with. They are aware of the life experiences, cultural heritage, and historical background of their culturally different clients. This particular competency is strongly linked to the "minority identity development models" available in the literature.
2. Culturally skilled counselors understand how race, culture, ethnicity, and so forth may affect personality formation, vocational choices. manifestation of psychological disorders, help-seeking behavior, and the appropriateness or inappropriateness of counseling approaches.
3. Culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge upon the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping, and powerlessness all leave major scars that may influence the counseling process.

Skills

1. Culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders of various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills.
2. Culturally skilled counselors become actively involved with minority individuals outside the counseling setting (community events, social and political functions, celebrations, friendships, neighborhood groups, and so forth) so that their perspective of minorities is more than an academic or helping exercise.

DEVELOPING APPROPRIATE INTERVENTION STRATEGIES AND TECHNIQUES

Beliefs and Attitudes

1. Culturally skilled counselors respect clients' religious and/or spiritual beliefs and values about physical and mental functioning.
2. Culturally skilled counselors respect indigenous helping practices and respect minority community intrinsic help-giving networks.
3. Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling (monolingualism may be the culprit).

Knowledge

1. Culturally skilled counselors have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture bound, class bound, and monolingual) and how they may clash with the cultural values of various minority groups.
2. Culturally skilled counselors are aware of institutional barriers that prevent minorities from using mental health services.
3. Culturally skilled counselors have knowledge of the potential bias in assessment instruments and use procedures and interpret findings keeping in mind the cultural and linguistic characteristics of the clients.

4. Culturally skilled counselors have knowledge of minority family structures, hierarchies, values, and beliefs. They are knowledgeable about the community characteristics and the resources in the community as well as the family.
5. Culturally skilled counselors should be aware of relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served.
6. The culturally skilled psychologist or counselor has knowledge of models of minority and majority identity, and understands how these models relate to the counseling relationship and the counseling process.

Skills

1. Culturally skilled counselors are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach to helping but recognize that helping styles and approaches may be culture bound. When they sense that their helping style is limited and potentially inappropriate, they can anticipate and ameliorate its negative impact.
2. Culturally skilled counselors are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a "problem" stems from racism or bias in others (the concept of healthy paranoia) so that clients do not inappropriately blame themselves.
3. Culturally skilled counselors are not averse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate.
4. Culturally skilled counselors take responsibility for interacting in the language requested by the client; this may mean appropriate referral to outside resources. A serious problem arises when the linguistic skills of the counselor do not match the language of the client. This being the case, counselors should (a) seek a translator with cultural knowledge and appropriate professional background or (b) refer to a knowledgeable and competent bilingual counselor.

5. Culturally skilled counselors have training and expertise in the use of traditional assessment and testing instruments. They not only understand the technical aspects of the instruments but are also aware of the cultural limitations. This allows them to use test instruments for the welfare of the diverse clients.
6. Culturally skilled counselors should attend to as well as work to eliminate biases, prejudices, and discriminatory practices. They should be cognizant of sociopolitical contexts in conducting evaluations and providing interventions, and should develop sensitivity to issues of oppression, sexism, and racism.
7. Culturally skilled counselors take responsibility in educating their clients to the processes of psychological intervention, such as goals, expectations, legal rights, and the counselor's orientation.
8. The culturally skilled psychologist or counselor can tailor his or her relationship building strategies, intervention plans, and referral considerations to the particular stage of identity development of the client, while taking into account his or her own level of racial identity development.
9. Culturally skilled counselors are able to engage in psychoeducational or systems intervention roles, in addition to their clinical ones. Although the conventional counseling and clinical roles are valuable, other roles such as the consultant, advocate, adviser, teacher, facilitator of indigenous healing, and so on may prove more culturally appropriate.

Appendix B: Davis' 2003 Statements of Cultural Competence

Cluster 1: Service Provider Competencies

- Providers take time to get to know and build rapport with children and families they serve
- Service providers welcome the involvement of an objective family advocate
- Providers don't assume families won't understand what's going on with the family or situation
- Service providers know when to offer empathic or sympathetic support to families
- Services are child centered and allow children to have a voice in what services they receive
- Providers work with and provide services to the entire family rather than only the identified child
- Service providers don't impose their own values and beliefs on families
- Providers are willing to ask questions and allow families to be experts on their own cultures

Cluster 2: Family-Centered Services

- Services provided are based on the specific needs of families
- Roles of each person involved in services are clear (parent, counselor, child)
- Services providers truly understand what's important to families
- Services and programs meet the scheduling needs of the family
- Services to families are nonjudgmental and affirming of the families' cultures and backgrounds
- Service provision involves mutual understanding between providers and families
- Services are family driven (families are in charge of their own services)

Cluster 3: Provider-Family Interaction

- Service providers truly support, value, and preserve the individual cultures of the families
- Service providers and families are able to use humor in their relationships
- Trusting relationships are built between providers and families
- Service providers and families truly work as a team
- Providers value and honor input from the whole family
- Families and service providers are not judgmental of one another
- Parents are kept informed of their child's treatment and progress
- Service providers use family-friendly language that is free of technical jargon
- Service providers respect parents' choices without being judgmental

Cluster 4: Culturally Accountable System Policies

- Services are inclusive of all persons without discrimination
- A continuum of coordinated services and providers enables smooth service transitions for families
- The service systems support efforts to broaden services beyond "traditional" service provision
- Services lead to improving families' progress toward meeting their goals
- Agencies work together (combine resources, information, and efforts) to meet families' goals
- There is equal opportunity services for all individuals
- Consumers are not submitted to abusive workers (verbal abuse, physical management, environmental constraints)
- Service providers are educated about the cultural differences of families they are serving
- Culturally appropriate services are ensured to meet the needs of families
- Systems and service providers reflect ("look like") the diverse cultures in their community

Cluster 5: Provider Accountability to Families

- Service plans are put in writing so everyone can be held accountable
- Providers think outside the box of their job description and extend themselves in serving families
- Service providers have a credible reputation for serving families
- Services are available for mental health and mental retardation dual diagnoses needs
- Care is developmentally appropriate and not diagnosis driven
- Providers make every effort to find help for families without passing the buck to another agency
- Providers actually do what they say they are going to do
- Providers can admit that they don't have the understanding necessary for working with a family
- Providers consider the culture of the whole person (spiritual, physical, financial, mental, family unit)

Cluster 6: Culturally Appropriate Services

- Services to families are provided using a multidisciplinary approach
- Flexibility is built into the service system to provide unique or nontraditional services to meet family needs
- There is consistency in who provides services to families
- Services are individualized (not everyone is offered the exact same services in the exact same way)
- Services are provided within families' own communities
- Services are available to families regardless of families' financial resources
- Services and supports are strengths based and draw on the exiting resources of families

Cluster 7: Government or Agency Community Involvement

- The government's understanding of the community's service needs is supported through appropriate funding allocation structures
- Decision-making bodies change services to meet the needs of the whole community
- Policy (legislated and agency) permits providers flexibility to do what's needed for families
- Organizations provide community-specific cultural competence training to employees at all levels
- There is interagency cultural and historical understanding
- Community ownership of services is valued by community members and supported by providers
- Practitioners can actually affect changes in the system of care
- The cultural demographics of those served reflect the community's population.

Cluster 8: Agency Policies

- Workers are given rapid due process for accusations made by consumers
- Agency policies allow employees to have case-related grief time
- Professional and direct-care staff receive equitable pay
- Staff are hired who have experienced mental health illnesses
- Services and systems are noncompetitive

Cluster 9: Removing Restrictions to Access

- "Red tape" is not a barrier to families accessing services
- Services to families remain consistent across political parties
- Employers are supportive of employees who have family members with special needs
- There is continuity of care for families over the long haul
- There are no more waiting lists
- People don't hear professionals make remarks based on ethnic origins
- Agency forms and documents are printed in the cultural language of families

Cluster 10: Education Involvement and Expectations

- The educational system is prepared to be a positive participant.
- The educational needs of all children are met and supported
- Higher education institutions know their communities and can teach students about alternative types of referrals
- There is not an overrepresentation of children in alternative education
- Continuing education is offered to both families and professionals.

Cluster 11: Family Empowerment

- Families are empowered by the strengths and differences of their culture
- Families are active in all aspects of services
- Families are invested in the service process
- Families have a lot of options for services
- Families view providers, policy makers, and agency administrators as helpful and motivating
- Family voice and choice are prioritized
- Families are given the time and consideration their situation deserves
- Opportunities are available for families to support and share information with one another
- Families feel they are treated with dignity and respect
- Families know that the service providers care
- Families feel listened to and heard by service providers
- Families are able to communicate in their own language with service providers.
- Families feel comfortable accessing services and asking questions of service providers.

Cluster 12: Respectful Responsiveness to Families

- Families get a response when they make a request
- Families have a lot of options available when choosing service providers
- Families are happy to see providers
- Families are referred to as people and don't feel labeled or stigma associated with receiving services
- Families' time is respected
- Families are accurately informed of services and resources that are available to them
- Families and service providers are willing to share their cultures and beliefs with each other

Cluster 13: Outcomes and Accomplishments

- Families can access services and providers with no barriers (transportation, language, education, cost)
- Families get politically involved in advocating for change in government policies.
- Noticeable progress is made in child outcomes
- Kids are happy with themselves
- Children are allowed to be children
- Communication between parents and their children improves
- The elderly are valued
- There are ways to measure achievement
- Kids begin taking responsibility for their own behavior

Cluster 14: Positive Family and Provider Regard

- People know how to appropriately respond to crisis situations
- Everyone is treated equally in the service process
- Services enhance family life
- Persons don't insult one another by trying to be too culturally polite
- Animosity is not present between systems and families

Cluster 15: Responsive Family and Provider Communication

- Families understand how to use impartial grievance procedures
- The needs of families are met
- Families are satisfied with the services they receive
- Families are educated about the organizations' cultures and mandates
- There is two-way respectful communication between children and service providers
- Parents and children are individually treated with respect.
- The line of communication is always open
- Families are able to find resources on their own and use new resources to help themselves

Appendix C: California Brief Multicultural Competence Scale and Provider Demographic Form

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*

PRACTITIONER DEMOGRAPHIC FORM Date:

Identification Number

Gender (circle)

Male Female

Age _____

Race/Ethnicity (circle as many as apply)

Hispanic/Latino Black or African American White

American Indian or Alaska Native Asian

Native Hawaiian or other Pacific Islander Other _____

Sexual Orientation

Heterosexual Homosexual Bisexual Other_____

Degree Type (circle)

BA/BS MA/MS PhD/PsyD MD Other _____

Licensure Type _____

Site _____

Appendix D: Client Experience of Provider Cultural Competence Inventory and Client Demographic Form

Please circle your response

1. My counselor is helpful.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

2. My counselor does not judge me.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

3. My counselor considers how discrimination might affect me (e.g. racial, ethnic, language, immigration status, sexuality, economic, political, etc.).
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

4. If I asked him/her, my counselor would be willing to involve my family members in my treatment.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

5. My counselor understands my culture.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

6. My counselor talks about my strengths.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

7. My counselor motivates me.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

8. I am comfortable talking with my counselor about our differences.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

9. My counselor speaks in a way that I understand.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

10. My counselor is aware of the barriers (money, transportation, child care, language, schedule, etc.) I may have faced to participate in treatment here.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

11. My counselor respects my culture.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

12. My counselor tells me about services and resources that are available to me.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

13. My counselor keeps me informed about my treatment and progress.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

14. My counselor explains to me how therapy works.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

15. My counselor respects my values and beliefs.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

16. If I asked him/her, my counselor would be willing to get ideas from someone in my community about how to best help me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

17. My counselor explains my legal rights to me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

18. I feel comfortable asking questions in therapy.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

19. My counselor really understands what is important to me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

20. My counselor supports me in accessing other resources or services I might need.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

21. My counselor respects and values my language(s) and the way that I speak.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

22. I feel comfortable with my counselor.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

23. If I asked him/her, my counselor would be willing to get ideas from someone in my religious or spiritual group about how to best help me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

24. My counselor is willing to ask me questions about my culture.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

25. I have a say about what goes on in my treatment.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

26. My counselor is responsive.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

27. My counselor uses the language I am most comfortable with.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

28. My counselor and I decide together what to work on in therapy.

Strongly Disagree *Disagree* *Agree* *Strongly Agree*

29. My counselor lets me be an expert about my own culture.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

30. My counselor and I work as a team.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

31. I trust my counselor.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

32. My counselor takes time to get to know me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

33. My counselor doesn't impose his/her own values and beliefs on me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

34. My counselor does what they say they will.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

35. I am satisfied with my counselor.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

36. My counselor is comfortable talking about our differences.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

37. My counselor values my culture.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

38. My counselor cares about me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

CLIENT DEMOGRAPHIC FORM Date:

Identification Number _____

About how many sessions have you had with your counselor? _____

Gender (circle)

Male Female

Age _____

Highest Grade Completed in School _____

Sexual Orientation

Heterosexual (Straight) Gay or Lesbian Bisexual Other_____

Race/Ethnicity (circle as many as apply)

Hispanic/Latino Black or African American White

American Indian or Alaska Native Asian

Native Hawaiian or other Pacific Islander Other _____

Type of Service (circle)

Behavioral Health Medical Services Psychiatry Substance Use

Support Group Counseling (Individual) Counseling (Family)

Housing Services Other _____

Diagnosis (if any) _____

Site _____

Appendix E: Client Experience of Provider Cultural Competence Inventory and Client Demographic Form, Spanish

Por favor, encierre su respuesta en un círculo.

1. Mi consejero/a es servicial.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

2. Mi consejero/a no me juzga.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

3. Mi consejero/a considera cómo me pudiera afectar la discriminación (por ejemplo, discriminación racial, étnica, lingüística, de sexualidad, por estatus migratorio, o por razones económicas, políticas, etc.)
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

4. Si yo le preguntara a él / ella, mi consejero/a estaría dispuesto a involucrar a los miembros de mi familia en mi tratamiento.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

5. Mi consejero/a entiende mi cultura.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

6. Mi consejero/a habla de mis fortalezas.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

7. Mi consejero/a me motiva.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

8. Me siento cómodo/a hablando con mi consejero/a acerca de nuestras diferencias.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

9. Mi consejero/a habla de una manera que yo entiendo.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

10. Mi consejero/a está consciente de los obstáculos que he enfrentado para participar en esta consejería (dinero, transporte, cuidado infantil, el idioma, horario, etc.).
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

11. Mi consejero/a respeta mi cultura.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

12. Mi consejero/a me informa de los servicios y recursos disponibles que hay para mí.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

13. Mi consejero/a me mantiene informado/a sobre mi tratamiento y progreso.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

14. Mi consejero/a me explica cómo funciona la terapia.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

15. Mi consejero/a respeta mis valores y creencias.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

16. Si le preguntara a él / ella, mi consejero/a estaría dispuesto a recibir ideas de alguien de mi comunidad sobre la mejor manera de ayudarme.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

17. Mi consejero/a me explica mis derechos legales.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

18. Me siento cómodo/a haciéndole preguntas a mi consejero/a durante la terapia.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

19. Mi consejero/a verdaderamente entiende lo que es importante para mí.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

20. Mi consejero/a me apoya en acceder a otros recursos o servicios que pueda necesitar.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

21. Mi consejero/a respeta mi idioma(s) y la forma en que hablo.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

22. Me siento cómodo/a con mi consejero/a.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

23. Si le preguntara a él / ella, mi consejero/a estaría dispuesto a recibir ideas de alguien de mi grupo religioso o espiritual sobre la mejor manera de ayudarme.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

24. Mi consejero/a está dispuesto a hacerme preguntas sobre mi cultura.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

25. Tengo opinión sobre lo que pasa en mi tratamiento.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

26. Mi consejero/a responde con interés y entusiasmo.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

27. Mi consejero/a utiliza el idioma con el cual yo me siento más cómodo.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

28. Mi consejero/a y yo decidimos juntos en qué trabajar en la terapia.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

29. Mi consejero/a me permite ser un experto sobre mi propia cultura.
Completamente en desacuerdo En desacuerdo De acuerdo Completamente de acuerdo

30. Mi consejero/a y yo trabajamos como equipo.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

31. Confío en mi consejero/a.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

32. Mi consejero/a dedica suficiente tiempo para llegar a conocerme bien.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

33. Mi consejero/a no me impone sus valores y creencias.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

34. Mi consejero/a cumple con su palabra.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

35. Estoy satisfecho/a con mi consejero/a.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

36. Mi consejero/a se encuentra cómodo/a hablando de nuestras diferencias.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

37. Mi consejero/a valora mi cultura.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

38. Le importo a mi consejero/a.
Completamente en desacuerdo *En desacuerdo* *De acuerdo* *Completamente de acuerdo*

FORMULARIO DEMOGRÁFICO DEL CLIENTE Fecha:

Número de Identificación_____

Sexo (circular)
Hombre Mujer

Edad_____

Grado Más Alto Completado en la Escuela_____

Orientación Sexual

Heterosexual Homosexual Bisexual Otro_____

Raza/Origen étnico (circule todo los que apliquen)

Hispano Negro o Afroamericano Blanco

Indio Americano o Nativo de Alaska Asiático

Isleño Hawaiano u otro Nativo Pacifico Otro_____

Tipo de Servicio (circule)

Salud de la conducta Servicios Médicos Psiquiatría Uso de sustancias

Grupo de Apoyo Consejería (Individual) Consejería (Familiar)

Servicios de Vivienda Otro_____

Diagnóstico (si existe)_____

Sitio_____

Appendix F: Determination of Number of Factors

Figure 1

Scree Plot

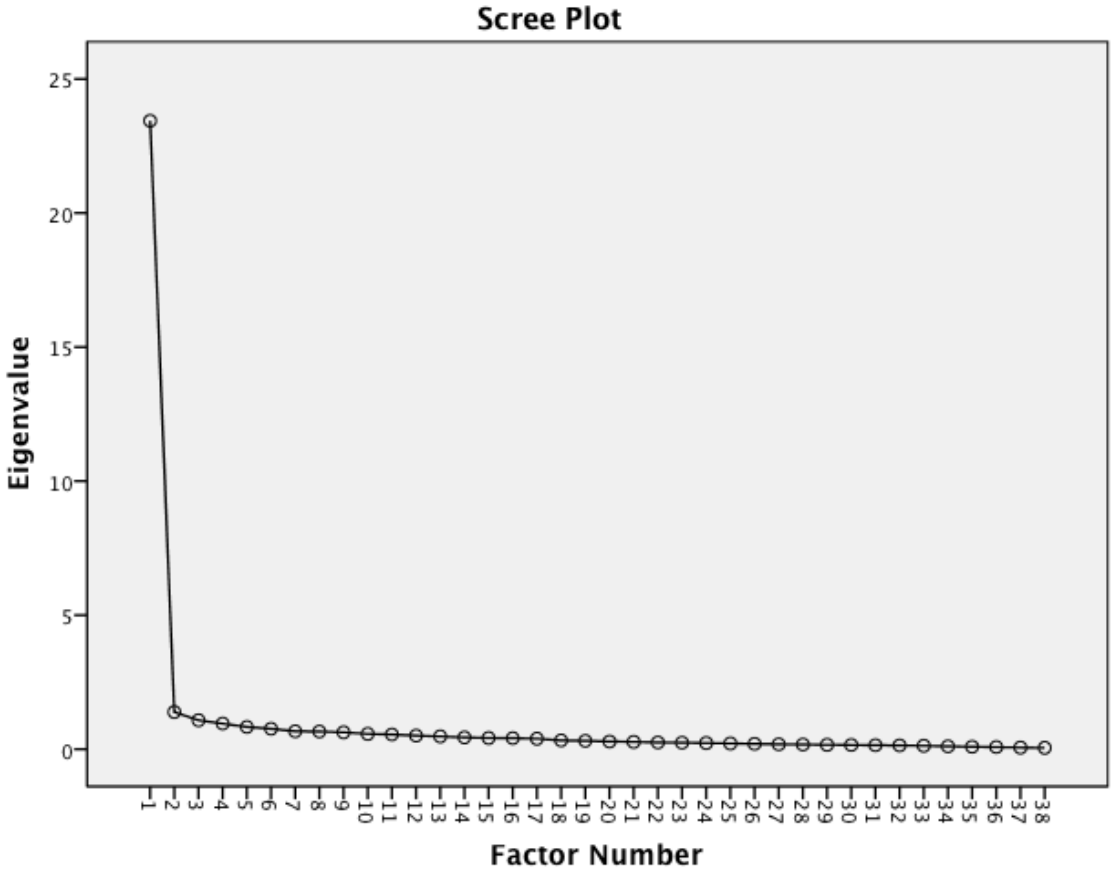


Table 9

Factor Analysis Eigenvalues

Factor	Eigenvalue	Percent of Variance Explained
1	23.41	61.69
2	1.39	3.65
3	1.08	2.84

Table 10

Factor Matrix for Three-Factor Solution (per Kaiser's Rule)

Item Number	Factor 1	Factor 2	Factor 3
1	.660	−.160	.146
2	.668	.015	.119
3	.640	.314	−.007
4	.660	.179	.051
5	.726	.231	.002
6	.801	−.103	.112
7	.794	−.081	.041
8	.766	.025	.037
9	.750	−.053	.102
10	.627	.051	.241
11	.782	.256	−.072
12	.749	−.026	.410
13	.777	−.073	.339
14	.772	.171	.254
15	.835	.116	−.043
16	.769	.207	−.078
17	.716	.274	.077
18	.847	−.074	−.006
19	.845	.063	.053
20	.858	.040	.104
21	.802	.107	−.146
22	.849	−.091	−.103
23	.672	.244	−.058
24	.711	.278	.000
25	.755	.028	.022
26	.858	−.090	−.042
27	.783	.089	−.074
28	.811	.006	−.020
29	.646	.333	−.007
30	.863	−.165	.105
31	.883	−.158	−.175
32	.898	−.192	−.095
33	.752	.052	−.215
34	.855	.018	−.196
35	.883	−.236	−.066
36	.769	.074	−.102
37	.763	.275	−.121
38	.860	−.192	.010

Appendix G: Assessment of Variable Normality

Table 11

Skew and Kurtosis Values

Variable	Kurtosis	Kurtosis SE	Kurtosis Z	Skew	Skew SE	Skew Z
Client CEPCCI Sum Score	−1.161	.788	1.473	.367	.403	.911
Provider "Sensitivity" Scale Sum Score	−.136	.788	.173	.991	.403	2.459*
Provider CBMCS Sum Score	.082	.788	.104	.603	.403	1.496

* = significant

Table 12

Shapiro-Wilk Statistic for Assessing Normality of Variable Distribution

	Statistic	df	Significance
Client CEPCCI Sum Score	.925	34	.023
Provider "Sensitivity" Scale Sum Score	.749	34	.000
Provider CBMCS Sum Score	.963	34	.300

Figure 2

Histogram of Client CEPCCI Scores

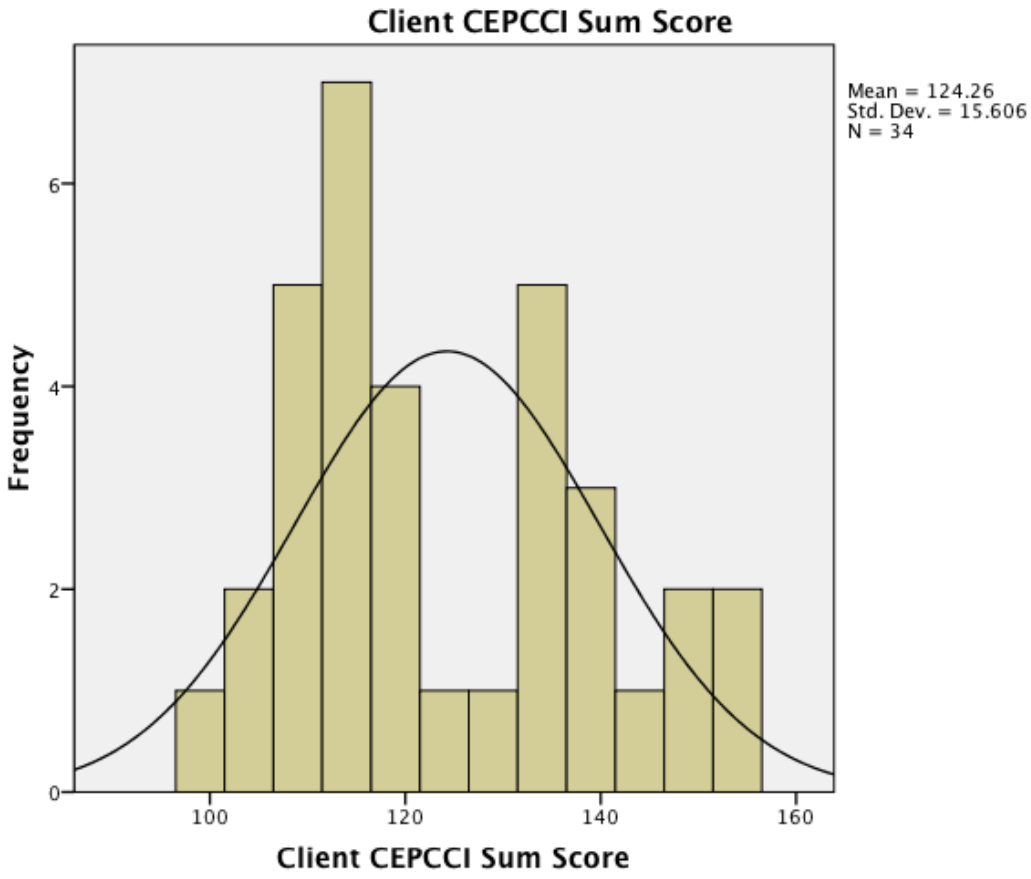


Figure 3

Histogram of Provider CBMCS "Sensitivity to Consumers" Sum Scores

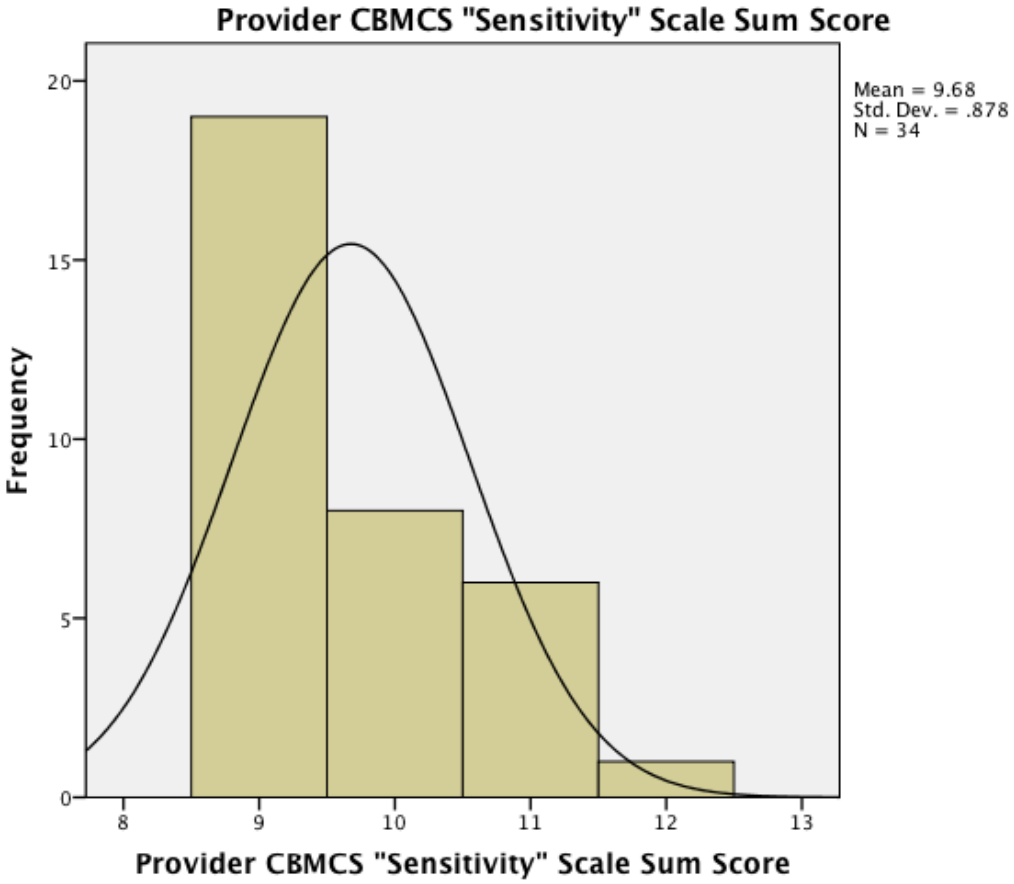
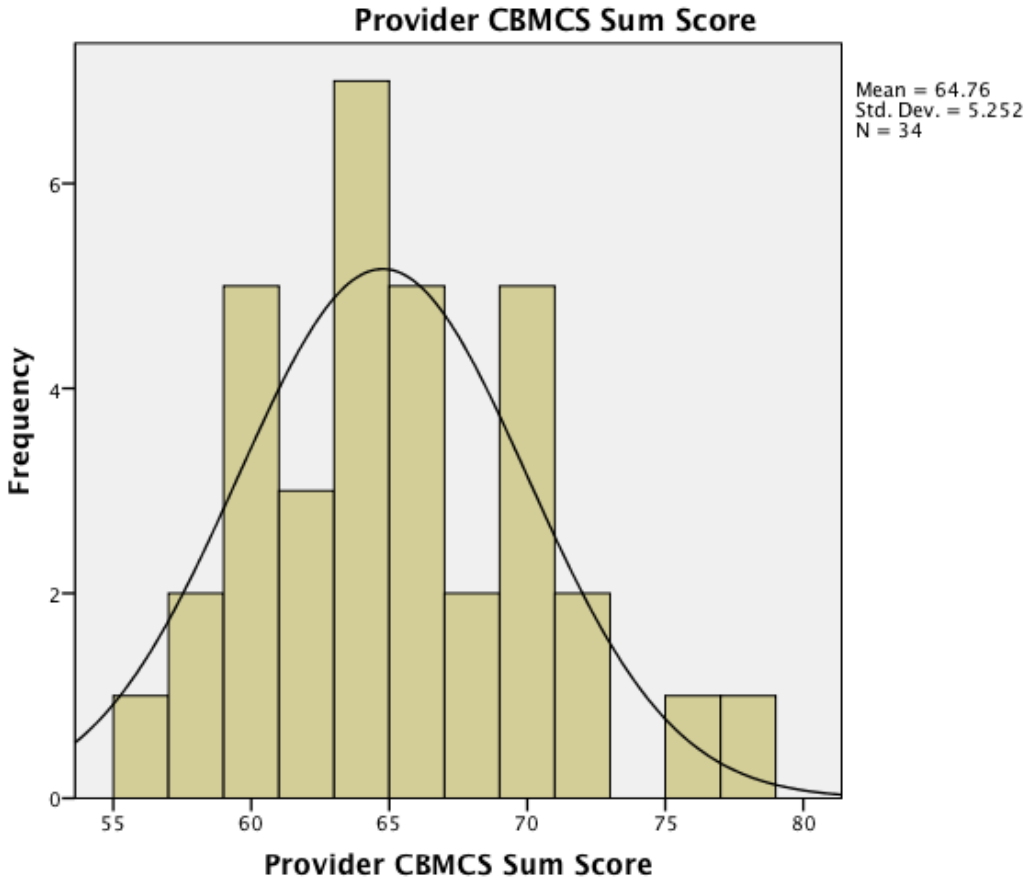


Figure 4

Histogram of Provider CBMCS Sum Scores



Appendix H: Scatterplots

Figure 5

Scatterplot—Provider CBMCS Sensitivity Scale Score and Client CEPCCI Sum Score

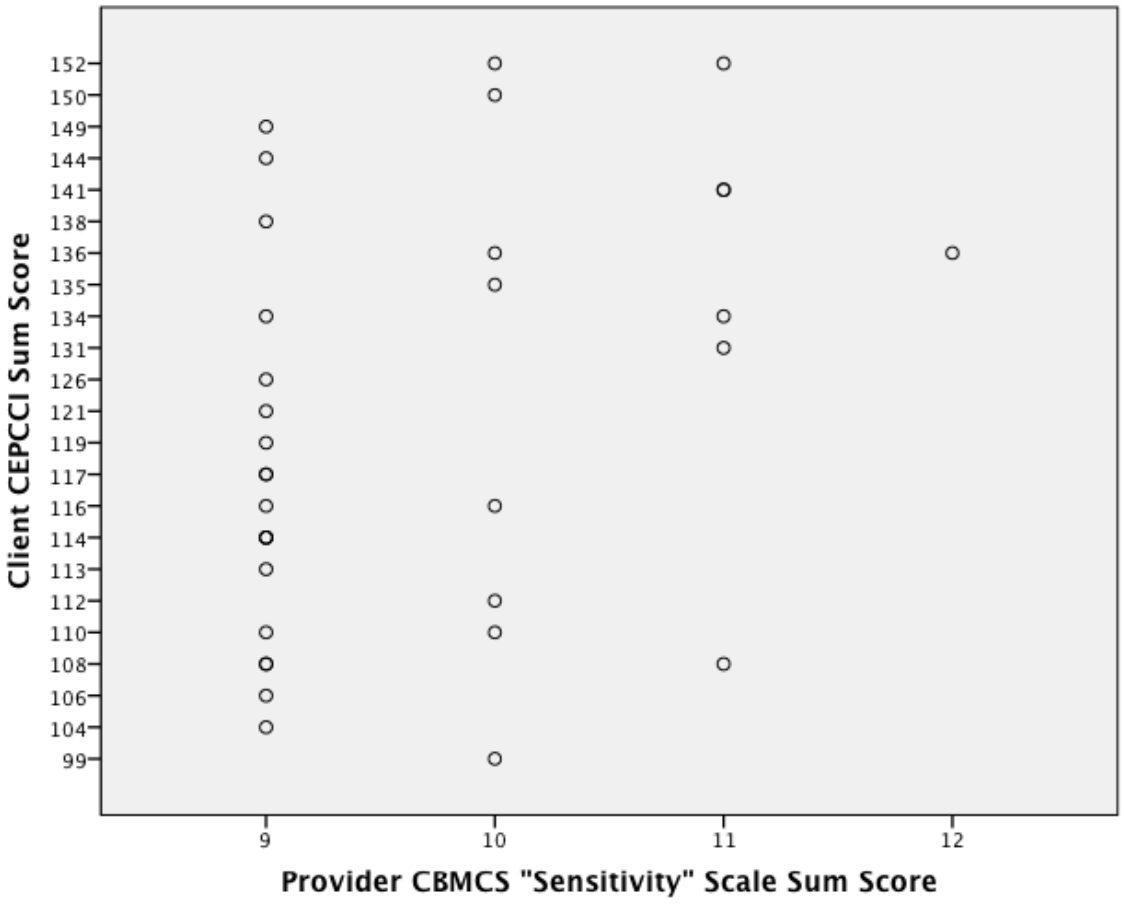
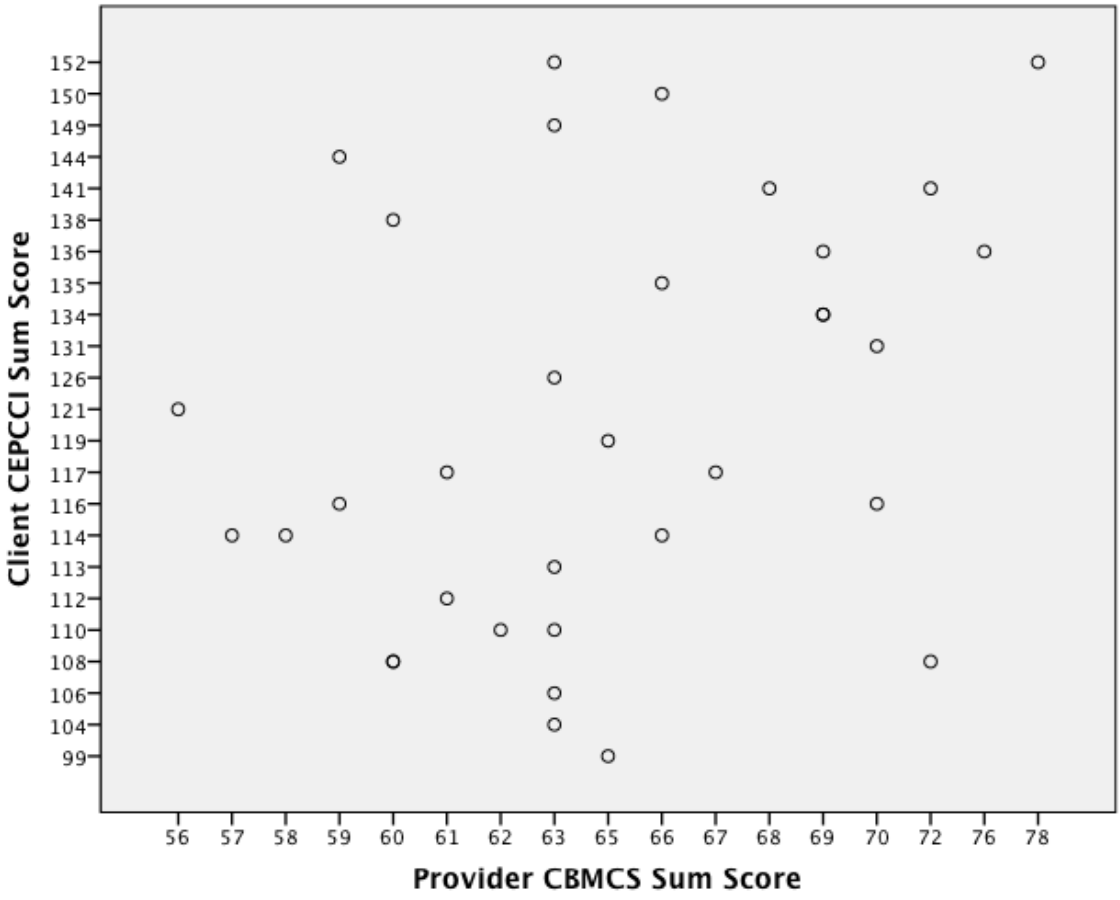


Figure 6

Scatterplot—Provider CBMCS Sum Score and Client CEPCCI Sum Score



References

American Counseling Association. (2005). *ACA code of ethics*. Alexandria, VA: Author.

American Psychological Association. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist, 48,* 45–48.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58,* 377–402.

American Psychological Association. (2008). *Report of the APA Task Force on the Implementation of the Multicultural Guidelines*. Washington, DC: Author. Retrieved from http://www.apa.org/pi/

American Psychological Association, (2011, April)**.** APA Multicultural Guidelines under review. [Announcement on website]. Retrieved from http://www.apa.org/pi/about/newsletter/2011/04/multicultural-guidelines.aspx

American Psychological Association, (2013, March)**.** Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. [Author note on website]. Retrieved from http://www.apa.org/pi/oema/resources/policy/multicultural-guidelines.aspx

Arredondo, P. (1999). Multicultural counseling competencies as tools to address oppression and racism. *Journal of Counseling & Development, 77*, 102–108.

Arredondo, P., Toporek, R., Brown, S. P., Jones, J., Locke, D. C., Sanchez, J., et al. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24,* 42–78.

Arthur, T. E., Reeves, I., Morgan, O., Cornelius, L. J., Booker, N. C., et al. (2005). Developing a cultural competence assessment tool for people in recovery from racial, ethnic, and cultural backgrounds: The journey, challenges, and lessons learned. *Psychiatric Rehabilitation Journal, 28,* 243–250.

Bartlett, M. S. (1937). Properties of sufficiency and statistical tests. *Proceedings of the Royal Statistical Society*, Series A 160, 268–282

Brown, D. (1996). Reply to Derald Wing Sue. *Spectrum,* 57, 5–7.

Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin, 56,* 81–105.

Comrey, A. L. (1988). Factor analytic methods of scale development in personality and clinical psychology. *Journal of Counseling and Clinical Psychology, 56,* 754–761.

Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology, 49*(2), 255–263.

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1–16.

Constantine, M. G., Gloria, A. M., & Ladany, N. (2002). The factor structure underlying three self-report multicultural counseling competence scales. *Cultural Diversity and Ethnic Minority Psychology, 8,* 334–345.

Constantine, M. G., & Ladany, N. (2000). Self-report multicultural counseling competence scales and their relation to social desirability and multicultural case conceptualization. *Journal of Counseling Psychology, 47,* 155–164.

Constantine, M. G., & Ladany, N. (2001). New visions for defining and assessing multicultural counseling competence. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 482–498). Thousand Oaks, CA: Sage.

Constantine, M. G., & Sue, D. W. (2008). The American Psychological Association's guidelines on multicultural education, training, research, practice and organizational psychology: Initial development and summary. In G. Gamst, A. Der-Karabetian, & R. H. Dana (Eds.), *Readings in multicultural practice* (pp. 91–100). Thousand Oaks, CA: Sage.

Cornelius, L. J., Booker, N. C., Arthur, T. E., Reeves, I., & Morgan, O. (2004). The validity and reliability testing of a consumer-based cultural competency inventory. *Research on Social Work Practice, 14,* 201–209.

Costello, Anna B. & Jason Osborne (2005). Best practices in exploratory factor analysis: four recommendations for getting the most from your analysis. *Practical Assessment Research & Evaluation*, *10*(7). Available online: http://pareonline.net/getvn.asp?v=10&n=7

Curran, P. J., West, S. G., & Finch, J. F. (1996). The robustness of test statistics to nonnormality and specification error in confirmatory factor analysis. *Psychological Methods, 1*, 16–29.

D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling and Development, 70,* 143–150.

Davis, T. S. (2007). Mapping patterns of perceptions: A community-based approach to cultural competence assessment. *Research on Social Work Practice, 17,* 358–379.

DeVellis, R. F. (2003). *Scale Development: Theory and Applications (2nd ed).* Thousand Oaks, CA: Sage.

Dziuban, C. D., & Shirkey, E. C. (1974) When is a correlation matrix appropriate for factor analysis? Some decision rules. *Psychological Bulletin, 81*(6) 358–361.

Fuertes, J. N., Bartolomeo, M., & Nichols, C. M. (2001). Future research directions in the study of counselor multicultural competency. *Journal of Multicultural Counseling and Development, 29,* 3–13.

Fuertes, J. N., & Brobst, K. (2002). Clients' ratings of counselor multicultural competency. *Cultural Diversity and Ethnic Minority Psychology, 8*, 214–223.

Gamst, G., Dana, R. H., Der-Karabetian, A., Aragon, M., Arellano, L., Morrow, G., et al. (2004). Cultural competency revised: The California Brief Multicultural Competence Scale. *Measurement and Evaluation in Counseling and Development, 37,* 163–183.

Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2000). Ethnic match and client ethnicity effects on global assessment and visitation. *Journal of Community Psychology, 28,* 547–564.

Gamst, G., Dana, R. H., Der-Karabetian, A., & Kramer, T. (2004). Ethnic match and treatment outcomes for child and adolescent mental health center clients. *Journal of Counseling and Development, 82,* 457–465.

Gamst, G., Der-Karabetian, A., & Dana, R. H. (Eds.). (2008). *Readings in multicultural practice.* Thousand Oaks, CA: Sage.

Gerkensmeyer, J. E., Austin, J. K., & Miller, T. K. (2006). Model testing: Examining parent satisfaction. *Archives of Psychiatric Nursing, 20,* 65–75.

Gorsuch, R. L. (1983). *Factor analysis* (2nd ed.). Hillsdale, NJ: Erlbaum.

Havlicek, L. L. & Peterson, N. L. (1976). Robustness of the Pearson correlation against violations of assumptions. *Perceptual and Motor Skills*, *43*(3), 1319–1334.

Hernandez, M., & Issacs, M. R. (Eds.). (1998). *Promoting cultural competence in children's mental health services.* Baltimore, MD: Brookes.

Holcomb-McCoy, C. C., & Meyers, J. E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling and Development, 77,* 294–302.

Kaiser, H. F., & Rice, J. (1974). Little jiffy, mark iv. *Educational and Psychological Measurement*, *34*(1), 111–117.

Kessler, R. C., Nelson, C. B., McKinagle, K. A., Edlund, M. J., Frank, R. G., & Leaf, P. J. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry, 66,* 17–31.

Kincaid, J. P., Fishburne R. P. Jr., Rogers R. L., & Chissom B. S. (1975). Derivation of new readability formulas (Automated Readability Index, Fog Count and Flesch Reading Ease Formula) for Navy enlisted personnel. *Research Branch Report 8-75.* Millington, TN: Naval Technical Training, U. S. Naval Air Station, Memphis, TN

Kline, P. (1999). *The handbook of psychological testing (2nd ed.).* London: Routledge.

Knitzer, J. (1982). *Unclaimed children.* Washington, DC: Children's Defense Fund.

Ladany, N., Inman, A. G., Constantine, M. G., & Hofheinz, E. W. (1997). Supervisee multicultural case conceptualization ability and self-reported multicultural competence as functions of supervisee racial identity and supervisor focus. *Journal of Counseling Psychology, 44,* 284–293.

LaFromboise, T. D., Coleman, H. L. K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory-Revised. *Professional Psychology: Research and Practice, 22,* 380–388.

MacCallum, R. C., Widaman, K. F., Zhang, S. B., & Hong, S. H. (1999). Sample size in factor analysis. *Psychological Methods, 4*(1), 84–99.

Owen, J., Leach, M., Wampold, B., & Rodolfa, E. (2011). Client and therapist variability in clients' perceptions of their therapists' multicultural counseling competence. *Journal of Counseling Psychology, 58* (1), 1–9.

Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48*(3), 274-282.

Ponterotto, J. G., & Alexander, C. M. (1996). Assessing the multicultural competence of counselors and clinicians. In L. A. Suzuki, P. J. Meller, & J. G. Ponterotto (Eds.), *Handbook of multicultural assessment* (pp. 651–672). San Francisco, CA: Jossey-Bass.

Ponterotto, J. G., Casas, J. M., Suzuki, L. A., & Alexander, C. M. (Eds.). (2001). *Handbook of multicultural counseling* (2nd ed.). Thousand Oaks, CA: Sage.

Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). A revision of the Multicultural Counseling Awareness Scale (MCAS). *Journal of Multicultural Counseling and Development, 30,* 153–180.

Ponterotto, J. G., Rieger, B. P., Barrett, A., & Sparks, R. (1994). Assessing multicultural counseling competence: A review of instrumentation. *Journal of Counseling and Development, 72*, 316–322.

Ponterotto, J. G., Rieger, B. P., Barrett, A., Sparks, R., Sanchez, C. M., & Magids, D. (1996) Development and initial validations of the Multicultural Counseling Awareness Scale. In G. R. Sodowsky & J. C. Impara (Eds.), *Multicultural assessment in counseling and clinical psychology* (pp. 247–282). Lincoln, NE: Buros Institute of Mental Measurements.

Pope-Davis, D. B., & Dings, J. G. (1995). The assessment of multicultural counseling competencies. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 287–311). Thousand Oaks, CA: Sage.

Pope-Davis, D. B., Liu, W. M., Toporek, R. L., Brittan-Powell, C. S. (2001). What's missing from multicultural competency research: Review, introspection, and recommendations. *Cultural Diversity and Ethnic Minority Psychology, 7,* 121–138.

Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto U.S. mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry, 50,* 85–94.

Ridley, C. R. & Shaw-Ridley, M. (2011). Multicultural counseling competencies: An analysis of research on clients' perceptions: Comment on Owen, Leach, Wampold, and Rodolfa (2011). *Journal of Counseling Psychology, 58*(1), 16-21.

Robinson, D. T., & Morris, J. R. (2000). Multicultural counseling: Historical contexts and current training considerations. *Western Journal of Black Studies, 24,* 235–249.

Roizner, M. (1996). *A practical guide for the assessment of cultural competence in children's mental health organizations.* Boston, MA: Judge Baker Children's Center.

Sabnani, H. B., & Ponterotto, J. G. (1992). Racial/ethnic minority-specific instrumentation in counseling research: A review, critique, and recommendations. *Measurement and Evaluation in Counseling and Development, 24,* 161–187.

Sapnas, K. G., & Zeller, R. A. (2002). Minimizing sample size when using exploratory factor analysis for measurement. *Journal of Nursing Measurement*, *10*, 135–154.

Si, L., & Callan, J. (2001, November). *A statistical model for scientific readability*. Paper presented at the ACM International Conference on Information and Knowledge Management, Atlanta, GA.

Sodowsky, G. R., & Impara, J. C. (1996). *Multicultural assessment in counseling and clinical psychology.* Lincoln, NE: Buros Institute of Mental Measurements.

Sodowsky, G. R., Kuo-Jackson, P. Y., Richardson, M. F., & Corey, A. T. (1998). Correlates of self-reported multicultural competencies: Counselor multicultural social desirability, race, social inadequacy, locus of control, racial ideology, and multicultural training. *Journal of Counseling Psychology, 45,* 256–264.

Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994). Multicultural Counseling Inventory (MCI): A self-report measure of multicultural competencies. *Journal of Counseling Psychology*, *41*, 137–148.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, DC: National Academy Press.

Stevens, J. (1996). *Applied multivariate statistics for the social sciences* (3rd ed.). Mahwah, N.J.: Lawrence Erlbaum Associates.

Sue, D. W. (1996). Multicultural counseling: Models, methods, and actions. *The Counseling Psychologist, 24,* 279–284.

Sue, D. W., Arredondo, P., & McDavis, R. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling & Development, 20* (2), 64–89.

Sue. D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E.J., et al. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*(2), 45–52.

Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., et al. (1998). *Multicultural counseling competencies: Individual and organizational development.* Thousand Oaks, CA: Sage.

Sue, D. W., & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice* (5th ed.). Hoboken, NJ: Wiley.

Tinsley, H. E. A., & Tinsley, D. J. (1987). Uses of factor analysis in counseling psychology research. *Journal of Counseling Psychology, 34,* 414–424.

U.S. Census Bureau. (2001). *Population profile of the United States.* Washington DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: Author.

U.S. Department of Health and Human Services. (2008). Mental health: Culture, race, and ethnicity—A supplement to *Mental health: A report of the Surgeon General.* In G. Gamst, A. Der-Karabetian, & R. H. Dana (Eds.), *Readings in multicultural practice* (pp. 91–100). Thousand Oaks, CA: Sage.

Velicer, W. F., & Jackson, D. N. (1990). Component analysis versus common factor-analysis: Some further observations. *Multivariate Behavioral Research, 25*(1), 97–114.

Weinrach, S. G., & Thomas, K. R. (1996). The counseling profession's commitment to diversity-sensitive counseling: A critical reassessment. *Journal of Counseling and Development, 74,* 472–477.

Worthington, R. L., Mobley, M., Franks, R. P., & Tan, J. A. (2000). Multicultural counseling competencies: Verbal content, counselor attributions and social desirability. *Journal of Counseling Psychology, 47,* 460–468.

Yeh, M., Eastman, K., & Cheung, M. K. (1994). Children and adolescents in community health centers: Does the ethnicity or the language of the therapist matter? *Journal of Community Psychology, 22,* 153–163.