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Measuring Multicultural Competence in Counseling

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Pedersen (1999) described multicultural counseling as the "fourth force" in psychology. The description is used to imply that multiculturalism is the next theory to understand human behavior, complementary to the other three forces: psychodynamic, behavioral, and humanistic explanations. Despite the attention being given to multiculturalism, professional organizations, training institutions, and service providers are still trying to understand what it means to have competency in multicultural counseling. Researchers have made decades of efforts to define and measure multicultural counseling competence; yet, there is still limited data about how multicultural training efforts influence these competencies and how counselor multicultural competency affects clients' experiences in therapy (Hays, 2008; Smith & Trimble, 2016). One of the major difficulties associated with evaluating multicultural competence is the traditional methods used to measure the construct.

The purpose of this study was to follow up on the recommendations of previous research: to examine the psychometric properties of the Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016). The participants in this study were graduate-level psychology students and their clinical supervisors. Participants completed a self-report survey containing the following measures: (a) a demographic data form, (b) the Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016), and (c) the Cross-Cultural Counseling

Inventory-Revised (CCCI-R; LaFromboise et al., 1991). Results indicated that the MCPT is a viable measure of knowledge related to multicultural counseling.

Scores on the MCPT had statistically significant positive correlations as expected with estimated face-to-face client contact hours, presentations/publications produced related to multicultural counseling/psychotherapy, degree held (i.e., graduate degree vs. bachelor's degree), and observer-reported multicultural competence (CCCI-R score). The overall MCPT scores had an $\alpha = .927$ ($n = 66$), indicating an adequate level of internal consistency (DeVellis, 2017). MCPT scores had evidence of convergent validity; however, MCI and CCCI-R scores did not account for a statistically significant portion of the variance beyond level of education. Implications for practice, training, and future research are then discussed.

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by

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CHAPTER I

INTRODUCTION

As proposed by Feagin (2013), the structural foundation of the U.S. "house" is that of racism. Using this metaphor, he wrote that U.S. society was built, from the beginning, with racial oppression as a central part of its structure. Not only does the United States have a foundation of structural racism, but also a complex array of recurring exploitative, discriminatory, and other oppressive practices that target groups based on language, gender, ethnicity, ability status, sexual orientation, age, gender identity, socioeconomic status, religion, spirituality, immigration status, education, and employment (Feagin, 2013; Robinson & Morris, 2000; Smith & Trimble, 2016). The hierarchical power structures in society collectively influence the research and practice of psychologists (Guthrie, 1998; Robinson & Morris, 2000; Smith & Trimble, 2016). The prevalence of biases in psychological research, theory, and practice reflects the biases found throughout society. Historically, those in the psychology field have not only ignored cultural differences but have also legitimized and rationalized the oppressive practices within society.

For decades, psychologists have been selective in the study and characterization of people. Early research in psychology focused on restricted classes of participants from Europe and North America who were Western, educated, industrialized, and rich (Smith & Trimble, 2016). Ignoring entire groups of people (e.g., women and people of color) resulted in large-scale insensitive treatment that included erroneous assessment conclusions, misdiagnoses, and inappropriate treatments (Guthrie, 1998; Robinson & Morris, 2000). As one example, psychologists played a vital role in the legitimization of eugenics through the misuse of

psychological testing designed to measure intelligence (Guthrie, 1998; Newman et al., 2007; Tucker, 1994). Cognitive psychologists in the U.S. such as Henry Goddard (1912), Lewis Terman (1925), and Robert Yerkes (1921) distorted the original use of intelligence tests and injected their own underlying presumptions about human ability in a way that fit their own racist and classist beliefs (Tucker, 1994). Their pseudo-scientific results were used to support the use of standardized testing to sort and rank humans by race, ethnicity, gender, and class according to supposedly inborn, biologically innate intelligence (Newman et al., 2007; Tucker, 1994). Policies derived from their evidence included the forced sterilization of the "feebleminded" and "insane." In addition, their evidence influenced an immigration law (the Immigration Act of 1924, also known as the Johnson-Reed Act or the National Origins Act) designed to keep out eastern and southern Europeans as well as all Asians, as they were determined to be inferior to northern Europeans (Guthrie, 1998; Newman et al., 2007; Tucker, 1994).

Psychologists attempted to speak out against the racism within psychology during the 1950s, 1960s, and 1970s. The passage of the Civil Rights Act of 1964 was a catalytic event that led to increased access in education, housing, and employment to previously excluded groups, which, in turn, influenced the way the psychology profession viewed racial and ethnic minority concerns (Jackson, 1995; Robinson & Morris, 2000). Led primarily by African-American psychologists, multiple formal attempts were made by some members of the American Personnel and Guidance Association (APGA) and the American Psychological Association (APA) to raise awareness of racial/ethnic minority concerns within the organization (Robinson & Morris, 2000). For example, the Association of Black Psychologists (ABPsi) was founded in 1968 to promote the mental health and well-being of Black individuals and communities. Similar associations exist for other ethnic groups, such as the Asian American Psychological Association (AAPA)

and the National Latina/o Psychological Association (NLPA). Then the field began to see articles and research projects describing how mainstream psychological practices failed to meet the needs of racial/ethnic minority clients (Smith, 1977; Sue & Sue, 1971; Sue et al., 1998, Vontress, 1971). Traditional models of therapy, research, training, and ethical guidelines were all called into question. These early professional efforts are now viewed as the birth of *multiculturalism* in psychology (Pedersen, 1990; Robinson & Morris, 2000).

Multiculturalism is a perspective, now accepted within psychology, that aims to incorporate culture into the understanding of the human experience. Multiculturalism includes ways of enhancing therapeutic alliance and meeting client need through strategies and approaches that specifically account for cultural contexts (APA, 2017). The term *culture* refers to contextual factors and intersectionality among and between reference group identities, including such elements as language, gender, race, ethnicity, ability status, sexual orientation, age, gender identity, socioeconomic status, religion, spirituality, immigration status, education, and employment (APA, 2017). Work with a client can be enhanced when therapists account for (a) their own cultural worldview, (b) the client's cultural worldview, and (c) the culture of the environment in which the therapy occurs (Smith & Trimble, 2016; Sue & Sue, 1971). Scholars (e.g., Domenech-Rodriguez & Bernal, 2012; Ridley & Kleiner, 2003; Smith & Trimble, 2016; Sue et al., 1982; Sue et al., 1992; Sue et al., 2009) have asserted that cultural complexities associated with providing mental health services necessitate specific multicultural competencies distinct from general therapy skills.

The first formal articulation of multicultural competencies was in the publication of the Division 17 of Counseling Psychology Education and Training Committee's report from the work of Sue and colleagues (1982). These competencies were arranged into three general

domains focusing on counselors' attitudes, knowledge, and skills in working with diverse clients (Sue et al., 1982). In 1992, additional competencies were added by Sue and colleagues, bringing the total to 31 competencies. In 1998, Sue and colleagues added another three competencies, bringing the total to 34 multicultural counseling competencies. As mentioned, these competencies are in three broad domains: (a) counselor's racial and cultural self-awareness; (b) the influences of the clients' worldview, beliefs, cultural values, and sociopolitical experiences and how the counselor uses these in the treatment process and case conceptualization; and (c) the use of culturally sensitive intervention strategies and contextual factors. These competencies and domains have been accepted and adopted by six divisions of the American Counseling Association (ACA) and two divisions within the APA (Fuertes et al., 2001). The APA (1990, 2003, 2017) also published guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. The guidelines served as general principles for psychologists when working with individuals within these groups.

Despite wide acknowledgment of multicultural competencies and attempts to evaluate them across three decades, scholars have limited data about how multicultural training efforts influence these competencies and how counselor multicultural competency affects clients' experiences in therapy (Hays, 2008; Smith & Trimble, 2016). One of the major difficulties associated with evaluating multicultural competence are the traditional methods used to measure the construct. Several reviews of measures assessing multicultural counseling competence have raised concerns regarding their applicability to psychologists and psychologists in training (Fuertes et al., 2001; Hays, 2008; Kocarek et al., 2001; Ponterotto et al., 1994; Pope-Davis & Dings, 1994). These concerns revolve around the effectiveness of these instruments in evaluating the skills and abilities of psychologists and trainees in multicultural counseling. The three most

widely used measures include (a) the Multicultural Counseling Awareness Scale-Form B/the Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 1996; Ponterotto et al., 2002: Lu, 2017); (b) the Multicultural Counseling Inventory (Sodowsky et al., 1994); and (c) the Multicultural Awareness Knowledge Skills Survey (D'Andrea et al., 1991). Some scholars (Constantine & Ladany, 2000; Dunn et al., 2006; Hays, 2008) have indicated that limited progress continues to be made in terms of available psychometric evidence to support the utility of any of these measures. Major themes found in the limitations of the majority of the instruments include (a) questions regarding the factor structure of the instrument, (b) aspects of instrument validity and reliability, and (c) issues related to social-desirability. Despite these critiques, the three self-report measures continue to be widely used to assess multicultural competence in training, research, and practice (Constantine & Ladany, 2000; Hays, 2008; Sheu et al., 2012; Tao et al., 2015). Researchers of multicultural counseling competence have identified a major need for the revision and modification of current instruments or the development of a new instrument to assess multicultural counseling competence (Kitaoka, 2005).

Mental health professionals have long understood the benefits of research in improving treatment practices and fostering well-being. The importance of research in the field is clear as evidence-based practices have become the standard for the profession (APA Presidential Task Force on Evidence-Based Practice, 2006). As such, multicultural psychology should also be based on research evidence. In order to solidify the research foundation of multicultural psychology, psychologists need more comprehensive, psychometrically sound, and contextually relevant instruments to measure multicultural competence (Constantine & Ladany, 2000). One such approach is to assess multicultural competency using the Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016).

While the MCPT continues to shows promise, it has been understudied. The MCPT is built upon established principles of multicultural competency in counseling. It is rooted in the belief that counselors should be sensitive to cultural diversity, have knowledge of various cultural backgrounds, and be able to adapt their therapeutic approaches accordingly. These principles have not fundamentally changed over time and remain integral to effective counseling. The MCPT provides a practical tool for assessing multicultural competency among counselors. It offers a structured and standardized way to evaluate a counselor's knowledge, awareness, and skills in working with diverse clients. This can be valuable for counselors, supervisors, and training programs to identify areas of strength and areas that need improvement. Further, using the MCPT alongside newer assessment tools, researchers can assess continued evidence of validity and reliability. Ongoing study can determine whether the MCPT remains a relevant and valuable tool in assessing multicultural competency.

The MCPT is a 50-item multiple-choice test that assesses knowledge of a wide variety of findings from the cultural competence research literature (e.g., racial identity development, cultural group norms/histories, culturally respectful language, stereotype threat, and microaggressions; Gillem et al., 2016). MCPT items displayed statistically significant level of discriminative power between multicultural counseling experts and non-experts, as well as significant correlations between MCPT scores and a variety of professional experiences (i.e., number of conferences or workshops attended, graduate courses taught, multicultural texts read, and multicultural professional presentations) in a sample of licensed counselors, psychologists, social workers, and marriage/family therapists (Gillem et al., 2016). However, additional psychometric support is needed for this scale to be viable.

Purpose of the Study

Presently, measures to assess competence in the area of multicultural counseling have limited support regarding the psychometric properties (Hays, 2008; Kim et al., 2003; Kitaoka, 2005; Kocarek et al., 2001). A valid and reliable means of measuring multicultural counseling competence would support a number of efforts that aims to ensure counselors are able to work effectively with a diverse population. The purpose of this investigation was to follow up on the recommendations of previous research: To examine the psychometric properties of the Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016).

Research Questions

The following research questions were examined:

1. Do scores on the MCPT show evidence of criterion-related validity through relating scores on the MCPT to demographic data, including level of education, number of courses taken focused on multicultural counseling/psychotherapy, number of workshops/seminars attended focused on multicultural counseling/psychotherapy, number of presentations or publications produced focused on multicultural counseling/psychotherapy, and face-to-face client contact hours?
2. Do scores on the MCPT show evidence of internal consistency through examining reliability estimates of the scores on the MCPT?
3. Do scores on the MCPT show evidence of convergent validity through comparing scores on the MCPT to the scores on the CCCI-R, an observer report measure, and scores on the MCI, a self-report measure?

CHAPTER II

LITERATURE REVIEW

Since 1973, the APA has maintained that the provision of multicultural competent mental health services is an ethical imperative. By 1990, multiculturalism was called "a fourth force" in psychology (Pedersen, 1991). The term suggests that multiculturalism represents a significant paradigm that equals in importance to previous movements represented by psychoanalysis (the first force), behaviorism (the second force), and humanistic/person-centered psychology (the third force) (Frisby, 2018). Counseling psychologists specifically have produced a large portion of scholarship focused on developing and refining multicultural standards for training, research, and practice (Arredondo et al., 1996; Cubero, 2011; Domenech-Rodriguez & Bernal, 2012; Sue et al., 1982; Sue et al., 1992). Scholarship on multicultural competence from the counseling field can be divided into five general categories: (a) the importance of multicultural competence; (b) characteristics, features, dimensions, and parameters of multicultural competence; (c) multicultural competency in training and supervision; (d) specialized applications of multicultural competence; and (e) the assessment of multicultural competence (Ridley & Kleiner, 2003). While evidence continues to accumulate that the multicultural competence of counselors positively influences clinical variables (e.g., client treatment utilization, counselor effectiveness, and treatment outcomes) (Domenech-Rodríguez & Bernal, 2012; Robinson & Morris, 2000), research in the area of multicultural competence is still in its infancy. A major concern about the assessment of multicultural competence is that some measures are widely used despite the lack of psychometric support (Fuertes et al., 2001; Hays, 2008; Kocarek et al., 2001; Ponterotto et al.,

1994; Pope-Davis & Dings, 1994). Psychologists may use measures of multicultural competence that lack psychometric evidence for several reasons: they do not have better alternatives, measures have been in use for a long time and have become traditional tools in the field, they may not be fully aware of the psychometric issues associated with specific measures, or they may use measures that are less rigorously validated as teaching tools to facilitate discussions and self-awareness among students, even if they are aware of the limitations. Criticisms about assessing multicultural competence are of particular concern, as psychometrically sound measurement is a necessary component to produce compelling and accurate research.

This literature review on multicultural counseling competence and its measurement will first cover a brief history of multicultural competence, including the current conceptualization of multicultural competence using the Tripartite Model of multicultural counseling (Arredondo et al., 1996; Sue et al., 1982; Sue et al., 1992). Then, a review is provided of the three most widely used self-report measures of multicultural competence, including the psychometric support for each scale. A description of the development and early research on a measure of multicultural competence, the Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016) will then be presented. Finally, the purpose of the present study will be provided.

History of Multicultural Competence in Counseling

Topics of culture, race, ethnicity, gender, religion and spirituality, sexual orientation, and so forth were rarely covered in social science theories and research until the second half of the 20th century. Mental health practitioners and scholars often presumed that theories and research findings could be applied to everyone, so they sought to establish universal validity. The majority of early publications in psychological research related to race or ethnicity has now been given the term *scientific racism* (Casas, 2017). Scientific racism involves, but is not limited to,

the depiction of non-White groups as biologically and mentally inferior, the use of research to support racial eugenics, and the use of research to institute barriers to racial/ethnic minority psychologists entering the psychology profession (Guthrie, 2004). Not only were the psychology community participants overtly perpetuating racism, but they also simply ignored racial/ethnic minority concerns, such as inadequate representation on APA committees, lack of Blacks hired by the APA central office, poor representation of Black graduate students in the nation's training pipelines, and questionable theoretical underpinnings on psychology directed toward racial and ethnic minority groups (Guthrie, 1998; Robinson & Morris, 2000). Although a small body of literature, the early scholarship focused on racial and ethnic concerns in psychology, the use of standardized tests for racial/ethnic children, and the use of a comparative approach in examining the psychological state of Blacks, primarily to Whites on various measures of intelligences (Davidson et al., 1950; Mussen, 1953; Seigman, 1958; Sperrazzo & Wilkins, 1959). Few journal articles were published during the 1950s that focused on counseling clients who were racial or ethnic minorities (Jackson, 1995). Led primarily by African American psychologists, multiple formal attempts were made by some members of the APGA and APA to raise awareness of racial/ethnic minority concerns in these organizations (Robinson & Morris, 2000).

The birth of the multicultural movement in the United States came following the expansion of civil rights to historically oppressed populations. The passage of the Civil Rights Act of 1964 was a catalytic event that led to increased access in education, housing, and employment to previously excluded groups which, in turn, influenced the manner in which the psychology profession viewed racial and ethnic minority concerns (Jackson, 1995; Robinson & Morris, 2000). Even though laws were passed to address and rectify segregation, prejudice and discrimination continued within the counseling psychology field (Jackson, 1995). In both APA

and APGA, racial and ethnic minorities continued to not hold key positions and had no input in writing the association's by-laws or establishing its principles (Jackson, 1995; Robinson & Morris, 2000). Inclusion of multicultural perspectives began to spread when an increased number of individuals from diverse backgrounds received graduate degrees in the mental health profession and joined together to form professional associations on multicultural issues. This began with the formation of the Association of Black Psychologists (ABPsi), which was a response by African American psychologists to feeling marginalized by the APA in governance as well as in the way persons of African heritage were discussed within the field of psychology in general (Jackson, 1995; Robinson & Morris, 2000). The example of ABPsi led to the formation in the 1970s and early 1980s of the Asian American Psychological Association, the National Hispanic Psychological Association (now known as the National Latina/o Psychological Association), and the Society of Indian Psychologists. These four racial/ethnic minority psychology organizations formed the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (CNPAAEMI). African American and other ethnic minority psychologists openly questioned how organizations such as the APGA and APA defined "humans" and phrases such as "guidance for all" (Jackson, 1995). Arguing that the majority of participants in research were White university students and laboratory animals, these professionals asserted that the findings and theories of psychological science were biased and not applicable to all humans. These psychologists called not only for eliminating racist themes and research from journals, but also for a greater focus on attracting racial minorities in the field, increasing the representation of psychologists from diverse racial and ethnic backgrounds in key governance positions, and desegregating all elements of the APA (Robinson & Morris, 2000).

The 1970s reflected an era of heightened awareness among mental health professionals regarding the strong relationship between racism and mental health systems (Robinson & Morris, 2000). With publication outlets available (e.g., the *Journal of Black Psychology* in 1974, the *Hispanic Journal of Behavioral Sciences* in 1979, and the *Asian American Journal of Psychology* in 1979), opportunities for scholarship broadened. Traditional models of therapy, training, research, and ethical guidelines were, consequently, called into question. Throughout the 1970s, various publications highlighted the ethnocentrism of psychology and began to focus, in affirmative ways, on the needs of ethnic/racial minority groups. Scholars described in detail how theories of counseling typically ignored the needs and cultural concerns of segments of America because they were not considered part of the U.S. mainstream society (Jackson, 1995). Among these publications were *Psychological Testing of American Minorities: Issues and Consequences* (Samuda, 1975), *Even the Rat Was White: A Historical View of Psychology* (Guthrie, 1998), and *Counseling American Minorities: A Cross-Cultural Perspective* (Atkinson et al., 1998). These books were essential in contradicting the pervasiveness of scientific racism in research (Jensen, 1969; Shockley & Shockley, 1972) that falsely asserted the intellectual inferiority of Blacks. In addition, Sue (1977) wrote a seminal article that described the breakdown in communication that may occur in counseling due to counselors' inability to understand cultural messages or communicate culturally appropriate information. Professional efforts during the 1970s led to replacing the term *minority counseling* with *cross-cultural counseling* and *multicultural counseling* (Robinson & Morris, 2000). Jackson (1995) indicated these terms describe interactions not only between majority group counselors and minority group clients but also between minority group counselors and majority group clients or between counselors and clients who belong to different minority groups. By shifting the focus away from minority groups

exclusively, these terms challenged majority group counselors to become aware of the role that their own cultural assumptions played in their interactions with clients (Robinson & Morris, 2000). Mental health practitioners began to realize that although much of human experience is universal (e.g., we desire companionship and grieve at its loss), interpretations of experience are informed by circumstances, values, and worldviews that differ from culture to culture.

Despite the powerful statements of early multicultural counseling scholars, the 1970s had little empirical evidence to support the powerful statements (Jackson, 1995; Sue & Sue, 2008; Sue et al., 2009). The field was thus primed for the emergence of specific, identifiable competencies with respect to multicultural counseling and sophisticated empirical research agendas pertaining to multicultural counseling (Ponterotto, 1998; Robinson & Morris, 2000). In 1981, Allen Ivey, president of APA Division 17, Counseling Psychology, commissioned a report from the Professional Standards Committee, headed by Derald Wing Sue, to address cross-cultural issues. Then, in 1982, the field saw the first formal description of multicultural competence developed by the education and training committee of Division 17 (Sue et al., 1982). In that position paper, Sue and colleagues (a) defined the term *cross-cultural counseling*, (b) outlined and challenged myths about counseling competence for the culturally different, and (c) recommended the adoption of specific cross-cultural counseling and therapy competencies. In the position paper, they also outlined 11 minimal characteristics necessary to provide appropriate services to racial ethnic minority clients (Sue et al., 1982). Each characteristic was conceptualized within three broad dimensions: attitudes/beliefs (awareness), knowledge, and skills. The committee proposed that training in all three areas was necessary to develop competency and made several recommendations regarding graduate-level training: (a) including a separate course on racial ethnic minority concerns, (b) infusing racial ethnic minority issues

into existing curricula, and (c) adding training experiences at practicum and internship sites, which offer opportunities for work with racial ethnic minorities (Robinson & Morris, 2000).

In 1991, Thomas Parham, president of the Association of Multicultural Counseling and Development (AMCD), a division of the American Counseling Association (ACA), commissioned the Professional Standards Committee to review and revise the 1982 cross-cultural competencies document. The AMCD committee produced 31 multicultural counseling competencies in the document titled *Multicultural Counseling Competencies and Standards: A Call to the Profession* (Sue et al., 1992). In the revised version, three broad counselor characteristics were introduced: (a) becoming aware of one's own assumptions, values, and biases; (b) understanding the worldview of culturally diverse clients, and (c) developing appropriate intervention strategies and techniques (Sue et al., 1992). Cross-classifying the three new proposed characteristics with the three original dimensions resulted in a matrix consisting of nine competency areas (Robinson & Morris, 2000; Sue et al., 1992).

To amplify the 1982 and 1992 multicultural counseling competencies, another AMCD Professional Standards Committee produced a document with 119 explanatory statements for the 31 competencies, which was published as *Operationalization of the Multicultural Counseling Competencies* (Arredondo et al., 1996). Arredondo and colleagues (1996) also introduced the dimensions of personal identity model, highlighting the concept of multiple or collective identities and multiple contexts.

Arredondo and colleagues (1996) further expounded on the 1992 standards by clarifying the terms *diversity* and *multiculturalism* (Robinson & Morris, 2000). The term *multiculturalism* is used to focus on ethnicity, race, and culture, while *diversity* refers to other characteristics (e.g., age, gender, sexual identity, religious spiritual identification, social and economic class

background, and residential location) (Arredondo et al., 1996; Robinson & Morris, 2000) by which individuals may define themselves (Robinson & Morris, 2000). Three competencies related to organizational change were added to the 1996 list, bringing the AMCD competency list to 34. The result was a book titled *Multicultural Counseling Competencies: Individual and Organizational Development* (Sue et al., 1998).

Adoption of multicultural competencies and guidelines by the APA came in 2003 following the Competencies Conference: Future Directions in Education and Credentialing and Professional Psychology in 2002. The conference was initiated and hosted by the Association of Psychology Postdoctoral and Internship Centers (APPIC). The steering committee, which consisted of 10 members representing a range of education, training, credentialing, and practice constituencies, reflected diversity in work settings and locations, professional roles and responsibilities, and areas of competence (e.g., credentialing and regulatory bodies affiliated with the Council of Credentialing Organizations in Professional Psychology [CCOPP], ethnic minority psychology organizations such as the Asian American Psychological Association, the American Board of Professional Psychology, American Psychological Association's Board of Educational Affairs, Board of Professional Affairs, Association of Counseling Center Training Agencies, Association of Directors of Psychology Training Clinics, Association of Postdoctoral Programs in Clinical Neuropsychology, and others). The conference was organized to move the competency movement forward. A task force composed of members of APA Divisions 17 and 45, co-chaired by Nadya Fouad and Patricia Arredondo, developed a multicultural guidelines document. *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, the task force document, was unanimously approved by the APA Council of Representatives in August 2002 and published in the *American*

Psychologist (APA, 2003). In a collateral action, in 2002, the ACA endorsed the 31 competencies.

In August 2015, the APA developed two task forces: the Task Force on Re-envisioning the Multicultural Guidelines for the 21st Century and the Task Force on Guidelines Focused on Race/Ethnicity. The goals of the task forces were to revisit the original multicultural guidelines and promote the application of multicultural knowledge to contemporary psychological practice, education, research, and consultation. In 2017, the APA published a new set of guidelines for multicultural competence: *The Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*. The 2017 version of the guidelines encourages psychologists to consider how knowledge and understanding of identity develops from and is disseminated within professional psychological practice. The 2017 guidelines incorporate broad reference group identities (e.g., Black/African American/Black American, White/White American, and Asian/Asian American/Pacific Islander) to acknowledge within-group differences and the role of self-definition in identity. In developing the guidelines, the authors focused on incorporating intersectionality. *Intersectionality* refers to an individuals' possession of multiple salient identities (APA, 2017). It is a term used to capture the interaction among the array of cultural, structural, sociobiological, economic, and social contexts by which individuals are shaped and with which they identify (APA, 2017).

Models of Multicultural Competence

Several of the models of multicultural competence are discussed in the following sections. The first model introduced is the Tripartite Model espoused by Sue and colleagues (1982). Sue's (1990) work is credited with establishing multicultural competencies not only for the counseling field but also across many specialty associations within and outside of the APA

(Mollen et al., 2003). In addition, the APA credits their historic and current conceptualization of multicultural competence to the seminal research of Sue and colleagues during the 1980s and 1990s. Further, Constantine and Ladany (2000) asserted that the definition of multicultural counseling presented in the Tripartite Model has gone "virtually unchallenged by multicultural scholars and practitioners in counseling psychology" (p. 162). The Tripartite Model is the focus of the current review because it is the most often cited and most frequently discussed in the multicultural counseling literature (Hays, 2008; Mollen et al., 2003).

After the Tripartite Model is discussed, eight alternative models of multicultural counseling are introduced. These models are considered alternative because they are less elaborate than the Tripartite Model and have had less influence on the field (Mollen et al., 2003; Pope-Davis et al., 2003). The specific models discussed are (a) the Counselor Development Model (Carney & Kahn, 1984); (b) the Cultural Competency Continuum (Cross et al., 1989); (c) the Developmental Model of Intercultural Sensitivity (Bennett, 1993); (d) the Culturally Competent Model of Health Care (Campinha-Bacote, 1994); (e) the Multicultural Communication Process Model (Beckett et al., 1997); (f) the Process Model of Cultural Competence (López, 1997); (g) the Three-Factor Model of Cultural Capacity (Castro, 1998); and (h) the Multicultural Counseling Competency Assessment and Planning (MCCAP) Model (Toporek & Reza, 2001).

Tripartite Model of Multicultural Competence

In the Tripartite Model, multicultural counseling competence is achieved by counselors' acquisition of awareness, knowledge, and skills needed to function effectively in a culturally diverse society. Multicultural counseling competence is seen as the ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds (Sue & Torino,

2005). Psychologists and other counseling professionals who have higher levels of multicultural competence function effectively on an organizational/societal level; advocate effectively to develop new theories, practices, and policies; and organize structures that are more responsive to all groups (Sue & Torino, 2005). In this model, characteristics of multicultural competency are conceptualized through three broad dimensions: attitudes/beliefs (awareness), knowledge, and skills.

Attitudes/Beliefs

The attitudes/beliefs dimension is frequently referred to as awareness. This dimension addresses the need for psychologists and other counseling professionals to be in the process of becoming aware of their own racial ethnic heritage, as well as their cultural attitudes, values, and biases. These professionals need to build awareness of how their attitudes, values, and biases influence psychological processes and counseling interactions with their clients (Robinson & Morris, 2000; Sue et al., 1992). The competencies in this dimension involve developing a positive orientation to multiculturalism and becoming comfortable with clients who are different. Using this dimension, culturally skilled counselors are expected to be aware of their negative and positive emotional reactions toward groups that may prove detrimental to the counseling relationship. They are expected to be willing to contrast their own beliefs and attitudes to those of their clients in a nonjudgmental fashion (Arredondo et al., 1996; Sue et al., 1992).

Knowledge

The knowledge dimension stresses gaining an understanding of how race, culture, ethnicity, and other cultural aspects may affect personality formation, vocational choices, manifestations of psychological disorders, help-seeking behaviors, and the appropriateness or inappropriateness of counseling approaches (Robinson & Morris, 2000; Sue et al., 1992). This

dimension also focuses on the need for professionals to learn how societal variables (e.g., discrimination) as well as personal variables (e.g., racist attitudes and beliefs) affect their professional lives (Sue et al., 1992). Culturally skilled counselors are expected to possess knowledge about their social impact on others. They are expected to be knowledgeable about communication style differences, such as how their style may clash with or foster the counseling process with persons different from themselves (Arredondo et al., 1996; Sue et al., 1992).

Skills

This last dimension focuses on the development and use of culturally appropriate intervention strategies, which reflect an appreciation of the clients' life experiences and values (Sue et al., 1992). Culturally skilled counselors are expected to communicate effectively, obtain assistance from multicultural competent colleagues or supervisors, and actively seek training and other sources of information to enhance proficiencies and multicultural counseling clients (Sue et al., 1992). Culturally skilled counselors take responsibility for interacting in the language requested by the client and, if not feasible, make appropriate referrals. A serious problem arises when the linguistic skills of the counselor do not match the language of the client. When language barriers arise, counselors should (a) seek a translator with cultural knowledge and appropriate professional background, or (b) refer to a knowledgeable and competent bilingual counselor.

Critique of Model

Critiques of this conceptualization of multicultural counseling include conflicting or mixed empirical evidence for its support, the primary focus on race/ethnicity, and loosely defined constructs (Mollen et al., 2003; Ponterotto et al., 2000). The Tripartite Model has been subjected to a wide degree of empirical testing (Ponterotto et al., 2000). The majority of these

empirical studies have used self-report instruments to measure participants' self-perceived multicultural competence (Hays, 2008; Ponterotto et al., 2000). Examining data from self-report measures, researchers have discovered that multicultural competence is influenced by many factors including, for example, multicultural training (Ponterotto et al., 2000), racial identity (Ladany et al., 1997), racial attitudes (Constantine, 2002), empathy and emotional intelligence (Constantine & Gainor, 2001), and counselor race (Constantine, 2000). However, there remains concern of the adequacy of the instruments developed to assess this model: the MKCAS (Ponterotto et al., 1996; Ponterotto et al., 2002), the MCI (Sodowsky et al., 1994), and the MAKSS (D'Andrea et al., 1991). A summary of these instruments and the associated critiques are the focus of the next section.

Counselor Development Model

Carney and Kahn (1984) offered a five-stage developmental model that describes how counselors acquire competencies by passage through their identified stages. Each stage has a pattern of growth in three areas: (a) knowledge of cultural groups, (b) attitudinal awareness and cross-cultural sensitivity, and (c) specific cross-cultural counseling skills (Carney & Kahn, 1984). In addition, the authors' discussion of each stage is divided into two parts: counselor characteristics and appropriate training environment (i.e., learning tasks for trainees at each stage) (Ridley & Kleiner, 2003). In stage 1, counselors have a limited knowledge of other cultural groups, and they may harbor ethnocentric attitudes. The learning task for counselors is to recognize the extent to which they may be relying on faulty treatment strategies and goals (Carney & Kahn, 1984). In stage 2, counselors begin to recognize their ethnocentric attitudes and behaviors. The learning task for counselors is to develop knowledge of the norms, values, and customs of other cultural groups and also to recognize how ethnocentrism would affect their

counseling practice (Carney & Kahn, 1984). In stage 3, counselors may experience internal conflicts derived from feelings of guilt and personal responsibility. The learning task for counselors during this stage is self-exploration and resolution of dissonance (Carney & Kahn, 1984). In stage 4, counselors begin to develop self-identity as a cross-cultural change agent. The learning task for counselors is to become autonomous decision makers regarding their personal and professional identities (Carney & Kahn, 1984). In stage 5, counselors assume an activist posture, promoting social equity and protecting cultural pluralism. The learning tasks for trainees are to clarify their commitment and to establish action strategies (Carney & Kahn, 1984). To summarize, counselors begin with a limited knowledge base of other cultural groups and eventually advance to an activist position, promoting cultural pluralism in our society. No specific measures have been developed in association with this model.

Cultural Competency Continuum

Cross (1978) developed a six-stage model of cultural competence. The model was originally developed for use with organizations, but it has also been adopted for use with individuals. He defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross et al., 1989, p. 14). Stage 1 is cultural destructiveness. In this stage, the individual or organization assumes the superiority of one culture over other cultures (Cross, 1978). Stage 2 is cultural incapacity. In this stage, there is support for segregation, and there are lower expectations for people of minority cultures (Cross, 1978). Stage 3 is cultural blindness. In this stage, services and activities are so ethnocentric that only those who are assimilated benefit from them (Cross, 1978). Stage 4 is cultural pre-competence. In this stage, attempts are made to address diversity issues. Examples

would be through hiring, promoting, and offering sensitivity training. Stage 5 is basic cultural competency. In this stage, attempts are made to hire unbiased employees, obtain feedback from communities of color, and assess possible provisions for diverse clients (Cross, 1978). Stage 6 is advanced cultural competency. In this stage, organizations and individuals conduct research, hire culturally competent staff, and advocate on behalf of diversity issues (Cross, 1978). No measures have been developed in association with this model.

Developmental Model of Intercultural Sensitivity

Bennett (1993) conceptualized a model with six stages along a continuum of intercultural development of which three are ethnocentric (denial, defense, minimization) and three are ethnorelative (acceptance, adaptation, integration). The model is applied to individuals, groups, and organizations in educational and corporate settings (Mollen et al., 2003). An individual, group, or organization in the denial stage does not accept cultural differences. Those in the defense stage acknowledge certain cultural differences but construct defenses against those differences. Those in the minimization stage acknowledge cultural differences but trivialize them. An individual, group, or organization in the acceptance stage recognizes and values cultural differences. Those in the adaptation stage develop and improve skills necessary for interacting and communicating with people of different cultures. Those in the integration stage do more than value other cultures; they define their own identity and integrate their own cultural perspectives with those of other cultures (Bennett, 1993).

The Intercultural Development Inventory (IDI; Hammer & Bennett, 1998) is an assessment tool developed to measure the level of intercultural competence/sensitivity across a developmental continuum for individuals, groups, and organizations based on model proposed by Bennett (1993). The IDI consists of 60 items, 10 for each of the six stages. Reliability

coefficients for individual stages ranged from .74 (Behavioral Adaptation) to .77 (Defense) (Hammer, 2011). Overall, a factor analysis provided strong empirical support for the broader two-factor (ethnocentric and ethnorelative) structure of the developmental model and modest support for the six-factor structure of intercultural sensitivity that the IDI is purporting to measure (Hammer, 2011).

Culturally Competent Model of Health Care

Campinha-Bacote (1994) developed the Culturally Competent Model of Health Care. According to the author, cultural competence is a process that consists of culturally responsive assessments and culturally relevant interventions (Campinha-Bacote, 1994). This model was developed for use within the nursing profession and approaches practice from a process in which the professional continually strives to achieve the ability to work within the cultural context of individuals, families, or communities (Campinha-Bacote, 1994). The model has five components: cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire. Cultural awareness is the process of sensitizing oneself to the worldviews of clients from other cultures. The process is deliberate and cognitive, beginning with professionals examining their own prejudices and biases and recognizing how these affect cross-cultural interactions. Cultural knowledge is the process of obtaining information about the illness belief systems and worldviews of other cultures (Campinha-Bacote, 1994). Cultural skill is the process of conducting a cultural assessment; an important benefit of this skill is the avoidance of stereotypical judgments. Cultural encounter is the process of directly engaging in interactions with diverse cultural groups, enabling health care providers to validate, negate, or modify their cultural perspectives. Cultural desire, seen as the most critical construct in the process of developing cultural competence, involves an intrinsic motivation or genuine passion to be open

and flexible with others, accept differences, build similarities, and be willing to learn from others as cultural informants (Campinha-Bacote, 1994). Campinha-Bacote believes that health care appropriateness in each of these domains can yield culturally responsive services. No measures have been developed in association with this model.

Multicultural Communication Process Model

Beckett et al. (1997) developed the Multicultural Communication Process Model (MCCPM) designed for application with social workers. The authors stated that the model defined a two-tiered process for intervention specifically with African American clients (Beckett et al., 1997). In the first tier, practitioners used the model to guide their individual study and growth in multicultural knowledge. In the second tier, they used the model directly to intervene with a client or indirectly through supervision. Beckett and colleagues then described eight components of the MCCPM that they indicated were strategic and interdependent. Because they considered multicultural competence as a process, Beckett et al. (1997) suggested that the components were not sequential or linear. The eight components of the model were as follows: (a) knew self, (b) acknowledged cultural differences, (c) knew other cultures, (d) identified and valued differences, (e) identified and avoided stereotypes, (f) empathized with persons from other cultures, (g) adapted rather than adopted, and (h) acquired recovery skills. The authors suggested that practitioners first use the model to guide their individual growth in multicultural perspectives and then use the model to inform interventions in a multicultural context (Beckett et al., 1997). No measures were developed in association with this model.

Process Model of Cultural Competence

Another model of cultural competence emphasizes the importance of recognizing the two cultural perspectives of the counselor and the client and the ability of the counselor to move

between both perspectives (López, 1997). In this model, López (1997) argued that the essence of cultural competence is moving between two cultural perspectives, that of the therapist and that of the client. López proposed four domains of culturally competent therapy as essential for accomplishing this objective (i.e., engagement, assessment, theory, and methods). Engagement involves the therapist's work getting clients to participate in therapy by establishing a positive working relationship. Engaged clients are able to share their culture-specific perspectives on the presenting problem and also help set goals for treatment (López, 1997). Assessment involves clinicians ascertaining the nature of the client's psychological functioning based on formal procedures (e.g., personality inventories) and informal procedures (e.g., clinical interviews). The process requires clinicians to apply the norms of the mainstream culture and those of the client's culture (López, 1997). Balancing cultural perspectives, exercising clinical judgment, and carefully considering all cultural data are integrated into the assessment. Theory, which is the third domain, involves therapists respecting and validating clients' theoretical models. At the same time, competent therapists recognize that the client's model may reflect dysfunction, not simply an alternative explanation of the presenting problem (López, 1997). The last domain, methods, is the procedures used to facilitate therapeutic change (López, 1997). Culturally competent clinicians adapt their methods and interventions to each client. No measures have been developed in association with this scale.

Three-Factor Model of Cultural Capacity

Castro (1998) borrowed from the work of other scholars (Cross et al., 1989; Kim et al., 1992; Orlandi, 1992; Siegman, 1958) to modify and expand the concept of a cultural capacity continuum. His conceptualization consists of six levels of cultural capacity ranging from a level of –3, cultural destructiveness, to +3, cultural proficiency. The lowest level, cultural

destructiveness (−3), is for professionals who harbor an attitude of superiority about their culture and inferiority about clients from other cultures. The next level is cultural incapacity (−2) (Castro, 1998). This is an orientation that emphasizes separate but equal treatment of clients who are outside of the cultural mainstream. The next level is cultural blindness (−1). This orientation emphasizes that all cultures and individuals are alike and equal (Castro, 1998). However, professionals who operate at this level discount the importance of culture as well as the need to incorporate multicultural perspectives during treatment. These three lower levels reflect cultural incompetence. The next three levels constitute Castro's three-factor model. He states that the model enables psychologists and other mental health professionals to "conduct culturally effective assessments, clinical interventions, and research with members of ethnic minority populations" (p. 127). The first level of the three-factor model is cultural sensitivity or openness (+1). It is an understanding and appreciation of sociocultural factors pertaining to the client and treatment (Castro, 1998). Cultural sensitivity is also an appreciation of within-group variation, recognizing the considerable heterogeneity within a given ethnic population. The next level of the model is cultural competence (+2). Professionals at this level can work with complex issues and understand cultural nuances. Therefore, they can plan culturally effective interventions. The highest level is cultural proficiency (+3). This is an ideal state and requires a commitment to lifelong learning (Castro, 1998). This state is indicated by professionals demonstrating excellence and being proficient in the design and delivery of interventions. According to Castro, a professional may be culturally proficient with one target population but not with another and that complete cultural proficiency across populations is rare. No measures have been developed in association with this model.

Multicultural Counseling Competency Assessment and Planning (MCCAP) Model

Toporek and Reza (2001) developed the Multicultural Counseling Competency Assessment and Planning Model (MCCAP). The model incorporates the cross-cultural competencies advanced by Sue et al. (1992). The authors describe the MCCAP as an enhancement of Sue and colleagues' model by integrating three additional dimensions: (a) contexts, (b) modes of change, and (c) a process for assessment and planning. Nine standards and competencies are identified, categorized into three areas: (a) having awareness of own assumptions, (b) understanding the client's worldview, and (c) developing appropriate interventions. For each category, competencies are described in terms of a professional's awareness, knowledge, and skills. The model describes three contexts of multicultural competence (Toporek & Reza, 2001). The personal context is the professional's identity, beliefs, attitudes, knowledge, and skills as a cultural being. The personal context may affect how professionals conceptualize counseling. The professional context is the individual's formal role within the mental health field (Toporek & Reza, 2001). The institutional context is the individual's membership and participation in a specific organizational setting.

The MCCAP model suggests that the complexity of change includes three domains: affective, cognitive, and behavioral learning and competence (Toporek & Reza, 2001). The resulting framework integrates self-assessment and strategic planning to assist counselors, psychologists, and educators in a more complete application of multicultural counseling standards. The model describes three modes of change: cognitive, affective, and behavioral (Toporek & Reza, 2001). The cognitive mode refers to the process of knowing or perceiving. The affective mode refers to the professional's feelings or emotions. The behavioral mode refers to the professional's actions and reactions. These modes of change encircle or encompass the

other dimensions of the cube (Toporek & Reza, 2001). No measures have been developed in association with this scale.

Measures of Multicultural Competence

Several instruments have been developed to measure multicultural competence in counseling training, practice, supervision, and evaluation (Ridley & Kleiner, 2003). Landmark work on multicultural competency assessment was conducted by LaFromboise and colleagues with their development and validation of the Cross-Cultural Counseling Inventory (CCCI; Hernandez & LaFromboise, 1985) and the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise et al., 1991). The CCCI-R is a 20-item instrument completed by an evaluator who observes a counselor working with a client of a different racial/ethnic background. Subsequent to work on the observer-report format of the CCCI, research began on the development of counselor self-report assessments of perceived multicultural competence.

In the early 1990s, three research teams, working independently, developed the following self-report instruments: the Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea et al., 1991), the Multicultural Counseling Inventory (MCI; Sodowsky, 1996; Sodowsky et al., 1994; Sodowsky et al., 1998), and the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1991; Ponterotto et al., 1996). The conceptual base for all three instruments is the Sue and colleagues' (1982) multicultural counseling competency report. Psychometric reviews of the instruments (Constantine & Ladany, 2001; Ponterotto et al., 1994; Pope-Davis & Dings, 1995; Pope-Davis & Nielson, 1996), along with direct empirical comparisons of the measures (Constantine & Ladany, 2000; Kocarek et al., 2001; Pope-Davis & Dings, 1994; Worthington et al., 2000; Worthington et al., 2007) suggest that although holding promise for research and training, the instruments need closer psychometric scrutiny and likely

revision. While these measures differ in some ways from one another, they are all theoretically based on the Tripartite Model of multicultural competence, covering conceptually similar domains (i.e., awareness, knowledge, and skills).

MCKAS

The Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 2002) is a revision of the Multicultural Counseling Awareness Scale-Form B (MCAS-B; Ponterotto et al., 1996). Understanding the MCAS-B is important to understanding the MCKAS. The MCAS-B is a 45-item scale that contains two domains—knowledge/skills (28 items) and awareness (14 items)—as well as three items for detecting social desirability. During the initial development of the MCAS-B, a total of 135 items was developed using independent card sorts, focus group discussions, content validity assessments, item analysis, and sequenced factor analytic procedures. Criticisms of the MCAS-B led to revision. Criticisms included (a) the lack of definitional clarity of the subscales, (b) the items questioned knowledge of specific scholars in the field, (c) the items were considered to be weaker in terms of psychometrics, (d) the lack of clarity on the function of the three-item social desirability cluster, and (e) the small sample size used to develop the factor structure of the MCAS-B (Ponterotto et al., 2002).

Ponterotto and colleagues (2002) revised the MCAS-B through examining the factor structure of the scale. They used a sample of 525 students and professionals in counseling and counseling psychology. The mean age for the sample was 35 years (*SD* = 9.9); the median was 34 years, with the range from 21 to 69 years of age. The sample was composed of 66.5% (*n* = 349) women and 33.5% (*n* = 176) men. Eighty-three percent (*n* = 436) of the sample participants were White, 7% (*n* = 37) African American, 6% (*n* = 32) Hispanic American, 2% (*n* = 10) Asian American, 1% (*n* = 5) Native American, and 1% (*n* = 5) other. On the 7-point

Likert-type scale used in the MCAS, the grand mean across the items was 4.7 (*SD* = 1.4). Means and standard deviations for the Knowledge/ Skills subscale scores (*M* = 4.14, *SD* = 1.4) and the Awareness subscale scores (*M* = 5.70, *SD* = .71) indicate a negative skew of Awareness scores. The results indicated reliability estimates of .92 on the Knowledge subscale scores and .79 on the Awareness subscale scores.

A principal component analysis produced nine eigenvalues greater than unity and the screen test indicated a three-factor solution. Both orthogonal and oblique rotations were conducted. Although the two extractions were highly similar in terms of factor structure and loadings, the orthogonal (varimax) rotation provided the clearest and most interpretable extraction. A factor-loading cutoff of |.40| was used with 40 of the 45 items loading on one of the three factors. Twenty-one items loaded on Factor 1, 12 on Factor 2, and 7 on Factor 3. The inter-correlations among the three factors ranged from |.01| (Factors 2 & 3) to |.28| (Factors 1 & 3). Items on Factor 3 were ultimately removed from the scale. Items on Factor 3 were about information of scholars in the multicultural field. There were two main criticisms mentioned for Factor 3: the use of double-barreled questions and the relevance of the scholars for those taking the assessment years later (e.g., 1991 compared to 2015). Item 33 was also eliminated from Factor 1 due its high cross-loadings on both Factors 1 and 2.

Eliminating items resulted in a revised scale—the MCKAS (Lu, 2017). The MCKAS is a 32-item instrument divided into two subscales: Multicultural Knowledge (20 items) and Multicultural Awareness (12 items) (Ponterotto et al., 2002). The MCKAS also uses a 7-point Likert scale that ranges from 1 (*not at all true*) to 7 (*totally true)*. A sample knowledge item is "I am familiar with the 'culturally deficient' and 'culturally deprived' depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination." In

contrast, all awareness items are aimed at exploring a Eurocentric worldview bias. A sample item is “I believe all clients should maintain direct eye contact during counseling.” Ten of the 12 awareness items are first reverse scored and then the ratings of items each subscale are added together. Higher scores indicate higher levels of multicultural knowledge/awareness and multicultural skills.

Ponterotto et al. (2002) conducted a second study to test the goodness of fit of the two-factor (Knowledge and Awareness) MCKAS model on a new sample. In addition, initial tests of convergent and discriminant validity were performed along with a test of internal consistency. Participants included 199 counselors-in-training recruited from five universities in the Northeast. The mean age for the sample was 30 years (*SD* = 8.9), with the median age falling at 26 years. Seventy-five percent (*n* = 149) of the sample participants were female, and the racial/ethnic breakdown was as follows: 45% (*n* = 90) White/Not Hispanic, 18% (*n* = 36) African American, 16% (*n* = 32) Hispanic American, 2% (*n* = 4) Asian American/Pacific Islander, and 1% (*n* = 2) Native American (the remainder was listed as either other or unspecified). In addition to the 32-item MCKAS, participants also completed the MCI (Sodowsky et al., 1994), the Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992), and the Social Desirability Scale (SDS; Crowne & Marlowe, 1964).

The means for the MCKAS Knowledge and Awareness subscales were 4.96 and 5.06, respectively, indicating a slight negative skew on the 1–7-point Likert-type scale. Alphas for the MCKAS Knowledge and Awareness subscale scores were .85 and .85, respectively. Confirmatory maximum likelihood factor analysis was used to test the underlying factor structure of the MCKAS. Three theoretical models were chosen for comparison with each other and with a baseline null model: (a) one global factor, (b) two independent (orthogonal) factors,

and (c) two correlated (oblique) factors. The null model represents a hypothetical worst case in which no underlying relationships between items are stipulated. The different models were compared using several indices of fit: (a) chi-square, (b) the goodness-of-fit index (GFI), (c) the adjusted GFI (AGFI), (d) the Tucker-Lewis index (TLI; Tucker & Lewis, 1973), (e) the relative noncentrality index (RNI; McDonald & Marsh, 1990), and (f) the root mean square residual (RMSR). For a description of fit indices, please see Appendix C. At the item level, the results did not support the two-factor structure (e.g., $\chi^2 = 968.81$ with $df = 463$, $p < .001$; GFI = .74, AGFI = .70, and RMSR = .09). The authors indicated the unsatisfactory fit was expected due to the models having more than four or five items per factor and a large sample size. To address this concern, new aggregate items were created for the MCKAS subscales. Seven aggregate Knowledge items and four aggregate Awareness items were created. Coefficient alphas for the two aggregate factors were .91 and .80, respectively. The aggregate fit improved with the GFI, TLI, and RNI at or above .90 and with the RMSR falling at .07. This pattern of fit indexes indicates an overall satisfactory fit for the two-factor models.

Convergent validity for MCKAS scores was examined through correlations with the MCI subscale scores. The MCKAS Knowledge subscale evidenced significant correlations and medium effect sizes with the MCI Knowledge ($r = .49$), Skill ($r = .43$), and Awareness (.44) subscales. The significant correlation between MCKAS Knowledge scores and MCI Knowledge subscale scores and Skills subscale scores was expected. The MCKAS Awareness subscale correlated highly and significantly with the MCI Counseling Relationship subscale ($r = .74$; large effect size) because both subscales focus to some degree on the counselor's perceived comfort working with culturally diverse clients. The Awareness subscales of the two instruments were not correlated ($r = –.06$; small effect size) because the items in the MCKAS Awareness subscale

focus on subtle Eurocentric bias, whereas the MCI Awareness items focus on the counselor's understanding of issues outside the counseling relationship. Discriminant validity for MCKAS scores was examined through correlations with the SDS scores. Knowledge subscale scores correlated significantly with the SDS scores (r = –.39; medium effect size). The authors indicated the Awareness subscale did not correlate significantly with the SDS scores yet did not present the statistical information.

In 2017, Lu conducted a study to re-examine the MCKAS. They examined a sample of 176 participants who completed the MCKAS. Thirty of the 176 participants were master's-level counseling students, 44 doctoral counseling students, 65 counselor educators, and 37 counselors. The first step in this study was to investigate the multicultural knowledge domain of the MCKAS and identify items that do not conceptually fit with this domain. To do so, the researchers collaborated with two doctoral students in a counselor education program. Each doctoral student independently analyzed each item in the knowledge domain in reference to Sue et al.'s (1982) conceptualization of attitudes/beliefs, knowledge, and skills regarding multicultural counseling competence (MCC). The result of item analysis indicated that three out of the total 20 items in the knowledge domain of the MCKAS were consistent with Sue and colleagues' description of beliefs/attitudes. These items were "to be aware of one's own biases," "to be comfortable with individual differences," and "to be aware of potential circumstances (e.g., personal biases) under which one needs to consider referral of clients to another counselor." The remaining 17 items related more directly to Sue et al.'s description of knowledge. After deleting these three items, the researchers re-explored the factor structure of the MCKAS without the items that had been identified as not substantially reflecting multicultural counseling knowledge. They used a principal factor analysis with a promax rotation. To determine the number of factors to retain, the

researchers used cutoff of (a) eigenvalues greater than 1, (b) the leveling point of the scree plot, and (c) factor at or over .40. The PFA on the MCKAS resulted in a two-factor structure involving 28 items. The factors were labeled the same as the original MCKAS (i.e., Multicultural Knowledge and Multicultural Awareness). The researchers suggested that their results supported the use of a 28-item two-factor MCKAS-R ("R" standing for refined). The major feature of the MCKAS-R is that its knowledge domain contains items that are conceptually consistent with the construct of interest, as opposed to the MCKAS, which includes items that attend to attitudes/beliefs within that domain. The refined scale has not undergone any further empirical investigation.

A significant critique of the MCKAS arises from the fact that, although it draws upon the Tripartite Model, it becomes evident that the MCKAS items fail to encapsulate the tripartite conceptualization adequately. Constantine et al. (2002) conducted an exploratory factor analysis on three self-report MCC scales all together (MAKSS, MCI, and MCKAS) and reported that both domains of the MCKAS loaded on the same dimension. Constantine et al. identified this dimension as multicultural counseling attitudes/beliefs. However, attitudes/beliefs, knowledge, and awareness, in most cases, are not interchangeable. Sue and his colleagues (1992) have maintained that awareness (defined as beliefs and attitudes), knowledge, and skill are distinct constructs.

MAKSS-CE-R

The MAKSS-CE-R (Kim et al., 2003) is a revised version of the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS; D'Andrea et al., 1991). The original instrument was designed to assess the effect of instructional strategies on students' multicultural counseling development (D'Andrea et al., 1991). The authors indicated the MAKSS assesses

development by measuring (a) awareness of one's attitude toward ethnic minorities, (b) knowledge about minority populations, and (c) cross-cultural communication skills. The MAKSS is a 60-item measure, with 20 items on each of the subscales that are consistent with Sue et al.'s (1982) Tripartite Model of multicultural competence (i.e., awareness, knowledge, and skills). Items are rated on a 4-point Likert scale, ranging from 1 (*very limited*) to 4 (*very good*). Reliability coefficients (Cronbach's alpha) for the instrument ranged from .75 (Awareness) to .96 (Skills) (D'Andrea et al., 1991). D'Andrea et al. (1991) examined the factor structure of each subscale using a principal axis extraction and orthogonal (varimax) rotation. Factors were determined through examining items loadings using a cutoff of .40. The Awareness subscale one-factor solution produced three negative factor loadings and two near-zero loadings. These authors concluded the analysis indicates that cross-cultural awareness represents a multidimensional construct. The Knowledge and Skills subscales produced one-factor solutions, with all items loading on the intended factor above .40. In developing the MAKSS, content validity was checked by matching the survey items with instructional objectives for a multicultural course. Examples of these objectives include learning activities designed to (a) examine the impact of stereotyping persons according to a given group (promoting awareness); (b) define and discuss fundamental terms and concepts like culture, ethnicity, racism, contact hypothesis, and cultural encapsulation (promoting knowledge); and (c) assist students in developing various counseling skills in role-playing situations to assess their effectiveness when working with clients from different populations (promoting skill development). The major criticisms of the MAKSS that ultimately led to revision were the need to examine the three-dimensional construct of the total scale and the need to provide stronger evidence of the construct validity of the MAKSS scores (Kim et al., 2003).

The MAKSS-CE-R (Kim et al., 2003) is the revised version of the MAKSS (D'Andrea et al., 1991). The MAKSS-CE-R is a self-report scale that measures a counselor's MCC across three subscales (Kim et al., 2003): (a) Awareness, (b) Knowledge, and (c) Skills. The MAKKSS-CE-R counselors rate themselves on 33 items. Each subscale uses a different 4-point Likert scale. The Awareness items are rated from 1 (*very limited*) to 4 (*very aware*). Knowledge items are rated from 1 (*very limited*) to 4 (*very good*). Skills items are rated from 1 (*strongly disagree*) to 4 (*strongly agree*). An example of an Awareness item is "The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities." An example of a Knowledge item is "At the present time, how would you rate your understanding of the following term: ethnicity?" An example Skills item is "How well would you rate your ability to accurately assess the mental health needs of lesbian women?" Scores on each subscale are added together and higher scores represent greater competency.

Kim and colleagues (2003) examined the factor structure, internal consistency, convergent validity, and discriminant validity of the scores on the MAKSS-CE-R. They used a sample of 338 (272 women and 66 men) students enrolled in graduate counseling courses at universities across the United States. Participants ranged in age from 20 to 53 years (M = 27.4, SD = 6.8). In terms of race and ethnicity of the respondents, there were 149 (44.1%) European Americans, 106 (31.4%) African Americans, 34 (10.1%) Asian Americans, 10 (3.0%) Hispanic/Latino(a), 7 (2. 1%) biracial Americans, 4 (1.2%) multiracial Americans, 1 (.3%) Native American, and 27 (8.0%) did not report their race. In terms of program, 87 (25.7%) participants reported being enrolled in a school counseling program, 86 (25.4%) in counseling psychology, 26 (7.7%) in school psychology, 25 (7.4%) in community counseling, 23 (6.8%) in

college student personnel counseling, 20 (5.9%) in rehabilitation counseling, 15 (4.4%) in counselor education, 9 (2.7%) in clinical psychology, and 33 (9.8%) in other specializations.

Data from 180 participants were randomly selected to conduct an exploratory factor analysis; the remaining 158 cases were used for confirmatory factor analysis. First, a three-factor solution was specified for a principal factor analysis using oblique rotation. The researchers used the following criteria to establish the factors: (a) retaining items with a structure coefficient greater than .30, (b) retaining items that clearly represented only one factor (i.e., structure coefficient greater than .30 on only one of the three factors); and (c) retaining items that were conceptually consistent with each other. The results indicated that the three-factor solution accounted for 29.80% of the variance, with the factors each accounting for 17.06%, 7.53%, or 5.21% of the variance. To examine the stability of the three-factor solution, a confirmatory factor analysis was then conducted with the data generated from 158 participants who were not used in the exploratory factor analysis. The maximum likelihood estimation method was used in this analysis. The authors determined the three-factor solution was a good fit ($\chi^2 = 1091.42$, $p = .00$; CFI = .96, TLI = .96, and Incremental Fit Index [IFI] = .96).

Cronbach's (1951) alpha for the scores of the MAKSS-CE-R subscale scores ranged from .71 (Awareness) to .87 (Skills). The internal consistency for the scores of the total MAKSS-CE-R was .82 (Kim et al., 2003). Using the total sample, Kim et al. (2003) examined correlations between the MAKSS-CE-R scores and MCKAS. A moderate correlation between the two instruments' scores was expected as both assess components of multicultural counseling but were developed separately. The comparison of the Awareness subscales yielded correlation coefficients of .67. A correlation of .48 was observed between the Knowledge subscales. In addition, the results showed a correlation of .31 between the Skills subscale of the MAKSS-

CE-R and the MCKAS Knowledge subscale and .24 between the Skills subscale of the MAKSS-CE-R and the MCKAS Awareness subscale. Evidence of MAKSS-CE-R scales' criterion-related validity was examined by comparing the scores between those participants who had taken at least one course on multicultural counseling and those who had not. Those participants who had completed at least one multicultural counseling course scored higher on MAKSS-CE-R Total scores, Awareness subscale, and Knowledge subscale than those who had not taken a multicultural counseling course in the past, $F(4, 303) = 4.11$, $p = .003$.

MCI

The MCI is a self-report 40-item scale that measures a counselor's multicultural counseling competence across four subscales: (a) Multicultural Awareness, (b) Multicultural Knowledge, (c) Multicultural Skills, and (d) Multicultural Counseling Relationship with diverse clientele (Sodowsky et al., 1994). The Skills subscale contains 11 items measuring both general counseling and specific multicultural counseling skills. The Awareness subscale is comprised of 10 items with the intent to measure perceived multicultural sensitivity, advocacy, and interactions that occur both in the professional counseling environment and in general life occurrences. The Knowledge subscale has 11 items developed to measure treatment planning, case conceptualization, and multicultural counseling research. Relationship is an added factor that has not been included in other measures of multicultural counseling competency. Sodowsky et al. (1994) defined relationship as "the counselors' interaction process with the minority client, such as trustworthiness, comfort level, stereotypes of the minority client, and worldview" (p. 142). The Relationship subscale has eight items measuring perceived counselor-client interaction process (Sodowsky et al., 1994). The counselor is asked to rate themselves on items using a 4-point Likert scale from 1 (*very inaccurate*) to 4 (*very accurate*) (Sodowsky et al.,

1994). Scores on each subscale are added, and higher scores reflect higher multicultural counseling competence. Sodowsky et al. conducted four studies to develop and validate the scores. In the first study, the sample was 604 psychology students, counselors, and psychologists in the Midwest United States. The second study had 220 university counseling center counselors who were dispersed throughout the nation. Studies 3 and 4 contained 80 counseling graduate students from the U.S. Midwest: 42 in study 3 and 38 in study 4. Results from studies 1 and 2 examined the reliability of the scores. Coefficient alphas for studies 1 and 2 were as follows, respectively: total scale, .90 and .90; Skills, .83 and .81; Knowledge, .79 and .78; Awareness, .83 and .81; and Relationships, .71 and .72. Studies 1, 3, and 4 were used to assess and demonstrate criterion-related validity of the instrument. In study 1, MCI scores were compared for those with and without multicultural experience. Experience was determined by those whose work incorporated more than 50% racial/ethnic minority clients compared to those whose work had less than 50% of minority clients. Studies 3 and 4 compared graduate students who had taken a multicultural counseling class or other formal training to graduate students who had not received any type of formal training or education (Sodowsky et al., 1994).

Evaluation of Measures

Researchers of multicultural counseling competence have identified a major need for the revision and modification of current instruments or the development of a new instrument to assess multicultural counseling competence (Kitaoka, 2005). Several reviews of these measures have voiced concerns of the use of the instruments on assessing counselors in training (Fuertes et al., 2001; Hays, 2008; Kocarek et al., 2001; Ponterotto et al., 1994; Pope-Davis & Dings, 1994). Major themes found in the limitations of the majority of the instruments were (a) questions about their factor structure, (b) the viability of reliability estimates and other

evidence of validity, and (c) issues of social desirability. Additional factor analyses appear to be needed to test the three-dimension construct of the MAKSS scores. Additionally, limited research has been conducted on this measure and thus further research is needed to explore the reliability and validity of the MAKSS scores (Kitaoka, 2005). The limitations of the MCI are twofold. First, there is limited evidence supporting its concurrent and convergent validity. Second, there is a need for further exploration into the four factors within the instrument. This need arises because it is plausible that the instrument may actually have fewer factors, as suggested by the high intercorrelations between these factors (Ponterotto et al., 1994).

Another significant criticism of the MCKAS is its failure to capture the tripartite conceptualization, despite being based on the Tripartite Model (Ponterotto et al., 2002).

Another theme from the review of the measures is the reliance on only the work of Sue (Sue et al., 1982; Sue et al., 1992) as the framework for multicultural counseling competence. Researchers (Hays, 2008; Kim et al., 2003; Kitaoka, 2005; Kocarek et al., 2001) have begun to question this framework, wondering if it is the only and best approach to defining multicultural competence. Kitaoka highlighted the discrepancy of the factor structures of the multiple measures of multicultural competence. Several different factor structures are available across the multiple assessments being used and yet they all fail to fit neatly into the work of Sue et al., which raises the question if multicultural counseling competency is best conceptualized as awareness, knowledge, and skills.

Measures designed to assess multicultural competence have also been criticized as putting too much emphasis on self-report method. Self-report scales have been criticized for their failure to address the potential effects of social desirability (Constantine & Ladany, 2000), which has been defined as the tendency of respondents to answer questions (particular on sensitive

topics) in a manner that would be viewed favorably by themselves or others (Crowne & Marlowe, 1960). Social desirability influences respondents to overreport good attitudes/behaviors while underreporting bad attitudes/behaviors (Crowne & Marlowe, 1960). To examine the potential relationship between self-reported multicultural counseling competence and social desirability, Constantine and Ladany (2000) conducted a univariate multiple regression analysis in a study on each of the three scales. The predictor variables were all of the subscales of the self-report multicultural competence scales, and the criterion variable was social desirability scores on the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960). Results indicated that higher Marlowe–Crowne social desirability scores were uniquely and significantly related to higher self-report ratings on the MAKSS Knowledge subscale (F[1,120] = 4.37, p = .04), higher self-report ratings on the MCI Relationship subscale, F(1, 120) = 5.14, p = .02, and lower self-report ratings on the MCKAS Awareness subscale, F(1, 120) = 12.14, p = .001. The authors indicated the reverse scoring of the Awareness subscale and possible lack of attention of the participants to the questions could have caused a misunderstanding of the true meaning of the items. Another explanation is that with a higher level of multicultural awareness also comes a low need to appear socially desirable. Due to these findings, Constantine and Ladany (2000) recommended that these scales not be used to evaluate the actual performance of clinicians or students in training and clinical practice working with diverse clients until these concerns are addressed through research.

Cartwright, Daniels, and Zhang (2008) used the MAKSS-CE-R to investigate social desirability and its relation to demonstrated ability via videotaped roleplays. Their findings were similar to Constantine and Ladany; a positive association was found between perceived multicultural counseling competence and participants' actual demonstrated ability in the

roleplays, but this positive association was also found between social desirability and demonstrated ability. Thus, authors also cautioned the use of these self-assessment scales on assessing individuals' multicultural competence. Previous research (Sodowsky et al., 1994) has also shown that individuals who self-report being multicultural competent score on the low to middle levels of multicultural conceptualization competence. This may be an indication of an overestimation of actual level of multicultural counseling competence. Thus, the instruments may be measuring multicultural counseling competence self-efficacy rather than actual ability (Constantine & Ladany, 2000).

While these three self-report measures are widely used to assess MCC in training, research, and practice (Constantine & Ladany, 2000; Hays, 2008; Sheu et al., 2012; Tao et al., 2015), they have faced persistent critiques. Some scholars have pointed out limited progress in providing empirical support for the utility of these measures (Constantine & Ladany, 2000; Dunn et al., 2006; Hays, 2008). In light of these challenges, some psychologists have called for the development of more comprehensive, psychometrically sound, and contextually relevant instruments to assess MCC (Swank et al., 2012).

While the focus has been on self-report measures, it is important to consider alternative methods for assessing multicultural competence. One such alternative is the use of psychometrically sound instruments for rating student performance, which not only offers a more robust means of assessment but also enables meaningful generalization of results. Recognizing the limitations of the current self-report scales, there has been an effort to develop a new self-report scale that may better assess multicultural competence. This new measure is known as the Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016).

The Multicultural Counseling and Psychotherapy Test

The MCPT **(**Gillem et al., 2016) is a multiple-choice examination designed to assess knowledge, skills, and abilities determined to be important for psychologists and professional counselors. It is comprised of 46 multiple choice and true/false items. The authors used a two-phase process to create this instrument. In the first phase, 600 multiple choice and true/false questions were generated about counseling racial/ethnic groups. The items were created using professional guidelines, including the APA 2003 guidelines, the scholarship of Sue et al. (1982), and the works that followed (APA, 2003; Arredondo et al., 1996; Kivel, 2002; Ridley, 2005; Sue & Sue, 2003). Items were created to reflect the areas of multicultural knowledge, awareness, and skills**.** The knowledge items reflect questions about important research findings, racial identity development, cultural group norms and history, culturally respectful language, and concepts, such as stereotype threat and microaggressions. Awareness items reflect awareness of biases and values, limits of competence regarding cultural issues, color-blindness, and impact of therapists' culture and background on attitude toward clients. Skills items involve case examples where the counselor is asked to choose the best course of action when multicultural skills are needed. The research team, along with two outside sources, rated and coded the items for fit in these three areas. Elimination of items that were inconsistently rated resulted in a 451-item version.

Phase one of the development then involved administration of this 451-item version to a sample of 30 experts and 30 nonexperts to determine what items best discriminated multicultural counseling experts from nonexperts. Experts were individuals who taught or published in the field of multicultural counseling, or who had incorporated multicultural counseling competency into practice. The nonexpert sample was 30 undergraduate students who were planning to pursue counselor training after graduation. Only students who had never taken a course related to

multicultural competence were included in the sample. The researchers examined the frequency of correct responses for each item. They then decided to retain 191 items that best discriminated experts from nonexperts. In the second phase, the scores were examined using logistic regression, and the scale was further reduced to a set of 49 items that best predicted expert/ nonexpert status. The next highest discriminating item was also retained to round the item set to 50. Phase one of Gillem et al.'s (2016) study offered evidence for validity of the scores, but there were limitations to the findings. Experts differed from nonexperts on a number of variables, including age, education, and experience. The focus of phase two of the study was to offer further evidence of validity by examining the scores of the 50 items with a sample of licensed mental health professionals.

In phase two, a sample of licensed mental health professionals was obtained to determine if scores on the MCPT were related to training, education, or professional indicators of multicultural competence. Participants included master's-level licensed counselors, psychologists, social workers, and marriage and family therapists. The sample identified primarily as female (n = 179; 78.9%). The primary race/ethnicity of participants was White (78.4%), followed by Black/African American (9.7%), Asian/Asian American (7%), Hispanic/Latina(o) (6.2%), Multiracial (4.4%), Jewish (4%), and Native American/American Indian/Alaska Native (2.2%). The median age of participants was 45 years. Over half of the participants indicated their social class status was middle class (56.4%), followed by upper middle class (32.6%), working class (7.9%), poor/lower class (1.3%), and upper class (0.9%). Most of the participants held a doctoral degree (65.2%), with 34.8% holding a master's degree.

Item analysis was conducted on the 50 items. The results indicated that four items had negative item discrimination because of having two potential correct answers. These items were

eliminated from further review, which resulted in 46 total items; thus, the maximum summary score one could receive was 46. Scores ranged from 18–45 (M = 36.45, SD = 5.91). Cronbach's alpha for scores was found to be .83. Scores on the MCPT were correlated with activities that could be associated with multicultural competency. Higher MCPT scores were associated with publishing more multicultural counseling research, giving more presentations on multicultural counseling, teaching more multicultural counseling courses, reading more multicultural counseling texts, attending more multicultural counseling workshops, and attending more multicultural-focused conferences than those with lower scores (Gillem et al., 2016). The MCPT seems like a promising solution to the concerns about the current MCC measures. However, only one study has been conducted on this measure; thus, additional evidence is needed to support the viability of this claim.

Purpose of Study

Presently, measures to assess competence in the area of multicultural counseling have limited support regarding the psychometric properties (Hays, 2008; Kim et al., 2003; Kitaoka, 2005; Kocarek et al., 2001). A valid and reliable means of measuring multicultural counseling competence would support a number of efforts that aim to ensure counselors are able to work effectively with a diverse population. The purpose of this investigation was to follow up on the recommendations of previous research: to examine the psychometric properties of the Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016).

Research Questions

The following research questions were examined:

RQ1: Do scores on the MCPT show evidence of criterion-related validity through relating scores on the MCPT to demographic data, including level of education,

number of courses taken focused on multicultural counseling/psychotherapy, number of workshops/seminars attended focused on multicultural counseling/psychotherapy, number of presentations or publications produced focused on multicultural counseling/psychotherapy, and face-to-face client contact hours?

Hypothesis One: Scores on the MCPT will be positively related to demographic data, including level of education, number of courses taken on multicultural counseling, number of workshops/seminars attended focused on multicultural competence/psychotherapy, number of presentations/ publications produced related to multicultural counseling/psychotherapy, and number of number of face-to-face client contact hours.

RQ2: Do scores on the MCPT show evidence of internal consistency through examining reliability estimates of the scores on the MCPT?

Hypothesis Two: MCPT scores will have evidence of internal consistency measured by Cronbach's coefficient alpha reliability estimates >.70 (minimally acceptable; DeVellis, 2017).

RQ3: Do scores on the MCPT show evidence of convergent validity through comparing scores on the MCPT to the scores on the CCCI-R, an observer-report measure, and scores on the MCI, a self-report measure?

Hypothesis Three: Total CCCI-R scores and MCI scores will account for a significant proportion of the variance in MCPT scores, above and beyond demographic variables.

CHAPTER III

METHOD

In this chapter, I outline the methodology of the present study. First, I provide a description of the study participants, including how I determined who was included in the final data analysis. Then, I explain the measures used in the study, highlighting the psychometric properties associated with each measure. After this, I report the specific recruitment and data collection procedures that were used.

Participants

There were a total of 156 participants who accessed the survey. Five cases were deleted because they did not agree to participate in the survey after reading the informed consent. Seven more cases were deleted because they agreed to participate, but did not answer any of the questions, including demographics. Thirty-eight more cases were deleted because, although agreeing to participate, they answered less than 50% of survey items. In addition, 40 participants could not be matched with a supervisor who completed the survey. This process resulted in a final sample of 66 participants. Demographic data related to the sample are presented in Tables 1 and 2.

Table 1

Demographic Data

Variable	*N*	%
Gender		
Female	49	74.2
Male	7	4.8
Non-binary	2	3.2
No Response	8	17.7
Sexual Orientation		
Bisexual	8	12.1
Gay	3	4.5
Straight	37	56.1
Queer	5	7.6
Lesbian	3	4.5
No Response	10	15.1
Race		
Asian	4	6.1
Black	9	13.6
Biracial	3	4.5
Latina	2	3.0
White	36	54.5
Ethnicity		
Hispanic	2	3.2
Japanese	1	1.6
Korean	2	3.2
Latina	1	1.6
Mexican	1	1.6
Pakistani	1	1.6
Citizenship		
US Citizen	57	91.9
JI Student Visa	2	4.5
Duel Citizen	1	1.5
SES		
Poor	7	10.6
Working Class	21	31.8
Middle Class	21	31.8
Upper-Middle Class	15	22.7
Wealthy	2	3.0
Highest Degree Obtained		
Bachelor's Degree	18	27.4
Master's Degree	36	53.2
PsyD or PhD	2	3.2
Program Type		
Counseling Psychology	16	25.8
Clinical Psychology	13	21.0
Psychology (unspecified)	23	37.1

Note. $N = 66$.

Table 2

Descriptive Statistics of Demographic Variables

	M	*SD*	Min	Max	Skew	Kurtosis
Age	32.17	8.90	21	58	1.30	.89
Face-to-face client contact hours	496.48	344.79	23	1,000	.24	–1.32
# of multicultural courses taken	6.55	8.76	0	41	1.98	3.62
# of multicultural workshops/seminars	8.26	8.27	0	37	1.29	1.66
Multicultural presentations	8.55	15.89	0	60	1.83	2.08

Note. $N = 66$.

The sample contained 49 (74.2%) who identified as a cisgender woman or female, seven (10.6%) who identified as male, two (3.0%) who identified as gender queer or nonbinary, and eight (12.1%) who preferred not to answer. The sample's self-reported ethnicity was mostly White (54.5%), followed by Black (13.6%), Asian (6.1%), Biracial (4.4%), and Latina (3.0%). Eight participants reported their ethnicity as Latino or Hispanic (3.2%), Japanese (1.6%), Korean (3.2%), Latina (1.6%), Mexican (1.6%), or Pakistani (1.6%). The majority of the sample (90.8%) identified as U.S. citizens, three participants (4.5%) reported citizenship status as permanent resident of the U.S., and three participants (4.5%) reported as duel citizen. The majority of participants identified their family's social class standing as working class ($n = 21$, 31.8%) or middle class ($n = 21$, 31.8%), followed by upper-middle class ($n = 15$, 22.7%), poor ($n = 7$, 10.6%), and wealthy ($n = 2$, 3.0%). In terms of level of education, 28 participants (42.4%) had obtained their bachelor's degree at the time of taking the survey, and 38 (57.6%) had their master's or another graduate degree. The degrees obtained were from clinical psychology (19.7%), counseling psychology (27.3%), and unspecified psychology (37.1%) programs. Age of

participants ranged from 21–58 years old (*M* = 32.17, *SD* = 8.90). Face-to-face client contact hours ranged from 20 hours to 1,000 hours (*M* = 482.36, *SD* = 346.62). Three demographic variables had an unexpected range of scores: number of courses taken, number of workshops or seminars attended, and number of presentations or publications produced focused on multicultural counseling therapy. For example, the number of multicultural counseling courses taken by participants ranged from 0–41 (*M* = 6.55, *SD* = 8.76). In the United States, a typical doctoral degree program consists of 30 to 60 credit hours of coursework. Each course is usually worth 3 credit hours. This would mean that students take approximately 10 to 20 total courses during the course of their entire Ph.D. program. Therefore, reporting having taken 41 courses with a specific focus on multicultural counseling/psychotherapy is outside of this range. Number of multicultural counseling workshops or seminars taken by participants ranged from 0–37 (*M* = 8.26, *SD* = 8.27). Number of multicultural presentations or publications produced ranged from 0–60 (*M* = 8.55, *SD* = 15.89). Thirteen individuals provided numbers to these responses with *z*-scores about 3 (see data management and discussion sections below for further details). Scores were replaced as missing values. With scores replaced, multicultural counseling courses taken by participants ranged from 0–5 (*M* = 2.02, *SD* = 1.20). Number of multicultural counseling workshops or seminars taken by participants ranged from 0–12 (*M* = 3.64, *SD* = 3.70). Number of multicultural presentations or publications produced ranged from 0–10 (*M* = 1.10, *SD* = 2.03).

Demographic Data Form

The demographic data form was created by the researcher and contained questions about participants' backgrounds (see Appendix D). The form included questions related to the following: race, gender orientation, social class, religion/spirituality, and sexual orientation. Other data gathered on the form were participants' educational level, licenses held, theoretical

orientation, years of counseling experience, estimated client contact hours, and percentage of client contact hours with culturally diverse clients. In addition, participants were asked to report the number of classes taken with a focus on multicultural counseling, number of classes taught that focus on multicultural counseling, number of workshops/seminars attended related to multicultural counseling, number of presentations/publications in multicultural counseling, professional development hours, and theoretical orientation. Because labels must be changed for some scales to lessen the effect of social desirability (Hays, 2020), this demographic data form was relabeled "Measure A" to maintain a consistent format.

The Multicultural Counseling and Psychotherapy Test

The Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016) is a measure of MCC, comprised of 50 multiple choice and true/false questions. The MCPT assesses whether individuals completing the test actually know and can identify appropriate skills to use with clients. An example of an item with its stem from the scale is the following:

> In counseling clients who are racially different from yourself,
>
> (a) it is best to take a color-blind approach, as it focuses on sensitivity and safety.
>
> (b) you should not address racial difference at the outset, it will be insulting to your clients.
>
> (c) you should recognize, name, and appreciate early in treatment both similarities and differences from your client.
>
> (d) you should switch from a color blind to a multicultural perspective only after you have built a strong therapeutic alliance.

Each item is scored using an answer key provided by the authors. The scores are then added to yield a total score. Higher scores are indicative of a greater level of multicultural competence with a potential for a maximum score of 50 (Gillem et al., 2016). Cronbach's alpha reliability estimates of the MCPT scores were reported as .83 (Gillem et al., 2016). Construct validity of the MCPT was based on its correlations (*r*s = .18 to .30) with self-reported areas of expertise (giving

lectures on MCC and number of multicultural courses taken) (Gillem et al., 2016). No factor analytic procedures have been conducted on this measure. The MCPT was relabeled "Measure B" when administered to help participants avoid acting in a socially desirable way.

The Multicultural Counseling Inventory

The MCI is a self-report 40-item measure that evaluates a counselor's multicultural counseling competence across four subscales: (a) Multicultural Awareness, (b) Multicultural Knowledge, (c) Multicultural Skills, and (d) Multicultural Counseling Relationship with diverse clientele (Sodowsky et al., 1994). The Skills subscale contains 11 items measuring both general counseling and specific multicultural counseling skills. The Awareness subscale is comprised of 10 items with the intent to measure perceived multicultural sensitivity, advocacy, and interactions that occur both in the professional counseling environment and in general life occurrences. The Knowledge subscale has 11 terms developed to measure treatment planning, case conceptualization, and multicultural counseling research. The Counseling Relationship subscale makes the MCI particularly unique, as it has thus far not been included in other measures of multicultural counseling competency. The counselor is asked to rate themselves on each item, using a 4-point Likert scale from 1 (*very inaccurate*) to 4 (*very accurate*) (Sodowsky et al., 1994). An example MCI item is "I am confident that my conceptualizations of client problems do not consist of stereotypes and biases." Scores on each subscale are added and higher scores reflect higher multicultural counseling competence. Coefficient alphas were as follows, respectively: total scale, .90 and .90; Skills, .83 and .81; Knowledge, .79 and .78; Awareness, .83 and .81; and Relationships, .71 and .72 (Sodowsky et al., 1994). This measure was relabeled "Measure C" to avoid biasing responses.

The Cross-Cultural Counseling Inventory-Revised

The CCCI-R is a 20-item instrument completed by an evaluator who observes a counselor working with a client of a different racial/ethnic background. Using a 6-point Likert-type format from 1 (*strongly disagree*) to 6 (*strongly agree*), respondents rate the extent to which the CCCI-R items describe the counselor. An example CCCI-R item is "Counselor demonstrates knowledge about client's culture." One item (item 15) is reverse scored. Total score ranges from 0–120, with a higher score indicating higher multicultural competency. The coefficient alpha for the CCCI-R, taken from a sample of 86 university students and faculty, was .95 (LaFromboise et al., 1991). The interrater reliability coefficients have ranged from .78 to .84 (LaFromboise et al., 1991). This measure was relabeled "Measure D" to avoid biasing responses.

Procedures

After obtaining approval from the Human Subjects Institutional Review Board to proceed with the study (Appendix E), graduate students (heretofore referred to as trainees) and their clinical supervisors (heretofore referred to as supervisors) were recruited from within APA-accredited clinical and counseling psychology programs across the United States. Trainees were recruited using email solicitation through (a) training directors in APA-accredited clinical and counseling psychology graduate programs, (b) training directors from APA-accredited pre-doctoral internships in psychology, and (c) clinical and counseling psychology supervision listservs. The introductory email included a request to the director of the program or supervisor to forward the introductory email to all graduate students and supervisors in their program. Those who received an email activated a weblink contained in the email. The link took participants to the online screener survey in Qualtrics, where they first saw an anonymous

consent. Clicking on the next button reflected giving consent and sent them to the survey. The screen survey was used to ensure inclusion criteria for the study was met.

To be included in the study, trainees had to meet the following criteria: (a) be currently enrolled in a graduate level program in clinical or counseling psychology, and (b) be currently participating in a clinical practicum or internship, where (c) they are seeing one client who is culturally different from them in one or more federal protected identity classes, including race, color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin, age, disability, and genetic information (including family medical history). The screener survey also included a request for the name, title, and email of their direct clinical supervisor. If inclusion criteria are met based on trainee responses to the screener survey, both the trainee and their supervisor received a new email with a link inviting them to take part in the surveys. The new link took participants to the online survey in Qualtrics, where they again first saw an anonymous consent. Clicking on the next button reflected giving consent and sent them to the survey.

At the start of the survey, trainees were instructed to enter a unique code, comprised of the last three letters of their last name, followed by the last three letters of their first name. Supervisors were instructed to enter the same code, the last three letters of their supervisee's last name, followed by the last three letter of the supervisee's first name. This code was used to later match the data. Trainees then completed the online survey containing (a) a demographic data form, (b) the Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016), and (c) the Multicultural Counseling Inventory (MCI; Sodowsky, 1996; Sodowsky et al., 1994). It took approximately 20–30 minutes for most trainees to complete the survey. Supervisors were asked to complete an online survey containing (a) the Cross-Cultural Counseling Inventory-

Revised (CCCI-R; LaFromboise et al., 1991). It took approximately 15–20 minutes for most supervisors to complete the survey. Incentive for participating was that trainees were entered to win one of 10 $50 Amazon gift cards.

CHAPTER IV

RESULTS

In this chapter, I present the results of the current study. First, I describe the process of data management to ensure accuracy of the included data. Next, I report descriptive statistics, including means, standard deviations, and bivariate correlations. Then, I describe the preliminary analyses. I conducted these analyses to assess multicollinearity, outliners, and normality. Finally, I present the statistical analyses associated with each research question. I end the chapter with a brief summary of the primary research findings.

Data Management

Prior to testing the hypotheses, several analyses were conducted to ensure the accuracy of the data. First, data were examined using frequency distributions to ensure that no cases had values outside of the range of possible values (Mertler & Reinhart, 2016). The changes to results based on each of my three major questions are described below. Categorical variables were assessed to ensure that all cases had values that corresponded to the coded values for the possible categories. MCPT Total scores were calculated taking the MCPT answer key given to this researcher by the test developer; the answers to each of the questions on the MCPT were re-coded on the same variable using a binary system (1 = correct answers; 0 = incorrect answers). MCI Total, MCI subscales, and CCCI-R total score were calculated by summing items. Level of education was transformed into a dummy-coded variable where those with a bachelor's degree at the time of taking the survey were coded at 0 and those with a master's degree, along with two

individuals indicating they held a Psy.D., were coded as 1. Then, data were examined for missing data and outliers.

During this initial examination of data, problems were identified related to three predictor variables: How many courses have you taken with a direct focus on multicultural counseling/psychotherapy? (Courses); How many workshops/seminars have you attended related to multicultural counseling/psychotherapy? (Workshops); and How many presentations/ publications have you produced that are related to multicultural counseling/psychotherapy? (Presentations). Thirteen of the sample of 66 had erroneous numbers for these variables (*z*-scores > 3). These same 13 individuals were not univariate or multivariate outliers across all other variables. Each of the 13 participants' scores across the three items was re-coded as missing data. A missing values analysis indicated that Little's (1988) test of missing completely at random (MCAR) was not significant, $\chi^2 = 3645.586$, $df = 3602$, $p = .30$. Therefore, there was no evidence to suggest that the data were not MCAR. As such, pairwise deletion was used in further statistical analyses. The data were then assessed for multivariate outliers using the Mahalanobis distance test (Mahalanobis, 1936; Tabachnick & Fidell, 2007). None of the cases exceeded the critical chi-square value of 24.32 ($df = 7$). Therefore, no additional cases were removed.

Descriptive Statistics

Descriptive statistics (i.e., mean, standard deviation, bivariate correlations, and reliability estimates) of scores on the MCI, MCPT, and CCCI-R are presented in Table 3. Cronbach's alphas were calculated for scores of each scale and, when applicable, for scores of each subscale. At the univariate level, individual items were tested for skewness and kurtosis.

Total MCPT scores ranged from 7–46 ($M = 28.92$, $SD = 10.72$). The overall MCPT scores had an $\alpha = .93$ indicating a strong level of internal consistency (i.e., between .80–.90;

DeVellis, 2017). Interitem correlations ranged from |.76| (MCPT1 with MCPT20) and |.00| (MCPT8 with MCPT15).

Table 3

Correlations and Descriptive Statistics of Scores on MCI, MCPT, and CCCI-R Scores

	1	2	3	4	5	6	7
1. MCI Total	—						
2. MCI Knowledge	.85*	—					
3. MCI Skills	.85*	.71*	—				
4. MCI Awareness	.76*	.46*	.49*	—			
5. MCI Relationship	.68*	.52*	.46*	.30*	—		
6. CCCI-R Total	.28	.32	.36	.22	–.07	—	
7. MCPT Total	.35*	.35*	.30*	.19	.44*	.27	—
M	124.27	32.45	36.47	29.82	22.37	101.00	28.74
SD	14.08	4.25	4.50	5.09	3.44	12.98	10.97
Range	87–149	23–40	26–44	14–40	13–28	71–120	7–46
Skew	–.29	–.09	–.35	–.44	–.48	–.73	–.56
Kurtosis	–.64	–.79	–.53	–.49	–.08	–.14	–.74
α	.89	.79	.78	.77	.60	.95	.930

Note. $N = 66$. MCI = Multicultural Counseling Inventory; MCPT = Multicultural Counseling and Psychotherapy Test.
*Correlations that were statistically significant at .01.

Total MCI Total scores ranged from 87–149 ($M = 124.74$, $SD = 13.98$). The Knowledge subscale scores ranged from 23–40 ($M = 32.67$, $SD = 4.22$); the Skills subscale scores ranged from 26–44 ($M = 36.42$, $SD = 4.61$); Awareness scores ranged from 14–40 ($M = 29.85$, $SD = 5.00$); and Relationship scores ranged from 13–28 ($M = 22.50$, $SD = 3.47$). Total MCI scores had an $\alpha = .89$ indicating an a strong level of internal consistency (i.e., between .80–.90; DeVellis, 2017). Interitem correlations ranged from |.63| (MCI item 9 with MCI item 13) and |.00| (MCI

item 23 with MCI item 14). Alpha for MCI subscale scores ranged from α = .60 (Relationship) to α = .79 (Knowledge).

Total CCCI-R scores ranged from 70–120 (*M* = 99.72, *SD* = 13.16). Total CCCI-R scores had an α = .95 indicating a strong level of internal consistency (i.e., between .70–.90; DeVellis, 2017). Interitem correlations ranged from |.83| (CCCI-R item 12 with CCCI-R item 7) and |.07| (CCCI-R item 15 with CCCI-R item 1). Alpha for MCI subscale scores ranged from α = .404 (Skills) to α = .796 (Knowledge).

Regression diagnostics were conducted to test the following assumptions of linear regression: (a) normality, (b) linearity, (c) homoscedasticity, and (d) multicollinearity (Keith, 2006; Mertler & Reinhart, 2016). Data were assessed for assumptions of normality and linearity, which were met, with all data being linear, no skew values exceeding ±2, and no kurtosis values exceeding ±7 (Fabrigar et al., 1999). The univariate skewness of the MCPT scores was –.561 and univariate kurtosis for MCPT was –.736. The univariate skewness of the MCI scores was –.561 and univariate kurtosis for MCI scores was .018. The univariate skewness of the CCCI-R scores was –.561 and univariate kurtosis for CCCI-R scores was .018. Standardized scores (*z*-scores) were calculated for MCPT, MCI, and CCCI-R scores; scores ranged from –1.99 to 1.57 for MCPT, –2.65 to 1.76 for MCI scores, and –2.31 to 1.46 for CCCI-R scores (all below a cutoff of greater than +3 or less than –3).

The assumptions of linearity, homoscedasticity, and normality were tested via visual inspection of scatterplot matrices and scatterplots of the residuals for the scores. The assumption of normality was supported because the Lowess line came close to the regression line in the scatterplots of the residuals (Keith, 2006; Mertler & Reinhart, 2016). The assumptions of linearity and homoscedasticity were supported because the values of the residuals were

consistently spread out in the scatterplot (Mertler & Reinhart, 2016). Finally, multicollinearity was assessed by examining Tolerance and Variance Inflation Factor (VIF) values for the predictor variables. Variables were considered multicollinear if they had values that fell below .10 for Tolerance and above 10 for VIF (Field, 2013; Mertler & Reinhart, 2016). Therefore, the absence of multicollinearity was supported.

Primary Analyses

Goal 1

The first goal was to establish evidence of criterion-related validity through relating scores on the MCPT to demographic data, including level of education, number of courses taken on multicultural counseling, number of presentations on multicultural counseling, and number of multicultural workshops attended. To examine the relationship between scores on the MCPT and continuous demographic variables, bivariate correlations were calculated. Number of courses taken with a direct focus on multicultural counseling therapy had a weak positive correlation with MCPT score $r(61) = .18$, $p > .05$. Number of workshops/seminars attended related to multicultural counseling/psychotherapy had a weak negative correlation with MCPT scores $r(61) = .18$, $p > .05$. Number of presentations or publications produced related to multicultural counseling and psychotherapy had a weak positive correlation with MCPT scores $r(61) = .23$, $p > .05$. Estimated number of face-to-face client contact hours had a moderate positive correlation with MCPT scores $r(61) = .35$, $p < .05$. An independent samples t test was run on level of education and Total MCPT scores. Participants holding a graduate-level degree scored higher ($M = 34.74$, $SD = 6.5$) than individuals holding a bachelor-level degree ($M = 29.31$, $SD = 7.43$), $t(61) = 2.63$, $p = .006$. MCPT scores could not be compared across all participants' identified race and ethnicity because the majority of the sample (54.8%) identified as White.

Although groups could not be compared individually, there was an adequate portion of individuals who did not identify as White such that comparison would be made between those who identified as White and those who identified as a race considered Black, Indigenous, or Person of Color (BIPOC). BIPOC participants included individuals who identified as Asian, Black, Biracial, or Latina. An independent samples *t* test was run on MCPT Total score based on BIPOC status. There was not a statistically significant difference in MCPT scores between individuals who were White (M = 32.51, SD = 7.07) and BIPOC (M = 33.93, SD = 7.61), $t(61)$ = .63, p = .266. A one-way ANOVA was conducted on Total MCPT by program type: (a) Counseling Psychology, (b) Clinical Psychology, and (c) Psychology. The ANOVA was not statistically significant, $F(2, 61) = 1.89$, p = .161. MCPT scores could not be compared based on gender, sexual orientation, and citizenship status due to inadequate sample of individuals who do not identify as female, straight, and as a U.S. citizen. The findings related to the first goal suggest that there were weak to moderate correlations between scores on the MCPT and certain demographic variables, such as the number of courses taken on multicultural counseling, the number of multicultural workshops attended, and the number of presentations or publications related to multicultural counseling. Additionally, individuals with graduate-level degrees scored significantly higher on the MCPT compared to those with bachelor-level degrees.

Goal 2

The second goal was to establish evidence of reliability of the scores on the MCPT. To accomplish this goal, Cronbach's alpha was calculated for MCPT total item scores. Total MCPT scores ranged from 7–46 (M = 28.74, SD = 10.97). The overall MCPT scores had an $\alpha = .93$ indicating a strong level of internal consistency (i.e., between .80–.90; DeVellis, 2017). Interitem correlations ranged from $|.762|$ (MCPT1–MCPT20) to $|.000|$ (MCPT8 with MCPT15).

Goal 3

The third goal was to establish evidence of convergent validity through comparing scores on the MCPT to the scores on the CCCI-R, an observer-report measure, and scores on the MCI.

A hierarchical linear regression analysis was conducted. The predictor variables were (a) scores on the face-to-face hours, (b) multicultural courses taken, (c) multicultural workshops/seminars attended, (d) multicultural presentation/publications, (e) level of education, (f) scores on the MCI, and (g) scores on the CCCI-R, while the criterion variable was scores on the MCPT. For this hierarchical regression, face-to-face hours, multicultural courses taken, multicultural workshops/seminars attended, multicultural presentation/publications, and level of education were entered into block one of the regression, and Total MCI score and CCCI-R score were entered into block two. Tolerance and Variance Inflation Factor (VIF) were examined to check for multicollinearity. None of the predictor variables had Tolerance value less than .10 or VIF values above 10. Examining the normal probability plot (P-P) of the regression standardized residuals suggests data also met assumptions related to normality, linearity, and homoscedasticity. The omnibus tests were statistically significant at the second step, respectively, $F(5, 49) = 0.614$, $p = 0.639$; $F(7, 49) = 3.239$, $p < 0.05$. In model 1, the main effects of face-to-face hours, multicultural courses taken, multicultural workshops/seminars attended, multicultural presentation/publications, and level of education accounted for approximately 22.4% of the variance in Total MCPT scores, whereas 38.9% (change in *R* square) of the variance in Total MCPT scores was accounted for by MCI and CCCI-R scores. In examining model 2, an examination of the unique contribution of the predictors revealed that only degree ($B = 1.16$, ß = 2.89, $p = .016$) and CCCI-R scores ($B = 0.833$, ß = 3.914, $p = .003$) made unique significant contributions. In general, participants with higher CCCI-R scores and individuals

holding a master's degree obtained higher Total MCPT scores. Hierarchical regression results are presented in Table 4 below.

Table 4

Hierarchical Regression Results for MCPT Scores

Variable	B	SE B	ß	R^2	ΔR^2
Model 1				.224	—
Constant	21.78	15.47			
Number of face-to-face client contact hours	.001	.007	.032		
Courses taken with a on multicultural	.783	1.50	.088		
Workshops/seminars attended related to multicultural	–.362	.487	–.125		
Presentations/publications related to multicultural	1.301	.770	.247		
Degree	7.382	4.160	.325		
Model 2				.613	.389**
Constant	21.78	15.47			
Number of face-to-face client contact hours	–.002	.006	–.074		
Courses taken with a on multicultural	.425	1.41	.048		
Workshops/seminars attended related to multicultural	–.172	.494	–.059		
Presentations/publications related to multicultural	1.02	.729	.195		
Degree	4.46**	4.05**	.196**		
MCI Total Score	.215	.108	.281		
CCCI-R Total Score	.206*	.124*	.253*		

*$p < .05$. **$p < .01$.

CHAPTER V

DISCUSSION

In this chapter I discuss the primary findings of the current study. This investigation offers compelling evidence of criterion-related validity for MCPT scores, firmly anchoring them in empirical associations with a range of demographic variables, including level of education, participation in multicultural counseling/psychotherapy courses and workshops, contributions to multicultural counseling/psychotherapy presentations and publications, and the extent of face-to-face client contact hours. The results provide evidence of strong internal consistency within MCPT scores, affirming the reliability of this assessment tool. Moreover, connections between MCPT scores and the observer-reported multicultural competence measured by the CCCI-R, as well as the influence of educational attainment were found.

First, I review the main findings associated with each research question and reference possible explanations of the findings and how they relate to the current literature. Next, I address limitations of the study, followed by suggestions for future research. Finally, I end the chapter by discussing the practice and research implications of the study.

Multicultural competence refers to a counselor's ability to work effectively with individuals from diverse cultural backgrounds. It involves having the knowledge, skills, and awareness necessary to understand and address the unique needs and experiences of clients from different cultures. While there is not a definitive way to measure multicultural competence, counselors and researchers utilize various methods and tools to assess a counselor's level of cultural proficiency. This complex and ongoing process requires a combination of self-reflection,

knowledge acquisition, skill development, and feedback from supervisors. Furthermore, cultural competence is not a fixed state, but rather cultural competence is a continuous journey of learning and growth for counselors throughout their professional careers. Despite the challenges, efforts are being made to develop and refine assessment tools that effectively capture multicultural competence, promote cultural awareness, and contribute to the improvement of culturally responsive counseling practices.

The implications of a validated multicultural competence test can be significant. It can be used in various settings (e.g., training programs, educational institutions, and professional settings) to assess and enhance individuals' multicultural competence. The test results can provide valuable feedback to individuals, helping them to identify areas for improvement, as well as to guide training and educational efforts. Additionally, organizations can use the test results to inform hiring decisions, evaluate the effectiveness of diversity and inclusion initiatives, and ensure culturally competent practices in various fields.

Major Findings

The purpose of this investigation was to follow up on the recommendations of previous research: to examine the psychometric properties of the Multicultural Counseling and Psychotherapy Test (MCPT; Gillem et al., 2016). In so doing, I had three goals. The first goal was to determine if the MCPT shows evidence of criterion-related validity through relating scores on the MCPT to demographic data, including level of education, number of courses taken focused on multicultural counseling/psychotherapy, number of workshops/seminars attended focused on multicultural counseling/psychotherapy, number of presentations or publications produced focused on multicultural counseling/psychotherapy, and face-to-face client contact hours. The second goal was to determine if the MCPT shows evidence of internal consistency

through examining reliability estimates of scores on the MCPT. Reliability means a measure performs in consistent, predictable ways. The third goal of the study was to determine if scores on the MCPT show evidence of convergent validity through comparing scores on the MCPT to the scores on the CCCI-R, an observer-report measure, and scores on the MCI.

Results from the current study added novel and important findings to the literature in each of these areas. In the remainder of this chapter, I cover each of the key findings, directions for future research, and implications of the results to training, research, and practice.

Criterion-Related Validity: MCPT Scores and Demographic Data

In my first research question, I sought to determine if scores on the MCPT showed evidence of criterion-related validity through relating scores on the MCPT to demographic data, including (a) level of education, (b) number of course taken focusing on multicultural counseling/psychotherapy, (c) number of workshops/seminars attended focused on multicultural counseling/psychotherapy, (d) number of presentations/publications produced focused on multicultural counseling/psychotherapy, and (e) face-to-face client contact hours.

Overall, results provided support for hypothesis one; MCPT score had evidence of criterion-related validity (an empirical association with some criterion or "gold standard") (DeVellis, 2017). As expected, scores on the MCPT had statistically significant positive correlations with estimated face-to-face client contact hours, presentations/publications produced related multicultural counseling/psychotherapy, degree held (graduate degree vs. bachelor's degree), and observer-reported multicultural competence (CCCI-R score). Self-reported multicultural competence (Total MCI scores), courses taken focused on multicultural competence in counseling/psychotherapy, and workshops/seminars attended focused on

multicultural competence in counseling/psychotherapy were positively correlated with MCPT scores but were not statistically significant ($p > .05$).

The current results were consistent with previous research. Gillem and colleagues (2016) found higher MCPT scores were associated with publishing more multicultural counseling research, giving more presentations on multicultural counseling, teaching more multicultural counseling courses, reading more multicultural counseling texts, attending more multicultural counseling workshops, and attending more multicultural focused conferences when compared with lower scores (Gillem et al., 2016). They also found that multicultural courses were not significantly related to MCPT Totals scores. In the development of the Multicultural Counseling and Psychotherapy Test (MCPT), researchers suggested that all of these methods, except for multicultural courses, are correlated with the development of MCC (Gillem et al., 2016). The authors suggested that this exception may be due to the fact that all other options for training represent personal choices as opposed to requirements not necessarily borne of personal interest. Another possible explanation may reflect quality. The lack of congruence between multicultural courses and the development of MCC may be because the practice of multicultural pedagogy seems to emphasize only two thirds of the Tripartite Model in practice. More specifically, researchers suggest a majority of faculty who teach about MCC tend to focus on multicultural awareness and knowledge but seem to underemphasize multicultural skill development (Powell, 2020; Ratts et al., 2016).

Evidence of Reliability of MCPT Scores: Internal Consistency of MCPT Scores

In my second research question, I sought to discover if the MCPT shows evidence of internal consistency through examining reliability estimates of scores on the MCPT. Overall, the results provided support for hypothesis two; MCPT scores had evidence of internal consistency

reliability. The overall MCPT scores had an $\alpha = .927$ ($n = 66$), indicating a very good level of internal consistency. The high internal consistency suggests that MCPT items are consistent with each other, and that the items are measuring the same construct.

Reliability means a measure performs in consistent, predictable ways. In other words, scores produced by the instrument should not change unless there has been an actual change in the variable being measured (DeVellis, 2017). Internal consistency, a type of reliability, is concerned with the homogeneity of the items within the scale. If items on a scale have a strong relationship to their latent variable, they will have a strong relationship to one another. A scale is internally consistent to the extent that its items are highly intercorrelated (DeVellis, 2017). Internal consistency is typically equated with Cronbach's coefficient alpha. Alpha can take on values from 0.0 to 1.0, although it is unlikely that it will attain either extreme. DeVellis (2017) suggested the following qualitative descriptors: (a) below .60, unacceptable; (b) between .60 and .65, undesirable; (c) between .65 and .70, minimally acceptable; (d) between .70 and .80, respectable; and (e) between .80 and .90, very good. These findings were consistent with previous research; Cronbach's alpha reliability estimates of the MCPT scores were reported as .83 in the original study (Gillem et al., 2016).

Evidence of Convergent Validity: MCPT Compared with CCCI-R and MCI

In my third research question, I wanted to determine if scores on the MCPT show evidence of convergent validity through comparing scores on the MCPT to the scores on the CCCI-R and scores on the MCI. The regression equations had statistically significant omnibus tests; coefficients that explained the most variability were the degree and CCCI-R Total. A person holding a master's degree who had high observer-report ratings of MCC is more likely to have higher MCPT scores. The results provided partial support for hypothesis three, MCPT

scores had evidence of convergent validity; however, MCI and CCCI-R scores did not account for a statistically significant portion of the variance beyond level of education. Construct validity is directly concerned with the theoretical relationship of a variable to other variables (DeVellis, 2017). It is the extent to which a measure relates to established measures of other constructs. Convergent validity, a type of construct validity, is established when there is evidence of similarity between measures of theoretically related constructs. Level of education, measured highest degree obtained at time of survey, was the strongest predictor of MCPT scores. These results are consistent with previous research in several ways. First, it was expected that self-reported multicultural competence, such as MCI scores, have been unrelated to, and usually higher than, demonstrated multicultural counseling skill, such as case conceptualization scores, even when social desirability is controlled (Gillem et al., 2016). The current results suggest that clinicians overestimate their multicultural competence. In fact, Constantine and Ladany (2000) found that of four self-report multicultural counseling competency scales administered, none accounted for a significant amount of the variance in multicultural case conceptualization ability. Thus, the lack of predictive power of MCI scores in the current study aligns with previous results.

The predictive power of level of education on MCPT scores is also in line with previous research. Students who have been in graduate education longer have higher levels of multicultural competency demonstrated by (a) higher self-reported multicultural competence (Barden & Greene, 2015; Barden et al., 2017), (b) higher levels of demonstrated multicultural knowledge (Boysen & Vogel, 2008; Gillem et al., 2016; Lee & Khawaja, 2013; Lynch, 2015), and (c) higher supervisor ratings of multicultural competency (Kocarek, 2001; LaFromboise et al., 1991).

Limitations of the Study

One limitation may be low response rate. Low response rates are common in the supervision literature, as several other researchers reported low response rates in their studies (e.g., Green & Dekkers, 2010; Hird et al., 2004; Nilsson & Duan, 2007; Schroeder et al., 2009; Stahl, 2020). Further, a meta-analysis of articles on the state of counselor supervision research from 2000-2019 suggests the sample size obtained in the current study is well above average. Basically, large sample size supervision studies (100–499 participants) have declined while the proportions of small sample sizes ($n < 30$ participants) have increased (Johnson et al., 2020). The median sample size decreased from 45 participants from 2010-2014 to 29 participants in 2015-2016 (Johnson et al., 2020). While the reasons behind this shift are not entirely clear from the literature, it is worth speculating that the emphasis on nuanced aspects of supervision and the need for in-depth analysis may be driving researchers toward smaller, more manageable samples. Further research in this area is warranted to better understand these trends and their implications for the field of supervision research.

Another limitation could be the sample size ($n = 66$), and small sample sizes lead to low statistical power, which increases the probability of committing a type II error (i.e., failing to detect a true effect) (Shen et al., 2011). Prior to data collection, power analyses were conducted, which identified the desired sample size for the current study was 82 supervision dyads. Despite not obtaining the initial goal of 82–100 pairs, there was a sufficient sample size based on a post hoc power analysis conducted using G*Power and observed effective sizes (Faul et al., 2007). The power achieved was higher than .80, a power level typically set by researchers, which means that there is an 80% probability the researcher will not commit a type II error.

In addition to avoiding a type II error, larger samples more closely approximate the population. Although the sample was skewed in terms of demographic variables (majority White and female) as compared to the general populations (U.S. Census Bureau, 2022), the sample does approximate demographic characteristics of students in the APA-accredited psychology program population. The racial/ethnic background of students enrolled in psychology doctoral programs in the United States was 0.2% Native Hawaiian/Pacific Islander, 0.6% Native American/Alaska Native, 5% multiethnic, 9% unknown, 10% Asian, 10% Black, 11% Hispanic, and 54% White (Assefa et al., 2023). The gender breakdown of men and women in psychology departments across doctoral programs is approximately 75% female students to 25% male students. This 3:1 ratio has remained constant over a 10-year timeframe, when data from 2004-2005 and 2009-2010 are analyzed with the current year's data (APA, 2017).

Overall, it is a limitation of the current study, and *psychology* generally, that demographic characteristics do not mirror the population served. Although all counselors and psychologists regardless of race/ethnicity should be adequately prepared to serve the needs of all individuals they serve, there is value in having a profession that more closely mirrors the population it serves. Increased racial and ethnic diversity in graduate programs enhances the discourse around diversity topics and facilitates the development of trainees' cultural competence and humility (Kennedy & Arthur, 2014). Cumulative evidence shows that diverse work groups produce more cognitive processing and more exchange of information (Arayssi et al., 2016). For this to happen, continued efforts by training programs to recruit and retain racially and ethnically diverse graduate students are needed.

The next limitation was measurement error on three of the primary predictor variables. Initial examination of data collected indicated problems related to (a) How many courses have

you taken with a direct focus on multicultural counseling/psychotherapy? (b) How many workshops/seminars have you attended related to multicultural counseling/psychotherapy? and (c) How many presentations/publications have you produced that are related to multicultural counseling/psychotherapy? Thirteen of the sample of 66 had erroneous numbers across these variables (*z*-scores > 3). These same 13 individuals were not univariate or multivariate outliers across all other variables. Slider bar scales were used for each of these items. For slider bar questions, rather than simply selecting a scale point, respondents drag a bar to indicate their preference level (Qualtrics, 2023). Some sliders require dragging the slider control to the desired position with a mouse, touchscreen, or other pointing device, which is a user interface design that is difficult for some users (Chyung et al., 2018).

The literature is inconsistent regarding the advantages of sliders over numeric scales. Respondents, especially in clinical settings, sometimes have more trouble physically completing sliders than numeric scales (Bolognese et al., 2003; Briggs & Closs, 1999; Jensen et al., 1986). Toepoel and Funke (2018) found more nonresponses with sliders than radio buttons and reported poorer performance with slider bars that required dragging-and-dropping than with more VAS-like sliders. Across several studies comparing slider with numeric scales having from 4 to 20 response options, there was no significant or practical difference in psychometric properties between the two (Bolognese et al., 2003; Couper et al., 2006; Davey et al., 2007; Larroy, 2002; Lee et al., 2009; Lewis & Erdinç, 2017; Rausch & Zehetleitner, 2014; van Laerhoven et al., 2004; van Schaik & Ling, 2007). Smartphone respondents appear more sensitive to the initial position of the handle and less affected by the presence of numeric labels, resulting in a lower tendency to rounding. Another potential explanation for the data is that the items were worded too complexly or too long. It may be that participants read the first half of items. For example,

they may have responded to “How many courses have you taken” instead of “How many courses have you taken *with a direct focus on multicultural counseling/psychotherapy?*” However, data would still be erroneous. For example, researchers have shown that the average number of presentations/publications for a Ph.D. student in psychology is 1.5. Even if participants attributed the questions to general publications and presentations produced, it is unlikely students in a master’s program would have 30–60 presentations (max and min of erroneous numbers; $n = 13$). Taken together, it is likely that the data were skewed due to the style of measuring each question.

Another limitation may be a self-selection bias related to participation. Trainees had to self-select into the survey. Thus, there may have been differences between those who chose to participate and those who did not. Participants who declined to respond to the survey may have provided different views than those who chose to participate (Schroeder et al., 2009), which could have influenced results. For example, participants may have perceived themselves to be more multiculturally competent than those who did not participate in the study. Trainees’ relationships with their supervisors may have also played a role in their decision to participate. Those who had positive or negative relationships with their supervisors might have been more or less inclined to participate, affecting the study’s results.

Directions for Future Research

Despite the limitations faced in this study, the psychometric support for the MCPT’s use offers a promising foundation for future research. Addressing the several limitations that have been identified offers opportunities for further research to enhance the robustness and generalizability of the findings. First, future researchers should consider expanding sample size. One of the primary limitations of this study was the relatively small sample size used for psychometric analysis. To improve the evidence of reliability and validity of the MCPT, future

research should aim to recruit larger and more diverse samples. A larger sample size would enhance the statistical power, allow for factor analysis, and enable the examination of potential subgroups or individual differences. The issue of biased sampling was another limitation encountered in this study, potentially affecting the generalizability of the results. Future research should be attentive to sampling methods and aim for more representative and diverse samples. Stratified random sampling or matching techniques can be employed to minimize sampling bias and ensure that the study findings are applicable to a broader population.

This study focused primarily on the internal consistency and criterion validity of MCPT scores. However, future research should use Exploratory Factor Analysis (EFA) followed by further validation using confirmatory factor analysis (CFA) or structural equation modeling (SEM) in independent samples (Byrne, 2010). EFA is an analytic tool that helps to determine empirically how many constructs, or latent variables, or factors, underlie a set of items (Byrne, 2010). This is done through identifying groups of items that covary with one another and appear to define meaningful underlying latent variables (Hair et al., 2010). After initial EFA, future researchers should consider the potential for measurement bias and its impact on cross-group comparisons, by assessing factorial invariance across different demographic groups (e.g., gender, ethnicity) or cultural contexts (Byrne, 2010). By examining whether the MCPT measures the same underlying construct consistently across these groups, future researchers could ascertain its fairness and applicability across diverse populations. By addressing these limitations and pursuing the suggested directions, researchers can further strengthen the MCPT's utility, contributing to a more comprehensive understanding of the construct under investigation (i.e., multicultural competence in counseling/psychotherapy) and facilitating its application in various settings.

Implications

The results of this study have implications for multicultural training, research, and practice in counseling/psychotherapy. With added psychometric support, the MCPT can be used to assess the multicultural competence of students in a standardized manner. As a result, the effectiveness of multicultural training can be evaluated. As an example, program or program faculty can administer the MCPT along with self-report multicultural competency scales to provide students feedback on the validity of their self-perceptions. Any discrepancies between scores on self-report measures and the MCPT may help students acknowledge deficits in their multicultural self-awareness and serve as motivation to seek further training.

A standardized measure will also help ensure that counselors adhere to ethical guidelines and avoid any inadvertent harm caused by cultural insensitivity or ignorance. Professional counseling organizations often emphasize the importance of multicultural competence as an ethical responsibility. Using the MCPT is one way to determine if counselors possess the necessary awareness, knowledge, and skills to work effectively with diverse clients, and thus more ethically. This can lead to improved counseling outcomes and client satisfaction, as clients feel understood and respected. With a standardized measure, counseling training programs can also identify, and thus intervene in, areas where students need further development in multicultural competence.

The MCPT can help pave the way for research on multicultural competence and its impact on counseling outcomes. By having a psychometrically sound measure, researchers are able to draw more accurate and compelling conclusions about their results. Increased research, in turn, can contribute to development of evidence-based practices and interventions in multicultural counseling. As societies continue to become more diverse, and as counseling

services are increasingly offered online as well as across borders, a standardized measure can ensure that counselors are prepared to work with clients from various cultural backgrounds regardless of location. This type of research will aid in demonstrating the psychology field's commitment to adapting interventions to promote the well-being of all individuals seeking counseling services, while maintaining standards of evidenced-based practices.

While it is not universally true that all doctoral-level counselors have higher multicultural competence than master's-level counselors, there are several factors that may contribute to doctoral-level counselors' potential enhanced multicultural competence. Doctoral programs in counseling or related fields often require more years of education and training compared to master's programs. This extended training period allows for a deeper exploration of multicultural issues, greater exposure to diverse populations, and more comprehensive coursework on multicultural competence. Doctoral-level counselors often engage in research, including studies on multicultural topics, which can deepen their understanding of cultural dynamics and diversity-related factors. Additionally, some doctoral programs offer specializations in multicultural counseling, allowing students to gain in-depth knowledge and skills in this area. Doctoral programs often include coursework that delves deeply into multicultural counseling theories, cultural identity development, social justice issues, and interventions for specific cultural groups. This level of exposure helps doctoral-level counselors better understand the complexities of working with diverse clients.

It is important to note that while doctoral-level counselors may have more opportunities to develop multicultural competence, it is not a guarantee of superior skills. Master's level counselors who pursue continuing education, engage in ongoing professional development, and seek out diverse clinical experiences can also develop high levels of multicultural competence.

Ultimately, the development of multicultural competence is a continuous journey for all counselors, regardless of their educational level. Counselors must actively seek to expand their understanding of diverse cultures, challenge their biases, and continuously work to improve their ability to provide effective and culturally sensitive counseling services.

In summary, this study explored the psychometric properties of the Multicultural Counseling and Psychotherapy Test (MCPT) and yielded several key findings and implications for the field of multicultural competence in counseling and psychotherapy. The results provided evidence of criterion-related validity for the MCPT scores by establishing empirical associations with demographic variables such as level of education, number of courses, workshops/seminars attended, presentations/publications produced related to multicultural counseling/psychotherapy, and face-to-face client contact hours. The results provided evidence of strong internal consistency of MCPT scores, indicating that items consistently measured the same construct. Finally, the results offered evidence of convergent validity of MCPT scores, particularly with regard to the observer-reported multicultural competence (CCCI-R) and level of education.

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Appendix A

11 Cross-Cultural Competencies

11 Cross-Cultural Competencies (Sue et al., 1982)

Beliefs/Attitudes

1. The culturally skilled counseling psychologist is one who has moved from being culturally unaware to being aware and sensitive to his/her own cultural heritage and to valuing and respecting differences.
2. A culturally skilled counseling psychologist is aware of his/her own values and biases and how they affect minority clients.
3. A culturally skilled counseling psychologist is one who is comfortable with differences that exist between the counselor and client in terms of race and beliefs.
4. The culturally skilled counseling psychologist is sensitive to circumstances (personal biases, stage of ethnic identity, sociopolitical influences, etc.) which may dictate referral of the minority client to a member of his/her own race/culture.

Knowledge

5. The culturally skilled counseling psychologist will have a good understanding of the sociopolitical system's operation in the United States with respect to its treatment of minorities.
6. The culturally skilled counseling psychologist must possess specific knowledge and information about the particular group they are working with.
7. The culturally skilled counseling psychologist must have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy.
8. The culturally skilled counseling psychologist is aware of institutional barriers which prevent minorities from using mental health services.

Skills

9. The culturally skilled counseling psychologist must be able to generate a wide variety of verbal and nonverbal responses.
10. The culturally skilled counseling psychologist must be able to send and receive both verbal and nonverbal messages accurately and “appropriately.”
11. The culturally skilled counseling psychologist is able to exercise institutional intervention skills on behalf of his/her client when appropriate.

Appendix B

31 Multicultural Counseling Competencies

31 Multicultural Counseling Competencies
(Arredondo et al., 1996; Sue et al., 1992)

I. Counselor awareness of own culture, values, and bias

A. Attitudes and Beliefs

1. Culturally skilled counselors believe that cultural self-awareness and sensitivity to one's own cultural heritage is essential.
2. Culturally skilled counselors are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychological process.
3. Culturally skilled counselors are able to recognize the limits of their multicultural competency and expertise.
4. Culturally skilled counselors recognize their sources of discomfort with difference that exist between themselves and clients in terms of race, ethnicity, and culture.

B. Knowledge

5. Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professional affects their definitions of and biases about normality/abnormality and the process of counseling.
6. Culturally skilled counselors possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows individuals 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 benefited from individual, institutional, and cultural racism as outlined in White identity development models.

7. Culturally skilled counselors possess knowledge about their social impact on others. They are knowledgeable about communication style differences, how their style may clash with or foster the counseling process with persons of color or others different from themselves based on the A. B. and C Dimensions, and how to anticipate the impact it may have on others.

C. Skills

8. Culturally skilled counselors seek out educational, consultative, and training experiences to improve 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 to more qualified individuals or resources, or (d) engage in a combination of these.
9. Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a nonracist identity.

II. Counselor Awareness of Client's World View

A. Attitudes and beliefs

10. Culturally skilled counselors are aware of their negative and positive emotional reactions toward other racial and ethnic groups that may prove detrimental to the counseling relationship. They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion.

11. Culturally skilled counselors are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups.

B. Knowledge

12. Culturally skilled counselors possess specific knowledge and information about the particular group with which they are working. 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.
13. 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.
14. Culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge on the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping, and powerlessness may affect self-esteem and self-concept in the counseling process.

C. Skills

15. Culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills for more effective counseling behavior.

16. Culturally skilled counselors become actively involved with minority individuals outside the counseling setting (e.g.. community events, social and political functions, celebrations, friendships, neighborhood groups) so that their perspective of minorities is more than an academic or helping exercise.

III. Culturally appropriate intervention strategies

A. Beliefs and attitudes

17. Culturally skilled counselors respect clients' religious and spiritual beliefs and values, including attributions and taboos because these affect worldview, psychosocial functioning, and expressions of distress.
18. Culturally skilled counselors respect indigenous helping practices and respect help-giving networks among communities of color.
19. Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling ('monolingualism" may be the culprit).

B. Knowledge

20. 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 cultural groups.
21. Culturally skilled counselors are aware of institutional barriers that prevent minorities from using mental health services.

22. Culturally skilled counselors have knowledge of the potential bias in assessment instruments and use procedures and interpret findings in a way that recognizes the cultural and linguistic characteristics of the clients.
23. Culturally skilled counselors have knowledge of family structures, hierarchies, values, and beliefs from various cultural perspectives. They are knowledgeable about the community where a particular cultural group may reside and the resources in the community.
24. Culturally skilled counselors should be aware of relevant discriminatory practices at the social and the community level that may be affecting the psychological welfare of the population being served.

C. Skills

25. 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 modify it.
26. 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 personalize problems.

27. 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.
28. Culturally skilled counselors take responsibility for interacting in the language requested by the client and, if not feasible, make appropriate referrals. 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.
29. 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 culturally different clients.
30. Culturally skilled counselors should attend to, as well as work to eliminate, biases, prejudices, and discriminatory contexts in conducting evaluations and providing interventions, and should develop sensitivity to issues of oppression, sexism, heterosexism, elitism, and racism.
31. Culturally skilled counselors take responsibility for educating their clients to the processes of psychological intervention, such as goals, expectations. legal rights, and the counselor's orientation.

Appendix C

Definitions of Statistical Terms

Definitions of Statistical Terms

Reliability

Reliability means a measure performs in consistent, predictable ways. In other words, scores produced by the instrument should not change unless there has been an actual change in the variable being measured (DeVellis, 2017).

Internal Consistency. Internal consistency reliability, is concerned with the homogeneity of the items within the scale. If items on a scale have a strong relationship to their latent variable, they will have a strong relationship to one another. A scale is internally consistent to the extent that its items are highly intercorrelated (DeVellis, 2017). Internal consistency is typically equated with Cronbach's (1951) coefficient alpha. **A**lpha can take on values from 0.0 to 1.0, although it is unlikely that it will attain either extreme. DeVellis (2017) suggests the following qualitative descriptors: (a) below .60, unacceptable; (b) between .60 and .65, undesirable; (c) between .65 and .70, minimally acceptable; (d) between .70 and .80, respectable; and (e) between .80 and .90, very good.

Alternate-Forms Reliability. If two strictly parallel forms of a scale exist, then the correlation between them can be computed as long as the same people complete both parallel forms. *Split-Half Reliability* is when a set of items that make up a single scale is divided into two subsets, and correlated to assess the reliability. There are a variety of ways in which a scale can be split. *First-half, last-half split* involves comparing the first half of items to the last half. *Odd-even reliability* involves comparing the subset of odd numbered items to the subset of even numbered items. *Balanced halves* is another way to split where the researcher identifies some potentially important item characteristics (e.g. first person wording or item length). The two subsets would then be constituted so as to have the characteristics equally represented in each

half. Another way to split items would be *random halves*. In this method each item is randomly allocated to a subset (Devellis, 2017).

Test Retest Reliability. Another method of computing reliability involves temporal stability of a measures, or how constant scores remain from on occasion to another (Hair et al., 2010). Test-retest reliability involves giving one group of items to a group of participants on two separate occasions. The scores from the first occasion are correlated to scores from the second occasions (DeVellis, 2017)

Validity

Validity is the adequacy of a scale as a measure of a specific variable (DeVellis, 2017).

Content Validity. Content validity concerns item sampling adequacy, in other words, the extent to which a specific set of items reflect a content domain. Content validity is easiest to evaluate when the domain is well defined (i.e. number of multicultural courses taken; DeVellis, 2017).

Criterion-Related Validity. In order to have criterion related validity an item or scale is required to have an empirical association with some criterion or "gold standard." Criterion validity is often referred to as *predictive validity* (DeVellis, 2017)

Construct Validity. Construct validity is directly concerned with the theoretical relationship of a variable to other variables (DeVellis, 2017). It is the extent to which a measures "behaves" the way that the construct purports to measure should behave with regard to established measures of other constructs. *Convergent* validity is established when there is evidence of similarity between measures of theoretically related constructs. *Discriminant (i.e. divergent) validity* is established when there is an absence of correlation between measures of unrelated constructs.

Factor Analysis

Factor analysis is an analytic tool that helps to determine empirically how many constructs, or latent variables, or factors, underlie a set of items (Byrne, 2010). Factor analysis can also provide a means of explaining variation among relatively many original variables (e.g., 25 items) using relatively few newly created variables (i.e., factors). This amounts to condensing information so that variation can be accounted for by using a smaller number of variables (DeVellis, 2017). This is done through identifying groups of items that covary with one another and appear to define meaningful underlying latent variables. *Principal components analysis* yields one or more composite variables that capture much of the information originally contained in a larger set of items (Hair et al., 2010). The components are defined as weighted sums of the original items. The components are linear transformations of the original variables. *Common factors analysis* also yields one or more composite variables that capture much of the information originally contained in a larger set of items (Hair et al., 2010). However, these composites represent hypothetical variables. Because they are hypothetical, all we can obtain are estimates of these variables. A common factor is an idealized, imaginary construct that presumably causes the items to be answered as they are (Hair et al., 2010.

Statistical Criterion. Inferential methods are used to determine whether the likelihood of a particular result is sufficiently small to rule out its chance occurrence (Byrne, 2010). This is accomplished by performing a test to see if, after extracting each successive factor, the remaining residuals contain an amount of covariation statistically greater than zero. If they do, the process is continued until that no longer is the case. *An eigenvalue* represents the amount of information captured by a factor. It is recommended factors with eigenvalues less than 1.0 should not be retained (Hair et al, 2010). *A Scree test* is also based on eigenvalues but uses their relative rather

than absolute values as criterion (Hair et al., 2010). The "right" number of factors is determined by looking at the drop in amount of information across successive factors. When plotted, this information will have a shape characterized by a predominantly vertical portion on the left transitioning to a relatively horizontal portion on the right (Hair et al., 2010).

Confirmatory Factor Analysis

Confirmatory factor analysis is most often used to describe methods based on structural equation modeling (SEM; Byrne, 2010). The SEM-based methods provide statistical criterion for evaluating how well the real data fit the specified model (Byrne, 2010).

Goodness of fit – Goodness of fit indicates how well the specified model reproduces the observed covariance matrix among the indictor items (i.e., the similarity of the observed and estimated covariance matrices; DeVellis, 2017). Once a model is estimated, model fit compares the theory to reality by assessing the similarity of the estimated covariance matrix (theory) to reality (the observed covariance matrix; Devellis, 2017).

Absolute Fit Indices. Absolute Fit Indices reflect a direct comparison between the observed variance-covariance matrix and the variance-covariance matrix reproduced based on the theoretical model (Hair et al., 2010). As such, they provide the most basic assessment of how well a researcher's theory fits the sample data (Hair et al., 2010).

Chi-square (χ^2) Goodness of Fit. The implied null hypothesis of SEM is that the observed sample and SEM estimated covariance matrices are equal, meaning the model fits perfectly (DeVellis, 2017). The (χ^2) value increases as differences (residuals) are found when comparing the two matrices. Then the statistical probability (p-value) is assessed for if the observed sample and SEM estimated covariance matrices are actually equal in a given population (DeVellis, 2017). A small (χ^2) value (and corresponding larger p-value) indicate no

statistically significant difference between the two matrices, to support the idea that a proposed theory fits reality (Byrne, 2010; Hair et al., 2010).

Goodness of Fit Index (GFI). GFI values range from 0 to 1, with higher values indicating better fit (GFI values greater than .90 are typically considered good).

***Root Mean Square Error of Approximation (RMSEA*).** RMSEA is an estimate of how well it fits a population not just a sample (DeVellis, 2017). The value ranges from 0 to 1.00. The fit is better when this value is close to 0.00; but a value equal or less than 0.08 indicates that the model fits the data well (Hair et al., 2010).

***Root Mean Square Residual (RMR) and Standardized Root Mean Square Residual (SRMR*)**. RMR and SRMR is sometimes considered badness of fit (Hair et al., 2010). RMR is the square root of the mean of the squared residuals: an average of the residuals. Lower RMR and SRMR values represent better fit and higher values represent worse fits. A rule of thumb is SRMR over .1 suggests a problem with fit (Byrne, 2010).

Normed Chi-Square. The Normed Chi-Square is a ratio of chi-square to degrees of freedom. Generally, ratios of 3:1 are associated with better fitting models (Hair et al., 2010).

Incremental Fit Indices. Incremental Fit Indices differ from absolute fit indices in that they assess how well the estimated model fits relative to some alternative baseline model (Hair et al., 2010). These indices evaluate the goodness of fit of the specified model against a more restrictive model considered to be nested in the specified model. Two models are considered as being nested when one is a special case of the other (Byrne, 2010). Several models can form a nested sequence when, hierarchically, each model includes the previous models as special cases.

Normed Fit Indices (NFI). NFI is a ratio of the difference in chi-squared value for the fitted model and a null model divided by the chi-square value for the null model. It ranges from 0 to 1, and a model with perfect fit produces an NFI of 1.

Tucker Lewis Index (TLI). TLI is similar to NFI but varies in that it is actually a comparison of the normed chi-square values for the null and specified model, which to some degree takes into account model complexity. Its value can fall below 0 or above 1. Typically, models with a good fit have values that approach 1, and a model with a higher value suggests a better fit than a model with a lower value.

Comparative Fit Index (CFI). CFI is an incremental fit index that is an improved version of the NFI. The CFI is normed so that values range between 0 and 1 with higher values indicating better fit.

Relative Noncentrailty Index (RNI). RNI also compares the observed fit resulting from testing a specified model to that of a null model. Possible values range from 0 to 1 and, like other incremental fit indices, higher values represent better fit.

Parsimony Fit Indices. Parsimony Fit Indices indicate which model among a set of competing models is best, considering its fit relative to complexity (Byrne, 2010). Parsimony refers to the small number of parameters to be estimated required to achieve a given goodness of fit. Moreover, it is important to consider that a good model fit as indicated by the fit indices is usually due to either the plausibility of the theoretical representation specified by the researcher or the over parameterization of the model, that is its lack of parsimony (Byrne, 2010). A parsimony fit measure is improved either by a better fit or a simplified model. In this case, a simpler model is one with fewer estimated parameter paths (Byrne, 2010).

The Parsimony ratio parsimony ratio (PRATIO). The PRATIO captures the relationship between the model and the number of degrees of freedom of the theoretical model and that of the null model.

Adjusted Goodness of Fit (AGFI). AGFI considers differing degrees of model complexity. It does so by adjusting GFI by a ratio of the degrees of freedom used in the model to the total degrees of freedom available. No statistical test is associated with AGFI, only guidelines to fit.

Parsimony Normed Fit Index (PNFI). PNFI adjusts the NFI by multiplying is time the PR. Relatively high values represent relatively better fit. PNFI values are meant to be used in comparing one model to another with the highest PNFI value being most supported with respect to the criteria captured by this index.

Root Mean Square Error of Approximation (RMSEA). The value of this index ranges from 0.00 to 1.00, with a ≤ 0.06 value indicating that the model fits the data well. Ideally, this value should have a confidence interval of 90%, with a minimum close to 0.00 and a maximum not exceeding 0.100.

Appendix D

Demographic Data Form

Demographic Data Form

Instructions: Please respond to the following items to the best of your ability.

1. Gender (specify)_____
2. Sexual Orientation (specify)_____
3. How old are you? Fill in the bubbles, using the first column as the first digit of your age and the second column for the second digit of your age. The age 19 would be bubbling in 1 in the first column and bubbling in 9 in the second column.

0	□	□
1	□	□
2	□	□
3	□	□
4	□	□
5	□	□
6	□	□
7	□	□
8	□	□
9	□	□

4. Race (specify)_____
5. Ethnicity (specify)_____

6. Citizenship: United States citizen □

Permanent Resident of the US □

Other □ _____

Length of time in the US_____

7. How would you describe your family's socioeconomic status?

Poor □ Working Class □ Middle Class □ Upper Middle □ Wealthy □

8. Indicate the highest degree you have obtained at the time of this survey.

_____

9. In what field of study is your highest degree obtained?

_____

10. Please note the highest psychology license/credential you hold right now.

_____

11. Please provide an estimated number of face-to-face client contact hours you have:

A. During master's level training _____

B. During doctoral level training _____

12. How many courses have you taken with a direct focus on multicultural counseling/psychotherapy?

    _____

13. How many workshops/seminars have you attended related to multicultural counseling/psychotherapy?

    _____

14. How many presentations/publications have you produced that are related to multicultural counseling/psychotherapy? _____

Appendix E

Human Subjects Institutional Review Board
Letter of Approval

WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board

Date: August 22, 2022

To: Eric Sauer, Principal Investigator

Re: Initial - IRB-2022-207 Measuring Multicultural Competence in Counseling

This letter will serve as confirmation that your research project titled Measuring Multicultural Competence in Counseling has been reviewed by the Western Michigan University Institutional Review Board (WMU IRB) and **approved** under the **Exempt** Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording).
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.
.

The conditions and duration of this approval are specified in the policies of Western Michigan University. You may now begin to implement the research as described in the application. **Please note:** This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., ***add an investigator, increase number of subjects beyond the number stated in your application, etc.***). Failure to obtain approval for changes will result in a protocol deviation.

In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB or the Associate Director Research Compliance for consultation.

Stamped Consent Document(s) location - Study Details/Submissions/Initial/Attachments

The Board wishes you success in the pursuit of your research goals.

Sincerely,

Amy Naugle

Amy Naugle, Ph.D., WMU IRB Chair

For a study to remain open after one year, a Post Approval Monitoring report (please use the continuing review

submission form) is required on or prior to (no more than 30 days) **August 21, 2023** and each year thereafter until closing of the study. When this study closes, complete a Closure Submission.

Note: All research data must be kept in a secure location on the WMU campus for at least three (3) years after the study closes.