# UNDERSTANDING THE RELATIONSHIP OF MULTICULTURAL CASE CONCEPTUALIZATION, MULTICULTURAL COUNSELING SELF-EFFICACY AND ETHNOCULTURAL EMPATHY IN PSYCHOLOGY TRAINEES

A Dissertation

Presented to

The Graduate Faculty at the University of Houston

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

Sharon Singh, B.A.

August 2010

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Doctor of Philosophy

by

Sharon Singh

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# UNDERSTANDING THE RELATIONSHIP OF MULTICULTURAL CASE CONCEPTUALIZATION, MULTICULTURAL COUNSELING SELF-EFFICACY, AND ETHNOCULTURAL EMPATHY IN PSYCHOLOGY TRAINEES

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## ABSTRACT

The multicultural competency instruments have been criticized for their ability to accurately assess this construct. Specifically, the lack of adherence to an operationalized definition is at the heart of the problem. In order to improve the theoretical foundation of multicultural competency, this study extended previous research by Ladany and his colleagues (1997) and Constantine and Ladany (2000) by utilizing an objective method to assess psychology trainees' ability to conceptualize a client of color. Furthermore, this study included additional variables hypothesized in the literature to address some of the deficits found in the existing literature including ethnocultural empathy and multicultural counseling self-efficacy. Participants included 156 masters and doctoral students who were currently enrolled in counseling, counseling psychology or clinical psychology programs throughout the United States. Those who volunteered to participate completed an online case conceptualization task (i.e., objective measure) for a hypothetical Black client that assesses two interrelated cognitive processes: differentiation and integration. *Differentiation* is defined as a trainees' capability of providing more than one way of viewing a client's presenting problems and ways of treating him/her. *Integration* refers to the level of associations between and among the distinguished interpretations. Two psychology students, 1 undergraduate level and 1 master's level, blind to the specifics of the study, were trained to code the data.

The first conceptualization was rated on the degree of differentiation and integration of ethnic/racial issues/factors(s) contributing the etiology of the client's difficulties. The second conceptualization was rated on the degree of differentiation and integration of the trainees' beliefs about what would be an effective treatment plan in handling the client's problems.

This study explored the relationship between psychology trainees' degree of multicultural case conceptualization with his/her level of self-reported multicultural self-efficacy as assessed by the online version of two recently developed measures, the Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSE-RD; Sheu & Lent, 2007) and self-reported ethnocultural empathy as measured by the scale of Ethnocultural Empathy (SEE; Wang, Davidson, Yakushko, Savoy, Tan & Bleier, 2003). According to counseling psychology literature, the last two variables may help clarify the underpinnings of multicultural counseling competency. A hierarchical multiple regression equation examined to what extent the trainees' scores on the MCSE-RD and SEE predicted his/her ability to conceptualize a multicultural client. Previous multicultural training (i.e., multicultural courses and clinical practice with multicultural clients), and year in the program were controlled for since these variables have been found to directly influence trainees' self-endorsed level of multicultural counseling competency. There were four major findings in the study.

First, self-reported multicultural counseling self-efficacy (MCSE-RD) scores were significantly and positively related to a hours of clinical experience, more specifically, hours spent working with racially/ethnically diverse clients and supervision discussing them. However, self-reported ethnocultural empathy (SEE) scores were not associated with any of the training demographic variables. Thirdly, amount and type of multicultural training had no relationship with multicultural case conceptualization in either the etiology or treatment response. Finally, self-reported multicultural counseling self-efficacy (MCSE-RD) scores did not add significant variance when predicting scores of trainees' demonstrated case conceptualization skills above and beyond his/her level of multicultural training. Therefore, further research is needed to investigate the utility of these assessment tools to clarify what constructs they are measuring of psychology trainees. Implications for research, training and practice are discussed.

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# CHAPTER 1

## INTRODUCTION

In 2000, White Americans constituted over 70 percent of the U.S. population; however, it is anticipated that by 2042, the population of racial and ethnic minorities will significantly increase and make-up 54 percent of the U.S. population (U.S. Census Bureau, 2008). Approximately two decades ago, many researchers in the field of psychology (e.g., Bernal & Padilla, 1982; LaFromboise & Foster, 1989; Ponterotto & Casas, 1987; Ridley, 1989) recognized the emergent need to train mental health professionals to effectively serve the growing population of racial/ethnic minorities. This movement was put into motion when an extensive review of the efficacy of traditional counseling methods and techniques implemented with culturally different clients found these interventions ineffective due to the mental health practitioners' lack of training (Bernal & Padilla, 1982; Casas, Ponterotto, & Gutierrez, 1986; Smith, 1982; Sue, 1990; Sue & Sue, 1990; Sue, Akutsu, & Higashi, 1995). In 1990, in response to the results in the literature, Pedersen introduced multiculturalism as another perspective to conceptualize counseling relationships and named it the "fourth force" in the field of counseling psychology. He prefaced the notion that multiculturalism would complement not compete with the other three forces (i.e., psychodynamic, behavioral and humanistic) as one of the explanations of human behavior. "Multiculturalism" refers to a broad construct which includes a person's demographic (e.g., age, sex, place of residence) and status (e.g., social, educational, economic) variables as well as his/her nationality, ethnicity and native language (Pedersen, 1991). With this definition in mind, inherently any counseling situation may be viewed as "multicultural" and psychologists should

attempt to adopt and support a multifaceted perspective and communication style with every client (Pedersen, 1990; 1991). With the intent of providing an operating framework for effective multicultural counseling, Sue, Arredondo, and Mc Davis (1992) underscored the importance of mental health professionals to develop certain cross-cultural competencies in their effort to be ethical practitioners for the four major racial/ethnic groups in our society: African Americans, American Indians, Asian Americans, and Hispanics/Latinos. In addition to the client's race/ethnicity, Sue and his colleagues, underlined that focusing in on the within and between group differences of each client with his/her therapist was equally as important. These authors cited the proposition that if practitioners are unaware of differences involving them and their clients, then these professionals may be at risk for engaging in cultural oppression by using detrimental practices. To promote ethical practice and integrate cross-cultural competencies, Sue, and Bernier, Durran, Feinberg, Pedersen, Smith, and Vasquez-Nuttal (1982) had already posited a tripartite model of multicultural competencies in their landmark position paper, *Cross-Cultural Counseling Competencies (1982).* Subsequently, this paper has served as a reference point for the foundational definition of multicultural competence within the mental health fields. More recently the multicultural competencies have been incorporated into the ethical and accreditation standards within The American Psychological Association (APA) and are most evident in the passage of the "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (APA, 2003).

*Introduction to Multicultural Counseling Competency*

Sue and his colleagues' model of multicultural counseling competence refers to a counselor's attitudes and/or beliefs, knowledge and skills in working with individuals from diverse cultural groups (e.g., racial, ethnic, gender, social class, and sexual orientation) (Arredondo, Toporek, Brown, Jones, Locke, Sanchez & Stadler, 1996; Sue et al., 1982; Sue et al., 1992). Sue (1982; 1992) encouraged researchers to focus on the ethnic and racial aspects of the definition so that it remains narrow and focused. Overarching and extending each of the three dimensions of the multicultural practitioner (i.e., attitudes and/or beliefs, knowledge and skills) are three main characteristics introduced by Sue and Sue (1990) and later operationalized by Arredondo and her colleagues in 1996. These include the professional's awareness of his/her own assumptions, values and biases, consideration of the worldview of a client of color and his/her capability in developing appropriate intervention strategies and techniques. These proficiencies outlined by Sue and his colleagues (1982; 1992) laid the groundwork for the development of several measures used to assess multicultural competencies. These scales include the (a) Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991), (b) Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), and (c) Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002), previously known as the Multicultural Counseling Awareness Scale-Form B (MCAS-B; Ponterotto, Sanchez, & Magids, 1991). A fourth scale, the Cross-Cultural Counseling Inventory-

Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991), was devised for supervisors' use in evaluating their trainees' multicultural counseling competence.

Since the development of these instruments, the measurement of multicultural competence has been a referent focus of inquiry within the empirical multicultural competency literature. These measures have been utilized to explore the relationship between multicultural counseling competency and various other constructs associated to counselor training. Some of the constructs found to relate to multicultural counseling competency include trainees' case conceptualization ability, his/her counseling self-efficacy and his/her empathy level. Before discussing these related variables, a brief review of the multicultural counseling competency research findings follows.

*Self-Report Multicultural Competency Measures*

In their respective initial validation studies, each of the self-report multicultural competency measures appeared to have moderate to strong reliability and validity properties (D'Andrea, 1991; Dunn, Smith & Montoya, 2006; Ponterotto et al., 2002; Sodowsky et al., 1994). The MAKSS, MCI and MCKAS' coefficient alphas range from 0.68-0.96 for example. The counseling psychology literature has extensively explored how trainees and professionals of different levels endorse the self-reported competency measures and how their scores interact with variables/constructs appearing to relate to multiculturalism (i.e., multicultural training and multicultural case conceptualization) (Constantine, 2002; Constantine & Ladany, 2000; Constantine, Warren, & Miville, 2005; D'Andrea, Daniels, & Heck, 1991; Ladany, Constantine, & Hofheinz, 1997; Neville, Heppner, Louie, Thompson, Brooks, & Baker, 1996).

D'Andrea et al.'s study (1991) initiated the movement of examining how the amount of multicultural training related to trainees' level of competency. These researchers found that trainees who were involved in a multicultural counseling course versus those who were not endorsed higher scores on the MAKSS. In addition to this study, other studies showed this type of relationship (Neville, et al., 1996 & Ponterotto, et al., 1996). Furthermore, in a more recent review of the literature, Ponterotto, Fuertes, and Chen (2000) found support for higher endorsed competency levels across instruments and subscales to be associated with more training related to multiculturalism. Despite showing initial promising psychometric properties the multicultural scales required further empirical research before being utilized in assessing multicultural competency due to the findings of the following studies by (Constantine, Gloria, & Ladany, (2002), Ponterotto, Rieger, Barrett, & Sparks (1994), Pope-Davis & Dings (1994; 1995)). Ponterotto and his colleagues reviewed (1994) the CCCI-R, MCAS-B, MCI and MAKSS to examine their concurrent validity, reliability properties, and provide future directions for the assessment of multicultural competence. Results of the factor analytic studies of these measures' original factor structure indicated minimal support for Sue et al.'s tripartite model. For example, the MCAS-B held a bi-dimensional construct while the MCI presented with a four-factor structure. Taken a step further, Pope-Davis and Dings (1994) performed a specific comparison of the MCAS-B and the MCI to explore their relationship due to both instruments' subscales being labeled in a similar manner. Their proposed hypothesis that the scales with the same name would correlate with one another was not supported. Under further examination, these scales actually revealed significant differences in the content of their items. For example, the authors concluded that the MCI

classifies most items in “behavioral terms as descriptions of one’s counseling”(Pope-Davis & Dings, 1994, p.7), while the MCAS-B assesses one’s beliefs related to multicultural counseling, such as his/her understanding of counseling techniques and his/her awareness of racism. In other words, these two measures appear to be measuring entirely different constructs of multicultural competency. In 1995, Pope-Davis and Dings, reported that in addition to not adhering to Sue’s (1982) model and measuring various aspects of multicultural competency, some scales may tend to measure a counselor’s “anticipated” or “perceived” rather than his/her “actual” behaviors or attitudes of multicultural proficiency. Furthermore, they proposed early on that counselors may be more accurate in reporting their behaviors than their attitudes. Given that admonition, this study chose to examine trainees’ self-reported anticipated behavior related to multicultural counseling.

In 2002, Constantine, Gloria and Ladany explored the factor structure of the MAKSS, the MCI and the MCKAS in an effort to address and further understand the validity qualities of these instruments. These authors sought to assess how much each scale reflected the tripartite model of multicultural competence. They first conducted a confirmatory factor analysis expecting the scales to fall into Sue’s three-factor model. The preselected three factors accounted for approximately 70% of the variance however; only two factors met the criteria of having eigenvalues of more than 1.0. Therefore these researchers followed up with an exploratory factor analysis. The specific results of these two analyses follow.

In the principal confirmatory factor analysis, the subscales of the competency measures, which loaded on factor one, were all the subscales of the MAKSS, the

Knowledge and Awareness subscales of the MCI and the MCKAS Knowledge subscale, along with the MAKSS Skills subscale and the MCI Skills, Relationship and Awareness subscales. This factor represented approximately 49 percent of the 72 percent encompassed by the three factors found from the analysis. The second factor accounted for 14 percent and included the Relationship and Skills subscales of the MCI. Due to the data not fitting the proposed tripartite model as mentioned above, the researchers performed an exploratory factor analysis. The MAKSS Skills subscale fit into factor one with the MCI Skills, Relationship and Awareness subscales. A further analysis of these items suggests that this factor was assessing a person's perceived multicultural counseling skills. The second factor included the MAKSS Awareness scale and the MCKAS Awareness and Knowledge subscales. It seems that the items in this factor were measuring participants' multicultural attitudes/beliefs.

The results of the aforementioned studies (Constantine et al., 2002; Ponterotto et al., 1994, and Pope-Davis & Dings 1994, 1995) uncovered the significant psychometric problems of the self-report multicultural competency measures. Specifically the MAKSS, MCI, and MCKAS do not adhere to Sue's three-factor model; rather they load on a different number of factors regardless if examined alone or against each other. Further, these assessment tools appear to be tapping into different constructs. For example one area could be assessing a person's actions performed in counseling versus his/her beliefs about his/her counseling ability. Notably, these are two distinct perspectives of a psychology trainee and need to be understood separately first before being examined together. For example, if a counselor in training displayed less than optimal interventions when treating a client of color then the trainee would require guidance from his/her

supervisor before continuing to provide additional therapeutic services. Equally important at this time would be to assess the counselor's perspective, to find out if he/she believed these abilities to be an "actual" or a "perceived" reflection of his/her skills. The level of supervision needed with the psychology trainee by his/her supervisor would depend on the trainees' level of accuracy of effectiveness in treating a client of color.

In an effort to isolate tangible and potentially more accurate measurement of multicultural counseling competency (MCC), this study measured the "skills" subset of the tripartite model. Sheu and Lent (2007) developed a measure based on social-cognitive theory and the multicultural competency literature, which examines only this factor of MCC when working with racially/ethnically diverse clients. From Bandura's definition (1982) self-efficacy theory has been referred to in the counseling psychology literature by many researchers as a better lens to view trainees' confidence to perform multicultural counseling (Constantine & Ladany, 2001; Ottavi, Pope-Davis & Dings, 1994; Worthington, Soth-McNett & Moreno, 2007).

Within the self-efficacy literature, psychometrically sound measures exist (e.g., Larson et al., 1992; Lent, Hill, & Hoffman, 2003) which are assessments of trainees' perceived abilities in performing general counseling; however, these scales are limited in their inclusion of multicultural competency tasks. The measure developed by Sheu and Lent was created to marry the two constructs and even more importantly to distinguish it from the other MCC measures since they have been shown to intermix all areas of multicultural competency. These researchers wanted to isolate and only measure the skills utilized within the counseling session, specific to working with diverse clients. Derald Wing Sue (1998), a pioneer in the counseling literature highlighted the

effectiveness of how cultural responsiveness benefits a client's experience and engagement in counseling (in Ponterotto, Fuertes and Chen, 2000). This study further explored the importance of addressing cultural factors when psychology trainees conceptual a client of color. Additionally, trainees' abilities were compared to their endorsement of certain multicultural competencies with the Multicultural Counseling Self-Efficacy Scale, Racial-Diversity Form (MCSE-RD). The inspiration for the MCSE-RD came when Constantine and Ladany (2001) first questioned if the construct of MCC needed to be measured more objectively due to its complexity and lack of a solid theoretical base. The construct of multicultural self-efficacy potentially solves this problem since it is developed from Bandura's social cognitive theory (1977; 1997) and defines a counselor's belief in his/her abilities in performing a specific set of therapeutic interventions with a client of color (Mobley, 2001). Constantine and Ladany's specific concerns about the accurate assessment of multicultural competency were two-fold and addressed below.

First, they speculated that the manner in which competency is currently evaluated (i.e., self-reported) might challenge the measurement of this construct. The theory of multicultural competence inherently may be difficult to assess and quantify using a self-report measure because it taps into many different perspectives (i.e., beliefs, attitudes, and behaviors) of the counselor, which he/she may not accurately endorse due to being unaware of his/her biases or wanting to be presented in a more positive light, for example. Secondly, these researchers contemplated if the underlying theoretical definition of this construct contributed to the difficulty in its measurement. In other words, even though the measures have been grounded in Sue et al.'s (1982; 1992)

competencies each measure may not necessarily be assessing the same construct (i.e., "perceived" versus "actual" ability) with the original three dimensions. This has been demonstrated in the spurious findings of each of the psychometric studies of the MCC self-report instruments. Other constructs such as self-efficacy and more recently, ethnocultural empathy have been hypothesized to provide a better framework to understanding multicultural counseling competency (Constantine & Ladany, 2000, Sheu & Lent, 2000 and Wang et al., 2003). To follow these lines of thinking, this study builds on this extant literature by analyzing how multicultural counseling competency (MCC) could be better measured by another more theoretically based construct called multicultural counseling self-efficacy. This notion was a result of the counseling psychology's research studies that found significant flaws with the operationalized definition of multicultural counseling competency. Furthermore many of the assessment tools used in these studies were based on the original tripartite definition and used to measure MCC and other related variables. Examination of these studies showed even more potential problems, as self-reported MCC was not consistently related to a hypothesized objective measure of MCC, a case conceptualization of a multicultural client, thus making the measurement of MCC more unclear and in need of further clarification. Researchers cited multicultural self-efficacy as an alternative lens for MCC as it has roots in social cognitive theory and fits in well with the psychology trainee developmental model. To investigate this rationale, a recently formed measure called the MCSE-RD with foundations in MCC, was utilized in this study as it was hypothesized to provide a more accurate way to assess a person's beliefs in his/her abilities of working with a diverse client. Additionally, the research supported the exploration of how another

construct, ethnocultural empathy, measured by the SEE, also grounded in the MCC research, would help predict psychology trainees' established proficiencies via a case conceptualization exercise in understanding and treating the problems of a Black client. Our study considered variables that have been found to directly related to MCC to be help constant during this investigation.

# CHAPTER 2

# LITERATURE REVIEW

The lines of thought mentioned above were a result of a critical body of researched which emerged in the late 1990's that examined the relationship between the subjective (i.e., self-report) and objective (i.e., demonstrated) endorsement of an individuals' multicultural counseling competency. In 1997, Ladany and his colleagues conducted the first study investigating how a counselor's demonstrated skills related to his/her self-reported proficiencies. Constantine and her colleagues continued Ladany et al.'s research, specifically examining how trainees' level of endorsement on the competency measures varied with his/her ability to conceptualize a case from a multicultural framework (Constantine et al., 2005; Constantine & Ladany, 2000). This new focus of investigation seemed vital to the development of the multicultural counseling literature due to the previously mentioned problems of the self-report competency tools. Additionally, it was important to clarify if trainees' perceived capability to understand a multicultural client relates to or was separate from his/her actual conceptualization skills in understanding the client's difficulties. Unfortunately, this body of research has displayed inconsistent findings of the relationship between these two perspectives of multicultural competency. The specific results of these research studies follow.

## *Self-Reported Multicultural Competence and Multicultural Case Conceptualization: Different sides of the same coin or two different coins?*

In 1997, Ladany and his colleagues conducted the first study examining the extent to which trainees' self-reported competency level related to his/her multicultural case

conceptualization ability particularly when instructed to focus on multicultural issues with a client. These researchers utilized previous related research theories to hypothesize that those identified as "competent" counselors would be more skillful in identifying and integrating the impact of racial factors on a client's present problems, and then following up with appropriate treatment. However, in this landmark study, the results of the multiple regression analysis were not significant and provided evidence against self-report multicultural competency scales predicting trainees' potential to understand and effectively treat the problems of a multicultural client. Therefore, trainees' subjective endorsement of his/her ability to work with a racially different client was not associated with and did not provide further evidence of his/her objective conceptual competence. As a result of these counterintuitive findings, follow-up studies were conducted investigating the relationship between trainees' "perceived" versus "actual" competency skills and this literature review expounded upon ones by Constantine and her colleagues in 2000 and 2005.

First, Constantine and Ladany (2000) explored the association between the four self-report multicultural competency scales and a general index of social desirability and multicultural case conceptualization ability. In the first step, the study found multicultural competency to be significantly related to social desirability in three out of the four scales (MAKSS, MCI, and MCKAS). However, in the follow-up analysis when the researchers held social desirability constant, none of the competency scales predicted a student's ability to conceptualize a case from a multicultural perspective. The specific analyses of this study follow.

One hundred and thirty-five doctoral and master's level counseling students were selected (random and non-random) as participants. The researchers instructed the respondents to imagine being an actual counselor for a client whose intake scenario they were about to read. The participants were then provided with a vignette which briefly described the client's symptoms and included his/her diagnosis. After reading this vignette, the respondents were asked to write a brief conceptualization of the etiology of the client's problems and how they would treat the client. Once completed, the participants filled out four self-report multicultural competency measures (CCCI-R, MAKSS MCI and MCKAS), a social desirability measure and demographic questionnaire. The researchers first conducted a multiple regression analysis to examine the relationship between the subscales of the self-report measures (in the case of the CCCI-R, only the overall score) and the social desirability measure. Due to social desirability accounting for a statistically significant portion of the multicultural competency variance ($p<.001$), univariate analyses were performed and found the two constructs to be uniquely and significantly ($p < .05$) related with certain subscales on a couple of the measures (i.e., MAKSS and MCI). Specifically, higher scores on the social desirability measure were related to higher scores on the MAKSS Knowledge and MCI Relationship subscales but lower scores on the MCKAS Awareness subscale. In other words, those who endorsed having the ability to work with racially diverse clients reported wanting to appear more socially desirable. However, due to the negative relationship between social desirability (higher score) and the MCKAS Awareness subscale (lower score) further investigation of this relationship was warranted. These researchers suggested using a social desirability scale alongside any self-report

multicultural competency scale as the relationship between the two is unclear in this study and the literature (Constantine & Ladany, 2001; Constantine, Juby, & Liang, 2001; Ponterotto, et al., 2002). To follow this recommendation, our study took the potential impact of social desirability into account and used two instruments which have not been found to correlate highly with measures of social desirability- SEE and MCSE-RD. Constantine & Ladany's (2000) studied also explored the association between the competency measures and a case conceptualization exercise which is a demonstrated version of multicultural counseling competency. This objective measure requires qualitative information to be translated into quantitative information. Ladany and his colleagues designed a coding system based on Tetlock & Suedfeld's (1998) system for assessing *cognitive complexity*, which was used in Constantine and Ladany's (2000) study. Specifically, this model examines a person's ability to perform two interrelated cognitive processes: differentiation and integration. *Differentiation* is defined in this study as a counselor' capability of providing more than one way of viewing the client's presenting problems and ways of treating him/her. The degree of differentiation influences the assigned level of integration. *Integration* refers to the level of associations between and among the distinguished interpretations. Raters then examine the response for the degree of integration of ethnic or racial issues of two separate conceptualizations of the client's presenting problems. Specifically, raters analyze the respondent's belief about the factors contributing to the etiology of a client's difficulties and his/her beliefs about what would be an effective treatment plan in handling the client's problems. After the codings of these two conditions were assigned in Constantine and Ladany's study, the four multiple regression analyses were performed. In each analysis, the competency

scales served as the predictor variables and the etiology and treatment ratings represented the criterion variables. The results displayed that the overall proportions of variance in the multicultural conceptualization exercise were not significant for any of the four multicultural competency measures. In other words, none of the scores on the self-report competency scales significantly predicted trainees' ability to effectively intervene with a racially diverse client. These findings are similar to the Ladany, et al. study (1997) and represent a potential area of concern. Furthermore, in Constantine and Ladany's (2000) study, trainees displayed elevated scores on the subjective measures (i.e., self-report scales) but low to middle levels of complexity on the objective measure (i.e., case conceptualization). This discrepancy seems crucial to point out that, at least for the participants in these studies, self-report measures may inflate trainees' actual level of competence which seems problematic and has been cited as an area of further exploration in the counseling psychology literature.

In contrast to the findings described above Constantine and her colleagues (2005) reported that trainees who were involved in supervisory dyads with higher racial identity attitudes (i.e., nonracist White Identity) performed better in the etiology and treatment of the hypothetical client as evidence by their multicultural case conceptualization scores and higher competency scores as reported by the CCCI-R. This study included fifty White doctoral students in counseling psychology and their respective White doctoral practicum supervisors. Most of the participants (supervisees and supervisors) in this study were female and approximately eighty percent of the supervisees reported taking at least one multicultural or cross-cultural course while only thirty-four percent of the supervisors had completed either type of course. The supervisees were given a packet which included

the case conceptualization exercise (as described above) first, followed by a racial identity scale, the CCCI-R and a demographic questionnaire while the supervisors only filled out the racial identity scale. For the multicultural case conceptualization piece, supervisees were asked to imagine being the counselor for the specific client whose intake notes they were about to review. To examine if significant differences existed between the self-reported multicultural competency measures and multicultural case conceptualization ability (and if they varied by White racial identity types), a multivariate analysis of variance (MANOVA) was conducted, using the CCCI-R and the conceptualization scores as dependent variables. Due to the MANOVA displaying significance ($p < .01$), follow-up univariate analyses were performed. The results showed significant differences by racial identity type on the CCCI-R ($p < .01$) and both the etiology ($p < .01$) and treatment ($p < .01$) scores from the conceptualization exercise. Overall, those students who were involved in more sophisticated racially identity dyads (i.e., more awareness of the need to explore cultural issues of a client in supervision) were found to hold higher competency and treatment and etiology scores. Thus showing a positive relationship between one's subjective endorsement of his/her multicultural competency level and an objective evaluation of his/her demonstrated multicultural skills.

As a result of Constantine and her colleagues (2005) findings conflicting with the Constantine and Ladany (2000) and Ladany and his colleagues (1997) studies, further investigation of the definition of multicultural competency is warranted. This exploration seems important on two distinct levels. First, both types of assessment of multicultural competence have been found to inconsistently relate to one another. This result may have been influenced by the psychometrically weak self-report measures, which have been

found to inconsistently assess the actual aptitude of trainees' multicultural counseling competency. Specifically, the measures have been criticized for not supporting the tripartite model. One's knowledge, awareness and skills appear to represent separate but related entities of a person's cognitions, affect and behaviors of multicultural counseling competency. Therefore, future studies may consider examining these three competency areas separately. This study concentrated on further understanding the relationship between the skills portion of Sue et al.'s (1982, 1992) model as endorsed on a self-report measure designed only to tap into this area when working with culturally different clients. This kind of measurement was then posed against a case conceptualization activity, which examined trainees' demonstrated ability of multicultural counseling competency to find out how the two were related. The importance of specifically addressing and understanding the needs of ethnic minorities has always been at the forefront of the counseling psychology literature. The MCC measures tap into general competencies not equipped to examine trainees' abilities in working with a diverse client, specifically. To potentially improve the previous multicultural counseling research, this study specifically chose to test out the hypothesis of using a rather specialized subjective measure's scores to predict an objective measure's scores, matching the client with the specific skills assessed. Another problem with the MCC model is the notion that other underlying factors may be related to multicultural counseling competency, and could be contributing to the discrepancy between the objective and subjective measures. Two such factors that may clarify the theoretical underpinnings of multicultural competency are multicultural self-efficacy and ethnocultural empathy. The following sections address the relevance of these two constructs to the study of multicultural counseling competence.

*Multicultural Self-Efficacy and Multicultural Counseling Competency: Does self-efficacy theory provide a better foundation for the construct of multicultural counseling competency?*

With the multitude of psychometric problems found with the MCC self-reported measures as well as their inconsistent relationship with a posited objective measure of Multicultural Counseling Competency Ability (MCCA) (Constantine & Ladany, 1997). Constantine and Ladany (2001) and other researchers began to focus on how to improve the assessment of this construct (Constantine, 2001; Constantine, Gloria and Ladany, 2002; Sheu & Lent, 2007). In the second edition of *The Handbook of Multicultural Counseling* (2001), Constantine and Ladany proposed that the definition of multicultural counseling competency needed to be broader and encompass six interrelated dimensions, one of which included "multicultural counseling self-efficacy." *Multicultural counseling self-efficacy* is defined as "counselors' confidence in their ability to perform a set of multicultural skills and behaviors successfully" (p., 490). Bandura's self-efficacy theory provides a way to enhance the understanding of multicultural competency due to its ability to provide a closer measurement of how well a person organizes his/her beliefs about his/her abilities and performs them (Constantine & Ladany, 2001; Sheu & Lent, 2007).

The acquisition of self-efficacy occurs when a person holds an appropriate amount of knowledge, beliefs, and skills to successfully perform a certain behavior (i.e., enactive mastery). Since multicultural counseling competency is grounded in similar roots and is in need of a stronger empirical base, social cognitive theory naturally provides a solid foundation for this construct. Self-efficacy corresponds with the

psychology developmental training model such that higher self-efficacy would be expected after a psychology trainee experiences more didactic training and partakes in clinical activities (Constantine & Ladany, 2001; Lent, Hill & Hoffman, 2003). Another reason to use counseling self-efficacy theory is based on the thought that trainees would be less susceptible to self-report bias on a measure which asks them to respond to questions about their "confidence" rather then their "competence" in performing specific skills. In other words, there may be fewer stigmas associated with endorsing lower levels of confidence versus lower levels of skills. As a result, trainees may be more open to discussing these beliefs with their supervisors during their clinical rotations. With this type of supervision early in their development, trainees' self-awareness would increase and in turn positively impact their work with current and future supervisors and clients (Worthington, Soth-McNett & Moreno, 2007). The application of self-efficacy theory to multicultural counseling competency is a relatively small boy of research. The following is a brief review of the merger of these two constructs.

In 1997, with the expansion of Bandura's definition of self-efficacy to include the notion that one's self-efficacy may differ depending on the context of the situation, the counseling self-efficacy literature thrived. Researchers in this area began to query if general counseling self-efficacy skills were different from specific counseling self-efficacy skills. Furthermore, Lent and his colleagues in 2006 contemplated if these proficiencies were more closely understood as a "trait" or a "state" such that general skills would be more trait-like and specific skills (i.e., those with a particular type of client) would be more state-like. This distinction became more complex when it included yet another facet:  racial/ethnic factors of a client. In Larson and Daniel's 1998 review of

the self-efficacy literature, they introduced how well the definition of self-efficacy can be applied to the definition of counselor self-efficacy. *Counselor self-efficacy* is one's beliefs or judgments about his/her abilities to counsel a client in the near future. Mobley (1999) identified the need to be even more precise about this definition and included trainees' perceived competencies in the context of multicultural counseling. Mobley introduced the concept of *multicultural counseling self-efficacy* and viewed it as a developmental journey of the counseling trainee, during which he/she forms beliefs about his/her ability to perform culturally appropriate interventions depending on his/her interactions with clients and people in their department (i.e., faculty and peers). Ultimately, Mobley and Neville (2001) cited the importance of developing a more accurate meaning of multicultural counseling self-efficacy in order to measure trainees' perceived abilities when working with culturally different clients. In 2007, Sheu and Lent presented a new measure entitled, the *Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSE-RD),* which assesses one's beliefs in his/her abilities to effectively counsel individuals who differ from his/her race. Sheu and Lent (2007) stated that this tool was initially validated on a MCC measure and specifically examines certain counseling behaviors in sessions with a culturally different client, tapping only into the skills subset of Sue et al.'s (1982, 1992) tripartite model. Furthermore, all the items adhere to Bandura's guidelines for developing a self-efficacy measure. Item development was based on a dual definition of efficacy beliefs from Bandura's theory (1997), which included content-specific self-efficacy and coping self-efficacy. Specifically, content-specific self-efficacy refers to the confidence in performing "fairly common counseling tasks but in a multicultural context" and coping efficacy is defined as the confidence in

"handling relatively difficult multicultural counseling scenarios" (Sheu and Lent, pg. 32, 2007). A review of the relevant literature was conducted by these researchers to develop an initial pool of items, which were then finalized by experts within the counseling psychology field and then further divided within each domain. For example, the coping efficacy domain was broken down into one's confidence in handling difficult presenting issues and cultural impasses and ruptures. A measure of multicultural social desirability was also included.

As a result of the stringent construction of the MCSE-RD, this measure was used in this study to assess how the skills component of the tripartite model relates to trainees' demonstrated multicultural competency. Knowing more about the association between the constructs of self-reported counseling self-efficacy and one's ability to explicitly perform counseling behaviors with client of color seems central to the multicultural counseling literature. Thus, this study proposed to determine if self-reported self-efficacy scores predicted an objective exercise of multicultural counseling competency. To provide the clearest picture of this relationship, the analysis controlled for multicultural training variables. Both of these constructs, multicultural counseling competency and counseling self-efficacy, are theoretically grounded on the notion that the behavioral component (i.e., skills) is most dependent upon the amount of cognitive (knowledge), and affective (awareness) of the individual. It is then not surprising to find out that the research in the area of multicultural counseling self-efficacy somewhat overlaps the research of general self-efficacy and multicultural counseling competency literature. A review of the relevant multicultural counseling self-efficacy research studies follows below.

In 2001, in an attempt to answer the question posed regarding the association between general counseling self-efficacy skills and self-perceived multicultural counseling competency skills, Constantine conducted a study with 94 masters counseling trainees in a year-long practicum course. Her sample of convenience completed a counter-balanced survey packet of the CCCI-R—a self-report MCC measure, CSES—a measure of general counseling self-efficacy and a brief demographic questionnaire. Most of the participants were White women. Constantine examined the extent to which training and supervision accounted for variance in the trainees' level of multicultural competency. Since they were found to significantly vary, she accounted for both in the hierarchical multiple regression analysis. The CCCI-R scores were the criterion (dependent) variable along with the training variables and entered first and followed by the CSES scores. Taken together and separately, these two variables accounted for significant variance in the regression, thus showing support for general self-efficacy beliefs of trainees to be, in part, related to their beliefs to work with culturally diverse clients. However, this relationship has not been consistently supported in the literature as counseling self-efficacy expectations have not been found to be significantly predictive of actual performance (Sharpley & Ridway, 1993). Many researchers have supported the inclusion of self-efficacy as a component of multicultural counseling competency in theory; however no other studies exist which examines this relationship. Thus, as a means to add to the literature, and follow-up with the field's suggestion, this study explored how self-reported self-efficacy as measured by the MCSE-RD compares with demonstrated multicultural counseling competency. Additionally, Constantine and other researchers have also more recently contemplated how empathy, specific to understanding the

worldview of a client of color's perspective may be part of multicultural counseling competency. A brief review of this literature follows below.

*Multicultural Counseling Competency and Empathy*

Fischer, Jome and Atkinson (1998) speculated that the counselor's ability to accurately understand the impact of the client's racial and ethnic group membership may be critical to the improvement of his/her presenting concerns. Furthermore, Fuertes, Stracuzzi, Bennett, Scheinholtz, and Mislowack (2006) more recently speculated that in order to be multiculturally competent, therapists should have an informed type of empathy; one that is based on knowledge and understanding of a client's worldview, culture and background. Along these lines, the multicultural counseling movement proposed that the degree to which the counselor demonstrates "ethnocultural empathy", might represent his/her level of multicultural counseling competency. Ethnocultural empathy was recently conceptualized by a group of researchers who adapted the definition from Ridely and Lingle's work (1996) on cultural empathy who defined it as intellectual empathy and empathic emotions. Constantine (2001) took this definition a step further by stating that depending on the level and type of empathy (i.e., affective or intellectual) a counselor holds may impact his/her understanding and ability to work with diverse clients. As a result of these queries, a few studies have examined the relationship of different aspects of empathy (i.e., affective and cognitive) to multicultural counseling competency (Constantine, 2000; 2001a, 2001b). Unfortunately, these studies provide an unclear picture of the aforementioned relationships. Therefore, further empirical evidence is needed to comprehend how empathy may relate to a subjective and objective measure

of multicultural competency. The findings regarding the association between these two constructs follows.

According to Duan and Hill (1996), in their major review of empathy research, empathy has been viewed in different lights from "situation-specific" (a cognitive state), to more "trait-like" characteristic, however, regardless of the way it develops, by personal development or naturally; some individuals inevitably be more empathic than others. What is missing from this literature is an operationalized definition of culturally specific empathy and any applicable assessment tools. In 2003, a group of researchers (Wang, Davidson, Yakushko, Savoy, Tan & Bleier) introduced the term *ethnocultural empathy*, which they conceptualized as a merge of both types of empathy (i.e., learned ability and personality trait). With this definition in mind, they developed a new empathy scale theoretically based on many multicultural competency measures (i.e., MAKSS, MCI and CCCI-R) called the Scale of Ethnocultural Empathy (SEE). In Wang et al's (2003) study, these researchers examined ethnocultural empathy in three related factors: intellectual empathy, empathic emotion and the expression of these two types towards a racially/ethnically diverse client (Ridley & Lingle, 1996). Unfortunately, no studies to date have utilized the SEE beyond the original validation study. However, Constantine (2000, 2001a, 2001b) has published three studies that looked at the relationship between multicultural counseling competency and different types of empathy.

Constantine's 2000 study examined how cognitive and affective empathy as measured by the Interpersonal Reactivity Index (IRI; Davis, 1980), gender and social desirability as assessed by the Marlowe-Crowne Social Desirability Scale (SDS) predicted counselor's self-reported multicultural competency. The Knowledge and

Awareness subscales of the MCKAS were utilized as separate criterion variables in the two hierarchical multiple regression analyses. In both of these calculations, social desirability did not predict competency; however gender accounted for a significant portion of variance in both, with women endorsing higher MCKAS scores. Taken a step further, after controlling for social desirability and gender, cognitive and affective empathy taken together explained 17% of the variance in the Knowledge subscale and 14% of the variance in the Awareness scale with affective empathy, alone, making a significant contribution. These results indicate that a counselor's level of empathy, more likely affective, may be part of his/her perceived multicultural competence.

However in a subsequent study, Constantine (2001b) investigated the relationship of these variables measured by the same measures along with another variable, emotionally intelligence, in school counselors. She found mixed results for counselors' level of empathy predicting his/her multicultural competence. 108 participants completed the Emotional Intelligence Scale (EIS; Shutte et al., 1998; IRI; Davis, 1980; MCKAS; Ponterotto, Gretchen, Utsey, Rieger & Austin, 2000) and a brief demographic questionnaire. The majority of the participants were White women who had taken at least one or more academic courses related to multicultural counseling. These variables are important to report due to majority of studies in the MCC literature obtaining similar demographics, thus not allowing the studies to be generalizable to a broader range of psychology trainees. Multiple regression analyses with previous multicultural counseling courses, EIS, and IRI scores (predictor variables) and the two MCKAS subscales (criterion variables) was significant for the predictor variables accounting for a substantial amount of variance in the Knowledge and Awareness scores. Follow-up

univariate analyses showed previous multicultural education and emotional intelligence to be significantly, positively and uniquely related while personal distress empathy was significantly conversely related to self-reported multicultural counseling knowledge. In other words, school counselors with more experience with multicultural courses, more emotional intelligence and less feelings of anxiety in response to marked distress in others resulted in a significant relationship with his/her endorsed general knowledge related to multicultural counseling but not to his/her endorsed Eurocentric worldview bias.

Given the mixed findings of the two previously mentioned studies and their reliance solely on self-reported measures, Constantine conducted a subsequent study (Constantine, 2001b) in an attempt to clarify the relationship between empathy and multicultural competency by including an objective measure. She examined to what degree cognitive and affective empathy as measured by the IRI's Perspective Taking and Empathic Concern subscales predicted trainees' ability to effectively conceptualize a client of color. Other demographic variables included in the analysis were previous multicultural training and theoretical orientation of the counselor. Hierarchical regressions were performed using the two MCCA indices as the criterion variables with the formal multicultural courses entered first, followed by the theoretical orientation and lastly the empathy subscales of the IRI. These analyses revealed that only affective empathy scores significantly, positively and uniquely predicted trainees' ability to formulate the etiology of the client's psychological difficulties. However, both affective and cognitive empathy scores taken together and separately significantly and positively predicted how well the student could effectively treat a client of color's presenting

problems. Constantine (2000), as cited above, found self-reported multicultural competency to be significantly related to self-reported affective empathy. Therefore, it appears as if those counselors who see themselves as more equipped to respond affectively to others may be more aware and able to incorporate cultural issues into their conceptualization of a client's mental health problems. Additionally, if the counselor in training is able to take the client's point of view (i.e., have cognitive empathy) then he/she may be similarly or more effective in conceptualizing treatment interventions with clients of color. Further research is needed to identify if affective and/or cognitive empathy plays a specific role in multicultural competency. The current study attempted to add to the literature and examined trainees' ethnocultural empathy as measured by the SEE in relation to his/her MCCA ability.

*Proposed Study*

Due to the increasing diversity of the U.S. population, the applied fields in psychology have acknowledged the need to continue to train psychologists to effectively treat individuals from diverse cultural groups (e.g., racial, ethnic, gender, social class, and sexual orientation). The counselor's ability to work with each client from a multicultural perspective and intervene by proposing appropriate treatment interventions and goals is essential to the client's positive outcomes in therapy. Despite the initial promising validity and extensive use in the literature the MCC self-report measures have been criticized for many reasons. Specifically, these scales may not be representative of tripartite model for which they were developed and may be assessing trainees' "perceived" rather than "actual" ability to work with ethnically diverse clients. When compared to an objective, multicultural case conceptualization exercise, a believed

demonstration of one's multicultural competency level, the self-report assessment tools do not consistently produce results showing that both methods of measurement are tapping into the construct of multicultural competency (Constantine, et al., 2005, Constantine & Ladany, 2000; Ladany et al., 1997). In 2001, Constantine and Ladany proposed the need to consider the relevance of Bandura's theory of self-efficacy to help clarify the measurement of multicultural counseling competency in self-report surveys. Many other researchers (Constantine and Ladany, 2000) supported this hypothesis as an alternate construct to MCC, which may be less susceptible to self-report bias and more representative of a counselor's genuine beliefs about his/her abilities. Along with multicultural counseling self-efficacy, the construct of ethnocultural empathy has emerged recently in the literature as another possible dimension of multicultural competency. Unfortunately, neither construct has been thoroughly researched in the counseling psychology literature and is in need of more empirical evidence to support or refute its relationship with multicultural counseling competency. The purpose of this study is to advance previous research related to the assessment of multicultural counseling competence. Specifically, the current study intended to address the methodological limitations in the literature by using a more robust construct, self-reported multicultural self-efficacy, to possibly better explain, self-reported multicultural counseling competency. The following research question was addressed in the study.

Research Question 1: What is the relationship between trainees' scores on the MCSE-RD, SEE, and his/her ability to include culturally relevant information in a case conceptualization of a client of color?

Based on existing literature and related to the research question above, the following hypotheses were tested in the study:

Hypothesis 1: Previous multicultural experience (i.e., multicultural courses and clinical practice with multicultural clients) was hypothesized to be positively correlated with more complex case conceptualization ability and higher self-reported multicultural counseling self-efficacy and ethnocultural empathy.

Hypothesis 2: The MCSE-RD was hypothesized to predict the greatest amount of variance of integration and differentiation by the trainee of the factors contributing to the etiology of a Black client's difficulties.

Hypothesis 3: The MCSE-RD was hypothesized to predict the greatest amount of variance of integration and differentiation by the trainee of his/her beliefs about what would be an effective treatment plan in handing a Black client's problems.

In Hypotheses 2 and 3, variables which have been shown in the literature to influence multicultural counseling competence such as clinical contact hours with diverse client were held constant in the analyses, while ethnocultural empathy, a construct hypothesized to influence objective competency was added to investigate if more variance would be explained.

# CHAPTER 3

# METHOD

## *Participants*

One hundred and seventy-six currently enrolled trainees in masters in counseling and APA-accredited clinical and counseling doctoral programs across the United States participated in this study. Twenty participants were dropped from the analyses due to missing 20% or more of their responses on a particular instrument thus, yielding a final sample size of one hundred and fifty-six. One hundred and twenty-nine participants were female (83%), 27 were male (17%), and participants ranged from 22-61 years of age (M=29.47). With regard to race, 80% participants were White (91.2% non-Hispanic and 8.8% Hispanic); 4.5% were Black, 5.1% were Asian, 1.9% were Multiracial, 7.1% were Other and 1.3% were Native American. In terms of other demographic variables, most of the participants were in their third year of graduate schooling and had taken at least one multicultural course. One-hundred and thirty-one participants endorsed being currently enrolled in an APA-accredited clinical psychology or counseling psychology program and twenty-five reported currently being enrolled in a counseling/mental health program. Additionally, 73% of the participants either had completed or were currently enrolled in a supervised practicum working with a racially/ethnically diverse population. Participants reported an average number of direct clinical hours between 6-20 hours with racially/ethnically diverse clients. Related to those clinical hours, they reported an average of between 1-5 direct hours of supervision discussing these clients. Details regarding the remaining demographic data are in Table 1.

*Recruitment procedure*

After obtaining IRB approval (Spring 2008 and re-approval in Spring 2009), names and email addresses of training directors of masters counseling programs and APA-accredited doctoral clinical and counseling programs were obtained from the University of Kentucky's, College of Education website (http://www.uky.edu/Education/EDP/psyprog.html). The directors of these programs were emailed to request their permission to post a recruitment email on their school's listserve to solicit students from their program (Appendix A). In addition, announcements were made on other psychology-related listserves, such as The Association of Black Psychologists, The South Asian Psychological Networking Association and The Counsel of Counseling Psychology Training Programs. After an initial email was sent to a program, a follow-up email was sent to each training director that included a brief description of the study, the informed consent statement, qualifications to participate in the study and a link to the study's website. The listserves were given a brief description of the study and were informed that any student's participation was entirely voluntary. The recruitment email included criteria for participation, and directions for the study and a web address as a hyperlink to obtain the study. The study was hosted on SurveyMonkey.com., and prior to beginning the study potential participants were instructed to read the consent form. Moving forward indicated their agreement to participate and then they were directed to complete the electronic package in the following counter-balanced order: case vignette (i.e., MCCA), SEE, MCSE-RD, and a demographic questionnaire. The directions that preceded the vignette asked them to imagine that they were the counselor for a client whose intake they were about to read.

After reading the vignette, participants were instructed to (a) first write a conceptualization of at least three sentences describing what they believed to be the etiology of the client's psychological problems and (b) write a conceptualization of at least three sentences describing what they considered to be an effective treatment plan. The participants then completed the SEE and the MCSE-RD. These instruments were counterbalanced to minimize ordering effects and given after the case conceptualization exercise to avoid as much as possible any influence on the trainees' responses. The investigator and her advisor (Dr. Nicole Coleman) were the only persons with access to the Survey Monkey's data and all the collected responses were confidential, secure and not shared with any third parties. Furthermore, the respondents were unidentifiable as no personal information was obtained.

*Data Analyses*

The data was analyzed using the Statistical Package for the Social Sciences (SPSS). Missing data points, which were few, within the independent variables (MCSE-RD and SEE) were accounted for by replacing the missing value with the mean of the item from each respective scale (Roth, 1994). Descriptive statistics were performed on the demographic variables, training variables and all the mean scores of the key variables (MCSE-RD, SEE and MCCA). Finally, interrater reliability estimates were calculated for the coders by performing an interclass correlation coefficient (two-way randomized) to assess interrater agreement. The research question was addressed in Table 2 while Hypothesis 1 was addressed below. Refer to Tables 3 and 4 for the two forced-entry hierarchical multiple regression analyses of the remaining two hypotheses. The following demographic and training variables were all entered first into a control block: race and

ethnicity, relevant training variables (i.e., current or past participation in a multicultural course, clock hours counseling culturally diverse clients and clock hours of supervision devoted to discussing these clients). In the second block the total score from the MCSE-RD was entered and in the third block, the total score from the SEE was entered. These three blocks were regressed against the dependent variable of MCCA scores, for etiology in the first analysis and treatment in the second analysis, to determine any statistically significance.

*Measures*

*Dependent variable*

*Multicultural case conceptualization exercise*.

All participants were given a vignette to read that was developed from other vignettes used in the previous studies investigating multicultural case conceptualization (Ladany et al., 1997; Constantine & Ladany, 2000). More specifically, the case provided information for a twenty-two year-old, Black female with depressive symptoms who is adjusting to her new environment in which she is a racial minority. The setting for the counseling was a college counseling center. See Appendix B for a copy of the vignette.

A coding system used in previous studies was utilized in this study. Two objective raters scored the extent to which the participants integrated salient racial/ethnic factors into two conceptualizations of the client's presenting concerns. This way of translating qualitative information into quantitative information was based on similar coding systems utilized to assess cognitive *integrative complexity* (Tetlock & Suedfeld, 1988) and has been used in previous studies similar to the current study (Ladany, et al., 1997; Constantine & Ladany, 2000). This study measured multicultural case conceptualization

ability by examining two interrelated cognitive processes: differentiation and integration. As mentioned earlier, *differentiation* is the participant's belief about the racial/ethnic factors contributing to the etiology of the client's problems and the ways to effectively treat him or her. The greater number of racial factors identified the greater the degree of differentiation. The second process, *integration*, was displayed by the participant's ability to form associations within and between differentiated interpretations. The coding system, taken from Ladany et al., 1997 produces scores that range from 0 to 6 with the following values associated with the corresponding number: *0=no differentiation, no integration,* 3=*moderate differentiation, low integration,* and 6=*differentiation, high integration*. In regards to the case conceptualization condition 0=no indication of ethnic or racial issues in conceptualizing the client's problems, 3=3-4 references to ethnic or cultural issues in the conceptualization of the client's problems, with 1-2 connection(s) made between two or more differentiated interpretations and 6=6 or more indications of ethnic or cultural issues in conceptualizing the client's problems, with three or more connections made between differentiated interpretations. The integrative cognitive complexity coding systems have been validated in previous studies (Constantine & Ladany, 2001; Ladany, et al., 1997) as an appropriate method to rate participants' responses for the etiology and treatment conditions of a case conceptualization exercise. The investigator calculated the intraclass correlation coefficient (ICCRR) for each response (i.e., etiology and treatment) for the rater as a means to establish interrater reliability. The ICCRR for the etiology was 0.74 and 0.77 for treatment in the study. When perfect agreement was not met the average score, calculated by adding both of the coder's scores and dividing by 2 was performed. This *average* score was calculated for

41% of the etiology responses and 30% of the treatment responses. All 156 participants completed the MCCA exercise for the vignette about the Black, undergraduate woman. Participants scored a mean of 1.24 (*SD*=1.14; Median=1.00; Range=0-5) for etiology and 1.07 (*SD*=1.33; Median=0.00; Range=0-6.) for treatment.

*Coders*

Coders were recruited by the investigator from undergraduate and master's students at the University of Houston and those who were interested in becoming raters for the case conceptualization piece were informed to contact Nicole Coleman, Ph.D., who would then help them connect with the investigator. The students were interviewed to determine their level of interest and understanding associated with their role in the study by Nicole Coleman, Ph.D. and the investigator. Two raters were chosen based on these qualifications and trained for approximately 10 hours in scoring the multicultural case conceptualizations. One coder was an undergraduate student, majoring in Psychology and the other coder was a master's-level research assistant at Baylor College of Medicine. The training process included reading the seminal article for case conceptualization based on Tetlock and Suedfeld's cognitive complexity, Ladany et al.'s study (1997) and reviewing a poster presentation by Arpana Inman, Ph.D., a researcher in the field. This presentation included copies of the multicultural case conceptualization scoring criteria along with a sample vignette of a South Asian female client with corresponding examples of each kind of score for etiology and treatment responses. After familiarizing themselves with this information and discussing it in detail with the investigator, the raters performed at least 15 practice exercises. The first 5 were reviewed and discussed with the investigator, paying attention to any discrepancies between the

actual score and the obtained score of the coder. After practicing with another 10, and if the coder established a high level of accuracy, then the coder was deemed sufficiently prepared to code the study's MCCA etiology and treatment conceptualizations independently. If not, then the coder practiced 10 additional practice exercises until a high level of accuracy was established.

*Independent variables*

*Ethnocultural empathy.*

The Scale of Ethnocultural Empathy (SEE: Wang, Davidson, Yakushko, Savoy, Tan, and Bleier, 2003) assesses empathy towards people of racial and ethnic backgrounds. The SEE is a 31-item self-report instrument, on a 6-point Likert scale (1=Strongly Disagree; 6-Strongly Agree). The SEE is divided into four factors: Empathic Feeling and Expression (EFE), Empathic Perspective Taking (EP), Acceptance of Cultural Differences (AC), and Empathic Awareness (EA). The EFE scale contains fifteen items that pertain to one's concern about communication of discriminatory or prejudiced attitudes or beliefs. It also includes items that focus on one's affective responses to the emotions and/or experiences of people from racial or ethnic groups different from one's own. An example of an item on the EFE scale is, "I seek opportunities to speak with individuals of other racial or ethnic backgrounds about their experiences." The EP scale is comprised of seven items that indicate an effort to understand the experiences and emotions of people from different racial and ethnic backgrounds by trying to take their perspective in viewing the world. An example of an item on the EP scale is, "I know what it feels like to be the only person of a certain race or ethnicity in a group of people." The AC scale includes five items that center on one's

understanding, acceptance, and valuing of cultural traditions and customs of individuals from differing racial and ethnic groups. An example of an item on the AC scale is, "I feel annoyed when people do not speak standard English." Finally, the EA scale contains four items that appear to focus on the awareness or knowledge that one has about the experiences of people from racial or ethnic groups different from one's own. This awareness is specifically related to their experiences of discrimination or unequal treatment of different groups. An example of an item on the EA scale is, "I am aware of how society differentially treats racial or ethnic groups other than my own." Higher scores indicate higher levels of ethnocultural empathy. According to Wang et al.'s (2003) study, Cronbach's alpha internal consistency estimates for the exploratory and confirmatory factor analysis for the final 31-item SEE total was 0.91. The four-factor structure was chosen, as it was most conceptually interpretable and statistically sound thus providing solid support for using the total composite score for the SEE. These researchers also found evidence for convergent and discriminant validity as the SEE was moderately correlated with other scales that examine empathy (i.e., IRI) and minimally with a social desirability scale. In this study, the internal consistency estimate for the entire scale was 0.90, which is consistent with alpha coefficient found for the SEE total by Wang, and her colleagues, in 2003. The mean total score and final score endorsed on the SEE was 152.69 and 4.95 respectively.

*Multicultural Counseling Self-Efficacy.*

The Multicultural Self-Efficacy Scale-Racial Diversity Form (MCSE-RD; Sheu & Lent, 2007) measures perceived ability to counsel racially diverse clients and assesses two different types of self-efficacy. These include: content-specific self-efficacy, and

coping self-efficacy (Bandura, 1997). Content-specific self-efficacy is defined as one's confidence in performing fairly routine counseling tasks in a multicultural context while coping self-efficacy is defined as confidence in managing relatively difficult multicultural scenarios. The MCSE-RD is made up of 37 items rated on a 0-9 scale (0=No Confidence; 9=Complete Confidence), with higher scores suggesting more perceived ability to counsel racial/ethnic clients. An exploratory factor analysis retained 37 items for the MCSE-RD scale made up of three factors: Multicultural Intervention (24 items), Multicultural Assessment (6 items) and Multicultural Session Management (7 items). The Multicultural Intervention subscale reflects one's perceived confidence in handling and resolving cross-cultural impasses in therapy. The Multicultural Assessment subscale focuses on one's perceived ability to select culturally appropriate assessment tools according to the client's racial/ethnic background. The Multicultural Session Management subscale taps one's perceived ability to encourage the client to actively participate in the counseling. The results of Lent and Sheu's initial development of the MCSE-RD found support for the reliability and validity of the measure. The MCSE-RD total score obtained an alpha of 0.98 while the alphas of the subscales scores ranged from 0.92 to 0.98. A second-order factor analysis showed support for a single factor solution of multicultural counseling self-efficacy. Discriminant validity was supported by small, non-significant correlations between the MCSE-RD scores and social desirability. Convergent validity was established when the MCSE-RD significantly and positively correlated with the CASES and MCI measures, particularly with the skills subscale of the MCI which is intended to represent the behavioral portion of Sue's tripartite model. The internal consistency estimate for the MCSE-RD total was 0.97, which is consistent with

the alpha coefficient found for the MCSE-RD total by Sheu and Lent, 2007. The mean total score and final score endorsed on the MCSE-RD was 241.40 and 6.57 respectively.

*Demographic Questionnaire.*

The demographic questionnaire was developed for this study (Appendix C). Participants were asked to indicate their gender, age, race/ethnicity, degree sought, program type, year in the program, geographic location of the program, and previous training related to multicultural counseling. Specifically, the trainees were asked to denote if they had taken a semester long multicultural course and if so, to report the exact number. In addition, the participants were asked if they had practicum training with racially/ethnically diverse clients and if so, to report the number of clock hours of direct hours and clock hours of supervision discussing these cases.

# CHAPTER IV

# RESULTS

## *Preliminary Analyses*

The means, standard deviations and intercorrelations were computed for all the measures for all the participants, and these results are presented in Table 2. The mean scores for the measures utilized in the study follow: Multicultural Counseling Self-Efficacy-Racial Diversity Form (MCSE-RD) (M= 6.57, SD=1.03), Scale of Ethnocultural Empathy (SEE) (M=4.95, SD=0.510), and Multicultural Case Conceptualization Ability (MCCA) for the Etiology condition (M= 1.24, SD=1.14) and Multicultural Case Conceptualization Ability for the Treatment condition (M= 1.07, S=1.33). The MCSE-RD and SEE scales do not have comparative scores since these tools have yet to be utilized in other studies. The MCCA (Etiology and Treatment) condition scores can be compared across studies, and are somewhat lower than the mean and standard deviations found in other studies (Constantine & Ladany, 2000; Constantine et al., 2005), (2.04, 1.41; 2.78, 2.30). However, consistent with these studies, the MCCA scores in our study also fell below the midpoint. Further comparison is limited across studies, as many of the previous studies do not report the range in scores obtained by the participants (Constantine 2001a; Constantine & Gunshue, 2003).

In terms of the research question (Table 2), this study examined if a relationship existed between the scores on the multicultural counseling self-efficacy scale (MCSE-RD) and ethnocultural empathy scale (SEE) with the scores of the two conditions of the multicultural conceptualization exercise. (MCCA Etiology and MCCA Treatment).

Results from the zero-order matrix yielded support for a significant, positive yet low correlation only between the SEE and MCCA etiology scores ($r=0.33$, $p < .01$). The independent variables (SEE and MCSE-RD) were significantly, positively and moderately correlated to one another ($r=0.49$, $p < .01$) as were the conditions within the dependent variables in a similar manner ($r=0.52$, $p < .01$).

The first hypothesis proposed that current/previous multicultural training (i.e., multicultural courses and clinical practice) would be positively correlated with more complex case conceptualization ability and higher scores on the MCSE-RD and SEE. Only parts of this hypothesis were supported. Clinical experience, more specifically, number of contact hours with racially/ethnically diverse clients ($r=0.231$, $p < .01$) and supervision hours spent conceptualizing them ($r=0.253$, $p < .01$) were significantly yet minimally correlated to the MCSE-RD scores. No other relationships were found between the training variables and the objective and self-report measure of multicultural counseling competency or ethnocultural empathy

*Main Analyses*

Refer to Tables 3 and 4 for a summary of the two forced-entry regression analyses for the relationship between multicultural counseling self-efficacy, ethnocultural empathy and MCCA etiology and treatment scores after controlling for race/ethnicity, current/past participation in a multicultural course and clinical and supervision hours. In the first analysis with MCCA Etiology scores serving as the criterion variable, the multicultural training variables were not found to contribute significant variance to the MCCA etiology scores $F (5,150) = 2.54$. After taking the variance of these four variables into account, multicultural counseling self-efficacy did not make a significant contribution, $F (1, 149)$

= 2.12, p = .54 in the third step, after accounting for the variability of the demographic and training variables and the multicultural counseling self-efficacy, ethnocultural empathy did not explain additional significant variance F (1, 148) = 4.42, p = 0. Thus after accounting race/ethnicity, previous or current enrollment in a multicultural course and clinical and supervisory experience, multicultural counseling competency and ethnocultural empathy did not account for a significant amount of variance in the first MCCA condition.

The MCCA treatment scores served as the criterion variable in the second forced-entry hierarchical regression analysis. In the first step, race/ethnicity, and the other training variables did not contribute significant variance to the MCCA treatment scores F (5, 150) = 1.13, R squared=0.04, (Adjusted R squared=0.00). After accounting for these control variables, multicultural counseling self-efficacy did not contribute a significant proportion of variance in the MCCA treatment scores F (6, 149) = 1.58. Finally, in the third block of the MHR, after accounting for the variables in the two previously mentioned blocks, ethnocultural empathy did not explain significant variance in the MCCA treatment scores, F (7,148) = 1.72. Thus after accounting race/ethnicity, previous or current enrollment in a multicultural course and clinical and supervisory experience, multicultural counseling competency and ethnocultural empathy, taken together did not account for a significant amount of variance in the second MCCA condition.

# CHAPTER V

# DISCUSSION

The purpose of this study was to build upon previous research of the construct of multicultural counseling competency. Specifically, it sought to contribute to the existing literature by evaluating the role of multicultural counseling self-efficacy and ethnocultural empathy (Lent & Sheu, 2003; Wang, et al., 2007). Methodological limitations in the multicultural counseling competency literature were addressed. In addition, the multicultural case conceptualization task was compared with self-report measures of multicultural counseling self-efficacy and ethnocultural empathy to illustrate the use of these methods of assessment. To achieve these objectives, the current study improved upon the procedural confines of previous studies by investigating multicultural counseling competence through the framework of a more robust construct called, multicultural counseling self-efficacy. Furthermore, the theory of ethnocultural empathy was hypothesized to help explain what other variables may be associated with multicultural counseling competency. These two concepts were examined along with the multicultural case conceptualization ability of psychology trainees from a wide range of master's and doctoral level programs across the U.S. This study also specifically considered the number of multicultural courses as well as number of hours of clinical practice with racially/ethnically diverse clientele and number of hours spent discussing them in supervision. These variables were taken into account when examining what may have influenced the self-report and objective measures of multicultural counseling competency.

*Results for the Research Question*

The results of this study with regards to the original research question and three hypotheses follow below.

The research question asked what the relationship would be amongst the composite scores of the self-reported measures of multicultural counseling self-efficacy and ethnocultural empathy and the coded scores of the two conditions of the multicultural counseling competency ability (MCCA). This study found the two dependent measures scores (MCSE-RD and SEE) and the two independent measures scores (MCCA 1 and MCCA 2) to be significantly, positively and moderately correlated. Additionally, the SEE was found to significantly, positively yet minimally correlate with MCCA 1 (Etiology Condition).

In terms of the existing research the relationship found with the MCSE-RD and SEE is likely as these measures were developed with other measures in the multicultural counseling competency literature. In their initial development study the MCSE-RD was correlated positively with the MCI (Sheu & Lent, 2007) and the SEE was developed with four of the main measures of multicultural counseling competency (MAKSS, MCAS, MCI and CCCI-R) (Wang et al., 2003).

The two conditions (etiology and treatment) of the MCCA tasks were found to be significantly related which is similar to what has been found in the literature in studies conducted by Ladany and his colleagues (1997) with $r= 0.45$, $p < .01$ and Constantine and Ladany (2000) with $r=0.34$, $p < .01$. This relationship seems somewhat intuitive, as a trainee who incorporates cultural factors when formulating the reasons for a client's

problems, would likely also consider these particular facets of the client when deciding how to intervene with the client.

In terms of the last relationship of the first research question, we found SEE scores to be significantly correlated with coded scores on the MCCA 1 (r=0.33) task but not with the MCCA 2 task. Constantine (2001a)'s study shows similar findings of a trainee's endorsed levels of empathy (on the IRI, Perspective Taking and Empathic Concern) scales and his/her ability to conceptualize the etiologies of a client's problems from a multicultural perspective (r=0.27, r=0.47) as well as his/her conceptualization ways to treat the client (r=0.34, r=0.46). Overall, it appears as if endorsed levels of empathy are related to trainees' multicultural conceptualization skills such that those with higher levels of (multicultural/ethnocultural) empathy are better equipped to put him/herself in the client's shoes in terms of understanding the different ways a client of color may have a particular problem. However, when planning their intervention strategies, perhaps they are not as well versed.

However, we did not find the MCSE-RD to be related with any of the MCCA tasks. Unfortunately this relationship has not yet been explored in the existing research. However, if we are conceptualizing multicultural counseling self-efficacy, as a more theoretically strong construct to better explain multicultural counseling competency of psychology trainees then this relationship is somewhat surprising. The counseling psychology literature has found some support for the relationship between self-reported multicultural competency scores of subscales/total scores for the MCCA treatment and etiology conditions such as in Constantine & Ladany, 2000, when using the MAKSS total score r=0.17 (significant at the .05 level) and the MCKAS total score, r=0.19 (significant

at the .05 level) for treatment, and Constantine and her colleagues (2005), when using the CCCI-R (r=0.61 for etiology; r=0.59 for treatment for $p < .01$). In this current study, trainees endorsed moderately high confidence in their beliefs in implementing certain tasks while working with a client of color (MCSE-RD Mean Score=6.57 out of 9.00). Theoretically, trainees who reported these higher levels of multicultural counseling self-efficacy should be more likely to differentiate and integrate racial and ethnic factors into case conceptualizations. However, higher endorsement of self-reported multicultural counseling self-efficacy was not associated in any way with multicultural case conceptualization ability in the etiology and treatment conditions. It is difficult to explain the reasons for the lack of relationships amongst these variables, and has been by researchers who have conducted studies examining these constructs. Consistently though, self-reported MCC scores have not been found to relate to a proposed objective measure of this construct for many hypothesized reasons (i.e., theoretical and psychometric). For the purposes of this study the MCSE-RD was chosen, as it was developed with theoretical roots in social cognitive theory and multicultural counseling competency, specifically examining only the skills component of the tripartite model when counseling a racially/ethnically diverse client. It lends itself to being a better measure of a trainee's beliefs about his/her in session skills. Perhaps though, the trainees' higher self-endorsed self-efficacy did not translate to a better conceptual understanding of how racial factors impact the reasons for a client's problems, and then how to incorporate them into a treatment plan.

*Results for Hypothesis 1*

We only found partial support for our hypothesis that previous and current multicultural training in terms of multicultural courses and clinical practice and supervision would be positively related to a hypothesized objective measure of multicultural case conceptualization, and total scores for the SEE and MCSE-RD. Self-endorsed multicultural counseling competency scores were positively correlated with trainees who had clinical experience and more strongly for those with more contact hours and clinical supervision time discussing their racially/ethnically diverse clientele. This finding has not been specifically investigated using the MCSE-RD but has with other measures of multicultural counseling competency and found evidence which supports these relationships (D'Andrea, 1991; Melchert, 1996; Ponterotto, et al., 1996). In this study, the training variables were not found to be related to the SEE scores or the multicultural case conceptualization conditions' scores. The lack of a relationship between SEE and the training variables may have been due to the fact that most of the trainees were in their 3rd year of school and perhaps they did not have enough experience with culturally diverse clientele yet in graduate school to develop these empathic skills. From another perspective, perhaps ethnocultural empathy levels may not necessarily be related to a trainee's development regarding these variables but may be attributed to interest or exposure to cultural experiences outside of the classroom. The lack of a relationship between the MCCA conditions and these training variables may also be because many of the participants were beginning their graduate career and do not yet have the skill-set to conceptualize a client of color. Interestingly, SEE scores were significantly related to race and ethnicity but not any of the training variables. This finding is expected as ethnically/racially diverse trainees have been found to be more

empathic when treating a client of a color, for instance. Finally, an additional consideration regarding psychometric rigor may be been due to the fact that these variables did not have enough effect size to show a meaningful relationship.

*Results for Hypothesis 2 and 3*

The study hypothesized that multicultural counseling self-efficacy scores would account for the most significant amount of variance when predicting psychology trainees' level of multicultural case conceptualization abilities for the etiology and treatment conditions while controlling for the training variables. Neither of these hypotheses was supported as the study did not find any significant results for either regression analyses. These two measures (MCSE-RD and SEE) have not yet been used together in a study; however, this finding is somewhat surprising. The literature has conjectured that self-efficacy may help explain multicultural counseling competency but it did not in this study, specifically self-reported self-efficacy scores did not add any significant variance when explaining trainees' ability to conceptualize a client of color. Within the literature though, empathy scores have been found to predict a significant amount of variance of a trainee's objective multicultural counseling competency in regression analyses. Constantine (2001a), for example, found empathy as measured by the IRI to account for significant variance in the multicultural case conceptualization etiology and treatment conditions. In this study, participants ranged in age from their mid-twenties to mid-seventies, with the majority of them being White, female, Master's level therapists with 12 years of clinical experience which is somewhat different than the demographics in our study.

*Limitations of Current Study*

*General research design/sample limitations*

General research design limitations included the use of an on-line survey to obtain information from voluntary participants in psychology programs across the U.S. such that self-selection bias may have been present in the sample. Additionally, the participants may have anticipated the details of the study, which influenced the way they completed the instruments and how they performed on the MCCA tasks.

*Self-report measures limitations*

The methodology of this study used self-report measures to gain the perspective of psychology trainees' beliefs about their skills. This approach is subject to many problems widely cited in the psychology literature, which may be prone to resulting in an inaccurate picture of the respondent for a number of reasons (i.e., social desirability, lack of insight, state-dependent). Social desirability needs to be considered in this case, as the sample population of students we gathered information from, presented in a mostly positive light, and did not from what we could gather, report to have difficulties with what many trainees are expected to struggle with during their training years.

*MCCA limitations*

To provide additional convergent validity to this manner (i.e., self-report) of obtaining information from the participant, this study utilized vignettes to prime the respondents to assess their multicultural counseling skills. However, the analogue design may detract from the validity of the study because the vignette is sufficiently different from doing therapy with an actual client. This distinction may have resulted in lower scores, and made the degree of differentiation and integration of the conceptualizations statistically insignificant. Additionally, only intake information was provided about the

client. Therefore, the trainees may not have felt like they had enough data to connect with and help the client with her issues. Such that, with the minimal background perhaps the trainees could not fully assess the client's problem areas related to cultural issues in her current situation. Even if trainees were able to conceptualize this client in a sophisticated manner, those ideas may not necessarily translate into behaviors conducted in therapy. Prior self-efficacy research and behavior has revealed only a moderate relationship between self-efficacy and objective measures of ability (Lent, Brown, & Larkin, 1986).

Another inherent problem with the MCCA task is its scorings system as it is "coded" by two objective individuals who in this study showed fairly high agreement in the score of each response, but may not have been accurate in each of their respective scores for the etiology and treatment conditions. Reexamining the coding system of the MCCA task may be needed as it could impede its scores from showing any kind of significance with any other measures (SEE and MCSE-RD) due to limited (i.e., truncated) range in their coded scores which is concerning. In other words, the MCCA 1 and MCCA 2 average coded scores for this study were 1.24 and 1.07 amongst a range of 0-6. These averages are somewhat but not significantly lower when compared to other computed averages in prior studies, for example, in Constantine's studies cited above, the scores were 2.04, 1.41 and 2.78, 2.30. The low scores of these two conditions is noteworthy, however, the more important point of interest is the limited variability found in this study regarding these scores. Even though the possible range of scores goes from 0 (minimum) to 6 (maximum), there was not as much variance in these scores, such that they all hovered around 0-2, sometimes 3. It seems important to further explore this lack

of variability amongst these scores, to find out how representative a low score is in a lesser-differentiated and integrated multicultural case conceptualization of the client.

*Ethnocultural empathy*

In this study trainees endorsed high levels of ethnocultural empathy. These scores we hypothesized would also help predict MCCA scores in the etiology and treatment conditions. The SEE scores provided additional variance, however, not at a significant level, but worth mentioning, as the percentage from the 2nd to the 3rd regression analysis rose, more drastically in the etiology than the treatment condition. This difference shows that the SEE may be playing more of a role in helping to predict the complexity of multicultural counseling skills of the trainee when understanding the reasons for the client's underlying problems. Our findings are somewhat consistent to what has been found in the limited literature examining the relationship between these two constructs (Constantine 2000, 2001). Of these, the most similar was in Constantine's 2001 study mentioned earlier, which found affective empathy to be significantly related to the etiology component of the multicultural case conceptualization exercise. When isolating these two components of empathy, our study found the MCCA etiology task to be significantly, moderately correlated with SEE scores. Constantine (2000) discusses how this may be due to how the participants in this study (i.e., trainees) felt more equipped to emotionally respond to a racial/ethnic client thus perceiving himself or herself as being more culturally aware. These beliefs in one's ability may translate into a counselor's ability to find all the possible cultural factors, which may be contributing to the client's presenting problems. Ethnocultural empathy then may be conceptualized as a more trait-dependent construct, which is supported in this study as it did not vary with any of the

training variables, but did with race and ethnicity. Specifically, psychologists by personality are more empathic, and are more naturally attuned to aspects about the client (i.e., racism), which may impacts him (i.e., client) or her in society at large. Those with more understanding of racial/ethnic issues are found to be more equipped to working with all types of clients.

*Implications*

In terms of the implications for the study, first and foremost, evidence is needed to substantiate that the MCCA task is actually measuring the construct of multicultural counseling competency, as it has not been found to be consistently relate to self-reported measures of MCC. Specifically examining if it is assessing the skills portion of the tripartite model. Even though it has been accepted as a reputable way of measuring trainees' competency level, as of late, the literature is beginning to question its utility and psychometric properties. The task in one way or another may not be the most salient manner in which to measure the behavioral component of multicultural counseling competency because it cannot fully capture trainees' ability level when seeing a client of color in therapy. This may be due to the notion that the MCCA task is too far removed from an actual or "real life" counseling and is not a reputable replacement. In other words, reading and commenting on a summary of a potential client's intake may make it difficult for a trainee to imagine how it would be to work with him/her over. On the other hand, a trainee may be good at envisioning him/herself as the therapist, and conceptualizing how to work with the client, but these factors may not be at all associated with his/her level of confidence in counseling him/her. From another related perspective, the MCCA may be representative of an advanced skill such that trainees have strong

conceptual skills in general but not when specifically asked to differentiate and integrate information for a client of color. If in fact the MCCA does measure conceptualization skills accurately, then beginning trainees may be overestimating their abilities on the measures and then cannot display those competencies when asked to do so in a case conceptualization exercise. Other reasons may be related to psychometric issues. For example, the scoring system may have not been developed with sufficient robustness so that significance can be found when comparing the scoring from coded scores and the scores from a self-report measure of multicultural competency (Schomburg, 2007). Furthermore, the coders may have inadvertently overestimated or underestimated trainees' demonstrated ability to conceptualize a client of color. Since the scores on the MCCA task were low then it seems important to determine if these are an accurate reflection of the trainees' conceptualization abilities or a function of the measure. If the premise of the MCSE-RD is to predict trainees' competency when working with clients, but does not correlate with scores that are supposed to be a criterion variable it is problematic to the theoretical premise of these two measures.

In regards to the MCSE-RD, it is a newly developed measure and needs additional usage to determine its validity and reliability in assessing this aspect of multicultural counseling competency. It is rooted in self-efficacy and multicultural competency counseling theory, which have been speculated by many researchers within the field of counseling psychology to be similar to each other (Constantine, 2001; Constantine and Ladany, 2000, Worthington, et al, 2000). As cited earlier in the literature review, Constantine (2001), using a self-reported measure of general counseling self-efficacy predicted 30% of variance of a self-reported measure of MCC. In terms of self-efficacy

theory, it is important to consider the postulate that multicultural counseling self-efficacy may be state dependent, such that a trainee may carry high levels of confidence overall but when encountered with a posed challenging client, may have lower levels in his/her ability to counsel the client according to Lent and his colleagues. With this in mind, the majority of the trainees in our study were White and their overall endorsed beliefs were quite confident but perhaps when presented with a Black client these diminished. Another reason that MCCA abilities and the MCSE-RD scores were not related may be due to the training level and experience with diverse cliental of the trainees such that most of the participants in this study were in their 3rd year and may not have accrued enough experience to have the insight into their levels of multicultural counseling self-efficacy thus overestimating their abilities (Schomberg, 2007). Future research may want to assess the aforementioned ideas before further research is conducted to predict future behavior on the MCCA task from self-reported measures of competency.

*Future Directions*

The field of multicultural counseling competency (MCC) continues to rely on early researchers' operationalized definition of this construct. These visionaries were before their times and as a result many assessment tools came out of their research. However, since then, after further appraisal these products were questioned for their ability to measure MCC effectively. Thus, the field has been encouraged to ground the theory on a more substantial foundations and one of the main thoughts is to use self-efficacy theory. In addition to this, it seems important to investigate, through quantitative and qualitative research, what other facets may make up multicultural counseling competency such as empathy, which was hypothesized in this study. In the regression

analysis empathy was found to add more variance in predicting the case conceptualization piece than self reported multicultural counseling self-efficacy. To obtain a better perspective of multicultural counseling competency, another manner of measurement for these could provide information about how trainees recognize and address racial issues as a therapist. For example, color blindness may be another variable of interest in clarifying the relationship between multicultural training and counseling competencies. Another future direction in need of more thorough consideration is for supervisors/advisors to understand how a trainee's MCC develops over time. There are studies, which hypothesize the knowledge, or the cognitive aspect must be acquired first, then awareness and finally the skills portion (LaFrombroise, 1991). Thus, it may be more important to examine each of these areas separately, which has been the recent thought in the literature and test each one at different times in trainees' development. As speculated in this study, perhaps if a trainee has the knowledge but not the awareness thus resulting in a lack of skill then he/she may not endorse an accurate picture of his/her competency level. Another hypothesis and area of little but somewhat debated research is the notion that multicultural counseling competency may be part or a higher application of general counseling competency skills (Coleman, 1998; Pedersen, 1991). All of these areas are worth examining to help strengthen the empirical research in multicultural counseling competency.

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# APPENDIX A

## BODY OF EMAIL TO TRAINING DIRECTIONS

Month Day, 2009

Dear Training Director,

Hello! My name is Sharon and I am a doctoral student at The University of Houston. I am emailing you this afternoon to ask your permission to post my dissertation recruitment document (please see below) on your Counseling Psychology listserv. Specifically, I would like to recruit Counseling Psychology doctoral students from your program. If you have any questions, or would like to view my human subjects approval document. please let me know. I look forward to hearing from you.

Thank you for your time.

Sincerely, Sharon (shar003@hotmail.com)

## PARTICIPANT LETTER OF PARTICIPATION AND INFORMED CONSENT

Month Day, 2009

Dear Student,

Hello. My name is Sharon Singh and I am doctoral Counseling Psychology candidate at the University of Houston and collecting data for my dissertation which is examining the perception of Counseling, and Counseling/Clinical Psychology trainees when working with potential clients. My doctoral advisor, Dr. Nicole Coleman, is supervising this project and The University of Houston Committee for the Protection of Human Subjects (713) 743-9204 has reviewed and approved my study.

If you are currently enrolled in a master's in Counseling or an APA-accredited doctoral Counseling or Clinical Psychology program, I would really like you to participate in my study. Your participation is completely voluntary and confidential. There is minimal to no risk involved in this study. The maximum time needed to complete the entire survey is approximately thirty-five minutes, which includes completing two measures and a short demographic questionnaire.

If you are interested in participating you can access the survey by right clicking this link:

https://www.surveymonkey.com/s.aspx?sm=bN86SlQYPYWAZA6SlMIrBw_3d_3d

Please consider being a part of this study as it will add to the literature and potentially help the training of counseling and psychology students. If you have any questions or concerns, please do not hesitate to email me at shar003@hotmail.com. Thank you in advance for your participation.

Sincerely,

Sharon Singh, B.A.
Doctoral Candidate, Department of Educational Psychology
University of Houston

# APPENDIX B

# MULTICULTURAL CASE CONCEPTUALIZATION VIGNETTES

**Please read this intake case vignette while imagining that you will be the therapist assigned to this client and then answer the two questions below.**

Tracey is a 22 year-old, single African American female who is seeking counseling at her university-counseling center in a predominately-White university in Iowa. She presents with the following symptoms over the past month: sad mood, tearfulness, decreased concentration, sleep difficulties, and mild suicidal ideation with no reported intent. Tracey is the oldest child in her family and has two siblings. Her parents have been married for twenty-nine years and they and her siblings live in Arizona. Tracey reports visiting her family and close friends about two times during the semester. Tracey also reports having started a "new, demanding and intense" semester as a senior. She has lived in her current apartment near campus for three years. Tracey has one close African American friend who moved to town over a year ago and who lives less than one mile from her. Tracey reports seeing her friend about every two weeks, typically over a few "social" drinks at a local bar near her apartment. She denies excessive alcohol use and reports no current or previous drug usage. She states that she does not interact much with people at her university because of their "different interests" and describes them as "interpersonally" distant but "pleasant." According to Tracey, her friend noticed recent changes in her affective disposition and encouraged Tracey to seek counseling at this time. This is Tracey's first counseling experience. With the information gathered, the intake counselor determined that Tracey meets the DSM-IV criteria for an Adjustment Disorders with Depressed Mood.

1. Please write a conceptualization of at least three sentences in length describing what you believe are the factors contributing to the etiology or origin of Tracey's current difficulties.

2. Please write a conceptualization of at least three sentences in length describing what you believe should be the treatment focus or foci to address Tracey's current difficulties.

# APPENDIX C

# QUALITATIVE EXEMPLARS OF PARTICIPANTS' RESPONSES TO MCCA VIGNETTES

EXAMPLES of SCORES OF 0, 3, AND 6 (by both coders) for ETIOLOGY AND TREATMENT CONDITIONS ON THE MCCA EXERCISE:

**ETIOLOGY:**

SCORE: 0

I believe that the client is showing the symptoms of depression. She obviously feels lonely, with only one friend and few ties to her classmates. The issues of senior year are complicating matters.

SCORE: 3

Based on the history presented, it would appear that Tracey's symptoms could be caused by a combination of "new, demanding and intense" stressors and a lack of easily available social support. If Tracey is an African American female from a far away place who only has one African American friend in a small school that is predominately White, it is very possible that Tracey feels isolated and uncomfortable in her surroundings. It is also very likely that she possesses solid ego strength and a healthy self-concept, because it is only after experiencing the stress of a difficult semester that Tracey has begun to display symptoms of psychological impairment.

SCORE: 6

No vignettes were given a score of 6.

**TREATMENT:**

SCORE: 0

Tracey should first receive a physical from her doctor to determine if there is a need for medication. Then I would focus on Tracey's feelings of isolation and mild suicidal ideation. She certainly should be encouraged to participate and interact more fully with fellow students.

SCORE: 3

Two examples are provided, as there was no agreement on any responses coded a 3.

The focus of the treatment would be on the issues of connectiveness with the university environment and possibly her racial identity and how she is dealing with her racial minority status. In addition, a strength-based approach to helping her cope would also be a treatment focus.

Using interpersonal psychotherapy, cognitive behavioral therapy, and person focused therapies as sources of conceptualization; I believe that the major focus of treatment should be to form a solid therapeutic alliance with Tracey to enable her to feel less emotionally isolated and to enable her actualizing potential to begin. I would recommend spending some time attempting to find out what factors are contributing to Tracey's stress and try to find out if she experienced similar behavior in the past and if so what she did to help herself. As a white male therapist, I would recommend carefully assessing Tracey to find out if she is feeling particularly isolated due to being an African American woman at a predominately White university. I would want to know if part of her problem is that she does not have any female companions (the gender of her friend was never mentioned) and use this information to help Tracey find social organizations to join. I would use the therapeutic alliance to determine if Tracey has any interpersonal issues that are contributing to her social isolation.

SCORE: 6

Because I am not an African-American and am a male, I would make sure to explore her comfort in working with someone not of her race or gender. If comfortable I would focus on helping Tracy become aware of her primary emotional experience of loneliness. It would be important to discuss the personal impact/implications of being a racial and cultural minority with limited support. In addition, exploration of transference and counter-transference issues would need to be explored (with emphasis to race/cultural difference). Finally, I would encourage Tracy to explore the existence of African-American or multicultural groups on campus/in the community. Tracy's difficulties would likely become less problematic if she were able to become aware of her feelings and relate them to her (presumed) need to connect with a group of culturally similar peers.

# APPENDIX D

# DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

Please answer all of the questions as accurately as possible.

(1) Gender (please circle): Male or Female

(2) Age (years): _____

(3) Race (please circle):
- (a) Black
- (b) White
- (c) Asian/Pacific Islander
- (d) Latino/a
- (e) Multiracial
- (f) Other: Please specify: _____

(4) Degree (please circle):
- (a) Master's
- (b) Ph.D.
- (c) Psy.D.

(5) Program Type (please circle):
- (a) Counseling
- (b) Counseling Psychology
- (c) Clinical Psychology

(6) Year in program (please fill in): _____

(7) Location of your program (please circle):
- (a) Northeast
- (b) Southeast
- (c) Midwest
- (d) Southwest
- (e) West

(8) Previous training related to multiculturalism

(a) Have you taken a semester long multicultural course?

Yes or No (please circle one)

(b) If Yes, How many courses have you taken? Please indicate: _____

(c) Are you currently engaged in or have you completed a supervised practicum working with a racially/ethnically diverse population (i.e., Black, Asian, Latino/a)

Yes or No (please circle one)

(1) If so, please estimate the number of direct contact hours with racially/ethnically diverse clients (please choose one):
- (a) 1-5

(b) 6-20
(c) 21-50
(d) 50+

(2) If so, please also estimate the number of hours spent in supervision discussing these clients (please choose one):
(a) 1-5
(b) 6-20
(c) 21-50
(d) 50+

# APPENDIX E

# MULTICULTURAL COUNSELING SELF-EFFICACY SCALE-RACIAL IDENTITY FORM

Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSE-RD) Copyright 2004 by H. Sheu and R. W. Lent

Instructions: The following questionnaire consists of 37 items asking about your perceived ability to perform different counselor behaviors in individual counseling with clients who are racially different from you. Using the 0-9 scale, please indicate how much confidence you have in your ability to do each of these activities at the present time, rather than how you might perform in the future. Please circle the number that best reflects your response to each item.

| No Confidence at all | | | Some Confidence | | | | Complete Confidence | | |
|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

When working with a client who is racially different from yourself, how confident are you that you could do the following tasks effectively over the next week?

1. Openly discuss cultural differences and similarities between the client and yourself.

2. Address issues of cultural mistrust in ways that can improve the therapeutic relationship.

3. Help the client to articulate what she or he has learned from counseling during the termination process.

4. Where appropriate, help the client to explore racism or discrimination in relation to his or her presenting issues.

5. Keep sessions on track and focused with a client who is not familiar with the counseling process.

6. Respond effectively to the client's feelings related to termination (e.g., sadness, feeling of loss, pride, relief).

7. Encourage the client to take an active role in counseling.

8. Evaluate counseling progress in an on-going fashion.

9. Identify and integrate the client's culturally specific way of saying good-bye in the termination process.

10. Assess the client's readiness for termination.

11. Select culturally appropriate assessment tools according to the client's cultural background.

12. Interpret standardized tests (e.g., MMPI-2, Strong Interest Inventory) in ways sensitive to cultural differences.

13. Deal with power-related disparities (i.e., counselor power versus client powerlessness) with a client who has experienced racism or discrimination.

14. Use non-standardized methods or procedures (e.g., card sort, guided fantasy) to assess the client's concerns in a culturally sensitive way.

15. Take into account the impact that family may have on the client in case conceptualization.

16. Assess relevant cultural factors (e.g., the client's acculturation level, racial identity, cultural values and beliefs).

17. Take into account cultural explanations of the client's presenting issues in case conceptualization.

18. Repair cross-cultural impasses that arise due to problems in the use or timing of particular skills (e.g., introduce the topic of race into therapy when the client is not ready to discuss).

19. Conduct a mental status examination in a culturally sensitive way.

20. Help the client to develop culturally appropriate ways to deal with systems (e.g., school, community) that affect him or her.

21. Manage your own anxiety due to cross-cultural impasses that arise in the session.

22. Assess culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness).

23. Help the client to set counseling goals that take into account expectations from her or his family.

24. Help the client to identify how cultural factors (e.g., racism, acculturation, racial identity) may relate to his or her maladaptive relational patterns.

25. Manage your own racially or culturally based countertransference toward the client (e.g., over- identification with the client because of his or her race).

26. Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstanding or impasses.

27. Assess the salience and meaningfulness of culture/race in the client's life.

28. Take into account multicultural constructs (e.g., acculturation, racial identity) when conceptualizing the client's presenting problems.

29. Help the client to clarify how cultural factors (e.g., racism, acculturation, racial identity) may relate to her or his maladaptive beliefs and conflicted feelings.

When working with a client who is racially different from yourself, how confident are you that you could do the following tasks effectively over the next week?

30. Respond in a therapeutic way when the client challenges your multicultural counseling competency.

31. Admit and accept responsibility when you, as the counselor, have initiated the cross-cultural impasse.

32. Help the client to develop new and more adaptive behaviors that are consistent with his or her cultural background.

33. Resolve misunderstanding with the client that stems from differences in culturally based style of communication (e.g., acquiescence versus confrontation).

34. Remain flexible and accepting in resolving cross-cultural strains or impasses.

35. Treat culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness).

36. Help the client to utilize family/community resources to reach her or his goals.

37. Deliver treatment to a client who prefers a different counseling style (i.e., directive versus non-directive).

# APPENDIX F

# SCALE OF ETHNOCULTURAL EMPATHY

Scale of Ethnocultural Empathy (SEE)

Please respond to each item using the following scale:

| 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|
| Strongly Disagree | Moderately Disagree | Slightly Disagree | Slightly Agree | Moderately Agree | Strongly Agree |

1. I feel annoyed when people do not speak Standard English.

2. I don't know a lot of information about important social and political events of racial and ethnic groups other than my own.

3. I am touched by movies or books about discrimination issues faced by racial or ethnic groups other than my own.

4. I know what it feels like to be the only person of a certain race or ethnicity in a group of people.

5. I get impatient when communicating with people from other racial or ethnic backgrounds, regardless of how well they speak English.
6. I can relate to the frustration that some people feel about having fewer opportunities due to their racial or ethnic backgrounds.

7. I am aware of institutional barriers (e.g., restricted opportunities for job promotion) that discriminate against racial or ethnic groups other than my own.

8. I don't understand why people of different racial or ethnic backgrounds enjoy wearing traditional clothing.

9. I seek opportunities to speak with individuals of other racial or ethnic backgrounds about their experiences.

10. I feel irritated when people of different racial or ethnic background speak their language around me.

11. When I know my friends are treated unfairly because of their racial or ethnic backgrounds, I speak up for them.

12. I share the anger of those who face injustice because of their racial and ethnic backgrounds.

13. When I interact with people from other racial or ethnic backgrounds, I show my appreciation of their cultural norms.

14. I feel supportive of people of other racial and ethnic groups, if I think they are being taken advantage of.

15. I get disturbed when other people experience misfortunes due to their racial or ethnic background.

16. I rarely think about the impact of a racist or ethnic joke on the feelings of people who are targeted.

17. I am not likely to participate in events that promote equal rights for people of all racial and ethnic backgrounds.

18. I express my concern about discrimination to people from other racial or ethnic groups.

19. It is easy for me to understand what it would feel like to be a person of another racial or ethnic background other than my own.

20. I can see how other racial or ethnic groups are systematically oppressed in our society.

21. I don't care if people make racists statements against other racial or ethnic groups.

22. When I see people who come from a different racial or ethnic background succeed in the public arena, I share their pride.

23. When other people struggle with racial or ethnic oppression, I share their frustration.

24. I recognize that the media often portrays people based on racial or ethnic stereotypes.

25. I am aware of how society differentially treats racial or ethnic groups other than my own.

26. I share the anger of people who are victims of hate crimes (e.g., intentional violence because of race or ethnicity).

27. I do not understand why people want to keep their indigenous racial or ethnic cultural traditions instead of trying to fit into the mainstream.

28. It is difficult for me to put myself in the shoes of someone who is racially and/or ethnically different from me.

29. I feel uncomfortable when I am around a significant number of people who are racially/ethnically different than me.

30. When I hear people make racist jokes, I tell them I am offended even though they are not referring to my racial or ethnic group.

31. It is difficult for me to relate to stories in which people talk about racial or ethnic discrimination they experience in their day-to-day lives.

Table 1
Means, Standard Deviations, Ranges and Intercorrelations of Demographic Variables in Study

| | M | SD | Range | Minimum | Maximum |
|---|---|---|---|---|---|
| Year | 3.03 | 1.60 | 1-7 | - | - |
| Race | 1.32 | 1.01 | 0-6 | - | - |
| Gender | 0.17 | 0.38 | 0-1 | - | - |
| M. Course | 1.82 | 0.39 | 1-2 | - | - |
| Number | 1.46 | 1.57 | 0-15 | - | - |
| Experience | 1.73 | 0.45 | 1-2 | - | - |
| C. Hours | 2.28 | 1.60 | 0-4 | - | - |
| S. Hours | 1.67 | 1.30 | 0-4 | - | - |
| MCSE-RD | 6.52 | 1.05 | - | 4.00 | 8.97 |
| SEE | 4.93 | 0.52 | - | 3.03 | 5.87 |
| MCCA 1 | 1.24 | 1.13 | 0-5 | - | - |
| MCCA 2 | 1.07 | 1.33 | 0-6 | - | - |

*Note*. Race: Black=0, White=1, Asian=2, Multiracial=3, Other=4, Hispanic=5, and Native American=6; Gender: Female=0, Male=1; M. Course=Multicultural Course, 1=No, 2=Yes, Number=Number of Multicultural Courses; Experience=Multicultural Clinical Experience, 1=No, 2=Yes; C. Hours=Clinical Hours, and S. Hours=Supervision Hours, 0-no hours, 1=1-5 hours, 2=6-20 hours, 3=21-50 hours, and 4=50+ hours. Example: S. Hours=1.67(between 1-5 and 6-20 hours), M. Course=1.82 (most taken a Multicultural Course).

Table 2
Intercorrelations of the MCSE-RD, SEE, MCCA Etiology and MCCA Treatment, and relevant demographic variables

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 MCSE-RD | 1 | .49** | .08 | -.12 | .25** | .23** | .22** | .02 | .19* | .16* |
| 2 SEE | .49** | 1 | .33** | .08 | .13 | .09 | .08 | .14 | .21** | .23** |
| 3 MCCA-E | .08 | .33** | 1 | .52** | .14 | .09 | .08 | .14 | .04 | .18* |
| 4 MCCA-T | -.12 | .08 | .52** | 1 | .01 | .00 | .02 | .03 | .08 | .19* |
| 5 S. Hours | .25** | .13 | .14 | .01 | 1 | .86** | .76** | .50** | .05 | -.02 |
| 6 C. Hours | .23** | .09 | .09 | .00 | .86** | 1 | .87** | .50** | -.03 | -.06 |
| 7 Experience | .22** | .08 | .08 | .02 | .76** | .87** | 1 | .45** | .00 | -.06 |
| 8 Year | .19* | .14 | .14 | .03 | .50** | .50** | .45** | 1 | .12 | .03 |
| 9 Ethnicity | .16* | .21** | .04 | .08 | .05 | -.03 | 0.00 | .12 | 1 | .48** |
| 10 Race | .09 | .23** | .18* | .19* | -.02 | -.06 | -.04 | .03 | .48** | 1 |

*Note.* 1= Multicultural Self-Efficacy, Racial Diversity Form (MCSE-RD); 2= Scale of Ethnocultural Empathy (SEE); 3= Multicultural Case Conceptualization Ability (MCCA) etiology; 4= MCCA treatment, 5=Supervision Hours, 6=Clinical Hours, 7=Clinical Experience, 8=Year in Graduate School, 9=Ethnicity of Trainee, and 10=Race of Trainee
*Significant at $p < .05$, **$p < .01$.

Table 3
Summary of the Forced-Entry Multiple Regression Analysis for Variables Predicting MCCA Etiology Scores (N=156)

| | Model 1a | | | Model 2b | | | Model 3c | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | *B* | *SE B* | *β* | *B* | *SE B* | *β* | *B* | *SE B* | *β* |
| Race | 0.23 | 0.10 | 0.21 | 0.23 | 0.10 | 0.21 | 0.17 | 0.10 | 0.15 |
| Ethnicity | -0.06 | 0.08 | -0.07 | -0.06 | 0.08 | -0.07 | -0.08 | 0.08 | -0.09 |
| MC Course | 0.41 | 0.24 | 0.14 | 0.24 | 0.24 | 0.14 | 0.38 | 0.23 | 0.13 |
| CH | -0.11 | 0.11 | -0.16 | -0.11 | 0.11 | -0.16 | -0.97 | 0.11 | -0.14 |
| SH | 0.23 | 0.14 | 0.27 | 0.23 | 0.14 | 0.26 | 0.21 | 0.13 | 0.24 |
| MCSE-RD | | | | 0.25 | 0.09 | 0.02 | -0.16 | 0.10 | -0.14 |
| SEE | | | | | | | 0.81 | 0.12 | 0.36 |

*Note*. MC Course=Multicultural Course, CH=Clinical Hours, SH=Supervision Hours, MCSE-RD=Multicultural Self-Efficacy Scale-Racial Identity Form, and SEE=Scale of Ethnocultural Empathy; a. Predictors: (Constant), MC Course, Race, S. Hours, Ethnicity, C. Hours, b. Predictors: (Constant), MC Course, Race, S. Hours, Ethnicity, C. Hours, Total MCSE-RD, c. Predictors: (Constant), MC Course, Race, S. Hours, Ethnicity, C. Hours, Total MCSE-RD, Total SEE, d. Total I Average (Etiology Scores).

Table 4
Summary of the Forced-Entry Multiple Regression Analysis for Variables Predicting MCCA Treatment Scores (N=156)

| | Model 1 | | | Model 2 | | | Model 3 | | |
|---|---|---|---|---|---|---|---|---|---|
| Variable | *B* | *SE B* | *β* | *B* | *SE B* | *β* | *B* | *SE B* | *β* |
| Race | 0.25 | 0.12 | 0.19 | 0.26 | 0.12 | 0.12 | 0.23 | 0.12 | 0.17 |
| Ethnicity | -0.01 | 0.10 | -0.01 | 0.01 | 0.10 | 0.01 | 0.00 | 0.10 | 0.00 |
| MC Course | 0.11 | 0.29 | 0.03 | 0.15 | 0.29 | 0.04 | 0.14 | 0.28 | 0.04 |
| CH | 0.00 | 0.14 | 0.00 | 0.01 | 0.14 | 0.01 | 0.02 | 0.14 | 0.02 |
| SH | 0.01 | 0.17 | 0.01 | 0.04 | 0.17 | 0.04 | 0.03 | 0.16 | 0.03 |
| MCSE-RD | | | | -0.21 | 0.11 | -0.16 | -0.30 | 0.12 | -0.23 |
| SEE | | | | | | | 0.38 | 0.24 | 0.15 |

*Note*. MC Course=Multicultural Course, CH=Clinical Hours, SH=Supervision Hours, MCSE-RD=Multicultural Self-Efficacy Scale-Racial Identity Form, and SEE=Scale of Ethnocultural Empathy; a. Predictors: (Constant), MC Course, Race, S. Hours, Ethnicity, C. Hours, b. Predictors: (Constant), MC Course, Race, S. Hours, Ethnicity, C. Hours, Total MCSE-RD, c. Predictors: (Constant), MC Course, Race, S. Hours, Ethnicity, C. Hours, Total MCSE-RD, Total SEE, d. Total I Average (Etiology Scores).