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Psychotherapy Task-Based Assessment of Therapists' Multicultural Orientation: A Measurement Development Study

Abstract

Multicultural competencies (MCCs) have laid the foundation for therapists and researchers to strongly consider culture as an important factor in psychotherapy. More recently, Owen (2013) developed the multicultural orientation framework (MCO) to better explicate the MCCs for psychotherapy. The purpose of this dissertation was to develop a Multicultural Orientation Performance Task (MCO-PT) and coding system with therapists-in-training. For the MCO performance task, participants responded to eight brief simulated therapy situations that centered on the intersection of various cultural identities. Responses were recorded and coded for multicultural orientation. Prior to administration, vignettes were vetted by experts in the field. Approximately 100 graduate and undergraduate participants participated in this study. The results from participants' coded MCO-PT were used to establish construct and concurrent validity for the measure. Additionally, participants' results from the coded MCO-PT were compared to the following measures: the Color Blind Racial Attitudes Scale (CoBRAS), Dehumanization Scale, Interpersonal Reactivity Index (IRI), and the Balanced Inventory of Desirable Responding (BIDR). This study was on one of the first performance multicultural measures for therapists. The data from this study will help inform therapists-in-training of their multicultural orientation and areas for growth before heading into the profession.

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A measurement development study

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In Partial Fulfillment

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by

Shaakira Haywood Stewart

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Advisor: Jesse Owen, PhD

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ABSTRACT

Multicultural competencies (MCCs) have laid the foundation for therapists and researchers to strongly consider culture as an important factor in psychotherapy. More recently, Owen (2013) developed the multicultural orientation framework (MCO) to better explicate the MCCs for psychotherapy. The purpose of this dissertation was to develop a Multicultural Orientation Performance Task (MCO-PT) and coding system with therapists-in-training. For the MCO performance task, participants responded to eight brief simulated therapy situations that centered on the intersection of various cultural identities. Responses were recorded and coded for multicultural orientation. Prior to administration, vignettes were vetted by experts in the field. Approximately 100 graduate and undergraduate participants participated in this study. The results from participants' coded MCO-PT were used to establish construct and concurrent validity for the measure. Additionally, participants' results from the coded MCO-PT were compared to the following measures: the Color Blind Racial Attitudes Scale (CoBRAS), Dehumanization Scale, Interpersonal Reactivity Index (IRI), and the Balanced Inventory of Desirable Responding (BIDR). This study was on one of the first performance multicultural measures for therapists. The data from this study will help inform therapists-in-training of their multicultural orientation and areas for growth before heading into the profession.

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TABLE OF CONTENTS

Chapter One: Introduction	1
Multicultural Orientation	15
Cultural Humility	16
Cultural Opportunities	19
Cultural Comfort.....	21
Chapter Two: Method.....	38
Participants.....	38
Procedures.....	39
Measures	41
Hypotheses.....	47
Chapter Three: Results.....	49
Preliminary Analysis.....	49
Primary Research Questions	51
Chapter Four: Discussion	63
Implications of Theory, Research, and Practice	74
Limitations	76
Recommendations for Future Directions	77
References.....	79
Appendices.....	92
Appendix A.....	92
Appendix B.....	94
Appendix C.....	96
Appendix D.....	98
Appendix E.....	102

LIST OF TABLES

Chapter Three: Results.....	49
Table 1. Intraclass Correlation among Coding Teams.....	50
Table 2. Total Variance Explained	53
Table 3. Factor Loadings Based on a Principal Components Analysis with Oblimin Rotation for 21items	54
Table 4. Multicultural Counseling Inventory Correlations.....	56
Table 5. Interpersonal Reactivity Index-Brief Form.....	57
Table 6. Color-Blind Racial Attitudes Scale Correlations.....	59
Table 7. Dehumanization Scale Correlations.....	60
Table 8. Balanced Inventory of Desirable Responding	62

CHAPTER ONE: INTRODUCTION

Psychologists have a strong history of emphasizing the importance of multiculturally competent psychotherapy to reduce disparities in mental health treatment for minorities (Benish, Quintana & Wampold, 2011; Huey et al., 2014; Sue et al., 1982; Sue, Arredondo, & McDavis, 1992; Vasquez, 2010; Whaley & Davis, 2007).

Discrimination and racism have been deeply rooted in the foundation of the United States since its inception. These roots forcefully hold the foundation of many U.S. institutions. Civil rights leaders and social activists have been attempting to break down the roots of discrimination and racism for centuries, but most notably during the Civil Rights Movement. Many civil rights activists increased the number of nonviolent protest and civil disobedience to fight for equal rights and bring about change for many marginalized identities. Hundreds of minority psychologists were involved in the battle to create equality for themselves and the greater community they served. As diversification in the U.S. was on the rise in the 20th century, many psychologists were not prepared to competently work with the increasingly diverse population. Multiculturalism continues to be an important conversation as clients and therapists in the field become more diverse. Multicultural competencies were developed by a group of psychologists that have been in the forefront of social justice issues, wanting to fill the void of multiculturalism in the field, and shift from the standard conceptualization of culturally diverse clients (Arredondo et al., 1996; Pedersen, 1994; Sue et al., 1982; Sue, Arredondo, & McDavis,

1992). These individuals sought to break down the barriers set forth to hinder minorities' growth and advancement in America. In the pursuit and development of cross-cultural competencies, Sue et al. organized three characteristics that personify a culturally competency: cultural awareness, knowledge, and skills (Sue, Arredono, & McDavis, 1992).

Cultural awareness refers to the attitudes and beliefs about individuals from minority and marginalized backgrounds. This is based on the need to check biases and stereotypes, develop a positive orientation towards multiculturalism, and the way one's values and biases may hinder effective cross-cultural therapy. For example, culturally aware therapists are actively and constantly under self-evaluation (e.g., aware of their own assumptions, values and biases). Additionally, these therapists understand their own worldview and they are comfortable with differences that exist between themselves and clients. Ideally, therapists with this level of self-awareness are also able to recognize their limits of expertise and competencies (Sue, Arredono & McDavis, 1992). In a study examining multicultural counseling competencies, researchers Chao, Wei, Good and Flores (2010) further explored multicultural training and its impact on multicultural competencies and color-blind racial attitudes. The results from this study describe a unique interaction between racial/ethnic minorities, training level and multicultural awareness. Specifically, at lower levels of multicultural training, racial/ethnic minority trainees demonstrated higher levels of multicultural awareness compared to their White counterparts (Chao, Wei, Good & Flores, 2010). On the contrary, results also reveal that White trainees who receive higher levels of multicultural training, demonstrated higher

levels of multicultural awareness. The results from this study not only highlight the disparity in multicultural awareness between trainees, but demonstrates the ability for multicultural awareness to be increased.

Therapists' cultural knowledge refers to their specific knowledge of cultural groups and their understanding of systemic influences (e.g., oppression). Culturally competent therapists seek expertise in minority culture, history, traditions and values. These therapists engage in learning about their own worldview and understand systemic issues that greatly impact clients of color. They possess knowledge and understanding about racism, power, privilege, oppression, discrimination and stereotyping (Sue et al., 1992). Knowledge is an integral aspect of competence, which ideally leads to deeper client understanding and perspective-taking. For example, Budge (2015) conducted a study that highlighted the gatekeeping role of psychotherapists when helping transgender clients with their medical transition process. In this evidence-based case study, the client reported improvements in mental health, support and identity development across all measures from baseline to termination. The client, pseudonym Lia, reported two important aspects of the letter-writing process: (a) having a therapist who knew the process well made it easy and (b) having a mental health diagnosis was considered to be a barrier (Budge, 2015). This article points to the importance of knowledge when working with minority clients.

Lastly, skills within the MCC framework refers to the specific interventions and strategies used to work with minorities. A culturally competent therapist demonstrates skill by utilizing cross-cultural interventions. To demonstrate skills within the MCC

framework, a therapist may use culturally adapted CBT for Latinos. For example, a therapist using culturally adapted treatment for Latinos could integrate values such as *familismo*, *machismo* or *marianismo* into their conceptualization and practice. Recently, a randomized clinical trial (RCT) was conducted to explore the efficacy of culturally adapted group treatment of substance abuse for Latino adolescents (Burrow-Sánchez, J.J., Minami, T., & Hops, H, 2015). Contrary to what prior research suggest, the results indicate that culturally adapted treatment was not more effective than standard treatment; however, there was a positive gain for clients who had a strong ethnic identity. Another study explored public child welfare workers and their perceptions of efficacy relative to multicultural awareness, knowledge and skills. Two-hundred and sixty case managers and supervisors were administered the Multicultural Awareness, Knowledge and Skills Survey (MAKSS) to measure their multicultural competencies. Regarding workers' perception of multicultural skills, results indicate that a large number do not perceive themselves as having the awareness, skills and ability to provide multicultural services, not being able to handle biases and prejudices directed toward them (Williams, Nichols & Williams, 2013). When asked, "A potential negative consequence of gaining information about a specific culture is stereotyping members of the cultural group," 43% agreed. When asked, "Psychological problems vary with the culture of the client," 44% agreed. A limitation of this study was the utilization of percentage frequency as the sole means of data analysis, however, these findings imply that the perception and use of multicultural skills do not contribute to the efficacy of treatment for minorities.

How multicultural competencies are translated into psychotherapy has been more difficult to elucidate. Traditionally, psychotherapy is a form of healing that occurs between one person and another. The healing process is diverse and rooted in a cultural context. Many cultural groups heal in various ways (e.g., shaman, medicine man, medication) and healing occurs within those contexts. Although the conventional approach to psychotherapy is appropriate for those in the dominant cultural groups within North America and Western Europe, it may be culturally inappropriate for various minority groups. In other words, psychotherapy should be congruent with client's cultural beliefs to be effective (Frank & Frank, 1993). Without an "illness," the psychotherapy healing process often times cannot occur. Effective psychotherapies offer adaptive explanations of the client's suffering and provide therapeutic actions consistent with those adaptive explanations (Frank & Frank, 1993). From this perspective, four essential psychotherapy components are necessary for healing: (1) a confiding relationship with a culturally recognized and sanctioned healer, (2) a context and/or setting distinguished from the ordinary, (3) a rationale or myth providing a plausible explanation for the illness, and (4) a ritual or intervention believed by both to be effective means of restoring health (Dow, 1986; Frank & Frank, 1993). Accordingly, cultural processes are inherently intertwined with healing. There are four general ways that multicultural competencies have been explored.

Multicultural Competencies Could Be Seen as Culturally Adapted Treatments

Cultural adaptation refers to active integration of culture into therapeutic interventions. There are several notable multicultural studies that have influenced

psychotherapy research. Benish et al. (2011) conducted a meta-analysis of published and unpublished studies ($n=21$) to further investigate the efficacy of culturally adapted psychotherapy and the impact of myth adaptation on outcomes. Myth adaptation refers to treatment that adapts a client's' belief of symptoms, etiology, course, and consequences (Benish et al., 2011). Procedurally, researchers coded whether the 21 studies adapted treatments on the basis of the myth. The results of this study suggest that culturally adapted psychotherapy produces far better outcomes for racial/ethnic minorities over conventional psychotherapy. This outcome was moderated solely by cultural adaptations of illness myth. In this study, no other variable moderated the improved outcomes (Benish et al., 2011). The results of this particular study affirm the importance of culturally modified psychotherapy and shows that it is more effective than unmodified treatment as usual, psychotherapy. Contrary to what previous literature supports, some research suggest that psychotherapy is generally effective with ethnic minorities, and treatment effects are robust across cultural groups and diagnoses. Huey et al. (2014) conducted a large review on the role of cultural competence when implementing evidence-based treatments (EBTs). This review is significant for its critical summary of cultural competence and evidence-based treatments over time. Results from this article demonstrate that psychotherapy is mostly effective for racial and ethnic minorities across symptomatology and cultural group. Additionally, culturally adapted treatments are mostly effective, but there is no evidence to suggest they should be used over standard treatment. Perhaps there is something greater than knowledge and skill that contribute to the efficacy of treatment for minorities. Further, a meta-analysis was conducted to

examine whether culturally adapted treatment was effective for ethnic minorities with depression and anxiety (van Loon et al., 2013). The total pooled effect size for the 9 studies included demonstrated an overall significant effect ($d=.51$). The results suggest that culturally adapted treatments that target anxiety ($d=1.73$) are more effective than those targeting depression ($d=0.35$). Another interesting finding shows that Asian Americans ($d=1.48$) had better outcomes compared to Latino Americans ($d=.58$). Among 6 of those studies, only 5 had a control or comparison group. The results from this meta-analysis show that culturally adapted treatments are generally effective for clients of color, however, the effectiveness varies on symptomology and ethnicity.

Culturally adapted treatments have been used to help merge multicultural competencies (MCCs) into the psychotherapy process. Many researchers believe that culturally adapted treatments should be used for specific racial/ethnic minorities (e.g., African Americans, Latinos). Broadly, culturally adapted treatments refer to the specific adaptation or modifications of interventions based on specific cultures. Following Sue and colleagues' (1992) call for multicultural competency, many therapists began developing and tailoring treatments for specific groups of clients. For example, a study sought to examine the degree to which a manualized behavioral therapy intervention can be adapted to be culturally sensitive in treating depression among low-income African American women with multiple stressors (Kohn et al., 2002). Didactic adaptations to the manualized treatment include adapting modules. Some adapted modules include: African American Female Identity and African American Family Issues. Exercises for this group therapy process include constructing a family genogram and identity affirmation

contracts. The main purpose of the adaptations was to tailor and strengthen African American women's identity as it relates to their mental health. Treatment occurred in two groups, the African American CBT (AACBT) group and the traditional CBT group. At post-treatment, both groups of women experienced a decrease in symptom intensity based on the average BDI scores. Additionally, the average final BDI score for both groups were in the moderate range (Kohn et al., 2002). Although both groups improved, this study does not demonstrate a more effective or preferred treatment method for African American women with depression.

In a different study, The Oh Happy Day class (OHDC) was developed for African American adults experiencing Major Depression Disorder (MDD). It was designed to be a culturally adapted depression intervention using a cognitive-behavioral approach. Ward and Brown (2014) believe that a cognitive-behavioral depression intervention with cultural adaptations would decrease symptoms of depression. Findings from this study suggest that there was a significant reduction in the symptoms of depression (Ward & Brown, 2014). Although these findings may be promising, there were several limitations to this study. The most significant limitation to this study was the lack of a control or comparison group. It is hard to determine if a culturally adapted treatment is better than something else when there lacks a comparison. Further, many studies examining culturally adapted treatment fail to provide a control group. This is fundamental in determining if a treatment is effective. Helms (2015) examined the evidence in quantitative research on culturally responsive evidence-based practice. This literature review revealed that there were issues with measurement and operationally defining race

and culture issues among cross-cultural studies (Helms, 2015). This review highlights the importance of thinking critically about the use of culturally-adapted treatments.

Specifically, when race and culture are not operationally defined, there has been room for issues in construct validity. Additionally, Helms (2015) points to issues of integrating measurement of culture and race into treatment process and outcomes. That is, culturally adapted research studies do not focus on the development or use of culturally adapted indicators of treatment effectiveness (e.g., quality of life). The studies outlined demonstrate varying outcomes pertaining to the use and efficacy of culturally adapted treatments for minorities. These treatments stray from the individual and intersection of various identities clients presents. Future researcher should capitalize on the use of measures that incorporate multiple cultural dynamics that occur in the psychotherapy process.

Multicultural Competencies via Racial/Ethnic Matching

Some may argue that in order for a therapist to exhibit the essence of MCCs, they must be of the same racial/ethnic background as the client. In theory, one might believe that racial and ethnic matching should increase mutual understanding and strengthen the therapeutic alliance, which in turn, has an impact on client outcomes. Research over the years has explored racial/ethnic matching as it relates to psychotherapy and MCCs. A meta-analysis was conducted to investigate individuals' preference for a therapist of their own race/ethnicity, clients' perceptions of therapists across racial/ethnic match, and therapeutic outcomes across racial/ethnic match (Cabral & Smith, 2011). To determine group differences, effect size was used. The results from this analysis conclude a

moderate effect size for preference for a therapist of one's own race/ethnicity ($d=.63$). African Americans strongly preferred to be matched with African American therapists (Cabral & Smith, 2011). However, there was almost no added benefit to treatment outcomes from racial/ethnic matching of clients with therapists ($d=.09$).

Another study examined racial/ethnic minority preference for racial/ethnic matching in psychotherapy (Swift et al., 2015). Participants were asked to indicate their strength of preference for 4 different methods on addressing culturally related variables in therapy. The four different methods include: (1) work with a therapist whose race/ethnicity matches their own, (2) work with a therapist with a high level of multicultural training and experience, (3) receive a culturally adapted treatment and (4) receive a therapist who is also a member of a racial/ethnic minority group, but not the same as their own (Swift et al., 2015). Results from a survey of college students suggest that preferences were significantly stronger for therapist multicultural training/experience and use of culturally adapted treatments. That is, students seeking therapy are not concerned with racial/ethnic matching, but instead, multicultural training and experience. Furthermore, Owen and colleagues (2011) found that neither clients' race/ethnicity, therapists' race/ethnicity, nor client-therapist ethnic match predicted perceptions of microaggressions. The results of this study imply that all therapists are capable of committing a microaggression towards a client.

Additionally, being a minority therapist does not assume comprehensive understanding of another minority. There is more evidence to support that racial/ethnic matching does not aid in the therapeutic process. Since racial/ethnic matching does not

contribute to therapists' multicultural competency, perhaps therapists need more than just innate knowledge of a minority group. That is to say, a Black therapist may have a significant amount of knowledge about Black culture, but that does not mean their knowledge qualifies them to be the best person to work with them. It is not about just knowing a culture, but a way of being aware and integrating that awareness into the therapeutic process.

Multicultural Competencies Could Be Seen By Therapist-specific Health Disparities

Researchers have been aware of health disparities between people of color and their White counterparts for decades. More specifically, these disparities are not only seen in physical health but mental health as well. Imel and colleagues (2011) further explored mental health disparities in youth involved in cannabis substance abuse treatment. Results show that after controlling for covariates, some therapists regularly acquired better outcomes with their clients than others. That is, some therapists were overall more effective in treating clients than other therapists. There was also evidence to suggest that therapist effectiveness varied across White and racial/ethnic minorities within their caseload (Imel et al., 2011). When delving further into racial/ethnic disparities, Owen, Adelson, Imel and Rodolfa (2012) examined mental health disparities in terminations. Owen and colleagues (2012) wanted to understand how and why clients of color terminate unilaterally. Unilaterally meaning clients that ended therapy without informing the therapist. The results show that racial/ethnic minority clients were more likely to unilaterally terminate as compared with White clients within therapist caseload (Owen, Adelson, Imel & Rodolfa, 2012). These results continue to demonstrate a mental

health disparity among clients of color. Minorities are seeking treatment and leaving treatment at earlier rates, from the study, the results show that therapists play a significant role in unilateral termination among clients of color (Owen et al., 2012). This study highlights how there are mental health disparities among clients of color and therapists may play a significant role in the disparities. Further understanding therapist effects will determine what aspects therapists are lacking when working with clients of color.

Another study sought to capture therapist differences in symptom change with racial/ethnic minority clients. Hayes, Owen and Bieschke (2014) investigated 36 therapists and 228 clients at a university counseling center. It was hypothesized that therapist would differ in the amount of symptom change they saw in their clients and those differences would be associated with minority clients. For measurement, the Outcome Questionnaire (OQ-45) was used to determine clients' psychological well-being. Using multilevel modeling, the authors found three significant findings. One, outcomes for racial/ethnic minorities and White clients did not differ. Two, some therapists produced better outcomes than others and three, this variance was attributed to client racial/ethnic minority status (Hayes, Owen & Bieschke, 2014). Although there are some limitations to this study, these findings continue to highlight the importance of considering racial/ethnic minority status in terms of treatment as it relates to specific therapists.

When continuing to explore how treatment outcomes and racial/ethnic minorities are impacted, Hayes and colleagues (2016) continued to investigate how therapists differ in their effectiveness. Specifically, the researchers took an exploratory approach in

examining the extent to which eight therapist factors may contribute to therapist variability. The 8 factors include: gender, race/ethnicity, age, highest degree, professional discipline, years of experience, staff position, and theoretical orientation. Researchers found that therapists differed in their effectiveness at reducing psychological symptoms with racial/ethnic minority clients as compared to their white clients (Hayes et al., 2016).

Nonetheless, these studies point to a significant finding among disparities for outcomes with clients of color, however, more research needs to be done outside of multicultural competencies to measure how and why these disparities exist above and beyond a therapists' awareness, knowledge and skill set. Mental health disparities validate the barrier to treatment that many minorities experience. The overwhelming majority of therapists should be willing to take a different approach to decrease these disparities.

Multicultural Competencies Could Be Seen as a Process

The process of multicultural competencies can be best seen through client ratings of their therapists' multicultural competencies. To further support the importance of multicultural considerations in psychotherapy, one of the first known meta-analysis was conducted. This meta-analysis summarized the relationship between clients' perceptions of their therapists' cultural competence and psychotherapeutic processes and outcomes and showed that cultural competence is correlated with better therapy outcomes. Indeed, client perceptions of therapist multicultural competence accounted for 8.4% of the variance in therapy outcomes (Tao, Owen, Pace & Imel, 2015). This demonstrates the importance of multicultural competency as it relates to the psychotherapy process that

leads to outcomes. If clients of color perceive their therapist to be insensitive to culture, aspects of the overall therapeutic process (e.g., working alliance) are compromised. The lack of attunement to culture is detrimental to the therapeutic working alliance. The findings from this study align with previous research on therapists' multicultural competence and working alliance. For example, in a study exploring the impact of microaggressions, one aspect of the study examined the association between clients' perceptions of microaggressions and therapy outcomes. The results reveal that there was a significant relationship between alliance and outcome (Owen et al., 2012). Furthermore, clients that perceived microaggressions during the therapeutic process also reported lower working alliance and even psychological well-being. The results from this study suggest the continued negative effects of microaggressions and the lack of cultural awareness.

Overall, multicultural competencies can be seen in various aspects of psychotherapy. First, MCCs could be seen as culturally adapted treatments. Yet, there is not robust empirical evidence to support this claim. Second, MCCs could be seen by racial and ethnic matching. However, there is more evidence to support that racial/ethnic matching does not aid in the therapeutic process than the opposite. Third, MCCs could be seen by health disparities. This is true, but how and why these disparities exist is currently unknown. Fourth, MCCs could be seen as a process. However, there is a need to have a strong measurement to properly assess cultural processes in therapy.

Furthermore, the teaching of competencies implies that there is an endpoint. It suggests that there are several things that should be learned about various cultural identities and once they are learned and earned a passing grade, the therapist is able to

work with various clients and the learning ceased. Additionally, the information presented through this approach often reinforces stereotypes. For example, a student might learn the historical and current oppression experiences (e.g., slavery, Jim Crow laws) but they fail to learn how intersectionality of various identities co-exist with oppressive experiences. Multicultural competencies have laid the foundation for therapists and researchers to strongly consider culture as an important factor in psychotherapy. Researchers and clinicians have thought profoundly about ways in which therapists can increase their awareness and tailor treatments to fit these cultural values, beliefs and abilities. Multicultural competencies should serve as a foundation for treatment (e.g., cultural awareness, knowledge, skills) and a different framework should be used to understand how competencies are expressed in therapy.

Multicultural Orientation

More recently, Owen (2013) developed the multicultural orientation framework (MCO) to better explicate the MCCs for psychotherapy. This framework was built on the premise that cultural interactions should be a “way of being.” It is built on the belief that cultural interactions and intersectional identities are ever changing. MCO takes a process approach to treatment, meaning, it aims to increase awareness of the therapist and the client in order to improve understanding. This process is ever ending and continues to grow as both clients and therapists grow. MCO includes three aspects: cultural humility, ability to create opportunities to discuss and integrate client’s cultural heritage into the therapy process and comfort or ease of engaging in these discussions (Owen, 2013).

Cultural Humility

Cultural humility is a therapist's ability to maintain an 'other-oriented' stance and is marked by curiosity as well as a non-superior approach to addressing cultural differences (Hook et al., 2013). It reflects the dyadic, interpersonal relationship between therapist and client marked by respect and empathic attunement. Cultural humility occurs when a therapist is genuine in their curiosity towards not only their client, but their client's cultural identities in a non-oppressive manner. Broadly, cultural humility can also be described by interpersonal and intrapersonal aspects. The intrapersonal aspects of cultural humility can be described as therapists' ability to view themselves as cultural beings. Specifically, it addresses the internal process of understanding one's biases, strengths, limitations, areas for growth, beliefs, values, attitudes and assumptions (Hook, Davis, Owen & DeBlaere, 2017). Direct feedback is a way to strengthen one's intrapersonal process, allowing them to think critically and engage openly with culturally diverse clients. Interpersonal aspects of cultural humility refer to the process of engaging with ideals that are different than others in an open and curious way. This process allows for therapists to interact with different values and ideals different than their own, but has an underlying assumption that these are not to be entirely accepted.

From this viewpoint, to express cultural humility a therapist must possess interpersonal skills as a mechanism of change. At the core of the interpersonal processes is corrective relational experiencing. Corrective relational experiencing can be defined as a new perception of reality regarding an event or a relationship (Franz, 1950; Hill, 2012). When therapists are genuine in their curiosity towards their clients' cultural identities, it

creates a unique bond in closeness and strengthens the therapeutic alliance. For instance, if a therapist is curious about their client's unique experience as Jewish and gay, the client will easily feel affirmed and supported. This significant experience may lead to clients gaining new understanding, insight and may allow the client to know that this understanding can be obtained by others around them. Corrective relational experiencing is linked to therapeutic alliance. Specifically, Teresa Chen-Chieh Huang and researchers (2016) conducted a mixed-methods approach to measuring the construct of corrective relational experiencing. Researchers suggest that relational experiences provided pivotal moments in psychotherapy and demonstrated mechanisms of change. More than half of the clients in this study reported that their therapist facilitated corrective relational experiencing by conveying personal attributes such as trustworthiness, care, understanding, and credibility. In order for a corrective relational experience to occur, the therapist must have an open and inviting space to all clients, regardless of their minority status. If therapists can attune to their clients and demonstrate awareness and openness, there will be positive impacts on the process of therapy and outcomes.

Several studies have also linked cultural humility (client reported) to therapy alliance, identity-related ruptures, and therapy outcomes (Davis et al., 2016; Hook et al., 2013; 2016; Owen et al., 2016). Clients who view their therapists as culturally humble tend to report stronger working alliances (Hook et al., 2013). Four studies were used to present findings and evidence for cultural humility. From those studies, researchers found that client perceptions of therapists' cultural humility could be assessed using the Cultural Humility Scale (CHS). The relationship between clients' perceptions of

therapists' cultural humility and perceived improvement occur within a strong alliance with a therapist (Hook et al., 2013). In a study examining the occurrence of racial microaggressions in counseling and the association between perceived cultural humility of the counselor and racial microaggressions (Hook et al., 2016). Using a large sample of 2,212 racial and ethnic minorities, the researchers asked participants to complete several measures including racial microaggressions, cultural humility, general and multicultural competence. Results from this study conclude that participants reported racial microaggressions that involved denial or lack of awareness of stereotypes and biases and avoidance of discussing cultural issues. Also, client-perceived cultural humility of the counselor was associated with fewer microaggressions experienced in counseling. In other words, racial and ethnic minorities had a better experience in therapy when their therapist did not commit a microaggression, and when they exhibited cultural humility. This study also shows that cultural humility predicts both microaggression impact and frequency, even when controlling for client perceptions of therapists' general competence and multicultural competence (Hook et al., 2016). In order to abstain from committing microaggressions in therapy, one must ascribe to aspects of cultural humility. Also, Owen and colleagues (2014) continued to explore cultural humility by investigating clients' religious commitment and their perceptions of therapists' cultural humility and therapy outcome. There were several findings from this study that demonstrate the importance of cultural humility. When clients whose religious/spiritual commitment were more salient, their view of their therapists' cultural humility was positively related to treatment outcomes as compared to those whose religious/spiritual commitment was less salient

(Owen et al., 2014). These findings add to the literature on the importance of cultural humility within the therapeutic process and the framework for MCO. Cultural humility has empirical support as its own aspect that predicts positive outcomes for clients of marginalized identities.

Cultural Opportunities

Cultural opportunities are timely and distinctive moments when cultural content is presented or could be explored in more depth (Owen, 2013). Cultural opportunity is the ability to be aware of and attune to cultural cues and take the opportunity to discuss, and not neglect, significant cultural interactions. A therapist may demonstrate a cultural opportunity by exploring a client's endorsement of salient identities as opposed to symptomatic markers. They may also conceptualize a client's conflict as it relates to cultural and systemic factors as opposed to symptomatology. Cultural opportunities are presented to clients in a timely fashion. These opportunities have a "sweet spot", meaning cultural interventions should be used in a meaningful way that moves the client into further insight. It is a strategic placement of an intervention that centers on culture and the client at a quintessential moment. The impact of the intervention depends on not only timeliness, but the intervention themselves. When engaging in a cultural opportunity, there is a right and wrong way to engage. The wrong way is to engage with a microaggression. A racial/ethnic microaggression is a direct or indirect insult, slight, or discriminatory message towards a person of color (Sue et al., 2007). These type of microaggressions occur in everyday life, but often present themselves in the therapeutic process. Owen and colleagues (2014) sought to address how microaggressions are

perceived in therapy and the impact they have on the therapeutic relationship. Findings from this study indicated 53% of clients reported experiencing a microaggression from their therapist. Clients' perceptions of microaggressions were negatively associated with the working alliance. Of the clients who reported a microaggression, 76% reported that the microaggression was not addressed. Those clients who did not have the opportunity to discuss the microaggression, had lower ratings of alliance compared to those who did not experience a microaggression or those who experienced a microaggression but discussed it (Owen et al., 2014). Thinking about cultural opportunities that were missed, even if was is a microaggression, had a significant impact on the therapeutic alliance. The results from this study imply the importance of addressing culture and how it is linked to the therapeutic alliance.

It has been shown that the way therapists engage in cultural opportunities, affect therapy outcome. Owen et al. (2016) found that clients had better therapy outcomes when they felt that their therapist attended to their cultural heritage and did not miss cultural opportunities. In a university counseling center, 247 clients were treated by 50 therapists. Owen and his colleagues examined the relationship between client's ratings of their therapists' cultural humility and the degree to which clients perceived that their therapist missed opportunities to discuss their cultural identity. Additionally, therapists that expressed the least cultural humility, also missed cultural opportunities and had compromised outcomes. Thus, this study demonstrates the importance of therapists taking cultural opportunities and attuning to cultural humility in psychotherapy.

Cultural Comfort

Cultural comfort is the third aspect of the multicultural orientation framework. It refers to the therapist's ability to engage cultural identities and themes with ease and without avoidance. Cultural comfort is implementing and talking about culture throughout treatment with confidence and openness. It requires therapist to stay genuinely attuned with clients that hold similar or different worldviews, values or cultural identities. Indeed, comfort within the therapeutic relationship is based on establishing therapeutic alliance. That is, engaging with a client with ease, confidence and openness lends itself to establishing a strong therapeutic alliance. Therapists demonstrate cultural comfort by managing their own anxieties around cultural and engage with a client in a relaxed manner. A therapist might exhibit cultural comfort by engaging a client in a conversation about police brutality with ease and openness. Cultural discomfort is the opposite of comfort, the process of highlighting anxieties and feelings of uncomfortableness. A therapist might have cultural discomfort around topics that challenge their worldview or values, such as gay marriage or immigration. The ability to be comfortable in the room with a client who discussed culture is important and linked to a stronger working alliance. For example, if a therapist is willing to have a sexuality-related discussion and is able to engage in this discussion with ease, the client is more likely to feel understood and deeply valued.

Several studies have examined aspects of cultural comfort. Specifically, Harris, Wenner and Hays (2008) found that sexuality education and supervision experience addressing sexuality issues were the best predictors of therapists initiating sexuality-

related discussions with their clients. Furthermore, more education and supervision around this topic allowed for increased level of comfort with sexual matters. The path model for this study suggests that perceived sexual knowledge and sexual comfort both lead to sexuality discussions (Harris, Wenner & Hays, 2008). Therapists that engage in these conversations are connecting and providing a safer space to discuss some of the most difficult conversations. Further, another study explored the potential influences on marriage and family therapists' comfort level when working with LGBT+ clients. Results indicated that higher levels of therapists' religious practices were related to lower levels of support and lower levels of comfort working with LGBT+ clients (Green et al., 2009). Additionally, the results of this study show that individuals that were the most comfortable working with gay/lesbian clients, learned about gay/lesbian individuals through personal experience (Green et al., 2009). These findings highlight the importance of therapists being a non-anxious presence during anxious times in session. When a therapist's anxiety is increased in session, sexuality discussion and other uncomfortable topics may be avoided or missed. The study also implies a personal motivation factor that pushes therapists to participate in additional training. This study also stresses the importance for trainees to extend their learning of the LGBT+ community outside of the classroom and actively engage in gay/lesbian human rights.

To emphasize, Owen and colleagues (2017) investigated unilateral termination within therapist caseload. In detail, therapists' racial/ethnic comfort and general comfort was examined. It was found that therapists' cultural comfort partially accounted for racial/ethnic disparities in therapy outcome within their caseloads. Therapist cultural

comfort is a unique predictor of racial/ethnic disparities in client dropout, accounting for up to 44% of variability in this disparity (Owen et al., 2017). Findings from this study are consistent with previous research, suggesting that therapists vary in racial/ethnic mental health disparities. From a MCO perspective, therapists may be able to enhance their engagement with clients by attending to, honoring and integrating the client's intersections of identity into treatment and potentially enhancing treatment outcomes. Therapists' cultural comfort send a signal to clients letting them know that it is safe to bring cultural issues into therapy.

Overall MCO Support

Overall, there is evidence to strongly suggest that each aspect of the multicultural orientation framework is significant in its own respect. In fact, all three aspects are shown to provide empirical support to the literature. This evidence highlights the importance of therapists bringing up topics around identity and culture, engaging clients in further exploration, and having a cultural presence to improve treatment outcomes. However, there are still many aspects of the MCO framework that need further development.

The Multicultural Psychotherapy Measurement Issue

Therapists' MCCs or MCO can be rated by clients, therapists, or observers (e.g., supervisors, independent evaluators). Although these are traditional ways of assessment, there are drawbacks to each perspective. From a client-rated or therapist-rated perspective, social desirability bias can influence responses. Furthermore, therapist-rated multicultural competencies are contingent on the unique dynamic between the client and therapist relationship. Thus, depending on the closeness of the relationship, a therapist or

client, may rate their experience on multicultural competencies differently. To further explore this, results from a study that examined the relationship between four therapist-rated multicultural counseling competence measures and a general index of social desirability. Constantine and Ladany (2000) revealed through their study that three of the four therapists-rated MCC measures exhibited a positive relationship to social desirability. In fact, when controlling for social desirability, none of the self-report MCC measures were significant in predicting multicultural case conceptualization (Constantine & Ladany, 2000). To take this a step further, researchers examined the validity of a MCC measure highlighted in the Constantine and Ladany (2000) article. Using the client-rated version of the Cross-Cultural Inventory-Revised (CCCI-R), Drinane, Owen, Adelson and Rodolfa (2016) validated the content and performed a confirmatory factor analysis to examine construct validity. Of the 20 items, 7 items were used to better represent client-rated MCCs. This study highlights how little attention has been paid to the measurement properties (e.g., reliability, validity) of this measure. Another study investigated therapists' misunderstanding of minority cultures (Martin, 1993). This study is unique since it capitalizes on gaining therapists' perspectives of a White adolescent and a Black adolescent with the exact therapeutic scenario. Therapists rated the behaviors of the Black adolescent less clinically significant than the behaviors of the White adolescent. These findings suggest that when therapist self-report behaviors, they are different depending on the culture presented.

Observer-rated reports of MCC could be beneficial since it eliminates social desirability bias, however, it does make room for rater bias. Moreover, studies have

found observer-rated reports of MCC to be somewhat accurate. Consistent with previous research, another study found a significant difference between clients' and therapists' ratings of MCCs. Fuertes and colleagues examined the role of therapist MCC in 51 therapy dyads (Fuertes et al., 2006). Results showed strong associations between clients' ratings of therapist MCC and ratings of working alliance, empathy, and satisfaction. Clients' combined ratings of therapist expertise, attractiveness, and trustworthiness were not associated with therapist MCC. Interestingly, the results also demonstrated that client and therapist ratings were lowly correlated. In another study, researchers examined therapist differences in their clients' ratings of their therapists' MCCs. Results demonstrated that therapists did not differ in how clients rated their MCCs, suggesting that clients' perceptions of their therapists' MCCs did not vary based on clients' or therapists' race/ethnicity. (Owen, Leach, Wampold, & Rodolfa, 2010). Additional findings suggest that clients of the same therapist did not agree on their perceptions of their therapist's MCCs. This largely points to clients' interpretation of what occurs in therapy. In a dynamic study of multicultural counseling competencies, the one-with-many method was used to investigate client and counselor reports of counselors' level of MCCs. Results showed that counselors' self-assessments of MCC did not relate to their clients' assessments of the counselors MCCs. Together, the findings from these studies suggests that each perspective brings a unique aspect to understanding MCCs/MCO. Ideally, utilizing multiple methods make a stronger case for understanding a construct, than one single method (Hoyt, Warbasse, & Chu, 2006).

Currently, the measurement of therapists' MCO has solely been from the client perspective. Although this vantage point is vital, these measures capture MCO processes that are influenced by the therapist-client interaction. There are likely other ways to assess therapists' MCO that could help advance the field. Specifically, MCO can potentially be used to assess therapist effects. Therapist effects can be defined as the amount of influence of a given therapist on patient outcomes. Researchers conducted a review to further illustrate the impact of therapist effects. Psychotherapy, and all its interrelated aspects, account for 20% of the variance in outcomes (Baldwin & Imel, 2013). Understanding therapist effects at a foundational level allows for researchers to answer imperative questions about the treatment of all clients, including those from marginalized identities. Since therapist effects vary, how might research progress in order to further understand the integral facets that contribute to the most effective therapists?

Naturalistic research studies have been shown to be a rare way to measure therapist effects in a real-world setting. Okiishi, Lambert, Nielsen and Ogles (2003) examined therapists' variability among 1,841 clients in a university counseling center. Results from this naturalistic design found that therapist effects were not controlled by therapist traits (e.g., gender, type of training, theoretical orientation) but the source of therapist effects in these naturalistic studies remain unidentified. Similarly, in another naturalistic study, researchers investigated between-therapist variation in working alliance, treatment effectiveness and client satisfaction (Artkoski & Saarnio, 2012). Findings indicated that between-therapist variation was larger in the therapists' ratings of the alliance than in the clients' ratings. These results are similar to previous research

conducted on between-therapist variation in the alliance (Crits-Christoph et al., 2011; Balwin & Imel, 2013). Thus, research should strive to understand therapist effects that go unaccounted for.

Anderson and colleagues (2009) sought to determine those therapist effects that remain unidentified in a naturalistic setting. It is known that alliance and empathy are predictors of client outcomes. When further operationalizing both empathy and alliance, theory aligns the two constructs under facilitating therapy processes. Empathy, paired with a strong, therapeutic alliance, fosters mechanisms of change for a client who may be struggling with depression and interpersonal difficulties. The Facilitative Interpersonal Skills performance task (FIS) was developed to assess therapists' ability to respond therapeutically to brief video case vignettes. The purpose of the FIS performance task is to further understand the sources of therapist effects. Facilitative is defined by a collaborative and encouraging way to engage with a person in need. Interpersonal is referred to as the warm and subtle dyadic response to a client in therapy. Since interpersonal processes are linked to client outcome, the present study wanted to investigate how this interaction occurs in a naturalistic setting. The FIS was designed to elicit responses that are indicants of a person's ability to perceive, understand and communicate a wide range of interpersonal dialogues. It also captures a person's ability to persuade others by utilizing suggested solutions to their problems (Anderson et al., 2009). This unique performance task was developed to measure therapists' abilities to respond to challenging interpersonal situations in a therapy setting.

Moreover, the Facilitative Interpersonal Skills performance task is composed of eight brief simulated therapy situations that were created to measure therapists' abilities to respond to challenging interpersonal situations in therapy (Anderson et al., 2009). The video segments used in the performance tasks were taken from four archival problematic therapy process segments. Clients ranged in various interpersonal patterns (e.g., anger, withdrawn). Two brief two-minute segments were used to create each transcript. Actors were then hired to act out the transcripts of the various clients used for the performance task. In addition to the performance task, the FIS rating and scoring was also created to measure people's responses. The item content was selected from prominent researchers on common therapist interpersonal skills and facilitative conditions. The FIS rating and scoring system was composed of 10 items that captured ratings of verbal fluency, emotional expression, persuasiveness, hopefulness, warmth, empathy, alliance-bond capacity, and problem focus (Anderson et al., 2009). Each item was scored using a 5-point Likert scale and all eight vignettes were coded by two licensed research psychologists. Raters (one of which developed the manual) were then provided with a manual for rating the FIS items by the researchers. After studying the manual, the two raters scored therapists responses from two separate locations. Interrater reliability for the all 10 FIS items were greater than .70.

The primary purpose of this validation study was to confirm the use of the FIS performance task (Anderson et al., 2009). Specifically, the researchers hypothesized that interpersonal skills would predict therapist effects. The study examined sources of therapist effects in a sample of 25 therapists who saw 1,141 clients at a university

counseling center. At each session, clients were assessed for outcomes using the Outcome Questionnaire-45. Therapist were assessed using the Social Skills Inventory (SSI) and Facilitative Interpersonal Skills (FIS) Performance Task and coding system. Anderson and colleagues found that approximately 25 percent of the variance in therapy outcomes attributed to therapists was accounted by their FIS ratings (Anderson et al., 2009). More recently, Anderson et al (2016) replicated these results in a prospective study with short-term and long-term therapies. Therapist FIS significantly predicted client symptom change. When looking at the difference between duration of therapies, higher FIS therapists were more effective than lower FIS therapists over shorter durations (e.g., less than 8 sessions). However, there were no differences in level of FIS in long-term therapies. This continues to validate the importance of therapists' interpersonal characteristics as it relates to client outcomes in therapy. Researchers also sought to examine the effectiveness of the Clara E. Hill model of helping skills training as it relates to facilitative interpersonal skills (Hill et al., 2016). A total of 191 undergraduate students completed self-report measures, the FIS performance measure, and nonverbal measures to determine if students' helping skills improved over the course of training. Results of this study suggest that the FIS performance measure predicted the end of training self-efficacy in helping skills when controlling for retrospective pre-levels and instructor effects. This study validates the use of the FIS performance measure to predict helping skills in undergraduate students.

Although this performance measure is one of the first to measure therapist effects in a naturalistic setting, there are some important considerations to take note of. The

majority of the participants and actors used in the measure were White. A measure is not representative when participants are not diverse, especially with such a large sample size. Second, the measure encompasses the interpersonal process of therapy but fails to measure any multicultural aspect of therapy. Further, the video did not have any culturally diverse client represented. It is difficult to capture a naturalistic setting when all clients represented are White. The study fails to incorporate one of the foundational guidelines in counseling and psychology professions: diversity. Another drawback to this study was coding system. The coding system used for this study did not incorporate cultural processes that occur in interpersonal interactions. This leaves a gap in what could be measured from participant responses, if the vignettes were culturally diverse.

Developing a way to assess therapist's' ability to be multiculturally oriented may lead to a better understanding of how therapists respond to clients and how it relates to therapy outcomes. Previously, research on therapists' and clients' perception of the tripart model of MCCs have been difficult to quantify, making it difficult to know exactly what area therapists' need improvement on (Drinane et al., 2016). The purpose of this dissertation was to develop a multicultural orientation performance task and coding system with therapists-in-training. This performance-based task is the first of its kind and provides a unique way of measurement within the multicultural orientation framework.

Constructs Related to MCO

The purpose of this study was to validate the use of the multicultural orientation performance task. To do this, several other measures were used to help determine concurrent validity. Several constructs have been used to predict multicultural processes

to psychotherapy. The following constructs have been used in the past: color blind racial attitudes, empathy, dehumanization, social desirability and therapist self-assessment of multicultural competencies.

Color-Blind Attitudes

Color-blind racial attitudes, or modern racism, refers to the denial of racial dynamics, or a general unawareness of the existence of racism (McConahay, 1986; Neville et al., 2000). These attitudes are often expressed in a statement such as, “I don’t see color.” This statement is often said by those who think they are making an endearing comment towards a person of color. By saying this type of statement, it is implied that there is no cultural awareness of racial or society barriers to people of color. This type of statement, or attitude, also comes with a sense of privilege, and is in direct opposition to ideas of cultural humility (Neville et al., 2000). Burkard and Knox (2004) further explored how the color-blind attitudes impact cross-cultural counseling. The analysis of this study revealed that therapists’ level of color-blindness (low, moderate, high) was directly related to their capacity for empathy. Therefore, color-blind attitudes are linked to capacity for empathy, a common factor for effective psychotherapy. Implications for this study suggest therapist biases have a negative effect on the counseling process. Another study examined color-blind attitudes and therapists’ multicultural competencies. Using two samples, findings provide support for the link between higher color-blind attitudes and lower multicultural competencies (Neville, Spanierman, & Doan, 2006). If cultural differences do not exist, cultural interactions and processes cannot occur. That is,

therapists that exhibit color-blind attitudes will not exhibit cultural humility, seek opportunities to discuss culture or feel comfortable discussing culture with clients.

Dehumanization

Dehumanization refers to the adaptive response to cope with one's own transgressions and the immoral treatment of others (Bastian et al., 2012). That is, it involves denying aspects of humanity and equating those aspects to something other than humane. This philosophical construct has been linked to out-group and in-group (Haslam & Loughnan, 2014). Specifically, those among the out-group may be perceived by the in-group as animal-like or unequal. The construct of dehumanization can be seen in society through police brutality towards Black bodies and Islamophobia. Unfortunately, the attitudes and behaviors associated with dehumanization may be latently present in the therapeutic space.

There are three aspects of dehumanization: self, other and meta-attribution. Self-dehumanization may help others understand the impact and their responses to harmful behavior. In theory, in order to deepen one's acceptance of another, there must first be self-acceptance. This means that in order to exude acceptance of others, it must come from an authentic place within. We see this in the psychodynamic concept of defense mechanisms. Defense mechanisms are ways in which people exhibit behaviors to defend against inner anxieties. Projection manifest when a person attributes their own thoughts and feelings to another person (A. Freud, 1936). If there is inner hate, then that hate will be projected out onto others and possibly even clients. A recent study investigated the experience of powerlessness and its impact on the experience of self-dehumanization.

After conducting a series of three experimental studies, researchers found that self-dehumanization is a negative consequence of powerlessness rather than an incidental result of change in mood or negative self-perception (Yang, Jin, Fan & Zhu, 2015). This is one of the first studies that link powerlessness and dehumanization. The findings from this study imply that powerless individuals view themselves as in fact, powerless. Those self-perceptions are coupled with feelings of inadequacy and viewing oneself as lacking human qualities. Therefore, it can be expected that a therapist who experiences a high level of self-dehumanization is less likely to express characteristics of cultural humility. Dehumanizing oneself leads to the ultimate disconnect from others. Thus, if a therapist views themselves as less than human, from an 'other-oriented' perspective, they will view clients as less than human. The three aspects of MCO thrive when therapist can see themselves in their clients. There are two other aspects of dehumanization, other and meta-attribution. Other refers to the dehumanizing views of other people, while meta-attribution refers to the dehumanizing views believed to be placed on oneself by society (Kteily, Hodson & Bruneau, 2015). There is little research that demonstrate the impact of dehumanization and its impact on psychotherapy.

Empathy

In 1957, Carl Rogers wrote a monumental article for the Journal of Consulting Psychology on the necessary and sufficient conditions of therapeutic change. In this article, Rogers outlined 6 conditions needed in the therapeutic environment to foster client change. The 5th condition is empathy. Empathy is defined as the ability to identify with another's feelings. As Roger's wrote, "To sense the client's private world as if it

were your own, but without ever losing the ‘as if’ quality—this is empathy, and this seems essential to therapy.” (Rogers, 1957). Since empathy is necessary for client change, strongly related to therapy outcomes, and theoretically connected to being comfortable, humble and attuned to the client. Investigators examined outcomes and predictors of outcomes for 85 undergraduates enrolled in three helping skills classes (Hill, Roffman, Stahl, Friedman, Hummel & Wallace, 2008). Empathy was hypothesized to be a predictor of outcome. Trainees used more exploration skills in helping sessions with classmates and were perceived as more empathic. A more recent study developed and tested a common factors feedback system (CFF). This system was created based on the Wampold and Imel’s (2015) model of therapeutic change and strongest predictors of treatment success. This system provides ongoing feedback to clients and therapists about client ratings of outcome expectations, empathy and alliance. Results from this study suggest that CFF provides large gains in perceived empathy and alliance over the course of treatment compared to clients who received treatment as usual. The use of empathy continues to play a strong role in therapeutic change for clients with varying symptomatology. These studies point to the importance of utilizing empathy as a way to measure a critical common factor of psychotherapy that contributes to the therapeutic alliance and change.

Multicultural Competence

In 1992, an influential article was written addressing the counseling profession and its lack of multicultural considerations (Sue, Arredono, & McDavis, 1992). The article was written to explore the need and rationale for a multicultural perspective in

counseling. The authors also advocated for the use of multicultural assessment, practice, training and research. They also propose specific multicultural standards and competencies for the profession. The three aspects of multicultural competencies include: awareness, knowledge and skills. Theoretically, in order to have a multicultural perspective, these three aspects must be developed. Together, these constructs have been used to develop the multicultural standards used in the profession of counseling and psychology. Multicultural competencies have been used to construct therapy modalities (e.g., culturally adapted treatments) and assessments (e.g., Multicultural Awareness-Knowledge-and-Skills Survey). For many decades, MCCs have been used as the ‘gold standard’ for multicultural considerations within the helping profession. MCCs have been used to measure constructs such as psychotherapy outcomes, color-blind racial attitudes and alliance.

The emphasis on program evaluation has led to an increase in the development of MCC instruments. These instruments were devised to assess knowledge, awareness and skills in therapists. Moreover, the Multicultural Inventory (MCI) is one of the most widely validated and administered MCC instrument. The inventory captures multicultural counseling competencies (awareness, knowledge, skills) and should not capture multicultural orientation (cultural humility, cultural opportunities, and cultural comfort). The use of this measure will help to discriminate the MCO measure with a self-report measure of multiculturalism. Researchers sought to understand the multiple predictors of anti-Black bias among counselors. Using an online survey composed of several measures, including the MCI, global cultural competency was measured as predictors of therapists’

expectancies for bond and prognosis with Black clients. The MCI did not account for anti-Black bias in prognosis ratings (Katz & Hoyt, 2014). Thus, this measure does not consider the roles of deliberate and automatic biases. This measure is self-report and does not capture biases in a naturalistic setting. Although there are limitations in self-report measures of MCCs, there is value in learning from these limitations to better measure multicultural processes in therapy.

Social Desirability

Social desirability refers to the bias one holds when self-reporting (Paulus, 1991). This desirability is based on current social norms and standards. People often inaccurately self-report on sensitive topics (e.g., multiculturalism) in order to present themselves in the best light possible. Culture is a sensitive topic and not an easy conversation to have. When asked about feelings towards minorities, there are likely to be few people who would feel comfortable disclosing their racist or discriminatory perspective. When it comes to therapists, even fewer numbers are perhaps willing to take ownership of their biases.

Hypotheses

For this study, there were two main hypotheses. One, it is hypothesized that the eight items from the MCO-PT will load on one factor. We examined items to factor fit indices as well as multiple factors. Two, to examine concurrent validity it is hypothesized (a) there will be positive associations between the MCO-PT and the following: higher MCCs, and higher empathy and perspective taking; (b) there will be negative associations

between the MCO-PT and each of the following: higher colorblind attitudes, higher self-dehumanization attitudes and higher social desirability.

CHAPTER TWO: METHOD

Participants

A total of 74 graduate student participants enrolled in a counseling/professional psychology and related profession participated in the study. A total of 26 undergraduate students participated in the study for comparison. Case ratio recommendations range from two times the number of cases to five or more times the number of items, regardless of the case-to-item ratio. According to absolute number of cases criterion, 100 cases is the suggested bare minimum sample size (Hahs-Vaughn, 2017). For the present study, we aimed to have at least 100 cases. We anticipated approximately 70% of participants to identify as White and female, according to overall demographics of therapist in 2013 (APA Center of Workforce Studies, 2015). We also assumed this percentage to be similar among undergraduate students enrolled in psychology or other helping professions. Approximately 80% of the participants self-identified as White, while 4% Black, 6% Latino, 4% Eastern Asian, 1% Middle Eastern, and 5% Biracial/Multiracial. In this sample, ages ranged from 18 to 40 years of age. Roughly 13% self-identified as cisgender male, 82% cisgender female, 1% transgender/gender non-conforming (TGNC). Further, 81% self-identified as heterosexual/straight, while 15% self-identified as LGBT+. Although the demographics of this study may be seen as a limitation, it is a more accurate representation of therapist within the U.S., providing generalizability. Inclusion criteria

included any graduate level student within the Counseling Psychology department and any undergraduate level student enrolled in a human service major.

Procedures

Data collection began in the Spring Quarter of 2018, upon IRB approval. In terms of recruitment, first year Counseling Psychology Master's level students from a university were recruited through a recruitment email sent through a department listserv. The email included a brief description of the study and a link to sign up for the study. Students chose an available time to participate in the study through Calendly, an online scheduler. The advertisement email provided the contact information of the principal investigator and faculty sponsor. For the undergraduate population recruitment, students received an advertisement of the study and a brief description provided on a university online research pool. Information on the dates, times, location and amount of extra credit obtainable was also presented in the advertisement.

The collection of data for the undergraduate population took place over several days in two separate lab rooms located at a university. For the graduate level population, two rooms in a counseling clinic were reserved for participant involvement. Each room was equipped with a laptop that has video recording capabilities. Laptops were rented through the Morgridge College of Education IT department. There was a total of 5 master's level counselors that helped to run participants through the study.

Before starting the study, lab assistants directed participants to the study room and retrieved the online informed consent located in Qualtrics, a research platform. Participants either accepted or declined the opportunity to participate in the study. Then,

lab assistants introduced the study by reading the study script. Once the study script was read in its entirety, the lab assistant then allowed participants to begin the study, which was held on the website Theravue. Theravue is an online platform used by psychotherapy professors and students for skill building and research. This platform ran the MCO-PT. Lab assistants signed participants up for Theravue prior to their arrival. The lab assistants directed participants to the MCO-PT within the website. Lab assistants left the room and allowed participants to complete the measure. After completing the MCO-PT, lab assistants walked back into the room and directed participants to Qualtrics, to complete the questionnaire and demographic information. Each participant finished with the study once informed consent was obtained, the MCO-PT and Qualtrics questionnaire were completed. The study took approximately forty-five minutes to one hour to complete. A research assistant remained outside of the experimental room for assistance, if needed. The lab assistants were responsible for monitoring the study to make sure no glitches occur in the program (e.g., laptop battery dead, program malfunction, re-recording). All signed informed consents were stored on the secure server of Qualtrics.

For the undergraduate population, two experimental rooms at a university were used. Data collection took place over several weeks. Each room was equipped with a computer that had video recording capabilities. Participants checked in at their scheduled time. Before starting the study, participants were directed to the study room and retrieved the online informed consent located in Qualtrics. Participants either accepted or declined the opportunity to participate in the study. Then, the study was introduced by reading the study script. Once the study script was read in its entirety, participants began the study,

which was held on the website Theravue. This platform ran the MCO-PT. Participants were signed up for Theravue prior to their arrival. Participants were left alone and allowed to complete the measure. After completing the MCO-PT, participants were directed to Qualtrics, where demographics and the other measures are housed. Each participant was finished with the study once informed consent was obtained, the MCO-PT and Qualtrics measures were completed. The study took approximately forty-five minutes to one hour complete. A research assistant was outside of the clinic room for assistance if needed. The lab assistants were responsible for monitoring the study to make sure no glitches occur in the program (e.g., computer issues, program malfunction, re-recording). All signed informed consents were stored within the secure server of Qualtrics. Extra credit was automatically be awarded to all students that participate in the study. Additionally, to gather more participant data, the study was also completed online by participants. A detailed list of instructions were sent to each participant that signed up for the study. Participants were encouraged to complete the study in a quiet space.

Measures

MCO Performance Task (MCO-PT). This measure was designed to elicit responses that are indicants of a person's ability to be culturally humble, to create opportunities to discuss and integrate client's cultural heritage into the therapy process, and comfort or ease of engaging in these discussions. The performance task was designed as a means of measuring MCO from a therapists' perspective and the ability to respond to challenging situations in a therapy setting. Participants were presented with eight brief simulated therapy situations that centered on the intersection of cultural identities and

prompted to respond to the client-actors (who were filmed directly facing the camera) as if they were the therapist in the situation. Video clips of the vignettes were presented via the computer and responses and explanations of responses were recorded. Each vignette was approximately 1 minute in length. Prior to recording, vignettes were developed over a series of time. First, multicultural vignettes were drafted by graduate students within a psychology research lab. Second, scripts were finalized and rated by graduate students on their challenge, overtness and symptomology. Fourteen vignettes were then finalized and vetted by approximately 20 experts in the field of psychotherapy and/or multicultural psychology. A total of 10 vignettes were chosen to be recorded and 8 were used for the final performance-task, with the first video as the ‘practice video.’ For data analysis, only 7 videos were used.

Coded MCO Constructs. As seen in Figure 1, is the MCO Coding Scale. This rating scale was modeled after the Session Evaluation Questionnaire (SEQ). The SEQ was originally developed by William B. Stiles and colleagues (2002) to evaluate psychotherapy sessions based on two dimensions: Depth and Smoothness. Items were created to measure how a person “feels” after a session using bipolar adjectives. For example, “bad-good,” “confident-afraid,” and “valuable-worthless.” Twenty-one items, in a 7-point format, were created and analyzed for psychometric properties. Specifically, factor analysis was used to obtain independence, robustness, and internal consistency (Stiles, Gordon, & Lami, 2002).

The SEQ has been used to evaluate several different types of psychotherapy sessions, including individual, group, and marriage therapy, as well as supervision (Stiles,

Gordon, & Lami, 2002). Thus, the MCO Coding Scale was modeled after the SEQ to evaluate participant responses to the MCO-PT. The coding scale has three subscales to reflect the three pillars of MCO, as well as an overall scale. Three items were taken from both the humility and comfort scales of the MCO Assessment (Kivlighan et al., 2019). The MCO Assessment is comprised of questions to assess MCO and cultural identity. Further, the MCO Coding Scale has been evaluated by expert reviewers, and was informed by previous assessments evaluating MCO and psychotherapy sessions. Reliability estimates for the MCO-PT were .94 for Cultural Comfort and .97 for Cultural Humility. Cronbach's alpha for Cultural Opportunity was .77, but when separated into two scales were .70 and .64. There was a total of 9 coders for the present study, 8 of which identified as cisgender female, and one cisgender male. 7 of the 9 coders self-identify as White.

Figure 1.

Please circle the appropriate number to show how you perceive this response.

Comfort

This response was:

Uncomfortable	1	2	3	4	5	6	Comfortable
Nervous	1	2	3	4	5	6	Calm
Tense	1	2	3	4	5	6	Relaxed

Humility

This response was:

Disrespectful	1	2	3	4	5	6	Respectful
Closed-minded	1	2	3	4	5	6	Open-minded
Superior	1	2	3	4	5	6	Non-superior

Opportunity

There was:

No cultural discussion	1	2	3	4	5	6	Definitive cultural discussion
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Overall

This response was:

Bad	1	2	3	4	5	6	Good
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Color Blind Racial Attitudes Scale (CoBRAS). This 20-item measure assesses individuals' color-blind racial beliefs. Items are rated on 5-point Likert scale rating ranging from 1= strongly disagree to 5= strongly agree. Higher scores on this measure represent individuals' greater endorsement of color-blind racial attitudes. The CoBRAS is composed of three factors: Racial Privilege, Institutional Discrimination, and Blatant Racial Issues. An example item is "White people are more to blame for racial discrimination than racial ethnic minorities." The CoBRAS has been used in several

studies as a predictor for other measures that capture racial attitudes, therapist self-reported multicultural competencies, and therapists' racial identity (e.g., Gushue & Constantine, 2008; Neville, Spanierman, & Doan, 2006). Recently, a study examined microaggression detection in therapists, the Cronbach's alpha in this study was .88 (Owen, Drinane, Tao, Gupta, Zhang, & Adelson, 2017). For the present study, reliability estimates for the CoBRAS four factors were .80 (Racial Privilege), .76 (Institutional Discrimination), and .76 (Blatant Racial Issues). The Cronbach's Alpha for the total scale was .89.

Dehumanization Scale. The Dehumanization Scale has three components: Self-Dehumanization, Other People Dehumanization and Meta-Attribution of humanity. They are each composed of 6 items on a 7-point Likert scale ranging from 1=completely disagree to 7=completely agree (Bastian & Haslam, 2010). Each component has a total of 12 items. For the current study, we used both the self-dehumanization and the other people dehumanization components of the scale. The Self and Other components of the scale both have two subscales: Human Nature and Human Uniqueness. The Cronbach's Alpha for the Self-Human Nature subscale was .80, while the Self-Human Uniqueness was .71. The Other-Human Nature subscale was .72, while the Other-Human Uniqueness was also .72. The total Dehumanization scale demonstrated an overall reliability of .70.

Interpersonal Reactivity Index--Brief Form (IRI-B). This measure was developed to assess empathy and is a 16-item scale this is rated on a Likert scale, ranging from 1=does not describe me well, 5=does describe me very well. The IRI contains four factors: Fantasy, Perspective Taking, Empathic Concern, and Personal Distress (Davis,

1983). All subscales reflect the reactions of one individual to the observed experiences of another. In a large sample of emerging adults, Cronbach's alpha was .82, .68, .69, and .71 for Fantasy, Empathic Concern, Perspective Taking, and Personal Distress (Ingoglia, Lo Coco, & Albiero, 2016). For the present study, Cronbach's Alpha was .84, .78, .62, and .38. The total Cronbach's Alpha for this scale was .75.

Multicultural Counseling Inventory (MCI). This 40-item scale that assesses therapists' multicultural counseling competencies. Using a 4-point Likert scale, therapist report the degree to which the items accurately describe their work as mental health care providers. (1= very accurate, 4= very inaccurate). The MCI consists of four factors: Multicultural Awareness, Multicultural Knowledge, Multicultural Counseling Skills and Multicultural Counseling Relationship. An example item from the Multicultural Counseling Relationship scale, "I perceive that my race causes the clients to mistrust me." In a sample of 135 masters-level and doctoral-level psychologists, Cronbach's alphas were computed. For the entire scale, Cronbach's alpha was .82 for the Awareness subscale, .84 for the Knowledge subscale, .81 for the Skills subscale, and .71 for the Relationship subscale (Constantine & Ladany, 2000). In terms of convergent validity, the MCI was moderately correlated ($r=.68$) with the Multicultural Awareness-Knowledge-Skills Scale (Sodowsky, 1996). This scale will be used only for the graduate population. Cronbach's alpha for the present study was .77 for Awareness, .80 for Knowledge, .84 for Skills, and .61 for Relationship. The reliability for the total scale was .82.

The Balanced Inventory of Desirable Responding (BIDR). The Balanced Inventory of Desirable Responding (BIDR) evaluates social desirability along two

subscales: Self-Deceptive Enhancement (e.g., “My first impressions of people usually turn out to be right”), and Impression Management (e.g., “I always obey laws, even if I’m unlikely to get caught”). Impression management involves conscious attempts to deceive others, whereas self-deception involves actively denying self-threatening thoughts. The validity and reliability of this instrument has been demonstrated in several studies (Linden, Paulhus & Dobson, 1988; Paulhus, 1991). In a population of first year university students, test-retest reliability ranged from .65 to .69, internal consistency ranged from .68 to .80 and convergent validity with the Multidimensional Social Desirability Inventory ranged from .71 to .80 (Peebles & Moore, 1998). Respondents were asked to rate 40-items on a 7 point Likert scale according to their level of agreement with the item. Cronbach’s alphas for the Self-Deceptive Enhancement subscale, Impression Management subscale, and total scale were .68, .74, and .81.

Hypotheses

1. It is hypothesized that the eight items from the MCO-PT will load on one factor. We examined item to factor fit indices as well as multiple factors. Exploratory factor analysis (EFA) was used to provide evidence of construct validity. The underlying focus of an exploratory factor analysis deals with finding shared variance and eliminating the unique variance. Coded responses to all vignettes were interval variables so that a linear relationship can exist between variables. Kaiser’s rule (Eigenvalues Greater Than One) was applied to determine the number of factors to retain.

2. To examine concurrent validity, it is hypothesized:
 - a. There will be positive associations between components of the MCO-PT and the following: the MCI (higher MCCs), IRI-B (e.g., higher empathy, perspective taking).
 - b. There will be negative associations between components of the MCO-PT and each of the following scales: CoBRAS (higher colorblind attitudes), Dehumanization (higher dehumanization attitudes) and the BIDR (higher social desirability).

CHAPTER THREE: RESULTS

Preliminary Analysis

Data screening

Prior to conducting the exploratory factor analysis, the data was screened to determine the extent to which the assumptions associated with an exploratory factor analysis were met. These assumptions included a) independence, b) linearity, and c) lack of extreme multicollinearity and singularity. Scatterplots of each combination of variables were generated and generally suggested that the assumption of linearity was feasible, as there was no evidence of curvilinear or other nonlinear relationships. The data was screened for missing values and found that for one participant, there was data missing at random (MAR), meaning the missing values were distributed across all observations. For this reason, this participant's data was deleted. The data was also screened for univariate outliers by examining the boxplots and histograms of the dependent variables. The graphs show that there were no outliers in the data more than two standard deviations from the mean. The minimum amount of data for a factor analysis was satisfied, with a final sample size of 100 (using pairwise deletion), providing a ratio of over one case per variable.

Interrater reliability

To test the reliability of the MCO-PT data, an intraclass correlation was used. An intraclass correlation, or ICC, can be helpful when estimating the interrater reliability amongst coders. Interrater reliability can be described as the agreement, or consistency, among individuals collecting data. It is important to establish high interrater reliability among the coders to demonstrate reliability, or accuracy, of the MCO-PT. Demonstrating reliability of the MCO-PT allows for confidence in the research findings. Cohen suggested that values between 0.01–0.20 have none to slight agreement, 0.21–0.40 have fair, 0.41–0.60 have moderate, 0.61–0.80 have substantial, and 0.81–1.00 have high agreement (Cohen, 1960). In SPSS, a One-Way Random intraclass correlation was used to determine the reliability of the items among the three coding teams. Overall, each coding team demonstrated high interrater reliability. However, the Overall Rating and Cultural Opportunity subscale for the seventh video demonstrated moderate interrater reliability (see Table 1).

Table 1. *Intraclass Correlation among Coding Teams*

	Video 1	Video 2	Video 3	Video 4	Video 5	Video 6	Video 7
Team 1							
Comfort	.92	.85	.89	.92	.92	.92	.84
Humility	.87	.88	.87	.89	.89	.85	.79
Opportunity	.66	.95	.90	.75	.89	.88	.76
Overall	.74	.84	.74	.74	.65	.66	.46
Team 2							

Comfort	.90	.90	.90	.88	.89	.90	.90
Humility	.92	.94	.91	.85	.92	.94	.94
Opportunity	.74	.91	.73	.72	.76	.76	.54
Overall	.82	.87	.79	.68	.80	.86	.82
Team 3							
Comfort	.80	.71	.89	.71	.63	.72	.61
Humility	.92	.93	.93	.87	.91	.91	.77
Opportunity	.97	.97	.85	.87	.94	.91	.74
Overall	.74	.81	.77	.80	.71	.72	.48

Note: Video 1=Cathy; Video 2= Anthony; Video 3=Aleemah; Video 4=Jasmine; Video 5=Julie; Video 6=Stephen; Video 7=Arlene.

Primary Research Questions

Hypothesis One

It was expected that the 21-items from the MCO-PT would load onto one factor. To test this hypothesis, an exploratory factor analysis was conducted using a Principal Components extraction method with a pairwise deletion strategy and direct oblimin rotation method. A pairwise deletion strategy was applied to minimize the loss of data for cases. Criteria that is often used to determine factorability of variables was applied in this analysis. Specifically, these factorability criteria included examination of the following 1) Kaiser-Meyer-Olkin measure of sampling adequacy (overall and individual), 2) Bartlett's test of sphericity. The overall Kaiser-Meyer-Olkin measure of sampling adequacy was .87, larger than the recommended value of .60 (Hahs-Vaughn, 2016). In addition, Bartlett's Test of Sphericity was statistically significant ($X^2(210) = 1738.12, p < .001$)

and suggest that some of the variables have significant correlations, therefore a factor analysis is appropriate for analysis. Finally, the communalities were all above .40, confirming that each item shared some common variance with the other items. Given these overall indicators, a factor analysis was suitable with all 21 items.

Principal components analysis was used to identify composite scores for the factors underlying the MCO-PT. Initial eigenvalues indicated that the first four factors explained 44%, 12%, 11%, and 5% of the variance respectively (see Table 2). The remainder of the factors had eigenvalues below one. Thus, the four factor solution was retained since it explained 73% of the variance. No items were eliminated since items contributed to a simple factor structure and met a minimum criteria of having a primary factor loading of .40 or above, and a minimum criteria of having no cross loadings of .30 or above. There was one item that had a cross loading above .30 (Cultural Opportunity-Stephen Video), however this item had a stronger primary factor loading of .47. Lastly, a principal components factor analysis of the 21 items, using a direct oblimin rotation method was used since it allows for a continuous range of correlations between factors. Four factors were extracted and provided the best defined factor structure. No items were eliminated since items contributed to a simple factor structure and met a minimum criteria of having a primary loading over .40 and no cross loadings of .30 or above. There was one item that had a cross loading above .30 (Cultural Opportunity-Video 6), however this item had a stronger primary factor loading of .47 (see Table 3).

Internal consistency for each of the factors was examined using Cronbach's alpha. Reliability estimates for the MCO-PT were moderate: .94 for Cultural Comfort and .97

for Cultural Humility. Cronbach's alpha for Cultural Opportunity-1 (Video 1, 2, 3, 5 and 6) was .70 and .64 for Cultural Opportunity-2 (Video 4 and 7).

Overall, these analyses demonstrate the MCO-PT loading onto 4 factors, with two separate factors for Cultural Opportunity, thus capturing Multicultural Orientation.

Factors of the MCO-PT include: Cultural Comfort, Cultural Humility, Cultural Opportunity-1, and Cultural Opportunity-2 (see Figure 2).

Table 2. *Total Variance Explained*

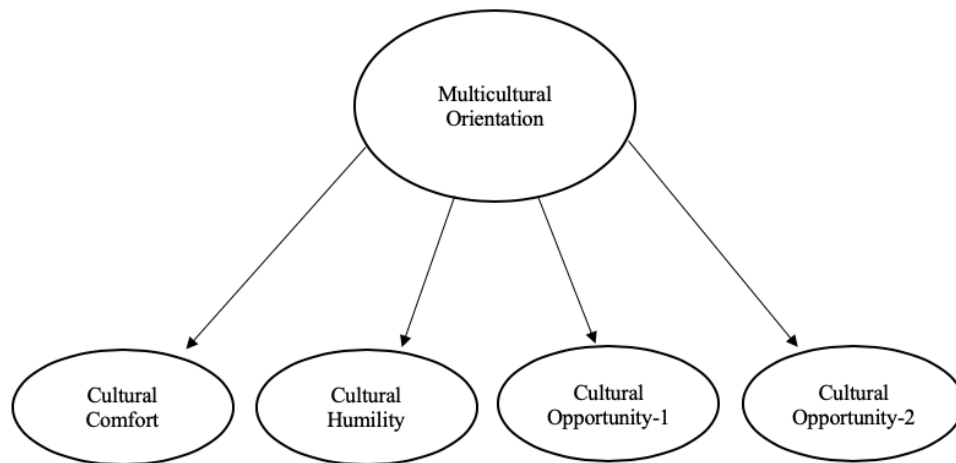
Component	Total	Cumulative % of Variance
1	9.38	44.71
2	2.57	56.95
3	2.39	68.36
4	1.07	73.46

Table 3. *Factor Loadings Based on a Principal Components Analysis with Oblimin Rotation for 21 items (N=100)*

	Factor 1	Factor 2	Factor 3	Factor 4
Comfort Video 1	-.03	-.82	.01	.00
Comfort Video 2	.05	-.87	-.01	-.05
Comfort Video 3	.02	-.85	.01	.03
Comfort Video 4	.10	-.84	-.11	.13
Comfort Video 5	-.00	-.83	.15	-.13
Comfort Video 6	-.01	-.87	.08	.00
Comfort Video 7	.06	-.81	-.07	.04
Humility Video 1	.87	-.07	-.04	.03
Humility Video 2	.95	.02	.04	-.07
Humility Video 3	.92	.00	.05	.00
Humility Video 4	.88	-.09	-.15	.16
Humility Video 5	.90	.01	.10	.00
Humility Video 6	.84	-.08	.16	-.04
Humility Video 7	.87	-.10	-.08	-.02
Opportunity Video 1	.30	-.08	.60	-.12
Opportunity Video 2	.29	.14	.54	.19
Opportunity Video 3	-.08	-.13	.81	-.05
Opportunity Video 4	-.02	-.02	.07	.79
Opportunity Video 5	-.01	.01	.68	.13
Opportunity Video 6	-.16	-.11	.45	.42
Opportunity Video 7	.09	.01	-.04	.84

Note: Factor loadings > .40 are in boldface. Video 1=Cathy; Video 2= Anthony; Video 3=Aleemah; Video 4=Jasmine; Video 5=Julie; Video 6=Stephen; Video 7=Arlene.

Figure 2.



Hypothesis Two

To examine concurrent validity of the MCO-PT, it was expected that there would be positive correlations between components of the MCO-PT with both the MCI and the IRI-B for the overall sample. It was also expected that there would be negative correlations between components of the MCO-PT with the following measures: the CoBRAS, Dehumanization, (Self and Other subscales) and the BIDR for the overall sample. Concurrent validity was measured by conducting a Pearson correlation. A Pearson correlation determines the directionality of a relationship (positive or negative). Additionally, it demonstrates the intensity of the relationship ranging from -1.00 to +1.00. Values near .50 or -.50 are considered moderate relationships. Values near 0 are considered weak relationships and values near -1.00 and +1.00 are considered strong relationships. It was anticipated that correlations would be above .30 or -.30, to

demonstrate a low to moderate relationship among measures. Moderate and strong relationships among the measures was not anticipated since the MCO-PT should capture different and unique aspects of multicultural psychotherapy. Proving validity to this measure is an important part in scale construction, evaluation and implementation of a new measure.

Multicultural Counseling Inventory

Correlational analyses were used to examine the relationship between the MCO-PT and self-report measures that capture aspects of multicultural psychotherapy. Specifically, it was hypothesized that there would be positive associations between components of the MCO-PT and the Multicultural Inventory (MCI). The MCI is a self-report measure completed only by the therapists-in-training. Results of the Pearson correlation indicated that there was a significant positive association between the Cultural Opportunity-2 subscale and the MCI total scale, $r(74) = .31, p = .007$. There were also significant correlations among the Cultural Opportunity-2 subscale and the MCI Knowledge subscale, $r(74) = .34, p = .003$, and the MCI Awareness subscale, $r(74) = .25, p = .026$ (see Table 4).

Table 4. *Multicultural Counseling Inventory Correlations (N=74)*

	Comfort	Humility	Opportunity-1	Opportunity-2
Knowledge	-.00	-.00	.18	.34**
Skills	.16	-.05	.01	.21
Awareness	-.11	.18	.20	.25*

Relationship	.08	.15	.05	-.14
MCI Total	-.01	.12	.20	.31**

* Correlation is significant at the .05 level (2-tailed).

** Correlation is significant at the .01 level (2-tailed).

Interpersonal Reactivity Index-Brief Form

It was also hypothesized that there would be positive associations between components of the MCO-PT and the Interpersonal Reactivity Index-Brief Form (IRI-B). Results of the Pearson correlation indicated that there was an overall significant negative association between Cultural Comfort and the IRIB perspective subscale for the total sample, $r(96) = -.22, p = .025$ (see Table 5). For the therapists-in-training group, there was no statistically significant correlations among MCO subscales and IRIB subscales.

Table 5. *Interpersonal Reactivity Index-Brief Form (N=96)*

	Comfort	Humility	Opportunity-1	Opportunity-2
Overall Sample ($n=96$)				
Fantasy	-.03	.05	.08	.15
Perspective Taking	-.22*	-.16	.05	.04
Empathic Concern	-.11	-.01	.01	.09
Personal Distress	.09	-.07	.02	.03
IRIB Total	-.12	-.06	.07	.14
Therapists-in-Training ($n=74$)				
Fantasy	-.16	-.14	.02	.13
Perspective Taking	-.19	-.07	.08	.05
Empathic Concern	-.14	-.13	-.01	.12
Personal Distress	.05	-.09	-.04	.01

IRIB Total	-0.21	-0.18	.03	.14
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* Correlation is significant at the .05 level (2-tailed).
** Correlation is significant at the .01 level (2-tailed).

Color-Blind Racial Attitudes Scale

It was also hypothesized that there would be negative associations between components of the MCO-PT and the CoBRAS. For the overall sample, there were both statistically significant negative and positive correlations among the CoBRAS subscales. Specifically, there was a significant positive correlation between Cultural Humility and Racial Privilege, $r(96) = .44, p < .01$. There was also significant negative correlations between Cultural Humility and Institutional Discrimination, $r(96) = -.27, p < .01$, Blatant Racial Issues, $r(96) = -.31, p < .01$, and the CoBRAS total scale, $r(96) = -.40, p < .01$. There was a significant positive correlation between Cultural Opportunity-1 and Racial Privilege, $r(96) = .28, p < .01$. There was also significant negative correlations between Cultural Opportunity-2 and Institutional Discrimination, $r(96) = -.23, p = .022$, Blatant Racial Issues, $r(96) = -.21, p < .035$, and the CoBRAS total scale, $r(96) = -.29, p < .01$. Lastly, there were significant negative correlations between Cultural Opportunity-2 and Institutional Discrimination, $r(96) = -.32, p < .01$, and the CoBRAS total scale, $r(96) = -.26, p < .01$.

For the therapists-in-training group, there were significant positive correlations among the Racial Privilege subscale and Cultural Opportunity-1, $r(74) = .25, p = .028$, and Cultural Opportunity-2, $r(74) = .26, p = .024$. There was a significant negative correlations between Cultural Opportunity-2 and Institutional Discrimination and, $r(74)$

= -.30, $p < .01$, and Blatant Racial Issues, $r(74) = -.23, p = .046$. Lastly, there was negative correlations between the CoBRAS total scale and Cultural Opportunity-1, $r(74) = -.24, p = .033$, and Cultural Opportunity 2, $r(74) = -.31, p < .01$ (see Table 6).

Table 6. *Color-Blind Racial Attitudes Scale Correlations (N=96)*

	Comfort	Humility	Opportunity-1	Opportunity-2
Overall Sample ($n=96$)				
RP	.12	.44**	.28**	.17
ID	-.08	-.27**	-.23*	-.32**
BRI	-.07	-.31**	-.21*	-.15
CoBRAS Total	-.11	-.40**	-.29**	-.26**
Therapists-in-Training ($n=74$)				
RP	-.02	.14	.25*	.26*
ID	.06	-.12	-.19	-.30**
BRI	.06	-.00	-.18	-.23*
CoBRAS Total	.06	-.12	-.24*	-.31**

Note. RP = Racial Privilege; ID = Institutional Discrimination; BRI = Blatant Racial Issues.

* Correlation is significant at the .05 level (2-tailed).

** Correlation is significant at the .01 level (2-tailed).

Dehumanization Scale

It was hypothesized that there would be negative associations between the Dehumanization Scale and the MCO-PT. For the overall sample, there was negative significant correlations between Other- High Human Uniqueness and Cultural Comfort, $r(96) = -.23, p = .020$, Cultural Humility, $r(96) = -.20, p = .045$, and Cultural Opportunity-

2, $r(96) = -.23, p = .022$. There was also significant positive correlation between Self-High Human Nature and Cultural Opportunity-2, $r(96) = .21, p = .032$.

For the therapists-in-training group, there was significant negative correlations between Other High-Human Nature and Cultural Comfort, $r(74) = -.28, p = .015$. There was significant negative correlations between Other High-Human Nature and Cultural Humility, $r(74) = -.32, p < .01$. There was significant negative correlations between Other High-Human Nature and Cultural Opportunity-1, $r(74) = -.26, p = .023$. Lastly, there was significant negative correlations between Other High-Human Nature and Cultural Opportunity-2, $r(74) = -.23, p = .046$ (see Table 7).

Table 7. *Dehumanization Scale Correlations (N=96)*

	Comfort	Humility	Opportunity-1	Opportunity-2
Overall Sample ($n=96$)				
Self HHN	.07	.02	.02	.21*
Self LHN	.18	.15	-.03	.07
Self HHU	-.05	-.07	.01	.13
Self LHU	-.14	.05	.05	.10
Other HHN	-.13	-.05	-.06	-.08
Other LHN	-.06	.19	.06	.04
Other HHU	-.23*	-.20*	-.19	-.23*
Other LHU	-.12	.10	-.01	.01
Dehumanization Total	-.10	.01	-.04	.03
Therapists-in-Training ($n=74$)				
Self HHN	.10	-.01	.01	.27*

Self LHN	.21	.03	-.03	.16
Self HHU	-.10	-.14	.00	.14
Self LHU	-.16	-.03	.11	.16
Other HHN	-.07	-.03	.07	.01
Other LHN	-.13	.16	.20	.12
Other HHU	-.28*	-.32**	-.26*	-.23*
Other LHU	-.13	.02	.08	.07
Dehumanization Total	-.11	-.09	.01	.13

Note: HHN=High Human Nature; LHN= Low Human Nature; HHU=High Human Uniqueness; LHU= Low Human Uniqueness.

* Correlation is significant at the .05 level (2-tailed).

** Correlation is significant at the .01 level (2-tailed).

Balanced Inventory of Desirable Responding

It was hypothesized that there would be negative associations between the BIDR and the MCO-PT. There was four significant positive correlations for the overall sample. Specifically, there was also a positive correlation between the BIDR total scale and Cultural Opportunity-1 subscale, $r(95) = .20, p = .048$, Cultural Humility was positively correlated with the Self-Deceptive Enhancement subscale, $r(95) = .25, p < .01$, the Impression Management subscale, $r(95) = .20, p = .043$, and the BIDR total scale, $r(95) = .26, p < .01$.

For the therapists-in-training group, there were no statistically significant correlations between MCO subscales and BIDR subscales (see Table 8).

Table 8. *Balanced Inventory of Desirable Responding (N=95)*

	Comfort	Humility	Opportunity-1	Opportunity-2
Overall Sample (n=96)				
SDE	.19	.25*	.19	.17
IM	.12	.20*	.15	.14
BIDR Total	.17	.26**	.20*	.18
Therapists-in-Training (n=74)				
SDE	.14	.14	.17	.16
IM	.03	.14	.09	.10
BIDR Total	.10	.17	.15	.15

Note. SDE = Self-Deceptive Enhancement; IM = Impression Management.

* Correlation is significant at the .05 level (2-tailed).

** Correlation is significant at the .01 level (2-tailed).

CHAPTER FOUR: DISCUSSION

The purpose of the present study was to develop and establish some initial validity and reliability estimates for a performance task that captures Multicultural Orientation framework (MCO). The Multicultural Orientation Performance Task, or MCO-PT, was designed to elicit responses that are indicants of a person's ability to be culturally humble, to create opportunities to discuss and integrate client's cultural heritage into the therapy process, and appear to be comfortable engaging in these discussions. The performance tasks were created as a means of measuring MCO from therapists' performance when responding to challenging situations in a therapy setting.

The development of the MCO-PT was a thoughtful multistep process. First, graduate students drafted several multicultural counseling vignettes. The scripts for the vignettes were finalized and rated by the graduate students on challenge, overtness, and symptomology. The ratings were used to obtain a range of vignettes in order to construct a scale that would cover a range of difficulty and presentation styles. Fourteen vignettes were finalized and vetted by 23 experts in the field of psychotherapy and/or multicultural psychology. A total of 10 vignettes were recorded, and 7 were used for the performance task. Ultimately, 7 vignettes were used for the performance task rather than the 10 that were recorded since 3 of the vignettes were not adequate. The actors in these vignettes either failed to memorize their lines and read directly from the printed script, stumbled

through the script, or failed to follow the script entirely. For those reasons, 3 vignettes were eliminated and only 7 were used in the final performance task to reduce measurement error. An additional video was selected from the online platform, Theravue, to act as a ‘practice video’ for all participants. Therefore, only 7 of the 8 videos were used in the final 4.

A coding scale was developed alongside the MCO-PT to evaluate participants’ responses. The coding scale has three subscales to reflect the three pillars of MCO, as well as an overall scale to measure general psychotherapy responses. Interrater reliability was important to establish among the coders to demonstrate reliability, or accuracy, of the MCO-PT ratings. To measure interrater reliability, an intraclass correlation (ICC) was used. It is suggested that values between 0.01–0.20 have none to slight agreement, 0.21–0.40 have fair, 0.41–0.60 have moderate, 0.61–0.80 have substantial, and 0.81–1.00 have high agreement (Koo & Li, 2016). Overall, each coding team demonstrated high interrater reliability, ranging from substantial (.66) to high (.97) agreement. However, the Overall General Rating for the seventh video demonstrated moderate interrater reliability with coefficients of .46 and .48 for coding Team 1 and Team 3. The Cultural Opportunity subscale for the seventh video also demonstrated moderate interrater reliability with a reliability estimate of .54 for coding Team 2. The seventh video, or Arlene, had the most overt challenge of all the videos, asking participants directly about their perception of her age. The video leans directly on culture, such as her Jewish identity and age, but fails to mention any symptomology. In the video, Arlene states the following, “Is it just that she and other people are rude, or am I really too old to have children. What do you think?”

This direct challenge may have led coders among coding teams to rate differently on Cultural Opportunity based on whether the response mentioned her age and/or her Jewish identity. One group may have believed that the mention of age was enough to be rated as a strong cultural opportunity, while another group may have believed that her cultural and religious identity should be mentioned and rated as a cultural opportunity. Further, the low interrater reliability among Overall Rating may have been impacted by coders personal perceptions of how participants may or may not have stumbled to answer this overt challenge.

Findings from the exploratory factor analysis revealed a meaningful four-factor solution with all 21 items. The resulting factors include the following: Cultural Comfort, Cultural Humility, Cultural Opportunity-1, and Cultural Opportunity-2. These four, unique factors appear to support MCO since all of the items designed to measure cultural comfort, humility, and opportunity loaded onto separate factors. Strong data for a factor analysis requires multiple variables loading strongly onto the factor and uniformly high communalities without a significant presence of cross-loadings (Hahs-Vaughn, 2016). There was one item that had a cross loading above .30, which was the sixth video on Cultural Opportunity, however this item had a stronger primary factor loading of .47. The factor loadings were adequate (.45) to excellent (.95) on the four-factor solution.

The results of the factor analysis indicated that cultural opportunity was best captured by two separate factors. Cultural Opportunity-1 captured five of the videos, whereas Cultural Opportunity-2 captured two of the videos. Specifically, Cultural Opportunity-1 included the following vignettes: Cathy, Anthony, Aleemah, Julie and

Stephen. For the first subscale of Cultural Opportunity, the video content that was discussed centered on various multicultural identities (e.g., race, gender identity, sexuality) as well as symptomology. Each of these five videos mentioned clinical symptoms in the script (e.g., loneliness, sadness, substance abuse, lack of motivation). Conversely, Cultural Opportunity-2 included the following videos: Jasmine and Arlene. The video content discussed in both of these videos center around symptomology, such as anxiety or depression, as well as how others in the world perceive them. Specifically, Jasmine disclosed that while visiting her friend's home, she felt as if everyone was watching her at the dinner table. Similarly, Arlene disclosed that people are consistently wondering if she is the grandmother of her young children. Both of these videos ask participants to respond to how they may be perceived outside of the therapy session as it relates to their symptoms of depression and anxiety. During the initial vetting process, scripts for both Jasmine and Arlene were rated as the most difficult to respond to due to the level of challenge. Therefore, the cultural opportunity items may have captured two distinct levels of difficulty creating the factors Cultural Opportunity-1 and Cultural Opportunity-2.

Internal consistency was measured using Cronbach's Alpha, where values range from 0 to 1, with higher indicating greater internal consistency. Typically, values ranging from .00 to .49 show poor reliability, .50 to .79 fair reliability, .80 to .89 good reliability, and .90 to .99 strong reliability (Cohen, 1960). Reliability estimates for the MCO-PT were .94 for Cultural Comfort and .97 for Cultural Humility, which demonstrated strong reliability. However, reliability estimates for Cultural Opportunity-1 (Video 1, 2, 3, 5 and

6) was .70 and .64 for Cultural Opportunity-2 (Video 4 and 7). The lower reliability estimates for each of the cultural opportunity subscales may be due to a) fewer number of items included for each subscale and b) the moderate interrater reliability obtained for the cultural opportunity items on the MCO Coding Scale. Despite two less than desired reliability estimates, the MCO-PT demonstrates fair to strong reliability. These are promising results which suggest that the MCO-PT may be a meaningful, accurate measure of the MCO construct, and warrants further investigation within therapist populations.

To establish initial concurrent validity, I examined the associations between MCO-PT and other established tests that measure aspects of multicultural psychotherapy such as multicultural competence and empathy as well as other known tests that do not measure aspects of multicultural psychotherapy such colorblind racial attitudes and dehumanization. The MCO-PT showed moderate concurrent validity with measures of multicultural competence, colorblind racial attitudes, and dehumanization. The data suggests, as hypothesized, that higher levels of multicultural orientation (e.g., cultural opportunity-2) is significantly associated with greater multicultural competency (e.g., knowledge, awareness). Thus, there appears to be a conceptual link between multicultural orientation and multicultural competencies. Responding to clients in a way that reflects cultural opportunity, it seems as if one must embody both knowledge and awareness of multicultural identities and understand how it intersects with symptomology. This would be the case since cultural opportunity is the ability to not only be aware of, but attune to cultural cues presented by the client. It takes both the awareness and knowledge of

cultural and systemic factors that impacts clients' ability to engage in a cultural opportunity. Owen et al. (2016) found that clients had better therapy outcomes when they felt that their therapist attended to their cultural heritage and did not miss cultural opportunities. This study highlights the importance of therapists taking cultural opportunities and attuning to cultural humility in psychotherapy, which seemingly incorporates both multicultural knowledge and awareness.

As hypothesized, colorblind racial attitudes would not be associated with multicultural orientation since theoretically, it moves away from multicultural psychotherapy. Colorblind racial attitudes indicate values that align with racial privilege, institutional discrimination, and blatant racial issues, which disavows marginalized identities and systems of power and oppression. The results of the present study demonstrate cultural humility and opportunity being significantly negatively associated with colorblind racial attitudes for the overall sample. When taking a closer look at the therapists-in-training sample, there were fewer significant negative associations between multicultural orientation and colorblind racial attitudes. In fact, the data did not yield a significant association between the two constructs. One possible explanation for this finding may be the difference between self-report and performance measures. Research has shown that there are differences between observer-ratings and self-report ratings of multiculturalism (Fuertes et al., 2006; Katz & Hoyt, 2014; Owen, Leach, Wampold, & Rodolfa, 2010). Performance measures are quantifiable indicators used to assess how well a person is achieving a desired objective. The difference between these two ways of measuring multicultural psychotherapy could be the reason for the lack of association.

Another possibility may be peoples' accurate view of their own racially biased attitudes. In a recent study, Kim, Di Domencio, and Connelly (2018) analyzed self-assessments of participants' personality with ratings from a close family member or friend. The researchers found that people were not inclined to self-enhancement when completing the self-assessment, in fact, their self-assessment agreed well with others' ratings of them on all of the "Big Five" traits. Results from this study suggests that self-assessments are a much more reliable source of information than previously studied (Kim, Di Domencio, & Connelly, 2018). Although contrary to prior research, this recent study supports the idea that participants are able to assess their areas of strength and weakness when it comes to racially biases attitudes. Perhaps this even highlights trainees' ability to accurately understand and report their biases, even if undesirable.

Dehumanization refers to the adaptive response to cope with one's own transgressions and immoral treatment of others (Bastian et al., 2012). In other words, it involves denying facets of humankind and equating those to something inhumane (Bastian et al., 2012). Other-dehumanization refers to the negative perceptions of others, while self-dehumanization refers to the negative perception of oneself. There were no significant negative correlations between dehumanization and multicultural orientation, except for on one scale (e.g., other high human nature). It makes sense that largely, the data suggests no significant association between these two constructs due to the difference between self and performance measures. This finding may suggest that therapists-in-training, especially earlier in their training, may have a more colorblind perspective as it relates to higher levels of other human nature. Another explanation may

be power and how it typically increases dehumanization. A study examining other dehumanization and decision-making found that power increases dehumanization. Specifically, participants who were deemed “more powerful” were more inclined to make a tough decision that led to a more dehumanized view of the outgroup (Lammers & Stapel, 2010). This experience may be relevant to the present study, especially among the therapists-in-training group. Perhaps the therapists-in-training do not hold a perspective of power, leading to nonsignificant findings between dehumanization and multicultural orientation.

The data also revealed unexpected results, with negative associations between multicultural orientation and certain components of empathy. For the overall sample, cultural comfort was negatively associated with perspective taking, often a component of empathy. However, when taking a closer look at the therapists-in-training sample, there were no significant associations between multicultural orientation and components of empathy (e.g., fantasy, perspective taking, empathic concern, personal distress). The results of this analysis are unexpected since empathy has been seen to be a basic component of psychotherapy. One potential explanation for this finding may be ones self-perceived sense of multicultural competence. Specifically, participants that exhibited more cultural comfort may have had an increased sense of perceived multicultural competence, which led to a decrease in perspective taking. Another explanation for this finding, again, may be the potential disconnection between therapist self-report and performance task assessments. Empathy can be a difficult construct to define and measure, especially measurements of empathy in psychotherapy. It may be that

multicultural orientation is related to components of empathy outside of empathic concern, fantasy, perspective taking, and personal distress. Instead, multicultural orientation may be associated with intellectual empathy which refers to the cognitive process, as well as empathic emotions which refers to the affective aspect of empathic experience (Duan & Hill, 1996). Perhaps a certain psychotherapy training level, or understanding of empathy needs to be reached in order for it to be seen in multicultural psychotherapy. Diversity courses offer trainees the opportunity to increase their perspective taking tendencies, develop empathy that is useful when working with clients of marginalized identities, and expand upon their openness to diversity. Another explanation for the lack of findings between the trainee sample and empathy may be their openness. In a recent research study, researchers investigated the link between openness, multiculturalism, and colorblindness (Sparkman et al., 2019). Results from this study revealed that openness positively predicted multiculturalism and colorblindness, and was dependent on perspective taking. The data suggests that individuals who are open to experience (e.g., imaginative, unconventional, curious) are likely to believe that marginalized individuals should be appreciated, and at the same time ignored (Sparkman et al., 2019). Further, openness influenced interpersonal perspective taking toward everyone, yet, was simultaneously associated with stronger beliefs in multiculturalism and colorblindness. The results of this study demonstrate that perspective taking, a component of empathy, can moderate multiculturalism and colorblindness. These findings may explain the negative association between perspective taking and cultural

comfort in the present study for the overall sample. Perhaps multiculturalism and colorblindness was moderated by perspective taking.

The potential, and unexpected link between multiculturalism and colorblindness was seen in the current study, specifically among some of the positive associations between colorblind racial attitudes and multicultural orientation. The results suggest that for therapists-in-training colorblindness, specifically racial privilege, was associated with cultural opportunities of multicultural orientation. That is, colorblind racial attitudes, such as a stronger belief that White people in the U.S. do not have advantages over other racial and ethnic minorities, was positively associated with cultural opportunity. A potential explanation may be increased verbal expression of curiosity and privilege among trainees who have not been exposed to multicultural psychotherapy. When examining what did not correlate within the trainee sample, cultural comfort and cultural humility was not significantly associated with colorblindness. One reason for this finding may be racial identity development, specifically White identity development. In the current study, approximately 80% of the sample self-identified as White. Researchers Johnson and Jackson-Williams (2014) sought to identify if White racial identity predicts MCC. The results of this study show that higher stages of White racial identity predicts significant variance in therapists-in-training multicultural counseling knowledge, skills, and awareness (Johnson & Jackson-Williams, 2014). Further, findings also revealed that lower multicultural training was related to higher color-blind attitudes. Additionally, the study also found that the lower three stages of White racial identity were related to lower multicultural counseling knowledge, skills, and awareness (Johnson & Jackson-Williams,

2014). This study underlines how White racial identity development and the level of multicultural training impact multicultural counseling. Moreover, for the present study, racial identity development and level of multicultural training may be the link between multicultural constructs and the negative associations to colorblind racial attitudes.

People may have the desire to inaccurately self-report on sensitive topics, such as multiculturalism, to present themselves as affirming and nonbiased. It was hypothesized that there would be negative associations between social desirability and multicultural orientation. It was anticipated that participants of this study would not respond in socially desirable ways, but with authenticity and honesty. For the overall sample, cultural humility was positively associated with social desirability. This would be the case since social desirability impacts self-report measures of multiculturalism (Constantine & Ladany, 2000). Further, this is also consistent with research that demonstrated that social desirability was positively correlated with higher endorsement of colorblind attitudes (Gushue, Walker, & Brewster, 2017). However, for the therapists-in-training group, there were no statistically significant correlations between multicultural orientation and social desirability. It is always important to explore the potential role of social desirability attitudes in studies that use various multicultural competency measurements. This scale was added to the study to contribute to the validity of the questionnaire data and strongly suggests that therapists-in-training answered this scale, the MCO-PT, and the other self-report measures in a genuine and authentic way. The MCO-PT shows concurrent validity and also discriminant validity in interesting ways. The section will further elaborate on

(a) implications of the four-factor model on theory, research, and practice, (b) limitations, (c) future directions, and (d) the summary and conclusion.

Implications of Theory, Research, and Practice

The development and initial validation of the MCO-PT is an important step in assessing MCO. As one of the first performance-based multicultural measures for therapists, the MCO-PT has demonstrated that it maps on the concept of MCO in a strong and unique way. The MCO-PT also showed good concurrent validity with the MCI, demonstrating that it relates to another well-established measure of multiculturalism within therapists, but also differentiates in ways that shows that it captures MCO and not MCC. The MCO-PT showed that it is a reliable and valid measure of MCO and has important implications for theory, research, and practice.

Cultural comfort, humility, and opportunity is a fresh and imperative way to look at multiculturalism within the field of psychology. In a society that is becoming increasingly conscious around areas of diversity, it is important that the field also progress in this way. Taking a MCO perspective creates spaces for marginalized individuals to feel safe, respected, and heard, which is sadly not reflective of their everyday world. Therapy provides an irreplaceable opportunity for marginalized individuals to heal and become whole again. To meet each client with MCO, allows for healing not only on an individual level but among families and communities.

Similar to facilitative interpersonal skills (FIS), therapists-in-training can engage in a performance task that measures challenging interpersonal situations in therapy. The FIS was validated as a measure, and also predicted therapy outcomes in its initial study.

Specifically, Anderson and colleagues found that approximately 25 percent of the variance in therapy outcomes attributed to therapists was accounted by their FIS ratings (Anderson et al., 2009). In a later study, Anderson et al (2016) replicated these results with short-term and long-term therapies. Therapist FIS significantly predicted client symptoms change. Additionally, when looking at the difference between duration of therapies, higher FIS therapists were more effective than lower FIS therapists over shorter durations (e.g., less than 8 sessions). The findings from the FIS studies led to researchers examining the effectiveness of the Clara E. Hill model of helping skills training as it relates to interpersonal skills (Hill et al., 2016). This study examined the FIS performance measure over time to see if it was predictive of improved helping skills over the course of training for students. The results of this study reveal that the FIS performance measure predicted high levels of helping skills among students. When thinking of the similarities between the FIS and MCO-PT, there is potential for the MCO-PT to be used in counseling programs to expand skills over a period of time. Future research should examine how the MCO-PT can be used for therapists-in-training to track improvements over time. In addition to tracking improvements of MCO over time, there also needs to be research done to determine if it predicts client symptom change.

Not only can the MCO-PT be used for therapists-in-training, but advanced therapists can also benefit from the use of this performance measure. Psychotherapy experts believe that psychotherapy expertise rests within continued, steady improvement over time (Goodyear, Wampold, Tracey, & Lichtenberg, 2017). Specifically, it is argued that the process of deliberate practice, using a performance measure and feedback, allows

for meaningful improvements for therapists. The benefits could be great not only for therapists-in-training, but also for advanced therapists looking to develop a more culturally-infused therapy practice.

Limitations

There are several limitations to present study. First, there was a small sample of participants for this study. Although the study was completed online, it took participants at least 45 minutes to complete. In the recruitment email, participants were advised that it would take at least 45 minutes to an hour to complete the study. This may have impacted the number of participants that signed up for the study. Perhaps if the study did not incorporate as many self-report measures, the total time would have been less and could have resulted in more participant recruitment. Due to the small sample of participants, we were not able to statistically compare therapists to non-therapists in the present sample.

A second limitation was the restricted demographics, specifically approximately 80% of the sample self-identified as White. Additionally, 82% self-identified as cisgender female and only 15% self-identified as part of the LGBT+ community. However, this is reflective of the demographics surrounding the counseling field today (APA Center of Workforce Studies, 2015). Continued outreach, advocacy, and funding needs to be prioritized so that the field can shift to be more representative and inclusive of all marginalized identities. The lack of diversity in the sample also meant that we were not able to examine the results by participant minority statuses.

The third limitation of this study was the Dehumanization Scale items should have been changed to reflect clients, instead of people in general for the therapists-in-

training sample. This would have allowed participants to reflect on their experience in the therapy room, versus in the world. The correlations were mixed, and perhaps would have been clearer if the items were specific to the therapeutic setting. Additionally, perhaps a different measure of empathy should have been used to capture empathy within the therapy setting. The IRI-B measures general empathy, such as empathic concern and perspective taking. However, from a multicultural perspective, there may be additional factors that enter the room that cannot be captured by those two constructs, but perhaps something more.

Lastly, the MCO-PT is not actual therapy. Since the performance measure uses simulated therapy sessions, it is important to highlight that it is not therapy in real time. Completing a performance measure is different than giving therapy with a client where the relationship has been established and a therapist is able to rely on content and social cues. Real-time therapy also allows for therapists-in-training to use a 45 to 60 minute session to explore culture in a comfortable and humble way, and makes room for interventions centered on cultural opportunities.

Recommendations for Future Directions

Research should move towards utilizing more performance-based measures of multiculturalism, such as the MCO-PT, to help therapists-in-training increase their MCO and potentially increase psychotherapy outcomes. It would be beneficial to look more closely at how therapists-in-training can improve their outcomes with clients over training. If the findings from this study suggest an importance in MCO when working with clients, it would be more than beneficial to explore how MCO can impact therapists-

in-training across helping professions. It would be also important to determine how the MCO-PT impacts varying clinical populations and clinical settings.

It would also be valuable for researchers to continue to explore how MCO can be applied to other modalities (e.g., couples therapy; group psychotherapy). Research has shown the benefit and importance of applying multicultural orientation in therapy groups (Kivlighan, Adams, Drinane, Tao & Owen, 2019). In the future, it would be beneficial to modify the MCO-PT to be used with group leaders and have videos that depict cultural situations among a psychotherapy group. In addition to exploring other modalities, it is recommended that researchers continue to explore MCO through qualitative methods. A qualitative perspective can advance the understanding of how clients or therapists experience cultural comfort, humility, and opportunity.

Summary and Conclusion

In conclusion, the MCO-PT is a robust performance measure of MCO. This study examined the construction of the MCO-PT and its coding system. Overall, the results of this study demonstrated reliability and validity of this measure. As one of the first multicultural performance measures to be constructed, practice of the MCO-PT is promising. The future of multicultural psychotherapy is optimistic, especially with the use of multicultural performance measures to increase the capability of mental health professionals meeting the imperative needs of underserved populations. More detailed examination of MCO will have major implications for researchers and practitioners that will have lasting impacts on the field of psychology.

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APPENDICES

APPENDIX A.

Color Blind Racial Attitudes Scale (CoBRAS)

Directions. The following is a set of questions that deal with social issues in the United States (U.S.). Using the 6-point scale, please give your honest rating about the degree to which you personally agree or disagree with each statement. Please be as open and honest as you can; there are no right or wrong answers.

1	2	3	4	5	6
Strongly Disagree					Strongly Agree

1. Everyone who works hard, no matter what race they are, has an equal chance to become rich.
2. Race plays a major role in the type of social services (such as type of healthcare or daycare) that people receive in the U.S.
3. It is important that people begin to think of themselves as American and not African American, Mexican American or Italian American.
4. Due to racial discrimination, programs such as affirmative action are necessary to help create equality.
5. Racism is a major problem in the U.S.
6. Race is very important in determining who is successful and who is not.
7. Racism may have been a problem in the past, but it is not an important problem today.
8. Racial and ethnic minorities do not have the same opportunities as White people in the U.S.
9. White people in the U.S. are discriminated against because of the color of their skin.

10. Talking about racial issues cause unnecessary tension.
11. It is important for political leaders to talk about racism to help work through or solve society's problems.
12. White people in the U.S. have certain advantages because of the color of their skin.
13. Immigrants should try to fit into the culture and adopt the values of the U.S.
14. English should be the only official language in the U.S.
15. White people are more to blame for racial discrimination in the U.S. than racial and ethnic minorities.
16. Social policies, such as affirmative action, discriminate unfairly against White people.
17. It is important for public schools to teach about the history and contributions of racial and ethnic minorities.
18. Racial and ethnic minorities in the U.S. have certain advantages because of the color of their skin.
19. Racial problems in the U.S. are rare, isolated situations.
20. Race plays an important role in who gets sent to prison.

APPENDIX B.

Self-Dehumanization Scale

Completely disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Completely agree
1	2	3	4	5	6	7

In interpersonal relationships, I perceive myself as:

Capable of interpersonal warmth.	1	2	3	4	5	6	7
Open-minded, and capable to think clearly.	1	2	3	4	5	6	7
Emotional, responsive, and warm.	1	2	3	4	5	6	7
Superficial, like I had no depth.	1	2	3	4	5	6	7
An object, not a human.	1	2	3	4	5	6	7
Mechanical and cold, comparable to a robot.	1	2	3	4	5	6	7

I generally perceive myself as:

Refined and cultured.	1	2	3	4	5	6	7
Mature as an adult.	1	2	3	4	5	6	7
Capable of self-control.	1	2	3	4	5	6	7
Logical and rational.	1	2	3	4	5	6	7
Not fully evolved as a human, closer to an animal.	1	2	3	4	5	6	7
Intellectually rough, unsophisticated.	1	2	3	4	5	6	7

I generally perceive other people as:

Capable of interpersonal warmth. 1 2 3 4 5 6 7

Open-minded, and capable to think clearly. 1 2 3 4 5 6 7

Emotional, responsive, and warm. 1 2 3 4 5 6 7

Superficial, like they had no depth. 1 2 3 4 5 6 7

Objects, not human beings. 1 2 3 4 5 6 7

Mechanical and cold, comparable to robots. 1 2 3 4 5 6 7

I generally perceive other people as:

Refined and cultured. 1 2 3 4 5 6 7

Mature as adults. 1 2 3 4 5 6 7

Capable of self-control. 1 2 3 4 5 6 7

Logical and rational. 1 2 3 4 5 6 7

Not fully evolved as humans, closer to animals. 1 2 3 4 5 6 7

Intellectually rough, unsophisticated. 1 2 3 4 5 6 7

APPENDIX C.

Interpersonal Reactivity Index (IRI)

The following statements inquire about your thoughts and feelings in a variety of situations. For each item, indicate how well it describes you by choosing the appropriate letter on the scale at the top of the page: 1, 2, 3, 4, or 5. When you have decided on your answer, fill in the letter on the answer sheet next to the item number. READ EACH ITEM CAREFULLY BEFORE RESPONDING. Answer as honestly as you can. Thank you.

1 2 3 4 5

DOES NOT
DESCRIBE ME
WELL

DESCRIBES ME
VERY
WELL

1. I often have tender, concerned feelings for people less fortunate than me.
2. I really get involved with the feelings of the characters in a novel.
3. In emergency situations, I feel apprehensive and ill-at-ease.
4. I try to look at everybody's side of a disagreement before I make a decision.
5. When I see someone being taken advantage of, I feel kind of protective toward them.
6. I sometimes try to understand my friends better by imagining how things look from their perspective.
7. After seeing a play or movie, I have felt as though I were one of the characters.

8. Being in a tense emotional situation scares me.
9. When I see someone being treated unfairly, I feel very much pity for them.
10. I would describe myself as a pretty soft-hearted person.
11. When I watch a good movie, I can very easily put myself in the place of a leading character.
12. I tend to lose control during emergencies.
13. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.
14. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.
15. When I see someone who badly needs help in an emergency, I go to pieces.
16. Before criticizing somebody, I try to imagine how I would feel if I were in their place.

APPENDIX D.

Multicultural Counseling Inventory (MCI)

The following statements cover counselor practices in multicultural counseling. Indicate how accurately each statement describes you as a counselor, psychologist, or student in a mental health training program when working in a multicultural counseling situation.

Give ratings that you actually believe to be true rather than those that you wish were true.

The Scale ranges from 1 (very inaccurate) to 4 (very accurate). The Scale indicates the following:

1	2	3	4
Very Inaccurate	Somewhat Inaccurate	Somewhat Accurate	Very Accurate

When working with minority clients.....

1. I perceive that my race causes clients to mistrust me.
2. I have feelings of overcompensation, over solicitation, and guilt that I do not have when working with majority clients.
3. I am confident that my conceptualizations of client problems do not consist of stereotypes and biases.
4. I find that differences between my worldviews and those of the clients impede the counseling process.
5. I have difficulties communicating with clients who use a perceptual, reasoning, or decision-making style that is different from mine.
6. I include the facts of age, gender roles, and socioeconomic status in my understanding of different minority cultures.

7. I use innovative concepts and treatment methods.
8. I manifest an outlook on life that is best described as “world-minded” or pluralistic.
9. I examine my own cultural biases.
10. I tend to compare client behaviors with those of majority group members.
11. I keep in mind research findings about minority clients’ preferences in counseling.
12. I know what are the changing practices, views, and interests of people at the present time.
13. I consider the range of behaviors, values, and individual differences within a minority group.

When working with minority clients.....

14. I make referrals or seek consultations based on the clients’ minority identity development.
15. I feel my confidence is shaken by the self-examination of my personal limitations.
16. I monitor and correct my defensiveness (e.g., anxiety, denial, minimizing, over confidence).
17. I apply the sociopolitical history of the clients’ respective minority groups to understand them better.
18. I am successful at seeing 50% of the clients more than once, not including intake.
19. I experience discomfort because of their different physical appearance, color, dress, or socioeconomic status.
20. I am able to quickly recognize and recover from cultural mistakes or misunderstandings.

21. I use several methods of assessment (including free response questions, observations, and varied sources of information and excluding standardized tests).
22. I have experience at solving problems in unfamiliar settings.
23. I learn about clients' level of acculturation to understand the clients better.
24. I understand my own philosophical preferences.
25. I have a working understanding of certain cultures (including African American, Native American, Hispanic, Asian American, new Third World immigrants, and international students).
26. I am able to distinguish between those who need brief, problem-solving structured therapy and those who need long-term, process-oriented, unstructured therapy.
27. When working with international students or immigrants, I understand the importance of the legalities of visa, passport, green card, and naturalization.

Evaluate the degree to which following multicultural statements can be applied to you.

28. My professional or collegial interactions with minority individual are extensive.
29. In the past year, I have had a 50% increase in my multicultural case load.
30. I enjoy multicultural interactions as much as interactions with people of my own culture.
31. I am involved in advocacy efforts against institutional barriers in mental health services for minority clients (e.g., lack of bilingual staff, multicultural skilled counselors, and outpatient counseling facilities).
32. I am familiar with nonstandard English.

33. My life experiences with minority individuals are extensive (e.g., via ethnically integrated neighborhoods, marriage, and friendship).
34. In order to be able to work with minority clients, I frequently seek consultation with multicultural experts and attend multicultural workshops or training sessions.
- When working with all clients.....*
35. I am effective at crisis interventions (e.g., suicide attempt, tragedy, broken relationship).
36. I use varied counseling techniques and skills.
37. I am able to be concise and to the point when reflecting, clarifying, and addressing problems.
38. I am comfortable with exploring sexual issues.
39. I am skilled at getting a client to be specific.
40. I make my nonverbal and verbal responses congruent.

12. I sometimes lose out on things because I can't make up my mind soon enough.
13. The reason I vote is because my vote can make a difference.
14. My parents were not always fair when they punished me.
15. I am a completely rational person.
16. I rarely appreciate criticism.
17. I am very confident of my judgments.
18. I have sometimes doubted my ability as a lover.
19. It is alright with me if some people happen to dislike me.
20. I don't always know the reasons why I do the things I do.
21. I sometimes tell lies if I have to.
22. I never cover up my mistakes.
23. There have been occasions when I have taken advantage of someone.
24. I never swear.
25. I sometimes try to get even rather than forgive and forget.
26. I always obey laws, even if I'm unlikely to get caught.
27. I have said something bad about a friend behind his or her back.
28. When I hear people talking privately, I avoid listening.
29. I have received too much change from a salesperson without telling him or her.

30. I always declare everything at customs.
31. When I was young I sometimes stole things.
32. I have never dropped litter on the street
33. I sometimes drive faster than the speed limit
34. I never read sexy books or magazines.
35. I have done things that I don't tell other people about.
36. I never take things that don't belong to me.
37. I have taken sick-leave from work or school even though I wasn't really sick.
38. I have never damaged a library book or store merchandise without reporting it.
39. I have some pretty awful habits.
40. I don't gossip about other people's business.