



2019

THE ROLE OF THERAPIST MULTICULTURAL COMPETENCY ON TREATMENT OUTCOMES

Minnah Farook

University of Kentucky, mwfarook@gmail.com

Author ORCID Identifier:

 <https://orcid.org/0000-0002-9949-8245>

Digital Object Identifier: <https://doi.org/10.13023/etd.2019.293>

Right click to open a feedback form in a new tab to let us know how this document benefits you.

Recommended Citation

Farook, Minnah, "THE ROLE OF THERAPIST MULTICULTURAL COMPETENCY ON TREATMENT OUTCOMES" (2019). *Theses and Dissertations--Educational, School, and Counseling Psychology*. 87.
https://uknowledge.uky.edu/edp_etds/87

This Doctoral Dissertation is brought to you for free and open access by the Educational, School, and Counseling Psychology at UKnowledge. It has been accepted for inclusion in Theses and Dissertations--Educational, School, and Counseling Psychology by an authorized administrator of UKnowledge. For more information, please contact UKnowledge@lsv.uky.edu.

STUDENT AGREEMENT:

I represent that my thesis or dissertation and abstract are my original work. Proper attribution has been given to all outside sources. I understand that I am solely responsible for obtaining any needed copyright permissions. I have obtained needed written permission statement(s) from the owner(s) of each third-party copyrighted matter to be included in my work, allowing electronic distribution (if such use is not permitted by the fair use doctrine) which will be submitted to UKnowledge as Additional File.

I hereby grant to The University of Kentucky and its agents the irrevocable, non-exclusive, and royalty-free license to archive and make accessible my work in whole or in part in all forms of media, now or hereafter known. I agree that the document mentioned above may be made available immediately for worldwide access unless an embargo applies.

I retain all other ownership rights to the copyright of my work. I also retain the right to use in future works (such as articles or books) all or part of my work. I understand that I am free to register the copyright to my work.

REVIEW, APPROVAL AND ACCEPTANCE

The document mentioned above has been reviewed and accepted by the student's advisor, on behalf of the advisory committee, and by the Director of Graduate Studies (DGS), on behalf of the program; we verify that this is the final, approved version of the student's thesis including all changes required by the advisory committee. The undersigned agree to abide by the statements above.

Minnah Farook, Student

Dr. Robert J. Reese, Major Professor

Dr. Michael D. Toland, Director of Graduate Studies

THE ROLE OF THERAPIST MULTICULTURAL COMPETENCY
ON TREATMENT OUTCOMES

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Education
at the University of Kentucky

By

Minnah W. Farook

Lexington, Kentucky

Director: Dr. Robert J. Reese, Professor of Counseling Psychology

Lexington, Kentucky

2019

Copyright © Minnah W. Farook 2019

ABSTRACT OF DISSERTATION

THE ROLE OF THERAPIST MULTICULTURAL COMPETENCY ON TREATMENT OUTCOMES

Racial and ethnic minority populations suffer disproportionately from mental health disparities in the United States (Dillon et al., 2015; Holden et al., 2014). Research has indicated that a lack of culturally competent care contributes to these disparities (Holden & Xanthos, 2009). As multicultural competencies (American Psychological Association [APA], 2002; Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2003) have been widely endorsed and implemented in professional organizations and training programs, research on their need and usefulness has increased over the last three decades (Worthington et al., 2007). However, the majority of research on multicultural competencies has relied on analogue studies, college students, and trainees as participants (Ridley & Shaw-Ridley, 2011; Worthington et al., 2007).

The current study contributed to the multicultural competency literature by including perspectives from real clients with diverse backgrounds in community settings, along with assessing therapist multicultural competency (MCC). The study examined the relationship between therapist ($n = 28$) multicultural competency (MCC) and psychotherapy outcomes of clients ($n = 2024$) from diverse racial/ethnic backgrounds in a community mental health agency. Therapist MCC did not have a statistically significant positive relationship with treatment outcome. Therapist MCC also did not have a statistically significant positive relationship with reliable or clinically significant change in treatment outcome. Results do not indicate any mediating effect of therapist MCC between race and treatment outcomes. Gender predicted overall treatment outcomes, clinically significant change and reliable change in treatment. Findings suggest cultural variables may have played a role in treatment outcomes given the differences in treatment outcomes for female clients, despite the lack of association found between therapist MCC and treatment outcomes. Implications for clinical practice and research are discussed.

KEYWORDS: multicultural Competency, therapist effects,
treatment outcome, racial disparities, multicultural training.

Minnah W. Farook

Student's Signature

7/15/2019

Date

THE ROLE OF THERAPIST MULTICULTURAL COMPETENCY
ON TREATMENT OUTCOMES

By

Minnah W. Farook

Robert J. Reese, Ph.D.

Director of Dissertation
Michael D. Toland, Ph.D.

Director of Graduate Studies
7/15/2019

Date

ACKNOWLEDGEMENTS

First, I would like to extend my sincerest gratitude to my advisor, Dr. Jeff Reese, for all his support, guidance, and encouragement throughout my graduate school career. Thank you for your patience with me during some difficult periods. Your passion for applied psychology inspired me to do the research and clinical practice that will make a difference in the lives of our clients today and tomorrow.

A huge thank you to my committee members. Thank you to Dr. Tyler for challenging me to think deeply and grow as a researcher. I am grateful to Dr. Rostosky for helping to me to grow as an academic writer since the first semester in EDP 606 to the end of my dissertation. I would like to acknowledge Dr. Ma for his patience and guidance with my data analysis. Thank you to Dr. Bob Bohanske and Dr. Barry Duncan for helping me with this project. Many thanks to all the participants in this study. This dissertation would not have happened without your support.

To my Mom and Dad, thank you for all the sacrifices you made and continue to make for your children. Your love and generosity can never be repaid. To Shammi and Tanni, thank you for your friendship and all the laughs that keep me going. To Shezoafa, I will be forever indebted to you for your love and support.

I am grateful to all my friends and mentors for your support and encouragement that helped me to keep going and believe in myself. Thanks to Roberto, Sanghee, MiKeiya, Mansi, and Danyella for keeping me focused. To Dr. Frieson Bonaparte, thank you for your patience, support, and listening ear. I would not have made it through the last leg of the journey without you.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	iii
LIST OF TABLES	vi
LIST OF FIGURES	vii
CHAPTER ONE: INTRODUCTION AND REVIEW OF LITERATURE.....	1
Introduction.....	1
Statement of the Problem.....	2
Multicultural Competency	4
Multicultural Competency Model.....	4
Empirical Literature on Therapist MCC.....	6
Multicultural Training	6
Therapist Effectiveness with REM Clients	8
Gender as a cultural variable.....	8
Culturally Responsive Treatment	9
Microaggressions in Treatment.....	10
Therapist MCC and Treatment Outcomes with Real Clients	11
Limitations in Existing MCC Research.....	13
Implications for Counseling Psychology	17
Goals for the Current Study	18
Hypotheses	18
CHAPTER TWO: METHOD.....	19
Participants.....	20
Measures	21
Data Analysis	24
CHAPTER THREE: RESULTS	28
Race as a Predictor of Treatment Outcomes.....	34
Therapist Effects due to MCC	35
CHAPTER FOUR: DISCUSSION AND CONCLUSIONS	38
REM Status in Client-Therapist Dyad	38
Therapist MCC.....	40
Study Limitations.....	43
Conclusion.....	45
REFERENCES	47
VITA.....	67

LIST OF TABLES

Table 1: Summary Statistics for Interval Variables	29
Table 2: Mixed Models of Final ORS Scores	36
Table 3: Generalized Linear Mixed Model for Clinically Significant Change	36
Table 4: Generalized Linear Mixed Model for Reliable Change	37

LIST OF FIGURES

Figure 1: Distribution of Final ORS Scores by Therapist.....	30
Figure 2: Distribution of Change Scores by Client and Therapist Race.....	31
Figure 3: Therapist Multicultural Competency by Therapist Race	32
Figure 4: Scatter Plots of Multicultural Competency and Change Scores.....	33

CHAPTER ONE: INTRODUCTION AND REVIEW OF LITERATURE

Due to changes in demographics in the United States, counselors and therapists are likely to serve clients who have a culturally diverse background. Data from the 2010 United States (U.S.) Census indicated that foreign-born individuals represented 13.3% (or 42.3 million) of the population in the United States (Colby & Ortman, 2014). In 2014, the U.S. population by race was represented by 62.2% of non-Latina/o Whites, while multiracial individuals and racial and ethnic minorities (Colby & Ortman, 2014) represented 37.8%. By 2044, this percentage is expected to grow to more than 50% for racial and ethnic minorities, and by 2060, 20% of the U.S. population is expected to be foreign born (Colby & Ortman, 2014).

These changes demand that counselors and therapists prepare to effectively serve the needs of these diverse populations. Although there has been growth in research and services on the health and mental health needs of racial and ethnic minorities, racial and ethnic minority populations suffer disproportionately from mental health disparities in the United States (Dillon et al., 2015; Holden et al., 2014; Smedley, Stith, & Nelson, 2003). The health disparities literature indicates that compared to White Americans, racial and ethnic minorities are less likely to have access to mental health services, less likely to utilize mental health services, more likely to receive lower quality mental health care, and less likely to remain in treatment (Dillon et al., 2015; Holden et al., 2014). When they do seek mental health care, they are more likely to be underdiagnosed and undertreated for affective disorders, overdiagnosed and overtreated for psychotic disorders, and less likely to receive newer and more comprehensive care (Agency for Health care Research and

Quality [AHRQ], 2012; Greenberg & Rosenbeck, 2003). The overall disparities in mental healthcare have been associated with a lack of cultural competency (Holden et al., 2015; Holden & Xanthos; Shim et al. 2013; van Ryn & Fu, 2003). The U.S. Department of Health and Human Services Office of Minority Health (2013) defines culturally and linguistically appropriate services as “care and services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients.” Researchers and leaders in mental health care have recommended and mandated mental health professionals provide culturally competent care to reduce mental health disparities (American Psychological Association [APA], 2002a; Arredondo et al., 1996; Sue et al., 1982).

APA ethical principles (2002a) and the American Counseling Association Code of Ethics (2014) advise psychologists and counselors on the boundaries of competence and instructs them to only provide services to populations included in their education, training, supervised experience, consultation, study, or professional experiences. APA has provided guidelines for multicultural education, training, research, practice, and organizational change for psychologists (2002b). ACA (2015) has also developed multicultural and social justice counseling competencies that offer guidance for counselors in practice and research. These guidelines, ethical principles and codes suggest that it is unethical for counselors and psychologists to provide services to culturally diverse populations if they have not had any education and training in multicultural competencies.

Statement of the Problem

Although the need for multicultural competencies have been widely accepted and multicultural competency guidelines have been widely implemented in professional psychological organizations and training programs (Worthington, Soth-McNett, & Moreno, 2007), the existing research on the effectiveness of multicultural competencies (MCC) and the validity of the widely used tripartite model of MCC (Sue et al., 1982) have produced mixed results (Barden, Sherrell, & Matthews, 2017; Owen, Leach, Wampold & Rodolfa, 2011; Owen et al., 2015; Ridley & Shaw-Ridley, 2011; Worthington, Soth-McNett & Moreno, 2007). Multicultural competence, as defined by D. W. Sue (2001a), is obtaining the awareness, knowledge, and skills to work with people of diverse backgrounds in an effective manner. Sue and colleagues (1982) developed the tripartite model of MCCs that include attitudes and beliefs, knowledge, and skills. They proposed that 1) culturally competent counseling psychologists are aware of their own beliefs, attitudes, values, and worldviews that might impact their work with their clients; 2) they have the knowledge of beliefs, attitudes, values, and worldviews that are common to the specific populations they work with; and 3) they have the skills necessary to work with diverse populations (Sue et al., 1982).

As the acceptance of MCC has grown over the last three decades, there have been many conceptual and empirical studies on MCC (Ridley & Shaw-Ridley, 2011; Worthington et al., 2007). However, much of the empirical MCC literature indicate an overreliance on analogue studies, college student populations, trainees, and indirect measures (Barden, Sherrell, & Matthews, 2017; Worthington et al., 2007; Worthington & Dillon, 2011). The existing literature has a lack of empirical studies that examines MCCs using strong measures and research design, real clients, independent practitioners, and

participants who are representative of the population at large. The purpose of the current study was to examine whether therapist multicultural competency predicts treatment outcomes of real clients with culturally diverse backgrounds. Below I provide a review of the existing MCC literature and the current study.

Multicultural Competency

Scholars and researchers have defined MCC in various ways (Cornish, Schreier, Nadkarni, Metzger, & Rodolfa, 2010). D. W. Sue and colleagues (1992) defined MCC as counselors having the awareness of their own worldviews, biases and beliefs related to racial and ethnic minorities, understanding the worldviews of individual clients, and acquiring and using culturally responsive interventions and strategies in their work with clients. According to Sue (1998), MCC is the ability to appreciate diverse cultures and populations, and the ability to effectively work with culturally diverse individuals. He stressed that MCC is also possessing culture-specific skills needed to work effectively with clients from specific populations. Cornish and colleagues (2010) defined MCC as, “the extent to which a psychotherapist is actively engaged in the process of self-awareness, obtaining knowledge, and implementing skills in working with diverse individuals” (p. 7). Likewise, Owen, Tao, Leach, and Rodolfa (2011), focused on the behavior of the counselor, and defined MCC as “a way of doing” that evaluates the counselor’s ability to apply their multicultural awareness and knowledge in counseling (p. 274). The definitions and dimensions of MCC continue to be defined and redefined, along with models counselors can use to develop their MCCs.

Multicultural Competency Model. Similar to the definition of MCC, there are many conceptualizations of MCC. Early MCC research focused on the model of racial

and ethnic matching of clients and therapists in the 1970s and 1980s (Pope-Davis, Coleman, Liu, & Toporek, 2003). Although clients might prefer to work with counselors who are a member of their group, research in this area has produced mixed results on the effectiveness of such matching (Karlsson, 2005; Smith & Trimble, 2016; Watkins & Terrel, 1988). Carney and Kahn (1984) offered a 5-phase developmental model of MCC and Bennett (2004) suggested a developmental model of MCC that includes six stages, with three stages of ethnocentrism and three stages of ethnorelativism. In addition to developmental models, some scholars have offered process models of MCC. Dungee-Anderson and Beckett (1995) presented the multicultural communication process model that is composed of eight steps: 1) acknowledge cultural differences, 2) know self, 3) know other cultures, 4) identify and value differences, 5) identify and avoid stereotypes, 6) empathize with people from other cultures, 7) adapt rather than adopt, and 8) acquire recovery skills. Lopez (1997) introduced a four-part process model of cultural competence designed to help supervisors guide counselors, while Cross (1989) introduced a six-stage model of cultural competence that can be used with individuals and organizations.

One of the most widely used and most researched models (Worthington et al., 2007) of MCCs in the literature is the tripartite model (Sue et al., 1982; Sue et al., 1992). Sue and colleagues' (1992) conceptualization of MCCs include three dimensions: 1) beliefs and attitudes, 2) knowledge, and 3) skills (Sue et al., 1982, Sue et al., 1992). Sue and colleagues (1992) described the three dimensions of a culturally competent counselor as: 1) being aware of one's own values, beliefs, and worldviews, and limitations that might impact their work with a culturally different client; paying special attention to the

impact ethnocentrism might have on one's work with racially, ethnically, and otherwise culturally different clients; 2) making a genuine effort to understand the client's values, beliefs, and worldviews, and how that impact the client's life; the counselor approaches this in a nonjudgmental manner and accepts the client's worldviews as a valid way of life; 3) and possessing the skills and interventions necessary for working with the culturally different client, and practices them in one's work with the particular client (Sue et al. 1982; Sue et al., 1992; Sue et al., 1998). For the purposes of this study, the tripartite model of MCC will be used to conceptualize MCC. Given that the tripartite model is the most commonly used model of MCC by training programs, scholars, and practitioners, it should be further examined to confirm its validity.

Empirical Literature on Therapist MCC

Multicultural training. Research supports that therapist training in multicultural issues and therapist MCC may predict psychotherapy processes and outcomes (Tao, Owen, Pace, & Imel, 2015). Therapists who reported higher levels of formal multicultural training rated higher on a self-report measure of empathy and had higher scores on their multicultural case conceptualization ability (Constantine, 2001a). Therapists who reported having prior multicultural training also scored higher on observer-rated therapist MCC (Constantine, 2001b). Multicultural training has been demonstrated to have a mediating role between higher levels of awareness/commitment to an individual's own ethnic identity and their MCC and higher levels of egalitarian gender role beliefs and MCC (Chao & Nath, 2011). In addition, therapist participation in cultural sensitivity training has been associated with higher client engagement, higher client satisfaction, and higher ratings from clients on expertness, trustworthiness,

attractiveness, unconditional regard, and empathy compared to counselors who did not receive the culture sensitivity training (Wade & Bernstein, 1991). Constantine (2002) found that clients' perceptions of their counselors' MCC and general counseling competencies predicted their satisfaction with treatment. Moreover, clients' perception of their counselors' MCC predicted satisfaction beyond the variance previously accounted for by general counseling competencies (Constantine, 2002). Clients' perception of their therapist's cultural humility has been positively associated with treatment outcomes (Owen et al., 2014; Owen et al., 2015). Cultural humility also moderated the association between missed opportunities to talk about cultural identities and treatment outcomes.

Cultural awareness and cultural knowledge, components of MCC, have also accounted for variability in therapist multicultural competency (Barden, Sherrell, & Matthews, 2017). Higher levels of awareness and commitment to one's own ethnic identity, for both REM and White therapists, have predicted higher levels of therapist MCC. Higher levels of multicultural self-efficacy have explained variance in therapist MCC (Matthews, Barden, & Sherrell, 2018). Similarly, there was a positive association between multicultural self-efficacy and awareness of and commitment to one's own ethnic identity. Barden, Sherrell, and Matthews (2017) found that both REM and White therapists reported having higher competence in the area of awareness than the area of knowledge. They also found that REM therapists scored higher in the knowledge area compared to White therapists, suggesting that multicultural training is still needed to improve trainees' and therapists' knowledge of values and worldviews of their culturally diverse clients. Given that knowledge and skills are closely connected, therapists with

lower competence in the knowledge area are likely to be less competent in skills, affecting their overall MCC.

Therapist effectiveness with REM clients. Some therapists vary in their effectiveness in treating REM clients. Research indicates that therapists vary, at least partially, on their ability to reduce symptoms of REM clients (Hayes, Owen, & Bieschke, 2015; Hayes, McAleavey, Castonguay, & Locke, 2016). Therapists' comfort with REM clients have predicted therapist variability between client REM status and unilateral termination (Owen et al., 2017). Additionally, REM clients are more likely to unilaterally terminate treatment compared to White clients (Owen, Imel, Adelson, & Rodolfa, 2012). Research suggests that some therapists may not be as successful at creating culturally welcome spaces for their clients compared to others, which may lead to cultural concealment in therapy (Drinane, Owen, & Tao, 2018). Drinane, Owen, and Tao (2018) found that clients who reported higher levels of concealing aspects of their cultural identities in treatment had worse outcomes compared to clients who engaged in lower levels of cultural concealment (Drinane, Owen, & Tao, 2018). Additionally, therapists whose clients engaged in more cultural concealment on average had clients who had worse treatment outcomes (Drinane, Owen, & Tao, 2018).

Gender as a cultural variable in psychotherapy. When discussing cultural diversity in psychotherapy, there is a tendency to focus on racial and ethnic identity. It is important to consider how other cultural variables such as gender identity may impact treatment. Kivlighan et al. (2019) found that therapist varied in their effectiveness with clients based on clients' intersecting identities of race and gender. Similarly, Owen, Wong and Rodolfa (2009) found that even though male and female clients did not differ

in overall treatment outcomes, some therapists were better at were more effective with men and some were more effective with women. Research also indicates that there are gender and ethnic differences in response to interventions (Gryczynski, Carswell, O'Grady, Mitchell, & Schwartz, 2018). These findings suggest that gender as a cultural variable affects psychotherapy outcomes.

Culturally responsive treatment. In analogue studies with African American (Poston, Craine, & Atkinson, 1991; Thompson, Worthington, & Atkinson, 1994), Mexican American (Atkinson, Casas, & Abreu, 1992), Japanese American (Atkinson & Matsushita, 1991), and other Asian American clients (Gim, Atkinson, & Kim, 1991; Kim, Li, & Liang, 2002), MCC scholars have found that culturally congruent and culturally responsive verbalizations in therapy had a more positive impact on client outcomes compared to verbalizations that focus on the universality of human experiences. Asian American volunteer clients' experience in psychotherapy showed that clients reported higher working alliance and higher therapist empathic understanding when their therapist used interventions that sought immediate resolution of problems rather than focusing on gaining insight through exploration. Clients with higher adherence to Asian values reported higher therapist MCC when therapists encouraged emotional expression rather than expression of cognitions. These results are congruent with the Asian value of favoring immediate problem resolution early in therapy and anticipating emotional needs of others for interpersonal harmony (Sue & Sue, 2012). Similarly, in randomized clinical trials with Latinx adolescents in substance abuse treatment, the Accommodated Cognitive-Behavioral Treatment, modified to include Latinx cultural values, produced

better treatment outcomes compared to the Standard Cognitive-Behavioral Treatment (Burrow-Sanchez, Minami, & Hops, 2015).

Microaggressions in treatment. Studies also indicated that therapists' culturally insensitive behaviors such as microaggressions predict poorer psychotherapy outcomes. Sue et al. (2007) defined microaggressions as "brief and commonplace daily verbal or behavioral indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults that potentially have a harmful or unpleasant psychological impact on the target person or group" (p. 273). Owen, Tao, and Rodolfa (2010) found that female clients' reports of gender-based microaggressions was negatively associated with therapeutic alliance and therapy outcomes. The results also demonstrated that clients' perception of a strong therapeutic alliance had a mediating effect on the relationship between perception of microaggressions and psychotherapy outcomes. These findings suggest that therapist biases can cause ruptures in the therapeutic relationship and may impact treatment outcomes and client attrition, particularly when the ruptures are not repaired (Owen et al., 2015; Owen et al., 2010). Similarly, Owen et al. (2011) found that clients' ratings of microaggressions had a negative relationship with psychological wellbeing and working alliance had a mediating effect on the relationship. Davis et al. (2016) confirmed these findings in their study with REM clients that indicated a negative relationship between clients' perceived gender-related microaggressions and cultural humility, therapeutic alliance, and treatment outcomes. However, Owen et al. (2011) did not find any relationship between REM status and clients' ratings of microaggressions.

Therapist MCC and treatment outcomes with real clients. A relationship between therapist MCC and psychotherapy processes and psychotherapy outcomes with actual clients has also been found. In a meta-analysis of 20 independent samples, Tao, Owen, Pace, and Imel (2015) found strong and positive effects of client perceptions of therapist MCC on important psychotherapy processes ($r = .58$ to $.72$), such as therapeutic alliance, and a moderate relationship between MCCs and psychotherapy outcomes ($r = .29$). This association between clients' ratings of therapist MCC and psychotherapy outcomes is supported by similar findings in the empirical literature, such as the association between therapist MCC and psychotherapy processes that include working alliance, empathy, genuineness, goal consensus and collaboration, and alliance-rupture repair (e.g., Elliott, Bohart, Watson, & Greenberg, 2011; Norcross & Lambert, 2011). The strong correlations between therapist MCC and psychotherapy process suggest that the two processes might occur simultaneously. When the client perceives the therapist as multiculturally competent, the client is more likely to have a strong therapeutic alliance with the therapist (Tao et al., 2015).

The association between cultural adaptations and therapist MCC, and treatment outcomes were also found in meta-analyses conducted by Soto, Smith, Griner, Domenech Rodriguez and Bernal (2018). Cultural adaptation is defined as making changes to standard treatments “to consider language, culture, and context in such a way that it is compatible with the client’s cultural patterns, meanings, and values” (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p. 362). Their meta-analysis of 99 studies investigating cultural adaptations yielded an average effect size of $d = 0.50$ and $d = 0.35$ after controlling for publication bias. The meta-analysis of 15 studies examining

therapist MCC indicated a strong correlation ($r = 0.38$) with treatment outcomes only when MCC was rated by clients, while studies with therapist-rated MCC did not predict treatment outcomes ($r = 0.06$). They also found that all 15 studies used convenience samples and 62% used university/college student samples.

While Tao et al.'s (2015) meta-analysis found a moderate relationship between clients' perceptions of their therapist MCC and their treatment outcomes, their analysis also indicated no correlations between different clients' perceptions of the same therapist's MCC. Previous studies have also found a lack of correlation between client ratings, observer ratings, and therapist self-ratings of MCC, casting a doubt on whether clients' perceptions of their therapist MCC is an accurate measure of the therapist's actual MCC. The results from this study also showed that client demographic variables had no impact on the association between clients' perceptions of their therapist MCC and psychotherapy outcomes. As racial disparities in mental health treatment persists, one would expect to see a relationship between lower therapist MCC with racial status or other demographic status of clients. Owen, Leach, Wampold and Rodolfa (2011) also did not find any variability in REM clients' perceptions of their therapist MCC. Clients' ratings of their therapist MCC did not predict treatment outcomes. Furthermore, there were no associations between REM status of clients, therapists, and client/therapist dyads, and treatment outcomes. Consistent with Owen et al.'s (2011) findings, Cabral and Smith's (2011) meta-analysis indicated that while clients tend to prefer a therapist of their own racial/ethnic identity and may perceive these therapists more positively than others, racial/ethnic matching did not predict treatment outcomes. These findings

indicate the relationship between therapist MCC and psychotherapy outcomes should be further investigated to account for racial/ethnic disparities in treatment outcomes.

Limitations in Existing MCC Research

A review of the literature indicates that while research on therapist MCC has increased over the last thirty years, many of the studies have yielded inconsistent findings (Owen et al. 2011; Soto et al., 2018; Tao et al. 2015; Worthington & Dillon, 2007), lacked methodological rigor (Atkinson, Casas, & Abreu, 1992; Atkinson & Matushita, 1991; Barden, Sherell, & Matthews, 2017; Constantine 2002; Davis et al., 2016; Gim, Atkinson, & Kim, 1991; Hayes et al., 2016; Soto et al., 2018), used indirect measures (Constantine, 2001a; Davis et al., 2016; Soto et al., 2018; Wade & Bernstein, 1991), and relied on volunteers (Kim, Li, & Liang, 2002), trainees (Constantine, 2001b; Hayes, Owen, & Bieschke, 2015; Kim 2002; Owen et al., 2011; Wade & Bernstein, 1991), and college/university students (Constantine, 2002, Davis et al., 2016; Drinane, Owen, & Tao, 2018; Hayes et al., 2016; Owen et al., 2010; Owen et al., 2011; Owen et al., 2012; Owen et al., 2014; Owen et al., 2015; Owen et al., 2017; Soto et al., 2018; Thompson, Worthington, & Atkinson, 1994). These limitations suggest that findings of the MCC literature are debatable as discussed below.

The validity of many of the existing MCC assessment instruments have been questioned (Kitaoka, 2005; Ridley & Shaw-Ridley, 2011). Research indicates that the theoretical basis of the current MCC assessment tools are questionable due to discrepancy in the factor structures (Constantine, Gloria, & Ladany, 2002; Kitaoka, 2005). Some direct measures use specific MCC models to assess therapist MCC by focusing on the therapists' skills and interventions (Tao et al., 2015), while indirect measures focus on

concepts related to MCC, such as engaging in microaggressions or measuring cultural humility (Tao et al., 2015). Outcome variables in MCC studies that investigate effectiveness of MCCs also use indirect measures. For example, some studies focus on treatment attrition as an indicator of therapeutic change or treatment effectiveness, as well as client perception of counselor as indicator of effective counseling (Ridley & Shaw-Ridley, 2011). Another critique of MCC measures is that some self-report measures of MCC might be assessing counselors' self-efficacy in multicultural counseling instead of actual MCC (Constantine & Ladany, 2001; Ottavi, Pope-Davis, & Dings, 1994).

Several MCC assessment tools are self-report measures, which are vulnerable to social desirability. Some limitations of using self-report measures include the possible influence of social desirability, political correctness, and attitudinal and attributional biases (Soto et al., 2018; Worthington et al., 2007). Constantine and Ladany (2000) found that social desirability attitudes are linked with the subscales of three of the four MCC measures they investigated. The three MCC measures are the Multicultural Counseling Inventory (MCI; Sadowsky, Taffe, Gutkin, & Wise, 1994), the Multicultural Awareness-Knowledge-and-Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991; Kim, Cartwright, Asay, & D'Andrea, 2003), and the modified self-report version of the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991). Their study also indicated that after controlling for social desirability, there was no association between the reported MCC and multicultural case conceptualization ability (Constantine & Ladany, 2000). Due to these results, it is important to use measures to control for social desirability in MCC studies that use

existing self-report measures (Constantine & Ladany, 2000; Dunn, Smith, & Montoya, 2006). These measures have been used in several studies without controlling for social desirability (Atkinson & Matushita, 1992; Constantine 2001b; Constantine 2002; Owen et al., 2011).

Inconsistent findings in existing studies that have examined therapist MCC and treatment outcomes are also concerning. Some studies indicate that there is a positive relationship between MCC and therapy outcomes (Atkinson & Lowe, 1995; Ponterotto, Fuertes, & Chen, 2000; Worthington & Dillon, 2011), while others indicate a lack of association or weak relationship between therapists' MCC and treatment outcome (Owen et al., 2011; Soto et al., 2018; Tao et al., 2015). Soto et al. (2018) found that clients' perception of their therapist MCC predicted treatment outcomes, while therapists' perception of their own MCC did not have a strong relationship with outcomes ($r = 0.06$).

Other limitations of the existing literature include use of analogue and retrospective studies. Worthington and colleagues (2007) noted that 24.7% of the studies in their meta-analysis of MCC research used analogue research (i.e., research in a laboratory setting meant to approximate reality) and 82.4% of studies that included client ratings of counselor MCCs included pseudo clients. Several recent studies have asked participants to recollect their past experiences in therapy (Davis et al., 2016; Owen et al., 2010; Owen et al., 2014). Retrospective studies may not be as reliable as researchers are relying on the participant's ability to accurately remember subtle details from their experience in psychotherapy. Study participants also lack diversity as there is an overreliance of female, young college students (Davis et al., 2016; Hayes et al., 2015; Hayes et al., 2016), White and female therapists (Barden et al., 2017; Davis et al., 2016;

Drinane et al., 2018; Hayes et al., 2016), and underrepresentation of real clients from racially diverse and low socioeconomic backgrounds (Worthington et al., 2007). While most studies published in the last ten years have included more gender and racially diverse participants, the majority of the participants were college/university students (Soto et al., 2018). Given that clients from diverse racial and low socioeconomic backgrounds in community mental health settings are the biggest consumers of mental health services in the United States and the preponderance of evidence indicates worse outcomes for racial minority clients compared to White clients (Holden et al., 2014), there is scant research that examines the experiences of racially diverse clients from community settings in the MCC literature.

Although multicultural competencies have been widely endorsed and implemented in professional organizations and training programs (Clauss-Ehlers, Chiriboga, Hunter, Roysircar, & Tummala-Narra, 2019; Ratts et al., 2016; Worthington, et al., 2007), there are a limited number of methodologically rigorous empirical studies evaluating how multicultural competencies influence psychotherapy treatment with real clients in community settings (Ridley & Shaw-Ridley, 2011; Soto et al., 2018; Worthington & Dillon, 2011). Existing multicultural competencies studies with actual clients have focused on the client's perspective, and there is a paucity of research that includes both client and therapist perspectives on multicultural competencies, therapeutic alliance, and treatment outcomes. Due to the abovementioned limitations of current studies and difficulties of capturing components of MCC, additional empirical research on psychotherapy processes and outcomes is necessary (Ridley & Shaw-Ridley, 2011; Worthington et al., 2007; Worthington & Dillon, 2011). The current study contributes to

the current MCC literature by including the treatment outcomes of real clients from the community who are racially diverse and have low socioeconomic backgrounds, and measuring therapists' assessment of their own MCC using strong measures and methodology.

Implications for Counseling Psychology

This study has implications for counseling psychology and the practice of professional psychology. The field of counseling psychology focuses on the functioning of individuals across the life span dealing with emotional, social, vocational, and other parts of the human experience (APA & Lichtenberg, 1999). The field was founded on the need to address personal, social, and environmental concerns, including culture and individual differences (Packard, 2009). The rationale and development of multiculturalism and multicultural competencies have been introduced by counseling psychologists, notably, D. W. Sue (1977, Sue et al., 1982). D. W. Sue and D. Sue (1977) asserted that an ethnocentric monocultural approach to professional training and counseling services creates and maintains barriers in communication that can hinder rapport and impact the therapeutic relationship, treatment retention, and treatment outcome with culturally diverse individuals. Given that multiculturalism and MCC play an important role in the field of counseling psychology, it is essential for counseling psychologists to continue to improve the current education, training, research, and practice related to MCC to promote the well-being of individuals as cultural beings. As the literature highlights the importance of MCC and the limitations in the existing research on MCC, this study sought to contribute to the literature by investigating the

relationship between MCC and treatment outcome with real clients from racially diverse and low socioeconomic backgrounds.

Goals for the Current Study

The purpose of this study was to examine the association between therapist multicultural competencies and psychotherapy outcomes. Specifically, this study evaluated how therapist MCC affects the treatment outcomes of culturally diverse individuals. The predictor variables in this study are MCC and race. The outcome variable in this study is treatment outcome. I have three research questions and two hypotheses to test the relationship between multicultural competency of therapists and treatment outcomes. The research questions and hypotheses are listed below.

Research questions:

1. Does race of the client, therapist, and client-therapist dyad predict treatment outcomes?
2. Does race predict differences in reliable/clinically significant change in treatment outcome?
3. Does therapist MCC mediate the relationship between race and treatment outcome?

Hypotheses:

1. Therapist MCC will have a statistically significant positive relationship with treatment outcome.
2. Therapist MCC will have a statistically significant positive relationship with reliable/clinically significant change in treatment outcome.

CHAPTER TWO: METHOD

The data from the current study were collected from therapists and clients of outpatient clinics of a large public behavioral health agency in Southwestern United States. The agency is a non-profit comprehensive community behavioral health organization that provides services to people living in five surrounding counties. The agency provides outpatient mental health services to clients from diverse racial and ethnic groups, and low socioeconomic backgrounds who present with a variety of mental health concerns. As part of its clinical processes, the therapists at this agency use the Partners for Change Outcome Management System (PCOMS; Duncan, 2012). The PCOMS is a client feedback system that includes the use of the Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003) and the Session Rating Scale (SRS; Duncan et al., 2003). The ORS and SRS were created to meet the practical needs and demands of clinicians using routine outcome monitoring (Duncan, 2012).

Therapists who have had at least 20 clients, who are adults ages 18 and older, (as indicated by an a-priori sample size calculator) were recruited for the study. In addition, therapist and client dyads that had at least three therapy sessions together were eligible to participate in the study. Having at least three sessions together allows for more accurate measurement of treatment outcome (Owen, Leach et al., 2011; Reese et al., 2013). Interested and eligible therapists were invited to complete a survey online or in person. The majority of the participants were recruited during agency staff meetings. They were assured that their responses will not be shared with their employer or supervisors. They were informed that their employee identification numbers will be shared with their employer to gather the archived data of their clients. Participants were provided with

information detailing the purpose, procedure, benefits and risks of the study. The survey included demographic questions, two MCC measures, and a social desirability measure all described below in the Measures section. Therapists provided their employee identification number that was used to link therapist data with archived data of their clients.

A total of 65 therapists completed the survey, but only 28 therapists were included in this study. The survey from other therapists were excluded as they did not provided treatment to at least 20 clients who are adults ages 18 or older. The excluded therapists primarily worked with children and adolescents. The archived data included clients' gender, age, race, education, number of therapy sessions, and ORS scores for each session that measured treatment outcome. All clients had completed treatment. After linking both sets of data, therapist employee identification numbers were assigned random identification numbers to ensure anonymity during data analysis. Only client data was used that preceded the therapists' completion of the measures.

Participants

Clients. There were 2,024 clients (1,259 females, 765 males; 1,114 White, 910 racial/ethnic minorities; REM). Of the 2,024 clients, 55% identified as White, 9.6% African American/Black, 15.9% Latinx, 0.5% Asian, 1.2% Native American, 0.2% Pacifica Islander, 6.5% multiracial, and 11% unknown/did not specify their racial/ethnic identity. Their ages ranged from 18 to 85 ($M = 38.15$, $SD = 12.72$). Clients' highest year of education ranged from 3 to 22 ($M = 12.01$, $SD = 1.828$). The agency provides services only to clients who have Medicaid or reported having incomes 100% below the federal poverty level. The number of sessions per client ranged from 3 to 278 sessions ($M =$

12.36, $SD = 18.25$). Clients had a variety of presenting concerns, but the majority of clients received mental health services for mood disorders, substance use disorders, schizophrenia spectrum and other psychotic disorders, posttraumatic stress disorder, generalized anxiety disorder and other anxiety disorders, and adjustment disorder.

Therapists. Twenty-eight therapists participated in the study (24 females, 4 males; 18 White, 10 REM). Of the 24 therapists, 18 identified as White, 2 identified as African American/Black, 2 Latinx, 1 Asian, 1 Native American, and 4 identified as Multiracial. Their ages ranged from 27 to 56 ($M = 36.57$, $SD = 7.666$). Twenty-five therapists identified as heterosexual, one identified as lesbian, one identified as Bisexual, and one did not specify their sexual orientation. Their annual household income ranged from less than \$25,000 to more than \$100,000, with median annual household income of \$50,000. Therapists' education ranged from bachelor's degree to doctorate degree (1 bachelor's, 24 masters, 3 doctorate). There were five therapists with 1 to 2 years of experience, 14 therapists had 2 to 5 years of experience, five therapists had 5 to 10 years of experiences, and four therapists had 10 to 15 years of experience. Three of 28 therapists provided therapy in English and Spanish, others provided therapy in English only. Therapists work from a variety of treatment approaches.

Measures

Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise et al., 1991). The CCCI-R is a 20-item instrument that assesses cross-cultural counseling skills, sociopolitical awareness, and cultural sensitivity. Items are rated on a 6-point Likert scale that range from 1 (strongly disagree) to 6 (strongly agree). The items on the CCCI-R were created to correspond with Sue et al.'s (1982) conceptualization of a

multiculturally competent counselor (Kitaoka, 2005; LaFromboise et al., 1991). In a validation study of the CCCI-R, where three expert judges evaluated the MCC of therapists in 13 counseling vignettes, the CCCI-R generated reliability estimates between .78 and .84 (LaFromboise et al., 1991). In another study (LaFromboise et al., 1991) where 86 university students evaluated a counseling interview, the CCCI-R produced an $\alpha = .95$ and interitem correlations between .18 and .73. Also, it has been found to have evidence of construct validity consistent with a three-factor model that parallels Sue et al.'s (1982) tripartite model (i.e., awareness, knowledge, and skills). The CCCI-R was intended to be used as an observer-rated measure (LaFromboise et al., 1991). However, the CCCI-R was successfully modified for client use and for use as a therapist self-report measure to assess perceived MCC in many studies (Constantine & Ladany, 2000; Ladany et al. 1997). The modified CCCI-R as a therapist self-report measure yielded a Cronbach's alpha of .88 in a study with 116 counselor trainees (Ladany et al., 1997). Similarly, the modified CCCI-R for client use ($N = 143$ clients and 31 therapists) generated a Cronbach's alpha coefficient of .96 (Owen, Leach, Wampold, & Rodolfa, 2011). The internal consistency of the CCCI-R in the current sample was $\alpha = 0.72$. The CCCI-R was used in this study given it was the only MCC measure that was not found to relate to social desirability (Constantine & Ladany, 2000).

Quick Discrimination Index (QDI; Ponterotto et al., 1995). The QDI is a 30-item measure that assesses therapist discriminatory attitudes. Items are responded to on a 5-point Likert scale that ranges from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate accepting and appreciative attitudes toward race and gender equity issues. A validation study ($N = 333$) of the QDI indicated a Cronbach's alpha coefficient

of .88 (Ponterotto et al., 1995). The results also showed concurrent validity ranging from .72 to .91, as evidenced by correlations with the New Racism Scale (NRS; Jacobson, 1985) and the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996). The internal consistency of the QDI in the current sample was $\alpha = 0.81$. To account for the weaknesses of self-report measures of MCC asserted by some scholars (e.g., Constantine & Ladany, 2000; Worthington et al., 2007), both the CCCI-R and the QDI were used to provide a more comprehensive evaluation of therapist MCC (Campbell & Fiske, 1959). Item 12 (i.e., It upsets or angers me that a racial minority person has never been president of the United States) of the QDI was removed from the survey as the item is no longer applicable.

Motivation to Control Prejudiced Reactions Scale (MCPRS; Dunton & Fazio, 1997). The MCPRS is a 17-item measure that assesses an individual's cultural social desirability, their motivation to appear non-prejudiced. The item responses are on a 7-point scale, where -3 is strongly disagree and +3 is strongly agree. Higher scores indicate greater social desirability. The internal consistency of the measure was .76 in a study with 429 undergraduate students (Dunton & Fazio, 1997). Dunton and Fazio (1997) found that MCPRS produced strong construct validity in study with 473 undergraduate students which found that MCPRS has two stable factors: "Concern with acting prejudiced" and "Restraint to avoid dispute" (Dunton & Fazio, 1997). Their study also demonstrated the resulting two factors predicted scores on the Modern Racism Scale (McConahay, 1986). The internal consistency of the MCPRS in the current sample was $\alpha = 0.78$. Research indicates that self-report measures of MCC may not be reliable due to the influence of social desirability on the participant's responses (Constantine & Ladany,

2000). The MCPRS was used to test whether social desirability has a statistically significant impact on the responses from the CCCI-R.

The Outcome Rating Scale (ORS; Miller et al., 2003). The ORS is a brief 4-item self-report measure that provides quick and visual feedback. The ORS assesses the client's level of functioning across four areas: individual, interpersonal, social, and overall. Scores on the ORS range from 0 to 40, with higher numbers indicating positive outcomes. The ORS has a cut-off score of 25. An improvement of 5 or more points is required to indicate reliable change on the ORS. The ORS was adapted from the Outcome Questionnaire-45 (OQ-45; Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994) and its correlation ($r = .59$) with the OQ-45 demonstrates its construct validity (Reese et al., 2009). The ORS produced strong internal consistency ranging from .87 to .96 (Miller et al., 2003). The concurrent validity of the ORS is indicated by correlation of .53 to .74 between the ORS and the OQ-45 (Bringhurst, Watson, Miller, & Duncan, 2006; Campbell & Helmsley, 2009; Miller et al., 2003).

Data Analysis

The primary outcomes are change in ORS scores, clinically significant change (increase of 6 or more points, with a cut-off score of 25), and reliable change (increase of 6 or more points). The first is measured on an interval scale, the latter two outcomes are binary. MCPRS scores were used to control for social desirability. Summary statistics are presented for the client and therapist demographics as well as the primary study variables. In addition to change in ORS, the multilevel models below also consider multicultural competencies as measured by the CCCI-R and QDI scales. The summary statistics for categorical variables are frequencies and percentages. The summary

statistics for interval variables are minimums, maximums, means, and standard deviations. Boxplots are used to visualize differences on the ORS change scores by client and therapist race, and scatterplots are used to visualize any associations between CCCIR, QDI, and ORS change scores. The figures provide evidence (or lack thereof) of any associations between the main independent variables and the primary outcome prior to fitting the full multivariate models.

Models were then fit to determine the effect of client race, therapist race, and the interaction between the two on each primary outcome. Given that there were not enough clients in each categories of REMs, the race variables were coded as dummy variables with REM being the reference category. With the inclusion of the interaction, the interpretation of the main effect for client race is the effect of having a REM therapist and a White client (relative to both being REM). The main effect for therapist race is the effect of having a White therapist and a REM client (relative to both being REM).

Given that the clients are nested within therapists, and therefore the observations are not completely independent, the outcomes are modeled using multilevel modeling (MLM; Hox 2002) that include a random effect to account for therapist variance. The final ORS score, being measured on an interval scale, is fit using a linear mixed model. The other two outcomes (i.e., reliable change and clinically significant change) require fitting a generalized linear mixed model using the logit link function (i.e., a multilevel logistic regression). I examined whether 1) therapists' race, clients' race, or race of therapist/client dyad predicted treatment outcomes; 2) therapists' race, client's race, or race of therapist/client dyad predicted reliable change or clinically significant change;

and 3) whether therapist MCC mediated the relationship between race and treatment outcomes.

To examine whether therapists' race, clients' race, or race of therapist/client dyad predicted treatment outcomes, I created a 2-level model to measure the therapist-level variance. Level one was the client level and level two was the therapist level. The null model is as follows:

$$\text{Final ORS}_{ij} = \gamma_{00} + u_{0j} + e_{ij}$$

where Y_{ij} is the Final ORS score for client i treated by therapist j ; γ_{00} is the intercept, u_{0j} is a random therapist effect or the variance between therapists, and e_{ij} is the variance at the client-level. Testing the null model indicated that there is statistically significant variance at the client-level but not at the therapist-level. Given that there is a lack of significance at the therapist-level, further analysis will be limited to client-level (level-one) variables.

Then, the final treatment outcome (i.e., Final ORS score) was fit using a linear mixed model. The model only includes client-level variables: client race, and other demographic variables to examine whether race predicts treatment outcomes. The model is the following:

$$\text{Final ORS}_{ij} = \gamma_0 + \gamma_1(\text{Client Race}_{ij}) + \gamma_2(\text{Client Age}_{ij}) + \gamma_3(\text{Client Gender}_{ij}) + \gamma_4(\text{Client Education}_{ij}) + \gamma_5(\text{Number of Sessions}_{ij}) + \gamma_6(\text{Initial ORS}_{ij}) + e_{ij}$$

where i is the patient treated by therapist j . The model also included Initial ORS as a covariate. Using backward deletion, variables were deleted if they were not statistically significant. The final model is as follows:

$$Y_{ij} = \gamma_0 + \gamma_1(\text{Initial ORS}_{ij}) + \gamma_2(\text{Client Gender}_{ij}) + \gamma_3(\text{Number of Sessions}_{ij}) + e_{ij}$$

(Final model 1)

For the multilevel logistic regression models, the dependent variable is the log odds of demonstrating clinically significant or reliable change. I used a generalized linear mixed model with logit link function to determine whether race predicted clinically significant change and reliable change. I used backward deletion to determine the final model for clinically significant change and reliable change.

$$Z \text{ (clinically significant change)} = \beta_0 + \beta_1(\text{Initial ORS}_{ij}) + \beta_2(\text{Number of Sessions}_{ij})$$

(Final model 2)

$$Z \text{ (reliable change)} = \beta_0 + \beta_1(\text{Initial ORS}_{ij}) + \beta_2(\text{Client Gender}_{ij}) + \beta_3(\text{Number of Sessions}_{ij})$$

(Final model 3)

Using the following formula, I predicted the probability clients achieving clinically significant change and reliable change in treatment:

$$prob(event) = \frac{1}{1 + e^{-Z}}$$

$$prob(event) = \frac{1}{1 + e^{-\beta_0 - \beta_1}}$$

The first model allows for a test of any mediating effect of multicultural competencies on the race and treatment outcomes. In the absence of a relationship between race and treatment outcomes in model one, there is nothing to mediate (Baron & Kenny, 1986; Krull & McKinnon, 2001).

CHAPTER THREE: RESULTS

Data were analyzed using SPSS 25. Table 1 presents the summary statistics describing the distribution of the primary study variables. Final ORS scores ranged from 1 to 40 with a mean of 25.2 and standard deviation of 9.12. Thirty-four percent ($n = 691$, 34.1%) of the clients demonstrated clinically significant change, and 41% ($n = 739$, 41.1%) demonstrated reliable change. Scores on the CCCI-R scale ranged from 92 to 112 with a mean of 100.93 and standard deviation of 5.39. Scores on the QDI scale ranged from 79 to 99 with a mean of 89.04 and a standard deviation of 5.33. The intraclass correlation among therapists was less than one percent (0.60%), indicating that the therapist level variance was quite low.

Figure 1 provides a visual summary of the data that, while not providing tests of significance, can help enlighten any significant or non-significant results that come from the statistical models presented later. Figure 1 displays the distribution of Final ORS scores by therapist. The figure shows that the distributions are relatively normal within therapist. Although there is some variability in median scores between therapist, the central tendency is roughly between 20 and 30. Figure 2 shows the distribution in change scores by therapist race and client race. The figure does not give the impression that change scores (i.e., change in ORS scores from initial ORS to final ORS, indicating treatment outcome) are greatly impacted by either race variable.

Figure 3 displays therapist multicultural competency by therapist race. The results show that REM therapists tend to score higher on multicultural competency (on both CCCI-R and QDI) insofar as the median line in the middle of the boxes are higher for REM therapists. However, the interquartile ranges (the edges of the boxes) overlap

between groups, suggesting that difference in the overall distributions is not large. More specifically, the mean CCCIR score for REM therapists is 103.1 ($SD = 3.64$), and the mean CCCI-R for White therapists is 99.72 ($SD = 5.91$). The mean QDI for REM therapists is 90.1 ($SD = 6.56$), and the mean QDI for White therapists is 88.44 ($SD = 4.62$). Independent samples t -tests indicates that there was a significant difference in the mean CCCI-R scores between REM therapists and White therapists ($t_{1961.448} = 16.347, p < .001$). REM therapists on average scored 3.378 points higher on the CCCI-R compared to White therapists. REM therapist also had higher (2.413 points) average QDI scores compared to White therapists ($t_{1866.304} = 11.544, p < .001$). Figure 4 presents scatterplots of each multicultural competency variable with Final ORS scores. Contrary to the third requirement for mediation, there does not appear to be any association between CCCI-R and Final ORS scores, nor between QDI and Final ORS scores. The points do not appear to increase or decrease as one moves along the horizontal axis.

Table 1
Summary Statistics for Interval Variables

Variable	Min	Max	Mean	SD
<i>Client Measures</i>				
Client Age	18	85	38.22	12.71
Number of Sessions	3	278	12.41	18.34
Initial ORS	1	40	20.94	8.29
Final ORS	1	40	25.20	9.12
ORS Change	-30	33	4.26	9.27
Client's Education	3	22	12.02	1.84
<i>Therapist Measures</i>				
Therapist's Age	27	56	36.57	7.67
CCCI-R	92	112	100.93	5.39
QDI	76	99	89.04	5.33

Note. Client $n = 2024$. Therapist $n = 28$.

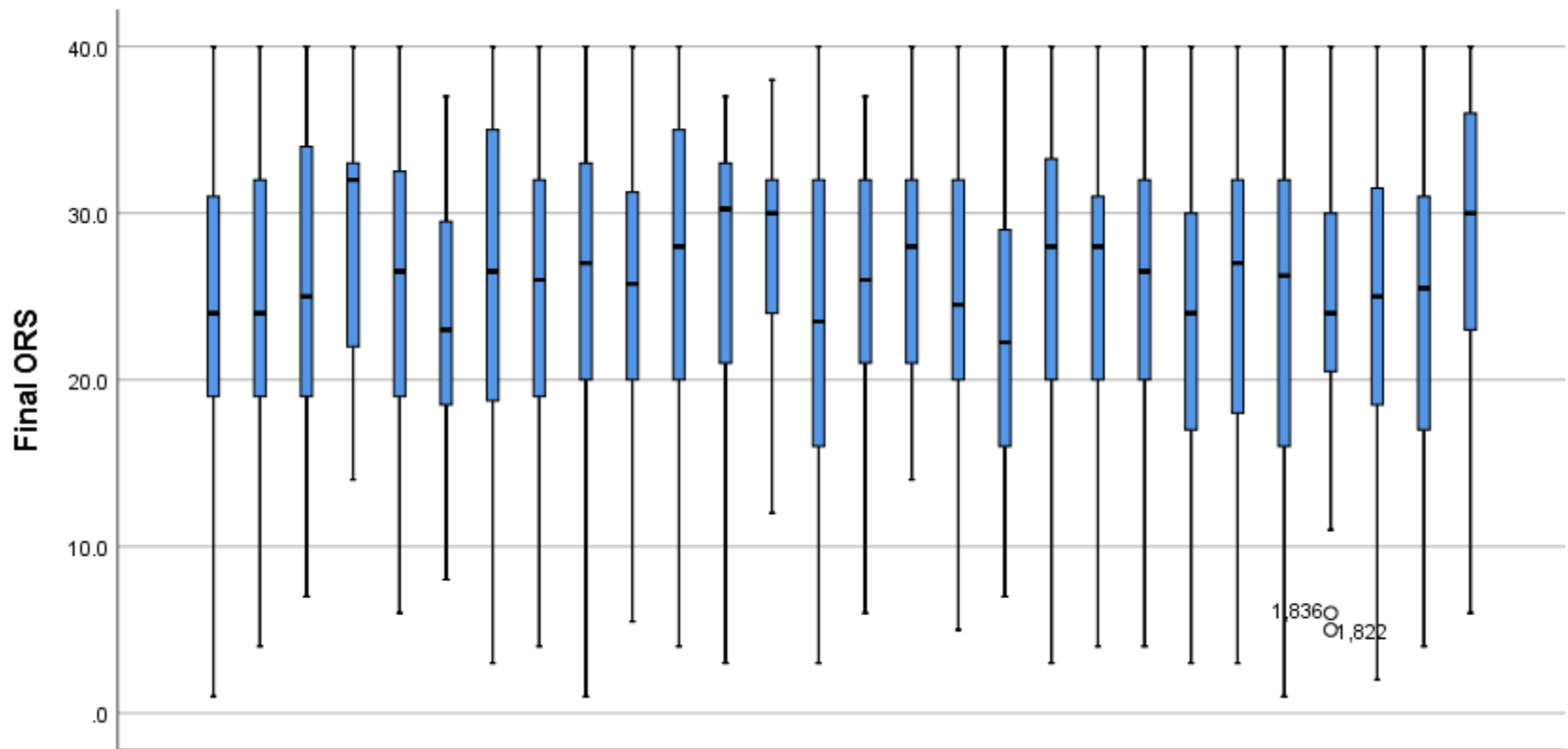


Figure 1. Distribution of Final ORS scores by therapist.

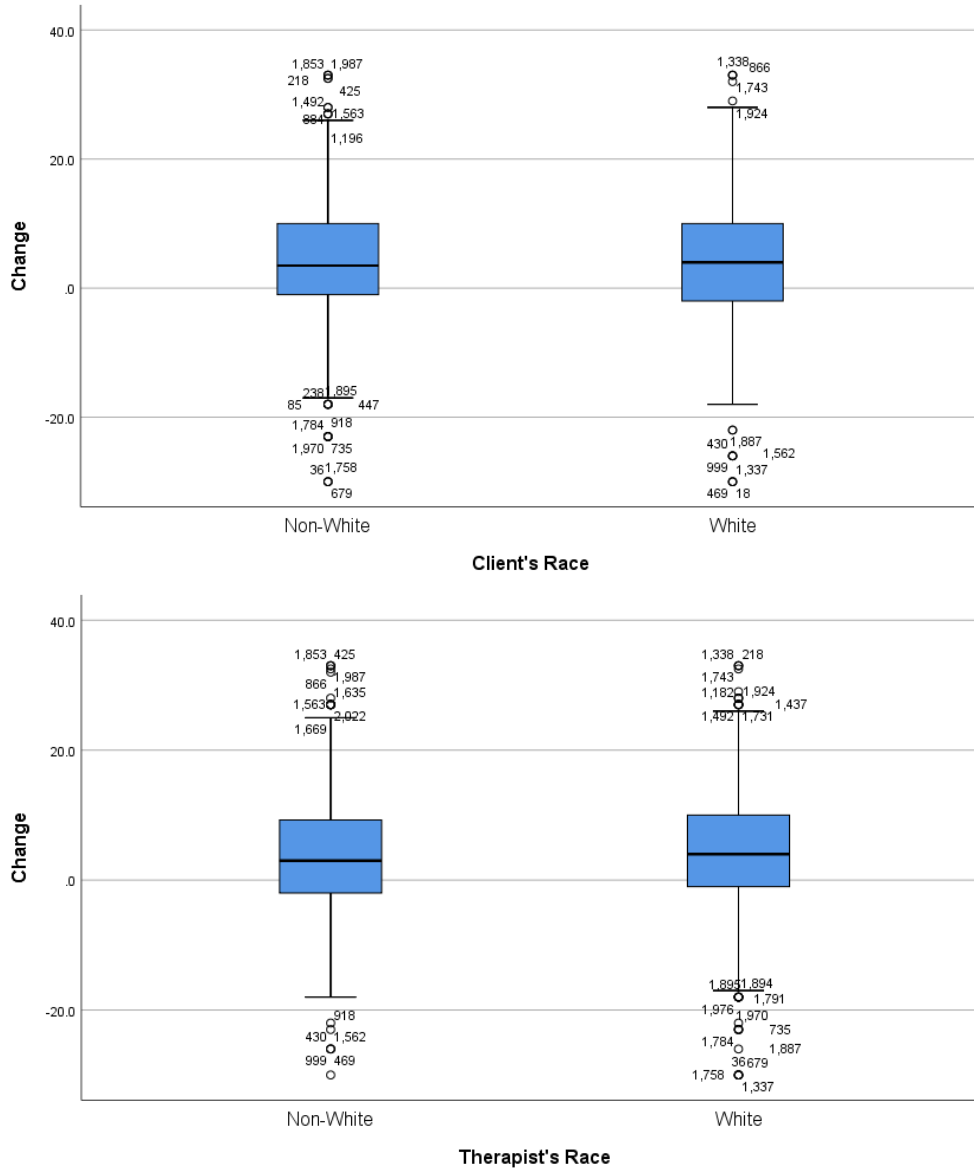


Figure 2. Distribution of change scores by client and therapist race.

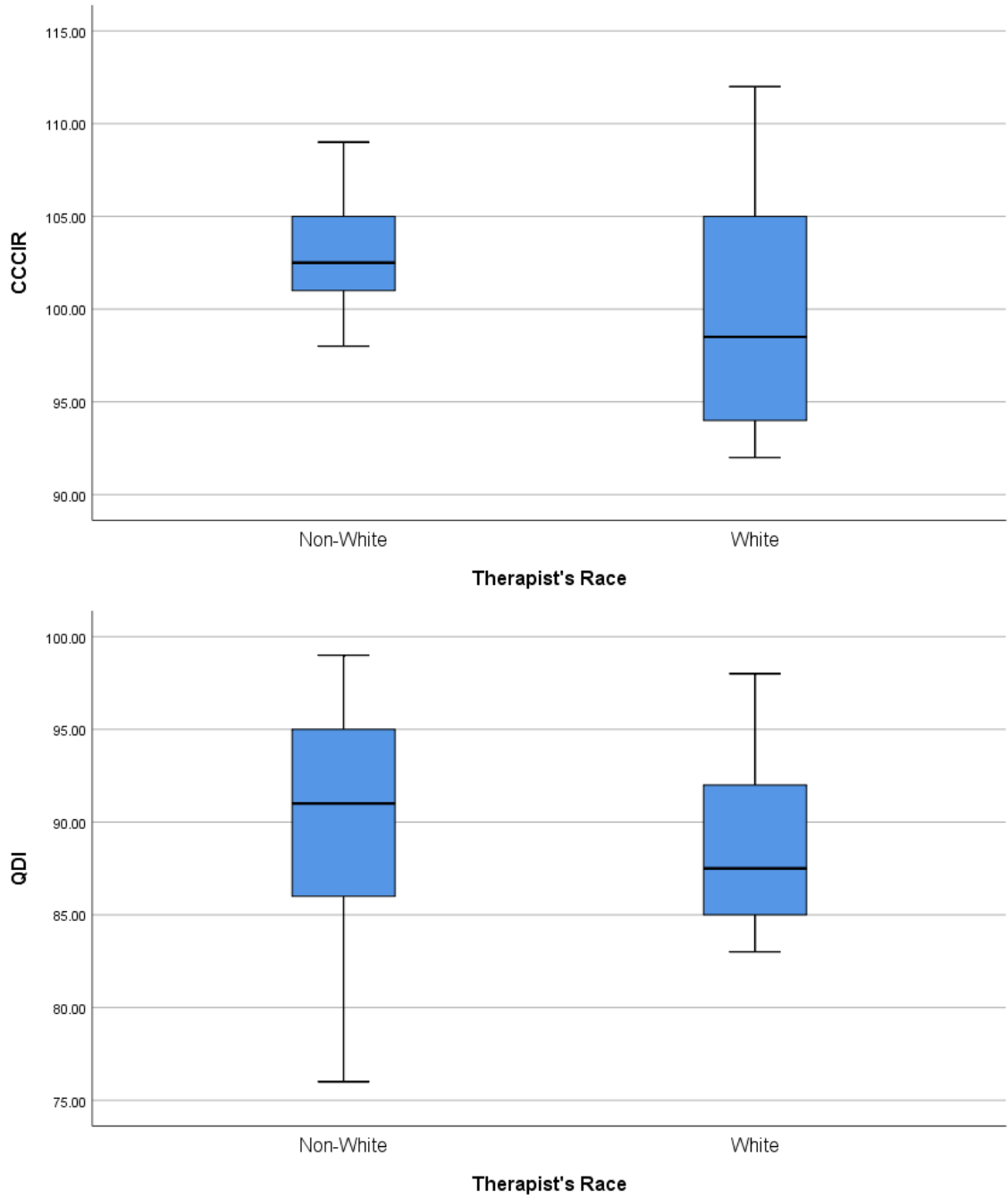


Figure 3. Therapist multicultural competencies by therapist race.

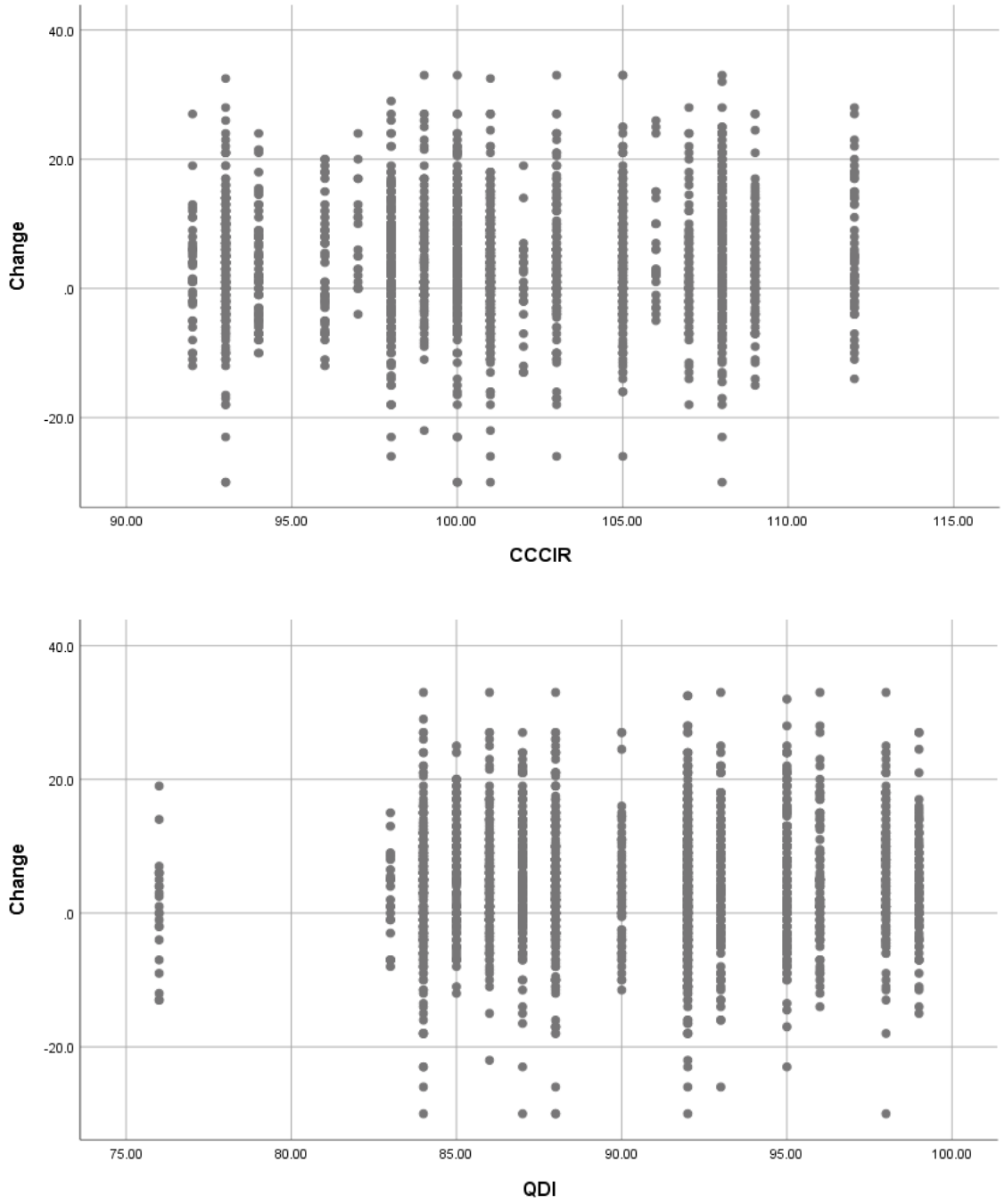


Figure 4. Scatterplots of multicultural competency (CCCI-R and QDI) and change scores.

Race as a Predictor of Treatment Outcome

In addressing the first research question, the results did not indicate that race of the client, therapist, or the race of the client-therapist dyad predicted overall treatment outcomes measured by the Final ORS score. Table 2 demonstrates the results from the mixed model analysis for overall treatment outcomes. Although race was not a predictor, client gender ($p = .002$) and number of sessions ($p < .001$) predicted outcome. Female clients were likely to have slightly higher Final ORS scores compared to male clients ($\beta = 1.175$; 95% CI [0.440, 1.909]). Clients who had more psychotherapy sessions were likely to score higher Final ORS scores ($\beta = 0.050$; 95% CI [0.031, 0.070]) compared to clients who had a lower number of sessions. Initial ORS scores ($\beta = 0.479$; 95% CI [0.436, 0.522] $p < .001$) were also positively associated with overall treatment outcomes indicated by Final ORS scores.

The second research question examined in this study was whether race predicts difference in reliable and/or clinically significant change in treatment outcome. Race of the client did not predict clinically significant change in treatment. Results from the generalized linear mixed model for clinically significant change are displayed in Table 3. Prediction success overall for this model was 65.6%. The model shows that client gender predicted clinically significant change ($p = .05$). Male clients were 1.23 times less likely to have to clinically significant change, that is female clients were more likely to have clinically significant change in treatment. Similar to overall treatment outcomes, number of sessions ($p < .001$) and initial ORS score ($p < .001$) predicted clinically significant change in treatment. Specifically, clients with higher number of sessions are 1.013 times less likely to have clinically significant change in treatment. Clients with higher initial

ORS scores are 0.968 times more likely to have clinically significant change in treatment. Table 4 demonstrates the results for the generalized linear mixed model for reliable change as the outcome. Prediction success overall for this model was 68.4%. The results indicate that race was not associated with reliable change in treatment. However, the model shows that client gender predicted clinically significant change ($p = .05$) and reliable change ($p = 0.012$). Male clients were 1.30 times less likely to have reliable change in treatment compared to females, that is female clients were more likely to have reliable change in treatment. Initial ORS score ($p < .001$) and number of psychotherapy sessions ($p < .001$) were significant predictors of reliable change in treatment. Clients who had a higher number of sessions were 1.024 times less likely to have reliable change while clients who had a higher initial ORS score were 0.894 times more likely to have reliable change.

Therapist effects due to multicultural competency

The current study also examined therapist effects due to MCC on treatment outcomes. The third research question addressed in the study was: Does therapist MCC mediate the relationship between race and treatment outcome? Given that the results of the research question one and two indicate no relationship between race and treatment outcomes and there are no random slopes for race variable, it can be assumed that therapist MCC did not explain the relationship between race and treatment outcomes. Specifically, there was no support for hypothesis one that therapist MCC would predict ORS scores at the end of treatment or hypothesis two that therapist MCC would predict reliable and clinically significant change.

Table 2

Mixed Model of Final ORS Scores

	Estimate	SE	t	Sig.	Lower Bound	Upper Bound
<i>Fixed Effects</i>						
Intercept	14.105	0.536	26.338	0.000*	13.053	15.157
Initial ORS	0.479	0.022	21.891	0.000*	0.436	0.522
Client Gender	1.175	0.375	3.136	0.002*	0.440	1.909
Number of Sessions	0.050	0.010	5.079	0.000*	0.031	0.070
Client Race	0.209	0.357	0.586	0.558	-0.491	-0.910
<i>Random Effects</i>						
Intercept	0.320	0.305		0.295	0.049	2.077
Residual	65.823	2.080		0.000*	61.870	70.028

Note. * $p < .05$.

Table 3

Generalized Linear Mixed Model
for Clinically Significant Change

	Estimate	SE	t	Sig.	Lower Bound	Upper Bound
<i>Fixed Effects</i>						
Intercept	0.330	1.620	0.204	0.839	-2.847	3.506
Initial ORS	0.032	0.006	5.196	0.000*	0.020	0.044
Client Gender	-0.209	0.106	-1.963	0.050*	-0.417	-0.000
Number of Sessions	-0.013	0.003	-4.680	0.000*	-0.019	-0.008
Client Race						
<i>Random Effects</i>						
Intercept	0.597	0.022		0.365	0.002	0.176

Note. * $p < .05$.

Table 4
*Generalized Linear Mixed Model
 for Reliable Change*

	Estimate	SE	t	Sig.	Lower Bound	Upper Bound
<i>Fixed Effects</i>						
Intercept	-1.522	0.152	-10.001	0.000*	-1.820	-1.223
Initial ORS	0.112	0.007	16.224	0.000*	0.098	0.125
Client Gender	-0.263	0.104	-2.528	0.012*	-0.467	-0.059
Number of Sessions	-0.023	0.003	-7.194	0.000*	-0.030	-0.017
Client Race	0.209	0.134	1.560	0.119	-0.054	0.473
<i>Random Effects</i>						
Intercept	0.024	0.023		0.301	0.004	0.158

Note. * $p < .05$.

CHAPTER FOUR: DISCUSSION AND CONCLUSION

The current study examined the association between therapist multicultural competency and psychotherapy outcomes. The study addressed whether race of the client, therapist, and client-therapist dyad predict treatment outcomes. The results indicated that neither race nor therapist MCC were associated with final ORS scores, clinically significant change or reliable change in treatment. Female clients were more likely to have higher Final ORS scores, clinically significant change and reliable change compared to male clients. Additionally, clients who had a higher number of psychotherapy sessions were more likely to have higher final ORS scores, but they were less likely to have clinically significant change and reliable change in treatment. The results did not indicate any mediating effect of therapist MCC between race and treatment outcomes. Contrary to the two hypotheses, therapist MCC did not have a statistically significant positive relationship with clinically significant change, reliable change or overall treatment outcome.

REM status in client-therapist dyad

The current study did not demonstrate race as a predictor of treatment outcomes. Race was not associated with final ORS scores, clinically significant change or reliable change in treatment. One explanation for this could be that race in fact does not have any relationship with treatment outcomes. This finding is corroborated by previous research that did not find any association between REM status and psychotherapy outcomes (Cabral & Smith, 2011; Own et al., 2011) or between therapist MCC and psychotherapy outcomes (Owen et al., 2011). Another reason for this lack of association between REM status and outcomes could be the small sample size of therapists ($n = 28$) in this study.

The small sample size may have limited the variability that may be observed in a larger more representative sample of therapists, clients, and therapist-client dyads.

Although race was not a significant factor in this study, gender was a predictor of treatment outcomes. Results indicated that female clients had better overall treatment outcomes and were more likely to incur clinically significant change and reliable change. These findings suggest that gender as a cultural variable may also impact treatment outcomes. One explanation for this may be the representation of gender diversity, or a lack thereof, among therapists in this study. Female therapists represented 86% of the therapists while male therapists represented only 14% of therapists. Yet 38% of the clients were male and 62% were female in the current sample. These percentages are representative of the gender diversity at the agency where participants were recruited.

Previous studies have included an overrepresentation of female therapists and clients as noted earlier (Barden et al., 2017; Davis et al., 2016; Drinane et al., 2018; Hayes et al., 2016). Although research on gender (Behn, Davanzo, & Errazuriz, 2018; Shiner, Leonard Westgate, Harik, Watts, & Schnurr, 2017) and race (Cabral & Smith, 2011; Karlsson, 2005; Smith & Trimble, 2016; Watkins & Terrel, 1988) matching show weak or no relation to outcomes, clients may be more open to treatment if they perceive their therapists, as more likely to understand their lived experiences due to perceived cultural similarities (Cabral & Smith, 2011). Given that cultural concealment is negatively associated with treatment outcomes (Drinante et al. 2018), clients may be more likely to engage in cultural concealment if they have therapists who they perceive as less likely to understand their experience, in turn reinforcing any past negative experiences with culturally dissimilar therapist. Having therapists who are more

representative of the clients they serve in race, ethnicity, gender and other variables may project a welcoming and inclusive environment to the potential clients.

In addition, number of psychotherapy sessions predicted outcomes, that is a higher number of psychotherapy sessions predicted a slightly higher final ORS score. However, clients who had more psychotherapy sessions were less likely to achieve clinically significant change and reliable change. These findings corroborate previous research that indicates that response to treatment may be curvilinear, that is improvements in treatment may plateau at a certain point (Robinson, Delgado, & Kellett, 2019). Research also found that trajectories of change may vary (Owen et al. 2015) and that some patients with poor outcome stability may deteriorate in treatment (Owen, Drinane, Adelson, & Kopta, 2019). Given that the final session's ORS score was used to measure outcome, the findings from the current study may not have accurately captured the different trajectories (e.g., curvilinear) of change in treatment.

Therapist Multicultural Competency

Given that gender, a cultural variable, predicted treatment outcomes in the current study, therapist MCC may be an important factor in psychotherapy. Although therapist MCC did not predict treatment outcomes, there were differences in therapist MCC based on therapist race. Therapists with REM status tended to score higher on the MCC measures compared to White therapists. While the differences in MCC scores were not large, the differences based on race and gender suggest cultural variables may be a factor in therapist MCC, which is a part of clinical competence and affects treatment outcomes. This possibility is consistent with previous MCC research that found an association

between therapist MCC and therapeutic alliance, and therapist MCC and treatment outcomes, as discussed earlier (Tao, Owen, Pace, & Imel, 2015).

One possibility for the lack of association between therapist MCC and treatment outcomes in our sample may be the weaknesses of measures used to assess therapist MCC. Previous research studies have found inconsistencies and weaknesses in the development of existing MCC measure (Kitaoka, 2005; Ridley & Ridley 2011). To account for the weaknesses of measures of MCC, both the CCCI-R and the QDI were used to promote validity of the measured MCC in the current study. While these measures are among the strongest existing measures of therapist MCC, it appears that they may not effectively capture therapist MCC. It is noteworthy that the internal consistency in the current sample for the CCCI-R ($\alpha = 0.72$) was at the lower end of acceptability.

A second explanation for the lack of relationship between therapist MCC and treatment outcomes might be the restricted range of scores for both MCC measures for all therapists as they tend to skew to the higher end of the possible scores. One reason for the low variability could be that therapist MCC may indicate a therapist's multicultural self-efficacy rather than competency. MCC refers to a therapist having actual skills needed to work with culturally diverse individuals. Multicultural self-efficacy refers to the therapist's perceived ability to work with culturally diverse individuals. Scholars have critiqued self-report measures of therapist MCC for measuring therapist's self-efficacy in multicultural counseling instead of MCC (Constantine & Ladany, 2001; Ottavi, Pope-Davis, & Dings, 1994). Another explanation for the low therapist variability could be that the therapists at this agency on average have higher MCC than

therapists in other settings. This agency uses client feedback (i.e., outcome monitoring) as part of their routine clinical practice. Studies have indicated that client feedback in and of itself can empower clients, help to raise consciousness among therapists, and promote therapist self-examination (Duncan, 2012; Minieri, Reese, Miserocchi, & Pascale-Hague, 2015). Furthermore, this agency serves culturally diverse clients from low socioeconomic backgrounds, which may attract therapists who are interested in multicultural counseling and may have higher level of MCC.

A third possibility that therapist MCC was not a predictor of treatment outcome is that therapists may be overestimating their skills and abilities. Greenberg et al. (2001) found discrepancies in the ability to assess empathy in treatment among clients, observers, and therapists. They found that client's ratings of empathy ($r = .25$) were the most predictive of treatment outcomes compared to observer ratings ($r = .23$) and therapist ratings ($r = .18$). Thus, therapist ratings were the least predictive of treatment outcomes (Greenberg et al., 2001). As discussed earlier, Soto et al. (2018) confirmed these findings as their meta-analysis indicated client-rated therapist MCC predicted treatment outcomes, but therapist self-rated MCC did not predict outcomes. These findings suggest that therapists may not be reliable in accurately assessing their own MCC.

A fourth reason for the lack of association between therapist MCC and treatment outcomes may be that therapist MCC does not predict treatment outcomes. Owen et al. (2011) found that therapist MCC did not account for the therapist variability associated treatment outcomes. Scholars have noted several explanations for this lack of association including client's ratings of their therapist's MCC might be related to their overall

perception of their therapeutic relationship; client's own racial/ethnic identity development may predict their ability to accurately assess their therapist's MCC; client's presenting concerns may not be related to cultural variables which may limit their therapist's overt behaviors demonstrating culturally relevant knowledge and skills (Owen et al., 2011; Ridley & Shaw-Ridley, 2011). Scholars have critiqued the construct of MCC for the appropriate definition of MCC (i.e., multicultural competency vs. competencies), on whether it accurately captures the complexity of the therapeutic relationship and the psychotherapy process, and on whether current measures have the ability capture this complex construct (Ridley & Shaw Ridley, 2011).

Another reason for the lack of significance of therapist MCC may be the use of self-report measures. Results from the current study indicated a positive association between social desirability, measured by the MCPRS, and clinically significant change. Although the MCPRS was used to control for social desirability among therapists, using only self-report measures for complex constructs such as therapist MCC and social desirability may be inadequate. Moreover, the internal consistency for the MCPRS was at the lower end of acceptability in the current sample ($\alpha = .78$). Observer-rated therapist MCC may capture a more accurate picture of the relationship between therapist MCC and treatment outcomes. Given the change in demographics in the United States, and the increased likelihood of therapists working with culturally diverse individuals, it is imperative for researchers to continue to examining therapist MCC as racial disparities in mental health remains in the U.S. Future MCC research using observer-rated therapist MCC may produce more promising results.

Study Limitations

The current study has some limitations that may impact the findings. First, the study only included the therapist perspective of their own MCC was examined. Previous research indicated that clients' perception of their therapist MCC was a better predictor of treatment outcomes than therapists' perception of their own MCC (Soto et al. 2018). Future studies could include client perspectives to strengthen the study. Second, the use of self-report measures and weaknesses of the measures used may have impacted the results of the study. The modified CCCI-R has been critiqued as it has not been adequately validated, although the original CCCI-R is cited as a strong measure of MCC. Previous research has found that when therapists complete self-report measures of MCC, they may be referring to their self-efficacy in multicultural counseling instead of their competency (Constantine & Ladany, 2001; Ottavi, Pope-Davis, & Dings, 1994). The ORS has received criticism for only using 4 items on the measure, which may not capture a full and accurate picture of the client's clinical concerns and nuances of their lived experience. Third, the sampling approach (i.e., convenience sampling) used to recruit participants may not be representative of all the therapists at the agency. Recruiting participants via email and at a limited number of staff meetings may have excluded many therapists who were not present at the meetings or may not have received or opened the email invitation for the study.

Fourth, as the participants were recruited from one agency, the generalizability of the findings may be limited. The findings from this study may not be generalizable to clients from all socioeconomic backgrounds as clients at this agency generally fall under the federal poverty line. Fifth, the sample of therapists used in this study was small which may not fully capture therapist effects. Future studies could include participants

from multiple types of agencies across the U.S. representing the racial, gender, and socioeconomic diversity of clients and therapists throughout the country. Sixth, the study sample lacked representation of the different experiences among different racial/ethnic minority groups as the study focused on Whites and REM clients. Given that sociopolitical climate affect how different racial and ethnic groups are perceived, certain racial and ethnic minority groups may have worse health outcomes depending on the current sociopolitical climate. Seventh, the study used final ORS scores to indicate treatment outcomes, which may have failed to capture the different trajectories of change that occur in treatment. Future studies should use a growth model to indicate change over the course of treatment to have a more accurate picture of treatment outcomes.

Conclusion

Despite the limitations of the current study, the findings contribute to the MCC research as it demonstrates that therapist MCC may not predict treatment outcomes. The sample used in this study also contributes to our understanding of the experiences of REM clients from low socioeconomic backgrounds in a community mental health agency. The majority of the existing MCC research is based on participants from university counseling centers, university-based community clinics, and therapists-in-training, while the majority of consumers of mental health services are culturally diverse individual who present with various mental health concerns at community mental health agencies that includes experienced therapists. The study also includes a large sample of clients that may have been more generalizable and effective in examining differences in treatments outcomes of REM clients. The results from the current study did not support my hypotheses on the relationship between race/ethnicity, therapist MCC, and treatment

outcomes. These findings suggest that the construct of MCC should be further investigated. They also bring into question whether the tripartite model of MCC accurately captures the complexity of the role culture plays in psychotherapy. Newer constructs proposed by some scholars such as cultural humility (Hook, Davis, Owen, Worthington, & Utsey, 2013), multicultural orientation (Owen, 2013), and multicultural personality (Ponterotto et al., 2014) may be used to build upon the current construct of therapist MCC.

References

- Agency Healthcare Research and Quality (AHRQ). (2012). *National health disparities report*. Retrieved from <http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/2012nhdr.pdf>
- American Counseling Association. (2014). *2014 ACA code of ethics*. Retrieved from <https://www.counseling.org/resources/aca-code-of-ethics.pdf>
- American Counseling Association. (2015). *Multicultural and social justice counseling competencies*. Retrieved from <https://www.counseling.org/docs/default-source/competencies/multicultural-and-social-justice-counseling-competencies.pdf?sfvrsn=20>
- American Psychological Association. (2002a). *American Psychological Association ethical principles of psychologists and code of conduct*. Retrieved from <http://www.apa.org/ethics/code/principles.pdf>
- American Psychological Association. (2002b). *APA guidelines on multicultural education, training, research, practice, and organizational change for psychologists*. Washington, DC: American Psychological Association. Retrieved from <http://www.apa.org/pi/oema/resources/policy/multicultural-guideline.pdf>
- American Psychological Association & Lichtenberg, J. W. (1999). Archival description of Counseling Psychology. *The Counseling Psychologist*, 27, 589-592.
- Anker, M. G., Owen, J., Duncan, B. L., & Sparks, J. A. (2010). The alliance in couple therapy. *Journal of Consulting and Clinical Psychology*, 78, 635–645.
doi:10.1037/a0020051

- Atkinson, D. R., Casas, A., & Abreu, J. (1992). Mexican-American acculturation, counselor ethnicity and cultural sensitivity, and perceived counselor competence. *Journal of Counseling Psychology, 39*, 515–520.
- Atkinson, D. R., & Lowe, S. M. (1995). The role of ethnicity, cultural knowledge, and conventional techniques in counseling and psychotherapy. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, C. M. Alexander, J. G. Ponterotto, J. M. Casas, ... C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 387-414). Thousand Oaks, CA, US: Sage Publications, Inc.
- Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and client variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*, 842– 852. doi:10.1037/0022-006X.75.6.842
- Bambling, M., King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-related working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16*, 317–331. doi:10.1080/10503300500268524
- Barden, S. M., Sherrell, R. S., & Matthews, J. J. (2017). A national survey on multicultural competence for professional counselors: A replication study. *Journal of Counseling & Development, 95*, 203–212. <https://doi-org.ezproxy.uky.edu/10.1002/jcad.12132>
- Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: conceptual, strategic, and statistical considerations. *Journal of Personality And Social Psychology, 51*, 1173–1182.

- Behn, A., Davanzo, A., & Errázuriz, P. (2018). Client and therapist match on gender, age, and income: Does match within the therapeutic dyad predict early growth in the therapeutic alliance? *Journal of Clinical Psychology, 74*, 1403–1421. <https://doi-org.ezproxy.uky.edu/10.1002/jclp.22616>
- Bennett, M. J. (2004). Becoming interculturally competent. In Wurzel, J. (Ed.), *Toward multiculturalism: A reader in multicultural education (2nd ed.)* (pp. 62-77). Newton, MA: Intercultural Resource Corporation.
- Bernal, G., Jiménez - Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*, 361–368. <https://doi.org/10.1037/a0016401>
- Blais, M.A., Lenderking, L.B., deLorell, A., Peets, K., Leahy, L., & Burns, C. (1999). Development and initial validation of a brief mental health outcome measure. *Journal of Personality Assessment, 73*, 359–373.
- Boswell, J. F., Kraus, D. R., Bringham, D. L., Watson, C. W., Miller, S. D., & Duncan, B. L. (2006). The reliability and validity of the Outcome Rating Scale: A replication study of a brief clinical measure. *Journal of Brief Therapy, 5*, 23–30.
- Budge, S. L., Owen, J. J., Kopta, S. M., Minami, T., Hanson, M. R., & Hirsch, G. (2013). Differences among trainees in client outcomes associated with the phase model of change. *Psychotherapy, 50*, 150–157. <https://doiorg.ezproxy.uky.edu/10.1037/a0029565>
- Burrow-Sánchez, J. J., Minami, T., & Hops, H. (2015). Cultural accommodation of group

substance abuse treatment for Latino adolescents: Results of an RCT. *Cultural Diversity & Ethnic Minority Psychology*, *21*, 571–583.

<http://dx.doi.org/10.1037/cdp0000023>

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A metaanalytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*, 537–554. <https://doi.org/10.1037/a0025266>

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

Campbell, A., & Hemsley, S. (2009). Outcome Rating Scale and Session Rating Scale in psychological practice: Clinical utility of ultra-brief measures. *Clinical Psychologist*, *13*, 1–9.

Carney, C. G., & Kahn, K. B. (1984). Building competencies for effective cross-cultural counseling: A developmental view. *The Counseling Psychologist*, *12*, 111-119.
[doi:10.1177/0011000084121010](https://doi.org/10.1177/0011000084121010)

Chao, R. C.-L., & Nath, S. R. (2011). The role of ethnic identity, gender roles, and multicultural training in college counselors' multicultural counseling competence: A mediation model. *Journal of College Counseling*, *14*, 50–64. <https://doi-org.ezproxy.uky.edu/10.1002/j.2161-1882.2011.tb00063.x>

Clauss-Ehlers, C. S., Chiriboga, D. A., Hunter, S. J., Roysircar, G., & Tummala-Narra, P. (2019). APA Multicultural Guidelines executive summary: Ecological approach to context, identity, and intersectionality. *American Psychologist*, *74*, 232–244.
[doi:10.1037/amp0000382](https://doi.org/10.1037/amp0000382)

- Colby, S. L. & Ortman, J. M. (2014). Projections of the size and composition of the U.S. population 2014 to 2060: Population estimates and projections. *Current Population Reports, P25-1143*. Washington, DC: U.S. Census Bureau.
- Connors, G. J., Carroll, K. M., DiClemente, C. C., Longabaugh, R., & Donovan, D. M. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of Consulting and Clinical Psychology, 65*, 588–598. doi:10.1037/0022-006X.65.4.588
- Constantine, M. G. (2001a). Multicultural training, theoretical orientation, empathy, and multicultural case conceptualization ability in counselors. *Journal of Mental Health Counseling, 23*, 357.
- Constantine, M. G. (2001b). Predictors of observer ratings of multicultural counseling competence in Black, Latino, and White American trainees. *Journal of Counseling Psychology, 48*, 456-462. doi:10.1037/0022-0167.48.4.456
- Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology, 49*, 255-263.
- Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*, 17–31.
- Constantine, M. G., Gloria, A. M., & Ladany, N. (2002). The factor structure underlying three self-report multicultural counseling competence scales. *Cultural Diversity and Ethnic Minority Psychology, 8*, 334-345. doi:10.1037/1099-9809.8.4.335

- Constantine, M. G., & Ladany, N. (2000). Self-report multicultural counseling competence scales: Their relation to social desirability attitudes and multicultural case conceptualization ability. *Journal of Counseling Psychology, 47*, 155-164. doi:10.1037/0022-0167.47.2.155
- Cornish, J. E., Schreier, B. A., Nadkarni, L. I., Metzger, L. H., & Rodolfa, E. R. (2010). *Handbook of multicultural counseling competencies*. Hoboken, NJ: John Wiley & Sons Inc.
- Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (2003). *Psychological treatment of ethnic minority populations*. Washington, DC: Association of Black Psychologists. Retrieved from <http://www.apa.org/pi/oema/resources/brochures/treatment-minority.pdf>
- Crits-Christoph, P., Barancackie, K., Kurcias, J. S., Beck, A. T., Carroll, K., Perry, K., Zitrin, C. (1991). Meta-analysis of therapist effects in psychotherapy outcome studies. *Psychotherapy Research, 1*, 81–91. doi:10.1080/10503309112331335511
- Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a Culturally Competent System of Care, Volume 1*. Washington, DC: CASSP Technical Assistance Center, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center
- D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling & Development, 70*, 143–150.
- Davis, D. E., DeBlaere, C., Brubaker, K., Owen, J., Jordan, T. I., Hook, J. N., & Van

- Tongeren, D. R. (2016). Microaggressions and perceptions of cultural humility in counseling. *Journal Counseling & Development, 94*, 483–493.
<http://dx.doi.org/10.1002/jcad.12107>
- Dillon, F. R., Odera, L., Fons-Scheyd, A., Sheu, H.-B., Ebersole, R. C., & Spanierman, L. B. (2015, October 5). A dyadic study of multicultural counseling competence. *Journal of Counseling Psychology*. doi:10.1037/cou0000118
- Drinane, J. M., Owen, J., & Tao, K. W. (2018). Cultural concealment and therapy outcomes. *Journal of Counseling Psychology, 65*, 239–246. <https://doi-org.ezproxy.uky.edu/10.1037/cou0000246>
- Duncan, B. L. (2012). The Partners for Change Outcome Management System (PCOMS): The heart and soul of change project. *Canadian Psychology, 53*, 93-104. doi:10.1037/a0027762
- Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., & Brown, J. (2003). The Session Rating Scale: Preliminary psychometric properties of a working alliance measure. *Journal of Brief Therapy, 3*, 3–12.
- Dungee-Anderson, D., & Beckett, J. O. (1995). A process model for multicultural social work practice. *Families in Society, 76*, 459-468.
- Dunn, T. W., Smith, T. B., & Montoya, J. A. (2006). Multicultural competency instrumentation: A review and analysis of reliability generalization. *Journal of Counseling and Development, 84*, 471–482.
- Dunton, B. C., & Fazio, R. H. (1997). An individual difference measure of motivation to control prejudiced reactions. *Personality and Social Psychology Bulletin, 23*, 316-326. doi:10.1177/0146167297233009

- Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy, 48*, 43–49. doi:10.1037/a0022187
- Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy, 43*, 480 – 490. doi:10.1037/0033-3204.43.4.480
- Gim, R. H., Atkinson, D. R., & Kim, S. J. (1991). Asian-American acculturation, counselor ethnicity and cultural sensitivity, and ratings of counselors. *Journal of Counseling Psychology, 38*, 57–62.
- Greenberg, G. A., & Rosenbeck, R. A. (2003). Changes in mental health service delivery among Blacks, Whites and Hispanics in the Department of Veterans Affairs. *Administration and Policy in Mental Health and Mental Health Services Research, 31*, 31–43. doi:10.1023/A:1026096123010
- Greenberg, L. S., Watson, J. C., Elliot, R., & Bohart, A. C. (2001). Empathy. *Psychotherapy: Theory, research, practice, training, 38*, 380–384. doi:10.1037/0033-3204.38.4.380
- Gryczynski, J., Carswell, S. B., O’Grady, K. E., Mitchell, S. G., & Schwartz, R. P. (2018). Gender and ethnic differences in primary care patients’ response to computerized vs In-person brief intervention for illicit drug misuse. *Journal of Substance Abuse Treatment, 84*, 50–56. <https://doi-org.ezproxy.uky.edu/10.1016/j.jsat.2017.10.009>
- Haggerty, G., Blake, M., Naraine, M., Siefert, C., & Blais, M. A. (2010). Construct validity of the Schwartz Outcome Scale-10: Comparisons to interpersonal distress, adult attachment, alexithymia, the Five Factor Model, romantic

relationship length and ratings of childhood memories. *Clinical Psychology & Psychotherapy*, 17, 44-50.

Hannan, C. W., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., & Shimokawa, K. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology*, 61, 155-163.

Hayes, J. A., McAleavey, A. A., Castonguay, L. G., & Locke, B. D. (2016). Psychotherapists' outcomes with White and racial/ethnic minority clients: First, the good news. *Journal of Counseling Psychology*, 63, 261–268. <https://doi-org.ezproxy.uky.edu/10.1037/cou0000098>

Hayes, J. A., Owen, J., & Bieschke, K. J. (2015). Therapist differences in symptom change with racial/ethnic minority clients. *Psychotherapy*, 52, 308–314. <https://doi-org.ezproxy.uky.edu/10.1037/a0037957>

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

Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., & ... Satcher, D. (2014). Toward culturally centered integrative care for addressing mental health disparities among ethnic minorities. *Psychological Services*, 11, 357-368. [doi:10.1037/a0038122](https://doi.org/10.1037/a0038122)

Holden, K. B., & Xanthos, C. (2009). Disadvantages in mental health care among African Americans. *Journal of Health Care for the Poor and Underserved*, 20, 17–23. [doi:10.1353/hpu.0.0155](https://doi.org/10.1353/hpu.0.0155)

- Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*, 353–366. <http://dx.doi.org/10.1037/a0032595>
- Jacobson, C. R. (1985). Resistance to affirmative action: Self-interest or racism. *Journal of Conflict Resolution, 29*, 306-329.
- Karlsson, R. (2005). Ethnic matching between therapist and patient in psychotherapy: An overview of findings, together with methodological and conceptual issues. *Cultural Diversity and Ethnic Minority Psychology, 11*, 113-129.
doi:10.1037/10999809.11.2.113
- Kim, B. S. K., Cartwright, B. Y., Asay, P. A., & D'Andrea, M. J. (2003). A revision of the Multicultural Awareness, Knowledge, and Skills Survey—Counselor Edition. *Measurement and Evaluation in Counseling and Development, 36*, 161–180.
- Kim, B. K., Li, L. C., & Liang, T. H. (2002). Effects of Asian American client adherence to Asian cultural values, session goal, and counselor emphasis of client expression on career counseling process. *Journal of Counseling Psychology, 49*, 342-354.
- Kitaoka, S. K. (2005). Multicultural counseling competencies: Lessons from assessment. *Journal of Multicultural Counseling & Development, 33*, 37-47.
- Kivlighan, D. M., III, Hooley, I. W., Bruno, M. G., Ethington, L. L., Keeton, P. M., & Schreier, B. A. (2019). Examining therapist effects in relation to clients' race-ethnicity and gender: An intersectionality approach. *Journal of Counseling Psychology, 66*, 122–129. <https://doi-org.ezproxy.uky.edu/10.1037/cou0000316>
- Krull, J. L., & MacKinnon, D. P. (2001). Multilevel modeling of individual and group level mediated effects. *Multivariate Behavioral Research, 36*, 249-277.

- Ladany, N., Inman, A. G., Constantine, M. G., & Hofheinz, E. W. (1997). Supervisee multicultural case conceptualization ability and self-reported multicultural competence as functions of supervisee racial identity and supervisor focus. *Journal of Counseling Psychology, 44*, 284-293. doi:10.1037/0022-0167.44.3.284
- LaFromboise, T. D., Coleman, H.L.K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory-Revised. *Professional Psychology: Research and Practice, 22*, 380-388.
- López, S. R. (1997). Cultural competence in psychotherapy: A guide for clinicians and their supervisors. In C. J. Watkins, C. J. Watkins (Eds.), *Handbook of psychotherapy supervision* (pp. 570-588). Hoboken, NJ: John Wiley & Sons Inc.
- Luborsky, L., Barber, J., Siqueland, L., Johnson, S., Najavits, L., Frank, A., & Daley, D. (1996). The revised Helping Alliance Questionnaire (HAQII). *Journal of Psychotherapy Practice and Research, 5*, 260–271.
- Matthews, J. J., Mehta Barden, S., & Sherrell, R. S. (2018). Examining the relationships between multicultural counseling competence, multicultural self-efficacy, and ethnic identity development of practicing counselors. *Journal of Mental Health Counseling, 40*, 129–141. doi:10.17744/mehc.40.2.03.
- McConahay, J. B. (1986). Modern racism, ambivalence, and the Modern Racism Scale. In J. F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 91-125). Orlando, FL: Academic Press.
- Miller, S. D., Duncan, B. L., Brown, J., Sparks, J. A., & Claud, D.A. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*, 91–100.

- Miller, S. D., & Lambert, M. J. (2015). Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions. *Psychotherapy Research, 25*, 6-19. doi:10.1080/10503307.2013.817696
- Minieri, A. M., Reese, R. J., Miserocchi, K. M., & Pascale-Hague, D. (2015). Using client feedback in training of future counseling psychologists: An evidence-based and social justice practice. *Counselling Psychology Quarterly, 28*, 305–323. <https://doi-org.ezproxy.uky.edu/10.1080/09515070.2015.105523>
- Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 113–141). Washington, DC: American Psychological Association.
- Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy, 48*, 4–8. doi:10.1037/a0022180
- Owen, J. (2012). Systemic alliance in individual therapy: Factor analysis of the ITAS-SF and the relationship with therapy outcomes and termination status. *Journal of Marital and Family Therapy, 38*, 320-331. doi:10.1111/j.1752-0606.2011.00268.x
- Owen, J. (2013). Early career perspectives on psychotherapy research and practice: Psychotherapist effects, multicultural orientation, and couple interventions. *Psychotherapy, 50*, 496–502. <http://dx.doi.org/10.1037/a0034617>
- Owen, J., Adelson, J., Budge, S., Wampold, B., Kopta, M., Minami, T., & Miller, S. (2015). Trajectories of change in psychotherapy. *Journal of Clinical Psychology, 71*, 817–827. <https://doi-org.ezproxy.uky.edu/10.1002/jclp.22191>

- Owen, J., Drinane, J. M., Adelson, J. L., & Kopta, M. (2019). The psychotherapy outcome problem: The development of the Outcome Stability Index. *Psychotherapy Research, 29*, 226–233.
<https://doi-org.ezproxy.uky.edu/10.1080/10503307.2017.1349352>
- Owen, J., Drinane, J., Tao, K. W., Adelson, J. L., Hook, J. N., Davis, D., & Fookune, N. (2017). Racial/ethnic disparities in client unilateral termination: The role of therapists' cultural comfort. *Psychotherapy Research, 27*, 102–111.
<http://dx.doi.org/10.1080/10503307.2015.1078517>
- Owen, J.J., & Imel, Z. (2009). Utilizing rating scales in psychotherapy practice: Rationale and practical applications. In L. Baer & M. Blais (Eds.), *Handbook of clinical rating scales and assessment in psychiatry and mental health* (pp. 257-270). New York, NY: Humana Press.
- Owen, J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). “No-show”: Therapist racial/ethnic disparities in client unilateral termination. *Journal of Counseling Psychology, 59*, 314–320. <https://doi-org.ezproxy.uky.edu/10.1037/a0027091>
- Owen, J., Imel, Z., Tao, K. W., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling & Psychotherapy Research, 11*, 204-212. doi:10.1080/14733145.2010.491551
- Owen, J. M., Jordan, T. A., Turner, D., Davis, D. E., Hook, J. N., & Leach, M. M. (2014). Therapists' multicultural orientation: Client perceptions of cultural humility, spiritual/religious commitment, and therapy outcomes. *Journal of Psychology & Theology, 42*, 91-98.

- Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. *Journal of Counseling Psychology, 58*, 1-9. doi:10.1037/a0021496
- Owen, J., Reese, R. J., Quirk, K., & Rodolfa, E. (2013). Alliance in action: A new measure of clients' perceptions of therapists' alliance activity. *Psychotherapy Research, 23*, 67-77. doi:10.1080/10503307.2012.731088
- Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2015). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice*. Advance online publication. doi:10.1037/pro0000046
- Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice, 45*, 283-290. doi:10.1037/a0037420
- Owen, J. J., Tao, K., Leach, M. M., & Rodolfa, E. (2011). Clients' perceptions of their psychotherapists' multicultural orientation. *Psychotherapy, 48*, 274-282. doi:10.1037/a0022065
- Owen, J., Tao, K., & Rodolfa, E. (2010). Microaggressions against women in short-term psychotherapy: Initial evidence. *The Counseling Psychologist, 38*, 923-946. doi:10.1177/0011000010376093
- Owen, J., Wong, Y. J., & Rodolfa, E. (2009). Empirical search for psychotherapists' gender competence in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 46*, 448-458. <https://doiorg.ezproxy.uky.edu/10.1037/a0017958>

- Packard, T. (2009). The 2008 Leona Tyler Award Address: Core values that distinguish counseling psychology: Personal and professional perspectives. *Counseling Psychologist, 37*, 610-624. doi:10.1177/0011000009333986
- Ponterotto, J. G., Burkard, A., Rieger, B. P., Grieger, I., D'Onofrio, A., Dubuisson, A., & ... Sax, G. (1995). Development and initial validation of the Quick Discrimination Index (QDI). *Educational and Psychological Measurement, 55*, 1016-1031. doi:10.1177/0013164495055006011
- Ponterotto, J. G., Fietzer, A. W., Fingerhut, E. C., Woerner, S., Stack, L., Magaldi-Dopman, D., ... Liao, P. W. (2014). Development and initial validation of the Multicultural Personality Inventory (MPI). *Journal of Personality Assessment, 96*, 544–558. <https://doi-org.ezproxy.uky.edu/10.1080/00223891.2013.843181>
- Ponterotto, J. G., Fuertes, J. N., & Chen, E. C. (2000). Models of multicultural counseling. In S. D. Brown, R. W. Lent, S. D. Brown, R. W. Lent (Eds.), *Handbook of counseling psychology (3rd ed.)* (pp. 639-669). Hoboken, NJ, US: John Wiley & Sons Inc.
- Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B., & Austin, R. (2002). A revision of the Multicultural Counseling Awareness Scale. *Journal of Multicultural Counseling and Development, 30*, 153–180.
- Ponterotto, J. G., Rieger, B. T., Barrett, A., Harris, G., Sparks, R.,...& Magids, D. (1996). Development and initial validation of the Multicultural Counseling Awareness Scale. In G. R. Sodowsky & J. C. Impara (Eds.), *Multicultural assessment in counseling and clinical psychology* (pp. 247-282). Lincoln, NE: Buros Institute of Mental Measurements.

- Pope-Davis, D. B., Coleman, H. K., Liu, W. M., & Toporek, R. L. (2003). *Handbook of multicultural competencies: In counseling & psychology*. Thousand Oaks, CA: Sage Publications, Inc.
- Poston, W. C., Craine, M., & Atkinson, D. R. (1991). Counselor dissimilarity confrontation, client cultural mistrust, and willingness to self-disclose. *Journal of Multicultural Counseling and Development, 19*, 65–73.
- Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2016). Multicultural and Social Justice Counseling Competencies: Guidelines for the Counseling Profession. *Journal of Multicultural Counseling and Development, 44*, 28–48. doi:10.1002/jmcd.12035
- Reese, R. J., Gillaspay, J. J., Owen, J. J., Flora, K. L., Cunningham, L. C., Archie, D., & Marsden, T. (2013). The influence of demand characteristics and social desirability on clients' ratings of the therapeutic alliance. *Journal of Clinical Psychology, 69*, 696-709. doi:10.1002/jclp.21946
- Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, & Training, 46*, 418-431. doi:10.1037/a0017901
- Ridley, C. R., & Shaw-Ridley, M. (2011). Multicultural counseling competencies: An analysis of research on clients' perceptions-- Comment on Owen, Leach, Wampold, and Rodolfa (2011). *Journal of Counseling Psychology, 58*, 16-21.
- Robinson, L., Delgado, J., & Kellett, S. (2019). The dose-response effect in routinely delivered psychological therapies: A systematic review. *Psychotherapy Research*. <https://doi-org.ezproxy.uky.edu/10.1080/10503307.2019.1566676>

- Shim, R. S., Baltrus, P., Bradford, L. D., Holden, K. B., Fresh, E., & Fuller, L. E. (2013). Characterizing depression and co-morbid medical conditions in African American women in a primary care setting. *Journal of the National Medical Association, 105*, 183–191.
- Shiner, B., Leonard Westgate, C., Harik, J. M., Watts, B. V., & Schnurr, P. P. (2017). Effect of patient-therapist gender match on psychotherapy retention among United States veterans with posttraumatic stress disorder. *Administration and Policy in Mental Health and Mental Health Services Research, 44*, 642–650.
<https://doi-org.ezproxy.uky.edu/10.1007/s10488-016-0761-2>
- Smith, T. B., & Trimble, J. E. (2016). Matching clients with therapists on the basis of race or ethnicity: A meta-analysis of clients' level of participation in treatment. In B. T. Smith, & J. E. Trimble, *Foundations of multicultural psychology: Research to inform effective practice* (pp. 115-128). Washington, DC: American Psychological Association. doi:10.1037/14733-006
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: The National Academies Press.
- Sodowsky, G. R., Taffe, R. C., Gutkin, T., & Wise, S. L. (1994). Development and applications of the Multicultural Counseling Inventory. *Journal of Counseling Psychology, 41*, 137– 148.
- Soper, D. (2016). *A-priori Sample Size Calculator for Hierarchical Multiple Regression*. Retrieved from <http://www.danielsoper.com/statcalc/calculator.aspx?id=16>

- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477-486.
- Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist, 10*, 45-52.
doi:10.1177/0011000082102008
- Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*, 271–286.
doi:10.1037/0003-066X.62.4.271
- Sue, D. W., Carter, R. T., Casas, J. M., Fouad, N. A., Ivey, A. E., Jensen, M., & ... Vazquez-Nuttall, E. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage Publications.
- Sue, D. W., & Sue, D. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology, 24*, 420-429.
- Sue, D. W., & Sue, D. (2012). *Counseling the culturally diverse: Theory and practice (6th ed.)*. Hoboken, NJ: John Wiley & Sons Inc.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*, 440-48.
- Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology, 62*, 337-350. doi:10.1037/cou0000086

- Thompson, C. E., Worthington, R., & Atkinson, D. R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology, 41*, 155–161.
- Tracey, T., & Kokotovic, A. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1*, 207–210.
- Tsang, R., Colley, L., & Lynd, L. D. (2009). Inadequate statistical power to detect clinically significant differences in adverse event rates in randomized controlled trials. *Journal of Clinical Epidemiology, 62*, 609-616.
doi:10.1016/j.jclinepi.2008.08.005
- U.S. Department of Health and Human Services Office of Minority Health. (2013). *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. Retrieved from <https://www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf>
- van Ryn, M., & Fu, S. S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health, 93*, 248–255.
- Wade, P., & Bernstein, B. L. (1991). Culture sensitivity training and counselor's race: Effects on Black female clients' perceptions and attrition. *Journal of Counseling Psychology, 38*, 9-15. doi:10.1037/0022-0167.38.1.9
- Watkins, C. E., & Terrel, F. (1988). Mistrust level and its effects on counseling

expectations in Black-White therapist relationships: An analogue study. *Journal of Counseling Psychology*, 35, 194–197. <http://dx.doi.org/10.1037/0022-0167.35.2.194>

Worthington, R. L., & Dillon, F. R. (2011). Deconstructing multicultural counseling competencies research: Comment on Owen, Leach, Wampold, and Rodolfa (2011). *Journal of Counseling Psychology*, 58, 10-15.

Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology*, 54, 351-361.

Young, J. L., Waehler, C. A., Laux, J. M., McDaniel, P. S., & Hilsenroth, M. J. (2003). Four studies extending the utility of the Schwartz outcome scale (SOS-10). *Journal of Personality Assessment*, 80, 130–138.
doi:10.1207/S15327752JPA8002_02

Zilcha-Mano, S., & Errázuriz, P. (2015). One size does not fit all: Examining heterogeneity and identifying moderators of the alliance–outcome association. *Journal of Counseling Psychology*, 62, 579-591. doi:10.1037/cou0000103

Zilcha-Mano, S., Solomonov, N., Chui, H., McCarthy, K. S., Barrett, M. S., & Barber, J. P. (2015). Therapist-reported alliance: Is it really a predictor of outcome? *Journal of Counseling Psychology*, 62, 568-578.
doi:10.1037/cou0000106

Vitae

Minnah W. Farook

Education

- 2013-2016** **Education Specialist in Counseling Psychology**
University of Kentucky
Lexington, KY
- 2010-2012** **Master of Arts in Clinical Psychology, Counseling Specialization**
The Chicago School of Professional Psychology
Chicago, IL
Concentration: Treatment of Addiction Disorders
- 2006-2008** **Bachelor of Science**
Wayne State University
Detroit, MI
Major: Psychology

Clinical Experience

- 8/2018 – 8/2019** **Predoctoral Psychology Intern**
Atlanta VA Health Care System
Atlanta, GA
- 8/2017 – 4/2018** **Psychology Trainee**
Robley Rex VA Medical Center
Louisville, KY
- 8/2016-6/2017** **Psychology Practicum Student**
Eastern State Hospital
Lexington, KY
- 09/2015-04/2016** **Psychology Intern**
Bluegrass.org/Bluegrass Comprehensive Care Center
Madison County
Richmond, KY
- 08/2014-05/2015** **Doctoral Practicum Student**
University of Kentucky Counseling Center:
Consultation and Psychological Services
Lexington, KY
- 01/2014-07/2014** **Doctoral Practicum Student**
Hope Center
Lexington, KY

01/2014-05/2014 **Doctoral Practicum Student/Process Observer**
University of Kentucky Counseling Center:
Consultation and Psychological Services
Lexington, KY

07/2011-07/2012 **Practicum and Internship**
Trilogy Behavioral Healthcare, Inc.
Chicago, IL

Additional Clinical Experience

05/2016-07/2016 **Community Access Specialist**
05/2015-10/2015 **Families Hope, LLC**
Lexington, KY

02/2009-08/2010 **Crisis Counselor**
Macomb County Crisis Center
Macomb County Community Mental Health
Chesterfield Township, MI

Research Experience

07/2016-07/2018 **Research Assistant**
Human Development Institute
University of Kentucky
Lexington, KY

01/2015-07/2018 **Research Team Member**
Reese Research Lab
University of Kentucky
Lexington, KY

08/2015-05/2016 **Research Assistant**
Department of Educational, School, and Counseling Psychology
University of Kentucky
Lexington, KY

08/2014-05/2015 **Research Assistant**
Department of Educational, School, and Counseling Psychology
University of Kentucky
Lexington, KY

09/2015-Present **Conference Presentation Peer-Reviewer**
University of Kentucky
Lexington, KY

08/2014-12/2015 **Assistant Editor: *Latina/o Psychology Today***
University of Kentucky
Lexington, KY

08/2011-05/2015 **Chavez & Adames Lab**
The Chicago School of Professional Psychology
Chicago, IL

10/2006-05/2007 **Undergraduate Research Assistant**
Industrial/Organizational Psychology Lab
Wayne State University
Detroit, MI

10/2006-05/2007 **Undergraduate Research Assistant**
Social Cognition Lab
Wayne State University
Detroit, MI

Publications

Farook, M. W., & Abreu, R. L. (2019). #Dismantling Islamophobia: A technology-based experiential activity to increase awareness and empathy toward Muslims. In M. Pope, M. Gonzalez, E. Cameron, & J. S. Pangelinan (Eds.) *Experiential activities for teaching social justice and advocacy competence in counseling*. New York, NY: Routledge.

Reese, R. J., Gismero-Gonzalez, E., Clements-Hickman, A. L., Clemons, J. M., **Farook, M. W., & Conoley, C. W. (2019).** The psychotherapy researcher – practice relationship: Through a clinical supervision lens. In J. D. Paquin (Ed.) *Clinician-Researchers in Psychotherapy*. New York, NY: Routledge.

Farook, M. W. (2018). The state of multicultural counseling competencies research. *Psychotherapy Bulletin, 53(4)*, 48-58.

Fedewa, A. L., Fettrow, E., Erwin, H., Ahn, S., & **Farook, M. W. (2018):** Academic-based and aerobic-only movement breaks: Are there differential effects on physical activity and achievement? *Research Quarterly for Exercise and Sport, 89*, 153-163.
doi: 10.1080/02701367.2018.1431602

Reese, R. J., Duncan, B. L., Kodet, J. D., Brown, H. M., Meiller, C., **Farook, M. W., Lengerich, A. J., Vasilj, I., Hong, S., & Bohanske, R. T. (in press).** Patient feedback as a quality improvement strategy in an acute care, inpatient unit: An investigation of outcome and readmission rates. *Psychological Services*.

Reese, R. J., Gismero-González, E., Clements-Hickman, A. L., Clemons, J. M., **Farook, M. W., & Conoley, C. W. (2017).** The psychotherapy researcher – practice relationship: Through a clinical supervision lens. *Counseling Psychology Quarterly*.
doi:10.1080/09515070.2017.1285270

Farook, M. W., & Abreu, R. L. (2016). Adult attachment assessments. In J. Carlson, & S. Dermer (Eds.), *The SAGE Encyclopedia of marriage, family, and couples counseling*. Thousand Oaks, CA: SAGE Publications, Inc. doi:10.4135/9781483369532.n13

Farook, M. W., & Abreu, R. L. (2016). Attachment and adolescents. In J. Carlson, & S. Dermer (Eds.), *The SAGE Encyclopedia of marriage, family, and couples counseling*. Thousand Oaks, CA: SAGE Publications, Inc. doi:10.4135/9781483369532.n29

Farook, M. W., & Abreu, R. L. (2016). Sex positivity. In J. Carlson, & S. Dermer (Eds.), *The SAGE Encyclopedia of marriage, family, and couples counseling*. Thousand Oaks, CA: SAGE Publications, Inc. doi:10.4135/9781483369532.n451

Salas Pizaña, S. P., **Farook, M. W.**, Chavez Dueñas, N. Y., & Adames, H. Y. (2016). Attachment and health. In Carlson, J., & Dermer, S. (Eds.), *Encyclopedia of marriage, family, and couples counseling*. Thousand Oaks, CA: SAGE Publications, Inc. doi:10.4135/9781483369532.n30

Farook, M. W., Alexander, D., & Smith, S. N. (2016). Our separate struggles are connected: The impact of Latina/o psychology on the lives of a Black and South Asian graduate students. In H.Y. Adames, & N.Y. Chavez-Dueñas, *Cultural foundation and interventions in Latino/a mental health: Considering history, theory, race, and within group differences* (pp. 231-237). New York, NY: Routledge.

Farook, M. W., & Salas Pizaña, S. P. (2015). Latina/o immigrants desafiando adversidades: Challenges faced by mixed-status families. *Latina/o Psychology Today*, 2, 26-32.

Other Publications

Farook, M. W. (2018, November). The association between cultural concealment and psychotherapy outcomes: An article review. *Society for the Advancement of Psychotherapy eNewsletter*. Retrieved from <http://societyforpsychotherapy.org/the-association-between-cultural-concealment-and-psychotherapy-outcomes/>

Farook, M. W. (2018). Investigating discrimination and distress with Dr. Ikizler. *AMENA-Psy Research Spotlight*. Retrieved from <https://www.amenapsy.org/research-spotlight>

Farook, M. W. (2018). দুই জগতের মধ্যে: Between two worlds. *Psychology International*, 29. Retrieved from <http://www.apa.org/international/pi/2018/05/bangladesh-learning-partner.aspx>

Farook, M. W., Abreu, R. L., & Garcia, J. (2017, June 21). On the Pulse massacre: Who is left out of the current discourse? [Web blog post]. Retrieved from <http://www.gradpsychblog.org/on-the-pulse-massacre-who-is-left-out-of-the-current-discourse/#.WUUs3MIJIPV>

Peer Reviewed Presentations

Farook, M. W., Reese, R. J., Duncan, B. L., & Bohanske, R. (2018, August). *The role of therapist multicultural competencies on therapeutic alliance and psychotherapy outcomes*. Poster presented at the annual meeting of the American Psychological Association, San Francisco, CA.

Clemons, J., Clements-Hickman, A., Goodwin, R. M., Lengerich, A. J., **Farook, M. W.**, Brown, H. M., Hong, S., & Reese, R. J. (2018, August). *Effectiveness, satisfaction, and feasibility of a mobile health application for distress*. Poster presented at the annual meeting of the American Psychological Association, San Francisco, CA.

- Tokarsky, M., Le, T., Mushiana, S., **Farook, M. W.**, Garrison, Y., Maung, J., & Phan, V. (2018, August). *Generating future leaders within AAPA: An exploration of the graduate leadership institute*. Symposium presented at Asian American Psychological Association Convention, San Francisco, CA.
- Farook, M. W.**, Brown, H. M., Hong, S., Clemons, J. M., Lengerich, A. J., Meiller, C. E....Reese, R. J. (2017, August). *Clients' experiences of providing feedback in psychotherapy: A qualitative study*. Poster to be presented at the annual meeting of the American Psychological Association, Washington, DC.
- Farook, M. W.**, & Abreu, R. L. (2017, August). *Student life concerns among LGBTQ students in higher education*. Poster to be presented at the annual meeting of the American Psychological Association, Washington, DC.
- Fedewa, A. L., Fettrow, E., Erwin, H. A., Ahn, S., & **Farook, M. W.** (2017, May). *Brain boosts: Does the type of movement matter in the elementary school classroom?* Paper to be presented at the Global Conference on Education and Research, Sarasota, FL.
- Farook, M. W.**, & Abreu, R. L. (2017, April). *Coping with oppression: Fear, anxiety, and addictive behaviors*. Symposium to be presented at the 9th Annual Muslim Mental Health Conference, Lansing, MI.
- Farook, M. W.**, & Abreu, R. L. (2017, March). *Managing stress, anxiety, and safety for immigrants post-election*. Roundtable to be presented at the Great Lakes Regional Counseling Psychology Conference, Muncie, IN.
- Meiller, C. E., Brown, H. M., Vasilj, I., Lengerich, A. J., Hong, S., **Farook, M. W.**, Clemons, J. M....Reese, R. J. (2016, August). *Collecting a current picture of outcome measurement in clinical practice*. Poster presented at the annual meeting of the American Psychological Association, Denver, CO.
- Vasilj, I., **Farook, M.W.**, Hong, S., Brown, H. M., Lengerich, A. J., Meiller, C. E....Reese, R. J. (2016, August). *Client feedback in an inpatient Setting: Fidelity, outcome, and readmission rates*. Poster presented at the annual meeting of the American Psychological Association, Denver, CO.
- Farook, M. W.**, Brown, H. M., Hong, S., Clemons, J. M., Lengerich, A. J., Meiller, C. E....Reese, R. J. (2016, August). *Clients' experiences of providing treatment outcome and alliance feedback in therapy*. Poster presented at the annual meeting of the American Psychological Association, Denver, CO.
- Farook, M. W.**, Mosley, D. V., Abreu, R. L. (2016, August). Exploring African American and Latino historical and cultural values in relation to LGBTQ Issues. In R. Abreu & A. Cerezo (Co-Chairs), *LGBTQ youth and parental acceptance among People of Color: A close(er) look at intersectionality*. Symposium presented at the annual meeting of the American Psychological Association, Denver, CO.
- Abreu, R. L., **Farook, M. W.**, & Mosley, D. V (2016, August). Consequence of parental acceptance and rejection in LGBTQ youth: A comprehensive overview. In R. Abreu & A. Cerezo (Co-Chairs), *LGBTQ youth and parental acceptance among people of color: A*

close(er) look at intersectionality. Symposium presented at the annual meeting of the American Psychological Association, Denver, CO.

Mosley, D. V., Abreu, R. L., & **Farook, M. W.** (2016, August). What about the parents? Journey to acceptance. In R. Abreu & A. Cerezo (Co-Chairs), *LGBTQ youth and parental acceptance among people of color: A close(er) look at intersectionality*. Symposium presented at the annual meeting of the American Psychological Association, Denver, CO.

Abreu, R. L., & **Farook, M. W.** (2016, April). *Breaking-down walls and standing in solidarity: The role of counseling psychologists in dismantling anti-immigrant rhetoric*. Roundtable presented at 2016 Great Lakes Regional Counseling Psychology Conference, Bloomington, IN.

Rosenkrantz, D., Abreu, R. L., Vasilj, I., **Farook, M. W.**, Jordan, C., & Glover, R. L. (2015, August). *Social justice training in the Literature: Moving Forward*. Poster presented at the annual meeting of the American Psychological Association, Toronto, Canada.

Farook, M. W., & Reese, R. J. (2015, March). *Muslim Americans: Acculturation, identity, perceived challenges, and life satisfaction*. Poster presented at 2015 Great Lakes Regional Counseling Psychology Conference, Muncie, IN.

Salas Pizaña, S. P., **Farook, M. W.**, Chavez-Dueñas, N. Y., & Adames, H. Y. (2015, February). *Breaking cycles of domestic violence: Mobilizing culturally congruent resources, a pilot study*. Poster presented at 32nd Annual Winter Roundtable Conference at Teacher's College Columbia University, New York, NY.

Farook, M. W., Salas Pizaña, S. P., Adames, H. Y., & Chavez Dueñas, N. Y. (2014, October). *Sin fronteras: Implications of U.S. immigration policies for Latino/a immigrants*. Poster presented at 2014 Biennial Conference of the National Latino/a Psychological Association, Albuquerque, NM.

Farook, M. W., & Chavez Dueñas, N. Y. (2012, October). *What's politics got to do with it? Sociopolitical factors that impact Latino/as*. Poster presented at 2012 Biennial Conference of the National Latino/a Psychological Association, New Brunswick, NJ.

Gutierrez, I., Salas, S. P., **Farook, M. W.**, & Chavez Dueñas, N. Y. (2012, October). *Buenos amigos: Using Latino values in the treatment and prevention of bullying*. Poster presented at 2012 Biennial Conference of the National Latino/a Psychological Association, New Brunswick, NJ.

Salas, S. P., Gutierrez, I., Chavez Dueñas, N. Y., & **Farook, M. W.** (2012, October). *Los que vamos contra la corriente: Latina/o graduate students' challenges and resiliency in psychology programs*. Paper presented at 2012 Biennial Conference of the National Latino/a Psychological Association, New Brunswick, NJ.

Farook M. W., Salas, S. P., & Chavez Dueñas, N. Y. (2012, June). *Salvando almas and giving hope: Using traditional healing as a clinical tool*. Paper presented at 2012 Multifaceted Themes of Diversity Conference, Chicago, IL.

Farook M. W., Johnson, K. S., & Langtiw, C. L. (2011, March). *Acculturation of Muslim American young adults*. Poster presented at 2011 Multifaceted Themes of Diversity Conference, Chicago, IL.

Professional/Outreach Presentations

Farook, M. W. (2018, January). *Working with immigrant clients*. Workshop presented at University of Kentucky, Lexington, KY.

Farook, M. W. (2017, August). *Creating safe spaces: Counselors, social workers, and administrators*. Workshop presented at Fayette County Public Schools, Lexington, KY.

Farook, M. W. (2017, August). *Creating safe spaces: Teachers and parents*. Workshop presented at Fayette County Public Schools, Lexington, KY.

Farook, M. W. (2016, December). *Addressing mental health disparities: Clinical and cultural competence*. Workshop presented at Eastern State Hospital, Lexington, KY.

Farook, M. W., & Vasilj, I. (2015, March). *Undocumented students*. Workshop presented to the Office of Student Involvement at University of Kentucky, Lexington, KY.

Abreu, R. L., **Farook, M. W.**, Glover, R. L., Hong, S., Knighton, J. P., & Vasilj, I. (2015, January). *Ally development workshop*. Workshop presented at University of Kentucky, Lexington, KY.

Abreu, R. L., **Farook, M. W.**, Glover, R. L., Hong, S., Knighton, J. P., & Vasilj, I. (2014, November). *Team building workshop*. Workshop presented at University of Kentucky, Lexington, KY.

Teaching Experience

01/2017-05/2017 **Lab Instructor**
Department of Human Health Sciences
University of Kentucky
Lexington, KY

08/2013-06/2014 **Instructor of Record**
Department of Educational, School, and Counseling Psychology
University of Kentucky
Lexington, KY

12/2010-05/2011 **Program Facilitator**
Mental Health Association of Greater Chicago
Chicago, IL

Honors & Awards

08/2018 **Graduate Student Travel Award** **\$650**
University of Kentucky-College of Education

01/2018	Arville and Ellen Turner Thacker Dissertation Award University of Kentucky-College of Education	\$1000
11/2017	Diversity Research Grant for Pre-Doctoral Candidates The Society for the Advancement of Psychotherapy (Division 29) American Psychological Association	\$2000
10/2017	AAPA Graduate Student Leadership Institute Fellow Asian American Psychological Association (AAPA)	
08/2017	Graduate Student Travel Award University of Kentucky-College of Education	\$650
07/2017	Psychology Summer Institute Fellow Minority Fellowship Program American Psychological Association	
08/2016	Conference Funding Award University of Kentucky-The Graduate School	\$325
08/2016	Conference Funding Award University of Kentucky-College of Education	\$250
02/2015	Conference Funding Award University of Kentucky-The Graduate School	\$400
2013-2015	Lyman T. Johnson Fellowship University of Kentucky	Over \$35000 and other benefits