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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
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THE ROLE OF THERAPIST MULTICULTURAL COMPETENCY
ON TREATMENT OUTCOMES

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DISSERTATION

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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

ABSTRACT OF DISSERTATION

THE ROLE OF THERAPIST MULTICULTURAL COMPETENCY
ON TREATMENT OUTCOMES

Racial and ethnic minority populations suffer disproportionally 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.

Minnah W. Farook

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Student's Signature
7/15/2019
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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

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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 disproportionally 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; Sodowsky, 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

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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

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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 α= .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

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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:

Final ORS$_{ij}$ = γ$_{00}$ + u_{oj} + 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:

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

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

(Final model 2)

Z (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
Client Measures				
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
Therapist Measures				
Therapist's Age	27	56	36.57	7.67
CCCI-R	92	112	100.93	5.39
QDI	76	99	89.04	5.33

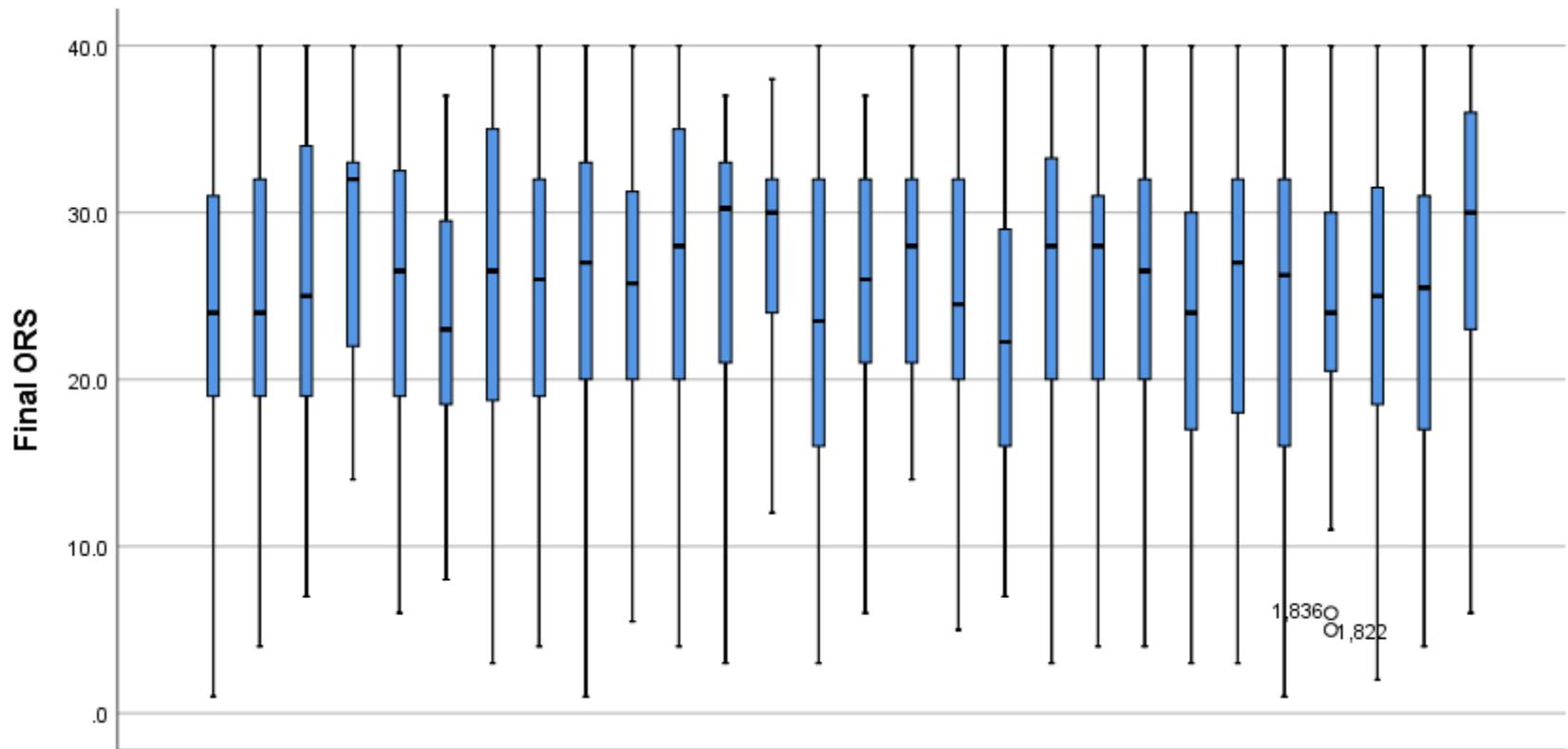*Note*. Client *n* = 2024. Therapist *n* = 28.

Figure 1. Distribution of Final ORS scores by therapist.
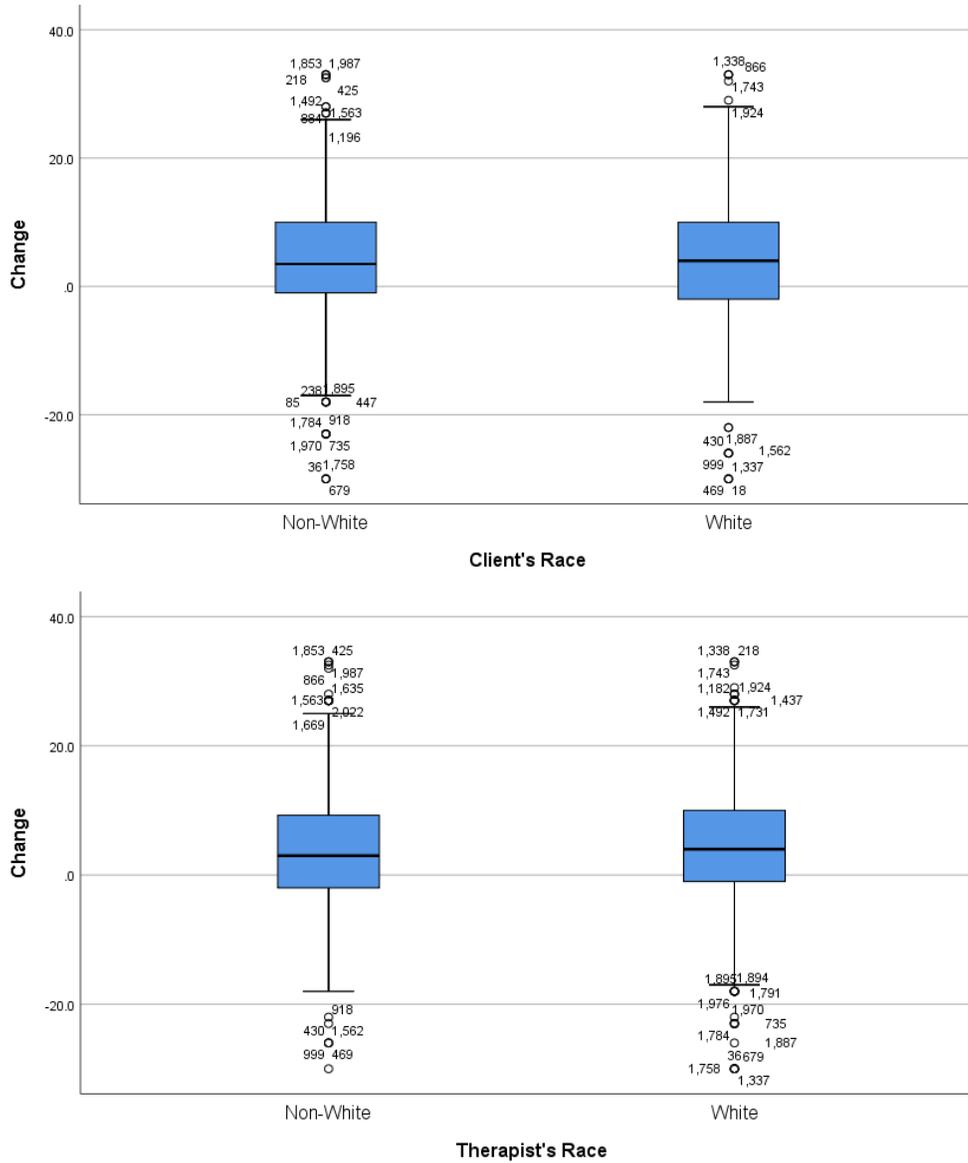
Figure 2. Distribution of change scores by client and therapist race.
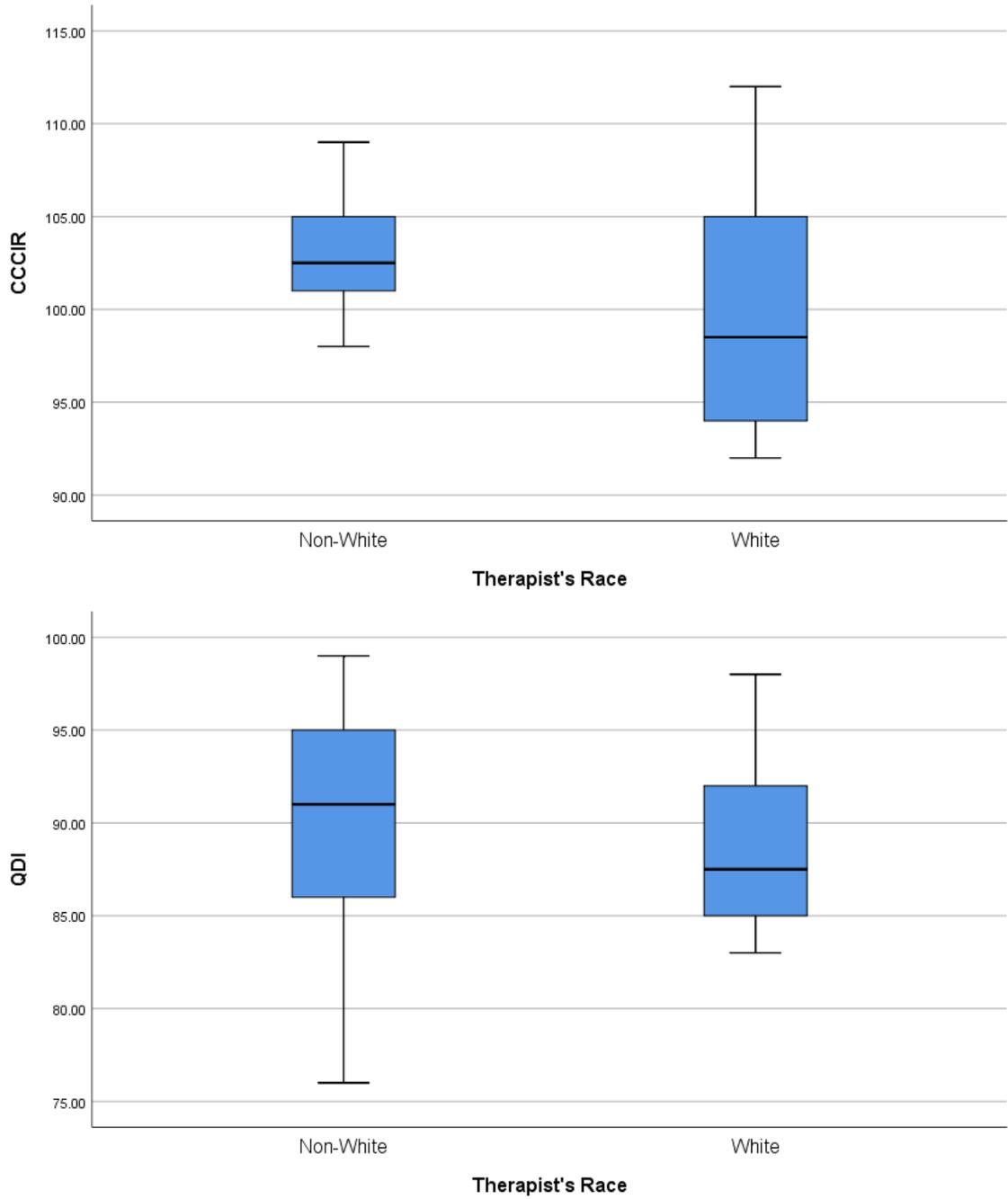
Figure 3. Therapist multicultural competencies by therapist race.
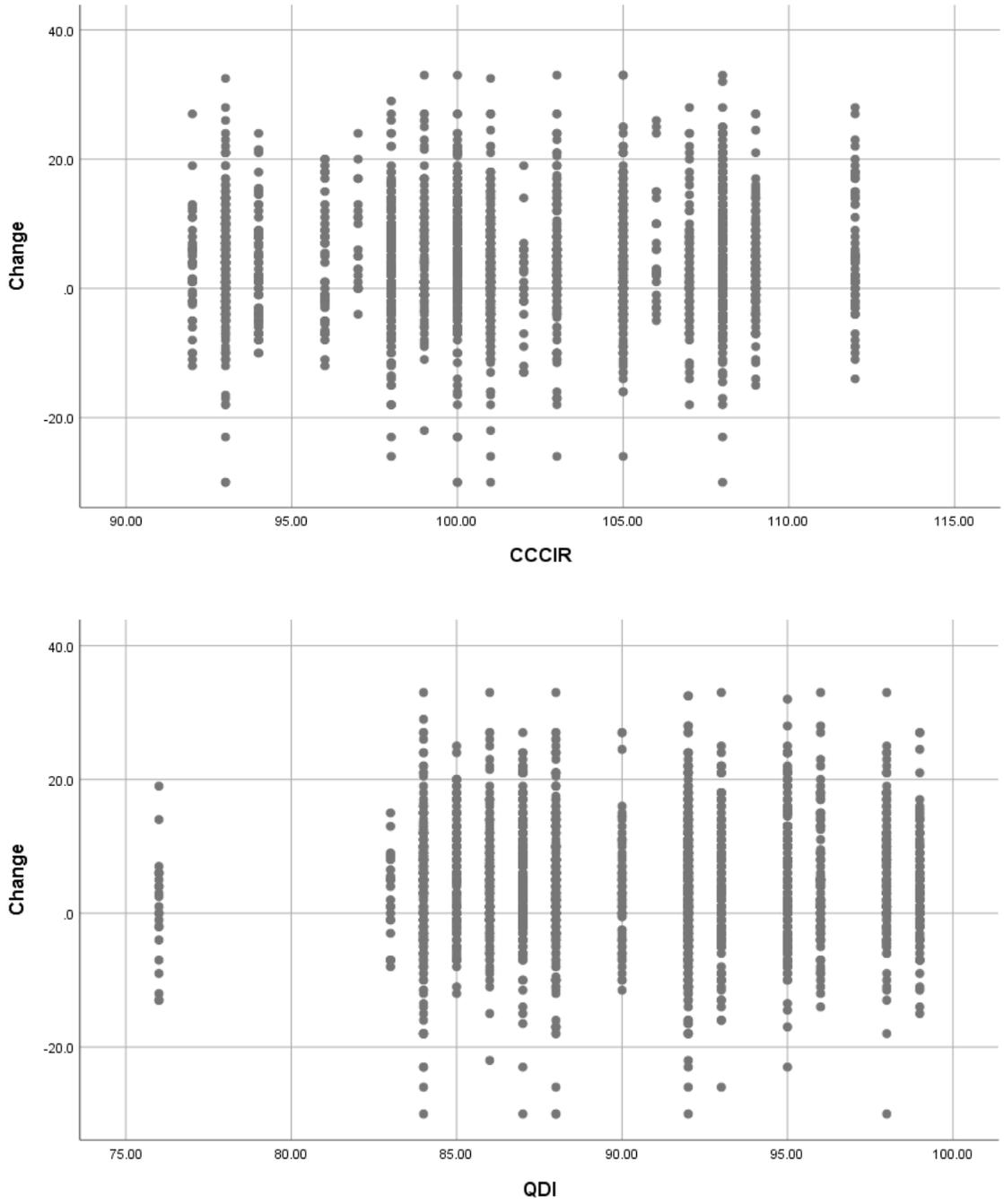
Figure 4. Scatterplots of multicultural competency (CCCI-R and QDI) and change scores.

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
Fixed Effects						
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
Random Effects						
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
Fixed Effects						
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						
Random Effects						
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
Fixed Effects						
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
Random Effects						
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, Delgadillo, & 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

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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.

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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.

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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 **05/2015-10/2015**	**Community Access Specialist** **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: Routlege.

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 S*AGE 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 thecurrent discourse? [Web blog post]. Retrieved from http://www.gradpsychblog.org/on-the-pulse-massacre-who-is-leftout-of-the-current-discourse/#.WUsu3MlJlPV

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** University of Kentucky-College of Education	**$650**

01/2018	**Arvile and Ellen Turner Thacker Dissertation Award**	**$1000**
	University of Kentucky-College of Education	

11/2017   **Diversity Research Grant for Pre-Doctoral Candidates**   **$2000**
The Society for the Advancement of Psychotherapy (Division 29)
American Psychological Association

10/2017   **AAPA Graduate Student Leadership Institute Fellow**
Asian American Psychological Association (AAPA)

08/2017   **Graduate Student Travel Award**   **$650**
University of Kentucky-College of Education

07/2017   **Psychology Summer Institute Fellow**
Minority Fellowship Program
American Psychological Association

08/2016   **Conference Funding Award**   **$325**
University of Kentucky-The Graduate School

08/2016   **Conference Funding Award**   **$250**
University of Kentucky-College of Education

02/2015   **Conference Funding Award**   **$400**
University of Kentucky-The Graduate School

2013-2015   **Lyman T. Johnson Fellowship**   **Over $35000 and other benefits**
University of Kentucky