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The Effect of Therapist White Privilege Attitudes on Client Outcomes and the Therapist-Client Relationship

Kristin M. Miserocchi

University of Kentucky, kwissin@gmail.com

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Kristin M. Miserocchi, Student

Dr. Robert J. Reese, Major Professor

Dr. Kenneth Tyler, Director of Graduate Studies

THE EFFECT OF THERAPIST WHITE PRIVILEGE
ATTITUDES ON CLIENT OUTCOMES AND THE
THERAPIST-CLIENT RELATIONSHIP

DISSERTATION

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

By
Kristin M. Miserocchi

Lexington, Kentucky

Directors: Dr. Robert J. Reese, Ph.D., Associate Professor of Counseling Psychology

Dr. Pamela Remer, Ph.D., Associate Professor of Counseling Psychology

Lexington, Kentucky

2014

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ABSTRACT OF DISSERTATION

THE EFFECT OF THERAPIST WHITE PRIVILEGE ATTITUDES ON CLIENT OUTCOMES AND THE THERAPIST-CLIENT RELATIONSHIP

Counseling Psychology has emphasized the importance of using multicultural and social justice frameworks in psychotherapy to avoid reenacting in session the privilege and oppression dynamics that exist in larger society. People of Color have historically underutilized psychotherapy services and have higher attrition rates when they do attend therapy, even though they have been more likely to face more sources of psychological distress (Kearney, Draper, & Baron, 2005; Sue & Sue, 2008). Additionally, White therapists have been over-represented in professional and training settings (Fouad & Arredondo, 2007; Hays & Chang, 2003). Add to that the fact that therapists have been trained in and practice psychotherapy theories developed primarily by White men and you have a system of counseling that works for some and not all. Thus, White therapists could be at risk for harming their clients of Color, and possibly their White clients as well, because of the utilization of these Euro-centrally biased ways of conceptualizing and treating clients (Mindrup, Spray, & Lamberghini-West, 2011). In this study, I examined the impact of therapist-reported White privilege attitudes on client-reported counseling outcomes and the therapeutic relationship. Participating therapists ($N = 36$) were recruited from a community mental health agency in the southeast and administered measures of White privilege attitudes, multicultural knowledge and awareness, and motivation to control prejudiced reactions. Outcome and therapeutic relationship data from clients of participating therapists, seen between fall 2012 and fall 2013 semesters, were provided by the agency. Therapist self-reported White privilege attitudes were not directly predictive of therapy outcomes and the therapeutic alliance. Therapists' willingness to confront White privilege, White privilege remorse, and apprehension about addressing White privilege moderated the effects first session outcome scores and client gender had on number of sessions attended by clients. Client race/ethnicity was not directly predictive of therapy outcome scores or therapeutic alliance scores. However, client race/ethnicity varied significantly across therapists, suggesting that therapists were differentially effective. Results of this study indicate that therapist White privilege awareness has an effect on outcomes and the therapeutic alliance, although the relationship is complicated. Study limitations, strengths, and implication for future research are discussed.

KEYWORDS: White Privilege, Counseling Outcome, Multicultural Competency,
Therapeutic Relationship, Cross-Cultural Counseling

Kristin M. Miserocchi
Student's Signature

June, 26, 2014
Date

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By

Kristin M. Miserocchi

Dr. Robert J. Reese
Co-Director of Dissertation

Dr. Pam Remer
Co-Director of Dissertation

Dr. Kenneth Tyler
Director of Graduate Studies

June, 26, 2014

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TABLE OF CONTENTS

Acknowledgments	iii
List of Tables	vii
Chapter One: Introduction and Review of Selected Literature	1
Statement of the Problem.....	4
Definitions.....	6
White Privilege	8
Examples of White privilege.	9
White privilege and MCC.....	12
White privilege and WRID.	14
Summary of research.	18
White privilege in the current study.....	19
Affective	20
Behavioral.....	21
Cognitive.....	21
White Privilege, Client Outcome and Therapeutic Relationship.....	23
Therapist-client matching	23
Treatment of racial/ethnic differences in therapy	25
Client perceptions of therapist MCC	26
Goals for Current Study	27
Hypothesis 1.....	28
Hypothesis 2.....	28
Hypothesis 3.....	28
Hypothesis 4.....	28
Hypothesis 5.....	28
Chapter Two: Method.....	29
Participants.....	29
Data Collection Site	31
Measures	32
Motivation to Control Prejudiced Reactions Scale.....	32
Multicultural Counseling, Knowledge and Awareness Scale.....	34
Outcome Rating Scale.....	35
Session Rating Scale.....	36
White Privilege Attitudes Scale.	37
Demographic Form	40
Procedures.....	40
Therapist data collection procedures	41
Client data collection procedures.....	41
Therapist – client data matching procedures	42
Data Analyses	42
Data analysis for psychotherapy outcome	44
Data analysis for psychotherapy relationship	46

Bi-variate correlational analyses.....	47
Chapter Three: Results	48
Preliminary Analyses	48
Results of the Hypotheses.....	51
Hypotheses one.....	51
Post ORS scores.....	51
Session number.....	54
Hypothesis two.....	57
Hypothesis three.....	588
Hypothesis four.....	58
Hypothesis five.....	611
Chapter Four: Discussion and Conclusions.....	62
Impact of White Privilege Attitudes on Therapy Outcomes.....	62
Interpretation.....	64
Impact of White Privilege Attitudes on Therapeutic Alliance.....	67
Interpretation.....	68
White Privilege and MCC.....	70
Study Limitations and Strengths.....	71
Implications and Future Recommendations.....	75
Implications.....	75
Future Directions.....	76
Appendix A: Motivation to Control Prejudiced Reactions Scale.....	79
Appendix B: Multicultural Counseling Knowledge and Awareness Scale.....	81
Appendix C: Outcome Rating Scale.....	86
Appendix D: Session Rating Scale.....	87
Appendix E: White Privilege Attitudes Scale	88
Appendix F: Demographics Questionnaire for Therapists	90
References	92
Vita	108

LIST OF TABLES

Table 2.1: Demographic Data for Therapist Participants and their Clients.....	30
Table 3.1: Means and Standard Deviations of Measures Completed by Therapists and Clients.....	50
Table 3.2: Bivariate Correlations between subscales of the WPAS.....	51
Table 3.3: Bivariate Correlations between MCPRS and all subscales of the WPAS and MCKAS.....	51
Table 3.4: Fixed and Random Effects for Two-level HLM for ORS Scores.....	52
Table 3.5: Fixed and Random Effects for Two-level HLM for Number of Sessions Attended.....	56
Table 3.6: Fixed and Random Effects for Two-level HLM for SRS Scores.....	59
Table 3.7: Bivariate Correlations between subscales of the WPAS and MCKAS.....	61

Chapter One: Introduction and Review of Selected Literature

Counseling Psychology has emphasized the importance of using multicultural and social justice frameworks in psychotherapy to avoid reenacting in session the privilege and oppression dynamics that exist in larger society. Therapists can lack awareness of their beliefs or values, and they may manifest in counseling sessions with clients in various ways, such as with interventions used or types of questions asked (Mintz, Jackson, Neville, Illfelder-Kaye, Winterowd, & Loewy, 2009). Many White individuals have difficulty articulating the ways in which they are cultural beings. “Whiteness is transparent precisely because of its everyday occurrence—its institutionalized normative features in our culture—and because Whites are taught to think of their lives as morally neutral, average, and ideal” (Sue & Sue, 2008, pp. 262-263). In other words, White individuals often see themselves as cultureless and unbiased because of the institutionalized invisibility of Whiteness, which makes it difficult to become aware of oppression and privilege and one’s participation in that dynamic. For White therapists, these blind spots could lead to unintentional oppression of clients, potentially harming them. Becoming aware of one’s own White privilege attitudes as a part of multicultural and social justice frameworks has become a focus of counseling psychology, as evidenced by the various groups and task forces that have a multicultural or social justice focus in Division 17 of the American Psychological Association (Society of Counseling Psychology).

These frameworks also fit with the current iteration of the American Psychological Association (APA) Ethical Principles and Code of Conduct (2010). All five of the General Principles are relevant to practicing within multicultural and social

justice frameworks. Beneficence and Nonmaleficence (Principle A), fundamental guiding principles of psychological practice, state that psychologists work to benefit and avoid doing harm to those with whom they work. Expanding one's cultural awareness of self and others could be both beneficial and non-harmful to clients of Color (Principle A). Principle B, Fidelity and Responsibility, refers specifically to psychologists establishing trust with clients, and committing to upholding professional standards. Psychologists are committed to practice with integrity (Principle C) and "accuracy, honesty, and truthfulness" (APA, 2010, p. 3). Making an effort to gain awareness could strengthen the trust a client of Color has with a White counselor, and could ensure the White counselor is maintaining high ethical standards and perceiving the client as accurately as possible (Principle B and C). Principle D, Justice, states that psychologists prevent their biases and boundaries of competence/expertise from leading to an unjust practice of psychology. Finally, psychologists commit to respect people's rights and dignity (Principle E) through awareness and consideration of differences (cultural and individual) when working with clients. Increased cultural self-awareness could increase awareness of one's biases, which could help prevent unjust practice and ensure that clients of Color are treated with dignity and respect (Principles D and E).

In addition to the General Principles, several ethical standards in the Code of Conduct could also be relevant to working within multicultural and social justice frameworks (APA, 2010). Standard 2.01, Boundaries of Competence, emphasizes that psychologists should not practice with individuals or groups who are outside their boundaries of competence. Further, psychologists have an ethical duty to either expand their boundaries of competence through training/education or refer those with whom they

are unqualified to work. Standards 2.03, Maintaining Competence, and 2.04, Bases for Scientific and Professional Judgments, refers to maintaining competence and making accurate judgments about clients based on a solid foundation of knowledge based on research, education, and training. Increased cultural awareness of self and others could ensure an ongoing expansion of one's boundaries of competence (Standards 2.01, 2.03, 2.04).

Standards 3.01 (Unfair Discrimination) and 3.03 (Other Harassment) make it unethical for psychologists to discriminate or harass individuals based on their social identities. Psychologists strive to avoid harming their clients (Standard 3.04). Increased awareness could also reduce the likelihood of unfair discrimination and harassment of clients of Color (Standards 3.01 and 3.03), and could increase the likelihood of avoiding harm (knowingly and unknowingly) to clients of Color (3.04). Self-awareness could be considered essential to adhere to this standard because without self-awareness psychologists could unknowingly harm their client. Informed consent (Standards 3.10 and 10.01), while generally relevant to all clients, could also be specifically adapted to have a more multicultural or social justice focus. Finally, discussing racial and ethnic differences with a client of Color as part of informed consent (Standards 3.10 and 10.01), could help increase a client's confidence in a White counselor's credibility, and could positively impact the therapeutic relationship (Chang & Yoon, 2011).

In addition to the ethics code, the APA developed aspirational guidelines for multicultural psychological practice. The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change (APA, 2002) were developed with the following goals in mind: (a) to assist psychologists in addressing

multiculturalism in education, training, research, practice and organizational change; (b) to provide information, terminology, and empirical research to support the guidelines; (c) to provide resources for on-going education, training, research, practice, and organizational change focused on multiculturalism and diversity; and (d) to provide examples as a means of broadening the focus of psychology as a profession.

The guidelines are grouped into two main sections: Commitment to Cultural Awareness and Knowledge of Self and Others, and Education, Research, Practice, and Organizational Change (APA, 2002). Particularly relevant to White therapists are the guidelines addressing Commitment to Cultural Awareness and Knowledge of Self and Others, and Practice:

- Guideline #1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.
- Guideline #2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.
- Guideline #5: Psychologists strive to apply culturally–appropriate skills in clinical and other applied psychological practices.

Statement of the Problem

The importance of a multicultural focus in counseling stemmed from the fact that counseling is a “sociopolitical act” (Sue & Sue, 2008). People of Color have historically underutilized psychotherapy services and have higher attrition rates when they do attend

therapy, even though they have been more likely to face more sources of psychological distress (Davidson, Yakushka, & Sanford-Martens, 2004; Kearney, Draper, & Baron, 2005; Sue & Sue, 2008). Additionally, White therapists have been over-represented in professional and training settings (Ancis & Szymanski, 2001; Fouad & Arredondo, 2007; Hays & Chang, 2003; Pack-Brown, 1999). Add to that the fact that therapists have been trained in psychotherapy theories and approaches developed primarily by White men, and later practice counseling with clients based on these theories, and you have a system of counseling that works for some and not all. Thus, White therapists utilizing theories based in Whiteness could be at risk for harming their clients of Color, and possibly their White clients as well, because of the utilization of these Euro-centrally biased ways of conceptualizing and treating clients (Mindrup, Spray, & Lamberghini-West, 2011). With these trends in mind, focusing on White therapists' attitudes toward White privilege and the effect these attitudes could have on their clients of Color could be important.

All individuals are cultural beings, including therapists and clients, and thus perceive the world through a unique cultural lens. Furthermore, clients tend to shift their value systems to match the therapist over time, and therapists tend to judge the progress of clients based on similarities in values with the therapist (Mintz et al., 2009).

Therefore, the potential for personal and ethical conflicts becomes apparent when considering: (a) therapists and clients are both cultural beings with unique cultural lenses through which they view the world; (b) therapy is a value-laden process; and (c) the power dynamic between therapist and client may facilitate a biased perception of client progress. A White therapist with little awareness that his or her White privilege attitudes are likely influenced by biases (conscious and unconscious) can result in potentially

biased conceptualizations and treatment of clients.

With all of this in mind, understanding how therapists' White privilege attitudes affect clients is a potentially important process for promoting a social justice and multicultural focus in counseling psychology, and practicing with all clients in an ethical and appropriate way. In this study, I sought to examine if: (a) White therapists are differentially effective with clients of Color as compared to White clients; (b) therapists' White privilege attitudes are predictive of client-reported therapy outcomes; (c) therapists' White privilege attitudes are predictive of clients' perceptions of the therapeutic relationship; and (d) a relationship exists between White privilege attitudes and multicultural competency (defined in the next section). The results of this study will contribute to multicultural counseling research and further the understanding of how a therapist's White privilege attitudes may affect the process and outcome of therapy.

Definitions

Important concepts will be defined in this section, to ensure clarity of discussion and to operationalize important concepts in this research study. All of the concepts presented here are relevant to the study of social justice in general and White privilege in particular. Social justice is defined as the "full and equal participation of all groups in a society. Social justice includes a vision of society in which the distribution of resources is equitable and all members are physically and psychologically safe and secure" (Bell, 2007b, p. 1). A socially just society is free of privilege and oppression and all of the "-isms." A social justice framework in counseling psychology refers to therapists working toward a more equitable society through clinical work, psycho-education, and social advocacy, among other activities (Fouad, Gerstein, & Toporek, 2006).

Aligned with a social justice framework is multicultural competency (MCC), defined as therapists increasing awareness of one's own multicultural identities, increasing awareness of other cultures, and developing culturally relevant interventions for use in practice (Sue, Arredondo, & McDavis, 1992). The first component of MCC is not only important in its own right, but also important in how a White therapist approaches the other two components. Therefore, one cannot truly work toward multicultural competence without focusing on awareness of one's White privilege attitudes and one's participation in the oppression of people of Color.

Goodman (2001) defined oppression as "prejudice + social power" (p. 16). Oppression is pervasive throughout society and also internalized by individuals. It restricts individuals from achieving their aspirations and limits their rights. Oppression and privilege are locked in dynamic tension, meaning that the dominant group gains privilege at the expense of the oppressed groups. Oppression overarches many social locations (e.g., gender, race, sexual identity, socioeconomic status), creating a complex web of oppression and privilege for each individual (Bell, 2007a). One type of systematic oppression is racism, defined as a "system of advantage based on race and supported by institutional structures, policies, and practices that create and sustain benefits for the dominant White group, and structure discrimination, oppression, and disadvantage for people from targeted racial groups" (Bell, 2007a, p. 118). The flip side to oppression is privilege, specifically White privilege, defined as a system of unearned advantages given to members of the dominant group (in this case, White people) simply because of their race (Goodman, 2001; Kendall, 2006). For the purposes of this study, therapists' White privilege attitudes will be examined, referring to the affective,

behavioral, and cognitive reactions to White privilege (Pinterits, Spanierman, & Poteat, 2009).

The last important concept to define is the therapeutic relationship. In this study, I operationalize the therapeutic relationship in terms of the working alliance. Bordin (1979) described the working alliance as involving an agreement between the client and therapist on goals and tasks of therapy, as well the development of the therapist-client bond. These components exist in all working alliances across all theoretical orientations, but the implementation and details of each component in therapy differ according to theory (Bordin, 1979). Thus, goals vary in their emphasis and focus (e.g., internal focus or external focus) across theories, the specific tasks assigned to achieve these goals vary, and the bonds differ depending on the therapist's role in the theory. The Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000) was developed with this idea of the working alliance at its foundation, and was used in the current study to measure the therapist-client relationship.

White Privilege

A paucity of research currently exists examining White privilege in the context of counseling psychology. Some research has been done examining White privilege in relation to MCC and WRID. Further examining these two constructs in relation to White privilege within a counseling context may help increase understanding of how White privilege affects the counseling process.

According to McIntosh (2009), White privilege "is the central actor in racism--the central force that creates racism and keeps it in place" (p. 2). Racism will exist as long as White privilege exists. Thus, awareness and understanding of privilege is key to

dismantling privilege and oppression. McIntosh famously referred to it as an “invisible weightless knapsack of unearned privileges” meaning that those who benefit from White privilege are typically unaware of its daily impact on their lives, or even that it exists (p. 2).

Because Whiteness is invisible and normative, it often goes ignored and unexplored. Those who have benefited from White privilege are often unaware of its daily impact on their lives, or even that it exists. Thus, one of the primary benefits of White privilege is obliviousness about privilege and oppression. According to Kendall (2006), people who are White can live with little awareness of the experiences of people of Color, which can often lead to an assumption that the White experience of privilege is actually normal and typical for everyone.

Examples of White privilege. The power differential created by White privilege manifests in many ways and at many levels in an individual’s life. White privilege enables people to selectively choose how or if they acknowledge the experience of people of Color, as well as enabling people who are White to view everything from a White perspective (Kendall, 2006). In other words, people who are White can successfully exist in that state of obliviousness and further discredit, silence, and minimize others’ experiences, especially if those experiences reflect negatively on White people (Kendall, 2006).

Another example of White privilege is the ability to surround oneself with only White people (Kendall, 2006; McIntosh, 1992). Because White people currently outnumber people of Color, segregation is more possible for White people without affecting their quality of life (in terms of finances, security, etc.). People who are White

can live in all White neighborhoods, send their children to all White schools, and socialize only with White people. People of Color, on the other hand, typically have to encounter people who are White on a daily basis (Kendall, 2006; McIntosh, 1992). Additionally, when segregation is a possibility for people of Color, often the choices are limited and less desirable.

White people have shaped language in this country by defining what is appropriate, and the result has been twofold. First, diverse ways of speaking (languages other than English as well as regional and cultural variations of English) are deemed incorrect or inappropriate, leading to the intolerance of those who do not speak English, as well as to a phenomenon known as “code switching” (Wheeler & Swords, 2004). Code switching is defined as the pressure to switch the way one speaks or behaves depending on the circumstances, such as switching from one style of speaking with family to standard English style at work. Thus, most Americans of Color are, in a sense, bilingual because of the expectation to proficiently speak in multiple ways. These struggles with language are representative of a bicultural dynamic tension that exists between fitting in with one’s racial/ethnic group and fitting in with the privileged racial/ethnic out-group.

The second result of language shaping is politeness, and its subsequent use to silence people of Color (Kendall, 2006). Many people of Color who have expressed themselves, especially in ways that reflect negatively on White people, have been told they were playing the race card, they were being too sensitive, they were pushing an agenda, they did not interpret the situation correctly, or they have been discredited in other ways (Kendall, 2006). As a result, many people of Color do not feel the freedom to

express themselves honestly for fear of hurting or offending others, and becoming further victimized.

McIntosh (1992) developed a list of privileges she noticed in her life as a White person. These privileges were day-to-day observations, as well as institutional level privileges including (but not limited to):

- “I can be pretty sure that my neighbors in such a location will be neutral or pleasant to me” (p. 2).
- “I can go shopping alone most of the time, pretty well assured that I will not be followed or harassed” (p. 2).
- “I can turn on the television or open to the front page of the paper and see people of my race widely represented” (p. 2).
- “When I am told about our national heritage or about “civilization,” I am shown that people of my color made it what it is” (p. 2).
- “I can go into a music shop and count on finding the music of my race represented, into a supermarket and find the staple foods which fit with my cultural traditions, into a hairdresser’s shop and find someone who can cut my hair” (p. 2).
- “Whether I use checks, credit cards or cash, I can count on my skin color not to work against the appearance of my financial reliability” (p. 2).
- “I am never asked to speak for all the people of my racial group” (p. 2).
- “I can do well in a challenging situation without being called a credit to my race” (p. 2).

- “I can be pretty sure that if I ask to talk to “the person in charge,” I will be facing a person of my race” (p. 2).
- “If a traffic cop pulls me over or if the IRS audits my tax return, I can be sure I haven’t been singled out because of my race” (p. 2).
- “If my day, week or year is going badly, I need not ask of each negative episode or situation whether it has racial overtones” (p. 2).
- “I can choose blemish cover or bandages in “flesh” color and have them more or less match my skin” (p. 2).

White privilege and MCC. Sue et al. (1992) identified three characteristics necessary to a multicultural framework in counseling: (a) trying to understand the worldview of clients of Color, (b) utilizing interventions and techniques that are culturally relevant and appropriate to one’s client, and (c) therapist self-awareness of assumptions, biases, and values. The third characteristic of multicultural competence, therapist self-awareness of biases and values, is particularly relevant to White privilege. This self-awareness involves knowledge of how privilege and oppression have affected one’s own life (Sue et al., 1992). Self-awareness has traditionally been addressed in counseling training programs on an intellectual or cognitive level, avoiding the difficult “emotional impact of attitudes, beliefs, and feelings associated with cultural differences such as racism, sexism, heterosexism, able-body-ism, and ageism” (Sue & Sue, 2008, p. 44).

Arredondo and her colleagues (1996) also identified self-awareness of one’s own cultural biases as being crucial to MCC. Four specific counseling competencies exist related to this self-awareness: (a) “culturally skilled therapists believe that cultural self-

awareness and sensitivity to one's own cultural heritage is essential;" (b) "culturally skilled therapists are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychological processes;" (c) "culturally skilled therapists are able to recognize the limits of their MCC and expertise;" and (d) "culturally skilled therapists recognize their sources of discomfort with differences that exist between themselves and clients in terms of race, ethnicity, and culture" (Arredondo et al., 1996, pp. 57–58).

A relationship between White privilege and MCC intuitively makes sense; however, little empirical research exists to test this assumption. Mindrup et al. (2011) conducted a study to examine if White privilege and MCC were positively correlated. Their sample ($N = 298$) of White graduate students in social work and clinical psychology programs were administered a measure of White privilege attitudes and a measure of MCC. Researchers found significant and positive correlations between scores on the White privilege measure and scores on the multicultural competence measure. Trainees who expressed more intention to address White privilege, understanding of White privilege, and emotional responses to White privilege also exhibited greater knowledge and awareness of multicultural competence in therapy. Although White privilege and MCC were positively correlated, the researchers also stated that, "while white privilege awareness and multicultural awareness are moderately correlated, they appear to be distinct constructs. White privilege awareness appears to be one component of a much broader context of multicultural awareness" (Mindrup et al., 2011, p. 31). These researchers did not assess the relationship between their constructs of interest and social desirability, a limitation that the current study addresses.

Chao (2006) also found a link between MCC and White privilege awareness. In her study of graduate counseling students, she administered a MCC measure and a measure of color-blind attitudes that included a racial privilege subscale, measuring one's lack of awareness of White privilege. She found that colorblind attitudes, and specifically, scores on the racial privilege subscale of the color-blind attitudes measure, were significantly and negatively correlated to MCC. Thus, higher scores of colorblindness and higher scores of White privilege unawareness were correlated with lower scores of MCC.

These two correlational studies used the same scale to measure MCC, and operationalized it as having both knowledge and awareness components (similar to this study). They measured White privilege differently, however. Mindrup et al. (2011) utilized a scale of White privilege that assessed affective, behavioral, and cognitive components of White privilege attitudes (similar to this study). Chao (2006) utilized a scale measuring color-blind cognitive attitudes, which included a scale measuring blindness to White racial privilege. While Chao focused on cognitive components of White privilege, Mindrup et al. operationalized White privilege in a multidimensional way that incorporated the cognitive attitudinal components from Chao's study.

White privilege and WRID. White racial identity often refers to an evolving White identity from racist to nonracist, which includes greater self-awareness. One of the most well-known models is Helms's (1993) model of White Racial Identity Development (WRID). Her model begins with the Contact stage, characterized by individuals typically engaging in casual exchanges with African Americans (such as work), subscribing to stereotypes, perpetrating microaggressions, being oblivious, and relying on African

Americans to educate them about the African American experience. The next stage is the Disintegration stage, which is rife with questioning and cognitive dissonance. Cognitive Dissonance is a powerful force that may cause individuals in this stage to change their behavior (e.g. stop engaging with African Americans) or their beliefs to be more congruent with their environment, in this case adopting the belief that being White means being superior to African Americans. This new belief defines the next stage, Reintegration, where, “Any residual feelings of guilt and anxiety are transformed into fear and anger toward Black people” (Helms, 1993, p. 60). An occurrence of an event, either at individuals’ micro or macro level environments, may trigger them to question their White racial identity and to acknowledge the unfairness of racism (Helms, 1993). The next stage, Pseudo-Independence, is characterized by questioning the superiority/inferiority dynamic between White people and African Americans, and redefining one’s White identity. The Immersion/Emersion stage is characterized by becoming more informed about what it means to be White, shifting focus from changing African Americans to changing White people. The final stage is Autonomy, where individuals are no longer oppressors but instead, begin to seek out learning opportunities from other racial/ethnic groups, as well as to learn about other forms of prejudice and discrimination.

White privilege awareness was not explicitly identified as a part of Helms’s process; however, greater self-awareness that is a part of her model is also the crux of White privilege awareness. Additionally, White privilege is a fundamental component of racism, thus acknowledging how one has benefited from White privilege is crucial to White racial identity development (Hays & Chang, 2003; Hays, Chang, & Havice, 2008).

This awareness of White privilege is likely to begin in the middle of Helms's model, during stages involving introspection, soul searching, and attempts to change "self" rather than "other" (Hays & Chang, 2003; Hays et al., 2008; Sue & Sue, 2008). For instance, Hays et al. (2008) found that the Contact and Reintegration stages of Helms's (1993) White Racial Identity Development model were negative predictors of White privilege awareness because individuals in these stages are either oblivious to oppression or intolerant of people of Color. Moreover, the Immersion/Emersion stage of Helms's model was found to be a positive predictor of White privilege awareness because these individuals are engaging in introspection and coming to terms with their own role in racism.

Branscombe, Schmitt, and Schiffhauer (2007) studied the impact of thinking about White privilege on White undergraduate students ($N = 189$). Participants in this study were asked to generate lists of ways they were privileged or disadvantaged as White individuals, or were asked to generate a list of race-neutral items. In general, they found that thinking about White privilege led to greater racist attitudes as compared to those who thought about White disadvantages or race-neutral topics. The researchers also examined how the strength of participants' White identity moderated the relationship between White privilege thoughts and racist attitudes. Their conceptualization of White identity can be understood in the context of the first three phases of Helms's model, i.e., the more racist stages. Individuals with stronger White identities are more likely to react negatively to White privilege awareness because of the feelings of defensiveness experienced in response to a perceived threat to their identity (i.e., learning about the unfair benefits that come with being White).

Branscombe et al. (2007) found that individuals who identified strongly with their White identity were more likely to express greater racist attitudes when thinking about White privilege. In other words, those participants who identified strongly with their Whiteness and generated White privilege lists were more likely to perceive their White identity as being threatened (Branscombe et al., 2007). These results suggested that a strong White identity is associated with the more racist levels of Helms's identity development model. Because individuals in these early stages have not explored or questioned their Whiteness, their identities would be easier to threaten with something like White privilege.

These two studies, one correlational (Hays et al., 2008) and one experimental (Branscombe et al., 2007), conceptualized White privilege and White racial identity differently. Hays et al. (2008) operationalized White privilege utilizing a five-item scale based on McIntosh's (1992) list of White privilege. While this list is well-known, it is also reflective of McIntosh's personal experience with White privilege and not a universal or standardized conceptualization of White privilege. What was salient for McIntosh may not be for other White people. Branscombe et al. operationalized White privilege based on a single instruction given to participants:

“We would like you to think about and consider the ways that you have received privileges or been advantaged [not received privileges or been disadvantaged] because you are White/Caucasian. Write down as many different ways as you can think of that you have benefited or been advantaged [not benefited or been disadvantaged] because of your race (p. 206).

This conceptualization was very simple and subjective, dependent entirely on the

participants' own conceptualization of their own White privilege.

Both studies also operationalized White racial identity very differently. Hays et al. (2008) utilized the White Racial Identity Attitudes Scale (WRIAS; Helms & Carter, 1993), based on Helms's White Racial Identity Development Model. White racial identity has been researched extensively in the counseling psychology literature, and this scale has been the primary way of operationalizing and measuring this construct. However, empirical evidence for the reliability and validity of the WRIAS, and in turn, for Helm's five dimensional White racial identity development model, has been mixed. Subscale alphas have ranged widely (.15 to .84) and validity testing has been inconsistent in identifying how many distinct factors exist in the scale (Behrens, 1997; Burkard, Juarez-Huffaker, & Ajmere, 2003; Burkard, Ponterotto, Reynolds, & Alfonso, 1999; Carter & Akinsulure-Smith, 1996; Carter, Helms, & Juby, 2004; Chae et al., 2010; Constantine, 2002b; Constantine, Warren, & Miville, 2005; Gushue & Carter, 2000; Gushue & Constantine, 2007; Helms & Carter, 1993; Middleton et al., 2005; Neville et al., 1996; Parks, Carter, & Gushue, 1996; Pope-Davis, Menefee, & Ottavi, 1993; Sciarra, Change, McLean, & Wong, 2005; Swanson, Tokar, & Davis, 1994; Tokar & Swanson, 1991; Utsey & Gernat, 2002). Branscombe and colleagues (2007) operationalized racial identity by creating five items about Whiteness in terms of: comfort level, naturalness of being White, pride in being White, feeling good about being White, and a lack of embarrassment about being White. The higher the scores the stronger the racial identity. Thus, an empirically solid and consistent method of measuring White racial identity development does not currently seem to exist.

Summary of research. The research studies reviewed above examined the

construct White privilege in relation to MCC and White racial identity development, and found a significant relationship in all cases. Overall, more White privilege awareness was positively correlated with MCC (measured in terms of skills and awareness). White privilege awareness was also found to be negatively correlated with the earlier and more “racist” stages of Helms’s White Racial Identity Model, and also with a stronger White identity.

These studies also have limitations, which the current study attempted to address. For instance, three of the above studies examined White privilege in the context of the mental health profession, but did not address the impact of White privilege awareness on clients, such as in the form of therapy process and outcome. Identifying and understanding White privilege attitudes in therapists is important, but the research has stopped there rather than extending this understanding to the therapy process and actual client outcomes. Another limitation of the research was social desirability. Three of the studies did not examine the impact of social desirability, which can be a confounding variable when using self-report measures (Babbie, 2008). Finally, three of the above studies samples consisted of college or graduate students, limiting the generalizability of their results.

White privilege in the current study. Like White racial identity development, a reliable and valid method of measuring White privilege has not been established. Researchers have measured White privilege in a wide variety of ways, such as using study participants’ or using Peggy McIntosh’s (1992) conceptualization of White privilege. Three brief measures of White privilege exist: Swim and Miller’s (1999) five-item scale, the seven-item Racial Privilege subscale of the Color-blind Racial Attitudes

Scale (Neville, Lilly, Duran, Lee, & Browne, 2000), the 13-item White Privilege Awareness subscale of the Privilege and Oppression Inventory (Hays, Chang, & Decker, 2007). All three of these measures have demonstrated strong reliability estimates (ranging from 0.71 to 0.92), though have not been used much because White privilege has not been empirically studied much. An important limitation of all three of these measures is their primary focus on the cognitive aspects of White privilege awareness and attitudes. A newly developed scale, White Privilege Attitudes Scale (WPAS; Pinterits et al., 2009), took a new approach to conceptualizing White privilege.

In their development of the WPAS, Pinterits et al. (2009) described White privilege attitudes as being a multifaceted experience for White individuals consisting of affective, behavioral, and cognitive reactions to White privilege. With this in mind, they developed a scale to more fully measure the complexity of one's experience of White privilege, rather than just focusing on the cognitive dimension like prior measures have. The items were designed to reflect all three components of White privilege attitudes. For the purposes of this study, White privilege attitudes in therapists has been operationalized in the same way that Pinterits and her colleagues conceptualized it for their scale.

Affective. A great deal of research has examined the affective part of White privilege attitudes, with a range of emotions being identified. One prominent emotion was guilt experienced in response to a variety of issues, including: raised awareness of White privilege, differential and unfair treatment of people of Color; in reaction to actions taken or not taken relating to privilege and oppression, and in response to ancestors' actions (Arminio, 2001; Iyer, Leach, & Crosby, 2003; Kernahan & Davis, 2007; Leach, Iyer, & Pedersen, 2006; Spanierman & Heppner, 2004; Swim & Miller,

1999). Also prominent was fear, which McIntosh (2009) identified as her largest obstacle in discovery of her White privilege because of the potential loss of “status, money, respect, purpose, life plans, family, friends, pleasure, institutional support and my current sense of my identity” (p. 7). Other research has found fear in response to White privilege may stem from the potential to lose status or power (Neville, Worthington, & Spanierman, 2001), rejection from significant others like family or friends (Goodman, 2001; Neville et al., 2001; Tatum, 2002), or rejection by people of Color (Jensen, 2005; Spanierman et al., 2008). Finally, anger type responses, including anger, defensiveness, and disgust, could stem from one’s identity being threatened (Ancis & Szymanski, 2001; Branscombe, Schmitt, & Schiffhauer, 2007; Fouad & Arredondo, 2007; Kivel, 2002; Spanierman, 2008) or could be a reaction to the injustice of privilege and oppression (Leach et al., 2006).

Behavioral. Behavioral components in response to White privilege stem from the affective or cognitive components. Research has shown that White individuals could deny the existence of White privilege in some cases, or could disconnect from the issue altogether, leading to a lack of willingness to engage in discourse or consciousness-raising (Ancis & Szymanski, 2001; Rains, 1998; Titone, 1998). On the other hand, some individuals have expressed a desire to take action against oppression, often motivated out of anger or empathy (Ancis & Szymanski, 2001; Iyer et al., 2003). Some who would like to take action could become overwhelmed by their emotions and the magnitude of the problem, and thus, are unsure how to take action (McKinney & Feagin, 2003).

Cognitive. Finally, research has examined the cognitive reaction to White privilege. Research in this area has centered on awareness and belief systems. On one

hand, research has found that White individuals who lack awareness of White privilege were likely to deny its existence and exhibited resistance to becoming more aware (Ancis & Szymanski, 2001; Hays, Chang, & Dean, 2004). Additionally, research has found that White individuals could distort or minimize the reality of privilege and oppression, endorse color-blindness or stereotypes, and believe in the myth of meritocracy (Branscombe et al., 2007; Hays et al., 2004; Neville, Lilly, Duran, Lee, & Browne, 2000). On the other hand, those individuals who have awareness of White privilege were more likely to accept responsibility and work toward change (Ancis & Szymanski, 2001; Hernandez, Almeida, & Dolan-Delvecchio, 2005; Spanierman et al., 2008).

Three scales examining White privilege have focused on the cognitive dimension of White privilege attitudes: (a) Swim and Miller's (1999) five-item White Privilege Scale focused on awareness and beliefs about White privilege; (b) the Racial Privilege subscale on the Color-blind Racial Attitudes Scale (seven items; Neville, Lilly, Duran, Lee, & Brown, 2000) focused on distorted beliefs about White privilege; and (c) the White Privilege Awareness subscale (13 items) on Hays, Chang, and Decker's (2007) Privilege and Oppression Inventory focused on awareness of White privilege.

Thus, the White Privilege Attitudes Scale (Pinterits et al., 2009) was selected for this study because of its multifaceted approach to White privilege attitudes, as opposed to the one-dimensional approach of the measures described above. Additionally, the developers of this measure were rigorous in their methodology, completing multiple validity and reliability analyses; however, this measure has not been utilized in much research. Although Pinterits et al. reported overall strong psychometric properties in their initial reliability and validity article, Mindrup et al. (2011) did not report reliability or

validity on their sample data. Even though this scale is in its infancy in terms of psychometric research, it shows promise as a reliable and valid measure of White privilege relative to alternative ways of measuring White privilege.

White Privilege, Client Outcome and Therapeutic Relationship

A lack of research exists linking therapist White privilege awareness to client outcomes in therapy. As a profession, counseling psychology has little understanding about how racial dynamics in therapy affect outcome; mostly professionals are left to work with speculations and assumptions – this is particularly problematic when cross-racial dyads in counseling involve White therapists and clients of Color. Clients of Color must contend with a great deal of extra distress stemming from racial oppression of which White therapists may not be aware. Under-prepared White therapists, then, potentially carry their known and unknown biases and a lack of awareness of oppression into counseling sessions with clients of Color. As a result, they may be unable to fully conceptualize and understand their clients' distress (Sue & Sue, 2008). Therapists may also over-pathologize their clients of Color, thus locating the source of their distress intrapsychically rather than societally (Sue & Sue, 2008). The result could be harming these clients rather than helping to heal them. Three main areas of research exist linking race/ethnicity to treatment process and outcome in counseling: (a) the effects of therapist-client matching on the therapeutic relationship and treatment outcome, (b) therapists' treatment of racial and ethnic differences, and (c) client perceptions of the therapist's MCC.

Therapist-client matching. Therapist-client matching generally refers to clients' preference for a therapist of the same race/ethnicity. Overall, the research in this area has

been mixed, with research both supporting (D'Andrea & Heckman, 2008; Farsimadan, Draghi-Lorenz, & Ellis, 2007; Thompson & Alexander, 2006) and not supporting (Cabral & Smith, 2011; Constantine, 2001) the notion that therapist-client matching supports improved client outcomes. The importance of therapist-client matching could be related to client presenting problem. Pope-Davis et al. (2002) found that clients for whom cultural concerns were strongly related to their presenting concerns, preferred therapists who matched them in terms of race/ethnicity and gender; however, those clients whose presenting concerns were not obviously related to cultural issues were less worried about therapist-matching.

Two meta-analyses have been conducted examining the impact of therapist-client matching on treatment outcomes, both reaching different conclusions. In their review of multicultural counseling studies, D'Andrea and Heckman (2008) found that clients of Color were more likely to use counseling and less likely to drop out of counseling when paired with a therapist of the same racial/ethnic group. D'Andrea and Heckman also reported on research that found client and therapist racial/ethnic matching was predictive of treatment outcome; however, the outcomes were reported by therapists not clients. The authors suggested the need for studying how therapist-client interracial and intra-racial dynamics could impact psychological improvements in clients, but recommended going beyond just researching therapist-client matching in therapy. They call for the use of racial development instruments and multicultural competence measures in this type of research (D'Andrea & Heckman, 2008).

Cabral and Smith (2011) found in their meta-analysis of 52 studies that clients' counseling outcomes in their sample did not differ significantly based on therapist-client

racial/ethnic pairings. The authors posited that racial/ethnic matching in counseling has more to do with clients' preferences for matching and perceptions of therapists' MCC. Furthermore, if a client does have a preference for matching, the authors opined that the development of a genuine therapeutic relationship would trump the desire for matching. Interestingly, the authors found that African Americans preferred being racially matched above other clients of Color, and experienced better counseling outcome when they were matched. Possible explanations may be a greater fear of prejudice compared to other racial/ethnic groups, or a stronger racial/ethnic identity (Cabral & Smith, 2011).

Treatment of racial/ethnic differences in therapy. Research examining the treatment of therapist and client racial/ethnic differences has centered on whether or not race/ethnicity is introduced in therapy, and if so, how it is introduced. Research has examined therapists' willingness to address issues of race in the counseling session and its impact on client outcome and client satisfaction in counseling. Maxie, Arnold, and Stephenson (2006) found that most therapists were willing to address cultural differences with clients, and that female, older, White, therapists especially felt comfortable addressing differences with clients. However, therapists actually addressed those differences with clients less than half of the time. Maxie et al. stated there was a high likelihood that, in some sessions, these conversations needed to happen but did not. This study seemed to identify a gap between therapists' own assessment of their abilities (in this case, talking to clients about cultural differences) and what they actually do in session with clients. Knox, Burkard, Johnson, Ponterotto, and Suzuki (2003) found that African American therapists routinely addressed race with clients of Color significantly more than did White therapists. Although all therapists were willing to address the issue

of race if clients brought it up, African American therapists were more likely to recognize a client's discomfort with bringing up the issue of race. These findings are contradictory to Maxie et al. (2006), who found that White therapists felt more comfortable than African American therapists with addressing differences.

Some research has found that clients take a cue from the therapist about addressing racial/ethnicity in session. For example, if a therapist seemed hesitant or unwilling to discuss race, sometimes it also became difficult or uncomfortable for the client to do so (Thompson & Jamal, 1994). Chang and Yoon (2011) found that the majority of clients of Color did not believe White therapists could understand their experience as a person of Color and would avoid bringing up race/ethnicity-related issues in session. These clients did report, however, that if a therapist showed empathy, compassion, or comfort with racial issues, they felt more comfortable with the therapist. Overall, this area of research is limited and mixed in terms of findings, but illustrates the potential complexity of the therapy relationship when racial/ethnic differences exist between therapist and client.

Client perceptions of therapist MCC. Research has found that clients who rated their therapists as being more multiculturally competent were more likely to experience satisfaction and greater benefit from therapy (Fuertes et al., 2006; Owen, Leach, Tao, & Rodolfa, 2011), especially for clients of Color (Constantine, 2002a; Fuertes & Brobst, 2002). Moreover, Owen et al. (2011) found that clients' ratings of therapists' multicultural orientation was positively related to their ratings of the working alliance, as well as mediating the relationship between the working alliance and client psychological well-being. This result could mean that "the formation of a strong alliance creates a

relational base for clients and psychotherapists to effectively manage cultural issues, which in turn can assist clients' therapeutic outcomes" (p. 280). In contrast, Owen, Leach, Rodolfa, & Wampold (2011) found that clients' perceptions of therapists' multicultural orientation were not related to outcome. Thus, therapists considered more effective in terms of client outcomes were no more likely to be multiculturally oriented with their clients than less effective therapists. The research in this area is also limited, but generally supports the idea that MCC can influence clients' experience of therapy.

Goals for Current Study

The purpose of this study is to examine therapists' White privilege attitudes in a counseling setting. Little is known about the role White privilege attitudes may play when working with clients, especially clients of Color. Thus, this study seeks to address the impact of therapist-reported White privilege attitudes on client-reported counseling outcomes and client perceptions of the therapeutic relationship. Research has been mixed with regards to the effect of racial issues on client outcomes in therapy and client satisfaction with the therapist. One narrative that has emerged from this research, however, is that clients of Color may initially view racially-matched therapists more favorably, but will be able to benefit from working with any therapist if a solid, empathic therapeutic relationship develops (Cabral & Smith, 2011).

Thus, White therapists may potentially be just as likely as therapists of Color to connect and successfully work with clients of Color, as long as they are building genuine relationships with their clients. MCC, as defined earlier, may be an integral part of this genuine relationship building with clients and with improved client outcomes. MCC may also be correlated with White privilege, although this relationship has yet to be explored.

With this rationale in mind, the hypotheses for the current study are:

Hypothesis 1: Scores on the WPAS (Pinterits et al., 2009) in terms of confronting White privilege, anticipated costs of White privilege, White privilege awareness, and White privilege remorse will predict psychotherapy outcomes for clients, as measured by the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and the number of attended sessions.

Hypothesis 2: White therapists' effectiveness with clients of Color as compared to White clients, measured by the ORS, will be different and moderated by scores on the WPAS in terms of confronting White privilege, anticipated costs of White privilege, White privilege awareness, and White privilege remorse.

Hypothesis 3: Scores on the WPAS in terms of confronting White privilege, anticipated costs of White privilege, White privilege awareness, and White privilege remorse will predict client perceptions of the therapeutic alliance, as measured by the Session Rating Scale (SRS; Miller et al., 2000).

Hypothesis 4: White therapists' therapeutic alliance scores with clients of Color as compared to White clients, measured by the SRS, will be different and moderated by scores on the WPAS in terms of confronting White privilege, anticipated costs of White privilege, White privilege awareness, and White privilege remorse.

Hypothesis 5: Scores on the WPAS in terms of confronting White privilege, anticipated costs of White privilege, White privilege awareness, and White privilege remorse will be positively correlated with multicultural knowledge and awareness.

Chapter Two: Method

This study was an original data collection utilizing longitudinal and correlational designs. Participating therapists completed a series of self-report measures assessing for White privilege attitudes, multicultural awareness and knowledge, and motivation to control prejudiced reactions. Clients of participating therapists completed an outcome measure at the beginning and end of each therapy session. Data from therapists and clients were analyzed utilizing multilevel modeling techniques. Participants, procedures, measures, and data analyses are described in this section.

Participants

Participants included both therapists ($N = 32$) working at a community mental health center in the southeast and their clients ($N = 468$). Therapists were recruited directly with assistance from the staff at the community mental health center. Therapists were included in the sample based on three criteria. First, therapists were currently using the ORS and SRS with their clients. Second, only therapists self-identifying as White were included as White privilege attitudes was the primary predictor variable of interest. Last, similar to methodology used by Baldwin, Wampold, and Imel (2007), therapists were included only if ORS and SRS data were available for at least two clients.

The majority of participating therapists were female (65.6%) with an average age of 40.38 ($SD = 10.38$, range = 25-65), and all self-identified as White. Therapists had an average of 12.19 years of clinical experience ($SD = 9.39$, range = 2-36) and saw clients on average for 6.38 sessions ($SD = 4.25$, range = 3-43). The vast majority of therapists reported having a master's degree (92.9%) in various disciplines, including education, rehabilitation counseling, and social work, and three-fourths of therapists identified using

either a cognitive based (46.9%) or an eclectic/integrated approach (28.1%) in their clinical practice. Therapists saw an average of 12.81 White clients ($SD = 8.12$, range = 1-35) and 1.84 clients of Color ($SD = 2.49$, range = 1-13). Please see Table 2.1 for a breakdown of demographic variables for therapists.

Most clients of participating therapists ($N = 468$) self-identified as female (66.9%) with an average age of 35.65 years ($SD = 14.85$, range = 13-80). The vast majority of clients identified as White (88.7%), with 7.5% identifying as African American, 4.1% identifying as multiracial, 0.21% identifying as Hispanic, 0.64% identifying as American Indian, and 0.21% as Hawaiian Islander. For the purposes of data analysis, the clients will be categorized in terms of race/ethnicity as either White or People of Color. Individuals who self-identified solely as White will be categorized as such, while individuals who self-identified in any other way will be categorized as People of Color. The majority of clients were given primary diagnoses in one of four categories: Mood Disorders (54.7%), Anxiety Disorders (19.7%), Disorders Diagnosed in Childhood or Adolescence (8.8%), and Adjustment Disorders (6.8%). Please see Table 2.1 for a breakdown of demographic variables for clients.

Table 2.1

Demographic Data for Therapist Participants ($N = 32$) and their Clients ($N = 468$)

	Therapists		Clients	
	<i>N</i>	%	<i>N</i>	%
<u>Gender</u>				
Women	21	65.6	313	66.9
Men	11	34.4	155	33.1
<u>Race/Ethnicity</u>				
White/Caucasian	32	100	415	88.7

Table 2.1 (continued)

	Therapists		Clients	
	<i>N</i>	%	<i>N</i>	%
African American	--	--	35	7.5
Hispanic Origin	--	--	1	.21
American Indian	--	--	3	.64
Hawaiian Islander	--	--	1	.21
Multi-racial			19	4.1
<u>Education</u>				
Master's Degree	30	93.8	--	--
Ph.D.	2	6.2	--	--
<u>Primary Theoretical Orientation</u>				
Cognitive/Behavioral Based Theories	15	46.9	--	--
Integrated/Eclectic	9	28.1	--	--
Christian/Catholic	4	12.5	--	--
CDOI	1	3.1	--	--
<u>Primary Diagnosis</u>				
Mood Disorders	--	--	256	54.7
Anxiety Disorders	--	--	92	19.7
Childhood/Adolescence Disorders	--	--	41	8.8
Adjustment Disorders	--	--	32	6.8
Schizophrenia/Psychotic Disorders	--	--	25	5.3
Substance Related Disorders	--	--	20	4.3
Impulse Control Disorders	--	--	1	.2
V Codes	--	--	1	.2

Data Collection Site

Data were collected from both therapists and clients at a community mental health agency in the southeast that provides services for 17 county-based community mental health centers. In 2013, this agency employed 528 licensed and certified professionals

(approximately 130 of those are employed as clinicians/therapists) to serve 28,716 clients. Services vary county-to-county, but include case management and mental health services to children and adults; case management and mental health services for individuals with intellectual disabilities; and mental health and detoxification services for substance dependent individuals.

Measures

Motivation to Control Prejudiced Reactions Scale (MCPRS; Dunton & Fazio, 1997; Appendix A). The MCPRS is an assessment of one's motivation to control reactions that are prejudiced toward people of Color, which could affect how genuine participants' responses are on a particular measure. A great deal of research has utilized the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) to assess for the likelihood of participants to respond on self-report measures in a way deemed favorable by others. Rather than assess generally for social desirability, the MCPRS assesses for social desirability specific to racial prejudice. Development of this scale arose from perplexing results from a study (Fazio, Jackson, Dunton, & Williams, 1995) examining automatic attitudes of White participants toward pictures of White and African American people. They found that automatic attitude scores were not related to scores on the Modern Racism Scale (McConahay, 1986), which assesses the level of agreement or disagreement individuals have regarding beliefs that White individuals may or may not have about African American individuals. Fazio et al. (1995) hypothesized that some participants were motivated to stifle their negative automatic attitudes and complete the measure in a more positive way. Thus, the MCPRS was created to determine whether or not individuals experienced high levels of motivation to control automatic prejudiced

thoughts and attitudes.

The MCPRS contains 17 items and utilizes a seven-point Likert scale ranging from -3 (strongly disagree) to +3 (strongly agree). Scores range from -51 to +51, and higher positive scores are indicative of higher levels of motivation to control prejudiced reactions and attitudes. Scale items were designed to cover three areas: appearing prejudiced to others, appearing prejudiced to oneself, and holding back from expressing oneself in a way that might offend or hurt someone else; however, for the purposes of this study, only full scale scores will be analyzed (Dunton & Fazio, 1997). The scale developers analyzed for concurrent and discriminant validity and found in the first sample ($N = 55$) a non-significant and small correlation ($r = .18$) between scores on this measure and automatic attitudes described above (level of significance not reported). They also performed a hierarchical regression analysis examining how the automatic attitudes data and scores on the MCPRS impacted scores on the Modern Racism Scale. They found that higher levels of motivation to control prejudiced reactions were associated with lower levels of prejudicial attitudes. Additionally, they found an interaction effect between automatic attitudes and motivation: individuals with high motivation had lower prejudicial attitudes on the Modern Racism Scale, which conflicted with their negative automatic attitudes. Construct validity was also assessed through factor analysis, which yielded two factors: concern with acting prejudice and restraint to avoid dispute. Internal consistency reliability on data from 55 students yielded an overall alpha for the scale of .81, and yielded correlations on three subsequent mass surveys of .77, .76, and .74 (Dunton & Fazio, 1997). Internal consistency reliability data collected for the current sample yielded an overall alpha of .75. In this study, the MCPRS was

used to determine the likelihood for participating therapists to respond in ways deemed favorable to others and to themselves on the White Privilege Attitudes Scale (Pinterits et al., 2009) and the Multicultural Knowledge and Awareness Scale (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002).

Multicultural Counseling, Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; Appendix B). The MCKAS is a 32-item scale utilizing a seven-point Likert scale ranging from 1 (not at all true) to 7 (totally true). This measure is divided into two subscales: The Knowledge subscale and the Awareness subscale. The subscale scores will be used in this study. The Knowledge subscale is comprised of 20 items assessing one's knowledge of multicultural issues. The Awareness subscale is comprised of 12 items assessing self-reported awareness of multicultural issues. Scores on the Knowledge subscale range from 20 to 140 using an aggregate score, and 12 to 84 for the Awareness subscale. Higher scores on these subscales are indicative of a higher self-perception of knowledge and awareness of multiculturalism (Ponterotto et al., 2002).

Convergent and discriminant validity tests were conducted on the revised MCKAS. The Knowledge subscale was found to correlate positively and significantly with Knowledge ($r = .49$), Skill ($r = .43$), and Awareness ($r = .44$) subscales on the Multicultural Counseling Inventory (MCI; Sadowsky, Taffe, & Gutkin, 1994). The Awareness subscale was found to have a significant positive correlation with the Counseling Relationship subscale on the MCI ($r = .74$); however, the Awareness subscales on both the MCI and MCKAS did not correlate with each other because each subscale is focused on different aspects of multicultural awareness. According to

Ponterotto and colleagues (2002), "...the items in the MCKAS Awareness subscale focus on subtle Eurocentric bias, whereas the MCI Awareness items focus on the counselor's understanding/knowledge of issues outside the counseling relationship" (p. 170). Finally, the MCKAS Awareness subscale did not correlate significantly with Marlowe-Crowne Social Desirability Scale (SDS; Crowne & Marlowe, 1960), though the Knowledge subscale had a negative and significant correlation with the SDS ($r = -.39$). Internal consistency have been reported to be strong for the Knowledge and Awareness subscales ($\alpha = .85$ for both). The MCKAS is intended to be used as a two-factor model, knowledge and awareness (Ponterotto et al., 2002). Internal consistency reliability data collected for the current sample yielded an overall alpha of .84, and alphas of .83 and .83 for the Knowledge and Awareness subscales, respectively.

Outcome Rating Scale (ORS; Miller & Duncan, 2000; Appendix C). The ORS is a brief four-item visual analog scale that measures four different domains of client functioning: individually, interpersonally, socially, and overall (Miller & Duncan, 2000, 2004; Miller, Duncan, Brown, Sparks, & Claud, 2003). Clients complete the measure at the beginning of their therapy sessions by placing a mark on the 10cm visual analog for each item. Each ORS item is scored by the nearest millimeter using a ruler, and then all four items are summed to get a total score. Scores range from zero to 40, with higher scores reflecting lower distress or fewer problems in living. Full scale scores will be utilized in this study.

Research has demonstrated strong validity and reliability properties. Concurrent validity between the ORS and Outcome Questionnaire-45 yielded a range of correlations from .53 to .74 across several studies (Duncan, 2011). Miller and his colleagues (2003)

postulate that these correlations are only moderately strong because of the brief nature and the visual analog format of the measure. Internal consistency across multiple studies was high with average Cronbach's alphas of .85 for clinical samples and .95 for non-clinical samples. However, test-retest correlations were lower and averaged .73 for non-clinical samples and ranged from .51 to .72 for adult clinical samples (Duncan, 2011). Lower test-retest correlations are to be expected for measures of change, which can make interpreting this type of reliability difficult (Miller & Duncan, 2004; Miller et al., 2003). Internal consistency data collected for the current sample yielded an overall alpha of .89. This study will utilize total ORS scores as a dependent variable.

Session Rating Scale (SRS; Miller et al., 2000; Appendix D). The SRS is a brief four item visual analog scale measuring different domains of the therapeutic relationship (Duncan et al., 2003; Miller & Duncan, 2004; Miller, Duncan, & Johnson, 2002). Clients complete the measure at the end of their therapy sessions by placing a mark on the 10cm visual analog line for each item, reflecting how they feel about the therapist-client relationship, the goals and topics discussed, the approach or method of the therapist, and overall about the session. The SRS is scored like the ORS, using a ruler to score each item to the nearest millimeter and then all four items are summed to get a total score, ranging from zero to 40. Higher scores reflect a more positive experience in session. Full scale scores will be utilized in this study

The SRS is based on Borden's (1979) conceptualization of the therapeutic alliance, assessing the therapeutic relationship, the goals and topics covered in therapy, the method or approach used in therapy, and the overall rating of the session. Like the ORS, research has demonstrated moderate validity and strong reliability properties.

Concurrent validity between the SRS and the Helping Alliance Questionnaire has yielded a correlation of .48, while the correlation with the Working Alliance Inventory was .58 (Duncan, 2011). Duncan posits that moderate level of these correlations could be due to the comparison of a very brief measure to longer measures. Duncan et al. (2003) reported that internal consistency estimates across multiple studies was high with a range of Cronbach's alphas of .88 to .96; however, test-retest correlations were lower ($r = .64$), but were comparable to the Helping Alliance Questionnaire II (HAQ-II; Luborsky et al., 1996). Lower test-retest correlations are to be expected for measures of change, which can make interpreting this type of reliability difficult (Miller & Duncan, 2004; Miller et al., 2002). Internal consistency data collected for the current sample yielded an overall alpha of .90. This study will utilize SRS total scores as a dependent variable.

White Privilege Attitudes Scale (WPAS; Pinterits, Spanierman, & Poteat, 2009; Appendix E). The WPAS is a 28-item measure utilizing a six-point Likert scale ranging from strongly disagree (1) to strongly agree (6). The items are comprised of cognitive ("Our social structure system promotes White privilege"), affective ("I feel awful about White privilege"), and behavioral domains ("I intend to work towards dismantling White privilege") of White privilege awareness. The measure is divided into four subscales with different combinations of cognitive, affective, and behavioral items. Confronting White Privilege is a 12-item scale with a range of scores from 12 to 72. This subscale assesses the behavioral domain of White privilege, specifically intentions or plans to address White privilege ("I plan to work to change our unfair social structure that promotes White privilege") or explore one's own White privilege ("I'm glad to explore my White privilege"). Anticipated Costs of Addressing White Privilege is a six-item

scale with a range of scores from 6 to 36. This scale is comprised of a combination of affective and behavioral items assessing apprehension about addressing White privilege (“I am worried that taking action against White privilege will hurt my relationships with other Whites”) or concern about losing White privilege (“I worry about what giving up some White privileges might mean for me”). White Privilege Awareness is a four-item scale with a range of scores from 4 to 24. This scale assesses the cognitive domain of White privilege, specifically the level of understanding regarding societal White privilege (“Our social structure system promotes White privilege.”) and racial inequality (“Plenty of people of color are more privileged than Whites”). White Privilege Remorse is a six-item scale, with a range of scores from 6 to 36. This scale assesses the affective domain of White privilege, specifically emotional responses to White privilege (“I am angry that I keep benefiting from white privilege”). Higher scores on each subscale are indicative of a greater likelihood of confronting White privilege, greater concern of the anticipated costs of addressing White privilege, a greater awareness of White privilege, and greater White privilege remorse (Pinterits et al., 2009).

In their exploratory factor analysis (EFA), Pinterits and colleagues (2009) recruited 250 White undergraduate and graduate students from various colleges and universities with an average age of 22 years old. Participants were mostly women from suburban areas, and most participants reported limited to moderate exposure to people of other races. The EFA yielded four factors: a) Willingness to Confront White Privilege, a behavioral factor that accounted for 43.8% of variance; b) Anticipated Costs of Addressing White Privilege, a mixed behavioral and affective factor that accounted for 10.35% of variance; c) White Privilege Awareness, a cognitive factor that accounted for

6.58% of variance; and d) White Privilege Remorse, an affective factor that accounted for 4.73% of variance (Pinterits et al., 2009). In their confirmatory factor analysis (CFA), Pinterits and colleagues (2009) recruited 251 White undergraduate and graduate students from various colleges and universities with an average age of 22 years old. Participants were mostly women from suburban areas, and more than half of participants had received didactic training related to White privilege. The CFA (Pinterits et al., 2009) confirmed that the four factor model was the best fit for the data, as compared to alternative models.

Pinterits and her colleagues (2009) conducted numerous psychometric tests as well. Convergent validity testing yielded significant correlations between scores on the Color-blind Racial Attitudes Scale (CoBRAS; Neville et al., 2000) and all four subscales on the WPAS: Confronting White Privilege, $r = -.75$; Anticipated Costs of Addressing White Privilege, $r = -.27$; White Privilege Awareness, $r = -.81$; White Privilege Remorse, $r = -.56$. Additionally, higher scores on the White empathy and White guilt subscales of the Psychosocial Costs to Racism Scale (PCRS; Spanierman & Heppner, 2004) were significantly and positively correlated with all four WPAS subscales. Finally, scores on the White fear subscale of the PCRS were significantly and negatively correlated to scores on the Confronting White Privilege and White Privilege Remorse subscales, and positively correlated to scores on the Anticipated Costs of Addressing White Privilege subscale. Discriminant validity tests yielded no significant correlations between scores on a social desirability measure and the WPAS subscales. Internal consistency tests across both studies yielded moderate to high coefficient alphas: Confront White Privilege, $\alpha = .93$ and $\alpha = .81$; Anticipated Costs of Addressing White Privilege, $\alpha = .78$ and $\alpha = .73$; White Privilege Awareness, $\alpha = .84$ and $\alpha = .74$; and White Privilege

Remorse, $\alpha = .89$ for both studies. Finally, researchers conducted test-retest analyses and found the following correlations between time 1 and 2 (two weeks apart): Confronting White Privilege, $r = .91$; Anticipated Costs of Addressing White Privilege, $r = .83$; White Privilege Awareness, $r = .81$; White Privilege Remorse, $r = .87$ (Pinterits et al., 2009). Internal consistency data collected for the current sample yielded an overall alpha of .89. Alphas for the subscales were as follows: Confronting White Privilege = .89, Anticipated Costs of Addressing White Privilege = .69, White Privilege Awareness = .73, and White Privilege Remorse = .79.

Demographic Form (Appendix F). A demographics form was completed by participating therapists for descriptive purposes. Data collected ensured the therapists participating identified as White, and also included additional demographic data: therapist gender, years of experience/practice, theoretical orientation, degree, professional credentials, and age. Client demographic information was provided by the data collection sites.

Procedures

Therapist data collection took place over the spring and fall 2013 semesters. ORS and SRS data from clients were collected starting in fall 2012. The mental health agency study site had just begun utilizing the electronic version of the ORS and SRS in their 17 community mental health centers. The electronic version of the ORS and SRS are accessed through a web-based program called MyOutcomes® (<http://www.myoutcomes.com/>). This program administers, scores, interprets, and stores scores for the ORS and SRS. The website states that MyOutcomes® “identifies in real time clients who are risk for negative or null outcomes; provides empirically based

suggestions to increase the likelihood of success; aggregate data into reports on provider, program, and agency effectiveness for supervisory, administrative, and payment purposes” (<http://www.myoutcomes.com/>). Using MyOutcomes® eliminated the need for traditional paper-pencil administrations, increasing the likelihood of maintaining confidentiality of the client.

Therapist data collection procedures. Therapists working at the community mental health agency were recruited by email to participate in the study. Of approximately 130 therapists emailed, 42 completed the questionnaires. Therapists were electronically administered the MCPRS, MCKAS, WPAS, and demographic form once, along with a consent form (Appendix G). Therapists were not asked to identify themselves in any way on these questionnaires, and instead were assigned a random four-digit code. I maintained a pass-word protected master list of names, email addresses, unique four-digit code on my laptop. These questionnaires were administered to the therapists in the spring and fall semesters 2013.

Client data collection procedures. Clients completed the ORS and SRS every session using MyOutcomes®, an electronic data management system that administers and scores the measures and stores the client data on a secure server. Because last sessions are difficult to predict, especially in a community mental health setting, treatment outcome was based on the last collected session of ORS. This is called the last observation carried forward method (Xu, 2009) as is often done in longitudinal psychotherapy outcome studies in naturalistic settings (see Shimokawa, Lambert, & Smart, 2010; Slade et al., 2008). The observed SRS score for the third session was used, and the fourth session was used if a third session score was not available then. Research

has found that the therapeutic alliance in the third, fourth, and fifth sessions “provides reliable prognosis not only for outcomes but also for dropouts” (Horvath, Del Re, Flückiger, & Symonds, 2010).

Therapist – client data matching procedures. The community mental health agency aggregated client data into a de-identified spreadsheet matching up coded client outcome data (coded within MyOutcomes® as first and last initials and last four digits of social security number) and client demographic data (collected using the agency’s intake form). Because names of the therapists were included in this client data spreadsheet, I replaced their names with their assigned four-digit codes to keep that spreadsheet de-identified.

Data Analyses

Several statistical analyses were conducted to address the above mentioned hypotheses using IBM SPSS 21 and HLM 7.0 software. Descriptive statistics (means, standard deviations, ranges, and frequencies) were calculated for all measures in this study and all client and therapist sample characteristics. Additionally, correlational analyses were conducted to analyze the relationship between scores on the MCPRS (Dunton & Fazio, 1997) and the MCKAS and WPAS subscales for the purposes of discriminant validity.

Hypotheses one and two were analyzed using hierarchical linear modeling (HLM; Bickel, 2007; Hox, 2010), which is a useful data analysis technique for hierarchical or nested data: clients nested within therapists. In this case, client scores on the ORS and SRS are likely to correlate more strongly within therapists rather than between therapists (Reese et al., 2010). Thus, the assumption of independence of observations, required for

regression analyses, is violated. This violation results in underestimated standard errors and an increased likelihood of making a type I error (Hox, 2010).

Another important consideration for the current study is potential therapist effects on the ORS and SRS scores, beyond White privilege attitudes. Research has consistently found that some therapists are more effective than others and contribute significantly to therapy outcomes (Brown & Minami, 2010). Whereas regression would aggregate the therapists and clients as one sample, HLM separates them into levels (Paterson, 1991). The purpose is to separate out therapist effects (level 2) on the criterion variable (ORS or SRS) from the client effects (level 1). Thus, multiple therapist factors were analyzed in this study, with the primary focus being White privilege attitudes.

In order to determine if using HLM is appropriate to address these hypotheses, intraclass correlation coefficients (ICC) were calculated. This is a necessary preliminary step to determine how much of the variance in the criterion variable is due to therapist variability at level 2 (Hox, 2010). Thus, a small ICC indicates that little of the variance in the criterion variable is attributable to level 2, making HLM unnecessary. Hox (2010) recommends the following categories for determining the size of an interclass correlation: .05 = small, .10 = medium, .15 = large. ICC are calculated using the following formula: $\tau / (\tau + \sigma^2)$, where τ is the random variance component at level 2, and σ^2 is the random component at level 1. These variance components are identified by analyzing an intercept-only model, which is a two-level model with no explanatory variables added (i.e., only intercepts and error terms).

Variables were entered systematically using Hox's (2010) suggested bottom-up method of modeling. Step 1 was analyzing the model with no explanatory variables

present, also known as the intercept-only model. This step provided the values for the variable components used to calculate ICC as described above. Step 2 was analyzing the model with level 1 explanatory variables fixed, meaning that corresponding variance components is zero. This step allowed me to assess the effects of each level 1 variable on the criterion. Step 3 was analyzing the model with level 2 explanatory variables, including the scores on the WPAS subscales. Because level 2 variables are at the highest level in my HLM analyses, they are understood as being fixed variables. These variables cannot be conceptualized as randomly varying across groups since there are no higher level group categories across which to vary. Step 4 was to ascertain which level 1 variables are fixed (i.e., do not vary across groups) and which are random (i.e., randomly varying across groups). This will be determined by examining the output after Step 3 and identifying if level 1 variables had significant effects on the criterion variable (t-test) and/or if the variable varied significantly across groups (chi-square test). Step 5 was to identify and interpret any cross-level effects, where a level 2 variable moderated the effect of a level 1 variable on the criterion variable.

Data analysis for psychotherapy outcome (Hypotheses 1 and 2). These hypotheses were analyzed using a two-level HLM, with clients and therapists categorized at levels 1 and 2, respectively. These hypotheses were analyzed using two outcome variables: scores from the ORS and the number of sessions attended. The first two-level HLM model was created using final session ORS scores for client *i* of therapist *j* as the criterion variable. The ICC for this model was .122, meaning that 12.2% of the variance in client ORS scores at the last session is explained at Level 2. Based on Hox's (2010) suggestion, this is a medium-large value, indicating that use of HLM is appropriate.

Variables entered at Level 1 (clients) were grand mean centered and included the following: ORS from session 1 (continuous), client race/ethnicity (categorical), client gender (categorical), and number of sessions (continuous):

$$\text{ORS}_{\text{Last}_{ij}} = \beta_{0j} + \beta_{1j} * (\text{ORS}_{\text{First}_{ij}}) + \beta_{2j} * (\text{RACE}_{ij}) + \beta_{3j} * (\text{GENDER}_{ij}) + \beta_{4j} * (\text{SESSION}_{ij}) + r_{ij}$$

Variables entered at level 2 (therapists) included the following: scores from the WPAS, therapist gender (categorical), years of experience/practice (continuous).

$$\beta_{0j} = \gamma_{00} + \gamma_{01} * (\text{GENDER}_{0j}) + \gamma_{02} * (\text{YEARS}_{j}) + \gamma_{03} * (\text{WPAS}_{j}) + u_{00}$$

$$\beta_{1j} = \gamma_{10} + \gamma_{11} * (\text{GENDER}_{1j}) + \gamma_{12} * (\text{YEARS}_{j}) + \gamma_{13} * (\text{WPAS}_{j}) + u_{10}$$

$$\beta_{2j} = \gamma_{20} + \gamma_{21} * (\text{GENDER}_{2j}) + \gamma_{22} * (\text{YEARS}_{j}) + \gamma_{23} * (\text{WPAS}_{j}) + u_{20}$$

$$\beta_{3j} = \gamma_{30} + \gamma_{31} * (\text{GENDER}_{3j}) + \gamma_{32} * (\text{YEARS}_{j}) + \gamma_{33} * (\text{WPAS}_{j}) + u_{30}$$

$$\beta_{4j} = \gamma_{40} + \gamma_{41} * (\text{GENDER}_{4j}) + \gamma_{42} * (\text{YEARS}_{j}) + \gamma_{43} * (\text{WPAS}_{j}) + u_{40}$$

Hypothesis 2 was analyzed utilizing the above model by examining the statistical significance of the relationship between client race/ethnicity and the final ORS score.

Psychotherapy outcomes were also assessed utilizing the number of sessions attended by client *i* of therapist *j* as the criterion variable in a two-level HLM model. The ICC for this model was .186, meaning that 18.6% of the variance in number of sessions attended is explained at Level 2. Based on Hox's (2010) suggestion, this is a large value, indicating that use of HLM is appropriate. The same predictor variables were included for levels 1 and 2:

Level 1:

$$\text{SESSION}_{ij} = \beta_{0j} + \beta_{1j} * (\text{ORS}_{\text{First}_{ij}}) + \beta_{2j} * (\text{RACE}_{ij}) + \beta_{3j} * (\text{GENDER}_{ij}) + r_{ij}$$

Level 2:

$$\beta_{0j} = \gamma_{00} + \gamma_{01}*(GENDER_{0j}) + \gamma_{02}*(YEARS_j) + \gamma_{03}*(WPAS_j) + u_{00}$$

$$\beta_{1j} = \gamma_{10} + \gamma_{11}*(GENDER_{1j}) + \gamma_{12}*(YEARS_j) + \gamma_{13}*(WPAS_j) + u_{10}$$

$$\beta_{2j} = \gamma_{20} + \gamma_{21}*(GENDER_{2j}) + \gamma_{22}*(YEARS_j) + \gamma_{23}*(WPAS_j) + u_{20}$$

$$\beta_{3j} = \gamma_{30} + \gamma_{31}*(GENDER_{3j}) + \gamma_{32}*(YEARS_j) + \gamma_{33}*(WPAS_j) + u_{30}$$

With the exception of client race/ethnicity and therapist scores on the WPAS, all of the remaining predictor variables were included to possibly explain variance in the criterion variables, and are not considered central to the study's hypotheses.

Additionally, the above models show all level 1 and level 2 variables entered; however, once data were analyzed, those variables that were non-significant were dropped from the model.

Data analysis for psychotherapy relationship (Hypothesis 3 and 4).

Hypothesis three is focused on the therapeutic relationship and was analyzed using a two-level HLM, similar to hypothesis one. This hypothesis was analyzed using third or fourth session SRS scores as the criterion variable. The ICC for this model was .227, meaning that 22.7% of the variance in third or fourth session SRS scores is explained at Level 2. Based on Hox's (2010) suggestion, this is a large value, indicating that use of HLM is appropriate. Variables entered at Level 1 (clients) were grand mean centered included the following: client race/ethnicity (categorical), client gender (categorical), and number of sessions (continuous):

$$SRSThird_{ij} = \beta_{0j} + \beta_{1j}*(RACE_{ij}) + \beta_{2j}*(GENDER_{ij}) + \beta_{3j}*(SESSION_{ij}) + r_{ij}$$

Variables entered at level 2 (therapists): included the following: scores from the WPAS, therapist gender (categorical), years of experience/practice (continuous).

$$\beta_{0j} = \gamma_{00} + \gamma_{01}*(GENDER_{0j}) + \gamma_{02}*(YEARS_j) + \gamma_{03}*(WPAS_j) + u_{00}$$

$$\beta_{1j} = \gamma_{10} + \gamma_{11}*(GENDER_{1j}) + \gamma_{12}*(YEARS_j) + \gamma_{13}*(WPAS_j) + u_{10}$$

$$\beta_{2j} = \gamma_{20} + \gamma_{21}*(GENDER_{2j}) + \gamma_{22}*(YEARS_j) + \gamma_{23}*(WPAS_j) + u_{20}$$

$$\beta_{3j} = \gamma_{30} + \gamma_{31}*(GENDER_{3j}) + \gamma_{32}*(YEARS_j) + \gamma_{33}*(WPAS_j) + u_{30}$$

Hypothesis 4 was analyzed utilizing the above model by examining the statistical significance of the relationship between client race/ethnicity and the final ORS score and the statistical significance, included in the HLM statistical output.

Bi-variate correlational analyses (Hypothesis 5). Hypothesis five stated that scores on the WPAS (Pinterits et al., 2009) in terms of confronting White privilege, anticipated costs of White privilege, White privilege awareness, and White privilege remorse will be positively correlated with multicultural knowledge and awareness (MCKAS; Ponterotto et al., 2009). Bivariate correlational analyses were conducted to determine the relationship between subscale scores on the WPAS and MCKAS. Additionally, correlational analyses were conducted to analyze the relationship between scores on the MCPRS (Dunton & Fazio, 1997), the MCKAS subscales, and the WPAS subscales. Scores on MCKAS subscales served as a convergent validity analysis for scores on the WPAS subscales, and scores on the full MCPRS served as a discriminant validity analysis for scores on both the WPAS and MCKAS subscales.

Chapter Three: Results

Data analysis was based on 32 therapists and 468 clients who attended at least three sessions between the 2012 and 2013 fall semesters.

Preliminary Analyses

Means and standard deviations were calculated for all measures used in this study (see Table 3.1). On the MCKAS, participants had a mean score on the Knowledge subscale of 95.38 ($SD = 13.28$), which is above the mid-point (80) of the possible range of scores for this subscale. On the Awareness subscale, participants had a mean score of 68.60 ($SD = 9.42$), also falling above the mid-point (48) of the possible range of scores for this subscale. Overall, this sample of participants was knowledgeable and aware of multicultural issues. Participating clients in this study had an average first session ORS score of 19.41 ($SD = 8.94$) and an average last session score of 24.79 ($SD = 9.58$). These mean scores fall below the clinical cutoff score for the ORS (25), meaning that on average, participants in this sample reported a level of distress expected of individuals in therapy (Duncan, 2011). Participating clients in this study had an average first session SRS score of 37.60 ($SD = 4.46$), and an average third/fourth session score of 38.81 ($SD = 2.89$). Both of these mean scores fell above the clinical cutoff score for the SRS (36), indicating therapeutic alliance were generally high (Duncan, 2011).

For the WPAS, means, standards deviations, internal consistency estimates were calculated for each subscale. Results from the Confronting White Privilege subscale showed that participants in this study had a mean score of 48.66 ($SD = 10.18$), a score falling near the middle of the range of possible scores. On the Anticipated Costs of Addressing White Privilege subscale, participants in this study had a mean score of 12.31

($SD = 4.52$) on this subscale, on the lower end of the range of possible scores.

Participants in this study had a mean score of 18.19 ($SD = 4.29$) on the White Privilege Awareness subscale, higher on the range of possible scores. Finally, results from the White Privilege Remorse subscale showed that participants had a mean score of 18.19 ($SD = 5.64$) on this subscale, which is in the low to middle part of the range of possible scores. Bivariate correlations were run between all four subscales of the WPAS. Not all subscales were significantly correlated with each other, though the significant correlations found were all positive. White Privilege Remorse was significantly and positively correlated with Confronting White Privilege ($r = .488, p < .01$), Anticipated Costs of Addressing White Privilege ($r = .488, p < .01$), and White Privilege Awareness ($r = .447, p < .05$). Thus, the more negative emotions (e.g. shame, anger) one has about having White privilege: the more likely they will endorse behaviors to address White privilege; the more likely they will experience unease about addressing White privilege; and the more understanding one will have of dynamics of White privilege. The only other significant correlation was between the White Privilege Awareness and Confronting White Privilege subscales ($r = .535, p < .01$). The more understanding one has of White privilege dynamics the more willingness they have to confront White privilege. The remaining correlations were not significant: Anticipated Costs of White Privilege and Confronting White Privilege ($r = .153, p > .05$), and Anticipated Costs of White Privilege and White Privilege Awareness ($r = .210, p > .05$). Uneasiness about giving up White Privilege was not significantly related to a willingness to confront White privilege or an understanding of White privilege dynamics.

For the MCPRS, participants had a mean score of +11.66 ($SD = 10.85$), which is

above the midpoint score in the possible range of scores (0). Bivariate correlational analyses were run between the MCPRS and all subscales of the WPAS and MCKAS. The MCPRS was used as a discriminant validity check, to ensure that social desirability did not influence the participating therapists' responses on the WPAS and MCKAS. Correlations were not significant (see Table 3.3), suggesting that motivation to control prejudiced reactions (i.e., social desirability) was not significantly influential on the WPAS and MCKAS.

Table 3.1

Means and Standard Deviations of Measures Completed by Therapists and Clients

Therapist-Completed Measures (<i>N</i> = 32)		<i>M</i> (<i>SD</i>)
<u>White Privilege Attitudes Scale:</u>		
Willingness to Confront White Privilege		48.66 (10.18)
Anticipated Costs of Addressing White Privilege		12.31 (4.52)
White Privilege Awareness		18.19 (4.29)
White Privilege Remorse		18.19 (5.64)
<u>Multicultural Counseling Knowledge and Awareness Scale:</u>		
Knowledge Subscale		95.38 (13.28)
Awareness Subscale		68.59 (9.43)
Motivation to Control Prejudiced Reactions Scale		11.66 (10.85)
	White Clients (<i>N</i> =409)	Clients of Color (<i>N</i> =59)
Client Measures	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)
<u>Outcome Rating Scale</u>		
Session 1	17.37 (8.12)	18.54 (8.65)
Last Session	22.99 (9.16)	23.71 (8.49)
<u>Session Rating Scale</u>		
Session 1	37.66 (4.15)	36.56 (6.27)
3 rd or 4 th Session	38.73 (2.95)	38.73 (2.39)
# of Sessions Attended	6.40 (4.34)	6.20 (3.52)

Table 3.2

Bivariate Correlations Between Subscales of the WPAS

	1	2	3	4
1. Confronting White Privilege	---			
2. Anticipated Costs of Addressing White Privilege	.153	---		
3. White Privilege Awareness	.535**	.210	---	
4. White Privilege Remorse	.488**	.466**	.447*	---

Notes. * $p < .05$, ** $p < .01$.

Table 3.3

Bivariate Correlations between MCPRS and all subscales of the WPAS and MCKAS

	<i>r</i> (MCPRS)	<i>p</i>
<u>White Privilege Attitudes Scale:</u>		
Willingness to Confront White Privilege	-.216	.234
Anticipated Costs of Addressing White Privilege	.046	.804
White Privilege Awareness	.068	.712
White Privilege Remorse	.291	.106
<u>Multicultural Counseling Knowledge and Awareness Scale:</u>		
Knowledge Subscale	-.275	.128
Awareness Subscale	-.116	.529

Results of the Hypotheses

Following are the results of statistical analyses used to test the research hypotheses.

Hypotheses one. I hypothesized that scores on the WPAS subscales would predict client psychotherapy outcomes, as measured by scores on the ORS at the last session and the number of sessions attended.

Post ORS scores. Results of HLM analyses utilizing clients' ORS scores from their final session as the dependent variable did not support this hypothesis (see Table 3.4 for results). I calculated R^2_1 which is the percent reduction in error of prediction (Bickel,

2007). This statistic can be calculated by dividing the sum of full model variance components by the sum of the intercept-only model variance components, and then subtracting that value from 1. In this case R^2_1 was .257, meaning that adding the variables to the model resulted in a 25.7% reduction in prediction error. Therapist factors in general were not shown to have significant predictive effects on client ORS scores. None of the subscales for the WPAS (Confronting White Privilege, Anticipated Costs of Addressing White Privilege, White Privilege Awareness, and White Privilege Remorse) were shown to predict ORS client scores.

The only client-level predictor variable that had a significant effect on clients' ORS scores at the last session was client-reported scores on the ORS at the first session ($\gamma_{10} = .53$, $SE = .037$, $p < .01$), indicating that clients who started therapy with higher ORS scores at the beginning of treatment ended therapy with higher scores at their final session. Client gender and race/ethnicity were not significantly predictive of ORS scores at the last session.

Table 3.4

Fixed and Random Effects for Two-level HLM for ORS Scores

(Level 1 N = 468; Level 2 N = 32)

	Intercept-only Coefficient (SE)	Full Model Coefficient (SE)
<u>Fixed Effects</u>		
Client Intercept (β_0)		
Intercept (γ_{00})	23.52 (.72) **	23.34 (.50) **
WPAS1 (γ_{01})	--	.048 (.069)
WPAS2 (γ_{02})	--	.028 (.162)
WPAS3 (γ_{03})	--	-.057 (.152)
WPAS4 (γ_{04})	--	-.114 (.143)

Table 3.4 (continued)

	Intercept-only Coefficient (SE)	Full Model Coefficient (SE)
<u>Fixed Effects</u>		
Therapist Gender (γ_{05})	--	-.042 (1.51)
Therapist Experience (γ_{06})	--	.042 (.064)
Client Gender (β_1)		
Intercept (γ_{10})	--	.263 (.894)
WPAS1 (γ_{11})	--	-.078 (.101)
WPAS2 (γ_{12})	--	.282 (.263)
WPAS3 (γ_{13})	--	.161 (.232)
WPAS4 (γ_{14})	--	-.280 (.210)
Therapist Gender (γ_{15})	--	-.917 (2.27)
Therapist Experience (γ_{16})	--	-.038 (.100)
ORS First Session Score (β_2)		
Intercept (γ_{20})	--	.530 (.037)**
WPAS1 (γ_{21})	--	-.002 (.006)
WPAS2 (γ_{22})	--	.008 (.015)
WPAS3 (γ_{23})	--	-.003 (.015)
WPAS4 (γ_{24})	--	-.007 (.012)
Therapist Gender (γ_{25})	--	.166 (.150)
Therapist Experience (γ_{26})	--	.002 (.006)
Number of Sessions Attended (β_3)		
Intercept (γ_{30})	--	-.070 (.107)
WPAS1 (γ_{31})	--	-.004 (.010)
WPAS2 (γ_{32})	--	-.033 (.030)
WPAS3 (γ_{33})	--	.022 (.028)
WPAS4 (γ_{34})	--	.025 (.021)
Therapist Gender (γ_{35})	--	-.604 (.299)
Therapist Experience (γ_{36})	--	-.010 (.010)

Table 3.4 (continued)

	Intercept-only Coefficient (SE)	Full Model Coefficient (SE)
<u>Fixed Effects</u>		
Client Race/Ethnicity (β_4)		
Intercept (γ_{40})	--	.656 (1.28)
WPAS1 (γ_{41})	--	-.158 (.145)
WPAS2 (γ_{42})	--	-.137 (.396)
WPAS3 (γ_{43})	--	.384 (.358)
WPAS4 (γ_{44})	--	.370 (.308)
Therapist Gender (γ_{45})	--	-1.14 (3.30)
Therapist Experience (γ_{46})	--	.267 (.142)
<u>Random Effects (Variance Components)</u>		
Client (r)	73.51 (8.57)	58.86 (7.67)
Intercept (u_0)	10.26 (3.20) **	3.36 (1.83) *
Client Gender Slope (u_1)	--	1.41 (2.00)
ORS First Session Slope (u_2)	--	.102 (.010)
Number Sessions Attended Slope (u_3)	--	.093 (.009)
Client Race/Ethnicity Slope (u_4)	--	.714 (.510)

Notes. WPAS1 = Confronting White Privilege subscale on WPAS; WPAS2 = Anticipated Costs of Addressing White Privilege subscale on WPAS; WPAS3 = White Privilege Awareness, WPAS4 = White Privilege Remorse subscale on WPAS. * $p < .01$, ** $p < .001$.

Session number. Results of HLM analyses utilizing the number of sessions attended as the dependent variable partially supported this hypothesis (see Table 3.5 for results). I calculated R^2_1 which was .064, meaning that adding the variables to the model resulted in a 6.4% reduction in prediction error. The direct effect of scores on the first session ORS did not significantly predict the number of sessions attended, though ORS scores were found to vary significantly across therapists. Additionally, a significant client gender effect was found ($\gamma_{10} = .75$, $SE = .27$, $p < .01$), indicating that women on

average attended more sessions than men.

Scores on the WPAS subscales were not directly predictive of number of sessions attended, but were found to have an effect when moderated by certain client variables. Scores on the Confronting White Privilege subscale of the WPAS significantly predicted the number of sessions attended when moderated by first session ORS scores ($\gamma_{21} = -.008$, $SE = 0.002$, $p < .01$). First session ORS scores also moderated scores on the Anticipated Costs of Addressing White Privilege (WPAS2) subscale ($\gamma_{22} = -.020$, $SE = .008$, $p < .001$). When the two WPAS subscales act as modifiers, the relationship between number of sessions attended and first session ORS scores became negative. Thus, higher scores on the Confronting White Privilege and Anticipated Costs of Addressing White Privilege subscales were not independently predictive of clients attending more sessions, as hypothesized. Scores on White Privilege Remorse (WPAS4), on the other hand moderated the relationship between scores on the first session ORS and number of sessions attended ($\gamma_{24} = .026$, $SE = .005$, $p < .001$). The relationship between number of sessions and first session ORS scores was not significant, but when this subscale was included as a moderator this relationship became significant.

The effect of scores on the Anticipated Costs of Addressing White Privilege subscale also moderated client gender ($\gamma_{12} = .208$, $SE = .06$, $p < .001$), indicating that when scores were higher on this subscale, men attended fewer sessions. When scores on Confronting White Privilege and Anticipated Costs of Addressing White Privilege (WPAS2; $\gamma_{22} = -.02$, $SE = .008$, $p < .05$) were lower, clients with higher ORS first session scores attended more sessions on average. When scores on White Privilege Remorse

(WPAS4; $\gamma_{23} = .026$, $SE = .005$, $p < .001$) were higher, clients with higher ORS first session scores attended more sessions on average.

Therapist gender and years of experience were not shown to have significant predictive effects on number of sessions attended, similar to the findings for last session ORS scores. Client race/ethnicity was not significantly predictive of number of sessions attended, which does not support hypothesis one.

Table 3.5

Fixed and Random Effects for Two-level HLM for Number of Sessions Attended

(Level 1 $N = 468$; Level 2 $N = 32$)

	Intercept-only Coefficient (SE)	Full Model Coefficient (SE)
<u>Fixed Effects</u>		
Client Intercept (β_0)		
Intercept (γ_{00})	6.71 (.39) *	6.60 (.41) ***
WPAS1 (γ_{01})	--	.029 (.065)
WPAS2 (γ_{02})	--	-.082 (.135)
WPAS3 (γ_{03})	--	-.006 (.083)
WPAS4 (γ_{04})	--	.029 (.164)
Therapist Gender (γ_{05})	--	.629 (.914)
Therapist Experience (γ_{06})	--	.028 (.047)
Client Gender (β_1)		
Intercept (γ_{10})	--	.75 (.27) **
WPAS1 (γ_{11})	--	.009 (.048)
WPAS2 (γ_{12})	--	.208 (.06) ***
WPAS3 (γ_{13})	--	-.018 (.069)
WPAS4 (γ_{14})	--	-.136 (.138)
Therapist Gender (γ_{15})	--	.676 (.716)
Therapist Experience (γ_{16})	--	-.038 (.033)

Table 3.5 (continued)

	Intercept-only Coefficient (SE)	Full Model Coefficient (SE)
<u>Fixed Effects</u>		
ORS First Session Score (β_2)		
Intercept (γ_{20})	--	.033 (.040)
WPAS1 (γ_{21})	--	-.008 (.002) **
WPAS2 (γ_{22})	--	-.020 (.008)*
WPAS3 (γ_{23})	--	.008 (.009)
WPAS4 (γ_{24})	--	.026 (.005) ***
Therapist Gender (γ_{25})	--	.136 (.098)
Therapist Experience (γ_{26})	--	.006 (.005)
Client Race/Ethnicity (β_3)		
Intercept (γ_{30})	--	.270 (.478)
WPAS1 (γ_{31})	--	-.003 (.058)
WPAS2 (γ_{32})	--	-.0001 (.163)
WPAS3 (γ_{33})	--	.017 (.151)
WPAS4 (γ_{34})	--	-.062 (.114)
Therapist Gender (γ_{35})	--	1.39 (1.19)
Therapist Experience (γ_{36})	--	-.069 (.042)
<u>Random Effects (Variance Components)</u>		
Client (r)	15.72 (3.96)	13.60 (3.69)
Intercept (u_0)	3.60 (1.90)*	4.48 (2.12)***
Client Gender Slope (u_1)	--	2.71 (1.65)
ORS First Session Slope (u_2)	--	.053 (.231)***
Client Race/Ethnicity Slope (u_4)	--	4.85 (2.20)

Notes. WPAS1 = Confronting White Privilege subscale on WPAS; WPAS2 = Anticipated Costs of Addressing White Privilege subscale on WPAS; WPAS3 = White Privilege Awareness, WPAS4 = White Privilege Remorse subscale on WPAS. * $p < .05$, ** $p < .01$, *** $p < .001$.

Hypothesis two. Hypothesis two stated White therapists' effectiveness with

clients of Color as compared to White clients, as measured by the ORS, will be different and moderated by scores on the WPAS subscales. The multilevel model from hypothesis one did not support this hypothesis. Client race/ethnicity was not found to have a direct significant effect on last session ORS scores. None of the WPAS subscales significantly moderated the relationship between client race/ethnicity and final session ORS scores. Please see Table 3.4 under the “Client Race/Ethnicity (β_4)” for full results.

Hypothesis three. I hypothesized that scores on the WPAS subscales would be predictive of client perceptions of the therapeutic relationship, as measured by the SRS. Results of HLM analyses utilizing SRS scores from sessions three or four as the dependent variable did not support this hypothesis (see Table 3.6 for full results). None of the subscales for the WPAS (Confronting White Privilege, Anticipated Costs of Addressing White Privilege, White Privilege Awareness, and White Privilege Remorse) were shown to have significant effects on third/fourth session SRS client scores. Additional therapist level variables, therapist gender and years of experience, were not significantly predictive of SRS scores. Also, none of the client level variables, gender, race/ethnicity, and number of sessions attended, were significantly predictive of third or fourth session SRS scores.

Hypothesis four. Hypothesis four stated that White therapists’ effectiveness at building the therapeutic alliance with clients of Color as compared to White clients, measured by the SRS, would be different and moderated by scores on the WPAS in terms of confronting White privilege, anticipated costs of White privilege, White privilege awareness, and White privilege remorse. The final model that did not support hypothesis three also did not support hypothesis four. Client race/ethnicity was not found to have a

direct significant effect on third/fourth session SRS scores. None of the WPAS subscales significantly moderated the relationship between client race/ethnicity and third/fourth session SRS scores. Please see Table 3.6 under the “Client Race/Ethnicity (β_3)” for full results.

SRS scores were found to significantly vary across therapists based on client race/ethnicity. Thus, even though SRS scores, on average, were not different based on client race/ethnicity, certain therapists were differentially effective at building therapeutic alliances with White clients and clients of Color. Additionally, while number of sessions attended was not directly predictive of SRS scores, this variable varied significantly across therapists (see Table 3.6 under Variance Components).

Table 3.6

Fixed and Random Effects for Two-level HLM for SRS Scores

(Level 1 N = 468; Level 2 N = 32)

	Intercept-only Coefficient (SE)	Full Model Coefficient (SE)
<u>Fixed Effects</u>		
Client Intercept (β_0)		
Intercept (γ_{00})	38.56 (.29)*	38.25 (.49)*
WPAS1 (γ_{01})	--	-.026 (.059)
WPAS2 (γ_{02})	--	.054 (.102)
WPAS3 (γ_{03})	--	-.008 (.078)
WPAS4 (γ_{04})	--	-.001 (.051)
Therapist Gender (γ_{05})	--	1.99 (2.05)
Therapist Experience (γ_{06})	--	.088 (.071)
Client Gender (β_1)		
Intercept (γ_{10})	--	.612 (.322)
WPAS1 (γ_{11})	--	.009 (.023)

Table 3.6 (continued)

	Intercept-only Coefficient (SE)	Full Model Coefficient (SE)
<u>Fixed Effects</u>		
WPAS2 (γ_{12})	--	.099 (.058)
WPAS3 (γ_{13})	--	-.018 (.060)
WPAS4 (γ_{14})	--	-.011 (.058)
Therapist Gender (γ_{15})	--	-.355 (.829)
Therapist Experience (γ_{16})	--	-.0004 (.032)
Number of Sessions Attended (β_2)		
Intercept (γ_{20})	--	.041 (.044)
WPAS1 (γ_{21})	--	.004 (.005)
WPAS2 (γ_{22})	--	-.022 (.010)
WPAS3 (γ_{23})	--	.003 (.007)
WPAS4 (γ_{24})	--	.006 (.005)
Therapist Gender (γ_{25})	--	-.225 (.172)
Therapist Experience (γ_{26})	--	-.006 (.006)
Client Race/Ethnicity (β_3)		
Intercept (γ_{30})	--	.771 (.624)
WPAS1 (γ_{31})	--	.109 (.073)
WPAS2 (γ_{32})	--	-.094 (.118)
WPAS3 (γ_{33})	--	-.015 (.098)
WPAS4 (γ_{34})	--	.025 (.078)
Therapist Gender (γ_{35})	--	-2.72 (2.40)
Therapist Experience (γ_{36})	--	-.107 (.082)
<u>Random Effects (Variance Components)</u>		
Client (r)	6.92 (2.63)	6.38 (2.53)
Intercept (u_0)	2.03 (1.42)*	4.74 (2.18)*
Client Gender Slope (u_1)	--	1.35 (1.16)
Number Sessions Attended Slope (u_2)	--	.002 (.048)*
Client Race/Ethnicity Slope (u_3)	--	4.72 (2.17)*

Notes. WPAS1 = Confronting White Privilege subscale on WPAS; WPAS2 = Anticipated Costs of Addressing White Privilege subscale on WPAS; WPAS3 = White Privilege Awareness; WPAS4 = White Privilege Remorse subscale on WPAS. * $p < .001$.

Hypothesis five. I hypothesized that scores on the WPAS subscales would be positively correlated with multicultural knowledge and awareness (MCKAS). Results of bivariate correlations between all subscales on the MCKAS and WPAS partially supported this hypothesis (see Table 3.7). Scores on the WPAS subscale, Confronting White Privilege, were positively correlated with both the Multicultural Knowledge ($r = .40, p < .05$) and Multicultural Awareness ($r = .50, p < .01$) subscales on the MCKAS. Thus, the higher the scores on Confronting White Privilege, the higher the scores on both MCKAS subscales. The only other significant correlation was between the White Privilege Awareness subscale on the WPAS and the Multicultural Awareness subscale on the MCKAS ($r = .60, p < .01$), meaning that, as scores on the White Privilege Awareness subscale increased, so did scores on the MCKAS Awareness subscale. This correlation is evidence of concurrent validity indicating that higher awareness of multicultural factors is related to higher awareness of white privilege.

Table 3.7

Bivariate Correlations between subscales of the WPAS and MCKAS.

	MCKAS	
	Knowledge	Awareness
<u>WPAS</u>		
Confronting White Privilege	.397*	.498**
Anticipated Costs of Addressing White Privilege	.046	-.108
White Privilege Awareness	.189	.604**
White Privilege Remorse	-.020	.068

* $p < .05$; ** $p < .001$

Chapter Four: Discussion and Conclusions

In the current study, I evaluated the impact of therapists' White privilege attitudes on their effectiveness with clients and on clients' perceptions of the therapist-client relationship. This study is exploratory in nature because the relationship between White privilege attitudes and therapy outcome and the therapeutic relationship has not been empirically studied. Further, what research has been conducted examining racial dynamics in cross-cultural therapy has been mixed. Research has supported and undermined the notion that clients of Color have better outcomes in therapy with a therapist of the same race/ethnicity (Cabral & Smith, 2011; Constantine, 2001; D'Andrea & Heckman, 2008; Farsimadan, Draghi-Lorenz, & Ellis, 2007; Thompson & Alexander, 2006). Some research has shown that a client's willingness to address racial/ethnic differences in session could be impacted by the therapist's willingness, which in turn can, possibly impact the therapeutic relationship (Chang & Yoon, 2011; Thompson & Jamal, 1994). Finally, being perceived by clients as multiculturally competent has been seen as a therapist characteristic that can facilitate better client outcomes in therapy (Constantine, 2002a; Fuertes & Brobst, 2002; Fuertes et al., 2006; Owen, Leach, Tao, & Rodolfa, 2011). These research findings, while not directly related to White privilege, all suggest that awareness of and willingness to address racial and ethnic differences can be beneficial, while obliviousness to and ignoring of differences can be harmful in therapy.

Impact of White Privilege Attitudes on Therapy Outcomes

Findings in this study were mixed regarding the impact of therapist scores from the WPAS on the effectiveness of therapy. Therapist scores on the WPAS subscales were not predictive of client scores on the ORS at the final session, which did not support my

hypothesis. Additionally, scores on WPAS subscales were not directly predictive of number sessions attended by clients. Results from this study also did not support the hypothesis that therapists' would be differentially effective with clients of Color and that this difference would be moderated by scores on the WPAS subscales. Client race and ethnicity and WPAS scores were not found to have direct or interaction effects on last session ORS scores. Thus, results indicate that no difference existed between clients of Color and White clients in terms of their distress levels at the conclusion of therapy.

However, WPAS subscales were found to have a moderating effect on the relationship between first session ORS scores and number of sessions attended. When therapists had higher scores on the Confronting White Privilege or Anticipated Costs of Addressing White Privilege subscales, clients with higher initial ORS scores attended fewer sessions and clients with lower initial ORS scores attended more sessions. The Confronting White Privilege subscale focuses on advocacy-type behaviors related to White privilege and a willingness to explore one's own White privilege, while the Anticipated Costs of Addressing White Privilege subscale focuses on apprehension about addressing or concern about losing White privilege.

The White Privilege Remorse subscale also moderated the relationship between first session ORS scores and number of sessions attended. In this case, when therapists had higher scores on this subscale, clients with higher initial ORS scores attended more sessions. The White Privilege Remorse subscale measures emotional responses to White privilege. While the predictive relationship above was negative, this relationship is positive. Thus, individuals who begin therapy with lower levels of distress are more likely to stay in therapy longer when their therapist indicated higher levels of White

privilege remorse. Overall, women attended more therapy sessions than men, and when scores on the Anticipated Costs of Addressing White Privilege subscale were higher women attended more sessions. The scores on this subscale seemed to be enhancing a relationship already present, namely that women were more likely to attend more sessions than men.

Interpretation. The WPAS subscales were not predictive of client distress at the final session, but were predictive of number of sessions attended when moderating client gender and first session ORS scores. No research exists to help clarify these relationships. Therapy dynamics are complex when considering the interaction of therapist effects and client effects, both of which have a significant effect on client outcomes. Thus, the moderating relationships described above could be indicative of the interaction of therapist White privilege awareness with various client factors not measured in this study.

Characteristics of the sample in this study provide possible explanations for these results. One possible explanation is that clients of Color did not comprise a large enough percentage of the client sample in this study, 11.3%. Additionally, the therapist sample may not have been large enough. If this is the case, then the statistical analyses run would not have been powerful enough to detect if any true differences that existed, resulting in a type II error. Another consideration is the fact that client scores on their last session ORS were, on average, below the clinical cut-off score (25), despite experiencing statistically significant improvements from the first session to the last session, $t(467) = -5.56, p < .001$. Thus, clients were still in a clinically significant amount of distress by the conclusion of therapy. Considering the ORS does not specifically assess for distress related to race and

ethnicity, and the fact that, on average, clients spent their entire course of therapy below the clinical cutoff, awareness of and attending to issues of race/ethnicity may not have been a priority for the therapists or the clients.

The trajectory of client change in therapy was not measured in this study, which could have been the explanatory variable as to why clients attended the number of sessions they did. Attending a greater number of sessions can be seen as a positive indicator of therapy effectiveness, representing a lack of attrition. If clients show little progress early in the therapeutic process, they are less likely to make progress later. (Duncan, 2012). For some clients, progress takes longer to level off, though usually change begins early in the process (Duncan, 2012). Thus, clients with more distress in the beginning of therapy may require more sessions to reach a plateau, whereas those starting with lower levels of distress may need fewer sessions. Thus, the therapist scores on the WPAS subscales mentioned above may have been enhancing a relationship that had not been fully measured in this study.

Another potentially important client factor is mental illness, especially relevant to this client population who are diagnosed with a wide range of mental disorders. For some clients where multicultural concerns are more salient or relevant to their presenting concerns, the therapists' multicultural competence and White privilege awareness could be a more relevant therapist factor in the process of therapy (Pope-Davis et al., 2002). With this in mind, clients in this study may have been differentially impacted by therapists' White privilege attitudes depending on their presenting concerns. Individuals with severe and persistent mental illness, particularly mental illness that impacts individuals' cognitive functioning, could reduce the likelihood that White privilege

awareness is a significant factor to psychotherapy outcomes.

Finally, the possibility exists that particular client factors not measured could have been significant in moderating this relationship. Client racial identity development is potentially significant, particularly if clients were early in their development. As demonstrated earlier, White privilege awareness and racial identity development are correlated, so logically clients early in their racial identity (i.e. lacking awareness about racial privilege/oppression) might not be as impacted by their therapists' willingness to confront White privilege, apprehension of addressing White privilege, White privilege awareness, and experience of White privilege remorse. Considering the women in this study attended more sessions than men, the intersection of gender and racial identity could affect how clients are impacted by therapists' White privilege awareness and attitudes that come up in session.

Therapist factors have been empirically found to be significantly predictive of therapy outcomes. Research has found that approximately 5% of variance in therapy outcomes is attributable to therapists (Baldwin & Imel, 2013; Laska, Wampold, & Gurman, 2013). In this study, therapist factors comprised 12.2% of the variation in last session ORS scores, and 18.6% of the variation in number of sessions attended by clients, which are both medium to large values. The findings from this study were larger than prior research findings, suggesting that therapist participants in this research significantly impacted outcomes. However, results were mixed with regards to therapist factors impacting outcome, which could mean that important therapist factors that were not accounted for in this study impacted outcomes. Therapist racial identity development, like for clients, was not measured in this study, but could be potentially impactful on client

psychotherapy outcomes. Therapists early in their White racial identity development may be less likely to attend to racial and ethnic factors in therapy due to a lack of awareness of racism and how it may impact their clients (Helms, 1993). Thus, they could be at risk for offending or harming their clients. Additionally, characteristics that make therapists more likely to experience White privilege remorse or have less apprehension related to addressing White privilege could make them more effective as therapists in general, such as a greater capacity for empathy or more of a willingness to initiate racially-based discussions in session.

Impact of White Privilege Attitudes on Therapeutic Alliance

Therapist scores on the WPAS subscales were not predictive of client scores on the SRS at the third/fourth session, which did not support my hypothesis. Results from this study partially supported the hypothesis that therapists' would be differentially effective with clients of Color and that this difference would be moderated by scores on the WPAS subscales. Client race/ethnicity had no overall significant direct effect on client SRS scores, and no significant interaction effects were present between client race/ethnicity and WPAS scores. However, the effect client race/ethnicity did vary significantly across therapists. Research has consistently found that some therapists are better at building relationships with clients than others, which aligns with findings in this study. Findings in this study indicate that some therapists were differentially effective at building the therapeutic alliance with White clients as compared to clients of Color, even though most therapists were equally effective.

Additionally, client race and ethnicity also did not have a direct effect on the therapeutic alliance, and the WPAS subscales did not have moderating effects. Even

though client race/ethnicity had no overall significant direct effect on client SRS scores, this effect significantly varied across therapists. Thus, some therapists were in fact differentially effective at building the therapeutic alliance with White clients as compared to clients of Color. Research has consistently found that some therapists are better at building relationships with clients than others, which aligns with findings in this study (Baldwin et al., 2007).

Interpretation. As with psychotherapy outcomes, characteristics of the sample in this study provide possible explanations for these results. The small number of clients of Color (11.3%), as well as the small sample of therapists, could have also impacted the power of the statistical analyses for the therapeutic alliance as well. Another consideration is the fact that client scores on their first and third/fourth session SRS scores were, on average, above the clinical cut-off score (36). High ratings of the therapeutic alliance predict good therapy outcomes (Duncan, 2011); however, both distributions for SRS scores at the first session and third/fourth session were negatively skewed, meaning most of the scores were located in the upper-bound of the possible range of scores (between 30-40). Most clients rated their therapeutic alliance as being strong, and thus variability in these scores is limited, meaning that interpretation of results could be impacted. Strong alliance scores on the SRS are indicative of high levels of client satisfaction within the therapeutic alliance, which could mean that the client and therapist may not feel as compelled to make issues of race and ethnicity a priority. In this sample, the vast majority of clients were White and all therapists sampled were White, therapeutic dyads that would typically not lend themselves to conversations about race/ethnicity. In cross-racial dyads with clients of Color, the relationship could be harmed by not attending to race and

ethnicity. Potentially, some White therapists were more effective with their clients of Color because they had established a strong working alliance and invited discussion related to race and ethnicity. Most were just as effective with both their White clients and clients of Color.

These mixed results align with empirical research that has investigated the relationship between MCC and the therapeutic alliance. Research has found that clients' who perceived their clients as multiculturally competent were more likely to rate the therapeutic alliance more positively (Owen et al., 2011). Relatedly, research has found that clients' level of satisfaction with a cross-racial therapeutic relationship may be based on the comfort of White therapists to address racial/ethnic differences, and their willingness to express empathy and compassion to their clients (Chang & Yoon, 2011; Thompson & Jamal, 1994). Considering that most therapists were not equally effective with White clients as they were with clients of Color, some clients in this study may have felt strongly about their therapists based on their therapists' level of empathy and compassion, unrelated to multicultural factors. On the other hand, some clients in this study may have had presenting concerns related to multicultural concerns and worked with a therapist who was comfortable to initiate discussions of race/ethnicity, potentially making that therapist more effective from the client perspective.

As stated, therapist factors have been empirically found to be significantly predictive of therapy outcomes as well as the therapeutic alliance. In this study, therapist factors comprised 22.7% of the variation in third/fourth session scores, which is considered a large value. Therapist factors measured in this study did not have a direct effect on SRS scores, indicating that additional factors not measured may have been

impactful. For instance, factors considered to be generally universal to strong therapeutic alliances, include exhibiting empathy, collaboration, genuineness, positive regard, and engaging in feedback, may transcend multicultural competence or therapist-client matching if the therapist effectively utilizes these factors.

White Privilege and MCC

Findings from this study provided some support that White privilege awareness was positively correlated with multicultural competence. Specifically, the higher one's multicultural knowledge, as measured by the MCKAS, the higher their willingness to confront White privilege. Multicultural awareness, measured by the MCKAS, was positively and significantly correlated with higher levels of confronting White privilege and White privilege awareness. These correlations are partially congruent with what Mindrup and colleagues (2011) found in their research examining the correlations between the WPAS and MCKAS. However, Mindrup et al. (2011) found additional correlations in their research that were not found in this study, likely due to small sample size.

Similar to Mindrup et al. (2011), the results of this study suggest that White privilege awareness is related to multicultural competence, but are not the same constructs evidenced by the fact that all subscales were not correlated and the correlations present were moderate. Additionally, Mindrup et al. (2011) posited that White privilege awareness was not only a separate construct but was a sub-construct of multicultural competence (MCC). This finding is significant because it highlights two things. First, White privilege awareness and attitudes is a focused and specific area of MCC, emphasizing racial privilege as a way of better understanding racial oppression. Additionally, White privilege awareness emphasizes the fact that MCC is not just about

learning about other groups, but also learning about one's self. Gaining awareness of one's privilege is a key component of multicultural competence because it will minimize the likelihood of inadvertently hurting a client, through an examination one's biases. Additionally, White privilege awareness offers the opportunity to know oneself better in relation to others, specifically gaining awareness of one's White heritage and how it plays out in society. Finally, White privilege awareness allows therapists to confront their own discomfort with privilege, which can increase the likelihood that a White therapist will be more likely to initiate discussion about race/ethnicity.

Study Limitations and Strengths

The greatest limitation in this study centers on measurement. The WPAS is in its infancy; thus, a limited amount of empirical psychometric evidence for this scale has been collected. Additionally, the research area of White privilege and White racial development are still emerging, and studies focused on these areas have yielded mixed results. As described above, researchers have consistently operationalized these two constructs differently, reflected in the fact that no one scale measuring either of these constructs has emerged as a leader.

The measure of White privilege attitudes used in this study is transparent in nature. The items were explicit in asking about White privilege. For instance, every item in the measure mentioned White privilege. The motivation to control prejudiced reactions was not significantly correlated with scores on the WPAS, and results from each subscale provided a range of scores that encompassed the range of possible scores. However, the lack of transparency could have elicited more aspirational responses instead of ones based in practice. Additionally, a limitation of both the WPAS and MCKAS is the fact that

therapists' skills in multicultural counseling were not measured. The WPAS items are not specifically geared toward therapy, asking more about personal attitudes. Utilizing this measure may be valid if assessing for one's general attitudes, beliefs, and feelings about White privilege. However, it seems likely that this measure's validity is limited in the context of therapist attitudes and how those attitudes impact therapy. The MCKAS is specifically geared toward counseling, as a measure of multicultural competence. The items in the Knowledge subscale measure what a therapist knows, and the Awareness subscale measures therapists' beliefs and attitudes. None of the items assesses for what a therapist actually does in multicultural therapy situations. Thus, this measure was limited in its ability to capture the process of therapy because of its focus on therapists' knowledge and attitudes.

Also each variable was measured using a mono method, so the possibility exists that this study only captured part of each of the variables of interest. For instance, all measures completed by the therapists in this study were self-report, each of the therapist variables of interest only had one measure associated with it, and client outcomes and perceptions of the therapeutic relationship had only one measure associated with it as well.

Although the use of actual therapists and clients is a strength, external validity is slightly limited in this study. All clients and therapists were recruited from a community mental health center in the southeast, which has unique features compared to other types of mental health agencies (e.g., college counseling centers). Generalizing these findings to clients and therapists in other types of agencies, such as college counseling centers, may be difficult.

Related is the fact that the sample size of therapists was small ($N = 32$). This

occurred because of the difficulty of recruiting therapists working to participate in this study outside, even with the bonus of a \$20 Amazon.com gift card incentive. As a result of the small therapist sample size, I was limited in terms of the archived client data utilized in my data analysis. Only a little over 11% of the 468 total clients in this study were clients of Color ($N = 53$). Additionally, clients were not evenly distributed among therapists, which impacted the multilevel data analysis. As a result of these sampling concerns, the power of my data analysis was compromised and may have contributed to a lack of significant findings for the main hypotheses.

Another limitation is that information about the clients was limited to demographic data. Thus, confounding variables, such as racial identity and awareness, may impact the criterion variables. Treatment fidelity is another potential limitation, in that implementation of the ORS and SRS and use of feedback from those measures in session with clients was fully in control of the therapists, not the researchers. In this study, a great deal of data had to be eliminated from analysis because of missing crucial data points (i.e., ORS scores at the first session, SRS scores at sessions 3 or 4). Finally, the use of feedback with clients has been shown to impact client outcomes. Specifically, outcomes have found to be higher when use of client feedback is part of treatment, as compared to treatment as usual without feedback. Because feedback was used with all clients, differences between groups did not need to be accounted for. However, the possibility exists that outcomes at this mental health agency could be inflated compared to other agencies because of the use of feedback.

An important strength of this study is the fact that this is novel research. White privilege has not been empirically studied in relation to therapy outcomes or the

therapeutic alliance. This research is an extension of the important psychotherapy outcome and therapeutic alliance research, ultimately focused on better understanding the process of therapy. Multicultural-related psychotherapy research has grown out of this research arena to focus on how multicultural factors can impact therapy. The current study fits within this multicultural area of research because of the focus on understanding, specifically how racial dynamics between the client and therapist (in terms of client race/ethnicity and therapist White privilege awareness) impact therapy outcomes and the therapeutic alliance. Gaining a better understanding of how race/ethnic issues play out in therapy can be helpful in preventing attrition, particularly for clients of Color.

A second strength of this study is that real-life therapy data were used. This type of research is challenging as it often relies on agencies to do the actual data collection, as in this case. However, data collected from a naturalistic setting offers the advantage of offering a more accurate reflection of how therapy is typically provided and of client distress and the therapeutic alliance. For instance, Owen and his colleagues (2011) carried out a study that asked clients to retroactively recall perceptions of their therapists' multicultural competency. They identified this as a limitation of the study because of the reliance on the accuracy of the client's memory of therapy.

Relatedly, HLM was used to analyze the real-life therapy data, which is an important strength of this study. HLM as a statistical analysis is able to partition out the effects of clients from the effects of therapists on the criterion variable. Being able to differentiate between therapist effects and client effects through use of HLM is important to better understand the process and outcomes of therapy. With therapist and client effects separated, therapists can begin to understand better what changes they can make in their

clinical work to improve their own effectiveness and reduce attrition rates.

Finally, a strength in this study is the inclusion of a social desirability measure assessing for therapists' motivation to control their prejudiced reactions, which much of the research covered previously failed to include. Social desirability is a well-researched phenomenon in the context of self-report measures (Babbie, 2008), which tend to be vulnerable to this confounding variable. Research focused on White privilege is also vulnerable to social desirability factors because of the often reported experiences of guilt and shame that White people experience when confronted with racial privilege and oppression (Pinterits et al., 2009). Thus White therapists in this study could have potentially experienced guilt and shame while completing the questionnaires, which could have motivated them to appear less prejudiced or more aware of White privilege.

Implications and Future Recommendations

Findings in this study provide some support for the idea that White privilege attitudes impacts therapy outcomes and the therapeutic relationship; however, most of the results were non-significant. While this could be due to the limitations describe above, the possibility exists that these results accurately reflect the relationship between White privilege, psychotherapy outcomes, and the therapeutic alliance. In other words, White privilege, as a therapist factor, may be irrelevant to the process and outcome of therapy.

Implications. The field of counseling psychology has moved toward implementing a social justice and multicultural framework into all aspects of the profession. Crucial to this is a focus on cultural self-awareness in order to better understand one's own biases. While the impact of therapist White privilege awareness was limited in this study, White therapists were found to be differentially effective with

clients of Color as opposed to White clients. This finding is significant in that the possibility exists that therapists lack awareness that they are differentially effective in this way. Awareness of White privilege is a form of self-awareness that is an important step to a greater awareness of how others are racially oppressed. Greater awareness may minimize the likelihood of a White therapist reenacting in session the oppression-privilege dynamic that exists in larger society, ultimately leading to more ethical treatment of clients. Most therapists are White, and most clients of Color underutilize mental health services, a sign that the mental health system is not accessible for all. An examination of how White privilege attitudes impact the effectiveness of therapy and the therapeutic relationship could shed light on how to improve therapy practice for all clients.

Apart from improving the actual practice of therapy, improving the training of therapists is another possible implication of this study, through use of treatment outcome and process data. Furthermore, pairing White privilege awareness and treatment outcome/process data collection has implications for the content of therapist training programs. White privilege was found to have a significant impact on the outcome of therapy and the therapeutic relationship in some cases. Thus, a more intentional approach to multicultural education seems necessary in counseling psychology training, especially training that will increase awareness of privilege and oppression issues, as well as how to address these issues in therapy.

Future Directions. This study is the first of its kind, so an important future direction for research is to continue to explore the relationship between White privilege awareness and attitudes and the therapeutic process. Methods used in this study could be

replicated using the same measures with a larger sample of therapists and clients.

However, White privilege as a standalone construct may not be relevant to the process and outcome of therapy, when removed from the context of attitudes toward racism as a whole. As stated in Chapter One, McIntosh (2009) described White privilege as being central to racism. Because White privilege and racism are so closely related, studying White privilege attitudes and awareness without considering attitudes and awareness of racism may not make sense. Thus, while a therapist's attitude towards race and racism may be a significant and relevant factor influencing therapy outcome and the alliance, a therapist's attitude toward White privilege may not be relevant. Additionally, a paucity of White privilege measures exist, as well as measures of related Whiteness constructs (i.e. White Racial Identity Development). The measures that do exist have not been used much in research, or have generated data with inconsistent psychometric properties. Considering all of this, I recommend replicating the methodology of this study using an alternative measure that assesses for attitudes toward racism as a whole while also incorporating items measuring White privilege attitudes, such as the Color-Blind Racial Attitudes Scale (Neville et al., 2000).

Another suggestion for future research is related to the relationship between multicultural competence and therapy process and outcome. In this study, multicultural competence was measured using an assessment that examined knowledge and awareness, but not a therapist's actual skills. Thus, a gap may exist between therapists' knowledge and awareness of multicultural issues and their ability to put that knowledge and awareness into practice. While an indirect relationship may exist between what a therapist knows and is aware of and the process and outcome of therapy, a therapist's practice of

therapy is more likely to directly impact the therapeutic outcome and process. I recommend replicating this methodology utilizing another measure of multicultural competence that assesses for therapists' skills related to multicultural competence.

An important angle not fully captured in this study is the client perspective. While use of the ORS and SRS in this study considered the client voice to a certain degree, future research directions should include the client more fully. Use of questionnaires assessing clients' perspectives on therapists' White privilege awareness or general multicultural competence would achieve this. Further, inclusion of a qualitative component would allow for richer data about clients' experiences in therapy.

Future research should try to capture a large and more diverse sample of clients and therapists. My sample was limited to one organization in the southeast and thus the diversity of both my therapists and clients were limited. A larger sample of therapists could potentially lead to more diversity in terms of White privilege attitudes. Although therapists in this study were not all on the high end of ranges of points on the WPAS subscales, data was limited because of the small sample size. Additionally, a larger sample of diverse clients could allow for a more powerful analysis of differential treatment effects between clients of Color and clients who are White. Finally, research utilizing therapists and clients at multiple mental health agency sites, as well as multiple types of agencies could help increase the generalizability of results.

**Appendix A:
Motivation to Control Prejudiced Reactions Scale**

Please read the each of the following statements carefully. Indicate the extent to which you agree or disagree with each statement by circling the appropriate number according to the following scale:

- 3 = strongly disagree
- 2 = disagree
- 1 = disagree somewhat
- 0 = no opinion
- +1 = agree somewhat
- +2 = agree
- +3 = strongly agree

		SD SA
1.	In today's society, it is important that one not be perceived as prejudiced in any manner.	-3 -2 -1 0 +1 +2 +3
2.	I always express my thoughts and feelings regardless of how controversial they might be.*	-3 -2 -1 0 +1 +2 +3
3.	I get angry with myself when I have a thought of feeling that might be considered prejudiced.	-3 -2 -1 0 +1 +2 +3
4.	If I were participating in a class discussion and a Black student expressed an opinion with which I disagreed, I would be hesitant to express my own viewpoint.	-3 -2 -1 0 +1 +2 +3
5.	Going through life worrying about whether you might offend someone is just more trouble than it's worth.*	-3 -2 -1 0 +1 +2 +3
6.	It's important to me that other people not think I'm prejudiced.	-3 -2 -1 0 +1 +2 +3
7.	I feel it's important to behave according to society's standards.	-3 -2 -1 0 +1 +2 +3
8.	I'm careful not to offend my friends, but I don't worry about offending people I don't know or don't like.*	-3 -2 -1 0 +1 +2 +3
9.	I think that it is important to speak one's mind rather than to worry about offending someone.*	-3 -2 -1 0 +1 +2 +3
10.	It's never acceptable to express one's prejudices.	-3 -2 -1 0 +1 +2 +3
11.	I feel guilty when I have a negative thought or feeling about a Black person.	-3 -2 -1 0 +1 +2 +3
12.	When speaking to a Black person, it's important to me that he/she not think I'm prejudiced.	-3 -2 -1 0 +1 +2 +3

13.	It bothers me a great deal when I think I've offended someone, so I'm always careful to consider other people's feelings.	-3 -2 -1 0 +1 +2 +3
14.	If I have a prejudiced thought or feeling, I keep it to myself.	-3 -2 -1 0 +1 +2 +3
15.	I would never tell jokes that might offend others.	-3 -2 -1 0 +1 +2 +3
16.	I'm not afraid to tell others what I think, even when I know they disagree with me.*	-3 -2 -1 0 +1 +2 +3
17.	If someone who made me uncomfortable sat next to me on a bus, I would not hesitate to move to another seat.*	-3 -2 -1 0 +1 +2 +3

*Reverse Scored

**Appendix B:
Multicultural Counseling Knowledge and Awareness Scale (MCKAS)**

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A Revision of the Multicultural Counseling Awareness Scale (MCKAS)

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Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

1. I believe all clients should maintain direct eye contact during counseling.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

2. I check up on my minority/cultural counseling skills by monitoring my functioning – via consultation, supervision, and continuing education.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

3. I am aware some research indicates that minority clients receive “less preferred” forms of counseling treatment than majority clients.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

4. I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

5. I am aware of certain counseling skills, techniques, or approaches that are more likely to transcend culture and be effective with any clients.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

6. I am familiar with the “culturally deficient” and “culturally deprived” depictions of minority mental health and understand how these labels serve to foster and perpetuate discrimination.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

7. I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted.

1 2 3 4 5 6 7

8. I am aware of individual differences that exist among members within a particular ethnic group based on values, beliefs, and level of acculturation.

1 2 3 4 5 6 7

9. I am aware some research indicates that minority clients are more likely to be diagnosed with mental illnesses than are majority clients.

1 2 3 4 5 6 7

10. I think that clients should perceive the nuclear family as the ideal social unit.

1 2 3 4 5 6 7

11. I think that being highly competitive and achievement oriented are traits that all clients should work towards.

1 2 3 4 5 6 7

12. I am aware of the differential interpretations of nonverbal communication (e.g., personal space, eye contact, handshakes) within various racial/ethnic groups.

1 2 3 4 5 6 7

13. I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions.

1 2 3 4 5 6 7

14. I realize that therapist-client incongruities in problem conceptualization and counseling goals may reduce therapist credibility.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

15. I am aware that some racial/ethnic minorities see the profession of psychology functioning to maintain and promote the status and power of the White Establishment.

1 2 3 4 5 6 7

16. I am knowledgeable of acculturation models for various ethnic minority groups.

1 2 3 4 5 6 7

17. I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups.

1 2 3 4 5 6 7

18. I believe that it is important to emphasize objective and rational thinking in minority clients.

1 2 3 4 5 6 7

19. I am aware of culture-specific, that is culturally indigenous, models of counseling for various racial/ethnic groups.

1 2 3 4 5 6 7

20. I believe that my clients should view a patriarchal structure as the ideal.

1 2 3 4 5 6 7

21. I am aware of both the initial barriers and benefits related to the cross-cultural counseling relationship.

1 2 3 4 5 6 7

22. I am comfortable with differences that exist between me and my clients in terms of race and beliefs.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

23. I am aware of institutional barriers which may inhibit minorities from using mental health services.

1 2 3 4 5 6 7

24. I think that my clients should exhibit some degree of psychological mindedness and sophistication.

1 2 3 4 5 6 7

25. I believe that minority clients will benefit most from counseling with a majority who endorses White middle-class values and norms.

1 2 3 4 5 6 7

26. I am aware that being born a White person in this society carries with it certain advantages.

1 2 3 4 5 6 7

27. I am aware of the value assumptions inherent in major schools of counseling and understand how these assumptions may conflict with values of culturally diverse clients.

1 2 3 4 5 6 7

28. I am aware that some minorities see the counseling process as contrary to their own life experiences and inappropriate or insufficient to their needs.

1 2 3 4 5 6 7

29. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.

1 2 3 4 5 6 7

30. I believe that all clients must view themselves as their number one responsibility.

1 2 3 4 5 6 7

Using the following scale, rate the truth of each item as it applies to you.

1	2	3	4	5	6	7
Not at All True			Somewhat True			Totally True

31. I am sensitive to circumstances (personal biases, language dominance, stage of ethnic identity development) which may dictate referral of the minority client to a member of his/her own racial/ethnic group.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

32. I am aware that some minorities believe therapists lead minority students into non-academic programs regardless of student potential, preferences, or ambitions.

1	2	3	4	5	6	7
---	---	---	---	---	---	---

Thank you for completing this instrument. Please feel free to express in writing below any thoughts, concerns, or comments you have regarding this instrument:

Knowledge Scale (20 items): 2, 3, 5, 6, 8, 9, 12, 13, 14, 15, 16, 17, 19, 21, 22, 23, 27, 28, 31, and 32.

Awareness Scale (12 items): (1), (4), (7), (10), (11), (18), (20), (24), (25), 26, 29, and (30). The ten items in parentheses need to be reversed scored.

**Appendix C:
Outcome Rating Scale (ORS)**

Client ID _____	Age (Yrs): _____
Therapist ID _____	Sex: M / F
Session # _____	Date: _____

Looking back over the last week, including today, help us understand how you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Individually:
(Personal well-being)

I-----I

Interpersonally:
(Family, close relationships)

I-----I

Socially:
(Work, School, Friendships)

I-----I

Overall:
(General sense of well-being)

I-----I

**Appendix D:
Session Rating Scale (SRS V.3.0)**

Client ID _____	Age (Yrs): _____
Therapist ID _____	Sex: M / F
Session # _____	Date: _____

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

Relationship:

I did not feel heard, understood, and respected

I-----I

I felt heard, understood, and respected

Goals and Topics:

We did *not* work on or talk about what I wanted to work on and talk

I-----I

We worked on and talked about what I wanted to

Approach or Method:

The therapist's approach is not a good fit for me.

I-----I

The therapist's approach is a good fit for

Overall:

There was something missing in the session today

I-----I

Overall, today's session was right for me

Appendix E:
White Privilege Attitudes Scale: Items, Scoring Key and Subscale Summaries

Directions. Below is a set of descriptions of different attitudes about white privilege in the United States. Using the 6-point scale, please rate the degree to which you personally agree or disagree with each statement. Please be as open and honest as you can; there are no right or wrong answers. Record your response to the left of each item.

If you identify primarily as a person of color, many items will not apply to you. You may leave those items blank. If you identify primarily as European American, Caucasian, or White, please answer all items.

1	2	3	4	5	6
Strongly Disagree					Strongly Agree

1. ____ I plan to work to change our unfair social structure that promotes white privilege.
2. ____ Our social structure system promotes white privilege.
3. ____ I am angry that I keep benefiting from white privilege.
4. ____ I am worried that taking action against white privilege will hurt my relationships with other Whites.
5. ____ I take action against white privilege with people I know.
- 6. ____ Everyone has equal opportunity, so this so-called white privilege is really White-bashing.**
7. ____ I accept responsibility to change white privilege.
8. ____ I feel awful about white privilege.
9. ____ If I were to speak up against white privilege, I would fear losing my friends.
- 10. ____ I have not done anything about white privilege.**
11. ____ I am ashamed of my white privilege.
12. ____ I look forward to creating a more racially-equitable society.
13. ____ I am anxious about the personal work I must do within myself to eliminate white privilege.

14. ____ I intend to work towards dismantling white privilege.
15. ____ I am ashamed that the system is stacked in my favor because I am White.
- 16. ____ I don't care to explore how I supposedly have unearned benefits from being White.**
17. ____ If I address white privilege, I might alienate my family.
18. ____ I am curious about how to communicate effectively to break down white privilege.
19. ____ White people have it easier than people of color.
20. ____ I'm glad to explore my white privilege.
21. ____ I am angry knowing I have white privilege.
22. ____ I worry about what giving up some white privileges might mean for me.
23. ____ I want to begin the process of eliminating white privilege.
- 24. ____ Plenty of people of color are more privileged than Whites.**
25. ____ White people should feel guilty about having white privilege.
26. ____ I take action to dismantle white privilege.
27. ____ I am anxious about stirring up bad feelings by exposing the advantages that Whites have.
28. ____ I am eager to find out more about letting go of white privilege

The items in bold are reverse scored (i.e., 6 = 1, 5 = 2, 4 = 3, 3 = 4, 2 = 5, 1 = 6): items 6, 10, 16 and 24. Higher scores correspond with higher levels of acknowledgment of White privilege.

Subscale 1: 'Confronting White Privilege' consists of the following 12 items: 1, 5, 7, 10r, 12, 14, 16r, 18, 20, 23, 26 and 28

Subscale 2: 'Anticipated Costs of Addressing White Privilege' consists of the following 6 items: 4, 9, 13, 17, 22 and 27

Subscale 3: 'White Privilege Awareness' consists of the following 4 items: 2, 6r, 19 and 24r

Subscale 4: 'White Privilege Remorse' consists of the following 6 items: 3, 8, 11, 15, 21 and 25

**Appendix F:
Demographics Questionnaire for Therapists**

1. Which of the following best represents your racial or ethnic heritage? Choose all that apply.

- | | |
|---|--------------------------------------|
| a. Non-Hispanic White or Euro-American | f. Middle Eastern or Arab American |
| b. Black, Afro-Caribbean, or African American | g. Native American or Alaskan Native |
| c. Latino or Hispanic American | h. Other (please specify) |
| d. East Asian or Asian American | _____ |
| e. South Asian or Indian American | |

2. What gender do you identify as?

- | | |
|------------------|------------------|
| a. Male | d. Self-identify |
| b. Female | _____ |
| c. Transgendered | |

3. Please indicate your age in years:

4. How many years have you been a practicing therapist?

5. Please identify your theoretical orientation

6. What is the highest degree you have attained?

7. What are your professional credentials?

8. Have you attended workshops, conferences, lectures, or other types of educational trainings about issues of Whiteness, multiculturalism, diversity, or race/ethnicity?

a. Yes (Please briefly describe)

b. No

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Vita

GENERAL INFORMATION

Full Name: Kristin Miserocchi

EDUCATION

Specialist in Education, Counseling
Psychology University of Kentucky,
Lexington, KY
August 2009-May 2011

Master of Science, Counseling
Psychology University of
Kentucky, Lexington, KY August
2007- May 2009

Bachelor of Arts, Music
Knox College, Galesburg, IL

PROFESSIONAL POSITIONS HELD

Clinical Experience

Predoctoral Intern,
University of Missouri Counseling Center, Columbia, MO
August 2013 – PRESENT,
Training Director: Jenny Lybeck-Brown, Ph.D.

Psychology Practicum Student
Eastern State Hospital, Lexington, KY
August 2012 – June 2013
Site Supervisor: David Susman, Ph.D.

Practicum Student – Therapist and Group Leader
Shepherd's House (Residential drug/alcohol treatment facility), Lexington, KY
July 2011 – June 2013/August 2009 – May 2010
Site Supervisor: April Tandy, MSW, LCSW/Jason Thomas, MSW, LCSW
University Supervisor: Jeff Reese, Ph.D., Pamela Remer, Ph.D.

Practicum Student – Therapist and Group Leader/Process Observer
University of Kentucky Counseling Center, Lexington, KY
September 2012 – December 2012/August 2010 – May 2011
Site Supervisors: Di Sobel, PhD, Linda Hellmich, PhD, Susan Mathews, PhD,
Mary Bolin, PhD Susan Mathews, PhD

University Supervisor: Jeff Reese, PhD

Supervisor of Master's Students, Clinical Supervision Course
University of Kentucky Counseling Psychology Program, Lexington, KY
February 2012 - May 2012/January 2011 – April 2011
University/Site Supervisor: Jeff Reese, Ph.D., Sharon Rostosky, Ph.D.

Practicum Student Counselor
Catholic Social Services Bureau, Lexington, KY
August 2008 – May 2009
Site Supervisor: Barbara Mulligan, MSW LCSW, Becky Crawford, MS,
LPCC
University Supervisor: Danelle Stevens-Watkins, Ph.D.

Diversity Trainer, Co-leader, Gatton Groups
University of Kentucky Gatton School of Business, Lexington, KY
August 2008 – December 2009
University/Site Supervisor: Pam Remer, PhD

Project P.E.C.O.T. – Promoting Enhanced Career Opportunities for Teens
*University of Kentucky, Educational, School, and Counseling Psychology
Department, Lexington, KY*
August 2008 – December 2008
University/Site Supervisor: Keisha Love, Ph.D.

Teaching Experience:

Instructor, EDP 202, Human Development and Learning (undergraduate course)
University of Kentucky, Lexington, KY
August 2011 – May 2012

Graduate Teaching Assistant, EDP 604, Lifespan Gender Development
University of Kentucky Counseling Psychology Program, Lexington, KY
January 2012 – May 2012

Guest Lecturer, EDP 604, Lifespan Gender Development
University of Kentucky Counseling Psychology Program, Lexington, KY
January 2011 – April 2011

Lab Instructor, Introduction to Psychology (undergraduate course)
University of Kentucky Department of Psychology, Lexington, KY
January 2009 – May 2009

Lab Instructor, Application of Statistics in Psychology (undergraduate course)
University of Kentucky Department of Psychology, Lexington, KY
August 2007 – December 2008

Research Experience:

Research Assistant, Center for Drug and Alcohol Research
University of Kentucky, Lexington, KY
June 2009 – August 2011

Research Team Member, Wilderness Therapy for Adolescent Girls
PI: Leslie Gerrard, Ph.D.
University of Kentucky, Lexington, KY
March 2011 – February 2012

PUBLICATIONS AND PRESENTATIONS

Reese, R. J., Slone, N. C., & **Miserochchi, K. M.** (in press). Utilizing client feedback in psychotherapy from an Interpersonal Process perspective. *Psychotherapy*.

Remer, P, Minieri, A. M., & **Miserochchi, K. M.** (2013). [Review of the book *Women psychotherapists: Journeys in healing*, edited by L. Comas-Diaz & M. B. Weiner]. *Psychology of Women Quarterly*.

Miserochchi, K. M., Minieri, A. M., Pascale-Hague, D., & Reese, R. J. (2012, August). *Using Client Feedback in the Training of Future Psychologists: Building a Bridge between Evidence-Based and Social Justice Practice*. Poster presented at the American Psychological Association Convention, Orlando, FL.

Miserochchi, K. M. (2012, August). *Methodological Review of Constructs of Whiteness in the Counseling Literature*. Poster presented at the American Psychological Association Convention, Orlando, FL.

Minieri, A. M., **Miserochchi, K. M.**, Remer, R. R., & McClellan, M. J. (2012, August). *Changes in Students' Cultural Awareness after Multiple Social Justice Courses*. Poster presented at the American Psychological Association Convention, Orlando, FL.

Miserochchi, K. M., Reese, R. J., Minieri, A. M. (2011, August). *An Analysis of Client Feedback in Supervision and the Relationship between Outcome and Counselor Self-Efficacy*. Poster presented for presentation at the American Psychological Association Convention, Washington, DC.

Miserochchi, K. M., Minieri, A. M., Reese, R. J. (2011, August). *Exploring how Various Presenting Concerns of Undergraduate Females Respond to Counseling*. Poster presented for presentation at the American Psychological Association Convention, Washington, DC.

Minieri, A. M., **Miserochchi, K. M.**, Remer, R. R., McClellan, M. J. (2011, August). *The Effects of Personal Goal Orientation on Students' Cultural Awareness in Social*

Justice-Focused Undergraduate Courses. Poster presented at the American Psychological Association Convention, Washington, DC.

Waldheim, K. A., **Miserochchi, K. M.**, & Reese, R. J. (2010, August). *Effectiveness of a Feminist group treatment for intimate partner violence*. Poster presented at the American Psychological Association Convention, San Diego, CA.

Reese, R. J., Banks, J. R., **Miserochchi, K. M.**, Minieri, A. M., & Gerrard, L. L., et al. (2010, August). *Client feedback in Psychotherapy: Improving Outcome and Empowering Clients*. Poster presented at the American Psychological Association Convention, San Diego, CA.

Remer, R. R., McClellan, M. J., Minieri, A. M., & **Miserochchi, K. M.** (2010, August). *Impact of Undergraduate Diversity Courses on Students' Cultural Awareness*. Poster presented at the American Psychological Association Convention, San Diego, CA.

Miserochchi, K. M., McConnell, A. E., Hart, D. L., Anderson, C. A., Vowels, W. B., Roberts, D. M., Kieffer, K. M., & Reese, R. J. (2009, August). *A Reliability Generalization Study of the Symptom Checklist - 90 – Revised*. Poster presented at the American Psychological Association Convention, Toronto, Ontario.

Research in Progress:

Miserochchi, K. M., Minieri, A. M., & Reese, R. J. *Review of Whiteness constructs in the counseling literature*. Manuscript in preparation.

Minieri, A. M., **Miserochchi, K. M.**, Pascale-Hague, D., & Reese, R. J. *Using client feedback in the training of future psychologists: Building a bridge between evidence-based social justice practice*. Manuscript in preparation

PROFESSIONAL AFFILIATIONS

April 2012 **Omicron Delta Kappa National Honor Society**

October 2011 **Kentucky Psychological Association**

March 2008 **American Psychological Association (Student Affiliate Member)**

- Division 17
- Division 29
- Division 35

PROFESSIONAL SERVICE

April 2013 Co-Facilitator, Empowerment Feminist Therapy Workshop

*University of Kentucky, Educational, School, and Counseling
Psychology Department, Lexington, KY*
Led by Pam Remer, Ph.D.

- August 2011 PsycAdvocates Day
American Psychological Association Convention, Washington, DC
- August 2011 APAGS Ambassador Program
American Psychological Association Convention, Washington, DC
- February 2011- Member, Student Consultant Self-Study Task Force
May 2011 *University of Kentucky Counseling Psychology Program, Lexington, KY*
- April 2010- Planning Committee Member and Co-Facilitator
August 2010 Diversity and Ally Workshop
University of Kentucky Counseling Psychology Program, Lexington, KY
- January 2009- Student Representative, Counseling Psychology Area Committee
August 2011 *University of Kentucky Counseling Psychology Program, Lexington, KY*

PROFESSIONAL HONORS

- November 2012 Recipient, **American Psychological Association Dissertation
Research Award** (\$1000)
- August 2012 Recipient, **Diversity Student Paper Award** for paper entitled:
*Methodological Review of Constructs of Whiteness in the
Counseling Literature.*
**Division of Psychotherapy, American Psychological
Association**