EXAMINING THE ASSESSMENT OF
MULTICULTURAL COUNSELING COMPETENCE
IN COUPLES THERAPY

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EXAMINING THE ASSESSMENT OF
MULTICULTURAL COUNSELING COMPETENCE
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Dissertation

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ABSTRACT

Much of the previous literature on the assessment of multicultural counseling competence has examined counselors’ abilities when working with individual clients; this study expanded prior research by investigating trainees’ multicultural case conceptualization ability (MCCA; Ladany, Inman, Constantine, & Hofheinz, 1997) with couples. Additional methodological limitations present in the assessment of multicultural case conceptualization ability were addressed by looking at variables that might detract from competence (i.e., color-blind racial attitudes), examining the stimulus value of the race of the client in the vignette, and exploring the effects of a multidimensional measure of social desirability. The current study also investigated two different assessment methods, self-report and observer-report, of multicultural counseling competence and ascertained how each method is related to multicultural training and clinical experience.

The present study represents an exploration of trainees' self-reported multicultural counseling competence, color-blind racial attitudes, social desirability, and multicultural case conceptualization ability when working with couples. Participants completed online a demographic questionnaire, a multicultural case conceptualization ability task (cf. Constantine & Ladany, 2000), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002), the Color-Blind Racial Attitudes Scale (CoBRAS; Neville et al., 2000), and the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1991).
Major findings of the study were: 1) socially desirable responding had no significant relation with the MCCA task, the MCKAS, and two of the three subscale of the CoBRAS; 2) self-reported multicultural knowledge was not related to an observable measure of multicultural counseling competence; 3) multicultural didactic training (other than coursework) accounted for a significant amount of variance in multicultural case conceptualization ability, and the number of multicultural courses taken accounted for a significant amount of variance in self-reported multicultural counseling competence; 4) color-blind racial attitudes did not account for significant variance in MCCA scores above and beyond social desirability and training; and 5) trainee responses to vignettes with African American clients did not differ in MCCA scores from trainee responses to vignettes with European American clients. Implications for research, training, and practice are discussed.
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CHAPTER I
THE PROBLEM

Introduction

Valuing diversity has long been a priority in counseling psychology, and an examination of the past several decades illustrates the attention and progress made in the areas of multiculturalism in research, practice, and training (Heppner, Casas, Carter, & Stone, 2000). From the Sue et al. (1982) general call to the profession to adopt basic competencies through the recent passage of the heavily Division 17 influenced “Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists” (APA, 2003), counseling psychology has demonstrated its longstanding commitment to diversity.

Counseling psychologists have also had a long standing interest in working with couples and families. Fitzgerald and Osipow (1986) surveyed members of Division 17 to investigate the work behaviors of the members and found that approximately 60% of respondents engaged in couples and family counseling. Watkins, Lopez, Campbell, and Himmell (1986) surveyed members of Division 17 and found that, of the counseling psychologists engaged in the practice of psychotherapy, 65% conducted marital therapy and 45% conducted family therapy. Birk and Brooks (1988) surveyed a sample of 300 recent graduates who were members of Division 17 and found that 73% indicated marriage and family counseling was an important job activity. Last, an informal survey of
training directors over the listserv for the Council of Counseling Psychology Training Programs (CCPTP) indicated that at least 25% of the APA-accredited counseling psychology programs in the United States either required or provided some type of didactic and/or practicum training in marriage and family issues for their students. Available training ranged from course offerings through programs being centrally focused on a marriage and family curriculum (L. Prieto, personal communication, May, 15, 2005).

Counseling psychology students also have expressed an interest in working with couples and families. Schneider, Watkins, and Gelso (1988) surveyed training directors of APA-accredited counseling psychology programs and found that directors rated students’ interest in marital and family counseling second out of twenty items, only behind socio-emotional counseling. Fitzgerald and Osipow (1988) sampled counseling psychology graduate students and found that 83% of the sample indicated a desire to do couples and family counseling.

Thus, students’ interests and counseling psychologists’ work behaviors are clear indications of the importance of marriage and family therapy to the field of counseling psychology. Counseling psychology, as a leader in the area of multicultural research, is in a unique position to contribute positively to the multicultural research base in marriage and family therapy.

*Multiculturalism in Marriage & Family Therapy*

Increased attention to multiculturalism in the field of marriage and family therapy (MFT) is evident within training, research, and practice bases. Within the past decade,
calls have been made for marriage and family programs to integrate multicultural issues proactively (Falicov, 1995; Green, 1998; McGoldrick, 1998). The Commission of Accreditation for Marriage and Family Therapy Education (COAMFTE, 2002) has suggested that training programs need to attend to issues of diversity in training to develop multicultural competence within students. There has also been increasing coverage of multicultural issues at MFT national conferences (Killian & Hardy, 1998). Numerous training programs have published descriptions of their efforts to further incorporate multiculturalism into their program (McDowell et al., 2003; McGoldrick et al., 1999), and MFT researchers have described a number of training strategies that may be used to increase students’ multicultural awareness (Arnold, 1993; Preli & Bernard, 1993).

Surveys of students and faculty in MFT programs have revealed programmatic strengths in integrating diversity issues into the curriculum, addressing multicultural issues in supervision, and using diverse teaching strategies and research methods (Inman, Meza, Brown, & Hargrove, 2004; Sierra, 1997). Although all of these efforts suggest that multiculturalism is quickly becoming an important value in the field of marriage and family therapy, the incorporation of multicultural issues has not been sufficiently and fully realized within many MFT training programs (McDowell, Fang, Brownlee, Young, & Khanna, 2002).

MFT researchers have attempted to develop guidelines for cultural competence based on the theoretical and empirical literature (Bean, Perry, & Bedell, 2001, 2002), and these guidelines include statements of the need to provide a mechanism for evaluating
students on their multicultural competence (Green, 1998; McDowell et al., 2002). Yet there is little empirical literature in the field of marriage and family therapy to suggest the best means by which to evaluate students. Constantine et al. (2001) examined self-perceived multicultural competence in marriage and family therapy trainees, yet recent literature in the field of counseling psychology has indicated problems with this method of assessment (Constantine & Ladany, 2000; Constantine, Gloria, & Ladany, 2002). Thus, both counseling psychology and marriage and family therapy appear to be struggling with how to best assess multicultural counseling competence in trainees.

**Conceptualizing Competence**

The model that has provided the primary foundation for conceptualizing and assessing multicultural counseling competence is the Cross-Cultural Counseling Competency Model, which was first developed by Sue and colleagues in a position paper in 1982, then later revised and expanded in 1992 and again in 1998. In this tripartite model, counselor competencies include knowledge of racial/ethnic minority groups, awareness of one’s own assumptions and biases, and skills to work effectively with clients of racial/ethnic groups. This model has significantly influenced training, research, practice, and policy within the field of counseling psychology, the larger field of psychology, and other disciplines such as marriage and family therapy (Green, 1998; Ponterotto, Fuertes, & Chen, 2000). The model has also served as the foundation for the development of several scales of multicultural counseling competency (e.g., D’Andrea, Daniels, & Heck, 1991; Sodowsky, Taffe, Gutkin, & Wise, 1994). The research supporting the tripartite model is indirect and incomplete, and scholars have called for
continued efforts to validate the competencies suggested within the model (Atkinson & Israel, 2003).

One primary reason for the existing weakness of the tripartite model, and the lack of empirical evidence supporting it, lies in the failure to develop reliable and valid measures of multicultural competencies. Self-report, paper-and-pencil measures of multicultural counseling competencies have significant psychometric and validity problems and are influenced by the respondents’ desire to appear multiculturally competent. As well, certain competencies reported on paper-and-pencil instruments, like multicultural skills, do not appear to match the actual employment of skills in real or analogue counseling situations (Constantine & Ladany, 2000; Constantine, Gloria, & Ladany, 2002). In an attempt to improve the way in which multicultural counseling competencies are assessed in trainees, Constantine, Ladany, and colleagues developed a method, multicultural case conceptualization ability (MCCA), to assess multicultural sensitivity in trainees (Constantine, 2001b; Constantine & Ladany, 2000). This method has been shown to have some weaknesses but has promise (Bromley, 2004). One way to understand the usefulness of both self-report and observer-report methods of assessing multicultural counseling competence is to examine their relationship with training and clinical experience variables because multicultural training is expected to be related to increased multicultural counseling competence. A comparison of the contribution of training to these measures may suggest implications for the use of these instruments.

MCCA has been used with counseling psychology trainees as a measure of multicultural counseling competence to investigate how it relates to self-report, paper-
and-pencil measures of multicultural counseling competence and social desirability (Constantine & Ladany, 2000); multicultural training, theoretical orientation, and empathy (Constantine, 2001b); demographic variables (Bromley, 2004); independent and interdependent self-construals (Constantine, 2001a); racial identity and supervisor focus (Ladany et al., 1997); and white racial identity dyadic interactions in supervision (Constantine, Warren, & Miville, 2005). Most past research has used self-report methods of measuring multicultural counseling competence with marriage and family trainees (Constantine et al., 2001), and MCCA only recently has been used to investigate multicultural counseling competence with this population (Inman, 2006). In addition, Inman’s (2006) study did not use a vignette consistent with the clients typically seen by marriage and family trainees. Continued refinement of and investigation with this methodology is needed with marriage and family trainees.

Important issues have surfaced related to the use of MCCA, including the impact of other relevant variables on MCCA and methodological concerns. Variables examined in relation to MCCA include social desirability, demography, previous multicultural training, ethnic tolerance and racism, group supervision, empathy, and theoretical orientation (Bromley, 2004; Constantine, 2001b; Constantine & Gushue, 2003; Constantine & Ladany, 2000; Gainor & Constantine, 2002). However, color-blind racial attitudes (Neville, Lilly, Duran, Lee, & Browne, 2000) are just beginning to receive attention in the multicultural case conceptualization ability literature (Bromley, 2004). Methodological concerns raised include variance (or lack thereof) of the race condition in vignettes as a means to test the stimulus value of the race of the client and the failure to
assess factors that might detract from multicultural competency (e.g., racial privilege) (Bromley, 2004). In addition, most previous investigations have examined the influence of social desirability as a one-dimensional construct (e.g., Constantine & Ladany, 2000), but recent theorizing has suggested that social desirability is multidimensional (Paulhus, 1991).

Another methodological limitation is that no study to date has used a vignette that includes a form of counseling other than individual therapy, including those having to do with MFT trainees’ multicultural competencies. Constantine and Ladany (2000) acknowledged that numerous items on the self-report scales measuring multicultural counseling competence appear to be based on the assumption that counselors are working with clients in an individual counseling context, and they suggest that the scales be expanded to include items or formats to assess multicultural competence in larger systems, such as families. This point relates directly to the utility of using vignettes to measure multicultural case conceptualization ability. Using a vignette of a couple or a family (versus only an individual client) could expand the assessment of multicultural competence to include working with multiple clients.

Significance of the Current Study

The purpose of this study was to build upon previous research examining multicultural case conceptualization ability (MCCA) as an observable measure of multicultural counseling competence (Bromley, 2004; Constantine, 2001a; Constantine, 2001b; Constantine & Ladany, 2000; Ladany et al., 1997). Constantine, Ladany, and colleagues have developed an observable measure of multicultural competence by
evaluating the degree to which trainees incorporate multicultural information into
etiology and treatment conceptualizations of case vignettes (Constantine & Ladany,
2000; Ladany et al., 1997). By focusing on observable behavior in analogue research,
investigators have a greater likelihood of tapping into a more proximal and ecologically
valid dimension of multicultural counseling competency.

The intent of the current research was to address previous methodological
limitations in the assessment of multicultural case conceptualization ability and to
examine how the MCCA task, in comparison to traditional paper-and-pencil measures, is
related to training.

Methodological limitations of previous research include restricting the
investigation of multicultural case conceptualization ability to counselors’ work with
individual clients, focusing primarily on things that enhance MCCA, only using clients of
color in the vignettes, and considering the influence of social desirability as a one-
dimensional construct. This study expanded upon prior theory-driven research
investigating multicultural case conceptualization ability by: 1) employing vignettes that
make reference to couples counseling versus individual counseling; 2) specifically
examining those factors (e.g., racial privilege) in trainees that detract from their ability to
conceptualize, in a culturally sensitive manner, issues in couples therapy; 3) testing the
stimulus value of race by examining two vignette conditions (European American and
African American); and 4) using a multidimensional measure of social desirability.

Due to a lack of correspondence in previous literature between self-report and
observer-report methods of assessing multicultural counseling competence (see
Constantine & Ladany, 2000), this study also sought to examine how the MCCA task performs as a method of assessment compared to a self-report measure of multicultural counseling competence by investigating the relationships between these two measures and multicultural training and clinical experience variables.

The general research questions that were examined in the study include the following: 1) Do the multidimensional components of social desirability relate to self-reported multicultural counseling competence, multicultural case conceptualization ability, or color-blind racial attitudes? 2) Are multicultural case conceptualization ability and self-reported multicultural counseling competency related? 3) Are color-blind racial attitudes related to multicultural case conceptualization ability after controlling training? 4) How are multicultural training and clinical experience variables related to multicultural case conceptualization ability and self-reported multicultural counseling competence? and 5) Does the race of the client influence multicultural case conceptualization ability?

The outcomes of this study contribute to a growing body of research on observed multicultural counseling competence in both counseling psychology and MFT. One criticism of multicultural training has been that many training approaches focus too much on attaining knowledge and not enough on developing skills (Carter, 2001). Through clinical vignettes, this study provides an assessment tool for measuring trainees’ application of cultural competence. In addition, by using couples in the vignette, we were more accurately able to measure multicultural counseling competence in the full range of
therapeutic approaches that counseling psychologists and counseling psychology trainees are actually employing.

A meta-analytic review of the multicultural education literature revealed that 65% of the outcome studies were associated with counseling or counseling psychology, and the authors indicated that information about the effectiveness of multicultural education in other disciplines is needed (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006). By drawing on the distinctive strengths of counseling psychology’s proficiency in multicultural research, this study provides that needed information by examining multicultural counseling competence in MFT.

Results of this study also contribute to a body of literature that will help programs evaluate their goal of providing multicultural training. Clients express greater satisfaction, disclose more deeply, and are more willing to return to counseling when counselors are culturally responsive (Atkinson & Lowe, 1995). Ultimately, when programs and professions can have confidence that the multicultural training they are providing to their trainees is effective, clients will benefit.
CHAPTER II
LITERATURE REVIEW

Introduction

Multiculturalism and diversity represent strongly held values within the field of counseling psychology (Howard, 1992). As a result, the specialty has made countless efforts and a great deal of progress over the years to address these issues within research, practice and training (Heppner et al., 2000). Conceptual models (e.g., Atkinson, Thompson, & Grant, 1993), multicultural counseling competencies (e.g., Sue, Arredondo, & McDavis, 1992), multicultural guidelines (APA, 2003), and practical interventions (e.g., Coleman, 1997) are just some examples of the many ways in which counseling psychologists are working to realize these values. Counseling psychologists have emerged as leaders in developing multicultural training in counseling psychology, the larger field of psychology, and in other disciplines (Quintana & Bernal, 1995; Constantine et al., 2001), and in particular, counseling psychologists have lead the way in constructing instruments to be used to assess multicultural counseling competence.

The current study represents the continuing attempt to appraise and refine the measures being developed to assess counseling psychology trainees’ multicultural counseling competency. The purpose of this chapter is to review the literature in order to substantiate an extension of the work of Constantine, Ladany, and colleagues on multicultural case conceptualization ability (Constantine, 2001b; Constantine & Ladany,
trainees’ multicultural counseling competency development (e.g., training, color-blind racial attitudes).

With respect to organization of the chapter, first, the intersections among counseling psychology, multicultural psychology, and marriage and family therapy are examined. Next, the history and development of multicultural counseling competencies within counseling psychology are addressed, followed by a review of the development of self-report instruments to measure these constructs. Within this section, a review of the literature on multicultural case conceptualization ability as an additional method of measuring multicultural counseling competencies is also explored; methodological limitations of this research are emphasized. The impact of training variables on multicultural counseling competence is addressed. Theory and research on color-blind racial attitudes are examined as a variable that influences trainee multicultural counseling competencies. As well, multidimensional social desirability is examined for its effects on multicultural counseling competence and color-blind racial attitudes. Throughout, theoretical and empirical literatures are used to support the rationale for this study.

Intersections Among Counseling Psychology, Multiculturalism, and Marriage and Family Therapy

Counseling Psychology and Multiculturalism

Counseling psychology has a history of responding to sociodemographic changes in the United States and addressing the needs of underserved populations. The specialty is recognized as first addressing ethnic and racial issues at the Greystone Conference in
1964 (Quintana & Bernal, 1995). Recommendations arising from numerous conferences on training in the 1960s, 1970s, and 1980s called for educators to attend to training in multicultural counseling (Hills & Strozier, 1992). In the 1990s, increased commitment to multicultural issues, especially training, was evident, and academic programs in counseling psychology began to incorporate more multicultural training into their curricula. The central role of multiculturalism in counseling psychology is reflected in the latest summaries of the field and predictions for the future of the specialty (Heppner et al., 2000; Neimeyer & Diamond, 2001). Several recent investigations of training programs also provide information on the present status of multicultural training in counseling psychology.

Hills and Strozier (1992) surveyed the training directors of 61 APA-accredited counseling psychology programs to ascertain how multicultural issues were being integrated into training. Of the 49 programs that responded, 87% of these programs offered at least one course on multicultural issues, 59% required a multicultural course, and 45% offered a multicultural subspecialty. Thirty-four of the 49 respondents evaluated multicultural issues as more important than in previous years. An important limitation of this study is that only one person in each program filled out the survey and therefore, the findings may not accurately represent the total multicultural activity of the programs.

Constantine, Ladany, Inman, and Ponterotto (1996) surveyed 168 doctoral students in APA-accredited counseling psychology training programs using the Multicultural Competency Checklist (MCC; Ponterotto, Alexander, & Greiger, 1995) to evaluate their programs’ multicultural training. Most students perceived that their
programs had at least one required multicultural counseling course, used diverse teaching strategies and evaluation methods, and had some faculty whose primary research area was in multicultural issues. Weaknesses of the programs perceived by students included a lack of bilingual faculty; a lack of support, leadership, space, and resources for multicultural issues; and an absence of reliable and valid assessment measures of multicultural competency. Additionally, fewer than half of the students perceived multicultural issues as being integrated into all coursework. Limitations of this study include potential sample bias, representation of only those programs that replied, possible unawareness by students of their programs’ multicultural efforts, and limited responses because the MCC focuses primarily on racial/ethnic diversity issues and not other diversity variables.

In 1999, Constantine and Gloria surveyed internship training directors from predoctoral internship sites; about 60% of the sites responded. Participants were asked to assess the degree to which multicultural issues were addressed in their programs. The programs were perceived to be most attentive to multicultural issues through recruitment of racially/ethnically diverse staff and interns, integration of multicultural issues into all curricula, conceptualizing and using treatment strategies that are culturally sensitive, a required seminar on multiculturalism, and supervision. Areas of perceived weakness included a lack of requirements for interns to have taken at least one multicultural course and to carry a designated percentage of diverse clients, low percentages of diverse and bilingual staff and interns, not implementing assessment strategies to measure interns’ multicultural competence, no research productivity on multicultural issues, and a lack of
leadership and support for multicultural issues. Training directors at university counseling centers reported significantly more attention to multicultural issues than did training directors at state hospitals, community mental health centers, or private psychiatric hospitals. Some potential limitations of this study are that the responses cannot be interpreted as representative of all internship training directors or of other colleagues in the internship, and the training directors may have provided socially desirable responses.

Overall, the results of these surveys indicate that multiculturalism is being increasingly addressed in the training of counseling psychologists. By attending to the environmental context, particularly culture, counseling psychology has distinguished itself from other disciplines in psychology (Quintana & Bernal, 1995). This attention to context overlaps with a systemic perspective in marriage and family therapy.

Counseling Psychology and Couples Therapy

Historically, there has been some resistance to accepting marriage and family therapy concepts into the field of psychology. Berger (1988) explains why:

“Traditionally, the major conceptual unit and research in psychology has been the individual, isolated from his or her context (Bronfenbrenner, 1979; Berger & Berger, 1985; L’Abate & Thaxton, 1983). Family or systemic therapy, which conceptualizes problems as occurring between people (in units as small as two, but usually larger) and suggests that behavior in living systems cannot accurately be reduced to either individual perception or individual behavior (Scheflen, 1978, 1980; Spiegel, 1971), threatens the entire conceptual and research tradition of
psychology as a discipline. The acceptance of family therapy theory as a way of thinking in psychology would require changes in psychologists’ basic unit of conceptualization, in their ideas of generally appropriate research methods and questions, and in their thinking about what sort of discipline-important knowledge it is appropriate to impart to students training to become members of the profession. Jay Haley (1975) noted years ago that changes of such magnitude tend also to involve changes in status and definitions of competence within the discipline, and therefore rarely occur easily, if at all.” (pg. 304-305).

Yet the field of psychology has found a way to embrace this approach. The Division of Family Psychology (43) of the American Psychological Association was developed in 1984 as a way to integrate marital and family therapy into psychology. The Journal of Family Psychology was created in 1987 as an outlet for empirical research in couples and family therapy. Finally, family psychology was recognized as a specialty by the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) in 2002.

Marital and family therapy has also been an important part of counseling psychology. For example, of the total membership of the Division of Family Psychology, 16.8% are counseling psychologists (APA, 2004). Counseling psychologists’ increasing interest in couples and family work echoes the discipline’s developmental and systemic perspectives, as well as its concern with person-environment fit (Friedlander & Tuason, 2000). This is evident in the definition of counseling psychology that outlines our philosophy and scope of duties.
Definition of counseling psychology. Specialty recognition elucidates the distinct patterns of education, training, and practice that are found among professional psychologists. Throughout psychology’s history, there has been debate as to whether psychology is a unitary profession or one that has a common foundation of knowledge from which different professional practices are derived. Eventually, in February of 1995, the American Psychological Association (APA) established the Commission for the Recognition of Specialties and Proficiencies in Professional Psychology (CRSPPP) to implement the process of recognizing specialties. Although counseling psychology’s history has been dated back to as early as 1908 (Whiteley, 1984), in February of 1999, counseling psychology was officially recognized as a specialty by CRSPPP. The most current official description of counseling psychology is found in the American Psychological Association’s (APA) archival definition of the specialty of counseling psychology:

Counseling psychology is a general practice and health service provider specialty in professional psychology. It focuses on personal and interpersonal functioning across the lifespan and on emotional, social, vocational, educational, health-related, developmental and organizational concerns. Counseling psychology centers on typical or normal developmental issues as well as atypical or disordered development as it applies to human experience from individual, family, group, systems, [italics added] and organizational perspectives. Counseling psychologists help people with physical, emotional, and mental disorders improve well-being, alleviate distress and maladjustment, and resolve crises. In addition,
practitioners in this professional specialty provide assessment, diagnosis, and

In this definition, family, group, and systems perspectives fall within a counseling
psychologist’s parameters of practice. The link between counseling psychology and
couples and family therapy can also be found in students’ interests, professionals’ work
behaviors, training, and research.

Student interest. Counseling psychology students have expressed an interest in
working with couples and families. Schneider et al. (1988) surveyed 41 training directors
of APA-accredited counseling psychology programs. Directors rated their perceptions of
the adequacy of their training program and reported their perceptions of the strength of
their students’ career interests on 9-point Likert scales. Respondents rated students’
interest in marital and family counseling second out of twenty items, only behind socio-
emotional counseling. Their assessment of training effectiveness in marital and family
counseling was lower than students’ interest in marital and family counseling, ranking
sixth. A limitation of this study is that it only offers the perspective of training directors.

Fitzgerald and Osipow (1988) sampled 210 counseling psychology graduate
students in their first, second, and third years of graduate training in fifty-eight programs
regarding their desired job after graduation, the work behaviors in which they would like
to engage, and the perceived importance and salience of those work behaviors for
professional identity. They received a 97% institutional response rate and a 58%
individual response rate. They found that 82.6% of the sample indicated a desire to do
couples and family counseling. This work behavior tied for a rank of fourth out of 64
desired work behaviors. Couples and family counseling also ranked third out of 64 work behaviors in terms of importance and salience to professional identity. These findings clearly indicate a strong interest in conducting couples and family therapy among counseling psychology trainees. Given that these studies (Fitzgerald & Osipow, 1988; Schneider, Watkins, & Gelso, 1988) were conducted nearly twenty years ago, it would be useful to obtain more current information on students’ interests and training in couples and family therapy. A limitation of the Fitzgerald and Osipow (1988) study is that what students say they want to do does not always reflect what they end up doing; therefore, it is also important to examine professionals’ work behaviors.

Work behaviors. Many counseling psychologists are currently involved in working with couples and families. Birk and Brooks (1988) surveyed a random sample of 300 recent counseling psychology graduates who were members of Division 17 of the American Psychological Association (APA) and received a 72% response rate with 183 usable questionnaires. They had respondents indicate on a 7-point Likert scale which competencies were important for successful job performance and the extent to which their doctoral program provided sufficient training. From a list of 34 activities and competencies, marriage and family counseling ranked eighth in importance for effective job performance. The authors found that 73% of the total sample indicated marriage and family counseling was an important job activity. Of those 73%, only 57% reported that their training in marriage and family counseling had been adequate. Birk and Brooks also examined several subgroups of the sample. When comparing graduates of APA-accredited programs with those of nonaccredited programs, there were no significant
differences in the ratings of importance of job activities. However, the nonaccredited
group rated the adequacy of their training as significantly higher for marriage and family
counseling. Upon comparing academic and direct service personnel, the direct service
group rated as significantly more important marriage and family counseling; there were
no differences in reported adequacy of training. One limitation of this study is that
counseling psychologists who are not Division 17 members may be working in jobs
requiring a different set of competencies. Another potential limitation is that the
questionnaire may have omitted some items crucial for job performance.

Fitzgerald and Osipow (1986) surveyed a selection of members of Division 17 to
investigate the actual work behaviors of the members, the amount of time spent in those
behaviors, the importance of work behaviors to good job performance, and the work
behaviors considered central to their professional identity. They found that 58.4% of
respondents engaged in couples and family counseling. Out of 64 work behaviors,
couples and family counseling ranked 7\textsuperscript{th} in importance to good job performance, 6\textsuperscript{th} in
centrality to professional identity, and 9\textsuperscript{th} in terms of the relative time spent doing the
activity. Additionally, younger division members were engaged in significantly more
couples and family counseling than were older division members.

Watkins et al., (1986) randomly surveyed 980 members of Division 17 examining
variables of demographics, professional activities, institutional affiliation, and training
satisfaction, resulting in 716 usable questionnaires. The authors found that 74% of the
sample of counseling psychologists engaged in the practice of psychotherapy, and of this
subgroup, 64.6% conducted marital therapy and 43.7% conducted family therapy.
Although the majority of time was spent in individual therapy (67.9%), marital and family therapy combined to represent a sizeable percentage (20.6%) of the time spent in therapy.

Training. Two of the previously mentioned studies (Birk & Brooks, 1988; Schneider et al., 1988) suggested that training in couples and family therapy for counseling psychologists is not adequate. The degree to which academic programs expose trainees to couples and family therapy can vary from no exposure to various combinations of theoretical and practical experiences (Ribordy, 1987). Solomon, Ott, and Roach (1986) surveyed predoctoral internship programs in psychology to examine the degree of training available in marriage and family therapy by sending a short questionnaire to internship site directors. With a 47% response rate, three-fourths of the sites reported that interns could engage in marital and family therapy training the entire year, and internship site directors estimated that 13.8% of an intern’s time was devoted to marriage and family training. The authors concluded that the quantity and quality of marital and family training available to psychology interns was “relatively insufficient” when contrasted with the interest in this approach and the need for these services.

Some counseling psychology doctoral programs, such as the one at Texas Woman’s University, integrate family psychology into the curriculum. Nutt (2005) indicated that the combination of family psychology and counseling psychology works well because both stress normal growth and development and the significance of context, serve many populations, and use science to inform practice. Thus, the degree to which programs provide substantial education and training in couples and family therapy
appears to vary greatly, and although students are clearly interested in conducting couples and family therapy, the provision of such training is generally lacking.

Research. The profession of marriage and family therapy has historically been rich in theory. The very foundations of MFT, such as the dynamic, systemic nature of change, challenged the traditional scientific methodology that typically focused on cause and effect and single variables. Early theorists openly expressed reservations as to whether these traditional empirical methods could inform such a multidirectional process (Sexton, Alexander, & Mease, 2004). However, later comprehensive analyses of the existent empirical literature (e.g., Gurman & Kniskern, 1981) clearly illustrated that conventional research methodology had a lot to contribute to the understanding of these multifaceted processes and confirmed that MFT was effective.

Psychology, on the other hand, has traditionally possessed the most interest and developed skills in research in the mental health field and is in a unique position to contribute significantly to research in marriage and family therapy. Psychologists have been great contributors to the theory, research, and journals of behavioral marriage and family therapy (Berger, 1988). In addition, much of the research to support the efficacy of marriage and family therapy is conducted by professionals in disciplines outside the formal realm of MFT, including psychology (Pinsof & Wynne, 1995). Psychologists have also contributed increased methodological rigor to the field of marriage and family therapy. Berger (1988) claimed that “much of the conceptually and methodologically sophisticated empirical research to date in family therapy…has been conducted by members of our profession” (pg. 312). Counseling psychologists in particular are
contributing to the research in marriage and family therapy by investigating multiculturalism (e.g., Constantine et al., 2001; Inman, 2006).

Summary. Couples and family therapy are an important component to counseling psychology. Students have expressed interest in this modality of therapy (Fitzgerald & Osipow, 1988; Schneider, Watkins, & Gelso, 1988) and counseling psychologists in the field are practicing this approach (Birk & Brooks, 1986; Fitzgerald & Osipow, 1986; Watkins, Lopez, Campbell, & Himmell, 1986). Counseling psychology students are being given various opportunities for training (Nutt, 2005) and counseling psychology researchers are contributing to the literature in couples and family therapy (Constantine et al., 2001). Because one important area of contribution surrounds multicultural issues, an examination of diversity issues in the marriage and family therapy literature is warranted.

Marriage and Family Therapy and Multiculturalism

McGoldrick (1982) was one of the first scholars to focus attention on culture and ethnicity as a fundamental influence on the structures and interactional styles of couples and families. The field of marriage and family therapy has evolved through several phases in its attention to multicultural issues, including: 1) the traditional, universalist perspective of the 1960s and 1970s where racism and sexism were not considered relevant; 2) the gender perspective, which challenged sexism in the field; 3) the cultural perspective, which involved including culture as a special feature of some families; and finally, 4) a perspective in which all families are seen as embedded in culture. This last phase is described more as a vision than a current reality (McGoldrick, 1998). In the last decade, the literature in family therapy reflects increased investigation into multicultural
issues. Scholars have written about the characteristics, strengths, and values of specific populations (e.g., McGoldrick, Giordano, & Pearce, 1996), and guidelines for working with diverse families have been created (Bean, Perry, & Bedell, 2001, 2002). Hardy and Keller (1991) found that increased emphasis on cultural diversity and the recruitment of minority students was third among nine emerging trends in marital and family education.

A study by Killian and Hardy (1998) examined the representation of racial/ethnic minorities and minority issues in the American Association for Marriage and Family Therapy conference programming from 1980 to 1996 and found that the percentage of minority programs rose from 0% in 1980 to 6.28% in 1996. However, only 3% of AAMFT members in 1994 identified themselves as ethnic minorities, and only 2 minority persons over the past 17 years acted as speakers at conference plenaries and general sessions. This suggests an increased interest in multicultural issues in the field of marriage and family therapy, but the racial composition of the AAMFT and its leaders continues to reflect the European American majority. Perhaps it is not surprising then that the field has not yet reached a consensus on how to deal with multicultural issues.

A debate surrounding the importance of and approach to ethnicity in the marriage and family therapy field continues today. Overall, family therapists have taken one of four positions on the incorporation of cultural variables: 1) universalist, in which families are viewed as more alike than different; 2) particularist, in which each family is viewed as unique; 3) ethnic-focused, which assumes that diversity is due primarily to ethnicity; and 4) multidimensional, which seeks a comprehensive definition of culture that includes numerous contextual variables (Falicov, 1995). A large number of scholars assert that
understanding cultural variables is crucial to working effectively with families and that therapists who are unaware of these variables may actually damage the therapeutic process (e.g., Hardy & Laszloffy, 1992). However, a sizable minority of other authors point to the difficulty of learning about all ethnic groups and cite a concern for overestimating ethnic differences to the exclusion of other important variables (Nichols & Schwartz, 1998). This group argues that successful therapeutic outcomes are more related to therapeutic skill than information about various cultures (Haley, 1996).

These divergent views of ethnicity in family therapy are reflected in a recent study conducted by Nelson, Brendel, Mize, Lad, Hancock, and Pinjala (2001). They interviewed 29 leading family therapists (26 were European American) regarding their views about ethnicity and family therapy. Overall, the results suggested diverse and frequently contradictory perspectives. They found that most interviewees believed ethnicity to be important to all families, but some participants indicated that a focus on ethnicity could be limiting and believed it is an error to routinely discuss race as a factor with clients. This group advocated a more global view that contends successful therapeutic skill development is key to positive outcome. The other group clearly focused on ethnicity as a distinct issue to be openly and specifically addressed in therapy. At this time, there exists very little outcome research to speak to this debate regarding how ethnicity issues are a factor in the success or failure of family therapy. The same could also be said about research on training in multicultural issues to inform what best prepares future therapists to work effectively with families. Until recently, the literature
on multicultural training in marriage and family therapy has been focused more on theory and experience rather than measurement development and outcome research.

*Training.* Some authors have proposed specific multicultural training techniques to be used in training programs. Kelly (1990) described a graduate practicum in multicultural counseling that uses required multicultural readings, examination of the trainees’ family of origin, interviewing families from various cultural groups, and working with clients from backgrounds different from their own to facilitate increased multicultural awareness. Arnold (1993) depicted a training exercise in which students form small groups and answer questions about their own families to facilitate cultural exploration. Other suggestions offered include using an ecological framework, providing both content and process experiences for trainees, increasing trainees’ ethnic self-awareness, and recognizing the impact of oppression on minority families. Hardy and Laszloffy (1995) described how the cultural genogram could be used to promote cultural awareness and sensitivity for trainees.

Other authors have critically examined the culture of training programs and how that impacts multicultural awareness. Hardy and Laszloffy (1992) examined some barriers in the curriculum (i.e., offering only one course on racial issues rather than infusing across the curriculum), the structural composition (i.e., underrepresentation of minority faculty and students), and the clinical components (i.e., lack of cross-racial contact with clients) of current training programs. They proposed that programs must not only attend to content to train racially sensitive therapists but also include introspection, multi-racial contact, and heightened racial self-awareness.
McDowell et al. (2002) offered a model that deals with the readiness, recruitment, retention, assessment, and professional development of students of color. McDowell et al. (2003) reviewed the efforts of a marriage and family therapy training program to create a deep commitment to racial sensitivity. McGoldrick et al. (1999) described the efforts of the faculty at the Family Institute of New Jersey to take into account cultural variables in their training program and as a result, modify their teaching, supervision, reading lists, and overall training approach. Although these descriptions, proposals, and models are important to the newly developing field of multiculturalism within marriage and family therapy, research on how to assess the impact of multicultural training is also crucial to inform program development.

Researchers have criticized the general lack of research in marriage and family therapy training and supervision (Kniskern & Gurman, 1988), in addition to the lack of research on multiculturalism and training. Arnold (1993) stated that the “training and supervision literature in family therapy does not reflect a widespread interest in the inclusion of ethnic awareness as a learning objective or as an essential skill for counselors in training to acquire” (p. 139) and recommended a research agenda that examines ethnicity as a dimension of training.

To assess the current status of multicultural training, Sierra (1997) surveyed directors of 122 accredited and nonaccredited MFT programs and received responses from sixty-two programs. Results indicated that all programs except one integrated multicultural content into existing coursework, 56% of the programs required students to take a multicultural course, 44% offered an elective course in multicultural issues, and
31% provided the option of a subspecialty in multicultural counseling. Accredited programs had fewer full-time minority faculty members.

Inman et al. (2004) surveyed 123 students (20% response rate) and 61 faculty (31% response rate) from 63 accredited MFT programs using the Cross Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise et al., 1991) and the Multicultural Competency Checklist (MCC; Ponterotto, Alexander, et al., 1995). Results revealed that faculty perceived more frequent integration of multicultural issues than students. Perceived multicultural strengths of programs included curriculum, counseling practice and supervision, and diverse research methods. Perceived multicultural deficits included minority representation at all levels of the program, primary research interests in multiculturalism, and competency evaluations. Perceptions of multicultural training were not significantly related to self-perceived multicultural competence. Limitations of this study include the possible contamination of social desirability in responses and the correlational design that does not allow for conclusions regarding the cause-effect relationship between training and competence.

In response to the need to further develop multicultural training, some authors have attempted to create multicultural training guidelines. Green (1998) proposed five programmatic elements necessary to prepare students for effective work with different cultural groups, including didactic training, sensitization, personal contact, supervised clinical experience, and hiring minority professionals in leadership positions in the program. Green then described 11 suggested guidelines to assist training programs in
transforming to meet these goals. One of these guidelines included evaluating students on their multicultural competencies.

*Multicultural counseling competence.* To date, only two studies have examined the multicultural counseling competence of marriage and family therapists and trainees. Constantine et al. (2001) randomly sampled 200 members of the American Association for Marriage and Family Therapy and received 113 usable questionnaires. Participants completed the Multicultural Counseling Knowledge and Awareness Scale (MCAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2000), the New Racism Scale (NRS; Jacobson, 1985), the White Racial Identity Scale (WRIAS; Helms & Carter, 1990), and the Marlowe-Crowne Social Desirability Scale (SDS; Crowne & Marlowe, 1960). Results indicated that through forced-entry multiple regression analyses controlling for social desirability attitudes and the number of multicultural courses taken, racism and White racial identity attitudes together accounted for a significant amount of variance in self-report multicultural counseling knowledge and awareness. A serious limitation of this study is that previous research has shown a lack of a significant relationship between self-report and observer-rated multicultural counseling competence (Constantine & Ladany, 2000), and therefore this study may be measuring anticipated rather than actual multicultural competence.

Inman (2006) randomly surveyed 147 marriage and family therapy trainees, obtaining a 22.6% response rate. Participants completed the Supervisor Multicultural Competence Inventory (SMCI; Inman, 2005) to have the trainees rate their perception of their supervisor’s multicultural competence, the Working Alliance-Trainee Version
(WAI-T; Bahrick, 1990) to measure trainees’ perceptions of the supervisory working alliance, the Supervision Satisfaction Questionnaire (SSQ; Ladany, Hill, Corbett, & Nutt, 1996), and a multicultural case conceptualization ability task. Results suggested that perceived supervisor multicultural competence, the supervisory working alliance and supervision satisfaction were all positively related, and the supervisory working alliance was a significant positive mediator between perceived supervisor multicultural competence and supervision satisfaction. Perceived supervisor multicultural competence was not related to trainee treatment conceptualization ability and had a negative relationship with trainee etiology conceptualization abilities.

The author offered several possible explanations for this surprising finding. It may be that other variables not assessed (such as self-awareness and self-efficacy) influenced conceptualization ability. The sample was primarily developmentally in the early stages of training and therefore may have been looking for concrete strategies rather than insights into conceptualizations. The means for multicultural case conceptualization ability were low and suggest a limited range. Additional limitations of this study are that all variables were assessed only from the trainee’s perspective, the instrument used to assess supervisor multicultural competence (the SMCI) was developed through this study, and limited validation data exists.

**Summary.** Recently, the literature in marriage and family therapy has increasingly investigated multicultural issues. Scholars have studied specific populations, created guidelines for working with diverse families, and examined racial/ethnic representation in educational and professional affiliation (Bean, Perry, & Bedell, 2001; Hardy & Keller,
1991; Killian & Hardy, 1998; McGoldrick et al., 1996). Specific training techniques have been proposed, the culture of training programs has been examined, and models have been proposed to recruit and retain students of color (Hardy & Laszloffy, 1992; Kelly, 1990; McDowell et al., 2002). However, further empirical research on how to best assess multicultural competence when working with couples and families is needed, and a review of the history and literature on multicultural counseling competence will help provide a context for the current study.

**Defining and Assessing Multicultural Counseling Competence**

**Multicultural Counseling Competencies**

The foundation for the recent multicultural counseling movement was laid through the 1960s and 1970s with a few authors making allusions that psychologists were failing to meet the mental health needs of ethnic minority populations (Atkinson & Israel, 2003). Yet it was not until the Education and Training Committee of Division 17 of the American Psychological Association (APA) published a landmark article in 1982 that identified 11 knowledge, attitude, and skill competencies necessary to work effectively with culturally diverse clients (Sue et al.) that the groundwork was established for the development of multicultural counseling competencies.

Sue et al. (1982) asserted that a cross-cultural perspective in counseling was needed because empirical research indicated that the current research methods and mental health practices were not always appropriate for all minority groups. The authors defined cross-cultural counseling as “any counseling relationship in which two or more of the participants differ with respect to cultural background, values, and lifestyle” (p. 47).
Although they acknowledged that all counseling is “slightly cross-cultural” (p. 47), they argued that the focus should be on racial/ethnic minorities due to a lack of consideration of these worldviews leading to a failure to meet the mental health needs of these populations. The ambiguous definition of culture as inclusive or exclusive has created a debate that continues today.

Sue et al. (1982) recognized the need to incorporate cross-cultural counseling competencies into training programs and developed guidelines to this end. The guidelines characterized the construct of multicultural counseling competency to be composed of beliefs/attitudes, knowledge, and skills of one’s own cultural group and other cultural groups. The 11 broad areas of competency were too general to interpret and implement effectively (Constantine & Ladany, 2001). Yet because no empirical or conceptual framework for multicultural counseling existed at that time, the field embraced the guidelines and accepted them as valid. This acceptance of the initial foundation without empirical validation has had wide-reaching effects on the field (Atkinson & Israel, 2003).

In an attempt to further articulate the original conceptual framework, Sue et al. (1992) expanded the list of multicultural counseling competencies to 31 knowledge, attitude, and skill competencies. Although these competencies attempted to be inclusive of other cultural variables, they clearly referred to four primary minority groups in the United States: African Americans, Asian Americans, American Indians, and Latina/os Americans. The reasoning for creating a more narrow definition of cross-cultural counseling was to not dilute the focus on racial/ethnic groups so that these populations get ignored. The authors argued that “universal” and “focused” approaches to
multiculturalism are not inevitably contradictory and both can bring richness to the field. Yet, the authors chose to focus their guidelines on working with racial/ethnic minority groups.

Sue et al. (1992) argued that the counseling profession needed a multicultural perspective due to the increasing diversification of the United States, the historically monocultural nature of training, the sociopolitical realities of racism and oppression by majority and minority cultures, and the ethical responsibility counselors have to be competent when working with clients. The authors used the position paper of Sue et al. (1982), the *Guidelines for Providers of Psychological Services to Ethnic and Culturally Diverse Populations* (APA, 1991), and the three dimensions of the culturally competent counselor described by Sue and Sue (1990) to identify their cross-cultural counseling competencies. Sue et al. (1992) divided the competencies into a 3 x 3 matrix of characteristics and dimensions. The dimensions included beliefs and attitudes, knowledge, and skills, while the characteristics included the counselor’s awareness of self, understanding the worldview of culturally different clients, and implementing appropriate intervention strategies and techniques. A list of the important competencies for each area within the matrix was developed. The authors concluded their proposal with a call for the integration of multiculturalism into education, research, and practice.

Although the multicultural counseling movement did not begin to truly take off until the mid-1990s, the success of the multicultural counseling competencies can be seen in their incorporation into accreditation standards and ethical codes (Atkinson & Israel, 2003). The most recent example of their influence is evident in the passage of the
“Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists” (APA, 2003). Multicultural counseling competencies have largely impacted the field of counseling psychology and the wider profession of psychology. The competencies have also been cited as the foundation for multicultural competency in other disciplines (Green, 1998).

This is not to imply that the competencies developed by Sue and colleagues have been without criticism. Scholars have critiqued the theoretical and practical limitations of the model (Constantine & Ladany, 2001; Vera & Speight, 2003; Weinrach & Thomas, 2002) as well as the methodological problems and lack of empirical support (Atkinson & Israel, 2003; Weinrach & Thomas, 2002).

Sue et al. (1982; 1992) called attention to the debate regarding whether to focus the competencies on racial and ethnic differences or to include other cultural variables such as age, gender, socioeconomic status, sexual orientation, and ability status. Sue and colleagues decided to conceptualize the multicultural competencies as centering on racial/ethnic groups in the United States to avoid becoming too broad. Weinrach and Thomas (2002) criticized Sue et al. for this decision, citing that selecting a few groups for the profession to focus on excludes and demeans other clients and is incompatible with the counseling profession. Although many scholars likely disagree with Weinrach and Thomas’s proposition that the emphasis on race is outdated, this argument highlights the difficulty of balancing inclusiveness with the recognition of power disparities in the multicultural counseling competencies model.
Another criticism was levied by Constantine and Ladany (2001). They argued that the competencies were incomplete and proposed an alternative conceptualization of the competencies model that included “common factors” along with culturally specific information. Fischer, Jome, and Atkinson (1998) proposed that culturally relevant information could be considered within each of the common factors identified by previous research as leading to therapeutic effectiveness, including the therapeutic relationship, the shared worldview of the therapist and client, meeting the client’s expectations about therapy, and therapeutic interventions that both the therapist and client perceive as useful. Constantine and Ladany’s (2001) expanded conceptualization included six dimensions: (1) counselor self-awareness, (2) general knowledge about multicultural issues, (3) multicultural counseling self-efficacy, (4) understanding unique client variables, (5) an effective counseling working alliance, and (6) multicultural counseling skills (p. 490). They proposed that achieving competence in these areas would be an ongoing, lifelong process.

Vera and Speight (2003) criticized Sue et al.’s (1982; 1992) model for assuming that testing and psychotherapy are the primary methods for working with racial/ethnic populations. They faulted the competencies for not attending to social justice and propose that they be used to help counselors be advocates of social change by becoming involved outside the therapy room to remove oppression. They also note that the competencies take a remedial approach rather than one of prevention.

These criticisms (Constantine & Ladany, 2001; Vera & Speight, 2003; Weinrach & Thomas, 2002) of the tripartite model developed by Sue and colleagues (1982; 1992;
1998) are important in helping the field to continue to develop a robust knowledge base. However, Atkinson and Israel (2003) argued that the field must move from theoretical formulations and begin to develop a strong empirical foundation for the multicultural counseling competencies. They noted that the 31 competencies, although widely accepted, are merely hypotheses. Therefore, in order for the multicultural counseling competencies to survive in the current climate of empirically supported treatments (ESTs), they must be empirically tested. The Sue et al. model has formed the basis for the development of instrumentation and for empirical testing,

*Operationalization of Multicultural Counseling Competencies*

The Sue et al. (1982, 1992, 1998) tripartite model of multicultural counseling competence has served as the theoretical foundation for instrumentation developed to measure self-reported multicultural counseling competencies (Ponterotto, Fuertes, & Chen, 2000). Even though a number of additional comprehensive conceptual models of multicultural counseling exist (e.g., Atkinson et al., 1993; Fischer, Jome, & Atkinson, 1998), they have not received the same attention in terms of operationalization. The following self-report scales have been developed with the intention of evaluating students’ movement toward multicultural counseling competence. Even though this group of measures is still considered to be in the early phases of development and validation (Ponterotto, Fuertes, & Chen, 2000), they have been subject to wide use. Four of the most commonly used instruments include: the Multicultural Awareness-Knowledge-Skills Survey (MAKSS; D’Andrea et al., 1991; Kim, Cartwright, Asay, & D’Andrea, 2003); the Multicultural Counseling Inventory (MCI; Sodowsky et al., 1994); the revised
Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002), and the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFramboise, Coleman, & Hernandez, 1991), which was initially developed as an observer-report instrument but has been modified to also be used as a self-report instrument (Constantine & Ladany, 2000).

Criticism of self-report measures. This collective group of measures has been subject to a number of critical reviews, and concerns about the psychometrics of these measures have been raised (Constantine & Ladany, 2001; Ponterotto, Rieger, Barrett, & Sparks, 1994; Pope-Davis & Dings, 1994, 1995). Current research in this area continues to attempt to address some of these problems. To understand the strengths and weaknesses of these measures and to illustrate the difficulties in assessing multicultural counseling competence, research of interest to these issues is reviewed.

Research has suggested that socially desirable responding may contaminate the responses on self-report measures of multicultural counseling competence (Constantine & Ladany, 2001). Constantine and Ladany (2000) investigated the relationship between social desirability and four self-report measures of multicultural counseling competence. The authors had 135 bachelor’s-level, master’s-level, and doctoral-level counselors complete the CCCI-R (LaFramboise et al., 1991), the MAKSS (D’Andrea et al., 1991), the MCI (Sodowski et al., 1994), the MCKAS (Ponterotto et al., 1999), the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960), and a measure of multicultural case conceptualization ability. They found that higher MCSDS scores were significantly positively related to higher self-report ratings on the CCCI-R, the MAKSS
Skills subscale, and the MCI Relationship subscale. They found no significant relationship between the MCKAS Knowledge subscale and social desirability, and they found a significant negative relationship between the MCKAS Awareness subscale and social desirability, suggesting that the MCKAS may be the least affected by social desirability. Constantine and Ladany (2001) recommend that social desirability be incorporated statistically into any future research using these scales. Also, because social desirability may be understood to be a multidimensional construct made up of self-deception and impression management according to Paulhus (1991), rather than the one dimension measured by the MCSDS (Crowne & Marlowe, 1960), it is important that future research investigate the relationship of both dimensions to self-reported and observed multicultural counseling competence.

The four commonly-used instruments to measure multicultural counseling competence according to the tripartite model (Sue et al., 1982; 1992) differ in their number of subscales, their names for the subscales, and their methods of assessment. For example: the MAKSS (D’Andrea et al., 1991) offers a three-factor model of knowledge, awareness, and skills; the MCI (Sodowsky et al., 1994) suggests both a four-factor model of knowledge, awareness, skills, and relationship and a higher-order general multicultural counseling factor; the revised Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002) presents a two-factor model of knowledge and awareness; and the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFramboise, Coleman, & Hernandez, 1991) offers a three-factor model of awareness, skill, and sensitivity. This indicates that although the instruments
have similar goals, they either may not be assessing the same constructs or may be measuring different aspects of the same constructs.

Some empirical research has demonstrated that the four instruments designed to measure multicultural counseling competence may not be measuring similar constructs (Pope-Davis & Dings, 1994, 1995). Pope-Davis and Dings (1994) compared the MCI (Sodowski et al., 1994) and the MCAS-B (Ponterotto et al., 1994) using a sample of 92 university counseling center interns. When examining the subscales individually, they had adequate internal consistency estimates ranging from .67 to .90. However, upon examining the intercorrelations among the subscales, the Awareness subscales of both instruments shared only 10% of their variance, and the MCI Awareness subscale shared 42% of the variance with the MCAS-B Knowledge/Skill subscale. The authors conclude that, although both purport to measure multicultural counseling competence, the two instruments appear to be assessing different constructs.

In another investigation, Worthington, Mobley, Franks, and Tan (2000) used the MCI (Sodowski et al., 1994) and the CCCI-R (Laframboise et al., 1991) to assess the multicultural counseling competence of 38 counselors and 17 counselors-in-training. Participants watched a tape of a simulated client and then completed the MCI, attribution scales, and a social desirability scale (MCSDS; Crowne & Marlowe, 1960). Independent observers judged the verbal responses of the participants to the counseling simulation and rated the participants on the CCCI-R. The majority of the correlations between the MCI and the CCCI-R were negative or near zero, and only 19.6% of the variance in observed multicultural counseling competence was accounted for by self-reported multicultural
counseling competence. The authors argued that this suggests that the MCI and the CCCI-R are measuring two considerably different constructs.

Due to problems discerning exactly what constructs these self-report instruments are measuring, many scholars have cautioned against using these instruments to evaluate students or professionals (Constantine & Ladany, 2001; Pope-Davis & Dings, 1995); however, the measures can be useful for gathering further validity evidence and assessing the tripartite model.

Another criticism levied is that the inventories measure anticipated rather than demonstrated multicultural counseling competence and that they may instead be tapping multicultural counseling self-efficacy (Constantine & Ladany, 2000; Pope-Davis & Dings, 1995). For instance, using a sample of 113 trainees, Ladany et al. (1997) found no relationship between the CCCI-R (Laframboise et al., 1991) and multicultural case conceptualization etiology \( (r = -.04) \) and treatment \( (r = .01) \) scores. This sample exceeded the suggested sample size of 70 based on a power analysis. The multivariate multiple regression analysis was not significant, so no follow-up analyses were carried out. In another study, Constantine and Ladany (2000), using a sample that varied from 133-135 participants, found few significant relationships (no \( r \) was higher than .22) between a measure of multicultural case conceptualization ability and the CCCI-R (Laframboise et al., 1991), the MAKSS (D’Andrea et al., 1991), the MCI (Sodowski et al., 1994), and the MCKAS (Ponterotto et al., 1999). The authors ran four overall multivariate multiple regression analyses while controlling for social desirability, with the self-report (sub)scales as predictor variables and the etiology and treatment ratings as criterion.
variables. The proportion of variance in etiology and treatment scores accounted for by each of the self-report scales was not significant (CCCI-R $\eta^2_m = .03$; MAKSS $\eta^2_m = .04$; MCI $\eta^2_m = .06$; MCKAS $\eta^2_m = .02$); thus, no follow-up analyses were run. An examination of the intercorrelations reveals that the subscales for multicultural skills did not have higher correlations with MCCA than knowledge, awareness, relationship, or total scale scores. This evidence indicates that these self-report measures are not assessing demonstrated multicultural counseling competence.

Some critics also have indicated concerns about the initial validation of the measures, such as inadequate sample sizes, biased sampling procedures, and the insufficient and questionable use of some statistical analyses (Bromley, 2004; Pope-Davis & Dings, 1995). All the measures seem to assume that multicultural competence is expressed in individual counseling interactions rather than in larger systems (Constantine & Ladany, 2001). Additionally, many of the studies using these instruments have not been replicated (Ponterotto et al., 2002). Scholars have called for additional psychometric testing and revisions of all the competency measures (Ponterotto, Fuertes, & Chen, 2000), and it is critical that continued research corroborates previous findings and enhances the foundation of measurement of multicultural counseling competencies.

Multicultural Counseling Knowledge and Awareness Scale (MCKAS). The MCKAS (Ponterotto et al., 2002) was chosen for this study as the self-report measure of multicultural counseling competence. Several considerations contributed to choosing the MCKAS over the MCI, the MAKSS, and the CCCI-R. The MCKAS is the least affected by social desirability of all the instruments and appears to be the most sound.
psychometrically (Constantine & Ladany, 2000; Ponterotto et al., 2002). The MCKAS has gone through several revisions as a result of previous research on the instrument (Ponterotto & Potere, 2003). It is of moderate length, which facilitates higher response rates (Ponterotto et al., 2002). The MCKAS has been used previously in two studies examining multicultural case conceptualization ability (Bromley, 2004; Constantine & Ladany, 2000). Finally, the MCKAS was used in the initial assessment of multicultural counseling competencies with marriage and family therapy trainees (Constantine et al., 2001), and using it in this study will help determine whether self-reported competencies as measured by the MCKAS are related to multicultural counseling competencies as measured by observer-ratings of multicultural case conceptualization ability.

One potential drawback is that the MCKAS does not have a subscale for skills, which one might expect to correspond with a skills-based assessment like the MCCA task; however, previous research (Constantine & Ladany, 2000) indicated that the skills subscales of the MAKSS and the MCI were not correlated any more highly with MCCA than knowledge or awareness subscales. Also, previous research (Pope-Davis & Dings, 1994, 1995) suggested that although some of the subscales share similar names between the instruments, they may not be measuring the same constructs. For these reasons, the lack of a skills subscale on the MCKAS did not appear to outweigh the benefits of choosing this self-report measure over the others.

The MCKAS items are grounded in Sue et al.’s (1982, 1992, 1998) multicultural counseling competency model. For the original MCAS, Ponterotto, Sanchez, and Magids (1991) used a rational-empirical approach to item development. Through a review of the
literature, they rationally developed 135 items, which were reduced to 70 items by checking for item clarity and by eliminating redundant items. These 70 items were then subject to three independent card sorts to assess if they could be classified according to the tripartite model. The card sorts resulted in only two categories: 42 Knowledge/Skills combined items, and 28 Awareness items. Five multicultural counseling experts then rated each of the items for clarity and domain appropriateness in an attempt to check for content validity; items were then reworded as necessary. Next, a focus group of 9 graduate students in counseling reacted to the scale and expressed concerns about the length of the instrument and social desirability. As a result, three social desirability items were added to the scale and, after item and factor analysis, the scale was shortened.

Ponterotto et al. (1996) tested the 70 items empirically through item and factor analysis. Upon a principal components analysis using varimax rotation, it was determined that 4 or fewer factors would lead to the best solution. Therefore, principal components analysis using oblique rotations was used to investigate 2-, 3-, and 4-factor extractions. The four-factor solution accounted for 37.6% of the common variance; the three-factor solution accounted for 33.3% of the common variance; and the two-factor solution accounted for 28% of the common variance. The authors chose the two-factor solution as the best factor structure because they found it to be the most interpretable and clear; in addition, it was consistent with the card sorts conducted earlier. This decision may be questionable given that the two-factor solution accounted for the least amount of variance. Item analysis led to the removal of 31 items, although the authors retained two
items that did not meet the inclusion criteria because they considered these items important to the construct.

The new version of the scale, now named the MCAS-B, was reduced to 45 items: 28 Knowledge/Skills items that assess general multicultural knowledge and familiarity with scholars in multicultural research; 14 Awareness items that assess a Eurocentric worldview bias of counseling; and 3 items tapping social desirability. Ensuing reliability studies resulted in a coefficient alpha of .93 for the total scale and coefficient alphas of .93 for Knowledge/Skills and .78 for Awareness. The correlation between the two subscales was .37, providing support for the two-factor model. Although Ponterotto et al. (1991; 1996) attempted to measure the three-dimensional model of multicultural counseling competence (awareness, knowledge, and skills), both rational and empirical procedures found that the items were best explained by a two-factor model of Knowledge/Skills and Awareness.

In an attempt to measure criterion-related validity, MCAS-B scores of the following groups were compared: 1) multicultural experts versus graduate students and practicing school counselors; 2) students with graduate-level multicultural training versus students with no graduate-level multicultural training; and 3) students who had worked with minority clients under supervision versus students with who had not (Ponterotto et al., 1996). The rationale for choosing these groups was not explained.

Results indicated that the expert group scored significantly higher than the students and school counselors on both subscales. Students with coursework in multicultural counseling did not significantly differ from students with no multicultural
coursework. Participants with supervision of work with minority clients scored significantly higher than those without supervision of work with minority clients only for the Knowledge/Skills subscale of the MCAS-B (Ponterotto et al., 1996). Ponterotto et al. (1996) also used these samples to examine the effects of race and sex given that previous research had suggested differences in multicultural counseling competencies on the basis of these variables (i.e. Pope-Davis, Dings, & Ottavi, 1995: Pope-Davis & Ottavi, 1994). Minority subjects (all minority groups were combined to achieve an adequate sample size of 32) scored significantly higher on the Knowledge/Skills subscale than White subjects. The difference in scores between men and women was not statistically significant (Ponterotto et al., 1996).

Additional criterion-related validity and construct validity were examined in two studies investigating the sensitivity of the MCAS-B in tapping changes resulting from taking a multicultural counseling course (Ponterotto et al., 1996). In the first study, the MCAS-B was administered on the first and last days of a multicultural counseling class taken by 19 graduate students. A significant increase in scores was found for Knowledge/Skills but not Awareness. Limitations of this study include a small sample size, a lack of a control group, and the course instructor acting also as the researcher. The second study addressed these concerns by including 3 samples: 8 students in a multicultural course, 30 students in a developmental psychology course (to serve as the control group), and 26 students enrolled in a multicultural course at another university. The MCAS-B was administered at the beginning and end of the semester. Results indicated that both groups of students in the multicultural classes had significantly higher
post-test scores on the Knowledge/Skills and Awareness subscales than those students in the developmental psychology course. Limitations of this study include a small sample size, lack of procedural consistency in collecting the post-test data, and the developmental course serving as only a partial control because the topic of multiculturalism was integrated to a degree into the curriculum. Overall, the authors suggested that these results support the content and construct validity of the MCAS-B measuring multicultural competence.

Convergent validity evidence was suggested by positive and significant correlations between the MCAS-B Knowledge/Skills subscale and the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise et al., 1991) and between the MCAS-B Awareness subscale and the New Racism Scale (NRS; Jacobson, 1985). Additionally, the subscales of the MCAS-B were not significantly correlated with social desirability (Knowledge/Skills $r = .22$; Awareness $r = .00$) as measured by the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960); however, the sample size of 45 graduate students resulted in insufficient power, creating inconclusive evidence that the MCAS-B is not contaminated by social desirability (Ponterotto et al., 1996).

The studies conducted by Ponterotto et al. (1996) provided some initial support for the MCAS-B’s reliability and content, construct, convergent, and criterion-related validity. Some limitations of these studies include small sample sizes (and therefore uncertainty about adequate power) and a lack of effect sizes reported. Additional studies have suggested criterion-related validity through positive correlations of the
Knowledge/Skills subscale with training variables (Kocarek, Talbot, Batka, & Anderson, 2001) and through gain scores in internship training programs (Manese, Wu, & Nepomuceno, 2001). Construct validity has been further suggested by expected relations between racial identity development and the MCAS-B (Vinson & Neimeyer, 2003). Yet a number of criticisms of the MCASB were raised, including: “(a) definitional clarity of the named subscales, (b) the inclusion of items that query knowledge of specific scholars in the field, (c) some weaker items (psychometrically speaking), and (d) the utility of the three-item social desirability cluster” (Ponterotto et al., 2002, p.157). Concerns about sample size were also raised (Ponterotto et al., 2002). As a result, Ponterotto et al. (2002) set out to revise the MCAS-B based on a larger sample.

The first study consisted of 525 students and professionals in counseling and counseling psychology. The scree plot and a principal components analysis with varimax rotation indicated a three-factor solution that accounted for 38.5% of the common variance. Factor 1 (knowledge/skills) accounted for 23.2% of the common variance; Factor 2 (awareness) accounted for 8.9% of the common variance; and Factor 3 (knowledge of leading well-published scholars in the multicultural counseling field) accounted for 6.3% of the common variance. Based on this analysis, the MCAS was revised. Items querying the respondents’ knowledge of specific scholars were removed, social desirability items were eliminated, and items with low communality estimates were removed. Factor 1 was renamed “Knowledge” to better reflect the content of the items, and the scale’s name was changed to the Multicultural Counseling Knowledge and Awareness Scale (MCKAS). The revised MCKAS is made up of 20 Knowledge items.
and 12 Awareness items (Ponterotto et al., 2002). Thus, the MCKAS appears to be measuring the knowledge and awareness components, and not the skills component, of the tripartite model.

The second study conducted by Ponterotto et al. (2002) was designed to test the goodness of fit of the two-factor model with a sample of 199 counselors-in-training, in addition to examining reliability and convergent, criterion-related, and discriminant validity. The coefficient alphas for the MCKAS Knowledge and Awareness subscales were both .85, and the correlation between the subscales was low (r = .04). Confirmatory maximum likelihood factor analysis was used to test three competing models (one global factor, two independent factors, and two correlated factors) against a baseline null model. Results suggested an unsatisfactory fit for any of the factor structures. Therefore, aggregate variables were created within each factor, which improved the fit for both of the two-factor models. The oblique and orthogonal fits for the aggregate models were basically the same, with goodness-of-fit indices, adjusted goodness-of-fit indices, and Tucker Lewis indices all at .85 or higher. The root mean square residual was .07 for both aggregate two-factor models. The authors suggest that the pattern of fit indices reveal a satisfactory fit for the two-factor models (Ponterotto et al., 2002).

Convergent validity evidence was indicated by expected correlations and medium effect sizes with the Multicultural Counseling Inventory (MCI; Sodowsky et al., 1994). The Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992) was used to examine criterion-related validity due to conceptual similarities between the two measures. The MEIM is made up of two subscales: Ethnic Identity and Other Group Orientation. The
MCKAS Knowledge scores were moderately and significantly correlated with MEIM Ethnic Identity scores ($r = .31$) but not with Other Group Orientation scores. The MCKAS Awareness scores did not correlate with any MEIM scores. The MCKAS Knowledge subscale did correlate significantly ($r = -.39$) with a measure of social desirability (MCSDS; Marlowe & Crowne, 1960) although the Awareness subscale did not.

Overall, the MCKAS demonstrated some degree of validity evidence, and Ponterotto et al. (2002) and Ponterotto and Potere (2003) suggest that it can be used appropriately for research purposes or as a pretest/posttest measure to evaluate training; however, continued psychometric concerns are evident, and for this reason, using the measure for individual decision-making is discouraged.

**Summary.** On the whole, all of the self-report, paper-and-pencil measures of multicultural counseling competencies have psychometric problems. Socially desirable responding appears to contaminate the results of several of the instruments, and the subscales of the instruments are not always correlated with each other in expected directions (Constantine & Ladany, 2000; Constantine et al., 2002; Pope-Davis & Dings, 1994). Constantine and Ladany (2001) suggest that self-report scales may be measuring expected behaviors rather than actual multicultural counseling competence, and as a result, they suggest using both self-report and observer methods of assessment.

**Case Conceptualization Skills**

Case conceptualization offers one possible method for observing counseling competence. Case conceptualization includes not only diagnosis but also the therapist’s
perception of how the client’s presenting problem is influenced by the client’s history, life experiences, context, and personality; in addition, it includes the interventions that are suggested by this understanding (Stoltenberg, McNeill, & Delworth, 1998). Multicultural case conceptualization, therefore, reflects trainees’ ability to take multicultural information into account in these etiological and treatment considerations.

*Multicultural case conceptualization ability.* Because respondents tend to overestimate their competence on self-report instruments (Constantine & Ladany, 2000), researchers have turned to observer ratings of multicultural counseling competencies in an attempt to improve measurement accuracy. One form of observer ratings that has gained increasing popularity is multicultural case conceptualization ability (MCCA; Constantine & Ladany, 2001), a means of evaluating multicultural counseling skills through written responses to case vignettes. Studies using this method have examined how respondents integrate and differentiate multicultural information into the etiologies and treatment strategies associated with a client’s presenting concerns. The intent of assessing multicultural case conceptualization ability is to observe how trainees demonstrate, as opposed to self-report, multicultural counseling competencies (Constantine & Ladany, 2000; Constantine & Ladany, 2001; Ladany et al., 1997).

To assess multicultural case conceptualization ability, Ladany et al. (1997) developed a coding system based on the literature in social perception (Streufert & Streufert, 1978; Tetlock, 1986; Tetlock & Kim, 1987; Tetlock & Suedfeld, 1988) and cognitive complexity (Blocher, 1981; Stoltenberg, 1981). The coding system was conceptually based on similar coding systems for the assessment of the respondent’s
integrative complexity (Ladany et al., 1997). These previous coding systems assessing integrative complexity have been supported in earlier studies and have high interrater agreement (Streufert & Streufert, 1978; Tetlock, 1986; Tetlock & Kim, 1987). Two interrelated cognitive processes of integrative complexity were used to determine multicultural case conceptualization ability: differentiation and integration. Differentiation consists of the ability to provide various interpretations of a client’s problems and the type of treatment that could be offered, with a greater number of interpretations signifying higher differentiation. For example, a trainee who conceptualizes only one etiological source (e.g., abnormal brain chemistry) would exhibit lower differentiation than would a trainee who sees multiple etiologies contributing to a psychological disorder, such as cognitive, cultural, and social components (Ladany, Marotta, & Muse-Burke, 2001). The second cognitive process, integration, refers to the ability to develop connections between differentiated interpretations. Therefore, “differentiation is necessary but not sufficient for integration” (Ladany et al., 2001, p. 205). For example, a trainee could simply list the possible sources of a disorder (low integration), or the trainee could indicate how those sources are connected to and influence each other (high integration) (Ladany et al., 2001). Hence, greater cognitive complexity is reflected in higher differentiation and integration.

Ladany et al. (1997) applied these concepts to multicultural case conceptualization, examining the extent to which trainees demonstrated differentiation and integration of racial or cultural factors into the etiologic and treatment conceptualizations of a client’s presenting concerns. The scoring system developed for
multicultural case conceptualization used in previous studies includes: (Ladany et al., 1997; Constantine & Ladany, 2000):

0 = No indication of race or cultural factors
1 = One mention of race or culture with no integration
2 = One mention of race or culture with some integration or 2 mentions of race with no integration
3 = Two or more mentions of race or culture with one integration
4 = Two or more mentions of race or culture with two integrations
5 = Three or more mentions of race or culture with three or more integrations (pulling everything together). (Ladany et al., 1997)

Hence, multicultural case conceptualization ability is operationalized as how well the participant recognizes and integrates cultural factors into etiological and treatment conceptualizations of the client’s presenting problems.

This coding system for multicultural case conceptualization ability has received support in numerous studies (Bromley, 2004; Constantine, 2001a; Constantine, 2001b; Constantine & Gushue, 2003; Constantine & Ladany, 2000; Gainor & Constantine, 2002; Inman, 2006; Ladany et al., 1997). Ladany et al. (1997) sampled 116 master’s- and doctoral-level trainees in counseling psychology, clinical psychology, and social work to examine how racial identity and supervisory instruction to focus on multicultural issues impacted self-reported multicultural competence and multicultural case conceptualization ability (MCCA). They received a 50% return rate. In the MCCA task, one group was told in the instructions by their “supervisor” to be sure to address racial issues, while the other
group was not given these instructions. The participants then completed a measure of racial identity, the CCCI-R (LaFromboise et al., 1991), and a demographic questionnaire. No measure of social desirability was included. Two doctoral students were trained for 8 hours in the multicultural case conceptualization coding system until they reached a minimum of 85% interrater agreement in the practice sessions. The final interrater agreement for the coding system was .86 for etiology ratings and .87 for the treatment ratings. Results indicated that the proportion of variance accounted for in multicultural case conceptualization ability by racial identity was not significant for both the treatment and etiology ratings. In addition, self-reported multicultural competence (CCCR-I) was not related to MCCA etiology ($r = -.04$) or treatment ($r = .01$) scores; the multivariate multiple regression analysis was not significant. Instructions from the supervisor to focus on racial issues did lead to increased MCCA treatment scores but not MCCA etiology scores. No significant relationships were found between the demographic variables and self-reported multicultural competency and MCCA.

The study by Constantine and Ladany (2000) (as previously discussed in the section on criticisms of self-report measures) investigated the relationship between 4 different measures of self-reported multicultural counseling competence and MCCA and social desirability. For the coding of MCCA, interrater agreements were .93 for etiology and .82 for treatment ratings.

Constantine (2001a) explored how race or ethnicity and independent and interdependent self-construals were related to MCCA. One hundred and twenty counseling and counseling psychology trainees participated; the response rate was 100%
because the surveys were given during class times. Interrater agreements for coding the MCCA were .91 for etiology ratings and .90 for treatment ratings. Findings indicated that Asian American and African American trainees had higher MCCA scores than did European American trainees. Higher levels of previous multicultural training were related to higher MCCA scores. Additionally, higher independent self-construal scores (centering one’s definition of self on one’s own unique, distinguishing attributes) were associated with lower MCCA scores, and higher interdependent self-construal scores (valuing connectedness to others) were related to higher MCCA scores.

Constantine (2001b) examined the proportion of variance accounted for by multicultural training, theoretical orientation, and empathy in multicultural case conceptualization ability in 130 members of the American Counseling Association. The author received a 66% response rate. Interrater agreement ratings for the MCCA task were .93 for etiology and .82 for treatment. Results indicated that more previous multicultural training was associated with higher etiology and treatment case conceptualization scores. Also, counselors with an eclectic/integrative theoretical orientation had higher MCCA etiology scores than did counselors with a psychodynamic or cognitive-behavioral orientation, and they had higher MCCA treatment scores than psychodynamic counselors. The authors proposed that the flexibility necessary for applying theories and techniques from various perspectives may assist counselors when working with culturally diverse clients. Finally, affective empathy attitudes contributed significant variance to etiology and treatment ratings, and cognitive empathy attitudes contributed significant variance to treatment ratings.
Gainor and Constantine (2002) investigated the effects of two types of multicultural peer group supervision (in-person and Web-based) on supervision satisfaction and multicultural case conceptualization ability. The participants were 45 trainees in a master’s program in school counseling. They were randomly assigned to the in-person or Web-based supervision format. At pretest, they completed a demographic questionnaire and the MCCA task, and at posttest, they responded to a supervision satisfaction survey and again completed the MCCA task. Interrater agreement for the MCCA coding was .90 for etiology ratings and .92 for treatment ratings. Results indicated that trainees in both groups displayed an increase in multicultural case conceptualization ability, although the participants in the in-person supervision format obtained higher MCCA etiology and treatment scores than participants in the Web-based format. Also, trainees in the in-person multicultural supervision peer group reported significantly higher satisfaction ratings than the trainees in the Web-based format.

Constantine and Gushue (2003) randomly sampled 139 school counselors (a response rate of 70%) who were members of the American School Counselor Association to explore how multicultural case conceptualization ability was predicted by ethnic tolerance attitudes and racism attitudes. Interrater agreements were .88 for both the etiology and the treatment ratings on the MCCA task. Due to the high correlation between etiology and treatment ratings (.77), the two were combined into one overall index of multicultural case conceptualization ability. Previous multicultural training and higher ethnic tolerance scores were positively predictive of multicultural case
conceptualization ability, and higher racism scores were associated with lower MCCA scores.

Bromley (2004) sampled 55 doctoral-level counseling psychology trainees in APA-accredited programs to examine methodological problems in the MCCA task by including two instruction conditions (one which asked the participants to “write at least three sentences” for both the etiology and the treatment and one which did not specify the number of sentences) and two conditions for the race of the client (European American and African American). Bromley also examined the impact of color-blind racial attitudes, a multidimensional measure of social desirability, self-reported multicultural counseling competence, previous training, and the demographic variable of sex on MCCA. The interrater agreements were .96 for etiology ratings and .86 for treatment ratings. Results indicated that trainees responding to a vignette of an African American client had higher MCCA scores than did those responding to a vignette of a European American client. In addition, trainees responding to the instructions to write “at least three sentences” had lower MCCA etiology scores than those trainees who received more general instructions, indicating that trainees who not identify a minimum limit produce more inclusions of racial factors into their conceptualizations. Unexpectedly, socially desirable responding was not related to self-reported multicultural counseling competence. Neither was socially desirable responding related to MCCA; however, the subscale Self-Deceptive Enhancement of the BIDR (Paulhus, 1991) was related to the Racial Privilege subscale of the CoBRAS (Neville et al., 2000). Females self-reported as more multiculturally competent and holding fewer color-blind racial attitudes but did not differ from males in
their MCCA scores. Most demographic and training variables were not significantly related to MCCA etiology and treatment scores. This study suffered from some limitations, including sample size, response rate, and measurement concerns, which may impact the interpretation of these results.

Constantine et al. (2005) surveyed 50 European American doctoral students and their European American practicum supervisors from four counseling psychology programs to examine the effects of racial identity on supervisees’ self-reported multicultural counseling competence and multicultural case conceptualization ability. Supervisees completed a demographic questionnaire, the CCCI-R (LaFromboise et al., 1991), the White Racial Identity Attitude Scale (WRIAS; Helms & Carter, 1990), and an MCCA task. Supervisors completed the WRIAS (Helms & Carter, 1990). The survey packets were coded by supervisory pairing so the White racial identity interactional pattern for each pair could be determined. For the MCCA task, supervisees read a vignette that supposedly reflected intake session notes. The interrater reliability coefficients were .90 for etiology ratings and .92 for treatment ratings. Results indicated that European American supervisees in progressive and parallel-high relationships with their supervisors had higher MCCA scores and self-reported higher multicultural counseling competence than supervisees in parallel-low relationships.

Inman (2006) (as previously discussed in the section on multicultural counseling competence in marriage and family therapy) investigated the effects of trainees’ perceived multicultural competence of their supervisors on multicultural counseling
competence, the supervisory working alliance, and supervision satisfaction. For the MCCA task, interrater agreement was .82 for etiology and .88 for treatment ratings.

A number of common limitations can be found in many of the previous studies using the MCCA task. Many of the samples may suffer from volunteer bias in that those participants who responded could be different from those individuals who did not respond. Several of the studies used convenience sampling through personal contacts. All were analogue in design, which does not necessarily translate directly to clinical practice. All of the studies were based solely on one vignette at one point in time, and responses to case conceptualization exercises across numerous instances may result in different determinations of the participants’ multicultural case conceptualization ability. The MCCA task was presented first so as to not to influence participants’ responses to the vignette; however, if respondents were aware that their responses on the vignette were being compared to the measures that followed, then they may have been cued in to the research intent and therefore responded differently on the measures that followed. On the other hand, the MCCA task consistently received high interrater agreement for both etiology and treatment ratings, and the developing body of literature using multicultural case conceptualization ability as a measure of observed multicultural counseling competence provides support for the use and investigation of this measure in the current study.

Vignettes: Stimulus characters. The vignettes used in previous MCCA studies centered primarily on racial/ethnic group membership as the cultural component incorporated in the descriptions of the clients, and the types of clients, settings, and
disorders were varied. Ladany et al. (1997) employed a vignette describing the intake information of a 19 year-old African American female undergraduate student attending a predominantly European American university, which included criteria for Adjustment Disorder with Depressed Mood as outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV; American Psychiatric Association, 1994). Constantine and Ladany (2000) developed a vignette that described a 25 year-old Mexican American woman seeking counseling at a local mental health clinic, and the vignette depicted information about the client moving to a small, rural, predominantly European American town in Iowa, symptoms of depression, and an intake worker’s diagnosis of Adjustment Disorder with Depressed Mood (DSM-IV; American Psychiatric Association, 1994). Constantine (2001b) utilized a vignette that described a 32 year-old, gay, Native American male stockbroker seeking counseling at a local mental health clinic. The vignette included information about the client’s involvement in traditional Native American rituals and social advocacy for gay men, work stressors, romantic relationship concerns, anxiety about coming out to his family members, and recreational drug use. However, no specific DSM-IV diagnosis was given in this vignette. Constantine (2001a) used a vignette describing a 22-year-old, Asian American female graduate student requesting services at the counseling center of a predominantly European American university and included a diagnosis by the intake worker of Adjustment Disorder with Depressed Mood according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994). Gainor and Constantine (2002) employed a vignette of a 10-year-old, African American male
entering a predominantly European American suburban school being referred for school counseling. No specific DSM-IV diagnosis was provided in this vignette. Constantine and Gushue (2003) utilized a vignette of a 12-year-old, African American female who recently immigrated to the United States from Ghana, West African, and was referred to school counseling at a predominantly European American suburban school. The vignette did not specify any diagnosis. Constantine et al. (2005) employed a vignette of a 30-year-old, college-educated, single African American female living in a rural town requesting counseling services at a mental health clinic after losing her job. The intake worker diagnosed the client with Adjustment Disorder with Depressed Mood according to the DSM-IV-TR (American Psychiatric Association, 2000). Inman (2006) utilized a vignette of a 22-year-old Asian Indian female in law school looking for counseling due to problems with her parents. The intake worker indicated that this client fit the criteria for Adjustment Disorder with Depressed Mood according to the DSM-IV (American Psychiatric Association, 1994). Bromley (2004) used two vignettes of a female undergraduate student seeking services at the counseling center of a racially mixed university, and the intake worker determined that this client met the criteria for Adjustment Disorder with Depressed Mood as outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; American Psychiatric Association, 1994). The race of the client in the otherwise identical vignettes was varied and described as either African American or European American.

One of the primary problems with the vignettes used in previous research is that they all described one client seeking individual counseling services. Clinicians also
engage in couples and family therapy as important work behaviors (Birk & Brooks, 1988; Fitzgerald & Osipow, 1986), and there is a lack of research examining trainees’ multicultural case conceptualization ability when working with more than one client in the room. Scholars have called for additional measures that “assess such competence in the context of larger systems (e.g., families, groups, and organizations)” (Constantine & Ladany, 2001, p. 486-487). In addition, all of the vignettes but one described a client of color; they failed to assess whether counselors account for the impact of race for European American clients. Historically, multicultural scholarship has focused primarily on people of color (e.g., Sue et al., 1992), and although this has brought increased attention to previously ignored groups, it may also have led trainees to overlook racial factors when working with majority clients. Bromley (2004) found that trainees responding to a vignette of an African American client had higher MCCA scores than did those responding to a vignette of a European American client, but this finding needs to be replicated on another sample.

Based on the design of these studies and with the goal of replicating and expanding the most recent previous findings regarding multicultural case conceptualization ability, the development of the vignette for this study took into account the following considerations. The clients were a married, heterosexual couple. The race conditions for the clients were varied as either African American or European American for each couple in two vignettes as a way to assess counselors’ attention to racial issues for both majority and minority clients. The description of the problem by the couple was “communication” because this is one of the most common presenting concerns of couples
in therapy (Doss, Simpson, & Christensen, 2004). The setting for counseling was a local mental health center.

**Sampling.** Most of the samples used in examining the multicultural case conceptualization abilities of counseling trainees have consisted of students in counseling psychology and counselor education. Ladany et al. (1997) sampled trainees in counseling psychology, clinical psychology, and social work. Constantine and Ladany (2000) surveyed counselors, counseling psychologists, and trainees in counseling or counseling psychology. Constantine (2001a) tested counseling psychology trainees. Constantine (2001b) sampled members of the American Counseling Association. Gainor and Constantine (2002) used trainees in a school psychology program. Constantine and Gushue (2003) surveyed school counselors who were members of the American School Counselor Association. Bromley (2004) questioned counseling psychology trainees. Constantine et al. (2005) studied counseling psychology supervisees and their clinical or counseling psychology supervisors. Choosing samples from counseling and counseling psychology is not surprising given that counseling psychologists have been leaders in the field of multicultural research (Heppner et al., 2000). Counseling psychology scholars have also been pioneers in multicultural research in other disciplines, and only recently has research on multicultural counseling competence included samples of marriage and family therapy trainees and school counselor trainees (Constantine, 2002; Constantine et al., 2001; Inman, 2006). As a result, future research on observer-rated methods of multicultural counseling competence, particularly multicultural case conceptualization ability, with additional samples of trainees from various disciplines is needed. The
current study addressed this limitation by surveying both counseling psychology and marriage and family therapy trainees.

Training variables. Theoretically, one would expect that additional training in multiculturalism would lead trainees to work more competently with diverse clients. Specifically, in using the MCCA task to operationalize competence, training should lead to further incorporation of race into etiology and treatment conceptualizations of clients. However, the empirical data on the relationship between multicultural training and MCCA scores is mixed. Constantine (2001a; 2001b) and Constantine and Gushue (2003) found that multicultural training was associated with higher MCCA scores. On the other hand, Bromley (2004) and Ladany et al. (1997) found no relationship between multicultural training and MCCA scores. Several other studies did not provide data on the relationship between MCCA scores and training variables (Constantine et al., 2005; Constantine & Ladany, 2000; Gainor & Constantine, 2002; Inman, 2006).

Previous research using self-report methods of assessing multicultural counseling competence has also provided conflicting results regarding the relationship between the subscales of the self-report measures and training variables (e.g., Kocarek et al., 2001; Manese et al., 2001; Ponterotto et al., 1991; Pope-Davis & Dings, 1994). For example, a number of studies have reported significant correlations between training variables and the Knowledge subscale of the MCKAS but not between training variables and the Awareness subscale (Kocarek et al., 2001; Manese et al., 2001; Pope-Davis et al., 1994; Pope-Davis et al., 1995; Vinson & Neimeyer, 2003).
In the absence of an established benchmark for competency against which self-report and observer-report methods of assessing multicultural counseling competence can be compared, training may serve as an index to clarify if one of these assessment methods is superior. Because we expect multicultural training to be related to increased multicultural counseling competence, if training is more highly correlated to one measure than the other, this could shed light on which method is more useful in assessing trainee competence.

**Summary.** Case conceptualization skills are developed as the trainee progressively differentiates and integrates information into the etiology and treatment conceptualizations of clients. Multicultural case conceptualization ability is based on this same process examining the integration and differentiation of cultural information for racially and ethnically diverse clients. The scoring system used to measure MCCA has received support in previous research (Bromley, 2004; Constantine, 2001a; Constantine, 2001b; Constantine & Gushue, 2003; Constantine & Ladany, 2000; Constantine et al., 2005; Gainor & Constantine, 2002; Ladany et al., 1997). However, previous studies have methodological and sampling limitations that should be attended to in future research examining MCCA.

One study (Bromley, 2004) has identified that race as an experimental condition is an important component in order to check the stimulus value of the race of the client in the vignette; this study reflects an attempt to replicate this finding. Bromley’s (2004) study also demonstrated that open-ended instructions which do not identify how many sentences to write produce more responses from participants that can yield higher MCCA
scores; therefore, the current study chose to provide more general instructions for the vignette task as a means to maximize MCCA scores. No vignettes have previously examined a method of therapy other than individual counseling, so this vignette considered couples therapy. Previous research has also focused primarily on samples from counseling psychology and counselor education; this study broadened the population to include counselors outside psychology by using marriage and family therapy trainees. Also, only one previous study has examined factors that may impede multicultural case conceptualization ability (i.e., color-blind racial attitudes; Bromley, 2004), and given the limitation of a very small sample size in that study, further replication of these findings are necessary.

In addition to methodological considerations, another important finding in the literature is that self-reported multicultural competence does not account for significant variance in multicultural case conceptualization ability (Ladany, 1997; Constantine & Ladany, 2000). This, combined with the evidence that self-report measures are contaminated by socially desirable responding (Constantine & Ladany, 2000), suggests that self-report measures may be assessing expected behaviors rather than actual multicultural counseling competence. If this is true, then one would expect training to be more related the MCCA scores than to self-report methods of assessing multicultural counseling competence; this study will investigate that possibility.

**Measurement of Social Desirability**

*Multicultural counseling competence.* Most of the studies examining the effect of social desirability on self-reported multicultural counseling competence and MCCA
scores (e.g., Constantine, 2000; Constantine & Ladany, 2000; Constantine et al., 2001; Kim et al., 2003; Ponterotto et al., 1996; Ponterotto et al., 2002; Worthington et al., 2000) have used the Marlowe-Crowne Social Desirability Scale (SDS; Crowne & Marlowe, 1960), which regards social desirability as a one-dimensional construct. However, some scholars, such as Paulhus (1988; 1991), have argued that social desirability is a multi-dimensional construct, consisting of two distinct categories, self-deceptive enhancement (fooling oneself) and impression management (fooling others). People high in self-deceptive enhancement generally provide self-reports that are positively biased and overly confident yet honest. People high in impression management consciously self-report higher levels of desirable behavior and lower levels of undesirable behaviors as a way to present themselves positively to others. Paulhus (1988; 1991) developed the Balanced Inventory of Desirably Responding (BIDR) to reflect the two facets of socially desirable responding: Self-Deceptive Enhancement (SDE) and Impression Management (IM). People with high scores on self-deceptive enhancement actually believe in their overly positive self-reports, while people with high scores on impression management consciously present themselves in a favorable light.

Worthington et al. (2000) examined the impact of social desirability using the SDS (Crowne & Marlowe, 1960) on two inventories of multicultural counseling competence, the MCI (Sodowsky et al., 1994) and the CCCI-R (LaFromboise et al., 1991). The authors found that social desirability correlated moderately with the MCI, although the shared variance in MCI and CCCI-R scores accounted for by social desirability was insignificant. Worthington et al. suggested that these findings were
difficult to interpret and proposed that it might be due to conceptualizing and measuring social desirability as a one-dimensional construct. They called for future studies on multicultural counseling competence to examine the multi-dimensional nature of social desirability. Until now, only one study has done so.

Bromley (2004) examined the impact of social desirability on self-reported multicultural counseling competence and multicultural case conceptualization ability. Using both subscales of the BIDR, Bromley found no relationship between social desirability and multicultural case conceptualization etiology ($r = .00$ for Impression Management; $r = .12$ for Self-Deceptive Enhancement) and treatment scores ($r = .21$ for IM, $r = .09$ for SDE). Additionally, no relationship was found between social desirability and self-reported multicultural counseling competence as measured by the Knowledge subscale ($r = .04$ for IM, $r = .04$ for SDE) and the Awareness subscale ($r = .08$ for IM, $r = .21$ for SDE) of the MCKAS. However, Bromley (2004) suffered from a small sample size, limiting the conclusions that can be drawn from the results.

*Color-blind racial attitudes.* Similar to the studies examining multicultural counseling competence and social desirability, most of the studies examining the effect of social desirability on color-blind racial attitudes also have used the Marlowe-Crowne Social Desirability Scale (e.g., Burkard & Knox, 2004; Neville et al., 2000; Spanierman & Heppner, 2004). Neville et al. (2000) found that the SDS (Crowne & Marlowe, 1960) correlated significantly with the Blatant Racial Issues subscale ($r = .20$) but not with the Racial Privilege ($r = .12$) or Institutional Discrimination ($r = .03$) subscales. Burkard and Knox (2004) reported that the CoBRAS and the SDS were not significantly correlated ($r$
Spanierman and Heppner (2004) used the Marlowe-Crowne Social Desirability Scale-Form C (M-C Form C; Reynolds, 1982) and found no significant correlations with Racial Privilege ($r = .07$), Institutional Discrimination ($r = .02$), or Blatant Racial Issues ($r = .09$). Only Awad et al. (2005) and Bromley (2004) have examined how color-blind racial attitudes are impacted by the multi-dimensional nature of social desirability.

Awad et al. (2005) sampled psychology students to examine the relationships between modern racist attitudes, color-blind racial attitudes, and attitudes toward affirmative action. The impact of social desirability on these attitudes was examined using the Impression Management subscale of the BIDR (Paulhus, 1988); the authors did not explain their rationale for using only this subscale. Results indicated that social desirability was not correlated significantly with any of the other measures in the study, including the CoBRAS (Neville et al., 2000), the Modern Racism Scale (MRS; McConahay, 1986), and the Attitude Toward Affirmative Action Scale (ATAAS; Kravitz & Platania, 1993). The correlation between the CoBRAS overall score and the IM subscale of the BIDR was $r = .013$ for European American participants and $r = .15$ for African American participants. Limitations of this study include the use of only one of the two subscales of the BIDR and the absence of data on how the IM subscale was related to the 3 subscales of the CoBRAS.

Upon examining the relationship between color-blind racial attitudes and social desirability as measured by the BIDR, Bromley (2004) found that only Self-Deceptive Enhancement significantly correlated with the Racial Privilege subscale of the CoBRAS.
SDE did not correlated significantly with the CoBRAS subscales Blatant Racial Issues \(r = .11\) or with Institutional Discrimination \(r = .06\). Impression Management did not correlate significantly with Racial Privilege \(r = .22\), Institutional Discrimination \(r = .03\), or Blatant Racial Issues \(r = .01\), consistent with the findings from Awad et al. (2005). Although most of the previous findings suggest that social desirability as a whole is not strongly related to color-blind racial attitudes, Bromley’s (2004) results suggest that the various dimensions of social desirability (e.g., impression management vs. self-deception) may operate differentially on color-blind racial attitudes, so it is important to further examine this finding.

**Summary.** Previous research has primarily conceptualized and measured social desirability as a one-dimensional construct. However, Paulhus (1991) proposed that social desirability is composed of two dimensions, self-deceptive enhancement (reports that are positively biased, overly confident, yet honest) and impression management (reports that are intentionally positively biased). The current study attempted to address prior limitations in the literature by using a multidimensional measure of social desirability to examine its impact on multicultural competence and color-blind racial attitudes.

**Color-Blind Racial Attitudes**

When examining trainees’ multicultural case conceptualization skills, consideration should be given to possible obstacles that might interfere with trainees’ abilities to consider cultural factors in a client’s etiology and treatment. One potential obstacle is color-blind racial attitudes (CoBRAs). Atkinson and Lowe (1995) called for
an investigation of the effect of therapists’ biases on the counseling process. Specifically, Burkard and Knox (2004) suggest examining the effect of color-blind racial attitudes on multicultural case conceptualization ability. Color-blind racial attitudes include the denial of racism and the denial that race plays a significant role in the lives of people of color; essentially, “race should not and does not matter” (Neville et al., 2000, p. 60). These attitudes have been conceptualized as a form of ultramodern racism reflecting socially acceptable expressions of racial beliefs (Neville, Worthington, & Spanierman, 2001). They contribute to a cognitive schema used to interpret racial stimuli whereby the meaning of events is attributed to other explanations rather than to race (Neville et al., 2000). However, as long as racism continues in society, race does matter and should be addressed.

Moreover, the denial of the importance of race in our society also reflects a denial of “White privilege.” White privilege is “an expression of power arising from receipt of benefits, rights, and immunities and is characterized by unearned advantages and a sense of entitlement that results in both societal and material dominance by Whites over people of color” (Neville et al., 2001, p. 262). White privilege is often invisible or unacknowledged, and according to McIntosh (1988), Whites consider their experiences to be the norm and the standard by which to compare all other people’s experiences. This privileged position of power can lead Whites to expect people of color to be like them, which in turn could lead to distortions in etiology and treatment decisions with clients of color. Awareness of White privilege is an important component of multicultural counseling competence because the competencies proposed by Sue and colleagues (1982,
1992, 1998) call for knowledge and awareness of the disadvantaged, and “one cannot understand ‘disadvantaged’ without having a critical understanding of ‘advantaged’” (Neville et al., 2001, p. 260). However, in order to recognize White privilege, one must first acknowledge that color and race does matter.

Neville et al. (2001) outlined four major tenets of color-blind racial attitudes. The first tenet is that color-blind racial attitudes reflect a new form of racial attitudes that are related to but distinct from individual racism and prejudice. Racism refers to the belief in the superiority and inferiority of groups of people based on race, whereas color-blind racial attitudes reflect a denial that ideological and structural racism exists. Thus, although color-blind racial attitudes are different from racism, because they still reflect an erroneous view of race relations, this denial could be inadvertently used to justify, rationalize, and promote racial discrimination.

The second tenet is that color-blind racial attitudes make up a cognitive schema that influences how people utilize information related to race, and that schema carries with it affective responses. The cognitions and the feelings attached to them influence how people encode, store, and retrieve race-related information. For example, a cognitive schema that states that race does not matter, combined with feelings of anxiety about race, may lead someone to reject the impact of race on a given situation.

These racial schemas are related to the democratic ideology in the United States, such as the belief that everyone has an equal opportunity if they simply work hard enough and the belief that people should not be judged by their group membership but rather by their individual behavior (Neville et al., 2001; Schofield, 1986). These
principles are ideal in theory, but in truth, we do not live in an ideal, just world. And as Neville states, “To ignore, deny, distort, or evade this reality is the core of CoBRA” (p. 270).

The third tenet is that color-blind racial attitudes are complex and multidimensional, consisting of a pattern of beliefs that reflect color evasion and power evasion. Color evasion involves denying the concept of European American racial superiority by insisting that all people, regardless of color, are the same. Power evasion is the belief that all people have the same opportunities for success, which therefore blames the individual for failure as opposed to structural hindrances like racism.

The fourth and final tenet is that color-blind racial attitudes have different implications and are expressed differently in European Americans and people of color. European Americans tend to adopt color-blind racial attitudes in significantly greater numbers, and these attitudes serve to reduce anxiety and guilt and to maintain the benefits European Americans receive from their racial privilege (cf. White Privilege a la McIntosh, 1998). For European Americans, color blindness protects their group interest by maintaining racial privileges. To deny racism is to blame racial and ethnic minorities for the racial disparities. The status quo goes unchallenged, which, in turn, perpetuates the inequality. For a person of color, color-blind racial attitudes may function as a way to cope with experiences of racism, especially if that person does not have the adequate resources or support to cope. By denying that experiences of discrimination are related to race, then a person does not have to find a way to cope with racism. This leads to the continuation of oppression.
CoBRAs exist on a structural level (denial of racism as a primary racial ideology) and on an individual level (cognitive framework for understanding racial stimuli), which together maintain European American racial privilege. The American Psychological Association (APA, 1997) suggests that to move beyond racism, people must avoid color-blind racial attitudes and instead take people’s differences into account. In other words, color consciousness is needed (Neville et al., 2001).

Neville et al. (2001) asserted that knowledge of color-blind racial attitudes is crucial to multicultural counseling competence. They contended that:

“counselors with relatively high endorsement of CoBRA (regardless of race or ethnicity) will be (a) less likely to conceptualize the potential influence of race or ethnocultural factors on the client’s presenting concern and thus (b) less likely to verbally express race-related information in counseling sessions (p. 281).”

Previous research has indicated that racism attitudes (as measured by the New Racism Scale; NRS; Jacobson, 1985) are predictive of multicultural case conceptualization ability (Constantine & Gushue, 2003), and color-blind racial attitudes are viewed as a modern form of racism (Neville et al., 2000). In addition, Neville et al. (2001) recommended that future research investigate the relationship between CoBRA and self-reported and observed multicultural counseling competence. Therefore, examining the relationship between color-blind racial attitudes and multicultural case conceptualization ability in trainees could reveal important implications for training, research, and practice.
**Empirical support.** Neville et al. (2000) developed a scale to assess color-blind racial attitudes. The Color-Blind Racial Attitudes Scale was rationally developed using previous work in the theoretical and empirical literature on color-blindness and color-blind racial attitudes (e.g., Carr, 1997; Frankenberg, 1993; Schofield, 1986), consultation with experts, and informal discussions with racially diverse students and community members. At first, 17 items were developed and reviewed by a small, diverse research team. To establish content validity, these items were given to five experts in psychometrics or racial studies who rated each item for content and clarity on a 5-point Likert scale (1 = not at all appropriate or clear; 5 = very appropriate or clear). Items not receiving a rating of 4 or 5 were dropped. As a result of this process, 2 items were dropped, 7 items were revised, and 11 more items were created to make up a 26-item scale. Half of the items were worded negatively to address for possible response bias. The reading level of the scale was identified to be just above the 6th grade level. The scale was given to 2 educators, one high school student, and a newspaper editor to continue to assess clarity, and four items were reworded as a result.

Neville et al. (2000) conducted 5 separate investigations to establish the initial validation and psychometric data on the scale. Samples included college students, community members, and students enrolled in a multicultural training course. The majority of the samples were European American, and all of them came from the Midwest or the West Coast.

Factor analysis revealed a three-factor solution with 20 items retained, which the authors described as 1) Racial Privilege, which is the denial of White privilege; 2)
Institutional Discrimination, which reflects a lack of awareness of discriminatory institutional practices, and 3) Blatant Racial Issues, which refers to the denial of the pervasiveness of racism in society. The CoBRAS demonstrated initial internal consistency estimates of .83, .81, and .76 for the three factors and .91 for the total score. In the second sample, the Cronbach’s alpha was .86 for the total score and .80, .76, and .70 for the three factors respectively. Guttman’s split-half reliability estimate was .72. In the fourth sample, the internal consistency estimates were .71, .73, and .70 for the three factors respectively, and .84 for the overall score. Test-retest reliability was .80 for Racial Privilege and Institutional Discrimination, .68 for the total score, and .34 for Blatant Racial Issues. The authors propose that this low coefficient may be due to a prejudice reduction seminar the majority of the sample participated in between the two-week test interval.

The CoBRAS demonstrated concurrent validity evidence by correlating with the Global Belief in a Just World Scale (GBJWS; Lipkus, 1991). The intercorrelations were .53 for the total score and .49, .39, and .46 for the three factors respectively. Also, the CoBRAS correlated with the sociopolitical subscale of the Multidimensional Belief in a Just World Scale (MBJWS; Furnham & Procter, 1988), with intercorrelations of .61 for the total score and .61, .34, and .46 for the respective three factors. Additional concurrent validity evidence was presented by examining correlations with measures of racial attitudes. Intercorrelations with the Modern Racism Scale (MRS; McConahay, 1986) were .52 for the total score and .36, .39, and .55 for the respective three factors. Significant intercorrelations for the Quick Discrimination Index (QDI; Ponterotto,
Burkard, et al., 1995) ranged from -.25 to -.83. This implies that color-blind racial attitudes are associated with greater racial prejudice, although they remain distinct from racism. Color-blind racial attitudes do not necessarily indicate an adoption of negative attitudes toward racial/ethnic minorities, and the correlation between the CoBRAS total score and the MRS of .52 indicates shared variance as well as unique variance (Neville et al., 2000).

Discriminant validity evidence was suggested by an insignificant correlation with a short version of the Marlowe-Crowne Social Desirability Scale (MCSDS; Reynolds, 1982). Intercorrelations were .13 for the total score and .12, .03, and .20 for the three factors, respectively. Although the correlation with Blatant Racial Issues was significant, the amount of variance accounted for was only 4%. However, because Neville et al. (2000) did find one significant correlation, only used the short form of the MCSDS (Reynolds, 1982), and did not investigate the multidimensional nature of social desirability, future research should further examine the relationship between color-blind racial attitudes and social desirability.

Criterion-related validity was established by examining group differences by race and sex. Women scored lower than did men on all three subscales in one study, and in another sample there were no sex differences, and in a third sample men scored higher on Institutional Discrimination and Blatant Racial Issues. According to the authors, this supports previous research which indicates that women tend to be more sensitive to social inequality (Neville et al., 2000). In one sample, Latinos scored significantly lower on Racial Privilege and Blatant Racial Issues than African Americans and European
Americans. European Americans scored significantly lower on Blatant Racial Issues than African Americans, and African Americans scored significantly lower on Institutional Discrimination than Latinos and European Americans. In another sample, European Americans scored significantly higher on Institutional Discrimination than racial/ethnic minorities. Overall, European Americans scored higher than African Americans and Latina/os on most of the subscales, although there were some differences for the Blatant Racial Issues subscale.

The Racial Privilege subscale also indicated sensitivity to multicultural training intervention, with these scores declining after a multicultural training course. The authors suggest that the other two subscales did not evidence a decrease possibly due to floor effects (below average scores to begin with) and sample effects (most of the participants were racial/ethnic minorities who were interested in diversity). Because color-blind racial attitudes and multicultural counseling competence may both be influenced by the amount of training a person receives in multicultural issues, the current study controlled for training to examine the degree to which color-blind racial attitudes influence multicultural counseling competence above and beyond training variables.

Overall, the CoBRAS has adequate reliability, other than test-retest reliability for the Blatant Racial Issues subscale. Concurrent and discriminant validity evidence is also sufficient. Several empirical investigations have used the CoBRAS in subsequent research (Awad, Cokley, & Ravitch, 2005; Bromley, 2004; Burkard & Knox, 2004; Gushue, 2004; Neville, Coleman, Falconer, & Holmes, 2005; Spanierman & Heppner, 2004).
Awad et al. (2005) examined the relationship between modern racist attitudes, color-blind racial attitudes, and attitudes toward affirmative action. They sampled 375 undergraduate psychology students using a measure of attitudes toward affirmative action, the Modern Racism Scale (MRS; McConahay, 1986), the CoBRAS (Neville et al., 2000), and the Impression Management scale of the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1988). The internal consistency coefficient for the CoBRAS was .81. Social desirability scale scores were not significantly correlated with any of the other measures, including the CoBRAS. The CoBRAS was correlated with the MRS at .40 for African Americans and .54 for European Americans, indicating that color-blind racial attitudes are related to, yet distinct from, modern racial attitudes. Results indicated that color-blind racial attitudes were predictive of affirmative action attitudes and were a stronger predictor of attitudes toward affirmative action than modern racism.

Burkard and Knox (2004) sampled 247 psychologists who are members of the APA Practice Directorate to examine color-blind racial attitudes, empathy, and attributions of clients’ responsibility for causing and solving their problems. The response rate was 32%, although the investigators established that those who responded reflected accurately the demographics of the population of the Practice Directorate. In this sample, the reliability coefficient was .88 for the CoBRAS. Social desirability as measured by the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) was significantly positively related to therapists’ self-reported empathy and attributions of client responsibility for the cause of and solution to a problem. This indicates that therapists were motivated to respond in way that portrayed them favorably, which the
authors suggest may be a sign of race-related guilt. None of the CoBRAS subscales were significantly correlated with MCSDS scores. They recommend accounting for social desirability in future investigations of multicultural issues. After controlling for social desirability, the authors found that the level of color-blindness in therapists was directly related to the therapists’ degree of empathy regardless of the race of the client, and it was related to their attributions of responsibility for solutions to the problem for African American clients but not for European American clients. Therapists more aware of the role of race in people’s lives demonstrated more empathy overall. In addition, therapists high in color-blindness attributed more client responsibility to solving their problems than therapists low in color-blindness.

Gushue (2004) also used the CoBRAS scale to investigate the effects of color-blind racial attitudes on therapists’ perception of clients’ symptom severity. One hundred fifty-eight European American graduate students in clinical and counseling psychology from seven different universities responded to a fictitious intake report from a college counseling center. Half of the participants responded to an intake report of an African American client, and the other half responded to an intake report of a European American client; otherwise, the reports were identical. The reliability coefficient for the CoBRAS was .88 for the total scale score. Results indicated that higher levels of color-blind racial attitudes were positively related to higher perceptions of symptom severity for African American clients but not European American clients.

In an attempt to understand the complex variety of racial beliefs among African Americans, Neville et al. (2005) examined how color-blind racial attitudes are related to
psychological false consciousness (PFC), specifically the justification of social roles, the attribution of blame, and internalized oppression. The authors surveyed 211 African Americans. College students at a predominantly European American Midwestern university were enlisted from classes and from the student union, and people from work groups and informal environments were solicited in the Midwest and on the West Coast. This study represented one of the first samples to obtain psychometric data on the CoBRAS with African Americans. The reliability coefficient for this sample was marginal at .70. Results indicated that stronger color-blind racial attitudes were significantly positively related to the three dimensions of PFC, suggesting a relationship between color-blind racial ideology and the use of a cognitive framework that works against the individual’s or the social group’s interest.

Spanierman and Heppner (2004) conducted a study on the initial development and validation of the Psychosocial Costs of Racism to Whites Scale (PCRW) using 727 undergraduate participants in three studies. In their first study, the coefficient alphas for the CoBRAS subscales were .77 for Racial Privilege, .69 for Institutional Discrimination, and .64 for Blatant Racial Issues. A three-factor solution best fit the data, and the three factors were named White Empathic Reactions Toward Racism, White Guilt, and White Fear of Others. CoBRAS scores were significantly negatively correlated with White Empathic Reactions Toward Racism and White Guilt, indicating that people with lower color-blind racial attitudes were more likely to feel empathic towards experiences of racism and to feel guilt and shame about being White. A positive correlation between
CoBRAS scores and White Fear of Others suggests that people high in color-blind racial attitudes were more likely to fear people of other races.

Another previous study (Bromley, 2004), as discussed earlier, examined how color-blind racial attitudes impact multicultural case conceptualization ability. Counseling psychology trainees responded to a client vignette. Results indicated that the Racial Privilege subscale of the CoBRAS was significantly related to the Self-Deceptive Enhancement subscale of the BIDR. All three CoBRAS subscales were significantly related to the MCKAS knowledge and awareness subscales. Color-blind racial attitudes were not related to multicultural case conceptualization ability to the degree expected; only the Racial Privilege subscale was related to MCCA etiology scores. However, this study suffered from several limitations, including sample size. The current study represents an attempt to expand upon and clarify this previous research.

**Summary.** Color-blind racial attitudes, and in particular, the scale used to measure them (CoBRAS; Neville et al., 2000), are receiving increasing attention in the literature. However, because color-blind racial attitudes are a somewhat underdeveloped component in the field of psychology (Neville et al., 2000), more attention to this variable is needed. For counselors in training, color-blind racial attitudes could affect their conceptualizations and treatment of racially and ethnically diverse clients by causing them to ignore or minimize the influence of race on the therapeutic process. This may lead to difficulty developing a strong therapeutic alliance and to increased drop out rates for racial/ethnic minorities in counseling. Both European American trainees and trainees of color can hold color-blind racial attitudes (Neville et al., 2000), which might interfere
with their capability to incorporate cultural issues in client conceptualizations. Because color-blind racial attitudes could impede trainees’ self-awareness in the development of multicultural competencies and could affect their work with diverse clients by distorting the realities of clients of color, these attitudes are important to assess.

Purpose of Study

The purpose of this study is to advance previous research which has examined the assessment of multicultural counseling competence, specifically, the ability to conceptualize clients from a multicultural perspective (Landay et al., 1997, Constantine & Ladany, 2000). The current study intended to address methodological limitations in the MCCA literature, to consider variables that may detract from multicultural case conceptualization ability (i.e., color-blind racial attitudes), and to examine the relationship of the MCCA task (an observer-report measure of multicultural counseling competence) and a self-report measure (MCKAS) of multicultural counseling competence with training variables.

Several methodological problems with this body of research exist. First, previous studies have always used a vignette with an individual client. Additional modalities of treatment, such as couples therapy, are an important work behavior of counseling psychologists (Birk & Brooks, 1988). In addition, multicultural scholars have called for research that investigates the multicultural competence of psychologists when working with larger systems (e.g., couples) (Constantine & Ladany, 2001). Thus, this study will used a vignette with couples presenting for treatment.
A second methodological problem is that the stimulus value of the client’s race/ethnicity has rarely been examined. Most of the earlier studies have only described a client of color and as a result, they fail to assess whether counselors account for the impact of race for European American clients. Therefore, this study will provide two conditions using the same vignette except for the race of the clients: one vignette describes a European American couple, and the other vignette describes an African American couple. By varying the race condition of the vignette, counselors’ attention to racial issues for both majority and minority clients can be assessed.

A third methodological problem in this research has been the primary reliance on counseling psychology and counselor education trainees (Ladany et al., 1997; Constantine & Ladany, 2000). Research on multicultural counseling competence with additional samples of trainees from various disciplines is needed. Because this study is investigating multicultural counseling competence when working with couples, marriage and family therapy trainees, in addition to counseling psychology trainees, were surveyed.

A fourth methodological problem in this body of literature has been the reliance on a one-dimensional measure of social desirability (e.g., Marlowe-Crowne Social Desirability Scale; Crowne & Marlowe, 1960). Scholars have proposed that social desirability is multidimensional, and therefore, the current study used a measure that reflects the various dimensions of the construct (i.e., BIDR; Paulhus, 1991) to examine the impact of social desirability on multicultural counseling competence and color-blind racial attitudes.
Previous investigations have examined a number of variables that might increase counselors’ multicultural case conceptualization ability (Constantine, 2001b; Ladany et al., 1997). However, few have examined factors that could detract from MCCA. One factor that might hinder the incorporation of culture into case conceptualizations, color-blind racial attitudes (Neville et al., 2000), is investigated in the current study.

This research also compared an observer-report measure (MCCA task) with a self-report measure (MCKAS) of multicultural counseling competence. Previous research has revealed a lack of relationship between these two measures (Constantine & Ladany, 2000; Bromley, 2004). Also, evidence suggests that self-report measures are contaminated by socially desirable responding (Constantine & Ladany, 2000), which may indicate that self-report measures are assessing expected behaviors rather than actual multicultural counseling competence. One of the difficulties in the assessment of multicultural counseling competence is that the constructs of multicultural knowledge, skills, and abilities (and therefore the measures used to assess them) have no fully valid criterion measure. However, because multicultural training is expected to be related to increased multicultural counseling competence, if training is more highly correlated to one measure than the other, this could clarify which method is more useful in assessing trainee competence.
CHAPTER III

METHOD

The purpose of this study was to build upon previous research investigating multicultural case conceptualization ability (MCCA) as an observable measure of multicultural counseling competence (Bromley, 2004; Constantine & Ladany, 2000; Ladany et al., 1997). Specifically, previous methodological limitations in the assessment of multicultural case conceptualization ability were addressed and a comparison between the MCCA task and a self-report measure of multicultural counseling competence was made to further understand the utility of these methods in measuring multicultural counseling competence.

This study included the following methodological improvements: 1) use of a couples case vignette instead of a vignette of an individual client; 2) examining color-blind racial attitudes as a potential hindrance to trainees’ ability to conceptualize clients from a multicultural perspective; 3) utilizing a multidimensional measure of social desirability; and 4) examining two conditions for race in the vignette (African American and European American).

In addition, this study used a self-report measure of multicultural counseling competence to examine the relationship between self-report and observer-rated multicultural counseling competence (cf. Constantine & Ladany, 2000). The relationship
that the two measures of multicultural counseling competence had with multicultural training and clinical experience variables was also assessed.

Participants

Participants were counseling psychology and marriage and family therapy trainees currently enrolled in APA-accredited and AAMFT-accredited training programs across the country. The list of APA-accredited training programs in counseling psychology was obtained from the Council of Counseling Psychology Training Programs’ (CCPTP) web page and used to locate counseling psychology programs’ training directors. The list of accredited programs in marriage and family therapy provided by the American Association for Marriage and Family Therapy (AAMFT) website was used to locate the directors of marriage and family therapy programs. The directors of CP and MFT graduate training programs were sent an e-mail requesting that they pass along to their students the corresponding information soliciting participation in the study.

Final participants for this study. A total of 116 counseling psychology and marriage and family therapy trainees across the United States and Canada responded to the survey. Three participants were dropped from the analyses because they did not complete all of the instruments, yielding a final sample size of 113 participants. The trainees in this study reported a mean age of 31.2 (SD = 8.6; Median = 28.0; range 22-72 years). There were 88 women (77.9%) and 25 men (22.1%). Participants reported the following racial/ethnic identification: European American (69%), African American (6.2%), Asian American (6.2%), Hispanic/Latino/a (2.7%), International students (6.2%),
mutiracial (3.5%), and other (6.2%). When asked their partner status, 42 (37.2%) participants said they were single/never married, 57 (50.4%) participants said they were partnered/married, 9 (8.0%) reported being divorced, 1 (0.9%) reported being remarried, and 4 (3.5%) said “other.”

Procedures

The names and email addresses for training directors of the appropriate programs were obtained from the aforementioned websites. The training directors of CP and MFT graduate training programs were sent an e-mail, to pass on to their students, soliciting participation in the study (see Appendix A for solicitation letter). Potential respondents read an introduction to the study and the informed consent statement, and they were provided a link to the survey web page (see Appendix B for participant letter of participation and informed consent). The survey web page also contained an introduction to the study and informed consent. SurveyMonkey was used to collect data. This system allowed the researcher to create a web-based survey for participants to complete from any location over the Internet. The information and questions were presented to the participants online, and then the responses were collected and all quantitative data were exported from entry on the web into an SPSS file to be analyzed. The participants were randomly assigned to the African American or European American vignette condition by first entering their year and month of birth; participants with birthdays occurring in odd months were directed to the vignette of the African American clients, and participants with birthdays occurring during even months were directed to the vignette of the European American clients. Data were collected and stored by SurveyMonkey but were
only made available to the account holder. All information collected was kept confidential and secure and was not shared with any third parties. Data were reported in aggregate form so that individual participants or institutions could not be identified.

After the first email, a reminder email was sent to training directors to pass on to their students which again contained an introduction to the study, the informed consent statement, and a link to the survey web page. In an effort to increase participation, in the second email students were offered the chance to list their email addresses to be entered into a drawing for two $50 gift certificates; after completing the survey, students were directed to a separate page to enter this information. Their email addresses were not in any way connected to their survey responses, nor could their email addresses be used in any way to identify the data they provided.

Two coders were trained for three hours in scoring the multicultural case conceptualizations. One of the coders was a master’s level student in a counseling program and the other was an undergraduate psychology major. Coders were unaware of the research hypotheses and independently rated the etiology and treatment responses. Coders were provided with copies of an MCCA scoring manual based on those used by Ladany et al. (1997) and Inman (2006). During the training, coders read the scoring manual, which contained examples of each possible score. Next, the coders practiced scoring several examples of conceptualizations. Results were compared and rationales were discussed. The coders then were given fourteen responses to code (7 from the European American condition and 7 from the African American condition). The data from these fourteen responses was used to calculate interrater reliability using Cohen’s
Kappa (Cohen, 1960), which was sufficiently high enough for the coders to continue coding the MCCA data independently. The Kappa coefficient for etiology was 1.00 and for treatment was .85.

**Measures**

The survey web page included a demographic questionnaire, a clinical vignette, the MCKAS, the CoBRAS, and the BIDR. The vignette was presented first to protect responses from being influenced by the ensuing questionnaires (see Constantine & Ladany, 2000), followed by the BIDR, the CoBRAS, the MCKAS, and then the demographic questionnaire. All quantitative data was transferred from entry on the web into an SPSS file.

*Demographic questionnaire.* The following demographic and training variables were included on the demographic questionnaire: age; sex; race/ethnicity; partner status; whether the training program was accredited; degree sought; semesters of graduate study; number of multicultural courses and marriage and family therapy courses taken; clock hours in multicultural and marriage and family therapy workshops, presentations, and trainings; clock hours of counseling individual clients and couples or families in practicum; clock hours of counseling with racially/ethnically diverse clients in practicum; clock hours of supervision devoted to multicultural issues; amount of integration of multicultural issues into curriculum (using a Likert scale of 1 to 7 with anchors of 1 = *Not at all* and 7 = *Totally*); and degree of interest in and perceived preparation for conducting couples therapy (using the same Likert scale) (See Appendix D).
Vignettes & multicultural case conceptualization ability (MCCA). Participants were provided with a vignette to read, identical across experimental conditions except for the race of the clients, who were presented as either African American or European American as way to assess counselors’ attention to racial issues for both majority and minority clients. The vignette used was developed for this study and was based on the vignettes used in previous studies of multicultural case conceptualization ability (Bromley, 2004; Constantine & Ladany, 2001; Ladany et al., 1997) and on marriage and family therapy clinical vignettes (Boyd-Franklin & Franklin, 1998; Snyder, Cozzi, Grich, & Luebbert, 2001). The clients were a married, heterosexual couple. The description of the problem by the couple was “communication” because this is one of the most common presenting concerns of couples in therapy (Doss, Simpson, & Christensen, 2004). The setting for counseling was a local mental health center. See Appendix C for copies of the vignettes.

A coding system developed in previous research was used to score participants’ responses to the vignettes in order to assess multicultural case conceptualization ability (Bromley, 2004; Constantine & Ladany, 2001; Ladany et al., 1997). Multicultural case conceptualization ability is made up of two distinct yet interrelated cognitive factors. Differentiation consists of a counselor’s ability to provide alternative interpretations of a client’s presenting problems and possible treatment strategies, while integration consists of a counselor’s ability to make associations between and among these different interpretations (Ladany et al., 1997). Integrative cognitive complexity coding systems
have been validated in several previous investigations (Constantine & Ladany, 2001; Ladany et al., 1997; Tetlock; 1986).

The multicultural case conceptualization scoring system, taken from Ladany et al. (1997), ranges from 0-5, with the following values associated with each number: 0 = no indication of race or cultural factors (no differentiation, no integration); 1 = one mention of race or culture with no integration; 2 = one mention of race or culture with one integration or two mentions of race or culture with no integration; 3 = two or more mentions of race or culture with one integration; 4 = two or more mentions of race or culture with two or more integrations; and 5 = three or more mentions of race or culture with three or more integrations (high differentiation, high integration). This investigation comparatively examined how trainees incorporated race or culture in their conceptualizations with African American and European American clients.

*Multicultural Counseling Knowledge and Awareness Scale (MCKAS).* The MCKAS (Ponterotto et al., 2002) is a revision of the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996). The MCKAS is a 32-item self-report instrument that assesses dimensions of multicultural counseling competence on a 7-point Likert scale (1 = *not at all true*, 7 = *totally true*). Higher scores suggest higher perceived multicultural counseling competence. It is made up of two subscales: Knowledge (20 items) and Awareness (12 items). The Knowledge subscale measures general knowledge of multicultural counseling, and the Awareness subscale measures counselors’ attitudes and beliefs about working with culturally diverse clients. No cutoff scores have been determined to reflect acceptable multicultural knowledge and awareness. Internal
consistency estimates for both subscales were .85, and the two subscales had a very small correlation ($r = .04$) (Ponterotto et al., 2002). Convergent validity evidence for the Knowledge subscale has been established through significant correlations with the Knowledge subscale of the MCI (Multicultural Counseling Inventory; Sodowsky et al., 1994). Criterion-related evidence for the Knowledge subscale is suggested by a significant correlation in the expected direction with ethnic identity development (Ponterotto et al., 2002). (See Appendix G for a copy of the MCKAS.)

**Color-blind Racial Attitudes Scale (CoBRAS).** Neville et al. (2000) developed the CoBRAS to measure the degree to which a person denies racism and the effect of race on people’s lives. The CoBRAS is made up of 20 items rated on a 6-point Likert scale ranging from 1 (Strongly Disagree) to 6 (Strongly Agree), with higher scores reflecting higher levels of color-blindness in respondents. The CoBRAS taps three factors: 1) Racial Privilege, which indicates the denial of White privilege; 2) Institutional Discrimination, which refers to a lack of awareness of discriminatory institutional practices; and 3) Blatant Racial Issues, which includes the denial of the pervasiveness of racism and discrimination in society. Neville et al. (2000) reported coefficient alphas for internal consistency estimates of .91 (Total Score), .83 (Racial Privilege), .81 (Institutional Discrimination), and .76 (Blatant Racial Issues) for the first sample and .86, .80, .76, and .70 respectively for the second sample. Two-week test-retest reliability coefficients were .68 for the total score, .80 for the Racial Privilege and Institutional Discrimination factors, and .34 for the Blatant Racial Issues factor (suggesting this factor may be unstable). Concurrent validity evidence is suggested by the CoBRAS
demonstrating moderate to strong correlations with two measures of racial discrimination (i.e., Modern Racism Scale; McConahay, 1986; Quick Discrimination Index; Ponterotto, Burkard, et al., 1995), and discriminant validity evidence is suggested by a low, insignificant correlation with the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960). Exploratory and confirmatory factor analyses provided evidence of construct validity, and significant racial differences on the CoBRAS served as criterion-related validity evidence (Neville et al., 2000). (See Appendix E for a copy of the CoBRAS.)

**Balanced Inventory of Desirable Responding (BIDR).** The BIDR (Paulhus, 1988; 1991) is a measure consisting of 40 items that reflect two facets of socially desirable responding: Self-Deceptive Enhancement (SDE) and Impression Management (IM). People with high scores on self-deceptive enhancement actually believe in their overly positive self-reports, while people with high scores on impression management consciously present themselves in a favorable light. Each subscale is made up of twenty items measured on a 7-point Likert scale ranging from 1 = *not true* to 7 = *very true*. Items that are negatively keyed are reverse scored and then one point is added to all items that have a 6 or 7-point response while all other responses are given a score of 0, leading to total scores on the SDE and IM subscales that can range from 0-20. Paulhus (1991) argued that this scoring procedure ensures that only respondents who give exceedingly desirable responses attain high scores, which “provides some assurance that style rather than content is being tapped” (p. 39).
According to Paulhus (1991), the internal consistency reliability coefficients for the sum of the scales was .83, for the SDE scale ranged from .68 to .80, and for the IM scale ranged from .75 to .86. Test-retest correlations across a 5-week time period were .65 for the IM scale and .69 for the SDE scale. Concurrent validity has been established by a .71 correlation with the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) and a .80 correlation with the Multidimensional Social Desirability Inventory (Jacobson, Kellogg, Cauce, & Slavin, 1977) with the total scale score for the BIDR. Construct validity for the SDE subscale was demonstrated when high self-deception participants were more likely than low self-deception participants to show a self-serving bias after a failure experience. Additionally, high scorers showed more hindsight bias, more confidence in memory judgments, and were more likely to claim familiarity with non-existent products (Paulhus, 1988). Construct validity for the IM subscale was supported by an increase in scores when testing conditions went from private to public (while SDE scores were not affected by the administration conditions) (Paulhus, 1984). Discriminant validity was demonstrated when self-deception and impression management formed discrete factors in factor analyses (Paulhus, 1984, 1988). According to Paulhus (1991), the range of correlations between the two subscales was .05 to .40, which varied based on situational demands. Bromley (2004) found that the two subscales correlated moderately (.56) and that only SDE was related to the Racial Privilege subscale of the CoBRAS (Neville et al., 2000). This indicates that the subscales are measuring distinct yet related concepts. See Appendix F for a copy of the BIDR.
Research Questions

1. Is either facet of social desirability (self-deceptive enhancement or impression management) related to self-reported multicultural counseling competence, multicultural case conceptualization ability, or color-blind racial attitudes?

2. Are self-reported multicultural competencies related to the observed ability of trainees to include multicultural information in case conceptualizations of African American and European American clients?

3. Do color-blind racial attitudes affect the observed ability of trainees to include multicultural information in case conceptualizations of European American and African American clients, even after controlling for previous training and clinical experiences?

4. Are there differences in trainees’ observed ability to include multicultural information in case conceptualizations as a function of the race of the vignette clients (European American or African American)?

5. Does previous training in multicultural issues, experience with culturally diverse clients, or supervision focused on multicultural issues relate to trainees’ observed ability to include multicultural information in case conceptualizations of African American and European American clients or to trainees’ self-reported multicultural counseling competence?

Hypotheses

This study tested the following hypotheses as they relate to the research questions:

1. The dimensions of social desirability on the BIDR (impression management and self-deceptive enhancement) are statistically significantly positively correlated with self-
reported multicultural counseling competencies (both the Knowledge and Awareness subscales of the MCKAS).

2. The dimensions of social desirability on the BIDR (impression management and self-deceptive enhancement) are not statistically significantly positively correlated with color-blind racial attitudes on the CoBRAS (Racial Privilege, Institutional Discrimination, and Blatant Racial Issues).

3. The dimensions of social desirability on the BIDR (impression management and self-deceptive enhancement) are not statistically significantly positively correlated with trainees’ etiology and treatment MCCA scores.

4. The Knowledge and Awareness subscales of the MCKAS are not statistically significantly positively correlated with MCCA etiology or treatment scores.

5. Color-blind racial attitudes on the CoBRAS are not statistically significantly negatively correlated with MCCA etiology and treatment scores, after controlling for multicultural training (courses and workshop hours) and multicultural-based clinical experience (supervision, culturally diverse client hours).

6. Main effects for vignette race exist for MCCA etiology and treatment scores, with participants responding to a vignette of African American clients generating statistically significantly higher mean scores than participants responding to a vignette of European American clients.

7. The degree to which academic multicultural training and multicultural-based clinical experience account for variance in MCCA and MCKAS scores is assessed to ascertain
which type of measure (self-report vs. case conceptualization) best relates with variables presumed or known to theoretically or empirically affect such measures.

Data Analyses

Demographic and training variables and all key variables of interest (MCCA, BIDR, CoBRAS, MCKAS) underwent descriptive analyses. Cronbach’s alpha coefficients were calculated for the BIDR, CoBRAS, and MCKAS subscales. Interrater reliability estimates were calculated for the coders on the MCCA etiology and treatment ratings using Cohen’s Kappa to assess agreement over and above that which would occur by chance (Cohen, 1960).

A zero-order correlation matrix was calculated for the subscale scores of the BIDR, CoBRAS, MCCA, and MCKAS to illustrate the inter-correlations of the independent and dependent variables in this study. Hypotheses 1-4 were addressed through this correlation matrix.

Hypothesis 5 was addressed by two forced-entry hierarchical multiple regression analyses. The two social desirability subscales were entered first in a control block; then, relevant training variables (e.g., number of multicultural courses, clock hours of multicultural workshops, clock hours of counseling with racially/ethnically diverse clients in practicum, clock hours of supervision devoted to multicultural issues) were regressed against the dependent variable of MCCA scores in a second block, followed by a third block entry of CoBRAS subscale scores to determine any statistically significant change in $R^2$. 

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A two-way multivariate analysis of covariance (MANCOVA) was conducted to test hypothesis 6. The independent variable was the race of the clients in the vignette condition (European American or African American) and the dependent variables were MCCA scores for etiology and treatment. The two social desirability subscales (Self-Deceptive Enhancement and Impression Management) were entered as covariates.

Hypothesis 7 was addressed through two forced-entry hierarchical regression analyses. The relevant training variables (number of multicultural courses, clock hours of multicultural workshops, clock hours of counseling with racially/ethnically diverse clients in practicum, and clock hours of supervision devoted to multicultural issues) were entered as a block and regressed against the dependent variable of MCCA scores in one analysis and against the dependent variable of MCKAS scores in the second analysis.
CHAPTER IV

RESULTS

The significance level for all statistical analyses was set at the .05 level unless otherwise indicated. The data were explored for outliers and missing data. Per Tabachnick and Fidell (2001), outliers were identified by converting raw scores to \( z \) scores to assess the distance of the raw scores from their means. Any outlying scores (\( z \) scores larger than the absolute value of 3.3) were then assigned a raw score that was one unit larger than the next most extreme score, and missing data points were replaced using mean substitution; this allowed for the retention of cases that would have otherwise been lost. Although these procedures can attenuate the variance, given the small number of outliers and missing values, the risk for this in the current study is low and (Roth, 1994).

Prior to the main analyses, to examine the potential relationship between sex and race of the trainee with the primary variables of interest (multicultural case conceptualization ability, social desirability, color-blind racial attitudes, self-reported multicultural counseling competence), a series of univariate analyses were run to determine whether participants differed significantly on the BIDR, the CoBRAS, the MCKAS, and the etiology and treatment components of the MCCA task. Race of the trainee was dichotomized into two groups: Whites and trainees of color. Results indicated that no instrument revealed significant differences by sex or race of the trainee, so these demographic variables were not included in the main analyses.
Demographic Data

One hundred and eleven participants indicated that they were enrolled in an APA-accredited counseling psychology program or AAMFT-accredited marriage and family program; two participants indicated that they were not enrolled in either. The participants reported that they were enrolled in the following programs: 23 in a master’s program, 85 in a Ph.D. program, 1 in a Psy.D. program, and 4 in “other” programs. Participants indicated a mean of 7.61 semesters of graduate study ($SD = 4.31$; Median = 7.00; Range 1-19).

Participants reported taking a mean of 1.48 ($SD = 1.21$; Median = 1.00; Range 0-6) multicultural and/or diversity courses in graduate school and reported spending a mean of 37.05 ($SD = 60.47$; Median = 20; Range 0-326) hours attending multicultural and/or diversity workshops, presentations, trainings, and readings (not including courses taken). Participants provided a mean of 202.59 ($SD = 388.15$; Median = 88; Range 0-2002) hours of counseling to racially/ethnically diverse clients. Participants reported receiving a mean of 36.49 ($SD = 66.93$; Median = 15; Range 0-401) hours of supervision devoted to discussing multicultural issues. Participants were asked to rate on a 7-point Likert scale (1 = Not at all; 4 = Somewhat; 7 = Totally) the extent to which they felt multicultural issues were infused in the overall curriculum and coursework of their training program; they reported a mean of 5.02 ($SD = 1.41$; Median = 5.00; Range 2-7).

Participants reported taking a mean of 3.32 ($SD = 4.37$; Median = 2.00; Range 0-22) couples and/or family therapy courses in graduate school and reported spending a
mean of 48.41 ($SD = 76.38$; Median = 20; Range 0-401) hours attending couples and/or family therapy workshops, presentations, trainings, and readings (not including courses taken). Participants provided a mean of 251.04 ($SD = 469.71$; Median = 50; Range 0-2001) hours of counseling to couples and families.

Participants were asked to rate on a 7-point Likert scale (1 = Not at all prepared; 7 = Totally prepared) the extent to which they felt prepared to conducted couples therapy; they reported a mean of 4.28 ($SD = 1.90$; Median = 5.00; Range 1-7). Participants also were asked to rate on a 7-point Likert scale (1 = Not at all interested; 7 = Extremely interested) the extent to which they were interested in conducting couples therapy; they reported a mean of 5.55 ($SD = 1.89$; Median = 6.00; Range 1-7). See Table 1 for descriptive data on training variables.

Table 1

Descriptive Data for Training Variables

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Table 1 (continued)

Descriptive Data for Training Variables

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<td>5.55</td>
<td>1.89</td>
<td>6.00</td>
<td>7</td>
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</tr>
</tbody>
</table>

Measurement Properties

MCCA. For the two vignette conditions, 57 participants completed the African American client vignette and 56 completed the European American vignette. Interrater reliability estimates for etiology and treatment were 1.00 and .85, respectively.

Participants responding to the African American vignette scored a mean of .25 ($SD = .83$; Median = 0.0; Range 0-4) for etiology and .35 ($SD = .86$; Median = 0.0; Range 0-4) for treatment. Participants responding to the European American vignette scored a mean of .23 ($SD = .66$; Median = 0.0; Range 0-3) for etiology and .25 ($SD = .72$; Median = 0.0; Range 0-3) for treatment. The coding range possible for the MCCA task was 0-5. See Table 2 for the descriptive data for the vignettes.
### Table 2
Descriptive Data for Vignettes by Race Condition of Vignette

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MCCA Etiology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>.25</td>
<td>.83</td>
<td>0-4</td>
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<tr>
<td>European American</td>
<td>.23</td>
<td>.66</td>
<td>0-3</td>
</tr>
<tr>
<td><strong>MCCA Treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>.35</td>
<td>.86</td>
<td>0-4</td>
</tr>
<tr>
<td>European American</td>
<td>.25</td>
<td>.72</td>
<td>0-3</td>
</tr>
</tbody>
</table>

The means and standard deviations in this study are much lower than the means and standard deviations obtained in previous studies. Most of the earlier research did not report the range of scores actually attained by participants; rather, only the range possible was reported. This limits comparisons across studies. However, even in previous MCCA studies with higher average scores, trainees still scored well below the midpoint. For a comparison of descriptive data across MCCA studies, see Table 3.

### Table 3
Comparisons of Descriptive Data Across MCCA Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>M</th>
<th>SD</th>
<th>Range Possible</th>
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</thead>
<tbody>
<tr>
<td>Ladany et al. (1997)</td>
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<tr>
<td>MCCA etiology</td>
<td>1.82</td>
<td>1.39</td>
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<tr>
<td>MCCA treatment</td>
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<td>1.62</td>
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Table 3 (continued)

Comparisons of Descriptive Data Across MCCA Studies

<table>
<thead>
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<th>Study</th>
<th>$M$</th>
<th>$SD$</th>
<th>Range Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constantine &amp; Ladany (2000)</td>
<td></td>
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<tr>
<td>MCCA etiology</td>
<td>2.04</td>
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<tr>
<td>MCCA treatment</td>
<td>1.41</td>
<td>1.43</td>
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</tr>
<tr>
<td>Constantine (2001a)</td>
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<tr>
<td>MCCA etiology</td>
<td>2.48</td>
<td>1.13</td>
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<td>MCCA treatment</td>
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</tr>
<tr>
<td>Constantine (2001b)</td>
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<td>3.02</td>
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<td>Gainor &amp; Constantine (2002)</td>
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<td>Web-based supervision:</td>
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<tr>
<td>MCCA etiology pre-test</td>
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<td>0-5</td>
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<td>MCCA etiology post-test</td>
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<td>In-person supervision</td>
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<td>MCCA treatment post-test</td>
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<td>Constantine &amp; Gushue (2003)</td>
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<tr>
<td>MCCA etiology and treatment</td>
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<td>1.88</td>
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### Table 3 (continued)

Comparisons of Descriptive Data Across MCCA Studies

<table>
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<td><strong>Bromley (2004)</strong></td>
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<td>MCCA etiology</td>
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<td>1.28</td>
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<td>MCCA treatment</td>
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<td>.89</td>
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<tr>
<td>European American vignettes</td>
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<tr>
<td>MCCA etiology</td>
<td>.45</td>
<td>.83</td>
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</tr>
<tr>
<td>MCCA treatment</td>
<td>.39</td>
<td>.90</td>
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<tr>
<td><strong>Constantine et al. (2005)</strong></td>
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<td>MCCA etiology</td>
<td>2.78</td>
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<td>0-5</td>
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<td>1.02</td>
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<td><strong>Inman (2006)</strong></td>
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<td>MCCA treatment</td>
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<td>1.04</td>
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<td><strong>Schomburg (2007)</strong></td>
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<td>African American vignettes</td>
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<tr>
<td>MCCA etiology</td>
<td>.25</td>
<td>.83</td>
<td>0-5</td>
</tr>
<tr>
<td>MCCA treatment</td>
<td>.35</td>
<td>.86</td>
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<tr>
<td>European American vignettes</td>
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</tr>
<tr>
<td>MCCA etiology</td>
<td>.23</td>
<td>.66</td>
<td></td>
</tr>
<tr>
<td>MCCA treatment</td>
<td>.25</td>
<td>.72</td>
<td></td>
</tr>
</tbody>
</table>

*a Constantine (2001a) reported the separate means for etiology and treatment scores; however, the primary analyses were run using a total score, which was calculated by adding the etiology and treatment scores together. 
*b Constantine & Gushue (2003) collapsed (added) etiology and treatment scores together and did not average them.

Qualitative examples of participants’ responses to the vignettes can be found in Appendix H to illustrate the operationalization of the coding system for the MCCA task.
Examples of high and low scores obtained on the MCCA coding system for both vignette conditions (i.e., African American and European American) are presented.

*MCKAS.* The MCKAS is a 32-item self-report instrument that assesses dimensions of multicultural counseling competence on a 7-point Likert scale (1 = *not at all true*, 7 = *totally true*). Higher scores suggest higher perceived multicultural counseling competence. The MCKAS is made up of two subscales: Knowledge (20 items) and Awareness (12 items). In this study, internal consistency estimates for the MCKAS subscales were .87 for Knowledge and .75 for Awareness. The correlation between the two subscales was .23; this is higher than the correlation \( r = .04 \) reported by Ponterotto et al. (2002), although still well within in range found in previous research \( r = .22 \) to .44 (Ponterotto & Potere, 2003). The scales appear to be independent and measuring different constructs. See Table 4 for the descriptive data for the MCKAS.

Table 4

<table>
<thead>
<tr>
<th>Scale</th>
<th>( M )</th>
<th>( SD )</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>5.22</td>
<td>.77</td>
<td>2.95-7.00</td>
</tr>
<tr>
<td>Awareness</td>
<td>6.09</td>
<td>.59</td>
<td>4.17-7.00</td>
</tr>
<tr>
<td>Total Scale</td>
<td>5.55</td>
<td>.58</td>
<td>4.00-6.88</td>
</tr>
</tbody>
</table>

*Note.* Mean subscale scores were derived by dividing the total sum score of the subscale by the number of subscale items to retain the Likert-scale conversion.
The CoBRAS is made up of 20 items rated on a 6-point Likert scale ranging from 1 (Strongly Disagree) to 6 (Strongly Agree), with higher scores reflecting higher levels of color-blindness in respondents. Internal consistency coefficients for the subscales of the CoBRAS in the current study were .83 for Racial Privilege, .80 for Institutional Discrimination, and .60 for Blatant Racial Issues, similar to the range found in previous research ($r = .61$ to .83) (Bromley, 2004; Neville et al., 2000). The subscale correlations ranged from .43-.61, slightly higher than the range of magnitudes (.42-.54) reported in the development of the scale (Neville et al., 2000). See Table 5 for the descriptive data for the CoBRAS.

Table 5
Descriptive Data for the CoBRAS

<table>
<thead>
<tr>
<th>Scale</th>
<th>$M$</th>
<th>$SD$</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Racial Privilege</td>
<td>2.46</td>
<td>.91</td>
<td>1.00-5.38</td>
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<tr>
<td>Institutional Discrimination</td>
<td>2.67</td>
<td>1.05</td>
<td>1.00-5.33</td>
</tr>
<tr>
<td>Blatant Racial Issues</td>
<td>1.57</td>
<td>.55</td>
<td>1.00-3.33</td>
</tr>
<tr>
<td>Total Scale</td>
<td>2.26</td>
<td>.72</td>
<td>1.00-4.05</td>
</tr>
</tbody>
</table>

*Note.* Mean subscale scores were derived by dividing the total sum score of the subscale by the number of subscale items to retain the Likert-scale conversion.

The BIDR is made up of 40 items measured on a 7-point Likert scale ranging from 1 = *not true* to 7 = *very true*, and each subscale is made up of twenty items. Items that are negatively keyed are reverse scored and then one point is added for all
items that have a 6 or 7-point response while all other responses are given a score of 0, leading to total scores on the SDE and IM subscales that can range from 0-20. Internal consistency coefficients for the subscales of the BIDR in the current study were .70 for Self-Deceptive Enhancement and .80 for Impression Management, comparable to estimates obtained in the development of the scale (Paulhus, 1991). The correlation between the two subscales was .38. This is consistent with the range of magnitudes (.05-.40) reported by Paulhus (1991). See Table 6 for the descriptive data for the BIDR.

Table 6

Descriptive Data for the BIDR

<table>
<thead>
<tr>
<th>Scale</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDE</td>
<td>5.30</td>
<td>3.21</td>
<td>0-16</td>
</tr>
<tr>
<td>IM</td>
<td>6.68</td>
<td>4.05</td>
<td>0-15</td>
</tr>
<tr>
<td>Total Scale</td>
<td>11.98</td>
<td>6.05</td>
<td>1-24</td>
</tr>
</tbody>
</table>

Tests of Hypotheses

Table 7 provides the intercorrelations among the MCCA treatment and etiology ratings, the CoBRAS subscales, the BIDR subscales, and the MCKAS subscales. On the diagonal of the table are the Cronbach alpha coefficients, with the exception of MCCA; for MCCA, the Cohen’s Kappa coefficients are in the diagonal.
Table 7

Intercorrelations of the MCKAS, CoBRAS, BIDR, MCCA Etiology, and MCCA Treatment

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
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</thead>
<tbody>
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<td>1</td>
<td>MCKAS K</td>
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<tr>
<td>2</td>
<td>MCKAS A</td>
<td>.23&lt;sup&gt;*&lt;/sup&gt;</td>
<td>.75&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>3</td>
<td>RP</td>
<td>-.50&lt;sup&gt;**&lt;/sup&gt;</td>
<td>-.41&lt;sup&gt;**&lt;/sup&gt;</td>
<td>.83&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>4</td>
<td>ID</td>
<td>-.35&lt;sup&gt;**&lt;/sup&gt;</td>
<td>-.31&lt;sup&gt;**&lt;/sup&gt;</td>
<td>.61&lt;sup&gt;**&lt;/sup&gt;</td>
<td>.80&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>5</td>
<td>BRI</td>
<td>-.34&lt;sup&gt;**&lt;/sup&gt;</td>
<td>-.30&lt;sup&gt;**&lt;/sup&gt;</td>
<td>.57&lt;sup&gt;**&lt;/sup&gt;</td>
<td>.43&lt;sup&gt;**&lt;/sup&gt;</td>
<td>.60&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>6</td>
<td>MCCA E</td>
<td>.09</td>
<td>.20&lt;sup&gt;*&lt;/sup&gt;</td>
<td>-.15</td>
<td>-.16</td>
<td>-.10</td>
<td>1.00&lt;sup&gt;b&lt;/sup&gt;</td>
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<tr>
<td>7</td>
<td>MCCA T</td>
<td>.13</td>
<td>.21&lt;sup&gt;*&lt;/sup&gt;</td>
<td>-.14</td>
<td>-.09</td>
<td>-.12</td>
<td>.12</td>
<td>.85&lt;sup&gt;b&lt;/sup&gt;</td>
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<tr>
<td>8</td>
<td>SDE</td>
<td>-.04</td>
<td>.04</td>
<td>.12</td>
<td>.06</td>
<td>.10</td>
<td>-.18</td>
<td>-.01</td>
<td>.70&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>9</td>
<td>IM</td>
<td>-.12</td>
<td>.08</td>
<td>.15</td>
<td>.17</td>
<td>.27&lt;sup&gt;**&lt;/sup&gt;</td>
<td>-.13</td>
<td>-.01</td>
<td>.38&lt;sup&gt;**&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Note. 1 = MCKAS Knowledge; 2 = MCKAS Awareness; 3 = CoBRAS Racial Privilege; 4 = CoBRAS Institutional Discrimination; 5 = CoBRAS Blatant Racial Issues; 6 = MCCA etiology; 7 = MCCA treatment; 8 = BIDR Self-deceptive Enhancement; 9 = BIDR Impression Management.

<sup>a</sup>Alpha coefficients are in the diagonal except for MCCA etiology and treatment, which have the <sup>b</sup>Cohen’s Kappa coefficient.

<sup>*</sup>Significant at <i>p</i> < .05; **significant at <i>p</i> < .01.

The first hypothesis stated that social desirability would be related to self-reported multicultural counseling competencies. The two subscales of the MCKAS (Knowledge and Awareness) were not statistically significantly related to the two subscales of the
BIDR (Self-Deceptive Enhancement and Impression Management). Contrary to expectations, socially desirable responding was not related to trainees’ self-reported multicultural counseling competencies. Hypothesis 1 was not supported.

The second hypothesis proposed that the two dimensions of social desirability (Self-Deceptive Enhancement and Impression Management) would not be related to color-blind racial attitudes. Only the Impression Management subscale of the BIDR was significantly but weakly related to the Blatant Racial Issues subscale of the CoBRAS ($r = .27; p < .01$). The two subscales of the BIDR were not statistically significantly related to any other subscales of the CoBRAS. The second hypothesis was partially supported in that the conscious presentation of oneself in a favorable light was related to the denial of the pervasiveness of racism in society (Blatant Racial Issues).

The third hypothesis proposed that the dimensions of social desirability on the BIDR (Self-Deceptive Enhancement and Impression Management) would not be statistically significantly related to trainees’ observed ability to include multicultural information in case conceptualizations. The two subscales of the BIDR were not statistically significantly related to etiology or treatment scores on the MCCA task ($r = |.01\text{ to } .18|; p > .05$). The third hypothesis was supported, indicating that social desirability was not related to trainees’ ability to account for cultural factors in case conceptualizations.

The fourth hypothesis stated that self-reported multicultural counseling competence would not be correlated with MCCA etiology or treatment scores. This hypothesis was partially supported (see Table 7). The Knowledge subscale of the
MCKAS was not correlated with MCCA etiology or treatment scores. The Awareness subscale of the MCKAS was significantly but weakly related to MCCA etiology ($r = .20; p < .05$) and to MCCA treatment ($r = .21; p < .05$), indicating that trainees who had higher levels of multicultural awareness were more likely to incorporate racial factors into their conceptualizations of clients.

The fifth hypothesis predicted that color-blind racial attitudes would be inversely related to MCCA etiology and treatment scores, after controlling for multicultural academic training and clinical experience variables. Two 3-step forced-entry multiple regression analyses were conducted. The criterion variables were MCCA etiology and treatment scores. Social desirability indices were added to the regression analyses as the first control block. This was followed by training variables (number of multicultural courses; clock hours of multicultural workshops, clock hours of counseling with racially/ethnically diverse clients in practicum, and clock hours of supervision devoted to multicultural issues) in the second block, and the three subscales of the CoBRAS in the third block (Racial Privilege, Institutional Discrimination, Blatant Racial Issues).

Tables 8 and 9 provide a summary of the two forced-entry regression analyses for the relationship between color-blind racial attitudes and MCCA etiology and treatment scores after controlling for social desirability and training and experience variables. In the first analysis with MCCA Etiology scores serving as the criterion variable, social desirability attitudes were not found to contribute significant variance to the MCCA etiology scores, $F(2, 110) = 2.12, p = .13; R^2 = .04$ (adjusted $R^2 = .02$). After taking into account the variability in MCCA etiology scores due to social desirability attitudes,
multicultural training and experience did not make a significant contribution, $R^2$ change $= .03$, $F(6, 106)$ change $= 1.27$, $p = .28$, $R^2 = .07$ (adjusted $R^2 = .01$). After accounting for the variability in the MCCA etiology scores due to social desirability and multicultural training and experience, color-blind racial attitudes did not explain additional significant variance $R^2$ change $= .01$, $F(9, 103)$ change $= 1.00$, $p = .44$, $R^2 = .08$ (adjusted $R^2 = .00$). Thus, after controlling for social desirability and multicultural training and experience, color-blind racial attitudes accounted for 1% of the variance in MCCA etiology scores.

Table 8
Summary of the Forced-Entry Multiple Regression Analysis for Variables Explaining MCCA Etiology Scores.

<table>
<thead>
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<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
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<td>IM</td>
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<td>.02</td>
<td>-.04</td>
<td>-.39</td>
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Table 8 (continued)
Summary of the Forced-Entry Multiple Regression Analysis for Variables Explaining MCCA Etiology Scores.

<table>
<thead>
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<th>Variables</th>
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<tr>
<td>RP</td>
<td>-.01</td>
<td>.01</td>
<td>-.05</td>
<td>-.40</td>
</tr>
<tr>
<td>ID</td>
<td>-.01</td>
<td>.02</td>
<td>-.10</td>
<td>-.80</td>
</tr>
<tr>
<td>BRI</td>
<td>.01</td>
<td>.03</td>
<td>.04</td>
<td>.35</td>
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</tbody>
</table>

Note. SDE = Self-Deceptive Enhancement; IM = Impression Management; Courses = number of multicultural counseling courses taken. Training = clock hours of multicultural and/or diversity workshops, presentations, training, or reading (not including courses); Client Hrs = clock hours of counseling provided to racially/ethnically diverse clients; SV Hrs = clock hours of supervision received that were devoted to discussing multicultural issues; RP = Racial Privilege; ID = Institutional Discrimination; BRI = Blatant Racial Issues.

The MCCA treatment scores served as the criterion variable in the second forced-entry regression analysis (see Table 9). In the first step, social desirability attitudes did not contribute significant variance to MCCA treatment scores, $F(2, 110) = .01, p = .99; R^2 = .00$ (adjusted $R^2 = -.02$). After accounting for social desirability, multicultural training and experience did account for a significant proportion of the variance in the MCCA treatment scores, $R^2$ change = .11, $F(6, 106) \text{ change } = 2.27, p < .05, R^2 = .11$.
(adjusted $R^2 = .06$). Specifically, more clock hours of multicultural and/or diversity workshops, presentations, training, or reading (not including courses) were associated with higher MCCA treatment scores. After controlling for the previous variables, color-blind racial attitudes did not explain additional significant variance in MCCA treatment scores $R^2$ change $= .00$, $F(9, 103)$ change $= 1.53$, $p = .15$, $R^2 = .12$ (adjusted $R^2 = .04$). After controlling for social desirability and multicultural training and experience, color-blind racial attitudes accounted for none of the variance in MCCA treatment scores.

Table 9
Summary of the Forced-Entry Multiple Regression Analysis for Variables Explaining MCCA Treatment Scores.

<table>
<thead>
<tr>
<th>Variables</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
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<td>SDE</td>
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<td>.03</td>
<td>.01</td>
<td>.08</td>
</tr>
<tr>
<td>IM</td>
<td>.01</td>
<td>.02</td>
<td>.05</td>
<td>.44</td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Courses</td>
<td>.12</td>
<td>.07</td>
<td>.18</td>
<td>1.74</td>
</tr>
<tr>
<td>Training</td>
<td>.00</td>
<td>.00</td>
<td>.27</td>
<td>2.81**</td>
</tr>
<tr>
<td>Client Hrs</td>
<td>.00</td>
<td>.00</td>
<td>-.03</td>
<td>-.30</td>
</tr>
<tr>
<td>SV Hrs</td>
<td>.00</td>
<td>.00</td>
<td>-.08</td>
<td>-.74</td>
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</tbody>
</table>
Table 9 (continued)

Summary of the Forced-Entry Multiple Regression Analysis for Variables Explaining MCCA Treatment Scores.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Variables</th>
<th>$B$</th>
<th>SE $B$</th>
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<th>$t$</th>
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<tr>
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<td>RP</td>
<td>-.01</td>
<td>.01</td>
<td>-.07</td>
<td>-.55</td>
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<td>ID</td>
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<td>.02</td>
<td>.05</td>
<td>.44</td>
</tr>
<tr>
<td></td>
<td>BRI</td>
<td>.00</td>
<td>.03</td>
<td>-.01</td>
<td>-.11</td>
</tr>
</tbody>
</table>

Note. SDE = Self-Deceptive Enhancement; IM = Impression Management; Courses = Number of multicultural counseling courses taken. Training = clock hours of multicultural and/or diversity workshops, presentations, training, or reading (not including courses); Client Hrs = clock hours of counseling provided to racially/ethnically diverse clients; SV Hrs = clock hours of supervision received that were devoted to discussing multicultural issues; RP = Racial Privilege; ID = Institutional Discrimination; BRI = Blatant Racial Issues.

**Significant at $p < .01$.**

The sixth hypothesis anticipated differences in trainees’ observed ability to include race-based information in case conceptualizations as a function of the race of the client in the stimulus vignette. Specifically, participants responding to a vignette of African American clients were expected to generate higher MCCA scores than participants responding to a vignette of European American clients. This hypothesis was
tested using a multivariate analysis of covariance (MANCOVA) with the independent variables of the race of the clients in the vignette (i.e., African American or European American). The dependent variables were the MCCA scores for etiology and treatment. The covariates were the two subscales of the BIDR, self-deceptive enhancement and impression management.

A significant amount of variance was not accounted for by the covariate Self-Deceptive Enhancement subscale (Wilks’ Lambda [2, 108] = 1.29; \( p = .28 \)) or by the Impression Management subscale (Wilks’ Lambda [2, 108] = .18; \( p = .83 \)). The dependent variables were not significantly affected by the race of the clients in the vignette (Wilks’ Lambda [2, 108] = .30; \( p = .74 \)). As a result, no follow-up univariate tests were examined.

The seventh hypothesis examined whether higher amounts of multicultural training and multicultural-based clinical experience better explained variance in MCCA scores than MCKAS scores. Two forced-entry regression analyses were conducted for the purpose of gross comparison of total \( R^2 \) value. The criterion variables were MCCA total scores and MCKAS total scores. Total scores were used in these analyses to account for all of the components in each assessment measure.

Table 10 provides a summary of the forced-entry regression analysis for the relationship among training and experience variables (number of multicultural courses, clock hours of multicultural workshops, clock hours of counseling with racially/ethnically diverse clients in practicum, and clock hours of supervision devoted to multicultural issues) and MCCA scores. With MCCA scores serving as the criterion
variable, training and experience variables were found to account for a small but significant amount of variance in the MCCA scores, $F(4, 108) = 3.65, p < .01; R^2 = .12$ (adjusted $R^2 = .09$). In particular, the number of clock hours of multicultural and/or diversity workshops, presentations, training, or reading (not including courses) made a significant contribution. Thus, multicultural training and experience accounted for 9% of the variance in MCCA total scores.

Table 10
Summary of the Forced-Entry Regression Analysis for Training Variables Explaining MCCA Scores.

<table>
<thead>
<tr>
<th>Variables</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
</tr>
</thead>
<tbody>
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<td>Courses</td>
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<td>.16</td>
<td>1.67</td>
</tr>
<tr>
<td>Training</td>
<td>.01</td>
<td>.00</td>
<td>.29</td>
<td>3.23**</td>
</tr>
<tr>
<td>Client Hrs</td>
<td>.00</td>
<td>.00</td>
<td>-.06</td>
<td>-.61</td>
</tr>
<tr>
<td>SV Hrs</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>-.01</td>
</tr>
</tbody>
</table>

*Note. Courses = number of multicultural counseling courses taken. Training = clock hours of multicultural and/or diversity workshops, presentations, training, or reading (not including courses); Client Hrs = clock hours of counseling provided to racially/ethnically diverse clients; SV Hrs = clock hours of supervision received that were devoted to discussing multicultural issues.

*Significant at $p < .05$; **significant at $p < .01$. 

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Table 11 provides a summary of the forced-entry regression analysis for the relationship among training and experience variables (number of multicultural courses, clock hours of multicultural workshops, clock hours of counseling with racially/ethnically diverse clients in practicum, and clock hours of supervision devoted to multicultural issues) and MCKAS scores. With MCKAS scores serving as the criterion variable, training and experience variables were found to account for a small but significant amount of variance in the MCKAS scores, $F(4, 108) = 6.34, p < .01; R^2 = .19$ (adjusted $R^2 = .16$). In particular, the number of multicultural courses taken made a significant contribution. Thus, multicultural training and experience accounted for 16% of the variance in MCKAS total scores.

Table 11
Summary of the Forced-Entry Regression Analysis for Training Variables Explaining MCKAS Scores.

<table>
<thead>
<tr>
<th>Variables</th>
<th>MCKAS</th>
<th>$B$</th>
<th>SE $B$</th>
<th>$\beta$</th>
<th>$t$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Courses</td>
<td>5.93</td>
<td>1.42</td>
<td>.39</td>
<td>4.16**</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>.05</td>
<td>.03</td>
<td>.17</td>
<td>2.00</td>
<td></td>
</tr>
<tr>
<td>Client Hrs</td>
<td>.00</td>
<td>.00</td>
<td>.05</td>
<td>.52</td>
<td></td>
</tr>
<tr>
<td>SV Hrs</td>
<td>.00</td>
<td>.03</td>
<td>-.01</td>
<td>-.12</td>
<td></td>
</tr>
</tbody>
</table>
Table 11 (continued)

Summary of the Forced-Entry Regression Analysis for Training Variables Explaining MCKAS Scores.

| Note | Courses = number of multicultural counseling courses taken. Training = clock hours of multicultural and/or diversity workshops, presentations, training, or reading (not including courses); Client Hrs = clock hours of counseling provided to racially/ethnically diverse clients; SV Hrs = clock hours of supervision received that were devoted to discussing multicultural issues. *Significant at $p < .05$; **significant at $p < .01$. |

**Summary**

Hypothesis 1 was not supported, indicating that socially desirable responding was not related to trainees’ self-reported multicultural counseling competence. Hypothesis 2 was partially supported with the Blatant Racial Issues subscale correlating significantly but weakly with the Impression Management subscale. Hypothesis 3 was supported; social desirability was not related to trainees’ MCCA etiology and treatment scores. Hypothesis 4 was partially supported. Self-reported knowledge of multicultural counseling was not related to an observable measure of multicultural counseling competence; however, self-reported awareness was related to MCCA etiology and treatment scores. In contrast to expectations, hypothesis 5 was not supported. After controlling for social desirability and multicultural training and experience, color-blind racial attitudes did not explain additional significant variance in MCCA etiology or treatment scores. Hypothesis 6 was not supported. Trainees’ ability to incorporate racial factors into their case conceptualizations was not influenced by the race of the clients in the vignette. Hypothesis 7 was partially supported. The number of clock hours of
multicultural and/or diversity workshops, presentations, training, or reading (not including courses) accounted for some variance in MCCA scores, and multicultural courses taken accounted for some variance in MCKAS scores. Overall, more variance was accounted for by training in MCKAS scores (16%) versus MCCA scores (9%).
CHAPTER V

DISCUSSION

The purpose of this study was to build upon previous research investigating the assessment of multicultural counseling competence through a multicultural case conceptualization task (Bromley, 2004; Constantine, 2001a; Constantine, 2001b; Constantine & Gushue, 2003; Constantine & Ladany, 2000; Inman, 2006; Ladany et al., 1997). Methodological limitations in the MCCA literature were addressed, and the MCCA task was compared with a self-report measure of multicultural counseling competence to illustrate the utility of these methods of assessment.

To achieve these objectives, the current study improved upon prior methodological shortcomings by investigating multicultural case conceptualization ability in couples therapy, by examining a factor (i.e., color-blind racial attitudes) that could detract trainees from incorporating cultural factors into their conceptualizations, by examining the stimulus value of the clients in the vignette through the use of two vignette conditions (European American and African American), and by using a multidimensional measure of social desirability. This study also compared how multicultural training and clinical experience variables influence a self-report measure and an observer-report measure of multicultural counseling competence.
Implications of Results

The findings of the current study suggest some implications for future research, training, practice, and theory.

Social desirability. This study employed a two-dimensional measure of social desirability as opposed to a one-dimensional measure most commonly used in previous research (e.g., the Marlowe-Crowne Social Desirability Scale; Crowne & Marlowe, 1960). Consistent with previous studies, social desirability was not significantly correlated with scores on an observed measure of multicultural counseling competence or with color-blind racial attitudes on the whole. It is possible that the participants may have recognized the measure as tapping social desirability and adjusted their responses accordingly. The means for the current sample were 5.30 for self-deceptive enhancement and 6.68 for impression management. In a sample of college students, Paulhus (1991) reported means for self-deceptive enhancement of 7.5 and 6.8 and means of 4.3 and 4.9 for impression management, the latter of which are lower than the mean in the current sample. The overall mean for the current sample was 11.98, comparable to overall means of 11.9 and 11.2 reported previously (Paulhus, 1991).

The current study did not reveal a relationship between the MCKAS and social desirability. One possible explanation comes from a closer examination of the previous literature investigating the relationship between social desirability and self-report measures of multicultural counseling competence. The MCKAS was chosen as the self-report measure for the current study because in previous investigations, this scale appeared to be the least related to social desirability. Constantine and Ladany (2001)
found that higher scores on the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) were significantly positively related to higher self-report ratings on the CCCI-R (LaFramboise et al., 1991), the MAKSS Skills subscale (D’Andrea et al., 1991), and the MCI Relationship subscale (Sodowski et al., 1994). However, they found no significant relationship between the MCKAS Knowledge subscale and social desirability, and they found a significant negative relationship between the MCKAS Awareness subscale and social desirability. In addition, Bromley (2004) also did not find a relationship between the two subscales of the BIDR and the Knowledge and Awareness subscales of the MCKAS. Thus, the current findings appear to support the notion that the MCKAS is not related to social desirability as it is measured by the BIDR or the MCSDS.

The current study does not reveal that the two dimensions of social desirability as measured by the BIDR are related to the construct multicultural counseling competence (as measured by self-report or observer-report) differentially. However, an examination of the correlation matrix alludes to a trend this direction, as the relationship between MCCA etiology scores and self-deceptive enhancement was approaching significance ($r = -.18, p = .05$). This trend suggests that people who provide honest yet overly confident self-reports may score be less likely to incorporate racial factors in etiological conceptualizations of clients. However, because this finding was not statistically significant in the current study, this interpretation should be considered very tentative and should be examined in future research.
On the other hand, when examining color-blind racial attitudes, the pattern of relationships between the CoBRAS and the two dimensions of social desirability was different. Specifically, people who consciously self-reported higher levels of desirable behavior and lower levels of undesirable behavior (i.e., Impression Management) were more likely to deny that racism is pervasive in society (i.e., Blatant Racial Issues). This finding suggests that the two dimensions of social desirability may relate to color-blind racial attitudes differently. Future investigations should seek to replicate this outcome. If future results are consistent with the present study, researchers may want to incorporate a two-dimensional, as opposed to one-dimensional, measure of social desirability in investigations of color-blind racial attitudes.

Measuring multicultural counseling competence. In this study, trainees endorsed high levels of multicultural counseling competence. Trainees who endorsed high levels of awareness were also more likely to incorporate racial factors into case conceptualizations. However, high endorsement of multicultural knowledge was not associated with multicultural case conceptualization ability. These findings are consistent to some extent with previous research (e.g., Bromley, 2004; Constantine & Ladany, 2000) and illustrate the importance of using multiple methods for assessing trainee multicultural counseling competence.

The significant correlation between self-reported awareness and MCCA etiology and treatment scores was surprising. Ladany et al. (1997) did not find a significant correlation between MCCA etiology and treatment scores and the CCCI-R. Bromley (2004) did not find a significant relationship between the Knowledge or Awareness
subscales and MCCA etiology or treatment scores. One the whole, Constantine and Ladany (2000) did not find multicultural counseling competence as measured by 4 self-report instruments to be related to MCCA etiology and treatment, although similar to the current study, the correlation between the MCKAS Awareness subscale and MCCA treatment scores was significant ($r = .18$).

Given the low correlations between the 2 subscales on the MCKAS in this study and others (Ponterotto & Potere, 2003), it appears that the two subscales of the MCKAS are measuring different constructs. It is possible that that the MCKAS awareness subscale is tapping a similar component of multicultural counseling competence as the MCCA task and that the MCKAS Knowledge subscale is assessing some other component of multicultural counseling competence. Another possibility is that because the Knowledge subscale has consistently not been related to MCCA scores, this subscale may not accurately measure multicultural counseling competence. In any case, clearer definitions of the constructs being tapped by the MCKAS would be useful.

An alternative explanation for the differences found on the Knowledge and Awareness subscales may be that the development of knowledge precedes awareness. The results indicated that trainees who endorsed high levels of awareness were more likely to incorporate racial factors into case conceptualizations, whereas the same was not true for trainees who endorsed high levels of knowledge. Perhaps cultural knowledge alone is not enough to translate into behaviors (i.e., the MCCA task). More information about the progression of the development of multicultural counseling competence would better inform this speculation.
The lack of a correlation between the MCKAS Knowledge subscale and the MCCA task in the current study was consistent with previous studies. One measurement limitation that may have influenced the lack of relationship between these two measures is the limited range of scores on the MCCA task. Research that has demonstrated a lack of relationship between the two measures (MCKAS and MCCA) reflects a weakness in concurrent validity for the two instruments. One possible explanation is that the two measures are tapping different components of multicultural counseling competence. However, it is difficult to discern whether the MCCA task is measuring what it is assumed to measure without a similar behavioral demonstration of known cultural competence as a concurrent validity point of reference. Evidence is needed to substantiate that MCCA is truly gauging multicultural counseling skill by comparing MCCA scores with another measurement of multicultural skill.

If the goal behind assessing self-reported multicultural counseling competence is to use it as a predictor for competent work with clients, the fact that self-reported competence does not correlate with scores that are supposed to be a criterion measure of this construct is concerning. Future research could examine how self-reported multicultural counseling competence predicts future behavior on the MCCA task.

An alternative explanation may be that participants are responding in ways that inflate their perceived competence. An examination of the mean scores on the MCKAS suggests that participants considered themselves multiculturally competent. However, mean scores on the MCCA task were very low, which may indicate that participants overestimated their true level of multicultural counseling competence. Previous
researchers have suggested that the difference between self-report measures of multicultural counseling competence and the MCCA task may be accounted for by the influence of social desirability (Ladany et al., 1997); however, in the current study, social desirability was not significantly correlated with the MCKAS, and prior research did not reveal that self-reported multicultural counseling competence was significantly related to multicultural case conceptualization ability after controlling for social desirability (Constantine & Ladany, 2000).

Another possible explanation for the lack of relationship between the two measures is that the self-report measures are actually tapping multicultural counseling self-efficacy beliefs (Constantine & Ladany, 2001), whereas the MCCA task is measuring genuine competence. Prior research on self-efficacy and behavior has revealed only a moderate relationship between self-efficacy and objective measures of ability (Lent, Brown, & Larkin, 1986).

In fact, Constantine (2001c) acknowledged that the conceptual and empirical differences between counseling self-efficacy and counseling self-perceptions are not always apparent. Constantine even proposed using self-report instruments as a measure of self-efficacy when she said, “it is feasible to consider that general counseling self-efficacy evaluations and multicultural counseling self-efficacy evaluations (as assessed through self-report multicultural measures) may be empirically similar, or at least overlapping constructs” (p. 83). Using a measure of self-reported multicultural counseling competence, Constantine found that general counseling self-efficacy beliefs accounted for 30% of the variance in the CCCIR (LaFromboise et al., 1991). However,
elsewhere, Constantine and Ladany (2001) distinguished between self-efficacy (expectations directly tied to specific behaviors) and self-perceptions (beliefs about one’s knowledge and self-awareness). Thus, it remains unclear what exactly the self-report instruments of multicultural counseling competence are measuring.

This suggests that the self-report measures of multicultural counseling competence, such as the MCKAS, may be most useful as a measure of students’ own self-perceptions of their multicultural counseling competency as opposed to using the instrument to evaluate trainees, which the authors of the MCKAS have continued to warn against since the instrument’s development (Ponterotto et al., 2002). If the MCCA task is a truer measure of multicultural counseling competence, given that the mean scores on the MCCA task have been fairly low across numerous studies, this is concerning; it seems important to examine whether these low scores are a function of the measure or a true reflection of the state of trainee multicultural counseling competence.

Another consideration that must be made when interpreting the low correlations between self-report and observer-report measures of multicultural counseling competence relates to shared method variance. When obtaining scores from similar measurement methods (e.g., self-report), correlations of about $r = .5$ to $r = .7$ suggest a moderate to strong relationship between measures of the same construct (Cohen, 1988). However, when obtaining scores from different measurement methods (i.e., self-report and observer-report), associations between the measures may be lower. Mischel (1968) observed that correlations between self-reported measures of personality traits and observed behavior were rarely larger than $r = .3$. One reason is that criterion variables
which are not self-reported have additional sources of error not found in self-reports. Another reason is that the shared method variance tends to inflate correlations between constructs measured by the same method. However, even though the multimethod correlation coefficients may be lower, one advantage they have is that they rule out the possibility of method covariance.

Thus, when examining correlations between self-report measures of multicultural counseling competence and MCCA scores, we would not expect to see correlations much higher than $r = .3$. On the whole, this has been consistent with previous research. Ladany et al. (1997) obtained low correlations between the CCCI-R and MCCA etiology ($r = -.04$) and treatment ($r = .01$). Constantine and Ladany (2000) found correlations between the MCKAS Knowledge and Awareness subscales and MCCA etiology and treatment scores ranging from .09 to .18. Bromley (2004) found correlations between the MCKAS subscales and MCCA scores ranging from -.07 to .17. In contrast, Constantine et al. (2005) found strong correlations between the CCCI-R and MCCA etiology ($r = .61$) and treatment ($r = .59$). The current study revealed correlations between the MCKAS subscales and MCCA scores ranging from .09 to .21. Although the correlations are still relatively low even when taking into account the lack of method covariance, perhaps the lack of relationship between self-report and observer-report methods is not as dire as some have proposed, especially if one considers possible measurement problems (e.g., restricted range of scores) related to the MCCA task that would also attenuate these correlations. Improvements made in the design of the MCCA task may reveal improved correlations between it and self-report measures of multicultural counseling competence.
Training variables. Multicultural training variables (i.e., multicultural courses, additional multicultural academic training, working with diverse clients, and multicultural supervision) were found to account for significant variance (9%) in MCCA scores; in particular, the number of hours spent attending multicultural and/or diversity workshops, presentations, training, or reading (not including courses taken) contributed significantly. Also, multicultural training variables were found to contribute significant variance (16%) to MCKAS scores; specifically, multicultural coursework accounted for significant variance in MCKAS scores.

Comparing the MCCA task with the MCKAS based on these results, it is not clear that one measure is strongly outperforming the other, although training did account for more variance in the MCKAS than the MCCA. Even though trainees are scoring high on one measure (the MCKAS) and low on the other (the MCCA task), training is still accounting for a fairly substantial portion of the variance in both measures. This finding is particularly convincing if one considers the possible measurement problems with the instruments (e.g., not assessing for quality of training, restricted range of scores on the MCCA).

Given that training programs assume multicultural competence will be gained through exposure to coursework, practica, and supervision, the substantial amount of variance accounted for by training is an encouraging finding. It suggests that previous didactic training and clinical experience do help trainees to better conceptualize the mental health issues of minority clients. In particular, didactic training appears to be especially useful.
Didactic training accounted for more variance than clinical experience. Previous research is consistent with the current findings. A study by Ladany et al. (1997) indicated that instructions by a “supervisor” in an analogue vignette to focus on racial issues lead to more sophisticated treatment considerations but not to etiological conceptualizations. Inman (2006) found that supervisor multicultural competence was not related to MCCA treatment scores and was negatively related to MCCA etiology scores. In addition, several previous studies that did find a positive relationship between training and multicultural counseling competence examined coursework in their analyses, not clinical experience (Constantine, 2001a; Constantine, 2001b; Constantine & Gushue, 2003). These collective findings seem to suggest that multicultural clinical experience does not relate to multicultural counseling competency, although the reasons for this are unclear. Perhaps the information that trainees are learning in their didactic training is not translating well into clinical experience such that simply seeing more diverse clients or having a supervisor emphasize racial issues is not enough to lead to actual demonstrated competency. On the other hand, although the lack of relationship between clinical experience and multicultural counseling competence may appear troublesome because educators assume that working with diverse clients and engaging in multiculturally-focused supervision lead to higher competency, it is also possible that the quality of supervision and the quality of the counseling with diverse clients is not enough to make a difference in trainees’ multicultural counseling competence. For instance, if the supervision is more administrative in nature, multicultural issues may not get processed as much as they would in a multicultural class, thus explaining why didactic training
experiences appear to be more influential than clinical experiences. Perhaps if clinical experience were more explicitly focused on thoroughly attending to multicultural issues, clinical experience would lead to increased multicultural counseling competence. This could be another avenue for future research.

No established benchmark for competency exists against which self-report and observer-report methods of multicultural counseling competence can be compared, and because conceptually one would expect multicultural training to be associated with increased competence, the current study utilized training as an index to assess the usefulness of two measures of multicultural counseling competence. Due to the considerable amount of variance accounted for by training in these measures, even with the presence of potential measurement problems, the current findings seem to support the usefulness of both the MCCA task and the MCKAS as measures of multicultural counseling competence.

*Color-blind racial attitudes.* Contrary to expectations, color-blind racial attitudes did not account for significant variance in multicultural case conceptualization ability above and beyond social desirability and training variables. In part, this unanticipated finding may be a result of variability problems in the current study. One feasible explanation is that the MCCA scores were too low to detect a relationship with color-blind racial attitudes.

Another possibility concerns the reliability coefficient for the Unawareness of Blatant Racial Issues subscale. The current study revealed a rather low internal consistency estimate (.60) for the Blatant Racial Issues subscale; this is consistent with
previous research (Bromley, 2004; Neville et al., 2000). Future studies investigating the factor structure of the instrument could be useful in improving the internal consistency of the Blatant Racial Issues subscale and in ensuring that there is adequate discriminant validity among the subscales so that each subscale serves as an indicator of a distinct construct. Another possibility is to determine whether this subscale is even needed. Examining the data for the current study revealed that scores on this subscale were positively skewed and had a restricted range. It seems plausible that this subscale may not perform well with more sophisticated populations.

This is further suggested by the significant correlations between the Blatant Racial Issues subscale and the Impression Management subscale of the BIDR. This finding suggests that the subscale may be subject to social desirability, specifically, the conscious attempt to present oneself in a favorable light. Neville et al. (2000) also found that the Blatant Racial Issues subscale correlated significantly ($r = .20$) with the Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960). Because only the Impression Management subscale and not the Self-Deceptive Enhancement subscale was related to the BRI, different dimensions of social desirability may operation differentially on color-blind racial attitudes. Future studies could further clarify this possibility. Overall, more reliability and validity evidence is needed for the CoBRAS, as it has not been widely used in empirical investigations.

*Race of client in vignettes.* The current study represented an attempt to address some of the measurement issues related to the MCCA task; in particular, the stimulus value of race in the MCCA vignette was investigated. The current study revealed that the
race of the clients in the vignette did not affect trainees’ ability to incorporate race-based information in case conceptualizations.

One explanation for the unanticipated finding could be floor effects on the MCCA task, which therefore made it too difficult to detect meaningful differences according to the race of the clients in the vignette. Although the MANCOVA analysis was not significant, the range of scores obtained for the African American condition was higher (0-4) than for the European American condition (0-3), which could suggest a trend in the expected direction.

On the other hand, these results could suggest that trainees are equally attentive (or inattentive, as the low scores in this study suggest) to racial factors when working with all clients. Multicultural training has historically focused on racial/ethnic minorities while overlooking racial issues for the majority group (Neville et al., 2000). This is a problem because White privilege also comes at a cost to Whites (McIntosh, 1988). However, more recent writings in the field have begun to identify issues relevant for Whites and White trainees (e.g., White Racial Identity Development, White privilege, color-blind racial attitudes, psychosocial costs of racism to Whites) (Helms & Carter, 1990; McIntosh, 1988; Neville et al., 2000; Spanierman & Heppner, 2004). It is possible that this increased attention to the construct of Whiteness has led trainees to be more aware of racial factors regardless of the race of the client.

In spite of the lack of expected differences between the two race conditions on the vignettes, overall, the sample performed very poorly on the MCCA task. Mean scores for the African American vignette condition were .25 for etiology and .35 for treatment, and
mean scores for the European American vignette condition were .23 and .25. These low scores seem to reflect that trainees are not adequately taking racial factors into account in their conceptualizations.

**Summary.** Even though trainees provided high self-report ratings of multicultural counseling competence and exposure to multicultural issues through training and clinical and supervision experience, overall, this sample performed very poorly on the MCCA task. This finding likely impeded the resultant analyses and may explain why several of the hypotheses were not borne out. It also raises doubts about what the MCCA task is actually measuring and the relation it has to multicultural counseling competence. It is important for future studies to replicate and expand upon the current findings.

**Limitations of the Current Study**

**Research design limitations.** The methodology for this study utilized vignettes instead of actual clients as stimuli to generate conceptualizations. This analogue design limited the external validity of this study, making the translation of results to clinical practice more difficult. The written measure may have felt too removed from actual counseling, making the conceptualization seem inconsequential. Another possibility is that because the MCCA task was not related to any evaluation of performance (e.g., case presentations in practicum), the task may have felt less relevant to trainees. These scenarios could have led to lower MCCA scores.

Only one method of assessing multicultural case conceptualization ability was used, and furthermore, only one vignette was used to assess multicultural case conceptualization ability. It is possible that having trainees respond to multiple vignettes
across different occasions may lead to a different discernment of their ability to conceptualize clients from a multicultural perspective.

Also, measuring case conceptualization ability does not necessarily translate directly into behaviors when working with clients. Thus, this ability may not correspond entirely with trainees’ true level of multicultural counseling competence. Additional assessment measures could provide important information about trainees’ ability to recognize and address racial issues in counseling.

Although data were obtained from two different sources (marriage and family trainees and counseling psychology trainees), the data was not coded to reflect those sources, and therefore, potential differences between these two groups were not investigated. Future researchers may want to examine possible differences across these two groups.

Additionally, caution should be employed because some of the hypotheses tested the null. Even if the null is retained, that does not mean that it can be concluded that there is no relationship between two variables.

*Sample limitations.* The sample size approximated those obtained in similar previous studies of multicultural case conceptualization ability. Volunteer bias could be present in this sample; however, even if that were the case, it is interesting to note that on the whole, trainees did not perform well on the MCCA task. Another way in which the sample may have been self-selected is that taking the time to write a conceptualization or to calculate clock hours spent in training and clinical experience may have been perceived by some participants to be too time or labor intensive.
Limitations in measurement and analyses. The internal consistency coefficient for the Blatant Racial Issues of the CoBRAS was low at .60; this subscale was also very positively skewed ($z = 4.14; p < .01$) with a restricted range (1.00-3.33; range possible = 1-6), signifying that most of the participants strongly acknowledged the pervasiveness of racism and discrimination in society. The low MCCA scores and limited range of scores (0-3 for European American vignettes and 0-4 for African American vignettes out of a possible range of 0-5) also may have influenced the results.

Future Directions

The findings and problems encountered in the current study are informative regarding improvements for future research. In addition, they are suggestive of additional avenues of investigation for theory, training, and practice.

MCCA measurement issues. Due to the low means and restricted range on the MCCA task that likely attenuated many of the findings in this study, foremost attention is given to measurement issues related to the MCCA task.

A number of issues surfaced in relation to the MCCA task and coding system. First, there are no consistent guidelines across MCCA studies as to how to adequately develop a vignette for the task, and the vignettes have varied in the amount of race-based content presented. This study did not have many obvious references to race beyond the description of the race of the clients and their recent move to a racially diverse neighborhood. Although some participants in this study did incorporate race into their conceptualizations, previous studies that have used vignettes that included many more noticeable cues concerning race (e.g., Inman, 2006) have had higher mean scores.
Although still relatively low compared to what is possible and what is desired). Hence, the content of the vignette seems to influence the range of scores on the coding system.

One possible explanation is that previous vignettes, which included a great deal of racial information, were priming trainees to address multicultural issues, whereas the vignette used in the current study, which included very few racial cues, did not. The vignette in the current study may actually be measuring a different, unprimed aspect of multicultural counseling competence that taps students’ ability to consider racial issues when these issues are not presented as a primary focus. Ultimately, the low scores on this type of a measure are problematic because some clients will present with more race-based concerns than others and the goal of training is for students to think about multicultural issues spontaneously and to integrate these issues in a complex manner into their understanding of all clients.

Prospective research could test the stimulus value of the race-based content and examine whether different vignettes are actually measuring different aspects of multicultural counseling competence. For example, responses to primed versus unprimed vignettes could be compared to illustrate whether trainees are more likely to attend to racial factors when they are explicitly present. It is also possible that this may be developmentally related to multicultural counseling competence such that trainees with more experience are more likely to attend to unprimed racial factors; future research could also investigate this possibility.

In addition to examining the amount of racial stimuli present in the vignette (primed versus unprimed), another option for future research would be to examine the
way in which trainees address racial and cultural information depending upon how that information is presented. For instance, how do the scores compare if race is part of the treatment focus as opposed to race being presented as a contextual variable? For example, in one vignette the client may report that she is having difficulty making friends in a new environment due to discrimination whereas another vignette may state that the client is African American and then indicate that she is having difficulty making new friends in a new environment (while not explicating stating that the difficulty has anything to do with discrimination).

In any case, future researchers need to be clear about what they are actually measuring. The lack of guidelines in the development of the vignette makes it difficult to ascertain what exactly is being measured and to draw conclusions about the data obtained from the measure across studies. Future research should always report on the vignette that was used for the study, indicating what race or other cultural factors were included. In addition, developing guidelines as to how much racial information should be included in vignettes in accordance with the construct being measured (e.g., primed vs. unprimed multicultural counseling competence) would allow for some consistency across studies to facilitate interpretation of the accumulated findings. When developing vignettes, using independent judges to rate the vignette’s racial content could ensure proper operationalization of the established guidelines.

Another problem with the MCCA task is that a consistent coding system does not exist. Previous studies have employed either a 0-5 range or a 0-6 range whereby scores in each range are defined differently. No rationale has been provided for the choice of one
scale over the other. However, given the overall low means that have been obtained in previous studies, it seems likely that the 0-5 coding system is adequate. Moreover, two previous studies (Constantine 2001a; Constantine & Gushue, 2003) have collapsed MCCA etiology and treatment scores to create a total MCCA score that is not averaged. This makes comparisons across studies more difficult.

A further problem with the scoring system is that for this study and some others (e.g., Bromley, 2004), the conceptualization scores were not reflective of the entire range included in the MCCA scoring system. The highest score obtained for the African American vignette for treatment was 4 and for etiology was 4; the highest score obtained for the European American vignette for treatment was 3 and for etiology was 3. Most of the previous research using the MCCA task has not reported the range of scores obtained, so it is unknown the extent to which participants have scored in the higher end of the coding system. Future studies using the MCCA task may need to revise the coding system to more accurately reflect the range of responses typically provided. The qualitative examples provided in Appendix H could provide illustrations of anchor scores for the reworking of the coding system.

Due to problems with the analogue nature of the MCCA task, future research should consider other methodological approaches in using the task, such as having participants write a conceptualization based on a simulated client, a video of a client, or direct observation of an actual counseling session. These other conditions may affect the scoring range or quality of responses.
Other methods of measuring multicultural counseling competence could also be employed, such as behavioral observations, acquaintance ratings, longitudinal designs, or qualitative coding of themes. An advantage that these methods would expectedly share with the MCCA task is that they are unlikely to be influenced by social desirability, which is in contrast with most self-report measures of multicultural counseling competence. In addition, case conceptualization alone does not represent the entire range of counselor behaviors and by itself is likely not an adequate measure of multicultural counseling competence, and these other methods might tap components of competence that might be missing in the MCCA task (e.g., interventions used in the room with the client, the timing of the interventions, etc.). Using another measure of demonstrated multicultural counseling would also provide additional concurrent validity evidence for the MCCA task. Some researchers (e.g., Atkinson & Israel, 2003) have suggested that measures like the MCCA task are best used to observe multicultural counseling skill, whereas multicultural knowledge could be tapped through objective testing methods and multicultural awareness could be assessed through reports by others (e.g., supervisors or clients) who have observed trainees’ level of multicultural awareness.

Hence, the MCCA task has a number of problems that need to be addressed in future research, including the vignette content, the scoring system, and the validity evidence for the task. On the whole, multimethod approaches to assessing trainees’ multicultural competence need to be identified and employed.

Another important observation related to the MCCA task is a reflection of problems discussed earlier related to the theory of multicultural counseling competence.
The MCCA task has focused almost exclusively on racial issues as opposed to other relevant cultural factors. This is similar to the self-report measures of multicultural counseling competence and reflects the primary theoretical writings in the field, stemming directly from Sue et al.’s (1982) initial pioneering model. Sue and colleagues decided to conceptualize the multicultural competencies as centering on racial/ethnic groups in the United States to avoid becoming too broad, and resultant measures have maintained this focus. However, this approach has been criticized as not being inclusive of other groups (e.g., Weinrach & Thomas, 2002) and likely does not reflect the broader training in multiculturalism that trainees are receiving. Thus, self-report measures and the MCCA task may be limited in assessing the true extent to which trainees are multiculturally competent.

This presents implications for future research using the MCCA task as well as for multicultural counseling theory. In prospective studies, researchers should consider including additional cultural variables in the MCCA vignettes, although attention should be given to the operationalization of this content as well. In addition, the field may need to expand upon and empirically test the original model, as some scholars have more recently suggested (e.g., Atkinson & Israel, 2003; Constantine & Ladany, 2001).

*Conceptualizing multicultural counseling competence.* Because no empirical or conceptual framework for multicultural counseling existed at the time that Sue et al. (1982) proposed the multicultural counseling competency guidelines, the field embraced them as valid. However, as a result, the construct of multicultural counseling competence
has never been adequately defined. The field may need to revisit some fundamental questions regarding multicultural counseling theory.

Qualitative research may be one avenue to provide rich data to further refine multicultural counseling theory. Qualitative methods could help establish a foundation for the domain of multicultural counseling competency, upon which new quantitative measures could be built. Qualitative research may reveal constructs that are more sensitive by allowing the meaning to emerge from the data (Morrow & Smith, 2000). This would provide for a more thorough exploration of the concept of multicultural counseling competence that was missing in the beginning stages of the multicultural movement. For example, the MCCA task could be modified to be used in an interview format or certain participants may be selected for follow-up interviews as a result of their responses to the MCCA task. A mixture of qualitative and quantitative research methods could uncover a broader picture of the construct, which would then influence the use and development of measures such as the MCCA task.

Another problem with theory in this area is that little is known about how multicultural counseling competence develops over time. Some scholars have suggested that knowledge and awareness may develop first as precursors to the later expression of skills (Constantine & Ladany, 2000), which would make inadequate the current conceptualization of knowledge, awareness, and skills developing simultaneously. One model that may offer promise for future study comes from Carney and Kahn (1984), who proposed a development model consisting of 5 stages through which trainees gain knowledge, awareness, and skills. In this model, movement through the 5 stages is
complex, not necessarily smooth, forward, or parallel among the 3 domains. More information is needed about the process by which multicultural counseling competencies are obtained, and longitudinal studies, as well as studies of counselors from a wide range of experience and settings, could better clarify this process.

As an example of how scholars may need to re-examine some of the fundamental assumptions regarding multicultural counseling theory, perhaps the construct of multicultural counseling competence is simply a specific factor within a larger domain, such as general counseling competence. Coleman (1998) found that ratings of high multicultural counseling competence were associated with high ratings of general counseling competence; the correlations between the measures of the two constructs were high (.78-.85). Coleman suggested that counselors should learn to use their general counseling skills to take into account the context of clients’ lives. Pedersen (1991) has suggested that perhaps the skills needed to work with culturally different clients are not different but rather are applied differently.

Constantine (2002) also examined the relationship between general and multicultural counseling competence. She found that although general counseling competence and multicultural counseling competence were strongly related \( (r = .78) \), racial and ethnic minority clients’ ratings of their counselors’ multicultural counseling competence accounted for satisfaction with counseling above and beyond general multicultural counseling competence. In addition, clients’ perceptions of their counselors’ multicultural counseling competence partially mediated the relationship between general counseling competence and satisfaction with counseling. The author suggests that this
evidence indicates these constructs are “somewhat operationally distinct” (p. 260).

Research that could further clarify how multicultural counseling competence fits within the broader development of general counseling knowledge, skills and awareness is needed.

One possible avenue for understanding the awareness component of multicultural counseling competence is to examine self-awareness more broadly. A recent alternative conceptualization of multicultural counseling competence proposed by Constantine and Ladany (2001) is consistent with this idea. These authors proposed that six dimensions of competency are important: multicultural knowledge, multicultural counseling self-efficacy, multicultural counseling skills, unique client variables, the working alliance, and self-awareness. Self-awareness reflects a state of self-directed attention due to either temporary factors or to inherent dispositions. Research on the transient state of self-awareness may suggest whether there are certain conditions in therapy that, when present, could influence the effectiveness of multicultural counseling (e.g., a mirror or a camera).

When self-awareness is a consistent propensity to focus attention inward, this trait is called self-consciousness (Fenigstein, Scheier, & Buss, 1975). Fenigstein, Scheier, and Buss (1975) developed a scale to measure self-consciousness. The scale measures three factors: private self-consciousness, which refers to attention directed towards inner thoughts and feelings; public self-consciousness, which reflects an awareness of the self as a social object; and social anxiety, which is discomfort around others. Both public and private self-consciousness include the process of self-focused attention; in contrast, social anxiety describes one’s reactions to this process.
Individual differences in self-consciousness may influence multicultural counseling competence. For example, is multicultural awareness training more effective for someone who is already high in self-consciousness? Are people high in self-consciousness more easily able to recognize the limits of their competencies? Does increased awareness of the client’s view of the therapist lead to an evaluation of the self that causes apprehension, therefore interfering with effective intervention with clients? How does self-consciousness affect attributions that are made in counseling related to the client or counselor’s cultural background?

Self-consciousness could also inform some of the measurement problems related to multicultural counseling competence. Previous research has found that self-consciousness is correlated with greater accuracy of self-reported behavior (Scheier, Buss, & Buss, 1978). It is possible that the trait of self-consciousness functions as a moderator variable between self-reported multicultural counseling competence and observed multicultural counseling behavior; in other words, self-reports of people high in self-consciousness may have greater predictive validity than self-reports of people low in self-consciousness. Interestingly, in this study, the Awareness subscale of the MCKAS was correlated with MCCA scores such that higher levels of multicultural awareness were associated with higher MCCA scores; the MCKAS Knowledge subscale was not related to MCCA scores. Examining the trait of self-consciousness may help shed light on the relationship between the self-report measures of multicultural counseling competence and the MCCA task.
In sum, the primary theory that provides the foundation for understanding multicultural counseling competence might need to be refined or revised, and additional variables that might influence MCCA, such as self-consciousness, should be investigated.

Assessing multicultural counseling competence in couples therapy. One of the contributions of the current study was to examine multicultural case conceptualization ability in a modality other than individual therapy. Couples therapy is something that counseling psychology students have reported an interest in (Schneider et al. 1988), that counseling psychologists have reported is an important work behavior (Birk & Brooks, 1988), and that counseling psychology researchers have investigated (e.g., Inman, 2006). Scholars have called for research that examines multicultural competence in larger systems, such as couples therapy (Constantine & Ladany, 2001), and for research that examines multicultural case conceptualization ability with trainees from other disciplines, such as marriage and family therapy.

The current study suffered from a number of limitations; however, if the results do represent an accurate estimate of the degree of multicultural counseling competence demonstrated by trainees when working with couples, this is alarming. The mean scores for etiology and treatment on the MCCA were much lower than in previous studies; it is possible that this is a result of the modality of therapy in the current vignettes. Perhaps trainees have a more difficult time incorporating racial factors into conceptualizations of couples versus individuals. This could be an option for future research to investigate.

Measures of multicultural counseling competence that assess competence in other systems (families, groups, organizations) are needed. In addition, instruments that assess
competence regarding the additional roles that a counselor might enter into outside of the therapy room (research, outreach, consultation, advocacy, training, assessment, supervision) are needed. One example of recent developments in this area is a study conducted by Liu, Sheu, and Williams (2004), which examined multicultural research training and self-efficacy. The authors adapted an instrument that was used to measure the effect of general research self-efficacy to one that specifically measures multicultural research self-efficacy. Avenues for future instrument development may modify or build on previous measures, such as in the Liu et al. study, or they may need to be created in order to incorporate the issues unique to that particular modality of intervention.
REFERENCES


Fitzgerald, L. F., & Osipow, S. H. (1988). We have seen the future, but is it us? The vocational aspirations of graduate students in counseling psychology. Professional Psychology: Research and Practice, 6, 575-583.


APPENDICES
APPENDIX A

BODY OF EMAIL TO TRAINING DIRECTORS

Month Day, 2006

Dear Training Director,

My name is Allison Schomburg, and I am a doctoral candidate in the Collaborative Program in Counseling Psychology at The University of Akron. I am conducting dissertation research under the direction of my research advisor Dr. Loreto R. Prieto.

We would like to enlist your assistance with this project by asking you to forward the following letter of participation and informed consent and survey web page link to all of the students in your program. The surveys for trainees will consist of a demographic questionnaire, a clinical vignette, and three brief questionnaires. The cover letter informs participants of all human subjects’ rights. Please know that students’ participation is voluntary and that all research materials are coded in such a way that makes identification of individual respondents virtually impossible. Also, findings will be reported only in aggregate form; no institution or program will be specifically identified in any presentation of the research findings.

If you have any questions concerning this study, you can contact me at my office (402) 323-3448 or my faculty advisor, Dr. Loreto R. Prieto (330) 972-6743. This study was approved by The Institutional Review Board for The Protection of Human Subjects at The University of Akron. Questions regarding human subjects’ rights can also be directed to the UA Institutional Review Board, Office of Research Services and Sponsored Programs, (330) 972-7666 or 1-888-232-8790. Thank you for your assistance in this project!

Sincerely,

Allison M. Schomburg, M.A.     Loreto R. Prieto, Ph.D.
Southeast Community College    Collaborative Program in
1111 O St.       Counseling Psychology
Lincoln, NE 68508    The University of Akron
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E-mail: lprieto@uakron.edu
APPENDIX B

PARTICIPANT LETTER OF PARTICIPATION AND INFORMED CONSENT

Month Day, 2006

Dear Student,

My name is Allison Schomburg, and I am a doctoral student in the Collaborative Program in Counseling Psychology at the University of Akron. I know that you are extremely busy with your own work; therefore, I will make this as brief as possible. For my dissertation, I am conducting research on clinical training, and I would greatly appreciate your input on this topic.

This survey web page link (http://www.surveymonkey.com/s.asp?u=641592666829) will take you to a site where you can complete a case conceptualization vignette, a demographic questionnaire, and three self-report instruments. The materials should take no more than 30 minutes or so to complete. All information you provide will be confidential. All research materials are coded in such a way that makes identification of individual respondents virtually impossible. Findings will be reported only in aggregate form; no institution, program, or individual will be specifically identified in any presentation of the research findings. Your completion of materials will constitute your informed consent to participate. We would greatly appreciate your completing this survey. Of course, participation is voluntary, you may decline participation in this study with no penalty whatsoever, and you may discontinue participation, even after submitting materials.

At the end of the survey, you will be directed to a page where you can chose to enter your email address to be included in a drawing for one of two $50 gift certificates to Target. Your email address will not in any way be connected to your survey responses, nor can your email address be used in any way to identify the data you provide.

If you have any questions or comments concerning this study, please contact either me or my research advisor at the numbers listed below. This study was approved by The Institutional Review Board for The Protection of Human Subjects at The University of Akron. Questions on human subjects’ rights can also be directed to the UA Institutional Review Board, Office of Research Services and Sponsored Programs, (330) 972-7666 or 1-888-232-8790. We very much hope that you will elect to assist us by completing this survey, as we believe this study could contribute to the understanding of an important topic!
Sincerely,
Allison M. Schomburg, M.A.
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APPENDIX C
MULTICULTURAL CASE CONCEPTUALIZATION VIGNETTES

Please read the following vignette and write a conceptualization of the etiology of this couple’s presenting concern and of your approach to treatment with this couple.

Tanya, 24, and Mike, 25, are a European American (White) couple who have been married for 2 years. Tanya works as a loan officer and Mike is a graphic designer. They are both from a moderately sized urban city where they have gone to school (including college) and lived their whole lives. Both have recently accepted new jobs that necessitated their move to a new location in a major metropolitan city. The couple bought a house in a racially diverse neighborhood, a change from their previous neighborhood. They miss their old friends and have struggled to develop relationships with their new neighbors. The purchase of their house has also placed a financial strain on them, leaving little room for unplanned expenses.

They presented to counseling with what they described as “communication problems.” Typically, they argue intensely over an issue, become angry and withdraw emotionally and physically from each other, and remain separated from each other for hours or sometimes days. These reoccurring conflicts have been happening more often and increasing in intensity over the past few months. They report less satisfaction in their marriage and perceive receiving less support from each other. They have identified several concerns in their relationship, including increasing work stress, their lack of a social network for fun and recreation, and anxieties over finances.

Please read the following vignette and write a conceptualization of the etiology of this couple’s presenting concern and of your approach to treatment with this couple.

Tanya, 24, and Mike, 25, are an African American (Black) couple who have been married for 2 years. Tanya works as a loan officer and Mike is a graphic designer. They are both from a moderately sized urban city where they have gone to school (including college) and lived their whole lives. Both have recently accepted new jobs that necessitated their move to a new location in a major metropolitan city. The couple bought a house in a racially diverse neighborhood, a change from their previous neighborhood. They miss their old friends and have struggled to develop relationships with their new neighbors. The purchase of their house has also placed a financial strain on them, leaving little room for unplanned expenses.
They presented to counseling with what they described as “communication problems.” Typically, they argue intensely over an issue, become angry and withdraw emotionally and physically from each other, and remain separated from each other for hours or sometimes days. These reoccurring conflicts have been happening more often and increasing in intensity over the past few months. They report less satisfaction in their marriage and perceive receiving less support from each other. They have identified several concerns in their relationship, including increasing work stress, their lack of a social network for fun and recreation, and anxieties over finances.
APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

DEMOGRAPHIC INFORMATION

Please click on/write in the appropriate response for each question.

Age: Month _________ Year________

1. Sex: Female _____ Male_____ 

2. Race/Ethnicity:
   • African American____
   • Asian American____
   • European American (White)____
   • Hispanic/Latino____
   • American Indian____
   • International ____ (Country ________)
   • Multiracial ____
   • Other (please specify)__________________

3. Partner Status:
   • Single / Never Married _____
   • Partnered / Married _____
   • Divorced _____
   • Widowed _____
• Remarried ____
• Other (please specify) ____

4. Are you enrolled in an APA-accredited Counseling Psychology or AAMFT-accredited Marriage and Family therapy program? Yes ____  No ____

5. What degree are you currently seeking?
• M.A./M.S. _____
• Ph.D. _____
• Psy.D. _____
• Ed.D. _____
• Other (please specify) _____

6. How many semesters of graduate study have you completed including Fall, 2006_______?

7. How many multicultural and/or diversity courses have you taken in graduate school: ________?

8. How many couples and/or family therapy courses have you taken in graduate school: ________?

9. How many clock hours have you spent attending multicultural and/or diversity workshops, presentations, training, or reading, NOT including courses taken_______?

10. How many clock hours have you spent attending couples and/or family therapy workshops, presentations, training, or reading, NOT including courses taken_______?

11. How many total clock hours of counseling have you provided to racially/ethnically diverse clients ________?
12. How many total clock hours have you spent providing counseling to couples or families ________?

13. How many clock hours of supervision have you received that were devoted to discussing multicultural issues ________?

14. To what extent do you feel prepared to conduct couples therapy?

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

15. To what extent are you interested in conducting couples therapy?

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

16. In your opinion, to what extent are multicultural issues infused in the overall curriculum and course work of your training program?

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

COLOR-BLIND RACIAL ATTITUDES SCALE (CoBRAS)

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

1             2    3     4  5  6
Strongly Disagree Strongly Agree

1. _____ Everyone who works hard, no matter what race they are, has an equal chance to become rich.

2. _____ Race plays a major role in the type of social services (such as type of health care or day care) that people receive in the U.S.

3. _____ It is important that people begin to think of themselves as American and not African American, Mexican American or Italian American.

4. _____ Due to racial discrimination, programs such as affirmative action are necessary to help create equality.

5. _____ Racism is a major problem in the U.S.

6. _____ Race is very important in determining who is successful and who is not.

7. _____ Racism may have been a problem in the past, but it is not an important problem today.

8. _____ Racial and ethnic minorities do not have the same opportunities as White people in the U.S.

9. _____ White people in the U.S. are discriminated against because of the color of their skin.

10. _____ Talking about racial issues causes unnecessary tension.
11. _____ It is important for political leaders to talk about racism to help work through or solve society’s problems.

12. _____ White people in the U.S. have certain advantages because of the color of their skin.

13. _____ Immigrants should try to fit into the culture and adopt the values of the U.S.

14. _____ English should be the only official language in the U.S.

15. _____ White people are more to blame for racial discrimination in the U.S. than racial and ethnic minorities.

16. _____ Social policies, such as affirmative action, discriminate unfairly against White people.

17. _____ It is important for public schools to teach about the history and contributions of racial and ethnic minorities.

18. _____ Racial and ethnic minorities in the U.S. have certain advantages because of the color of their skin.

19. _____ Racial problems in the U.S. are rare, isolated situations.

20. _____ Race plays an important role in who gets sent to prison.
### APPENDIX F

**BALANCED INVENTORY OF DESIRABLE RESPONDING (BIDR)**

For each statement, indicate how much you agree with it by clicking on the corresponding number.

<table>
<thead>
<tr>
<th>NOT</th>
<th>SOMEWHAT</th>
<th>VERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUE</td>
<td>TRUE</td>
<td>TRUE</td>
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<table>
<thead>
<tr>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My first impressions of people usually turn out to be right.</td>
<td>2. It would be hard for me to break any of my bad habits.</td>
<td>3. I don’t care to know what other people really think of me.</td>
<td>4. I have not always been honest with myself.</td>
<td>5. I always know why I like things.</td>
<td>6. When my emotions are aroused, it biases my thinking.</td>
<td>7. Once I’ve made up my mind, other people can seldom change my opinion.</td>
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<td>8. I am not a safe driver when I exceed the speed limit.</td>
<td>9. I am fully in control of my own fate.</td>
<td>10. It’s hard for me to shut off a disturbing thought.</td>
<td>11. I never regret my decisions.</td>
<td>12. I sometimes lose out on things because I can’t make up my mind soon enough.</td>
<td>13. The reason I vote is because my vote can make a difference.</td>
<td>14. My parents were not always fair when they punished me.</td>
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<td>15. I am a completely rational person.</td>
<td>16. I rarely appreciate criticism.</td>
<td>17. I am very confident about my judgments.</td>
<td>18. I have sometimes doubted my ability as a lover.</td>
<td>19. It’s all right with me if some people happen to dislike me.</td>
<td>20. I don’t always know the reasons why I do the things I do.</td>
<td>21. I sometimes tell lies if I have to.</td>
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<td>22. I never cover up my mistakes.</td>
<td>23. There have been occasions when I have taken advantage of someone.</td>
<td>24. I never swear.</td>
<td>25. I sometimes try to get even rather than forgive and forget.</td>
<td>26. I always obey laws, even if I’m unlikely to get caught.</td>
<td>27. I have said something bad about a friend behind his or her back.</td>
<td>28. When I hear people talking privately, I avoid listening.</td>
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<td>29. I have received too much change from a salesperson without telling him or her.</td>
<td>30. I always declare everything at customs.</td>
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31. When I was young I sometimes stole things.
32. I have never dropped litter on the street.
33. I sometimes drive faster than the speed limit.
34. I never read sexy books or magazines.
35. I have done things that I don’t tell other people about.
36. I never take things that don’t belong to me.
37. I have taken sick-leave from work or school even though I wasn’t really sick.
38. I have never damaged a library book or store merchandise without reporting it.
39. I have some pretty awful habits.
40. I don’t gossip about other people’s business.
APPENDIX G

MULTICULTURAL COUNSELING KNOWLEDGE AND AWARENESS SCALE (MCKAS)

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

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<tr>
<td></td>
<td>Not at All True</td>
<td>Somewhat True</td>
<td>Totally True</td>
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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 of some research that 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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.

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

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

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.

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.

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.

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

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.

32. I am aware that some minorities believe counselors lead minority students into nonacademic programs regardless of student potential, preferences, or ambitions.
APPENDIX H

QUALITATIVE EXEMPLARS OF PARTICIPANTS’ RESPONSES TO MCCA VIGNETTES

African American Vignettes

Low Score
MCCA Etiology Score 0
MCCA Treatment Score 0

I would say they could be diagnosed with Adjustment disorder. They have lost several major supports for their relationship by moving to the new community, starting new jobs, and increasing their financial commitments. They need to increase their intimacy and support for one another. I would try to help them increase their friendship and time spent together based on Gottman's research or use EFT to increase their intimacy and overcome their pattern of attack-withdrawal.

High Score
MCCA Etiology Score 0
MCCA Treatment Score 4

The frame I use for conceptualization comes from a biopsychosocial model. From a biological perspective, I would determine whether Tanya or Mike had experienced past psychological difficulties or if they have a family history of psychological concerns. This would provide potential evidence toward a biological basis for psychological concerns. After ruling out any biological influence, I would focus more specifically on psychological and social influences on their relationship concerns. From a psychological perspective, I would assess their pattern of interaction throughout the relationship, pointing out consistent patterns as well as changes that seem to have occurred. From a social perspective, I would determine how much the recent environmental changes (work stress, lack of social network, and financial concerns) have affected both the psychological state for each individual, as well as the interaction within their relationship. My approach to treatment would come for a culture-sensitive and interpersonal approach to therapy. I would discuss the cultural differences that may exist between myself and this couple, and make this an available aspect of the discussion between us. I would also explore the cultural implications of moving from their original neighborhood to a more racially diverse neighborhood. From an interpersonal perspective, I would try to highlight changes that have occurred in their relationship, and try to determine the influences that have caused these changes. I would emphasize communication and highlight the level of
communication between this couple in the here-and-now of therapy. My overall goal would be to increase communication between the couple. As communication increases, I would also focus on strategies for the couple to reduce stress and ways to find a social network within their new community.

*European American Vignettes*

**Low Score**
- MCCA Etiology Score: 0
- MCCA Treatment Score: 0

It's difficult to say without an understanding of the specifics of the arguments (i.e. who initiates, who withdraws, whether there's a recurring issue that's argued, etc.). Generally, I believe couples become engaged in increasingly rigid negative interaction cycles due to unmet emotional needs and a desire to protect oneself from perceived threats to one's sense of security. My approach to treating this couple, therefore, would include an attempt to determine the couple's interaction style, discover the unmet emotional needs, how those needs are being communicated/expressed, and help to create a new pattern of interaction in which each person feels safe to directly ask for those needs to be met.

**High Score**
- MCCA Etiology Score: 3
- MCCA Treatment Score: 2

Tanya and Mike came to counseling after a change in work and geographical location. These changes included moving to a larger city, a more racially diverse location, and increased financial stress related to the purchase of their new home. If I was seeing one person from this couple, the recent stressor and attendant anxiety, quarreling, withdrawal, and conflicts would indicate the presence of an adjustment disorder with mixed anxiety and depressed mood (309.28). However, from a systems perspective, my view changes a bit. Certainly, the new situations present stressors for this couple, including grief for their former home and friends, a necessary adjustment to a different racial environment, and reduced emotional support related to having fewer friends and family immediately available. However, instead of their reactions diminishing over time as is usual with an adjustment disorder, they have been increasing. Because this relates to changes associated with normal developmental changes in life, in this case orienting to careers, there are aspects of a phase of life problem (V62.89). However, I am primarily concerned about their patterns of cohesiveness and communication within their family. In this time of increased stress and developmental changes, this couple has withdrawn from each other, become more conflictual, and become more isolated vis a vis the larger systems in their lives. I believe a systems approach, with emphasis on how they are interacting with each other and improving their patterns of communication between the marital dyad will provide additional support and emotional resources for this couple. In turn, that will allow them to approach work, living in a racially diverse neighborhood, and financial
stresses in a different manner, leading to a reduction in conflict, anxiety, and depressive symptomology (e.g., anger and fighting).
APPENDIX I

INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

Office of Research Services and Sponsored Programs
Akron, OH 44325-2102
330-972-7666 Office
330-972-1011 Fax

October 6, 2006

Allison M. Schumburg
3127 S. 35th St.
Lincoln, Nebraska 68506

Ms. Schumburg:

The University of Akron’s Institutional Review Board for the Protection of Human Subjects (IRB) completed a review of the protocol entitled “An Investigation of Trauma’s Self-Reported Multicultural Counseling Competence, Social Desirability, Color-Blind Racial Attitudes and Multicultural Case Conceptualization Ability in Couples Therapy”. The IRB application number assigned to this project is 20061001.

The protocol was reviewed on October 6, 2006 and qualified for exemption from continuing IRB review. The protocol represents minimal risk to subjects and matches the following federal category for exemption:

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior; provided: (i) Information is recorded in such a manner that subjects can be identified, directly or through identifiers linked to subjects; AND (ii) any disclosure of responses outside the research could reasonably be expected to place the subjects at risk of civil or criminal liability or be damaging to subjects’ financial standing, employability or reputation.

Enclosed is a copy of the informed consent document, which the IRB has approved for your use in this research. In addition, your request for a waiver of documentation of informed consent, as permitted under 45 CFR 46.117(c), is also approved.

Annual continuation applications are not required for exempt projects. If you make any changes or modifications to the study’s design or procedures that either increase the risk to subjects or include activities that do not fall within one of the categories exempted from the regulations, please contact the IRB first, to discuss whether or not a request for change must be submitted. Any such changes or modifications must be reviewed and approved by the IRB prior to their implementation.

You are required to submit a Final Report to the IRB, upon completion of this research.

Please retain this letter for your files. If the research is being conducted for a master’s thesis or doctoral dissertation, the student must file a copy of this letter with the thesis or dissertation.

Sincerely,

Sharon McWhorter
Interim Director

Cc: Loreto Prieto, Advisor
    Rosalie Hall, IRB Chair

The University of Akron is an Equal Education and Employment Institution.