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The Development and Validation of the Multicultural Competency Assessment© (MCA©)

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THE DEVELOPMENT AND VALIDATION OF THE
MULTICULTURAL COMPETENCY ASSESSMENT© (MCA©)

by

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ABSTRACT

A sound and tested multicultural therapeutic approach is an essential component in providing

ethical services to all client populations (e.g., Medley, Lipari, Bose, Cribb, Kroutil, &

McHenry, 2015). Therefore, concepts of multiculturalism have been integrated in ethical

codes, guidelines on competence, and standards for training in preparation programs within

counseling, psychology, and social work fields (e.g., American Counseling Association *Code

of Ethics*, 2014; American Psychological Association *Guidelines on Multicultural Education,

Training, Research, Practice, and Organizational Change for Psychologists,* 2002; Council

for Accreditation of Counseling and Related Educational Programs *Standards*, 2016;

National Association of Social Workers *Standards and Indicators for Cultural Competence

in Social Work Practice*, 2015). Despite mandates for therapists to utilize a multicultural

perspective, multiculturalism has remained a challenging construct to measure. Thus, the

goal of this research was to develop and test the psychometrics features of the *Multicultural

Competency Assessment©* (MCA) scores with a national sample of therapists in clinical

practice. The MCA and items were constructed employing instrument development best

practices (e.g., AERA, APA, & NCME, 2014; DeVellis, 2017; Dimitrov, 2012; Haladyna &

Rodriguez, 2013; Lambie, Blount, & Mullen, 2017). The initial 50 item MCA scores were

tested with Data1 ($N = 407$) using exploratory factor analysis (EFA) and parallel analysis

(PA), resulting in a 25-item MCA with a four-factor structure that accounted for 64.11% of

the total variance. Next, the 25-item MCA scores were tested with Data 2 ($N = 233$) using

confirmatory factor analysis (CFA) and the results supported the four-factor MCA structural

model.

The four-factor MCA structure represents (a) *Knowledge, Skills, and Interventions* (21.86% of the variance); (b) *Awareness of Self* (19.27% of the variance); (c) *Awareness of Client Worldview* (11.95% of the variance); and (d) *System and Institutional Structures* (11.03% of the variance). In addition, the MCA scores yielded sound internal consistency reliability (e.g., .953). Evidence of concurrent validity was supported with a positive correlation between MCA and *Multicultural Counseling Self-Efficacy Scale -Racial Diversity Form* (MCSE-RD) scores (r = .746; p < .001; 55.61% variance explained). Further, a positive correlation was identified between the MCA scores and participants' reported age. The findings from the investigation may be used to: (a) assist researchers in measuring the construct of multicultural competence, (b) aid therapists in evaluating their levels of as multicultural competence, and (c) promote sound curriculum in counselor education programs to promotion trainees' development of multicultural competence. Limitations of the study and areas for future research are presented.

"Where no counsel is, the people fall: but in the multitude of counsellors there is safety."
Proverbs 11:14 KJV

I dedicate this dissertation to my grandmother, Towanda Carter, who is one of the strongest and most supportive people. From checking my 2nd grade homework to listening to my graduate school presentations, you've taught me by example what it means to invest in those I love.
Thank you for your investments in me.

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be able to work so closely with such a dynamic counselor educator and leader. To everyone

who has prayed or sent encouraging words, I truly thank you from the depths of my heart.

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CHAPTER ONE: INTRODUCTION

The introduction of cross-cultural counseling competence in 1982 was a significant contribution to the counseling literature (Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vasquez-Nuttall, 1982). Since 1982, the United States (US) population has continued to diversify; however, disproportionate rates of mental health disparities among culturally diverse clients remain (Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011; Medley, Lipari, Bose, Cribb, Kroutil, & McHenry, 2015; Miranda, McGuire, Williams, & Wang, 2008). Since mental health is recognized as a foundational aspect of holistic health (World Health Organization, 2008); inadequate and limited access to mental health services contributes to health care disparities among underprivileged populations. Individuals' physical and mental illness are connected, impacting significant segments of the population (Sue & Sue, 1977). Specifically, the promotion of individuals' mental health well-being has a positive impact on their physical health (Herrman, Saxena, Moodie, & World Health Organization, 2005). As a result, limited access to insurance, economic disparities, and racism experienced by African Americans impact health outcomes negatively (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016). Given the insurgence of standards designed to address the disparities among historically underserved populations (APA, 1999; Cashwell & Watts, 2010; Grant et al., 2011; Harper et al., 2013; NASW, 2015) and the significant economic costs associated with untreated mental health disorders (WHO, 2001); cultural competence among mental health providers has become an imperative competent in-service delivery to clients.

Definitions of Multiculturalism in Mental Health Professions

Multiculturalism has been referred to in several ways throughout the literature, including cross-cultural, cultural, and transcultural therapy; however, for this purpose of this investigation, the term *multicultural competence* explains the global concept. Like varying terminology, several definitions of multicultural therapy are present within literature. Sue and Sue (1977) note that culture is comprised of traditions, values, customs, beliefs, skills, resources, and institutional memberships in which individuals are born. Rasmussen and Lavish (2014) captured the concept by stating "culture describes the whole of an individuals' learned behaviors, thoughts, and perceptions that have been transmitted throughout generations from institutions, organizations, or group membership" (p. 18). However, for the current investigation, *culture* was defined as an integrated pattern of behaviors, set of beliefs, and/or a collection of information shared by a group of people who share commonalities in social structure (Gilbert, Goode, & Dunee, 2007; NASW, 2015).

As a result of an inclusive concept, multicultural competence among therapists is defined and understood in various ways. Krentzman and Townsend (2008) recognize cultural competence involves the obtainment and utilization of beliefs, knowledge, and skills when working with culturally different clients, not excluding the importance of social justice work. However, other scholars have utilized the tripartite definition (e.g., awareness, knowledge, and skills) of multicultural competence (Sue et al., 1982). Within the present investigation, *multicultural competence* is defined as, an intersectional approach that enables therapists to use a collection of abilities including (a) self-awareness; (b) knowledge; (c) skills; and (d)

action, to address the concepts of privilege, oppression, and discrimination within their clinical practice (NASW, 2015; Ratts et al., 2016; Sue, Arredondo, & McDavis, 1992).

<div align="center">Historical Position of Multiculturalism Among Therapists</div>

Conceptualized and introduced through Sue and colleagues' (1982) publication, concepts of beliefs/attitudes, knowledge, and skills were proposed for use by mental health professionals (e.g., counselors, psychologists, and social workers). In contemporary society, multiculturalism is integrated in ethical codes, professional guidelines on competence, and standards for training in preparation programs within counseling, psychology, and social work fields (e.g., American Counseling Association [ACA] *Code of Ethics*, 2014; Council for Accreditation of Counseling and Related Educational Programs *Standards* [CACREP], 2016; American Psychological Association [APA] *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists,* 2002; National Association of Social Workers [NASWP] *Standards and Indicators for Cultural Competence in Social Work Practice*, 2015). In fact, therapists have an ethical commitment to embrace a multicultural approach throughout clinical practice in an effort to do no harm (ACA, 2014; Assembly, 2008; APA, 2002).

Despite standards for therapists to honor diversity and embrace a multicultural approach, the psychometric properties of data yielded through current multicultural competence assessments have been criticized (e.g., Constantine & Ladany, 2000; Worthington, Soth-Nett, & Moreno, 2007). Specifically, explaining the relationship between multicultural therapy and treatment outcomes is a challenge in the fields of counseling and

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psychology (Huey & Polo, 2008; Worthington, Soth-McNett, & Moreno, 2007). Notwithstanding criticism relating to multicultural research, multicultural therapeutic competence correlates with clients' perceived symptom reduction, social and personal improvement, cultural humility, and strengthened working alliance, as well as having fostered positive changes in clients' psychological functioning (D'Andrea & Heck, 2008; Owen et al., 2011; Sue, Zane, Nagayama Hall, & Berger, 2009; Worthington & Dillon, 2011).

A challenge in the area of multiculturalism is limited research testing the theoretical tenets of multiculturalism. Specifically, philosophical beliefs about the importance of multiculturalism have been discussed for decades (Fukuyama, 1990; Locke, 1990; Sue et al., 1982; Sue et al., 1992); however, additional research appears to be needed in testing contemporary definitions of multiculturalism. Therefore, an initial step in examining the construct of multiculturalism is the presence of a well-designed psychological assessment tool designed to measure the construct. Preliminary research relating to multicultural competence assessments have methodological limitations such as poor respondent data and sampling methods (e.g., Constantine, Gloria, & Ladany, 2002; D'Andrea & Heckman, 2008; Worthington et al., 2007). Therefore, the development of a multicultural competency assessment aligned to instrument development and quantitative method best practices is needed (e.g., American Educational Research Association [AERA], the American Psychological Association [APA], & the National Council on Measurement in Education [NCME, 2014]; DeVellis, 2017; Dimitrov, 2012; Haladyna & Rodriguez, 2013; Lambie, Blount, & Mullen, 2017).

Multicultural assessment measures with the exception the *Cross-Cultural Counseling Inventory-Revised* (LaFromboise, Coleman, & Hernandez, 1991) provide self-perceived respondent data from therapists on their confidence in working with culturally diverse populations (Constantine et al., 2002). Although self-perception of multicultural therapeutic skills is subjective, identifying therapists' self-efficacy is important in predicting their behaviors with clients (Bandura, 2006). Therefore, social cognitive theory (SCT; Bandura, 2006) was utilized as a conceptual framework to understand therapists' self-perception of their multicultural competencies.

Overtime, therapists' focus on multicultural competencies has adapted with societies growing conceptualization of culture (Wong, Wong, & Scott, 2006); for instance, previous multicultural assessments have utilized the *Multicultural Counseling Competencies* (MCC; Sue, Arredondo, McDavis, 1992) as a conceptual framework upon which items focused primarily on visible racial/ethnic minority groups. However, contemporary multiculturalism integrates racial/ethnic diversity, sexual orientation, gender identification, social economic status, spiritual and/religious beliefs and many other relevant social identities (Ratts et al., 2016; Robinson, 1999). In addition, concepts of privilege, oppression, marginalization, and the intersection of social identities are explored to provide therapists with a comprehensive understanding of potential dynamics taking place in the lives of clients and in therapy sessions. Similarly, Kimberlé Crenshaw coined *Intersectionality Theory* (IT; Samuels & Ross-Sheriff, 2008) as a means to analyze oppression, discrimination, and domination as displayed through elements of diversity. Although grounded in a feminist perspective, IT recognizes countless identities individually and collectively that may result in oppression

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within society (Samuels & Ross-Sheriff, 2008); thus, the integration of its theoretical underpinnings within the development and construction of the *Multicultural Competency Assessment©* (MCA).

<div align="center">Multicultural Therapy Assessments</div>

The following section provides an overview of existing self-report multicultural therapy assessments. Specifically, the following seven multicultural assessments are reviewed: (a) the *Cross-Cultural Counseling Inventory Revised* (CCCI-R; LaFromboise, Coleman, Hernandez,1991), (b) the *Multicultural Awareness Knowledge Skills Scale* (MAKSS; D'Andrea, Daniels, & Hecks, 1991), (c) the *Multicultural Competency Inventory* (MCI; Sodwosky, Taffe, Gutkin, & Wise, 1994), (d) the *Multicultural Counseling Awareness Scale-Form B* (MCAS:B; Ponterroto, Gretchen, Utsey, Rieger, & Austin, 1994), (e) the *Multicultural Counseling Competence and Training Survey* (MCCTS; Holcomb-McCoy & Myers, 1999), (f) the *California Brief Multicultural Competence Scale* (CBMCS; Gamst, Dana, Der-Karabetian, & Aragon, 2004), and (g) the *Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form* (MCSE-RD; Sheu & Lent, 2007).

LaFromboise and colleagues (1991) developed the CCCI-R, a 20-item assessment utilizing a 6-point Likert scale format to measure multicultural counseling competence. The CCCI-R is comprised of three subscales, assessing (a) sociopolitical awareness, (b) cross-cultural skills, and (c) cultural sensitivity. Sample items from the CCCI-R include, "counselor is aware of his or her own cultural heritage" and "counselor has a clear understanding of counseling and therapy process." A strength of the CCCI-R includes its

ability to be used by a third-party observer; however, the research methods employed in the development of the CCCI-R limit validity of the assessment data (e.g., small sample size).

The MAKSS (D'Andrea et al., 1991) is a 60-item measure developed to assess the impact of multicultural training upon counseling students. The 4-point Likert response scale includes sample items such as, "psychological problems vary with the culture of the client" and "racial and ethnic persons are underrepresented in clinical and counseling psychology". The MAKSS utilizes three subscales: (a) awareness, (b) knowledge, and (c) skills. Given the low intercorrelation reliability coefficients reported in the validation of the MAKSS, revised versions of the MAKSS (e.g., *Multicultural Awareness Knowledge Skills Scale-Counselor Edition-Revised* [MAKSS-CE; Kim, Cartwright, Asay, & D'Andrea, 2003]; *Multicultural Awareness Knowledge Skills Survey-Teachers Form* [MAKSS-TF]) have been developed. A strength of the MAKSS is its status as the first assessment designed to measure multicultural training within the therapeutic fields. Conversely, the scale length (e.g., 60-items) and low intercorrelation reliability may cause issues in collection of data and score interpretation, respectively.

The MCI (Sodoswky et al., 1994) is a 40-item self-report assessment designed to measure the multicultural counseling competencies. Sample MCI items include, "I am involved in advocacy efforts against institutional barriers in mental health services for minority clients (e.g., lack of bilingual staff, multiculturally skilled counselors, and outpatient counseling facilities)" and "I have difficulties communicating with clients who use a perceptual, reasoning, or decision-making style that is different from mine." The items of the MCI encompass four subscales, evaluating (a) multicultural counseling skills, (b)

multicultural awareness, (c) multicultural counseling relationship, and (d) multicultural counseling knowledge. A strength of the MCI is the identification of the counseling relationship among a multicultural competency assessment; however, MCI scores yield low factor matrix correlations.

The MCAS: B (Ponterotto et al.,1996) is a 45-item assessment developed to measure multicultural awareness, knowledge, and skill. Utilizing a 7-point Likert scale, the MCAS: B incorporates sample items such as, "I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive" and "I am aware that counselors frequently impose their own cultural values upon minority clients". Although designed to measure the tripartite definition of multicultural counseling, the MCAS: B encompasses two subscales (a) knowledge-skills and (b) awareness. While the MCAS: B is commonly used in multicultural competence literature (Pope-Davis, Coleman, Liu, & Toporek, 2003), the assessment is lengthy and may impact test fatigue in research investigations. Thus, researchers continued optimization with the revised, *Multicultural Counseling Knowledge and Awareness Scale* (MCKAS; Ponterroto, Gretchen, Utsey, Rieger, & Austin, 2002).

The MCCTS (Holcomb-McCoy & Myers, 1999) is a 32-item assessment that was developed to assess multicultural competence. With a 4-point Likert response item scale, the MCCTS is comprised of five subscales, measuring: (a) knowledge of multicultural issues, (b) awareness, (c) definition of terms, (d) racial identity development, and (e) skills. The sample items on the MCCTS include, "I can define prejudice" and "I am able to discuss how my culture has influenced the way I think". Strengths of the MCCTS include the identification of two new factor domains, definition of terms and racial identity development; however,

because the 'definition of terms' factor encompasses only two-items, low internal consistency reliability coefficients were reported.

The CBMCS (Gamst et al., 2004) is a 21-item measure designed to assess mental health practitioner cultural competency. Utilizing a 4-point Likert scale ranging from *strongly disagree* to *strongly agree* the assessment is comprised of four subscales (a) sensitivity to consumers, (b) non-ethnic ability, (c) cultural awareness, and (d) cultural knowledge. Sample items of the CBMCS include, "I am aware of institutional barriers that affect the client" and "I have an excellent ability to assess, accurately, the mental health needs of gay men". The CBMCS produced adequate internal consistency reliability, which is a strength of the assessment. The generalizability of the CBMCS among all mental health service providers is questionable based on the development sample and the researchers sampling methods.

The MCSE-RD (Sheu & Lee, 2007) is a 37-item assessment designed to measure self-perceived capability in counseling racially diverse clients. The MCSE-RD uses a unipolar response scale ranging from 0 (*no confidence at all*) to 9 (*complete confidence*). Sample items include "openly discuss cultural differences and similarities between the client and yourself" and "help the client to utilize family/community resources to reach her or his goals". Through the analysis of MCSE-RD scores three new subscales emerged (a) multicultural intervention, (b) multicultural assessment, and (c) multicultural session management. The MCSE-RD yields reliable and valid scores; however, because of the homogeneity of the development sample, generalizing findings may be difficult.

In summary, the reviewed multicultural assessments establish a foundation for measuring multicultural competence among therapists; nevertheless, limitations exist relating to the research methods employed to develop these psychological measures (Constantine & Ladany, 2000). In particular, the heterogeneity of factor loadings suggest inconsistency among the measure of constructs across multicultural competence assessments. In addition, previous measures have not utilized a comprehensive definition of multiculturalism, including the concepts of privilege, discrimination, and advocacy. Thus, this research investigation intended to address the current limitations among multicultural assessments in the development of a new assessment, the MCA.

Statement of the Problem

Researchers have examined the psychometric properties of multicultural competence assessment data (Constantine, Gloria, Ladany, 2002; Worthington et al., 2007); yet, limited variety regarding scale development procedures, research design, sampling procedures, and factor retention methods are present within literature. Specifically, limitations exist in retrieving an adequate sample size (n) for use of factor analysis, the use of validation measures, faulty factor extraction procedures, and the use of instrument development best practices (AERA, APA, & NCME, 2014; Constantine & Ladany, 2000; DeVellis, 2017; Dimitrov, 2012; Haladyna & Rodriguez, 2013; Hay Hayton, Allen, Scarpello, 2004; Lambie et al., 2017). Therefore, this investigation addresses the limitations identified within self-perceived multicultural competence assessment measures. The assessment of multicultural competence in therapists is significant as multicultural competence is associated

with client outcomes and the working alliance (Hook, Davis, Owen, Worthington, & Utsey, 2013; Michalopoulou, Falzarano, Butkus, Zeman, Vershave, Arfken, 2014); however, a sound method for quantifying competence within a multicultural assessment with sound validity and reliability scores is needed.

Purpose Statement and Research Questions

Present multicultural competence measures for therapists align with the APA Division 17 report and/or the MCC (Sue et al., 1992) as foundational elements upon which scales were developed. Nevertheless, scholars agree that multiculturalism spans beyond the tripartite definition and encompasses concepts of privilege, advocacy, and social identities beyond race/ethnicity (NASW, 2015; Ratts et al., 2016). Therefore, the need for a measure designed to assess self-perceptions surrounding working with all clients is imperative.

This study sought to develop and assess the factor structure of a new psychological assessment, the *Multicultural Competency Assessment* (MCA) for therapists utilizing an inclusive definition of multiculturalism. The purpose of developing the MCA was to examine the psychometric properties of multicultural competence (as measured by MCA scores) among a sample of therapists (e.g., counselors, psychologists, social workers). The specific research questions that guided the investigation included:

Research Question 1

What is the factor structure of the items within the MCA among a sample of
therapists (examining evidence of construct validity)?

Research Question 2

What is the internal consistency reliability of the MCA scores among a sample of
therapists?

Research Question 3

What is the relationship between MCA scores and the *Marlowe-Crowne Social
Desirability Scale-Short Form* (MSDS-X1) scores among a sample of therapists (examining
evidence of social desirability)?

Research Question 4

What is the evidence of concurrent validity of the MCA scores (as measured by the
correlation between MCA and MCSE-RD scores)?

Research Question 5

Are there any significant differences in MCA scores based on the participants'
demographic groups? If yes, what are the differences?

Research Methods

Research Design

The present investigation focuses on the measurement of two or more variables to determine the interconnectivity of the variables, calling for a correlational research design (Mitchell & Jolley, 2004). In addition, a descriptive research design involves the description of single, as well as, multiple variables. Thus, the present study utilized a descriptive, correlational research design to better understand the relationships between and among the domains within the MCA (Gall, Gall, & Borg, 2007).

Population and Sample

The targeted population for the present study was therapists including counselors, social workers, psychologists, counselors-in-training, social workers-in-training, and psychologists-in-training throughout the United States. The researcher collected data from respondents who were members of professional organizations, mental health related listserv's, and/or students within training preparation programs. Therefore, convenience and random sampling methods with inclusion criteria was employed (Gall et al., 2007). Inclusion criteria for participation within this study included: (a) persons must be a therapist who has provided therapeutic services which for the purpose of this investigation is defined as psychologists, counselors, social workers, psychologists-in-training, counselors-in-training, and social workers-in-training (e.g., practicum and internship students); (b) persons must be able to read English at a sixth-grade reading level; and (c) persons must be 18 years of age or

older. A sample meeting the outlined inclusion criteria was recruited from different regions of the United States.

In determining an appropriate sample size for the investigation, researchers determine a minimum sample size required by calculating the ratio of sample N (total of cases) and p (number of variables) ratio to render an acceptable sample size (Mvududu & Sink, 2013). Within literature N: p ratios are known to range from 3 to 20 (Comrey & Lee, 1992; Everitt, 1975). In fact, Comrey and Lee (1992) developed a scale to evaluate the adequacy of a sample size with the intention of using factor analysis (e.g., $N = 50$ - very poor; 100 – poor; 200- fair; 300 – good; 500 - very good; 1000 - excellent; p. 217). Based upon www.danielsoper.com, assuming a 25% response rate, at least 400 assessment packets would need to be disseminated to obtain the minimum sample size of 100, which is required to obtain an effect size of .5, a desired power of .95, and a probability level of .05. Considering small sample sizes (e.g., 100) hinder the ability to generalize study findings (DeVellis, 2017); therefore, a minimum of 1,000 total participants was obtained using a 20:1 ratio for the validation of the MCA scores.

Thus, a total of 5,124 therapists who provide mental health services were invited to participate in the present research investigation (e.g., pilot, data one, data two). In particular, a total of 29 participants completed the original 50-item MCA during the pilot. A total of 407 participants completed the original version of the MCA and MCSDS-X1 during dataset one. After the MCA scores were analyzed and evaluated, the researcher optimized the assessment which resulted in the reduction of 25-items. Next, the 25-item MCA was administered to a sample of 233 therapists during dataset two. Among previous multicultural competency

studies, response rates have ranged from 10% to 40% (Barden, Sherrell, & Matthews, 2017; Holcomb-McCoy & Day-Vines, 2004); within the present research study the overall study yielded a total usable response rate of 13%. Specifically, a 97% response rate was achieved from the pilot, a 13% response rate was gained from data one, and a 11% response rate was attained from data two.

<div align="center">Instrument Procedures and Instrumentation</div>

The research study focused on two main areas (a) the development of the MCA and (b) assessing the psychometric features of the MCA data. Prior to participation in the study, participants received a statement of informed consent for research once approved by the university's Institutional Review Board (IRB). After participants voluntarily agree to participate in the study, they were provided either a series of three (data one) or four (data two) assessments that assisted in the evaluation of the MCA.

From conception, the construction of the MCA has utilized instrument development best practices (e.g., AERA, APA, & NCME, 2014; DeVellis, 2017; Dimitrov, 2012; Haladyna & Rodriguez, 2013; Kline, 2005; Lambie et al., 2017). It is through the integration of the aforementioned guidelines and standards that the researcher developed a stepwise procedure for the study. The specific steps that the researcher implemented included: (a) a definition of the measurement purpose, (b) a set of assessment specifications, (c) the development of draft assessment items, (d) a reviewal of the draft assessment items using an expert panel, (e) the dissemination of the assessment to a pilot sample, (f) the evaluation of the scale prior to running an Exploratory Factor Analysis (EFA), (g) the optimization of the

assessment, (h) a consideration of validation measures, (i) the administration of the three scale assessment packet to sample of therapists, (j) the analyzation of the scale after running an EFA using dataset one, (k) the optimization of the assessment, (l) the analyzation of the scale after running an Confirmatory Factor Analysis (CFA) using dataset two, and (m) a final optimization of the assessment.

As a foundational resource, an assessment manual was created to explain how to replicate administering the MCA to therapists. In addition, the assessment manual serves as a reference guide to scoring and interpreting the MCA, containing (a) a review of literature from which the MCA was developed, (b) operationalized definitions of each item, (c) instructions for administration, and (d) instructions for scoring of the MCA.

This research study employed four data collection assessments. The first assessment is the MCA, developed for this research investigation. The second assessment, the MCSDS-XI (Strahan & Gerbasi, 1972) was administered to measure social desirability. The third assessment, the MCSE-RD (Sheu & Lee, 2007) was administered to measure self-perceived capability in counseling racially diverse clients examining convergent validity of the MCA scores. Lastly, a general demographic questionnaire was administered to collect demographic information about the sample of therapists.

Multicultural Competency Assessment

The first assessment is the MCA, which has been developed for the purpose of this study. The MCA is a self-report assessment that measures multicultural competence self-efficacy among therapists. Thus, the assessment is designed to measure therapists' perception

of self-efficacy regarding their ability provide specific clinical tasks. Since multicultural competency assessments are susceptible to social desirability bias (Larson & Bradshaw, 2017); the assessment was identified through a code name (e.g., MCA) upon dissemination to minimize response bias (Bandura, 2006).

Mvududu and Sink (2013) suggests the use of continuous (e.g., interval, ratio) data in scale development. The scoring method and the question style were constructed based upon recommendations of self-efficacy scale development (Bandura, 2006). While unipolar response scales are suggested when measuring self-efficacy (Bandura, 2006); Likert scales are commonly used within the fields of counseling and psychology (Dimitrov, 2012) and are compatible with use of theoretical models (DeVellis, 2017). Therefore, a 5-point Likert scale ranging from (1= *Not Competent in Providing Specified Clinical Task* to 5 = *Very Competent in Providing Specified Clinical Task*) was utilized to measure MCA response data.

Previous multicultural competence assessments have found subscales focusing on (a) awareness, (b) knowledge, (c) skills, and (d) the therapeutic relationship; however, the most frequent re-occurring subscales found in literature are (a) awareness, (b) knowledge, and (c) skills (Constantine & Ladany, 2000). Thus, the researcher hypothesized identifying at least three sub-scales within the MCA (e.g., awareness, knowledge, and skills and interventions) and intends to test the relevance of additional multicultural focused domains (e.g., systemic and institutional structures, the therapeutic relationship, and social justice advocacy). Since the construction of self-efficacy assessments require strong conceptual examination (Bandura, 2006); the exploration of theoretical underpinnings for the MCA are found in The Training Manual (*see* Appendix L).

Marlowe Crowne Social Desirability Scale

As noted, multicultural competence assessments are known for social desirability bias (Constantine, 2000; Larson & Bradshaw, 2017); yet, with use of the MCSDS-X1 (Strahan & Gerbasi, 1972), no significant relationship among social desirability scores and multicultural competence scores have been found (Larson & Bradshaw, 2017). Therefore, the 10-item scale (true, false) MCSDS-X1 that measures an individual's motivation to respond in ways that are deemed positive within society. The MCSDS-X1 is being used to address a threat to internal validity, social desirability, when participants complete the MCA. The MCSDS-X1 is one of the most widely used social desirability measures (DeVellis, 2017). The MCSDS-X1 is the short form as the original form encompasses a total of 33-items. The MCSDS has a satisfactory internal consistency reliability range (α = .50 - .80; Barger, 2002; Mullen et al., 2014; Reynolds, 1982; Strahan & Gerbasi, 1972).

Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form

The MCSE-RD (Sheu & Lee, 2007) is a 37-item self-report assessment that uses a unipolar response scale (0 = *no confidence at all*, 9 = *complete confidence*) that measures self-perceived confidence in providing counseling to racially diverse clients. The MCSE-RD utilizes three sub-scales: multicultural intervention (MI), multicultural assessment (MA), and multicultural session management (MSM). The MCSE-RD has satisfactory psychometric features as evidenced by an internal consistency of .98 (Sheu & Lee, 2007).

Furthermore, the MCSE-RD has been used to measure validity (e.g., convergent and discriminate) by the *Counselor Activity Self-Efficacy Scale* (CASES; Lent, Hill, & Hoffman,

2003) and the MCI. Positive significant correlations have been found when using the MCSE-RD with both CASES and MCI. This has been affirmed statistically as CASES and MCSE-RD total scores ($r = .79$), as well as, MCI and MCSE-RD total scores ($r = .79$ and $.68$) yielded satisfactory correlations (Sheu & Lent, 2007). Thus, the inclusion of this measure within the present research investigation.

General Demographic Questionnaire

The fourth assessment is the *General Demographic Questionnaire*, which assesses general demographics of the therapists within the research study. The questionnaire allowed a means to secure data related to therapist's demographic information such as gender, age, race/ethnicity, years in practice, and years of schooling. In addition, the questionnaire inquired about the following: training program type (e.g., accredited, not accredited), primary work setting, and identified professional field.

Data Collection

Following approval of the researcher's Institutional Review Board (IRB), the MCA was administered via online survey (e.g., a Qualtrics survey link), mail-out, and face-to-face administration, employing elements of the *Tailored Design Method* (TDM; Dillman, Smyth, & Christian, 2009). The TDM is a set of survey processes that work together to form a survey request and to motivate a diversity of respondents to respond to surveys (Dillman et al., 2009). In addition, the TDM attends to multiple sources of survey error including: (a) coverage, (b) sampling, (c) measurement, and (d) nonresponse with a focus on minimizing

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overall survey error. An essential benefit to the TDM of data collection is the focus on reluctance reduction among research participants. Reluctance reduction can be facilitated through the (a) establishment of trust among the participants, (b) an increase of potential benefits of participation, and (c) a decrease of potential cost of participation (Dillman et al., 2009). In particular, the researcher utilized a cover letter highlighting the importance of the study, provided pre-paid return envelopes, and reviewed introspective benefits of participation in the study. Thus, a modified TDM guided the framework of data collection when disseminating survey data among the sample of therapists.

The recruitment methods for data one included inviting therapists through mail-out out procedures, providing participants with a Qualtrics link, and face-to-face procedures. Specifically, the researcher rented membership information from professional organizations. All rented membership information was used once; therefore, participants were only contacted once either through a USPS mailing or an emailed Qualtrics link. Additional study invitations were sent through a regional mental health listserv, a professional organization listserv, and face-to-face procedures through practicum and internship courses from two universities located in the southeast. The second dataset included inviting therapists via mail-out out, Qualtrics link, and through face-to-face procedures. Similar to data one, the researcher rented membership information from a professional organization. In addition, participations were recruited through a professional organization listserv, and face-to-face through community-based organizations.

Ethical Consideration

Ethical guidelines were followed in the completion of this research investigation. In particular, the researcher obtained her university's IRB approval prior to conducting any recruitment or data collection. Furthermore, all research participants were educated about the research investigation, the purpose of the study, and the study procedures. An informed consent outlined pertinent study information and participation was voluntary. In addition, to ensure anonymity, all study documents were coded.

Limitations of Study

Limitations within the present research investigation involve equity across the sampled professional identities (e.g., counselors, psychologists, and social workers). Despite recruitment efforts, the sample of therapists largely reflect responses from counselors across studies (e.g., pilot, data one, data two). Therefore, the generalizability of the study results may not be fully reflective of each mental health discipline. Furthermore, in the development of the MCA, a limitation may exist in the identified domain areas of multiculturalism. The areas explored are relevant to the construct of interest (multiculturalism); however, additional domain areas may exist in therapists' work with diverse clients. Thus, all areas relevant to the measurement of multiculturalism among therapists' may not been reflected in the MCA.

Chapter Summary

The procedures required in the development of a sound assessment among a sample of therapists with the intention to measure multicultural competence was discussed within this chapter. This chapter included a brief review of literature concerning the increasing diversity among the US population, definitions of multiculturalism in mental health professions, the historical position of multiculturalism among therapists, and previous multicultural assessments utilized in literature were reviewed. In addition, the chapter explored the rationale for a new multicultural competence assessment which includes limited definitions of culture among previous assessments, poorly employed research methods, and the use of tested scale development procedures in the construction of previous measures. Consequently, the chapter concludes with an explanation of the present research study, identifying the research methods and statistical analysis intended to establish a stable multicultural competence assessment.

CHAPTER TWO: LITERATURE REVIEW

With over 150 definitions of culture (Kroeber & Kluckhohn, 1952), it is difficult to

debate the heterogeneity of modern day society. Over the past two decades there has been an

increased emphasis on topics of diversity (e.g., Cartens & De Kock, 2017; Chartier, Negroni,

Hesselbrock, 2010; Giami, 2002; Sinha, 1990); however, mental health concerns among

clients of diversity (e.g., persons of color, sexual minorities, etc.) remain a significant issue.

According to the Surgeon General (2001), racial minorities disproportionately lack access

and receive poorer quality mental health services than white counterparts. The disparities

experienced by racial/ethnic diverse segments of the population may be caused by a wide

range of socio-factors including, but not limited to, inequalities in quality providers,

difference or lack of insurance coverage as well as discriminatory clinical encounters

(Miranda, McGuire, Williams, & Wang, 2008). Considering the recent minority-majority

(e.g., less than 50% of the total population identifying as White, Non-Hispanic) projections

among racially diverse persons within the United States (Colby & Ortman, 2015); disparities

among racially diverse clients may have a widespread impact. In addition, approximately

11% of respondents identifying as transgender or non-gender conforming reported a denial of

mental health services and 41% reported having at some point attempted suicide (Grant et al.,

2011). Similarly, the National Survey on Drug Use and Health (NSDUH) found 39.1% of

participants identifying as a sexual minority reported use of illicit drug use within the past

year comparative to 17.1% of sexual majority adults (Medley, Lipari, Bose, Cribb, Kroutil, &

McHenry, 2015). Although encompassing approximately four percent of the total population

based upon the NSDUH (2015) data, significant disparities among sexual minorities display a need for culturally responsive clinicians (Medley et al., 2015).

Mental health concerns impact individuals' overall health (WHO, 2008). Specifically, the rates of psychological disorders for Mexican, African, and Caribbean Immigrants increase with time spent in the US. Native Americans are at an increased risk for posttraumatic stress disorder (PTSD) and alcohol dependency when compared to a sample representative of the U.S population. Black Americans, however, are three times more likely to be diagnosed with schizophrenia and when controlling for family social economic status two times more likely than their White counterparts, a symptom of pervasive clinician over diagnosis of schizophrenia among mental health professionals (Bresnahan, Begg, Brown, Schaefer, Sohler, Insel, Vella, Suser, 2007; Miranda et al., 2008). Considering the large societal and economic costs of mental health disorders (Surgeon General, 2001; WHO, 2001); adequate mental health services are imperative to the well-being of individuals and the financial vitality of the nation.

To address the aforementioned mental health concerns, mental health preparation programs have taken steps to ensure professionals (e.g., counselors, psychologists, and social workers) are equipped to provide mental health services to diverse populations. In fact, within both training and clinical practice, multiculturalism is an essential concept among mental health professionals. Multiculturalism and social justice are considered the fourth and fifth forces within the fields of counseling and psychology (Pedersen, 1988; Ratts, 2009). Therefore, concepts of multiculturalism are integrated in ethical codes, guidelines on competence, and standards for training in preparation programs within counseling,

psychology, and social work fields (e.g., ACA *Code of Ethics*, 2014; CACREP *Standards*, 2016; APA *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists,* 2002; NASW *Standards and Indicators for Cultural Competence in Social Work Practice*, 2015). In fact, mental health professionals are challenged to uphold an ethical commitment to embrace a multicultural approach throughout clinical practice to do no harm (ACA, 2014; APA, 2017; NASW, 2008). Thus, to uphold the integrity of mental health professions, therapists should consider the cultural dynamics in sessions with clients to ensure professional dispositions are in line with ethical conduct (Corey & Herily, 2014).

The expectation of utilizing ethical conduct assumes a requirement of proficiency within mental health professionals' field of study. To determine professionals' level of competence, an individual must engage in (a) self-monitoring, (b) self-assessment, and (c) self-reflection (Johnson, Barnett, Elman, Forrest, & Kaslow, 2012). For these reasons, within mental health professions competence is not a destination, but an ongoing pursuance (Corey & Herily, 2014). Although opposing perspectives exist (Coleman, 1998); multicultural competence has been identified as an area of expertise independent from general mental health competence (Constantine, 2002; Drinane, Owen, Adelson, & Rodolfa, 2016). The distinction between general and multicultural competence is a foundational element upon which previous multicultural competency measures have been developed. Although contributions to multicultural literature, significant limitations exist in the construction of previous multicultural competency assessments. Most notably, clinicians from various professions utilize present multicultural competency assessments across fields of study;

however, none of these measures appeared to be constructed with the intention of cross disciplinary use.

<center>Overview of the History of Multiculturalism</center>

<center>Definitions</center>

Culture is defined in a variety of ways. For instance, Yamamoto, Silva, Ferrari, and Nukariya (1997) conceptualized culture as, a term that "…refers to social reality. It can be defined as a complex collection of components that a group of people share to help them adapt to their social and physical world" (p. 34). However, other scholars have defined culture as,

> …a set of denotative (what is or beliefs), connotative (what should be, or attitudes, norms and values), and pragmatic (how things are done or procedural roles) knowledge, shared by a group of individuals who have a common history and who participate in a social structure. (Basabe, Paez, Valencia, González, Rimé, & Diener, 2002, p. 104)

Gilbert, Goode, and Dunee (2007) describes culture as

> an integrated pattern of human behavior which includes but is not limited to— thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of an ethnic group or social groups whose members are uniquely identifiable by that pattern of human behavior. (p. 14)

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For the current investigation, *culture* is defined as an integrated pattern of behaviors, set of beliefs, and/or a collection of information distributed by a group of people who share commonalities in social structure (Gilbert et al., 2007; NASW, 2015).

Among fields of counseling, psychology, and social work, multicultural competence is defined in multiple ways and has developed overtime (Fukuyama, 1990). Gilbert and colleagues (2007) define cultural competence as, "…a developmental process that evolves over an extended period of time. Both individuals and organizations are at various levels of awareness, knowledge, and skills along the cultural competence continuum" (p. 5). Multicultural therapy refers to "preparation and practices that integrate multicultural and culture specific awareness, knowledge, and skills into counseling interactions" (Arredondo Toporek, Brown, Jones, Locke, Sanchez, & Stadler, 1996, p. 43). Other scholars have defined competence based upon the role of the clinician, focusing on behaviors by which a culturally competent professional should possess. Thus, Holcomb-McCoy and Myers (1999) defined multiculturally competent therapists as individuals who possess the skills necessary to provide culturally responsive services to clients from culturally diverse backgrounds. Specifically, therapists must (a) have awareness of their biases, (b) seek understanding regarding client worldviews, and (c) obtain and implement culturally appropriate interventions within clinical practice (Sue, Arredondo, & McDavis, 1992; Arredondo et al., 1996).

Amid psychologists, multicultural competence has been referred to as, "a helping role or process that implements techniques; conceptualizes client focused goals and cultural values; recognizes client identities; advocates for universal and cultural specific strategies;

and balances individualism and collectivism in assessment, diagnosis, and treatment of

clients" (Sue & Torino, 2005, p. 6). Social work, on the other hand, has defined cultural

competence as, a concept requiring the use of an intersectional approach in clinical practice.

The multifaceted intersectional perspective allows for the examination of oppression,

discrimination, and domination in all forms given social identity statuses of race and

ethnicity, immigration and refugee status, religion and spirituality, sexual orientation, gender

identity and expression, social class, and abilities (NASW, 2015). Although the concept of

multicultural competence is understood in numerous ways, in the context of the present

research investigation, *multicultural competence* is defined as, an intersectional approach that

enables for therapists to use a collection of abilities including (a) self-awareness; (b)

knowledge; and (c) skills to address the concepts of privilege, oppression, and discrimination

within clinical practice (NASW, 2015; Ratts et al., 2016; Sue et al., 1992).

<div align="center">The Historical Progression</div>

The 1970s.

The conception of multiculturalism among mental health providers was initiated at

The Vail Conference in 1973 through a discussion surrounding the importance of cultural

diversity as it relates to professional training and clinical practice (Korman, 1974).

Specifically, to provide clinical services broadly and in a non-discriminatory manner; thus,

the conclusion that lack of competence in or failure to prepare psychologists to work with

clients of diversity violates ethical guidelines. A few years later, Sue and Sue (1977)

highlighted the major characteristics found in therapeutic settings that limit the usefulness of

mental health engagement among racially diverse populations, including (a) language barriers, (b) cultural-bound values, (c) nonverbal communication, (d) personal space, (e) eye contact, and (f) conversation conventions. Implications in working with racially diverse client populations outlined, but did not explicitly review, the general concepts of self-awareness, knowledge, and skills (Sue & Sue, 1977), serving as a springboard for multicultural literature among mental health service providers.

The 1980s.

The introduction of multiculturalism among therapeutic professions gained attention three decades ago with Sue and colleagues' (1982) position paper establishing characteristics and highlighting the importance of cultural competence in the psychology field. During this time, attempts among mental health professions were made to define multicultural competence, as well as, identify behavioral skillsets required for competence (Pope-Davis, 2003). Sue and colleagues' (1982) article became a seminal work within multicultural literature as social work and counseling fields began to utilize the embedded concepts within psychology-based literature. Although not founded upon research, the cross-cultural counseling competencies were the catalyst from which mental health organizations (e.g., ACA, APA, and NASW) have developed standards, competencies, and ethical codes. By the mid-1980's, an insurgence of publications related to training issues and multicultural practice emerged within literature (e.g., Atkinson, 1985; Ivey, 1987; Lee, 1989; Lloyd, 1987; Pedersen & Marsella, 1982; Pedersen & Pedersen, 1989; Ponterotto & Casas, 1987).

<u>The 1990s.</u>

In the early 1990's, the counseling profession formerly adopted the competencies from the APA Division 17 report (Sue et al., 1982) to establish the *Multicultural Counseling Competencies* (MCCs; Sue et al., 1992). Approved by the Association for Multicultural Counseling and Development (AMCD), the MCCs were first within the counseling profession to establish and highlight competencies needed when working with diverse client populations. However, the MCCs focus primarily upon working with racial and ethnic diverse client populations (Sue et al., 1992), fostering debate on the inclusivity of the term multicultural counseling (Fukuyama, 1990; Locke, 1990). Although, all counseling is to some degree multicultural counseling, the exclusiveness of the MCCs definition of multiculturalism was utilized to focus upon the concerns of working with racial ethnic groups in therapy (Sue et al., 1992).

A 3 (characteristics) x 3 (dimensions) matrix was utilized in the conceptualization of the MCCs. The matrix design allowed for the exploration of characteristics including (a) counselor awareness of own assumptions, values, and biases; (b) understanding of client worldview; and (c) the development of interventions that were described through three dimensions: (a) attitudes and beliefs, (b) knowledge, and (c) skills (Sue et al., 1992). Thereafter, increased reference of the nine MCC areas within the fields of counseling, psychology, and social work were made to the literature (e.g., Abernethy, 1995; Ponterotto, Alexander, & Grieger, 1995; Pope-Davis & Ottavi, 1994; Ronnau, 1994; Whitfield, 1994), the operationalization of the competencies (Arredondo, Toporek, Brown, Jones, Locke, Sanchez, & Stadler, 1996), and multicultural theory (Sue, Ivey, & Pedersen, 1996).

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Not until the late 1990s did ACA formerly known as the American Association of Counseling and Development (AACD) endorse the MCCs (Pope-Davis, Coleman, Liu, & Toporek, 2003), supporting the need for counselors to understand and utilize cultural responsive services in clinical practice. In a similar fashion, APA (1999) Divisions 17 and 45 endorsed cultural competence standards for psychologists; thus, creating a space for multicultural literature among mental health professions.

<u>The 2000s to the Present.</u>

By the turn of the century, the fields of psychology, counseling, and social work all developed guidelines when providing cross-cultural mental health services, including the *Guidelines on Multicultural Education, Training, Research, Practice, and Organization Change for Psychologists* (Anderson, 2000) and the *Standards for Cultural Competence in Social Work Practice* (NASW, 2001). As literature surrounding multicultural competence and the development of multicultural assessments have grown (e.g., Constantine, Gloria, Ladany, 2002; Gamst, Dana, Der-Karabetian, Aragon, Arellano, Morrow, & Martenson, 2004; Sheu & Lent, 2007), guidelines specific to non-ethnic cultural groups have also been developed to assist practitioners in clinical practice (e.g., APA, 2012; Cashwell & Watts, 2010; Harper et al., 2013; NASW, 2007).

A more inclusive perspective of MCC has been prominent as standards have conceptualized identity as an intersectional concept (NASW, 2015; Ratts et al., 2016). Grounded in Intersectionality Theory (IT; Samuels & Ross-Sheriff, 2008), *the Standards and Indicators of Social Work Cultural Competence* utilize multicultural concepts of self-

awareness, knowledge, and skills; the revised the *Standards and Indicators of Social Work Cultural Competence* (NASW, 2015) outline behaviors and skillsets of culturally competent social workers. However, significant contributions were made with the introduction of standards including: (a) advocacy in professional education, (b) the diversity of the workforce, (c) empowerment and advocacy of multicultural client populations, (d) service delivery to and within multicultural communities, (e) language and communication, and (f) ethics and values (NASW, 2015). Organized through interpretation and indicators, each standard provides detailed descriptors and action-oriented language to assist social workers in clinical practice.

Similarly, a revised version of the MCCs were developed to address two aims, (a) to broaden the definition of the multiculturalism within the field of counseling and (b) to incorporate elements of social justice through advocacy within the competencies (Ratts et al., 2016). The revisions to the MCCs resulting in the *Multicultural and Social Justice Counseling Competencies* (MSJCCs), providing a comprehensive view and conceptual framework for counselors working with diverse populations. Unlike the MCCs, the MSJCCs utilizes Bronfenbrenner's (1979) socioecological perspective when discussing multicultural competence. Therefore, a socioecological matrix is used to explain the dimensions and competencies within MSJCC. The dimensions within the MSJCCs matrix include: (a) self-awareness, (b) client worldview, (c) the counseling relationship, and (d) counseling and advocacy interventions. The MSJCCs also address each dimension in terms of: (a) attitudes and beliefs, (b) knowledge, (c) skills, and (d) action (Ratts, et al., 2016). Aspirational at best,

the MSJCCs provide counselors with a model by which relationships between competencies and constructs can gauge, understand, and improve their multicultural competence.

<center>Multicultural Paradigms</center>

<center>Theoretical Foundations of Multiculturalism among Therapeutic Professions</center>

Social cognitive theory.

First introduced by Albert Bandura as *Social Learning Theory* (SLT; Bandura, 1977), *Social Cognitive Theory* (SCT; Bandura, 1986) is a concept that emphasizes the learning process through observation and modeling. Primary learning principles within SCT include (a) attention, (b) retention, (c) reproduction, and (d) motivation. As individuals learn either formally within an academic setting or informally through social interactions these principles are vital to ensure positive learning outcomes occur.

Bandura (1977) highlights the importance of self-efficacy in the learning process, which is defined as individuals' belief in their own abilities to perform specific tasks or skills. Specifically, individuals avoid areas they believe are unattainable; however, the opposite is true of tasks that are believed to be achievable (Bandura, 1982). In contrast, highly self-efficacious individuals often invest less time toward skill development (Bandura, 1982); thus, inferences linking high levels of self-efficacy to preparatory behaviors must be assessed.

Perceived self-efficacy, judgements regarding one's abilities to execute specific tasks, does not deal with one's objective abilities (Bandura, 1982). Competence refers to the integration of skills enacted to demonstrate proficiency in a topic area (Bandura, 1982); thus,

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one of the distinctive differences in the development of the MCA compared to multicultural competence assessments presently found in literature. Consequently, assessment measures of self-perception are tailored to the psychological domain(s) being examined (Bandura, 1982); as a result, the integration of SCT within the present investigation and the development of the MCA.

Intersectionality theory.

Grounded in political literature, IT (Samuels & Ross-Sheriff, 2008) was conceptualized by Kimberlé Crenshaw who discusses the importance in considering the multidimensional elements within experiences of persons with multiple social identities (Crenshaw, 1989). In particular, anti-discrimination doctrine, historically rooted in mutual exclusivity of race and sex discrimination, has been to the detriment of victims claiming their intersectional identities as factors toward discrimination. Unfortunately, the lack of acknowledgement of intersectional identities does not explain civil cases like *Moore vs. Hughes Helicopter, Inc.*, which permitted use of cross-sectional identities of race and sex. To adequately understand systemic intersectional identity disparities, one must consider the legal use or nonuse of cross-current social identities is often to the disadvantage of victims. Thus, persons looking to cite intersectional discrimination are seen as attempting to yield unreasonable benefits given their social statuses or recognized for purposes of losing legal cases (Crenshaw, 1989).

Grounded in a feminist perspective, IT (Crenshaw, 1989) purports that a single lens perspective in understanding gender is faulty without the recognition of other social identity

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experiences (e.g., race, social class, immigration status). Imperative to the experiences of intersectional identities is the interlocking privileges and oppressions that may result in society (Samuels & Ross-Sheriff, 2008). The ever-shifting social paradigm based upon one's identity provides comprehensive complexity to the analyses of the human experience (Samuels & Ross-Sheriff, 2008). In this way, social identity statuses alone are not indicative of pre-ordained privileges or oppressions as they are fluid, not fixed. Therefore, IT emphasizes the analysis of the structures (e.g., oppression, discrimination, domination, and privilege) making certain identities the vehicle for vulnerability (Crenshaw, 1989), aligning with the principles of multiculturalism among mental health professions.

Understood as disparate theoretical perspectives, the commonalities among the underpinnings of feminist and multicultural frameworks exist (Crethar, Torres, & Nash, 2008). The overarching emphasis of both feminist and multicultural perspectives stress the importance of therapeutic adaptability to meet the needs of persons with multiple social identity statuses during clinical practice (Crethar et al., 2008). Specifically, multicultural and feminist perspectives underscore (a) the awareness and knowledge of forms of injustice, oppression, discrimination, marginalization, and social-cultural privileges of clients; (b) the importance of validating client experiences; and (c) the importance of promoting and engaging in social, political, and environmental related discussions from a therapeutic lens (Crethar et al., 2008). Similarities and overlapping objectives of feminist and multicultural frameworks support the use of IT throughout the present study.

Importance of Multicultural Competence Among Mental Health Professions

Within our contemporary integrated society, multicultural competence is essential for therapists in clinical practice (Corey & Herily, 2014). While it may appear that multicultural competence is a therapeutic preference, when understood as an ethical requirement, competency takes on new meaning. According to Crenshaw (1950), discrimination is defined as, "…the identification of a specific class or category; either a discriminator intentionally identifies this category, or a process is adopted which somehow disadvantages all members of this category" (p.150). When therapists fail to utilize a multicultural approach with clients, the risk of engaging in discriminatory and unlawful behavior is possible. Social injustices (e.g., discrimination, oppression) are often unintentionally perpetuated because of ongoing complicit practices (Crethar et al., 2008). Thus, the necessity of multicultural approaches in mental health services not only ensure ethical conduct, but ensure therapists employ legal behaviors.

Scholars have engaged in investigations to assess multicultural competence, resulting in the production of 68 retrospective and 47 outcome studies of multicultural education, 53 studies on the participation of clients in mental health services as a function of racial or ethnic matching, and 16 studies of regarding the association of multicultural competence and client experiences in mental health treatment (Smith & Trimble, 2016). Among the retrospective investigations, the effects of random weighted effect sizes for multicultural education yield, $d = .41$ ($SE = .034$, 95% $CI = .34, .47, p > .05$) and $d = .29$ ($SE = .066$, 95% $CI = .16, .42, p > .05$) for multicultural experience. Neither multicultural education or

experience yielded statistical significance within the meta-analysis; however, less than a third of multicultural experience studies provided effect sizes (Smith & Trimble, 2016).

Additional results from retrospective investigations found (a) individuals with more multicultural related education were more likely to report multicultural competence and positive racial attitudes ($d = .41$), (b) the level of exposure with culturally diverse clients was positively related to self-report competence and racial attitudes ($d = .29$), and (c) the prevalence of multicultural competence increases in score by one standard deviation ($d = .95$) from initial competence scores and two-thirds of a standard deviation ($d = .67$) compared to individuals who have not obtained multicultural education (Smith & Trimble, 2016). Hence, the self-perception of multicultural competence and education focused upon multicultural topics are linked to culturally affirming attitudes and beliefs; although, meta-analyses yielded a smaller magnitude than anticipated.

Multicultural education outcome specific studies, have yielded 24 single group and 23 comparison studies (Smith & Trimble, 2016). Among the single group studies comparing multicultural education exposure an average effects random weighted effect size of $d = .67$ ($SE =.114$, 95% $CI = .44, .89, p < .0001$) was found (Smith & Trimble, 2016). Therefore, moderate practical significance can be accounted for in exposure to multicultural related educational prowess. Although measuring various dependent variables, single group studies measuring multicultural competence yielded on average a higher effect size than those assessing for racial attitudes and client ratings of therapists (Smith & Trimble, 2016). In addition, pre-post-test single group studies measuring changes in multicultural education revealed the average random effects (weighted effects size of $d = .95$; $SE =.154$, 95% $CI =$

.65, 1.25, *p* < .0001; Smith & Trimble, 2016), indicating significant score improvement between among pre- post-tests changes when participants received training from a multicultural course or program. Nevertheless, though researchers found significant heterogeneity across the 24 studies (I^2 = 86.1, 95% CI = [81, 91]; Q $_{(23)}$ =165.7, *p* < .00001; π^2 =.44); comparison studies assessing client ratings of therapists produced the highest effect sizes.

Participation in mental health services by clients when matched with therapists based upon racial or ethnic identity has generated results with a correlation coefficient of *r* = .07 (*p* < .0001). Specifically, 49% of the variance in client attendance in therapy can be accounting for in matching therapists and their clients' race or ethnicity. However, when client attendance among all racial and/or ethnic groups were reviewed, low practical significance was identified with the random effects weighted effect size of *d* = .22 (*SE* = .03, 95% *CI* = .16, .28; Smith & Trimble, 2016). A marked difference in effect size comparative to other racial groups with a *d* = .46 (*SE* = .07, 95% *CI* = .31, .60, *p* < .001), Asian American clients yielded moderate significance when matched by race or ethnicity.

Although no evidence exists linking the mastery of cultural competence to enhanced clinical skills (Weinrach & Thomas, 2002); multicultural competence is linked to: (a) symptom reduction, (b) positive psychological outcomes, (c) increased therapeutic working alliance, (d) social and personal improvement, and (e) perceived cultural humility among clients (e.g., Hook, Davis, Owen, Worthington, & Utsey, 2013; Michalopoulou, Falzarano, Butkus, Zeman, Vershave, Arfken, 2014). Specifically, scholars have identified correlations between counselors' culture-sensitive dispositions, with higher cross-cultural competence (*M*

= 34.7; as measured by the CCC) with a main effect, (F [l, 39] = 4.26, p < .05) than

counselors who inhabit culture-blind dispositions (M = 28.4; Pomales, Claiborn, &

LaFromboise, 1986), suggesting clients perceived culturally sensitive counselors as more

cross-culturally competent than counselors who do not. In addition, client perceptions of

therapists' MCCs (e.g., CCCI-R) were found to be a significant predictor of the working

alliance (β = .40, p < .001). Similarly, clients who perceived their therapists as more

culturally humble (e.g., *the Cultural Humility Scale*) reported a stronger working alliance (β

= .35, p < .001; Hook et al., 2013). Thus, affirming the utility of culturally responsive skills

within therapeutic settings. Furthermore, the effect of cultural skills has a significant (p =

.005) effect on client outcomes (Michalopoulou et al., 2014). While cultural skill was not

found to be directly associated with functional outcomes (p = .35), cultural skill was found to

be associated to process of care, involving behaviors including: trust, respect, listening, etc.

(total effect = 1.202, SE =.12, p < .001) and process of care was associated with functional

outcomes (total effect = 1.100, SE = .52, p = .038, Michalopoulou et al., 2014). While it

appears that cultural skill is the only factor of cultural competency with practical implications

of impacting clients' outcomes, it is important to note the difficulty for clients to distinguish

and assess cultural knowledge and awareness in service providers. In addition, missing data

impacted the ability to assess the role of cultural awareness (20% of responses missing) and

cultural knowledge (18% of responses missing) within the research study compared to only

7% of missing responses for cultural skills. Thus, one must take caution in interpreting

results as distinguishing cultural skill as most important, cultural skill is based upon

observations which is easier to evaluate (Michalopoulou et al., 2014).

Literature Gap

Despite scholars suggesting the importance of a multicultural therapeutic approach (Vera & Speight, 2011) and the belief that multicultural competence is an important component to graduate programs; the need for an assessment to measure the overall construct remains (Sue, 1996). While multicultural competence assessments exist, scholars have called for assessments that focus on multicultural awareness, knowledge, skills, and behaviors associated with competence (Smith & Trimble, 2016; Worthington et al., 2007). The need for multicultural assessments remain relevant as a result of homogenous populations from multicultural counseling course(s), workshop(s), and/or clinics used to retrieve convenience samples (Smith & Trimble, 2016). In addition, previous investigations fail to use the recommended sample size as per Comrey and Lee (1992) to perform the necessary statistical analysis and samples have predominately comprised of persons identifying as white female graduate students (Smith & Trimble, 2016). The normalization of previous instruments based upon such a limited sample calls for additional research investigations encompassing a more diverse population.

In summary, multiculturalism is an important element in ensuring ethical conduct and anti-discriminatory practices among therapists. Multicultural behaviors have been helpful in assessing self-efficacy of therapists in the community. Contributions made through previous investigations have demonstrated the need and importance of a multicultural approach; however, further research inquiry and instrument construction are essential. The following sections of this chapter review factors influencing multiculturalism among therapists and multicultural competence assessments.

Factors Influencing Multiculturalism in Clinical Practice

Factors of multicultural competence underscored within the following section include: (a) awareness, (b) knowledge, (c) systemic and institutional structures, (d) skills, (d) advocacy interventions, and (e) the therapeutic relationship (Corey & Herily, 2014; Ratts et al., 2016; Smith & Trimble, 2016; Sue et al., 1992).

Awareness Domain

Multicultural awareness is the most common domain found among multicultural competency assessments and is presented a variety of ways (D'Andrea et al., 1991; Holcomb-McCoy & Myers, 1999; LaFromboise, Coleman, & Hernandez, 1991; Ponterotto, Rieger, Barrett, Harris, Sparks, Sanchez, & Magids, 1996; Sheu & Lent, 2007; Sodosky, Taffe, Gutkin, & Wise, 1994). Often measured through a self-report format, the measurement of multicultural awareness refers to general knowledge of cultural concerns, not one's own attitudes and beliefs (Constantine et al., 2002). The difference in the operationalization of the multicultural awareness construct theoretically versus within multicultural assessments presents concerns about what is being measured (Constantine et al., 2002). Conceptually, scholars have described multicultural awareness as a movement toward a sensitivity to one's own cultural heritage, including experiences, attitudes, values and biases that may influence psychological processes, as well as, comfort with differences that may exist between self and clients (Sue et al., 1992). However, Ratts and colleagues (2016) define awareness as a lifelong process involving the exploration of one's attitudes and beliefs as a foundational element in understanding social group identities along with the practical implications of

power, privilege, assumptions, values, and biases. Within this study, *multicultural awareness* is defined as, a continued mindfulness of self and others as it relates to culture within the therapeutic process (Arredondo et al., 1996; NASW, 2015; Ratts et al., 2016; Sue & Sue, 1982).

Knowledge Domain

Sue and colleagues (1992) refer to multicultural competence knowledge as the possession of specific information about clients and their racial and ethnic group. Knowledge within multicultural competence incorporates an understanding of life experiences, cultural heritage along with how race, culture, ethnicity may affect development, career decisions, the manifestation of psychological disorders, and the appropriateness or lack thereof of therapeutic approaches (Sue et al., 1992). Ratts and colleagues (2016) expounded upon the previous definition of multicultural competence knowledge to broaden the cultural context beyond race and ethnicity to include all clients and their intersecting identities as relevant data. Thus, for the current study, the definition of *multicultural knowledge* is culturally relevant information that directly informs subsequent therapeutic work with clients (NASW, 2015; Ratts et al., 2016).

Systemic and Institutional Structures Domain.

Systemic and institutional structures are a set of social dynamics that positively impact some individuals at the expense of others (Arredondo et al., 1996; Ratts et al., 2016). Previous multicultural competence models have not overtly identified systemic and

institutional structures as an independent domain; however, an awareness and knowledge of relevant discriminatory practices, institutional barriers, and understanding of the minority family structure and hierarchy as it relates to psychological welfare of clients is highlighted within literature (Sue et al., 1992). Therefore, for the current research investigation, *systemic and institutional structures* is defined as an organized set of social dynamics that positively impact some individuals at the expense of others (Arredondo et al., 1996; Ratts et al., 2016).

Skills Domain

Multicultural skills are a common domain explored among multicultural assessments and is an imperative element of competence evaluation (D'Andrea et al., 1991; Holcomb-McCoy & Myers, 1999; LaFromboise et al., 1991; Sodosky, Taffe, Gutkin, & Wise, 1994). In fact Michalopoulou and colleagues (2014) found a positive association between mental health service providers' cultural skills with (a) behaviors identified as process of care (e.g., listening, understanding, confidentiality, respect, decision, plan, trust; chi-square = 51.16, *df* = 2, *p* < .001), (b) visit satisfaction (chi-square = 16.37, *df* = 1, *p* < .001), and (c) strongly linked to functional outcomes (mean score high skills = 12.9, *t* = 3.64, *df* = 78, *p* < .001) as defined by life problem management, career/academic improvement, and improved social interactions.

According to Sue and colleagues (1992), multicultural skills refers to the recognition that helping styles may be culture bound; thus, engaging in a variety of helping responses. Whereas Ratts and colleagues (2016) focus on the possession of analytic abilities to interpret and evaluate how forms of power and privilege influence client experiences and presenting

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issues. However, within the current study, *multicultural skills* refer to culturally responsive techniques, interventions, and behaviors utilized to develop accurate client conceptualizations and presenting concerns (NASW, 2015; Ratts et al., 2016; Sue et al., 1992).

Therapeutic Relationship Domain.

The therapeutic relationship is discussed as an independent factor within one multicultural competency assessment and was examined to identify its role as an independent factor or an element of the skills domain (Sodosky et al., 1994). Theoretically, Ratts and colleagues (2016) acknowledge how cultural differences of therapist-client may impact the therapeutic relationship. Throughout the present study, the *therapeutic relationship* is referred to as a therapeutic connection between a mental health professional and client(s) throughout clinical practice (APA, 2003; Sodowsky, Taffe, Gutkin, & Wise, 1994).

Advocacy Interventions Domain.

A new conceptual addition in multiculturalism, social justice advocacy has been discussed as an inherent element of multiculturalism (Toporek & Reza, 2001; Vera & Speight, 2003). Ratts and colleagues (2016) describe multicultural competence action as the utilization of culturally relevant interventions and strategies to enact change on individual and community levels. Therefore, culturally responsive therapy and social justice advocacy are interconnected to better equip therapists to address their clients' concerns (Ratts et al., 2016). As a result, with the current study, *multicultural advocacy interventions* address a means to address, integrate, and engage in social justice behaviors with clients during

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therapeutic practice (Lewis, Arnold, House, & Toporek, 2003; NASW, 205; Ratts et al., 2016).

<div align="center">Multicultural Assessments</div>

The measurement of multiculturalism is important among researchers and mental health professionals. Many multicultural assessments utilize the tripartite definition of multiculturalism highlighted among the MCCs (Pedersen, 1994), focusing on racial and ethnic diversity. The limited scope of multiculturalism utilized in the tripartite definition excludes other elements of diversity including: sexual orientation, religion, spirituality, disability status, along with the socio-political components required to comprehensively address diverse elements of client experiences.

Previous multicultural competency assessments have made significant contributions to literature; however, the necessity of multicultural assessments with strong psychometric features remains (Atkinson & Israel, 2003). Utilizing an emic approach, item content from previous multicultural assessments have been criticized for the use of committee consensus and not empirical investigation (Gamst et al., 2004). In the following section, seven multicultural competency assessments are reviewed. The theoretical underpinnings, validation data, and empirical support for each assessment are reviewed.

<div align="center">Cross-Cultural Counseling Inventory</div>

The *Cross-Cultural Counseling Inventory- Revised* (CCCI-R; LaFromboise et al., 1991) is a 20-item assessment designed to measure cross-cultural competence. The CCCI-R

is a 6-point Likert item response scale, which ranges from 1 (*strongly disagree*) to 6 (*strongly agree*; LaFromboise et al., 1991). The CCCI-R was developed based upon concepts provided in the APA's Division 17 report (Sue, Beriner, Durran, Feinberg, Pedersen, Smith, & Vasquez-Nuttall, 1982). Derived from the CCCI, an 18-item measure (Pedersen, 1994); the cross-cultural assessment has been optimized by researchers for best model fit. Originally designed and validated for supervisors to evaluate trainee's multicultural competence through the evaluation of videotaped counseling sessions; the CCCI-R has been adapted for use as a self-report measure (LaFromboise et al., 1991).

Although recruitment and sampling methods were not provided, the initial version of the CCCI-R was administered to a small sample ($N = 97$) comprising of (a) graduate students from education and counseling psychology Ph.D. Programs ($N = 8$), (b) expert raters ($N = 3$), and (c) university students ($N = 86$) in three research investigations (LaFromboise et al., 1991). It is through the sample of administration of the CCCI-R to the sample that content validity, interrater reliability, and the factor structure of the CCCI-R were evaluated (LaFromboise et al., 1991). Utilizing Cattell's scree test and factor interpretability as factor solution criteria, researchers found a three-factor Orthogonal Model among the 20-item assessment.

Factor one of the CCCI-R, *Cross-Cultural Counseling Skill* refers to counselor awareness, ability to communicate appropriately, and an overall understanding of the counselor role. Accounting for most of the common variance ($\sigma^2 = .51$) prior to factor rotation, LaFromboise and colleagues (1991) posit the CCCI-R's ability to assess cross-cultural competency. However, the large common variance may be indicative of failed

content validity of the overall assessment, suggesting the items in the remaining factors may not be measuring what they posit they are measuring. Factor two, *Socio-Political Awareness* refers to the counselors' ability to recognize their own strengths and/or limitations which may impact the counseling process when working with diverse clients. Factor three, *Cultural Sensitivity* refers to the degree to which counselors empathize with their clients' feelings and recognize interpersonal and environmental stressors clients encounter (LaFromboise et al., 1991). With use of Cronbach's coefficient alpha, inter-item correlations among CCCI-R items were moderate (α =.81 - .73; LaFromboise et al., 1991). Yet, the CCCI-R yielded high internal consistency reliability via Cronbach's coefficient alpha (α=.95; Larson & Bradshaw, 2017); affirming the measurement of the same construct within the CCCI-R. While the CCCI-R item content does overlap with the Division 17 report competencies, it is difficult to differentiate cultural skill and behavior among the various concepts of multiculturalism (LaFromboise et al., 1991).

Given the psychometric properties and the research of the CCCI-R, there are several appropriate uses for the measure. Thus, the CCCI-R can be (a) a source behavioral feedback from supervisors to supervisees, (b) used as self-assessment, and (c) utilized by counseling researchers (LaFromboise et al., 1991; Pedersen, 1994). Nevertheless, significant limitations exist within the CCCI-R, including the small sample size (e.g., *N* < 100) when utilizing factor analysis as per Comrey and Lee's (1992) guidelines.

Multicultural Awareness Knowledge Skills Survey

The second multicultural competency assessment developed, the *Multicultural Awareness Knowledge Skills Survey* (MAKSS; Pedersen, 1994) was created to assess the impact of multicultural training on counseling students (D'Andrea et al., 1991). The 60-item measure utilizes a 4-point Likert scale with 22 items ranging from *Strongly Agree* to *Strongly Disagree* and 38-items ranging from *Very Limited* to *Very Good*. Utilizing a small sample of master's level counseling students ($N = 90$), the MAKSS established a three-facture structure of (a) awareness, (b) knowledge, and (c) skills.

Within the MAKSS, assessment cross-cultural awareness, knowledge, and skills refer to awareness of one's own attitudes and biases, comprehension of diverse populations, and communication skills, respectively (D'Andrea et al., 1991). Reliability of the MAKSS was assessed through calculating Cronbach's alpha, which yielded a moderate score for Awareness ($\alpha = .75$) and high scores for Knowledge and Skills ($\alpha = .90$; .96; D'Andrea et al., 1991). Intercorrelation reliability was calculated through pre-posttest results, which resulted in the following: awareness and knowledge ($\alpha = .45$; .32), awareness and skills ($\alpha = .32$; .48), and knowledge and skills ($\alpha = .51$; .11). Thus, the assessment appears to yield adequate internal consistency reliability; however, the MAKSS yielded low intercorrelation reliability.

The MAKSS has provided an assessment that can be used to identify how various training formats can impact scores and it was suggested that it is more difficult to acquire counseling skills comparative to gaining awareness and knowledge among the sample of students (Pedersen, 1994). Since the development of the MAKSS, revised measures (e.g., *Multicultural Awareness Knowledge Skills Scale-Counselor Edition-Revised* [MAKSS-CE];

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Multicultural Awareness Knowledge Skills Survey-Teachers Form [MAKSS-TF]) were

developed in an attempt to address criticisms of limited psychometric support in the

validation of MAKSS scores and increase generalizability among participants (Kim,

Cartwright, Asay, & D'Andrea, 2003).

Multicultural Competency Inventory

The *Multicultural Competency Inventory* (MCI; Sodosky et al., 1994) was the third

assessment developed to measure multicultural competencies among counselors working

with diverse clients. The 40-item self-report assessment designed to measure the

multicultural counseling competencies. Utilizing a sample of 1,049 respondents, the MCI

was normed on a group of psychology students and professional counselors to validate the

measurement. Formatted as a 4-point Likert response scale ranging from 1 (*very inaccurate*)

to 4 (*very accurate*), higher score indicated increased multicultural competence; however,

developers did reverse score 22 or the initial 87 items to control for response bias among

study participants.

Through factor analysis (e.g., exploratory, confirmatory) a four-factor oblique model

emerged through the assessment data, identifying the following domains: (a) multicultural

counseling skills, (b) multicultural awareness, (c) multicultural counseling relationship, and

(d) multicultural counseling knowledge. Unique within the literature, the MCI was the first

multicultural assessment to identify the counseling relationship as a domain within the

assessment data (Ponterotto, Rieger, Barrett, Sparks, 1994; Sodosky et al., 1994).

Initial assessment of the MCI yielded the following internal consistency reliability coefficient alphas: multicultural awareness (α = .83), multicultural counseling skills (α = .83), multicultural counseling knowledge (α = .79), multicultural counseling relationship (α = .65), and the full MCI (α = .88; Sodosky et al., 1994). However, additional analyses found MCI data yielded coefficient alphas of (α = .87), multicultural awareness (α = .78), multicultural counseling skills (α = .80), multicultural counseling knowledge (α = .77), and multicultural counseling relationship (α = .68; Larson & Bradshaw, 2017); thus, indicating a stable and adequate reliability of MCI scores. In addition, internal consistency reliabilities (via Cronbach's alphas) were adequate yielding .81, .80, .67, .80 and .86 for skills, awareness, relationship, knowledge, and the entire scale, respectively (Sodosky et al., 1994). Furthermore, the factor correlation matrix indicated poor correlations among the factors, with correlations ranging from .16 to .31.

The MCI provided significant contribution to literature with the discovery of the counseling relationship as a factor domain; however, the psychometric properties of the MCI score are questionable. Reliability and validity coefficients for the MCI identified the need for further validation and optimization of the assessment.

<center>Multicultural Counseling Awareness Scale- Form B</center>

The *Multicultural Counseling Awareness Scale-Form B* (MCAS: B; Ponterotto et al., 1996) was developed to measure multicultural awareness, knowledge, and skill. The MCAS: B is a 45-item measurement utilizes a 7-point Likert scale ranging from 1 (*not at all true*) to 7 (*true*). The initial validation of the MCAS: B utilized a small sample (*N* = 126) of

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counselors and counselors-in-training through data analysis, a two-factor structure emerged titled (a) knowledge-skills and (b) awareness.

Initial reliability and validity coefficients identified adequate and stable assessment scores as evidenced by an excellent coefficient alpha ($\alpha = .93$) for the 41-item scale, prior to the inclusion of 4 new items (e.g., 3 social desirability, 1 awareness). In addition, the factors yielded adequate coefficient's reporting .93 and .78 for the knowledge-skills and awareness subscales, respectively. Over the years, a revised version of the MCAS: B has been developed, the *Multicultural Counseling Knowledge and Awareness Scale* (MCKAS; Ponterotto, Grethcen, Utsey, Rieger, & Austin, 2002). Although still utilizing a two-factor extraction model (e.g., knowledge, awareness), the MCKAS has optimized the previous scale by eliminating 13 items. Thus, the 32-item scale was administered to large sample ($N = 724$) of students and professionals with counseling and psychology fields, yielding adequate coefficient alphas for knowledge ($\alpha = .92$) and awareness ($\alpha = .79$; Ponterotto et al., 2002), the revised version improved the statistical structure of the assessment.

Utilized in over 16 publications (Pope-Davis et al., 2003), the MCKAS has been a significant contribution to literature in the measurement of multicultural competence; however, limitations exist in the initial development and validation of the MCAS: B. Specifically, the utilization of a small sample size limits researcher's ability to generalize results to the development sample. Moreover, data analysis results failed to include each item on the MCAS: B as evidenced by coefficients reported based upon a 41-item assessment, not the full 45-item scale. Lastly, although developers optimized the scale to establish the

MCKAS; both versions (e.g., MCAS: B and MCKAS) are lengthy and have the potential to hinder future research studies based upon test fatigue.

Multicultural Counseling Competence and Training Survey

The *Multicultural Counseling Competence and Training Survey* (MCCTS; Holcomb-McCoy & Myers, 1999) was developed to assess multicultural competence. The MCCTS, a 32-item assessment utilizes a 4-point Likert scale ranging from 1 (*not competent*) to 4 (*extremely competent*). Unique to previous assessments, Holcomb-McCoy and Myers (1999) utilized a stratified sample of 500 professional counselors, oversampling ethnic minorities. The sampling method resulted in a total of 151 completed assessments rendering a 30% response rate (Holcomb-McCoy & Myers, 1999). Through factor analysis five factors emerged from the data including (a) knowledge of multicultural issues, (b) awareness, (c) definition of terms, (d) racial identity development, and (e) skills.

Internal consistency reliability was adequate ranging from .66 to .92. In particular, knowledge of multicultural issues (α = .92), awareness (α = .92), and skills (α = .91), yielded the highest internal consistency. Definition of terms produced an adequate coefficient (α = .79) and racial identity development yielded the lowest coefficient alpha (α = .66). In general, the reliability coefficients for the MCCTS are satisfactory; however, the low internal consistency of the racial identity development domain may have resulted from the two-item factor loading (Holcomb-McCoy & Myers, 1999). Furthermore, the MCCTS produced satisfactory validity scores with eigenvalues of 14.97 for knowledge of multicultural issues,

2.3 for awareness, 1.14 for definition of terms, .92 for racial identity development, and .59 for skills.

The MCCTS introduced a new factor domain, definition of terms, suggesting multicultural competency spans beyond previous definitions of awareness, knowledge, and skills (Holcomb-McCoy & Myers, 1999). Although producing adequate reliability and validity coefficients, limitations do exist in the development of the MCCTS. The inclusion of the two-item factor in an attempt to measure racial identity development does not yield consistent scores. In addition, the moderate sample size may limit researchers' ability to generalize findings to the overall development sample, requiring additional validation of the MCCTS (Holcomb-McCoy & Myers, 1999). Lastly, given the small ($N < 200$) sample size, the use of factor analysis (FA) and the interpretation of study's results are debatable as the minimum desired sample size of 200 participants per 40 items was not met (Comrey, 1988).

California Brief Multicultural Competence Scale

Based upon the previously discussed multicultural competence assessments (e.g., CCCI-R, MAKSS, MCAS: B, MCCTS), the *California Brief Multicultural Competence Scale* (CBMCS; Gamst et al., 2004), a 21-item measure was designed to assess self-reported mental health practitioner cultural competency. The 4-point Likert scale ranges from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*) was completed by a large sample ($N = 1,244$) of mental health professionals. After data analysis, the researchers identified a four-factor structure, including (a) sensitivity to consumers, (b) non-ethnic ability, (c) cultural awareness, and (d) cultural knowledge (Gamst et al., 2004).

The CBMCS was developed with the main tenets of the awareness, knowledge, and skills as foundational concepts. Roughly coinciding with the MCCs, factors multicultural knowledge, awareness of cultural barriers, and sensitivity to consumers align with the conceptual framework. Reporting a final factor structure that yielded adequate internal consistency reliability for the full scale (α = .89), non-ethnic ability (α = .90), awareness of cultural barriers (α = .78), multicultural knowledge (α = .80), and sensitivity to consumers (α = .75; Gamst et al., 2004). Researchers utilized the MCI as validation measure (e.g., criterion-related) in the assessment of the CMBCS, providing low to moderate correlations between the full scales (mean correlation of .31), MCI and CMBCS knowledge subscales (r = .21), and the MCI awareness and CBMCS awareness of cultural barriers subscales (r = .45). An exception, the MCI-Relationship subscale yielded a mean of .02, not surprising given the unrelated content found within the CMBCS. Overall, Gamst (2004) affirm the evidence of criterion-related validity despite lack of consistency between similar subscales, which has been criticized within literature (Kocarek, Talbot, Batka, & Anderson, 2001). The CMBCS contributed a new factor domain to the literature, non-ethnic ability; however, limitations exist in generalizability of assessment results to all mental health service providers with convenience sampling methods and the exclusion of college students and academic practitioners.

Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form

Sheu and Lent (2007) developed the *Multicultural Counseling Self-Efficacy Scale-Diversity Form* (MCSE-RD) as a means to measure self-perceived capability in counseling

racially diverse clients. Given the measurement of confidence in counseling capabilities, the MCSE-RD was the first to integrate social cognitive theory and multicultural counseling competence literature to develop a self-efficacy measure, given the self-report format (Sheu & Lent, 2007). The MCSE-RD is a 37-item assessment utilizes unipolar response scale ranging from 0 (*no confidence at all*) to 9 (*complete confidence*), higher scores indicating greater confidence in one's multicultural counseling capabilities. The developmental sample for the MCSE-RD encompassed 181 pre-practicum graduate students through snowball sampling methods yielding a 48% response rate from recruitment participants (Sheu & Lent, 2007). Resulting from an orthogonal solution, a three-factor structure emerged, including (a) multicultural intervention, (b) multicultural assessment, and (c) multicultural session management.

Producing strong internal consistency reliability coefficients, the subscales of the MCSE-RD yield the following multicultural intervention ($M = 5.66$; $SD = 1.63$; $\alpha = .98$), multicultural assessment ($M = 3.77$, $SD = 2.02$; $\alpha = .92$), multicultural session management ($M = 5.84$; $SD = 1.53$; $\alpha = .94$), and the MCSE-RD total score ($M = 5.39$; $SD = 1.57$; $\alpha = .98$; Sheu & Lent, 2007). Moreover, the MCSE-RD reported adequate 2-week test-retest reliability correlations among the subscales (a) multicultural intervention ($r^a = .73$), multicultural assessment ($r^a = .88$), multicultural session management ($r^a = .69$), and the total MCSE-RD scale score ($r^a = .77$). Furthermore, the MCSE-RD generated high intercorrelations among subscales ($r = .65 - .85$) ranging from and between the subscales and the MCSE-RD total score (all $\geq .83$; Sheu & Lent, 2007). Additional validation of the MCSE-RD includes convergent and discriminate validity as measured by the *Counselor*

Activity Self-Efficacy Scales (CASES; Lent, Hill, & Hoffman, 2003) and the MCI. Both

CASES and MCI produced positive significant correlations among the CASES and the

MCSE-RD subscales (r = .55 - .79), CASES and MCSE-RD total scores (r = .79), MCI and

MCSE-RD subscales (r = .37 - .67), and MCI MCSE-RD total scores (r = .68; Sheu & Lent,

2007).

Overall the MCSE-RD scores produced adequate psychometric properties; however,

validation of the measure has been conducted on a single development sample, requiring

additional research investigations to affirm research findings. In addition, the homogeneity of

the development (e.g., graduate students) limits researchers' ability to generalize study

results to broader population (e.g., counseling professionals).

In summary, the multicultural competency assessments found in literature utilize the

MCCs as the conceptual framework in defining multicultural counseling (e.g., awareness,

knowledge, and skills). While most of the assessments encompass MCC components,

additional factor domains (*see* Table 1) emerged in the data (e.g., racial identity

development, cultural sensitivity, etc.), contributing to criticisms of inconsistency among

multicultural competence assessments. Furthermore, all measurements reviewed utilize a

self-report format, with the exception of the CCCI-R, which erate issues with social

desirability threat. The MCSE-RD measures confidence in one's abilities, controls for social

desirability bias as it is designed as a self-efficacy measure.

Among the assessments described, the majority failed to utilize a large-scale (e.g.,

geographically dispersed, N > 1,000) factor analytic study, a needed addition within literature

(Ponterotto, Rieger, Barrett, & Sparks, 1994). In addition, previous assessments have failed

to incorporate broader development samples (e.g., professional counselors, psychologists, social workers), are often normed among a sample of students, and previous assessments utilized homogenous factor retention methods (e.g., Cronbach coefficient alpha). In addition, previous assessments have failed to measure concepts of privilege, advocacy, and institutional structures. Thus, the multicultural model for the current research study investigated the aforementioned domains.

Table 1

Summary of Multicultural Therapy Assessment- Factor Domains

	A	K	S	CR	RI	CS	DOT	MI	MA	MSM	NEA
CCCI-R	X		X			X					
MCI	X	X	X	X							
MAKSS	X	X	X								
CMBCS	X	X				X					X
MCCTS	X	X	X		X		X				
MCKAS	X	X									
MCSE-RD								X	X	X	

Note. Key of Terms: A=Awareness, K=Knowledge, CR=Counseling Relationship, RI=Racial Identity, CS=Cultural Sensitivity, DOT=Definition of Terms, MI=Multicultural Interventions, MA=Multicultural Assessment, MSM=Multicultural Session Management, NEA=Non-ethnic Ability

Chapter Summary

The chapter encompassed four main sections. The first section provided an overview of multiculturalism, involving definitions and a historical progression of multicultural counseling within clinical practice. The second topic area described the importance of multicultural competence among mental health providers. Sections three and four reviewed factors influencing multiculturalism and multicultural competence assessments used in mental health professions. The literature reviewed within this chapter affirms the need for contributions to multicultural competency literature and the need for a novel multicultural

competence assessment designed to assess therapists' confidence in their multicultural

competence when working their clients.

CHAPTER THREE: RESEARCH METHODS

Chapter three presents the research methods utilized to develop the *Multicultural Competency Assessment©* (MCA) and examine the psychometric properties of the MCA data with a sample of therapists who provide mental health services. The chapter reviews the following information regarding the investigation: (a) the research design, (b) the population and sample, (c) data collection, (e) instrumentation, (f) research purpose and questions, (g) data analysis procedures, (h) ethical considerations, and (i) potential limitations of the study.

Research Design

Utilizing a correlational research design (Gall, Gall, & Borg, 2007), this quantitative study developed and examined the psychometric properties of multicultural competence self-efficacy (as measured by MCA data) among a sample of therapists (e.g., counselors, psychologists, social workers, counselors-in-training, psychologists-in-training, and social workers-in-training) that provide mental health services. Designed to examine the relationships between dimensions of multiculturalism, this investigation focused on developing the MCA and testing the validity and reliability of the initial MCA model scores with a sample of therapists that provide mental health services.

Population and Sample

The target population for the investigation of the MCA consisted of practicing counselors, psychologists, and social workers as well as master's level counselors-in-

training, master's level social workers-in-training, and master's level psychologist-in-training. Practicing counselors included: (a) marriage, couple, and family therapists; (b) school counselors; and (c) mental health counselors. The practicing psychologist participants included licensed psychologists (e.g., counseling, clinical, and school psychologists). Similarly, practicing social workers included both licensed and unlicensed clinical social workers. The counselors-in-training population included students of counseling programs in: (a) marriage, couple, and family therapy; (b) school counseling; and (c) mental health counseling tracks that provide clinical services to clients (e.g., practicum and internship). Psychologists-in-training included graduate-level counseling, clinical, and school psychology students that provide services to clients (e.g., practicum and internship). Finally, social workers-in-training included graduate-level social work students that provide services to clients (e.g., practicum and internship). In all, the aforementioned population defines the sample for the research investigation as therapists.

Recruitment for the research study began one week after the researcher received approval from her university's Institutional Review Board (IRB). Simple random and convenience sampling methods with inclusion criteria was employed to recruit participants (Gall et al., 2007). Participants were recruited via face-to-face, mail out, and email lists. Lists containing therapists' emails and/or physical addresses were obtained and/or purchased from the professional organizations (e.g., ACA, NASW, AERA), regional listserv's, and community organizations (e.g., Aspire Health Partners, Counseling and Psychological Services). Once obtained, emails were sent following a modified *Tailored Design Method* (TDM; Dillman et al., 2009). In addition, the researcher recruited face-to-face participants

through regional organizations (e.g., Mental Health Counselors of Central Florida) and faculty who taught either practicum or internship courses between fall 2017 and spring 2018.

The administration of assessment packets took place through an online survey program, Qualtrics, for the email sample of therapists. The face-to-face administration were given a paper-and-pencil assessment packet to complete during a designated data collection meeting(s). Mail-out administration were sent to participants following a modified TDM (Dillman et al., 2009) through one letter of contact. Given the contractual agreement(s) involved in obtaining confidential membership information from professional organizations, the researcher was only able to contact participants once to both advertise and encourage participation in the present study. Based upon the various data collection procedures for this research study and inability to provide constant compensation; therefore, participants did not receive any incentive compensation for participation in this research investigation.

In determining an appropriate sample size for the investigation, researchers determine a minimum sample size required by calculating the ratio of sample N (total of cases) and p (number of variables) ratio to render an acceptable sample size (Mvududu & Sink, 2013). Within the literature, N:p ratios are known to range from 3 to 20 (Cattell, 1978; Comrey & Lee, 1992; Everitt, 1975). In fact, Comrey and Lee (1992) developed a scale to evaluate the adequacy of a sample size with the intention of using factor analysis (e.g., $N = 50$ - very poor, 100 - poor, 200 - fair, 300 - good, 500 - very good, 1000 - excellent; p. 217). Thus, the desired sample size for examining the psychometric properties of the MCA scores was based on the number of cases (initial 50-MCA items) to the number of item ratio at 20:1 items,

resulting in a minimum of 1,000 total participants (Comrey & Lee, 1992; Costello &

Osborne, 2005; Hair et al., 2010; Mvududu & Sink, 2013).

The sample of 5,124 total therapists who provide mental health services was sought.

A total of 29 participants completed the original version of the MCA during the pilot dataset

of the assessment items. Next, a total of 407 participants completed the original version of

the MCA and *Marlowe Crowne Social Desirability Scale-X1* (MCSDS-X1) for data one prior

to the researcher conducting exploratory factor analysis (EFA) with the MCA data. After

MCA scores were analyzed, the overall scale was optimized through the deletion of

irrelevant items. Subsequently, 233 participants completed the revised MCA (25-items), the

Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSE-RD), and the

MCSDS-X1. Once the second round of assessment dissemination was complete, EFA and

confirmatory factor analysis (CFA) was conducted. A total of 5,124 therapists were invited to

participate in the investigation (e.g., pilot, data one, data two), with a total of 673 individuals

completed the data collection assessments. Specifically, the overall study yielded a total

usable response rate of 13%, including a 97% response rate (e.g., face-to-face) was obtained

from the pilot, a 13% (e.g., face-to-face [98%], mail-out [18%], online [5%]) response rate

was acquired from data one, and a 11% (e.g., face-to-face [10%], mail-out [17%], online

[3%]) response rate was attained from data two.

Data Collection

Before engaging in the initial recruitment stages, the researcher obtained permission

from her university's IRB prior to beginning recruitment and data collection. Participant

recruitment began November 2017 and lasted through March 2018. Furthermore, participants were recruited for the research study through face-to-face, mail-out, and email-list methods. The three forms of data collection allowed for diversity among research participants and the potential to generalize study results.

Specifically, for face-to-face administration, the researcher administered the MCA and affiliated scales (e.g., MCSDS-X1, MCSE-RD, General Demographic Questionnaire) to a diverse array of therapists through paper assessments. Participants receiving face-to-face administration of the MCA were recruited in either their course (e.g., practicum, internship) or during a membership meeting. Therefore, the administration of all face-to-face data collection was completed by the Principal Investigator (PI), ensuring accurate and reliable data collection procedures.

For the email and mail-out administration, the researcher employed the TDM (Dillman et al., 2009). To clarify, TDM is a set of survey processes that work together to form a survey request and to motivate a diversity of respondents to respond to surveys (Dillman et al., 2009). TDM attends to multiple sources of survey error including: (a) coverage, (b) sampling, (c) measurement, and (d) nonresponse with a focus on minimizing overall survey error. An essential benefit to TDM of data collection is the focus on reluctance reduction among research participants. Reluctance reduction can be facilitated though the (a) establishment of trust among the participants, (b) an increase of potential benefits of participation, and (c) a decrease of potential cost of participation (Dillman et al., 2009). Dillman and colleagues (2009) suggests web questionnaires protocols utilize three personalized emails; however, given contractual restrictions the researcher was only able to

recruit through a single email correspondence. In addition, several organizations requested a recruitment email be sent internally (from inside the company organization) as a means to protect membership information. For this reason, recruitment emails were not all sent from the same email address; however, the researchers email and telephone number was included in each correspondence. Thus, a modified TDM procedure was implemented for recruitment among web-based survey administration, which was administered via Qualtrics survey. Examples of the web-based recruitment letter can be found in Appendix H.

For mail-out administration of data collection, a similar modified TDM (Dillman et al., 2009) was implemented. The first contact letter included information about the research investigation and information about the assessment packets that was mailed in the following contact. A sample letter of the cover letter can be found in Appendix I. Along with the cover letter, the packet for the pilot dataset included information about the research investigation and the packet of assessments, including the informed consent document and the MCA. Whereas the packet for data one included information about the research investigation and the packet of assessments, including the informed consent document, the MCA, the MCSDS-X1(Strahan & Gerbasi, 1972), a General Demographic Questionnaire, and a stamped envelope. The packet provided to data two participants included information about the research investigation along with the informed consent document, the MCA, the MCSDS-X1, the MCSE-RD (Sheu & Lent, 2007), the General Demographic Questionnaire, and a stamped envelope. It is through the implementation of the aforementioned data collection procedures that face-to-face, email, mail-out data administration utilized rigorous research methods for the present research investigation.

Purpose and Research Questions

The integration of a multicultural approach is a highlighted ethical commitment by mental health professional organizations (ACA, 2014; APA, 2002; NASW, 2015) and within training programs (APA, 2006; CACREP, 2016; Council on Social Work Education, 2015). Multiculturalism has also gained considerable attention (e.g., Gamst et al., 2009; Hooper & Huffman, 2014; Ramirez et al., 1996; Whealin & Ruzek, 2008). Scholars have identified dimensions of multiculturalism, including (a) awareness, (b) knowledge, (c) skills, (d) systemic and institutional structures, (e) advocacy interventions, and (f) the therapeutic relationship. Thus, the researcher hypothesized factor structure of the MCA scores among therapists. Although, the present hypothesized factor structure for the MCA scores was ground within a theoretical framework, the hypotheses about the factor structure were not assumed, resulting in research questions.

The purpose of this research was to (a) develop the MCA and (b) examine the psychometric properties of MCA scores with a sample of therapists that provide mental health services (e.g., counselors, psychologists, social workers, counselors-in-training, psychologists-in-training, and social workers-in-training) to clients. The specific research questions guiding this investigation include:

Research Question 1

What is the factor structure of the MCA items with a sample of therapists (examining evidence of construct validity)?

Research Question 2

What is the internal consistency of the MCA scores with a sample of therapists?

Research Question 3

What is the relationship between MCA scores and the MSDS-X1 scores among a

sample of therapists (examining evidence of social desirability)?

Research Question 4

What is the evidence of concurrent validity of the MCA scores (as measured by the

correlation between MCA and MCSE-RD scores)?

Research Question 5

Are there any significant differences on MCA scores based on the participants'

demographic groups? If yes, what are the differences?

Instrumentation

Multicultural Competency Assessment

The MCA is a 25-item self-report assessment that was developed with the intention to

measure multicultural competency among therapists. Mvududu and Sink (2013) suggests the

use of continuous (interval or ratio) data in scale development. The scoring method and the

question style were constructed based upon recommendations for instrument development

best practices and self-efficacy scale development (AERA, APA, & NCME, 2014; Bandura,

2006; DeVellis, 2017; Dimitrov, 2012; Haladyna & Rodriguez, 2013; Lambie et al., 2017). Unipolar response scales are often used in self-efficacy assessments given the measurement of perceived ability (Bandura, 2006). However, because Likert-item scales are common within the field of counseling (Dimitrov, 2012), a Likert-item response scale ranging from 1 (*Not Competent in Providing Specified Clinical Task*) to 5 (*Very Competent in Providing Specified Clinical Task*) was used. Furthermore, the construction of self-efficacy requires a strong conceptual examination (Bandura, 2006); therefore, the construction of the MCA was grounded on the theoretical underpinnings of social cognitive and intersectional theories in an effort to support the MSJCC. In addition, to minimize response bias, the assessment was identified through a code name upon dissemination, not by title (Bandura, 2006).

Instrument Development Procedures

The steps in constructing an instrument vary within the literature (e.g., AERA, APA, & NCME, 2014; Crocker & Algina, 2006; DeVellis, 2017; Dimitrov, 2012; Lambie et al., 2017). For the purposes of this research investigation, a combination of the aforementioned scholars' step-wise processes were followed. The specific instrument development steps that were employed were: (a) determined clearly what is being measured, (b) set psychological assessment specifications and structural framework, (c) created an item pool, (d) determined the type for measurement, (e) had an initial item pool reviewed by experts, (f) considered the inclusion of validation items, (g) administered items to a development sample (e.g., pilot data), (h) evaluated pool of items, (i) administered items to a training sample (e.g., data one),

(j) evaluated pool of items, (k) optimized scale length, (l) administering items to a validating sample (e.g., data two), (m) evaluating pool of items, and (n) optimizing scale length.

Step 1: Determined measurement construct(s).

To determine what was being measured, it was important review multicultural literature and to comprise a definition of multiculturalism. Because multicultural competency is a difficult construct to define (e.g., as indicated by the plethora of definitions in the literature), this researcher included the qualities of multicultural competence most cited within the literature and developed a definition for the study. This step involved being clear and specific regarding identification of the construct (DeVellis, 2017). In constructing the MCA, the construct of interest was identified as multicultural counseling competence self-efficacy, which relates to the factors that contribute to proficiency in the delivery of cross-cultural counseling services. Additionally, the multicultural counseling literature supports that competence may include factors such as: awareness, knowledge, and skills. For the purposes of this research investigation, multicultural counseling competence was defined as the factors that comprise cultural proficiency and the promotion of culturally sensitive therapeutic environment. Thus, the constructs involved in the measurement of multicultural counseling competence involves (a) awareness, (b) knowledge, (c) skills, (d) systemic and institutional structures, (e) advocacy interventions, and (f) the therapeutic relationship.

Step 2: Setting Psychological Assessment Specification or Structural Framework.

To establish content-oriented evidence for the MCA, the researcher did a thorough review of the literature and outlined the domains necessary to measure multicultural

competence among therapists. Lambie and colleagues (2017) suggest assessment developers

create a blueprint to specify measurement content and the intended types of items that would

be included within the assessment. Therefore, to ensure assessment items were developed to

match established performance domains, the researcher constructed the MCA

Blueprint/Manual, which can be found below (*see* Appendix L).

Step 3: Created an item pool.

Creating an item pool consisted of developing MCA items that contribute to

multicultural counseling competence. The researcher conducted an extensive literature

review to examine the existence of items contributing to multiculturalism. The examination

of the literature involved reviewing instruments that measure similar constructs (e.g., CCCI-

R; MCI; MCKAS) as well as competency standards of multiculturalism across the mental

health professions (e.g., MCC, MSJCC, National Social Work Standards for Cultural

Competence in Social Work Practice, APA [2003] Division 17 report). Additionally, the

researcher reviewed the CACREP (2016) *Standards*, the ACA (2014) *Code of Ethics*, the

APA (2010) *Ethical Principles of Psychologists and Code of Conduct*, and the NASW (1996)

Code of Ethics.

During this step, the researcher modified the existing list of items by adding and

deleting items based on multicultural therapy literature. The researcher constructed items

based upon Kline's (2005) nine rules in the development of sound scale items, which

included (a) deal with only one central thought in each item, (b) be precise, (c) be brief, (d)

avoid awkward wording or dangling constructs, (e) avoid irrelevant information, (f) present

items in positive language, (g) avoid double negatives, (h) avoid terms like all or none, and (i) avoid indeterminate terms like frequently or sometimes (pp. 34–35). As a result, the researcher developed a 64-item assessment.

Step 4: Determined the format for measurement.

The third instrument development step involved choosing the type of scaling to be used for the MCA. Mvududu and Sink (2013) and DeVellis (2017) suggest that Likert-type scaling is relevant for factor analysis and common in social sciences literature; however, recommendations for self-efficacy scale development suggests the use of a unipolar response scale (Bandura, 2006). Nevertheless Likert-type scaling commonly used within the field of counseling (Dimitrov, 2012) and in an effort to ensure study participants were able to associate scale responses with tangible competency levels, the MCA uses a 5-point Likert scale ranging from one (*Not Competent in Providing Specified Clinical Task)* to five (*Very Competent in Providing Specified Clinical Task).*

Step 5: Had an initial item pool reviewed by experts.

Following the initial item development of the MCA, 64-items were selected based on theory and the literature review, and a team of experts reviewed the items to maximize content validity of the instrument. To the evidence of content-oriented validity of the MCA items, the expert reviewer process involved individuals who were familiar with the multicultural counseling literature and instrument development. The expert panel included 13 faculty members (females; $n = 10$, 77%, males; $n = 3$, 23%) who represented a diverse background of professionals with experience with multicultural counseling, scale

development, and methodology paradigms. In fact, the experts race/ethnicity included Black/African American ($n = 6$, 46%), Asian ($n = 3$, 23%), White/Caucasian ($n = 3$, 23%), and Hispanic/ Latino(a) ($n = 1$, 8%). The majority of the experts ($n = 6$, 46%) held positions as an Assistant Professor, 38% ($n = 5$) held positions as an Associate Professor, and 15% ($n = 2$) held positions as a Professor. The diversity of experts allowed for a collection of knowledgeable feedback related to the construct of interest (i.e., multiculturalism), the population of interest, and scale development procedures (Dimitrov, 2012).

The researcher contacted each expert inquiring if they would be willing to provide expert reviewer feedback for the initial item pool of the MCA. Once the expert confirmed their willingness to assist, the researcher sent each expert reviewer (a) expert reviewer instructions (found in Appendix K), (b) the MCA training manual, and (c) the 64-item MCA. Each expert was asked to rate the relevance of each item (e.g., low, moderate, or high) and to evaluate each item for clarity, wording, and readability of the MCA and the training manual. It must be noted three experts provided feedback exclusively on the MCA training and the remainder ($n = 10$) provided feedback on both the MCA items and the MCA training manual. Since the final decision of accepting, rejecting, and/or modifying items based upon expert reviewers is the responsibility of the instrument developer (DeVellis, 2017), the researcher created an item ranking procedure to ensure item acceptance and removal was done systemically. Therefore, the researcher converted all reviewer ratings using quantitative responses ranging from one (*Low*) to three (*High*). With a possible total score of 30, each item was tallied and converted into percentages. Items that obtained an average score of 80% or below were eliminated with the exception of MCA item 33. This item was completely re-

worded based upon expert feedback and thus retained. Through this process items were eliminated from the following factor domains: (a) advocacy interventions ($n = 4$), (b) awareness ($n = 3$), skills and interventions ($n = 3$), systemic and institutional structures ($n = 2$), and the therapeutic relationship ($n = 2$). Therefore, through this process a total of 14 items were eliminated. Thus, a 50-item MCA was retained for the purposes of the present research investigation.

Step 6: Considered the inclusion of validation items.

Next, MCA items were considered for validation and inclusion. Specifically, this instrument development step includes two types of items: (a) items to detect problems and (b) items relating to construct validity (DeVellis, 2017). Social desirability is an example of a common issue faced when using self-report measures (Crowne & Marlowe, 1960). Thus, the researcher used the MCSDS-X1 (Strahan & Gerbasi, 1972) to assess for social desirability. The 10-item, true and false MCSDS-X1 is a shortened version of the original 33-item MCSDS (Crowne & Marlowe, 1960), which is a frequently used measurement of social desirability (Beretvas, et al., 2002). The MCSDS-X1 has a similar effect size to the original scale (e.g., .96; Cohen, 1992) and has an internal consistency range of around .50 to .90 (Ballard, 1992; Strahan & Gerbasi, 1972). Mullen, Lambie, and Conley (2014) found the Kuder-Richardson 20 (KR-20) reliability of the MCSDS-X1 as .69 among a population of mental health counselors, marriage and family therapists, and school counselors ($n = 584$). The population in the Mullen et al. (2014) investigation is similar to the sample for this investigation in the development of the MCA. Thus, the MCSDS-X1 is a cost-effective,

shortened social desirability scale that allowed for assessment of the level of social desirability among participants' responses in this research investigation.

Convergent and concurrent validity are additional types of validation that was assessed through examining the correlation between therapists' MCA scores and their MCSE-RD scores (Sheu & Lent, 2007). Although, the use of a previous multicultural self-efficacy assessment can assist in the validation of the MCA (a multi-dimensional assessment); the researcher recognized potential limitations in utilizing a measure designed to focus on a single dimension of diversity (race, ethnicity; Sheu & Lent, 2007). Considering the reviewed list of multicultural counseling assessments in Chapter 2, the researcher choice the MCSE-RD given over instrument develop procedures and reported psychometric properties. With this in mind, the researcher hypothesized there would be a positive correlation between the therapists' MCSE-RD scores that measures self-perceived capabilities in counseling racially diverse clients and their MCA scores. (e.g., therapists with higher self-perceived capabilities scores would theoretically have higher multicultural competence self- efficacy scores).

Step 7: Administering items to a development sample.

The MCA was administered to an initial development sample of 29 participants during the pilot data. The administration of the MCA to an initial sample was the first round of data collection for the assessment. The sample of therapists (e.g., counselors) who participated in the pilot study were all masters or doctoral level therapists in training. Furthermore, face-to-face data collection procedures were utilized when gathering all pilot data.

Step 8: Evaluation of items.

Following administration of the MCA to the sample of therapists, the researcher evaluated the 50-item measure with an EFA. In addition, internal consistency reliability of the MCA was assessed through the examination of the Cronbach's coefficient alpha. Furthermore, the researcher utilized a varimax component rotation as a preliminary analysis of the MCA items and the factor loadings for the MCA.

Step 9: Administered items to a training sample.

The researcher aimed to recruit a sample of 500 participants to satisfy a 10:1 participant/item ratio for the purpose of exploratory factor analysis (EFA; Comrey & Lee, 1992). Ultimately, the MCA was administered to a development sample of 407 participants yielding an 8:1 participant/item ratio during data one. The sample of therapists (e.g., counselors, social workers, psychologists) who participated in data one involved individuals from various levels of experience (e.g., students-in-training, professionals, licensed professionals). Furthermore, face-to-face, mail-out, and email data collection methods were utilized when collecting data one responses.

Step 10: Evaluation of items.

Following administration of the MCA, items were evaluated and eliminated utilizing EFA. The researcher evaluated the 50-item measure by reviewing the internal consistency reliability based upon Cronbach's coefficient alpha and parallel analysis (PA). Furthermore, the researcher reviewed the theoretical basis of each item, allowing for the comparison of the

researcher's hypothesized loading of items against factor loadings from the development sample in data one.

Step 11: Optimized scale length.

An essential step in scale development (DeVellis, 2017), includes adjusting scale length by reducing items based on statistical analysis and theory. Therefore, following data analysis the researcher eliminated and retain items based on EFA and PA criteria. The researcher utilized a varimax with Kaiser normalization and principal component analysis (PCA) as rotation and extraction methods for the MCA, respectively. Specifically, factor loadings that encompassed less than three MCA items were eliminated based upon instrument development best practices (DeVellis, 2017). Furthermore, items that yielded less than a .10 difference across multiple factors were eliminated with the exception of MCA items 31, 33, and 49. The aforementioned items were retained for further analysis among data two. In total 25-items were eliminated through the optimization of the MCA.

Step 12: Administered items to a validating sample.

The 25-item MCA and a validation assessment (MCSE-RD; Sheu & Lent, 2007) were administered to a second sample of therapists (e.g., counselors, psychologists, social workers) during data two. Thus, the researcher aimed to obtain a minimum development sample of 250 participants to satisfy a 10:1 participant/item ratio for the purpose of CFA. Recommendations suggest a larger sample when utilizing CFA then EFA (DeVellis, 2017); however, the researcher secured 233 participants for data two. Thus, the participants yielded a 9:1 participant/ratio for the primary purpose of CFA. The sample of therapists (e.g.,

counselors, social workers, psychologists) who participated in data two involved individuals from various levels of experience (e.g., students-in-training, professionals, licensed professionals). Furthermore, face-to-face, mail-out, and email data collection methods were utilized when collecting data for dataset two.

Step 13: Evaluation of items.

To further study the construct validity, the researcher used CFA to confirm the identified factor model of the MCA using a validating sample. In addition, evidence of validity of the MCA scores was assessed through (a) criterion-related validity, (b) construct validity, and (c) content validity.

Step 14: Optimized scale length.

The final step in scale development (DeVellis, 2017), included an adjustment in model fit indices based on statistical analysis (e.g., CFA). Following data analysis, the researcher reported the final CFA model and model fit indices.

Manual Development.

The researcher created a test manual for the MCA to explain how to administer the instrument. A panel of experts reviewed and edited the MCA training manual and changes were made in accordance with experts' suggestions. The manual serves as a training tool to assist individuals administering the MCA. In addition, the manual serves as reference guide to scoring the MCA. The MCA manual contains: (a) a review of the literature from which the MCA was developed, (b) definitions for each item, (c) directions for administration, and (d)

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instructions for scoring of the MCA. Individuals can obtain a copy of the MCA manual by contacting the developer via email.

Marlowe-Crowne Social Desirability Scale

Multicultural competence assessments are known for social desirability bias (Constantine & Ladany, 2000; Larson & Bradshaw, 2017); however, with use of the MCSDS-X1 (Strahan & Gerbasi, 1972), no significant relationship among social desirability scores and multicultural competence scores have been found (Larson & Bradshaw, 2017). Therefore, the use of this 10-item scale (true, false) that measures an individual's motivation to respond in ways that are deemed positive within society. Sample items from the MCSDS-X1 include: "I always practice what I preach" and "I sometimes try to get even rather than forgive and forget". The MCSDS-X1 is being used to address a threat to internal validity and social desirability when participants complete the MCA. The MCSDS is one of the most widely used social desirability measures (DeVellis, 2017). The MCSDS-X1, however, is the short form as the original form encompasses a total of 33-items. The MCSDS has a satisfactory internal consistency reliability range (α = .50 - .80; Strahan & Gerbasi, 1972; Mullen et al., 2014).

Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form

The MCSE-RD (Sheu & Lent, 2007) is a 37-item self-report 5-point unipolar scale that ranges from 0 (*no confidence at all*) to 9 (*complete confidence*), which measure's self-perceived capability in counseling racially diverse clients. The MCSE-RD utilizes three sub-

scales: multicultural intervention (MI), multicultural assessment (MA), and multicultural

session management (MSM) all designed to assess various areas of capability in providing

mental health services to racially diverse clients. Sample items from the MCSE-RD include,

"assess the client's readiness for termination" and "manage your own racially or culturally

based countertransference toward the client (e.g., over-identification with the client because

of his or her race)".

Since multiculturalism is a large construct that encompasses a range of factors

including, but not limited to, age, disability status, educational level, language (Sue & Sue,

2003), previous assessment developers have focused primarily upon one dimension of

diversity (e.g., Bidell, 2005; Strike, 2001; Robertson, 2010). This single lens perspective has

inherent weaknesses in the measurement of the multicultural counseling since competence in

one dimension of diversity does not guarantee competence in others. However, given

previous multicultural therapy assessments grounded in MCC's and MSJCC's, MCSE-RD

scores have produced satisfactory psychometric properties.

MCSE-RD scores have rendered satisfactory psychometric features as evidenced by a

total score internal consistency of .98 score (M= 5.39; SD = 1.57; Sheu & Lent, 2007) and a 2

-week test-retest reliability correlation coefficient of r^a = .77 for the MCSE-RD total score.

Specifically, the subscales of the MCSE-RD yield strong internal consistency reliability

coefficients as evidenced by a Cronbach alpha (α) of .98 for multicultural intervention (M =

5.66; SD = 1.63), .92 for multicultural assessment (M = 3.77, SD = 2.02), and .94 for

multicultural session management (M =5.84; SD = 1.53). In addition, the subscales produce

acceptable 2-week test-retest reliability correlations with a r^a = .73, .88, and .69 for MI, MA,

and MSM, respectively (Sheu & Lent, 2007). Therefore, the psychometrics properties of the MCSE-RD scores demonstrate reliability and validity of the assessment in measuring individuals' self-perceived capability in counseling racially diverse clients.

The MCSE-RD has been used as a means to measure convergent and discriminate validity by the *Counselor Activity Self-Efficacy Scale* (CASES; Lent, Hill, & Hoffman, 2003) and the MCI. Among both assessments (e.g., CASES and MCI) positive significant correlations were found. In fact, CASES and MCSE-RD total scores, as well as, MCI and MCSE-RD total scores yielding satisfactory correlations with a $r = .79$ and .68 (Sheu & Lent, 2007). Thus, the inclusion of this measure within the present research investigation.

General Demographic Questionnaire

The fourth instrument included a questionnaire designed to assess the demographics of the mental health professional population. The general demographic questionnaire inquired about information such as professional field, gender, race/ethnicity, highest level of education, years in practice, primary service provided, and possession of licensure(s) and/certification(s). Additional questions for student participants include: (a) the amount of completed credit hours and (b) accredited program enrollment status.

Data Analysis Procedures

In the development of the MCA, it was imperative to evaluate both the reliability and the validity of the scores. The importance of internal consistency reliability is discussed as a vital element in the development of the MCA among a population of therapists. In addition,

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the exploration of reliability is discussed through construct and content validity. Data analyses were conducted in the Statistical Package for Social Science (SPSS; 2013) and SPSS Analysis of a Moment Structures (AMOS) software packages for Mac and Windows Version 24.0.

<div align="center">Reliability</div>

The dependability of an assessment is a vital element in its development; thus, the need to evaluate reliability of scores upon the conception of a novel instrument is imperative. Reliability refers to the amount by which an assessment provides consistent results (DeVellis, 2007; Reynolds, Livingston, & Willson, 2009). Often within literature, instruments are referred to as reliable (DeVellis, 2017); although the AERA, APA, and NCME (2014) identifies reliability as a characteristic of scores. In determining the reliability of scores, assessment results must represent some true state of the variable being assessed (e.g., multiculturalism; DeVellis, 2017). Reliability among scores is assessed by the proportion of variance attributable to the true score of the latent variable, multiculturalism (DeVellis, 2017). Thus, within the MCA, the reliability measure assessed internal consistency. To evaluate internal consistency reliability, Cronbach's coefficient alpha was used (Cronbach, 1951).

<div align="center">Internal Consistency and Cronbach's Coefficient Alpha</div>

Since assessment scores are internally consistent to the degree to which the items measure the latent variable and are inter-correlated (DeVellis, 2017); the relationships

between items in the MCA was assessed. A widely-used measure of reliability, Cronbach's

coefficient alpha (α) is an internal consistency reliability method used to assess sampling

error after a single administration of an assessment (DeVellis, 2017; Reynolds et al., 2009).

Assuming the assessment items are both tau equivalent and the absence of correlated errors

(Dimitrov, 2012), high inter-item correlation suggests items are measuring the same

construct (DeVellis, 2017; Dimitrov, 2012). Unfortunately, explaining the use of Cronbach's

coefficient alpha as a means of verifying internal consistency is incomplete without

addressing common criticisms of its statistical use. In fact, Sijtsma (2009) questions the use

of Cronbach's coefficient alpha in evaluating the important elements of internal consistency

reliability, an imprecise concept. In addition, scholars argue the use of alpha as a reliability

coefficient since it was intended to be used with continuous, not ordinal data (Gadermann,

Guhn, & Zumbo, 2012). The present investigation, similar to other social science

assessments, utilizes a Likert-type item response format. Furthermore, Dunn, Bagley, and

Brundsen (2014) have criticized alpha's ability to meet tau equivalence, requiring all items to

be equal indicators of the underlying construct. To ensure tau equivalence is not violated

within the current investigation, a thorough theoretical framework and use of expert

reviewers was implemented. Lastly, the process by which alpha is used to optimize

assessment, the individual deletion of items, is assumed to reflect an increased true scored

variance. However, the deletion of items is suggested to reflect less error variance among the

participants scores used to analyze a construct (Dunn et al., 2014). To address the limitations

within the single item deletion process, bootstrapping was utilized to determine confidence

intervals (e.g., 95% confidence), providing accurate bounds of true reliability (Dunn et al., 2014).

<center>Validity</center>

The accuracy of assessments measuring what it purports to measure is a vital component in the construction of an instrument (DeVellis, 2017). Thus, the necessity to assess evidence of validity of assessment scores, which refers to the appropriateness of the assessment score interpretation (Reynolds et al., 2009). Validity, like reliability, is not property of an instrument; validity refers to the interpretation of scores generated from the completion of an assessment (Dimitrov, 2012). Historically, validation has been described as being comprised through (a) criterion-oriented validity, (b) content validity, and (c) construct validity (Cronbach & Meehl, 1955). However, a debate within literature regarding the amount of types of validity, as well as, validity as a unitary concept exists (DeVellis, 2017; Goodwich & Leech, 2003; Messick, 1995). Messick (1995) discusses six types of validity; whereas, DeVellis (2017) explores three forms of validity. Less cited, Goodwich, and Leech (2003) highlights the various aspects of validity while maintaining the differences are only necessary to assess the degree to which statistical evidence supports the intended interpretation of assessment results. Therefore, within the following section: (a) construct validity, (b) criterion-related validity, and (c) content validity are reviewed.

Construct Validity

Focused on theoretical relationships between variables (e.g., scores on a scale) and other variables; construct validity is determined by the extent to which an assessment performs in the manner it is theoretically intended to measure comparative to other assessments (DeVellis, 2017). Construct validity is comprised of convergent and discriminant validity. In particular, *convergent* validity refers to correlation between two measures that affirm similarity between the related constructs. Conversely, *discriminant* validity refers to the absence of correlation between measures of unrelated constructs (DeVellis, 2017). To determine convergent validity within the present research investigation, the MCSE-RD (therapists' self-perceived capability in counseling racially diverse clients) was used as it is predicted to yield a positive correlation when assessment along with the MCA (therapists' multicultural competency).

Factor Analysis

Factor analysis (FA) is a frequently used statistical analysis to assess evidence of construct validity of the instrument developed because the goal of FA is to find the largest variance within an inter-correlation matrix using the least among of variables (Mvududu & Sink, 2013; Tinsley & Tinsley, 1987). It is through FA that the following can be determined: (a) how many factors underlie a set of variables, (b) which variables encompass which specific factors that have been found, (c) the correlation between the individual variables and the factors, (d) the correlation (if any) among the factors found within the data, and (e) the proportion of variance among variables within factor data (Dimitrov, 2012).

After the full development sample has completed the full battery of assessments the data must be vetted for missing info, data entry errors, and irregular response patterns (Mvududu & Sink, 2013). An assessment to identify the percentage of missing data will take place prior to negotiating any further steps; thus, if the data sample has less than 5% of data missing no action was required. If more than 5% of the data sample has missing data an assessment took take place to indicate if the data is missing at random (MAR) or missing completely at random (MCAR). After data has been vetted the researcher determined if the following parametric assumptions have been met: (a) normality on univariate, bivariate, and multivariate levels (Osborne, 2012); (b) extreme outliers (e.g., bivariate, multivariate) must be identified and removed (Field, 2009); and (c) linearity will be examined through bivariate scatterplots.

Factor extraction methods are important during this portion of data analysis in determining the factor structure of the MCA scores. Most commonly used methods within literature include: (a) Bartlett's test of sphericity, which examines whether the variables are largely uncorrelated, based on chi square approximation with degrees of freedom $p\ (p-1)/2$ (Bartlett, 1950) and (b) Kaiser-Meyer-Olkin (KMO) method retains factors based upon eigenvalues measuring greater than 1 (Kaiser, 1960); however, a less utilized method is (d) Parallel Analysis (PA) compares correlation matrices of average eigenvalues from random correlation matrices against the eigenvalues of the real dataset (e.g., MCA scores; Hayton, Allen, & Scarpello, 2004). Although KMO is known to yield inaccurate factor retention results (Hayton et al., 2004), several multicultural competency assessments and meta-analysis have utilized this method to confirm and/or disconfirm the factor structure(s)

presented within literature (e.g., Barden et al., 2017; Constantine et al., 2002; Holcomb-McCoy & Day-Vines, 2004; Ponterotto, Rieger, Barrett, Harris, & Sparks, 1996). Given the robust nature of PA and its proven ability to most accurately identify the factor structure among items, the PA process was utilized in the present study (Hayton et al., 2004).

Within the research study both EFA and CFA was utilized to assess the psychometric features of MCA scores. Once the parametric assumptions are met, the researcher ran an EFA during data one since sufficient theoretical and/or empirical information was not present to predict how the presented variables created a factor structure. After clear patterns were located among items and factors were adequately identified and labeled, the researcher optimized the MCA and utilized both an EFA and CFA during data two with the remaining revised items. CFA was used to verify the predicted relationships among the set of variables and factors and test the theory established by EFA. Once both latent and observed variables were identified, a structural model was constructed that predicted the item loadings along hypothesized factors (Mvududu & Sink, 2013).

Criterion-Related Validity

Criterion-related validity refers to the accuracy that takes place follows, precedes, or coincides with an assessment (DeVellis, 2017). The most important aspect of criterion-related validity is the strength of the empirical relationship between the measure (e.g., the MCA) and the criteria by which value is inferred (DeVellis, 2017). To determine the strength of an assessment and the criteria of value, concurrent validity utilizes criterion being measured at the same time as the instrument administered (Reynolds et al., 2009). However,

predictive validity requires the administration of a scale followed by a time interval, and then criterion measurement. The present research investigation assessed concurrent validity since the MCA was administered along with other assessments (e.g., the MCSE-RD) to assess the similar, but different constructs (predicting a positive correlation between the MCA and the MCSE-RD).

Content Validity

Content validity refers to the extent to which a specific set of items reflects the content domain being investigated (DeVellis, 2017). Content validity is easiest to evaluate when the construct is well defined and items are linked to variable content. Therefore, writing items specific to the construct and utilizing expert reviewers to assess the initial item pool based upon the conceptual definition of the construct is vital. Thus, within the present research study a training manual has been developed, which outlines literature supporting the development of each item (*see* Appendix L) and the initial item pool has been reviewed by a panel of expert reviewers.

It is through additional content validity checks (e.g., construct-item pairing, expert reviewers) that helped ensure relevant data was included and irrelevant content was removed from the scale (DeVellis, 2017). In this way, the inclusivity of how multiculturalism is defined through the validation of the MCA may have caused content validity concerns. In particular, accounting for various social identities when assessing one's self-efficacy can impede content validity because participants responded to general questions that may not be relevant or may require context (DeVellis, 2017). Previous multicultural assessments have

utilized between 3-20 expert reviewers throughout scale development (e.g., LaFromboise et al., 1991; Hook, Davis, Owen, Worthington, & Utsey, 2013; Sheu & Lent, 2007). Therefore, to address potential content validity concerns a panel of 13 expert reviewers were secured to achieve the same degree of confidence in item content.

Ethical Considerations

Ethical guidelines were followed within the development and analyses of the MCA. In particular, recruitment and data collection did not begin prior to institutional IRB approval. Furthermore, once data collection began, all participants were provided with an informed consent document, which included: (a) the purpose of the study, (b) study procedures, and (c) potential risks to study involvement. In addition, all participants were informed that involvement in the present research study was on a voluntary basis. Lastly, assessment results were coded to ensure confidentiality.

Limitations of the Study

There were limitations within the present research investigation. Despite intended recruitment efforts among therapists and students within preparation programs, the total sample of participants (e.g., pilot, data one, data two) was not equitable cross professional identity (e.g., counselors, psychologists, and social workers). Thus, the generalizability of the study results may not be fully reflective of each mental health discipline.

Furthermore, in the development of the MCA, a limitation may exist in the identified explored domain areas of multiculturalism. While the identified areas are relevant to the

construct of interest, additional domain areas may exist in therapists' work with diverse

clients that are not fully explored within the present instrument. Therefore, all relevant areas

to the measurement of multiculturalism among therapist may not been reflected in the MCA.

Chapter Summary

The purpose of the current investigation was to develop the MCA and to examine the

psychometric properties of MCA scores with a sample of therapists. This chapter presented

(a) the research design, (b) the population and sample, (c) data collection, (e)

instrumentation, (f) research purpose and questions, (g) data analysis procedures, (h) ethical

considerations, and (i) potential limitations of the study.

CHAPTER FOUR: RESULTS

Chapter four presents the results that were investigated within the present study.

Specifically, the researcher investigated the psychometric properties of the *Multicultural*

Competency Assessment (MCA) scores within a sample of therapists. Data collected for the

study were analyzed using the Statistical Package for the Social Sciences (SSPS; Mac and

Windows Version 24.0) and SPSS Analysis of a Moment Structures (AMOS; Mac and

Windows Version 24.0), while the research questions were examined using (a) Factor

Analysis (exploratory factor analysis [EFA], confirmatory factor analysis [CFA]), (b) Parallel

Analysis (PA), (c) Cronbach's coefficient alpha, (d) Spearman Rho Correlation, (e) One-Way

MANOVA and (f) One-Way ANOVA. Furthermore, descriptive statistics of the population

and research questions results are presented in this chapter in the following order: (a)

research question 1 (PA, EFA, CFA), (b) research question 2 (Cronbach's coefficient alpha),

(c) research question 3 (Spearman Rho Correlation), (d) research question 4 (Spearman Rho

Correlation), and (e) research question 5 (One-Way MANOVA, One-Way ANOVA,

Spearman Rho Correlation).

Data Collection

A total of 5,124 therapists were invited to participate in the investigation.

Specifically, 30 individuals were invited to participate in a paper and pencil version via face-

to-face administration for the pilot data; 3,045 (1,697 online version via an email, 113 paper

and pencil via face-to-face, 1,235 paper and pencil via mail out procedures) were invited to

participate in dataset one; and 2,049 (785 online version via email, 29 paper and pencil via

face-to-face, 1,235 paper and pencil via mail out) were invited to participate in dataset two. Although, the researcher calculated the total number of individuals who participated in the pilot; additional demographic data was not collected among pilot participants. The primary purpose of the pilot was to obtain preliminary results of item responses and receive feedback on the overall assessment (MCA). Thus, the following section does not include information on pilot participants' demographic data.

Response Rate

In total, 673 therapists participated in the investigation (pilot, data 1, and data 2), resulting in a 13% useable response rate. For the face-to-face administration, the researcher examined the number of data collection packets versus the number of data collection packets returned. For the face-to-face data administration, 143 out of 172 opted to participate in the overall investigation, yielding an 83% useable response rate. For the mail out data collection, the researcher tracked the response rate using Microsoft Excel for Mac version 16.11.1. Out of the initial mass mailing (2,500 data collection packets), 30 packets were returned to sender; therefore, out of 2,470 packets sent, 429 of packets were returned to the researcher (17% useable response rate). Further, the online version administration yielded a total of 101 participations out of the 2,482 who were sent an email invitation, which produced a 4% response rate.

The pilot data produced overall a 97% useable response rate through face-to-face data collection methods (29 out of 30 therapists completed research packets). In addition, a 13% useable response rate was generated from data one (411 of 3,045 individuals participated). In

particular, 111 out of 113 individuals partook in the study through face-to-face administration (98% useable response rate), 221 out of 1,235 packets were returned to the researcher from mail out data administration (18% useable response rate), and 79 out of 1,697 individuals completed the online version of the research materials through an email invitation (yielding a 5% useable response rate) during data one. Further, an 11% useable response rate was produced from data two. Specifically, three out of twenty-nine participants completed research packets through face-to-face data administration (10% useable response rate), 208 out of 1,235 packets were returned to the researcher from mail out data administration (17% useable response rate), and 22 out of 785 individuals completed the online version of the research materials through an email invitation (3% useable response rate) during data two.

Participants' Demographic Data

Dataset one participants included a national sample of 407 therapists (female; $n = 314$, 77.1%, male; $n = 85$, 20.9%, other; $n = 3$, .7%, transgender; $n = 2$, .5%) who were working with clients in clinical practice. The therapists' self-reported race/ethnicity included, White/Caucasian ($n = 291$, 71.5%), Black/African American ($n = 39$, 9.6%), Hispanic/ Latinx ($n = 31$, 7.6%), Multiracial ($n = 30$, 7.4%), Asian ($n = 6$, 1.5%), Other ($n = 5$, 1.2%), and Native Hawaiian or Pacific Islander ($n = 1$, .2%). Participants' reported age ranged from 22 to 78 years ($M = 39.90$, $SD = 14.55$).

Dataset two participants included a national sample of 233 therapists (females; $n = 182$, 74.3%, males; $n = 39$, 15.9%, transgender; $n = 3$, 1.2%, other; $n = 1$, .4%) who were

working with clients in clinical practice. The therapists' self-reported race/ethnicity included, White/Caucasian (*n* = 182, 74.3%), Black/African American (*n* = 17, 6.9%), Multiracial (*n* = 16, 6.5%), Hispanic/ Latinx (*n* = 5, 2%), Asian (*n* = 3, 1.2%), and American Indian or Alaska Native (*n* = 3, 1.2%). Participants' reported age ranged from 25 to 76 years (*M* = 46.49, *SD* = 13.65). Please note all of the percentages do not total 100 percent because of missing responses within the datasets. The personal characteristics for both data one and data two participants can be found in table 1 and 2, respectively.

Table 2

Categorical Demographic Variables – Data One Participants' Personal Characteristics

Data Category	Total (*n*)	Percentage
Gender (*N* = 407)		
Female	314	77.1%
Male	85	20.9%
Other	3	.7%
Missing	3	.7%
Transgender	2	.5%
Race/Ethnicity (*N* = 407)		
White/Caucasian	291	71.5%
Black/African American	39	9.6%
Hispanic/Latinx	31	7.6%
Multiracial	30	7.4%
Asian	6	1.5%
Other	5	1.2%
Missing	4	1%
Native Hawaiian or Pacific Islander	1	.2%

Table 3

Categorical Demographic Variables – Data Two Participants' Personal Characteristics

Data Category	Total (*n*)	Percentage
Gender (*N* = 233)		
Female	182	74.3%
Male	39	15.9%
Missing	8	3.4%
Transgender	3	1.2%
Other	1	.4%
Race/Ethnicity (*N* = 233)		
White/Caucasian	182	74.3%
Black/African American	17	6.9%
Multiracial	16	6.5%
Missing	7	3%
Hispanic/Latinx	5	2%
Asian	3	1.2%
American Indian or Alaska Native	3	1.2%

Participants' Professional Demographic Data

The therapists in data one most identified as counselors (*n* = 361; 88.7%), while 5.7% (*n* = 23) and 3.4% (*n* = 14) identified as social workers and psychologist, respectively. The majority of the therapists (*n* = 289, 71%) worked in Community settings, 16.5% (*n* = 67) worked in K-12 School settings, 6.6% (*n* = 27) at University settings, 3.2% (*n* = 13) worked in Hospital settings, and 1% (*n* = 4) worked in Correctional Facilities. Participants' reported years of experience ranged from 0 to 50 years (*M* = 12.077, *SD* = 11.83). Participants' who identified 0 years of experience also identified as practicum or internship students in preparation programs.

The therapist in data two most identified as counselors (*n* = 206; 84.1%), while 4.1% (*n* = 10) and 2% (*n* = 5) identified as psychologist and social workers, respectively. The

majority of the therapists ($n = 167$, 68.2%) worked in Community settings, 10.2% ($n = 25$) worked in K-12 School settings, 7.3% ($n = 18$) at University settings, 3.7% ($n = 9$) worked in Hospital settings, and 1.6% ($n = 4$) worked in Correctional Facilities. Please note all percentages do not total 100 percent because of missing responses within the datasets. Participants' professional characteristics for data one can be found in table 3, while data two participants can be found in table 4.

Table 4

Categorical Demographic Variables – Data One Participant Characteristics

Data Category	Total (n)	Percentage
Professional Identity ($N = 398$)		
Counseling	361	88.7%
Social Work	23	5.7%
Psychology	14	3.4%
Missing	9	2.2%
Primary Work Setting ($N = 400$)		
Community	289	71%
School	67	16.5%
University/College	27	6.6%
Hospital	13	3.2%
Missing	7	1.7%
Justice System	4	1%
Level of Education ($N = 395$)		
Masters	243	59.7%
Bachelors	100	24.6%
PhD, EdD, or PsyD	52	12.8%
Missing	12	2.9%

Table 5

Categorical Demographic Variables – Data Two Participant Characteristics

Data Category	Total (*n*)	Percentage
Professional Identity (*N* = 233)		
Counseling	206	84.1%
Missing	12	5.2%
Psychology	10	4.1%
Social Work	5	2%
Primary Work Setting (*N* = 233)		
Community	167	68.2%
School	25	10.2%
University/College	18	7.3%
Missing	10	4.3%
Hospital	9	3.7%
Justice System	4	1.6%
Level of Education (*N* = 233)		
Masters	165	67.3%
Ph.D., Ed.D., or Psy.D.	55	22.4%
Missing	9	3.9%
Bachelors	4	1.6%

Data Collection Instruments

Marlowe Crowne Social Desirability Scale – Short Form.

The internal consistency reliability for the *Marlowe Crowne Social Desirability Scale – Short Form* (MCSDS-X1) scores was calculated through a Kuder Richardson 20 (KR-20) reliability analysis for the 10-item dichotomous scale. Given the True/False response items options for the MCSDS-X1, the researcher used a KR-20, a common version of alpha for dichotomous response scales (DeVellis, 2017). The MCSDS-X1 yielded a Cronbach alpha of .702 among the data one dataset (*N* = 407), while a Cronbach alpha of .692 was generated among the second (*N* = 233) dataset. Given previous research, the internal consistency reliability of the MCSDS-X1 scores was consistent with previous reported Cronbach

coefficient alpha values (Barger, 2002; Mullen et al., 2014; Reynolds, 1982; Strahan & Gerbasi, 1972).

Multicultural Counseling Self Efficacy Scale -Racial Diversity Form.

The internal consistency reliability for the *Multicultural Counseling Self-Efficacy Scale -Racial Diversity Form* (MCSE-RD) scores was calculated through a reliability analysis for the 37-item, 9-point Likert scale instrument. The MCSE-RD total score yielded a Cronbach alpha of .968, while the subscale 1 (*Multicultural Interventions*), subscale 2 (*Multicultural Assessment*), and subscale 3 (*Multicultural Counseling Session Management*) generated Cronbach alpha's of .969, .880, and .913, respectively among the data two ($N =$ 233) dataset.

Data Analyses

The data were analyzed using SPSS and SPSS AMOS (Mac and Windows Version 24.0). Prior to the examination of the research questions, the researcher examined data for missing information, data entry errors, irregular response patterns, and outliers. Furthermore, the researcher conducted statistical tests to assess the assumptions associated with the statistical analyses (e.g., EFA, PA, CFA, KR-20, One-Way MANOVA, One-Way ANOVA, Spearman Rho Correlation) for each research question.

For research question 1, an EFA was conducted to uncover the factor structure of the MCA scores to generate theory as well as identify and retain the fewest set of factors, while explaining the most amount of shared variance among the variables (Henson & Roberts,

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2006). Next, a CFA was utilized as a means to test the identified factors and the correlations between variables and factors (Henson & Roberts, 2006). Specifically, the researcher utilized an EFA analysis to develop parsimony among the assessment model, which can best reproduce variables in replicated conditions (Henson & Roberts, 2006) using data one. The EFA was then followed up with a CFA analysis using data two to test the MCA measurement model established based on the EFA results and theory (Gorsuch, 1983).

For research question 2, Cronbach's coefficient alpha (α) was calculated to assess internal consistency reliability of the assessments' scores. The purpose of using Cronbach's alpha with the MCA was to assess to what extent the items and latent variables were interconnected (DeVellis, 2017). In the study, both the 25-item revised MCA (data one) and the 25-item MCA (data two) reliability coefficients were calculated. Cronbach α values range from 0 to 1 with higher values generally indicating higher reliability and lower values representing lower internal consistency reliability (DeVellis, 2017; Streiner, 2003). In fact, according to Streiner (2003), the cutoff for moderate internal consistency is a Cronbach alpha of .70 or higher (not exceeding .90 as that may indicate item redundancy).

For research question 3, a Spearman Rho correlation was used to examine the direction and strength of the relationship between the 25-item MCA and the MSDS-X1 scores obtained from data one participants. In this way, the direction indicates either a positive or negative relationship between variable; thus, with a positive relationship when one variable increases, so does the other variable (Pallant, 2007). Conversely, when a negative relationship is identified, when one variable decreases the other variable also decreases (Pallant, 2007).

For research question 4, similar to research question 3, a Spearman Rho correlation calculated the strength and direction of the relationship between the 25-item MCA and the MCSE-RD scores retrieved from data two participants, testing concurrent validity of MCA scores. Specifically, the purpose of research question 4 to examine concurrent validity of the MCA scores (*concurrent validity*, "the extent to which individuals' scores on a new test correspond to their scores on an established test of the same construct that is administered at approximately the same point of time"; Gall, Gall, & Borg, 2007, p. 635); thus, the researcher examined the direction (e.g., positive or negative) of the relationship between the two variables assessing for evidence of concurrent validity (Pallant, 2007).

For the final research question 5, the researcher used an one-way MANOVA, one-way ANOVA, and Spearman Rho correlation to examine differences between the means of two or more groups between the 25-item MCA and demographic characteristics (e.g., professional field, primary work setting, gender, race/ethnicity) and to calculate the strength and direction of 25-item MCA and demographic characteristic (e.g., age) from data two participants. The purpose of research question 5 is to assess the relationship between 25-item MCA (total, subscales) scores and the participants' reported demographic data.

Results

For research question 1, in dataset one, the researcher used an EFA with the 50-item MCA scores ($N = 407$) to optimize the assessment through the elimination of weak items and revising items with problems. Prior to conducting an EFA, statistical assumptions were evaluated in order to assess if the data was suitable for factor analysis (FA). The parametric

assumptions that were assessed in this investigation included: (a) sampling adequacy, (b)

normality, (c) multicollinearity, and (d) linearity. With a sample of 407 participants for data

one and 50 scale items, a participant/item ($N:p$) ratio of approximately 8:1 was yielded. Firm

sample size rules for FA are difficult to assert (Henson & Roberts, 2006; Costello &

Osborne, 2005), given the complex dynamics of FA. In fact, many FA rules of thumb are

misleading (MacCallum, Widaman, Zhang, & Hong, 1999) since preferred sample size is

largely dependent upon the specific features of the obtained data. Specifically, the level of

commonalities are vital in determining the importance of sample size within factor analytic

solutions (MacCallum et al., 1999). In this way, items with higher commonalities (> .6)

yields a reduced sampling impact; whereas, if commonalities are lower (approximately .5), a

larger sample size is necessary to obtain recovery of population factors (MacCallum et al.,

1999). Therefore, Henson and Roberts (2006) suggested that when utilizing FA, researchers

obtain the largest sample possible; however, after an analysis of FA articles, the majority

(62%) of researchers reported $N:p$ ratios of less than 10:1 (Costello & Osborne, 2005). Thus,

within the present study a satisfactory sample size and commonalities (as displayed in table

1) were adequate for the use of FA.

The assumption of normality indicated that data one initial MCA data was normally

distributed. Normality (e.g., univariate level, multivariate level) was evaluated through the

assessment of (a) Skewness and Kurtosis scores, (b) Shapiro-Wilk values, (c) Quartile-

Quartile (Q-Q) Plots, (d) Probability-Probability (P-P) Plots, and (e) Histograms.

Since the skewness values denote the symmetry of score distribution and kurtosis

values inform the placement of 'peakedness' of score distribution, both values are important

in evaluating normality (Pallant, 2007). Perfectly normal distribution render skewness and kurtosis values of 0; since this is not a typical occurrence in social science research, the closer values are to 0 indicate the degrees to which the data is normally and not normally distributed (Pallant, 2007). Dataset one from the 50-item MCA assessment yield skewness values that ranged from -1.088 [MCA4] to -.144 [MCA29] and the MCA Total Score yielding a skewness value of -.242; kurtosis values, on the other hand ranged from -.576 [MCA36] to 1.520 [MCA50] and the MCA Total Score yielding a kurtosis value of -.342. Although variance was found among individual MCA items, overall the 50-item MCA (e.g., MCA total score) violated the assumption of normality.

Further analysis of Shapiro-Wilks values identified significant results (value less than .05) for all MCA items (including the MCA total score), suggesting a violation of normality, which is common when utilizing large sample sizes (Pallant, 2007). Lastly, after the examination of histograms from each MCA item and the MCA total score, the item data plots suggested non-normality of data (e.g., plots did not follow a bell curved shape peaking in the center of the image). In addition, the P-P and Q-Q plots identified the same conclusion of varying normality amongst individual items; however, the MCA total score yielded normal data. Further examples (e.g., MCA total score) of normality can be found in figures 1, 2, and 3.

In an effort to check the assumption of multicollinearity through the examination of tolerance and variance inflation factor (VIF) values. Since multicollinearity can be identified through tolerance values less than .10, indicating multiple correlation with other variables are high and VIF values greater than 10 (the inverse of tolerance [1/tolerance value]) are also a

not ideal (Pallant, 2007). Therefore, the researcher utilized common cut-off points, tolerance > .10 and VIF < 10 to assess data one MCA data (MCA items and total score) to find there was no presence of multicollinearity (Pallant, 2007). Therefore, items were not removed from the model based upon high inter-correlation and the assumption of multicollinearity was not violated in first dataset. Lastly, to assess for linearity, the researcher reviewed and assessed the associations between variables through scatterplots of the MCA items. Evidence of patterns resembling nonlinear relationships between variables were identified. Thus, the assumption of linearity was met within the first dataset.
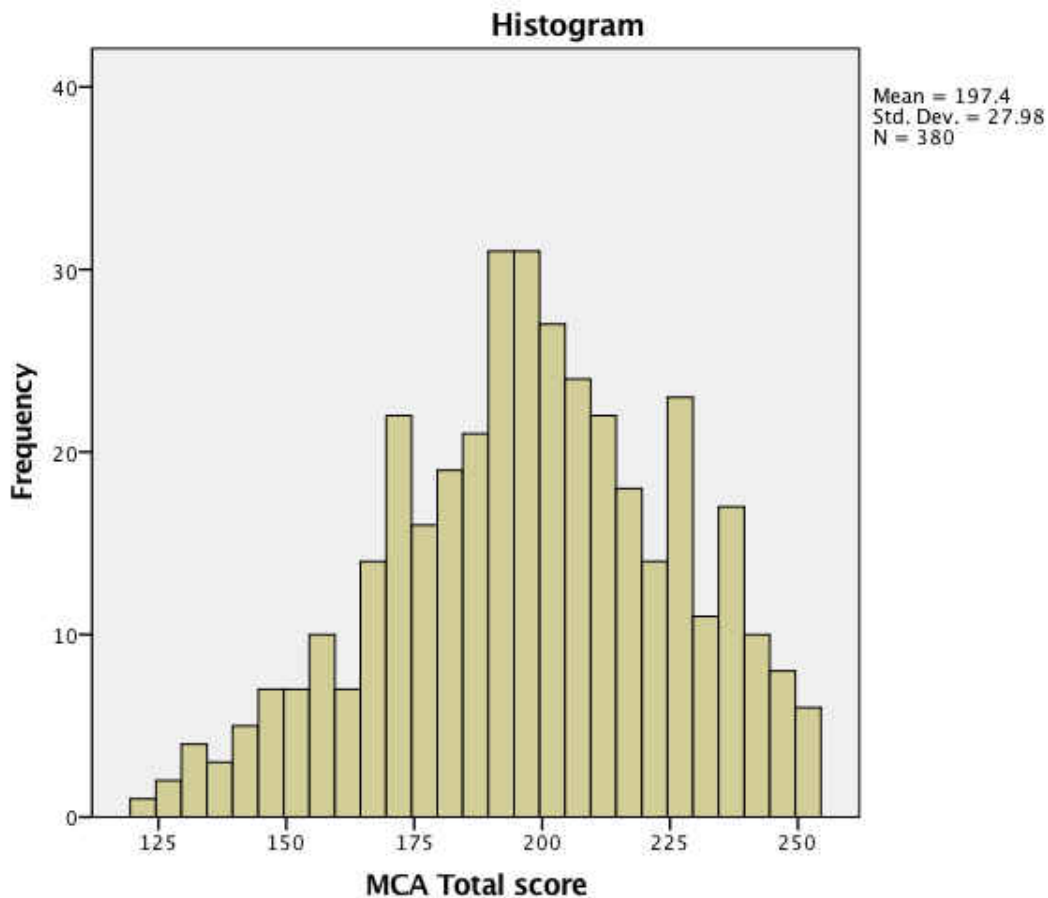
Figure 1: Initial MCA Total Score Histogram
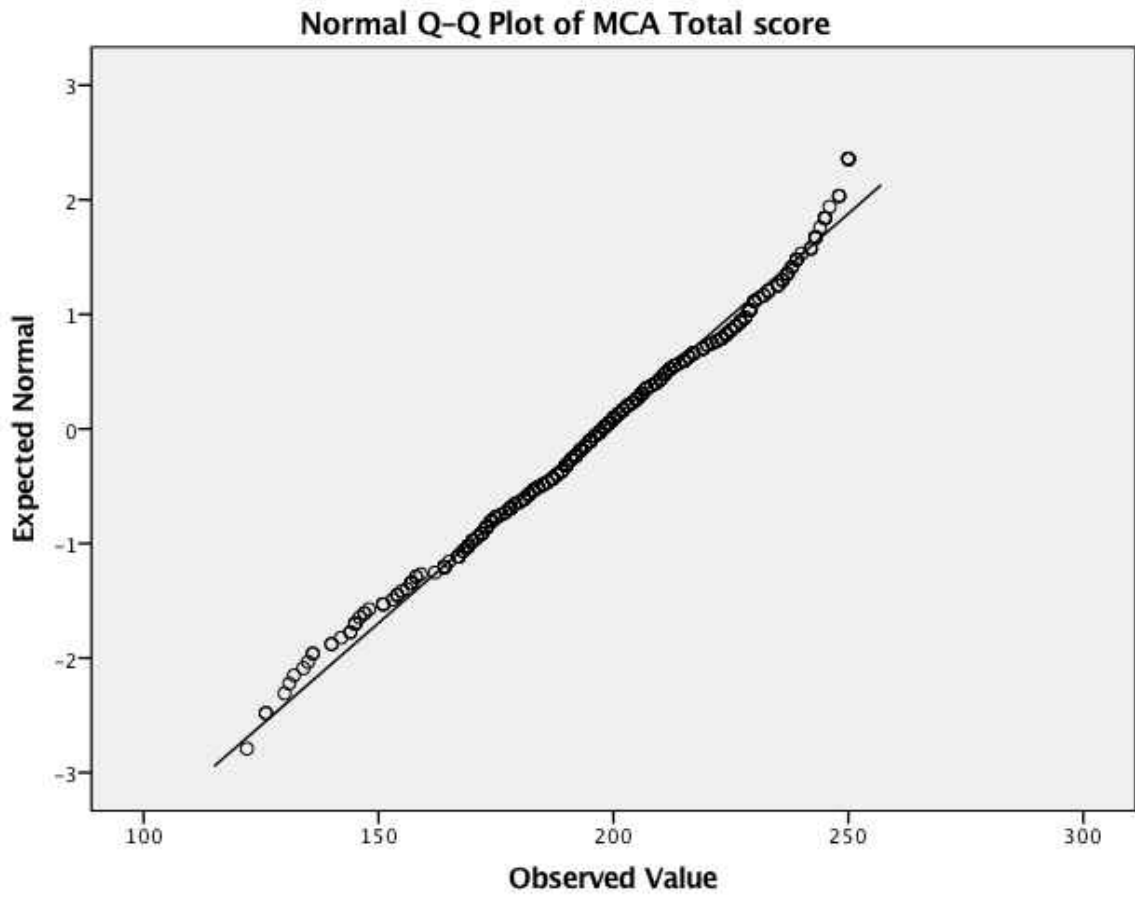
Figure 2: Initial MCA Total Score P-P Plot
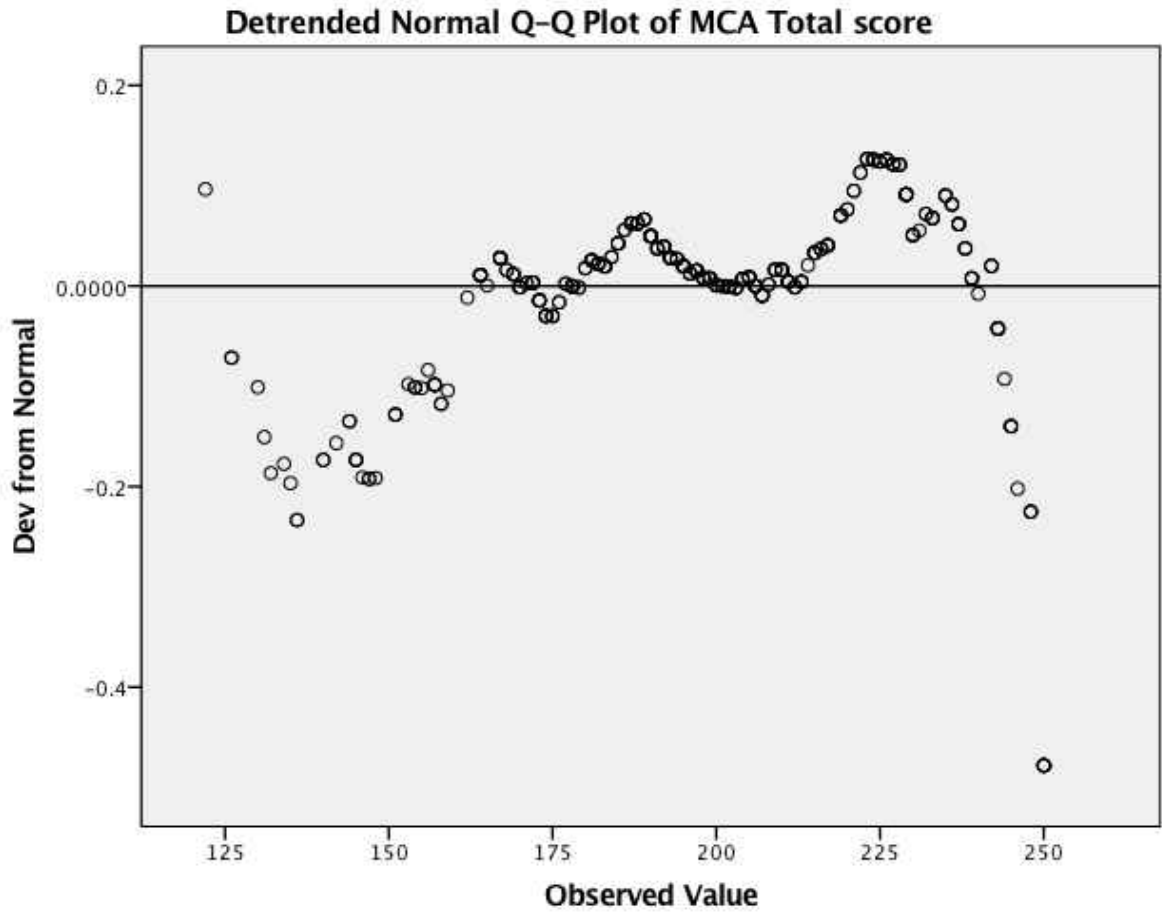
Figure 3: Initial MCA Total Score Q-Q Plot

After checking the assumptions of the first MCA dataset (data one), the researcher applied Watson's (2017) step-wise process in conducting an EFA in an effort to determine the internal structure of the MCA scores. Therefore, the following EFA steps were employed: (a) evaluated the factorability of the intercorrelation matrix, (b) determined how many factors to extract, (c) determined how many factors to retain, (d) determined the appropriate factor rotation method, and (e) evaluated and interpreting factor structure and naming factors.

Step 1: Evaluate the factorability of the intercorrelation matrix

The initial steps in conducting an EFA requires an evaluation of the data to ensure the use of FA is acceptable (Watson, 2017). Creating an intercorrelation matrix to assess interitem correlations is one way to evaluate factorability of the data. When reviewing the correlation coefficients, a range between .20 and .80 are most ideal to ensure items are representative of the measured construct without violating the assumption of multicollinearity. The researcher ran and reviewed the correlation coefficients of the 50-item MCA and found all item values fell between the recommended coefficient range of .20 to .80. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and Bartlett's test of sphericity were evaluated to review variable intercorrelations. The researcher utilized a KMO index range of 0 to 1 to identify good FA with higher values representing better adequacy (Pallant, 2007; Tabachnick & Fidell, 2001; Watson, 2017). In fact, Kaiser's (1974) guidelines provide additional information to assist in interpreting KMO index values, which involve the following: (a) .90 to 1.0 (marvelous), .80 to .89 (meritorious), .70 to .79 (middling), .60 to .69 (mediocre), .50 to .59 (miserable), and below .50 (unacceptable).

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Whereas, Bartlett's test of sphericity was used to estimate the degree that the intercorrelation matrix that was produced was reflective of the current correlation coefficients. In this way, when all of the off-diagonal bivariate correlations in the matrix are zero, items are not correlated with one another (Watson, 2017). Therefore, statistical significance ($p < .05$) for Bartlett's test of sphericity, was used to determine the appropriateness of FA. Yielding a KMO index of .967 and statistical significance ($x^2 = 12913.448$, $df = 1225$, $p < .001$) for Bartlett's test of sphericity, according statistical assumptions, the first dataset was considered appropriate for FA.

Step 2: Determine how many factors to extract

Following the evaluation of factorability of the first dataset, the researcher extracted factors, a process where shared variance in each item (variable) was separated from its unique and error variance (Watson, 2017). Principal component analysis (PCA) is a factor extraction method that provides an empirical summary of the dataset by identifying relationships among variables (Tabachnick & Fidell, 2013; Watson, 2017). PCA is criticized as not being a true form of factor analysis for failure to recognize error variance (Fabrigar, Wegener, MacCullum, & Strahan, 1999). However, given the large sample size of data one scores and the use of a recommended conjunctive analysis, parallel analysis (PA), which accounts for sampling error (Hayton, Allen, & Scarpello, 2004), the researcher used both PA and PCA as extraction methods for the first dataset.

Step 3: Identify factors structure

Next, the researcher identify the factor structures by examining how many and which constructs should be identified and retained for further investigation (Watson, 2017). Developed based upon the Kaiser greater than one criteria and scree test, PA was developed to resolve overestimation concerns (Horn, 1965; Watson, 2017). Since eigenvalues represent explained variance by a factor, PA compares eigenvalues of parallel factors from random datasets of the sample size and number of variables with the expectation that meaningful factors will be larger than the random generated parallel factors (Watson, 2017). Therefore, factors that yielded eigenvalues above the mean eigenvalues according to PA (Hayton et al., 2004) were retained in the overall model (*see* tables 2 and 5). PA eigenvalues were calculated using an online random generator (https://analytics.gonzaga.edu/parallelengine/), allowing the researcher to generate a custom number of random correlation matrices (e.g., 100). Within the present investigation, initial mean eigenvalues generated through PA were as follows: 1.743 (*Factor 1*), 1.672 (*Factor 2*), 1.619 (*Factor 3*), 1.571 (*Factor 4*), 1.529 (*Factor 5*), 1.49 (*Factor 6*), and 1.45 (*Factor 7*). However, the first dataset yielded the following initial eigenvalues: 22.327 (*Factor 1*), 2.195 (*Factor 2*), 1.584 (*Factor 3*), 1.545 (*Factor 4*), 1.367 (*Factor 5*), 1.160 (*Factor 6*), and 1.032 (*Factor 7*). Given the factors yielded eigenvalues close, but below the average eigenvalues the researcher retained all factors for further analysis until after factor rotation procedures. Often an examination of a scree plot is used to determine factor retention through the identification of a break or elbow in the graph, where a steep slope of larger eigenvalues ends, and smaller eigenvalues begin

(Watson, 2017). After the inspection of the scree plot, factors located above the slight break between factors 3 and 5 (*see* figure 4) were retained.

Step 4: Identifying the appropriate factor rotation method

Another vital decision by the researcher is how to rotate factors to maximize (high, low) loadings and to create the most parsimonious factor structure (Watson, 2017). When researchers use an orthogonal rotation, factors are assumed to be statistically independent, providing no information about the location of another factor when the two perpendicular (DeVellis, 2017; Watson, 2017). The researcher chose the varimax, the most common statistical rotation (Costello & Osborne, 2005), since it seeks to maximize the variance of the squared loadings of each item and based upon its superiority compared to other factor rotation methods (e.g., quartimax, equimax; DeVellis, 2017; Hair, Black, Babin, & Anderson, 2010). Therefore, the researcher chose to use the varimax rotation method with Kaiser Normalization to clarify and simplify the correlations between each item and each factor.

Step 5: Evaluating and interpreting factor structure and naming factors

Lastly, the researcher evaluated the factor structure of the factors and variables to establish discriminant validity among each factor (Watson, 2017). The researcher reviewed the data by first assessing communality values. A good factor analytic solution is one that displays a maximized shared variance through a variable's communality (h^2) and minimizes unexplained and error variance utilized in the equation (Mvududu & Sink, 2013). Therefore,

the closer a variable's communality is to 1.0, the greater the variance; hence, when the majority (e.g., 50%-75%) of the variance in the intercorrelation matrix, the better factor solution (Mvududu & Sink, 2013). For this reason, the retention of only items with values greater than .5; detailed values from the MCA can be reviewed within Table 1. For the present study, the researcher removed items that had significant cross loadings (.3 or higher; Costello & Osborne, 2005), with the exception of items MCA28, MCA31, MCA33, MCA45, and MCA49. The aforementioned items were retained based upon the multicultural theory and in an effort to further test the new factor structure. Next, the researcher reviewed the communalities of each item, which all revealed moderate to strong (e.g., .50 - .74) loadings across a minimum of four variables (e.g., items). With the aforementioned stepwise process in mind, the researcher (a) ran an EFA with the initial 50 MCA items; (b) reviewed MCA items for potential low communalities; (c) removed MCA items based upon cross-loading; (d) examined MCA items' eigenvalues; and (e) developed a final exploratory MCA model. The examination of the multiple criterion allowed the researcher to identify the retained factors for the revised 25-item MCA. In addition, there is no objective process in naming factors; therefore, the researcher reviewed the variables on each factor to appropriately reflect the factor names (Watson, 2017), which can be found below.

Table 6

Communality Values for Data One Initial MCA Items

Communalities	Initial	Extraction (h^2)
MCA1- I can identify how clients' beliefs affect the therapeutic process	1.0	.610
MCA2 - I can create emotionally safe environments for my clients	1.0	.752
MCA3 - I am able to recognize clients' cultural expectations of the therapeutic process	1.0	.652
MCA4 - I am able to pursue consultation with colleagues concerning multicultural issues with clients	1.0	.498
MCA5 - I can initiate discussions about cultural mores (e.g., roles, expectations) when working with clients	1.0	.533
MCA6 - I am able to identify barriers that may impede clients' access to mental health services	1.0	.684
MCA7 - I can discuss the dynamics between oppression and discrimination in clinical practice	1.0	.591
MCA8 - I am able to use clients' colloquialisms (popular expressions) in therapeutic sessions	1.0	.343*
MCA9 - I am capable of seeking therapeutic consultation from community leaders regarding my clinical approach	1.0	.645
MCA10 - I can describe the elements of culture specific (e.g., faith, sexual orientation, race) developmental models during clinical practice	1.0	.613
MCA11 - I can explain the implications of privilege as they relate to my clinical practice	1.0	.716
MCA12 - I can recognize the limitations of assessments based upon the cultural profiles of persons selected for sampling	1.0	.666
MCA13 - I can identify how my principles impact the therapeutic process	1.0	.602
MCA14 - I am capable of acknowledging cultural differences and similarities with my clients when developing a therapeutic relationship	1.0	.576
MCA15 - I am capable of identifying culture specific responses among clients within the therapeutic process	1.0	.662
MCA16 - I can identify cultural information (e.g., cultural expectation, cultural issues) during client conceptualization	1.0	.587
MCA17 - I can integrate clients' cultural heritage when implementing therapeutic techniques	1.0	.645
MCA18 - I am capable of connecting clients with culture specific resources	1.0	.680
MCA19 - I can engage in therapeutic consultation with indigenous, spiritual, and/or religious leaders	1.0	.637
MCA20 - I am able to identify cultural dynamics in sessions as they relate to the therapeutic relationship	1.0	.638
MCA21- I am able to describe identity-focused (e.g., queer, critical-race, feminist) theories during clinical practice	1.0	.594

Communalities	Initial	Extraction (h^2)
MCA22 - I am able to initiate dialogue about how socio-political issues relate to my clients' mental health	1.0	.642
MCA23 - I can utilize a variety of therapeutic techniques to honor clients' cultural identities	1.0	.662
MCA24 - I am capable of identifying the cultural communities in which my membership impacts how I conceptualize clients	1.0	.571
MCA25 - I can identify how cultural information (e.g. cultural expectations, cultural issues) impacts my clients' presenting issue(s)	1.0	.649
MCA26 - I can recognize when clients are having difficulty accessing mental health services	1.0	.570
MCA27 - I am able to identify the power dynamics between the therapist and client during sessions	1.0	.490*
MCA28 - I can identify which beliefs are most important to my clients	1.0	.597
MCA29 - I am able to conceptualize clients through culture specific developmental models in clinical practice	1.0	.650
MCA30 - I am capable of explaining how my client's wellness may be impacted by oppression	1.0	.621
MCA31- I can tailor therapeutic approaches based upon clients' cultural beliefs	1.0	.674
MCA32 - I can identify how privilege may influence the therapeutic relationship	1.0	.693
MCA33 - I can recognize how societal mistreatment of my clients may impact their self-esteem	1.0	.653
MCA34 - I can identify when dominant cultural values impact the assessment of my clients' mental health concerns	1.0	.621
MCA35 - I am able to recognize how my values may interfere with providing clients with therapeutic services	1.0	.611
MCA36 - I can identify culturally appropriate resources for my clients	1.0	.627
MCA37 - I will continue to seek ongoing education focused upon multicultural issues to improve my clinical practice	1.0	.570
MCA38 - I am able to identify training on cultural topics that will benefit my clinical practice	1.0	.642
MCA39 - I am capable of utilizing culture specific developmental models in my clinical practice	1.0	.712
MCA40 - I can modify therapeutic strategies to honor the cultural identities of clients	1.0	.739
MCA41 - I am able to articulate how cultural group membership impacts the lives of clients	1.0	.698
MCA42 - I can convey the beliefs of my own cultural groups to my clients	1.0	.516
MCA43 - I can identify how my cultural identity impacts the therapeutic process	1.0	.669
MCA44- I can identify the limitations of assessment items based upon word usage	1.0	.529
MCA45 - I can modify therapeutic interventions to meet the cultural needs of my clients	1.0	.743

Communalities	Initial	Extraction (h^2)
MCA46 - I can recognize that my beliefs may create clinical limitations when working with clients	1.0	.648
MCA47 - I am capable of utilizing culturally affirming language during client engagement	1.0	.559
MCA48 - I can identify cultural apprehension in clients seeking mental health services	1.0	.566
MCA49 - I can identify when clients from marginalized cultural groups experience the world differently than dominant cultural groups	1.0	.593
MCA50 - I am capable of creating emotional safety within the therapeutic relationship for my clients	1.0	.771

Note. *low communalities

Table 7

Eigenvalues for Data One Initial MCA Items

Component or Factor	Mean Eigenvalues (PA)	Initial MCA Eigenvalues	Rotation of Sums of Squared Loadings
1	1.743625	22.327	8.660
2	1.672530	2.195	7.811
3	1.619738	1.584*	4.566
4	1.571251	1.545*	2.958
5	1.529978	1.367*	2.640
6	1.492646	1.160*	2.419
7	1.454296	1.032*	2.156

Note. *low eigenvalues
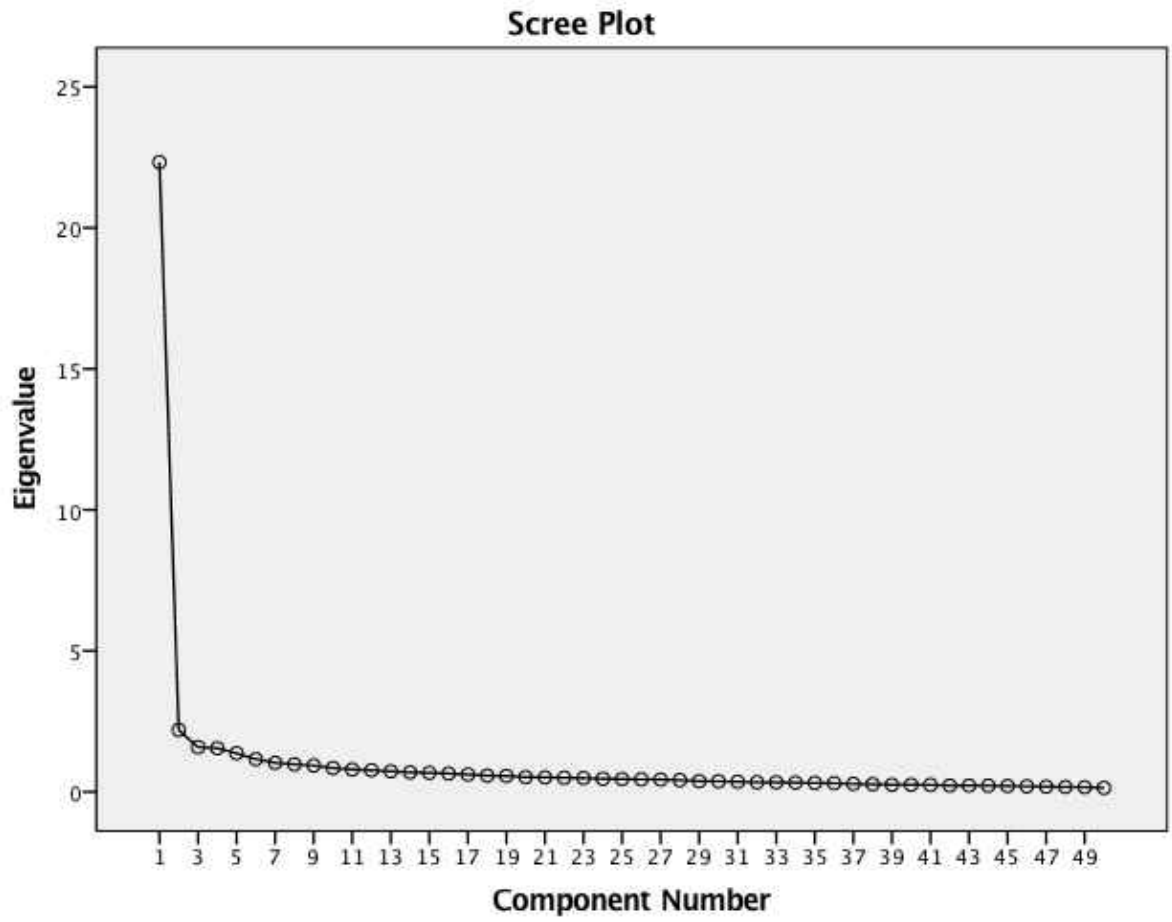
Figure 4: Scree Plot for Data One Initial MCA Items

Table 8

Exploratory Factor Analysis of Data One Initial MCA Items

Items	Factors							Comm.
	1	2	3	4	5	6	7	
MCA39	.738							.712
MCA40	.674							.739
MCA29	.655							.650
MCA18	.640							.680
MCA17	.610							.645
MCA36	.607							.627
MCA45	.604							.743
MCA31	.599							.674
MCA41	.598							.698
MCA10	.597							.613
MCA23	.570*							.662
MCA21	.564*							.594
MCA19	.547							.637
MCA15	.539*							.662
MCA20	.509*							.638
MCA47	.497*							.559
MCA16	.494*							.587
MCA48	.475*							.566
MCA30	.468							.621
MCA43		.725						.669
MCA35		.707						.611
MCA46		.684						.648
MCA33		.577						.653
MCA49		.570						.593
MCA34		.552*						.621
MCA32		.542						.693
MCA13		.513						.602
MCA25		.509*						.649
MCA27		.501*						.490
MCA42		.493						.516
MCA44		.490*						.529
MCA28		.475						.597
MCA24		.430*						.571
MCA6			.716					.684
MCA3			.609					.652
MCA1			.581					.610
MCA5			.482					.533
MCA7			.472*					.591

	Factors							
Items	1	2	3	4	5	6	7	Comm.
MCA14			.447					.576
MCA8			.423*					.343
MCA11				.773				.716
MCA22				.537				.642
MCA12				.498*				.666
MCA37					.663*			.570
MCA38					.660*			.642
MCA26					.497*			.570
MCA9						.711*		.645
MCA4						.500		.498
MCA50							.768*	.771
MCA2							.761*	.752
Eigenvalue	8.660	7.811	4.566	2.958	2.640	2.419	2.156	
Variance (%)	17.321	15.622	9.132	5.916	5.279	4.838	4.311	

Note. *removal of cross loadings

After the researcher reviewed the aforementioned stepwise process to develop a final exploratory MCA model; the researcher was left with the optimized 25-item MCA. Since the first dataset has already met parametric assumptions, the final EFA model yielded a KMO index of .952 and statistical significance ($x^2 = 6167.727$, $df = 300$, $p < .001$) for Bartlett's test of sphericity, thus according statistical assumptions, the final exploratory MCA model was considered appropriate for FA. With use of both PA and PCA as extraction methods and a varimax with Kaiser normalization as the rotation method, the final exploratory MCA model yielded communality values greater than .5, which is presented within Table 4.

Furthermore, the final exploratory model was reviewed to ensure all items with significant cross-loadings (.30 or higher) were removed, item communality loadings were all moderate to strong (e.g., .50 -.70) across factor loadings, eigenvalues per factor yielded at least the met the minimum criteria, with the exception of factors 3 and 4 (as displayed in table 10) which were slightly below the eigenvalues produced from data one and were

imperative in upholding the theoretical framework (DeVellis, 2017), and the only factors retained were located above the slight break between factors 4 and 5 as per *figure 5*. Through the aforementioned stepwise process, the researcher identified a four-factor structure in the final exploratory MCA model, accounting for 64.108% of the total variance, yielding practical significance within social science research (Hair et al., 2010). Specifically, Factor one represents *Knowledge, Skills, and Interventions* and accounted for 21.857% of the variance, Factor two represents *Awareness of Self* and accounted for 19.268% of the variance, Factor three represents *Awareness of Client Worldview* and accounted for 11.950% of the variance, and Factor four represents *System and Institutional Structures* and accounted for 11.033% of the variance.

Table 9

Communality Values for Final Exploratory MCA Model

Communalities	Initial	Extraction (h^2)
MCA1- I can identify how clients' beliefs affect the therapeutic process	1.0	.665
MCA3 - I am able to recognize clients' cultural expectations of the therapeutic process	1.0	.669
MCA5 - I can initiate discussions about cultural mores (e.g., roles, expectations) when working with clients	1.0	.543
MCA6 - I am able to identify barriers that may impede clients' access to mental health services	1.0	.619
MCA10 - I can describe the elements of culture specific (e.g., faith, sexual orientation, race) developmental models during clinical practice	1.0	.585
MCA11- I can explain the implications of privilege as they relate to my clinical practice	1.0	.688
MCA13 - I can identify how my principles impact the therapeutic process	1.0	.554
MCA17 - I can integrate clients' cultural heritage when implementing therapeutic techniques	1.0	.616
MCA18 - I am capable of connecting clients with culture specific resources	1.0	.663
MCA22 - I am able to initiate dialogue about how socio-political issues relate to my clients' mental health	1.0	.607
MCA28 - I can identify which beliefs are most important to my clients	1.0	.566
MCA29 - I am able to conceptualize clients through culture specific developmental models in clinical practice	1.0	.608
MCA31- I can tailor therapeutic approaches based upon clients' cultural beliefs	1.0	.626
MCA32 - I can identify how privilege may influence the therapeutic relationship	1.0	.725
MCA33 - I can recognize how societal mistreatment of my clients may impact their self-esteem	1.0	.660
MCA35 - I am able to recognize how my values may interfere with providing clients with therapeutic services	1.0	.662
MCA36 - I can identify culturally appropriate resources for my clients	1.0	.663
MCA39 - I am capable of utilizing culture specific developmental models in my clinical practice	1.0	.697
MCA40 - I can modify therapeutic strategies to honor the cultural identities of clients	1.0	.742
MCA41 - I am able to articulate how cultural group membership impacts the lives of clients	1.0	.697
MCA42 - I can convey the beliefs of my own cultural groups to my clients	1.0	.518
MCA43 - I can identify how my cultural identity impacts the therapeutic process	1.0	.682
MCA45 - I can modify therapeutic interventions to meet the cultural needs of my clients	1.0	.738

Communalities	Initial	Extraction (h^2)
MCA46 - I can recognize that my beliefs may create clinical limitations when working with clients	1.0	.666
MCA49 - I can identify when clients from marginalized cultural groups experience the world differently than dominant cultural groups	1.0	.569

Table 10

Eigenvalues for Final Exploratory MCA Model

Component or Factor	Mean Eigenvalues (PA)	Final MCA Eigenvalues	Rotation of Sums of Squared Loadings
1	1.482584	12.014	5.464
2	1.405682	1.763	4.817
3	1.347407	1.161*	2.987
4	1.297180	1.089*	2.758

Note. *low eigenvalues
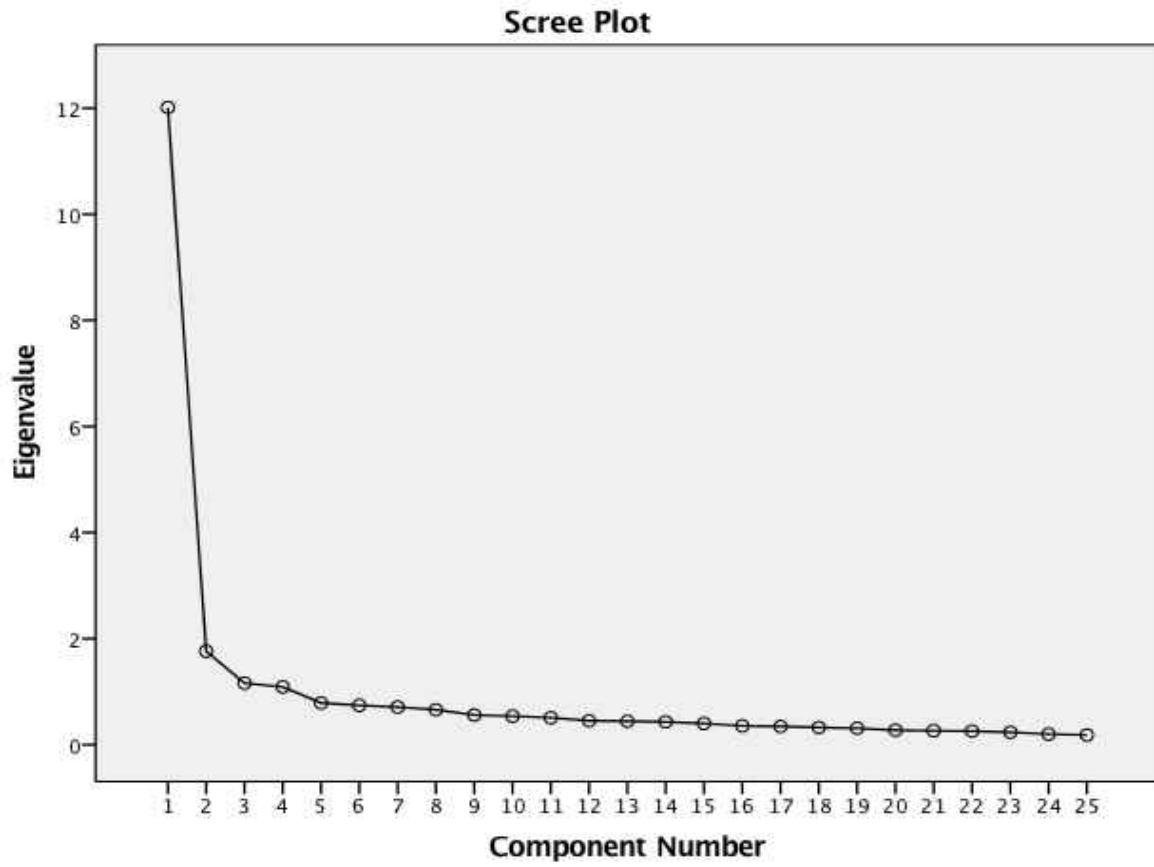
Figure 5: Scree Plot for Final Exploratory MCA Model

Table 11

Exploratory Factor Analysis of Final Exploratory MCA Model

	Factor				
Items	1	2	3	4	Comm.
MCA39	.765				.697
MCA18	.736				.663
MCA36	.726				.663
MCA40	.703				.742
MCA45	.646				.738
MCA29	.642				.608
MCA10	.636				.585
MCA41	.624				.697
MCA17	.585				.616
MCA31	.567				.626
MCA35		.746			.662
MCA43		.744			.682
MCA46		.725			.666
MCA13		.560			.554
MCA42		.548			.518
MCA28		.538			.566
MCA6			.680		.619
MCA1			.674		.665
MCA3			.670		.669
MCA5			.557		.543
MCA11				.758	.688
MCA32				.645	.725
MCA22				.595	.607
MCA33				.565	.660
MCA49				.495	.569
Eigenvalue	5.464	4.817	2.987	2.758	
Variance (%)	21.857	19.268	11.950	11.033	

For data two, the researcher used CFA with the 25-item MCA scores ($N = 233$) to test the assessment through the elimination of items. Prior to conducting CFA, statistical assumptions were evaluated in order to assess if the data was suitable for FA. Similar to the first dataset, parametric assumptions were assessed which included: (a) sampling adequacy, (b) normality, (c) multicollinearity, and (d) linearity. With a sample of 233 participants for

data two and 25 scale items, a participant/item (N:p) ratio of approximately 9:1 was obtained. Although, CFA sample size recommendations fall between 250 to 500 participants (Schumacher & Lomax, 2010); however, smaller sample sizes have been found to be adequate in conducting FA (Mvududu & Sink, 2013). Specifically, factor analytic solution elements (e.g., commonalities, over- under- factoring) are imperative in the determination of adequate sample size. High (> .80) commonalities, low cross factor loadings (< .32), and moderate to high (> .50) factor loadings allows for smaller sample sizes (Mvududu & Sink, 2013). Within the present sample, (a) all commonalities (with the exception of MCA 5) yielded commonalities between the ranges of .50 - .789, (b) the majority (> 15) of items yielded low cross factor loadings, and (c) all (with the exception of 3 items) yielded moderate to high factor loadings. Thus, an adequate sample size for the use of FA.

The assumption of normality indicated that data two initial MCA data was not normally distributed. Normality (e.g., univariate level, multivariate level) was evaluated through the assessment of (a) Skewness and Kurtosis scores, (b) Shapiro-Wilk values, (c) Q-Q Plots, (d) P-P Plots, and (e) Histograms. The researcher reviewed the second dataset for missing values, exceeding 5% on the univariate level, suggesting the dataset failed to meet the assumption of normality. Upon further examination, the data two values were missing at random. Therefore, the researcher utilized multiple imputation with a Statistical Analysis System (SAS) code in SPSS to replace missing values within the second dataset.

After the researcher addressed the missing values within the second dataset through multiple imputation, further evaluation of statistical assumptions commenced. The researcher evaluated the skewness and kurtosis of the second dataset; at which time dataset two from the

25-item MCA assessment yielded skewness values that ranged from -1.299 [MCA15] to -.274 [MCA18] and the MCA Total Score yielding a skewness value of -.584; kurtosis values, on the other hand ranged from -.295 [MCA11] to 2.471 [MCA15] and the MCA total score yielding a kurtosis value of .888. Although individual variance was found among MCA items, overall the 25-item MCA (e.g., MCA total score) did not meet the assumption of normality as the scores were negatively skewed.

Further analysis of Shapiro-Wilks values identified significant results ($p < .05$) for all MCA items (including the MCA total score), suggesting a violation of normality (Pallant, 2007). After the examination of histograms from each MCA item and the MCA total score, the item data plots suggested non-normality of data (e.g., plots did not follow a bell curved shape peaking in the center of the image). In addition, the P-P and Q-Q plots suggested the same conclusion of varying normality amongst individual items; however, the MCA total score yielded normal data. Further examples (e.g., MCA total score) of normality can be found in figures 6, 7, and 8. In checking the assumption of multicollinearity, the researcher reviewed tolerance and VIF values. Items were not removed based upon high inter-correlation and the assumption of multicollinearity was not violated in the second dataset. Finally, to assess for linearity, the researcher reviewed and assessed the associations between variables through scatterplots of the MCA items. Evidence of patterns resembling nonlinear relationships between variables were identified. Thus, the assumption of linearity was met within the second dataset.

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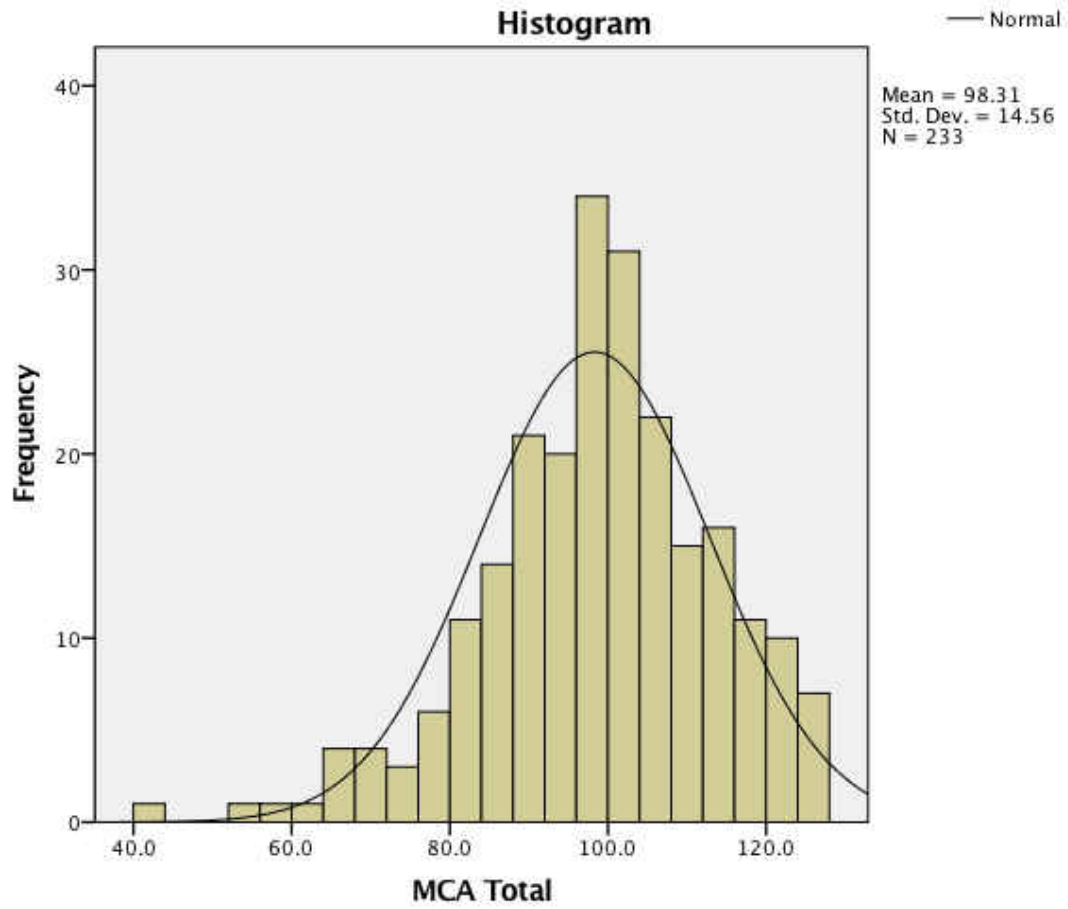
Figure 6: Data Two MCA Total Score Histogram
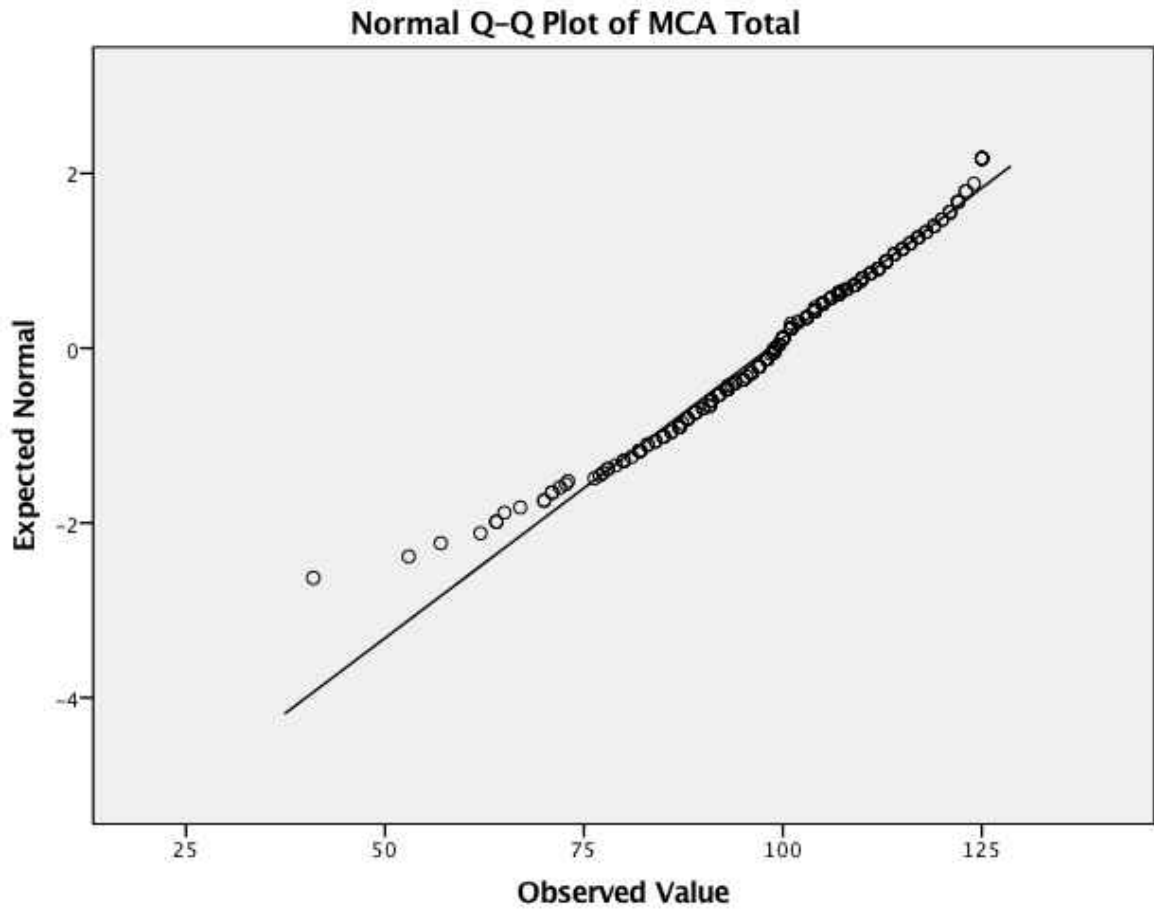
Figure 7: Data Two MCA Total Score P-P Plot
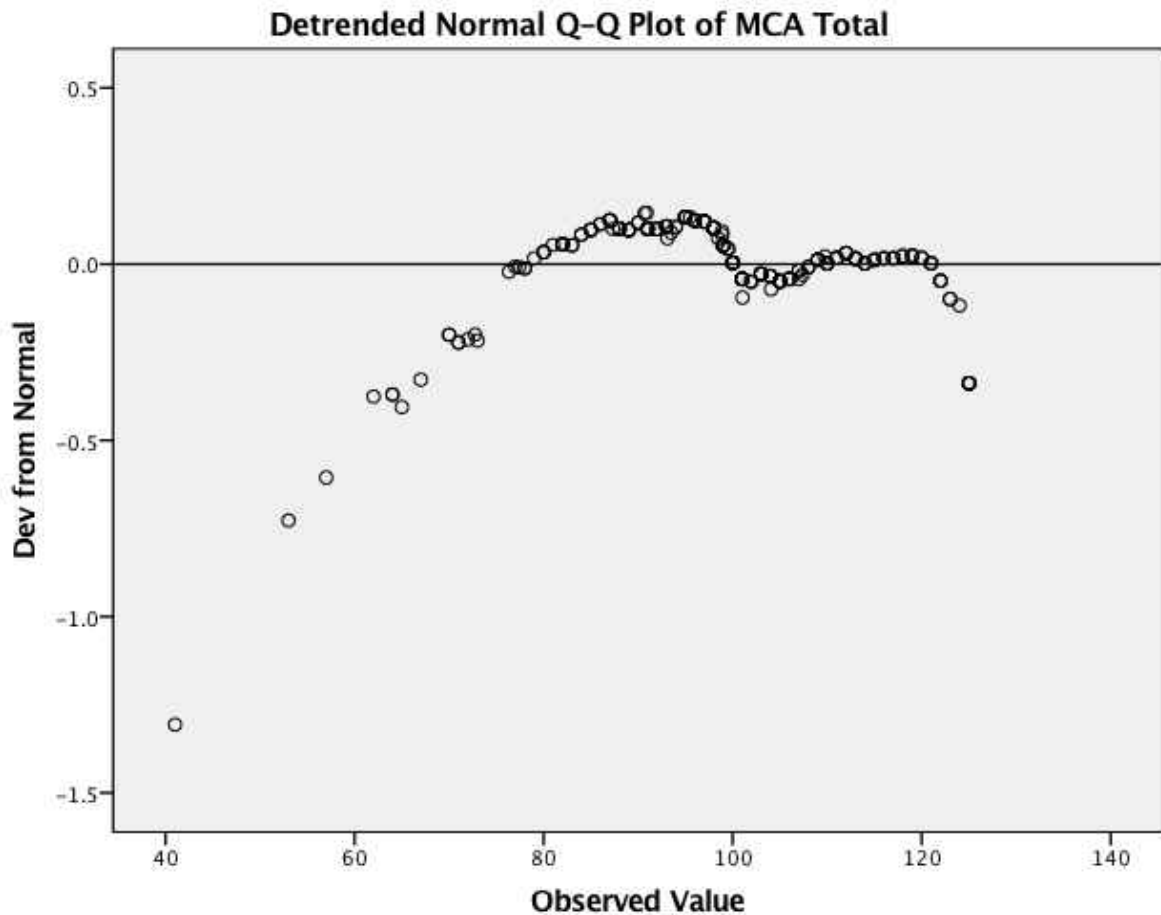
Figure 8: Data Two MCA Total Score Q-Q Plot

After checking the assumptions of the second MCA dataset, the researcher utilized a combination of scholars' step-wise process in conducting the CFA analysis (Brown, 2015; Hair, et al., 2006; Lewis, 2017; Schumacher & Lomax, 2010). Therefore, the specific CFA steps were employed: (a) model specification, (b) model identification, (c) model estimation, (d) model testing, and (e) model modification.

Step 1: Model Specification.

Initial steps in conducting a CFA necessitates the specification of the model structure. In the development of such a model, thorough knowledge of the theoretical framework and previous research is needed as one justifies the hypothesized relationships within the model (Lewis, 2017; Schumacher & Lomax, 2010). Based on a thorough review of the literature, and the results of the EFA within data one; the researcher used both the CFA model to further collect evidence of construct validity of MCA scores. The model specification step involved a clear determination of latent variables, as well as, how and if they were correlated (DeVellis, 2017; Lewis, 2017). In this way, the researcher considered theory and the EFA results to determine the correlation between the four latent factors (e.g., knowledge, skills, and interventions [KSI]; awareness of self [AS]; awareness of client worldview [ACW]; and Systemic and Institutional Structures [SIS]).

Step 2: Model Identification.

In determining if the model was identified, the researcher specified the number of free parameters to be estimated (e.g., factor loadings, measurement of error terms, pathway analysis/correlations among latent factors) within the model (Lewis, 2017). Moreover, scholars note that at least three to four observed variables (items) load onto each identified latent construct in an effort to increase probability of an overidentified model (Hair et al., 2006; Lewis, 2017). An overidentified model necessitates the degrees of freedom exceed the free parameters within the model structure (Hair et al., 2006; Lewis, 2017). Within the current CFA model, there were a total of 85 free parameters to be estimated. In particular, 25

factor loadings (relationships between individual MCA items among the four MCA factors), 25 measurement errors, 0 measurement error covariances, and 6 correlations among latent variables (four factors [KSI, AS, ACW, SIB]).

Step 3: Model Estimation.

Following model identification, the researcher choose the method by which the parameters would be measured. The most common method of estimation (fitting function) in CFA is maximum likelihood (ML; Brown, 2015), which was used in the present investigation. Prior to the use of ML, the researcher ensured the second dataset met assumptions, including: (a) large sample size, (b) continuous scale of measurement, and (c) normal data on the multivariate level. All of the aforementioned assumptions were vetted and met prior to identifying a CFA model estimation method.

Step 4: Model Testing.

When testing a CFA model, it is imperative to assess the chi-square (χ^2) as it can assist in identifying the feasibility of the theoretical model (Lewis, 2017). When assessing model fit researchers hope to identify non-statistically significant chi-squared values ($p >$ .05); such a value affirms the dataset and the specified model are not distinctive from one another (Lewis, 2017). In addition, an analysis of the following indexes are often examined: (a) absolute fit indexes (e.g., root mean square error of approximation [RMSEA]), (b) parsimony-adjusted indexes (e.g., goodness-of-fit index [GFI], parsimony of goodness-of-fit index [PGFI]), and (c) incremental fit indexes (e.g., normed fit index [NFI], comparative fit index [CFI]).

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Specifically, the absolute fit indexes are used to assess the differences between the researcher's dataset and the theoretical model fit (Hair et al., 2006). When using the RMSEA to assess the absolute fit indexes, values less than .05 indicate good model fit and values less than .08 indicate acceptable model fit (Hu & Bentler, 1999; Sivo, Fan, Witta, & Willse, 2006). On the other hand, parsimony-adjusted indexes are used to correct for model complexity and sample size. In essence, parsimony-adjusted indexes assess for least complex and most simple model. Both GFI and PGFI values range from 0 to 1, with values closer to 1 indicating better fit and parsimony within the scale (Hair et al., 2006). Given a moderate sample size ($N = 233$), optimal index cut-off values of .93 for GFI and .75 for PGFI were used to assess the model (Sivo et al., 2006). Lastly, incremental (comparative) fit indexes are used to compare the predicted model with a restricted baseline model, which typically sets all correlations and observed variables at zero (Brown, 2015; Hair et al., 2006). Both NFI and CFI are used to measure incremental fit indexes. NFI values range from 0 to 1 with values closer to 1 identifying better model fit. Specifically, NFI ranges between .90 to .95 is considered good model fit (Lewis, 2017; Sivo et al., 2006). Similarly, CFI also measures incremental fit indexes; however, it is the most commonly used incremental fit indexes. An improvement from NFI, CFI values above .90 signify good model fit (Lewis, 2017; Sivo et al., 2006). Within the initial CFA structure of MCA Model, the model fit indices yielded some challenging index values, $\chi^2 (270) = 804.469$; $p < .001$; GFI = .786; PGFI = .653; NFI = .803; CFI = .859; RMSEA = .092 (90% confidence interval (CI) = .085-.100). The initial confirmatory MCA model yielded factor loadings greater than .5, which can be explored in more detail within Figure 9.
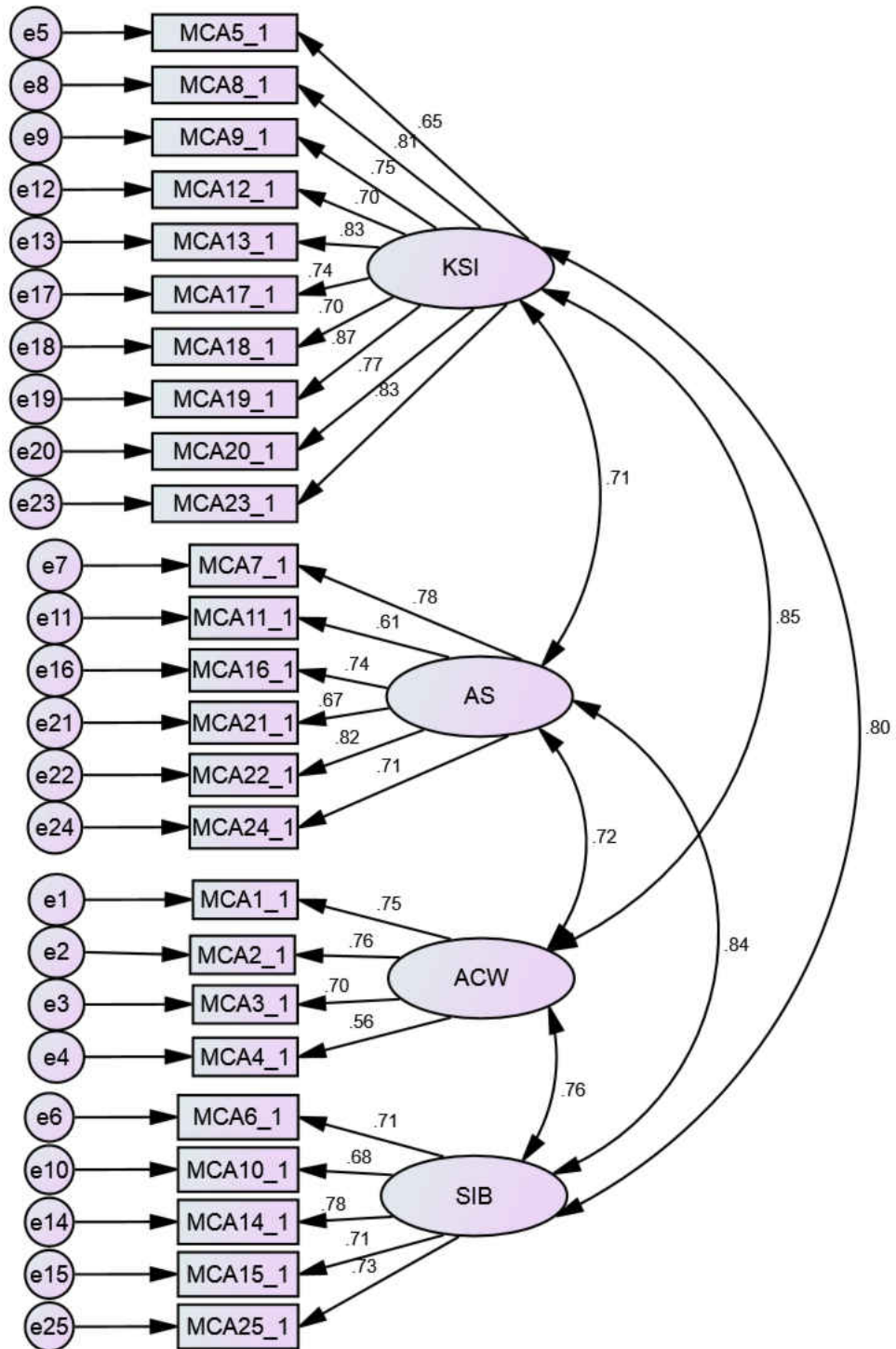
Figure 9: Initial Confirmatory Factor Analysis Structure of MCA Model

Step 5: Model Modification.

Since original model fit may yield poor model fit indices, options such as, specifying paths between errors terms, are used to improve model fit (Lewis, 2017). The modification of CFA models is debated; however, most criticisms arise when model pathways are eliminated, which compromises construct validity and the underlying theoretical framework (Bandalous & Finnery, 2010; Lewis, 2017). Therefore, after a review of the initial CFA structure model fit indices and standardized residual values (Madson, Mohn, Schumacher, & Landry, 2015), the researcher discovered seven significant (modification index [MI] greater than 10) measurement error covariances (e.g., e22 & e11; e24 & e22; e14 & e6; e18 & e12; e18 & e17; e23 & e22; e23 & e19). The researcher then modified the model identification to reflect a CFA model that has a total of 92 free parameters to be estimated. The new model included 25 factor loadings (relationships between individual MCA items among the four MCA factors), 25 measurement errors, 7 measurement error covariances, and 6 correlations among latent variables (four factors [KSI, AS, ACW, SIS]). Within the final CFA structure of MCA Model, the model fit indices yielded acceptable index values, χ^2 (263) = 573.449; p < .001; GFI = .841; PGFI = .680; NFI = .860; CFI = .918; RMSEA = .071 (90% confidence interval (CI) = .063-.79). The final confirmatory MCA model produced factor loadings greater than .5, which are presented within Figure 10.
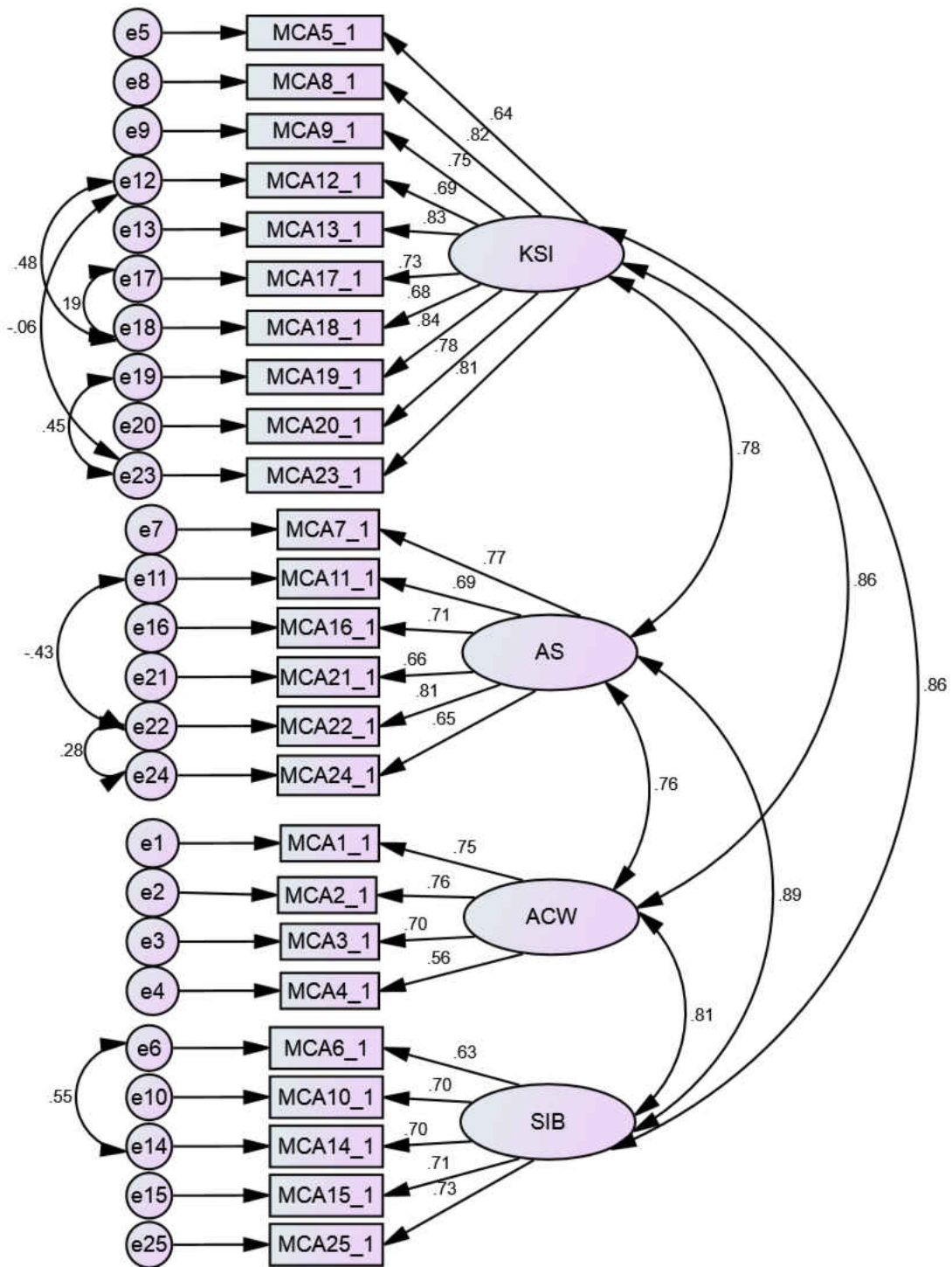
Figure 10: Final Confirmatory Factor Analysis Structure of MCA Model

Research Question 2

For research question 2, the researcher computed Cronbach's alpha (α) to assess the internal consistency reliability of the MCA data for both data one and data two. Cronbach's coefficient alpha value ranges from 0 to 1, with values closer to 0 denoting lower reliability and values closer to 1 representing higher reliability (DeVellis, 2017; Streiner, 2003). In essence, Cronbach's α equals 1 – the error of variance; in this way, a higher Cronbach α value suggests less error among the relationship between scale items and the latent variable (DeVellis, 2017). Within the present research investigation, the researcher used a Cronbach's α value of .70 to indicate adequate internal consistency of assessment items (Streiner, 2003). Cronbach's α were calculated for the initial (50-items) MCA items ($N = 407$), the final exploratory MCA model (25-items), and for each individual factor that comprises the final exploratory MCA model within dataset one.

The Cronbach's α value for the initial 50-items ($N = 407$) was calculated as .973. While this reliability coefficient appears to yield high reliability for the initial MCA model, internal consistency reliability via Cronbach's α is strongly affected by scale length (Streiner, 2003). In this way, scales with more items yield higher reliability when using Cronbach's α values. The Cronbach's α value for the revised 25-item MCA ($N = 407$) was .953. For Factor One, *Knowledge, Skills, and Interventions*, the Cronbach's α value was .927; Factor Two, *Awareness of Self*, the Cronbach's α value was .867; Factor Three, *Awareness of Client Worldview,* the Cronbach's α value was .811; and Factor Four, *System and Institutional Structures*, the Cronbach's α value was .839. Thus, Cronbach's α values for factors 2, 3, and

4 yielded values for above the recommended .70 value, indicating a strong internal consistency. However, the MCA total score and factor 1 yielded Cronbach's α values greater than .90, indicating redundancy in items (Streiner, 2003). Nevertheless overall the 25-item MCA model yielded strong internal consistency. Table 7 displays the measures of central tendencies for the MCA model.

Table 12

Final Exploratory MCA Model Measures of Central Tendencies

Item	(*M*)	*SD*	Range	*Mdn*	Mode
MCA39	3.44	1.000	4.00	4.00	4.00
MCA18	3.52	1.017	4.00	4.00	3.00
MCA36	3.66	.926	4.00	4.00	4.00
MCA40	3.89	.889	4.00	4.00	4.00
MCA45	3.89	.830	4.00	4.00	4.00
MCA29	3.34	.920	3.00	4.00	4.00
MCA10	3.55	1.017	4.00	4.00	4.00
MCA41	3.90	.841	4.00	4.00	4.00
MCA17	3.65	.926	4.00	4.00	4.00
MCA31	3.84	.884	4.00	4.00	4.00
MCA35	4.25	.673	3.00	4.00	4.00
MCA43	4.23	.720	3.00	4.00	4.00
MCA46	4.26	.685	3.00	4.00	4.00
MCA13	4.33	.654	3.00	4.00	4.00
MCA42	4.02	.850	4.00	4.00	4.00
MCA28	4.11	.673	3.00	4.00	4.00
MCA6	4.11	.851	4.00	4.00	4.00
MCA1	3.97	.755	3.00	4.00	4.00
MCA3	3.70	.813	4.00	4.00	4.00
MCA5	4.08	.836	4.00	4.00	4.00
MCA11	3.97	.827	4.00	4.00	4.00
MCA32	4.16	.773	4.00	4.00	4.00
MCA22	3.77	.983	4.00	4.00	4.00
MCA33	4.43	.669	3.00	5.00	5.00
MCA49	4.13	.798	4.00	4.00	4.00

Furthermore, the Cronbach's α value was calculated for the 25-items ($N = 233$) among data two participants, which was calculated as .954. For Factor One, *Knowledge, Skills, and Interventions*, the Cronbach's α value was .931; Factor Two, *Awareness of Self*, the Cronbach's α value was .854; Factor Three, *Awareness of Client Worldview,* the Cronbach's α value was .779; and Factor Four, *System and Institutional Structures*, the Cronbach's α value was .834. Similar to the reliability coefficients among data one participants, Cronbach's α factors 2, 3, and 4 values within data two yielded values above the recommended .70 value and the MCA total score and factor 1 yielded Cronbach's α values greater than .90, indicating item redundancy (Streiner, 2003). However, strong internal consistency reliability was displayed in the 25-item MCA model.

<u>Research Question 3</u>

For research question 3, a Spearman Rho Correlation was used to assess the correlation between the final confirmatory MCA scores with the second ($N = 233$) dataset and a social desirability assessment (MCSDS-X1, Strahan & Gerbasi, 1979). Utilizing a total score of 5 or less as a cut-off, 54.9% of respondents ($M = 5.14$, $SD = 2.23$) yielded scores that suggested limited social desirability in their responses. Therefore, more than half of the participants within the data two did not identify items in a socially desirable manner. The researcher utilized Spearman Rho Correlation to analyze the MCSDS-X1 total score with the final confirmatory MCA model total scores.

Initial steps included the assumption checking of (a) homoscedasticity, (b) linearity, and (c) normality of the dataset. Non-normality was identified prior to EFA and CFA analysis; hence, the use of a Spearman Rho Correlation. In an effort to examine homoscedasticity, the researcher generated a scatterplot, which resulted in a variety of horizontal straight lines across the graph for data one and random distribution of responses for the second dataset. Within the depicted image, within data two the assumptions of homoscedasticity and linearity were both met (Pallant, 2003).

The researcher examined the relationship between the items on the MCA ($N = 233$) and the MCSDS-X1 scores (Strahan & Gerbasi, 1979), which is displayed in table 8. The results identified the MCA and MCSDS-X1 total scores did yield a statistically significant relationship ($r = .263$; $p < .001$; 6.92% variance explained). Specifically, subscale correlations identified similar results as evidenced by: Subscale 1 ($r = .277$; $p < .001$; 7.67% variance explained); Subscale 2 ($r = .268$; $p < .001$; 7.18% variance explained), Subscale 3 ($r = .176$; $p < .001$; 3.10% variance explained), and Subscale 4 ($r = .187$; $p < .001$; 3.50% variance explained). These results identified a correlation between social desirability and multicultural competence as measured by MCA among data two participants.

Table 13

Correlations between MCA and MCSDS-X1

	Subscale 1 *Knowledge, Skills, and Interventions*	Subscale 2 *Awareness of Self*	Subscale 3 *Awareness of Client Worldview*	Subscale 4 *Systemic and Institutional Structures*	MCA Total Score
Data 2: MCSDS-X1 Total Score	.277*	.268*	.176*	.187*	.263*

Note. *p* < .001

Research Question 4

For research question 4, a Spearman Rho Correlation was used to assess the correlation between the final confirmatory MCA scores with data two (*N* = 233) and a multicultural competency assessment (MCSE-RD, Sheu & Lent, 2007). Utilizing a total score of 6 or more as a cut-off (indicating proficiency in multicultural counseling), 88% of respondents (*M* = 7.140, *SD* = 1.04) yielded scores suggesting high multicultural competence in the majority of responses. Therefore, more than half of the participants within data two provided responses that indicate high multicultural competence as measured by the MCSE-RD. The researcher utilized Spearman Rho Correlation to analyze the MCSES-RD total score and subscales (e.g., subscale 1 [*Multicultural Intervention*], subscale 2 [*Multicultural Assessment*], subscale 3 [*Multicultural Counseling Session Management*]) with the final confirmatory MCA model total score and subscales (e.g., subscale 1 [*Knowledge, Skills, and Interventions*], subscale 2 [*Awareness of Self*], subscale 3 [*Awareness of Client Worldview*], subscale 4 [*Systemic and Institutional Structures*]).

Initial steps in the assessing statistical correlation included the assumption checking of (a) homoscedasticity, (b) linearity, and (c) normality of the dataset. Non-normality was identified prior to EFA and CFA analysis; thus, the use of a Spearman Rho Correlation. To examine homoscedasticity, the researcher generated a scatterplot, which resulted in random distribution of responses among data two. Hence the researcher concluded given the depicted image, the assumption of homoscedasticity and the assumption for linearity were both met (Pallant, 2003).

The researcher examined the relationship between the items on the MCA ($N = 233$) and the MCSES-RD (Sheu & Lent, 2007) using a Spearman Rho Correlation. Displayed in table 9, the results identified the MCA and MCSES-RD total scores yielded statistically significant relationship ($r = .746$; $p < .001$; 55.61% variance explained). Specifically, MCA subscale correlations with the MCSES-RD total score identified similar results as evidenced by: MCA Subscale 1 ($r = .723$, $p < .001$; 52.27% variance explained); MCA Subscale 2 ($r = .603$, $p < .001$; 36.36% variance explained), MCA Subscale 3 ($r = .626$, $p < .001$; 39.19% variance explained), and MCA Subscale 4 ($r = .574$, $p < .001$; 32.95% variance explained). Furthermore, the results identified the MCSES-RD subscale 1 (*Multicultural Intervention*) and the MCA total score yielded statistically significant relationship ($r = .739$, $p < .001$; 54.61% variance explained). In addition, MCA subscale correlations with the MCSES-RD subscale 1 identified similar results: subscale 1 ($r = .698$; $p < .001$; 48.72% variance explained); subscale 2 ($r = .620$; $p < .001$; 38.44% variance explained), subscale 3 ($r = .632$; $p < .001$; 39.94% variance explained), and subscale 4 ($r = .587$; $p < .001$; 34.46% variance explained).

Furthermore, the results identified the MCSES-RD subscale 2 (*Multicultural Assessment*) and the MCA total score yielded statistically significant relationship ($r = .579$, $p < .001$; 33.52% variance explained). MCA subscale correlations with the MCSES-RD subscale 2 revealed similar results which include: subscale 1 ($r = .626$, $p < .001$; 39.19% variance explained); subscale 2 ($r = .390$, $p < .001$; 15.21% variance explained), subscale 3 ($r = .430$, $p < .001$; 18.49% variance explained), and subscale 4 ($r = .404$, $p < .001$; 16.32% variance explained). Lastly, the MCSES-RD subscale 3 (*Multicultural Counseling Session Management*) and the MCA total score yielded statistically significant relationship ($r = .637$, $p < .001$; 41.58% variance explained). Likewise, MCA subscale correlations with the MCSES-RD subscale 3 revealed similar outcomes: subscale 1 ($r = .584$, $p < .001$; 34.11% variance explained); subscale 2 ($r = .590$, $p < .001$; 34.81% variance explained), subscale 3 ($r = .602$, $p < .001$; 36.24% variance explained), and subscale 4 ($r = .487$, $p < .001$; 23.72% variance explained). These results identified positive correlations between multicultural competence as measured by MCSES-RD and multicultural competence as measured by MCA among data two participants.

Table 14

Correlations between MCA and MCSES-RD

	Subscale 1 *Knowledge, Skills, and Interventions*	Subscale 2 *Awareness of Self*	Subscale 3 *Awareness of Client Worldview*	Subscale 4 *Systemic and Institutional Structures*	MCA Total Score
MCSES-RD Total Score	.723*	.603*	.626*	.574*	.746*
Subscale 1 *Multicultural Intervention*	.698*	.620*	.632*	.587*	.739*
Subscale 2 *Multicultural Assessment*	.626*	.390*	.430*	.404*	.579*
Subscale 3 *Multicultural Counseling Session Management*	.584*	.590*	.602*	.487*	.637*

Note. *p < .001

For research question 5, the researcher used an one-way multivariate analysis of variance (MANOVA) to test the combined MCA subscale scores among each participant demographic characteristic (e.g., professional field, primary work setting, gender, race/ethnicity, and highest level of education) individually. The researcher then used an one-way ANOVA and to examine the differences of means between the final exploratory MCA scores (e.g., total score, statistically significant combined subscales) with the data two ($N = 233$) responses and the groups of participant demographic characteristics (e.g., professional field, primary work setting, gender, race/ethnicity, and highest level of education). The researcher utilized a Spearman Rho Correlation to examine the relationships between the MCA scores (total and subscales) and age. Within data two, 221 (90.2%%) participants completed the general demographic question 1 (professional field), 223 (91%) participants completed the general demographic question 2 (primary work setting), 225 (91.8%) participants completed the general demographic question 3 (gender), 224 (91.4%) participants completed the general demographic question 4 (age), and 226 (92.2%) participants completed the general demographic question 5 (race/ethnicity) during the current research investigation. The researcher utilized a one-way MANOVA and if values were found to be statistically significant followed up with an one-way ANOVA to analyze the general demographic characteristics with data two participants.

Initial steps included the assumption checking of: (a) sample size, (b) normality, (c) outliers, (d) linearity, (e) homogeneity of regression, (f) multicollinearity and singularity, and (g) homogeneity of variance-covariance matrices of the second ($N = 233$) dataset. First the

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researcher checked to ensure the dataset met the minimum sample size, which demands there are more cases per cell than dependent variables (Pallant, 2007). Since there are a total of four subscales, the researcher examined the dataset set to ensure a minimum of four cases were present which was met.

Next the researcher, examined the assumption of normality. Utilizing a sample size of at least 20 cases per cell (Tabacknick & Fidell, 2001), the researcher tested the dataset for both univariate and multivariate normality. Non-normality was identified through a series of visual inspection and statistical analysis (e.g., KMO values, skewness and kurtosis, Shapiro-Wilk values, Histograms); hence, the use of a Spearman Rho Correlation; however, a one-way MANOVA and a one-way ANOVA were used based upon the robustness of the tests. MANOVA is sensitive to outliers; thus, the need to examine univariate and multivariate outliers (Pallant, 2007). Upon the inspection of boxplots, the researcher identified 12 univariate outliers among the demographic characteristics (Pallant, 2007); however, the researcher ran the analyses both with and without the outliers and found no statistical difference between the results. Thus, in an effort to maintain generalizability among the population, the researcher retained the full sample of 233 participants in the following analyses.

The researcher then reviewed the assumption of linearity, which required the examination of scatterplots for each of dependent variables in hopes of identifying a straight-line relationship (Pallant, 2007). After a review of scatterplots, the researcher concluded the assumption of linearity was met by all demographic characteristics with the exception of professional field (Not Counseling), gender (Male), and race/ethnicity (Not

White/Caucasian). Thus, the aforementioned demographic characteristic categories violated the assumption of linearity. Next, the researcher reviewed the assumption multicollinearity and singularity. Utilizing correlation coefficients between .20 and .80 to indicate acceptable correlation (Watson, 2017), the second dataset met the assumption for multicollinearity.

Lastly, the assumption of homogeneity of variance-covariance matrices through the Box's M test of equality of covariance matrices. Violation of this assumption is displayed with statistical significance less than .001 (Pallant, 2007); the researcher uncovered no statistical violations among the demographic characteristics. For the use of a one-way MANOVA, Wilks' Lambda (Λ) is one of the most commonly reported multivariate tests of significance (Pallant, 2007); however, given some demographic characteristics (e.g., professional identity, race/ethnicity) only involved two group's the Hotelling's Trace was used. Therefore, both the Wilks' Λ and Hotelling's Trace were used in reporting statistical significant differences between MCA scores (Pallant, 2007; Tabacknick & Fidell, 2001).

The results among data two participants identified no statistically significant differences between professional field (Counseling, $n = 206$; $M = 98.60$, $SD = 13.86$; Not Counseling [e.g., social workers, psychologists], $n = 15$; $M = 103.50$, $SD = 12.46$) and the MCA total score $F(1, 219) = 1.78$, $p = .184$; partial $\eta^2 = .008$. The researcher then reviewed differences among the following subscales: (a) MCA Subscale 1 (Counseling, $n = 206$; $M = 36.615$, $SD = 7.01$; Not Counseling [e.g., social workers, psychologists], $n = 15$; $M = 40.03$, $SD = 5.80$), (b) MCA Subscale 2 (Counseling, $n = 206$; $M = 24.97$, $SD = 3.27$; Not Counseling [e.g., social workers, psychologists], $n = 15$; $M = 25.33$, $SD = 3.29$), (c) MCA Subscale 3 (Counseling, $n = 206$; $M = 16.30$, $SD = 2.25$; Not Counseling [e.g., social

workers, psychologists], n = 15; M = 16.80, SD = 2.65), and (d) MCA Subscale 4

(Counseling, n = 206; M = 20.71, SD = 3.19; Not Counseling [e.g., social workers,

psychologists], n = 15; M = 21.33, SD = 3.09). At this time, the researcher identified

differences between the professional fields (e.g., counseling, not counseling) on the

combined MCA subscales, which were not statistically significant F (4, 216) = 1.163, p =

.328; Hotelling's Trace = .022; partial η^2 = .021.

In addition, there are no statistically significant relationships between work setting

(Community, n = 167; M = 98.95, SD = 13.04; Not Community [e.g., school, hospital

university, correctional facility], n = 56; M = 97.12, SD = 15.50) and the MCA total score F

(1, 221) = .748, p = .388; partial η^2 = .003. The researcher then reviewed differences among

MCA following subscales, including: (a) MCA Subscale 1 (Community, n = 167; M = 36.75,

SD = 6.65; Not Community [e.g., school, hospital university, correctional facility], n = 56; M

= 36.43, SD = 7.70), (b) MCA Subscale 2 (Community, n = 167; M = 25.05, SD = 3.19; Not

Community [e.g., school, hospital university, correctional facility], n = 56; M = 24.55, SD =

3.42), (c) MCA Subscale 3 (Community, n = 167; M = 16.35, SD = 2.24; Not Community

[e.g., school, hospital university, correctional facility], n = 56; M = 15.95, SD = 2.40), and (d)

MCA Subscale 4 (Community, n = 167; M = 20.81, SD = 2.99; Not Community [e.g., school,

hospital university, correctional facility], n = 56; M = 20.20, SD = 3.68). Mean differences

were identified between the work setting (e.g., community, not community) on the combined

MCA subscales, F (4, 218) = .783, p = .538; Wilks' Λ = .986; partial η^2 = .014.

Similarly, there were no statistically significant relationships identified between

gender when using the gender binary (Female, n = 182; M = 98.90, SD = 14.56; Male, n =

39; $M = 96.13$, $SD = 11.74$) and the MCA total score $F (1, 219) = 1.24$, $p = .266$; partial $\eta^2 = .006$. The researcher then reviewed differences among MCA subscales: (a) MCA Subscale 1(Female, $n = 182$; $M = 36.87$, $SD = 7.11$; Male, $n = 39$; $M = 35.45$, $SD = 6.71$), (b) MCA Subscale 2 (Female, $n = 182$; $M = 25.03$, $SD = 3.36$; Male, $n = 39$; $M = 24.35$, $SD = 3.19$), (c) MCA Subscale 3 (Female, $n = 182$; $M = 16.29$, $SD = 2.41$; Male, $n = 39$; $M = 15.88$, $SD = 2.16$), and (d) MCA Subscale 4 (Female, $n = 182$; $M = 20.71$, $SD = 3.34$; Male, $n = 39$; $M = 20.45$, $SD = 2.67$). At this time the researcher identified the differences between the gender (e.g., female, male) on the combined MCA subscales was not statistically significant $F (4, 216) = 1.20$, $p = .597$; Hotelling's Trace $= .011$; partial $\eta^2 = .665$.

Statistically significant relationships were identified between the participants' reported race/ethnicity (White/Caucasian, $n = 182$; $M = 97.363$, $SD = 13.50$; Not White/Caucasian [e.g., American Indian, Alaska Native, Asian, Black/African American, Hispanic/Latinx, Multi-racial, Native Hawaiian/Pacific Islander], $n = 44$; $M = 103.47$, $SD = 15.78$) and their MCA total score, $F (1, 224) = 6.92$, $p = .009$; partial $\eta^2 = .030$. The differences were examined among the identified MCA subscales: (a) MCA Subscale 1 (White/Caucasian, $n = 182$; $M = 35.94$, $SD = 6.80$; Not White/Caucasian [e.g., American Indian, Alaska Native, Asian, Black/African American, Hispanic/Latinx, Multi-racial, Native Hawaiian/Pacific Islander], $n = 44$; $M = 39.92$, $SD = 7$), (b) MCA Subscale 2 (White/Caucasian, $n = 182$; $M = 24.81$, $SD = 3.22$; Not White/Caucasian [e.g., American Indian, Alaska Native, Asian, Black/African American, Hispanic/Latinx, Multi-racial, Native Hawaiian/Pacific Islander], $n = 44$; $M = 25.39$, $SD = 3.68$), (c) MCA Subscale 3 (White/Caucasian, $n = 182$; $M = 16.07$, $SD = 2.22$; Not White/Caucasian [e.g., American

Indian, Alaska Native, Asian, Black/African American, Hispanic/Latinx, Multi-racial, Native

Hawaiian/Pacific Islander], $n = 44$; $M = 16.98$, $SD = 2.78$), and (d) MCA Subscale 4

(White/Caucasian, $n = 182$; $M = 20.54$, $SD = 3.15$; Not White/Caucasian [e.g., American

Indian, Alaska Native, Asian, Black/African American, Hispanic/Latinx, Multi-racial, Native

Hawaiian/Pacific Islander], $n = 44$; $M = 20.54$, $SD = 3.15$). The differences between the

participants' reported race/ethnicity (e.g., White/Caucasian, not White/Caucasian) on the

combined MCA subscales was statistically significant $F (4, 221) = 3.90$, $p = .004$;

Hotelling's Trace $= .071$; partial $\eta^2 = .066$. To analyze the statistical significance further, the

researcher utilized a one-way ANOVA to determine which subscale was contributing

statistically significant values to the one-way MANOVA. The analysis identified non-

statistically significant differences in subscale 2 (*awareness of self*) scores, $F (1, 224) = 1.06$,

$p = .305$; partial $\eta^2 = .005$ and subscale 4 (*Systemic and Institutional Structures*) scores, $F (1,$

$224) = 1.42$, $p = .235$; partial $\eta^2 = .006$. However, statistically significant differences were

identified between the participants' reported race/ethnicity and their MCA subscale 1

(*knowledge, skills, and intervention*) scores, $F (1, 224) = 12.03$, $p < .001$; partial $\eta^2 = .051$

and subscale 3 (*awareness client worldview*) scores, $F (1, 224) = 5.36$, $p = .022$; partial $\eta^2 =$

.023.

     Lastly, the second dataset results identified statistically significant relationships

between the participants' reported age and their MCA total score ($r = .156$, $p = .019$ .05;

2.43% variance explained), subscale 2 ($r = .150$, $p = .025$; 2.25% variance explained),

subscale 3 ($r = .148$, $p = .027$; 2.19% variance explained), and subscale 4 ($r = .154$, $p = .021$;

2.37% variance explained). However, no relationship was identified between the participants reported age and their MCA subscale 1 scores ($r = .113$, $p = .09$; 1.28% variance explained).

Chapter Summary

The current chapter presented the results for the research investigation. The research questions were analyzed using a variety of statistical analyses, including: (a) EFA, (b) PA, (c) CFA, (d) Internal Consistency Reliability through Cronbach's Coefficient Alpha, (e) KR-20, (f) Spearman Rho Correlation, (g) One-Way MANOVA (h) One-Way ANOVA, and (i) Spearman Rho Correlation. The initial 50-item MCA scores were tested with data one ($N = 407$) using EFA and PA, resulting in a 25-item MCA with a four-factor structure that accounted for 64.11% of the total variance. Next, the 25-item MCA scores were tested with data two ($N = 233$) using CFA and the results supported the four-factor MCA structural model. The four factors within the MCA encompassed the domain areas of: (a) *Knowledge, Skills, and Interventions* (21.86% of the variance); (b) *Awareness of Self* (19.27% of the variance); (c) *Awareness of Client Worldview* (11.95% of the variance); and (d) *System and Institutional Structures* (11.03% of the variance). In addition, the MCA yielded adequate internal consistency reliability (e.g., .953 [data one]; .954 [data two]). Furthermore, evidence criterion-related validity was supported with positive correlations between the MCA and MCSE-RD (e.g., total score, subscales) yielded among data two participants with moderate effect sizes. Differences between data two participants' MCA (e.g., total score, combined subscales, subscale 1, subscale 3) scores according to race/ethnicity on were identified.

Lastly, a positive correlation was found between the MCA (e.g., total score, subscale 2, subscale 3, subscale 4) and participants age.

CHAPTER FIVE: DISCUSSION

Chapter 5 provides a review of the investigation and a discussion of the results from Chapter four. Moreover, Chapter 5 reviews the results presented in Chapter 4 and compares them to previous literature and research findings outlined within Chapter 2. In addition, the findings from the five research questions are examined. Lastly, Chapter 5 presents: (a) limitations to the investigation, (b) recommendations for future research, and (c) implications for therapists and counselor educators.

Introduction

The combination of the increasing cultural diversity of the population and the continued disproportionate rates of mental health disparities among culturally diverse clients within the US is significant (Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011; Medley, Lipari, Bose, Cribb, Kroutil, & McHenry, 2015; Miranda, McGuire, Williams, & Wang, 2008). Mental health is a foundational aspect of holistic health (World Health Organization, 2008); therefore, inadequate and limited access to mental health services significantly contribute to health care disparities among underprivileged populations. Given ethical guidelines focused on the integration of therapists' multicultural perspective in providing services to all clients (ACA, 2014; CACREP, 2016; APA, 2002; Harper et al., 2013; NASW, 2015), there is a need for therapists to engage in self-assessment of multicultural competence.

As noted, therapists' have several guidelines supporting the use of a multicultural approach in working with clients. Specifically, ACA (2014) states, "Counselors maintain

awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information. Counselors hold ongoing discussions with clients as to how, when, and with whom information is to be shared" (*Standard B.1.a*, p.6). In addition, ACA (2014) calls for counselor educators to, "infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors" (*Standard F.7.b*, p.14). Similarly, APA (2002) notes the need for an

> understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services… (*Standard 2.01*, p. 5)

NASW (2015) developed standards and indicators of cultural competence, including the domains of self-awareness (*Standard 2*), cross-cultural knowledge (*Standard 3*), cross-cultural skills (*Standard 4*), service delivery (*Standard 5*), as well as, empowerment and advocacy (*Standard 6*). CACREP (2016) supports the premise of a multicultural approach through the integration of social and cultural diversity throughout course curriculum (*Section 2.F.2*). Hence the integration of multiculturalism and multicultural perspectives is within the ethical codes, standards, and guidelines for therapists. As a result, therapists failing to utilize multicultural approaches in their service delivery to clients is unethical and harmful.

Though a multicultural approach to clinical practice is perceived as an imperative element in culturally responsive services (ACA, 2014) and significant economic costs are associated with untreated mental health disorders (WHO, 2001); there are limited assessments designed to measure of therapists self-perception of the cultural competence when working with diverse populations. Although essential to clinical practice, there are *limited* assessment instruments designed to assess multicultural competence through an intersectional lens. In addition, *no* prior research was identified that examined multicultural self-efficacy of a diverse sample of therapists' according to professional field and level of education. Therefore, within this research investigation, the MCA was developed and the psychometric features of multicultural competence (as measured by the MCA scores) was examined among a national sample of therapists.

Review of Research Methods

The following section provides a brief review of the research methods employed in the investigation. The study utilized a correlational research design (Gall, et al., 2007), including instrument development best practices (e.g., AERA, APA, & NCME, 2014; DeVellis, 2017; Dimitrov, 2012; Haladyna & Rodriguez, 2013; Lambie et al., 2017) and an examination of the psychometric features of the MCA data from a large national sample of therapists and therapists-in-training. Prior to data collection, the researcher received IRB approval at her university (*see Appendix A*). The primary research questions included: (a) What is the factor structure of the MCA items with a sample of therapists (examining evidence of construct validity)? (b) What is the internal consistency of the MCA scores with

a sample of therapists?, (c) What is the relationship between MCA scores and the *Marlowe-Crowne Social Desirability Scale-Short Form* (MSDS-X1) scores among a sample of therapists (examining evidence of social desirability)?, (d) What is the concurrent validity of the MCA scores (as measured by the correlation between MCA and MCSE-RD scores)?, and (e) Are there any significant differences in MCA scores based on the participants' demographic groups? If yes, what are the differences?. For a more thorough description of the research methods, please refer to Chapter 3.

Participants

The sampling procedures involved convenience (e.g., face-to-face data collection) and random (e.g., mail-out, email data collection) sampling methods with inclusion criteria was employed to recruit participants (Gall et al., 2007). Participants included practicing counselors, psychologists, and social workers as well as master's level counselors-in-training, master's level social workers-in-training, and master's level psychologist-in-training that were providing clinical services to clients. Participants were recruited via face-to-face, mail out, and email lists. Lists containing therapists' emails and/or physical addresses were obtained and/or purchased from the professional organizations (e.g., ACA, NASW, AERA), regional listserv's, community organizations, and master's level courses (e.g., practicum, internship). A total of 5,124 therapists were sought to participate in the study. A total of 29 individuals participated in the pilot, 407 individuals participated in the data one, and 233 individuals participated in the data two.

Data Collection

The researcher used three methods of collecting data (e.g., pilot, data one, and data two), including: (a) face-to-face ($N = 143$), (b) email ($N = 101$), and (c) mail-out ($N = 429$) administration. The email and mail out followed a modified *Tailored Design Method* (Dillman et al., 2009). The researcher invited face-to-face and mail out administration participants to take a survey on pencil and paper. Email administration participants were invited to take the survey via online survey (www.qualtrics.com). In the recruitment of face-to-face participants, the researcher attending master's level courses (e.g., practicum, internship) to explain the investigation and to inquire about potential participation in the study. Both recruitment emails and mail-outs were sent out once, including an (a) cover (recruitment) letter and (b) research packet. Specifically, for the mail out administration mailings also included stamped envelope to assist potential participants in returning the packets.

Instrumentation

The researcher used three assessment measures (e.g., MCA, MCSDS-X1, and MCSE-RD) and a general demographic questionnaire. For the investigation, the researcher focused on the development of the MCA and the examination of the psychometric features of the assessment scores (e.g., reliability and validity) with a sample of practicing therapists. In order to develop the MCA utilizing best instrument development practices (e.g., AERA, APA, & NCME, 2014; Crocker & Algina, 2006; DeVellis, 2017; Dimitrov, 2012; Lambie et al., 2017), including the use of the following stepwise process: (a) determined clearly what is

being measured, (b) set psychological assessment specifications and structural framework, (c) created an item pool, (d) determined the type for measurement, (e) had an initial item pool reviewed by experts, (f) considered the inclusion of validation items, (g) administered items to a development sample (e.g., pilot), (h) evaluated pool of items, (i) administered items to a development sample (e.g., data one), (j) evaluated pool of items, (k) optimized scale length, (l) administering items to a development sample (e.g., data two), (m) evaluating pool of items, and (n) optimizing scale length.

Multicultural competence assessments are known for social desirability bias (Constantine & Ladany, 2000; Larson & Bradshaw, 2017), which is a common issue when using self-report assessments in social sciences (DeVellis, 2017). Hence, the use of the MCSDS-X1 (Strahan & Gerbasi, 1972), a 10-item scale (true, false) that measures participants' motivation to respond in ways that are deemed positive throughout the present research investigation. Developed from the *Marlowe Crowne Social Desirability Scale* (MCSDS, Crowne & Marlowe, 1960), the original 33-item form, the MCSDS-X1 is a shorten version which is comprised of 10-items that used a dichotomous (e.g., true, false) response scale. Sample items from the MCSDS-X1 include: "I always practice what I preach" and "I sometimes try to get even rather than forgive and forget". Moreover, the internal consistency reliability is satisfactory with ranges failing between .50 and .80 (Strahan & Gerbasi, 1972; Mullen et al., 2014). Within the present investigation, the researcher used a KR-20, which yielded acceptable Cronbach alphas (data one, .702; data two, .692). Comparative to previous research, the internal consistency reliability of the MCSDS-X1 scores was consistent with

previous reported Cronbach coefficient alpha values (Barger, 2002; Mullen et al., 2014; Reynolds, 1982; Strahan & Gerbasi, 1972).

The MCSE-RD (Sheu & Lent, 2007) is a 37-item self-report measure designed to assess various areas of counselors' self-perceived capability in providing mental health services to racially diverse clients. The MCSE-RD includes three sub-scales: (a) multicultural intervention (MI), (b) multicultural assessment (MA), and (c) multicultural session management (MSM). For the MCSE-RD, participants use a 5-point unipolar scale that ranges from 0 (*no confidence at all*) to 9 (*complete confidence*) to reflect current levels of perceived capability. Example items from the MCSE-RD include, "assess the client's readiness for termination" and "manage your own racially or culturally based countertransference toward the client (e.g., over-identification with the client because of his or her race)". Furthermore, internal consistency reliability of MCSE-RD scores in previous research is sound, including .98 (MCSE-RD total score), .98 (MI), .92 (MA), and .94 (MSM); while 2-week test-rest reliability correlations of .73, .88, and .69 for MI, MA, and MSM, respectively (Sheu & Lent, 2007). Within the present investigation, internal consistency reliability values yielded .968, .969, .880, and .913 among the MCSE-RD total score, subscale 1 (*Multicultural Interventions*), subscale 2 (*Multicultural Assessment*), and subscale 3 (*Multicultural Counseling Session Management*), respectively. Given previous research, the internal consistency reliability contributes to literature with some consistent (subscale 1, 2) and slightly lower Cronbach coefficient alpha values (subscale 2) than those found within the literature (Sheu & Lent, 2007).

The researcher developed the general demographic questionnaire (*see Appendix G)*

used throughout the research investigation. The general demographic questionnaire contained

questions that inquired about the therapists' professional field, gender, race/ethnicity, highest

level of education, years in practice, primary service provided, and possession of licensure(s)

and/certification(s). Additional questions for therapists-in-training participants included: (a)

the amount of completed credit hours and (b) accredited program enrollment status.

Data Analysis

Prior to data analysis, the researcher cleaned the data, including the assessment for

missing data and outliers within the first and second datasets. Next, the researcher examined

the statistical assumptions to evaluate the appropriateness for each statistical analysis for the

research questions. Although the statistical assumptions varied dependent upon the specific

analyses, some of the assumptions that were tested included: (a) normality, (b)

multicollinearity, (c) linearity, (d) sampling adequacy, and (e) homoscedasticity. The

researcher used the Statistical Package Social Sciences (SSPS; 2013) software package for

Mac and Windows Version 24.0 and SPSS Analysis of a Moment Structures (AMOS; Mac

and Windows Version 24.0).

Discussion

Descriptive Data

A total of 5,124 therapists were invited to participate in the research. Specifically, 30

individuals were invited to participate in a paper and pencil version via face-to-face

administration for the pilot; 3,045 (1,697 online version via an email, 113 paper and pencil via face-to-face, 1,235 paper and pencil via mail out administration) were invited to participate in data one; and 2,049 (785 online version via email, 29 paper and pencil via face-to-face, 1,235 paper and pencil via mail-out administration) were invited to participate in data two.

In total, 673 therapists participated in the investigation (pilot, data one, data two), resulting in a 13% useable response rate. For the face-to-face administration, the number of data collection packets were examined and compared to the number of data collection packets returned. Thus, among the face-to-face data, 143 out of 172 opted to participate in the overall investigation, yielding an 83% useable response rate. For the mail-out administration, the researcher tracked the response rate using Microsoft Excel for Mac version 16.11.1. Out of the initial mass mailing (2,500 data collection packets), 30 packets were returned to sender; therefore, out of 2,470 packets sent, 429 of packets were returned to the researcher (17% useable response rate). Lastly, the online version administration yielded 101 participations out of the 2,482 who were invited through an email invitation, producing a 4% response rate. Although yielding a response rate on the lower end of the spectrum, the present study produced an overall response rate consistent with response rates of other studies investigating the construct of multicultural competency (10 – 40%, Barden, Sherrell, & Matthews, 2017; Holcomb-McCoy & Day-Vines, 2004).

Survey response rate for the present study may have been impacted by participants not receiving an incentive for their participation. Furthermore, the response rate for the email surveys may have been impacted by the researcher's inability to send the data collection

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packets directly to potential research participants, as recommended (Dillman et al., 2009).

Thus, the response rate for the online data collection appears lower than anticipated. In

addition, the researcher continued to receive returned mail-out surveys after the pre-

established cut-off dates. Therefore, the actual returned surveys and response rates for the

mail out surveys may be higher than the researcher's reported value within the study.

Within the present investigation (e.g., data one, data two) the participants ($N = 640$)

were mostly compromised of individuals who identified as females ($N = 496$; data one, $n = 314$, 77.1%; data two, $n = 182$, 74.3%) and White/Caucasian ($N = 473$; data one, $n = 291$,

71.5%; data two, $n = 182$, 74.3%). The participants' demographic data reflected within the

investigation reflect practicing counselors' demographic characteristics represented in

previous multicultural competence literature (Gamst et al., 2004; Holcomb-McCoy & Myers,

1999; Ponterotto et al., 1996; Sodosky et al., 1994) and are consistent with the demographic

data of full time faculty and students enrolled within counseling programs, which are

comprised predominantly of White/Caucasian females (CACREP 2105; 2016). In addition,

the participants' demographic data also reflect the racial composition of the fields of social

work and psychology, which represent 92 and 93 percent of the U.S. mental health care

workforce respectively (Miranda et al., 2008). Furthermore, participants mostly identified

their professional field as Counseling ($N = 567$; data one, $n = 361$, 88.7%; data two, $n = 206$,

84.1%), while others worked within a Community setting ($N = 453$; data one, $n = 286$, 71%;

data two, $n = 167$, 68.2%), and reported their highest level of education as having a Master's

degree ($N = 408$; data one, $n = 243$, 59.7%; data two, $n = 165$, 67.3%). The additional

participants demographics add to multicultural competency literature. Although previous

assessments have included mental health professionals within their samples (e.g., Gamst et al., 2004; Holcomb-McCoy & Myers, 1999; LaFromboise et al., 1991; D'Andrea et al., 1991; Ponterotto et al., 1996; Sheu & Lent, 2007; Sodosky et al., 1994), the present study is predominately comprised of master's-level therapists. Thus, the participants' demographic data in the current investigation aligns with counseling professionals' demographic data within the United States.

Results

Research Question 1

For research question 1, the researcher conducted an EFA, PA, and a CFA to examine the factor structure of the MCA score in data one and data two. Prior to assessing the potential variable correlations in the MCA, the researcher evaluated the statistical assumptions for each analysis.

EFA steps resulted in a series of statistical decisions, including the determination of (a) factor extraction, (b) factor retention, and (c) factor rotation. Given the large sample size of data one data scores, the assumption of normality was met, and the use of the conjunctive analysis (PA), PCA was used as the factor extraction method (Hayton et al., 2004). Since PA compares eigenvalues of parallel factors from random datasets of the sample size and number of variables with the expectation that meaningful factors will be larger than the random generated parallel factors (Watson, 2017), the researcher used factors that yielded eigenvalues above the mean eigenvalues according to PA results (Hayton, Allen, & Scarpello, 2004). In addition, the research used a varimax rotation method with Kaiser

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Normalization since that method is the most common statistical rotation (Costello & Osborne, 2005) and is designed to maximize the variance of the squared loadings of each item (DeVellis, 2017; Hair et al., 2010).

Similarly, CFA steps involved a series of statistical decisions, including (a) model specification, (b) model estimation, and (c) model modification. Since the development of a CFA model requires a thorough knowledge of the theoretical framework and previous research (Lewis, 2017; Schumacher & Lomax, 2010), the researcher used the results of EFA from data one to construct the CFA model to further provide evidence of construct validity of the MCA scores. Furthermore, the researcher choose a method by which the parameters would be measured, including ML as the fitting function for the CFA (Brown, 2015). Lastly, the researcher specified paths between error terms as recommended to improve model fit (Lewis, 2017).

The final four-factor MCA model was identified based on the EFA results and supporting theory, and the CFA confirmed the four factor MCA model with a second dataset. The final MCA model includes some factors that were consistent with other multicultural competence assessments (e.g., CCCI-R [LaFromboise et al., 1991]; MAKSS [D'Andrea et al., 1991]; MCI [Sodosky et al., 1994]; MCAS: B [Ponterotto et al., 1996]; MCCTS [Holcomb-McCoy & Myers, 1999]; CBMCS [Gamst et al., 2004]). For instance, the *Knowledge, Skills, and Interventions* (e.g., items 5, 8, 9, 12, 13, 17, 18, 19, 20, 23) factor found in the MCA model is consistent with several other multicultural competence assessments, including the CCCI-R (LaFromboise et al., 1991), MCI (Sodosky et al., 1994), MAKSS (Pedersen, 1994), MCCTS (Holcomb-McCoy & Myers, 1999), and MCSE-RD

(Sheu & Lent, 2007). Moreover, the MCA *Awareness of Self* (e.g., items 7, 11, 16, 21, 22, 24) and *Awareness of Client Worldview* (e.g., items 1, 2, 3, 4) factors are reflective within other multicultural competence assessments, including the CCCI-R (LaFromboise et al., 1991), MAKSS (Pedersen, 1994), MCI (Sodosky et al., 1994), MCAS: B (Ponterotto et al., 1996), MCCTS (Holcomb-McCoy & Myers, 1999), and CBMCS (Gamst et al., 2004). However, the MCA model adds to literature as *Awareness of Self and Awareness of Client Worldview* are distinctive factors, a concept not reflected in previous assessments, but supported through literature (Ratts et al., 2016). Lastly, the *Systemic and Institutional Structures* (e.g., items 6, 10, 14, 15, 25) factor is a newly measured domain among multicultural competence assessments. Although, new to multicultural competence assessment literature, the concepts explored within the MCA *Systemic and Institutional Structures* factor has been reviewed within literature (Lewis et al., 2003; NASW, 2015; Sue et al., 1992; Ratts et al., 2016).

The *Knowledge, Skills, and Interventions* factor on the MCA refers to, the collection of culturally relevant information along with cultural appropriate techniques and interventions, which inform client conceptualization and are utilized in addressing and presenting concerns (Anderson, 2000; NASW, 2015; Ratts et al., 2016). Similar to the MCAS:B (Ponterotto et al., 1996), the *Knowledge* and *Skills* domains combined to create a single factor within the MCA assessment model. Not surprising since theoretically knowledge is defined through the understanding of multicultural information (Ratts et al., 2016); the researcher formulated the items to inquire about therapists' abilities understanding

their clients' multicultural information within session. For this reason, the MCA items pertaining to *Knowledge* and *Skills* structurally appear similar.

Based upon the final MCA model, the *Awareness of Self* factor refers to, the recognition of therapists' own cultural values, beliefs, and biases as it relates to the therapeutic process (Arredondo et al., 1996; NASW, 2015; Ratts et al., 2016; Sue & Sue, 1982). As the most common domain found among multicultural competency assessments (D'Andrea et al., 1991; Holcomb-McCoy & Myers, 1999; LaFromboise, Coleman, & Hernandez, 1991; Ponterotto, Rieger, Barrett, Harris, Sparks, Sanchez, & Magids, 1996; Sheu & Lent, 2007; Sodosky, Taffe, Gutkin, & Wise, 1994), *Awareness of Self* on the MCA is consistent with other multicultural competence assessments. Although, often referring to as general knowledge of cultural concerns, as compared to a therapist's own attitudes and beliefs; differences in the operationalization of multicultural awareness within literature versus how it is defined within assessments has presented concerns about what is being measured (Constantine et al., 2002). Therefore, the MCA model presents a theoretically consistent measurement of a therapist's awareness of self.

The *Awareness of Client Worldview* factor was based upon the final MCA model, referring to therapists' recognition of their clients' cultural context and its unique impact on clients' therapeutic process (Lewis et al., 2003; Ratts et al., 2016). While *Awareness* is a common domain found within multicultural competency assessments (D'Andrea et al., 1991; Holcomb-McCoy & Myers, 1999; LaFromboise et al., 1991; Ponterotto et al., 1996; Sheu & Lent, 2007; Sodosky et al., 1994), therapists' awareness of their clients' worldview has not

conceptually been a part of assessment domain areas. Thus, the *Awareness of Client Worldview* factor domain is a new area being measured within the MCA.

The *Systemic and Institutional Structures* factor on the MCA refers to, therapists' consideration of a set of social dynamics that positively impact some individuals at the expense of others based upon cultural identity status (Arredondo et al., 1996; Lewis et al., 2003; NASW, 2015; Ratts et al., 2016). The *Systemic and Institutional Structures* factors is a new domain among most multicultural competency assessments, however, the CCCI-R (LaFromboise et al., 1991) includes a *Socio-Political Awareness* factor. The *Socio-Political Awareness* factor incorporates counselors' ability to recognize their own strengths and limitations which may impact the counseling process while working with clients. In this way, the new domain (*Systemic and Institutional Structures*) introduces items that measure therapists' self-efficacy in incorporating the concepts of privilege and marginalization found through the MSJCC.

In summary, the final EFA and CFA MCA models were developed and constructed with items that were supported through a theoretical framework and statistical results. Table 9 provides additional information concerning the supported literature used in the construction of the final 25-item MCA structure.

Table 15

MCA Items, Associated Factors, and Literature Support

MCA Item	Factor Name	Literature Support
Question 5- Describe elements of culture specific developmental models Question 8- Integrate clients' cultural heritage when implementing techniques Question 9- Connecting clients with culture specific resources Question 12- Conceptualize clients through culture specific developmental models Question 13- Tailor approaches based upon clients' cultural beliefs Question 17- Identify culturally appropriate resources Question 18- Utilizing culture specific developmental models Question 19- Modify therapeutic strategies to honor the cultural identities Question 20- Articulate how cultural group membership impacts clients lives Question 23- Modify therapeutic interventions to meet the cultural needs	Knowledge, Skills, & Interventions	Anderson, 2000; Arredondo et al., 1996; Harper, Finnerty, Martinez, Brace, Crethar, Loos,…Lambert, 2012; Lewis et al., 2003; Ponterotto, Rieger, Barrett, & Sparks, 1994 Ratts et al., 2016
Question 7- How my principles impact the therapeutic process Question 11- Which cultural beliefs are most important Question 16- Recognize my values may interfere with providing services Question 21- Convey the beliefs of my cultural groups Question 22- Cultural identity impacts the therapeutic process Question 24- Recognize beliefs may create clinical limitations	Awareness of Self	Anderson, 2000; Arredondo et al., 1996; Ratts et al., 2016; Sue, Arredondo, & McDavis, 1992
Question 1- Identify how clients' beliefs affect the therapeutic process Question 2- Recognize clients' cultural expectations of the therapeutic process Question 3 - Discussions about cultural mores (e.g., roles, expectations) Question 4- Identify barriers that impede mental health service access	Awareness of Client Worldview	Anderson, 2000; Arredondo et al., 1996; Lewis et al., 2003; Ratts et al., 2016; Sue, Arredondo, & McDavis, 1992
Question 6- Implications of privilege and clinical practice Question 10- Dialogue about socio-political issues and clients' mental health Question 14- Identify how privilege may influence the therapeutic relationship Question 15- Recognize how societal mistreatment impact their self-esteem Question 25- Identify when clients experience the world differently	Systemic and Institutional Structures	Arredondo et al., 1996; Lewis et al., 2003; NASW, 2015; Ratts et al., 2016

Research Question 2

For research question 2, the researcher computed Cronbach's coefficient alpha (α) to examine internal consistency reliability of the MCA scores. In this way, Cronbach's α was used to determine whether and to what degree MCA items were correlated (DeVellis, 2017). The researcher utilized a minimum Cronbach α value of .70 to indicate adequate internal consistency of the MCA items (Streiner, 2003).

The Cronbach's α value for the initial 50-items ($N = 407$) was calculated as .973. The Cronbach's α value for the revised 25-item MCA ($N = 407$) was .953. For MCA Factor One (*Knowledge, Skills, and Interventions*), the Cronbach's α value was .927; Factor Two, (*Awareness of Self*), the Cronbach's α value was .867; Factor Three (*Awareness of Client Worldview*), the Cronbach's α value was .811; and Factor Four (*System and Institutional Structures*), the Cronbach's α value was .839. Among the data two participants, the Cronbach's α value was calculated for the 25-items ($N = 233$) was calculated as .954. For Factor One (*Knowledge, Skills, and Interventions*), the Cronbach's α value was .931; Factor Two, (*Awareness of Self*), the Cronbach's α value was .854; Factor Three, (*Awareness of Client Worldview*), the Cronbach's α value was .779; and Factor Four (*System and Institutional Structures*), the Cronbach's α value was .834.

Cronbach's coefficient alpha value ranges from 0 to 1, with values closer to 0 denoting lower reliability and values closer to 1 representing higher reliability (DeVellis, 2017; Streiner, 2003). In essence, Cronbach's α equals 1 – the error of variance; in this way, a higher Cronbach α value suggests less error among the relationship between scale items

and the latent variable (DeVellis, 2017). The internal consistency reliability for the MCA yielded a Cronbach's α that is comparable to the Cronbach's α values other multicultural competency assessments (.66 to .92, MCCTS [Holcomb-McCoy & Myers, 1999]; .75 to .96, MAKSS [D'Andrea et al., 1991]; .79 to .92, MCKAS [Ponterotto et al., 2002]; .81 to .95, CCCI-R [LaFromboise et al., 1991; Larson & Bradshaw, 2017]; .88, MCI [Sodosky et al., 1994; Larson & Bradshaw, 2017]; .89, CBMCS [Gamst et al., 2004]; .98, MCSE-RD [Sheu & Lent, 2007]).

Research Question 3

The researcher utilized a correlation analysis to assess for participants responding to the MCA in a social desirability fashion by examining the relationship between MCA scores and MCSDS-X1 scores (Strahan & Gerbasi, 1979) in data two ($N = 233$). Since the use of a social desirability scale is recommended in conjunction with self-report assessments (DeVellis, 2017) and no significant relationships among social desirability scores (as measured by the MCSDS-X1) and a previous multicultural competence scores have been found (Larson & Bradshaw, 2017), the researcher included the assessment within the study.

Utilizing the coding of 1 for socially desirable items and 0 for items that are not social desirable, MCSDS-X1 total scores range from 0 – 10. The researcher utilized a spearman rho correlation because the second dataset ($N = 233$) violated the assumptions of normality. The positive correlations between the MCA and MCSDS-X1 scores identifies that as MCA scores increase, so did social desirability bias among data two participants. Social desirability bias is common among multicultural competency assessments (Constantine, 2000; Larson &

Bradshaw, 2017); similarly, among the second dataset, a statistically significant position correlation was found between MCA (e.g., total score, subscales) and MCSDS-X1 scores. It should be noted, although positive correlations were identified, small effect sizes were yielded, which suggests minimal variance was explained. Therefore, minimal practical significance can be attributed to social desirability among positive correlations between MCA (e.g., total and subscale) and MCSDS-X1 scores.

<div align="center">Research Question 4</div>

For research question 4, a bivariate correlation was used to examine concurrent validity of MCA scores with MCSE-RD scores (Sheu & Lent, 2007) in data two ($N = 233$). Used to measure concurrent validity, the MCSE-RD is comprised of three subscales of *Multicultural Intervention, Multicultural Assessment,* and *Multicultural Counseling Session Management*. Item responses ranged from 0 (*No confidence at all*) to 9 (*Complete confidence*), which are then used to compute the MCSE-RD total score through the following equation: (Σ[MCSE-RD items]/37). Therefore MCSE-RD total scores range from 0 to 9 (Sheu & Lent, 2007).

The researcher utilized a spearman rho correlation because the second dataset ($N = 233$) violated the assumptions of normality. The positive correlations between the MCA and the MCSE-RD scores suggest as MCA scores increase, MCSE-RD scores increase among data two participants. *All* correlations yielded medium to large statistically significant positive correlations with the majority of the correlations having accounted for a moderate to large variance ($r = .30$ to 1.0; Pallant, 2007). Correlations between the MCA and MCSE-RD

subscale 3 yielded low variance, which may be evident given the latent variable

(*Multicultural Assessment*) was not a factor within the MCA. Overall, the strength of the

correlations between the MCA and MCSE-RD scores were medium to large, providing

evidence of concurrent validity for the MCA data. The support of the evidence of concurrent

validity for the MCA data is an important interpretation as the two assessments measure

similar, but different domains within the construct of therapists' multicultural competency.

Research Question 5

The researcher utilized an one-way MANOVA, one-way ANOVA, and spearman rho

correlation to identify if there are any significant differences in MCA scores based on the

participants' demographic groups. Specifically, the researcher explored the relationships

between a dependent variable (DV; e.g., MCA scores) and independent variables (IVs; e.g.

demographic characteristic). For the purposes of the present investigation the demographic

characteristics examined include: (a) professional field (e.g., Counselors, Not Counselors),

(b) work setting (e.g., Community, Not Community), (c) gender (e.g., Female, Male), (d)

race/ethnicity (e.g., White/Caucasian, Not White/Caucasian), and (e) age.

Results from the analyses identified there were no statistically significant differences

in participants' MCA scores (e.g., total score, combined subscales) according to their (a)

professional field, (b) work setting, or (c) gender; suggesting that MCA scores are suitable

across therapists' different demographic characteristics. Previous literature has not explored

some demographic characteristics (e.g., professional field, work setting) within the present

study. However, the non-statistically significant difference according to gender adds to

previous literature as some researchers have found differences in therapists' level of multicultural competence based on gender and others have not (Pope-Davis & Ottavi, 1994; Pope-Davis, Reynolds, Dings, & Ottavi, 1993; Sodowsky, 1996). Furthermore, a small, but statistically significant positive correlation was identified between MCA scores (e.g., total score, subscales [2, 3, 4]) and the therapists' age. The positive correlations between MCA scores and age suggest that the older participants had higher MCA scores in data two. While statistical significance was present within the results, the low variance explained (< 3%) suggests limited practical significance. The aforementioned results add to literature as some research has found age to correlate with multicultural counseling competency assessment scores, while others have not (Pope-Davis & Ottavi, 1994; Pope-Davis et al., 1993; Sodowsky, 1996).

Additional results identified statistically significant differences between participants' reported race/ethnicity and their MCA scores (e.g., total score, combined subscales). Specifically, statistical significance was found in the participants' MCA total score, MCA subscale 1 (*knowledge, skills, and intervention*) and MCA subscale 3 (*awareness client worldview*) score based on race/ethnicity. In addition, the researcher identified therapists of Color (19%) yielded higher MCA scores (e.g., total score, subscale 1, subscale 3) as compared to the therapists who identified as White/Caucasian (78%) in data two. These findings are consistent with previous research that found therapists of color score higher on multicultural counseling competency assessments comparative to therapists who identify as White/Caucasian (Berger, Zane, & Hwang, 2014; Pope-Davis & Ottavi, 1994; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998).

Limitations of the Investigation

In the development of the MCA, a limitation may exist in the identified domain areas of multiculturalism. The domains explored are relevant to the construct of interest; however, additional areas may exist in therapists' work with clients. Hence, all areas relevant to the measurement of multiculturalism among therapists' may not been reflected in the MCA.

In addition, since the MCA is a self-efficacy measure, it does *not* measure multicultural counseling proficiency. Therefore, the MCA is unable to be used as an evaluative measure. In particular, when determining the retention of factors during the EFA, five items were retained that yielded significant cross loadings (.3 or higher; Costello & Osborne, 2005). Although the items were retained based upon theoretical framework, the final CFA model may have yielded more improved model fit indices if they were previously removed.

Throughout the investigation, the researcher aimed to obtain a total sample of 750 participants in an effort to yield a 20:1 (data one, 10:1 [EFA]; data two, 10:1 [CFA]) N:p ratio). The researcher was unable to predict the specific features of the obtained dataset a priori; therefore, the recommendation to obtain the largest sample size possible. In addition, the researcher was unable to utilize the TDM (Dillman et al., 2009) given contractual agreement(s) in utilizing membership information from national organizations and community agencies. Furthermore, equal representation of each professional identity was *not* present within the present investigation. The responses within the investigation are from counselors; therefore, the results may be not reflective of each mental health discipline.

The assessment instruments (e.g., MCSE-RD [Sheu & Lent, 2007], MCSDS-X1 [Strahan & Gerbasi, 1972], *General Demographic Questionnaire*) included within the investigation were all self-report by design. Although self-report is common in social science research (DeVellis, 2017), participant scores may have experienced response bias. In addition, the concurrent validity assessment measure (MCSE-RD), yielded an internal consistency reliability of .98, suggesting an over redundancy in items (Streiner, 2003). It is positive the psychological assessment over factor as compared to under factor (DeVellis, 2017); however, such a high reliability coefficient for the MCSE-RD scores suggest high redundancy of items. Lastly, within data two, the participants may have experienced research fatigue since a total of 83 items were present within the data collection packet, resulting in the high number of missing values.

Recommendations for Future Research

The researcher provides recommendations for future researcher to be conducted with the MCA, including (a) conducting a CFA on a larger national sample of therapists; (b) using the MCA with a more diverse group of therapists; and (c) conducting a study to assess if the MCA scores reflects similar results of therapist multicultural competence as rated by their clients.

As the validation sample ($N = 233$) yielded a $N{:}p$ that was less than the recommended 10:1 ratio, future research utilizing a CFA on a larger dataset would help further validate the MCA through improved model fit indices. An additional area for future research involves using the MCA among more professionally diverse samples (e.g., Social Work, Psychology).

Although, the researcher attempted to recruit participants from a range of mental health professional fields, dataset samples were disproportionately comprised of counseling professionals. Thus, additional research within this area would be beneficial in norming the MCA on a larger population of professionals. Lastly, incorporating both clients and therapists' perspectives of therapy may be important to formulating a more comprehensive understanding of the construct of multicultural competence in mental health professions. Utilizing responses from both members of clinical dyads may allow researchers to derive more accurate determinations of therapists' in-session skills to address their clients' concerns in a culturally competent manner (Constantine et al., 2002).

Implications of the Findings

The findings from the present investigation contributes to the literature on therapists' multicultural competence (e.g., counselors, social workers, psychologists). As noted, ACA (2014), APA (2002, 2006), CACREP (2016) and NASW (2015) *all* support using a multicultural approach in clinical practice among therapists. Hence, the psychometrically tested MCA scores offer a contribution to researchers, therapists, and counselor educators.

Implications for Researchers

As a psychometrically sound assessment that has used best practices in its development and validation (AERA, APA, & NCME, 2014; Constantine & Ladany, 2000; DeVellis, 2017; Dimitrov, 2012; Haladyna & Rodriguez, 2013; Hay Hayton, Allen, Scarpello, 2004; Lambie et al., 2017), the MCA is a new measure that can be used to

measure multicultural counseling competence in therapists based upon contemporary definitions of the construct (e.g., multiculturalism) and sound data. More specifically, the MCA introduces two new subscales among multicultural competency assessments, awareness of client worldview and social and institutional structures. Through the use of the MCA, researchers are able to gain a more comprehensive understanding of individuals' self-perceived multicultural competency and will be able to assess potential relationships between MCA scores and other general clinical skillsets (e.g., general counseling competency, the therapeutic relationship).

<div align="center">Implications for Therapists</div>

Given the recommendations for continued research of self-report multicultural counseling competency measures (Constantine et al., 2002), as well as, the effects self-efficacy has on choice intentions given interceding variables (e.g., outcome expectations, interests, supports, and barriers; Sheu, Lent, Brown, Miller, Hennessy, Duffy, 2010); the MCA can be a method to increase awareness of abilities and introduce others among therapists working with clients in clinical practice. Specifically, the MCA can be used during supervision and consultation meetings as a springboard for discussion about client conceptualization among therapists.

Furthermore, although the MCA is a self-report measure for therapists, individual MCA items can be used as a temperature check when working with clients. Therefore, MCA items can be utilized to spark conversation between the therapist and client to gauge which multicultural domain(s) are most important to be integrated for individualized care. In

particular, the MCA items can be used in preparation for and/or throughout the course of joint treatment planning with clients.

Implications for Counselor Education

Given the counseling professions ethical commitment to honor diversity and multiculturalism through ethical guidelines (ACA, 2014; CACREP, 2016), the MCA can be used as a tool to gauge progress in students implementation of a multicultural approach in clinical practice. While MCA is not intended to be used as an evaluative measure, since it is a self-report measure, educators may benefit from the MCA as it may provide a framework by which feedback can be explored and/given to students based upon the overall measure and/or the individual domain areas (MCA subscale 1[*Knowledge, Skills, and Interventions*], MCA subscale 2 [*Awareness of Self*], MCA subscale 3 [*Awareness of Client Worldview*], MCA subscale 4 [*Systemic and Institutional Structures*]). In this way, the MCA can be used to as a preliminary appraisal of students' confidence in utilizing a multicultural clinical approach in an effort to assess ethical guidelines programmatically.

Furthermore, since the MCA bridges the theoretical underpinnings of the multicultural competencies through a quantitative measure, the assessment can be used as an educational tool (e.g., pre-, mid-, -post) to provide students' with scores on the overall measure (MCA total score) or within a specific domain area (MCA subscale 1[*Knowledge, Skills, and Interventions*], MCA subscale 2 [*Awareness of Self*], MCA subscale 3 [*Awareness of Client Worldview*], MCA subscale 4 [*Systemic and Institutional Structures*]) by, which they can gauge their confidence about their abilities. Such knowledge can allow students to

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seek out professional development, and clinical resources in targeted clinical areas of multiculturalism. In addition, instructors may find it helpful to structure the multicultural counseling course based upon the subscales identified within the MCA. Utilizing this new framework would allow instructors to focus upon pertinent material in addition to descriptions of cultural identity status'.

Chapter Summary

Chapter 5 summarizes the findings for the five research questions discussed in in Chapter 4. The development and evidence of validity for the MCA scores with a sample of therapists (data one, data two) was conducted and completed. However, given the limitations of the investigation reviewed within the chapter, the use of the MCA may not be applicable to populations beyond those used within the present investigation. Findings within the study may assist in the exploration of future research in the area of therapists' multicultural competence. The findings of the study contribute to the literature on multicultural competence and provide implications for researchers, therapists, and counselor educators.

APPENDIX A:
UNIVERSITY OF CENTRAL FLORIDA INSTITUTIONAL REVIEW BOARD FORM

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Michelle D. Mitchell**

Date: **October 30, 2017**

Dear Researcher:

On 10/30/2017, the IRB reviewed the following activity as minor modifications to human participant research that is exempt from regulation:

Type of Review:	Exempt Determination
Modification Type:	Minor changes to demographic questionnaire and MCA assessment. Total time was changed from 15 minutes to 5-10 minutes. Revised Protocol, questionnaires, and consent were uploaded in iRIS.
Project Title:	The Development and Factor Structure of the Multicultural Competency Assessment (MCA)
Investigator:	Michelle D. Mitchell
IRB Number:	SBE-17-13380
Funding Agency:	
Grant Title:	
Research ID:	N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Kamille Chap

Signature applied by Kamille Chaparro on 10/30/2017 03:47:30 PM EDT

Designated Reviewer

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APPENDIX B:
UNIVERSITY OF CENTRAL FLORIDA INSTITUTIONAL REVIEW BOARD
ADDENDUM FORM

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Determination of Exempt Human Research

From: **UCF Institutional Review Board #1**
         FWA00000351, IRB00001138

To: **Michelle D. Mitchell**

Date: **December 05, 2017**

Dear Researcher:

On 12/05/2017, the IRB reviewed the following activity as modifications to human participant research that is exempt from regulation:

Type of Review:	Exempt Determination
Modification Type:	Revised timeline and replaced the AMES assessment with the MCSES-RD. Revised PI contact information. MCSES-RD, Revised Protocol, and revised Explanation of Research were uploaded in iRIS.
Project Title:	The Development and Factor Structure of the Multicultural Competency Assessment (MCA)
Investigator:	Michelle D. Mitchell
IRB Number:	SBE-17-13380
Funding Agency:	
Grant Title:	
Research ID:	N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

This letter is signed by:

Kamille Chap

Signature applied by Kamille Chaparro on 12/05/2017 07:52:22 AM EST

Designated Reviewer

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APPENDIX C:
INFORMED CONSENT FOR RESEARCH

The Development and Factor Structure of the MCA
Informed Consent for Research

Principal Investigator:	*Michelle D. Mitchell, M.S.Ed, LPC, NCC*
Faculty Advisor:	*Glenn Lambie, Ph.D.*
Investigational Site(s):	*University of Central Florida*

Introduction: Researchers at the University of Central Florida (UCF) study many topics. To do this we need the help of people who agree to take part in a research study. You are being invited to take part in a research study which will include about 2,000 people nationally. You have been asked to take part in this research study because you are a psychologist, counselor, social worker, psychologist-in-triaining, counselor-in-traning, or social worker-in-training. You must be 18 years of age or older to be included in the research study.

The person doing this research is a Doctoral Candidate within the Counselor Education Progam at UCF. Because the researcher is a graduate student, she is being guided by Glenn W. Lambie, Ph.D., a UCF faculty member in the Department of Child, Family, and Community Services.

What you should know about a research study:
- Someone will explain this research study to you.
- A research study is something you volunteer for.
- Whether or not you take part is up to you.
- You should take part in this study only because you want to.
- You can choose not to take part in the research study.
- You can agree to take part now and later change your mind.
- Whatever you decide it will not be held against you.
- Feel free to ask all the questions you want before you decide.

Purpose of the research study: The purpose of this study is to develop an instrument designed to measure professionals' confidence in their abilities to provide therapeutic services to diverse clients.

What you will be asked to do in the study: Throughout this study, you will complete 4 assessments designed to measure your confidence in your abilities to provide therapeutic services to diverse populations. The completion of the study will require a total of 5-10 minutes of time. You will be asked to complete a general demographics form and three additional assessments.

Location: Survey completion will be located at the UCF John Hitt Library, UCF Community Counseling and Research Center, through an online platform (e.g., Qualtrics), via postal mail, or another mutually agreed upon location.

Time required: We expect that you will participate in this research study for the duration of 5-10 minutes to complete the four assessments.

Risks: There are no reasonably foreseeable risks involved in taking part in this study. However, It is possible that review of assessment items may cause you to experience discomfort when reflecting upon perceived skillsets. Ms. Mitchell is a Licensed Professional Counselor who is trained to recognize mental health risks. If you are uncomfortable you may withdrawal from the completion of this study at any time and seek out a mental health provider near you. If you are a UCF student and would like to speak with a professional counselor please contact, (407) 823-2811. If you are not a UCF student please utilize the Psychology Today website address (http://www.psychologytoday.com) to find mental health services in your area.

Benefits: We cannot promise any benefits to you or others from your taking part in this research. However, possible benefits include reflecting upon perceived ability when working with diverse populations.

Compensation or payment: There will be no compensation for participation in this research investigation.

Confidential research: This study is confidential. That means that the principal investigator will secure any personal information that is provided through the completion of the research study.

Study contact for questions about the study or to report a problem: If you have questions, concerns, or complaints, or think the research has hurt you, talk to Michelle Mitchell, Doctoral Candidate, College of Education and Human Performance, (412) 436-9078 or by email at Michelle.Mitchell@ucf.edu or Dr. Glenn Lambie, Faculty Advisor, College of Education and Human Performance at (407)-823-4779 or by email at Glenn.Lambie@ucf.edu.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901. You may also talk to them for any of the following:
- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You want to get information or provide input about this research.

APPENDIX D:
MULTICULTURAL COMPETENCY ASSESSMENT (MCA) FINAL FORM

MCA© **Directions:** The MCA is designed to measure therapists' competence in their abilities to provide clinical services to clients. All presented clinical tasks may NOT be relevant for all clients; however, please rate how confident you are in your abilities to provide the clinical services listed below per the rating scale, when appropriate. Your response will be anonymous.	Not Competent in Providing Specified Clinical Task	Somewhat Competent in Providing Specified Clinical Task	Moderately Competent in Providing Specified Clinical Task	Competent in Providing Specified Clinical Task	Very Competent in Providing Specified Clinical Task
1. I can identify how clients' beliefs affect the therapeutic process	1	2	3	4	5
2. I am able to recognize clients' cultural expectations of the therapeutic process	1	2	3	4	5
3. I can initiate discussions about cultural mores (e.g., roles, expectations) when working with clients	1	2	3	4	5
4. I am able to identify barriers that may impede clients' access to mental health services	1	2	3	4	5
5. I can describe the elements of culture specific (e.g., faith, sexual orientation, race) developmental models during clinical practice	1	2	3	4	5
6. I can explain the implications of privilege as they relate to my clinical practice	1	2	3	4	5
7. I can identify how my principles impact the therapeutic process	1	2	3	4	5
8. I can integrate clients' cultural heritage when implementing therapeutic techniques	1	2	3	4	5
9. I am capable of connecting clients with culture specific resources	1	2	3	4	5
10. I am able to initiate dialogue about how socio-political issues relate to my clients' mental health	1	2	3	4	5
11. I can pinpoint which cultural beliefs are most important to my clients	1	2	3	4	5
12. I am able to conceptualize clients through culture specific developmental models in clinical practice	1	2	3	4	5
13. I can tailor therapeutic approaches based upon clients' cultural beliefs	1	2	3	4	5
14. I can identify how privilege may influence the therapeutic relationship	1	2	3	4	5
15. I can recognize how societal mistreatment of my clients may impact their self-esteem	1	2	3	4	5

	Not Competent in Providing Specified Clinical Task	Somewhat Competent in Providing Specified Clinical Task	Moderately Competent in Providing Specified Clinical Task	Competent in Providing Specified Clinical Task	Very Competent in Providing Specified Clinical Task
16. I am able to recognize how my values may interfere with providing clients with therapeutic services	1	2	3	4	5
17. I can identify culturally appropriate resources for my clients	1	2	3	4	5
18. I am capable of utilizing culture specific developmental models in my clinical practice	1	2	3	4	5
19. I can modify therapeutic strategies to honor the cultural identities of clients	1	2	3	4	5
20. I am able to articulate how cultural group membership impacts the lives of clients	1	2	3	4	5
21. I can convey the beliefs of my own cultural groups to my clients	1	2	3	4	5
22. I can identify how my cultural identity impacts the therapeutic process	1	2	3	4	5
23. I can modify therapeutic interventions to meet the cultural needs of my clients	1	2	3	4	5
24. I am able to recognize that my beliefs may create clinical limitations when working with clients	1	2	3	4	5
25. I can identify when clients from marginalized cultural groups experience the world differently than dominant cultural groups	1	2	3	4	5

Thank you for completing this scale!

APPENDIX E:
MARLOWE-CROWNE SOCIAL DESIRABILITY SHORT FORM (MCSDS-X1)

Directions: Listed below are 10 statements concerning personal attitudes and traits. Please read each item and decide whether the statement is "**True**" or "**False**" as it pertains to you personally.

	True	False
1. I'm always willing to admit it when I make a mistake.	True	False
2. I always try to practice what I preach.	True	False
3. I never resent being asked to return a favor.	True	False
4. I have never been irked when people expressed ideas very different from my own.	True	False
5. I have never deliberately said something that hurt someone's feelings.	True	False
6. I like to gossip at times.	True	False
7. There have been occasions when I took advantage of someone.	True	False
8. I sometimes try to get even rather than forgive and forget.	True	False
9. At times I have really insisted on having things my own way.	True	False
10. There have been occasions when I felt like smashing things.	True	False

APPENDIX F:
MULTICULTURAL COUNSELING SELF-EFFICACY SCALE RACIAL DIVERSITY
FORM (MCSE-RD)

Instructions: The following questionnaire consists of 37-items asking about your perceived ability to perform different counselor behaviors in individual counseling with clients who are **racially different** from you. Using the 0-9 scale, please indicate how much confidence you have in your ability to do each of these activities at the present time, rather than how you might perform in the future. Please circle the appropriate number that best reflects your response to each item.

When working with a client who is **racially different** from yourself, how confident are you that you could do the following tasks effectively over the next week?	No Confidence At All				Some Confidence					Complete Confidence
1. Openly discuss cultural differences and similarities between the client and yourself.	0	1	2	3	4	5	6	7	8	9
2. Address issues of cultural mistrust in ways that can improve the therapeutic relationship.	0	1	2	3	4	5	6	7	8	9
3. Help the client to articulate what she or he has learned from counseling during the termination process.	0	1	2	3	4	5	6	7	8	9
4. Where appropriate, help the client to explore racism or discrimination in relation to his or her presenting issues	0	1	2	3	4	5	6	7	8	9
5. Keep sessions on track and focused with a client who is not familiar with the counseling process.	0	1	2	3	4	5	6	7	8	9
6. Respond effectively to the client's feelings related to termination (e.g., sadness, feeling of loss, pride, relief)	0	1	2	3	4	5	6	7	8	9
7. Encourage the client to take an active role in counseling.	0	1	2	3	4	5	6	7	8	9
8. Evaluate counseling progress in an on-going fashion.	0	1	2	3	4	5	6	7	8	9
9. Identify and integrate the client's culturally specific way of saying good-bye in the termination process.	0	1	2	3	4	5	6	7	8	9
10. Assess the client's readiness for termination.	0	1	2	3	4	5	6	7	8	9
11. Select culturally appropriate assessment tools according to the client's cultural background.	0	1	2	3	4	5	6	7	8	9
12. Interpret standardized tests (e.g., MMPI-2, Strong Interest Inventory) in ways sensitive to cultural differences.	0	1	2	3	4	5	6	7	8	9

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	No Confidence At All				Some Confidence					Complete Confidence
13. Deal with power-related disparities (i.e, counselor power versus client powerlessness) with a client who has experienced racism or discrimination.	0	1	2	3	4	5	6	7	8	9
14. Use non-standardized methods or procedures (e.g., card sort, guided fantasy) to assess the client's concerns in a culturally sensitive way.	0	1	2	3	4	5	6	7	8	9
15. Take into account the impact that family may have on the client in case conceptualization.	0	1	2	3	4	5	6	7	8	9
16. Assess relevant cultural factors (e.g., the client's acculturation level, racial identity, cultural values and beliefs).	0	1	2	3	4	5	6	7	8	9
17. Take into account cultural explanations of the client's presenting issues in case conceptualization.	0	1	2	3	4	5	6	7	8	9
18. Repair cross-cultural impasses that arise due to problems in the use or timing of particular skills (e.g., introduce the topic of race into therapy when the client is not ready to discuss).	0	1	2	3	4	5	6	7	8	9
19. Conduct a mental status examination in a culturally sensitive way.	0	1	2	3	4	5	6	7	8	9
20. Help the client to develop culturally appropriate ways to deal with systems (e.g., school, community) that affect him or her.	0	1	2	3	4	5	6	7	8	9
21. Manage your own anxiety due to cross-cultural impasses that arise in the session.	0	1	2	3	4	5	6	7	8	9
22. Assess culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness).	0	1	2	3	4	5	6	7	8	9
23. Help the client to set counseling goals that take into account expectations from her or his family.	0	1	2	3	4	5	6	7	8	9
24. Help the client to identify how cultural factors (e.g., racism, acculturation, racial identity) may relate to his or her maladaptive relational patterns.	0	1	2	3	4	5	6	7	8	9
25. Manage your own racially or culturally based countertransference toward the client (e.g., over-identification with the client because of his or her race).	0	1	2	3	4	5	6	7	8	9

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	No Confidence At All					Some Confidence				Complete Confidence
26. Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstanding or impasses.	0	1	2	3	4	5	6	7	8	9
27. Assess the salience and meaningfulness of culture/race in the client's life.	0	1	2	3	4	5	6	7	8	9
28. Take into account multicultural constructs (e.g., acculturation, racial identity when conceptualizing the client's presenting problems.	0	1	2	3	4	5	6	7	8	9
29. Help the client to clarify how cultural factors (e.g., racism, acculturation, racial identity) may relate to her or his maladaptive beliefs and conflicted feelings.	0	1	2	3	4	5	6	7	8	9
30. Respond in a therapeutic way when the client challenges your multicultural counseling competency.	0	1	2	3	4	5	6	7	8	9
31. Admit and accept responsibility when you, as the counselor, have initiated the cross-cultural impasse.	0	1	2	3	4	5	6	7	8	9
32. Help the client to develop new and more adaptive behaviors that are consistent with his or her cultural background.	0	1	2	3	4	5	6	7	8	9
33. Resolve misunderstanding with the client that stems from differences in culturally based style of communication (e.g., acquiescence versus confrontation)	0	1	2	3	4	5	6	7	8	9
34. Remain flexible and accepting in resolving cross-cultural strains or impasses.	0	1	2	3	4	5	6	7	8	9
35. Treat culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness).	0	1	2	3	4	5	6	7	8	9
36. Help the client to utilize family/community resources to reach her or his goals.	0	1	2	3	4	5	6	7	8	9
37. Deliver treatment to a client who prefers a different counseling style (i.e, directive versus non-directive).	0	1	2	3	4	5	6	7	8	9

APPENDIX G:
GENERAL DEMOGRAPHIC QUESTIONNAIRE

General Demographic Questionnaire
Mitchell, 2018

Research ID # (Office Use): _____   Date: _____

Directions: Please circle only one answer or fill in the blank.

1. What professional field do you most identify with?

   A. Fill in the blank: _____

2. As a professional that provides therapeutic services to clients, what is your primary work

   setting? (i.e., School, Community)

       A. Fill in the blank: _____

3. What gender do you most identify with?

   A. Male   C. Transgender

   B. Female   D. Other _____

4. What is your age?

   A. Fill in the blank: _____ years

5. What race(s) do you most closely identify with?

   A. American Indian or Alaska Native   E. Multi-racial

   B. Asian   F. Native Hawaiian or Pacific Islander

   C. Black or African American   G. Other: _____

   D. Hispanic or Latino(a)   H. White

6. What is the highest level of education and degree you have completed?

   A. Fill in the blank: _____

7. How many years have you been working in the field as a professional that provides
   therapeutic services to clients?

       A. Fill in the blank: _____ years

Please continue to the next page… ➡

General Demographic Questionnaire
Mitchell, 2018

Directions: Please circle only one answer or fill in the blank.

8. Are you currently enrolled as a Masters student?

      A. Yes   B. No

9. How many credit hours have you completed in your current preparation program?

      A. Fill in the blank: _____

10. Are you enrolled in a Nationally Accredited Program (e.g., APA, CACREP, CSWE)?

      A. Yes   B. No

11. What licenses or certifications do you possess? _____

Thank you for Completing the General Demographic Questionnaire!

APPENDIX H:
RECRUITMENT EMAIL

Subject: Multicultural Competent Therapy: Potential Assistance in Study 2nd Call-AERA Division E Graduate Students

Date: Tuesday, March 13, 2018 at 5:59:32 PM Eastern Daylight Time

From: Michelle Mitchell

To: cmckinzie

Mrs. Bennett,

I hope this email finds you well. I am emailing you because we recently spoke about providing AERA Division E Graduate Students with another opportunity to assist with my dissertation study which focuses on multicultural competence self-efficacy. Participation in this study would require for me to disseminate a battery of assessments to your students (e.g., counselors in training). Engaging in this research study allows for participants to become introspective about their clinical skills and working with persons that are different from them. Additional information about my IRB-approved (*IRB Number: SBE-17-13380*) research investigation can be found below.

Participation in this study is part of an academic effort to learn more about professionals' confidence in their abilities to provide therapeutic services to diverse client populations. In particular, the results of this study will **assist in the development of a new assessment**. Therefore, I kindly ask you to consider providing your members with this research opportunity, which will allow for them to share their confidence about providing therapeutic services to client populations through the completion of the enclosed surveys. The surveys will only take approximately **5-10 minutes** to complete.

If you have any additional questions or comments about this study, please direct them to the principal investigator by calling (412) 436-9078 or by email at Michelle.Mitchell@ucf.edu or Dr. Glenn Lambie, Faculty Advisor, College of Education and Human Performance at (407)-823-4779 or by email at Glenn.Lambie@ucf.edu.

Click here to participate in the research study:
http://ucf.qualtrics.com/jfe/form/SV_0lGx8NQX9mrhepT

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Michelle D. Mitchell, MSEd, LPC-PA, NCC
2017 NBCC Minority Fellow
2017-18 AMCD Graduate Student Representative
Doctoral Candidate, Counselor Education
College of Education and Human Performance
University of Central Florida
Email: MDMitchell@knights.ucf.edu

"Everything that irritates us about others can lead us to an understanding of ourselves." - Carl Jung

APPENDIX I:
MAIL OUT COVER LETTER

UNIVERSITY OF CENTRAL FLORIDA

Community Counseling and Research Clinic
College of Education and Human Performance
Attention: Michelle Mitchell
P.O. Box 161250
Orlando, FL 32816-1250

February 1, 2018

Dear Participant,

This letter is to ask you to help us conduct our research study conducted at the University of Central Florida. This study is part of an academic effort to learn more about professionals' confidence in their abilities to provide therapeutic services to diverse client populations. In particular, the results of this study will assist in the development of a new assessment.

We want you to know that we highly value your participation. Your participation is very important for therapists, researchers, and preparation programs, as the results from this study will lead to better understanding of your own ability and educational experiences as a professional and/or graduate student.

Therefore, we kindly ask you to take a few minutes and share your confidence with us about providing therapeutic services to diverse client populations through the completion of the enclosed surveys. The surveys will take approximately **5-10 minutes** to complete.

Please be assured of the confidentiality of your answers. We will not identify individual respondents in any of the reports originating from this survey project. In addition, we want you to know that this is an academic survey effort with absolutely no ties to any corporate or marketing interests. We are sincerely interested in conducting this survey as part of an academic study. Your participation in this study is voluntary. However, your response would be great value to us.

If you have any questions or comments about this study, please direct them to the principal investigator by calling (412) 436-9078 or by email at Michelle.Mitchell@ucf.edu. We would be happy to assist you in any way we can. Thank you so much for your participation in this study. We really appreciate your feedback.

Most sincerely,

Michelle D. Mitchell, MSEd, LPC-PA, NCC
UCF College of Education and Human Performance, ED 192L
Orlando, FL 32816-1250
Phone: 412-436-9078
Michelle.Mitchell@ucf.edu

COLLEGE OF EDUCATION & HUMAN PERFORMANCE

APPENDIX J:
EMAIL PERMISSION FOR USE OF MCSE-RD

Subject: RE: Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSES-RD): Research Dissemination Request

Date: Wednesday, November 8, 2017 at 7:34:31 PM Eastern Standard Time

From: Sheu, Hung-Bin

To: Michelle Mitchell

CC: boblent@umd.edu

Attachments: MCSE-RD-37_Distribution Copy_R1.pdf

Michelle,

Thank you for your interest in the MCSE-RD! Attached please find the instrument, a brief introduction, and its scoring protocol. You have my permission to use it for your dissertation project. Best luck!!

Hung-Bin

Hung-Bin Sheu, Ph.D.
Associate Professor
Department of Educational and Counseling Psychology
University at Albany, SUNY

From: Michelle Mitchell [mailto:MDMitchell@Knights.ucf.edu]
Sent: Wednesday, November 08, 2017 7:25 PM
To: Sheu, Hung-Bin
Cc: boblent@umd.edu
Subject: Re: Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSES-RD): Research Dissemination Request

Drs. Sheu & Lent,

I hope this email finds you well. My name is Michelle Mitchell and I am a Doctoral Candidate at the University of Central Florida (UCF) in Orlando, FL. I am presently constructing an assessment for my dissertation, the MCA. The purpose of this investigation is to develop and assess the factor structure of an instrument designed to measure mental health professionals' confidence in their abilities to provide clinical services to diverse clients. When reviewing potential validation measures the Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form (MCSES-RD) appears to be an excellent instrument to incorporate. Please let me know if I would be able to utilize this measure in my research study. Thank you for your time and consideration.

--
Michelle D. Mitchell, MSEd, LPC-PA, NCC
2017 NBCC Minority Fellow
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"Everything that irritates us about others can lead us to an understanding of ourselves." - Carl Jung

APPENDIX K:
EXPERT REVIEWER INSTRUCTIONS

Expert Reviewer Instructions

1. Please briefly review the attached document entitled, MCA Training Manual. Information on the construct of multicultural counseling competency and other areas comprising multicultural competency as supported in the literature is provided.

2. Please open the attached word document and rate the relevance of each individual item **(High, Moderate, or Low)** to the construct of multicultural counseling competency. If an item is identified as having low relevance, **please note the reasoning and comment on any other individual items as you see fit.**

3. Please review the relevance of each sub-scale to the theoretical domain. Please feel free to **use track changes or use notes** if you find the subscales are not relevant to the theoretical domain or if you have suggestions for where the irrelevant sub-scales might fit in.

4. Please evaluate the items for clarity, wording, and readability. Please feel free to **use track changes or use notes** if you have **suggestions that would to assist with wording, clarification, and readability of the items.**

APPENDIX L:
MCA BLUEPRINT/MANUAL

MCA Item	Factor Name	Literature Support
Question 5- Describe elements of culture specific developmental models Question 8- Integrate clients' cultural heritage when implementing techniques Question 9- Connecting clients with culture specific resources Question 12- Conceptualize clients through culture specific developmental models Question 13- Tailor approaches based upon clients' cultural beliefs Question 17- Identify culturally appropriate resources Question 18- Utilizing culture specific developmental models Question 19- Modify therapeutic strategies to honor the cultural identities Question 20- Articulate how cultural group membership impacts clients lives Question 23- Modify therapeutic interventions to meet the cultural needs	Knowledge, Skills, & Interventions	Anderson, 2000; Arredondo et al., 1996; Harper, Finnerty, Martinez, Brace, Crethar, Loos,...Lambert, 2012; Lewis et al., 2003; Ponterotto, Rieger, Barrett, & Sparks, 1994 Ratts et al., 2016
Question 7- How my principles impact the therapeutic process Question 11- Which cultural beliefs are most important Question 16- Recognize my values may interfere with providing services Question 21- Convey the beliefs of my cultural groups Question 22- Cultural identity impacts the therapeutic process Question 24- Recognize beliefs may create clinical limitations	Awareness of Self	Anderson, 2000; Arredondo et al., 1996; Ratts et al., 2016; Sue, Arredondo, & McDavis, 1992
Question 1- Identify how clients' beliefs affect the therapeutic process Question 2- Recognize clients' cultural expectations of the therapeutic process Question 3 - Discussions about cultural mores (e.g., roles, expectations) Question 4- Identify barriers that impede mental health service access	Awareness of Client Worldview	Anderson, 2000; Arredondo et al., 1996; Lewis et al., 2003; Ratts et al., 2016; Sue, Arredondo, & McDavis, 1992
Question 6- Implications of privilege and clinical practice Question 10- Dialogue about socio-political issues and clients' mental health Question 14- Identify how privilege may influence the therapeutic relationship Question 15- Recognize how societal mistreatment impact their self-esteem Question 25- Identify when clients experience the world differently	Systemic and Institutional Barriers	Arredondo et al., 1996; Lewis et al., 2003; NASW, 2015; Ratts et al., 2016

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