12-2022

Therapists' Demonstrated Multicultural Competence in Treating Latinx Immigrants

Dulce Diaz Benitez
University of Arkansas, Fayetteville

Therapists' Demonstrated Multicultural Competence in Treating Latinx Immigrants

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Psychology

by

Dulce Diaz Benitez
University of Illinois at Chicago
Bachelor of Arts in Psychology, 2014

December 2022
University of Arkansas

This thesis is approved for the recommendation to the Graduate Council.

Ana J. Bridges, Ph.D.
Thesis Chair

Lindsay Ham, Ph.D.
Committee Member

Scott Eidelman, Ph.D.
Committee Member

Abstract

Studies suggest that health disparities occur when people from marginalized communities receive care that is inadequate based on their cultural needs (USDHHS, 2011). Multicultural competence (MCC) models have been proposed to provide a framework of the competencies that therapists should develop to work with multicultural populations (Sue et al., 1992). Researchers have questioned the validity of measures, which are mostly based on therapist self-report (Cartwright, 2008). The multicultural case conceptualization ability task has been used in previous studies as a measure of demonstrated cultural competence using a vignette to assess case conceptualization abilities (Ladany et al., 1997). However, it has not been determined if higher scores on the task indicate multicultural competence, or if it is a measure of good case conceptualization skills in general. The purpose of the current study was to examine the construct and criterion validity of a measure of demonstrated multicultural competence. I hypothesized that (1a) demonstrated multicultural competence would be positively correlated with self-reported competence (evidence of construct validity), (1b) demonstrated multicultural competence scores would be higher for the vignette depicting the client with multiple marginalized identities (undocumented Salvadoran woman) than the vignette depicting a White woman (evidence of construct validity), and (2) demonstrated and perceived multicultural competence would be predicted by greater hours of multicultural training, more clinical experiences with diverse clients, if participants were professionals rather than students, if therapists identified as a person of color, and lower colorblind racial attitudes (evidence of criterion validity). A sample of 80 psychologists were recruited to participate in a between-subject study. Participants were randomly assigned to read one of two vignettes portraying a woman referred to a therapist by her physician. One of the vignettes portrayed a minoritized

client (undocumented Salvadoran woman) while the other depicted a White woman. Participants were asked to imagine that this person was seeking services and were asked to write a description of the client's problems, the origins of those problems, and to generate a potential treatment plan. Participants answered self-report questionnaires, including demographic information, a multicultural competence scale, a colorblind racial attitudes scale, questions about their training and experience with diverse clients, and a social desirability scale. Hypothesis 1a was not supported, as no association was found between the measures of self-reported multicultural competence and demonstrated tasks of multicultural competence. This study did not demonstrate construct validity of the MCCA. Hypothesis 1b was also not supported, as there were no significant differences between scores for the two vignette conditions and failed to establish construct validity of the MCCA. Results of hypothesis 2 was partially supported. The MCCA was not predicted by therapist variables, but other measures of multicultural competence were predicted by some of the therapist variables. This study suggests the importance of several forms of learning multicultural competence, through courses, experience with diverse clients, or other methods of engaging with people from other cultures. It also suggests the value in measurement of multicultural competence, and the utility of both self-reported measures and demonstrated tasks.

Table of Contents

Therapists' Demonstrated Multicultural Competence in Treating Latinx Immigrants

Introduction

Research has demonstrated that there are existing mental health disparities in the United States by race, ethnicity, gender, sexual orientation, and other sociodemographic characteristics (USDHHS, 2011). People from systematically marginalized communities, such as those who are low-income, immigrants and refugees, or people with disabilities, continue to be underserved despite calls for action (APA, 2017). Individuals from groups that face racism, sexism, and other forms of discrimination have worse mental and physical health outcomes than their dominant group counterparts because of these social stressors (Schwartz & Meyer, 2010). Despite a growing literature on mental health disparities in underserved groups, people from marginalized communities continue to lack access to appropriate mental health services (Safran et al., 2009).

One group that faces multiple barriers when attempting to accessing care is undocumented immigrants. As of 2017, about 44.4 million immigrants from around the world live in the United States (Radford, n.d.). It is estimated that about 10.5 million undocumented immigrants live in the United States. The term "undocumented immigrant" refers to immigrants who are in a country without documentation who have overstayed their visas or have entered the country without inspection (Messias, 1996). Low mental health service utilization rates have been found for immigrants, and even lower rates for undocumented immigrants (Derr, 2016). Even when immigrants can access care, they tend to drop out of therapy at faster rates than those who were born in the U.S. (Perez & Fortuna, 2005).

Barriers to accessing care for undocumented immigrants include lack of health insurance and language barriers. Lack of health insurance is a major reason that immigrants do not access mental health care (Chen & Vargas-Bustamante, 2011; Derose et al., 2007). Chen & Vargas-

Bustamante (2011) estimate that if non-citizens had the same access to insurance and services that U.S. citizens do, mental health care utilization disparities for non-citizens would be reduced by 20-30 percent. Without insurance, affording therapy is not easy for immigrants (Shattell et al. 2008). A qualitative study looking at the experiences of undocumented immigrants when accessing healthcare found that many were unable to get services because of language barriers and experienced hostile environments when they did seek care due to their documentation status or lack of English fluency (Cleaveland & Ihara, 2012).

Additionally, undocumented immigrants have reported a reduced trust in the healthcare system, further decreasing their likelihood of accessing services. State-level immigration laws have spiked since 2007 and appear to negatively impact immigrant and non-immigrant Latinx health (Philbin et al., 2018). Researchers have found that a decrease in outpatient mental health service use was associated with the passage of Proposition 187 in 1994, a California policy that would have made undocumented immigrants ineligible for state-funded services (Berk & Schur, 2001; Fenton et al., 1996). In certain states, laws require documentation when accessing services (Ayon, 2014). An increase in Immigration and Customs Enforcement (ICE) activity in Everett, Massachusetts was associated with reduced health and health access according to health providers in the area (Hacker et al., 2012). Immigrant communities in Everett reported that they did not trust those in positions of authority, such as police, health care providers, and health insurers, as they believed authorities could report them to ICE. In a qualitative study of health concerns and access to care in undocumented youth, mistrust of health and mental health providers was a theme (Raymond-Flesch et al., 2014).

Studies have found that undocumented immigrants do not feel welcome or understood by mental health care providers. For example, participants expressed that providers lack knowledge

and sensitivity about their status and reported experiences with discrimination (Raymond-Flesch et al., 2014). Research has suggested that building trust with mental health providers occurs when the client is understood both in terms of their preferred language and their culture (Ruiz et al., 2013).

In a study examining perceptions of undocumented immigrants held by providers, Alfaro and Bui (2018) found that most mental health providers were not in agreement with Arizona SB 1070 (a law requiring that non-citizens carry proof of documentation) and similar bills in other states. In their study, mental health providers were given a measure of cultural competence. Higher cultural competence scores and an indication of less negative stereotypes by the providers were associated with more positive attitudes towards undocumented immigrants.

Because of the unique sociocultural issues that marginalized communities face in accessing and continuing therapy, it is important to acknowledge these issues in assessment and treatment. Hernandez and colleagues suggest that disparities in mental health access exist not only because of how policies and processes for seeking local services are related to availability of services and their accessibility, but also because of a disconnect between the available services and the sociocultural context of the communities served (Hernandez et al., 2009).

According to the American Psychological Association's (APA) *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, therapists are advised to consider how race and racism can impact clients as well as the dangers in having color-blind racial beliefs as a therapist (APA, 2003). Colorblindness racial ideology refers to the denial or minimizing of race and racism (Neville et al, 2000). According to the APA report, therapists who do not acknowledge the impact of racism on mental health may also minimize the impact of racism on the therapeutic process. Spanierman &

Heppner (2004) found that higher levels of colorblindness were positively associated with higher levels of fear of minorities and less negative feelings about racism. Neville et al. (2006) examined the association between color-blind racial ideology and cultural competency, finding that therapists who held color-blind racial ideologies were less likely to consider race in a case conceptualization. Although not explicitly measuring colorblindness ideology, other studies have found evidence that clients become frustrated when counselors avoid talking about race, and rate racially conscious therapists more positively than therapists who avoid race (Thompson & Jenal, 1994; Want et al., 2004).

Multicultural Competence

One method of addressing disparities based on a person's sociodemographic group characteristics is through multicultural competence. One of the most prominent models of multicultural competence was developed by Sue and colleagues (Sue et al., 1992). According to this tripart model, culture includes race, ethnicity, class, religion, sex, age, and sexual orientation. This model emphasizes three competencies or tools for working with culturally diverse populations: (1) beliefs or attitudes, (2) knowledge, and (3) skills. It is based on a previous call for cultural competence in mental health services (Sue et al., 1982) and on the *Guidelines for Providers of Psychological Services to Ethnic and Culturally Diverse Populations* (Guzman, 1993). These three competencies apply to the counselor's awareness of their own assumptions, values, and biases, their understanding of the client's worldview, and in the development of appropriate treatment.

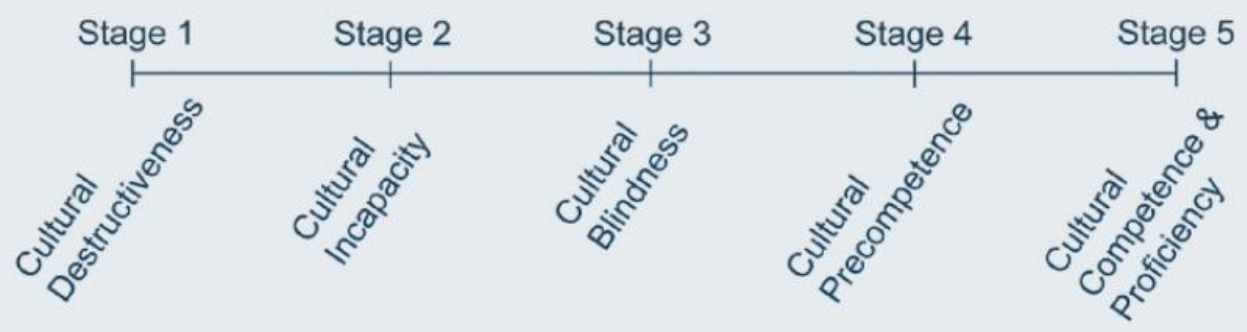
Sue (1998) has outlined characteristics that are important for multicultural competence including scientific mindfulness, dynamic sizing, and culture-specific skills. Providers who are scientifically minded can develop multiple hypotheses and rely on data to conceptualize their

clients' difficulties rather than reaching premature conclusions based on the client's cultural background. Similarly, dynamic sizing refers to the clinician's ability to know when to generalize and consider larger cultural explanations and when to focus on the client's individuality. Culture-specific skills refer to having some knowledge about the client's culture.

Cross and colleagues (1989) have outlined several states or levels of cultural competence (see Fig. 1). They state that a culturally competent clinician recognizes the importance of culture, is attuned to cultural differences, and focuses interventions to attend to relevant cultural needs. This continuum has been used to describe levels of cultural competence at the individual and organizational levels. At the lower end of the scale is cultural destructiveness (Stage 1), or intentionally harmful attitudes and practices towards other cultures. The next stage is cultural incapacity (Stage 2), or a lack of knowledge of the cultural implications of health behavior. At this stage, the intent to be harmful is not present, but harm through ignorance still occurs. Cultural blindness is in the middle of the spectrum (Stage 3) and describes a colorblind system that claims to be equal. A system or individual at this stage believes that there are no differences among cultures. Cultural pre-competence (Stage 4) occurs when there is awareness of lack of development in multicultural competence. Systems or individuals at this level are open to training but may be limited in the knowledge they have already acquired. The last stage (Stage 5), cultural competency and proficiency, occurs when organizations or therapists recognize that cultural differences exist and need to be considered in assessment, treatment planning, and therapy. Cultural proficiency occurs when a clinician commits themselves to the task of continuous learning and striving for cultural competence.

Figure 1

The Continuum of Cultural Competence



Note. Reprinted from Improving Cultural Competence, *Substance Abuse and Mental Health Services Administration*, 2014.

Importance of Multicultural Competence

Working with clients from diverse backgrounds without suitable training can be harmful (Sue et al., 1992). According to Sue (2003), health disparities are caused in part when people get care that is biased, racist, or inadequate. Sue argues that despite the growth in attention to multiculturalism in mental health care, psychologists continue to need to advocate for the importance of cultural competence. For example, the field of psychology has historically developed interventions using primarily middle-class White populations (Sue, 2003), but as communities of color continue to grow, the need for mental health services for these communities also grows. Additionally, as the push for evidence-based practice in psychology grows, it leaves behind communities that are typically excluded from that research.

In a study with counselor-client dyads, clients of color (Black American, Latinx American, Asian American, and Biracial American) assessed their clinicians (Black, Latinx, and White) on four major multicultural counseling factors: awareness, knowledge, skills, and the therapist-client relationship (Constantine, 2001a). Results indicated that Black American and Latinx American clinicians were rated as more multiculturally competent than White Americans,

and that prior clinician training in multiculturalism was associated with higher multicultural competence ratings. These findings correspond with what undocumented immigrants have stated they want in their providers (namely, for their providers to be culturally competent; Hacker et al., 2011) and point to a potentially important modifiable factor that can increase therapy retention rates of marginalized groups, thus reducing health disparities (Shattell et al., 2008).

Constantine (2001b) proposes that understanding the cultural variables in a person's life can lead to a more accurate diagnosis and more effective treatment than approaching treatment without cultural context. Cardemil & Battle (2003) report that although clinicians may have an appreciation of the importance of race and ethnicity, they may not be comfortable bringing up issues related to race and ethnicity in therapy and do not know when or how they should be brought up. They suggest that bringing up these types of issues with clients can serve to enhance the therapeutic alliance and combat the issue of retention. Therapists should raise cultural elements related to the client's concerns first, due to the power differential in the relationship (Day-Vines et al., 2018). Day-Vines and colleagues call this process "broaching," or an ability to include and address factors such as race, ethnicity, and culture with clients (Day-Vines et al., 2007). Nevertheless, discussions of these types require skills to navigate them successfully and avoid creating larger rifts, which is where multicultural competency training becomes important.

Training

The American Psychological Association recently updated their multicultural guidelines, which for the first-time focus on a broader definition of culture (APA, 2017). These guidelines include recommendations for working with clients from diverse gender, social class, immigration status, and ethnic groups; a second set of guidelines focused exclusively on race and ethnicity (APA, 2019). The guidelines define cultural competence as including cultural humility, focusing

on lifelong learning rather than an end goal of cultural competence. While the last report, published in 2003 (APA, 2013), focused on Sue and colleagues' (1982, 1992) multicultural competence model, the APA guide was based on a new model created by the task force. This model, called the Layered Ecological Model of the Multicultural Guidelines, is based on Bronfenbrenner's ecological model (Bronfenbrenner, 1977). While these guidelines incorporate a lot of the newer multicultural competency literature, the guidelines are aspirational rather than articulating concrete training guidelines.

Historically, psychology graduate programs have had limited multicultural training (Allison et al., 1994; Quintana & Bernal, 1995). Training in professional psychology programs typically involves courses or workshops focused on multiculturalism. Outcome studies on trainings are limited. Bardone-Cone and colleagues (2016) found that multicultural training in a clinical psychology program was evaluated positively by students. However, concrete indicators of increased multicultural competence were not evaluated.

A recent study found differences in students' perception of multicultural training and general climate towards the importance of multiculturalism by student characteristics (Gregus et al., 2019). Specifically, there was an association between perception of training and student ethnicity, such that Black students were less likely to perceive their program as having adequate training compared to White students. Relatedly, Chao (2013) found that student survey respondents who had prior multicultural training had higher multicultural competence scores across racial and ethnic backgrounds. However, Chao's study suggested that at higher levels of multicultural training, White and non-White students have similar levels of multicultural competence, while at low levels of training, non-White students have higher levels of multicultural competence. Chao suggests that students of color might benefit from different

training, since many multicultural competence trainings might be geared towards White therapists.

Measuring Multicultural Competence

While there are multiple measures of multicultural competency for individuals, most rely on self-report. Many measures are based on Sue et al.'s (1982) model of cultural competency and assess knowledge, awareness, and skills therapists must work with individuals from different cultural backgrounds. These measures are reviewed below.

The Multicultural Awareness-Knowledge-and-Skills Survey (MAKSS) was originally designed for a cross-cultural course evaluation for use with trainees (D'Andrea et al., 1991). The 60-item self-report measure uses a four-point rating scale and is composed of three subscales measuring awareness of attitudes towards ethnic minorities, knowledge about ethnic minorities, and communication skills for working with culturally diverse populations. Item responses on the MAKSS use a four-point Likert-type scale ranging from "Strongly disagree/very limited to "strongly agree/ very aware." The measure shows good internal consistency reliability, with Cronbach alpha coefficients of .75 for the Awareness scale, .90 for Knowledge, and .96 for the Skills subscale. Critiques of this scale include the small sample size used for validation ($N = 90$), and the use of factor analysis by subscale rather than the entire scale (Pope-Davis & Dings, 1995).

The Multicultural Counseling Inventory (MCI; Sodowsky et al., 1994) measures awareness, knowledge, skills, and the counseling relationship with clients of diverse cultures with 40 self-report Likert-scale questions. The MCI seeks to measure concrete behavioral aspects related to cultural competency, with questions such as "When working with minority clients, I keep in mind research about minority clients." Responses are on a four-point rating scale from

"very inaccurate" to "very accurate." This measure was normed with Psychology students, psychologists, and counselors. Cronbach alpha for the total MCI score is .87, and mean Cronbach alphas of .78 for the Awareness subscale, .77 for Knowledge, .80 for Skills, and .68 for Counseling Relationship. The Multicultural Counseling Awareness Scale (MCKAS) (Ponterotto et al., 1996) is a 32-item measure using a 7-point Likert-type scale assessing self-reported multicultural counseling knowledge and awareness of bias. Item responses range from not at all true to totally true and assess bias with items such as "I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted." and knowledge with items such as "I am knowledgeable of acculturation models for various ethnic minority groups." This measure was normed with students and professionals in counseling psychology. Cronbach alpha for both scales (Knowledge and Awareness) is .85 (Ponterotto et al., 2002).

The Multicultural Counseling Self-Efficacy Scale–Racial Diversity Form (MCSE-RD; Sheu & Lent, 2007) also aims to measure more of the behavioral aspect of cultural competence and focuses on the skills component. It is based on Bandura's (1977) social cognitive concept of self-efficacy. This survey measures perceived abilities, or the therapist's confidence in providing services to diverse clients. The MCSE-RD scale correlated more highly with the Multicultural Counseling Skills subscale of the MCI than the scales of the MCI that did not intend to measure behavior. Cronbach alpha for the overall scale is .98, and subscale reliability coefficients were .98 for Intervention, .92 for Assessment, and .94 for Session Management.

The Cross-Cultural Counseling Inventory- Revised (CCCI-R; LaFromboise et al., 1991) is one of the only measures of cultural competency that does not rely on self-report. Instead, supervisors can use this as an assessment tool for measuring trainees' cultural competence. It is a

20-item measure of counselor effectiveness in working with culturally diverse clients, measuring therapist awareness, knowledge, and skills. Cronbach alpha for the measure is .90. The original version of this measure (CCCI; Hernandez & LaFromboise, 1985) was one of the first measures of multicultural competence.

Problems with Current Measures

Since most measures of cultural competence are based on self-report, some authors have questioned their construct validity—do they measure actual multicultural competence, or only perceived competence? Previous research has shown that self-report is not always associated with assessed or observed behaviors (Vazire & Mehl, 2008). Cartwright and colleagues (2008) suggested that self-reported cultural competence scores were higher than observer-rated cultural competence in role-plays in counseling psychology graduate students. There is also a problem with social desirability, as people tend to self-report in a manner that appears favorable (Pope-Davis & Dings, 1994). Some cultural competency measures attempt to account for social desirability, but it is unclear how effective they are. Constantine and Ladany (2000) found an association between social desirability and three of four multicultural competence scales (the MCI, the MAKSS, and the CCCI-R). Most measures are based in Sue et al.'s (1982) model of cultural competence, but APA has been moving towards a more ecological model of cultural competence. model lacks empirical support. Additionally, most measures do not accurately capture the different dimensions that comprise cultural competency, such as skills or actual behaviors.

Demonstrated Cultural Competence

Despite the development of several self-report measures, there is a need for measures that can directly assess multicultural competence. Ladany et al. (1997) were the first to empirically

test therapists' ability to conceptualize a case from a multicultural perspective. The authors developed a measure to investigate the relationship between demonstrated multicultural ability, through a case conceptualization task, self-reported multicultural competence, and racial identity. The multicultural case conceptualization ability (MCCA) task requires that participants read a case study discussing a 19-year-old African American female undergraduate student, her depressive symptomology, and psychosocial issues potentially relevant to the case. Participants are asked to write about the potential origins of the client's difficulties and a potential treatment plan or approach. Responses are coded for use of culture in conceptualization through differentiation and integration, processes that are similar to Sue's (1998) dynamic sizing and scientific mindfulness. Differentiation is defined as the ability to offer a greater number of interpretations of the client's difficulties and treatment, and integration is the ability to form connections between the interpretations. Higher differentiation and integration scores indicate a higher multicultural case conceptualization ability. In this way, the MCCA focuses more on cognitive flexibility and integration than on a specific skill or specific knowledge about a culture.

The MCCA has good reliability for both etiology conceptualization and treatment, with alpha coefficients ranging from .82 to .93 (Constantine, 2001b; Constantine & Ladany, 2000; Inman, 2006; Ladany et al., 1997). However, Ladany et al. (1997) did not find a significant association between scores on the MCCA and self-report measures of multicultural competency, potentially supporting previous research that shows therapists overestimate their counseling abilities, as therapist self-reported ratings were higher than their MCCA ratings (Oskamp, 1965). Since this study, several others have found similar outcomes when comparing self-reported multicultural competence and demonstration of the competence through a case conceptualization task.

Neville et al. (2006) examined the relationship between levels of colorblind ideologies and self-reported and demonstrated levels of multicultural competency using the MCCA (demonstrated competence) and the MCKAS (self-reported competence). Additionally, the authors controlled for multicultural training (number of courses and practica focused on multicultural education). Neville et al.'s study found an association between higher colorblind racial ideology and lower scores on both the MCKAS and the MCCA. While the study contributed to previous research on the association between colorblind racial ideology and conceptualization of client problems, it did not control for social desirability, it potentially primed one of their samples about the nature of the study by having them complete the colorblind ideology measure first, and it did not include a racially diverse sample of mental health providers. Additionally, perceived (MCKAS) and demonstrated (MCCA) cultural competence were collected separately to reduce participant fatigue, thus preventing comparative associations between the two MCC measures.

One remaining critique of the MCCA is that it has not been determined if it is assessing multicultural competence or if is a measure of good case conceptualization skills generally. It is likely that good therapists would generate multiple explanations for the origin of symptoms and create more complex treatment recommendations in response to a clinical vignette because they are good therapists generally, and not necessarily because they are good multicultural therapists specifically. The ability to determine whether the MCCA can differentiate good multicultural therapists from good therapists in general is critical to establishing the construct validity of this measure.

Another measure of demonstrated multicultural competence is the Multicultural Counseling and Psychotherapy Test (MCPT). This measure is a standardized test in which items

reflect content from multicultural therapy guidelines and including questions related to knowledge, awareness, and skills (Gillem et al., 2016). The test was validated with 32 experts in the field of multicultural research and practice and with licensed mental health professionals. The authors developed this measure as a less subjective way to measure cultural competence than the MCCA, but to help with the problem with discrepancies between self-report measures and actual behaviors in therapy.

Purpose

The current study examined variables previously found to be associated with perceived or self-reported multicultural competence and extends that literature by incorporating a task requiring therapists to demonstrate multicultural competence in a case conceptualization task. Previous studies have used generic terms such as "ethnic minorities" in measures to evaluate multicultural competence. This study used more specific language to describe a client in a clinical vignette and incorporated sociodemographic variables other than race/ethnicity (specifically: immigration/documentation status). The study explored predictors of perceived and demonstrated cultural competence in therapists. Specifically, this study examined how clinical experiences with diverse clients, extent of prior multicultural training, prior multicultural experiences, professional status (student or professional), participants' race/ethnicity, and colorblind racial attitudes were associated with perceived and demonstrated multicultural competence. The study aimed to establish the construct and criterion validity of a measure of demonstrated multicultural competence (the Multicultural Case Conceptualization Ability task; MCCA). I hypothesized the following:

- H1a: The Multicultural Case Conceptualization Ability task would show good construct validity. Specifically, demonstrated multicultural competence (MCCA) would be positively correlated with self-reported multicultural competence (MCKAS).
- H1b: Further supporting the Multicultural Case Conceptualization Ability task's construct validity, I hypothesized that ratings of differentiation and integration would be higher in the vignette depicting a client with multiple marginalized sociodemographic identities (undocumented Salvadoran woman) than in the vignette depicting a White woman.
- H2: The Multicultural Case Conceptualization Ability task would show good criterion validity. I hypothesized that Multicultural Case Conceptualization Ability task scores would be predicted by greater hours of multicultural training, more clinical experiences with diverse clients, more multicultural experiences, professional (vs. student) status, identifying as a person of color, and lower colorblind racial attitudes.

Method

Participants

Participants included psychologists or psychologists-in-training from APA-accredited programs who had at least one current client. All participants had to reside in and have received their graduate training in the United States. A total of 80 participants were recruited online through social media (Twitter, Facebook) and professional listservs (ABCT, NLPA, APA division listservs). Participants mostly identified as female (86%) and ranged between 21 to 67 years of age (M = 30.30, SD = 7.62). Regarding race/ethnicity, 40% of participants identified as non-Hispanic White, 30% as Latinx, 17% as Asian, 6% as Black, and 6% as biracial/multiracial. Most participants were born in the United States (78%), 50% had at least one parent that was

born outside of the U.S., and 51% spoke at least one other language. Additional participant demographic data can be found in Table 1.

Table 1

Participant demographics

Variable	M (SD)	%
Age	30.30 (7.62)	
Years living in US (*n* = 18)	14.89 (8.27)	
Years in practice	5.06 (5.94)	
Profession		
Graduate trainee		66
Professional		34
Gender		
Female		86
Male		10
Other		4
Country of birth		
U.S.		78
Other		22
Language		
Other language		51
Only English		49
Parents country of birth		
Both in US		50
One in US		11
Neither in US		39
Education completed		
Bachelors		10
Masters		60
PhD		25
PsyD		5
Type of program		
Counseling psychology		34
Clinical psychology		61
Other		3
Race/Ethnicity		
Latinx		30
Black		6
Asian		17
Biracial/Multiracial		6
White, non-Hispanic		40

Measures

Demographic information. Participants completed a demographic questionnaire. Questions included age, gender, ethnicity, country of birth, generational status in the US, current geographical location, and highest level of education completed. Participants were also asked about the type of facility they work in, length of time practicing, and primary theoretical orientation.

Colorblind attitudes. The Colorblind Racial Attitudes Scale (CoBRAS) is a 20-item self-report scale (Neville et al., 2000). The scale was developed to assess the extent to which respondents minimize or deny the existence of institutional racism. Items are responded to on a 6-point Likert type scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Total scores are calculated by summing all items and can range from 20 to 120; higher scores indicate higher levels of colorblindness or unawareness of institutional racism. The scale is comprised of three factors: Unawareness of Racial Privilege, Unawareness of Institutional Discrimination, and Unawareness of Blatant Racial Issues. Internal reliability coefficients for all three factors in the original sample ranged from .70 to .86 (Neville et al., 2000). Correlations between the CoBRAS's three factors and two scales measuring belief in a just world ranged from .39 to .61, suggesting good concurrent validity. In this study, an overall score was used, for which internal consistency was .83.

Multicultural training. Level of clinician multicultural training was assessed by asking participants to estimate the total number of hours spent in courses, practica, workshops, and research projects that had a multicultural focus. Higher scores indicated more hours of multicultural training. Similar estimates of multicultural training have been used in prior studies. However, previous studies have primarily measured training by number of courses and practica

(e.g., Constantine & Ladany, 2006; Neville & Spanierman, 2006), or as a dichotomous (yes/no) measure (e.g., Ladany et al., 1997). Hours was determined to be a preferred measure of prior multicultural training and was thus what was used in this study.

Experience with diverse clients. Clinicians were asked to estimate the number of hours they had spent working with diverse clients. Categories of diverse clients included clients of non-White background, members of the lesbian, gay, bisexual, and transgender community (LGBT+), and immigrants and refugees. Higher scores indicated greater time spent working with diverse clients.

Multicultural experiences. The Bidimensional Multicultural Experience Scale was used to measure experiences participants had with cultures other than their own (Sparkman & Eidelman, 2018). This scale consists of 10 items rated on a 5-point scale and is comprised of two components: 1) experiences with other cultures, and 2) experiences with people from other cultures. Items on this scale included: "How many times have you been in a situation where you must behave in a way that is different from your own culture?" and "I eat at restaurants specializing in cuisine from different cultures." This measure has been found to correlate negatively with a measure of ethnic and immigrant prejudice, and positively with an identification with humanity, a measure of how connected participants felt to others in the world. Internal consistency for this measure is adequate (.80 for culture, and .70 for cultural members). Internal consistency for this study was .70 for experiences with other cultures and .73 for contact with members from other cultures. These two scales were positively correlated (r = .55).

Perceived cultural competence. Perceived cultural competence was assessed using the revised version of the Multicultural Counseling Knowledge and Awareness Scale (MCKAS) (Ponterotto et al., 1996). The MCKAS is a 32-item self-report scale assessing two domains of

cultural competence: knowledge (20 items) and awareness (12 items). Each item is answered using a 7-point scale ranging from 1 (*not at all true*) to 7 (*totally true*). A sample knowledge domain question is: "I understand the impact and operations of oppression and the racist concepts that have permeated the mental health professions." A higher score in the knowledge domain indicates more knowledge about multicultural counseling. A sample awareness domain question is: "I am aware that being born a White person in this society carries with it certain advantages. A higher score in the awareness domain indicates more multicultural awareness. Total scores for each subscale are obtained by reverse coding 10 items in the awareness scale and summing the total items in each scale. Internal reliability coefficients in the original sample for both subscales were .85 (Ponterotto et al., 2002). The MCKAS correlates with other self-report measures of multicultural competence, such as the Cross-Cultural Counseling Inventory-Revised (r = .61), the Multicultural Awareness-Knowledge-and-Skills Survey (r = .76), and the Multicultural Counseling Inventory (r = .61) (Constantine & Ladany, 2000). In this study, internal consistency was .93 for Knowledge and .87 for Awareness.

Demonstrated cultural competence: Multicultural Case Conceptualization Ability. A modified version of the vignette used in the Multicultural Case Conceptualization Ability (Ladany et al., 1997, modified by Constantine, 2001, and Inman, 2006) was used to assess demonstrated multicultural competence. In this between-subjects study design, participants were presented with one of two vignettes portraying a woman referred to a therapist by her physician. After participants read the vignette, they were asked to describe the etiology of the client's psychological difficulties and potential treatment strategies.

The modified procedure by Inman (2006) was used for scoring vignette case conceptualization responses. Ladany et al. (1997) define multicultural case conceptualization

ability as the extent to which salient race/ethnicity factors are integrated into the source of and treatment for the client's presenting concerns. Coding incorporated two cognitive processes: differentiation and integration. Differentiation refers to the ability to offer culturally-based interpretations, measured as the number of different ideas or interpretations of the client's problems and treatment strategies. The more culturally-based interpretations offered that are relevant to the case, the higher the differentiation score. Integration refers to the ability to form connections between the differentiation responses. This coding system has been found to have high interrater reliability for both etiology (r = .82) and treatment (r = .88) (Inman, 2006).

In the current study, two coders were trained on the coding system until they reached at least 85% interrater agreement. Consistent with scoring developed by Inman (2006), total scores for each participant's vignette responses ranged from 0 to 6, where 0 = no differentiation, no integration (no indication of race/ethnicity or other cultural considerations in case conceptualization and treatment planning); 3 = moderate differentiation, low integration (two or more indications of potential cultural issues in the conceptualization of the client's problems, with one integration, i.e., one connection made between the two or more differentiated concepts); and 6 = high differentiation, high integration, (six or more mentions of potential cultural issues in the conceptualization of the client's problems, with three or more connections made between differentiated concepts). Participants had two scores, one for their conceptualization of treatment, and one for their conceptualization of the etiology.

Demonstrated Cultural Competence: Multicultural Counseling and Psychotherapy Test. Demonstrated cultural competence was also measured using the Multicultural Counseling and Psychotherapy Test. This test is a 50-item multiple choice test that assesses knowledge, awareness, and skills (Gillem et al., 2016). Questions were developed from multicultural

counseling guidelines and include both true/false and multiple-choice formats. Internal consistency for this measure was .83 (Gillem et al., 2016); in the current study, internal consistency reliability was .88.

Professional status. Participants were asked about levels of education. If participants were students, they were coded as a "0" and participants who were working professionals were coded as a "1."

Person of color. Participants who identified as only White, non-Hispanic were coded as a "0" and participants that identified as Latinx, Black, Asian, Biracial, or Multiracial were coded as "1."

Social desirability. Because many psychologists and psychologists-in-training are familiar with the most used measure of social desirability (the Marlowe-Crowne Social Desirability Scale; Crowne & Marlowe, 1960), the Balanced Inventory of Desirable Responding (BIDR) Version 6 Impression Management (IM) subscale was used to measure social desirability (Paulhus, 1991). The BIDR IM subscale is a 20-item scale. Items are scored on a 1 (*not true*) to 7 (*very true*) Likert-type scale. A sample item is "I never cover up my mistakes." Higher scores indicate higher impression management. The BIDR demonstrated high concurrent validity with the Multidimensional Social Desirability Inventory (r = .80; Paulhus, 1991). Internal consistency reliability for this subscale is .78 (Paulhus, 1991); in the current study, internal consistency reliability was .82.

Procedure

Participants were recruited nationally through academic contacts and professional listservs, such as the American Psychological Association (APA) divisions, National Latinx Psychological Association (NLPA), American Psychological Association of Graduate Students

(APAGS), and the Association for Behavioral and Cognitive Therapies (ABCT). Interested participants were directed to an online screening survey on Qualtrics. Once participants indicated that they met criteria, they were emailed an individual link to the study survey through Qualtrics.

Participants read about the study and any risks and benefits associated with their participation and were given the option to continue only if they consented to participation. Participants were told that the researchers were interested in studying how different training experiences are associated with case conceptualization but were not informed about the multicultural competence focus of the study.

Participants read one of two vignettes portraying a woman who was referred by her primary care physician to a therapist. The vignettes were randomly assigned to each participant and were identical except that one version of the vignette described the woman as an undocumented Salvadoran woman, while the second version described her as a White woman.

Following the vignette presentation, participants were asked to imagine that this person was seeking services from them and were asked to write a description of the client's problems, the origins of those problems, and a potential treatment plan. Participants were instructed to write at least three sentences for their conceptualization of the problem, and at least three sentences for their proposed treatment plan. The vignette and case conceptualization components were completed before participants could move on to the self-report measures. Participants answered self-report questionnaires (described above, including demographic information, a multicultural competence scale, a colorblind racial attitudes scale, questions about their training and experience with diverse clients, and a social desirability scale). Finally, participants were debriefed at the end of the study and compensated with a $10 Amazon e-gift card. They were

also given the opportunity to share their contact information if they wanted to learn of the results of the study.

Power Analysis

An *a priori* power analysis for multiple regression was conducted using *G* Power* (Faul, et al., 2007). An anticipated effect size of $f^2 = .237$ was used in the calculation based on previous research on applied integration of conceptual material (Ladany et al., 1997). With an alpha = .05, power = 0.80, and three predictors, the projected sample size needed with this effect size was approximately 51 participants per vignette condition (102 participants total). A total of 131 participants started the survey. Out of those who began the survey, 102 completed the survey and, of these 102, 22 were identified as bots. Bots were identified by the time it took to complete the survey (under 30 minutes), as well as those who did not answer the qualitative questions correctly. Therefore, the study was slightly underpowered (final $N = 80$ vs. planned $N = 102$).

Results

A total of 80 participants were used in analyses. Skewness and kurtosis values were within normal range for most variables. For the CoBRAS scale, these values were not within normal range but made sense for the population being studied (i.e., therapists being less likely to hold colorblind attitudes). A total of 41 participants received the vignette with the undocumented Salvadoran woman and 39 received the vignette describing the White woman.

Hypothesis 1a

Hypothesis 1a (demonstrated multicultural competence would be positively correlated with self-reported multicultural competence) was examined with a bivariate correlation between MCCA scores and MCKAS scores for participants who received the Salvadoran woman vignette (i.e., excluding participants who received the White woman vignette).

The MCKAS is comprised of two individual scales: knowledge and awareness. Because these scales were not strongly correlated (.37), they were kept as individual scales. The MCCA also comprises two scores: etiology and treatment. Correlation coefficients for all measures of cultural competence can be found in Table 2.

Correlations were run between etiology and knowledge, etiology and awareness, treatment and knowledge, and treatment and awareness (See Table 2). None of the four correlations were significant. The hypothesis was not supported. No association was found between measures of self-reported multicultural competence and demonstrated tasks of multicultural competence, which suggests that the Multicultural Case Conceptualization Ability (MCCA) did not demonstrate construct validity in this study.

Table 2

Correlations between cultural competence measures

Measure	1	2	3	4	5
1. Self-report (Knowledge)	1.00	-			
2. Self-report (Awareness)	.37	1.00	-		
3. Demonstrated (Etiology)	.19	.18	1.00	-	
4. Demonstrated (Treatment)	.04	.07	.35	1.00	-
5. Multicultural Counseling and Psychotherapy Test	.42	.56	.30	.31	1.00

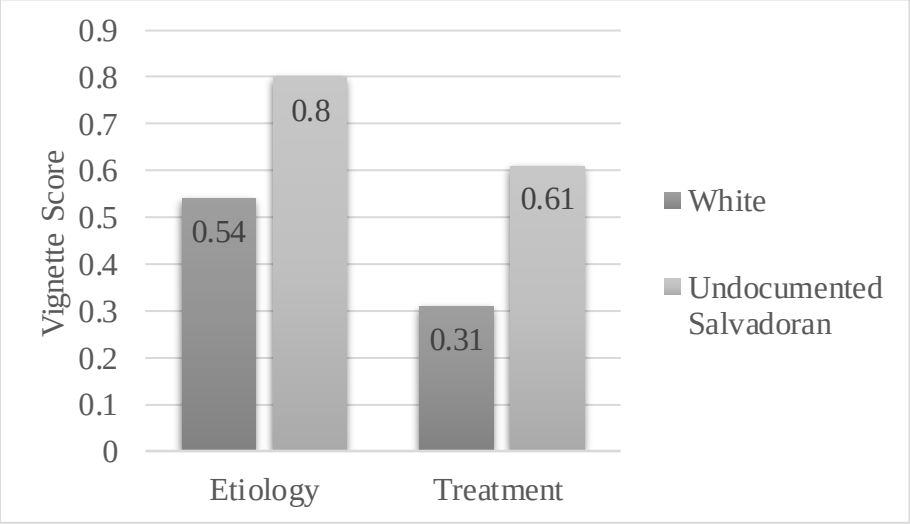
Hypothesis 1b

Hypothesis 1b (ratings of differentiation and integration would be highest in the vignette depicting a client with multiple marginalized sociodemographic identities than in the vignette with fewer marginalized identities) was evaluated using an independent sample *t*-test comparing MCCA scores in participants who got the White woman vs. the Salvadoran woman vignettes.

Although mean scores were in the expected direction (Figure 2), results of the independent samples *t*-tests indicated that there were not significant differences in differentiation and integration scores between the two vignette conditions for etiology ($t(77.26) = -1.34$, $p = .184$) and for treatment ($t(69.02) = -1.70$, $p = .093$. The second hypothesis was also not supported. The lack of significant differences in scores between these two vignettes further demonstrates a lack of construct validity of the Multicultural Case Conceptualization Ability. Had this measure accurately measured demonstrated multicultural competence, scores should have been higher when the vignette presented a case with a woman with multiple marginalized identities compared to a vignette where the woman was only described as White.

Figure 2

Average Vignette Scores



Hypothesis 2

To examine H2 (multicultural competence would be predicted by greater hours of multicultural training, more clinical experiences with diverse clients, more multicultural experiences, if participants were professionals, identification as a person of color, and lower colorblind racial attitudes), I used multiple regressions.

Results of the first regression indicated that the model as a whole significantly predicted multicultural knowledge scores, ($F(8, 71) = 9.466$, $p < .001$, $R^2 = .52$). CoBRAS, multicultural training hours, and more exposure to cultural elements (Multicultural Experiences measure) were found to be significant predictors of perceived multicultural knowledge. (See Table 3 below.) When predicting perceived multicultural awareness, the model was found to be significant, ($F(8, 71) = 8.11$, $p < .001$, $R^2 = .47$). CoBRAS scores and being a person of color were found to be significant predictors of perceived multicultural awareness. For the model predicting demonstrated multicultural skills through the MCCA for etiology of the vignette, the overall model was not significant, ($F(8, 32) = 1.39$, $p = .167$). When demonstrated multicultural skills through the MCCA for treatment was evaluated, the model was also not significant, ($F(8, 32) = 0.81$ $p = .268$). When predicting demonstrated multicultural skills with the MCPT, the model was significant ($F(8, 71) = 7.03$, $p < .001$). Experience with diverse clients, and CoBRAS scores were significant predictors in the model.

These results fail to establish concurrent validity for the MCCA, as predictors of multicultural competence did not significantly predict scores on the MCCA. The results demonstrate that common predictors of higher scores on other multicultural competence measures such as more experience with diverse populations and lower colorblind attitudes, were not predictive of scores on the MCCA.

Table 3

Predictors of Multicultural Competence

Predictors	Self-report (Knowledge)	Self-report (Awareness)	Demonstrated (Etiology)	Demonstrated (Treatment)	Multicultural Counseling and Psychotherapy Test
1. Diverse clients	*ns*	*ns*	*ns*	*ns*	$p = .003$
2. CoBRAS	$p < .001$	$p < .001$	*ns*	*ns*	$p < .001$
3. Multicultural training	$p = .004$	*ns*	$p = .013$	$p = .051$	*ns*
4. Cultural elements	$p = .006$	*ns*	$p = .031$	*ns*	*ns*
5. Cultural members	*ns*	*ns*	*ns*	*ns*	*ns*
6. Professional	*ns*	*ns*	*ns*	*ns*	*ns*
7. Therapist of color	*ns*	$p = .007$	*ns*	*ns*	*ns*
8. Social desirability	*ns*	*ns*	*ns*	*ns*	*ns*

Discussion

This study sought to build on the literature assessing the usefulness of measures of multicultural competence. First, I sought to establish construct validity for the MCCA, a measure of demonstrated multicultural competence with the MCKAS, a more commonly used multicultural competence measure. The vignette-based measure of demonstrated competence in case conceptualization skills (the MCCA; Ladany et al., 1997) did not correlate with a self-report measure of cultural competence (MCKAS; Ponterotto et al., 1996)) in this study. This finding was consistent with previous studies using the MCCA. Research studies in multicultural psychology have found that people are not good at accurately assessing their level of multicultural competence (Ladany et al., 1997). Additionally, studies find that self-report and behavioral measures tend to have weak correlations both due to methodology and measurement of different abilities (Dang et al., 2020). Participants may have the knowledge, awareness, and skills, but may not be putting these to use. Reading a vignette does not replicate the experience of meeting with a client in person. It is more difficult to apply some of the approaches to multicultural competence discussed in this paper such as Sue's dynamic sizing and scientific mindedness, or Day-Vines broaching approach.

It could also be due to the measure itself. In this study, participants were instructed to write at least three sentences for explaining the origins of the client's problems and treatment goals or approaches. This did not necessarily give people much room to elaborate. Perhaps participants needed to write more than three sentences to get into specifics. Responses on this measure were rated on a scale of 0-6, where higher scores meant participants included more differentiations and integrations. As seen in Figure 2, mean scores for both etiology and treatment were under 1 point for both the vignette with the White woman and the vignette with

the undocumented Salvadoran woman. Mean scores were very low for both vignettes and did not demonstrate significant score differences between the two vignettes.

Previous studies using the MCCA have typically only used one vignette and primed participants that their studies were about multicultural competence. This study sought to identify if participant responses would differ if we had a control group (White-woman vignette) in addition to a vignette that described a client with multiple marginalized identities. This would help determine if the MCCA was a measure of multicultural competence, or if it was only measuring good therapy, or the ability to make differentiations and integrations regardless of cultural and contextual factors. This study suggested that the MCCA did not measure competence to multicultural factors specifically, as there were no significant differences in score means between the two vignettes (Figure 2). The study failed to demonstrate construct validity. This could have been due to participants not being primed about the focus on multicultural competence, meaning participants may have the ability to attend to these issues but did not do so in this study.

This study also sought to examine if certain training and demographic variables predicted both perceived and demonstrated measures of multicultural competence. The models predicting perceived (MCKAS) multicultural competence were significant, as were the models predicting demonstrated multicultural competence using the MCPT. However, the models predicting demonstrated multicultural competence using the MCCA were not significant. This finding demonstrated that the MCCA failed to establish criterion validity. Again, this could be due to measurement error, as the MCCA could have not been a good measure for this study. For example, there can be variance in how coders from one study to another code qualitative data.

The regression analyses suggested a few interesting results that can be learned about training and measurement of multicultural competence. For example, this study suggests the importance of not having colorblind ideologies as a therapist. Lower CoBRAS scores were a significant predictor of both measures of self-reported multicultural competence (MCKAS) and the demonstrated test of multicultural competence (MCPT). Perhaps if therapists do not hold on to colorblind ideologies, they may be more likely to approach topics related to their client's culture and racial background.

This study demonstrated that social desirability did not predict any of the scales used, including self-report multicultural competence scales. This suggests that therapists are not responding to these scales to look good, despite previous criticism about these types of scales for multicultural competence.

Findings in this study also indicated that being a therapist of color was not a predictor for most multicultural competence scales, except for the Knowledge scale of the MCKAS. This finding suggests a couple of things: 1) you do not have to be a therapist of color to be culturally competent, 2) therapists of color may have experiences that have given them more awareness of multiculturalism, racism, discrimination, and other issues that their clients may go through as members of a marginalized group.

More experience with diverse clients was predictive of higher scores on the Multicultural Counseling and Psychotherapy Test. Although variables such as experience with other cultures (Cultural Elements on Table 3) predicted self-reported knowledge, more multicultural training and lower colorblind attitudes predicted higher cultural competence scores across several measures of multicultural competence. This emphasizes the importance of not only learning

about multicultural competence, but the importance of learning to apply it directly to clients, where a lot of learning usually takes place.

The best predictor of higher scores on the demonstrated cultural competence vignette task was hours of multicultural training. This could demonstrate the utility of these trainings and experiences in helping therapists translate knowledge into application.

Implications

There were several implications to this study. This study was the first to compare two vignettes when using the MCCA. This study demonstrated that scores did not differ between the two vignettes, thus failing to demonstrate that this measure is measuring multicultural competence, specifically. Future studies should use multiple vignettes to determine if the same effect is found.

This study did not find other measures of cultural competence, such as lower colorblind attitudes or experience with working with diverse populations, predicted MCCA scores. It could be due to the lack of applicability. A vignette does not replicate the experience of seeing a person in the therapy room and having the time to process and create a treatment plan and case conceptualization.

Low scores for the MCCA could indicate that participants were not attending to cultural and sociodemographic identities in determining case conceptualization and best course for treatment. This study suggests that since cultural competence is composed of knowledge, awareness, and skills, as well as ability for scientific mindfulness, dynamic sizing, and culture-specific skills (Sue, 1998), trainees need plenty of opportunity to gain and practice these abilities. This suggests that things such as having lower colorblind attitudes, more experience with diverse clients, and higher number of hours spent learning about these communities are related to

multicultural competence and should be considered when developing curriculum for students. Programs should focus on expanding not only courses for students, but also include more learning opportunities in research, class, and clinical settings.

Limitations and Future Directions

This study used the MCCA to assess applied cultural competence skills through requiring participants to write three sentences describing the etiology of the client's problem and three sentences describing their treatment plan. Participants were not told to pay attention to multicultural factors to mimic whether they take those factors into consideration regularly. Perhaps these questions were not enough to elicit more detail and were not a valid measure of behavior in session. Future studies may ask for more detail on the participants case conceptualization. Additionally, future studies may validate this measure with observation of tape, or with an experimental design where participants can present their case conceptualization as they would to a supervisor or client.

Additionally, the MCCA is open ended and requires trained coders to score. Although coders were trained until they reached 85% interrater reliability, there is a possibility that there were errors in coding. This measure requires resources and time to use and would be difficult to implement in training programs.

Conclusion

This study sought to explore measurement of multicultural competence when working with diverse populations. Previous studies have found that there is a disconnect between the self-report measures typically used and actual behavior. This study sought to address this using two demonstrated skill measures, the MCCA and MCPT, as well as to explore predictors of multicultural competence scores. The results of the study suggested that the MCAA did not

capture multicultural competence in this sample, as scores between identical vignettes (one describing a White woman and one describing an undocumented Salvadoran woman) did not differ. Additionally, this study suggests that lower colorblind attitudes, higher training experiences with diverse populations, and more hours learning about diverse populations were predictive of multicultural competence scores. Overall, there was no large overlap between what the different measures were capturing and suggested that they capture different aspects of what it takes to be multiculturally attentive. Previous research has shown evidence of health disparities, and disparities in access to culturally attentive treatment. This research highlighted the importance of training therapists that have the knowledge, awareness, and skills to work with diverse clients through multiple avenues, such as through courses and direct experience.

References

Alfaro, M. A., & Bui, N. H. (2018). Mental health professionals' attitudes, perceptions, and stereotypes toward Latino undocumented immigrants. *Ethics & Behavior*, *28*(5), 374-388. https://doi.org/10.1080/10508422.2017.1300773

Allison, K. W., Crawford, I., Echemendia, R., Robinson, L., & Knepp, D. (1994). Human diversity and professional competence: Training in clinical and counseling psychology revisited. *American Psychologist, 49(9)*, 792–796. https://doi.org/10.1037/0003-066X.49.9.792

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377–402. doi:10.1037/0003-066X.58.5.377

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. Washington, DC: American Psychological Association. http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2019). *APA guidelines on race and ethnicity in psychology: Promoting responsiveness and equity*. Washington, DC: American Psychological Association. https://www.apa.org/about/policy/guidelines-race-ethnicity.pdf

Ayon, C. (2014). Service needs among Latino immigrant families: Implications for social work practice. *Social Work, 59(1)*, 13–23. https://doi.org/10.1093/sw/swt031

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. Psychological review, 84(2), 191. https://doi.org/10.1037/0033-295X.84.2.191

Bardone-Cone, A. M., Calhoun, C. D., Fischer, M. S., Gaskin-Wasson, A. L., Jones, S. C. T., Schwartz, S. L., Wise, E. H., & Prinstein, M. J. (2016). Development and implementation of a diversity training sequence in a clinical psychology doctoral program. *The Behavior Therapist, 39(3)*, 65–75.

Berk, M. L., & Schur, C. L. (2001). The effect of fear on access to care among undocumented Latino immigrants. *Journal of Immigrant Health, 3(3)*, 151–156. https://doi.org/10.1023/A:1011389105821

Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. American psychologist, 32(7), 513. https://doi.org/10.1037/0003-066X.32.7.513

Cardemil, E. V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice*, *34*(3), 278.

Cartwright, B. Y., Daniels, J., & Zhang, S. (2008). Assessing multicultural competence: Perceived Versus Demonstrated Performance. *Journal of Counseling & Development, 86(3*), 318–322. https://doi.org/10.1002/j.1556-6678.2008.tb00515.x

Chao, R. C.L. (2013). Race/ethnicity and multicultural competence among school counselors: multicultural training, racial/ethnic identity, and color-blind racial attitudes. *Journal of Counseling & Development, 91(2)*, 140–151. https://doi.org/10.1002/j.1556-6676.2013.00082.x

Chen, J., & Vargas-Bustamante, A. (2011). Estimating the effects of immigration status on mental health care utilizations in the United States. *Journal of Immigrant and Minority Health, 13(4)*, 671–680. https://doi.org/10.1007/s10903-011-9445-x

Cleaveland, C., & Ihara, E. S. (2012). "They treat us like pests:" Undocumented immigrant experiences obtaining health care in the wake of a "crackdown" ordinance. *Journal of Human Behavior in the Social Environment, 22(7)*, 771–788. https://doi.org/10.1080/10911359.2012.704781

Constantine, M. G. (2001a). Predictors of observer ratings of multicultural counseling competence in Black, Latino, and White American trainees. *Journal of Counseling Psychology*, *48*(4), 456.

Constantine, M. G. (2001b). Multicultural training, theoretical orientation, empathy, and multicultural case conceptualization ability in counselors. *Journal of Mental Health Counseling; Alexandria, 23(4)*, 357–372.

Constantine, M. G., & Ladany, N. (2000). Self - report multicultural counseling competence scales: Their relations to social desirability attitudes and multicultural case conceptualization ability. *Journal of Counseling Psychology, 47*, 155–164. https://psycnet.apa.org/doi/10.1037/0022-0167.47.2.155

Cross, T. L. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology, 24,* 349-354. https://psycnet.apa.org/doi/10.1037/h0047358

D'Andrea, M., Daniels, J., & Heck, R. (1991). Evaluating the impact of multicultural counseling training. *Journal of Counseling & Development, 70*, 143—150. https://doi.org/10.1002/j.1556-6676.1991.tb01576.x

Dang, J., King, K. M., & Inzlicht, M. (2020, February 19). Why Are Self -Report and Behavioral Measures Weakly Correlated?.

Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development, 85(4),* 401-409.

Day-Vines, N. L., Booker Ammah, B., Steen, S., & Arnold, K. M. (2018). Getting comfortable with discomfort: Preparing counselor trainees to broach racial, ethnic, and cultural factors with clients during counseling. *International Journal for the Advancement of Counselling*, *40*(2), 89-104.

Derose, K. P., Escarce, J. J., & Lurie, N. (2007). Immigrants and health care: sources of vulnerability. *Health Affairs, 26(5),* 1258–1268. https://doi.org/10.1377/hlthaff.26.5.1258

Derr, A. S. (2016). Mental health service use among immigrants in the United States: A systematic review. *Psychiatric Services, 67(3),* 265–274. https://doi.org/10.1176/appi.ps.201500004

Faul, F., Erdfelder, E., Lang, A., & Buchner, A. (2007). GPower 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods, 39(2),* 175-191.

Fenton, J. J., Catalano, R., & Hargreaves, W. A. (1996). Effect of Proposition 187 on mental health service use in California: A Case Study. *Health Affairs, 15(1),* 182–190. https://doi.org/10.1377/hlthaff.15.1.182

Gillem, A. R., Bartoli, E., Bertsch, K. N., McCarthy, M. A., Constant, K., Marrero-Meisky, S., ... & Bellamy, S. (2016). Validation of a standardized multiple-choice multicultural competence test: Implications for training, assessment, and practice. *Journal of Multicultural Counseling and Development*, *44*(3), 209-224. https://doi.org/10.1002/jmcd.12047

Gregus, S. J., Stevens, K. T., Seivert, N. P., Tucker, R. P., & Callahan, J. L. (2019). Student perceptions of multicultural training and program climate in clinical psychology doctoral programs. *Training and Education in Professional Psychology.* https://doi.org/10.1037/tep0000289

Guzman, L. P. (1993). Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations. American Psychologist, 48(1), 45-48.

Hacker, K., Chu, J., Arsenault, L., & Marlin, R. P. (2012). Provider's perspectives on the impact of Immigration and Customs Enforcement (ICE) activity on immigrant health. Journal of health care for the poor and underserved, 23(2), 651–665. https://doi.org/10.1353/hpu.2012.0052

Hacker, K., Chu, J., Leung, C., Marra, R., Pirie, A., Brahimi, M., English, M., Beckmann, J., Acevedo-Garcia, D., & Marlin, R. P. (2011). The impact of Immigration and Customs Enforcement on immigrant health: Perceptions of immigrants in Everett, Massachusetts,

USA. *Social Science & Medicine (1982), 73(4)*, 586–594. https://doi.org/10.1016/j.socscimed.2011.06.007

Hernandez, M., Nesman, T., Mowery, D., Acevedo-Polakovich, I. D., & Callejas, L. M. (2009). Cultural competence: A literature review and conceptual model for mental health services. *Psychiatric Services, 60(8)*, 1046–1050. https://doi.org/10.1176/ps.2009.60.8.1046

Hernandez, A. G., & LaFromboise, T. D. (1985). The development of the cross-cultural counseling inventory. In annual meeting of the American Psychological Association, Los Angeles.

Inman, A. G. (2006). Supervisor multicultural competence and its relation to supervisory process and outcome. *Journal of Marital and Family Therapy, 32(1)*, 73–85. https://doi.org/10.1111/j.1752-0606.2006.tb01589.x

Ladany, N., Inman, A. G., Constantine, M. G., & Hofheinz, E. W. (1997). Supervisee multicultural case conceptualization ability and self-reported multicultural competence as functions of supervisee racial identity and supervisor focus. *Journal of Counseling Psychology*, *44*(3), 284. https://psycnet.apa.org/doi/10.1037/0022-0167.44.3.284

LaFromboise, T. D., Coleman, H. L. K., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory-Revised. *Professional Psychology: Research and Practice, 22*, 380-388. https://psycnet.apa.org/doi/10.1037/0735-7028.22.5.380

Messias, D. K. H. (1996). Concept development: exploring undocumentedness. *Scholarly Inquiry for Nursing Practice; New York, 10(3)*, 235–252. https://doi.org/10.1891/0889-7182.10.3.235

Neville, H. A., Lilly, R. L., Duran, G., Lee, R., & Browne, L. (2000). Construction and initial validation of the Color-Blind Racial Attitudes Scale (CoBRAS). *Journal of Counseling Psychology*, *47*, 59–70. https://doi.org/10.1037/0022-0167.47.1.59

Neville, H., Spanierman, L., & Doan, B.-T. (2006). Exploring the association between color-blind racial ideology and multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology, 12(2)*, 275–290. https://doi.org/10.1037/1099-9809.12.2.275

Oskamp, S. (1965). Overconfidence in case-study judgments. *Journal of Consulting Psychology, 29*, 261–265. https://doi.org/10.1037/h0022125

Paulhus, D. L. (1991). Measurement and control of response bias. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), Measures of personality and social psychological attitudes (pp. 17–59). San Diego: Academic Press. https://doi.org/10.1016/B978-0-12-590241-0.50006-X

Perez, M. C., & Fortuna, L. (2005). Psychosocial stressors, psychiatric diagnoses and utilization of mental health services among undocumented immigrant Latinos. *Journal of Immigrant & Refugee Services, 3(1-2),* 107-123. https://doi.org/10.1300/J191v03n01_06

Philbin, M. M., Flake, M., Hatzenbuehler, M. L., & Hirsch, J. S. (2018). State-level immigration and immigrant-focused policies as drivers of Latino health disparities in the United States. *Social Science & Medicine, 199*, 29–38. https://doi.org/10.1016/j.socscimed.2017.04.007

Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). A revision of the Multicultural Counseling Awareness Scale. *Journal of Multicultural Counseling and Development, 30(3),* 153–180. https://doi.org/10.1002/j.2161-1912.2002.tb00489.x

Ponterotto, J. G., Rieger, B. P., Barrett, A., Harris, G., Sparks, R., Sanchez, C. M., & Magids, D. (1996). 7. Development And Initial Validation Of The Multicultural Counseling Awareness Scale.

Pope-Davis, D. B., & Dings, J. G. (1994). An empirical comparison of two self-report multicultural counseling competency inventories. *Measurement and Evaluation in Counseling and Development, 27*(2), 93–102.

Pope-Davis, D. B., & Dings, J. G. (1995). The assessment of multicultural counseling competencies. In J. G Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 287-311). Thousand Oaks, CA: Sage Publications, Inc.

Quintana, S. M., & Bernal, M. E. (1995). Ethnic minority training in counseling psychology: Comparisons with clinical psychology and proposed standards. *The Counseling Psychologist, 23*(1), 102-121. https://doi.org/10.1177/0011000095231010

Radford, J. (n.d.). Key findings about U.S. immigrants. Pew Research Center. Retrieved September 8, 2019, from https://www.pewresearch.org/fact-tank/2019/06/17/key-findings-about-u-s-immigrants/

Raymond-Flesch, M., Siemons, R., Pourat, N., Jacobs, K., & Brindis, C. D. (2014). "There is no help out there and if there is, it's really hard to find": A qualitative study of the health concerns and health care access of Latino "DREAMers." *Journal of Adolescent Health, 55(3*), 323–328. https://doi.org/10.1016/j.jadohealth.2014.05.012

Ruiz, J. J. M., Gallardo, M. E., & Delgado-Romero, E. A. (2013). Latinas/os and Immigration Reform: A Commentary to "Crossroads: The Psychology of Immigration in the New Century"—The Report of the APA Presidential Task Force on Immigration. https://doi.org/10.1037/lat0000002

Safran, M. A., Mays, R. A., Jr, Huang, L. N., McCuan, R., Pham, P. K., Fisher, S. K., McDuffie, K. Y., & Trachtenberg, A. (2009). Mental health disparities. *American journal of public health, 99(11),* 1962–1966. https://doi.org/10.2105/AJPH.2009.167346

Schwartz, S., & Meyer, I. H. (2010). Mental health disparities research: The impact of within and between group analyses on tests of social stress hypotheses. *Social science & medicine, 70(8)*, 1111-1118. https://doi.org/10.1016/j.socscimed.2009.11.032

Shattell, M. M., Hamilton, D., Starr, S. S., Jenkins, C. J., & Hinderliter, N. A. (2008). Mental health service needs of a Latino population: A community-based participatory research project. *Issues in Mental Health Nursing, 29(4)*, 351–370. https://doi.org/10.1080/01612840801904316

Sheu, H.-B., & Lent, R. W. (2007). Development and initial validation of the Multicultural Counseling Self-Efficacy Scale–Racial Diversity Form. *Psychotherapy, 44(1)*, 30–45. https://doi.org/10.1037/0033-3204.44.1.30

Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology, 41(2)*, 137. https://doi.org/10.1037/0022-0167.41.2.137

Spanierman, L. B., & Heppner, M. J. (2004). Psychosocial costs of racism to Whites scale (PCRW): Construction and initial validation. *Journal of Counseling Psychology, 51*, 249–262. https://doi.org/10.1037/0022-0167.51.2.249

Sparkman, D. J., & Eidelman, S. (2018). We are the "human family": Multicultural experiences predict less prejudice and greater concern for human rights through identification with humanity. *Social Psychology*, *49*(3), 135. https://psycnet.apa.org/doi/10.1027/1864-9335/a000337

Substance Abuse and Mental Health Services Administration. (2014). *Improving Cultural Competence*. Treatment Improvement Protocol (TIP) Series No. 59. HHS Publication No. (SMA) 14-4849. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20(2)*, 64–88. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The counseling psychologist*, *10*(2), 45-52. https://doi.org/10.1177/0011000082102008

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. American Psychologist, 53, 440–448. https://doi.org/10.1037/0003-066X.53.4.440

Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist, 58(11)*, 964–970. https://doi.org/10.1037/0003-066X.58.11.964

Thompson, C.E., & Jenal, S.T. (1994). Interracial and interracial quasi-counseling interactions when counselors avoid discussing race. *Journal of Counseling Psychology, 41*, 484–491. https://doi.org/10.1037/0022-0167.41.4.484

United States Department of Health and Human Services. (2011). *HHS action plan to reduce racial and ethnic health disparities*. Washington, DC: HHS.

Vazire, S., & Mehl, M.R. (2008). Knowing me, knowing you. The accuracy and unique predictive validity of self-ratings and other ratings of daily behavior. *Journal of Personality and Social Psychology, 95*, 1202-1216. https://doi.org/10.1037/a0013314

Want, V., Parham, T. A., Baker, R. C., & Sherman, M. (2004). African American students' ratings of Caucasian and African American counselors varying in racial consciousness. *Cultural Diversity & Ethnic Minority Psychology, 10*, 123–136. https://doi.org/10.1037/1099-9809.10.2.123

Appendix A: Institutional Review Board Approval Letter

UNIVERSITY OF ARKANSAS

To:	Dulce Elizabeth Diaz Benitez BELL 4188
From:	Douglas J Adams, Chair IRB Expedited Review
Date:	10/07/2020
Action:	**Exemption Granted**
Action Date:	10/07/2020
Protocol #:	2009282757
Study Title:	Therapist Case Conceptualization and Treatment Planning

The above-referenced protocol has been determined to be exempt.

If you wish to make any modifications in the approved protocol that may affect the level of risk to your participants, you must seek approval prior to implementing those changes. All modifications must provide sufficient detail to assess the impact of the change.

If you have any questions or need any assistance from the IRB, please contact the IRB Coordinator at 109 MLKG Building, 5-2208, or irb@uark.edu.

cc: Ana J Bridges, Investigator

Page 1 of 1