

Development of the Multicultural Therapy Competency Inventory-Client Version

by

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ABSTRACT

Family therapists face a dramatic increase in the cultural diversity of their clients. Multicultural competence will help family therapists meet the needs of their increasingly diverse clientele (Kocarek, Talbot, Batka, & Anderson, 2001). The measurement of multicultural competence is necessary in order to evaluate the outcomes of multicultural competence programs and the services that minority persons receive. This study reports the development of an instrument to assess clients' perceptions of their therapists' multicultural competence that can be used in individual and family therapy. This instrument was developed through three phases: item generation and theme development, client feedback and evaluation of interrater reliability, and pilot and validity testing. *Winsteps* (Linacre, 2001) software was used to scale the measurement data to the Rasch Rating Scale Model, and evaluate the dimensionality, rating scale use, item fit, person fit, reliability and precision, as well as to create norms for interpreting the measures. Preliminary support for the MTCI-CV suggests a fairly reliable and valid measure at this stage. Additionally, logistic ordinal regressions were conducted to determine whether MTCI-CV measures are associated with client satisfaction level and goal attainment level. We found that positive client perceptions of therapist cultural competence (on the MTCI-CV) significantly contribute to the probability of clients expressing satisfaction and goal attainment in therapy.

Key Words: Multicultural Therapy Competence, Instrument Development

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CHAPTER I

Introduction

Statement of the Problem

We are fast becoming a multiracial, multicultural, multilingual society (Sue, 1991). The diversification of America has made it necessary for the therapy profession to take a proactive stance on cultural diversity (Sue, Arredondo, & McDavis, 1992). McGoldrick, Giordano, and Pearce (1996) stated, “Most family therapy has been developed and conducted by White Americans for other White Americans, without reference to people of color” (p. 15). Ho (1987) stated that family therapy has traditionally been conceptualized in western individualistic terms. Literature reveals the prevalent ineffectiveness of traditional western therapy approaches and techniques when they are applied to racial and ethnic minority populations (Bernal & Padilla, 1982; Casas, 1982; Ibrahim & Arredondo, 1986; Smith, 1982; Sue, Bernier, Durran, Feinberg, Pedersen Smith, & Vasquez-Nuttal, 1982; Sue & Sue, 1990). Several studies have revealed that ethnic minority clients frequently felt that they received services that were inappropriate, insensitive, or condescending (Dana, 1994; Sue & Sue, 1990). Sue, Akutsu, and Higashi (1985) contend that the main reason for ineffectiveness lies in the training of mental health professionals.

Throughout the last two decades, concern regarding the underutilization of mental health services by minorities has prompted a revision of the paradigms in counseling psychology and family therapy (D’Andrea & Daniels, 1991; Ho, 1987). In 1974, at the APA conference in Colorado, it was suggested that “the therapy of persons of culturally diverse backgrounds by persons who are not trained or competent to work with such groups should be regarded as unethical” (Casas, Ponterotto, & Gutierrez, 1986, p.347). A range of conceptual frameworks has emerged for integrating curricula and practicum in the training of therapists working with

ethnically diverse clients (Casas et al., 1986; McGoldrick, 1998). McGoldrick et al. (1996) and Falicov (1995) believe that training is essential for professionals to understand and appreciate the role of socio-cultural variables associated with persons from ethnic minority groups. Sue (1998), and Sue and Sue (1999) agree that multicultural therapy competence among therapists is crucial given the multitude of cultural factors that can impact the validity of assessments, the quality of therapeutic relationships, and the effectiveness of treatment.

The measurement of multicultural competence is necessary in order to evaluate the outcomes of multicultural competence training programs and the services that minority persons receive. Compared to the amount of literature on multicultural issues there has been little attention aimed at the development of acceptable, conceptually anchored, and psychometrically sound instruments for measuring multicultural therapy competency (Ponterotto, Rieger, Barrett, & Sparks, 1994). Given the need for culturally competent therapy, there is also a need for a valid, reliable instrument to measure the dimensions of multicultural therapy competence. The focus of this study is the development of a valid and reliable instrument to assess clients' perceptions of their therapists' multicultural competence.

Previous Attempts to Measure Multicultural Therapy Competence

Since the 1990s, a few multicultural competency instruments have been developed. The four primary instruments available to measure the cultural competence of individual therapists are based on Sue et al.'s (1982) three domains: knowledge, skills, attitudes and beliefs (see literature review). These instruments include the Cross-Cultural Competence Inventory (CCCI-R) (LaFromboise, Coleman, & Hernandez, 1991), the Multicultural Counseling Awareness Scale (MCAS-B) (Ponterotto, Sanchez, & Magids, 1991), the Multicultural Awareness-Knowledge-

Skills Inventory (MAKSS) (D'Andrea, Daniels, & Heck, 1991), and the Multicultural Counseling Inventory (MCI) (Sodowsky, Taffe, Gutkin, & Wise, 1994).

While some of these instruments have been widely used, they are all relatively new surveys that have only been moderately tested in terms of reliability and validity and have significant flaws (Kocarek et al., 2001). The initial development of the CCI-R indicated acceptable levels of internal consistency (coefficient alpha of .95) (LaFromboise et al., 1991). The CCI-R indicated moderate evidence for content, criterion, and construct validity (Kocarek et al., 2001). Regarding criterion related validity, Hernandez and Kerr (1985) found that counselors trained in multicultural issues rated higher on the CCI-R than counselors without such training. Regarding content validity, eight trained raters classified items into categories with 80% agreement. Lastly, regarding construct validity, using factor analysis with orthogonal rotation, the scree test indicated one factor accounting for 51% of the variance (LaFromboise et al., 1991). Using the same data, LaFromboise et al. (1991) forced a three factor orthogonal rotation to support Sue's (1982) conceptualization of cultural competency which accounted for 63% of the variance. The test-retest reliability of the CCI-R has not been examined (Kocarek et al., 2001).

The MCAS-B was found to have satisfactory internal consistency, particularly for the knowledge/skills dimension (coefficient alpha of .93) and acceptable criterion related validity (Kocarek et al., 2001). Using multivariate analysis of variance, Ponterotto et al. (1991) found that doctoral students in counseling scored significantly higher on the knowledge/skills factor of the MCAS-B than the Masters level students.

The initial development of the MCI indicated satisfactory internal consistency (total scale coefficient alpha of .90) and moderate support for construct validity (Kocarek et al., 2001). Concerning construct validity, using factor analysis with varimax rotation a four factor model

was chosen which accounted for 37.4% of the variance (Sodowsky et al., 1994). Lastly, using a sample of 90 graduate students in counseling the MAKSS was found to have adequate internal consistency (coefficient alphas: Awareness: .75, Knowledge: .90, and Skills: .96) and initial discriminatory validity (Kocarek et al., 2001). Using a Wilcoxon rank sum test D' Andrea et al. (1991) found that two groups of students who took a multicultural counseling course differed from control groups in level of cultural competence at the posttest.

Despite the research supporting the reliability and validity of the CCI-R, MCAS-B, MCI, and MAKSS, several limitations exist in these measures. The first limitation of the current instruments is that the dimension outcomes from factor analysis do not match the theoretical construct the instruments purport to measure. Contrary to the three dimensions of multicultural therapy competence in the literature (Sue et al., 1982; Sue & Sue, 1990), the results of the factor analyses suggest that the instruments measure anywhere from one to four factors. For example, the results of factor analysis suggest that the MCAS-B has two dimensions (knowledge-skills, awareness) (Ponterotto et al., 1991). The MAKSS has three dimensions for awareness, and one dimension for knowledge and skills (D'Andrea et al., 1991). The MCI has been found to have either one general factor or four factors (skills, awareness, knowledge, and the multicultural therapy relationship) (Sodowsky et al., 1994). Lastly, the CCI-R has been found to have either one general factor or three factors (skill, awareness, and cultural sensitivity) (LaFromboise et al., 1991). These instruments seem to be measuring different constructs, although they are based on the same literature.

A second limitation of these instruments is that there are no clear descriptions of what the subscales are purported to measure that are readily available related to the instruments. The lack of operational definitions requires persons to make assumptions about the instruments and their

subscales which prevents consistent use of the instruments (Kocarek et al., 2001). This affects the construct validity of an instrument; operationalizations are needed in order to make legitimate inferences.

Third, the existing multicultural competency instruments are developed from a priori theoretical assumptions. That is, the dimensions and items of the construct of multicultural competence are developed from the theoretical literature, and in some cases validated by experts (who have been exposed to the same literature) (LaFromboise et al., 1991; Ponterotto et al., 1991; Sadowsky et al., 1994). While it is important to have a theoretical base for an instrument, the formation of the construct should also be informed by the population for whom the instrument is intended to serve (i.e., clients, ethnic minorities) (Boyle & Springer, 2001). Instead, these instruments have been validated primarily on White, middle socioeconomic class students in the counseling psychology field (Boyle & Springer, 2001). A common criticism of multicultural literature is that there is inadequate input from minorities (Pederson, 1995).

Fourth, all four of these instruments (MCI, MCAS-B, CCI-R, and MAKSS) are written and developed from the counseling field for the counseling field (D'Andrea et al., 1991; LaFromboise et al., 1991; Ponterotto et al., 1991; Sadowsky et al., 1994). The focus of these instruments is on counselors' knowledge, attitudes and beliefs, and skills in working with individual clients rather than couples or families, for example, "Counselor is aware of how own values might affect the client," or "Counselor demonstrates knowledge about client's culture" (LaFromboise et al., 1991). Constantine, Juby, and Liang (2001) report that little empirical information exists regarding the self-reported multicultural competence of family therapists. The family as a system is an especially important concept when working with ethnic minorities; collectivist cultures place a strong emphasis on the family (Culhane-Pera, Vawter, Xiong,

Babbitt, & Solberg, 2003; Guerin, Guerin, Diiriye, & Yates, 2004; Miranda, Frevert, & Kern, 1998). If an instrument is intended to serve ethnic minority populations it should be more inclusive and assess therapist knowledge, attitudes and beliefs, and skills in working with not only individuals, but also couples and families.

A fifth limitation of the instruments that are currently available for measuring cultural competency relates to their construct dimensions. The construct dimensions of the instruments account for only 37.4% (MCI), 28% (MCAS), and 51% (CCCI-R) of the total variance of the cultural competence construct (MAKSS original total score was not factor analyzed) (D'Andrea et al., 1991; LaFromboise et al., 1991; Ponterotto et al., 1991; Sadowsky et al., 1994). These variance amounts imply that there may be an aspect of the construct (multicultural therapy competence) that is not being accounted for. In addition, Constantine and Landany (2000) found that the MCI, the most widely used and psychometrically sound instrument in the therapy setting (Boyle & Springer, 2001), does not correlate with an alternative measure of cultural competence assessed by independent raters (Constantine & Landany, 2000). This implies that there may be aspects of cultural competence that the raters are observing that is not being measured by the MCI. This relates to the sixth limitation of the available instruments for measuring cultural competency. Pope-Davis and Dings (1995) warn that self-report instruments designed for therapists to self-administer may measure anticipated rather than actual behaviors or attitudes representing multicultural competence, they are prone to social desirability, and we cannot be certain as to what the instruments really measure. For this reason, Green, Kiernan-Stern, Bailey, Chambers, Claridge, Jones, Kitson, Leek, Leisey, Vades, and Walker (2005) also suggest including client reports in the evaluation of mental health workers' cultural competencies.

A few studies have been conducted to examine the reliability and validity of the cultural competency measures beyond research reporting their initial development. For example, Kocerek et al. (2001) collected data from 120 master's level therapy students and found that the MCAS-B and MAKSS demonstrated test-retest reliability with the exception of the awareness sub-scale of the MAKSS. In addition, in their validity study as measured by item-to-subscale correlation, they found that on the MCAS-B the variable "taking courses" was significantly related to the knowledge/skills subscale, but not to the awareness subscale as the model predicts, and the validity for the MAKSS indicated some weaknesses in the knowledge and awareness subscales. The MAKSS has since been revised to account for these weaknesses, however, the revised version accounts for only a third of the variance (29.8%) that the original MAKSS accounted for (Kim, Cartwright, Asay, & D'Andrea, 2003).

It is clear that further work needs to be done in the area of instrument development to measure multicultural therapy competence more completely. A more comprehensive instrument is needed to evaluate the outcomes of multicultural competence programs and the services that minority individuals and families receive. The predominant cultural literacy model used in the measurement of multicultural therapy competency puts emphasis on knowledge and skill over the experiential and phenomenological. It is problematic to judge multicultural therapy competence based on incomplete measurement of the construct. Inaccurate measurement of the construct can lead to inaccurate interpretations and decisions regarding therapists' multicultural competence and the care that clients receive. This model poses a risk that both family and individual therapists will see clients as their culture rather than as themselves (Dyche & Zayas, 1995).

Purpose

While a few therapist self-report multicultural competency instruments have been developed (MCI, MCAS-B, and MAKSS), as well as a supervisor observation survey (CCI-R) (D'Andrea et al., 1991; LaFromboise et al., 1991; Ponterotto et al., 1991; Sadowsky et al., 1994), Fuertes et al. (2001) stated that there is currently no measure to assess clients' perceptions of their therapists' multicultural competence. This is an important step to take because clients are the consumers of therapy and their perceptions can be very important to the process and outcome of therapy (Fuertes et al., 2001).

The primary purpose of this study is the development of an instrument to assess clients' perceptions of their therapists' multicultural competence that can be used in individual and family therapy. The Multicultural Therapy Competency Inventory-Client Version (MTCI-CV) will measure multicultural therapy competencies through inductively derived categories using existing literature as sensitizing concepts. Through this "ground up" method, it may be possible to identify competencies not presently found in existing theory derived instruments.

In addition, while it is assumed that there is a positive relationship between multicultural therapy competence and process or outcome indexes of therapy, no research has yet studied this relationship (Atkinson & Lowe, 1995; Fuertes et al., 2001; Steenbarger & Pels, 1997; Sue, 1998). The second purpose of this study is to assess the relationship between client ratings of therapist multicultural therapy competence and their reports regarding both the outcome of therapy and their satisfaction with therapy.

The MTCI-CV is best conceptualized as criterion referenced because its goal is to measure from the client's perspective how well a person demonstrates a specific body of knowledge and skills judged important in both the extant literature and by prospective clients.

Measures of the construct are intended to be used to assess clients' perceptions of therapists' attitudes and beliefs, skills, and knowledge related to multicultural competence, as well as to aid in assessing the adequacy of multicultural therapy training programs and psychological services for culturally diverse individuals and families.

The contexts in which the instrument can be used include private and state funded therapy agencies, and family therapy training programs. For example, family therapy training programs could use the MTCI-CV to assess the client's perceptions of therapist multicultural competence at various points in their practicum experience. The combined results across several clients, could then be used in supervision, and/or as a summative indicator of multicultural competence at the end of one's training. This is particularly important, since multicultural competence as a training goal is becoming more and more important in the field's accreditation standards (COAMFTE, 2002). Also, agencies could use the MTCI-CV to assess for culturally competent treatment of culturally diverse individuals and families at their agencies. Given the many contexts in which the MTCI-CV can be applied, it will be vital to have clarity and parsimony in the scale's directions, procedures, and items.

Definitions

Culture

For the purposes of this paper, culture will be defined as the sum total of the ways of living built up by a group of human beings and transmitted from one generation to the next (Murry, Smith, & Hill, 2001). Culture alludes to elements such as values, norms, beliefs, attitudes, folkways, behavior styles, and traditions that are joined together to form a whole that functions to preserve the society (Nobles, 1997). The focus of this study is on culture as it pertains to ethnicity. McGoldrick et al. (1996) state, "Ethnicity refers to a common ancestry

through which individuals have evolved shared values and customs” (p.1). However, this writer acknowledges the importance of the process of negotiating differences between therapists and clients, regardless of ethnicity (e.g., differences in social class, age, gender, and sexual orientation etc.) (McGoldrick et al., 1996).

Cultural Competence

For the purposes of this paper, both Sue’s (1998) and Sue et al.’s (1992) definitions of cultural competence will be used. Sue (1998) defined cultural competence as “the belief that people should not only appreciate and recognize other cultural groups, but also be able to effectively work with them” (p. 441). Sue suggested that therapists have achieved cultural competency when they possess the cultural knowledge and skills essential to delivering effective interventions to individuals who are members of cultural groups different from their own. Sue et al. (1992) stated that attitudes and beliefs are also an important aspect of cultural competence in therapy. For example, Dyche and Zayas (1995) stress an attitude of openness and respect for cultural experience when working with culturally diverse clients. This writer believes all three of these dimensions (knowledge, attitudes and beliefs, and skills) are essential components of cultural competence in both individual and family therapy. While the focus of this study is on cultural competence as it pertains to the field of family therapy, because much of the literature on cultural competency comes from the field of counseling, the terms counseling and therapy will be used interchangeably.

CHAPTER II

Review of the Literature

The following chapter will review literature on multicultural competency in the fields of counseling and family therapy.

Theoretical Framework: Internal Model

Cognitive Approach to Multicultural Competency

In 1982, the Education and Training Committee of the American Psychological Association's Division of Therapy Psychology (Division 17) was the first in the field to define multicultural counseling competence. Sue et al. (1982) defined multicultural therapy as "any counseling relationship in which two or more of the participants differ with respect to cultural background, values, and lifestyle" (p.47). Multicultural counseling competence was further defined as an ongoing process that involves three domains: knowledge, beliefs and attitudes, and skills (Sue et al., 1982).

The first dimension refers to therapist's attitudes and beliefs about racial and ethnic minorities, including biases or stereotypes. The second dimension refers to the therapist acknowledging his or her own worldview, the need for knowledge regarding the specific cultural groups he/she works with, and an understanding of sociopolitical influences. The last dimension refers to specific therapy skills needed for working with ethnic minority groups. Sue and Sue (1990) additionally identified three characteristics of a culturally skilled therapist. A culturally skilled therapist becomes aware of his/her own worldview, assumptions, biases, values, and limitations. The focus is on the therapist knowing himself/herself so that values and biases will not interfere with the process of therapy. Second, a culturally skilled therapist actively tries to understand the worldview of his/her clients. Third, a culturally skilled therapist practices

appropriate and sensitive intervention strategies and skills with culturally diverse clients. In 1992, Sue, Arredondo, and McDavis developed a 3 (characteristics) by 3 (dimensions) matrix of cross-therapy skills to include 31 competencies; each characteristic is assessed in terms of the three dimensions.

These developments were followed by an operationalization of Sue et al.'s (1992) competencies by Arredondo et al. (1996). Subsequently, Sue et al. (1998) expanded the 31 competencies to 34 adding the competencies of scientific mindedness (ability to develop and test hypotheses), skills in dynamic sizing (placing clients in socio-cultural contexts), and proficiency with specific cultural groups. Sue et al.'s (1992) conceptual model is the most widely used conceptualization of culturally competent practice (Boyle & Springer, 2001; Kim, Bean, & Harper, 2004). The competencies set forth by Sue et al. (1992) were well received by the American Counseling Association (ACA), the American Psychological Association (APA), and the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) (Altmaier, 1993).

The cultural literacy movement (e.g., Lynch & Hanson, 1998; McGoldrick et al., 1996; Sue et al., 1982; Sue et al., 1992) served clinical and political agendas by giving direction to therapists while also elevating the profile of marginalized populations and improving their mental health services (Dyche & Zayas, 1995). However, some disadvantages of the model are becoming evident. Sue et al.'s (1992) model of cultural competency emphasizes knowledge and skill over the experiential and phenomenological in therapy. This approach poses a risk that therapists will see clients as their culture rather than as themselves (McGoldrick, 1998). Sue and Zane (1987) controversially stated, "The major problem with approaches emphasizing either cultural knowledge or culture-specific techniques is that neither is linked to particular processes

that result in effective psychotherapy” (p. 39). The cultural literacy model has been influential. For example, several family therapy journal articles and books list cultural traits that therapists need to be aware of when treating clients from a specific background (e.g., McGoldrick et al., 1996; Lynch & Hanson, 1998). While understanding differences, similarities, and variations among cultures helps family therapists to consider the many variables important in forming a treatment plan for a family, there are several drawbacks to an approach that places emphasis on cultural information.

First, the status of the information is often not clear. For example, does it come from an expert therapist, a person of ethnic minority, or several persons? Another issue is how the writer(s) came to know this cultural information, whether they experienced it or read it somewhere. The informant and nature of the information becomes important because if we are to generalize this information to clients, it is important that it comes from a reliable source. Another problem regards how authors discuss culture and ethnicity without defining it. Often the groups of people authors are referring to is unclear; this makes it difficult to know how to apply the cultural knowledge. There is also an assumption that if therapists have cultural information that they will know how to use in a therapy session, when this is not necessarily the case (Krause & Miller, 1995). Additionally, each family is different with different needs, so there can be no how-to guide that pertains to multicultural therapy for all families. Cultural values are not held equally by all persons who would define themselves as part of a particular culture (McGoldrick, 1998). Lastly, a logistical problem with the cultural literacy model involves the difficulty for therapists to achieve a meaningful literacy regarding all of their clients with respect to the increase in national diversity. Cultural diversity is rising more rapidly than the professional literature can describe and therapists can absorb (Dyche & Zayas, 1995).

Process Approach to Multicultural Competence

More recently, authors have been focusing on process aspects of multicultural therapy competency (e.g., Dyche & Zayas, 1995; Fuertes, Bartolomeo, & Nichols, 2001; Krause & Miller, 1995). Krause and Miller (1995) suggest that answers regarding cultural competence will be found through interaction and relationships, because it is through relationships that we acquire experiences of others and experience ourselves with others. Gelso and Hayes (1998) believe that the therapist-client relationship is paramount in all therapy relationships; therefore this dimension should be included in the conceptualization of multicultural therapy competency. Fuertes et al. (2001) stated that therapists should be particularly attentive to relationship factors associated with multicultural competence. This includes the working alliance (Gelso & Carter, 1985) and theoretical components such as cultural trust. Fuertes, Mueller, Chauhan, Walker, and Ladany (2002) interviewed White Americans working with African-American clients and found that they reported using core relationship building skills, such as listening, attending, paraphrasing, asking open-ended questions, and using accepting nonverbal cues to engage their clients in therapy. In addition, they found that communication of empathy from the therapists appeared to strengthen rapport with the client. All of these characteristics define the relational aspect of multicultural therapy competence.

Dyche and Zayas (1995) suggest a model of multicultural therapy competence that gives importance to respectful curiosity and naiveté for a process-oriented approach. They define naiveté as a state of openness and receptivity. Cross-cultural therapists who work with confidence and skill while remaining sensitive and receptive to the differences between themselves and their clients are upholding cultural naiveté. Sources of naiveté include disclosure, meditation, and play. Curiosity is defined as an activity that flows from naiveté and is composed

of the love of surprise and the desire to look beyond assumptions; curiosity stimulates the act of knowing and supplies the energy for discovery in multicultural therapy. It may be this process aspect of multicultural competence that needs to be taken into account in the conceptualization of the construct in order for the evaluation of multicultural competence to be more accurate and meaningful.

Proposed Internal Model of Multicultural Therapy Competence

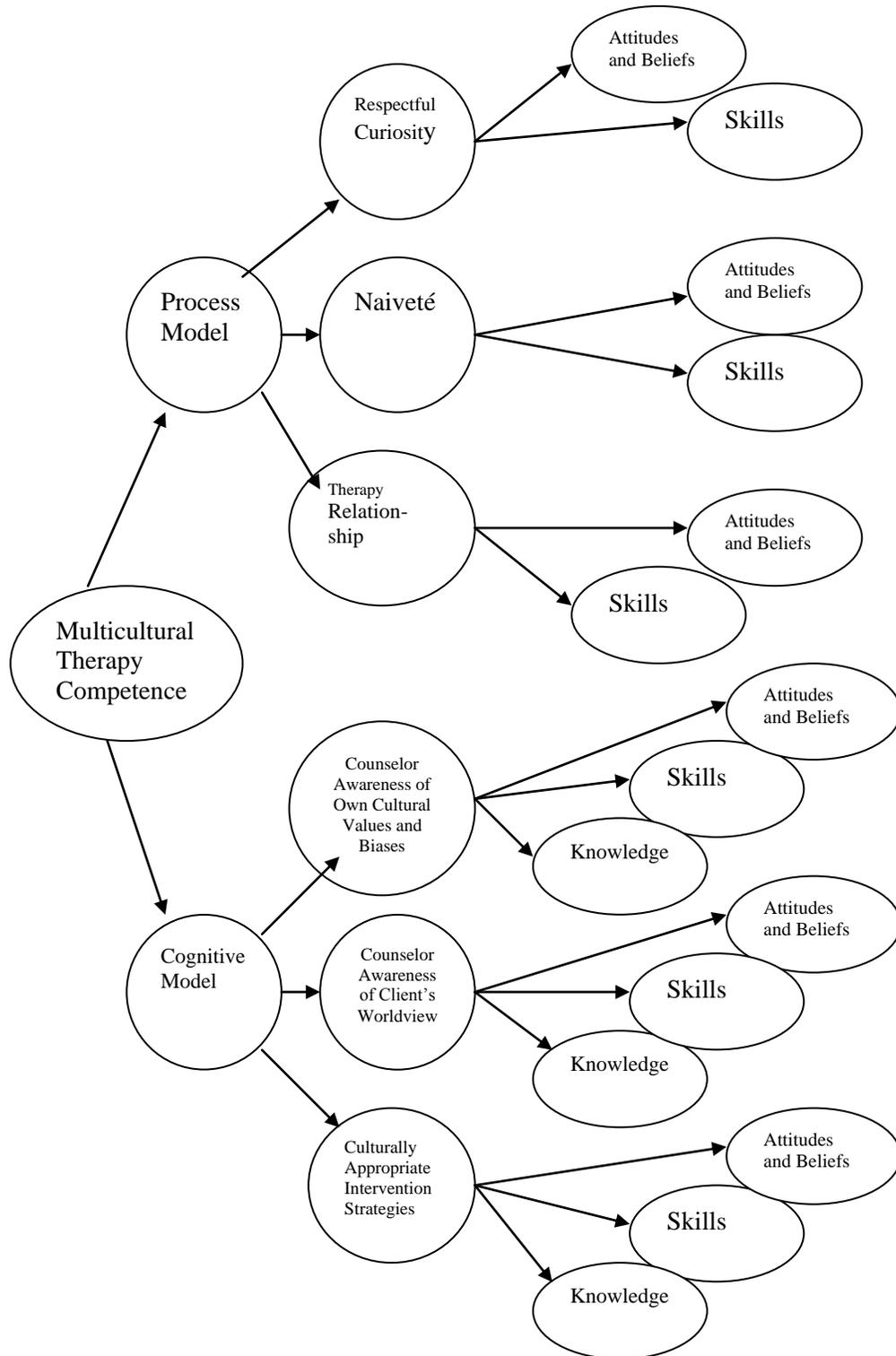
While process components have been suggested in the literature, most therapist training programs are still based on Sue et al.'s 1992 (cognitive) model of cultural competency (Inman et al., 2004). Training in cultural competence is most often obtained through formal coursework (Ponterotto, 1997; Sue et al., 1998), which reflects a cognitive orientation, as well as through supervision. However, research findings indicate a lack of relationship between the perception of multicultural competencies in training programs and self-perceived multicultural competence (Inman et al., 2004). Constantine and Landany (2000) suggest that a broader conceptualization may be needed to understand multicultural competence. This writer proposes a comprehensive model of multicultural therapy competency that includes both process dimensions and cognitive dimensions. It is important to include the aspects of the cognitive model because cultural knowledge is an outcome of curiosity and an important body of professional knowledge. However, because cultural knowledge lies in the realm of theory, there is a danger when it is infused into the process of listening and learning with clients, or when it becomes the primary basis of treatment goals (Dyche & Zayas, 1995). Carrithers (1992) stated that reading cultural information can serve as a pool from which information about diversity can be drawn, but it will not provide easy answers. This writer agrees with Carrithers that cultural information is a good starting point, but that it should be challenged and broadened through the therapeutic process

(respectful curiosity, naiveté, multicultural therapy relationship). McGoldrick et al. (1996) stated, “We have become increasingly convinced that we learn about culture primarily not by learning the ‘facts’ of another’s culture, but rather by changing our attitude” (p. XI). While cultural paradigms help us recognize patterns, the key to cultural understanding is openness to those who are culturally different from us (McGoldrick et al., 1996).

Taken together, the cognitive and process concepts in the literature can create a more comprehensive picture of multicultural therapy competence. The process dimensions of this new model of multicultural therapy competence include the concepts of respectful curiosity, naiveté, and characteristics of the multicultural therapy relationship (see Dyche & Zayas, 1995; Fuertes et al., 2002) which can be indicated through skills, beliefs, and attitudes (see Figure 1). The cognitive dimensions include the concepts of therapist awareness of his/her own cultural values and biases, therapist awareness of client’s worldview, and culturally appropriate intervention strategies, which can be indicated through attitudes, beliefs, knowledge, and skills (see Sue et al., 1982; Sue et al., 1992).

Figure 1

Sensitizing Concepts of the MTCI-CV



Developmental Model

Literature suggests that cultural competency is learned. Lum (2003) stated that persons vary on a continuum of cultural competence because it is part social skill and part personal development. Social skills and personal development are both learned, but may occur at different rates. Therefore, an individual's cultural competency can change throughout his/her lifetime. Pedersen (1994) also considers the development of multicultural competence (knowledge, skills, awareness) to be a continuous process; each component builds on the former toward a comprehensive and balanced perspective that fits the culture and the therapist's development.

Carney and Kahn (1984) proposed a developmental model of multicultural competence based on Sue et al's 1982 position paper. Carney and Kahn believe that trainees pass through five stages of development as they acquire multicultural therapy competencies. Each of the five stages reflects a pattern of growth in knowledge, awareness, and multicultural therapy skills and has a complex relationship with the learning environment. Since therapist development is not uniform, they believe multicultural competence development will occur in spurts with occasional plateaus, regression, and some overlap among stages.

In the first stage, therapists are characterized as having little knowledge of persons dissimilar in culture and ethnicity, thus an appropriate learning environment at this stage would be a highly structured and supportive one, such as a classroom setting. The second stage reflects an emerging awareness of therapist's ethnocentric attitudes and behaviors and is best supported by a training environment that examines the accuracy of trainee behaviors that impede cross-cultural communication. For example, this could be done through the use of role plays, media stimulation, and encouraging creative counseling techniques. The third stage reflects a focus on

conflict and resolution of guilty feelings. This stage is associated with an attitude of colorblindness. Trainees are encouraged to explore their colorblind attitudes and behaviors towards those that are culturally different through cross-cultural encounters, trainings, and readings.

The fourth stage reflects an emerging self-identity as a cross-cultural change agent and participant. A less structured environment that promotes supervised therapy experience with representatives of cultural group's best supports this stage. Lastly, the fifth stage reflects a therapist who assumes a self-directed activist posture in expanding cross-cultural knowledge. A therapist at this stage would benefit most from an environment that helps clarify therapy objectives. This is most often done through peer consultation (Carney & Kahn, 1984).

External Model

Extant literature focusing on multicultural therapy competence has investigated the relationship of several variables to multicultural therapy competence. While it is assumed that there is a positive relationship between multicultural therapy competence and process or outcome indexes of therapy, little research has been done to study this relationship (Atkinson & Lowe, 1995; Fuertes et al., 2001; Steenbarger & Pels, 1997; and Sue, 1998). Researching the effect of therapist cultural competence on client satisfaction and client outcomes from therapy is an important endeavor in assessing whether or not cultural competence is helpful from the client's perspective. There has only been one study in the field of counseling that has attempted to look at the effects of cultural training on client satisfaction and attrition (Wade & Bernstein, 1991). Wade and Bernstein (1991) assessed the effects of a cultural training program and the therapist's race on black female clients' perception of therapist characteristics, clients' satisfaction with therapy, and attrition. Eight counselors and 80 clients were used as participants in this study.

Measures included the Revised Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1978), a Counselor Effectiveness Scale (Linden, Stone, & Shertzer, 1965), and the Counselor Rating Form-Short Form (Barak & LaCrosse, 1976). Clients reported greater satisfaction with therapists who had received the cultural sensitivity training, and same race counseling dyads resulted in less attrition. However, the authors chose to use instruments in this study that focused on client's satisfaction with counseling rather than measures assessing therapists' cultural competence, therefore it is unknown whether cultural competence in fact changed over time, and whether this variable affected client satisfaction.

While it is intuitively appealing to teach therapists about specific ethnic cultures (cognitive model) and expect that it will lead to enhanced treatment outcomes, it also can be argued that such knowledge could have undesirable effects, such as increased risk of stereotyping minority clients (Atkinson & Lowe, 1995; Sue & Zane, 1987). Research is needed to assess whether multicultural training programs result in enhanced therapeutic services and outcomes for ethnic minority clients (Atkinson & Lowe, 1995).

While no studies have assessed the impact of multicultural competence on therapeutic outcomes, a few studies have offered evidence supporting the positive effect of training on self-reported multicultural therapy competence. In a control study of 58 undergraduate students Robinson and Bradley (1997) found that students' multicultural awareness and knowledge increased after taking a multicultural class. Other studies provide evidence of positive relationships between participation in multicultural training courses, workshops and supervision, and self-reported multicultural therapy competence (D'Andrea et al., 1991; Gutierrez, 1996; Moss, 1997; Robinson, 1997).

Ottavi, Pope-Davis, and Dings (1993) examined the relationship between several educational and demographic variables with self-reported multicultural competence. They found gender, age, and years since degree to correlate with multicultural awareness. Gender, multicultural workshop hours and coursework correlated with multicultural knowledge and skills. In their results, women scored higher than men, more recently educated therapists scored higher than those less recently educated and younger therapists scored higher than older therapists on self-reported multicultural competence. Using a national sample of 220 counselors Pope-Davis and Ottavi (1994) also found significant gender and age effects in therapists related to multicultural competence. Survey responses indicated that men were more confused about racial identity than women, and older students reported greater discomfort with racial interactions.

Additionally, research has shown that ethnic status, racial identity development, and amount of client-therapist contact have been found to be related to self-perceived multicultural competence. Ponterotto et al. (1996) found that therapists with higher degrees and non-white ethnic status reported more multicultural knowledge and skill. In a survey study of 344 counseling and psychology graduate students Pope-Davis, Reynolds, Dings, and Nielson (1995) also found that minority therapy students reported higher levels of self-perceived multicultural competence.

Research shows that higher levels of racial identity development are related to higher levels of multicultural therapy competencies (Middleton et al., 2005; Neville, Heppner, Louie, Thompson, Brooks, & Baker, 1996; Kelly, 1998). Helms and Carter (1990) define racial identity development in terms of five attitudes: contact (obliviousness to racial issues), disintegration (awareness of the social implications of race at a personal level), reintegration, (idealization of everything perceived to be White and denigration of everything Black), pseudo-independence

(internalization of Whiteness and ability to recognize responsibility to ameliorate the consequences of racism), and autonomy (a racially transcendent worldview). Lastly, amount of client-therapist contact has been found to relate to self-perceived multicultural therapy competence (Sodowsky, Taffe, & Gutkin, 1994).

Research Questions

The evaluation of multicultural competence is necessary in order to evaluate the outcomes of multicultural competence programs and the services that minority persons receive. The primary goal of this project is to develop a psychometrically sound client self-report measure of therapist multicultural competence.

Phase One: Item Generation and Theme Development

1. For the purposes of generating items for the MTCI-CV, how do people diverse in terms of ethnicity, race, age, and gender, describe the qualities they would want in a multiculturally competent therapist?" We predicted that participant responses would reflect both cognitive and process aspects of cultural competence.

Phase Two: Client Feedback, Interrater Reliability

2. How will client suggestions regarding improving the readability and clarity of the instrument shape the development of the MTCI-CV? We predicted that client suggestions regarding the readability and clarity of the items would help to shape the MTCI-CV.

3. To what degree will family therapists agree on the categorization of the MTCI-CV items for the purposes of making the instrument more parsimonious? We predicted an adequate agreement level on the categorization of the MTCI-CV items.

Phase Three: Pilot Testing, Reliability and Validity Testing

4. To what degree does the MTCI-CV achieve adequate levels of reliability and validity?

We predicted that the MTCI-CV would achieve adequate levels of reliability and validity.

5. Are MTCI-CV measures significantly associated with client satisfaction level with

therapy? We predicted that high levels of client perceived therapist multicultural competence on the MTCI-CV would be positively associated with high levels of client satisfaction with therapy.

6. Are MTCI-CV measures significantly associated with client goal attainment in

therapy? We predicted that high levels of client perceived therapist multicultural competence on the MTCI-CV would be positively associated with high levels of client goal attainment in therapy.

CHAPTER III

Phase 1: Item Generation and Theme Development

Methods

A number of different formats could be used to measure multicultural therapy competency. For example, an interview format could be used. An informal interview would allow the subject and interviewer to direct the interview to the topics or characteristics believed to be most important. While this method could provide rich data, it is also time intensive.

Therapy sessions could be video recorded to observe and code therapist cultural competency behaviors. An observer could use a checklist to indicate the culturally competent behaviors observed. However, this observation may not represent the typical behaviors of the therapist. In addition, while observational measurement can take behaviors into account, it may be difficult for an observer to measure beliefs and attitudes relating to the construct, particularly over the course of only one session.

Most commonly, multicultural therapy competency has been measured through the use of a survey. The benefits of using a survey are that it can be completed in a time sensitive manner. It can therefore be used with a larger number of individuals and in a pretest-posttest manner to assess for growth in multicultural therapy competencies over time. A self-report instrument was developed in this study. Clients indicated their perceptions of their therapist's attitudes and behaviors related to the construct of multicultural competence.

The first phase of this research project included the development of a self-report instrument that measures clients' perceptions of their therapists' multicultural competence. To support content validity, the creation of the items was informed by the literature (as illustrated in

the internal model) (Dyche & Zayas, 1995; Fuertes et al., 2002; Sue et al., 1982; Sue et al., 1992) as well as indigenous knowledge.

Participants

One hundred twenty-three participants were asked to complete an open-ended questionnaire (Appendix C). Participants were recruited through a number of means. Participants were recruited by word of mouth, and e-mail at Virginia Tech. international clubs/associations' activities and meetings. E-mail advertisements and word of mouth were used to recruit participants from local church communities. Additionally therapists at The Family Therapy Center of Virginia Tech. were asked by word of mouth or by e-mail to participate in the study.

Clark and Watson (1995) state that initial phases of instrument development should include moderately sized samples of convenience (between 100 and 200 participants). During the item generation phase the goal was to gather indigenous knowledge regarding cultural competence, therefore an over-representation of minorities and international students was included in the study. Participants included: 46 students and their families from the Cranwell International Center at Virginia Tech., 72 individuals and couples from the community of Blacksburg, VA, and five therapists from the Family Therapy Center of Virginia Tech.

Frequencies determined the sample characteristics of the 123 participants. As shown in Table 1, the majority of the participants were between 18 years old and 34 years old. Slightly more females than males participated, 51.2% ($n = 63$) and 48.8% ($n = 60$) respectively; 60.2% ($n = 74$) of the participants categorized themselves as Caucasian, followed by 12.2% ($n = 15$) Korean, and 9.8% ($n = 12$) Asian Indian. Ninety six of the participants identified English as their first language (78.1%). Seventy two of the participants reported being married (59.0%) and 35

(28.7%) reported never being married. Seventy six (61.8%) of the participants had education between an undergraduate degree and a master's level degree. Additionally, 61.5% ($n = 72$) of the participants reported household incomes above \$35,001. Average time living in the United States was 25 years, with a range of 3 months to 64 years, and a standard deviation of 192.62. One hundred seventeen participants reported being fluent in English and five reported not being fluent in English.

Table 1

Phase One Sample Characteristics

	<i>n</i>	%
Age		
18-24 years old	30	24.59
25-34 years old	63	51.64
35-44 years old	8	6.56
45-54 years old	12	9.84
55-64 years old	9	7.38
Gender		
Male	60	48.78
Female	63	51.22
Race		
African American	3	2.44
Caucasian	74	60.16
Hispanic	3	2.44

Japanese	2	1.63
Chinese	6	4.88
Korean	15	12.20
Asian Indian	12	9.76
Other	8	6.50
Language		
English	96	78.05
Spanish	2	1.63
Japanese	2	1.63
Chinese	2	1.63
Korean	10	8.13
Hindi	4	3.25
Other	7	5.69
Relationship Status		
Never Married	35	28.69
Married	72	59.02
Living with Partner	4	3.28
Dating and Partnered	9	7.38
Other	2	1.64
Education		
High School Diploma or GED	11	8.94
Some College/Technical School	16	13.01

Technical School Degree	1	0.81
College Degree	25	20.33
Some Graduate School	6	4.88
Masters Degree	45	36.59
Doctorate/Medical Degree	19	15.45
Household Income		
Under 5,000	10	8.55
Between 5,001 and 15,000	10	8.55
Between 15,001 and 25,000	10	8.55
Between 25,001 and 35,000	15	12.82
Between 35,001 and 50,000	23	19.66
Over 50,001	49	41.88

Procedures

To support content validity, the creation of the instrument's items was informed by the literature (as illustrated in the internal model) (Dyche & Zayas, 1995; Fuertes et al., 2002; Sue et al., 1982; Sue et al., 1992) as well as indigenous knowledge. Participants were asked to complete an open ended questionnaire stating, "If you or your family were seeing a therapist of a different ethnicity or culture, what attitudes, beliefs, knowledge, skills, and behaviors would you like that therapist to have?" There were separate sections on the questionnaire for participants to indicate the knowledge, attitudes, and behaviors they would like a therapist of a different ethnicity or culture to have. Surveys were available in paper/pencil format as well as through Virginia Tech's web-based survey tool. Eighty-six of the surveys were administered by the

principal investigator and completed in paper/pencil format and 37 of the surveys were completed through Virginia Tech's web-based survey tool.

Measures

An open ended questionnaire (Appendix C) and a demographic form (Appendix B) were used during phase one. The open ended questionnaire includes three questions for participants to write about the knowledge, beliefs, and skills they would like in a culturally competent therapist. The demographic form is composed of ten questions. Most of the questions are general questions which encompass the areas of: age, gender, ethnicity, marital status, primary language, level of education, and annual household income. In addition, there are two questions that look at acculturation; time lived in the United States, and the ability to speak English fluently.

Analyses

To account for more variance and potential categories than existing measures of cultural competency, the categories of the instrument were inductively derived and the predominant domains and existing literature were used as sensitizing concepts (see Dyche & Zayas, 1995; Fuertes et al., 2002; Sue et al., 1982; Sue et al., 1992) as this researcher placed the responses into conceptual themes. Aspects that participants and literature both considered to be important indicators of multicultural therapy competence informed the final categories and resulting survey questions.

The categories for the MTCI-CV were indicated in item development in several different ways. Each aspect of the cognitive model (therapist awareness of own cultural values and biases, therapist awareness of client's worldview, culturally appropriate intervention strategies) was indicated through knowledge, attitudes and beliefs, and skills (see Sue et al., 1992) as seen in the internal model (see Figure 1). The aspects of the process model (respectful curiosity, naiveté,

multicultural therapy relationship) were indicated through attitudes, beliefs, and skills (as well as knowledge for the multicultural therapy relationship aspect). For example, naiveté is described as a state of openness and receptivity exhibited when one works with confidence and skill while remaining sensitive and receptive to the complex differences between themselves and their clients. This definition implies that naiveté is both an attitude or state of being as well as a skill. Curiosity is composed of the love of surprise and the desire to look beyond assumptions (Dyche & Zayas, 1995); this also implies an attitude which can be expressed as a behavior. Lastly, developing a multicultural therapy relationship includes knowledge of therapy and how to form a multicultural relationship, an attitude of cultural trust, the belief that it is important to create a working alliance, as well as skills such as empathy, active listening, and attending (Feurtes et al., 2002).

Content and substantive validity were established by matching the distribution of the items and the weight of each component, because all aspects were deemed important indicators by participants or extant literature they were given equal importance in item development. Items were worded to reflect therapist cultural competence with both families and individuals.

Since multicultural therapy competence is a latent trait, the Rasch measurement model (Wright & Masters, 1982), a latent trait model, was used to structure the MTCI-CV. There are several benefits to using the Rasch model, including: the multicultural therapy competence level of each participant and the endorsability of each item in the MTCI-CV are estimated independently of the sample of persons or sample of items, homogeneity of error variances is not necessary, unbiased estimates are produced for random missing data, and powerful diagnostic indices are available (Bond & Fox, 2001). In addition, the Rasch model is able to transform participants' multicultural therapy competence scores to a nonlinear measure and generate an

Item Response Function (IRF) for each item, which represents the probability that a participant will make a specific response to a specific item through several parameters that describe the participant (e.g., multicultural therapy competence) and the item (e.g., endorsability) (Bond & Fox, 2001). The Rasch model assumes that the IRF for each item has the same slope (Bond & Fox, 2001). The construct of multicultural therapy competence is conceptualized as a continuous variable. Different items were created for each dimension, and each item is rated on a continuum, therefore, the Rasch Rating Scale model was employed.

The rating scale consists of Likert-type items to measure all of the components of the construct. Items were categorized into a 3-point Likert rating scale, where 1 indicates “does this well,” 2 indicates “does this adequately,” and 3 indicates “does this poorly.” A rating scale was used in order to include a range of responses from participants. The sum (lower scores reflect good ratings) of the client’s ratings of the therapist is interpreted as indicating the client’s perceptions of the therapist’s level on each dimension of the multicultural therapy competence construct.

Results

As described in the methods section instrument development is a common practice in the field of psychotherapy. The use of theory in developing an instrument is important. Identifying distinctions, dependencies, and relations of the items is an essential part of instrument development (Dawis, 1987). This section describes the beginning stages of creating the MTICI-CV.

The participants open-ended responses to the three survey questions were typed up (see Appendix C). Based on content the responses were grouped into the six category themes and their according indicators (knowledge, attitudes and beliefs, skills) identified by the literature

review (see Figure 1). Items that did not fit into one of these themes were set aside. These items were later assessed for commonalities and a new indicator was developed to fit these responses, Multicultural Counseling Relationship, Knowledge (see Appendix K). Participant responses reflected both the Process and Cognitive dimensions in the internal model.

Process examples:

I am more interested in the therapists' open mindedness and willingness to learn (their process) than in what they know.

Not take anything for granted - did not have any assumptions about me just because of my "ethnicity". Even within "ethnicities" we are so different. Even from our own country, we are so different. I would like him/her to ask.

Cognitive examples:

I would want a counselor to have knowledge about the practices and customs of cultures, the accepted behaviors, and general attitudes and beliefs.

I would want a counselor to have basic knowledge of culture, family, and difficulties that people face commonly in the culture.

Items were then developed to reflect the content of the themes. Items were worded to reflect therapist cultural competence with both families and individuals. During the brainstorming process, initially 212 items were developed (see Appendix D) to represent the six categories and their according indicators (knowledge, attitudes and beliefs, skills) as expressed in a matrix format (see Figure 2 below). Later for the purposes of eliminating items, the principal investigator and two secondary investigators judged the items based on clarity and content. The principal investigator then eliminated items based on considering the feedback from the secondary investigators together with how well the items appeared to represent their intended

content area (cell) on the matrix. This process resulted in 58 items (see Appendix E); three or four items remained to represent each content area (cell) in the matrix. Lastly, items were categorized into a 3-point Likert rating scale, where 1 indicates “does this well,” 2 indicates “does this adequately,” and 3 indicates “does this poorly.”

Figure 2

Item Development Matrix

	Attitudes and Beliefs	Skills	Knowledge
Counselor Awareness of Own Cultural Values and Biases	My therapist values both his/her own perspective as well as my/my family's perspective.	My therapist is open about her/his values.	My therapist is aware of how discrimination and oppression can affect relationships.
Counselor Awareness of Client's Worldview	My therapist has an accepting attitude towards my/my family's personal values and beliefs.	My therapist acknowledges the perspective of each person in therapy.	My therapist appears to have some knowledge about my culture and background.
Culturally Appropriate Intervention Strategies	My therapist shows respect for my/my family's ideas and behaviors in therapy.	My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, etc.).	My therapist appears to be knowledgeable about several different approaches to helping me/my family.
Respectful Curiosity	My therapist takes a curious attitude towards learning about me/my family.	My therapist asks me/my family to tell him/her about my/our expectations for care.	X
Naiveté	My therapist is interested in my/my family's expertise on my/our life.	My therapist is receptive (through body language and communication) to the differences between us.	X
Multicultural Counseling Relationship	My therapist focuses on building a relationship with me and my family in a culturally appropriate manner.	My therapist uses relationship-building skills, such as listening, attending, and paraphrasing.	My therapist knows basic principles that are helpful in my life/family relationships.

Discussion

During phase one of this research study, participant responses were initially grouped into the six categories (15 total indicators) identified by the literature review (see Figure 1). Most of the participant responses fit into the categories identified by the literature on cultural competence. The categories identified by the literature include the process dimensions of respectful curiosity, naiveté, and characteristics of the multicultural therapy relationship (see Dyche & Zayas, 1995; Fuertes et al., 2002) which can be indicated through skills, beliefs, and attitudes. Additionally, the cognitive dimensions of cultural competence identified by the literature include the concepts of therapist awareness of his/her own cultural values and biases, therapist awareness of client's worldview, and culturally appropriate intervention strategies, which can be indicated through attitudes, beliefs, knowledge, and skills (see Sue et al., 1982; Sue et al., 1992).

As was hypothesized, participant responses reflected both the process and cognitive dimensions in the internal model. Items that did not fit into one of these themes were set aside. These items were later assessed for commonalities and an additional sixteenth indicator was developed to fit these responses, Multicultural Counseling Relationship, Knowledge. Examples of responses that fit into this category include the following:

I would want a counselor the have technical or practical counseling knowledge.

I would want a counselor to be knowledgeable about the kinds of problems that I'd be seeking help for.

I would want my counselor to have an understanding of psychology.

Previous self-report instruments (MCI, MCAS-B, and MAKSS) that have been developed to measure therapist cultural competence have focused on incorporating cognitive dimensions, especially those developed by Sue et al. (1982) (knowledge, skills, attitudes and

beliefs). However, process dimensions have not been included in measures of therapist cultural competence. The participant responses in this study confirm the importance of including process and relational dimensions (Fuertes, Bartolomeo, & Nichols, 2001; Krause & Miller, 1995), such as naiveté and respectful curiosity (Dyche & Zayas, 1995) when measuring cultural competence. Participants reported wanting their counselor to have knowledge about their culture and perspective, as well as wanting their therapist to express curiosity and openness in learning about them as unique people.

CHAPTER IV

Phase 2: Client Feedback, Interrater Reliability

Methods

During the second phase of this study client feedback was received on the MTCTI-CV to determine readability, clarity, and the ability of the items to provide sufficient variability of responses. Additionally, interrater feedback was received on the categorization of the MTCTI-CV items for the purposes of making the instrument more parsimonious.

Participants

Family therapists at UNMC were asked to recruit several of their clients to participate in this phase of the study, with the intent of primarily recruiting minority clients. Seven of the family therapists' clients from the Behavioral Health, Family Medicine Department at UNMC completed the pilot instrument on their current therapist. Participants included: 3 males and 4 females, 4 Caucasian, 2 African American, and 1 Arabic participant. The average age of participants was 36 years old, with a range of 28 to 41 years of age.

Item raters were recruited by word of mouth from the Behavioral Health, Family Medicine Department at UNMC. Item raters included three Caucasian, male, marriage and family therapy faculty at UNMC with a minimum of three years experience and an understanding of cultural competence.

Procedures

Family therapists' clients from the Behavioral Health, Family Medicine Department at UNMC were asked to complete the pilot instrument on their current therapist. The consent form (Appendix A) and instrument (Appendix E) were administered by the principal investigator.

Clients were asked to complete the instrument and to indicate questions that did not make sense or were unclear.

To support content validity, three trained raters independently grouped items into category and cell level (Appendix F); the grouping was evaluated across persons for consensus. After the first rating, revisions were made to the instrument, and trained raters met for a brief phone conference with the principal investigator to discuss rating instructions and general definitions (Appendix G), after which the raters rated the items a second time.

Measures

Client participants were administered the MTCI-CV, a demographic form, and a client feedback form (Appendix E). During this phase the MTCI-CV was composed of 58 items. The client feedback form provided space for participants to document items that were unclear and provide general suggestions and feedback on the survey. The demographic form was composed of 18 questions. Most of the questions were general questions which encompass the areas of: age, gender, ethnicity, marital status, primary language, level of education, and annual household income. Additionally, one question looked at acculturation; three questions assessed the amount of therapy the participant received and which family members participated, two questions looked at satisfaction with therapy, and two questions looked at goal attainment in therapy.

During the first (Appendix F) and second ratings (Appendix G), raters were given a set of directions, including category definitions and two written examples, followed by the list of MTCI-CV items with blank columns inserted for entering the category and cell level ratings.

Analyses

Items were modified based on client feedback concerning the readability, clarity, and variability of the items. Inter-rater agreement was assessed through the use of Cohen's Kappa.

Percent agreement was calculated by adding up the number of items that received the same grouping by raters and dividing that number by the total number of items rated by the raters. The items which were not grouped into the categories the items were developed to represent were omitted or reworded.

Results

Participants were asked to provide feedback on the clarity, readability, and content of the demographic and MTCI survey items (see Appendix E). Items were reworded and omitted based on participant feedback. Some participants suggested shortening the length of the survey, a few participants identified demographic questions that were not relevant to them, and participants identified wording that was difficult for them to understand. For example, on the demographic form several participants indicated that it was difficult to mark an appropriate box for number of therapy sessions attended; participants also indicated that on the relationship status question there was no “single” option. On the MTCI-CV participants identified the following words as difficult to understand: attentive, receptive, tolerance, and exhibits. The items that contained these words were either eliminated or reworded. Participant feedback regarding item relevance and clarity guided the elimination of excess items (the intent was to retain 48 items, three items for each cell area; see Figure 2). The MTCI was shortened from 58 to 48 items (see Appendix H) and the demographic questionnaire was shortened from 18 to 14 items (see Appendix H).

Content and substantive validity were established by matching the distribution of the items and the weight of each component, because all aspects were deemed important indicators by participants or extant literature they were given equal importance in item development. Therefore, three items were retained to represent each content area (matrix cell) (see Figure 2; six categories, and their respective indicators) for a total of 48 items.

Final Items created from Phase 2 for Pilot Phase

Counselor Awareness of Own Cultural Values and Biases

Attitudes and Beliefs

- 2. My therapist values his/her own background/culture.
- 8. My therapist values his/her own perspective.
- 43. My therapist respects his/her cultural heritage as well as valuing differences.

Skills

- 6. My therapist appropriately applies his/her own values in therapy.
- 25. My therapist shares her/his beliefs when they are relevant to therapy.
- 31. My therapist provides the opportunity to discuss his/her values related to family, culture, religion, etc. when they are relevant to therapy.

Knowledge

- 9. My therapist knows about the customs of his/her culture, accepted behaviors, and general values.
- 20. My therapist is aware of how his/her beliefs and values can affect therapy.
- 41. My therapist knows about how his/her biases can affect me/my family.

Counselor Awareness of Client's Worldview

Attitudes and Beliefs

- 1. My therapist has a respectful attitude towards my/my family's personal values and beliefs.
- 10. My therapist accepts my/my family's values and beliefs.
- 30. My therapist is able to see things from my perspective without judgment.

Skills

- 4. My therapist tries to understand my/my family's values and beliefs.
- 15. My therapist acknowledges my/my family's point of view.
- 35. My therapist acknowledges my/my family's values and beliefs.

Knowledge

- 18. My therapist is familiar with the difficulties that may be commonly faced by persons from my/my family's culture.
- 21. My therapist appears to have some knowledge about my/my family's culture and background.
- 42. My therapist is familiar with how culture, religion, and gender can shape me/my family.

Culturally Appropriate Intervention Strategies

Attitudes and Beliefs

- 12. My therapist accepts different ways I/my family express(es) feelings in therapy.
- 19. My therapist cares about helping me/my family in appropriate ways.
- 40. My therapist values my/my family's ideas and behaviors in therapy.

Skills

11. My therapist provides the opportunity to incorporate my/my family's traditional sources of healing into therapy.
24. My therapist is able to explain things in a way that demonstrates familiarity with my/my family's ethnicity/culture.
38. My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, etc.).

Knowledge

26. My therapist appears to understand that therapy needs to fit me/my family (i.e.: race, class, gender, culture, sexual orientation, etc.).
39. My therapist is knowledgeable about how my/my family's background may affect my/our availability of resources.
46. My therapist knows about normal social behaviors in my/my family's culture (e.g., eye contact, touch, greetings).

Respectful Curiosity

Attitudes and Beliefs

22. My therapist is curious about my background and experiences.
29. My therapist desires to know me as an individual with unique experiences.
48. My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family.

Skills

14. My therapist asks me/my family to tell him/her about my/our unique expectations for care.
32. My therapist displays a genuine interest to learn about me/my family.
33. My therapist takes a curious approach towards learning about me/my family.

Naiveté

Attitudes and Beliefs

13. My therapist has an open mind to our differences.
34. My therapist is open to my/my family's expertise on my/our life.
36. My therapist is open to my/my family's uniqueness.

Skills

23. My therapist displays openness towards me/my family as expert(s) on my/our life.
27. My therapist shows openness to my/my family's perspective.
37. My therapist is open (through body language and communication) to the differences between us.

Counseling Relationship

Attitudes and Beliefs

5. My therapist has an accepting attitude.
7. My therapist has a positive and warm attitude.
16. My therapist cares about building relationships with people.

Skills

3. My therapist uses relationship-building skills, such as listening and attending.
44. My therapist creates a comfortable environment in therapy.
45. My therapist connects well with people.

Knowledge

17. My therapist knows about several different ways of helping people.
28. My therapist is familiar with the kinds of problems that people seek help for.
47. My therapist knows basic principles that are helpful in relationships.

The 48 items were then given to three Marriage and Family Therapy Faculty from UNMC to assess the reliability of the items. The raters were given written instructions that included definitions of the categories (see Appendix F). Raters were asked to independently group items into the category and cell level. The grouping was evaluated across persons for consensus. Inter-rater agreement was assessed through the use of Cohen's Kappa. Cohen's Kappa was .33 at the category level, and .32 at the cell level after the first round of ratings.

The three raters and the principal investigator met together after the initial rating for the purposes of rating agreement. All items that did not have 100% agreement were discussed and the three raters agreed on a category level rating for these items. The raters also discussed alternate wording for problem items so that the items would better fit their intended categories. In addition, after making the suggested changes to the items, the principal researcher assessed the items again to evaluate if they represented their intended category and cell definitions. Several changes were made to the items with the goal of increasing the clarity and content of the items. For example, items containing the words "individuals" and "relationships" were changed to "me/my family." Another change involved focusing items related to counselor awareness of their own cultural values and biases only on the therapist's values and behaviors, rather than including client wording in the items.

In preparation for the second rating the principal investigator further defined the categories and rating directions for increased distinction (see Appendix G). Prior to the second

rating the three raters and principal investigator scheduled a phone conference to discuss category definitions, directions, to practice rating a few items together, and to answer any questions. Several clarifications were made. The raters practiced rating four items together and discussed their reasons for assigning the items as they did. The three raters then independently rated the 48 items. Cohen's Kappa for the second rating was .65 at the category level and .64 at the cell level. Items that were not categorized into their intended category by at least two of the three raters were examined and some of these items were reworded. This process identified nine items to be examined (items 8, 12, 14, 17, 19, 29, 39, 40, and 46). Changes were made considering item content and clarity. Several of the changes made are listed in the table below. Additionally, item 17, "My therapist appears to be knowledgeable about several different ways of helping me/my family" switched categories (from the Counseling Relationship, Knowledge category to the Culturally Appropriate Intervention Strategies, Knowledge category) with item 46, "My therapist knows about normal social behaviors in cultures (e.g., eye contact, touch, greetings)." Items 19, "My therapist cares about helping me/my family in appropriate ways," 29, "My therapist desires to know me as an individual with unique experiences," and 39, "My therapist is knowledgeable about how my/my family's background may affect my/our availability of resources" were evaluated on clarity and content, but remained unchanged due to the importance of their content in representing the construct of cultural competence.

Table 2

Phase Two Item Revisions

Item	Old	New
8	My therapist values both his/her own perspective as well as my/my family's perspective.	My therapist values his/her own perspective.
12	My therapist appears accepting of different ways I/my family express (es) feelings.	My therapist accepts different ways I/my family express (es) feelings in therapy.
14	My therapist asks me/my family to tell him/her about my/our expectations for care.	My therapist asks me/my family to tell him/her about my/our unique expectations for care.
40	My therapist respects my/my family's ideas and behaviors in therapy.	My therapist values my/my family's ideas and behaviors in therapy.

Discussion

Client suggestions regarding improving the readability and clarity of the instrument helped to shape the MTCI-CV. Client suggestions helped to shape the content, format and wording of the MTCI-CV. Literature has criticized the lack of adequate input from minorities in multicultural literature and research (Boyle & Springer, 2001; Pederson, 1995). Incorporating feedback from diverse clients at this stage of instrument development was intended to increase the applicability of the instrument with the population it is intended to serve.

The interrater process on the categorization of the MTCI-CV items helped to make the instrument more parsimonious. Interraters gave helpful feedback regarding concepts and wording that they did not view as applicable to a particular category of cultural competence. The interrater process resulted in an adequate level of agreement providing support that the content of the MTCI-CV was judged by the raters to be appropriate for measuring multicultural therapy competence.

CHAPTER V

Phase 3: Pilot Testing, Reliability and Validity Testing

Methods

Phase three included a pilot test with the purpose of receiving initial information regarding the reliability and validity of the measures. Following the pilot test, changes were made to the MTCI-CV, after which 211 participants were recruited for the purpose of validation testing.

In order to participate in this phase of the study, participants must have previously seen a therapist or counselor. All participants were recruited from the Behavioral Health Division (Marriage and Family Therapy), Department of Family Medicine, at the University of Nebraska Medical Center (UNMC). Participants were recruited by mailings sent out to a database generated list of clients seen at UNMC.

Participants

During the pilot test, 150 previous and current UNMC clients were sent mailings with the goal of receiving initial data on the reliability and the validity of the measures. The pilot participant list was formed using stratified random sampling; clients were randomly selected to represent the ratio of each ethnic group in the UNMC family therapy department client population. This was done so that the pilot and validation test samples could be similar in terms of opportunity for ethnic diversity. The UNMC family therapy client population was comprised of the following: Caucasian 80.42%, African American 12.68%, Hispanic 3.49% Native American .92%, and other 2.48%.

During the pilot test, each of the four mailings were mailed to participants a week apart from each other. The second week of mailings was sent to 141 participants. Nine participants

were deleted from the mailing list due to incorrect addresses or personal request. The third week of mailings was sent to 136 participants. Five additional envelopes were returned with incorrect addresses. The last week of mailings was sent to 110 participants. Twenty-two surveys had already been returned, two mailings had incorrect addresses, and 2 participants asked to be taken off of the mailing list. In all, 32 surveys were returned and completed during the pilot test, for a response rate of 21%. The clients that had been sent mailings during the pilot test were taken off of the database generated list of clients seen at UNMC so that these clients were unable to participate in the validation phase of this study.

Thirty-two people participated in the pilot test of this study. Frequencies determined the sample characteristics of the 32 participants. As shown in Table 3, the majority of the participants were between 31 years old and 57 years old. Females made up 75.0% ($n = 24$) of the sample compared to 25.0% ($n = 8$) males, and 71.9% ($n = 23$) of the participants categorized themselves as Caucasian followed by 15.6% ($n = 5$) African-American and 6.3% ($n = 2$) Hispanic. Thirty one of the participants identified English as their first language (96.9%). Nineteen of the participants reported being married (59.4%), 12.5% ($n = 4$) reported being single, and 15.6% ($n = 5$) reported being divorced. Ten (32.3%) of the participants had a high school diploma or GED and 58.1% ($n = 18$) of participants had a college or technical school degree. Household income was varied with 21.9% ($n = 7$) of the participants reporting household incomes between \$35,001 and 50,000. Average time living in the United States was 41 years with a range of 22 years to 65 years. Thirty-one participants reported being fluent in English and one reported not being fluent in English. The average number of counseling sessions attended by participants was 7.80, with a range of 2 to 36 sessions. Twenty eight of participants reported being satisfied or very satisfied with the counseling they received (87.5%), while 9.4% ($n = 3$) of the participants reported being

somewhat unsatisfied with the counseling they received. Twenty six of the participants reported attaining most or some of their therapeutic goals in counseling (83.9%), while five (16.1%) reported they did not attain any of their therapeutic goals.

Table 3

Pilot Test: Sample Characteristics

	<i>n</i>	%
Age		
22-30 years old	5	16.13
31-39 years old	10	32.26
40-48 years old	6	19.35
49-57 years old	8	25.81
58-66 years old	2	6.45
Gender		
Male	8	25.00
Female	24	75.00
Race		
African American	5	15.63
Native American	1	3.13
Caucasian	23	71.88
Hispanic	2	6.25
Other	1	3.13
Language		

English	31	96.88
Spanish	1	3.13
Relationship Status		
Single	4	12.50
Dating or Partnered	1	3.13
Living with Partner	2	6.25
Married	19	59.38
Separated	1	3.13
Divorced	5	15.63
Education		
Less than High School	2	6.45
High School Diploma or GED	10	32.26
College/Technical Degree	18	58.06
Masters Degree	1	3.23
Household Income		
Under 5,000	3	9.38
Between 5,001 and 15,000	3	9.38
Between 15,001 and 25,000	3	9.38
Between 25,001 and 35,000	4	12.50
Between 35,001 and 50,000	7	21.88
Between 50,001 and 80,000	5	15.63
Between 80,001 and 110,000	3	9.38

Over 110,001	4	12.50
Satisfaction with Counseling		
Very Satisfied	22	68.75
Somewhat Satisfied	6	18.75
Neutral	1	3.13
Somewhat Unsatisfied	3	9.38
Very Unsatisfied	0	0.00
Goal Attainment		
Most	8	25.81
Some	18	58.06
Did Not Attain	5	16.13

Following the pilot test changes were made to the MTCI-CV, after which an additional 211 UNMC clients were recruited to take part in the validation phase of this study. This sample size was selected based on Wright & Stone's (1979) recommendation to use a minimum of 20 items and 200 respondents for a dichotomous measurement model. Since sample size guidelines have not been presented for polytomous models, the chosen sample size is likely less than optimal. Over sampling occurred in order to recruit the desired amount of participants.

For four consecutive weeks a mailing was sent to potential participants. The first set of mailings was sent to 949 previous and current UNMC clients. The list was formed by selecting all of the remaining previous or current UNMC clients in the hospital database system apart from the mailings that had already been sent out for the pilot phase of the study.

The second week of mailings was sent to 897 participants. The second week of mailings included a fifty cent piece with the survey to increase response rates. Participants were deleted from the mailing list due to incorrect addresses or personal request. The third week of mailings was sent to 819 participants. The last week of mailings was sent to 718. Several surveys from week two had been returned, some of the mailings were undeliverable due to incorrect addresses, and some participants asked to be taken off the mailing list. In all, 211 surveys were returned and completed during the validation phase of this study for a response rate of 22% (see Table 4).

Table 4

Validation Test: Response Rate

Week	Mailings Sent	Incorrect Address	Decline Participation	Surveys Returned	Response Rate Percentage
1	949	48	4	Not Applicable	Not Applicable
2	897	39	7	32	3.37
3	819	29	8	64	6.74
4	718	13	11	211	22.23

Two hundred eleven people participated in the validation phase of this study. Frequencies determined the sample characteristics of the 211 participants. Table 5 displays the sample characteristics for the validation test in comparison to the entire client population at UNMC. One hundred fifteen of the participants (54.8%) were between 39 years old and 58 years old. Females made up 70.1% ($n = 148$) of the sample compared to 29.9% ($n = 63$) males; 82.4% ($n = 173$) of the participants categorized themselves as Caucasian, followed by 11.0% ($n = 23$) African-American participants, and 2.9% ($n = 6$) Native American/Alaskan Native participants, as well as

2.9% ($n = 6$) Hispanic/Latino participants. Two hundred eight of the participants identified English as their first language (98.6%). One hundred four (49.5%) of the participants reported being married, 18.6% ($n = 39$) single, and 14.8% ($n = 31$) divorced. Eighty three 39.7% of the participants had a high school diploma or GED and 44.0% ($n = 92$) of participants had a college or technical school degree. Household income varied widely across the sample, 14.1% ($n = 29$) of participants reported annual household incomes between 5,001 and 15,000, and 15.1% ($n = 31$) of participants reported annual incomes between 50,001 and 80,000. Average time living in the United States was 44.73 years with a range of 3 years to 77.75 years. Two hundred participants reported being fluent in English and 10 reported not being fluent in English. The average number of counseling sessions attended by participants was 15.21, with a range of one to 128 sessions. One hundred sixty eight of participants reported being very or somewhat satisfied with the counseling they received (80.4%), while 9.1% ($n = 19$) of the participants reported being unsatisfied or very unsatisfied with the counseling they received. One hundred sixty nine of the participants reported attaining some or most of their therapeutic goals in counseling (81.7%), while 18.4% ($n = 38$) reported they did not attain any of their therapeutic goals.

Table 5

Validation Test: Comparison of Sample and Population Demographics

	Sample Demographics		Population Demographics	
	<i>n</i>	%	<i>N</i>	%
Age				
19-28 years old	29	13.81	191	17.56
29-38 years old	34	16.19	282	25.92
39-48 years old	51	24.29	271	24.91
49-58 years old	64	30.48	200	18.38
59-68 years old	23	10.95	99	9.10
69-78 years old	9	4.29	39	3.58
79 and over	0	0.00	6	.55
Gender				
Male	63	29.86	367	33.73
Female	148	70.14	721	66.27
Race				
African American	23	10.95	138	12.68
Native American	6	2.86	10	0.92
Caucasian	173	82.38	875	80.42
Hispanic/Latino	6	2.86	38	3.49
Other	2	0.95	27	2.48

Table 6

Validation Test: Additional Sample Characteristics

	<i>n</i>	%
Language		
English	208	98.58
Spanish	2	0.95
Other	1	0.47
Relationship Status		
Single	39	18.57
Dating or Partnered	13	6.19
Living with Partner	10	4.76
Married	104	49.52
Separated	7	3.33
Divorced	31	14.76
Widower	5	2.38
Other	1	0.48
Education		
Less than High School	8	3.83
High School Diploma or GED	83	39.71
College/Technical Degree	92	44.02
Masters Degree	18	8.61
Doctorate/Medical Degree	8	3.83

Household Income

Under 5,000	8	3.88
Between 5,001 and 15,000	29	14.08
Between 15,001 and 25,000	26	12.62
Between 25,001 and 35,000	29	14.08
Between 35,001 and 50,000	29	14.08
Between 50,001 and 80,000	31	15.05
Between 80,001 and 110,000	25	12.14
Over 110,001	29	14.08

Satisfaction with Counseling

Very Satisfied	137	65.55
Somewhat Satisfied	31	14.83
Neutral	22	10.53
Somewhat Unsatisfied	15	7.18
Very Unsatisfied	4	1.91

Goal Attainment

Most	99	47.83
Some	70	33.82
Did Not Attain	38	18.36

Procedures

Participants from the pilot phase were mailed the MTCI-CV, a demographic questionnaire (Appendix H), and an informed consent form (Appendix A). During the validation phase participants were sent the updated version of the MTCI-CV, as well as a demographic questionnaire (Appendix I) and an informed consent form (Appendix A). During the pilot and validation tests participants were assured that their participation in this study is entirely voluntary. An altered version of Dillman's (2007) five step process was used during the pilot and validation tests to encourage a high response rate (i.e., week one: brief prenotice letter; week two: cover letter, questionnaire, return envelope; week three: thank you letter; week four: cover letter, replacement questionnaire, return envelope; week five: final contact) (Appendix J). An alternative final contact (week five) was not used in this study because the UNMC Institutional Review Board was not supportive of an additional contact. A fifty cent piece was enclosed in the original questionnaire packets as an incentive.

Measures

The MTCI-CV and a demographic questionnaire were the only measures used during this phase three of this study. The same demographic form was used for the pilot and validation tests. The demographic form was composed of 14 questions. Most of the questions were general questions which encompass the areas of: age, gender, ethnicity, relationship status, primary language, level of education, and annual household income. Additionally, two questions looked at acculturation, one question assessed the amount of therapy the participant received, two questions looked at satisfaction with therapy, and two questions looked at goal attainment in therapy.

Different versions of the MTCI-CV were used during the pilot test from that used in the validation test. The MTCI-CV version that was used during the pilot test was composed of 48 items (see Appendix H). Prior to mailing surveys for the validation phase the MTCI-CV was shortened from 48 to 32 items, and five items were reworded with the purpose of increasing the item endorsabilities (see Appendix I).

Analyses

Separate analyses were run for the pilot and validation phases using *Winsteps*. The *Winsteps* (Linacre, 2001) software was used to scale the measurement data to the Rasch Rating Scale Model, and evaluate the dimensionality, rating scale use, item fit, person fit, and reliability and precision, as well as to create norms for interpreting the measures.

Using the procedures listed above, the pilot data were used initially to assess the validity and reliability of the measures. After the data were collected and assessed, items were modified based on the item point measure correlations and item content.

To determine the dimensionality, a principle component analysis was conducted on the residuals from the Rasch model. If the Rasch model is suitable for the data, then residuals should be uncorrelated. Existence of inter-item correlations beyond those accounted for by the joint (unidimensional) covariance indicates possible departures from the unidimensionality assumed by the Rasch model. Decisions regarding the retention of non-Rasch components were guided by a scree plot, Kaiser's adjusted criteria, and Linacre's (2001) guidelines for retaining factors based on *Winsteps* software. Kaiser's (1960) criteria were used in the decision to retain factors. That is, factors that have eigenvalues greater than 1.00 were retained. A scree plot was produced to aid in this decision, where factors before the asymptote were explored for substantive interpretability (Cattell, 1966). Additionally, Linacre's (2001) criteria states that if 60% or more

of the variance is accounted for by the Rasch component and less than 5% of the variance accounted for by residual components, this is sufficient reason for claiming unidimensionality.

The adequacy of the rating scale was evaluated based on guidelines recommended by Linacre (2004). Specifically, these guidelines include whether (a) rating categories were used with sufficient frequency (i.e., at least 130 observations per category), (b) the distribution of observations within each category was unimodal, (c) the rating scale thresholds increased in value with the rating categories, (d) the average measures associated with each rating category increased monotonically, (e) the mean square statistics associated with each category were reasonable (i.e., less than 2.0), and (f) the minimum and maximum distances between rating scale thresholds was greater than 1.4 and less than 5, respectively.

Item quality was evaluated based on item point measure correlations, standardized unweighted mean square values (or bootstrap weighted mean square values), and item importance to content coverage. First, using the point measure correlation (i.e., item score-theta correlation), items were flagged if the value of this index was less than .30 (Nunnally & Bernstein, 1994). Second, in the pilot phase the standardized unweighted mean square fit indices were considered, and based on simulations performed by Smith et al (1998) items were flagged if the value of this index was greater than 2.00. In the validation phase, the bootstrap weighted mean square value was used instead of the standardized unweighted mean square fit indices because the implications during this phase were more serious and the bootstrap criteria are considered more accurate (Wolfe, in press). Using the bootstrap weighted mean square values, items were flagged if the values were less than 0.73 or greater than 1.30. Flagged items were then examined for potential problems.

Person fit was also evaluated based on point measure correlations and standardized unweighted mean square values (or bootstrap weighted mean square values). Using the bootstrap weighted mean square values during the validation phase, persons were flagged if the values were less than 0.61 or greater than 1.44. Flagged persons were examined for patterns.

To determine the degree to which the MTCI-CV scale produces internally consistent measures the present researcher used the reliability of separation index. This index expresses reliability as one minus the ratio of the mean squared errors of the MTCI-CV measures (MSE_{θ}) to the variance of those measures (V_{θ}). This index is interpreted in a manner comparable to coefficient alpha.

Several additional analyses were run on the validation results. A test information function was used to evaluate the precision with which people are being measured on the MTCI-CV. Also, a comparison of item versus person measures and item difficulty values were used to illustrate the norms of the sample.

Lastly, ordinal logistic regressions were conducted to determine whether MTCI-CV measures are associated with client satisfaction level and goal attainment level (Tabachnick & Fidell, 2007). Logistic ordinal regression assumptions were checked. The first assumption being that one dependent variable is being used in analysis. The second assumption is that the relationship between each pair of outcome groups is the same (proportional odds) (Tabachnick & Fidell, 2007).

Results

Pilot Testing

During the pilot test 150 previous and current UNMC clients were sent MTCI-CV surveys with the goal of receiving initial data on the reliability and the validity of the measures; 32 surveys were returned completed. *Winsteps* (Linacre, 2001) software was used to scale the pilot data to the Rasch model, and tests of dimensionality, rating scale, item fit, person fit, and reliability and precision were conducted based on the results of this scaling. Stevens (1996) indicates that measurement analyses should have five participants per variable, and Wright & Stone (1979) recommend a minimum of 200 respondents for a dichotomous measurement model. Because these standards were not upheld during the pilot test, the purpose of the analyses was primarily to evaluate item quality. Caution should be taken in drawing conclusions about the instrument or measures based on the pilot test.

Dimensionality. Apart from the Rasch component, which accounted for 88.6% of the total variance, no additional factors were extracted from the residual with adjusted Kaiser Values greater than 1.0. The eigenvalues and the percentage of variance explained by each factor can be seen in Table 7 below. Decisions regarding the retention of non-Rasch components were guided by a scree plot, Kaiser's adjusted criteria, and Linacre's (2001) guidelines for retaining factors based on *Winsteps* software.

Table 7

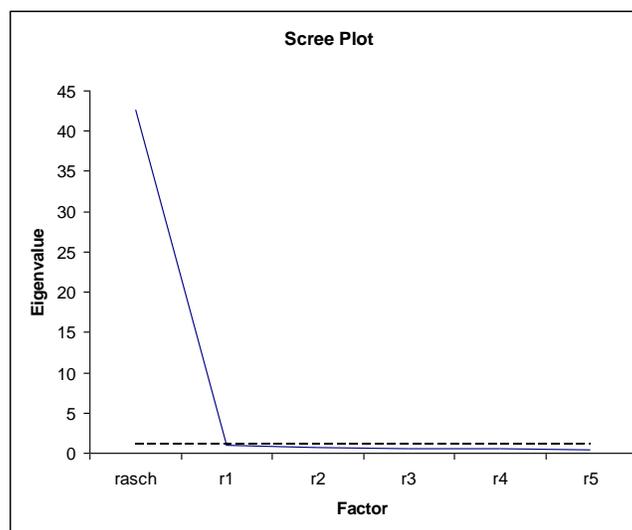
Pilot Test: Eigenvalues and Percent of Total Variance Explained for Each Residual Factor

Factor	Eigen Value	% Variance	Adjusted Kaiser's
Rasch	373.6	88.6	42.54
1	8.2	2.0	0.93
2	5.7	1.3	0.65
3	5.6	1.3	0.64
4	4.6	1.1	0.52
5	3.8	0.9	0.43
Residual	48		
Total	421.6		

The scree plot below indicates the eigenvalues of the Rasch factor and the residual components.

Figure 3

Pilot Test: Scree Plot of Each Factor's Eigen Value



Apart from the Rasch value it appears that there are no components above the Kaiser value of 1.0, prior to where the line reaches an asymptote on the scree plot. This suggests that the instrument reflects one primary factor, the Rasch component. This is further supported by Linacre's (2001) criteria that if 60% or more of the variance is accounted for by the Rasch component and less than 5% of the variance accounted for by residual components. In this study the Rasch component accounts for 88% of the total variance and the remaining residual components each account for less than 5% of the variance, supporting the unidimensionality of the instrument.

Rating scale analysis. One rating scale was used across all 48 items. The Likert rating scale for the MTCI-CV ranged from one to three, 1 indicating does this very well, 2 indicating does this adequately, and 3 indicating does this poorly.

The table below displays the effectiveness of the rating scale when evaluated by Linacre's (2004) criteria. On the Rasch component, category one has 565 observations (59%), category 2 has 305 observations (32%), and category three has 69 observations (7%). While category three has less than 130 observations, this may be due in large part to the small participant population. The distributions of ratings across the scale are unimodal. The rating scale generated satisfactory results. The observed averages increase with each rating scale category. The observed average for category one is -6.43, the observed average for category two is -1.08, and the observed average for category three is 4.24. None of the categories are over the unweighted mean square of 2.0 logits.

The ratings imply the measures (greater than 39%) all of the time: 93%, 78%, and 82%. The measures imply the ratings (greater than 39%) all of the time: 91%, 83%, and 77%. Regarding threshold increases, the category thresholds consistently increase by at least 1.4 logits

(but less than 5) with each rating category, the threshold between category one and two the threshold is -3.63, and between category two and three the threshold is 3.63. Based on meeting most of the criteria above, it appears that the current rating scale is being used in the manner it is intended to. However, due to the small sample size of the pilot test, caution should be taken in drawing conclusions about the instrument or measures.

Table 8

Pilot Test: Rating Scale Effectiveness Summary

Linacre's Criteria	Criteria Met
N	No
Unimodal	Yes
$M(\theta)$	Yes
$MS_{\text{unweighted}}$	Yes
Coherence Measures	Yes
Coherence Categories	Yes
τ_s increase	Yes
τ_s distance	Yes

Item fit. Looking at *Winsteps* item calibrations, it appears that 2 of the 48 items had standardized unweighted mean square indices (ZUMS) greater than 2.0 (Smith et al., 1998) (see Table 11). This means that roughly 4% of the items are misfit items. These items were numbers 5 and 8. There were no items with low or negative point measure correlations (below .30) (Nunnally & Bernstein, 1994).

These items were then examined for substantive explanations to evaluate whether any items need to be deleted or revised. For example, item 5 (My therapist has an accepting attitude.) and item 8 (My therapist values his/her own perspective.) slightly showed misfit, 2.6 and 3.6 respectively. Participants may feel that they do not know their therapist well enough to answer these questions. I decided to retain these items because the amount of misfit is small, the point measure correlations are acceptable, and the items did not covary enough from the Rasch component to generate their own residual components.

Table 9

Pilot Test: Item Fit

		PTMEA	Endors-	ZUMS
		Corr.	abilities	
1.	My therapist has a respectful attitude towards my/my family's personal values and beliefs.	.71	2.75	0.50
2.	My therapist values his/her own background/culture.	.67	1.22	1.10
3.	My therapist uses relationship-building skills, such as listening and attending.	.86	0.66	0.50
4.	My therapist tries to understand my/my family's values and beliefs.	.87	0.66	-0.10
5.	My therapist has an accepting attitude.	.63	2.75	2.60
6.	My therapist appropriately applies his/her own values in therapy.	.86	-1.99	1.50
7.	My therapist has a positive and warm attitude.	.86	2.75	-0.80
8.	My therapist values his/her own perspective.	.68	1.26	3.60

9.	My therapist knows about the customs of his/her culture, accepted behaviors, and general values.	.85	0.28	0.40
10.	My therapist accepts my/my family's values and beliefs.	.88	-0.32	-0.10
11.	My therapist provides the opportunity to incorporate my/my family's traditional sources of healing into therapy.	.81	-1.62	0.30
12.	My therapist accepts different ways I/my family express(es) feelings in therapy.	.88	0.15	-0.50
13.	My therapist has an open mind to our differences.	.83	-0.33	0.30
14.	My therapist asks me/my family to tell him/her about my/our unique expectations for care.	.84	-0.32	0.10
15.	My therapist acknowledges my/my family's point of view.	.92	-1.22	-1.30
16.	My therapist cares about building relationships with people.	.88	0.87	-0.20
17.	My therapist knows about several different ways of helping people.	.84	-0.76	1.00
18.	My therapist is familiar with the difficulties that may be commonly faced by persons from my/my family's culture.	.80	-0.32	0.90
19.	My therapist cares about helping me/my family in appropriate ways.	.83	0.66	0.70
20.	My therapist is aware of how his/her beliefs and values can affect therapy.	.90	-0.78	-0.60

21.	My therapist appears to have some knowledge about my/my family's culture and background.	.89	-0.72	-0.40
22.	My therapist is curious about my background and experiences.	.84	0.28	0.50
23.	My therapist displays openness towards me/my family as expert(s) on my/our life.	.88	-0.32	-0.10
24.	My therapist is able to explain things in a way that demonstrates familiarity with my/my family's ethnicity/culture.	.90	0.28	-0.50
25.	My therapist shares her/his beliefs when they are relevant to therapy.	.87	-0.73	-0.20
26.	My therapist appears to understand that therapy needs to fit me/my family (i.e.: race, class, gender, culture, sexual orientation, etc.).	.87	-0.76	1.50
27.	My therapist shows openness to my/my family's perspective.	.89	-1.15	-0.40
28.	My therapist is familiar with the kinds of problems that people seek help for.	.81	-0.32	1.50
29.	My therapist desires to know me as an individual with unique experiences.	.89	-0.32	-0.40
30.	My therapist is able to see things from my perspective without judgment.	.83	-0.76	1.70
31.	My therapist provides the opportunity to discuss his/her	.90	-0.33	-0.80

values related to family, culture, religion, etc. when they are relevant to therapy.

32.	My therapist displays a genuine interest to learn about me/my family.	.90	-0.32	-0.90
33.	My therapist takes a curious approach towards learning about me/my family.	.86	0.66	-0.20
34.	My therapist is open to my/my family's expertise on my/our life.	.88	0.15	-0.60
35.	My therapist acknowledges my/my family's values and beliefs.	.93	-0.76	-1.70
36.	My therapist is open to my/my family's uniqueness.	.85	-0.24	0.10
37.	My therapist is open (through body language and communication) to the differences between us.	.86	-0.24	0.00
38.	My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, etc.).	.90	-0.76	-0.60
39.	My therapist is knowledgeable about how my/my family's background may affect my/our availability of resources.	.93	-0.76	-1.70
40.	My therapist values my/my family's ideas and behaviors in therapy.	.93	-0.76	-1.70
41.	My therapist knows about how his/her biases can affect me/my family.	.93	-0.76	-1.70
42.	My therapist is familiar with how culture, religion, and	.90	-0.76	-0.60

	gender can shape me/my family.			
43.	My therapist respects his/her cultural heritage as well as valuing differences.	.89	0.15	-0.60
44.	My therapist creates a comfortable environment in therapy.	.85	1.23	-0.10
45.	My therapist connects well with people.	.83	0.66	0.70
46.	My therapist knows about normal social behaviors in my/my family's culture (e.g., eye contact, touch, greetings).	.87	0.66	-0.20
47.	My therapist knows basic principles that are helpful in relationships.	.87	1.23	-0.40
48.	My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family.	.93	-0.76	-1.70

Person fit. Concerning the person fit statistics, 2 participants out of 31 or 6.45% had standardized unweighted mean square indices greater than the value of 2.0. Person misfit can exist for numerous reasons (response set, differential multidimensionality, non attending behaviors etc.). The unweighted mean square indices are flags for identifying individual cases that for whatever reason do not behave in a manner that is predicted by the model. Examination of the most misfitting response strings generated by *Winsteps* revealed the following patterns of the misfit: one participant appears to commonly use indicator 1; three participants appear to commonly use indicator 2; and one participant appears to commonly use indicator 3. These response sets appear to account for the idiosyncratic patterns. The table below provides the averages for the person fit statistics.

Table 10

Pilot Test: Average Standardized Weighted and Unweighted Indices for Misfitting Persons

Total Persons	ZSTD > 2.0	%	Average Weighted ZSTD	Average Unweighted ZSTD
31	2	6.45	-0.3	0.0

Reliability and precision. The person reliability and reliability of separation value (Cronbach’s alpha) are shown below for the Rasch component. These reliability coefficients are respectable, especially since this instrument is not meant to be used for high stakes purposes. The decisions that will be made with this instrument are concerned with improving service utilization for persons with diverse ethnic and cultural backgrounds.

Table 11

Pilot Test: Reliability Coefficients

Component	Person Reliability	Raw Cronbach’s Alpha
Rasch Component	.91	.99

DeVellis (2003) states that acceptable reliability levels for research scales like this are: unacceptable below .60, undesirable between .60 and .65, minimally acceptable between .65 and .70, respectable between .70 and .80, and very good between .80 and .90. Taking into account these criteria, we can have some confidence in the reliability of the MTICI-CV.

However, due to the small sample size of the pilot test, caution should be taken in drawing conclusions about the instrument or measures.

Revisions. Because the reliability during the pilot test was so high ($r=.99$), items could be deleted and the measure would still be able to retain adequate reliability indices. The Spearman-Brown Prophecy Formula (Nunnally & Bernstein, 1994) can be used to estimate the reliability for a shortened version of the MTCI-CV. When this formula is applied the following estimates pertain (47 items, $r=.97$; 28 items, $r=.95$; 17 items, $r=.93$; 13 items, $r=.9$). It appears that the number of items could be cut down to about 13 and still get a very good level of reliability.

Additionally, since the MTCI-CV was developed to be used in clinical settings it seemed wise to keep the instrument brief enough to be used with clients on a regular basis without jeopardizing its reliability. Items were evaluated based on their point measure correlations and their content. After examining the survey items it initially appeared that there was some overlap in content, therefore, one item was deleted for each content area of the internal model.

Ten of the deleted items had the lowest point measure correlations for those content areas: 1, 2, 4, 5, 11, 13, 18, 22, 28, and 46. Six of the items that were deleted were deleted primarily based on repeated content coverage: 12, 20, 23, 25, 33, and 44. When item content was repeated the item with a lower point measure correlation was deleted. The following items were slightly altered to increase their endorsability: 15, 26, 38, 40, and 45.

Table 12

Pilot Test: Revisions

Item	Deletions
1	My therapist has a respectful attitude towards my/my family's personal values and beliefs.
2	My therapist values his/her own background/culture.
4	My therapist tries to understand my/my family's values and beliefs.
5	My therapist has an accepting attitude.
11	My therapist provides the opportunity to incorporate my/my family's traditional sources of healing into therapy.
12	My therapist accepts different ways I/my family express(es) feelings in therapy.
13	My therapist has an open mind to our differences.
18	My therapist is familiar with the difficulties that may be commonly faced by persons from my/my family's culture.
20	My therapist is aware of how his/her beliefs and values can affect therapy.
22	My therapist is curious about my background and experiences.
23	My therapist displays openness towards me/my family as expert(s) on my/our life.
25	My therapist shares her/his beliefs when they are relevant to therapy.
28	My therapist is familiar with the kinds of problems that people seek help for.
33	My therapist takes a curious approach towards learning about me/my family.
44	My therapist creates a comfortable environment in therapy.
46	My therapist knows about normal social behaviors in my/my family's culture (e.g., eye contact, touch, greetings).

Revisions

- 15** My therapist encourages me/my family to share my/our point of view.
- 26** My therapist appears to understand that therapy needs to fit me/my family (i.e.: race, class, gender, culture, sexual orientation, religion, etc.).
- 38** My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, religion, etc.).
- 40** My therapist values my/my family's ideas, behaviors, and feelings in therapy.
- 45** My therapist connects well with people in socially appropriate ways (e.g., eye contact, touch, greetings).
-

Validation Testing

This phase of the study is focused on evaluating the validity of the MTCI-CV instrument. The *Winsteps* (Linacre, 2001) software was used to scale the data to the Rasch model, and dimensionality, rating scale, item fit, person fit, reliability and precision, and norm evaluates were conducted based on the results of this scaling.

Dimensionality. Apart from the Rasch component, which accounted for 79% of the total variance, no additional factors were extracted from the residual with adjusted Kaiser Values greater than 1.0. The eigenvalues and the percentage of variance explained by each component can be seen in Table 13 below. Decisions regarding the retention of non-Rasch components were guided by a scree plot (Figure 4), Kaiser's adjusted criteria, and Linacre's (2001) guidelines for retaining factors based on *Winsteps* software.

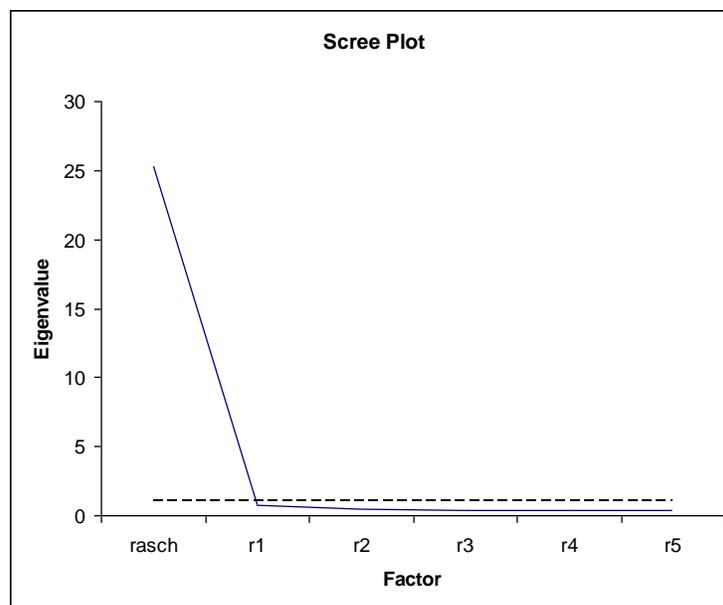
Table 13

Validation Test: Eigenvalues and Percent of Total Variance Explained for Each Residual Factor

Factor	Eigen Value	% Variance	Adjusted Kaiser's
Rasch	120.4	79.0	25.28
1	3.6	2.3	0.76
2	2.3	1.5	0.48
3	1.9	1.2	0.40
4	1.8	1.2	0.38
5	1.6	1.1	0.34
Residual	32		
Total	152.4		

Figure 4

Validation Test: Scree Plot of Each Factor's Eigen value



Apart from the Rasch component it appears that there are no components above the Kaiser value of 1.0, prior to where the line reaches an asymptote on the scree plot. This suggests that the instrument reflects one primary factor, the Rasch component. This is further supported by Linacre's (2001) criteria that if 60% or more of the variance is accounted for by the Rasch component and less than 5% of the variance accounted for by residual components this is reason for claiming unidimensionality. In this study the Rasch component accounts for 79% of the total variance and the remaining residual components each account for less than 5% of the variance. This supports the unidimensionality of the instrument. These items appear to represent therapist cultural competence; the beliefs, knowledge, curiosity, naiveté, and relational skills that represent competence when working with people from diverse backgrounds.

Rating scale analysis. One rating scale was used across all 32 items. The Likert rating scale for the MTCI-CV ranged from one to three, 1 indicating does this very well, 2 indicating does this adequately, and 3 indicating does this poorly.

Table 14 displays the effectiveness of the rating scale when evaluated by Linacre's (2004) criteria. On the Rasch component, category one has 2105 observations (50%), category 2 has 1625 observations (39%), and category three has 365 observations (9%). All categories have at least 130 observations. The distributions of ratings across the scale are unimodal. The rating scale generated satisfactory results. The observed averages increase with each rating scale category, the observed average for category one is -3.78, the observed average for category two is -.89, and the observed average for category three is 2.43. None of the categories are over the unweighted mean square of 2.0 logits.

The ratings imply the measures (greater than 39%) all of the time: 84%, 78%, and 56%. The measures also imply the ratings (greater than 39%) all of the time: 84%, 73%, and 83%.

Regarding threshold increases, the category thresholds consistently increase by at least 1.4 logits (but less than 5) with each rating category, the threshold between category one and two the threshold is -2.06, and between category two and three the threshold is 2.06. Based on meeting the criteria above, it appears that the current rating scale is being used in the manner it is intended to.

Table 14

Validation Test: Rating Scale Effectiveness Summary

Linacre's Criteria	Criteria Met
N	Yes
Unimodal	Yes
M(θ)	Yes
MS _{unweighted}	Yes
Coherence _{Measures}	Yes
Coherence _{Categories}	Yes
τ s increase	Yes
τ s distance	Yes

Item fit. Looking at the *Winsteps* item calibrations, using bootstrap critical values of 0.73 and 1.30 (Wolfe, in press), it appears that 5 of the 32 (16%) items had weighted mean square indices that were flagged as either overfit or misfit items (see Table 15). These items were numbers: 1, 4, 20, 21, and 22. Three of these items (9%) exhibited overfit and 2 (6%) exhibited misfit. There were no items with low or negative point measure correlations (below .30) (Nunnally & Bernstein, 1994). It is worth noting that these percentages are about three times

higher than the expected Type I error rate, indicating that some amount of unexplained variability exists in the data. Based on the substantive explanations below for the misfit and overfit items, this may be due to idiosyncratic cases.

Table 15

Validation Test: Analysis of Item Fit

Bootstrap WMS	Critical Value	<i>N</i>	%Flagged
Overfit	<0.73	3	9.38
Fit	0.73 to 1.30	27	84.38
Misfit	>1.30	2	6.25

The misfit and overfit items were examined for potential substantive explanations to evaluate whether any items should be deleted or revised. When examining the responses for the items, it appears that a number of unexpected middle range responses were given to the overfitting items. This could mean that these items were confusing to participants, and, because they were unsure how to answer them, respondents may have chosen the middle rating category too frequently. Item 1 (My therapist uses relationship-building skills, such as listening and attending.) showed misfit at 1.40. It is noteworthy that item 1 is the only item to contain a phrase “such as ...” This wording could be part of the problem with this item. Item 4 (My therapist values his/her own perspective.) showed misfit at 1.91. Participants may feel that they do not know the therapist adequately to answer this question. In addition, these two items are toward the beginning of the instrument, and there may have been a warm-up effect for participants. Item 20 (My therapist is open to my/my family’s expertise on my/our life.) showed overfit at .67. Item 21 (My therapist acknowledges my/my family’s values and beliefs.) showed overfit at .67,

and item 22 (My therapist is open to my/my family’s uniqueness.) showed overfit at .61. These items may not have been given as much consideration, as it is common for therapists to ask their clients some about their values, beliefs, and uniqueness. It is interesting to note that the items 20-22 are all listed close together at the bottom of the first page of the survey that was mailed to participants. Therefore participants may not have given these items as much thought when answering. I have decided to retain these items because the point measure correlations are good and the items did not covary enough from the Rasch component to generate their own residual components.

The tables below display the descriptive statistics for the item quality indices. The standard error (s.e.) indicates how variable, on average, the parameter estimates are around their parametric values. In this case, a 95% confidence interval is approximately .86 logits wide. In many applications, a distance of about .50 to .64 logits is considered to be large (Draba, 1977; Wilson, 2005; Ziemy, 1993). Hence to be within those bounds, we can say that we are 84% confident that a bandwidth of .44 logits contains the parametric value.

Table 16

Validation Test: Item Averages

	Mean	Minimum	Maximum	Standard Deviation
PTMEA Corr.	.80	.62	.86	.06
Endorsability	0.00	-0.82	1.24	0.57
WMS	1.00	0.61	1.91	0.27
S.E.	0.22	0.20	0.23	0.01

Table 17

Validation Test: Item Measure Indices

	Item	PTMEA Corr.	Endorsability	WMS	S.E.
1.	My therapist uses relationship- building skills, such as listening and attending.	.66	1.18	1.41	0.23
2.	My therapist appropriately applies his/her own values in therapy.	.78	-0.51	1.30	0.21
3.	My therapist has a positive and warm attitude.	.72	1.12	1.06	0.23
4.	My therapist values his/her own perspective.	.62	0.63	1.91	0.23
5.	My therapist knows about the customs of his/her culture, accepted behaviors, and general values.	.74	0.25	1.30	0.23
6.	My therapist accepts my/my family's values and beliefs.	.74	0.46	1.23	0.23
7.	My therapist asks me/my family to tell him/her about my/our unique expectations for care.	.75	0.06	1.28	0.22

8.	My therapist encourages me/my family to share my/our point of view.	.73	1.24	0.92	0.23
9.	My therapist cares about building relationships with people.	.77	0.51	1.00	0.22
10.	My therapist knows about several different ways of helping people.	.82	-0.43	1.03	0.21
11.	My therapist cares about helping me/my family in appropriate ways.	.82	0.16	0.76	0.22
12.	My therapist appears to have some knowledge about my/my family's culture and background.	.82	-0.82	1.03	0.20
13.	My therapist is able to explain things in a way that demonstrates familiarity with my/my family's ethnicity/culture.	.84	-0.68	0.86	0.21
14.	My therapist appears to understand that therapy needs	.83	-0.25	0.91	0.21

	to fit me/my family (i.e.: race, class, gender, culture, sexual orientation, religion, etc.).				
15.	My therapist shows openness to my/my family's perspective.	.81	0.39	0.82	0.22
16.	My therapist desires to know me as an individual with unique experiences.	.81	-0.39	1.16	0.21
17.	My therapist is able to see things from my perspective without judgment.	.80	-0.30	1.13	0.21
18.	My therapist provides the opportunity to discuss his/her values related to family, culture, religion, etc. when they are relevant to therapy.	.81	-0.81	1.08	0.21
19.	My therapist displays a genuine interest to learn about me/my family.	.82	0.20	0.80	0.22
20.	My therapist is open to my/my family's expertise on my/our life.	.85	-0.11	0.67	0.21

21.	My therapist acknowledges my/my family's values and beliefs.	.84	0.05	0.67	0.22
22.	My therapist is open to my/my family's uniqueness.	.86	-0.25	0.61	0.21
23.	My therapist is open (through body language and communication) to the differences between us.	.79	0.14	1.04	0.22
24.	My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, religion, etc.).	.82	-0.51	0.98	0.21
25.	My therapist is knowledgeable about how my/my family's background may affect my/our availability of resources.	.86	-0.76	0.74	0.21
26.	My therapist values my/my family's ideas, behaviors, and feelings in therapy.	.84	-0.14	0.75	0.21
27.	My therapist knows about how	.86	-0.67	0.80	0.21

	his/her biases can affect me/my family.				
28.	My therapist is familiar with how culture, religion, and gender can shape me/my family.	.84	-0.42	0.84	0.21
29.	My therapist respects his/her cultural heritage as well as valuing differences.	.81	-0.15	1.05	0.22
30.	My therapist connects well with people in socially appropriate ways (e.g., eye contact, touch, greetings).	.74	0.64	1.19	0.22
31.	My therapist knows basic principles that are helpful in relationships.	.82	0.28	0.75	0.22
32.	My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family.	.83	-0.11	0.86	0.22

Person fit. Weighted mean square (WMS) indices are used as flags for identifying individual cases that for whatever reason do not behave in a manner that is predicted by the Rasch model. Concerning the person fit statistics, using the bootstrap critical values of 0.61 and 1.44 for the weighted mean square indices, 35 participants of 211 (17%) are identified as misfitting or overfitting persons with 9% (18) of the persons exhibiting overfit and 8% (17) exhibiting misfit. It is noteworthy that these percentages are triple the expected Type I error rate of 5% indicating that some amount of unexpected variability exists in the observed data.

Table 18

Validation Test: Analysis of Person Fit

Bootstrap WMS	Critical Value	<i>N</i>	%Flagged
Overfit	<0.61	18	8.53
Fit	0.61 to 1.44	176	83.41
Misfit	>1.44	17	8.06

Examination of the most misfitting response strings generated by *Winsteps* revealed the following patterns of unexpected misfit: three participants appear to commonly use indicator 1, four participants appear to commonly use indicator 2, four participants appear to commonly use indicator 3, and 6 participants appear to primarily use a combination of indicators 1 and 3. These response sets appear to account for the idiosyncratic patterns. The table below provides the descriptive statistics for the person quality statistics.

Table 19

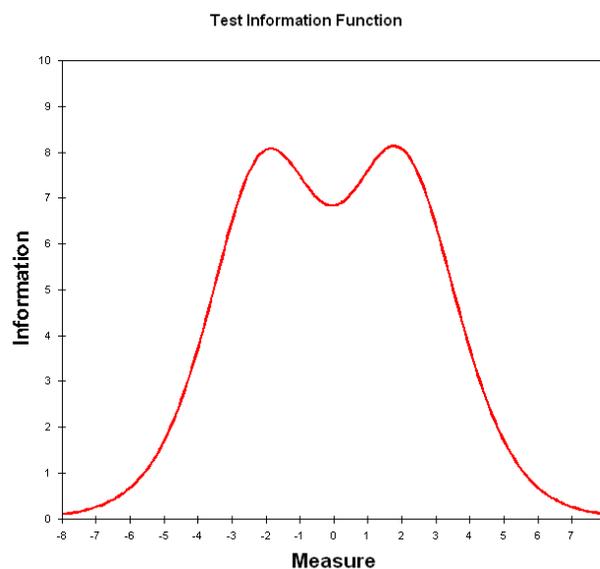
Validation Test: Person Averages

	Mean	Minimum	Maximum	Standard Deviation
PTMEA Corr.	.21	-.38	.66	.22
Endorsability	-3.87	-6.85	4.91	3.05
WMS	1.00	0.07	2.31	0.36
S.E.	1.01	0.35	1.84	0.66

Reliability and precision. The reliability of separation value for the Rasch component is .98. DeVellis (2003) states that acceptable levels for research scales like this are: unacceptable below .60, undesirable between .60 and .65, minimally acceptable between .65 and .70, respectable between .70 and .80, and very good between .80 and .90. Taking into account these criteria, we can have confidence in the reliability of the MTCI-CV.

Figure 5

Validation Test: Test Information Function



The Test Information Function reflects the precision of the person measures, with higher values of information being associated with higher levels of measurement precision and lower standard errors (Linacre, 2001). In Figure 5, 43.13% of person measures fall between 4 and -4, this range shows relatively high levels of precision indicating that the people with measures between these values are precisely measured. Person measures that fall outside of this range reflect less information and more error of measurement. Additional items would be needed, items that are more difficult and items that are easier to endorse than those in the current pool, in order to gain more information and precision about individuals with measures in this range. This means that the MTCI-CV is better at recognizing therapists who display poor skills than it is in recognizing distinctive differences among individuals.

Norms. Table 20 displays a substantive interpretation of the relationship between item and person measures. This table aligns item measure values and item examples at each decile of person measures, with low measures being associated with high levels of multicultural counseling competence (i.e., a predominance of assigned ratings of 1) and high measures being associated with low levels of multicultural counseling competence (i.e., a predominance of assigned ratings of 3). The items lined up with person measures are item examples where a person has an equal probability of responding in the top versus bottom category (category 1 versus category 3) and will therefore likely respond at the middle category (category 2). Note that counselors with measures around -0.71 and the 80th percentile of the measures are about equally likely to be rated in the highest and lowest rating categories on items similar to the one cited, which references the relationship between family background and availability of resources. Counselors with measures around 0.00, on the other hand, are at the 90th percentile in terms of lacking multicultural counseling competencies, and these counselors are equally likely to be

rated in the top and bottom categories on items like the one provided as an example that references the counselor’s ability to acknowledge a family’s values and beliefs. This makes sense from a substantive perspective; it may be that therapists who work to connect families’ backgrounds to their availability of resources and to acknowledge families’ values and beliefs are therapists that are more experienced in cultural competence. These are overt actions that show cultural competence and it may take a certain comfort level to express these.

The fact that a large proportion of the person measure deciles have no items exhibiting endorsabilities in that range (indicated by “Not Observed”) can be attributed to a ceiling effect in the instrument ratings. Approximately 65% of participants are expected to rate counselors very positively (assign all ratings in the 1 category). This makes the instrument very good for diagnosing therapists with poor skills (i.e., at the high end of the scale, those assigning 3’s).

Table 20

Validation Test: Norms for Person and Item Measures

Deciles	Person Measures	Items	Item Measures
10	-6.85	Not Observed.	
20	-6.85	Not Observed.	
30	-6.85	Not Observed.	
40	-5.62	Not Observed.	
50	-4.44	Not Observed.	
60	-3.43	Not Observed.	
70	-2.12	Not Observed.	

80	-0.71	My therapist is knowledgeable about how my/my family's background may affect my/our availability of resources.	-.76
90	0.00	My therapist acknowledges my/my family's values and beliefs.	.05
100	4.91	Not Observed.	

Table 21 below shows the relative rank ordering of the item difficulties. The rank ordering is somewhat predictable, given that the first few statements are more general and may be easier to endorse, whereas the statements that are ranked higher and are more difficult to endorse appear to be more specific. For example, “my therapist shows openness and cares about helping” are easier to endorse than “my therapist is familiar with how culture can shape my family or how his/her biases can affect my family.” An additional observation is that the items that are easiest to endorse are also more observable in nature. For example, it is easier to observe connecting well than it is to observe knowledge about culture. It may also be that the more difficult to endorse tasks are more difficult for therapists to perform. The rank ordering of item difficulties supports that the MTCI-CV is being used as it is intended; items that are more difficult for therapists to perform should be more difficult for clients to endorse.

Table 21

Validation Test: Item Difficulty Rank Examples

Difficulty Rank	Item
4	My therapist connects well with people in socially appropriate ways (e.g., eye contact, touch, greetings).
8	My therapist shows openness to my/my family's perspective.
12	My therapist cares about helping me/my family in appropriate ways.
16	My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family.
20	My therapist appears to understand that therapy needs to fit me/my family (i.e.: race, class, gender, culture, sexual orientation, religion, etc.).
24	My therapist is familiar with how culture, religion, and gender can shape me/my family.
28	My therapist knows about how his/her biases can affect me/my family.
32	My therapist appears to have some knowledge about my/my family's culture and background.

Logistic ordinal regression. An ordinal logistic regression was conducted to determine whether MTCI-CV measures are associated with client satisfaction level. MTCI-CV measures were found to be statistically significant predictors of satisfaction ($\chi^2(1) = 82.40, p < .0001$). The parameter estimate indicates that a one-unit increase in MTCI-CV measures is associated with a 0.60 increase in the log-odds of increasing a category on the satisfaction scale. As was expected,

increasing person measures (higher scores reflect more negative ratings) are positively associated with higher satisfaction levels (higher scores reflect lower satisfaction). The means of the five satisfaction levels can be seen in Table 22 below. The assumption of proportional odds is met ($\chi^2(3) = 7.04, p=.07$), indicating that the relationship between each pair of outcome groups is similar. The model correctly classifies 61% of clients into the correct satisfaction level (see Table 23 below).

Table 22

Validation Test: Satisfaction Group Averages on the MTCI-CV

	Mean	S.D.
Very Satisfied	-5.16	2.11
Somewhat Satisfied	-3.42	2.41
Neutral	-0.58	2.62
Somewhat Unsatisfied	0.61	2.11
Very Unsatisfied	2.70	1.94

Table 23

Validation Test: Predicted Group Membership for Satisfaction

Predicted Response Category		Original Category					Total
		Very Satisfied	Somewhat Satisfied	Neutral	Somewhat Unsatisfied	Very Unsatisfied	
Very Satisfied	Count	104	14	3	0	0	121
	Percent	85.95	11.57	2.48	0.00	0.00	100.00
Somewhat Satisfied	Count	29	14	8	5	0	56
	Percent	51.79	25.00	14.29	8.93	0.00	100.00
Neutral	Count	4	3	9	7	2	25
	Percent	16.00	12.00	36.00	28.00	8.00	100.00
Somewhat Unsatisfied	Count	0	0	2	3	2	7
	Percent	0.00	0.00	28.57	42.86	28.57	100.00

An ordinal logistic regression was also conducted to determine whether MTCI-CV person measures are associated with client's goal attainment. MTCI-CV measures are statistically significant predictors of goal attainment ($\chi^2(1) = 51.75, p < .0001$). The parameter estimate indicates that a one-unit increase in MTCI-CV measures is associated with a 0.37 increase in the log-odds of increasing a category on the goal attainment scale. As was expected, increasing person measures (higher scores reflect more negative ratings) are positively associated

with higher levels of goal attainment (higher scores reflect less goal attainment). The means of the three goal attainment levels can be seen in Table 24 below. The assumption of proportional odds is not supported for these analyses ($\chi^2(1) = 6.71, p=.01$), meaning that the relationship between each pair of outcome groups is not the same. The model correctly classifies 50% of clients into the correct goal attainment (see Table 25 below).

Table 24

Validation Test: Goal Attainment Group Averages on the MTCI-CV

	Mean	Std. Deviation
Most	-5.08	2.17
Some	-4.03	2.81
Did Not Attain	-0.33	2.91

Table 25

Validation Test: Predicted Group Membership for Goal Attainment

Predicted Response Category	Original Category				Total
	Most	Some	Did Not Attain		
Most	Count	58	30	4	92
	Percent	63.04	32.61	4.35	100.00
Some	Count	41	39	27	107
	Percent	38.32	36.45	25.23	100.00
Did Not Attain	Count	0	1	7	8
	Percent	0.00	12.50	87.50	100.00

General Discussion

The purpose of this study was to develop an instrument to assess clients' perceptions of their therapists' multicultural competence that can be used in both individual and family therapy. This instrument was developed through three phases: item generation and theme development, client feedback and interrater reliability, and pilot and validity testing through the application of principal component analysis and other statistical methods to evaluate its reliability and validity.

During the item generation and theme development phase open ended responses from 123 participants from Blacksburg, VA were used in conjunction with literature (Dyche & Zayas, 1995; Fuertes et al., 2002; Sue et al., 1982; Sue et al., 1992) to inform the creation of 58 items for the MTCI-CV.

During the client feedback and interrater agreement phase feedback was received from 7 clients on the readability, clarity, and content of the MTCI-CV. Items were reworded and omitted based on participant feedback. The MTCI was shortened from 58 to 48 items and the demographic questionnaire was shortened from 18 to 14 items.

Interrater agreement was conducted twice on the MTCI-CV items. Three trained raters independently grouped items into the category and cell level. Items that were not categorized into their intended categories were examined and some of these items were reworded regarding item content and clarity.

During the pilot test MTCI-CV survey mailings were sent to 150 previous or current UNMC clients. Thirty-two surveys were returned and completed during the pilot test. The *Winsteps* (Linacre, 2001) software was used to scale the pilot data to the Rasch model, and dimensionality, rating scale, item fit, person fit, and reliability and precision were conducted

based on the results of this scaling. Based on these results, the MTCI-CV was shortened from 48 items to 32 items.

During the validation phase of this study the MTCI-CV was mailed to 949 previous or current UNMC clients. Two hundred eleven surveys were returned and completed during this phase. Once again, The *Winsteps* (Linacre, 2001) software was used to scale the data to the Rasch model, and dimensionality, rating scale, item fit, person fit, reliability and precision, and norm evaluates were conducted based on the results of this scaling. Additionally, logistic ordinal regressions were conducted to determine whether MTCI-CV person measures are associated with client satisfaction and goal attainment in counseling. The primary questions guiding this study were:

Phase One: Item Generation and Theme Development

1. For the purposes of generating items for the MTCI-CV, how do people diverse in terms of ethnicity, race, age, and gender, describe the qualities they would want in a multiculturally competent therapist?" We predicted that participant responses would reflect both cognitive and process aspects of cultural competence.

Phase Two: Client Feedback, Interrater Reliability

2. How will client suggestions regarding improving the readability and clarity of the instrument shape the development of the MTCI-CV? We predicted that client suggestions regarding the readability and clarity of the items would help to shape the MTCI-CV.

3. To what degree will family therapists agree on the categorization of the MTCI-CV items for the purposes of making the instrument more parsimonious? We predicted an adequate agreement level on the categorization of the MTCI-CV items.

Phase Three: Pilot Testing, Reliability and Validity Testing

4. To what degree does the MTCI-CV achieve adequate levels of reliability and validity?

We predicted that the MTCI-CV would achieve adequate levels of reliability and validity.

5. Are MTCI-CV measures significantly associated with client satisfaction level with therapy? We predicted that high levels of client perceived therapist multicultural competence on the MTCI-CV would be positively associated with high levels of client satisfaction with therapy.

6. Are MTCI-CV measures significantly associated with client goal attainment in therapy? We predicted that high levels of client perceived therapist multicultural competence on the MTCI-CV would be positively associated with high levels of client goal attainment in therapy.

Phases 1 and 2: Item Generation and Client and Interrater Feedback

Results from the first two phases of this study helped to develop and further refine the MTCI-CV. During phase one, we found that participant responses on the qualities they would want in a multiculturally competent therapist supported the inclusion of cognitive and process aspects of therapist cultural competence. During phase two, clients and raters gave evaluative feedback on the MTCI-CV, which helped to shape the content, length, and formatting of the instrument.

Phase 3: Pilot Testing, Reliability and Validity Testing

Validity and Reliability of the Measures

Preliminary support for the MTCI-CV suggests a fairly reliable and valid measure at this stage. The MTCI-CV shows evidence of a reliable and valid measure assessing the concept of

therapist cultural competence which holds promise to be an intervention as well as a clinical outcome measure.

This study investigated the dimensionality of the MTCI-CV. The theoretical model it was built upon specified six dimensions (Counselor Awareness of Own Cultural Values and Biases, Counselor Awareness of Client's Worldview, Culturally Appropriate Intervention Strategies, Respectful Curiosity, Naiveté, and Multicultural Counseling Relationship). The data did not support the theoretical model; principal component analysis only recognized the Rasch component. This means that the items did not form discrete dimensions, they were better perceived as a single construct rather than separate constructs. Therapist cultural competence appears to be a unidimensional concept due to percent of variance accounted for by the Rasch component (Linacre, 2001). The Rasch component accounted for 79% of the variance and using Kaiser's adjusted criteria (1960) the residuals did not produce any significant components. In addition, all items resulted in high point measure correlations, above .5, suggesting a significant relationship with the Rasch component and a high reliability of separation index (.98), supportive of unidimensionality.

It appears that the MTCI-CV is a measure of a single continuous variable representing multicultural therapy competence. Why were the theoretical model and data not a good fit? While the literature review identified six components of therapist cultural competence (Dyche & Zayas, 1995; Fuertes et al., 2002; Sue et al., 1982; Sue et al., 1992), the literature does not explicitly define these components. It is difficult to find a consistent description of cultural competence and its components. This inconsistency makes it difficult to capture the distinctions posited by the theoretical model. The primary focus related to cultural competence has been on

generating descriptions of acceptable practice with various populations rather than theory development.

Additionally, one issue that raters brought up while grouping items into theoretical categories for interrater agreement was that it seemed difficult to prevent overlap in terms of item content for each of the theoretical components of cultural competence. In addition to overlap in the theoretical components of cultural competence, there may also be overlap between the content of cultural competence and other constructs, such as therapeutic alliance and satisfaction with therapy. For example, there are some items on the MTCI-CV which could be argued also represent therapeutic alliance, such as, “My therapist connects well with people in socially appropriate ways (e.g., eye contact, touch, greetings).” Additionally, the strong relationship between MTCI-CV person measures and the outcome variables (satisfaction and goal attainment) in this study suggests overlap in what these variables are measuring. In part, this is to be expected, it makes sense that therapist multicultural competency would be related to such things as therapeutic alliance and client satisfaction with therapy. However, this makes the task of defining and measuring therapist multicultural competency that much more difficult.

Similar to the data not supporting the theoretical model of the MTCI-CV, the dimension outcomes from factor analysis for previously developed multicultural counseling instruments (CCI-R, MCAS-B, MCI, and MAKSS) did not match the theoretical constructs these instruments purported to measure (Sue et al., 1982; Sue et al., 1992). Contrary to Sue et al.’s (1982) three dimensions of multicultural therapy competence, the results of the factor analyses suggest that these instruments measure anywhere from one to four factors. It could be that cultural competency instruments are particularly sensitive to participant effects and the

dimensionality of the instruments are reflective of this (the variance or lack of variance in responses limits the number of dimensions the measures can detect).

The norm evaluates for the MTCTI-CV indicate that approximately 65% of participants are expected to rate counselors very positively (assign all ratings in the 1 category). This makes the MTCTI-CV very good for diagnosing therapists with poor skills (i.e., at the high end of the scale, those assigning 3's). However, this makes the instrument not as good for detecting individual differences among therapists. This may be a result of the fact that the majority of the sample participants were Caucasian. It may be that some Caucasian participants were confused about the relevance of cultural competence to themselves and primarily see culture as a reflection of race. They might, therefore, be less able to distinguish between the items because they would likely be working with a therapist of the same race.

Overall, this instrument emerges from the analyses as a fairly good measure of multicultural therapy competency. Particularly pleasing aspects were the use of the rating scale and the reliability coefficients. Based on meeting Linacre's (2004) criteria, it appears that the rating scale is being used in the manner it is intended to. Based on DeVellis (2003) reliability criteria, we can have confidence in the reliability of the MTCTI-CV, with a reliability of .98. The length of the instrument appears to be acceptable, since the reliability coefficients are high and most participants appear to have completed the survey.

MTCTI-CV Relationship with Satisfaction and Goal Attainment

While it is assumed that there is a positive relationship between multicultural therapy competence and process or outcome indexes of therapy, little research has been done to study this relationship (Atkinson & Lowe, 1995; Fuertes et al., 2001; Steenbarger & Pels, 1997; and Sue, 1998). Researching the effect of therapist cultural competence on client satisfaction and

client outcomes from therapy is an important endeavor in assessing whether or not cultural competence is helpful from the client's perspective.

Logistic ordinal regressions were used to determine whether MTCI-CV measures are associated with client satisfaction and goal attainment in counseling. MTCI-CV measures were found to be statistically significant predictors of satisfaction and of goal attainment. The model correctly classified 61% of clients into the correct satisfaction level, and correctly classified 50% of clients into the correct goal attainment level. As was expected, high levels of client perceived therapist multicultural competence on the MTCI-CV were positively associated with high levels of client satisfaction and goal attainment in therapy. Positive client perceptions of therapist cultural competence (on the MTCI-CV) significantly contribute to the probability of clients expressing satisfaction and goal attainment in therapy.

These results provide evidence of construct validity; cultural competence is related to positive counseling outcomes (satisfaction, goal attainment) as reported by clients. These findings demonstrate a positive relationship between multicultural therapy competence and process or outcome indexes of therapy. These results support the use of cultural competence and the importance of including it in training programs for counselors and therapists.

Implications for the MTCI-CV as a Clinical Intervention

The MTCI-CV can be used by therapists to give their clients at the beginning of treatment as an intervention. This can help therapists give thought to incorporating purposeful cultural competence into the therapy sessions. The MTCI-CV also can be used by therapists to generate conversations with their clients around cultural competence. Therapists could use the items from the survey to generate conversation. For example, areas in which the therapist

receives lower ratings from their clients the therapist could request feedback from his/her clients on ways to improve.

Since the MTCI-CV appears to have adequate reliability and validity, it may be useful in clinical training and outcome research. As for training, therapy programs could select items as outcome goals for specific cultural competency training. The MTCI-CV also could be given at pre and post treatment to see if a therapist's cultural competency improves. Pairing the MTCI-CV with additional outcome measures may show whether client perceptions of therapist cultural competency produces other indicators of improvement (i.e., increased satisfaction, lower rates of attrition). Finding significant correlations between cultural competency and increased satisfaction and positive outcomes from counseling will be essential for using the MTCI-CV in outcome research.

Supervisory

The MTCI-CV could also be used in a supervisory manner. Supervisors can give their clinical supervisees the MTCI-CV to rate the supervisees' level of cultural competence. The supervisor can help supervisees track their MTCI-CV scores to determine areas of strength and growth. The therapists' MTCI-CV scores could be discussed in supervision periodically to help therapists who want to grow in cultural competence.

Total MTCI-CV Score

Several psychological instruments use a score to classify individuals into specific categories (e.g. Hamilton Anxiety Scale, Beck Depression Inventory). Although the MTCI-CV gives a total score, it does not classify the score into categories. Scores on the MTCI-CV are continuous rather than categorical, therefore, lower scores indicate better cultural competency. The total score on the MTCI-CV can be used by researchers as an indicator of ability or progress.

Changes in the total score could be a goal of training programs that value cultural competency training. Also, researchers can use this total score as an outcome measure for a wide range of interventions. In a clinical setting clients and therapists can interpret the total MTCI-CV score however it is meaningful. For example, scores can be compared over time to assess therapist growth in cultural competence.

Strengths of this Study

To date, this is the only client version of a cultural competence instrument. While a few therapist self-report multicultural competency instruments have been developed (MCI, MCAS-B, and MAKSS), as well as a supervisor observation survey (CCI-R), Fuertes et al. (2001) stated that there is currently no measure to assess clients' perceptions of their therapists' multicultural competence. This is an important step because clients are the consumers of therapy and their perceptions can be important to the process and outcome of therapy (Fuertes et al., 2001). Pope-Davis and Dings (1995) warn that self-report instruments designed for therapists to self-administer may measure anticipated rather than actual behaviors or attitudes representing multicultural competence, they are prone to social desirability, and we cannot be certain as to what the instruments really measure. For this reason, Green, Kiernan-Stern, Bailey, Chambers, Claridge, Jones, Kitson, Leek, Leisey, Vades, and Walker (2005) also suggested including client reports in the evaluation of mental health workers' cultural competencies. This study is in response to this call. The goal of this study was the development of a psychometrically sound instrument that clients can use to rate the cultural competency of their therapists.

Client feedback on therapist cultural competency has also been deemed important because several studies have revealed that ethnic minority clients frequently felt that they received services that were inappropriate, insensitive, or condescending (Dana, 1994; Sue & Sue,

1990). This study responded to this concern by using participatory methods (Sprenkle & Piercy, 2005). Clients were included in all stages of the MTCI-CV development because clients are affected the most by the topic being addressed (therapist cultural competency).

Further, this is the only cultural competency instrument developed from indigenous knowledge in combination with literature from the field. These methods gave rise to including process dimensions (respectful curiosity, naiveté, and characteristics of the multicultural therapy relationship) (see Dyche & Zayas, 1995; Fuertes et al., 2002) in combination with the commonly used cognitive dimensions (therapist awareness of his/her own cultural values and biases, therapist awareness of client's worldview, and culturally appropriate intervention strategies) (see Sue et al., 1982; Sue et al., 1992) that are found in other cultural competency instruments. This study attempted to investigate empirically whether or not the concept of therapist cultural competence has distinct components. Findings indicate that therapist cultural competence, as measured by the MTCI-CV, is a unidimensional concept.

This instrument was validated on a clinical population diverse in age and socioeconomic status. Whereas, most cultural competency instruments in the counseling field have been validated primarily on middle socioeconomic class, students in the counseling psychology field (Boyle & Springer, 2001).

Additionally, little research has been done to study the relationship between multicultural therapy competence and process or outcome indexes of therapy (Atkinson & Lowe, 1995; Fuertes et al., 2001; Steenbarger & Pels, 1997; and Sue, 1998). This study found that positive client perceptions of therapist cultural competence (on the MTCI-CV) significantly contribute to the probability of clients expressing satisfaction and goal attainment in therapy.

The MTCTI-CV was created not only to provide a method for evaluating therapist cultural competence from the clients' perspective, but to also aid in evaluating the outcomes of multicultural competence programs and the services that minority persons receive, written for use with both individuals and families.

Limitations of this Study Sample

One limitation of this study is that phase three was completed on a population that was relatively homogenous. The homogeneity of the sample limits the generalizations that can currently be made from the results of this research. Specifically, 71.9% of the pilot phase sample was Caucasian and 82.4 % of the validation phase was Caucasian. In addition, the validation phase was composed of 70.1% females and more middle aged participants. These demographics are fairly representative of the client population at UNMC (Caucasian 80.4%, females 66.3%), and are typical for survey participation (typically more Caucasians, women, and older persons take part in surveys). The study sample may have certain characteristics or beliefs that would differentiate them from the rest of the population. For example, Caucasian participants may be less attuned to cultural differences between themselves and their therapist, women might be more attuned than men to cultural competencies that relate to feelings or forms of verbal communication, and older persons may put emphasis on different cultural competencies than younger persons (i.e., respect shown). Since this instrument is meant to be used with diverse racial and cultural groups (i.e., gender, socioeconomic status), it will be important to norm and validate this instrument on various racial and cultural groups (i.e., African-Americans, Hispanic/Latino, low versus middle socioeconomic status, various religious groups, young versus aging population etc.).

Additionally, the lack of heterogeneity limits the response variance, which in turn limits the number of dimensions the measures can detect. This can lead to the conclusion that the measures are unidimensional when they may not be. This can potentially lead to other problems. For example, if a unidimensional instrument is used to measure a construct that is in fact multidimensional, then the accuracy of the information gathered and any implications are called into question because the measures may be unable to pick up the intricacies of the construct.

While the sample for phase one was relatively racially diverse, a large proportion of the participants were international students. International students may differ from persons of minority status that are American citizens in their expectations for therapist cultural competence. In order to research similarities and differences in indigenous knowledge regarding therapist cultural competency expectations, future research should also be done on various diverse populations.

Survey Return Rates

In addition, returns for the pilot phase and validation phase yielded less than the anticipated results. During the pilot phase 50 surveys were expected while only 32 surveys were received and during the validation phase 300 surveys were expected while 211 surveys were returned. Attempts were made to increase the sample size; initially only 100 surveys were intended to be mailed for the pilot phase and 500 surveys were to be mailed during the validation phase. In the end, 150 surveys were mailed during the pilot phase and 949 surveys were mailed to the remaining previous or current UNMC clients in the UNMC family therapy client database. Additional attempts were made to recruit clients from other mental health sites, but due to client confidentiality rules, this did not end up working out. The power of the implications for the pilot phase can be called into question due to the small return rate. In order to make generalizations to

a larger population, future research using the MTCI-CV should be done on additional client populations.

Future Directions and Implications

While a few therapist self-report instruments measuring multicultural competence have been developed, it is clear that several limitations exist in these instruments and that further work needs to be done in the area of instrument development to measure multicultural therapy competence more completely. For further research, this researcher intends to create a therapist self-report version of the MTCI. With both client and therapist versions of this instrument this researcher will be able to assess the relationship among the outcomes of each. The items that are developed for the client version of the MTCI will begin with “My therapist....” After the client survey is developed a therapist self-report version of the instrument will be developed by altering the beginning of each item statement from “My therapist....” to “I...” Additionally, in order to further develop the MTCI-CV this researcher plans to continue to work on building the instrument through additional testing, such as test-retest reliability, and comparison to external measures for increased validity.

Research is also needed to assess whether multicultural training programs result in enhanced therapeutic services and outcomes for ethnic minority clients (Atkinson & Lowe, 1995). While it is intuitively appealing to teach therapists about specific ethnic cultures (cognitive model) and expect that it will lead to enhanced treatment outcomes, it can also be argued that such knowledge could have undesirable effects, such as increased risk of stereotyping minority clients (Atkinson & Lowe, 1995; Sue & Zane, 1987). This researcher intends to create a training program based on the results of this study (using indigenous knowledge from clients) and to follow up by evaluating outcomes in terms of therapist growth on

the construct as well as the effects on therapeutic services for ethnic minority clients. This has implications for both practice and training. Effective modifications in multicultural competency training and education can only be made when there is a more definitive assessment of its direct impact on therapist multicultural competence and outcome indexes.

Conclusions

Sue et al. (1992) stated that the multicultural competencies they defined were not meant to be “the final word” in establishing standards for the therapy profession; they suggested that new competencies be added. This writer believes it is necessary to continue to develop the construct of multicultural therapy competence in order to improve the comprehensiveness and accuracy of its measurement. This writer believes that in this day and age of client centered services it is crucial to gain clients’ perspectives of multicultural competence and to include process and relational aspects of multicultural therapy into the measurement of the construct, because therapists’ competence has the greatest impact on clients.

This study resulted in the first client version of an instrument designed to measure therapist multicultural competency. The Multicultural Therapy Competency Inventory-Client Version was informed by indigenous knowledge and addresses both the process and cognitive aspects of the construct. Consequently, this instrument has the potential to be useful in the practice, training, and future research of multicultural individual and family therapy competence.

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Appendices

Appendix A. Informed Consent Forms and IRB Approval Letters

Informed Consent for Participants in Research Projects Involving Human Subjects

Title of Project: Multicultural Therapy Competency Inventory-Client Version
Principal Investigator: Fred Piercy, Ph.D.
Co-Investigator: Elise Cole, MA MFT

I. Purpose of this Study

The purpose of this study is the development of an instrument to assess clients' perceptions of their therapists' multicultural competence that can be used in both individual and family therapy.

II. Procedures

Feel free to ask questions about this study. Once your questions are answered, you will be asked to sign two copies of this consent form. One copy will be for the researcher and one will be for you to keep. Then, you will be asked to complete a participant information form and an open ended questionnaire stating, "If you or your family were seeing a therapist of a different ethnicity or culture, what attitudes, beliefs, knowledge, skills, and behaviors would you like that therapist to have?". It should take you 15 minutes or less to finish the questionnaire. When you finish taking the questionnaire, you are finished with the study.

III. Risks

The risks of participating in this study are very small. However, you might have some uncomfortable feelings such as sadness or anger. You do not have to answer any questions that make you feel uncomfortable. You can stop at any time. If you would like to talk about your feelings, the researchers will give you the name of a trained professional you can contact. Any professional treatment sought will be at the participant's expense.

IV. Benefits

While we cannot promise that you will benefit from being in this study, you might learn more about the skills and characteristics that a therapist can hold regarding cultural competence, and possibly an increased ability to evaluate the characteristics you desire in a future therapist. The information you share may be used to help design programs that can enhance the clinical services that minorities receive. As a result, you might feel a sense of personal satisfaction from knowing that you are helping others.

V. Extent of Anonymity and Confidentiality

Your participation in this research study is confidential. Only the researchers will see your answers to the survey questions. After you complete the survey, the survey will be separated from this informed consent form, so your name will not be attached to your survey responses. Instead of using your name, the researchers will assign a code number to your survey. Once your survey is assigned a code number, we will not know which survey is yours. After the survey is completed, members of the research team will type out what you say. When members of the research team type your answers to the survey questions, we leave out your name.

All information collected during this research study will be stored in a locked file cabinet in the researcher's locked office. Following the end of the study, this informed consent form will be

destroyed. The completed survey will be kept for future use, but it will only be identified by its code number, and only the research team will have access to these documents.

We will protect your confidentiality unless we learn about current child abuse/neglect or elder abuse/neglect. We are legally required to report such information to the appropriate authorities. Also, if we think you are a danger to yourself or someone else, we must tell the authorities. These are the only times when your confidentiality would not be protected.

VI. Compensation

Once you complete the survey and demographic form, your name will be entered into a raffle for a twenty dollar gift card at Amazon.com. You will have a 1/25 chance of receiving a gift card. You will be asked to fill out a slip of paper that is separate from your questionnaire that will ask for your name, address, phone, and email, so that the co-researcher can contact the raffle winners at the end of this research study. The co-researcher will draw the winning names, and the principle investigator will observe the drawing.

VII. Withdrawal Procedures

You do not have to be a part of this study, you can stop at any time. If you stop, there is no penalty.

VIII. Participant's Responsibilities

I voluntarily agree to participate in this study. I have the following responsibilities:
To complete a participant information form and to complete an open ended questionnaire on the knowledge, skills, and beliefs I would like a therapist of a differing ethnicity or culture than me to have. When I have finished taking the questionnaire, I am finished with the study.

IX. I HAVE READ THIS INFORMED CONSENT FORM AND HAVE HAD THE CHANCE TO ASK QUESTIONS ABOUT THIS RESEARCH STUDY. I UNDERSTAND WHAT IS BEING ASKED OF ME AND I AM PREPARED TO PARTICIPATE IN THIS STUDY.

Participant's Signature

Date

Participant's Name

Researcher's Signature

Date

X. IRB Contact Information

If you have any questions about this study, please contact Elise Cole, M.A. MFT at 952-334-2753, mtci@vt.edu, or Fred Piercy, faculty advisor and department head, at (540) 231-4794, piercy@vt.edu.



PT NAME

MR #

CONSENT FORM

IRB PROTOCOL # 422-07-EP

Page 1 of 3

Phase Two

Title of this Research Study: MULTICULTURAL THERAPY COMPETENCY INVENTORY-CLIENT VERSION

Invitation

You are invited to take part in this research study. The information in this form is meant to help you decide whether or not to take part. If you have any questions, please ask.

Why are you being asked to be in this research study?

It is my understanding that you have received counseling services from the University of Nebraska Medical Center (UNMC). We are contacting clients from UNMC to ask for your perception of your previous or current counselor's cultural competence. Because there are cultural differences between all people, groups, and families, it is not necessary that you be from a specific ethnic background to participate in this study.

What is the reason for doing this research study?

The main purpose of this study is the development of an inventory to assess clients' perceptions of their therapists' multicultural competence that can be used in both individual and family therapy. The second purpose of this study is to assess the relationship between client ratings of therapist multicultural therapy competence and their reports regarding both the outcome of therapy and their satisfaction with therapy.

What will be done during this research study?

You will be asked to sign two copies of this consent form. One copy will be for the researcher and one will be for you to keep. Then, you will be asked to complete a participant information form and a survey on your perceptions of your therapist's cultural competence. You will be asked to complete the survey and to indicate questions that do not make sense or are unclear. It should take you 30 minutes or less to finish the survey and feedback form.

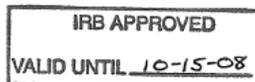
When you finish taking the survey, you are finished with the study.

What are the possible risks of being in this research study?

You might have some uncomfortable feelings such as sadness or anger. You do not have to answer any questions that make you feel uncomfortable. You can stop at any time. If you would like to talk about your feelings, the researchers will give you the name of a trained professional you can contact. Any professional treatment sought will be at your expense.

Version

CON-MR-0019 (Rev. 7/03)



Subject's Initials _____

CONSENT FORM

CONSENT

What are the possible benefits to you?

You might learn more about the skills and characteristics that a therapist can hold regarding cultural competence, and possibly an increased ability to evaluate the characteristics you desire in a future therapist. You might feel a sense of personal satisfaction from knowing that you are helping others. However, you may not get any benefit from being in this research study.

What are the possible benefits to other people?

The information you share may be used to help design programs that can enhance clinical services.

What are the alternatives to being in this research study?

Instead of being in this research study you can choose not to participate.

What will being in this research study cost you?

There is no cost to you to be in this research study.

Will you be paid for being in this research study?

You will not be paid to be in this research study.

What should you do if you have a problem during this research study?

Your welfare is the major concern of every member of the research team. If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the end of this consent form.

How will information about you be protected?

Reasonable steps will be taken to protect your privacy and the confidentiality of your study data.

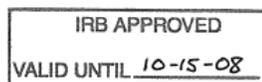
After you complete the survey, the survey will be separated from this informed consent form, so your name will not be attached to your survey responses. Instead of using your name, the researchers will assign a code number to your survey. Once your survey is assigned a code number, we will not know which survey is yours. After the survey is completed, members of the research team will type out what you say. When members of the research team type your answers to the survey questions, we leave out your name. All information collected during this research study will be stored in a locked file cabinet in the researcher's locked office.

The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person or agency required by law. The information from this study may be published in scientific journals or presented at scientific meetings but your identity will be kept strictly confidential.

What are your rights as a research subject?

You have rights as a research subject. These rights have been explained in this consent form and in *The Rights of Research Subjects* that you have been given. If you have any questions concerning your rights or complaints about the research, talk to the investigator or contact the Institutional Review Board (IRB) by:

Version



Subject's Initials _____

PT NAME
MR #

CONSENT FORM

IRB PROTOCOL # 422-07-EP

Page 3 of 3

- Telephone (402) 559-6463.
- Email: IRBORA@unmc.edu
- Mail: UNMC Institutional Review Board, 987830 Nebraska Medical Center, Omaha, NE 68198-7830

What will happen if you decide not to be in this research study or decide to stop participating once you start?

You can decide not to be in this research study, or you can stop being in this research study (“withdraw”) at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator, or with

The University of Nebraska Medical Center or The Nebraska Medical Center hospital.

You will not lose any benefits to which you are entitled.

If the research team gets any new information during this research study that may affect whether you would want to continue being in the study you will be informed promptly.

Documentation of informed consent

You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had the consent form explained to you, (3) you have had your questions answered and (4) you have decided to be in the research study. If you have any questions during the study, you should talk to one of the investigators listed below. You will be given a copy of this consent form to keep.

Signature of Subject:	Date:	Time:
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My signature certifies that all the elements of informed consent described on this consent form have been explained fully to the subject. In my judgment, the participant possesses the legal capacity to give informed consent to participate in this research and is voluntarily and knowingly giving informed consent to participate.

Signature of Investigator:	Date:
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Authorized Study Personnel

Principal Investigator: Elise Cole, M.A., (402) 559-8072

Secondary Investigator(s):

Fred Piercy, Ph.D., (540) 231-4794

Ed Wolfe, Ph.D., (540) 231-9725

Megan Dolbin-MacNab, Ph.D., (540) 231-6807

Version
CON-MR-0019 (Rev. 7/03)

IRB APPROVED VALID UNTIL <u>10-15-08</u>

Subject's Initials _____

CONSENT FORM

CONSENT



PT NAME
MR #

CONSENT FORM

IRB PROTOCOL # 422-07-EP

Page 1 of 3

Phase Three

Title of this Research Study: MULTICULTURAL THERAPY COMPETENCY INVENTORY-CLIENT VERSION

Invitation

You are invited to take part in this research study. The information in this form is meant to help you decide whether or not to take part. If you have any questions, please contact one of the researchers at the end of this consent form.

Why are you being asked to be in this research study?

It is my understanding that you have received counseling services from the University of Nebraska Medical Center (UNMC). We are contacting clients from UNMC to ask for your perception of your previous or current counselor's cultural competence. Because there are cultural differences between all people, groups, and families, it is not necessary that you be from a specific ethnic background to participate in this study.

What is the reason for doing this research study?

The main purpose of this study is the development of an inventory to assess clients' perceptions of their therapists' multicultural competence that can be used in both individual and family therapy. The second purpose of this study is to assess the relationship between client ratings of therapist multicultural therapy competence and their reports regarding both the outcome of therapy and their satisfaction with therapy.

What will be done during this research study?

Participation in this study involves completing a participant information form and a survey on your perceptions of your therapist's cultural competence. You will be asked to sign this consent form and mail it back with the completed enclosed survey in the pre-paid envelope. It should take you 20 minutes or less to finish the survey. You may complete the survey at a place that you choose.

What are the possible risks of being in this research study?

You might have some uncomfortable feelings such as sadness or anger. You do not have to answer any questions that make you feel uncomfortable. You can stop at any time. If you would like to talk about your feelings, the researchers will give you the name of a trained professional you can contact. Any professional treatment sought will be at your expense.

Version

IRB RE-APPROVED	<u>2-1-08</u>
VALID UNTIL	<u>10-15-08</u>

Subject's Initials _____

What are the possible benefits to you?

You might learn more about the skills and characteristics that a therapist can hold regarding cultural competence, and possibly an increased ability to evaluate the characteristics you desire in a future therapist. You might feel a sense of personal satisfaction from knowing that you are helping others. However, you may not get any benefit from being in this research study.

What are the possible benefits to other people?

The information you share may be used to help design programs that can enhance clinical services.

What are the alternatives to being in this research study?

Instead of being in this research study you can choose not to participate.

What will being in this research study cost you?

There is no cost to you to be in this research study.

Will you be paid for being in this research study?

We will include a token of appreciation with the questionnaire to thank you in advance for your help.

What should you do if you have a problem during this research study?

Your welfare is the major concern of every member of the research team. If you have a problem as a direct result of being in this study, you should immediately contact one of the people listed at the end of this consent form.

How will information about you be protected?

Reasonable steps will be taken to protect your privacy and the confidentiality of your study data.

After you complete the survey, the survey will be separated from this informed consent form, so your name will not be attached to your survey responses. Instead of using your name, the researchers will assign a code number to your survey. Once your survey is assigned a code number, we will not know which survey is yours. After the survey is completed, members of the research team will type out what you say. When members of the research team type your answers to the survey questions, we leave out your name. All information collected during this research study will be stored in a locked file cabinet in the researcher's locked office.

The only persons who will have access to your research records are the study personnel, the Institutional Review Board (IRB), and any other person or agency required by law. The information from this study may be published in scientific journals or presented at scientific meetings but your identity will be kept strictly confidential.

What are your rights as a research subject?

You have rights as a research subject. These rights have been explained in this consent form. If you have any questions concerning your rights or complaints about the research, talk to the investigator or contact the Institutional Review Board (IRB) by:

- Telephone (402) 559-6463.

Version

IRB RE-APPROVED	<u>2-1-08</u>
VALID UNTIL	<u>10-15-08</u>

Subject's Initials _____

CONSENT FORM

IRB PROTOCOL # 422-07-EP

Page 3 of 3

- Email: IRBORA@unmc.edu
- Mail: UNMC Institutional Review Board, 987830 Nebraska Medical Center, Omaha, NE 68198-7830

What will happen if you decide not to be in this research study or decide to stop participating once you start?

You can decide not to be in this research study, or you can stop being in this research study (“withdraw”) at any time before, during, or after the research begins. Deciding not to be in this research study or deciding to withdraw will not affect your relationship with the investigator, or with

The University of Nebraska Medical Center or The Nebraska Medical Center hospital.

You will not lose any benefits to which you are entitled.

If the research team gets any new information during this research study that may affect whether you would want to continue being in the study you will be informed promptly.

Documentation of informed consent

You are freely making a decision whether to be in this research study. Signing this form means that (1) you have read and understood this consent form, (2) you have had your questions answered and (3) you have decided to be in the research study.

If you have any questions during the study, you should talk to one of the investigators listed below.

Signature of Subject:	Date:	Time:
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Authorized Study Personnel

Principal Investigator:

Elise Cole, M.A., (402) 559-8072

Secondary Investigator(s):

Fred Piercy, Ph.D., (540) 231-4794

Ed Wolfe, Ph.D., (540) 231-9725

Megan Dolbin-MacNab, Ph.D., (540) 231-6807

Layne Prest, Ph.D., (402) 559-5393

IRB RE-APPROVED	2-1-08
VALID UNTIL	10-15-08

Version

Subject's Initials _____

DATE: March 26, 2007

MEMORANDUM

TO: Fred P. Piercy
Elise Cole

FROM: David M. Moore 

Approval date: 3/23/2007
Continuing Review Due Date: 3/8/2008
Expiration Date: 3/22/2008

SUBJECT: **IRB Expedited Approval:** "Multicultural Therapy Competency Inventory-Client Version", IRB # 07-166

This memo is regarding the above-mentioned protocol. The proposed research is eligible for expedited review according to the specifications authorized by 45 CFR 46.110 and 21 CFR 56.110. As Chair of the Virginia Tech Institutional Review Board, I have granted approval to the study for a period of 12 months, effective March 23, 2007.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

Important:

If you are conducting **federally funded non-exempt research**, this approval letter must state that the IRB has compared the OSP grant application and IRB application and found the documents to be consistent. Otherwise, this approval letter is invalid for OSP to release funds. Visit our website at <http://www.irb.vt.edu/pages/newstudy.htm#OSP> for further information.

cc: File
Department Reviewer: Joyce A. Arditti

Invent the Future

DATE: April 6, 2007

MEMORANDUM

TO: Fred P. Piercy
Elise Cole

FROM: David M. Moore 

Approval date: 3/23/2007
Continuing Review Due Date: 3/8/2008
Expiration Date: 3/22/2008

SUBJECT: **IRB Amendment 1 Approval:** "Multicultural Therapy Competency Inventory-Client Version", IRB # 07-166

This memo is regarding the above referenced protocol which was previously granted approval by the IRB on March 23, 2007. You subsequently requested permission to amend your IRB application. Since the requested amendment is nonsubstantive in nature, I, as Chair of the Virginia Tech Institutional Review Board, have granted approval for requested protocol amendment, effective as of April 5, 2007. The anniversary date will remain the same as the original approval date.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

cc: File

Invent the Future

DATE: May 29, 2007

MEMORANDUM

TO: Fred P. Piercy
Elise Cole

FROM: David M. Moore 

Approval date: 3/23/2007
Continuing Review Due Date: 3/8/2008
Expiration Date: 3/22/2008

SUBJECT: **IRB Amendment 2 Approval:** "Multicultural Therapy Competency Inventory-Client Version", IRB # 07-166

This memo is regarding the above referenced protocol which was previously granted approval by the IRB on March 23, 2007. You subsequently requested permission to amend your IRB application. Since the requested amendment is nonsubstantive in nature, I, as Chair of the Virginia Tech Institutional Review Board, have granted approval for requested protocol amendment, effective as of May 29, 2007. The anniversary date will remain the same as the original approval date.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

cc: File
Department Reviewer: Joyce A. Arditti

Invent the Future

DATE: June 1, 2007

MEMORANDUM

TO: Fred P. Piercy
Elise Cole

FROM: David M. Moore 

Approval date: 3/23/2007
Continuing Review Due Date: 3/8/2008
Expiration Date: 3/22/2008

SUBJECT: **IRB Amendment 3 Approval:** "Multicultural Therapy Competency Inventory-Client Version", IRB # 07-166

This memo is regarding the above referenced protocol which was previously granted approval by the IRB on March 23, 2007. You subsequently requested permission to amend your IRB application. Since the requested amendment is nonsubstantive in nature, I, as Chair of the Virginia Tech Institutional Review Board, have granted approval for requested protocol amendment, effective as of June 1, 2007. The anniversary date will remain the same as the original approval date.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

cc: File

Department Reviewer: Joyce A. Arditti

Invent the Future

DATE: September 10, 2007

MEMORANDUM

TO: Fred P. Piercy
Elise Cole

FROM: David M. Moore 

Approval date: 3/23/2007
Continuing Review Due Date: 3/8/2008
Expiration Date: 3/22/2008

SUBJECT: **IRB Amendment 4 Approval:** "Multicultural Therapy Competency Inventory-Client Version", IRB # 07-166

This memo is regarding the above referenced protocol which was previously granted approval by the IRB on March 23, 2007. You subsequently requested permission to amend your IRB application. Since the requested amendment is nonsubstantive in nature, I, as Chair of the Virginia Tech Institutional Review Board, have granted approval for requested protocol amendment, effective as of September 6, 2007. The anniversary date will remain the same as the original approval date.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

cc: File
Department Reviewer: Joyce A. Arditti

Invent the Future



DATE: January 31, 2008

MEMORANDUM

TO: Fred P. Piercy
Elise Cole

FROM: David M. Moore 

Approval date: 3/23/2007
Continuing Review Due Date:3/8/2008
Expiration Date: 3/22/2008

SUBJECT: **IRB Amendment 5 Approval:** "Multicultural Therapy Competency Inventory-Client Version", IRB # 07-166

This memo is regarding the above referenced protocol which was previously granted approval by the IRB on March 23, 2007. You subsequently requested permission to amend your IRB application. Since the requested amendment is nonsubstantive in nature, I, as Chair of the Virginia Tech Institutional Review Board, have granted approval for requested protocol amendment, effective as of January 31, 2008. The anniversary date will remain the same as the original approval date.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

cc: File
Department Reviewer: Joyce A. Arditti

Invent the Future

DATE: February 4, 2008

MEMORANDUM

TO: Fred P. Piercy
Elise Cole

FROM: David M. Moore 

Approval date: 3/23/2007
Continuing Review Due Date: 3/8/2008
Expiration Date: 3/22/2008

SUBJECT: **IRB Amendment 6 Approval:** "Multicultural Therapy Competency Inventory-Client Version", IRB # 07-166

This memo is regarding the above referenced protocol which was previously granted approval by the IRB on March 23, 2007. You subsequently requested permission to amend your IRB application. Since the requested amendment is nonsubstantive in nature, I, as Chair of the Virginia Tech Institutional Review Board, have granted approval for requested protocol amendment, effective as of February 4, 2008. The anniversary date will remain the same as the original approval date.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

cc: File
Department Reviewer: Joyce A. Arditti

Invent the Future

DATE: February 26, 2008

MEMORANDUM

TO: Fred P. Piercy
Elise Cole

FROM: David M. Moore 

Approval date: 3/23/2008
Continuing Review Due Date: 3/8/2009
Expiration Date: 3/22/2009

SUBJECT: **IRB Expedited Continuation 1:** "Multicultural Therapy Competency Inventory-Client Version", IRB # 07-166

This memo is regarding the above referenced protocol which was previously granted expedited approval by the IRB. The proposed research is eligible for expedited review according to the specifications authorized by 45 CFR 46.110 and 21 CFR 56.110. Pursuant to your request, as Chair of the Virginia Tech Institutional Review Board, I have granted approval for extension of the study for a period of 12 months, effective as of March 23, 2008.

Approval of your research by the IRB provides the appropriate review as required by federal and state laws regarding human subject research. As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

cc: File
Department Reviewer: Joyce A. Arditti

Invent the Future

DATE: March 7, 2008

MEMORANDUM

TO: Fred P. Piercy
Elise Cole

FROM: David M. Moore 

Approval date: 3/23/2008
Continuing Review Due Date: 3/8/2009
Expiration Date: 3/22/2009

SUBJECT: **IRB Amendment 1 Approval:** "Multicultural Therapy Competency Inventory-Client Version", IRB # 07-166

This memo is regarding the above referenced protocol which was previously granted approval by the IRB on March 23, 2008. You subsequently requested permission to amend your IRB application. Since the requested amendment is nonsubstantive in nature, I, as Chair of the Virginia Tech Institutional Review Board, have granted approval for requested protocol amendment, effective as of March 7, 2008. The anniversary date will remain the same as the original approval date.

As an investigator of human subjects, your responsibilities include the following:

1. Report promptly proposed changes in previously approved human subject research activities to the IRB, including changes to your study forms, procedures and investigators, regardless of how minor. The proposed changes must not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subjects.
2. Report promptly to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.
3. Report promptly to the IRB of the study's closing (i.e., data collecting and data analysis complete at Virginia Tech). If the study is to continue past the expiration date (listed above), investigators must submit a request for continuing review prior to the continuing review due date (listed above). It is the researcher's responsibility to obtain re-approval from the IRB before the study's expiration date.
4. If re-approval is not obtained (unless the study has been reported to the IRB as closed) prior to the expiration date, all activities involving human subjects and data analysis must cease immediately, except where necessary to eliminate apparent immediate hazards to the subjects.

cc: File

Department Reviewer: Joyce A. Arditti

Invent the Future

November 15, 2007

Elise Cole, M.A.
Family Medicine
UNMC - 3075

IRB # 422-07-EP

TITLE OF PROPOSAL: Multicultural Therapy Competency Inventory-Client Version

SECONDARY INVESTIGATORS: Megan Dolbin-MacNab, PhD; Fred Piercy, PhD; Ed Wolfe, PhD

DATE OF FULL BOARD REVIEW _____ DATE OF EXPEDITED REVIEW 10-15-07

DATE OF FINAL APPROVAL 11-15-07 VALID UNTIL 10-15-08

EXPEDITED CATEGORY OF REVIEW: 45CFR46.110; 21CFR56.110, Categories 5 and 7

The Institutional Review Board (IRB) for the Protection of Human Subjects has completed its review of the above-titled protocol and informed consent document(s), including any revised material submitted in response to the IRB's review. The Board has expressed its opinion that you are in compliance with HHS Regulations (45 CFR 46) and applicable FDA Regulations (21 CFR 50, 56) and you have provided adequate safeguards for protecting the rights and welfare of the subjects to be involved in this study. The IRB has, therefore, granted unconditional approval of your research project. This letter constitutes official notification of the final approval and release of your project by the IRB, and you are authorized to implement this study as of the above date of final approval.

Please be advised that only the IRB approved and stamped consent forms can be used to make copies to enroll subjects. Also, at the time of consent all subjects must be given a copy of *The Rights of Research Subjects*. The IRB wishes to remind you that the PI is responsible for ensuring that ethically and legally effective informed consent has been obtained from all research subjects.

Finally, under the provisions of this institution's Federal Wide Assurance (FWA00002939), the PI is directly responsible for submitting to the IRB any proposed change in the research or the consent document(s). In addition, any unanticipated adverse events involving risk to the subject or others must be promptly reported to the IRB. This project is subject to periodic review and surveillance by the IRB and, as part of their surveillance, the IRB may request periodic reports of progress and results. For projects which continue beyond one year, it is the responsibility of the principal investigator to initiate a request to the IRB for continuing review and update of the research project.

Sincerely,



Ernest D. Prentice, Ph.D.
Co-Chair, IRB

EDP/kje

March 11, 2008

Elise Cole, M.A.
Family Medicine
UNMC - 3075

IRB #: 422-07-EP

TITLE OF APPLICATION/PROTOCOL: Multicultural Therapy Competency Inventory-Client Version

Dear Ms. Cole:

The Institutional Review Board for the Protection of Human Subjects has completed its review of your Request for Change dated March 4, 2008 for the above titled protocol.

This letter constitutes official notification of the approval of the protocol and/or consent form change. **All copies of the outdated consent/assent form(s) must be discarded immediately.** The original IRB stamped form may be archived. You are, therefore, authorized to implement this change accordingly.

Sincerely,



Ernest D. Prentice, Ph.D.
Co-Chair, IRB

EDP/kje

Appendix B. Demographic Questionnaire for Phase One

Who Are You?

ID # _____

The following questions are about you and your family. Please mark or write in your answer. Try to answer the questions as honestly as you can.

4. What is your age? _____

5. Are you male or female?

- Male
- Female

6. What is your racial or ethnic background?

- Black or African-American
- Native American or Alaskan Native
- White or Caucasian
- Hispanic
- Japanese
- Chinese
- Korean
- Asian Indian
- African
- Other (specify) _____

7. What is the primary language you speak?

- English
- Spanish
- Japanese
- Chinese
- Korean
- Hindi
- Somali
- Other (specify) _____

8. Do you speak English fluently (speak English at a regular pace)?

- Yes
- No
- Other (specify) _____

9. How long have you lived in the United States (please record in years and months)?

10. What is your current relationship status?

- Never Married

- Married
- Living with Partner
- Dating or Partnered
- Separated
- Divorced
- Other (specify) _____

11. What is your spouses or partners ethnic background?

- Black or African-American
- Native American or Alaskan Native
- White or Caucasian
- Hispanic
- Japanese
- Chinese
- Korean
- Asian Indian
- African
- Other (specify) _____
- N/A

12. What is the highest level of education that you completed?

- Less than high school
- High school diploma or GED
- Some college or technical school
- Technical school degree
- College degree (Associates or Bachelors)
- Some graduate school
- Masters degree
- Doctorate/Medical Degree

13. What is your annual household income (before taxes)? (This includes your partner/spouse or parent(s)/guardian(s) if they financially support you).

- Under \$5,000
- Between \$5,001 and \$15,000
- Between \$15,001 and \$25,000
- Between \$25,001 and \$35,000
- Between \$35,001 and \$50,000
- Between \$50,001 and \$80,000
- Between \$80,001 and \$110,000
- Between \$110,001 and \$140,000
- Over \$140,001

Open Ended Questionnaire (Study 1)

Please list attitudes/beliefs, knowledge, and skills/behaviors you would like a psychotherapist/counselor of a different ethnicity or culture to have if he/she were to work with you or your family. It is not necessary to have actually received counseling services in the past or present to fill out this survey.

A. If you or your family were seeing a psychotherapist/counselor of a different ethnicity or culture, what knowledge would you like that therapist to have?" (Note: Knowledge refers to ideas, facts, or concepts you would like a therapist to be familiar with and understand about your culture.)

B. If you or your family were seeing a psychotherapist/counselor of a different ethnicity or culture, what attitudes and beliefs would you like that therapist to have?" (Note: Attitudes and Beliefs refer to a therapist's feelings, emotions, or thoughts about a certain culture.)

C. If you or your family were seeing a psychotherapist/counselor of a different ethnicity or culture, what behaviors or skills would you like that therapist to have?" (Note: Behaviors and Skills refer to the ways in which a therapist acts and his or her use of physical tasks in therapy.)

Appendix D. Initial Item List

A1. Counselor Awareness of Own Cultural Values and Biases/ Attitudes and Beliefs

My therapist values and respects differences.

My therapist attempts to understand things from my/my family's point of view.

My therapist does not show prejudice or bias towards different cultures or backgrounds.

My therapist does not push his/her beliefs and attitude on me/my family.

My therapist does not appear to believe that his/her way of viewing things is the "right" way.

My therapist does not make judging statements about me or my culture by things they have seen or heard about my culture.

My therapist appears to believe that the cultural influences on me are positive, rather than my heritage holding negative attributions.

My therapist appears open and receptive towards treating a family that may be different from their own.

A2. Counselor Awareness of Own Cultural Values and Biases/Skills

My therapist has shared with me personal beliefs that may influence their interpretations of me/my family.

My therapist provides the opportunity to discuss values related to family, religion, etc. when they are relevant to therapy.

My therapist's values and biases do not interfere with my individual or family therapy, nor does he/she make anyone feel uncomfortable.

My therapist is able to be open and honest about her/his values and biases.

My therapist is able to recognize when a cultural/ethnic issue arises in therapy and does not avoid addressing it.

My therapist shares positive feelings, emotions, or thoughts, about my culture.

When my therapist has a differing opinion or belief he/she either keeps it to himself/herself or discusses it in an open and accepting manner.

My therapist does not enforce that therapy follow her/his values and morals.

My therapist is not afraid to bring up gender and race issues in therapy instead of having to follow my lead.

My therapist uses understanding of his/her own culture to provide new counseling ideas to me/my family.

A3. Counselor Awareness of Own Cultural Values and Biases/Knowledge

My therapist is aware of how discrimination and oppression can affect relationships and therapy.

My therapist appears to be self-aware and know himself/herself, including preferences and values.

My therapist shows that they are aware of my cultural heritage.

My therapist is able to recognize areas of strength and limitation in their culture.

My therapist appears to be aware of how differences in culture, family, religion, gender, etc. may shape thinking and attitude.

My therapist is knowledgeable about the practices and customs of his/her culture, accepted behaviors, and general values and beliefs.

My therapist is knowledgeable about cultural differences regarding such things as: communication, interaction, religion, common gender roles, relationship dynamics between genders, parent-child relationships, and ways to cope with stress.

B1. Counselor Awareness of Client's Worldview/Attitudes and beliefs

My therapist appears willing to contrast her/his own beliefs with those of mine/my families in a non-judgmental manner.

My therapist appears understanding and open to the practices of a different culture.

My therapist does not appear to expect me to trust him/her just because they are educated.

My therapist appears open and accepting to cultural differences.

My therapist is respectful and sensitive to cultural difference.

My therapist is respectful of my culture, for example, my religion, beliefs, and family values.

My therapist is able to see things from my point of view without judgment.

My therapist has an attitude of acceptance and understanding towards my/my family's personal values and beliefs.

B2. Counselor Awareness of Client's Worldview/Skills

My therapist values all persons in therapy and encourages each to share their perspective including: males and females, adults, children, the individual, couple, and family unit.

My therapist incorporates their understanding of my culture and background into therapy.

My therapist validates my values and beliefs.

My therapist is supportive of my/my family's goals and is respectful of my/our commitments.

My therapist encourages my family to continue cultural traditions that are positive for us.

My therapist is familiar with my/my family's cultural norms, and is able to interact with us in a culturally appropriate manner.

My therapist is attentive and aware of cultural differences.

My therapist values my/my family's perspective as bringing new viewpoints to discussion.

My therapist makes it clear through communication and action that they want to understand me/my family and my/our culture.

My therapist acknowledges the perspective of each person in therapy.

My therapist is patient and courteous when he/she may not understand me/my family.

B3. Counselor Awareness of Client's Worldview/Knowledge

My therapist appears to be knowledgeable about several different approaches to helping me/my family and has shifted the focus of therapy when needed.

My therapist appears to have some knowledge about my culture and cultural background.

My therapist appears to understand or have empathy regarding what it might be like to feel different like an "other" within a culture.

My therapist appears to understand the behaviors my culture emphasizes and cultural expectations and is supportive of these.

My therapist appears to understand and respect differences, for example in: family structures, how respect is observed, religious background differences, family and individual values, morals, and differences in child-rearing styles

My therapist appears to understand that within and among cultures persons develop in different ways at different rates.

My therapist appears to have some knowledge about the history and current events in my country or culture.

My therapist appears to know enough about my culture to appreciate the good things about it, but also to be able to recognize when problems are part of the larger society.

My therapist appears knowledgeable and supportive of the practices, customs, the accepted behaviors, general attitudes, beliefs, and cultural values of my culture.

My therapist appears to have an understanding of the experiences of immigrants and non-immigrants

My therapist is familiar and sensitive to culture, religion, and gender and how they can shape individuals.

My therapist is familiar and empathetic regarding the expectations and difficulties may be commonly faced by individuals from my culture.

My therapist is knowledgeable about how my culture may serve as a contextual influence on my life and affect my resources, problems, and strengths.

My therapist is knowledgeable about several ethnicities and cultures, knowing that people may not fit into only one.

C1. Culturally Appropriate Intervention Strategies/Attitudes and beliefs

My therapist appears to value my use of language rather than viewing it as a hindrance to counseling.

My therapist appears to value and incorporate the individual, couple, and family unit in therapy when appropriate.

My therapist shows patience with communication and a desire to understand me/my family.

My therapist appears to have no preconceptions about what and how emotions and feelings should be expressed.

My therapist shows understanding and respect for institutionalized norms/authority.

My therapist shows respect for my/my family's ideas, shared behavior, emotions, and beliefs in therapy.

C2. Culturally Appropriate Intervention Strategies/Skills

My therapist is not averse to incorporating my/my family's traditional sources of healing into therapy.

My therapist is able to restate issues/problems in practical ways I can benefit from.

My therapist is able to understand my language either on their own or with the use of an interpreter.

My therapist offers to incorporate my beliefs/religious views into therapeutic activities.

My therapist offers advice consistent with my values and beliefs.

My therapist is able to approach an issue without disrespecting me/my family members.

My therapist is creative in offering different ideas and solutions to help me/my family meet our goals.

My therapist allows me to choose whether or not to follow suggestions and whether or not they are right for me.

My therapist is respectful and responsive to my/my family's emotional and behavioral expressions.

When my therapist chooses to confront something about me, he/she does so in a way that preserves my core values and beliefs.

My therapist is attentive to me/my family to find the right balance of direct and passive communication.

My therapist responds to my/our cues to find an appropriate balance of listening as well as advising.

My therapist offers good insight and positive suggestions for me/my family.

My therapist is able to challenge my/my family's ideas and beliefs without looking down at them.

My therapist gives everyone a chance to be heard and understood.

My therapist is sensitive to cultural differences and norms having to do with personal space, interpersonal distance, touching behaviors, and other behavioral interactions that might be culturally offensive or uncomfortable for some clients.

My therapist appears to understand and apply my/my family's customs to make me/us feel comfortable.

My therapist uses methods that apply different styles of learning (visual, audio, touch).

My therapist carefully explains therapy activities and physical tasks.

My therapist gives me/my family an un-coerced choice to participate in all therapeutic activities.

My therapist provided suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, etc.).

My therapist appeared to understand my/my family's problems within my/our cultural context and was able to provide appropriate suggestions.

My therapist gave me/my family attention, patience, and respect even if we had broken English.

My therapist was able to read my/my family's cues and respond appropriately.

My therapist was able to explain things/tasks/questions in a way that demonstrated familiarity with my ethnicity/culture.

My therapist worked to understand my/my family's verbal and non-verbal language (language, body language, slang spoken in my culture).

My therapist was willing to adjust plans or provide new suggestions when I/my family did not respond positively to something.

My therapist was open to working with me/my family actively to support a different way of thinking about solving a problem or working through a relationship.

My therapist used skills in communicating with me/us using elements of my/our own language.

C3. Culturally Appropriate Intervention Strategies/Knowledge

My therapist is aware of my/my family's mental health resources and is aware of potential barriers that can prevent people from using mental health services.

My therapist utilizes his/her knowledge of resources within the culture to aid in positive change.

My therapist is familiar with cultural differences in a family system related to closeness and how this can be shown.

My therapist is familiar with differences in family dynamics, family development timelines, and relationship roles.

My therapist is aware that behaviors have different meanings in different cultures, for example a raised voice may only be expressive rather than indicating conflict.

My therapist is aware and respectful of different emotional and behavioral expressions.

My therapist applies his/her knowledge about my/my family's culture to work towards my/our therapeutic goals.

My therapist is aware of communication style differences in terms of balancing direct/indirectness and listening/advising.

My therapist appears to understand and my/my family's customs and beliefs.

My therapist appears to understand and apply different styles of learning (visual, audio, touch).

My therapist appeared to understand that interventions need to fit the individual/family and their context (i.e.: race, class, gender, culture, sexual orientation, etc.).

My therapist seems well versed in this society and culture.

My therapist has knowledge of cultural norms regarding lifestyles, appropriate family behavior, customs, attitudes and beliefs, and cultural arts/entertainment.

My therapist is familiar with methods to heal injured feelings.

D1. Respectful Curiosity/Attitudes and beliefs

My therapist believes it is important to look beyond assumptions and stereotypes to what fits for me/my family.

My therapist avoids assuming similarities or projecting differences that might not be relevant to me/my family.

My therapist desires to know me as an individual with individual experiences.

My therapist does not assume that because I am of a certain race or ethnicity that I am just like others of that race/ethnicity.

My therapist seems to believe that cultural background is highly influenced by several factors.

My therapist believes that there is a great deal of variety even within groups and does not pigeonhole me or my family into a stereotype.

My therapist believes that people do not fit one mold, and does not assume based on my skin or eye color.

My therapist does not judge me/my family based on my culture, but instead based on my actions and shared thoughts.

My therapist believes that it is their job to learn about my world rather than my job to learn about theirs.

My therapist takes a curious attitude and appears aware that there is not one way of looking at things.

D2. Respectful Curiosity/Skills

My therapist asks me/my family to tell him/her about my/our expectations for care.

My therapist seeks to know my/my family's beliefs out of curiosity and discusses them from my perspective.

My therapist desires to genuinely understand me/my family.

My therapist displays a genuine interest to learn about me/my family.

My therapist is nonjudgmental and does not jump to conclusions about me/my family.

My therapist is willing to listen and learn about my/our cultural background and experiences.

My therapist asks about several cultural facets that are less recognizable than race.

My therapist seeks a specific understanding of my life experience as an immigrants or non-immigrant.

My therapist does not stereotype me, but seeks to know me individually.

My therapist does not display assumptions about me just because of my ethnicity.

My therapist is willing to explore the way my beliefs are a part of my culture.

My therapist is inquisitive/curious about my culture, and respectful of my individuality.

My therapist openly discusses cultural issues he/she does not understand.

My therapist uses an exploring, questioning approach that is open-ended.

My therapist desires to listen and understand me/my family.

My therapist is willing to ask about my own experience of difference rather than make assumptions.

My therapist asks about my thoughts and feelings about tasks they use in therapy.

My therapist asks questions when I am hesitant and accepts when I might not be comfortable with something.

E1. Naiveté/Attitudes and beliefs

My therapist believes it is important to remain open to my/my family's expertise on my/our life and culture.

My therapist has an open mind to different understandings and interpretations.

My therapist does not appear to believe that he/she knows everything.

My therapist is willing to learn about what he/she might not understand or comprehend.

My therapist is open to the possibility that I am different than he or she would have expected.

My therapist is open minded about different races and cultures.

My therapist exhibits an openness and willingness to know about my/my family's culture.

My therapist does not assume I am a certain way because of my culture.

My therapist is open to new thoughts/ideas, and ways of viewing issues discussed in therapy.

My therapist believes that each individual is unique no matter his/her ethnicity.

My therapist is open to what might be different about me/my family.

My therapist takes a not knowing, non-judging stance with me and my family.

My therapist appears to believe that I have the ability to feel better within me and that their job is to help me find the processes to get at the right solutions for me.

My therapist is open to the possibility that I may be different than he or she is expecting.

My therapist is open to learning about my culture as it applies to the therapy.

E2. Naiveté/Skills

My therapist remains open and receptive (through body language and communication) to the differences between us.

My therapist is willing to talk openly about possible cultural and value differences that may exist between us.

My therapist refers to me/my family as local experts rather than work off of their assumptions.

My therapist is open to different viewpoints.

My therapist asks for information and shows interest in my/my family's perspective.

My therapist seeks to understand me and my family.

My therapist is open and accepting of differences in personality and emotion management.

My therapist tries to listen and actually hear what I am saying.

My therapist is receptive and responsive to what I/we share.

My therapist intently listens and is slow to make conclusions.

My therapist is open and willing to learning new things.

When my therapist is aware of differences he/she asks for my/our thoughts and feelings on possible differences.

My therapist is willing to hear and understand my explanations of my views and feelings.

My therapist is humble and accepting of my/my family's culture and ethnicity and is willing to learn more.

My therapist takes my word for what I say about my culture and its influence on me.

F1. Multicultural Counseling Relationship/Attitudes and Beliefs

My therapist believes it is important to focus on building a relationship with me and my family in a culturally appropriate manner.

My therapist exhibits a positive and warm attitude towards me/us.

My therapist exhibits sympathetic, and compassion towards me and my struggles.

My therapist has a humble attitude, not arrogant.

My therapist appears to hold a hopeful attitude regarding my treatment outcome or healing.

My therapist exhibits a kind and patient attitude.

My therapist holds a professional and ethical attitude towards my/my family's treatment.

My therapist has an accepting attitude towards me and/or my family.

F2. Multicultural Counseling Relationship/Skills

My therapist uses relationship-building skills, such as listening, attending, and paraphrasing.

My therapist is service oriented.

My therapist exhibits a willingness to listen to me/my family.

My therapist works to speak so that I/we can understand him/her.

My therapist is attentive to my/our needs in therapy.

My therapist's behavior is respectful and sincere.

My therapist is authentic; he/she is able to be congruent in his/her feelings, thoughts and emotions.

My therapist has good listening skills.

My therapist uses skills to be socially compatible with me/us.

My therapist acts calm and reassuring.

My therapist shows care and support.

My therapist appears to be familiar with different therapy techniques.

My therapist is able to relate to me about what is going on in my life, and the struggles I go through.

My therapist works to build connection, and share commonalities with me/us.

My therapist rephrases and clarifies statements he/she does not understand.

My therapist is able to establish a comfortable environment in therapy.

My therapist acts professional.

My therapist is courteous and attempts to use culturally appropriate greetings.

My therapist puts effort into making a positive impression.

My therapist uses good communication skills, and is sociable.

My therapist is able to connect well with me/my family.

My therapist is calm and patient with me/my family.

My therapist attempts to use appropriate eye contact.

My therapist is able to guide the conversation without dominating it or letting it go on and on.

My therapist helps me/my family feel comfortable/at ease.

F3. Multicultural Counseling Relationship/Knowledge

My therapist is knowledgeable about relationships and people.

My therapist understands normal greeting and social behaviors in my culture.

My therapist understands the meanings my culture attributes to body language, such as eye contact.

My therapist appears competent in individual/family therapy.

My therapist has an education in mental health.

My therapist has both technical and practical knowledge of therapy.

My therapist seems familiar with cultural differences in the family system, related to closeness.

My therapist is knowledgeable about the kinds of problems that I'd be seeking help for.

My therapist is knowledgeable about the process of therapy.

My therapist seems to understand that multiple influences can affect a person/relationship.

My therapist knows basic principles that can be helpful in my life/family relationships.

My therapist is familiar with helpful therapy techniques.

Appendix E. MTCI for Phase 2, Demographic Form, and Participant Feedback

MULTICULTURAL THERAPY COMPETENCY INVENTORY

Please check the box under the description that most accurately describes your perception of a counselor you have met with. Please note that the statements are written as if they are occurring now, but you may also fill this out for a therapist you are no longer seeing.

	Does this very well	Does this adequately	Does this poorly
1. My therapist shows tolerance towards different backgrounds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My therapist values both his/her own perspective as well as my/my family's perspective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. My therapist's open-mindedness assists my/my family's therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. My therapist provides the opportunity to discuss values related to family, religion, etc. when they are relevant to therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My therapist is open about her/his values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My therapist is able to recognize when a cultural/ethnic issue arises in therapy and addresses it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. My therapist applies his/her own values as well as my/my family's values in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. My therapist is aware of how discrimination and oppression can affect relationships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. My therapist is aware of his/her beliefs and values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. My therapist is knowledgeable about the customs of his/her culture, accepted behaviors, and general values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. My therapist is accepting of the practices of a different culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. My therapist is sensitive to cultural difference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. My therapist is able to see things from my point of view without judgment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. My therapist has an accepting attitude towards my/my family's personal values and beliefs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. My therapist is supportive of my values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. My therapist is able to interact with me/my family in a culturally appropriate manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. My therapist makes it clear through communication that they want to understand me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. My therapist acknowledges the perspective of each person in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. My therapist appears to have some knowledge about my culture and background.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. My therapist is familiar with how culture, religion, and gender can shape individuals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. My therapist is familiar with the difficulties that may be commonly faced by persons from my culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. My therapist is knowledgeable about how my culture influences my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. My therapist appears to value the individual, couple, and family unit in therapy when appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. My therapist desires to understand me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. My therapist appears accepting of different ways feelings are expressed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. My therapist shows respect for my/my family's ideas and behaviors in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. My therapist is open to incorporating my/my family's traditional sources of healing into therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. My therapist is responsive to my/my family's emotional and behavioral expressions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. My therapist is able to explain things in a way that demonstrates familiarity with my ethnicity/culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. My therapist works to understand my/my family's verbal and non-verbal language (language, body language, slang spoken in my culture).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. My therapist appears to be knowledgeable about several different approaches to helping me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. My therapist applies his/her knowledge about my/my family's culture to work towards my/our therapeutic goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. My therapist appears to understand that therapy needs to fit the individual/family (i.e.: race, class, gender, culture, sexual orientation, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. My therapist is knowledgeable about how my background may affect my availability of resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. My therapist desires to know me as an individual with individual experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. My therapist believes that it is their job to learn about my world rather than my job to learn about theirs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. My therapist takes a curious attitude towards learning about me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. My therapist asks me/my family to tell him/her about my/our expectations for care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. My therapist displays a genuine interest to learn about me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. My therapist is curious about my background and experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. My therapist is interested in my/my family's expertise on my/our life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. My therapist has an open mind to different understandings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. My therapist exhibits an openness to know about my/my family's uniqueness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. My therapist is receptive (through body language and communication) to the differences between us.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. My therapist refers to me/my family as local experts instead of working off of his/her stereotypes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. My therapist asks for information about my/my family's perspective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. My therapist focuses on building a relationship with me and my family in a culturally appropriate manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. My therapist exhibits a positive attitude towards me/us.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. My therapist has an accepting attitude towards me and/or my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. My therapist uses relationship-building skills, such as listening, attending, and paraphrasing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. My therapist is attentive to my/our needs in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

54. My therapist is able to establish a comfortable environment in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. My therapist is able to connect well with me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. My therapist understands normal social behaviors in my culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. My therapist is knowledgeable about the kinds of problems that people seek help for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. My therapist knows basic principles that are helpful in my life/family relationships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who Are You?

ID # _____

The following questions are about you and your family. Please mark or write in your answer. Try to answer the questions as honestly as you can.

1. What is your age? _____

2. Are you male or female?

- Male
- Female

3. What is your racial background?

- African-American
- Native American or Alaskan Native
- White or Caucasian
- Hispanic or Latino
- Asian
- Other (specify) _____

4. What is the primary language you speak?

- English
- Spanish
- An Asian Language
- Other (specify) _____

5. How long have you lived in the United States (please record in years and months)?

6. What is your current relationship status?

- Married
- Living with Partner
- Dating or Partnered
- Separated
- Divorced
- Other (specify) _____

7. What is your partner's or spouse's racial background?

- African-American
- Native American or Alaskan Native
- White or Caucasian
- Hispanic or Latino
- Asian
- Other (specify) _____
- N/A

8. Please indicate the amount of therapy or counseling sessions you attended (from the therapist you will fill out this survey on).

- 1 Session
- 2-3 Sessions
- 4-5 Sessions
- 6-10 Sessions
- 11-15 Sessions
- 16 or more Sessions

9. Did your partner or spouse attend any therapy sessions with you (from the therapist you will fill out this survey on)?

- Yes
- No
- N/A

10. If you have a child or children, did your child attend any therapy sessions with you (from the therapist you will fill out this survey on)?

- Yes
- No
- N/A

11. Please indicate the outcome of the counseling you received (from the therapist you will fill out this survey on). Only mark one answer below.

- I felt **much better** after receiving counseling than I felt before receiving counseling.
- I felt a **little better** after receiving counseling than I felt before receiving counseling.
- I felt the **same** after receiving counseling as I felt before receiving counseling.
- I felt a **little worse** after receiving counseling than I felt before receiving counseling.
- I felt **much worse** after receiving counseling than I felt before receiving counseling.

12. Please indicate what contributed to how you felt after receiving counseling.

13. Please indicate your level of satisfaction with the counseling you received (from the therapist you will fill out this survey on). Only mark one answer below.

- I am **very satisfied** with the counseling I received.
- I am **somewhat satisfied** with the counseling I received.
- I feel **neutral** about the counseling I received.
- I am **somewhat unsatisfied** with the counseling I received.
- I am **very unsatisfied** with the counseling I received.

14. Please indicate what contributed to your satisfaction or lack of satisfaction with the counseling you received.

15. Please indicate the outcome of the counseling you received (from the therapist on whom you will fill out this survey). Only mark one answer below.

- I attained **most** of the goals for which I entered therapy.
- I attained **some** of the goals for which I entered therapy
- I **did not attain** the goals for which I entered therapy.

16. Please indicate what contributed to the attainment or lack of attainment of your goals.

17. What is the highest level of education that you completed?

- Less than high school
- High school diploma or GED
- College degree or Technical school degree
- Masters degree
- Doctorate/Medical Degree

18. What is your annual household income (before taxes)? (This includes your partner/spouse or parent(s)/guardian(s) if they financially support you).

- Under \$5,000
- Between \$5,001 and \$15,000
- Between \$15,001 and \$25,000
- Between \$25,001 and \$35,000
- Between \$35,001 and \$50,000
- Between \$50,001 and \$80,000
- Between \$80,001 and \$110,000
- Over \$110,001

1. Were any questions unclear? If so, which ones and why?

2. Do you have any suggestions regarding how to improve this survey?

3. What other feedback do you have about this survey?

RATING DIRECTIONS

Please mark next to each Item (below) the Category level (e.g., A, B, C, D, E, F) and the Cell level (e.g., A1, A2, A3, B1, B2....F3) that the Item reflects.

DEFINITIONS

CATEGORY

A=Counselor Awareness of Own Cultural Values and Biases

(definition: aware of own worldview, assumptions, biases, values, and limitations)

B=Counselor Awareness of Client's Worldview

(definition: desire to understand clients' worldviews)

C=Culturally Appropriate Intervention Strategies

(definition: appropriate and sensitive intervention strategies with culturally diverse clients)

D=Respectful Curiosity

(definition: composed of the love of surprise and the desire to look beyond assumptions; curiosity stimulates the act of knowing and supplies the energy for discovery in multicultural therapy)

E=Naiveté

(definition: a state of openness and receptivity, remaining sensitive and receptive to the differences between oneself and one's clients)

F=Multicultural Counseling Relationship

(definition: core relationship building skills, related to the working alliance)

ROW

1=Attitudes and Beliefs

(definition: attitudes and beliefs about ethnic minorities, including biases or stereotypes)

2=Skills

(definition: therapy skills needed for working with ethnic minority groups)

3=Knowledge

(definition: knowledge regarding cultural groups one works with)

CELL: Note both the Category and Row for the Cell rating (see chart below, e.g., A3)

	ROW	1	2	3
CATEGORY		Attitudes and Beliefs	Skills	Knowledge
A	Counselor Awareness of Own Cultural Values and Biases	A1 CELL	A2 CELL	A3 CELL
B	Counselor Awareness of Client's Worldview	B1 CELL	B2 CELL	B3 CELL
C	Culturally Appropriate Intervention Strategies	C1 CELL	C2 CELL	C3 CELL
D	Respectful Curiosity	D1 CELL	D2 CELL	
E	Naiveté	E1 CELL	E2 CELL	
F	Multicultural Counseling Relationship	F1 CELL	F2 CELL	F3 CELL

EXAMPLES

Example One: Item: "My therapist is open to my/my family's expertise on my/our life." This statement reflects Category E (Naiveté), and Cell E1 (Naiveté: ATTITUDES AND BELIEFS) because within the category (Naiveté) this statement reflects an attitude.

Example Two: Item: "My therapist shares her/his values when they are relevant to therapy." This statement reflects Category A (Counselor Awareness of Own Cultural Values and Biases), and Cell A2 (Counselor Awareness of Own Cultural Values and Biases: SKILLS) because within the category (Counselor Awareness of Own Cultural Values and Biases) this statement reflects a skill or behavior.

Example Three: Item: "My therapist knows basic principles that are helpful in my life/family relationships." This statement reflects Category F (Multicultural Counseling Relationship), and Cell F3 (Multicultural Counseling Relationship: KNOWLEDGE), because within the category (Multicultural Counseling Relationship) this statement reflects knowledge.

Directions: Please mark next to each Item (below) the Category level (e.g., A, B,C, D, E, F) and the Cell level (e.g., A1, A2, A3, B1, B2....F3) that the Item reflects.

Items	Category (e.g., A)	Cell (e.g., A,1)
1. My therapist is aware of how his/her beliefs and values can affect therapy.		
2. My therapist values different backgrounds/cultures, including their own.		
3. My therapist uses relationship-building skills, such as listening and attending with me/my family.		
4. My therapist asks me/my family to tell him/her about my/our expectations for care.		
5. My therapist has an accepting attitude towards me and/or my family.		
6. My therapist applies his/her own values as well as my/my family's values in therapy.		
7. My therapist knows about how discrimination and oppression can affect relationships.		
8. My therapist values both his/her own perspective as well as my/my family's perspective.		
9. My therapist knows about the customs of his/her culture, accepted behaviors, and general values.		
10. My therapist is respectful of different values and beliefs.		
11. My therapist is able to see things from my point of view without judgment.		
12. My therapist appears accepting of different ways feelings are expressed.		
13. My therapist has an open mind to our differences.		
14. My therapist makes it clear through communication that they want to understand my/my family's perspective.		
15. My therapist acknowledges the perspective of each person in therapy.		
16. My therapist cares about building a relationship with me and my family.		
17. My therapist appears to be knowledgeable about several different ways of helping me/my family.		
18. My therapist is familiar with the difficulties that may be commonly faced by persons from my culture.		

19. My therapist cares about helping me/my family in appropriate ways.		
20. My therapist has a respectful attitude towards my/my family's personal values and beliefs.		
21. My therapist appears to have some knowledge about my culture and background.		
22. My therapist is curious about my background and experiences.		
23. My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, etc.).		
24. My therapist is open (through body language and communication) to the differences between us.		
25. My therapist is familiar with how culture, religion, and gender can shape individuals.		
26. My therapist appears to understand that therapy needs to fit the individual/family (i.e.: race, class, gender, culture, sexual orientation, etc.).		
27. My therapist asks for information about my/my family's perspective.		
28. My therapist knows basic principles that are helpful in my life/family relationships.		
29. My therapist desires to know me as an individual with individual experiences.		
30. My therapist is open to incorporating my/my family's traditional sources of healing into therapy.		
31. My therapist provides the opportunity to discuss values related to family, religion, etc. when they are relevant to therapy.		
32. My therapist displays a genuine interest to learn about me/my family.		
33. My therapist takes a curious approach towards learning about me/my family.		
34. My therapist is open to my/my family's expertise on my/our life.		
35. My therapist is supportive of my values.		

36. My therapist is open to my/my family's uniqueness.		
37. My therapist is able to explain things in a way that demonstrates familiarity with my ethnicity/culture.		
38. My therapist refers to me/my family as local experts instead of working off of his/her stereotypes.		
39. My therapist is knowledgeable about how my background may affect my availability of resources.		
40. My therapist is respectful of my/my family's ideas and behaviors in therapy.		
41. My therapist has a positive and warm attitude towards me/us.		
42. My therapist shares her/his values when they are relevant to therapy.		
43. My therapist appears to be aware of his/her cultural heritage and respects differences.		
44. My therapist is able to establish a comfortable environment in therapy.		
45. My therapist connects well with me/my family.		
46. My therapist knows about normal social behaviors in my culture (e.g., eye contact, touch, greetings).		
47. My therapist is familiar with the kinds of problems that people seek help for.		
48. My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family.		

RATING DIRECTIONS

Please mark next to each Item (below) the Category level (e.g., A, B, C, D, E, F) and the Cell level (e.g., A1, A2, A3, B1, B2....F3) that the Item reflects.

DEFINITIONS

CATEGORY

A=Counselor Awareness of Own Cultural Values and Biases

(definition: therapist aware of his/her worldview, background/culture/heritage, customs, assumptions, perspectives, values, biases, and limitations)

Reflected in attitudes/beliefs, skills, and knowledge.

B=Counselor Awareness of Client's Worldview

(definition: desire to understand/accept without judgment/acknowledge specific clients' cultures, worldviews, perspectives, experiences, common cultural difficulties, beliefs/values)

Reflected in attitudes/beliefs, skills, and knowledge.

C=Culturally Appropriate Intervention Strategies

(definition: appropriate and sensitive intervention strategies in therapy with culturally diverse clients; includes traditional healing methods, awareness of client resources, different and appropriate methods of helping, accounting for context, acceptance of different feeling expressions and behaviors in therapy)

Reflected in attitudes/beliefs, skills, and knowledge.

D=Respectful Curiosity

(definition: composed of the love of surprise and the desire to look beyond assumptions; curiosity stimulates the act of knowing and supplies the energy for discovery in multicultural therapy, asks for expectations, curious about background, curious/interested in uniqueness)

Reflected in attitudes/beliefs and skills.

E=Naiveté

(definition: a state of openness and receptivity; viewing clients as experts on themselves; open to learning from clients, open to differences/ diverse perspectives/ uniqueness)

Reflected in attitudes/beliefs and skills.

F=Counseling Relationship

(definition: generic core relationship building skills, helpful attitudes and knowledge related to the working alliance, helping people)

Reflected in attitudes/beliefs, skills, and knowledge.

ROW

1=Attitudes and Beliefs

(definition: attitudes and beliefs about ethnic minorities, including biases or stereotypes; e.g.: values, attitude, accepts, cares, desires, respects)

2=Skills

(definition: therapy skills needed for working with ethnic minority groups; e.g.: uses, asks, shows, acknowledges, suggests, communicates, provides, displays, refers to, shares, creates)

3=Knowledge

(definition: knowledge regarding cultural groups one works with; e.g.: aware of, knows about, knowledge of, familiar with, understands)

CELL: Note both the Category and Row for the Cell rating (see chart below, e.g., A3)

	ROW	1	2	3
CATEGORY		Attitudes and Beliefs	Skills	Knowledge
A	Counselor Awareness of Own Cultural Values and Biases	A1 CELL	A2 CELL	A3 CELL
B	Counselor Awareness of Client's Worldview	B1 CELL	B2 CELL	B3 CELL
C	Culturally Appropriate Intervention Strategies	C1 CELL	C2 CELL	C3 CELL
D	Respectful Curiosity	D1 CELL	D2 CELL	
E	Naiveté	E1 CELL	E2 CELL	
F	Multicultural Counseling Relationship	F1 CELL	F2 CELL	F3 CELL

EXAMPLES

Example One: Item: “My therapist is open to my/my family’s expertise on my/our life.” This statement reflects Category E (Naiveté), and Cell E1 (Naiveté: ATTITUDES AND BELIEFS) because within the category (Naiveté) this statement reflects an attitude.

Example Two: Item: “My therapist shares her/his values when they are relevant to therapy.” This statement reflects Category A (Counselor Awareness of Own Cultural Values and Biases), and Cell A2 (Counselor Awareness of Own Cultural Values and Biases: SKILLS) because within the category (Counselor Awareness of Own Cultural Values and Biases) this statement reflects a skill or behavior.

Example Three: Item: “My therapist knows basic principles that are helpful in my life/family relationships.” This statement reflects Category F (Multicultural Counseling Relationship), and Cell F3 (Multicultural Counseling Relationship: KNOWLEDGE), because within the category (Multicultural Counseling Relationship) this statement reflects knowledge.

Directions: Please mark next to each Item (below) the Category level (e.g., A, B,C, D, E, F) and the Cell level (e.g., A1, A2, A3, B1, B2...F3) that the Item reflects.

Items	Category (e.g., A)	Cell (e.g., A,1)
1. My therapist has a respectful attitude towards my/my family’s personal values and beliefs.		
2. My therapist values his/her own background/culture.		
3. My therapist uses relationship-building skills, such as listening and attending.		
4. My therapist tries to understand my/my family’s values and beliefs.		
5. My therapist has an accepting attitude.		
6. My therapist appropriately applies his/her own values in therapy.		
7. My therapist has a positive and warm attitude.		
8. My therapist values his/her own perspective as well as accepting my/my family’s perspective.		
9. My therapist knows about the customs of his/her culture, accepted behaviors, and general values.		
10. My therapist accepts my/my family’s values and beliefs.		
11. My therapist provides the opportunity to incorporate my/my family’s traditional sources of healing into therapy.		

12. My therapist appears accepting of different ways I/my family express(es) feelings.		
13. My therapist has an open mind to our differences.		
14. My therapist asks me/my family to tell him/her about my/our expectations for care.		
15. My therapist acknowledges my/my family's point of view.		
16. My therapist cares about building relationships with people.		
17. My therapist appears to be knowledgeable about several different ways of helping me/my family.		
18. My therapist is familiar with the difficulties that may be commonly faced by persons from my/my family's culture.		
19. My therapist cares about helping me/my family in appropriate ways.		
20. My therapist is aware of how his/her beliefs and values can affect therapy.		
21. My therapist appears to have some knowledge about my/my family's culture and background.		
22. My therapist is curious about my background and experiences.		
23. My therapist displays openness towards me/my family as expert(s) on my/our life.		
24. My therapist is able to explain things in a way that demonstrates familiarity with my/my family's ethnicity/culture.		
25. My therapist shares her/his beliefs when they are relevant to therapy.		
26. My therapist appears to understand that therapy needs to fit me/my family (i.e.: race, class, gender, culture, sexual orientation, etc.).		
27. My therapist shows openness to my/my family's perspective.		

28. My therapist is familiar with the kinds of problems that people seek help for.		
29. My therapist desires to know me as an individual with unique experiences.		
30. My therapist is able to see things from my perspective without judgment.		
31. My therapist provides the opportunity to discuss his/her values related to family, culture, religion, etc. when they are relevant to therapy.		
32. My therapist displays a genuine interest to learn about me/my family.		
33. My therapist takes a curious approach towards learning about me/my family.		
34. My therapist is open to my/my family's expertise on my/our life.		
35. My therapist acknowledges my/my family's values and beliefs.		
36. My therapist is open to my/my family's uniqueness.		
37. My therapist is open (through body language and communication) to the differences between us.		
38. My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, etc.).		
39. My therapist is knowledgeable about how my/my family's background may affect my/our availability of resources.		
40. My therapist respects my/my family's ideas and behaviors in therapy.		
41. My therapist knows about how his/her biases can affect me/my family.		
42. My therapist is familiar with how culture, religion, and gender can shape me/my family.		
43. My therapist respects his/her cultural heritage as well as valuing differences.		
44. My therapist creates a comfortable environment in therapy.		

45. My therapist connects well with people.		
46. My therapist knows about normal social behaviors in cultures (e.g., eye contact, touch, greetings).		
47. My therapist knows basic principles that are helpful in relationships.		
48. My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family.		

MULTICULTURAL THERAPY COMPETENCY INVENTORY

ID #

Please check the box under the description that most accurately describes your perception of a therapist you have met with. Please note that the statements are written as if they are occurring now, but you may also fill this out for a therapist you are no longer seeing.

		Does this very well	Does this adequately	Does this poorly
1	My therapist has a respectful attitude towards my/my family's personal values and beliefs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	My therapist values his/her own background/culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	My therapist uses relationship-building skills, such as listening and attending.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	My therapist tries to understand my/my family's values and beliefs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	My therapist has an accepting attitude.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	My therapist appropriately applies his/her own values in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	My therapist has a positive and warm attitude.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	My therapist values his/her own perspective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	My therapist knows about the customs of his/her culture, accepted behaviors, and general values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	My therapist accepts my/my family's values and beliefs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	My therapist provides the opportunity to incorporate my/my family's traditional sources of healing into therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	My therapist accepts different ways I/my family express(es) feelings in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	My therapist has an open mind to our differences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	My therapist asks me/my family to tell him/her about my/our unique expectations for care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	My therapist acknowledges my/my family's point of view.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	My therapist cares about building relationships with people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	My therapist knows about several different ways of helping people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	My therapist is familiar with the difficulties that may be commonly faced by persons from my/my family's culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	My therapist cares about helping me/my family in appropriate ways.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20	My therapist is aware of how his/her beliefs and values can affect therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	My therapist appears to have some knowledge about my/my family's culture and background.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	My therapist is curious about my background and experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	My therapist displays openness towards me/my family as expert(s) on my/our life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24	My therapist is able to explain things in a way that demonstrates familiarity with my/my family's ethnicity/culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	My therapist shares her/his beliefs when they are relevant to therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	My therapist appears to understand that therapy needs to fit me/my family (i.e.: race, class, gender, culture, sexual orientation, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	My therapist shows openness to my/my family's perspective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	My therapist is familiar with the kinds of problems that people seek help for.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	My therapist desires to know me as an individual with unique experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	My therapist is able to see things from my perspective without judgment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31	My therapist provides the opportunity to discuss his/her values related to family, culture, religion, etc. when they are relevant to therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	My therapist displays a genuine interest to learn about me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33	My therapist takes a curious approach towards learning about me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34	My therapist is open to my/my family's expertise on my/our life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35	My therapist acknowledges my/my family's values and beliefs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36	My therapist is open to my/my family's uniqueness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37	My therapist is open (through body language and communication) to the differences between us.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38	My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39	My therapist is knowledgeable about how my/my family's background may affect my/our availability of resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40	My therapist values my/my family's ideas and behaviors in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41	My therapist knows about how his/her biases can affect me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42	My therapist is familiar with how culture, religion, and gender can shape me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43	My therapist respects his/her cultural heritage as well as valuing differences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44	My therapist creates a comfortable environment in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45	My therapist connects well with people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46	My therapist knows about normal social behaviors in my/my family's culture (e.g., eye contact, touch, greetings).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47	My therapist knows basic principles that are helpful in relationships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48	My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who Are You?

ID #

The following questions are about you. Please indicate your answer. Try to answer the questions as honestly as you can.

A couple questions ask about your satisfaction with counseling; please fill this out on one therapist, either a therapist you are currently seeing or a therapist you saw in the past.

- 1 What is your age?

- 2 Are you:
 Male
 Female
- 3 What is your racial background?
 African-American
 Native American or Alaskan Native
 White or Caucasian
 Hispanic or Latino
 Other (specify)

- 4 *What is the primary language you speak?*
 English
 Spanish
 Other (specify)

- 5 Are you fluent in the same language that your therapist speaks (the therapist you are filling out this survey on)?
 Yes
 No
- 6 How long have you lived in the United States (please record in years and months)? _____
- 7 What is your current relationship status?
 Single
 Dating or Partnered
 Living with Partner
 Married
 Separated
 Divorced
 Other (specify)

- 8 Please indicate the number of counseling
- 10 Please indicate your level of satisfaction with the counseling you received up to this point (only from the therapist you are filling out this survey on). Only mark one answer below.
 I am **very satisfied** with the counseling I received.
 I am **somewhat satisfied** with the counseling I received.
 I feel **neutral** about the counseling I received.
 I am **somewhat unsatisfied** with the counseling I received.
 I am **very unsatisfied** with the counseling I received.
- 11 Please indicate **what contributed** to your satisfaction or lack of satisfaction with the counseling you received (as you indicated in question 10).

- 12 Please indicate the outcome of the counseling you received up to this point (only from the therapist you are filling out this survey on). Only mark one answer below.
 I attained **most** of the goals for which I entered therapy.
 I attained **some** of the goals for which I entered therapy
 I **did not attain** the goals for which I entered therapy.
- 13 Please indicate **what contributed** to the attainment or lack of attainment of your goals (as you indicated in question 12).

- 14 What is your annual household income (before taxes)?
 Under \$5,000
 Between \$5,001 and \$15,000
 Between \$15,001 and \$25,000

sessions you received (only from the therapist you are filling out this survey on). _____ Sessions

9 What is the highest level of education that you completed?

- Less than high school
- High school diploma or GED
- College degree or Technical school degree
- Masters degree
- Doctorate/Medical Degree

- Between \$25,001 and \$35,000
- Between \$35,001 and \$50,000
- Between \$50,001 and \$80,000
- Between \$80,001 and \$110,000
- Over \$110, 001

Appendix I. MTCI Survey and Demographic Form, Phase 3 Validation Phase

MULTICULTURAL THERAPY COMPETENCY INVENTORY

ID #

Please check the box under the description that most accurately describes your perception of a therapist you have met with. Please note that the statements are written as if they are occurring now, but you may also fill this out for a therapist you are no longer seeing.

		Does this very well	Does this adequately	Does this poorly
1	My therapist uses relationship-building skills, such as listening and attending.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	My therapist appropriately applies his/her own values in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	My therapist has a positive and warm attitude.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	My therapist values his/her own perspective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	My therapist knows about the customs of his/her culture, accepted behaviors, and general values.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	My therapist accepts my/my family's values and beliefs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	My therapist asks me/my family to tell him/her about my/our unique expectations for care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	My therapist encourages me/my family to share my/our point of view.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	My therapist cares about building relationships with people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	My therapist knows about several different ways of helping people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	My therapist cares about helping me/my family in appropriate ways.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	My therapist appears to have some knowledge about my/my family's culture and background.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	My therapist is able to explain things in a way that demonstrates familiarity with my/my family's ethnicity/culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	My therapist appears to understand that therapy needs to fit me/my family (i.e.: race, class, gender, culture, sexual orientation, religion, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	My therapist shows openness to my/my family's perspective.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	My therapist desires to know me as an individual with unique experiences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	My therapist is able to see things from my perspective without judgment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18	My therapist provides the opportunity to discuss his/her values related to family, culture, religion, etc. when they are relevant to therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	My therapist displays a genuine interest to learn about me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	My therapist is open to my/my family's expertise on my/our life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	My therapist acknowledges my/my family's values and beliefs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	My therapist is open to my/my family's uniqueness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	My therapist is open (through body language and communication) to the differences between us.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Does this very well	Does this adequately	Does this poorly
24	My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, religion, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25	My therapist is knowledgeable about how my/my family's background may affect my/our availability of resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26	My therapist values my/my family's ideas, behaviors, and feelings in therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27	My therapist knows about how his/her biases can affect me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28	My therapist is familiar with how culture, religion, and gender can shape me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29	My therapist respects his/her cultural heritage as well as valuing differences.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30	My therapist connects well with people in socially appropriate ways (e.g., eye contact, touch, greetings).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31	My therapist knows basic principles that are helpful in relationships.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32	My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Who Are You?

ID #

The following questions are about you. Please indicate your answer. Try to answer the questions as honestly as you can.

A couple questions ask about your satisfaction with counseling; please fill this out on one therapist, either a therapist you are currently seeing or a therapist you saw in the past.

- 1 What is your age?

- 2 Are you:
 - Male
 - Female
- 3 What is your racial background?
 - African-American
 - Native American or Alaskan Native
 - White or Caucasian
 - Hispanic or Latino
 - Other (specify)

- 4 *What is the primary language you speak?*
 - English
 - Spanish
 - Other (specify)

- 5 Are you fluent in the same language that your therapist speaks (the therapist you are filling out this survey on)?
 - Yes
 - No
- 6 How long have you lived in the United States (please record in years and months)? _____
- 7 What is your current relationship status?
 - Single
 - Dating or Partnered
 - Living with Partner
 - Married
 - Separated
 - Divorced
 - Other (specify)

- 8 Please indicate the number of counseling
- 10 Please indicate your level of satisfaction with the counseling you received up to this point (only from the therapist you are filling out this survey on). Only mark one answer below.
 - I am **very satisfied** with the counseling I received.
 - I am **somewhat satisfied** with the counseling I received.
 - I feel **neutral** about the counseling I received.
 - I am **somewhat unsatisfied** with the counseling I received.
 - I am **very unsatisfied** with the counseling I received.
- 11 Please indicate **what contributed** to your satisfaction or lack of satisfaction with the counseling you received (as you indicated in question 10).

- 12 Please indicate the outcome of the counseling you received up to this point (only from the therapist you are filling out this survey on). Only mark one answer below.
 - I attained **most** of the goals for which I entered therapy.
 - I attained **some** of the goals for which I entered therapy
 - I **did not attain** the goals for which I entered therapy.
- 13 Please indicate **what contributed** to the attainment or lack of attainment of your goals (as you indicated in question 12).

- 14 What is your annual household income (before taxes)?
 - Under \$5,000
 - Between \$5,001 and \$15,000
 - Between \$15,001 and \$25,000

sessions you received (only from the therapist you are filling out this survey on). _____ Sessions

9 What is the highest level of education that you completed?

- Less than high school
- High school diploma or GED
- College degree or Technical school degree
- Masters degree
- Doctorate/Medical Degree

- Between \$25,001 and \$35,000
- Between \$35,001 and \$50,000
- Between \$50,001 and \$80,000
- Between \$80,001 and \$110,000
- Over \$110, 001

Appendix J. Cover Letters for Mailings

Department of Family Medicine
Marriage & Family Therapy Section
983075 Nebraska Medical Center
Omaha, NE 68198-3075
Phone: (402) 559-8072
mtci@vt.edu

Date
Name

A few days from now you will receive in the mail a request to fill out a brief questionnaire for a research project being conducted in collaboration between the University of Nebraska Medical Center and Virginia Tech.

It concerns the experience of people who have seen a mental health counselor or therapist, and their opinion regarding their counselor's cultural competence (competence in working with people different from themselves). It is my understanding that you previously received counseling services from the University of Nebraska Medical Center (UNMC). Because there are cultural differences between all people, groups, and families, it is not necessary that you be from a specific ethnic background to participate in this study.

I am writing in advance because we have found that many people like to know ahead of time that they will be contacted. This study may be used to help design programs that can enhance the clinical services that clients receive. As a result, you might feel a sense of personal satisfaction from knowing that you are helping others.

A small token of appreciation will be included with the questionnaire as a way of saying thanks for your help.

Thank you for your time and consideration. We appreciate your participation.

Sincerely,
Elise Cole, M.A.

Multicultural Therapy Competency Inventory-Client Version, IRB#422-07-EP
Principal Investigator: Elise Cole, M.A. MFT
Secondary Investigators: Fred Piercy, Ph.D., Ed Wolfe, Ph.D., Megan Dolbin-MacNab, Ph.D.,
Layne Prest, Ph.D.

Department of Family Medicine
Marriage & Family Therapy Section
983075 Nebraska Medical Center
Omaha, NE 68198-3075
Phone: (402) 559-8072
mtci@vt.edu

Date
Name

I am writing to ask your help in a study of people who have seen a mental health counselor or therapist, and their perceptions regarding their counselors' cultural competence (competence in working with people different from themselves). Because there are cultural differences between all people, groups, and families, it is not necessary that you be from a specific ethnic background to participate in this study.

It is my understanding that you previously received counseling services from the University of Nebraska Medical Center (UNMC). We are contacting clients from UNMC to ask for your opinion of your previous or current counselor's cultural competence. The main purpose of this study is to develop an instrument to assess clients' opinions of their therapists' cultural competence that can be used in both individual and family therapy. Results from this study may be used to help design programs that can enhance the clinical services that clients receive. As a result, you might feel a sense of personal satisfaction from knowing that you are helping others.

A comment on our survey procedures. A questionnaire identification number is printed on the questionnaire so we can check your name off the mailing list when it is returned. Only the primary and secondary researchers have access to this list of names. It will be destroyed at the end of this study so that names cannot be connected to the results in any way.

We have enclosed a small token of appreciation as a way of saying thanks for your help. This survey is voluntary. However, you can help us very much by taking a few minutes to share your perceptions of your counselor. If for some reason you prefer not to respond, please let us know by returning the blank questionnaire in the enclosed stamped envelope. If you have any questions or comments about this study, we would be happy to talk with you. Our number is 402-559-8072, or you can e-mail us at: mtci@vt.edu

If you choose to participate please return the following in the enclosed envelope: the completed survey packet and the last page of the consent form signed. **All forms that need to be returned have an X in the upper right hand corner.** Thank you very much for helping with this study.

Sincerely,

Elise Cole, MA
Multicultural Therapy Competency Inventory-Client Version, IRB#422-07-EP
Principal Investigator: Elise Cole, M.A. MFT
Secondary Investigators: Fred Piercy, Ph.D., Ed Wolfe, Ph.D., Megan Dolbin-MacNab, Ph.D.,
Layne Prest, Ph.D.

Department of Family Medicine
Marriage & Family Therapy Section
983075 Nebraska Medical Center
Omaha, NE 68198-3075
Phone: (402) 559-8072
mtci@vt.edu

Date
Name

Last week a questionnaire was mailed to you seeking your perceptions regarding your counselor's cultural competence. Your name was drawn from a list of persons who received counseling services from the University of Nebraska Medical Center (UNMC).

Because there are cultural differences between all people, groups, and families, it is not necessary that you be from a specific ethnic background to participate in this study.

If you have already completed and returned the questionnaire to us, please accept our sincere thanks. If not, please do so today. We are especially grateful for your help because it is only by asking people like you to share your experiences that we can understand what improvements need to be made in clinical services concerning cultural competence and appropriateness.

If you did not receive a questionnaire, or if it was misplaced, please call us at 402-559-8072, or email mtci@vt.edu, and we will get another one in the mail to you today.

Sincerely,
Elise Cole

Multicultural Therapy Competency Inventory-Client Version, IRB#422-07-EP
Principal Investigator: Elise Cole, M.A. MFT
Secondary Investigators: Fred Piercy, Ph.D., Ed Wolfe, Ph.D., Megan Dolbin-MacNab, Ph.D.,
Layne Prest, Ph.D.

Department of Family Medicine
Marriage & Family Therapy Section
983075 Nebraska Medical Center
Omaha, NE 68198-3075
Phone: (402) 559-8072
mtci@vt.edu

Date
Name

About two weeks ago I sent a questionnaire to you that asked about your perceptions of your counselor's cultural competence (competence in working with people different from themselves). To the best of our knowledge, it has not yet been returned.

We are writing again because of the importance that your questionnaire has for helping to get accurate results. It is only by hearing from nearly everyone in the sample that we can be sure the results are truly representative. Because there are cultural differences between all people, groups, and families, it is not necessary that you be from a specific ethnic background to participate in this study. The comments of people who have responded include various perceptions of their counselors' cultural competence. We think these results will be very useful in understanding what improvements need to be made in clinical services concerning cultural competence and appropriateness.

A comment on our survey procedures. A questionnaire identification number is printed on the questionnaire so we can check your name off the mailing list when it is returned. Only the principal and secondary researchers have access to this list of names. It will be destroyed at the end of this study so that names cannot be connected to the results in any way.

Thank you very much for helping with this study. If you choose to participate please return the following in the enclosed envelope: the completed survey packet and the last page of the consent form signed. **All forms that need to be returned have an X in the upper right hand corner.** We hope that you will fill out and return the questionnaire soon, but if for any reason you prefer not to answer it, please let us know by returning a note or blank questionnaire in the enclosed stamped envelope.

Sincerely,

Elise Cole, MA

P. S. If you have any questions, please feel free to contact me. The number where I can be reached is 402-559-8072, or you can e-mail me at mtci@vt.edu

Multicultural Therapy Competency Inventory-Client Version, IRB#422-07-EP
Principal Investigator: Elise Cole, M.A. MFT
Secondary Investigators: Fred Piercy, Ph.D., Ed Wolfe, Ph.D., Megan Dolbin-MacNab, Ph.D., Layne Prest, Ph.D.

Appendix K. Category Responses for Multicultural Counseling Relationship, Knowledge

- A. 106. Understanding of psychology
- A. 107. understanding people
- A. 109. understand how different cultures express emotion
- A. 119. understanding what is normal behavior/practice in different cultures
- A. 122. Understanding relational emphasis, for example on respect
- A. 122. Understanding the meaning different cultures attribute to body language, such as eye contact
- A. 124. Highly educated
- A. 124. competent in new theories on family therapy
- A. 125. positive attitude, calm, reassuring
- A. 131. understanding the effects of discrimination
- A. 137. having technical or practical counseling knowledge
- A. 144. Familiar with cultural differences in the family system, related to closeness
- A. 150. understand cultural concepts and general cultural knowledge
- A. 151. Standard knowledge
- A. 153. Knowledge specific to field
- A. 177. Knowledge of cultures and sub-cultures, training in field
- A. 186. Understand human biology
- AI 3. knowledgeable about the kinds of problems that I'd be seeking help for
- AI 15. familiar with my personal values on key issues that might relate to why we're in counseling
- AI 17. knowledge of self systemic perspective committed to on-going learning ability to meet client where they are at intelligence/adequate training
- AI 23. knowledge about therapy
- AI 24. in systems theory so that they would already have an understanding of multiple systems that could possibly affect the relationship
- AI 33. degree in that field. Experience working with people like me.
- AI 37. knows of basic principles that could be helpful in my family relationships.
- C 101. Familiar with helpful techniques?