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THE ROLE OF EXPERIENTIAL LEARNING IN DEVELOPING MULTICULTURAL
COMPETENCE

By

KAORU ALLISON POWELL

Dissertation

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for the degree of

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in Clinical Psychology

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Abstract

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Although much importance has been placed on training programs to develop multiculturally competent service providers, the question remains as to when and where clinicians acquire their multicultural competence (MCC). Currently, most training programs appear to focus on the development of multicultural awareness and knowledge, without adequate focus on skills. However, experientially based learning exercises are associated with skills development in many areas, including general clinical skills development. Thus, students who engage in higher levels of experiential learning in their multicultural training may rate themselves as more competent with multicultural skills than students with less frequent experiential learning. I hypothesize that experiential learning will moderate the strength of the association between multicultural training and multicultural skills competence. The present study examines the training experiences of clinical and counseling psychology doctoral students ($N = 83$), using students' self-reports of multicultural training, experiential training exercises, as well as their ratings of perceived multicultural competence using the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS-CE-R). While the proposed model was not significant ($\Delta R^2 = .025$, $\Delta F(1, 76) = 2.098$, $p = .152$), experiential exercises did have a significant moderating effect on the relationship between students' multicultural training and their estimated acquisition of multicultural skills competence ($\Delta R^2 = .219$, $\Delta F(1, 76) = 12.089$, $p = .001$). Although more research is needed to better understand the role of experiential learning, these results bring into question the reliability of self-report in capturing multiculturally competent skills. Implications for training and practice are discussed.

The Role of Experiential Learning in Developing Multicultural Competence

Introduction

The population of the United States is increasingly characterized by ethnically diverse individuals, with projections that the country will become a minority-majority country within the next three decades (U.S. Census Bureau, 2015). Nonetheless, there is evidence of longstanding disparities in the health services provided to and utilized by racial and ethnic minorities (Ben, Cormack, Harris, & Paradies, 2017; Census Bureau, 2015; Kessler et al., 2005; Todd, Samaroo, & Hoffman, 1993); likewise, the field of mental health is no exception to these findings (APA, 2017). To continue providing relevant and ethically sound treatment, it is necessary for the mental health community to develop a workforce of service providers who are competent in delivering effective and appropriate services to an ethnically diverse clientele. However, guidance on multicultural competence (MCC) remains largely fragmented, and it has been frequently criticized as being difficult to operationalize for both training and evaluation purposes (e.g., Chu, Leino, Pflum, & Sue, 2016; Smith & Trimble, 2016; Worthington, Soth-McNett, & Moreno, 2007).

Nonetheless, MCC has been considered a primary tenant in ethical therapeutic practice for nearly four decades (APA, 1981). Indeed, multiculturalism has been described as the “fourth force” in psychology, and has been conceptualized as a complementary dimension to contemporary psychological perspectives (e.g., humanistic, psychodynamic, etc.; Pedersen, 1991). Although much importance has been placed on training programs to develop multiculturally competent service providers, the question remains as to when and where clinicians acquire their MCC (Holcomb-McCoy & Myers, 1999). While most graduate training programs in psychology require that their students complete a multicultural training course, most

programs do not require its completion prior to students' first practicum experiences (Smith & Trimble, 2016). Moreover, these trainings often offer guidance around a limited selection of diverse identities (Reynolds, 2011). This might suggest that students are obtaining instruction relevant to working with diverse clients through other means.

Clinical supervision is a core component of clinical training and may be many students' first and most formative experience related to the development of their clinical skills. Research suggests that culturally competent supervision is one way to increase the quality of the therapy that students provide to diverse clients (Falendar, Burnes, & Ellis, 2013). A recent meta-analysis of studies examining the effectiveness of multicultural education programs reported that students benefit from balanced development in knowledge, skills, and awareness (Smith, 2016); however, many programs focus on awareness and knowledge, without adequate focus on students' skills development (Reynolds, 2011). Notably, research in this area has focused almost exclusively on multicultural course content (Rogers-Sirin, 2008), and there is little information available about other sources of training that might function as an important avenue of skill development (Smith, 2016).

Experiential exercises are associated with acquiring and improving a variety of clinical skills (Falendar & Shafranske, 2004; Fleming, Oliver, & Bolton, 1996; Friedberg, Gorman, & Beidel, 2009; Morris & Bilich-Eric, 2017; Priester et al., 2008), but are frequently absent from multicultural course curricula (Reynolds, 2011). Supervision is a unique training experience wherein students have the opportunity to engage in practical application in parallel with their development of skills and knowledge (Morris & Bilich-Eric, 2017). Further, due to the individualized sessions between supervisor and student, supervision provides an ideal setting for engaging in skills-focused experiential exercises. Thus, exploring the role of experiential

learning and the status of supervision as a specific training setting is a promising avenue for research into MCC skills development. To achieve this, the current research will provide a review of ethnic minority health disparities, MCC skills development, and supervision practices, and then propose a study that examines the impact of experiential learning on perceptions of students' MCC and explores the current status of supervision as a training setting for experiential learning.

Literature Review

Healthcare Disparities for Diverse Populations

Current characterizations of the diversity of the people of the United States of America typically highlight statistics about the continually growing numbers of non-White racial and ethnic minority groups. For example, for several decades the population of the United States of America has continued to become increasingly more multiethnic, multilingual, and multicultural (Livingston, 2015; U.S. Census Bureau, 2017). Many historically minority ethnic groups are rapidly growing in number, superseding the relatively slow population growth of White Americans (U.S. Census Bureau, 2015). In fact, it is predicted that by 2044, non-Hispanic White Americans will no longer make up the ethnic majority in the United States (U.S. Census, 2015). Despite the American population becoming less predominantly White, the characteristics of individuals who access healthcare services continues to represent a demographically skewed landscape that is dominated by White Americans (Demyttenaere et al., 2004; Hunt, Eisenberg, Lu, & Gathright, 2015; Kessler et al., 2005).

This population trend, as well as the importance for healthcare providers to evaluate the appropriateness of their services for racial and ethnic minority clients, has been documented in psychological literature for several decades; however, movement within the field to address these

concerns came slowly. As the population of the United States continues to diversify, the issue of multicultural competence, or the ability to work ethically and efficiently with clients of diverse racial and ethnic backgrounds, is a necessary focus of modern psychology.

In its report titled *Unequal Treatment*, the Institute of Medicine (IOM) defined disparities in healthcare as “a difference in health care quality not due to differences in health care needs or preferences of the patient” (Smedley, Stith, & Nelson, 2003). Additionally, a significant body of research over the past several decades has documented substantial evidence of disparities in mental health care (see, for example, Kessler et al., 2005). Individuals from racial and ethnic minorities are less likely to seek mental health services, are less likely to receive evidence-based treatments, and may be less likely to receive preventative clinical resources when compared to White clients (Hunt et al., 2015; Kessler et al., 2005; Tervalon & Murray-Garcia, 1998; Todd et al., 1993; U.S. Department of Health and Human Services, 2001; Wang, Berglund, & Kessler, 2000). Clear mental healthcare disparities exist for racial and ethnic minority individuals in both access to and the utilization of mental health services. Although this trend has been documented, efforts towards eliminating these disparities have been generally unsuccessful and racial and ethnic minorities continue to experience significant disparities in healthcare (Hunt et al., 2015; Kessler et al., 2005).

The factors driving these pervasive patterns of disparity in mental health services are multiple and complexly related (Ben et al., 2017). For example, at the individual level, a prospective client may be geographically limited to accessing a single care option, which can intensify provider-level shortcomings such as lack of experience or training related to working with racial and ethnic minorities. In a similar vein, having access to multiple types of insurance coverage has been shown to affect the quality of care that a client receives, and racial and ethnic

minorities are more likely to be uninsured or to be on more limited plans (Baicker & Chandra, 2005; Monheit & Vistnes, 2000; Phillips, Mayer, & Aday, 2000).

Although socioeconomic status and access to financial coverage are important factors driving unequal utilization, these sociodemographic differences do not sufficiently explain disparities in access to treatment and treatment response for minority groups. For example, disparities associated with lack of insurance coverage or limited geographical access to care will affect minority groups, and may do so disproportionately when compared to White Americans, but other non-minority individuals share similar geographically and financially-limited circumstances. Despite this, there continues to be an observable disparity for racial and ethnic minorities (McGuire & Miranda, 2008).

Moreover, these disparities persist when sociodemographic factors are controlled for in study design or through statistical methods (Balsa & McGuire, 2003; McGuire & Miranda, 2008). For example, Hunt and colleagues (2015) found that among college-aged racial and ethnic minority students, many of whom were able to access similar levels of care in both geographic and financial accessibility as their White counterparts, there was a persistent discrepancy in terms of service utilization. The authors suggested that beyond accessibility and geography, other factors must be influencing racial and ethnic minority groups' utilization of mental health services. They specified that factors such as racial and ethnic diversity among providers, cultural mismatch between provider and client, and forms of discrimination may be more influential in determining mental health service utilization than past research has considered (Hunt et al., 2015). Supporting these assertions, Hook and colleagues (2016) found that, in a survey of racial and ethnic minority adults in the United States ($N = 2,212$), the majority of participants (81%) reported that they had experienced at least one racial

microaggression during counseling. Most commonly, participants reported that counselors were unaware of or denied the existence of stereotypes and biases affecting the participant or avoided engaging in discussions about cultural issues (Hook et al., 2016).

In examining forms of discrimination in healthcare services, investigators typically focus on three types: cognitive stereotyping, affective biases, and statistical discrimination (Balsa & McGuire, 2003; McGuire, Ayanian et al., 2008). These types of discrimination can be experienced in many forms. Providers may hold cognitive stereotypes about racial and ethnic minority clients, such as the assumption that minority clients are less likely to comply with treatment plans, which may influence how service providers engage with clients belonging to minority groups. Affective biases include healthcare providers who may be less willing to work with clients who belong to a racial or ethnic minority group, and thus are more likely to spend less clinical effort on treatment with these clients. Statistical discrimination refers to the application of a decision-making rule that leads to the unequal treatment of two groups, which the authors also described as *clinical uncertainty* (Balsa & McGuire, 2001; 2003).

Balsa and McGuire (2003) define clinical uncertainty as the provider's uncertainty towards interpretation of an individual's symptoms because of their racial or ethnic minority status. For example, when providing clinical care, a provider must evaluate the likelihood that a client has a condition. The provider enters the clinical interaction with a predetermined perspective on the likelihood of an existing condition that they then update through the clinical interaction. The hypothesis testing approach may be intuitively appealing, as such an approach appears to be sensitive to adjustments based on salient factors that become apparent through the clinical interaction; however, this process is influenced by assumptions and problems in communication that appear to disproportionately affect racial and ethnic minorities. For

example, a provider may make assumptions about a client's diagnostic status based on group characteristics (e.g., African-Americans may be more likely to develop schizophrenia) that are inappropriate given other symptoms or characteristics of the individual client. This type of discrimination has been observed in studies examining providers' reactions to depression severity in both racial and ethnic minority clients and White clients. Balsa and colleagues (2005) found that providers were less responsive to variations in symptom severity for racial and ethnic minority clients than White clients. Instead, providers tended to rely on epidemiological assumptions about the diagnostic status of a minority client and were less likely to alter these assumptions when presented with indicators from the client that suggested a condition was more or less likely.

McGuire and Miranda (2008) examined whether differences in mental health diagnoses were responsible for the noted disparities in healthcare services accessed by and provided to racial and ethnic minority individuals. The authors found that there was no evidence that disparities in mental health status existed between racial and ethnic minority groups and White individuals. This finding further highlights the alarming disparities in the care provided to racial and ethnic minorities, as beyond their status as a minority individual, there is little evidence that other factors are influencing the unequal treatment they receive. McGuire and Miranda (2008) argued that in order to effectively address the disparity, the field of mental healthcare needs to review system policies affecting access to services, the quality of provided services, implement appropriate screening to improve detection of conditions at varying levels of intensity, and provide specific training related to working with racial and ethnic minorities for providers.

As illustrated in this section, it is clear that the healthcare disparities experienced by racial and ethnic minorities is a multi-faceted issue; however, it also seems clear that at the root

of each of these facets is an individual's status as a racial or ethnic minority. While this could be considered concerning solely due to the immediate lack of services being provided to racial and ethnic minority groups, its ramifications are numerous. These health care disparities have immediate implications for those employed in and training for healthcare roles who may play a role in perpetuating these inequalities. These concerns, recognition of a historically White-exclusive perspective in psychology, and the increasing presence of racial and ethnic minorities in healthcare professions have contributed to the development of MCC as a promising answer to effective, ethical, and equitable care for racial and ethnic minorities. While the specific effects of MCC are still being examined, training in MCC has been associated with increased service utilization and decreased treatment drop-out for racial and ethnic minority clients, making this an incredibly promising avenue for providing equitable care (Lefley & Bestman, 1991).

History of Multiculturalism in Psychology

The relatively recent documentation of existing healthcare disparities for racial and ethnic minority groups highlights an issue in psychology that has been developing for nearly 50 years (Worthington et al., 2007). Advocates for addressing the appropriateness of services provided to racial and ethnic minority clients have pushed the field of psychology to reevaluate its assumptions about effectiveness and fit, given that the mental health field has been rooted in an uncontested Eurocentric perspective (Katz, 1985). This section provides an overview of the development of multiculturalism in psychology and discusses current theoretical models for understanding multicultural competencies.

Throughout the history of psychology, predominantly White, upper middle-class values have directed the development of the field (Katz, 1985; Sue, Arredondo, & McDavis, 1992). The assumed "responsibility" of superior races to guide and govern inferior races spurred

worldwide colonization by European nations, and characterized a broader worldview in which Whites were superior to other races. This worldview persists when examining the directions for theory and research development over the last couple centuries. For example, early research on intelligence sought to identify racial differences in intelligence and frequently described non-White races as possessing “inferior intelligence” when compared to Whites (Pintner, 1934; Porteus, 1937). Researchers attributed these results to the evolutionary inferior development or genetic deficiency of non-White races (Pintner, 1934; Sue et al., 1992).

As research and time progressed, focus was shifted from the idea of innate, biological inferiority of non-White individuals to a model of cultural inferiority—that is, a model of learned disadvantages. Initially, this approach was undertaken to oppose models of genetic or evolutionary deficiency and was considered progressive for its time; notably, the American civil rights movement progressed concurrently (Abreu, Chung, & Atkinson, 2000). Nonetheless, the cultural inferiority model continued to pathologize those who did not share in the culture of the White scientists developing the theories that guided the scientific community and its applications. As Sue and colleagues noted, all humans have culture, but the research during this period developed a lens for culture that placed it upon the “other” (Sue et al., 1992). From this perspective, minority groups have culture which influences their pathology, but the dominant group, whose culture aligns with the White middle-class, does not have a shared culture nor a cultural deficiency that influences pathology. Katz (1985) describes this pervasive cultural dominance as an “invisible veil” that prevents those within the dominant culture from recognizing their own cultural system. Audre Lorde (1980) described a similar concept called the *mythical norm*, which she defined as a list of characteristics that members of a society compile as representative of power. In America, these characteristics are often: “white, thin,

male, young, heterosexual, Christian, and financially secure” (Lorde, 1980, p. 18). When an individual does not possess one of these characteristics, they identify that difference as the source of all oppression, neglecting to recognize the heterogeneity of experience and characteristics of existence affecting oppression (Lorde, 1980). This phenomenon may contribute to the pervasive tendency for healthcare providers to frequently deny that their clients experience negative stereotypes or bias in their lives (Hook et al., 2016).

Since the 1960s, some psychologists have argued that the mental health community needed to reexamine its approach in order to develop a multicultural perspective to guide its research and services as they applied to a diversifying American population. Much of the field’s examination of what constitutes effective and ethical practices for racial and ethnic minority clients was spurred by D. W. Sue and colleagues’ seminal publication “Cross-cultural Counseling Competencies” (Sue et al., 1982). In this publication, Sue and colleagues argued that mental health work with racial and ethnic minorities required a set of professional competencies distinct from general counseling competencies. This argument is supported by past research that demonstrates that traditional counseling techniques are less effective for racial and ethnic minority groups (Casas, Ponterotto, & Gutierrez, 1986).

Despite advancements in human rights and connected decreases in racially discriminatory psychological research and theory, vestiges of White/Western-centric perspectives can still be found in modern psychology. For example, most psychology graduate programs require completion of a course that focuses on gaining information about the group characteristics of visible ethnic or racial minority cultures but lacks a similar approach to examining White American culture (Reynolds, 2011). Further, despite the increasingly substantial ethnic and racial minority population of the United States, most psychological

treatment studies underrepresent these groups and overrepresent White Americans in their samples (Alvidrez, Azocar, & Miranda, 1996; Chen, Kramer, Chen, & Chung, 2005). The lack of representative sampling in this area likely impedes clinicians' abilities to conduct evidence-based care for racial and ethnic minority clients, who are already less likely to receive an evidence-based treatment when engaging in mental health services (U.S. Department of Health and Human Services, 2001; Whaley & Davis, 2007).

Despite this, many areas of multicultural training and competence have received little attention in research. This lack of focus may be due to substantial variations in perspectives on the importance or utility of multicultural competencies among healthcare providers. For some, multiculturalism is considered a niche interest that is unnecessary for general clinical practice (Abreu et al., 2000). This may be due to a belief that general clinical skills and knowledge encompass multicultural client/provider interactions, in such a way that specialized skills or knowledge are unnecessary to effectively provide care (Cates, Schaeffle, Smaby, Maddux, & Le Beauf, 2007). Others may perceive multicultural training as limited in its applicability to their personal practice. In other words, such providers might see multicultural competencies as applicable only when the client is part of a racial or ethnic minority group, and, due to the demographics of their client base, may view such competencies as unlikely to be utilized in their setting. Additionally, it has proven difficult to clearly define what is meant by *multiculturalism*, making it a difficult phenomenon to research (Worthington et al., 2007).

Addressing this issue, Sue and colleagues (1982) published the first set of competencies to describe and guide clinical interactions for racially, ethnically, or culturally diverse client-clinician pairings. Sue and colleagues (1982) identified three dimensions to characterize these competencies, knowledge, beliefs and attitudes, and skills, which they termed *cross-cultural*

competencies (updated by Sue et al., 1992 to *multicultural competencies*, or *MCC*). The authors further describe three characteristics of and ongoing goals for multiculturally competent counselors: (1) awareness of own assumptions, values, and biases, (2) attempt to understand the worldview of the client, and (3) actively develops and applies appropriate interventions for use with racially or ethnically diverse clients (Sue et al., 1992).

In 1992, Sue and colleagues further clarified the competencies put forth a decade earlier, providing a detailed conceptual framework describing a matrix in which each trait of a multiculturally competent counselor can be characterized by the three dimensions. To exemplify this matrix, one can consider the principle of counselor awareness, which Sue and colleagues broke into specific competencies organized within each of the other MCC dimensions (i.e., knowledge and skills). Within the matrix location of beliefs and attitudes, a multiculturally competent counselor is aware of how their cultural background influences their psychological processes. Under knowledge, a multiculturally competent counselor possess knowledge about racism, oppression, stereotyping, and discrimination and how they have been affected by them personally and professionally. In skills, a multiculturally competent counselor seeks education, training, and consultation to further their understanding and their ability to work with racially and ethnically diverse populations.

This framework was further operationalized by Arredondo and colleagues (1996), adding criteria to explain and enable achievement of competencies, and organizing these definitions similarly to Sue and colleagues (1992). Later representations of Sue and colleagues' model distills it into a tripartite model comprised of *knowledge* about diverse cultures, *awareness* of personal attitudes and beliefs towards diverse clients, and possessing effective and appropriate *skills* for work with diverse groups (Abreu et al., 2000). Sue and colleagues' tripartite model is

considered to be the most influential model guiding competent multicultural work and is utilized in the bulk of MCC-related literature (Abreu et al., 2000; Worthington et al., 2007).

Knowledge refers to the therapist's understanding of their own cultural background and worldview, as well as the therapist's specific knowledge about the culture of the clients that the therapist works with (Arredondo et al., 1996; Sue et al., 1992). Arredondo and colleagues describe that a multiculturally competent counselor can "articulate the historical, cultural, and racial context in which traditional theories and interventions have been developed" (para. 74).

Awareness represents the therapist's recognition of their own values and biases towards racial and ethnic minority groups (Arredondo et al., 1996; Sue et al., 1992). This sense of awareness about a clinician's own cultural values and experiences as they relate to racial or ethnic minority clients aims to prevent or rectify ethnocentric perspectives (Sue et al., 1992). In their explanatory descriptions, Arredondo and colleagues (1996) wrote that a culturally competent counselor can "identify the culture(s) to which they belong and the significance of that membership including the relationship of individuals in that group with individuals from other groups institutionally, historically, educationally..." (para. 50).

Skills are the specific interventions or therapeutic techniques that aid effective therapy with racial and ethnic minority groups (Arredondo et al., 1996; Sue et al., 1992). Arredondo and colleagues (1996) provide an extensive number of applied examples that help clarify the guidelines set forth by Sue and colleagues (1992). One example that the authors provide is the ability to recognize and describe forms of discriminatory bias embedded in institutions and society that might be interacting with a client's presenting concerns (Arredondo et al., 1996). These skills are conceptualized as an overlapping, but disparate construct from general clinical skills (Cates et al., 2007; Coleman, 1998). For example, utilizing Socratic questioning to

communicate with a client is a type of general clinical skill, and can be categorized as a form of communication. A related multicultural skill might be the ability to utilize different verbal or nonverbal communications based on knowledge of cultural appropriateness. While there appears to be some relationship between general clinical skills and multicultural skills, the nature of that relationship remains unclear.

In research on multicultural skills, multicultural verbal content is used most frequently to operationalize the term. Fisher and colleagues (1998) reported that studies examining multicultural counseling behaviors have described them as “[verbally] introducing or responding to cultural content (including acknowledging and reinforcing the client's cultural values) in the counseling session” (p. 553). This can be seen in a number of other studies that utilize counselors’ explicit verbalizations in order to rate their multicultural characteristics (Atkinson, Casas, Abreu, 1992; Sadowsky, 1991; Thompson, Worthington, & Atkinson, 1994; Worthington, Mobley, Franks, & Tan, 2000). Although multicultural skills have been limited in many instances to verbalizations, the operationalizations of skills provided by Arredondo and colleagues (1996), in addition to skills described by other multicultural authors, have extended beyond just verbal content. Future research on multicultural skills should attempt to examine other forms of multicultural skills, such as nonverbal communication adaptations and consultations with healing figures from non-Western traditions.

Following the publication of Sue’s theoretical model, considerable effort was focused on identifying appropriate operationalizations of MCC in practical, applied clinical work. MCC has been considered to include both cognitive and behavioral variables, meaning MCC is related to what or how a counselor thinks as well as how they act or speak. As past observer-ratings of counselor MCC have focused on verbal content to assess MCC, these studies lack information

about a counselor's intention and cognition that may capture additional elements related to their self-rated MCC. Ladany and colleagues (1997) recommended the use of case conceptualizations to evaluate MCC, such that a multiculturally competent counselor is able to utilize a multicultural framework to identify important cultural and racial/ethnic factors that are related to a presenting etiology and to integrate those factors into a subsequent treatment plan.

Worthington and colleagues (2000) suggested that the types of a counselor's causal attributions could be used as a metric for counselors' ability to identify the sociocultural factors relevant to a client. The authors specified attributions made about the locus of the cause and beliefs about the specific causes acting as antecedents to physical or mental health issues.

The period of literature beginning with Sue and colleagues' (1982) publication present the conceptualizations of MCC in its nascence (Worthington et al., 2007). Although Sue and colleagues' model of competencies was, and remains, the most influential model of MCC, throughout the next two decades there was much discussion and debate about whether their tripartite model of skills, knowledge, and awareness sufficiently captured the competencies required for working with racial and ethnic minority populations.

The tripartite model can be conceptualized as focused at the person-level (i.e., competencies focus on the behaviors, beliefs, and knowledge of the provider; Whaley & Davis, 2007). However, other models of MCC emphasize the processes involved or the intervention strategies and skills utilized in the clinical interaction (Chu, Leino, Pflum, & Sue, 2016). Process models focus on the interactions that occur between the skills and knowledge of the provider and the interactions between the client, provider, and treatment. Whaley and Davis (2007) suggest that utilizing a process model makes it less likely to rely on stereotypes of cultures than using a content model that emphasizes the differences between cultures. Despite this advantage, process

models are inherently difficult to characterize and examine in practical application (Chu et al., 2016). Intervention models involve a focus on developing specialized skills to utilize with racial and ethnic minority clients. One example of this model is cultural adaptations of evidence-based treatments (EBTs) to increase their effectiveness with minority groups. Culturally-adapted EBTs typically refer to treatments that have been changed in the method of service delivery, aspects of the therapeutic relationship, or the integration of cultural beliefs into parts of the treatment (Whaley & Davis, 2007).

In 1998, Tervalon and Murray-Garcia contended that MCC was inappropriate for education in multicultural clinical interactions and should be separated from the concept of *cultural humility*. The authors argued that the concept of competence implied the potential for mastery and that a finite amount of knowledge was available and was therefore less appropriate for training. They further expressed that equating the completion of educational or training experiences with competence or mastery in multicultural clinical encounters was dangerous, inadequate, and placed clients at risk of undue harm (Tervalon & Murray-Garcia, 1998). Instead, the authors recommended a model of lifelong commitment and reflection, which they characterize as flexible and responsive to individual clients. This involves an individual continually seeking to increase their knowledge and, more importantly, their perceptions of and attitudes towards racial and ethnic minority clients, as well as continually self-reflecting on their achievement in those areas. This model is dynamic and focuses on the ongoing complex processes involved in multicultural clinical care. While such a model has several advantages in orienting a philosophical perspective, process models are inherently difficult to examine. Psychological training currently relies on competency-based models in which students are able to identify the expectations of their performance and development, and evaluating bodies are able

to identify and rate the quality of their training and performance based on these criteria. As such, process models have made little traction in superseding the prevailing tripartite model (Sue et al., 1992).

Further dividing the field, the breadth of populations to which multicultural competencies applied is a heavily debated topic (Worthington et al., 2007). For some theorists, MCCs refer specifically to clinical interactions involving the four predominant “Visible Racial and Ethnic Minority Groups” (i.e., African Americans, Asian Americans, Native Americans, and Hispanics and Latino; Sue et al., 1992). Others have argued that MCC should encompass a broader definition of culture that includes race, ethnicity, gender, sexual orientation, ability status, and socioeconomic status (Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009). Addressing the former, proponents argue that expanding MCC outside of racial and ethnic minority groups allows providers and systems to ignore the effects of racism, and to continue to avoid identifying the specific needs and addressing service gaps for those groups (Sue et al., 1992). Those who argue that a broader definition of culture in MCC is more appropriate note that ostensibly all counseling interactions are multicultural, in that each participating individual differs from the other on some metric of culture (Whaley & Davis, 2007). Whaley and Davis (2007) observed that the concept of *culture* has received inadequate attention in the MCC literature, which may contribute to this division of MCC. For this project, the author has decided to limit their definition of culture to racial and ethnic minority individuals in the United States of America. This decision was made in part to ensure the feasibility of the project, as well as to enable the project to speak to certain aspects of culture, with the aim of exploring variables specifically related to minority racial or ethnic group membership.

The APA formally recognized the need to address cultural diversity in training for future professionals in 1973, speaking specifically to the lack of attention being paid to cultural diversity and recognizing the ethical imperative to do so (Falendar, Shafranske, & Falicov, 2014; Korman, 1973). In 2002, the APA Council of Representatives passed the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, which were then published in *American Psychologist* in 2003 (APA, 2003). These guidelines were the result of 22 years of development and provided aspirational goals. In the most recently published version of the *Standards of Accreditation for Health Service Psychology*, which outline the requirements for a training program's accreditation with the APA, a student's competence in individual and cultural diversity is described as a critical requirement for all students who graduate from accredited programs (APA, 2017).

Notably, although the APA has taken an explicit stance in recognizing the importance of multicultural training, the bulk of literature on MCC has come from the field of counseling psychology (Pope-Davis, Reynolds, Dings, & Nielson, 1995). There is less information readily available for other subspecialties of psychology, which may impede the ability for non-counseling psychology students to access information about MCC. Pope-Davis and colleagues (1995) observed that relative to clinical psychology students, counseling psychology students scored significantly higher on a self-report measure of MCC in the subdomains of knowledge, awareness, and skills. Similarly, multicultural training for non-counseling psychology students may be negatively impacted due to the relative lack of information to guide course development and other training experiences (Pope-Davis et al., 1995).

Assessment of Multicultural Competence

Following the clarification and operationalization of MCC came the need for the ability to assess MCC (Pope-Davis et al., 1995). As noted with the development of operationalized MCC by Arredondo and colleagues (1996), training programs and governing bodies of psychology sought the ability to characterize and evaluate relative achievement of MCC for individuals in order to guide and evaluate training for MCC. Thus, with the aim of being able to present a measured characterization of MCC, several instruments were developed to assess MCC. Examples of measures include the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991), Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991), the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), and the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002). Several of these measures rely on clinician self-report and have been criticized for being influenced by social desirability and measuring a respondents' anticipated behaviors, rather than assessing the actual presence of behaviors, skills, and attitudes associated with MCC (Constantine & Ladany, 2000).

The CCCI-R (LaFromboise et al., 1991) was the first measure to be developed and contains 20 items which were developed based on the 11 characteristics of multiculturally competent counselors provided by Sue and colleagues (1982). Thus, the measure contains items that were intended to reflect the tripartite model: skills, knowledge, and attitudes/beliefs. During initial validation procedures, the authors conducted an analysis that revealed a unidimensional factor structure. Following Sue and colleagues MCC model, the authors then utilized a three-factor model and named the factors "Cross-Cultural Counseling Skill," "Sociopolitical Awareness," and "Cultural Sensitivity." Despite this, the authors recommend the measure be

scored on the single dimension (i.e., total score). The CCCI-R was developed to be administered by an evaluator observing a clinician's behaviors but has been adapted for self-report use (Ladany et al., 1997; LaFromboise et al., 1991). Evaluators are instructed to use a 6-point Likert scale (1 = *strongly disagree*, 6 = *strongly agree*) to rate the extent to which an item describes the clinician being evaluated or respondent.

The MCKAS (Ponterotto et al., 2002) is a 32-item self-report measure that is a revision of the Multicultural Counseling Awareness Scale – Form B (MCAS-B; Ponterotto et al., 1996). The measure is rated along a 7-point Likert scale (1 = *not at all true*, 7 = *totally true*) reflecting agreement with statements along two factors: Knowledge and Awareness. Prior versions of this measure labelled the first factor as Knowledge/Skills; however, the authors revised the factor name to more accurately reflect item content (Ponterotto et al., 2002). The MCKAS may be least influenced by social desirability from the respondents (Constantine & Ladany, 2000).

The MAKSS (D'Andrea et al., 1991) is a 60-item self-report measure that was developed from reviews of the MCC training literature for counseling psychologists. It is aligned with three areas identified by the authors during their review: cross-cultural communication skills, awareness of attitudes towards minorities, knowledge about minority populations. The scales are each made up of 20 rationally derived items pertaining to each area. Items on this measure are rated on 4-point Likert scales (1 = *strongly agree*, 4 = *strongly disagree*; 1 = *very limited*, 4 = *very aware*; 1 = *very limited*, 4 = *very good*). Factor analysis of this measure has indicated that the scales pertaining to knowledge and skills are each best interpreted as single factors, and that the scale related to awareness may be three dimensional; however, the measure has not been factor analyzed in full (only the scales), which is a noted limitation of this measure (Ponterotto et al., 1994). Relative to other measures, it has little research, but has been shown to discriminate

between groups of students who have and have not been trained in multicultural issues. The MAKSS was revised in 2003 in response to noted criticisms and named the MAKSS-CE-R (Kim, Cartwright, Asay, & D'Andrea, 2003).

Researchers have found the MAKSS-CE-R to be a reliable and valid measure of multicultural competence. In terms of the reliability of the MAKSS-CE-R, coefficient alphas of .80, .87, and .85 were reported for the scores across two separate samples on the Awareness, Knowledge, and Skills subscales, respectively, and .81 for the entire 33-item scale (Kim et al., 2003). The MAKSS-CE-R's construct validity was established through item-scale correlations between the MAKSS-CE-R and the Multicultural Counseling Inventory, scale-specific exploratory factor analysis, and subsequent confirmatory factor analysis. Furthermore, criterion-related validity of the MAKSS-CE-R scores was evidenced in significantly higher scores for (a) individuals who had successfully completed a course in multicultural counseling in comparison with those who had not and (b) individuals who had more experiences with clients from culturally diverse backgrounds in comparison with those who had fewer experiences with culturally different clients (Kim et al., 2003).

The MCI (Sodowsky et al., 1994) is a self-report inventory made up of 43-items using a four-factor structure: Multicultural Counseling Awareness, Multicultural Counseling Knowledge, Multicultural Counseling Skills, and Multicultural Counseling Relationship. The Awareness subscale is made up of items that evaluate a respondent's general understanding of culture, their multicultural interactions (including life experiences), casework with minority individuals, and responsiveness to multicultural issues (Sodowsky et al., 1994). The Knowledge subscale consists of items related to case conceptualization and treatment planning abilities and knowledge about multicultural research. The Skills portion consists of items evaluating retention

of minority clients, experiences with cultural mistakes (recognition of mistakes and recovery attempts) and attempts at cultural responsiveness in modifying treatment and assessment procedures. The Relationship subscale was a novel inclusion relative to prior studies and measures of MCC (Ponterotto, Rieger, Barrett, & Sparks, 1994). This subscale contains items that refer to the respondent's stereotypes of minority clients, their trustworthiness, and their comfort level with minority clients (Sodowsky et al., 1994). The items for this measure are worded using behavioral terms (e.g., "I use," "I make," and "I perceive") in order to assess the respondent's behavior instead of their attitudes or beliefs for each item.

These measures represent significant effort by the field to bring concreteness to the abstract conceptualization of MCC. However, though each measure purportedly assesses MCC, there have been substantial criticisms particularly focused on the limited validity evidence available for these measures (Constantine & Ladany, 2000; Hoyt, Warbasse, Chu, 2006; Worthington et al., 2000). For example, there is limited evidence of their construct validity (Constantine & Ladany, 2000; Hoyt et al., 2006; Worthington et al., 2000). All of the measures summarized above are theoretically-based on Sue and colleagues' (1982) tripartite conceptualization; however, there is little evidence supporting a three-factor structure in analyses of these measures (Hoyt et al., 2006).

There has also been limited evidence of convergent and concurrent validity among MCC measures. In past studies, there has been little correlation between measures of self-rated MCC and observer-rated MCC (Constantine, 2001; Worthington et al., 2000). Worthington and colleagues (2000) examined correlations between the self-rated MCI (Sodowsky et al., 1994) and trained observers' ratings of counselor MCC using the CCCI-R (LaFromboise et al., 1991) and found that CCCI-R scores were not significantly predicted by total scores on the MCI ($r = .09$).

Further examination of the pattern of bivariate correlations did not support concurrent validity between the two scales. Many of the correlations were near zero or negative values, which suggests that, although both measures are supposed to evaluate MCC, they are evaluating two distinct constructs that have limited overlap (Worthington et al., 2000). The lack of validity evidence in these studies suggests that one's assessment of their multicultural-related skills, knowledge, and awareness may not be highly predictive of one's multicultural competence in delivering services to diverse clients (Hoyt et al., 2006).

Constantine (2001) argued that these measures were more accurately characterized as multicultural self-efficacy, or a respondent's perceptions or beliefs of their abilities and their anticipated behaviors, rather than a measurement of their actual behaviors and attitudes working with diverse clients. Thus, it is possible that an individual's beliefs about their ability to provide multiculturally competent therapy does not accurately reflect their ability to do so, such that an individual may believe they possess the skills, knowledge, and attitudes characteristic of a multiculturally competent clinician and respond in kind, when in fact, they do not. While these issues represent significant limitations in the utilization of these measures to assess MCC, it is important to note that self-efficacy has been identified as an important factor in performance and may be a helpful indicator of the complex construct of MCC. In response to these issues, Gillem and colleagues (2016) developed the Multicultural Counseling and Psychotherapy Test (MCPT), which is a standardized multiple-choice test to assess MCC.

The MCPT (Gillem et al., 2016) was developed to assess MCC following Sue's tripartite model and contains 50 multiple-choice and true/false items. Knowledge-based items included questions related to relevant research, cultural norms, cultural histories, and key concepts such as stereotype threat. Awareness-based items assess awareness of personal biases, limits of

competence, and the effects of one's culture on perceptions of minority clients. Skill items include descriptions of case examples where respondents are asked to select the most appropriate course of action. The MCPT has been found to be positively correlated with practical measures of multicultural expertise and is a promising method of MCC evaluation (Gillem et al., 2016).

Assessments of MCC are further complicated by settings, who is rating or completing the measure, issues of social desirability, and how the measures are used to impact client services. The majority of these measures are completed through self-report, which is a method of evaluation limited by potentially inaccurate retrospective recall or prospective inference, inaccurate reflections of one's behavior, and potentially applying different definitions or interpretations to measure items (Schwarz, 1999). Further, these measures are susceptible to threats of rater biases including central tendency bias, halo effects, and socially desirable responding (Worthington et al., 2000).

Due to the social attitudes towards issues of diversity/competence, these measures have been criticized for their susceptibility to social desirability responding. Social desirability responding refers to a pattern of response selection in which a reporter attempts to create a more favorable image of themselves (Van de Mortel, 2008). This type of responding most likely to occur when items are about sensitive social issues. The motivations for socially desirable responding may be tied to a desire to avoid criticism, to conform to social norms, or as an attempt to gain approval (Marlowe & Crowe, 1960). Research that utilizes self-report measures rely on the truthfulness of respondents. Socially desirable responding can obfuscate relationships between variables or indicate relationships that would otherwise not exist. Thus, psychologists have created measures to assess socially desirable responding. These scales are typically comprised of improbable, but socially desirable responses (Crowne & Marlow, 1960).

The Marlowe-Crowe Social Desirability Scale (MCSDS; Crowne & Marlow, 1960) is a well-established and frequently utilized measure used to detect socially desirable responding; however, within the past two decades, it has been demonstrated that socially desirable responding may be better conceptualized as a two-dimensional, rather than unidimensional construct, which the MCSDS does not capture (Paulhus, 1991). The two components making up this construct are impression management and self-deception (Paulhus, 1991). While some past research has demonstrated that socially desirable responding has a nonsignificant influence on measures of MCC, more recent research has found significant positive correlations between socially desirable responding and self-report MCC (Constantine & Ladany, 2000). It is important for future studies to continue to utilize measures to detect socially desirable response patterns to address its potential influence on variable of interest. For multicultural issues, which is a socially sensitive topic that may draw more socially desirable responses, the desire to conform to perceived socially desirable characteristics could significantly affect respondents.

Van de Mortel (2008) conducted an examination of health-related research that used questionnaires to determine the proportion of those studies that utilized scales of social desirability and to estimate the proportion of studies affected by socially desirable responding. Van de Mortel (2008) evaluated 14,275 questionnaire-based studies published in 2004-2005. From that pool, only 31 studies (0.2%) included a scale of social desirability. Of studies that assessed socially desirable responding, 43% were determined to have outcomes influenced by socially desirable responding and 10% of studies controlled for it in statistical analyses. In multicultural research, early investigations into the influence of socially desirable responding showed nonsignificant correlations between measures of MCC and social desirability (Ponterotto et al., 1996; Sadowsky et al., 1994). However, more recent research has demonstrated that some

measures of MCC were significantly and positively correlated with higher social desirability scores (Constantine & Ladany, 2000).

Some researchers have cautioned against the use of existing measures of MCC in service settings to evaluate providers MCC and their related abilities to work with diverse clients (Constantine & Ladany, 2000). Given the limited validity evidence and concerns related to whether available measures assess MCC or one's beliefs about their MCC and whether those two constructs overlap, it appears that these measures are limited in their applicability for healthcare settings seeking to evaluate and address their workforce's competencies. However, there may be other variables related to providers' MCC, such as client demographics relative to the demographics of the area in which the organization operates, drop-out rates for racial and ethnic minority clients, and other factors related to the access and utilization disparities seen in healthcare services for racial and ethnic minorities (Balsa & McGuire, 2005; Lefley & Bestman, 1991; McGuire & Miranda, 2008).

Multicultural Competencies in Clinical Care

Thus far, it has been established that there exists an ethical rationale to implement and assess MCC in health services, substantial evidence that minority groups are disproportionately provided lower quality care, and organizational mandates to pursue the development of MCC in the field of mental health. With the development of MCC theories, training, and research, we can also evaluate the effect of MCC on more specific instances of clinical care (e.g., therapeutic outcomes, client perceptions, treatment seeking behaviors). Notably, healthcare utilization information (e.g., retention, engagement, satisfaction) is one important facet with which we can evaluate the impact of MCC in clinical care.

The use of culturally-specific knowledge and skills with ethnic minority populations has been shown to influence participants' perceptions of the cultural and general competence of mental health service providers (Atkinson et al., 1992; Cates et al., 2007; Thompson et al., 1994; Worthington et al., 2000). In one study, Atkinson and colleagues (1992) examined whether a counselor's *cultural responsiveness* or *cultural unresponsiveness* affected participants' ratings of the portrayed counselor's therapeutic effectiveness and the counselor's level of cultural competence. Counselors portraying cultural responsiveness engaged with cultural statements made by the client and provided specific content related to the culture of the client. Culturally unresponsive counselors emphasized the universality of clients' experiences and did not engage with clients about their specific cultures. The authors found that counselors' cultural responsiveness was positively related to clients' perceptions of counselor cultural competence (Atkinson et al., 1992). In a similar vein, other studies have demonstrated that counselors rated as culturally responsive were more likely to be evaluated by clients as more culturally competent and as more credible (Gim, Atkinson, & Kim, 1991; Sadowsky, 1991; Thompson et al., 1994).

In the survey by Hook and colleagues (2016) summarized in an earlier section, most respondents reported experiencing at least one microaggression from their counselor. Importantly, one of the most common microaggressions reported was the counselor avoiding engaging with cultural statements made by the client or denying that a client experienced negative stereotypes or discrimination. Taken with earlier findings demonstrating the negative impact of such unresponsiveness to a client's culture, it is likely that a significant number of racial and ethnic minority clients may find counselors less credible sources of help, be less willing to disclose information to counselors, and may prematurely terminate treatment (Tao,

Owen, Pace, & Imel, 2015). These studies demonstrate the clinical impact of MCC in direct clinical care with diverse clients.

When assessing the impact of MCC in psychological practice for racial and ethnic minorities, many examine therapeutic outcomes, client/provider relationship factors, or treatment satisfaction (Tao et al., 2015). However, the effects of MCC on psychotherapeutic practice cannot be constrained to examining the processes occurring within the therapy room. Although the interactions that occur within the therapeutic relationship can feel isolated from the therapist's and client's lives outside of the session, we need to recognize that the discrimination experienced by many racial and ethnic minorities pervades interpersonal interactions as well as the constructs of modern society (e.g., access to services, institutional discrimination, etc.), which includes psychotherapy (Ancis, 2004; Sue et al., 1992). Psychology needs to recognize itself as a part of the greater social system in which bias and discrimination based on racial or ethnic minority status is a lived reality, and as such, is likely to perpetuate existing systemic racism (Katz, 1985; Halleck, 1971). Thus, the effects of multiculturally competent practice for the clinical care provided to racial and ethnic minority groups must be examined beyond psychotherapeutic outcomes, utilizing information about system engagement such as treatment drop-out rates and service utilization (Horrell, 2008).

Multicultural Competence Training

Since approximately the 1970s, psychology graduate training programs have increasingly added multicultural components to their training models (Abreu et al., 2000; Sue et al., 1992). In 1980, approximately 41% of clinical psychology programs offered a multicultural course; however, only 9% of the surveyed programs required completion of the course for graduation (Bernal & Castro, 1994). At the time their reflection was published, Bernal and Castro (1994)

observed that the proportions had increased to 62% of programs offering a multicultural course and 26% of programs requiring completion for graduation. Ridley and colleagues (1994) noted that as there were ethical reasons, empirical evidence that minority groups received less effective services, and organizational mandates to incorporate multicultural training, the issue of whether such training should be included in graduate training was no longer relevant. Currently, the APA's *Standards of Accreditation for Health Service Psychology* explicitly recognizes the importance of multicultural training as an integral part of graduate training for psychologists (APA, 2015). The handbook lists "individual and cultural diversity" as a required profession-wide competency for all graduate students (APA, 2015, p.11).

Ridley, Mendoza, and Kanitz (1992) developed the Multicultural Development Pyramid (MDPT) as a model of the developmental stages of multicultural training for programs, which provides a helpful framework from which to evaluate past and current progress in available training models. Ridley and colleagues (1992) identified six approaches to multicultural training: (a) traditional program, (b) workshop design, (c) separate course, (d) interdisciplinary design, (e) area of concentration, and (f) integrated program. In a traditional design, a program assumes that psychological interventions developed for White Americans are appropriate for use with non-White clients without modification, additional techniques, or alterations to perspective or theory. Similarly, the workshop design does not alter the training program, but encourages students to seek diversity-related workshops. These approaches are considered wholly inadequate in meeting the requirements of multicultural training (Abreu et al., 2000).

Currently, the majority of graduate programs fall at the third level, utilizing a separate course to meet training needs (Abreu et al., 2000). Most graduate training programs offer at least one course that focuses on multicultural issues, and some infuse elements of multiculturalism

into other courses (Abreu et al., 2000; Collins, Arthur, Brown, & Kennedy, 2015; Mena & Rogers, 2017; Priester et al., 2008). Ridley and colleagues (1992) noted that this design may negatively affect training outcomes due to the lack of depth covering multicultural topics. Students may be presented with general information about minority groups, without adequate focus on intragroup variations, and thus be at risk of stereotyping minority clients, which may harm the therapeutic relationship, diminish the client's trust in the therapist, and contribute to early drop out (Ben et al., 2017). Students may be less likely to be aware of their own biases and unaware of important skills that facilitate effective clinical interactions with racial and ethnic minorities, all of which could contribute to what McGuire and Miranda (2008) describe as *clinical uncertainty*. In other words, an emphasis on group characteristics may make instances of clinical uncertainty more likely, such that provider assumptions about minority groups and their epidemiological probabilities of mental health diagnoses exert undue weight, influencing a provider to ignore additional client-specific factors that are related to their diagnostic status.

Although Ridley and colleagues (1994) argue that the provision of a specific multicultural course is not the most effective stage for developing MCC, there is a dearth of empirical literature demonstrating programs who have progressed to the top of the developmental stages, as well as effectiveness information related to the further development. On the other hand, there is evidence that completing a multicultural course is associated with increased levels of self-reported multicultural competence (Abreu et al., 2000). Several studies have demonstrated that having taken a graduate level multiculturally-focused course was associated with increased self-reported multicultural competence (Smith, 2016).

While the extensive availability of MC training courses represents a significant improvement in the number of graduate students being trained in multicultural issues, there are

some difficulties in parsing out the specific effects of courses on developing MCC. Analyses of training courses suggest that a great breadth and variation in the content and format of these courses across programs remains, making general comparisons of effectiveness difficult (Falendar et al., 2014; Ponterotto & Austin, 2005). For example, the majority of courses cover content related to the largest racial and ethnic minority groups in the United States (African American, Native American, Hispanic or Latinx, and Asian American), but there is significant variability in whether additional forms of diversity, such as gender, sexual orientation, ability status, or age was covered as a part of the course (Lyons, Bieschke, Dendy, Worthington, & Georgemiller, 2010; Pieterse et al., 2009; Priester et al., 2008). The amount of information that these courses seek to address seems to necessitate an approach focused on breadth of content at the expense of depth. Thus, while some research demonstrates that completion of a multicultural course is effective in increasing some aspects of self-reported multicultural competence, the field needs more in-depth examinations of the integral components of each course, such as content or style, that are effectively impacting students' MCC (Cates et al., 2007; D'Andrea et al., 1991; Pieterse et al., 2009; Smith, 2016).

The variations across multicultural courses also extend to instructors. Mena and Rogers (2017) noted that there is little information available related to the qualities and competencies of instructors for multicultural education courses through which most graduate students receive their multicultural training. As faculty, instructors of multicultural courses have significant control over the format and content of their courses and play a significant role in the effectiveness of their course. Mena and Rogers (2017) found that instructors varied in their personal training background in multicultural psychology. The majority of instructors had completed at least one course on multicultural issues during their graduate training, while a

minority (22%) had not. However, those in the latter group described having completed conference activities, workshops, or engaged in self-study in multicultural issues. Instructors varied in the number of times they had taught multicultural courses and were employed at different levels of faculty appointment (e.g., adjunct, senior, etc.).

Further, many instructors consider multicultural courses as unique courses due to their emphasis on the varying group dynamics of each instance of the course (Mena & Rogers, 2017; Reynolds, 2011). Instructors of multicultural courses have reported that these courses require a higher level of flexibility and are subject to dynamics that are not present in other graduate courses (Priester et al., 2008). As noted in an earlier section, some examples of difficult group dynamics include difficulties related to student defensiveness, negative interactions, and culturally insensitive comments. In a recent meta-analysis, Smith (2016) found that the presence of racial and ethnic minority peers in multicultural courses was associated with greater effect sizes in assessments of MCC. This finding adds credence to the theory that exposure to culturally different groups, which many training programs lack in peer interactions and client availability, may contribute significantly to MH providers perceptions of their abilities to work with minority clients (Smith, 2016; Sue et al., 1992). Sue and colleagues (1992) argued that most psychologists do not have enough experience with racial and ethnic minority groups in their training, which may influence how multiculturalism can be neglected as a less important aspect of clinical training.

Further complicating our understanding of training effectiveness, most multicultural courses are evaluated based on student satisfaction as a metric of effectiveness, instead of an assessment of the MCC the course works to develop (Falendar et al., 2014). As noted by Constantine and Ladany (2000), due to the limitations of current self-report measures of MCC,

including insufficient evidence of construct validity, it is understandable that training programs may be hesitant to rely on such measures to evaluate the effectiveness of their courses. Despite this, student satisfaction is also a difficult metric to rely on, particularly due to documented patterns of negative student reactions to multicultural training (Abreu et al., 2000; Ponterotto, 1988). For students with negative perceptions of multicultural training, they typically described specific multicultural education as meaningless and unnecessary (Steward, Morales, Bartell, Miller, & Weeks, 1998).

While the specific causes leading to students to experience dissatisfaction with course content and defensiveness related to the pointlessness of multicultural training are unclear, it seems likely that some of these reactions are associated with the sensitive nature of the course content and an individual feeling challenged, criticized, or having their worldview threatened. For example, a multicultural course may cover the healthcare disparities faced by racial and ethnic minorities, which, for a student belonging to the majority culture, may contradict their experience of healthcare institutions. Addressing this contradiction may require that the student shift their cultural perspective, aspects of which might be at odds with their cultural understanding of the world. A student might endorse self-sufficiency, or a “pull yourself up by your bootstraps” approach to dealing with barriers, and from that perspective, the student might have difficulty shifting their worldview to understand the effects of pervasive institutional bias for racial and ethnic minority individuals that impedes their ability to be self-sufficient. Thus, evaluating effectiveness based on student satisfaction following a course may provide an inaccurate representation of the effect of the course on students’ MCC development. Some research suggests that providing didactic training prior to other methods of instruction may

increase comfort and engagement with material, which may speak to the importance of providing adequate development for each component of MCC (Tomlinson-Clarke, 1999).

While the field requires additional research in order to better elucidate the effects of multicultural training courses, available literature suggests that a single course does not provide most graduate students with the confidence or preparedness to work with clients of diverse backgrounds (Arredondo & Arciniega, 2001; Hill, Vereen, McNeal, & Stotesbury, 2015; Holcomb-McCoy & Myers, 1999). This may be related to a substantially imbalanced training focus for most multicultural training approaches in which there is a significant lack of attention paid to developing students' multicultural skills (Pieterse et al., 2009; Priester et al., 2008; Reynolds, 2011; Smith, 2016). As noted by Dinsmore and England (1996), few programs integrate multicultural content into courses focused on counseling skills, theories of intervention, and applied clinical experiences (i.e., practica/clinical placements). This lack of integration into courses focused on clinical work may have implications for the effectiveness with which students attempt to integrate their multicultural training to applied experiences and may contribute to the lack of confidence that students' experience with relation to their ability to work in multicultural clinical settings.

Following the tripartite model of competencies, it has been asserted that training should focus on each of the three components: skills, knowledge, and attitudes, and much of the literature examining multicultural training evaluates the extent to which each area is developed (Smith, 2016; Sue et al., 1992). Available information about the content of MC training courses indicates that most courses have a heavy emphasis on developing knowledge about cultural groups and increasing students' self-awareness. In contrast, there is a noted and significant lack of focus on students' development of multicultural skills (Pieterse et al., 2009; Smith, 2016).

Sue and colleagues (1992) argued that competencies in the areas of multicultural knowledge and attitudes did not necessarily translate to multicultural skills competencies, and more recent research has supported their initial assertion. For example, Cates and colleagues (2007) further demonstrated that higher rated competence in multicultural knowledge was not significantly related to competence in multicultural skills, highlighting the potential impacts of discounting the existing imbalance in multicultural training.

The limited focus on skills development in multicultural training has been noted since the early 2000s, and current research has not demonstrated that the content of multicultural training has shifted to greater focus on skills development (Kuba & Bluestone, 2002; Smith, 2016). Students who have engaged in practicum experiences perceive themselves to have greater multicultural skills than students who have no practicum experience (Carlson, Brack, Laygo, Cohen, & Kirkscey, 1999). However, it is unclear whether this could be attributable to an overlap in general counseling competencies and the measures used to assess MCC (Cates et al., 2007). Despite the lack of clarity in available research, there is evidence that multicultural skills are distinct, although related, to general clinical skills (Cates et al., 2007; Holcomb-McCoy & Myers, 1999; Smith, 2016).

Multicultural courses and workshops have been most closely associated with increases in students' knowledge and awareness (Abreu et al., 2000). Examinations of course syllabi have indicated that knowledge is the most frequently and heavily represented area of competence, followed by a more modest majority emphasizing multicultural attitudes (Pieterse et al., 2009; Priester et al., 2008). While there is some research associating self-reported levels of MCC and completion of multicultural courses, most courses utilize evaluations of students' knowledge as a measure of demonstrating success in the course (Pieterse et al., 2009). For example, evaluations

included literature reviews, self-reflective journaling, reaction papers, research critiques, and presentations on multicultural issues (Priester et al., 2008). These types of assignments were some of the most commonly found didactic assignments used in multicultural courses. As such, it seems arguable that demonstrations of acquired competence exist and are utilized for primarily for multicultural knowledge, and with slightly less emphasis, for multicultural awareness. This may be one factor impeding courses from addressing multicultural skills with greater frequency and intensity – a lack of method for evaluating development.

Beyond evaluations of performance, the barriers related to course instruction and skills acquisition may involve the format or methodology through which course content is relayed. For example, commonly utilized exercises include group discussions, textbook reading, attendance at cultural events, and reflection-based writing assignments. These commonly endorsed methods utilized in multicultural courses are related to increases in students' multicultural knowledge and awareness (Pieterse et al., 2009; Priester et al., 2008; Reynolds, 2011). However, there appears to be significant gap between teaching students to identify and self-reflect on their attitudes and biases, learn about their own culture and the culture of others, and teaching students how to apply that information in their work with diverse clients (Priester et al., 2008). From a survey of 169 instructors of multicultural courses, most reported that they focused on awareness (93%) and knowledge (82%), while less than half emphasized multicultural skills (49%) (Reynolds, 2011). Two separate reviews of multicultural course syllabi discovered similar results, such that the majority of courses focused on developing knowledge and awareness but had limited content and assignments focused on skills (Pieterse et al., 2009; Priester et al., 2008). In a recent meta-analysis, Smith (2016) found that most multicultural training experiences have been designed to

develop multicultural knowledge and awareness and lack sufficient attention to skills development.

One particularly relevant finding is that most multicultural classes lacked experiential learning activities, which in some instances was associated with their lack of or limited focus on skills development (Pieterse et al., 2009; Priester et al., 2008). Experiential learning may be an important component to bettering MCC training and for improving multicultural skill development specifically. There is some support for the utility of experiential exercises in developing MCC; however, it remains a neglected area of research (Roysircar, Gard, Hubbell, & Ortega, 2005). Students' who have engaged in multicultural experiences and who have experienced applied clinical work tend to rate themselves more highly on self-report scales of MCC (Carlson et al., 1999; Dickson & Jepsen, 2007). Based on this author's review of the literature, multicultural experiential learning has not been the explicit focus of existing research. Due to this, there is no commonly used definition with which to operationalize the types of experiences that are considered experiential in nature.

In one study, Roysircar and colleagues (2005) utilized self-reflection with a community-based experiential activity, mentoring ethnic and racial minority English second language learners (ESL), to build students' MCC. The authors observed an increase in students' "Connection/Closeness," which was described as students demonstrating awareness of the interrelationships between the context, themselves, and their clients. Students' ratings on the MCI (Sodowsky et al., 1994) were significantly correlated with "Connection/Closeness," which suggests that the domain may be responsive to the development of multicultural competencies. Other descriptions of experiential learning include role-playing, simulations of culture-related conversations, designing culturally appropriate interventions, presenting multicultural case

conceptualizations, imagery, and group activities (Pieterse et al., 2009; Priester et al., 2008; Morris & Bilich-Eric, 2017; Reynolds, 2011). One overarching description for experiential learning comes from Milne and colleagues (2002) who define experiential learning as:

...leading practical learning activities in which the learner actively develops competence (e.g. demonstrating correct performance); observing model (video/audio tape or live); simulations (e.g. role play exercise); behavioral rehearsal; learning tasks (e.g. diaries, charts, forms); behavioral tests; problem-based, active learning approach in which the learner shares responsibility for own learning. (Milne et al., 2000, p. 191).

As a whole, ongoing training efforts to develop MCC are predominated by coursework that lacks such experiential exercises (Smith, 2016). However, most of the research on MCC training continues to be limited by the examination of the impact of a single graduate multicultural training course with little attention paid to skills development (Mena & Rogers, 2017; Rogers-Sirin, 2008). Through this literature, it has become abundantly clear that current approaches to training MCC provide an unbalanced training experience in which there is substantially greater focus on developing students' competencies related to knowledge and attitudes (Priester et al., 2008; Smith, 2016). Literature in this area has little information about the settings or training experiences through which students develop multicultural skills; however, due to factors such as the length of the course, the amount of content covered, and the format of the course, multicultural courses might be more conducive to developing multicultural knowledge and attitudes and not multicultural skills. It is possible that the limited utilization of experiential learning opportunities in multicultural courses plays a role in this (Smith, 2016).

Alternatively, practica and clinical supervision are an integral and unique component of clinical training, in that the experiential nature of these training facets position them as ideal

opportunities for promoting students' multicultural skills. While MCC-focused courses are valuable training experiences, such courses have not demonstrated that they are sufficient in developing all of the areas involved in being multiculturally-competent. Moreover, Bradley and Fiorini (1999) reported that 70% of academic programs surveyed did not require specific training in multicultural competence before students' first practicum experiences, which may suggest that students are obtaining knowledge relevant to working with diverse clients through other means, such as direct clinical work itself. Thus, it might be valuable to examine the role of supervision and early practica as avenues for MCC development in graduate training.

Some studies that have utilized open-ended formats of inquiry into understanding students' multicultural education experiences have found that students frequently refer to their practicum or supervisory clinical experiences in graduate school as important in their MCC development (Collins et al., 2015; Lee & Khawaja, 2013; Mena & Rogers, 2017; Pieterse et al., 2009). Several theorists have argued that supervision provides a critical training opportunity for students to gain practical experience in a setting with a developmental focus (Constantine, 2001; Falendar et al., 2014; Ridley et al., 1994). Further, as supervision is often delivered in an individualized setting, it may serve as a unique opportunity for experiential learning focused on multicultural skills development, which multicultural courses persistently lack (Smith, 2016). It has been argued that supervision may provide a link between practical application and didactic coursework that may lessen student defensiveness and negative attitudes towards the utility of multicultural training (Carlson et al., 1999). Thus, further examination of supervision as an avenue of multicultural training is a promising endeavor.

Clinical Supervision

Clinical supervision is a core component of clinical training and may be many students' first and most formative experiences related to the development of their clinical skills. Research suggests that culturally competent supervision is one way to increase the quality of the therapy that students provide to diverse clients (Falendar et al., 2013). However, there is limited information available to characterize the specific elements of supervision, and consequently, the components of supervision that exist and are effective for clinical training. Despite this limitation, supervision has been shown to play an integral and influential role in developing the general clinical competence of students (Falendar et al., 2014; Kilminster & Jolly, 2000). Further, the individualized structure and setting of many supervisory interactions may make it an ideal opportunity to engage in experiential training exercises (Friedberg, Gorman, & Beidel, 2009). In this section, current findings related to the status of experiential versus other modes of training in supervision are discussed.

Clinical supervision has been documented as a core component of psychology students' training since the early 1900s, quickly following the development of psychotherapy as a distinct health profession. However, it is likely that supervision as a component of psychological practice was present from the beginning of the development of the field within the apprenticeship model of training, in which an individual is taught a profession by someone with more experience and skill, which is seen in a variety of cultures across the world and through history and persists to the modern day (Milne, 2009). The documented use of supervision in psychotherapy is attributed to the small informal groups of psychoanalytic therapists who convened to discuss each other's work (Carroll, 2007). By the 1920s, supervision was formalized as a required part of psychoanalytic training, although the specifics of psychological training were unsystematic and typically left to the student to organize (Carroll, 2007; Milne,

2009). There were several psychologists during this time that sought to formalize and standardize the training prospective psychologists underwent, most notably Max Eitingon and Lightner Witmer (Carroll, 2007; Shakow, 2007).

The expansion of therapeutic styles throughout the 1950s and 1960s led to the development and use of additional orientations of supervision which diverged from the traditional forms of psychoanalytic supervision and were tied to the therapeutic orientations of the supervisor and student. Common to each form of supervision during this time period was that the goal of supervision focused on the student as an individual and less on the clinical work in which the student was engaged. During the 1970s, supervision began to change its focus from a form of professional counseling for the student to focusing on the psychotherapy that the student provided, with the purpose of improving the work the student delivered in the future. This development marked a significant theoretical shift in clinical supervision that has carried into the present day.

Supervision provides a unique and crucial training experience that ensures ethical and effective practice in an environment with increasingly more emphasis on accountability (Falendar & Shafranske, 2004; Milne, 2009). Both post-graduate and current psychology graduates cited clinical supervision as one of the main influences on their psychotherapeutic practice (Lucock, Hall, & Noble, 2006; Orlinsky & Ronnestad, 2005). Supervision is considered to be the primary way in which psychologists impart knowledge to students (Binder, 1993; Holloway, 1992). Indeed, Bernard & Goodyear (2009) described supervision as the “major form of transmission” of psychological practice.

Although the importance of clinical supervision as a central part of clinical training and practice is infrequently disputed, there is markedly little empirical information about the nature,

content, and method of supervision (Wheeler & Richards, 2007). Despite this, or perhaps due to the paucity of empirical literature in this area, there are a number of available definitions for clinical supervision that vary in their prescribed range of functions of supervision (Milne, 2009; O'donovan, Halford, & Walters, 2011).

The most frequently cited definition comes from Bernard and Goodyear (2004), which describes supervision as:

“...an intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients, she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession.” (p. 8)

In more succinct terms, Falendar and Shafranske (2004) describe supervision as “a distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through an interpersonal process” (p. 3). Although these examples are frequently utilized in literature on supervision, more recently, these definitions have been criticized for lacking precision and operationalization, which some have argued has impeded our ability to research and evaluate clinical supervision (Milne, 2007; Milne, 2009). Milne (2007) specifically noted the available definitions make measurement difficult, as it is unclear what the role of the supervisor or supervisee entails and what variables are relevant to examination. Further, Milne (2007) argued that the ambiguity of these definitions prevents examination, collaboration, and replication.

Past research on supervision has relied predominantly on case studies or qualitative methodology and focus on one specific supervisory experience (Ladany, Mori, & Mehr, 2013). Oftentimes, these studies have attempted to characterize students' best and worst supervisors, best and worst supervision sessions, and effective versus ineffective supervision. While this research has provided important information for contextualizing supervisory practices, it is limited in its ability to provide information about supervision in more general terms.

In 2013, Ladany and colleagues examined effective and ineffective supervisory behaviors and techniques while looking at a broader array of supervision experiences. The authors found a nonsignificant difference between respondents' "best" and "worst" supervisors in their frequency of effective supervisory behaviors; however, there was a significant difference in the frequency with which supervisors utilized ineffective supervisory behaviors. According to the study, effective supervisory behaviors included encouraging students' autonomy, developing a positive supervisory relationship, maintaining an open space for students to engage in discussion, and demonstrating clinical knowledge (Ladany et al., 2013). Ineffective behaviors included supervisors' apparent disregard for supervision (e.g., ending early, appearing unfocused during session), were perceived as ineffective at conceptualizing clients and appropriate intervention recommendations, did not engage in sufficient observation of students, and relatedly, did not provide adequate feedback for students. These descriptions were coded by the authors from responses by students describing multiple supervisory experiences. This study provides a substantial improvement in the literature that provides helpful characterization of supervision; however, it is still unclear *how* supervisors are engaging in these behaviors, and what other behaviors or interactions make up clinical supervision.

One promising method to assess specific elements of supervision is through measures of direct observation (Milne, James, Keegan, & Dudley, 2002). The Process Evaluation of Teaching and Supervision (PETS; Milne et al., 2002) is a direct measure of supervision that is coded using video-recordings of supervision sessions and examines both supervisor and student behaviors. Milne and colleagues (2002) noted that PETS allows the recording of subtle interactions between supervisor and student that may provide unique information about the effectiveness of a supervisor. Using PETS, Milne and James (2002) found that supervisors most frequently engaged in verbal reflection-focused interactions (84%) and infrequently engaged in experiential learning activities (7%). Through feedback and training related to the role of experiential learning in the learning process, supervisors increased the amount of experiential activities (29%) and decreased the amount of time spent listening (40% to 24%). PETS is a promising measure to evaluate supervision effectiveness, supervisory competence, and to collect specific information about the specific interactions in supervision. However, the measure has distinct limitations that may impact the feasibility of its use outside of research settings.

The observational component of PETS is a significant strength, as identified by Milne and colleagues (2002); however, methods of direct observation are limited in their feasible utilization outside of research settings. To obtain direct observations, supervision sessions must be recorded, then coded by trained staff, which leads to significant burdens for time and labor. These measures require the availability of staff to complete the measure, which necessitates training in coding for the measure, the length of time per supervision to observe, and access to equipment to audio or video record. This creates a resource burden which may not be feasibly implemented in many healthcare settings. Thus, while measures that utilize direct observation are useful, it is important to consider the feasibility of such measures.

In community-based healthcare settings, indirect measurements of clinical practice have several advantages. The use of an indirect measure, such as clinician self-reports, lessens the burdens associated with resources such as time, finances, and staffing. However, indirect measures rely on retrospective reporting that may be influenced by a reporter's intentions instead of their observable behavior. Indirect measures are further affected by the issues that affect other self-report inquiries (e.g., central tendency bias, halo effects, and socially desirable responding; Schwarz, 1999; Van de Mortel, 2008; Worthington et al., 2000). As supervision is an important part of clinical training and ensuring the provision of quality care, future research should focus on developing a feasible method for characterizing elements of supervision, such as supervisor and student perceptions of satisfaction and usefulness, as well as specific activities utilized (e.g., reflection, role-playing, and feedback).

Ultimately, clinical supervision serves an essential role in training current and future mental health professionals. Nonetheless, there is limited information regarding many important aspects of supervision, such as its overall effectiveness, the mechanisms through which supervision operates in clinical skills development, effective supervisory techniques, and supervisor development and competency (Milne, 2009; Falendar & Shafranske, 2007). Future research in supervision should aim to address these gaps. Notably, a similar trend holds true for the multicultural facets of clinical supervision, such that research in the area is sparse and limited in scope (Falendar et al., 2013).

Multicultural Competence and Clinical Supervision

Given the individualized and readily applicable nature of supervision, it is uniquely situated to serve as possible avenue for developing students' MCC. Research in this area has focused on *multicultural supervision*, which researchers define as guiding interactions between

supervisors and students that are focused on cultural issues related to providing effective therapeutic interventions for diverse clients (Ancis & Marshall, 2010; Leong & Wagner, 1994). Multicultural supervision is an important part of general clinical training, as it might serve as a form of quality control for diverse clients (Falendar & Shafranske, 2007). In other words, multicultural supervision has the potential to oversee clinical interactions with diverse clients that ensure effective and ethical practice. Others have argued that multicultural supervision is a crucial component of multicultural training that contributes to the development of MCC beyond the benefits gained by multicultural courses (Abreu et al., 2000; Constantine, 2001; Falendar et al., 2014; Ridley et al., 1994). Despite the general acceptance of the importance of including multicultural discussions in supervision, as well as the argument that multicultural supervision provides unique and significant benefits to MCC, there is a paucity of literature that examines the content, process, or frequency of multicultural supervision (Ancis & Marshall, 2010; Cates et al., 2007).

Several studies have demonstrated an association between multiculturally-focused clinical supervision and higher self-reported MCC among psychology students (Ancis & Marshall, 2010; Constantine, 2001; Dickson & Jepsen, 2007; Pope-Davis et al., 1994; Pope-Davis et al., 1995). Despite these results, information regarding *how* to engage in effective multicultural supervision is sparse (Ridley et al., 1994). This lack of information prevents the construction of a working definition for multicultural supervision, thereby stymying the development of a theoretical framework for its further propagation.

In regard to the supervisory relationship, supervisees report higher satisfaction with supervisors who engage in cultural discussions (Inman, 2006; Silvestri, 2003; Tsong, 2005; Yang, 2005). Moreover, research suggests that students perceive supervisors who engage in

cultural discussions as more credible and as having better working alliances (Inman, 2006; Silvestri, 2003; Tsong, 2005; Yang, 2005). It is possible that these findings are related to the fact that supervisees tend to have more understanding and greater interest in cultural factors as compared to supervisors, and are therefore more likely to think positively of supervisors with similar treatment foci (Falendar et al., 2014).

Narrowing in on supervisees' personal experiences, Pope-Davis and colleagues (1994) reported that receiving multicultural supervision (which they operationalized as supervision in which multicultural issues are discussed) was positively associated with higher self-reported MCC. Supervisees also reported higher levels of multicultural awareness when cultural discussions took place during supervision (Pope-Davis et al., 1994). Despite these noted benefits, available literature suggests that supervisors infrequently initiate discussions about culture, ethnicity, and other facets of culture, leaving students to initiate such discussions (Duan & Roehlke, 2001; Gatmon et al., 2001).

Notably, most research on multicultural supervision relies on largely White samples. To address this gap, Fukuyama (1994) coded critical incidents related to multicultural supervisory experiences solicited from racial and ethnic minority psychology graduate students who had completed an internship at a university counseling center. The results from this study were separated into positive and negative critical incidents. Positive critical incidents included experiences of culturally relevant supervision, openness in the supervisory relationship, and general support from supervisors. Negative critical incidents included supervisors who questioned the ability of study participants and who lacked awareness of cultural issues.

Similarly, Duan and Roehlke (2001) found that in cross-cultural supervisory experiences, supervisees' satisfaction with supervision was rated higher when supervisors initiated

discussions about cultural issues and demonstrated interest in the supervisee's cultural background, as well as when supervisors demonstrated support for the supervisee. Additionally, supervisors reported that a supervisees' openness, willingness, and commitment to learning were major contributors to satisfaction with supervision. Notably, few supervisors expressed that cultural discussions contributed to satisfaction (Duan & Roehlke, 2004).

Ancis and Marshall (2010) found that graduate students described their multiculturally competent supervisors as genuine, open, and encouraging of supervisees' exploration of their own culture. Such descriptions of positive multicultural supervision, which seemed to converge across studies on the topic, overlap substantially with descriptions of effective and competent general supervision more broadly. It may be that, similar to multicultural skills, multicultural supervision competencies overlap with general supervisory competencies. Future research in this area should seek to clarify the relationship between these concepts.

The studies summarized here have provided valuable insights into the role of supervision in multicultural training and many of the complex factors involved; however, notable gaps related to the specific content and nature of MCC development remain in the literature. There is a lack of information regarding the frequency with which multicultural supervision takes place, whether addressing multicultural issues in supervision occurs as part of instruction for all students engaged in supervision, and whether instances of multicultural supervision is limited to supervisor- or student-identified multicultural clinical encounters. Further, it is unclear whether multicultural supervision is made up of predominantly verbal interactions and learning activities, or whether experiential training activities are utilized. Thus, exploring the role of experiential learning in levels of MCC, where experiential learning takes place, and the relationship between experiential learning and MCC skills may be a promising avenue for future research.

The Current Study

Multicultural courses, which are the primary method through which students receive training in MCC, focus heavily on developing knowledge and awareness, with little to no attention on skills (Pieterse et al., 2009, Priester et al., 2008; Smith, 2016). Experiential exercises, such as roleplaying, are associated with acquiring and improving a variety of clinical skills (Fleming, et al., 1996; Morris & Bilich-Eric, 2017; Priester et al., 2008), but there is limited information about the use of experiential exercises in developing multicultural skills (Carlson et al., 1999). While clinical experiences (e.g., supervision and practica) and multicultural training (i.e., a multicultural course) are associated with higher self-reported MCC (Carlson et al., 1999; Dickson & Jepsen, 2007), it is not clear what aspects of these experiences contribute to these findings, or whether there are additional factors affecting these associations.

As procedural exercises are associated with skills development, students who engage in higher levels of experiential learning in their multicultural training may rate themselves as more competent with multicultural skills than students who completed multicultural training with lower levels of experiential learning. Thus, experiential learning may moderate the strength of the association between multicultural training and perceived multicultural skills competence. Further, the extent to which students engage in experiential learning and the specific exercises utilized may help explicate the association between experiential learning and multicultural skills competence.

With regards to clinical experiences, there is little information about the aspects of clinical supervision that may contribute to increased MCC. Clinical supervision may serve as an alternative training setting for multicultural skills development, as it is a unique, individualized training experience that offers a direct opportunity for students to engage in procedural

experiences (Friedberg, Gorman, & Beidel, 2009). Thus, a closer examination of specific training experiences that may fall outside the purview of multicultural courses may highlight an important but overlooked component of multicultural training. Such an examination may help to explain the gap between trainees' perceptions of the inadequacy of their MCC-focused training and their perceptions of their ability to work with diverse clients (Holcomb-McCoy & Myers, 1999).

The purpose of the current study is to examine the potential role of experiential exercises in developing perceived multicultural skills and to explore the training settings in which they take place. This study has three aims: 1) to determine whether student-rated multicultural skills competence varies based on student endorsement of experiential exercises; 2) to explore the types of experiential exercises students engage in and their associations with perceived multicultural skills competence; and 3) to gain insight into the settings in which experiential exercises are utilized.

Quantitative analyses were used to address two hypotheses and several exploratory aims:

- Hypothesis 1: The level of *experiential exercises* will moderate the association between *multicultural training* and perceived *multicultural skills*, such that more frequent engagement in *experiential exercises* is expected to increase the impact of *multicultural training* on perceived *multicultural skills*.
- Hypothesis 2: After accounting for *social desirability attitudes* and *multicultural training*, students' endorsement of specific *experiential exercises* will contribute to a significant amount of the variance in their perceived *multicultural skills*.
- Exploratory Aims: What training settings are students engaging in experiential exercises most frequently? What do students perceive as the most effective

learning activity for developing multicultural skills? In what settings are students asked to demonstrate multicultural competence?

Method

Participants

Participants were recruited from clinical and counseling psychology doctoral programs in the United States of America ($N = 83$), which satisfied a power analysis conducted using G*Power (Faul, Erdfelder, Lang, & Buchner, 2014) for a hierarchical linear multiple regression with a medium effect size ($f^2 = .15$) and where $p < 0.05$. The variables for this analysis were based on the effect size and power estimates of similarly designed studies (Hill, 2013; Lee & Khawaja, 2013). Participants were recruited via listservs and recruitment emails sent to academic training directors at accredited clinical and counseling psychology doctoral programs in the United States. Participants for the current study were entered into a drawing for one of five \$20 Amazon gift cards. Institutional Review Board approval was obtained prior to beginning the study.

One hundred thirty-three people accessed and consented to the study. Participants who entered the study portal and consented to the study but did not enter any data ($n = 10$), were eliminated through listwise deletion. Participants who began the study but completed less than 50% of the survey were omitted from analysis ($n = 39$). Eighty-three participants, including participants who had missing data but completed more than 50% of the survey ($n = 3$) were retained for analysis. Using available demographic information, people who did not complete the study were not significantly different from those who completed the survey. Upon examination of the data, one case was removed due to participant's report that they entered data regarding number of clinical hours, REM participants, and REM applied hours based on work

prior to their graduate training. As the instructions and purpose of this study were to focus on students' graduate training experiences, this case was removed from analysis.

Measures

Demographics. A demographic form asked participants their age, gender, sexual orientation, race or ethnicity, program type, number of years in program, questions about multicultural course completion, questions related to their general clinical experience, perception of preparedness, and their clinical experience with racial or ethnic minority clients. Student responses to whether they have completed a multicultural course (rated as yes/no) and an estimation of the number of hours they have spent engaged in multiculturally-focused course content were used as indicators of their *multicultural training*. The Demographic Form is shown in Appendix A.

Experiential Exercises. Experiential exercises were assessed through a brief questionnaire developed for this study (see Appendix B). The questionnaire asked students to endorse the frequency with which they have engaged in experiential exercises, followed by a breakdown of specific exercises. The wording and definitions in this survey are based on the literature available describing experiential exercises that have been utilized to develop general clinical skills (Friedberg et al., 2009; Milne et al., 2002; Morris & Bilich-Eric, 2017). Responses were rated from 1 to 5 (1 = *never*; 3 = *sometimes*; 5 = *frequently*). This questionnaire also asked students to indicate the settings in which they have engaged in experiential exercises.

Multicultural Skills Competence. Students' perceptions of their multicultural awareness, knowledge, and skills will be evaluated with the Multicultural Awareness/Knowledge/Skills Survey-Counselor Edition-Revised (Kim et al., 2003). The MAKSS-CE-R is a 33-item self-report measure that revised the original 60-item MAKSS

developed by D'Andrea and colleagues (1991). The revised measure (talk about validity and reliability evidence and procedure of CFA which was a weakness of original measure. The MAKSS-CE-R was developed to examine the effect of multicultural training on students' development of multicultural competence (see Appendix C). It is aligned with three areas identified by the authors via reviews of cross-cultural training literature and Sue and colleagues' (1992) tripartite model: cross-cultural communication skills, awareness of attitudes towards minorities, and knowledge about minority populations. Items on this measure are rated on 4-point Likert scales (1 = *strongly agree*, 4 = *strongly disagree*; 1 = *very limited*, 4 = *very aware*; 1 = *very limited*, 4 = *very good*), with seven items that are reverse scored. Scores on each subscale range from 10 to 52 and total scores on the MAKSS-CE-R range from 33 to 132. Scores are calculated by totaling participants' ratings on each item. Subscale means are calculated by totaling item ratings within a subscale and dividing by the number of items in the subscale. Students' perceived *multicultural skills* were evaluated with their scores on the MAKSS-CE-R Skills subscale, which ranges from 10-40.

The MAKSS-CE-R has been shown to be a reliable and valid measure of multicultural competence (Kim et al., 2003). Awareness, Knowledge, and Skills subscales reliability coefficient alphas across two samples were reported as .80, .87, and .85 respectively, and .81 for the full scale (Kim et al., 2003). Kim and colleagues (2003) reported evidence of good criterion validity for the MAKSS-CE-R, as the measure was shown to differentiate between students who had and had not completed a multicultural course and between respondents with more and less experience with REM clients.

Social Desirability. The Marlowe-Crowne Social Desirability Scale (SDS; Crowne & Marlowe, 1960) was used in the current study to measure and control for the possible

contributions of social desirability attitudes to the measure of *multicultural competence* (see Appendix C). The SDS is a 33-item true/false self-report measure. Scores range from 0 to 33, with higher scores representing greater tendency towards socially desirable responding.

Evidence of construct validity for the SDS has been established and in previous investigations internal consistency and test-retest coefficients have ranged from .73 to .88 (Constantine, 2001; Crowne & Marlowe, 1960; Paulhus, 1991; Worthington et al., 2000).

Procedure

During recruitment, participants were directed to an online Qualtrics survey that contained the measures for the current study through a recruitment email. The email briefly described the study and available incentive. Participants completed an assent process prior to accessing study content. Within the study, participants completed demographic questions, the MAKSS-CE-R, the SDS, and a questionnaire about experiential exercises developed for this study. After completion of the study, participants were provided with this author's contact information and were redirected to another Qualtrics form and asked to enter an email address in order to be entered into a drawing for one of five \$20 Amazon gift cards. The email address was not associated with their study responses.

Results

Participants

Demographic information was used to organize and describe the characteristics of the sample (Table 1). A total of 83 participants completed this study. Seventy-eight percent of the sample identified as women, 20.5% identified as men, and 1.2% identified as non-binary or genderqueer. Sixty-seven percent of the sample identified their racial or ethnic group as White, 6% as Black or African-American, 9.6% as Asian, 7.2% as Hispanic or Latino, and 9.6% as two

or more categories. Respondents' ages ranged from 22 – 50 years, with a mean reported age of 28.16 years. More than half of the sample reported they are currently enrolled in a Clinical Psychology PhD program (57.8%), followed by 21.7% who reported they are enrolled in a Counseling Psychology PhD program, and lastly 20.5% reported enrollment in a Clinical Psychology PsyD program. Regarding participants training experiences (Table 2), respondents' number of years completed in graduate school ranged from 1 – 8 years, with a mean of 3.17 years. Twenty-three percent of the sample reported that they had not completed a MC-focused course and 75.3% of respondents reported they had completed a MC-focused course (1.2% of sample did not respond to this question). Respondents reported completing 54.24 hours of multiculturally-related coursework on average, ranging from 0-200 (median 50, mode 45). Total clinical hours ranged from 0-3000, mean 618.4, median 450, mode 300. Total hours of direct clinical interaction with REM clients ranged from 0-1800, with a mean of 158.3 hours, a median of 75, and mode of 100. The number of REM clients with whom respondents have worked ranged from 0-536, with a mode of 10 clients. Total hours engaged in practical or applied learning activities for work with racial or ethnic minority clients ranged from 0-350, with a mean of 28.66, a median of 25, and mode of 45.

Respondents were asked a series of questions to examine potentially defensive attitudes around multicultural competence (rated on a 1-7 scale), which was used in conjunction with the Marlowe-Crowne Social Desirability Scale (SDS) to examine socially-desirable patterns of responding. Respondents tended to disagree that they would be upset if a supervisor provided feedback that they needed to further develop their skills in working with diverse populations ($M = 2.73$, $SD = 1.39$). Respondents agreed that there are specific skills that are needed to competently work with REM clients ($M = 5.84$, $SD = 1.04$), strongly agreed that they could

imagine a situation in which they needed to seek additional consultation due to their limited understanding of a client's REM background ($M = 6.29$, $SD = 1.14$), and agreed that their graduate training programs do not offer enough experiences in working with REM clients to gain multicultural competence ($M = 4.10$, $SD = 1.85$). Total scores on the SDS ranged from 0-24 with a mean of 16 ($SD = 3.6$; $\alpha = .087$; Table 3), which suggests that this sample did not tend to engage in socially desirable responding. Further, scores on the SDS were not significantly correlated with scores on the MAKSS-CE-R ($r(81) = .126$, $p = .258$; Table 4).

To assess perceived competence, participants completed the Multicultural Awareness/Knowledge/Skills Survey-Counselor Edition-Revised (MAKSS-CE-R) and were asked to rate themselves on the amount (0-100%) of knowledge, awareness, and skills that they possess of what is needed to be a competent psychologist for racial and ethnic minority clients. Responses to each question ranged from 0-100%, with a mean of 54.61% of knowledge, 71.22% of awareness, and 55.16% of skills (Table 3). Total scores on the MAKSS-CE-R ranged from 67-111 with a mean of 90.14 ($SD = 8.75$; $\alpha = 0.797$; Table 3). Scores on the MAKSS-CE-R Skills subscale ranged from 20-40 with a mean of 27.87 ($SD = 4.10$). The percentages for self-rated skills competence was positively correlated with scores on the MAKSS-CE-R Skills subscale ($r(81) = .492$, $p < .000$).

To evaluate Hypothesis 1, a hierarchical linear multiple regression analysis was used to test the potential moderating effect of *experiential exercises* (see Question 1, Appendix B) on the association between *multicultural training* and perceived *multicultural skills*. In this model (Table 5), *multicultural training* was the independent variable, *experiential exercises* was the moderator variable, and *multicultural skills* was the dependent variable. In the first step, two variables were included: *multicultural training* and *experiential exercises*. These variables did

not account for a significant amount of variance in *multicultural skills*, $R^2 = .034$, $F(2, 77) = 1.356$, $p = .264$. To avoid potentially problematic high multicollinearity with the interaction term, the variables were centered and an interaction term between *multicultural training* and *experiential exercises* was created (Aiken & West, 1991; Baron & Kenny, 1986). Next, the interaction term between *multicultural training* and *experiential exercises* was added to the regression model, which did not account for a significant proportion of the variance in *multicultural skills*, $\Delta R^2 = .006$, $\Delta F(1, 76) = .436$, $p = .511$. In sum, the interaction of *multicultural training* and *experiential exercises* did not account for significantly more variance than *multicultural training* and *experiential exercises* alone. Thus, *experiential exercises* do not appear to contribute a meaningful amount of predictive value in this model and the hypothesis of moderation is not supported by this analysis.

Based on existing criticisms regarding the limitations of self-report measures of competence, an additional analysis was run to re-examine the study hypothesis using an alternative measure of skills competence collected in this study. Participants' self-estimated percentages of the skills that they possess of what is needed to be a competent psychologist for racial and ethnic minority clients (see Question 11, Appendix A) replaced the MAKSS-CE-R skills subscale score as the dependent variable. To re-examine Hypothesis 1, *multicultural training* (i.e., hours of multicultural-focused coursework) was the independent variable, *experiential exercises* (i.e., hour of applied training for working with REM clients) was the moderator variable, and *skills percentage* (i.e., self-rated percentage of skills) was the dependent variable (Table 8). In the first step, two variables were included: *multicultural training* and *experiential exercises*. These variables did account for a significant amount of variance in *skills percentage*, $R^2 = .135$, $F(2, 77) = 6.020$, $p = .004$. Next, the interaction term between

multicultural training and *experiential exercises* was added to the regression model, which accounted for an additional significant proportion of the variance in *skills percentage*, $\Delta R^2 = .051$, $\Delta F(1, 76) = 4.792$, $p = .032$. This suggests that the relationship between *multicultural training* and *skills percentage* is moderated by *experiential exercises*.

To address Hypothesis 2, a hierarchical linear multiple regression was utilized to predict perceived *multicultural skills* from *specific experiential exercises* (see Question 3, Appendix B). The predictor variables were the total score on the SDS, hours of multicultural course content completed, and student endorsements of the frequency of utilization of *specific experiential exercises*, which were represented as the mean sum of participants' endorsements of sub-items in Question 3 to increase power in this analysis. Students' perceived *multicultural skills* served as the dependent variable in this model. SDS scores and hours of multicultural course content completed were entered in Step 1 for statistical control, as this study hoped to evaluate the contributions of *specific experiential exercises* independent of socially desirable responding patterns and other forms of multicultural training. These variables did not account for a significant amount of variance in perceived *multicultural skills*, $R^2 = .053$, $F(2, 77) = 2.133$, $p = .125$. *Specific experiential exercises* were entered in Step 2. The addition of these variables to the model did not contribute statistically significantly to the prediction of *multicultural skills*, $\Delta R^2 = .025$, $\Delta F(1, 76) = 2.098$, $p = .152$ (Table 7).

Following the re-examination of Hypothesis 1, Hypothesis 2 was re-examined using a hierarchical linear multiple regression to predict perceived *skills percentage* (see Question 11, Appendix A) from *specific experiential exercises* (see Question 3, Appendix B). The predictor variables were the total score on the SDS, hours of multicultural course content completed, and student endorsements of the frequency of utilization of *specific experiential exercises*. Students'

perceived *skills percentage* served as the dependent variable in this model. SDS scores and hours of multicultural course content completed were entered in Step 1 for statistical control. These variables did account for a significant amount of variance in perceived *skills percentage*, $R^2 = .129$, $F(2, 77) = 5.708$, $p = .005$. *Specific experiential exercises* were entered in Step 2. The addition of this variable to the model was statistically significant to the prediction of *multicultural skills*, $\Delta R^2 = .120$, $\Delta F(1, 76) = 12.089$, $p = .001$ (Table 9), which suggests that *specific experiential exercises* is a significant predictor of students' *skills percentage*.

Information regarding the setting in which students engaged in experiential exercises (see Question 2, Appendix B) was used to address one of the current study's exploratory aims. Students reported that they engaged in applied or experiential learning activities most frequently in a course focused on multicultural issues (68.3% endorsed yes). A little more than half of respondents indicated they did this in supervision (53.7% endorsed yes) and about half of respondents did this in practicum (47.6% endorsed yes).

Responses to three open-ended questions were examined using quantitative content analysis to address the remaining exploratory aims of this study (Hsieh & Shannon, 2005). Given the exploratory nature of this part of the project, quantitative content analysis was chosen as there is limited existing information and theory about these topic areas. Categories were identified using an inductive coding approach, based on the types of activities students reported for each question (Cho & Lee, 2014; Kondracki, Wellman, & Amundson, 2002; Patton, 2002).

The first question asked respondents to identify activities that they had engaged in, through their graduate training, to *develop* multicultural competence. The second question asked respondents to identify the areas in which they had been asked to *demonstrate* multicultural competence. The third question asked respondents to identify the activities which they thought

were *most effective* in developing their perceived multicultural skills. Results are visually summarized in three respective bar graphs (see Figures 1-3). To *develop* MCC, participants reported that they most frequently attended lectures, seminars, or presentations (42.68%), completed coursework in a specific multicultural or diversity-focused class (35.37%), and completed multiculturally-related coursework from other classes (31.71%). In answer to the second question, participants most frequently reported that they *demonstrated* competence through clinical work (67.9%), coursework (44.4%), and disseminating information to others (18.52%). In answer to the third question, participants most frequently identified direct clinical work with REM clients (42.5%), receiving supervision (31.25%), and completing coursework (31.25%) as *most effective* in their development of perceived multicultural skills.

Discussion

Implications

This study aimed to address existing gaps in the multicultural training literature, specifically by focusing on the effects of experiential training on developing students' multicultural competence. This author hypothesized that the level of a student's reported frequency of experiential training would increase the strength of the association between multicultural training and self-reported multicultural skills competence. Based on Model 1, the interaction effect did not add significant predictive value to the original model. This suggests that based on the current sample, there is no evidence to support that the frequency with which students reported that they engaged in experiential training affected the relationship between multicultural training and self-reported multicultural skills competence. The implications of this finding may suggest that increasing the opportunities for students to engage in experiential training is not necessary to increase students' perceptions of their own multicultural skills

competence. However, this finding may also have been affected by various limitations in the design of the study.

This finding may have been affected by students' understanding of what was included within "experiential exercises" as the prompt allowed for respondents to consider exercises that were not specifically mentioned by this author. Thus, students may have endorsed learning experiences that would not be considered experiential as defined within this study. It is also important to note that due to the limited research in this area, there is no definitive definition or list of exercises by which to make this determination. For this study, a guiding definition of clinically relevant experiential exercises was developed on this author's research into experiential learning for general clinical skills, which was then used to develop questions. The resulting list of possible experiences was, by nature of its development, limited in scope and applicability, leading to the decision to allow respondents to consider other possible training experiences that they perceived to be similar to those listed in this project.

Further, the variable used to indicate multicultural training was made up of students' estimates of the number of hours that they have spent engaged in multicultural coursework. Students in this sample reported that they most frequently engaged in experiential activities related to REM clients in multiculturally-focused courses. The variable *multicultural training* may have included much of students reported experiential training, and thus specifying the extent of students' experiential training may have had little effect as it may have been redundantly captured within the variable *multicultural training*. Differentiating experiential and non-experiential coursework related to working with REM clients, instead of asking more generally about multicultural coursework, may have been more useful in capturing those experiences separately and identifying potential differences.

Available literature suggests that multicultural courses do not provide adequate focus on skills development (Pieterse et al., 2009; Priester et al., 2008; Reynolds, 2011; Smith, 2016); however, in this study, students reported that they most frequently engaged in experiential exercises in a multiculturally-focused course. Experiential exercises may be integrated into coursework without an evaluative component, such that the use of exercises might not be accurately represented on course syllabi, which may contribute to this difference. There may also be differences between how the authors of past research on multicultural courses defined course content focused on skills and this author's interpretation of experiential training as indicative of skills-focused development.

This study used the MAKSS-CE-R to evaluate student perceptions of their multicultural skills competence. Past research in this area has utilized this and similar self-report measures to gain information about areas of multicultural competence including skills; however, it is arguable that using a self-report measure negatively affected this study's ability to accurately capture this information. For example, the results of this study may have been affected by a tendency observed in prior research, where students and professionals typically reported high levels of competence in all areas of multicultural competence, while also reporting limited to no specific training to develop skills competence (Holcomb-McCoy & Myers, 1999). Similarly, Cartwright and colleagues (2008) found that graduate students in their sample rated themselves more highly on all subscales of the MAKSS-CE-R relative to observer-ratings of roleplayed multicultural clinical interactions, which may suggest that students' perceptions of their ability are not an accurate representation of their actual ability. If students tend to rate themselves more highly on measures of competence regardless of prior training, it is possible that levels of

experiential training do have an impact on the relationship between multicultural training and skills competence that was unobserved in this sample due to this response pattern.

In the present study, students were asked to rate themselves on the extent to which they perceived themselves to have achieved the knowledge, awareness, and skills required to competently provide services for REM clients. On average, participants reported that they had achieved 55.16% of the skills required to be a competent psychologist for REM clients (Table 3). These ratings were used to re-examine the hypotheses set forth in this study, as the MAKSS-CE-R scores may have been limited as discussed in the above section. The model generated suggests that *experiential exercises* moderated the association between *multicultural training* and perceived *multicultural skills*, such that as *experiential exercises* increased, the influence of *multicultural training* on *multicultural skills* became more negative (Table 8). The direction of the moderating influence of *experiential exercises* did not correspond with the hypothesized direction; however, this model provides an interesting perspective on the role of experiential learning and perceptions of competence that aligns with recent observations of students' perceptions of their learning varying based on their participation in active or passive learning (Deslauriers et al., 2019).

In a study comparing student's perceived learning versus their actual learning through active and passive instruction, Deslauriers and colleagues (2019) found that students learned more from active instruction but perceived themselves to have learned less in comparison to passive instruction, where students learned less, but perceived themselves to have learned more. The authors concluded that students' perceptions of their own learning may not be associated with their actual learning. Relevant to the present study, students' perceptions of their competencies may be similarly affected, such that students self-reported competencies are not

valid indicators of their actual competencies. As students engaged more frequently in experiential learning, it is possible that they perceived themselves to have learned less and rated themselves as less competent. Conversely, students who engaged more frequently in passive learning (i.e., lectures and presentations), may have perceived themselves to have learned more and rated themselves more positively. However, an alternative interpretation of this phenomenon could also be made through the lens of cultural humility.

Cultural humility differs from competency-based models as it focuses on the process of development instead of achievement. An integral part of this process is in acknowledging that one cannot achieve competence but must continuously pursue it as a lifelong learner. From this perspective, the present model could be interpreted as a reflection of the “humbling” effect of engaging in experiential activities on one’s perceptions of one’s own skills (Kardas & O’Brien, 2018). In other words, as one engages in more active learning, one may develop a more nuanced perspective of their level of skills competence such that they are more likely to identify areas for growth or the need for continued development, and consequently rate themselves lower.

The differences between using the MAKSS-CE-R skills subscale score and the self-rated percentage of achieved skills could also be due to the wording and perceived implications of each measurement. On the MAKSS-CE-R, questions asked a respondent to rate their current skill level on ten items, with ratings from “limited” to “very good.” The self-rated percentage asked respondents to rate themselves in relation to their progress in obtaining the necessary skills to be a competent provider for REM clients. MAKSS-CE-R items may have led to increased defensiveness as it inquired about respondents’ perceptions of current abilities, where the skills percentage lowered defensiveness as it framed acquisition developmentally. The wording of the self-rated percentage of achieved skills question might have also pulled for a more culturally

humble response, as the question asked participants to evaluate their skills relative to what they believe is required to be competent. As this study found differences based on the measurement used for perceived skills competence, future research could consider examining multiple methods for evaluating student competencies.

Overall, respondents in this study did not endorse overly socially desirable response patterns (mean total score on SDS = 15.98; Table 3). In response to questions about possible defensive attitudes towards MCC development, they described themselves as able to imagine a scenario in which they were not competent to work with a client and would be receptive to feedback from a supervisor about their need for further development of their multicultural competence. These results suggest that respondents were not defensive about their perceptions of competence and did not engage in positive impression management. In contrast to prior research, scores on the SDS were not significantly correlated with scores on the MAKSS-CE-R in this sample; however, the SDS demonstrated poor reliability in this study ($\alpha = .087$; Constantine & Ladany, 2000). This could suggest that participants completed the MAKSS-CE-R such that they responded in alignment with their personal perceptions and without significant influence from perceived socially desirable responses; however, due to the noted poor reliability, it is difficult to make conclusions based on this measure.

The second hypothesis of this study proposed that the frequency with which students reported engaging in specific types of experiential exercises would add significant predictive value to the model containing scores on the SDS and multicultural training. However, the results obtained were nonsignificant. These results may have also been affected by the limitations noted above in relation to Hypothesis 1. Similarly, when *skills percentage* was used in the model instead of the MAKSS-CE-R skills subscale score to represent perceived skills competence, the

frequency with which participants reported engaging in experiential exercises was a significant predictor of perceived skills competence based on the model.

Despite the nonsignificance of the initial model, the Pearson correlations between specific exercises and their scores on the MAKSS-CE-R skills scale provide some information about how these variables may be related (Table 4). Future projects could focus more specifically on types of exercises to better understand how they relate to perceptions of competence. For example, role play exercises might function as a more significant predictor than observing behavioral models for developing multicultural skills. The correlation between frequency of demonstrations of competence and MAKSS-CE-R skills score was ($r(81) = .252$, $p < .05$; Table 4) and has interesting implications for understanding the effect of training. More frequent engagement in demonstrations of competence may give students better insight into their ability, instead of basing their perceptions on evaluations unrelated to skills/demonstrated ability. Frequent engagement in demonstrations of competence may also be related to greater frequency of practice, which is also associated with increased ability (Ericsson, Krampe, & Tesch-Romer, 1993; Morris, 2017).

The exercises specified in the brief questionnaire assessing experiential training within this study were developed based on a review of relevant literature as guiding definitions of experiential training (Friedberg et al., 2009; Milne et al., 2002; Morris & Bilich-Eric, 2017). Although the effects within a predictive model of skills competence were nonsignificant, the identification of these exercises as clinically relevant forms of experiential training may provide a starting point for future research to further explore this area. This author examined a similar model using a different measurement of skills competence, which demonstrated that more frequent endorsement of engagement in these exercises was predictive of perceived skills

competence and further indicates that these exercises may be a useful representation of experiential training.

In answer to exploratory efforts in understanding the role that supervision may play in students' experiential training, more than half of the respondents in this study reported that they engaged in experiential training in supervision. This provides some evidence that supervision may be an important setting in which students engage in experiential training and develop related skills. Future research should examine the types of experiences that are most frequently used in supervision and whether the types of exercises utilized in supervision and multicultural courses differ and, if so, how those specific exercises might differentially affect skills development or perceptions of competence. Further, more in-depth examinations of supervision may contribute to understanding the apparent discrepancies between the lack of skills-focused instruction in multicultural courses and students' reports that they feel competent in utilizing multicultural skills.

Participants most frequently reported that they demonstrated multicultural competence through their direct clinical work with clients of diverse backgrounds. The responses obtained in this study did not provide further information about the evaluative method through which competence in these interactions was assessed but provides helpful information about the experiences of students within this sample. Based on responses, participants' understanding of competence in this situation appears to be linked to the provision of successful treatment, as students most frequently identified clinical work as an evaluative area. In coursework, where participants reported engaging in experiential training, participants reported that they were most frequently graded on presentations, papers, and exams. Few responses were found to include information about evaluation of skills performance outside of direct clinical work. This suggests

that evaluations of competence utilized in graduate training may be more closely tied to the constructs of knowledge and awareness as this sample did not report that competence assessments incorporated a demonstration of skills acquisition. If participants tended to be evaluated highly in these areas, it is possible that may have affected their perceptions of their skills competence despite the lack of evaluations in this area.

The results of the current study may be used to guide future development of multicultural training and research. In this study, more frequent engagement in experiential exercises was not associated with higher levels of multicultural competence as assessed by the MAKSS-CE-R, which suggests that training programs may not need to consider greater utilization of these exercises. However, given the noted limitations of this study, the findings using an alternative measurement of perceived skills competence, and the possible effects of noted phenomena in self-appraisal and response patterns, one should be cautious with this interpretation. Further, the findings of this study somewhat contradict current criticisms and recommendations for multicultural training based on a larger body of theoretical and empirical work in this area. For example, Sue and colleagues (1992) recommended specific training for skills, which has been further echoed by more recent examinations of multicultural courses and the perception of their lack of focus on multicultural skills (Pieterse et al., 2009; Priester et al., 2008; Reynolds, 2011; Smith, 2016).

Limitations and Future Directions

This study has several limitations. First, this study used self-report measures, which are limited by inaccurate retrospective recall or prospective inference, inaccurate reflections of one's behavior, and potentially applying different definitions or interpretations to measure items (Schwarz, 1999). For example, participants may have interpreted concepts in the qualitative

prompts, such as competence, in varying ways that affected their responses. Additionally, this study used the MAKSS-CE-R as a self-report measure of perceived multicultural competence, which may not accurately reflect respondents' actual competencies (Cartwright, Daniels, & Zhang, 2011). Due to phenomena summarized above (e.g., gaps between perceived abilities and performance of abilities), it may be possible that self-report measures are inherently invalid representations of skills competence. Although this may limit the accessibility of studying these effects, observation of skill and associated ratings may be the most representative measurement of an individual's skill acquisition. Future research should consider using observer-rated measures of MCC, such as the Multicultural Counseling Assessment Survey (MCAS; D'Andrea, 2004), in future studies.

Second, the experiential exercises queried in this study do not encompass a comprehensive list of relevant activities through which students may develop skills, which may result in limited understanding of the effects of specific types of exercises. Further, the survey used in this study to assess experiential exercises was developed for this study and is not established as a useful, reliable, or accurate method of obtaining this information.

Lastly, the sample for this study was comprised of graduate students, whose perceptions of course content and training experiences may substantially differ from the intent and effect of instruction (Deslauriers et al., 2019; Kardas & O'Brien, 2018). Students' reports about the frequencies with which they engaged in various types of training may be inaccurate or misrepresentative of the intended effects of instruction. For example, while this study provided descriptive information about the role of supervision in facilitating experiential exercises within this sample, it did not provide detailed information about the process or quality of these experiences.

Future Directions

Based on participants' reports, direct clinical work was most often identified as how they demonstrated multicultural competence and it was frequently identified as one of the most effective methods for developing multicultural skills. Direct clinical work can be characterized as the application of multicultural competence, including multicultural skills. Students in this sample reported that lectures, seminars, and presentations were the primary way in which they engaged in multicultural training and they infrequently identified being tasked with demonstrations of skill competence outside of their direct clinical work. In fact, clear activities that involved skills training were rarely identified as a method that was used in their training to develop competence. Thus, an independent assessment of skills via live or recorded observations, or accessing supervisor or instructor perceptions, may be a more useful tool to assess skills competence, as the arguments against using self-reported measures of learning and ability gain more credence (Deslauriers et al., 2019). Future research should explore whether students are primarily using clinical work to develop multicultural skills, and perceiving significant benefit for their own skill development, without receiving explicit or focused MCC-related training prior to clinical engagement with REM clients, and whether their perceptions of increased skills competence is associated with actual increases in skills competence.

Future research might explore how students' multicultural competencies are evaluated in settings, delivery, and method to better understand the role of feedback and evaluation in students' self-reported multicultural competencies. Specific to supervision, future research might consider how focused training and feedback occurs through supervision, as students within this sample more frequently reported that their MCC was evaluated through direct clinical work. Further, it is unclear how supervisors might make the determination of competent use of

multicultural skills delivered in therapy where general clinical skill also plays a role. Future research should continue to delineate these skills for more sensitive measurements of competencies.

Lastly, multicultural competence may be better conceptualized using alternative models, such as through cultural humility. For example, within the model of cultural humility, the processes of gaining competence and engaging in accurate assessment of one's development, or areas of needed development, are intertwined. The moderation model in this study suggests that an increase in active learning, which may be associated with more accurate self-ratings of skills, led to hours of multicultural coursework having a more negative effect on perceptions of multicultural skills competence. Thus, a process model may be a more accurate portrayal of how MCC acquisition and development takes place, and future research could consider methods for conceptualizing this model in research (Falendar & Shafranske, 2004; Owen et al., 2016).

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Table 1

Sample Characteristics

Characteristic	N (%)
Gender	
Woman	65 (78.3)
Man	17 (20.5)
Non-binary/genderqueer	1 (1.2)
Racial/Ethnic Group	
White/Caucasian	56 (67.5)
Black or African-American	5 (6.0)
Asian	8 (9.6)
Hispanic or Latino	6 (7.2)
More than two groups	8 (9.6)
Doctoral Program	
Clinical Psychology PhD	48 (57.8)
Clinical Psychology PsyD	17 (20.5)
Counseling Psychology PhD	18 (21.7)

Note. $N = 83$. Participants were on average 28 years old ($SD = 4.36$).

Table 2

Training experiences

Training experience	Range	Mean (SD)	Median	Mode
Number of years in graduate school	1-8	3.175 (1.59)	3	2
Hours of MC related coursework	0-200	54.24 (36.70)	50	45
Total number of clinical hours	0-3000	618.4 (590.82)	450	300
Total hours with REM clients	0-1800	158.29 (257.04)	75	100
Total REM clients	0-536	31.19 (67.36)	12	10
Applied training for REM clients	0-350	28.66 (25.19)	25	45

Note. $N = 83$.

Table 3

Descriptive Statistics of Competency Measures

Measure/Subscale Name	Mean (SD)	Median	Mode
Self-rated Knowledge (%)	54.61 (20.70)	55	50
Self-rated Awareness (%)	71.22 (19.27)	75	80
Self-rated Skills (%)	55.16 (23.49)	60	50
SDS Total (0-33)	15.98 (3.64)	16	15
MAKSS-CE-R Total (33-132)	90.14 (8.75)	90	88
MAKSS-CE-R Skill (10-40)	27.87 (4.10)	28	28

Note. $N = 83$.

Table 4
Correlations

Variable	1	2	3	4	5	6	7	8	9	10	11	12
1. Hours of multiculturally-focused coursework	-	-	-	-	-	-	-	-	-	-	-	-
2. Frequency of experiential activities	.007	-	-	-	-	-	-	-	-	-	-	-
3. Hours of applied training for REM clients	.437**	.346**	-	-	-	-	-	-	-	-	-	-
4. Observe Video	.068	.510**	.408**	-	-	-	-	-	-	-	-	-
5. Roleplay	.113	.616**	.444**	.497**	-	-	-	-	-	-	-	-
6. Case Conceptualization	.181	.491**	.436**	.420**	.557**	-	-	-	-	-	-	-
7. Socratic Questioning	-.025	.455**	.235*	.388**	.441**	.552**	-	-	-	-	-	-
8. Behavioral Practice	.058	.514**	.430**	.429**	.693**	.429**	.568**	-	-	-	-	-
9. Demonstration of Competence	.137	.542**	.435**	.359**	.508**	.567**	.462**	.580**	-	-	-	-
10. MAKSS_Total	.272*	.053	.001	.135	.101	.069	.181	.099	.274*	-	-	-
11. MAKSS_Skill	.184	.147	.131	.100	.129	.056	.188	.145	.252*	.734**	-	-
12. MCSDS_Total	.065	.043	.007	-.025	.128	-.029	.143	.088	.104	.126	.147	-

Note. ** indicates the correlation is significant at the 0.01 level and * indicates the correlation is significant at the 0.05 level.

Table 5

Frequencies of specific experiential exercises

Type of exercise	Mean (SD)	Median	Mode
Video Observation	2.44	3	3
Roleplay	2.20	2	1
Conceptualization	3.14	3	3
Socratic Dialogue	2.79	3	3
Behavioral Practice	1.9	1	1
Competence	2.49	2	1
Sum	14.95 (5.26)	15	19

Note. $N = 83$.

Table 6
Hierarchical Regression Hypothesis 1

	B	SEB	β	Sig.
Step 1				
Constant	26.69	.87		.00
Number of hours of MC coursework	.02	.01	.15	.25
Number of hours of experiential training for REM clients	.01	.02	.07	.59
Step 2				
Constant	26.64	.88		.00
Number of hours of MC coursework	.02	.01	.15	.25
Number of hours of experiential training for REM clients	.02	.02	.10	.47
Interaction Term	.00	.00	-.08	.51

Note. $N = 83$.

Table 7
Hierarchical Regression Hypothesis 2

	B	SEB	β	Sig.
Step 1				
Constant	24.44	2.13		.000
Social Desirability Scale	.15	.13	.14	.23
Total Score				
Hours of multiculturally- focused coursework	.02	.01	.18	.12
Step 2				
Constant	24.17	2.33		.000
Social Desirability Scale	.08	.12	.12	.27
Total Score				
Hours of multiculturally- focused coursework	.02	.01	.16	.16
Sum of specific experiential exercises	.13	.09	.16	.15

Note. $N = 83$.

Table 8
Hierarchical Regression Hypothesis 1 – Skills Percentage

	B	SEB	β	Sig.
Step 1				
Constant	41.95	4.64		.000
Hours of multiculturally-related coursework	.20	.08	.32	.008
Hours of experiential training for REM clients	.08	.109	.09	.45
Step 2				
Constant	41.08	4.56		.000
Hours of multiculturally-related coursework	.21	.073	.33	.01
Hours of experiential training for REM clients	.17	.13	.18	.15
Interaction Term	-.004	.002	-.244	.032

Note. $N = 83$.

Table 9

Hierarchical Regression Hypothesis 2 – Skills Percentage

	B	SEB	β	Sig.
Step 1				
Constant	47.23	2.13		.000
Social Desirability Scale	-.29	.69	-.05	.68
Total Score				
Hours of multiculturally-focused coursework	.23	.07	.36	.001
Step 2				
Constant	28.28	12.04		.021
Social Desirability Scale	-.47	.64	-.08	.46
Total Score				
Hours of multiculturally-focused coursework	.20	.06	.32	.002
Sum of specific experiential exercises	1.56	.45	.35	.001

Note. $N = 83$.

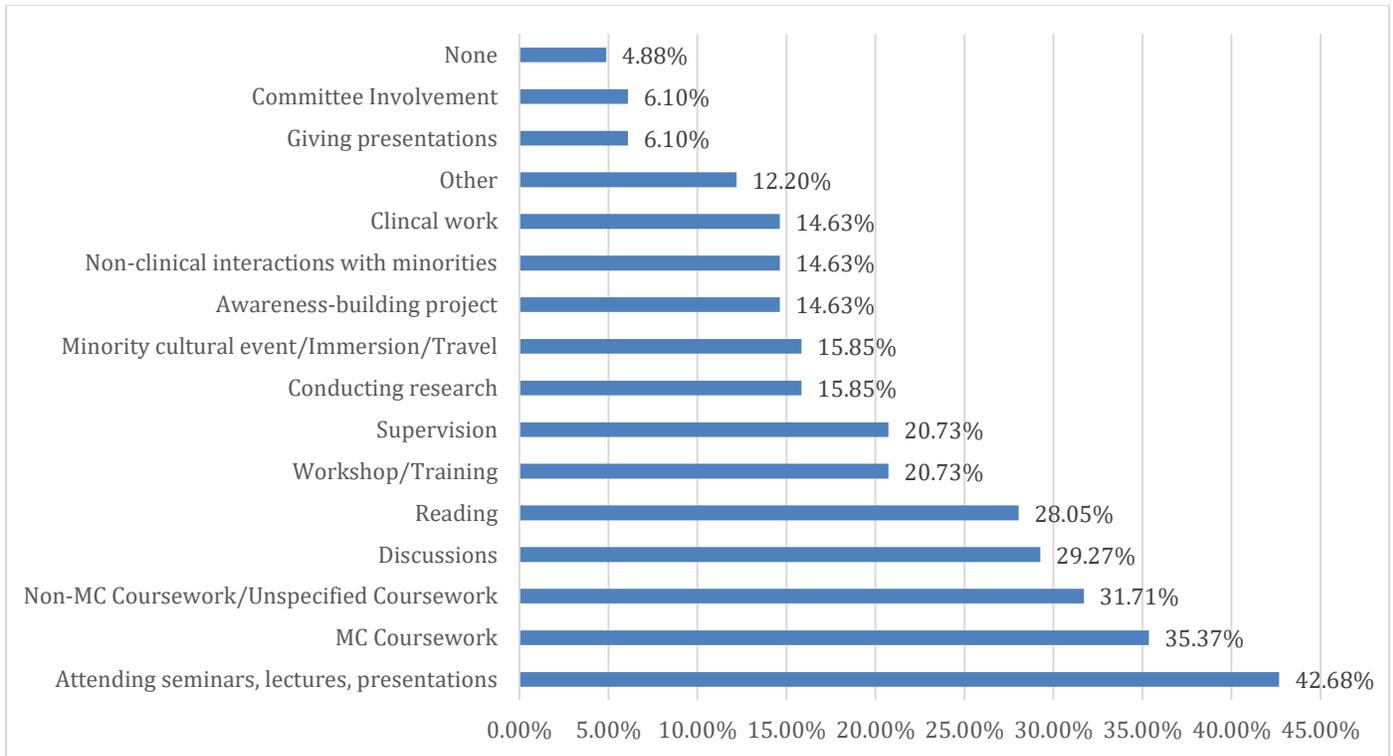


Figure 1. Activities to develop multicultural competence. This figure illustrates the activities students reported engaging in to develop multicultural competence.

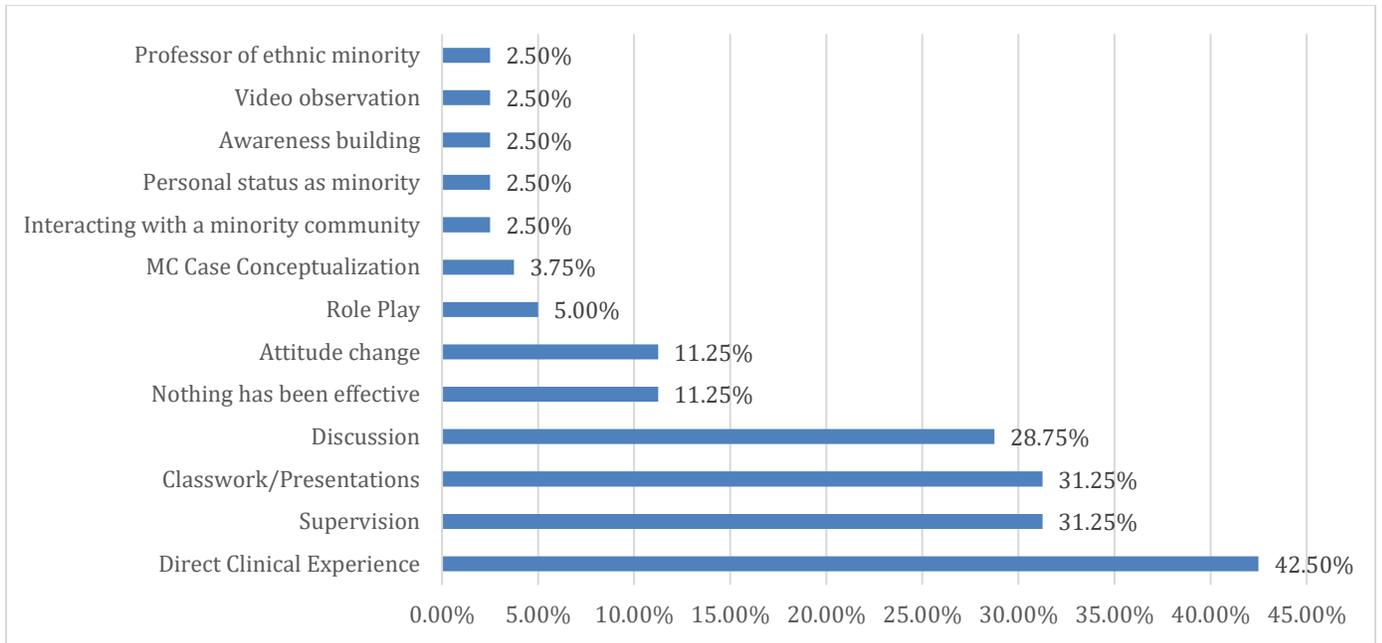


Figure 2. Effective activities for multicultural competence. This figure illustrates the activities students reported as most effective in developing their multicultural competence.

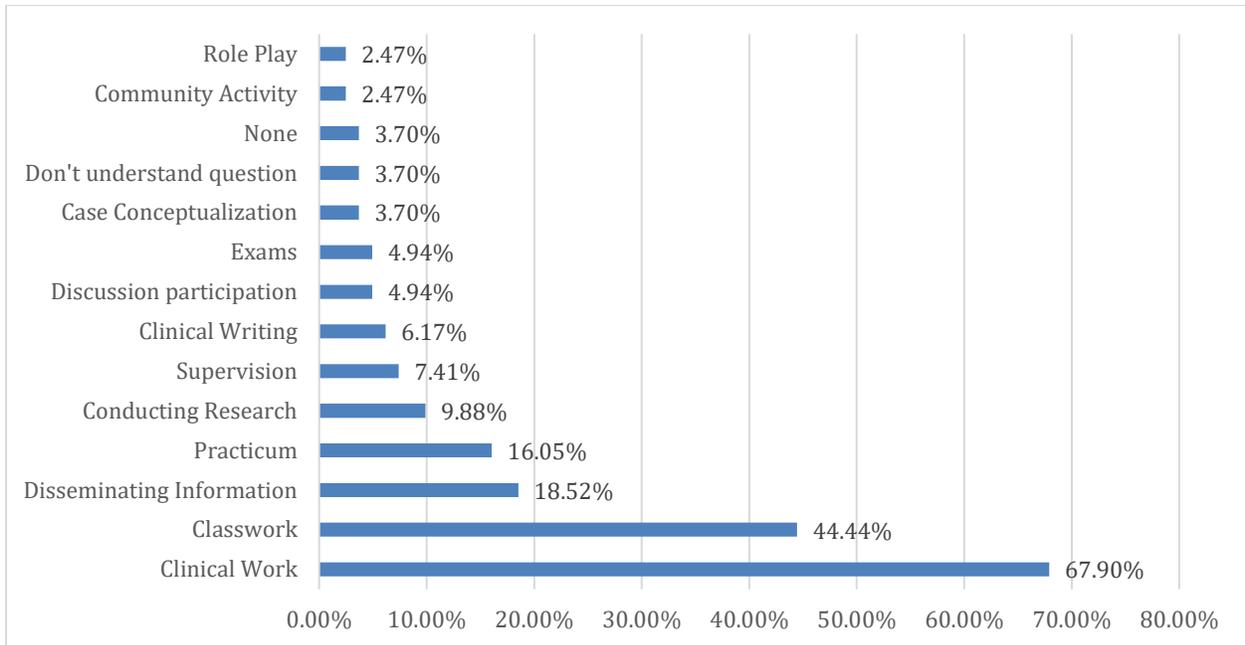


Figure 3. Activities demonstrating multicultural competence. This figure illustrates the frequencies and types of activities from which students were asked to demonstrate multicultural competence.

Appendix A

Demographic Form

1. What is your current age? _____
2. How would define your gender?
 - Woman
 - Man
 - Non-binary/Genderqueer
 - Other: _____
3. Select the racial or ethnic group(s) with which you identify: *(You may check more than one)*
 - American Indian/Alaska Native
 - Asian
 - Native Hawaiian or Other Pacific Islander
 - Black or African American
 - Hispanic or Latino
 - White, non-Hispanic or Latino
 - Other: _____
4. Which sexual identity most closely represents how you identify?
 - Heterosexual
 - Gay / Lesbian
 - Bisexual
 - Other (e.g., queer, pansexual): _____
5. Please select the psychology program you are enrolled in:
 - Clinical

School

Counseling

6. How many years have you completed in your program?: _____

7. Have you completed a graduate level course focused on multicultural issues?:

Yes

No

8. Please estimate the number of hours of graduate level coursework focused on multicultural issues that you have completed (for reference, a 15-week semester-long graduate course is approximately 45 hours). Please include hours from dedicated multicultural courses as well as hours from other courses during which multicultural issues were an explicit focus: _____

9. At this point in my graduate training, I feel that I have ___% of the knowledge needed to be a competent psychologist for racial and ethnic minority clients. Please enter an estimated percentage (0-100).

10. At this point in my graduate training, I feel that I have ___% of the awareness needed to be a competent psychologist for racial and ethnic minority clients. Please enter an estimated percentage (0-100).

11. At this point in my graduate training, I feel that I have ___% of the skills needed to be a competent psychologist for racial and ethnic minority clients. Please enter an estimated percentage (0-100).

12. Please estimate your total hours of direct clinical experience: _____

13. Please estimate the number of racial or ethnic minority clients with whom you have worked:

14. Please estimate your number of hours of direct clinical interactions with racial or ethnic

minority clients: _____

15. Through your graduate training program, what activities have you engaged in to develop multicultural competence?
16. In what areas of training were you given opportunities to demonstrate multicultural competence?
17. In your opinion, what was the most effective activity that taught you skills to work with racial and ethnic minority clients?
18. If I were given feedback from a supervisor that I needed to further develop my skills in working with diverse populations, I would be upset.
19. There are skills needed to competently work with racial and ethnic minority clients that are different from those used with racial and ethnic majority clients.
20. I can imagine a circumstance in which my limited understanding of a client's racial or ethnic background might require me to seek out resources (e.g., a consultant) in order to better understand a client's racial or ethnic background.
21. My graduate training program does not offer enough experiences in working with racial or ethnic minorities for me to gain multicultural competence.

Appendix B

Questionnaire

For the following questions, please provide answers as they pertain to training you have received to *work with racial or ethnic minority clients*.

Please rate how frequently you have engaged in practical or applied learning activities during your graduate training from 1 to 5 (1 = *never*; 3 = *sometimes*; 5 = *frequently*). These activities may include observing models (video/audio tape or live); engaging in simulations (e.g. role play exercises); supervised behavioral rehearsals; learning tasks (e.g. diaries, charts, forms); behavioral tests (e.g. demonstrations of achievement).

1. In what settings did you engage in these activities?:

- Graduate multicultural course
- Clinical supervision
- Group practicum
- Seminar or workshop with multicultural focus
- Other: _____

2. Please estimate the total number of hours you have engaged in practical or applied learning activities in your graduate training for work with racial or ethnic minority clients (for reference, one 15-week semester-long course is approximately 45 hours): _____

3. For this study, multicultural counseling interactions are defined as any interactions between a therapist and a client of racial or ethnic minority background. Please rate how frequently you have engaged in the following activities from 1 to 5 (1 = *never*; 3 = *sometimes*; 5 = *frequently*):

- Observed video/audio tape or live models of multicultural clinical interactions?

- Engaged in simulations of multicultural clinical interactions (e.g. role play)?
- Engaged in multicultural case conceptualization with a supervisor or instructor (i.e., a focus on the integration of cultural factors on a client's presenting concerns and the development of an appropriate treatment plan that takes cultural factors into consideration).
- Engaged in Socratic dialogue with a supervisor or instructor that prompted you to critically analyze cultural factors for a racial or ethnic minority client?
- Engaged in supervised behavioral rehearsal of multicultural-related skills?
- Were tasked to demonstrate competency for skills related to multicultural clinical interactions?

Appendix C

The Multicultural Awareness, Knowledge, and Skills Survey (MAKSS)

The Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) is a 60-item survey designed by Michael D'Andrea, Judy Daniels, and Ronald Heck, all from the University of Hawaii. Respond to all 60 items on the scale, even if you are not working with clients or actively conducting groups. Base your response on what you think at this time. Try to assess yourself as honestly as possible rather than answering in the way you think would be desirable.

The MAKSS is designed as a self-assessment of your multicultural counseling awareness, knowledge, and skills.

1. Culture is not external but is within the person.

Strongly disagree Disagree Agree Strongly agree

2. One of the potential negative consequences about gaining information concerning specific cultures is that students might stereotype members of those cultural groups according to the information they have gained.

Strongly disagree Disagree Agree Strongly agree

3. At this time in your life, how would you rate yourself in terms of understanding how your cultural background has influenced the way you think and act?

Very limited Limited Good Very good

4. At this point in your life, how would you rate your understanding of the impact of the way you think and act when interacting with persons of different cultural backgrounds?

Very limited Limited Good Very good

5. How would you react to the following statement? While counseling enshrines the concepts of freedom, rational thought, tolerance of new ideas, and equality, it has frequently become a form of oppression to subjugate large groups of people.

Strongly disagree Disagree Agree Strongly agree

6. In general, how would you rate your level of awareness regarding different cultural institutions and systems?

Very limited Limited Good Very good

7. The human service professions, especially counseling and clinical psychology, have failed to meet the mental health needs of ethnic minorities.

Strongly disagree Disagree Agree Strongly agree

8. At the present time, how would you generally rate yourself in terms of being able to accurately compare your own cultural perspective with that of a person from another culture?

Very limited Limited Good Very good

9. How well do you think you could distinguish “intentional” from “accidental” communication signals in a multicultural counseling situation?

Very limited Limited Good Very good

10. Ambiguity and stress often result from multicultural situations because people are not sure what to expect from each other.

Strongly disagree Disagree Agree Strongly agree

11. The effectiveness and legitimacy of the counseling profession would be enhanced if counselors consciously supported universal definitions of normality.

Strongly disagree Disagree Agree Strongly agree

12. The criteria of self-awareness, self-fulfillment, and self-discovery are important measures in most counseling sessions.

Strongly disagree Disagree Agree Strongly agree

13. Even in multicultural counseling situations, basic implicit concepts, such as “fairness” and “health,” are not difficult to understand.

Strongly disagree Disagree Agree Strongly agree

14. Promoting a client’s sense of psychological independence is usually a safe goal to strive for in most counseling situations.

Strongly disagree Disagree Agree Strongly agree

15. While a person’s natural support system (i.e., family, friends, etc.) plays an important role during a period of personal crisis, formal counseling services tend to result in more constructive outcomes.

Strongly disagree Disagree Agree Strongly agree

16. How would you react to the following statement? In general, counseling services should be directed toward assisting clients to adjust to stressful environmental situations.

Strongly disagree Disagree Agree Strongly agree

17. Counselors need to change not just the content of what they think, but also the way they handle this content if they are to accurately account for the complexity in human behavior.

Strongly disagree Disagree Agree Strongly agree

18. Psychological problems vary with the culture of the client.

Strongly disagree Disagree Agree Strongly agree

19. How would you rate your understanding of the concept of “relativity” in terms of the goals, objectives, and methods of counseling culturally different clients?

Very limited Limited Good Very good

20. There are some basic counseling skills that are applicable to create successful outcomes regardless of the client's cultural background.

Strongly disagree Disagree Agree Strongly agree

At the present time, how would you rate your own understanding of the following terms:

21. Culture

Very limited Limited Good Very good

22. Ethnicity

Very limited Limited Good Very good

23. Racism

Very limited Limited Good Very good

24. Mainstreaming

Very limited Limited Good Very good

25. Prejudice

Very limited Limited Good Very good

26. Multicultural Counseling

Very limited Limited Good Very good

27. Ethnocentrism

Very limited Limited Good Very good

28. Pluralism

Very limited Limited Good Very good

29. Contact Hypothesis

Very limited Limited Good Very good

30. Attribution

Very limited Limited Good Very good

31. Transcultural

Very limited Limited Good Very good

32. Cultural Encapsulation

Very limited Limited Good Very good

33. What do you think of the following statements? Witch doctors and psychiatrists use similar techniques.

Strongly disagree Disagree Agree Strongly agree

34. Differential treatment in the provision of mental health services is not necessarily thought to be discriminatory.

Strongly disagree Disagree Agree Strongly agree

35. In the early grades of formal schooling in the United States, the academic achievement of such ethnic minorities as African Americans, Hispanics, and Native Americans is close to parity with the achievement of White mainstream students.

Strongly disagree Disagree Agree Strongly agree

36. Research indicates that in the early elementary school grades girls and boys achieve about equally in mathematics and science.

Strongly disagree Disagree Agree Strongly agree

37. Most of the immigrant and ethnic groups in Europe, Australia, and Canada face problems similar to those experienced by ethnic groups in the United States.

Strongly disagree Disagree Agree Strongly agree

38. In counseling, clients from different ethnic/cultural backgrounds should be given the same treatment that White mainstream clients receive.

Strongly disagree Disagree Agree Strongly agree

39. The difficulty with the concept of “integration” is its implicit bias in favor of the dominant culture.

Strongly disagree Disagree Agree Strongly agree

40. Racial and ethnic persons are underrepresented in clinical and counseling psychology.

Strongly disagree Disagree Agree Strongly agree

41. How would you rate your ability to conduct an effective counseling interview with a person from a cultural background significantly different from your own?

Very limited Limited Good Very good

42. How would you rate your ability to effectively assess the mental health needs of a person from a cultural background significantly different from your own?

Very limited Limited Good Very good

43. How well would you rate your ability to distinguish “formal” and “informal” counseling strategies?

Very limited Limited Good Very good

44. In general, how would you rate yourself in terms of being able to effectively deal with biases, discrimination, and prejudices directed at you by a client in a counseling setting?

Very limited Limited Good Very good

45. How well would you rate your ability to accurately identify culturally biased assumptions as they relate to your professional training?

Very limited Limited Good Very good

46. How well would you rate your ability to discuss the role of “method” and “context” as they relate to the process of counseling?

Very limited Limited Good Very good

47. In general, how would you rate your ability to accurately articulate a client’s problem who comes from a cultural group significantly different from your own?

Very limited Limited Good Very good

48. How well would you rate your ability to analyze a culture into its component parts?

Very limited Limited Good Very good

49. How would you rate your ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural/racial/ethnic backgrounds?

Very limited Limited Good Very good

50. How would you rate your ability to critique multicultural research?

Very limited Limited Good Very good

51. In general, how would you rate your skill level in terms of being able to provide appropriate counseling services to culturally different clients?

Very limited Limited Good Very good

52. How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a client whose cultural background is significantly different from your own?

Very limited Limited Good Very good

53. How would you rate your ability to effectively secure information and resources to better serve culturally different clients?

Very limited Limited Good Very good

54. How would you rate your ability to accurately assess the mental health needs of women?

Very limited Limited Good Very good

55. How would you rate your ability to accurately assess the mental health needs of men?

Very limited Limited Good Very good

56. How well would you rate your ability to accurately assess the mental health needs of older adults?

Very limited Limited Good Very good

57. How well would you rate your ability to accurately assess the mental health needs of gay men?

Very limited Limited Good Very good

58. How well would you rate your ability to accurately assess the mental health needs of gay women?

Very limited Limited Good Very good

59. How well would you rate your ability to accurately assess the mental health needs of handicapped persons?

Very limited Limited Good Very good

60. How well would you rate your ability to accurately assess the mental health needs of persons who come from very poor socioeconomic backgrounds?

Very limited Limited Good Very good

Appendix D

The MCSDS

Directions: Read each item and respond whether it is true (T) or false (F) for you.

1. Before voting I thoroughly investigate the qualifications of all the candidates.
2. I never hesitate to go out of my way to help someone in trouble.
3. It is sometimes hard for me to go on with my work if I am not encouraged.
4. I have never intensely disliked anyone.
5. On occasions I have had doubts about my ability to succeed in life.
6. I sometimes feel resentful when I don't get my way.
7. I am always careful about my manner of dress.
8. My table manners at home are as good as when I eat out in a restaurant.
9. If I could get into a movie without paying and be sure I was not seen, I would probably do it.
10. On a few occasions, I have given up something because I thought too little of my ability.
11. I like to gossip at times.
12. There have been times when I felt like rebelling against people in authority even though I knew they were right.
13. No matter who I'm talking to, I'm always a good listener.
14. I can remember "playing sick" to get out of something.
15. There have been occasions when I have taken advantage of someone.
16. I'm always willing to admit it when I make a mistake.
17. I always try to practice what I preach.
18. I don't find it particularly difficult to get along with loudmouthed, obnoxious people.
19. I sometimes try to get even rather than forgive and forget.

20. When I don't know something I don't mind at all admitting it.
21. I am always courteous, even to people who are disagreeable.
22. At times I have really insisted on having things my own way.
23. There have been occasions when I felt like smashing things.
24. I would never think of letting someone else be punished for my wrong-doings.
25. I never resent being asked to return a favor.
26. I have never been irked when people expressed ideas very different from my own.
27. I never make a long trip without checking the safety of my car.
28. There have been times when I was quite jealous of the good fortune of others.
29. I have almost never felt the urge to tell someone off.
30. I am sometimes irritated by people who ask favors of me.
31. I have never felt that I was punished without cause.
32. I sometimes think when people have a misfortune they only got what they deserved.
33. I have never deliberately said something that hurt someone's feelings.