ABSTRACT

Title of thesis: DEVELOPMENT AND INITIAL VALIDATION OF THE MULTICULTURAL COUNSELING SELF-EFFICACY SCALE – RACIAL DIVERSITY FORM

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The purpose of the study is to develop and validate the *Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form* (MCSE-RD). Theoretical underpinnings of the study were derived from social cognitive theory and the literature of multicultural counseling. Specifically, the MCSE-RD is designed to assess the helping professional's perceived abilities in providing individual counseling to racially diverse clients. Data were collected from 181 graduate students in counseling-related programs. Results of an exploratory factor analysis retained 37 items and indicated that the MCSE-RD consists of three underlying factors. The MCSE-RD subscale and total scores showed adequate internal consistency and test-retest reliabilities. Also, convergent and discriminant validity was initially supported by differential relations of MCSE-RD scores to general counseling self-efficacy, multicultural counseling competency, and social desirability. Finally, the MCSE-RD scores correlated significantly with demographic variables and educational/training

backgrounds. In conclusion, psychometric properties of the MCSE-RD were initially supported by findings of the study.

# DEVELOPMENT AND INITIAL VALIDATION OF THE MULTICULTURAL COUNSELING SELF-EFFICACY SCALE – RACIAL DIVERSITY FORM

by

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# Chapter I: Introduction

With the dramatically increasing diversification of the U.S. population, helping professionals have become aware of the important role that culture plays in service delivery and training (Hall, 1997; Sue, Arrendondo, & McDavis, 1992). In fact, Neimeyer and Diamond (2001) recently identified commitment to issues of diversity, among 11 roles, as the most central feature of the identity of the counseling psychology profession in the future. Awareness of the importance of cultural diversity has provided the discipline a necessary impetus to advance our knowledge about, and develop effective services for, culturally different populations. The existing multicultural literature has echoed this trend, and theories and theory-derived instruments have been developed to facilitate the training of culturally competent helping professionals.

Not only is incorporating cultural factors in our work with diverse clienteles a competence issue, it is also an ethical issue that lays the foundation of our profession. A recent collaboration by the Society of Counseling Psychology (Division 17) and the Society for the Psychological Study of Ethnic Minority Issues (Division 45) of the American Psychological Association produced the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2002). The Guidelines offer helping professionals aspirational principles when working in the multicultural setting. Six specific multicultural guidelines call for psychologists to: (a) recognize their attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically/racially different from themselves; (b) recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically/racially different individuals; (c) employ the constructs of

multiculturalism and diversity in psychological education; (d) recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds; (e) apply culturally appropriate skills in clinical and other applied psychological practice; and (f) use organizational change processes to support culturally informed organizational development and practice.

In addition to the APA *Multicultural Guidelines*, the Council of National Psychological Associations for the Advancement of Ethnic Minority Issues (CNPAAEMI) has developed two important monographs promoting culture-specific guidelines for working with four major racial/ethnic groups: African Americans, Asian Americans/Pacific Islanders, Hispanics/Latinos, and Native Americans. These two monographs are *Guidelines for Research in Ethnic Minority Communities* (2000) and *Guidelines for Cultural Competence in the Treatment of Ethnic Minority Populations* (2002). Another important guidelines document, *APA Professional Practice Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients* (APA, 2000), was developed for multicultural issues related to sexual orientation. These APA guidelines and CNPAAEMI guidelines clearly indicate the important role multiculturalism is expected to play in psychologists' professional activities. They also provide standards to ethically and effectively train students and deliver services to individuals and organizations with different cultural backgrounds.

Cultural factors need to be taken into account in different types of service delivery, such as assessment, training, outreach programs, direct therapy, and supervision (Abreu, Chung, & Atkinson, 2000). In terms of multicultural counseling practice, various models have been developed (see Fuertes & Gretchen, 2001; Ponterotto, Fuertes, & Chen, 2000

for reviews). Although its empirical foundation has been questioned, the multicultural counseling competency model, proposed and revised by Sue and his colleagues (Sue et al., 1992; Sue et al., 1982), has been extensively adopted by counseling training programs. In the past decade, several instruments, such as the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFormboise, Coleman, & Hernandez, 1991), the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), the Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991), and the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002), have been developed to measure and validate the Sue et al. model.

In reviewing multiculturalism as a new paradigm in counseling theory, Essandoh (1996) contended that progress has been made only in theory and research. Ponterotto (1998) described the body of multicultural counseling research as still in its infancy because of the many conceptual and psychometric limitations of instruments available to measure relevant constructs. Likewise, Constantine and Ladany (2000, 2001) indicated the strong need for testing and revision of self-report measures of multicultural counseling competency. Other researchers (Ridley, Mendoza, Kanitz, Angermeier, & Zenk, 1994) have argued that the underlying constructs represented by these measures are overlapping and not clearly defined. Moreover, these instruments have focused more on the knowledge and awareness dimensions of the Sue et al. model (1992), and paid less attention to the dimension of skills, specifically, the ability to develop culturally appropriate intervention strategies and techniques (e.g., the MCKAS). Those multicultural counseling competency instruments that do attempt to measure the

dimension of culturally appropriate counseling skills tend to assess general counseling skills rather than specific behaviors a counselor performs when working with culturally different clients. For example, the Skills subscale of the MCI includes items like "I use varied counseling techniques and skills," and "I am effective at crisis interventions (e.g., suicide attempt, tragedy, broken relationship)." Moreover, instead of specifying a particular multicultural subgroup or setting, instructions of these multicultural counseling competence instruments (e.g., the MAKSS and MCI) direct respondents to give their self-report ratings when working in a general multicultural counseling situation. The literature might, therefore, benefit from development of measures that assess more specific behaviors performed at various stages of counseling by culturally effective counselors when working with a specific class of diverse persons, such as racially different clients.

In reconceptualizing multicultural counseling competence, Constantine and Ladany (2001) envisioned multicultural counseling self-efficacy as one of the six dimensions of multicultural competence. This concept is defined as "counselors' confidence in their ability to perform a set of multicultural counseling skills and behaviors successfully" (p. 491). This definition stresses the central role of counselors' confidence in performing skills, as opposed to knowledge and awareness, in multicultural counseling settings. Since verbal and nonverbal behaviors are the only channels for counselors to demonstrate their multicultural counseling competency, other researchers have also cited the importance and necessity of developing more precise self-efficacy measures to assess what counselors believe they can do in the context of multicultural counseling (Neville & Mobley, 2001; Worthington, 2002).

Because of the various cultural factors involved, multicultural counseling may be quite different from general counseling. In addition to clients' presenting issues and personal dynamics, practitioners have to take into account cultural variables, such as race, ethnicity, sexual orientation, and religion as they design interventions for diverse clients. Some multicultural psychologists have suggested that we expand the dialogue on diversity to include, at a minimum, age, culture, disability, gender, educational level, ethnicity, language, physique, race, religion, sexual orientation, and socioeconomic situation (e.g., Sue & Sue, 2003; Weinrach & Thomas, 1996). I agree with the need to be inclusive in multicultural counseling. However, it is a daunting task, if possible at all, to develop a single instrument capable of assessing self-efficacy for conducting counseling with all possible multicultural subgroups. For the sake of the usefulness and brevity of the instrument, it is also impractical to design a scale that is to cover a variety of multicultural issues. In addition, self-efficacy is a domain-specific construct (Bandura, 1997). Thus, one may possess differing degrees of self-efficacy for working with different client groups, such as lesbian, gay, bisexual, and transgendered (LGBT) clients, racial minorities, or people with disabilities. To respond to the lack of a self-efficacy measure in the multicultural counseling literature, the current study is designed to develop and provide initial validation for a new instrument that focuses on counselors' perceived ability to effectively work with racially different clients.

## Problem Statement

Researchers have developed at least ten measures that assess counseling self-efficacy in general. Some of these instruments focus on basic or advanced individual counseling skills (e.g., Johnson, Baker, Kopala, Kiselica, & Thompson, 1989; Larson,

Suzuki, Gillespie, Potenza, Bechtel, & Toulouse, 1992), whereas others focus on certain content specialties, such as group counseling, career counseling, school counseling, or psychiatry (e.g., Margolies, Wachtel, & Schmelkin, 1986; O'Brien, Heppner, Flores, & Bikos, 1997; Sutton & Fall, 1995). Although a few items from some of these instruments were designed to assess self-efficacy in the multicultural context, they tend to focus only on parts of the counseling process and assess this construct at intermediate or general levels that may not be helpful in predicting specific outcomes. Self-efficacy for conducting multicultural counseling with racial/ethnic minority groups has been left largely unexamined. Research investigating multicultural counseling self-efficacy, its development, and relationship to general counseling self-efficacy is clearly needed. It seems important that researchers examine systematically the construct of self-efficacy for counseling racially/ethnically diverse groups, and disseminate the findings to trainers and graduate programs to improve the quality of mental health services provided to our diverse clienteles. To achieve this purpose, it is necessary, as the first step, to develop a psychometrically and conceptually adequate measure of multicultural counseling self-efficacy specifically for racially diverse groups.

The purpose of the current project is to develop and validate the Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD). The concept of self-efficacy from Bandura's (1986, 1997) social cognitive theory is chosen to be the theoretical underpinning of the proposed instrument because it is seen as central to multicultural competence (Constantine & Ladany, 2001) and is assessed in relation to specific behaviors. To measure self-efficacy, the MCSE-RD focuses exclusively on the behavioral aspect of multicultural counseling competency. In other words, this measure

taps the skills, as opposed to knowledge and awareness, component of Sue's (2001) cultural competency model. Instead of measuring actual or externally assessed competency for multicultural counseling, the MCSE-RD emphasizes confidence in one's perceived ability to provide effective counseling for racially diverse clients. To be thorough, MCSE-RD items cover various behaviors of counselors that are presumed to bring about successful outcomes at different stages of counseling for racially diverse clients.

# Chapter II: Literature Review

## *Self-Efficacy in Counseling and Counselor Training*

Self-efficacy, the core construct in social cognitive theory, refers to "people's judgment of their capabilities to organize and execute courses of action required to attain designated types of performance" (Bandura, 1986, p. 391). Posited as the central mechanism of psychological change, self-efficacy has mediating effects in at least three areas: (a) approach versus avoidance behavior, (b) quality of performance in the target domain, and (c) persistence in the face of adversity or disconfirming experiences (Bandura, 1977). Also, Bandura (1977, 1997) put forward four sources of information through which self-efficacy expectations are acquired and by which they can be modified: (a) performance accomplishments, that is, experiences of successfully performing the target behaviors; (b) vicarious leaning or modeling; (c) verbal persuasion, such as encouragement and support from significant others; and (d) physiological and affective states, such as the lack of anxiety and fear associated with the behavior. All of these areas are relevant to counselor training and clients' adjustment.

The concept of self-efficacy has been widely applied to counseling and psychotherapy. Research has indicated the important role that self-efficacy plays in interventions for anxiety (Williams, 1995), depression (Maddux & Meier, 1995), eating disorders, and alcohol and drug abuse (Bandura, 1997; DiClemente, Fairhurst, & Piotrowaki, 1995). From an agentic perspective, self-efficacytheory provides both counselors and clients with the framework to focus on enablement factors, "the personal resources to select and structure their environments in ways that set a successful course for their lives" (Bandura, 1997, p.177). For people with adjustment difficulties, such as

career development issues, self-efficacy also plays a key role in facilitating career interests, choice, and performance (Hackett, 1995; Lent, Brown, & Hackett, 2002).

With adequate levels of skills, counselors with higher self-efficacy will tend to have more self-aiding thoughts, experience anxiety as challenging rather than weakening, and set more realistic, moderately challenging goals (Larson, 1998). However, without prerequisite counseling skills, a sense of high self-efficacy may put the counselor in a situation where he or she is likely to set unrealistic goals and then fail to achieve them. These unsuccessful experiences caused by unrealistic self-efficacy and goals may later on diminish the counselor's efficacy beliefs because performance accomplishment (or failure) is a major source of self-efficacy. Moreover, clients who seek help from counselors whose counseling efficacy beliefs considerably exceed their skills are likely to be disappointed because counselors may not be able to perform those skills required to achieve counseling goals and meet clients' expectations. Actually, Bandura (1986) suggested it is best for self-efficacy beliefs to slightly exceed one's current skills levels. Because of its impact on counselors' performance and clients' satisfaction, the compatibility of counseling self-efficacy and skills is particularly germane in counselor training.

According to Larson and Daniels (1998), at the time of their review, more than thirty studies had explored counseling self-efficacy (CSE) in relation to counselor training and supervision. These studies focused on the central role of the self-efficacy construct apart from the larger social cognitive theory. For the purpose of developing a measure assessing CSE, Larson and her colleagues (Larson et al., 1992) defined this construct as one's beliefs or judgments about one's capabilities to effectively counsel a

client in the near future. Larson (1998), later on, proposed a social cognitive model of counselor training (SCMCT) that applied social cognitive theory to counselor development. Deemed to be responsible for effective counselor learning, the triadic reciprocal causality in the SCMCT includes three components: the counselor's personal agency, the resulting efficacious actions in supervision and counseling, and the learning environment. Personal agency includes CSE beliefs and the dynamic cognitive, motivational, and affective processes of the person. Among these self-determining influences, CSE beliefs are viewed as the primary causal determinants between knowing how to counsel and executing effective actions. Although the SCMCT added to the counselor training literature by providing the social cognitive framework, it pays relatively little attention to multicultural practice issues. Cultural factors were not included in the research hypotheses proposed by the SCMCT; and the process by which counselors develop differential efficacy beliefs for working with various multicultural subgroups was not discussed in the model.

Despite the progress made in counselor training, the concept of self-efficacy had not been applied to the multicultural counseling setting until very recently. Using a sample of 94 counselors in training, Constantine (2001b) found that general counseling self-efficacy correlated significantly and positively ($r = .51$) with self-perceived multicultural counseling competence. In another study, Constantine (2001a) further indicated that receipt of multicultural supervision was a significant predictor ($\beta = .28$, $p < .01$) of counselor trainees' multicultural counseling self-efficacy measured by the Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea et al., 1991). Although Constantine's findings look intriguing, the MAKSS was not actually designed

to be a self-efficacy measure. Several scholars have offered a definition of multicultural counseling self-efficacy. Constantine and Ladany (2001) defined this construct as "counselors' confidence in their ability to perform a set of multicultural counseling skills and behaviors successfully" (p. 491). Seemingly more inclusive, the definition of multicultural counseling self-efficacy provided by Neville and Mobley (2001) pertains to culturally based cognitive processes in which counselors in training construct beliefs regarding their capabilities in performing culturally appropriate tasks and behaviors during interaction with clients as well as with their peers and faculty. However, no instruments have been developed to operationalize these definitions. It is clear that the literature regarding the application of self-efficacy in the multicultural setting is still in its infancy. More appropriate measures and empirical studies are needed to assess the concept of multicultural self-efficacy and explore its importance in counselor training.

*General CSE Measures: Why They Are Not Sufficient for Multicultural Counseling*

Recognizing the important implications of social cognitive theory in counselor training and development, researchers have developed several measures to assess the construct of counseling self-efficacy. Most of the existing CSE literature focuses on the relationship between CSE and other important counselor training variables, such as counselor anxiety, counselor performance, and the supervision environment (Johnson et al., 1989; Ridgway & Sharpley, 1990; Sipps, Sugden, & Faiver, 1988). Ten CSE measures were identified by Larson and Daniels (1998). Four measures focusing exclusively on individual counseling include: (a) the Interpersonal Skills Efficacy Scale (ISES; Munson, Zoerink, & Stadulis, 1986); (b) the Counselor Behavior Evaluation – Self-efficacy (CBE-SE; Munson, Stadulis, & Munson, 1986); (c) the Counselor Self-

Efficacy Scale (CSES; Johnson et al., 1989); and (d) the Counseling Self-Estimate Inventory (COSE; Larson et al., 1992). Two instruments, the Counselor Self-Efficacy Scale (COSES; Melchert, Hays, Wiljanen, & Kolocek, 1996) and the Self-Efficacy Inventory (S-EI; Friedlander & Synder, 1983), assess self-efficacy in areas beyond individual counseling, such as group counseling, case management, and family interventions. Still other scales were developed for specific domains including the Counselor Self-Efficacy Survey (CSS; Sutton & Fall, 1995) for school counseling, the Career Counseling Self-Efficacy Scale (CCSES; O'Brien et al., 1997), and the Self-Efficacy Questionnaire (S-EQ; Margolies et al., 1986) for psychiatry.

With the exceptions of the COSE, COSES, and CCSES, these measures were designed for the purpose of particular studies and lacked psychometric information. According to Larson and Daniels' review (1998), the COSE has been the most popular (used in 43% of the studies reviewed by them) followed by the S-EI (13%). Although these instruments have advanced our understanding of how self-efficacy mediates counselor performance and effectiveness of training programs, Lent, Hackett, and Brown (1998) pointed out some problems in assessing and defining counselor self-efficacy. These issues include: (a) using items and formats that may be more appropriate in assessing constructs (e.g., knowledge, values) other than self-efficacy; (b) presuming a level of counseling skills that would surpass that of most novice trainees; and (c) sampling self-efficacy inadequately with respect to more advanced or complex counseling tasks. In tackling some of these issues, Lent, Hill, and Hoffman (2003) developed a new self-efficacy measure, the Counselor Activity Self-Efficacy Scales (CASES), for performing helping skills, managing the counseling process, and handing

challenging counseling situations. Nonetheless, these issues cited by Lent et al. (1998) warrant future conceptual work and empirical investigations.

The predictive usefulness of a CSE measure in a particular context is related to its level of generality or specificity. Bandura (1997) proposed three levels (specific, intermediate, general) of generality of assessment that have implications for predicting different outcomes. A self-efficacy measure at the specific level of generality is more likely to successfully predict performance in that particular domain. On the other hand, an undifferentiated and contextless measure of self-efficacy would have weak predictive value in the same domain. Likewise, context-free CSE measures are expected to be less helpful than more domain-specific CSE estimates in predicting counselor performance with particular types of clients or issues. According to this criterion, most of the existing CSE measures are, theoretically, not ideally designed to predict counselor performance in the multicultural setting because multicultural issues are not the main focus of most of them.

Among the ten CSE measures reviewed by Larson and Daniels (1998) plus the new scale developed by Lent et al. (2003), only the COSE and CCSES have subscales for assessing multicultural CSE. Out of 37 items, the Cultural Competence subscale of the COSE consists of four items focusing on social class and ethnicity issues. Instead of assessing self-efficacy for a particular performance under a specific set of conditions, these items tend to focus on a more intermediate or global level of perceived efficacy (e.g., "I will be an effective counselor with clients of a different social class," "In working with culturally different clients I may have a difficult time viewing situations from their perspective;" Larson et al., 1992, p. 111). Thus, for predicting counselor

effectiveness when working with racially diverse clients, the Cultural Competence subscale of the COSE is probably less helpful than would be a self-efficacy measure that taps specific counselor behaviors in this particular area. This problem is also relevant to the Multicultural Competency Skills subscale of the CCSES that takes a more general approach to tap self-efficacy for multicultural issues in the context of career counseling (e.g., "Understand special issues present for lesbian, gay, and bisexual clients in the workplace;" "Understand special issues related to gender in the workplace;" "Understand special issues related to ethnicity in the workplace;" O'Brien et al., 1997, p. 24). Moreover, these items seem less behaviorally based, and are more relevant to knowledge and awareness rather than skills. In the newly developed CASES (Lent et al., 2003), self-efficacy for working with multicultural issues is covered at a minimal level. There are only two items from the Counseling Challenges subscale of the CASES that assess participants' confidence in working with clients who are different from them in a major way or ways (e.g., race, ethnicity, gender, age, and social class), and who have core values or beliefs that conflict with their own regarding religion or gender roles. The remaining eight CSE measures do not attempt to assess self-efficacy in themulticultural setting.

Based on the above literature review, the existing CSE measures either pay little attention to efficacy percepts regarding multicultural counseling or confound this construct with other variables such as awareness and knowledge. In other words, these CSE instruments are not specifically situated in the multicultural setting. Although much progress has been made at understanding the relationship between general CSE and counselor performance and supervision, it is unclear whether or not we could translate

these findings into the multicultural counseling arena. A major obstacle has been the absence of a conceptually adequate and psychometrically sound measure of multicultural counseling self-efficacy. More efforts need to be made to advance our understanding about counselors' perceived ability and actual performance when delivering services to people with different cultural backgrounds.

*Strengths and Weaknesses of the Multicultural Counseling Literature in Relation to CSE*

Beginning in the early 1980s, training for multicultural counseling competence became an important issue for helping professionals. Multicultural researchers have made good progress in at least four areas: (a) definition of multicultural competencies (Constantine & Ladany, 2001; Sue, 2001; Sue et al., 1982; Sue et al., 1992); (b) models of multicultural counseling (D'Andrea & Daniels, 2001; Fuertes & Gretchen, 2001; Ponterotto et al., 2000); (c) assessment of multicultural counseling competence (Coleman, 1996; D'Andrea et al., 1991; LaFromboise et al., 1991; Ponterotto et al., 2002; Sodowsky et al., 1994; Worthington, Mobley, Franks, & Tan, 2000); and (d) training of multicultural competencies (Abreu et al., 2000; Constantine, 2001a; Constantine & Ladany, 2000; Constantine, Ladany, Inman, & Ponterotto, 1996; Ponterotto & Casas, 1987; Quintana & Bernal, 1995). In addition to the progress made in theory and assessment, a recent survey indicated that 73% of APA-accredited counseling psychology programs offered one or more multicultural courses, and 42% of them required a multicultural course (Quintana & Bernal, 1995). These research and practice efforts indicate the important role of multicultural issues in our professional identity.

Despite the growth in this literature, our knowledge regarding the phenomenon of multicultural counseling and how to effectively deliver services to culturally diverse

clients still has a long way to go. Training in multicultural counseling was criticized for focusing primarily on the knowledge and awareness domains of competence instead of on the skills domain (McRae & Johnson, 1991). A survey conducted by Allison, Crawford, Echemendia, Robinson, and Knepp (1994) revealed that in counseling, school, and clinical psychology programs opportunities for training with diverse clients are limited, and only a small percentage of doctoral students felt "extremely" or "very" competent when working with racial/ethnic minority clients. Moreover, in Quintana and Bernal's (1995) survey, they concluded thatmost counseling psychology programs are "providing training that leads to, at best, multicultural sensitivity, but very few appear to be providing training that prepares practitioners to be multiculturally proficient" (p.102). This status of multicultural counseling training presents a need for examining the missing link between what counselors know and what they do when providing services to culturally diverse clients.

Consistent with the literature on multicultural training, assessment of multicultural counseling competence tends to lean toward attitudes and knowledge dimensions and to pay less attention to the skills dimension of Sue et al.'s (1992) cross cultural counseling competence model. Although lacking empirical support, the model first proposed by Sue and his colleagues in 1982, and later revised in 1992, serves as the theoretical underpinning for most quantitative multicultural counseling competence measures. The only exception is the Multicultural Competency Checklist, which evaluates competency at the level of academic programs (Ponterotto, Alexander, & Grieger, 1995).

At the individual level, there are three self-report scales and one other-report inventory that tap the construct of multicultural counseling competency. All of them

have initially acceptable psychometric properties, but need more validity evidence (Pope-Davis & Dings, 1995). The only other-report measure is the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFormboise et al., 1991). The CCCI-R consists of 20 items assessing three underlying factors: (a) cross-cultural counseling skills; (b) socio-political awareness; and (c) cultural senstivity. The instructions of the CCCI-R direct the respondent to rate the extent to which a counselor demonstrates a particular competency on a 6-pojnt Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). Although ten out of these twenty items fall into the cross-cultural counseling skill factor, some of them may measure constructs other than skills, such as values and attitudes (e.g., "comfortable with differences," "aware of own cultural heritage," and "values and respects cultural differences").

Developed by Sodowsky and her colleagues (1994), the Multicultural Counseling Inventory (MCI) aims at operationalizing the Sue et al. model (1982, 1992). The Awareness, Knowledge, and Skills subscales consist of 10, 11, and 11 items, respectively. A Multicultural Relationship subscale of 8 items was added to assess the counselor's interactional process with minority clients. Compared with other multicultural counseling competence measures, the MCI has accumulated more psychometric evidence supporting its use and provides the most behaviorally based assessment of multicultural counseling competence (Pope-Davis & Dings, 1995). However, after taking a closer look at those items belonging to the Skills subscale, it would seem that some of them are more relevant in assessing the awareness dimension (e.g., "understand my own philosophical preferences," "comfortable with exploring sexual issues"). Moreover, some of these items seem to tap the skills dimension at the intermediate or general levels rather than at

the specific level of multicultural interactions (e.g., “effective at crisis interventions,” “use varied counseling techniques and skills”) (Sodowsky, 1996, pp. 297-300). Finally, the instructions of the MCI asks respondents to evaluate their competence when “working in a multicultural counseling situation.” Because the multicultural counseling situation may involve the counselor in working with different populations such as racial minorities, LGBT clients, or people with disabilities, participants may respond to the MCI with any of a number of multicultural subgroups in mind. In other words, the lack of domain-specificity may lessen the MCI’s predictive effectiveness relative to counselors’ competence, interest, and performance at providing services to a specific population.

Originally designed to evaluate the impact of a cross-cultural counseling course, the Multicultural Awareness/Knowledge/Skills Survey (MAKSS) consists of 60 items that form the three subscales corresponding to the instrument’stitle (D ’Andrea et al., 1991). In supporting its use, the MAKSS relies heavily on content validity, established by matching the survey items with the instructional objectives of the course. The lack of a statistical procedure for selecting items and forming the three subscales is a major weakness of the MAKSS, especially its Awareness subscale (Pope-Davis & Dings, 1995). Similar to the MCI, some items of the Skills subscale of the MAKSS do not seem to measure competence in directly delivering effective services to clients (e.g., “ability to accurately identify culturally biased assumptions as they relate to your professional training,” “ability to critique multicultural research,” “ability to consult with another mental health professional”). Also, the Skills subscale assesses competence in working with racial/ethnic minorities, women, men, older adults, gay persons, handicapped

persons, and persons with low socioeconomic backgrounds, which might obscure the MAKSS's predictive value relative to specific outcomes.

The Multicultural Counseling Knowledge and Awareness Scale (MCKAS), formerly titled the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996), was revised to assess the knowledge and awareness components of multicultural counseling competence (Ponterotto et al., 2002). Originally, Ponterotto, Sanchez, and Magids (1991) attempted to develop the MCAS to measure the Sue et al. tripartite model (awareness, knowledge, and skills). However, both qualitative and statistical procedures supported a two-factor model, with the knowledge and skills items loading together and the awareness items loading on a separate factor. After revision, the MCKAS comprises 32 items assessing only the knowledge and awareness dimensions and leaving out the skills dimension. Initial reliability and validity evidence was provided for the MCKAS (Ponterotto et al., 2002).

Based on the above literature review on quantitative assessment of multicultural counseling competency, it is fair to say that our field has progressed significantly in response to Ponterotto and Casas's (1991) concern that little effort has been made to measure multicultural competence. However, most of the existing instruments seem to focus more on the awareness and knowledge dimensions of Sue et al.'s (1992) tripartite model than on the skills dimension. For those instruments including a subscale to assess multicultural counseling skills (e.g., the MCI, MAKSS, and CCCI-R), their items tend to assess counselors' perceived ability at the intermediate and general level rather than at the domain-specific level. In other words, these items do not seem to assess specific counselor behaviors conducted in sessions with clients from a particular diversity group.

Some of these items may also be confounded with items measuring knowledge and awareness. The absence of domain-specificity in these measures may lead to their lessened predictive value in relation to particular multicultural training outcomes, such as counselors' interest in delivering services to certain multicultural subgroups and their effectiveness in carrying out culturally appropriate interventions. Therefore, it is necessary to develop a new instrument that specifically taps the behavioral aspect of the Sue et al. (1992; 2001) model.

*Theoretical Underpinnings of the Current Study*

In the past decade, our profession has witnessed an explosion of the multicultural literature. Critical reviews have been done on research, training, and conceptual models (see Ponterotto, Casas, Suzuki, & Alexander, 1995, 2001; Pope-Davis, & Coleman, 1997). Various theoretical models have been proposed to identify facets of multicultural counseling competency (Sue et al., 1992), describe the interactions between culturally different counselors and clients (Helms & Cook, 1999), and decide on appropriate roles for counselors when working with racial/ethnic minorities (Atkinson, Thompson, & Grant, 1993). For the current study, Sue's (1992) model of multicultural counseling competence seems most relevant for the purpose of developing a self-efficacy measure for providing services to racially diverse clients. Not only was it officially endorsed by two separate American Psychological Association divisions (17 and 45) and six divisions of the American Counseling Association, but this model also provides the theoretical framework for existing multicultural counseling competence measures. This conceptual platform will allow the self-efficacy instrument developed in this project to compare with and compensate for the deficiencies of other scales. This framework was recently revised

by Sue (2001) into a 3 (components of cultural competence) × 4 (foci of cultural competence) × 5 (specific racial/cultural attributes) multidimensional model of cultural competence. Specifically, the three components of cultural competence include awareness of attitude/beliefs, knowledge, and skills; the four foci consist of the individual, professional, organizational, and societal levels; and attributes of competence cover five racial groups (African Americans, Asian Americans, Latino Americans, Native Americans, and European Americans). The new self-efficacy instrument, the Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD) will be designed exclusively to tap the skills component at the individual level across five racial groups based on Sue's model.

The concept of efficacy beliefs from Bandura's (1986; 1997) social cognitive theory provides another theoretical base for the current study. The MCSE-RD will be developed on the basis of two types of counseling efficacy beliefs for working with racially diverse clients: (a) content-specific self-efficacy, and (b) coping efficacy (Lent et al., 1998). Content-specific self-efficacy pertains to the counselor's confidence in performing discrete helping skills relevant to different counseling stages under normative conditions. On the other hand, coping efficacy concerns counselors' perceived ability in successfully managing multicultural impasses and dealing with difficult presenting issues.

One of the weaknesses in existing skills subscales of multicultural counseling competence measures is related to the narrow range of item sampling that falls short of covering the whole counseling process. It is therefore important to review the literature on how counseling proceeds from the initial counselor-client contact through termination to lay out the structure for generating items for content-specific efficacy. Several stage

models have been proposed to depict different stages involved in the counseling process (Burke, 1989; Cormier & Hackney, 1987; Doyle, 1992; Egan, 1998; Hill & O'Brien, 1999; Peterson & Nisenholz, 1991). Waehler and Lenox (1994) concluded that most of these stage models include five general phases: (a) initial contact and relationship building; (b) assessment; (c) goals setting; (d) intervention; and (e) termination. Although criticized for their linear and hierarchical sequences that fail to explain the interactional nature of change processes (Steenbarger, 1991), these stage models represent important functions performed by counselors throughout the counseling process. Thus, this categorization of tasks will be used to develop the initial item pool of the Content-Specific Self-Efficacy scale of the MCSE-RD.

Another relevant concept from social cognitive theory is coping efficacy. Coping efficacy refers to the counselor's "perceived capability of managing threatening situations should they arise" (Bandura, 1997, p.141). Those who believe that potential threats or problems are unmanageable perceive many aspects of their environments as full of danger, amplify the severity of possible threats, and worry about things that rarely happen. This perceived inefficacy to cope with potential threats leads people to approach such situations anxiously, and the experience of disturbing physiological arousal may further lower their sense of efficacy that they will perform skillfully. On the other hand, people who believe they can exercise control over potential problems are neither overly vigilant nor preoccupied by disturbing thoughts about them (Bandura, 1995a). Within the counseling context, counselors' coping efficacy would influence how much stress they experience in difficult situations and their motivation to engage in providing mental health services despite encountering obstacles. This concept is particularly applicable to

the multicultural counseling setting. Because of cultural differences, it is very likely that communicative misunderstanding and therapeutic impasses occur in the racially different counselor-client dyad. It is therefore important for counselors who work with racially diverse clients to increase their coping efficacy to work through multicultural impasses. In summary, the MCSE RD was developed as an efficacy beliefs measure tapping exclusively the skills component of Sue's (2001) model of cultural competency. Derived from Bandura's social cognitive theory (1986, 1997), two types of efficacy beliefs -- content-specific self-efficacy and coping efficacy -- provided the structure for scale construction.

*Research Questions and Hypotheses*

The current study was designed to develop and validate the MCSE-RD. Consisting of two scales (Content-Specific Self-Efficacy and Coping Efficacy), the MCSE-RD aims at assessing counselors' perceived ability to successfully work with racially diverse clients in the context of individual counseling. In terms of reliability, it was hypothesized that the internal consistency estimate for the entire scale should be above .90, that of each scale should be above .85, and that of each subscale should be above .80. To initially validate the MCSE-RD, different methods were implemented including: (a) content validity; (b) structural validity; (c) convergent and discriminant validity; and (d) criterion validity. Specifically for convergent and discriminant validity, the Counselor Activities Self-Efficacy Scales (CASES), Multicultural Counseling Inventory (MCI), and Multicultural Social Desirability Index (MCSD) were included to assess efficacy beliefs for general counseling, multicultural counseling competency, and self-presentation biases in multicultural counseling. Because of the common emphasis on the behavioral aspect

of counseling, the MCSE-RD scales were expected to relate to the CASES scales both highly and positively. Also, due to the same focus on multicultural counseling, correlations between the MCSE-RD scales and the MCI subscales were expected to be significant with different magnitudes. The Skills subscale of the MCI was hypothesized to correlate with the MCSE-RD scales more highly than the other three non-behavioral MCI subscales (Awareness, Relationship, and Knowledge). Finally, low and nonsignificant associations between the MCSE-RD scales and the MCSD were expected to support the MCSE-RD's discriminant validity. More specific criteria for each type of validity were presented in the Results section.

# Chapter III: Method

## *Participants*

Participants were 181 graduate students (32 males, 149 females) who were either taking counseling practicum courses or at later stages of counselor training during the academic year of 2003-04. Most of them were White Americans (59%); others were African American (13%), Asian Americans/Pacific Islander (9%), Latino/a American (7%), students with multiethnic backgrounds (6%), or international students (6%). Fifty six percent of the sample had a bachelor's degree as their highest degree, 41% of them had a mater's degree, 2% had other degree, and 1% did not responded. The majority (54%) were working toward a Ph.D. degree, 44% were in a master's degree program, whereas the other 2% reported working toward other degrees. Thirty-eight percent of participants were first-year students, 29% were second-year students, and 33% were in their third-year or above. Most participants (40%) were in Counseling Psychology; other majors included School Counseling (13%), School Psychology (12%), College Student Personnel (8%), Community Counseling (8%), Rehabilitation Counseling (6%), Counselor Education (3%), Clinical Psychology (2%), and other graduate programs (8%). Participants were students from public universities on the West Coast (one school, n = 13), in the Mid West (six schools, n = 49), in the South (two schools, n = 40) and on the East Coast (one school, n = 79). Students ranged in age from 20 to 56 years ($M$ = 28.80, $SD$ = 7.02).

Data from a second sample of 41 undergraduate psychology students (9 males, 32 females) at a large eastern university were collected for test -retest reliabilities of the final version of the MCSE-RD (37 items, see Table 1). Participants were enrolled in a Basic

Helping Skills course. The majority of the sample were White Americans (73%), followed by Asian Americans/Pacific Islanders (12%), African Americans (12%), and participant with multiethnic backgrounds (3%). Ninety-five percept of participants were seniors and the other 5% were juniors. Their average age was 21.90 years with a standard deviation of 2.64.

*Scale Construction of the MCSE-RD*

The guidelines for developing a self-efficacy measure provided by Bandura (1995b, 1997) were followed in the scale construction of the MCSE-RD. These guidelines include: (a) scale construction must be domain-specific and contextualized; (b) the clear and comprehensive operationalization of the multicultural counseling self-efficacy must be specified; (c) the self-efficacy assessment should target a counselor's perceived ability to perform a function (i.e., link a number of subskills) rather than subskills; (d) items of the MCSE-RD should be developed to assess counselors' current perceived ability to perform various tasks rather than their intention or future plans to complete those tasks; and (e) only one task should be assessed in an item. According to these guidelines, multicultural counseling self-efficacy is defined in the current study as counselors' perceived abilities to successfully perform a set of helping skills when working with racially diverse clients in the context of individual counseling; and the MCSE-RD's instructions directed participants to respond to items based on their current confidence levels in performing various counseling tasks when working with racially diverse clients (see Appendix A). Content of items covered tasks required in the entire counseling process and in difficult situations that counselors typically encounter with this population.

Also, items of the MCSE-RD were positively stated and rated on a scale ranging from 0 (no confidence at all) to 9 (complete confidence).

Item development was based on two types of efficacy beliefs, including content-specific self-efficacy and coping efficacy (Bandura, 1997), with the former indicating one's confidence in performing tasks related to the whole counseling process and the latter representing one's confidence in handling difficult issues involved in multicultural counseling. The counseling stages/processes literature (Burke, 1992; Cormier & Hackney, 1987; Doyle, 1992; Egan, 1986; Hill & O'Brien, 1999; Peterson & Nisenholz, 1991) was adopted to inform item development for the domain of content-specific self-efficacy. These models describe counseling as a process involving from covering three (e.g., Egan, 1986; Hill & O'Brien, 1999) to five stages (e.g., Cormier & Hackney, 1987; Doyle, 1992). Moreover, writings on multicultural counseling competency (e.g., Roysircar, Arredondo, Fuertes, Ponterotto, & Toporek, 2003), multicultural issues in the therapeutic process (e.g., Mishne, 2002; Ponterotto, Cases, Suzuki, & Alexander, 2001), and multicultural assessment (e.g., Suzuki, Ponterotto, & Meller, 2001) were taken into account when developing items. Based on this literature, an initial pool of 103 items was generated to assess seven components of content-specific self-efficacy: initial contact (10 items), therapeutic relationship (8 items), assessment and diagnosis (24 items), case conceptualization and goal-setting (11 items), intervention/ treatment (29 items), termination (11 items), and session management (10 items). In addition to above sources, the literatures on multicultural counseling ruptures and impasses (e.g., Liu & Pope-Davis, in press) and culture-bound syndromes (*DSM-IV*) were sought out when developing the initial pool of 17 items for the coping efficacy domain. These items tapped the

counselor's confidence regarding skills required to solve multicultural impasses and deal with difficult presenting problems.

In addition to conceptual analysis, Bandura (1997) suggested that development of efficacy scales must be derived from expert knowledge of what it takes to succeed in a given task. Thus, the instructions of the MCSE-RD and initial pool of 120 items (103 for content-specific self-efficacy and 17 for coping efficacy) first went through a research team brainstorming process, in which feedback was sought from four of my graduate student peers in counseling psychology at the University of Maryland. Then, ten experts in the fields of counseling psychology or multicultural counseling were invited to rate each item and comment on the entire draft of the MCSE-RD. Among these experts were five White Americans (2 males and 3 females), one African American male, three Asian American males, and one Native American female. Seven of them were faculty in counseling psychology or counselor education programs, while the other three were licensed psychologists at university counseling centers. All of them had either Ph.D. or Ed.D. degrees. Using a 1-5 scale, these experts rated each item of the MCSE-RD for its clarity/readability and relevance of content to content-specific self-efficacy and coping efficacy in multicultural counseling. Their open-ended feedback was also elicited. Based on their ratings and suggestions as well as further review of the literature, the original items were either deleted or revised, and new items were added. Although classical stage-based counseling theories (e.g., Burke, 1992) were useful in generating initial items for the MCSE-RD to cover the entire counseling process, these theories have been criticized for their emphasis on linearity (Steenbarger, 1991). Some consultants also pointed out that some skills were required throughout the course of counseling, which

made it difficult to fit them into just one stage or category. Thus, the original configuration for content-specific self-efficacy, which was based on counseling stage theories, was revised to focus on various functions an effective counselor is expected to fulfill in multicultural counseling. Specifically, the final draft of the MCSE-RD contained 60 items assessing content-specific self-efficacy (46 items) and coping efficacy (14 items). The domain of content-specific self-efficacy was further broken down to a general factor (7 items for basic helping skills, 6 items for therapeutic relationship, 5 items for session management skills, and 6 items for termination/referral) and the culturally specific factor (6 items for multicultural assessment, 6 items for test interpretation/case conceptualization/goal-setting, and 10 items for intervention and treatment). Items included in the general factor tapped skills that cover the counseling process and are important to all kinds of counseling, whereas the culturally specific factor included items that assess the counselor's confidence in successfully delivering culturally appropriate interventions and handling cross-cultural impasses. The 14 items of the coping efficacy domain were culturally specific and were also further categorized into difficult issues (7 items) and cultural impasses and ruptures (7 items). Finally, three Counseling Psychology doctoral students were invited to pilot the final draft of the MCSE-RD; based on their feedback, additionalminor editing changes were made.

*Criterion Measures*

*Multicultural Counseling Inventory (MCI).* Developed by Sodowsky et al. (1994), the MCI consists of 40 self-report items designed to assess multicultural counseling skills (11 items), multicultural counseling awareness (10 items), multicultural counseling relationship (8 items), and multicultural counseling knowledge (11 items). Using a 4-

point Likert-type response mode (1 = very inaccurate; 4 = very accurate), scores on the MCI range from 40 to 160. The content validity of the MCI was established by raters' classification of items into correct subscale categories and expert evaluation of item clarity. Both exploratory and confirmatory factor analyses provided evidence supporting the oblique four-factor model underlying the MCI (Sodowsky et al., 1994; Sodowsky, 1996). To evaluate the use of the MCI in multicultural counseling training, the full scale and subscale posttest scores were found to be significantly higher than pretest scores after a multicultural counseling course. In terms of convergent and divergent validity, the full scale score of the MCI correlated positively and significantly (from .61 to .73) with other multicultural counseling competency measures, such as the CCCI-R, MAKSS, and MCKAS. With the exception of the Relationship subscale ($r = .30$, $p < .01$), the full scale and subscale scores of the MCI were found to have low, non-significant correlations (from .05 to .15) with social desirability (Constantine & Ladany, 2000).

After reviewing several studies conducted before 1998, Constantine and Ladany (2001) indicated that the mean Cronbach's $\alpha$ for the total MCI score is .87, and mean Cronbach's $\alpha$ of .78, .77, .80, and .68, have been reported for the Awareness, Knowledge, Skills, and Relationship subscales, respectively. A more recent study also provided similar evidence for the internal consistency reliability of the MCI (Worthington et al., 2000).

*Counselor Activity Self-Efficacy Scales (CASES).* The purpose of the CASES is to assess counselors' self-efficacy for performing helping skills, managing the counseling process, and handling difficult counseling situations, respectively, with the Helping Skills Self-Efficacy, Session Management Self-Efficacy, and Counseling Challenges Self-

Efficacy subscales (Lent et al., 2003). The Helping Skill Self-Efficacy scale consists of 15 items measuring skills involved in Hill and O'Brien's (1999) three-stage model (exploration skills, insight skills, and action skills). A three-factor solution accounted for 60% of the total variance of scores from this scale. A single-factor solution explained 66% of the total variance of the Session Management Self-Efficacy scale, which includes 10 items. Finally, a two-factor structure, which accounted for 67% of the total variance, applied to the Counseling Challenges Self-Efficacy scale (10 items for the Relationship Conflict and 6 items for the Client Distress subscales). In terms of convergent validity, the CASES' total score correlated highly with the total score of the Counseling Self-Estimate Inventory (COSE) ($r$ = .76). Also, large correlations were observed between scales of the CASES and corresponding subscales of the COSE (Lent et al., 2003). Discriminant validity was demonstrated through small and nonsignificant correlations ($r$ ranging from -.02 to .22) between the CASES scales and Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960; 1964). Lastly, internal consistency reliability of the CASES total scores was .97 and that of the six CASES scales ranged from .79 to.94, while the 2-week test-retest reliability of the CASES total score was .79 and that of the six CASES scales ranged from .59 to .76 (Lent et al., 2003).

*Multicultural Social Desirability Index (MCSD).* The MCSD was designed to assess the degree to which an individual claims favorable attitudes toward minorities all of the time on all personal, social, and institutional issues (Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). The 26 items of the MCSD are rated with a forced-choice format of true or false. Regarding internal consistency reliability, the average item-to-total correlation of the MCSD was .35 while the Cronbach's $\alpha$ was .80. Validity

evidence from two studies indicated interscale correlations of .32 (Sodowsky, 1996) and .48 (Sodowsky, O'Dell, Hagemoser, Kwan, & Tonemah, 1993) between the MCSD and the Marlowe-Crowne Social Desirability Scale. The moderate correlations between these two social desirability measures seem reasonable given that the Marlowe-Crowne Social Desirability Scale evaluates respondents' needs for approval in general while the MCSD assesses one's tendency to claim favorable attitudes toward minorities.

Finally, a one-page demographic sheet was developed to collect information regarding participants' age, gender, racial/ethnic background, educational background, multicultural counseling training and experiences, future desire to get involved in multicultural counseling (caseload %), and interest in multicultural counseling (see Appendix B).

*Procedures*

Data were collected from students in counseling-related graduate programs at ten different universities (one on the West Coast, six in the Mid-West, one on the East Coast, and two in the South). Assistance was obtained from faculty members at these schools to distribute the survey either in classes or through mailboxes, except in the case of the East Coast school, where participants were contacted directly by the researcher through mailboxes. Email was used to follow up participants. Three hundred and seven-five surveys were sent out and 181 were received, producing a return rate of 48%. A prize drawing was used to promote participation. Specifically, participants were informed that prize entry cards will be used later on to draw a lottery, in which four participants will each receive a cash prize of $25.

Included in the packet sent to each participant were the invitation letter, a demographic sheet, four instruments (MCSE-RD, CASES, MCI, and MCSD), a prize entry card, and two return envelopes. In order to reduce the impact of motivation and fatigue, after the demographic sheet and the MCSE-RD, the CASES, MCI, and MCSD were presented in counterbalanced order. Participants gave their informed consent by returning the completed survey and prize entry card in two separate envelopes (which were used to maintain anonymity); and the surveys and cards were kept separately as soon as they were received to ensure confidentiality.

After the factor structure and items of the MCSE-RD were determined, data from the second sample were collected for the 2-week test-retest reliability of the final version of the MCSE-RD (see Table 1). In addition to the MCSE-RD, demographic variables, such as sex, ethnicity, age, and year in school were also collected to describe characteristics of this sample.

Various statistical procedures performed in the study included exploratory factor analyses, correlation/regression analyses, and general linear models. Significance levels of .05 or lower were reported for these tests. Due to the relatively large numbers of hypothesis testing in the study, effect size indices were also presented, when relevant, to add to determination of practical meaning of these statistical tests.

# Chapter IV: Results

To explore psychometric properties of the MCSE-RD, items were first factor analyzed, and then internal consistency estimates, test-retest reliabilities, and intercorrelations among the resulting scales were calculated. I next examined the MCSE-RD's convergent and discriminant validity in relation to general counseling self-efficacy (assessed by the CASES), multicultural counseling competency (assessed by the MCI), and multicultural social desirability (assessed by the MCSD). Finally, relationships between the MCSE-RD and several criterion variables, such as demographic information and counseling training background, were investigated.

## *Factor Analysis*

Self-efficacy in conducting mental health services with racially/ethnically diverse populations is still a new territory for researchers to explore despite that the multicultural counseling competency literature has existed for two decades (Constantine & Ladany, 2001). Nevertheless, the literature on general counseling self-efficacy (e.g., Lent et al., 2003) suggests that different aspects of counseling self-efficacy, such as self‡ efficacyfor basic helping skills and session management, might be correlated with each other. In other words, an oblique rotation solution might be more suitable for exploring the factor structure of the MCSE-RD. However, given that very little is known to guide the application of the self-efficacy construct in the field of multicultural counseling, the 60 MCSE-RD items were subjected to the Principal Axis Factoring procedure with both orthogonal and oblique solutions. The results of both rotation solutions were compared to determine the factor structure of the MCSE-RD.

The Kaiser-Guttman rule (i.e., eigenvalue ≥ 1) was applied to decide the number of factors extracted (Loehlin, 1998). Also, two criteria were used simultaneously to select and anchor items in a given factor. First, items that loaded most highly and beyond .50 on a given factor were retained (Gorsuch, 1997). Second, where cross-loadings became an issue, items with loadings above .50 were anchored in the factor on which they loaded most highly if their loadings showed a difference of >.10 between this factor and the next highest loading factor. These criteria were designed to clean up the factor structure of the MCSE-RD scale and provide an appropriate framework for interpretation and prediction of criterion variables.

Using the aforementioned criteria for selecting and anchoring items, results of both orthogonal and oblique rotation solutions suggested the same number of factors (i.e., 3 factors) and similar factor structures for the MCSE-RD. For the first factor, 20 out of 23 items retained by the oblique solution were also retained by the orthogonal solution. For the second and the third factors, items retained by the oblique solution were all covered by the orthogonal solution. However, the orthogonal solution included more items than the oblique solution for each factor (24 vs. 23 items, 6 vs. 4 items, and 7 vs. 4 items for the 1$^{st}$, 2$^{nd}$, and 3$^{rd}$ factors, respectively). Because the orthogonal solution retained more items, it also tended to produce higher internal consistency reliabilities than did the oblique solution (.98 vs. .98, .92 vs. .87, and .94 vs. .92 for the 1$^{st}$, 2$^{nd}$, and 3$^{rd}$ factors, respectively). Given that construct underrepresentation is a threat to validity (AERA, APA, & NCME, 1999), the orthogonal solution was adopted as the basis for determining the factor structure of the MCSE-RD because the larger number of items retained by this solution would help to more adequately capture important aspects of the construct. For the

MCSE-RD subscale and total scores, the self-efficacy indexes ranged from 0 to 9, with higher scores indicating stronger confidence in one's multicultural counseling capabilities. The resulting factors, item content, and factor loadings are displayed in Tables 1.

Table 1

*Items and Factor Loadings of the Multicultural Counseling Self-Efficacy – Racial Diversity Form*

| Item | Factor | | |
|---|---|---|---|
| | 1 | 2 | 3 |
| 1. Multicultural Intervention | | | |
| Remain flexible and accepting in resolving cross-cultural strains or impasses. | **.77** | .33 | .26 |
| Manage your own racially or culturally based countertransference toward the client (e.g., overidentification with the client because of his or her race). | **.75** | .22 | .34 |
| Help the client to clarify how cultural factors (e.g., racism, acculturation, racial identity) may relate to her or his maladaptive beliefs and conflicted feelings. | **.73** | .43 | .36 |
| Admit and accept responsibility when you, as the counselor, have initiated the cross-cultural impasse. | **.73** | .22 | .27 |
| Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstanding or impasses. | **.72** | .31 | .30 |
| Assess the salience and meaningfulness of culture/race in the client's life. | **.71** | .35 | .35 |
| Resolve misunderstanding with the client that stems from differences in culturally based style of communication (e.g., acquiescence versus confrontation). | **.71** | .38 | .35 |
| Help the client to identify how cultural factors (e.g., racism, acculturation, racial identity) may relate to his or her maladaptive relational patterns. | **.70** | .41 | .34 |
| Take into account multicultural constructs (e.g., acculturation, racial identity) when conceptualizing the client's presenting problems. | **.68** | .41 | .40 |
| Manage your own anxiety due to cross-cultural impasses that arise in the session. | **.67** | .35 | .30 |
| Respond in a therapeutic way when the client challenges your multicultural counseling competency. | **.67** | .39 | .33 |

Table 1 continued.

| Item | Factor 1 | 2 | 3 |
|---|---|---|---|
| Assess relevant cultural factors (e.g., the client's acculturation level, racial identity, cultural values and beliefs). | **.66** | .43 | .35 |
| Help the client to set counseling goals that take into account expectations from her or his family. | **.66** | .42 | .36 |
| Openly discuss cultural differences and similarities between the client and yourself. | **.65** | .04 | .28 |
| Address issues of cultural mistrust in ways that can improve the therapeutic relationship. | **.65** | .13 | .34 |
| Help the client to develop culturally appropriate ways to deal with systems (e.g., school, community) that affect him or her. | **.65** | .45 | .37 |
| Help the client to develop new and more adaptive behaviors that are consistent with his or her cultural background. | **.65** | .48 | .39 |
| Repair cross-cultural impasses that arise due to problems in the use or timing of particular skills (e.g., introduce the topic of race into therapy when the client is not ready to discuss). | **.64** | .41 | .38 |
| Help the client to utilize family/community resources to reach her or his goals. | **.64** | .36 | .34 |
| Deal with power-related disparities (i.e., counselor power versus client powerlessness) with a client who has experienced racism or discrimination. | **.63** | .41 | .37 |
| Take into account cultural explanations of the client's presenting issues in case conceptualization. | **.63** | .38 | .45 |
| Where appropriate, help the client to explore racism or discrimination in relation to his or her presenting issues. | **.61** | .19 | .45 |
| Take into account the impact that family may have on the client in case conceptualization. | **.59** | .43 | .41 |
| Deliver treatment to a client who prefers a different counseling style (i.e., directive versus non-directive). | **.59** | .45 | .31 |
| 2. Multicultural Assessment | | | |
| Treat culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness). | .24 | **.81** | .06 |

Table 1 continued.

| Item | Factor | | |
|---|---|---|---|
| | 1 | 2 | 3 |
| Assess culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness). | .25 | **.79** | .11 |
| Interpret standardized tests (e.g., MMPI-2, Strong Interest Inventory) in ways sensitive to cultural differences. | .18 | **.70** | .30 |
| Select culturally appropriate assessment tools according to the client's cultural background. | .23 | **.67** | .33 |
| Use non-standardized methods or procedures (e.g., card sort, guided fantasy) to assess the client's concerns in a culturally sensitive way. | .35 | **.67** | .38 |
| Conduct a mental status examination in a culturally sensitive way. | .39 | **.64** | .31 |
| 3. Multicultural Counseling Session Management | | | |
| Encourage the client to take an active role in counseling. | .37 | .24 | **.79** |
| Evaluate counseling progress in an on-going fashion. | .40 | .29 | **.76** |
| Respond effectively to the client's feelings related to termination (e.g., sadness, feeling of loss, pride, relief). | .40 | .19 | **.69** |
| Keep sessions on track and focused with a client who is not familiar with the counseling process. | .43 | .25 | **.65** |
| Assess the client's readiness for termination. | .47 | .35 | **.64** |
| Help the client to articulate what she or he has learned from counseling during the termination process. | .44 | .29 | **.62** |
| Identify and integrate the client's culturally specific way of saying good-bye in the termination process. | .45 | .38 | **.55** |

*Note*. $N$ = 181. Kaiser-Meyer-Olkin index = .97. The Multicultural Intervention, Multicultural Assessment, and Multicultural Counseling Session Management accounted for 34.08%, 18.62%, and 17.88%, respectively, of the total variance. Factor loadings were obtained with the rotated factor matrix of the orthogonal solution.

Analysis of items of the MCSE-RD supported a three-factor solution; this solution retained 37 items and accounted for 71% of the total variance (see Table 1). The three factors were labeled (a) Multicultural Intervention (24 items), including such capabilities as remaining flexible and accepting in resolving cross-cultural strains or impasses; (b)

Multicultural Assessment (6 items), consisting of such capabilities as selecting and interpreting culturally appropriate assessment tools; and (c) Multicultural Counseling Session Management (7 items), including such skills as encouraging the client to take an active role in counseling and evaluating counseling progress in an on-going fashion. All 37 items loaded highly (above .50) on their corresponding factors.

To further explore the latent structure of the MCSE-RD, a second-order factor analysis of three subscale scores was performed. The purpose of this analysis was to assess whether these subscales reflected one or more higher order underlying dimensions of multicultural counseling self-efficacy. The results supported a single factor solution, which accounted for 76% of the total variance. All three MCSE-RD subscale scores loaded highly on this second-order factor: Multicultural Intervention (.96), Multicultural Assessment (.77), and Multicultural Counseling Session Management (.88). Therefore, in addition to three subscale scores (Multicultural Intervention, Multicultural Assessment, and Multicultural Counseling Session Management), a MCSE-RD total score, ranging from 0 to 9, was calculated by averaging all 37 items.

*Reliability Estimates and Scale Intercorrelations*

The intercorrelations, means, standard deviations, as well as internal consistencies (Cronbach's α) and 2-week test-retest reliabilities (Pearson correlation coefficient) for each MCSE-RD scale, including the total scale score, are displayed in Table 2. Internal consistency reliabilities of the MCSE-RD subscale scores ranged from .92 (Multicultural Assessment) to .98 (Multicultural Intervention); and the reliability of the MCSE-RD total score was .98. On the other hand, at the individual item level, 2-week test-retest reliabilities of the 37 items ranged from .38 to .86, all of which were significant at the .05 level. Test-

retest reliabilities of the MCSE-RD subscale scores ranged from .69 (Multicultural Counseling Session Management) to .88 (Multicultural Assessment), whereas that of the MCSE-RD total score was .77.

As expected, these three subscales correlated with each other highly and significantly, ranging from .67 to .85. All MCSE-RD subscale scores also had high correlations (*r* ranged from .83 to .98) with the total score. At the subscale level, participants tended to have lower confidence in conducting multicultural assessment (3.77) and higher confidence in managing multicultural counseling sessions (5.84). This finding suggested that selecting and interpreting multicultural assessment tools and results might be perceived by participants as more difficult tasks.

Table 2

*Correlations, Means, Standard Deviations, Internal Consistency Estimates, and Test-Retest Reliabilities for the Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form*

| Scale | 1 | 2 | 3 | 4 | *M* | *SD* | α | *r* [a] |
|---|---|---|---|---|---|---|---|---|
| 1. MC Intervention | - | | | | 5.66 | 1.63 | .98 | .73 |
| 2. MC Assessment | .74 | - | | | 3.77 | 2.02 | .92 | .88 |
| 3. MC Session Mgmt. | .85 | .67 | - | | 5.84 | 1.53 | .94 | .69 |
| 4. MCSE-RD | .98 | .83 | .89 | - | 5.39 | 1.57 | .98 | .77 |

*Note.* $N = 181$. All correlations were significant ($p < .001$). MC Intervention = Multicultural Counseling Intervention; MC Assessment = Multicultural Assessment; MC Session Mgmt. = Multicultural Counseling Session Management; MCSE-RD = Multicultural Counseling Self-Efficacy – Racial Diversity Form.

[a] Two-week test-retest reliability ($N = 41$).

*Convergent and Discriminant Validity*

Evidence of convergent validity of the MCSE-RD scores was provided by significant and positive correlations between the MCSE-RD and CASES (general counseling self-efficacy) as well as those between the MCSE-RD and MCI (self-reported multicultural counseling competence) (see Table 3). In addition, the discriminant validity of the MCSE-RD scores was supported by low and non-significant correlations between the MCSE-RD and social desirability (*r* ranged from .03 to .12).

Table 3

*Correlations of the Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form to the Criterion Variables (CASES, MCI, MCSD)*

| | MCSE-RD scale | | | |
|---|---|---|---|---|
| | MC Intervention | MC Assessment | MC Session Mgmt. | Total Score |
| CASES scale | | | | |
| Helping Skill | .71 | .55 | .72 | .72 |
| Session Mgmt. | .73 | .55 | .79 | .76 |
| Counsel. Chlg. | .72 | .58 | .71 | .73 |
| CASES total | .77 | .60 | .78 | .79 |
| MCI scale | | | | |
| Skills | .62 | .52 | .58 | .63 |
| Awareness | .56 | .50 | .43 | .56 |
| Relationship | .41 | .25 | .37 | .40 |
| Knowledge | .54 | .45 | .45 | .54 |
| MCI total | .67 | .55 | .58 | .68 |
| MCSD total | .12 | .04 | .03 | .09 |

*Note. N* ranged from 176 to 178 because of missing values. MCSE-RD = Multicultural Counseling Self-Efficacy – Racial Diversity Form: MC Intervention = Multicultural Intervention; MC Assessment = Multicultural Assessment; MC Session Mgmt. = Multicultural

Counseling Session Management. CASES = Counselor Activity Self-Efficacy Scales: Session Mgmt. = Session Management; Counsel. Chlg. = Counseling Challenges. MCI = Multicultural Counseling Inventory. MCSD = Multicultural Social Desirability Scale.

Correlation coefficients below .20 were not significant at the .05 level. Correlation coefficient of .25 was significant ($p = .001$). Correlation coefficients above .30 were significant ( $p < .001$).

Table 3 shows that the Multicultural Assessment subscale tended to have lower correlations with the Helping Skill, Session Management, and Counseling Challenges scales of the CASES (.55, .55, and .58, respectively). On the other hand, the Multicultural Intervention and Multicultural Counseling Session Management tended to have equally stronger associations with the Helping Skill, Session Management, and Counseling Challenges scales of the CASES (.71, .73, and .72 for Multicultural Intervention; .72, .79, and .71 for Multicultural Counseling Session Management). Finally, all three MCSE-RD subscale scores correlated highly with the CASES total score, ranging from .60 to .78; and the correlation between the MCSE-RD total score and the CASES total score was .79.

Next, the correlations between the MCSE-RD scores and the MCI scores were investigated to illuminate the relationship between multicultural counseling self-efficacy and multicultural counseling competency, which includes the three components of skills, awareness, and knowledge (Sue et al., 1992) (see Table 3). The high correlation (.68) between the MCSE-RD total score and the MCI total score indicated significant overlap (about 46%) between the behavior-oriented concept of multicultural counseling self-efficacy and the broader concept of multicultural counseling competency. As expected, all MCSE-RD subscales correlated more highly and positively with the Multicultural Counseling Skills subscale (*r* ranged from .52 to .62) than with the Multicultural Awareness (*r* ranged from .43 to .56), Multicultural Counseling Relationship (*r* ranged

from .25 to .41), or Multicultural Counseling Knowledge subscales (*r* ranged from .45 to .54) of the MCI. These higher correlations between the MCSE-RD subscales and the Skills subscale of the MCI provide initial evidence for the MCSE-RD's convergent validity because they all measure the behavior component of the multicultural counseling competency model. On the other hand, the MCSE-RD's lower, but still significant, correlations with the Awareness, Relationship, and Knowledge components of the MCI supported the MCSE-RD's discriminant validity since they tap different aspects of the competency model. Finally, the correlation between the MCSE-RD total score and the CASES total score (.79) was somewhat higher than that between the MCSE-RD total score and the MCI total score (.68), suggesting that the concept of multicultural counseling self-efficacy may be more closely associated with the construct of general counseling self-efficacy given their common focus on the behavior that a counselor performs in-session.

*MCSE-RD Scores and Demographic Variables*

The relationships between the MCSE-RD and demographic variables were investigated with a series of General Linear Models because of unequal cell sample sizes. In addition to *F* values for statistical significance tests, the effect size index, $\eta^2$, is also reported for determining practical meaning of these tests. According to Cohen (1988), $\eta^2$ larger than .0099 could be considered as a small effect size, $\eta^2$ larger than .0588 a medium effect size, and $\eta^2$ larger than .1379 a large effect size. As shown in Table 4, male participants seemed consistently more confident in providing multicultural counseling than females. Across three MCSE-RD subscales and the full scale, the gender differences not only were statistically significant but also had practical meaning with at least small effect sizes. The gender difference was most salient on the Multicultural Assessment

subscale ($F$ = 14.87, $\eta^2$ = .077). In short, males reported higher scores than females did on Multicultural Intervention (6.47 vs. 5.49), Multicultural Assessment (4.97 vs. 3.51) and Multicultural Counseling Session Management (6.70 vs. 5.66) subscales as well as on the MCSE-RD full scale (6.27 vs. 5.20).

Table 4

*Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form and Demographic Variables*

| | MCSE-RD scale | | | |
|---|---|---|---|---|
| | MC Intervention | MC Assessment | MC Session Mgmt. | Total Score |
| Sex | | | | |
| Males ($N$ = 32) | 6.47/1.28 | 4.97/1.75 | 6.70/1.19 | 6.27/1.26 |
| Females ($N$ = 149) | 5.49/1.65 | 3.51/1.98 | 5.66/1.54 | 5.20/1.57 |
| $F$ | 9.91** | 14.87** | 12.95** | 12.96** |
| $\eta^2$ | .052 | .077 | .067 | .067 |
| Ethnicity | | | | |
| White Americans ($N$ = 107) | 5.32/1.65 | 3.42/1.95 | 5.55/1.54 | 5.06/1.58 |
| Ethnic Minorities ($N$ = 74) | 6.14/1.50 | 4.28/2.02 | 6.27/1.42 | 5.87/1.45 |
| $F$ | 11.50** | 8.17** | 10.37** | 12.15** |
| $\eta^2$ | .060 | .044 | .055 | .064 |

*Note*. For all $F$ tests, degree of freedom = (1, 179). Those numbers before and after the slash are means and standard deviations of the corresponding scale. MCSE-RD = Multicultural Counseling Self-Efficacy – Racial Diversity Form: MC Intervention = Multicultural Intervention; MC Assessment = Multicultural Assessment; MC Session Mgmt. = Multicultural Counseling Sessions Management. ** $p$ < .01.

Ethnic differences were also both statistically significant and practically meaningful across three MCSE-RD subscales and the full scale. Specifically, ethnic minorities (including African Americans, Asian Americans/Pacific Islanders, Latino/a Americans, Native Americans/Alaskan Natives, international students from Asia, and participants with multiethnic backgrounds) had significantly higher perceived capabilities than their White American counterparts in conducting multicultural interventions (6.14 vs. 5.32) and multicultural assessment (4.28 vs. 3.42), as well as managing multicultural counseling sessions (6.27 vs. 5.55). Ethnic minorities (5.87) also had higher MCSE-RD total scores than White Americans (5.06). These ethnic differences represented small to medium effect sizes. Finally, except for the Multicultural Assessmentsubscale ($r$ = .12 n.s.), the other two MCSE-RD subscales and the full scale were significantly and positively (but modestly) correlated with participants' age ($r$ ranged from .20 to .21, $\alpha < .01$).

*MCSE-RD Scores, Educational Background, and Multicultural Counseling Training*

Table 5 showed that participants with a master's degree had consistently higher confidence in delivering multicultural counseling than those with a bachelor's degree across three MCSE-RD subscales. These statistically significant differences were also practically meaningful with effect sizes ($\eta^2$) of .099 and above. Similarly, those participants who were in a doctoral program had higher self-efficacy than those in a master's program on multicultural interventions (5.99 vs. 5.34), multicultural assessment (4.18 vs. 3.34), multicultural counseling session management (6.22 vs. 5.44), and the MCSE-RD total score (5.74 vs. 5.04). These statistically significant comparisons between

doctoral and master's students on MCSE-RD scores represented small to medium effect sizes.

Table 5

*Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form and Educational Backgrounds*

| | MCSE-RD scale | | | |
|---|---|---|---|---|
| | MC Intervention | MC Assessment | MC Session Mgmt. | Total Score |
| Highest Degree | | | | |
| Bachelor's (*N* = 102) | 5.19/1.53 | 3.12/1.76 | 5.37/1.45 | 4.89/1.42 |
| Master's (*N* = 75) | 6.22/1.57 | 4.61/2.05 | 6.42/1.46 | 6.00/1.55 |
| *F* | 19.15 | 27.00 | 22.73 | 24.45 |
| $\eta^2$ | .099 | .134 | .115 | .123 |
| Specialty Area | | | | |
| Counseling Psychology (*N* = 73) | 6.23/1.31 | 4.34/1.96 | 6.38/1.28 | 5.95/1.30 |
| Other Counseling Program (*N* = 108) | 5.28/1.72 | 3.39/1.98 | 5.48/1.59 | 5.01/1.63 |
| *F* | 16.15 | 10.04 | 12.33 | 17.07 |
| $\eta^2$ | .083 | .053 | .084 | .087 |
| Current Degree | | | | |
| Master's (*N* = 79) | 5.34/1.69 | 3.34/1.92 | 5.44/1.53 | 5.04/1.58 |
| Doctoral (*N* = 97) | 5.99/1.51 | 4.18/2.03 | 6.22/1.44 | 5.74/1.48 |
| *F* | 7.19 | 7.98 | 12.19 | 9.29 |
| $\eta^2$ | .040 | .044 | .065 | .051 |

Table 5 continued.

| | MC Intervention | MC Assessment | MC Session Mgmt. | Total Score |
|---|---|---|---|---|
| Years in program | | | | |
| 1st year ($N$ = 68) | 5.39[a] /1.71 | 3.27[a] /2.04 | 5.45[a] /1.65 | 5.05[a] /1.63 |
| 2nd year ($N$ = 53) | 5.07[a] /1.59 | 3.16[a] /1.78 | 5.49[a] /1.49 | 4.84[a] /1.50 |
| ≥ 3rd year ($N$ = 60) | 6.50[b] /1.23 | 4.88[b] /1.74 | 6.61[b] /1.11 | 6.26[b] /1.18 |
| $F$ | 14.08 | 15.94 | 12.56 | 16.26 |
| $\eta^2$ | .137 | .152 | .124 | .154 |

*Note.* Degrees of freedom for $F$ tests on highest degree, specialty area, current degree, and year in program are (1, 175), (1, 179), (1, 174), and (2, 178), respectively. Those numbers before and after the slash are means and standard deviations of the corresponding scale. MCSE-RD = Multicultural Counseling Self-Efficacy – Racial Diversity Form: MC Intervention = Multicultural Intervention; MC Assessment = Multicultural Assessment; MC Session Mgmt. = Multicultural Counseling Session Management.

All $F$ values were significant ($p < .001$).

[a, b] Results of Scheffé post-hoc comparisons: Mean scores with superscript [b] were significant higher than mean scores with superscript [a] ($p < .001$).

In terms of participants' specialty areas, participants in Counseling Psychology had significantly higher scores than those in other counseling-related areas (e.g., School Psychology, Student Personnel Services, School Counseling) on all MCSE-RD subscales. These differences in self-efficacy between Counseling Psychology and other students had at least a small effect size (.053 and above).

Participants' tenure in their graduate programs was also associated with their multicultural counseling self-efficacy (see Table 5). While MCSE-RD scores of first-year and second-year graduate students were close to each other, results of Scheffé post-hoc comparisons indicated that third-year and above students' MCSE-RD scores were significantly higher than those of first-year and second-year students on all MCSE-RD

subscales. All of these comparisons were practically meaningful, with medium to large effect sizes. These results indicated that advanced graduate students were more confident in providing counseling to racially diverse clients than were more junior graduate students.

Table 6

*Correlations of Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form to Multicultural Counseling Training Backgrounds*

| | MCSE-RD scale | | | |
|---|---|---|---|---|
| | MC Intervention | MC Assessment | MC Session Mgmt. | Total Score |
| # of MC Courses | .29** | .28** | .23** | .29** |
| # of MC Workshops | .35** | .37** | .30** | .37** |
| Direct MC Hours | .47** | .44** | .42** | .48** |
| Supervision Hours | .20** | .26** | .16* | .22** |
| Interest in MC | .34** | .31** | .24** | .34** |
| Future MC Training | .12 | .20** | .06 | .13 |

*Note*. *N* ranges from 178 to 181 because of missing values. MCSE-RD = Multicultural Counseling Self-Efficacy – Racial Diversity Form: MC Intervention = Multicultural Intervention; MC Assessment = Multicultural Assessment; MC Session Mgmt. = Multicultural Counseling Session Management. MC = Multicultural Counseling. Future MC Training = % of future clinical work devoted to see racially diverse clients.

* $p < .05$. ** $p < .01$

In terms of the relationships between participants' multicultural counseling self-efficacy and their specific training in multicultural counseling, Table 6 shows that all MCSE-RD scores had small and positive correlations with number of multicultural counseling courses (*r* ranged from .23 to .29) and supervision hours spent on racially diverse clients (*r* ranged from .16 to .26); and all MCSE-RD scores had medium and

positive correlations with number of multicultural workshops taken (*r* ranged from .30 to .37) and direct contact hours with racial diverse clients (*r* ranged from .42 to .48). Moreover, all MCSE-RD scores were associated weakly to moderately with interest in multicultural counseling (*r* ranged from .24 to .34). However, only the Multicultural Assessment subscale correlated significantly with intention for future multicultural counseling training ($r = .20$). The non-significant correlations involving intention in future multicultural counseling training might be due to the limited score ranges of the criterion variable as it was measured by a single item.

Social cognitive theory (Bandura, 1997) proposes four sources that contribute to self-efficacy appraisals: enactive mastery experiences, vicarious experiences, verbal persuasion, and physiological and affective states. Mastery experiences are seen as the most influential of the four sources of efficacy information. A hierarchical regression analysis (Table 7) was performed in order to examine the predictive utility of the various sources of multicultural counseling self-efficacy. Three blocks of predictors were entered at successive steps into the equation: (a) earned highest degree and year in the current program; (b) numbers of multicultural courses and multicultural workshops taken; and (c) direct contact hours with and supervision hours spent on racially different clients. It was assumed that the first block reflects a combination of efficacy source information, whereas the second and third blocks mostly represent vicarious and mastery experiences, respectively.

Table 7

*Summary of Hierarchical Regression Analyses Predicting Self-Efficacy in Counseling Racially Diverse Clients (MCSE-RD total score)*

| | Predictors | *R* | $\Delta R^2$ | *df* | $\Delta F$ | β |
|---|---|---|---|---|---|---|
| Step 1 | Earned Highest Degree | .39 | .15 | 2, 171 | 14.92** | .06 |
| | Year in the Current Program | | | | | .11 |
| Step 2 | MC Courses Taken | .46 | .06 | 2, 169 | 6.90** | .14 |
| | MC Workshops Taken | | | | | .04 |
| Step 3 | Direct Client Contact Hours | .54 | .08 | 2, 167 | 9.87** | .35** |
| | Supervision Hours Received | | | | | .03 |

*Note*. MCSE-RD = Multicultural Counseling Self-Efficacy – Racial Diversity Form.
** $p < .01$.

Results of the hierarchical regression (see Table 7) indicated that each of the variable sets contributed significantly to predicting multicultural counseling self-efficacy, as measured by the MCSE RD total score. Specifically, participants' earned highest degree and seniority together explained 15% of the variance; numbers of multicultural counseling courses and workshops taken by the participants accounted for an additional 6% of the variance; and participants' direct counseling experiences with, and supervision hours spent on, racially different clients explained another 8% of the variance in the MCSE-RD total score. These findings provide support for the notion that training experiences, particularly those based on vicarious and mastery exposure, help to inform multicultural counseling self-efficacy. Among the six individual predictors, direct contact hours with racially different clients had the highest $\beta$ weight (.35), supporting the hypothesized import of direct mastery experiences as a source of self-efficacy appraisals.

# Chapter V: Discussion

The APA Multicultural Guidelines (APA, 2002) acknowledge the racial/ethnic diversity of the U.S. population and encourage mental health professionals to consider the role of cultural factors in their work. Having existed for two decades, the multicultural counseling competency literature has increased our awareness of the importance of training culturally competent professionals. However, existing measurement tools, such as the MCI (Sodowsky et al., 1994) and the MCAS (Ponterotto et al., 2002), have focused primarily on multicultural knowledge and awareness while attending minimally to what a counselor actually does with racially diverse clients to bring about positive outcomes. The lack of an instrument to properly assess a counselor's behaviors when working with racially/ethnically diverse clients may have slowed progress in providing better services to these populations and impeded the effectiveness of multicultural training. The purpose of the current study was to develop the Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD). The MCSE-RD is intended to exclusively tap the behavioral aspect of counselors' work in the context of multicultural individual counseling; in other words, it focuses on one's self-perceived helping skills and confidence in effectively handling difficult issues involved in the multicultural counseling process.

## *Factor Structures of the MCSE-RD*

Findings of the current study provided initial support for the validity and internal consistency and test-retest reliabilities of MCSE-RD scores. The first subscale, Multicultural Intervention, covers counselor behaviors required to therapeutically handle cross-cultural impasses and bring about positive outcomes of multicultural counseling.

These behaviors include remaining flexible and accepting in resolving cross-cultural strains, managing the counselor's own anxiety or culturally based countertransference, helping the client clarify how cultural factors may relate to his or her presenting issues, and so on. Neither of these issues are assessed extensively in multicultural counseling competency measures (e.g., the MCI, MAKSS, CCCI-R), nor are they included in instruments assessing efficacy beliefs in general counseling (e.g., the COSE, COSES) or in specialty areas such as career counseling (e.g., the CCSES).

The second subscale, Multicultural Assessment, focuses on counselors' perceived capabilities to properly select assessment tools, conduct mental status exams, interpret test results, and deal with culture-bound syndromes according to the client's cultural background. These culturally sensitive assessment skills are not measured in most general counseling self-efficacy instruments (e.g., the COSE, CASES). Compared with the single-item regarding assessment in most multicultural counseling competency measures (e.g., the MCI, MAKSS), the Multicultural Assessment subscale seems to have better content validity in this area and, thus, may more adequately sample one's perceived capability in multicultural assessment. The third subscale, Multicultural Counseling Session Management, consists of counselor behaviors required to facilitate the entire counseling process, from engaging the client in counseling to helping the client get ready for termination. While overlapping somewhat with general counseling self-efficacy instruments (e.g., the Session Management scale of the CASES and the Process subscale of the COSE), items of the Multicultural Counseling Session Management subscale are contextualized specifically in situations where counselors work with racially different clients.

Putting these three subscales together, it seems clear that the first and second subscales directly tap culturally-specific issues (e.g., multicultural interventions and assessment) while the third subscale focuses on routine session management tasks with culturally diverse clients. Among the three subscales, participants scored lowest on the Multicultural Assessment subscale (3.77 on a 0-9 scale), followed by the Multicultural Intervention (5.66) and Multicultural Counseling Session Management (5.84) subscales. Since the training of psychological assessment may not be covered in master's counseling programs or the beginning of doctoral programs, more research is warranted to clarify whether participants' perceived abilities in selecting, administering, and interpreting results of multicultural assessments are confounded by their lack of knowledge on this area.

Finally, both the single higher-order factor derived from exploratory factor analysis using the three subscale scores of the MCSE-RD and the high internal consistency ($\alpha$ = .98) of the total score suggested that all items of the MCSE-RD seemed related closely to one another and reflect a single overarching construct, multicultural counseling self-efficacy. In comparison with the Multicultural Counseling Skills subscale of the MCI and the Skills subscale of the MAKSS, the MCSE-RD seems to do a more thorough job of sampling what a counselor actually does when working with racially different clients. Also, the MCSE-RD is more domain-specific than are multicultural counseling competency measures, such as the MAKSS, that only use single-item assessments of one's perceived abilities to work with various multicultural subgroups (e.g., LGBT clients, people with disabilities, culturally different clients) and in different areas (e.g., counseling, research, consultation). Because of its domain specificity and promising

psychometric properties, the MCSE-RD may better assess counselors' perceived capabilities to counsel racially diverse clients and may better predict outcomes of cross-racial counseling dyads. However, these possibilities require empirical confirmation.

*Convergent and Discriminant Validity of the MCSE-RD Scores*

Convergent validity of the MCSE-RD scores was initially supported by their high correlations with the CASES scales and the Multicultural Counseling Skills subscale of the MCI. The MCSE-RD might relate to these two instruments for different reasons. While high correlations between the MCSE-RD scores and the CASES scores might stem from their common emphases on the behavioral aspect of a counselor's work, the focus on the multicultural counseling domain might be the cause of the close relationship between the MCSE-RD and the Multicultural Counseling Skills subscale of the MCI. However, as opposed to the MCSE-RD's focus on specific behaviors, the MCI tends to measure counselors' skills at a more general level. This difference in domain specificity might explain the somewhat lower correlations between the MCSE-RD and the Multicultural Counseling Skills subscale of the MCI (median $r$ = .58, $r$ ranged from .52 to .62), compared with those between the MCSE-RD and the CASES (median $r$ = .71, $r$ ranged from .55 to .79). These high correlations might shed some light on the issue of whether general and multicultural counseling competencies are distinct competencies (Coleman, 1998). Although Coleman's literature review suggested that these two were separate sets of competencies, results of his analogue study showed no distinction between general and multicultural counseling competencies. While more research is needed to answer this question, the high correlations between the MCSE-RD and the

CASES in the current study seemed to suggest that perceived general and multicultural counseling abilities, if not the same construct, complement to each other.

Discriminant validity of the MCSE-RD scores was initially demonstrated by their nonsignificant and low correlations to social desirability ( *r* ranged from .03 to .12) as well as its differing correlations to the Multicultural Counseling Skills subscale and the other three non-behavior oriented subscales (Multicultural Awareness, Relationship, and Knowledge) of the MCI. Whereas most of the correlations between the MCSE-RD and the Multicultural Awareness, Relationship, and Knowledge subscales were medium (i.e., between .3 to.5), those between the MCSE-RD and the Skills subscale were high (i.e., above .5). These discriminant correlations not only initially supported the idea that the MCSE-RD was designed to measure counselors' perceived abilities, as opposed to knowledge and awareness, but also suggested that counselors' cultural awareness and knowledge about other cultures might be related to what they perceive they could do with racially diverse clients.

*Criterion Validity of the MCSE-RD Scores*

MCSE-RD scores were also found to be associated with several demographic and training background variables. Gender differences on the MCSE-RD scores suggested that males were more confident than females in delivering counseling to racially diverse clients. The literature on gender differences in multicultural counseling competence is not conclusive. Studying students in counseling and clinical psychology programs and doctoral interns at university counseling centers, Pope-Davis and his colleagues (Pope-Davis, Reynolds, Dings, & Nielson, 1995; Pope-Davis, Reynolds, Dings, & Ottavi, 1994) found no gender differences on the MCI subscale and total scores or on the MCAS

(Ponterotto et al. 1996) subscale scores. On the other hand, also using the MCI, Bellini (2002) found gender to be a significant predictor (β= .17) of multicultural counseling competency, with female vocational rehabilitation counselors reporting higher multicultural counseling competence than their male counterparts. Similarly, female counselors reported better multicultural knowledge and awareness as assessed by the MCAS (Constantine, 2000).

The social cognitive literature seems more conclusive on gender differences than the multicultural counseling competence literature. Using Holland's hexagon theory (1997) as the framework, researchers have developed several measures to assess self-efficacy on each Holland theme. In general, findings suggested that males were significantly more confident in the Realistic and Investigative areas while females reported significantly greater Social confidence (Betz, Harmon, & Borgen, 1996; Lapan, Boggs, & Morrill, 1989; Lenox & Subich, 1994). The significant gender differences in favor of males on multicultural counseling self-efficacy found in the current study seemed to contradict with the above findings because counseling is classified as a Social occupation according to Holland's theory (Holland, 1996). The reason for males reporting higher multicultural counseling self-efficacy than females is unclear. This finding should be interpreted with caution because of the small sample size for males (*N* = 32), which could make the gender differences on multicultural counseling self-efficacy a sample-specific finding. In addition, it is important for us to explore potential moderators or mediators for the observed gender differences. For example, it deserves further empirical scrutiny to examine how personality variables (e.g., generalized self-efficacy, positive and negative affectivity, introversion and extraversion) and cultural

factors (e.g., racial identity, universal-diverse orientation) interact with gender to affect counselors' confidence in providing multicultural counseling.

Ethnic minorities were found to report higher multicultural counseling self-efficacy than White Americans in the current study, which is consistent with findings in the multicultural counseling competency literature. Racial/ethnic minority counselors have consistently been found to describe themselves as more multiculturally competent than do White Americans in several samples, including counseling/clinical psychology students (Pope-Davis et al., 1995; Vinson & Neimeyer, 2003), vocational rehabilitation counselors (Bellini, 2002), and APA-approved university counseling center staff members (Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). This racial/ethnic difference was also cross-validated by the CCCI-R, an other-report multicultural counseling instrument (Constantine, 2001c). The current study added to the literature by demonstrating racial/ethnic differences using an exclusively skill-focused self-report measure, the MCSE-RD.

This racial difference in multicultural counseling self-efficacy may possibly be a function of differential experiences in counseling training. Findings from prior research (e.g., Bellini, 2002; Vinson & Neimeyer, 2003) and the current study have suggested that racial/ethnic minority counseling students and professionals tend to receive more multicultural counseling training and have a higher proportion of minority clients on their caseloads, which may, in turn, lead to higher perceived abilities to perform multicultural counseling (Pope-Davis et al., 1995; Pope-Davis et al., 1994). In other words, the racial differences on multicultural counseling competency or self-efficacy may be due to how

much multicultural counseling training and other relevant experience a counselor receives rather than being due to his or her race per se.

In addition, exploring how counselors identify themselves racially/ethnically may help to account for the observed racial differences in multicultural counseling self-efficacy. The concepts of ethnic and racial identity development (Helms & Cook, 1999; Phinney, 2003) and White racial identity development (Helms & Carter, 1990) are important in exploring the relationship between one's sense of self as a member of an ethnic group and his or her confidence in delivering multicultural counseling. Researchers have conceptually argued and empirically demonstrated that White racial identity development is predictive of multicultural counseling competencies for White counseling students and counselors (Constantine, 2002; Constantine, Juby, & Liang, 2001; Ottavi, Pope-Davis, & Dings, 1994; Sabnani, Ponterotto, & Borodovsky, 1991). The predictive and moderating effects of racial/ethnic identity relative to multicultural counseling self-efficacy merit empirical attention in future research.

In terms of educational background, Pope-Davis et al. (1995) found that neither highest degree held nor tenure in program were significant predictors of the MCI subscale scores for counseling psychology students. By contrast, results of the current study suggested that participants' educational backgrounds, such as earned highest degree, specialty area, current degree, and tenure in their program, were associated with their perceived abilities to conduct multicultural counseling. Specifically, participants, who had a master's degree, were working toward a doctoral degree, had longer tenure in the program, and were in counseling psychology programs, tended to have higher self-efficacy when working with racially diverse clients than those who held a bachelor's

degree, were working toward a master's degree, had shorter tenure, and were in other counseling-related programs.

Once again, a counselor's multicultural counseling training might help to explain these relationships. As indicated in previous research (Bellini, 2002; Coleman, 1998; Constantine, 2001c; Pope-Davis et al., 1995), multicultural training experiences were found to be related to one's perception of multicultural counseling competence. Findings of the current study were consistent with the literature by evidencing significant and positive correlations of all MCSE-RD scores to numbers of multicultural courses and workshops taken and to direct contact hours with, and supervision hours spent on, racially different clients. Results of a hierarchical regression analysis further suggested that, above and beyond educational background (earned highest degree and tenure in the program), participants' multicultural counseling training (multicultural counseling courses and workshops taken) and direct multicultural counseling and supervision experiences were significant predictors of their confidence in working with racially diverse clients. This finding supported the social cognitive assumption that enactive mastery experiences and vicarious learning experiences are important sources of efficacy beliefs (Bandura, 1997) in the domain of multicultural counseling.

Finally, all MCSE-RD scores correlated significantly and positively with interests in multicultural counseling. While this finding was consistent with the social cognitive assumptions (Lent, Brown, & Hackett, 1994), the self-efficacy-interest association was likely to be underestimated in the current study because interests in multicultural counseling was measured with a single item and the issue of restricted range seemed present (mean = 4.27 with SD = .87 at a 5-point scale). On the other hand, only the

Multicultural Assessment subscale of the MCSE-RD was significantly related to participants' desire for future multicultural counseling training. Once again, the nonsignificant correlations between most MCSE-RD scores and intention for future training might be due to participants' restricted responses to the singe item for this criterion variable. Researchers may be able to more reliably and thoroughly investigate the relationships between the MCSE-RD and interests in and preferences for multicultural counseling if dependent variable measureswith better psychometric properties, such as the Scientist-Practitioner Inventory (Leong & Zachar, 1991), are used in future research.

Overall, the MCSE-RD seems to be internally reliable and its construct validity was initially supported by clear factor structures and high factor loadings. Convergent validity was evidenced by high correlations between the MCSE-RD and CASES scores. Moreover, the MCSE-RD scores showed discriminant validity by correlating more highly with the Multicultural Counseling Skills subscale than with the other (non-skill-focused) subscales of the MCI. The low and nonsignificant correlations between the MCSE-RD scores and the multicultural social desirability measure (MCSD) might also suggest that perceived multicultural counseling capabilities were not substantially influenced by self-presentation biases. Finally, the MCSE-RD scores were associated with multicultural counseling training in the direction suggested by the multicultural counseling literature (i.e., greater relevant experiences promote stronger confidence in working with racially diverse clients). Although these results seem promising, it is important to cross-validate these findings with different or larger samples, especially for males, to obtain more stable estimates of the MCSE RD's psychometric properties.

# Chapter VI: Implications

Findings of the current study offer several implications for multicultural research, practice, and training. First, the MCSE-RD presents the first tool to exclusively and thoroughly assess the Skills dimension of the multicultural counseling competency model (Sue et al., 1992). It allows us to take a close look at what counselors believe they can do, as opposed to what they know, when working with racially diverse clients. Because of its domain specificity, the MCSE-RD has the potential to add to multicultural process and outcome research by focusing on what counselors believe they bring to counseling at the behavioral level.

Second, the MCSE-RD's potential utility in helping us better understand the interplay among multicultural skills, awareness, and knowledge is particularly important for multicultural counseling training. As pointed out by McRae and Johnson (1991), most training in multicultural counseling competence has focused on the awareness and knowledge dimensions of competence rather than on the skill dimension. An instrument with good psychometric properties and emphasis on the skill dimension, such as the MCSE-RD, can facilitate research on the relationships among these three dimensions. This body of knowledge may improve training programs' effectiveness at helping trainees translate their awareness and knowledge into what they believe they can do in multicultural counseling. Results of the hierarchical regression analysis in the current study specifically suggests that direct clinical experiences with racially diverse clients are of particular importance in improving trainees' perceived multicultural counseling abilities. Thus, instructors of multicultural counseling courses may want to emphasize

direct contacts with racially diverse clients, in addition to lectures and classroom activities, to increase trainees' confidence in this area.

Third, it is important to point out the possible discrepancies between (a) counselors' efficacy beliefs and in-session behaviors, and (b) counselor self-efficacy and supervisor perceptions of the counselor's current skill level. Bandura (1997) described several sources of discordance between efficacy judgment and action, including the lack of knowledge of task demands, faulty assessments of self-efficacy or performance, lack of incentive, and performance constraints. It is likely that beginning counselors may overestimate or underestimate their multicultural counseling self-efficacybecause of their lack of experiences and training in this arena. Similarly, the counselor's self-perceived helping skills may differ from supervisor perceptions of his or her current skill level for the same reasons. Since the MCSE-RD is a behavior-oriented instrument, supervisors and counselor educators may find it useful to adapt the MCSE-RD as an other-report assessment tool and provide feedback to trainees at the behavior level. For example, trainees and supervisors could discuss discrepancies of their ratings on the MCSE-RD and also compare these ratings with trainees' in-session behaviors. This performance information (i.e., self-observation and feedback from supervision) is crucial for trainees to achieve reasonably accurate efficacy judgments in multicultural counseling. An accurate self-efficacy assessment not only can help counselors set proper goals for training but also can help them to make better clinical judgments regarding referrals and the types of clients/issues with which they are best prepared to work.

One caution in using the MCSE-RD in training involves how supervisors communicate their feedback to trainees. According to Bandura (1997), persuasory

efficacy information can be conveyed in ways that undermine a sense of efficacy or boost it. Research on children with learning deficits suggested that evaluative feedback highlighting personal capabilities raises efficacy beliefs (Schunk & Cox, 1986). However, it is not clear how we can translate this finding into the area of counselor training; nor do we know much about how to improve trainees' performance in cross-racial sessions by enhancing their multicultural counseling self-efficacy. Although the MCSE-RD offers supervisors and counselor educators a tool to evaluate trainees' capabilities in multicultural counseling, further research is needed to increase confidence in its practical utility.

Fourth, along with general counseling self-efficacy measures (e.g., CASES), the MCSE-RD could help to clarify the relationship between general and multicultural counseling self-efficacy. More understanding of whether general and multicultural counseling are one or two separate, but related, constructs not only has implications for how we train our students but can also help us identify those skills that are particularly important and effective with racial/ethnic minority clients. Finally, although the MCSE-RD was developed to assess counselors' perceived capabilities to counsel racially diverse clients, researchers and educators could adapt the instructions and items for other multicultural subgroups (e.g., LGBT clients, people with disabilities). By doing so, a training program could identify weaknesses in its curriculum and help trainees to explore areas for counseling skill improvement.

## Chapter VII: Limitations and Future Directions

Although findings from the current study provide initial support for the validity and reliability of the MCSE-RD scores, there are several limitations and future directions that should be discussed. First, the sample used in the study was relatively small ($N$ = 181). A larger sample is preferred in future studies to provide more stable results. Second, the factor structure of the MCSE-RD requires cross-validation using different samples and different statistical procedures. It is important to investigate whether the same factor structure would hold up for counseling students with different professional interests (e.g., practice versus research) as well as for practicing psychologists. Third, confirmatory factor analysis not only can verify the factor structure of the MCSE-RD found in the current study but also can further explore the relationship between the MCSE-RD and general counseling self-efficacy measures, such as the CASES. One possibility to examine is that the relationship between, and latent structure of, general and multicultural counseling self-efficacy depends on counselor developmental or experiences level. For instance, with increasing experiences, counselors may be better able to differentiate between their generic skills and how well they can perform specifically in multicultural counseling situations.

Fourth, participants reported lowest self-efficacy in multicultural assessment, which involves administering culturally sensitive assessment tools and interpreting their results as well as dealing with culture-bound syndromes. Given that trainees may not be familiar with culture-specific mental issues and relevant assessment tools, training programs will benefit from research designed to explore how trainees' knowledge of culture-specificpsychological problems influences their perceived abilities in assessing

and treating these illnesses. Fifth, how the MCSE-RD scales relate to various self-report and other-report multicultural counseling competency instruments (e.g., the MCAS, CCCI-R) should be examined to provide more evidence for convergent and discriminant validity of the MCSE-RD scores. Sixth, the relationship between the MCSE-RD and multicultural counseling training was established in the current study by cross-sectional design. This relationship should be examined longitudinally and experimentally by, for example, investigating the MCSE-RD's sensitivity to actual practicum experiences that trainees receive. Responses to the MCSE-RD before and after taking counseling practicum, or between experimental and control groups, will offer opportunities to explore the causal link between training experiences and multicultural counseling self-efficacy.

Finally, trainees' personality variables (e.g., positiveand negative affect, extraversion and introversion) and cultural factors (e.g., racial/ethnic identity development, universal-diverse orientation) as well as the training program's multicultural environment should be included in future research on the MCSE-RD in order to more completely understand the correlates of multicultural counseling self-efficacy. Social cognitive theory (Bandura, 1997) provides a useful framework for organizing studies of the predictors and outcomes of multicultural counseling self-efficacy. Theory-guided research will help us to understand how personality and environmental factors contribute to multicultural counseling self-efficacy and how these efficacy beliefs relate to counselors' involvement and performance in multicultural counseling.

Appendix A

Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form
(60 items before exploratory factor analysis)

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

| | **No Confidence at all** | | | | **Some Confidence** | | | **Complete Confidence** | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| **When working with a client who is *racially different* from yourself, how confident are you that you could do the following tasks effectively over the next week?** | | | | | | | | | | |
| 1. Explain the counseling process to a client who is not familiar with Western mental health services. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 2. Develop a strong working alliance with the client. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 3. When appropriate, adopt different helping roles other than counselor/therapist (e.g., mentor, consultant, advocate, coach). | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 4. Make culturally appropriate referrals (e.g., to indigenous healers in the community) when necessary. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 5. Openly discuss cultural differences and similarities between the client and yourself. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 6. Address issues of cultural mistrust in ways that can improve the therapeutic relationship. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 7. Make use of the client's verbal and nonverbal communication to decide whether the session is going in the right direction. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 8. Help the client to articulate what she or he has learned from counseling during the termination process. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 9. Where appropriate, help the client to explore racism or discrimination in relation to his or her presenting issues. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10. Evaluate rapport to see where you and the client stand in the therapeutic relationship. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 11. Keep sessions on track and focused with a client who is not familiar with the counseling process | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

who is not familiar with the counseling process.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 12. Help the client to anticipate both culturally and non-culturally specific barriers that may hinder him or her from achieving future goals. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 13. Convey an understanding of the client's presenting issues in a way that is consistent with her or his cultural background. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 14. Facilitate the client's willingness to work with you as a team toward mutually-agreed goals. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 15. Pay attention to cultural differences between yourself and the client that may be affecting counseling. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 16. Respond effectively to the client's feelings related to termination (e.g., sadness, feeling of loss, pride, relief). | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 17. Encourage the client to take an active role in counseling. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 18. Collaborate with the client in developing a therapeutic relationship compatible with his or her cultural background. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 19. Evaluate counseling progress in an on-going fashion. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 20. Identify and integrate the client's culturally specific way of saying good-bye in the termination process. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 21. Help a client to deal with his or her fear of stigma about seeking counseling. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 22. Negotiate with the client regarding the tasks of counseling. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 23. Assess the client's readiness for termination. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 24. When relevant, introduce culture/race into counseling in a way the clients can easily understand and accept. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 25. Select culturally appropriate assessment tools according to the client's cultural background. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 26. Interpret standardized tests (e.g., MMPI-2, Strong Interest Inventory) in ways sensitive to cultural differences. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 27. Take into account cultural factors (e.g., the client's racial identity development, acculturation level | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| racial identity development, acculturation level, cultural values) when delivering treatment. | | | | | | | | | | |
| 28. Deal with power-related disparities (i.e., counselor power versus client powerlessness) with a client who has experienced racism or discrimination. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 29. Respond effectively to the client's resistant behaviors (e.g., anger, withdrawal) resulting from cross-cultural misunderstandings or impasses. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 30. Use non-standardized methods or procedures (e.g., card sort, guided fantasy) to assess the client's concerns in a culturally sensitive way. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 31. Take into account the impact that family may have on the client in case conceptualization. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 32. Develop homework that is appropriate given the client's cultural background. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 33. Manage language barriers with a client whose first language is not English. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 34. Address cross-cultural conflicts in a therapeutic way. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 35. Assess relevant cultural factors (e.g., the client's acculturation level, racial identity, cultural values and beliefs). | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 36. Take into account cultural explanations of the client's presenting issues in case conceptualization. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 37. Adjust existing counseling techniques (e.g., empty chair) to make them appropriate to the client's cultural background. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 38. Respond to the client's transference in a culturally sensitive way. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 39. Repair cross-cultural impasses that arise due to problems in the use or timing of particular skills (e.g., introduce the topic of race into therapy when the client is not ready to discuss). | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 40. Conduct a mental status examination in a culturally sensitive way. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 41. Help the client to set counseling goals that are consistent with his or her cultural values. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 42. Help the client to develop culturally appropriate ways to deal with systems (e.g., school, | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

community) that affect him or her.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 43. Manage your own anxiety due to cross-cultural impasses that arise in the session. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 44. Respond with the most appropriate counseling skill when therapy stalls as a result of culture. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 45. Assess culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness). | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 46. Help the client to set counseling goals that take into account expectations from her or his family. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 47. Help the client to identify how cultural factors (e.g., racism, acculturation, racial identity) may relate to his or her maladaptive relational patterns. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 48. Manage your own racially or culturally based countertransference toward the client (e.g., over-identification with the client because of his or her race). | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 49. Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstanding or impasses. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 50. Assess the salience and meaningfulness of culture/race in the client's life. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 51. Take into account multicultural constructs (e.g., acculturation, racial identity) when conceptualizing the client's presenting problems. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 52. Help the client to clarify how cultural factors (e.g., racism, acculturation, racial identity) may relate to her or his maladaptive beliefs and conflicted feelings. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 53. Respond in a therapeutic way when the client challenges your multicultural counseling competency. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 54. Admit and accept responsibility when you, as the counselor, have initiated the cross-cultural impasse. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 55. Help the client to develop new and more adaptive behaviors that are consistent with his or her cultural background. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 56. Resolve misunderstanding with the client that stems from differences in culturally based style of communication (e.g., acquiescence versus | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

confrontation).

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 57. Remain flexible and accepting in resolving cross-cultural strains or impasses. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 58. Treat culture-bound syndromes (DSM-IV) for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness). | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 59. Help the client to utilize family/community resources to reach her or his goals. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 60. Deliver treatment to a client who prefers a different counseling style (i.e., directive versus non-directive). | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

Appendix B

Demographic Sheet

This **double-sided** survey is designed to find out more about multicultural counseling experiences of graduate students. There are no right or wrong answers. Also, you and your program will not be identified at any time.

Please complete the demographic items listed below. Following the demographic section, you will find a list of statements related to multicultural counseling. Please read instructions and each statement carefully and do not skip any of them. Thank you for your participation!

1. Sex: ڤ Male ڤ Female

2. Ethnic background:

| | | |
|---|---|---|
| ڤ White American | ڤ African American | |
| ڤ Asian American/Pacific Islander | ڤ Latino/a American | |
| ڤ Native American/Alaskan Native | ڤ Multiethnic (specify):_____ | |
| ڤ International student from:_____ | | |

3. Age:_____

4. Highest educational degree earned: ڤ Bachelor's ڤ Master's ڤ Ph.D. ڤ Other (specify):

5. Currently in the specialty area of (check one):

| | | |
|---|---|---|
| ڤ College Student Personnel | ڤ Rehabilitation Counseling | ڤ Counseling Psychology |
| ڤ Community Counseling | ڤ Counselor Education | ڤ Clinical Psychology |
| ڤ School Counseling | ڤ School Psychology | ڤ Other (specify):_____ |

6. Currently working toward which of the following degree: ڤ Master's ڤ Ph.D. ڤ Other (specify): _____

7. Year in your current program: ڤ 1st year ڤ 2nd year ڤ 3rd year ڤ 4th year ڤ beyond 4th year (including internship)

8. Number of multicultural counseling courses taken since undergraduate (include ones currently taking): _____

9. Number of multicultural counseling workshops attended since undergraduate (include ones currently attending): _____

10. Approximately how many supervision hours have you and your supervisor(s) spent on clients who are racially different from you: _____ hrs

11. In the future, what percentage of your clinical training would you **ideally** like to devote to seeing clients who are racially different from you:_____ %

12. Please indicate the appropriate number of direct contact hours that you have worked with clients from the following racial/ethnic groups in individual, couple/family, or group counseling by circling the appropriate numbers:

| | 1 (0 – 8 hrs) | 2 (9 – 16 hrs) | 3 (17 – 24 hrs) | 4 (25 – 32 hrs) | 5 (above 32 hrs) |
|---|---|---|---|---|---|
| African Americans: | 1 | 2 | 3 | 4 | 5 |
| Asian Americans/ Pacific Islanders: | 1 | 2 | 3 | 4 | 5 |
| Latino/a Americans: | 1 | 2 | 3 | 4 | 5 |
| Native Americans/ Alaskan Natives: | 1 | 2 | 3 | 4 | 5 |
| White Americans: | 1 | 2 | 3 | 4 | 5 |
| Clients with multiethnic backgrounds: | 1 | 2 | 3 | 4 | 5 |

13. Please indicate your interest in delivering counseling to clients who are racially different from you in the near future by circling the appropriate number:

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Not at all interested | | Moderately interested | | Very interested |

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