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Client and Provider Experiences of Multicultural Competence in Community Mental Health

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Client and Provider Experiences of Multicultural Competence in Community Mental Health

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Client and Provider Experiences of Multicultural Competence in Community Mental Health

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A major problem in the United States is the existence of inferior mental healthcare outcomes for racial and ethnic minorities compared with their European American counterparts. The federal government has documented the existence of mental health disparities for racial and ethnic minorities, and has called for more culturally sound healthcare practices at the provider level. Sue et al.'s (1982, 1998) widely accepted theory of cultural competence in counseling highlights the importance of certain provider qualities, including being aware of their biases about human behavior, appreciative of the diverse worldviews of their clients, and skilled in working with culturally diverse clients. However, it remains unclear if clients are able to observe and measure to what extent providers are considerate of their sociocultural context and needs. Further, the relationship between provider and client experiences of provider multicultural competence has not been sufficiently addressed in the literature.

The current study used hierarchical linear modeling to examine how providers' self-reported multicultural competence, based on multiple measures, impacted client perceptions of multicultural competence in the community mental health setting. A unique aspect of the study was that it examined differences in ratings of clients who had the same provider. The study also examined how ethnic identity development, and majority or minority status match of race and ethnicity self-label affected the relationship between provider behaviors and client perceived multicultural competence. Results indicated that clients tend to view some providers as being more multiculturally competent than others. The aspect of self-reported multicultural competence that explained a significant amount of variance in client ratings was the sensitivity of providers to client needs. Ethnic identity development was not found to explain differences in perceived multicultural competence of providers. Match of client and provider based on reported racial and ethnic majority or minority status had a positive, significant impact on how clients rated their providers' multicultural competence.

The current study offers a launching base for the implementation of culturally competent practices at the provider level. It is an important addition to the field of counseling psychology to find that clients and providers in community mental health settings differentially measure and interpret multicultural competence.

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Chapter I: Introduction

Racial and ethnic minorities receive inferior mental healthcare compared with their European American counterparts in the U.S., and the federal government has recognized that these mental health disparities represent a national crisis (U.S. Department of Health and Human Services [HHS], 2011). Individuals from racial and ethnic minority populations tend to drop out of treatment at higher rates, have poorer communication with healthcare providers, and experience worse treatment outcomes compared with European Americans (e.g., Groman & Ginsberg, 2004; Wierzbicki & Pekarik, 1993). Mental health disparities are inherently tied to social injustice, and they underscore the prevalence of racial and ethnic inequality and the devaluing of minority groups in American society. In addition to the moral imperative to enhance the ability of all Americans to access and receive high quality healthcare, there are also significant economic benefits to reap from improving mental healthcare for all. Improved quality of healthcare leads to better treatment adherence, fewer office and emergency room visits, and a larger, more functional workforce. Racial and ethnic minorities represent an exponentially growing population, with Latino, African American, and Asian American individuals expected to account for almost half of the total population by 2050 (U.S. Census Bureau, 2008). The problem of mental health disparities will grow if left unaddressed. The passing of the Affordable Care Act (ACA) into law was one significant step undertaken by the government to enhance access to care for uninsured or underinsured individuals. While such political reform demonstrates movement toward

improving access to healthcare for all, there is a paucity of research about what specific practices and behaviors at the client and provider levels improve health outcomes for racial and ethnic minorities.

Scholars have hypothesized that multicultural competence (MCC) of healthcare providers is an important area to target to reduce health disparities. A widely accepted conception of multiculturally competent providers describes them as aware of their biases about human behavior, appreciative of the diverse worldviews of their clients, and skilled in working with culturally diverse clients (Sue et al., 1982, 1998). Providers who lack MCC, in contrast, tend to possess a singular, Eurocentric view of mental health, and to communicate to minority clients that the norms of the dominant European American culture are the ideal and practices that deviate from this norm are problematic (Sue & Sue, 2008). These messages can alienate and degrade culturally diverse clients, as well as hinder clients from tapping into unique cultural strengths and resources that aid in treatment.

Research has not yielded accurate and reliable measures of provider MCC, precluding the development of training and intervention strategies for improving the practices of mental healthcare providers. Most of the instruments that measure MCC are provider self-reports, and it has not been demonstrated that providers who report high scores on these measures also effectively demonstrate Sue et al.'s (1998) multicultural competencies. Self-report measures of MCC have been criticized for positively correlating with measures of social desirability, reflecting anticipated rather than actual practices of providers, and not corresponding with observer ratings of provider MCC

(e.g., Constantine & Ladany, 2001; Pope-Davis & Dings, 1995; Worthington, Mobley, Franks, & Tan, 2000). Among provider self-report measures, the California Brief Multicultural Competence Scale (CBMCS) is the best regarded; it has been found to have good validity and reliability and to be uncorrelated with measures of social desirability (Gamst et al., 2004). Nevertheless, we lack evidence of how provider reports on the CBMCS relate to client perceptions of provider MCC.

In the healthcare industry, quality assurance analysts, business developers, administrators, and researchers have begun to recognize the importance of consumer input in assessing the MCC of healthcare providers (e.g., Davis, 2007; National Committee for Quality Assurance [NCQA], 2009; Pope-Davis et al., 2002). Unfortunately, most existing client measures lack adequate psychometric properties and have not been normed on culturally diverse client populations (e.g., Constantine, 2001; Cornelius, Booker, Arthur, Reeves, & Morgan, 2004). In a promising effort to address these concerns, Ihorn (2013) created a client measure, the Client Experience of Provider Counseling Competence Inventory (CEPCCI-C), based on Sue's (1998) multicultural competencies and guidelines identified by consumers in a concept mapping study (Davis, 2007). Ihorn (2013) found the CEPCCI-C to have good reliability and content and construct validity of the measure. The CEPCCI-C may be viable for use with diverse client populations in community health centers.

The current study builds on Ihorn's (2013) promising work in developing a measure of clients' experience of multicultural competence (MCC), and extends this study to examine the relationship between provider and client reports of provider MCC

and to investigate if multiple clients rate the same provider similarly. The results yield information about the practicality of using provider self-reports as quality indicators of mental healthcare. If culturally diverse clients' perceptions about their healthcare experiences do not correspond with their providers' perceptions, it is unlikely that self-reported MCC relates to quality of care and subsequent health outcomes for clients. If clients' ratings appear to vary in a random fashion for the same providers, it may be that clients are unable to observe and label behaviors corresponding with Sue et al.'s (1998) or Davis' (2007) multicultural competencies. Governmental agencies, analysts, and researchers in the healthcare realm have failed to establish the measurability or importance of MCC in improving healthcare quality. The current study is a step toward understanding the measurability and importance of MCC to client healthcare experiences. The study also examined how ethnic identity development, and majority or minority status match of race and ethnicity self-label affected the relationship between provider behaviors and client perceived MCC.

Chapter II: Literature Review

The following literature review provides an overview of mental health disparities in the present demographic and sociopolitical context of the U.S., and examines how multicultural competence (MCC) of providers relates to reducing health disparities. The review will describe the most agreed upon theories in the psychological literature regarding provider MCC, and will discuss the methodologies and instruments used to quantify the construct of MCC in the empirical research. The congruence of findings across empirical studies, and the limitations of these studies in capturing and demonstrating the efficacy of the construct, will be reviewed. The relationship between provider- and client-reported measures of MCC, and variables that may affect perceived MCC, including ethnic identity and racial and ethnic match, will be reviewed.

Before beginning the literature review, there must be clarification of the terminology used. First, "mental healthcare providers" or "providers" will refer to any individuals who are providing mental health services to an individual or group of individuals. For example, among other mental health professionals, providers may include psychiatrists, psychologists, clinical social workers, nurses, or licensed professional counselors. Providers may offer a variety of services, such as individual counseling, family counseling, psychiatric services, housing assistance, or substance abuse treatment. The terms "counselor" and "clinician" will be used interchangeably with "provider" at times in relation to MCC. Dissecting the construct of MCC as it applies to different types of mental healthcare providers is beyond the scope of the present study.

"Clients" will refer to individuals who have received mental healthcare services. Finally, definitions of the following terms: culture, race, ethnicity, multiculturalism, and diversity, are included in Appendix A. The definitions are taken from the American Psychological Association's (APA's) *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA Multicultural Guidelines, 2003).

Mental Health Disparities

All Americans, regardless of their race, ethnicity, geographic location, or socio-economic status, deserve access to equal and high quality mental healthcare. The disproportionate distribution of mental health conditions among certain groups of individuals demonstrates the existence of health disparities and reflects a fundamental problem in the provision of healthcare in the U.S. (Whitehead & Dahlgren, 2007). An increasing number of Americans have presented with mental health concerns in the last few decades, and there has been little progress in decreasing mental health disparities between racial and ethnic minorities and European Americans (U.S. Department of Health and Human Services [HHS], 2009). As compared to European Americans in mental health settings, racial and ethnic minorities have been found to be more likely to drop out of treatment (Wierzbicki & Pekarik, 1993), be provided with less information about diagnosis and prognosis (Schaafsma, Raynor, & de Jong-van den Berg, 2003), and be more likely to be frustrated when they do not receive sufficient information (Levinson, Stiles, Inui, & Engle, 1993). It is distressing that, even after controlling for insurance status and socio-economic status in data analyses, ethnic and racial minorities tend to

receive lower quality healthcare and decreased access to healthcare in the U.S. compared to European Americans (e.g., Groman & Ginsberg, 2004; Keppel, Pearcy, J., & Wagener, 2002; Smedley, Stith, & Nelson, 2002). These disparities have continued in spite of interventions targeted at reversing this trend (e.g., Keppel et al., 2002).

Taking action to address the issue of healthcare inequity is particularly urgent as the trajectory of the U.S. population is expected to become increasingly diverse with respect to racial and ethnic minorities. According to the 2000 U.S. Census, 34.6 million individuals identified as African American, 10.2 million identified as Asian American, and 35.3 million people identified as Hispanic of any race (U.S. Census Bureau, 2008). Demographers estimate that by 2050, 14.6% of individuals in the U.S. will be African American, 8% will be Asian American, and about a quarter (24.4%) will be Latino (Passel & Cohn, 2008). Racial and ethnic minorities will represent an increasingly substantial portion of health care consumers in the U.S., and the need to identify and address factors that contribute to inadequate healthcare for these groups is imperative.

While there is a particular need to improve mental healthcare for racial and ethnic minorities, who tend to receive inferior care compared to European Americans, improving mental healthcare for all Americans is critical. Recent statistics on the mortality, prevalence, and cost associated with mental health disorders in the U.S. underscore the need for improved care and access in this domain. Suicide ranked as the 11th cause of death for individuals in 2006, and there were 12,988 reported alcohol-impairment related fatalities in 2007 (HHS, 2009). As of 2006, 30.4 million (13.9%) people in the U.S. had at least one depressive episode in their lifetime. The number of

people ages twelve and over who experienced drug dependence or abuse in 2007 was 22.3 million (9% of the total population). In 2004, about a quarter of all community hospital stays in the U.S. for individuals over the age of eighteen were related to psychological disorders, including depression, bipolar disorder, schizophrenia, and substance use-related disorders (HHS, 2009). These conditions are costly not only in terms of quality of life, but also in the contribution to overall medical expenditures. The total medical expenditures for treating mental health and substance abuse disorders in the U.S. in 2003 were estimated at about $121 billion dollars, and the cost has only increased in the last decade. Americans are experiencing the burden of inadequate mental healthcare, and the problem is growing.

The U.S. government has recognized the acute need to improve mental healthcare by addressing disparities in access to and outcomes of care for racial and ethnic minorities. For example, the Federal Collaborative for Health Disparities Research (FCHDR) was established in 2009 as part of the U.S. Department of Health and Human Services to promote coordinated efforts targeting health improvement in populations disproportionately affected by disease, injury and/or disability (HHS, 2011). The FCHDR identified mental health as one of four topics out of a total of 165 different health disparity conditions that warrants immediate national attention, and federal partners have formed expert workgroups for research and collaboration in this area (Safran, Mays, Huang, McCuan, Pham, Fisher et al., 2009). Since 2003, the Agency for Health Care Research and Quality (AHRQ) has released an annual National Healthcare Disparities Report to summarize data on access, utilization, and quality of health care across various

racial and ethnic groups (HHS, 2009). National reports have examined disparities in access to and treatment of depression, for example, as well as disparities related to help-seeking behavior for mental health needs, overall use of mental health services, and use of psychotropic medication (Levin, Hennessy, & Petrila, 2010). The federal government's push to create workgroups that produce and disseminate research surrounding mental healthcare disparities signifies the urgency of the issue. These groups are still in the process of identifying the scope of the problem.

The increase in examination and documentation of mental health disparities in the U.S. has yielded startling findings. According to the Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health, in 2007, the percentage of individuals who had a major depressive episode in the previous 12 months and who received any treatment for depression during that period was significantly lower for African Americans (52.6%) and Latinos (53.9%) when each subgroup was compared to European Americans (66.8%) (HHS, 2009). Based on analysis of the National Comorbidity Survey-Replication (NCS-R), another study found that racial and ethnic minorities had higher rates of no initial treatment contact after onset of a mental disorder, longer delays to seek treatment, and were less likely to use psychopharmacology and psychotherapy services compared to European Americans (Wang, Demler, Olfson, Pincus, Wells, & Kessler, 2006). In order to improve the mental health of all Americans, research must begin address these discrepancies in access to and effectiveness of treatment across groups and identify interventions that will bolster access, utilization, and/or outcomes for members of diverse racial and ethnic groups.

Since healthcare disparities are at the forefront of federal concerns, it is not surprising that healthcare reform is simultaneously a leading legislative priority. The passing of the Affordable Care Act (ACA) into law significantly affects Americans' access to healthcare due to the expansion of health insurance options, and the availability of more affordable health insurance. Under the health care law, for example, parents may cover their children through their insurance policies through the age of 26. Additionally, for families of four earning less than $88,000 a year, there are tax credits available to help cover insurance costs (www.healthcare.gov). Among many other changes engendered by the passing of the ACA, the U.S. is experiencing a shift away from private practice and emergency room healthcare settings and toward community health centers (CHCs).

CHCs are burgeoning into the leading mental healthcare settings for Americans, and are meant to primarily serve persons who are uninsured, underinsured, low-income, or those living in areas where little access to primary healthcare is available. Currently, CHCs serve over 20 million individuals in over 8,000 locations across the U.S. (www.nachc.com). A core goal in the establishment of CHCs was to counteract health disparities by increasing access to high quality healthcare for all. CHCs tend to be tailored to the needs of the local communities they serve, are composed of a multidisciplinary staff, and place an innovative emphasis on comprehensive preventative care (www.nachc.com). CHCs provide services to a substantially greater ratio of racial and ethnic minorities compared to European Americans than other healthcare settings. Capital investments under the ACA will provide $9.5 billion to expand services at CHCs over five years, and $1.5 billion to support major construction and renovation projects at

CHCs (HHS, 2012). As CHCs are rapidly increasing as healthcare settings in the U.S., and because they provide care to a significant population of racial and ethnic minorities, these sites serve as important contexts for mental health research. The overhaul of the U.S. healthcare system is a major part of the effort to narrow mental health disparities among those without access to high quality care – a group in which racial and ethnic minorities are overrepresented. However, there is a dearth of research about what specific characteristics and practices improve mental healthcare at the client, provider, and organizational levels for racial and ethnic minorities (e.g., Ashton, Haidet, Paterniti, Collins, Gordon, O'Malley et al., 2003; Brondolo, Gallo, & Meyers, 2009). Researchers and policy makers concerned with mental health disparities have begun to recognize MCC among providers and organizations as a key factor in reducing health disparities.

Provider Multicultural Competence (MCC)

The provision of mental healthcare in the U.S. was founded in a Eurocentric context, and the training of mental healthcare providers, the development of assessment measures, and the diagnostic criteria for disorders in the U.S. reflect the values, norms, customs, and communication styles of the dominant/White culture. Therefore, providers of mental healthcare in the U.S. who lack competence in interacting with clients from diverse cultural backgrounds tend to communicate the notion that the norms and values of the dominant/White culture are the ideal; this can be carried out verbally or nonverbally, automatically, and unconsciously (Sue & Sue, 2008). For example, a clinician might suggest to an African American female client that she is being paranoid in feeling like a victim of racism in the workplace, a response that denies the client her

unique racial and ethnic experiences. As another example, a provider might advise an Asian American male client that he is too quiet and needs to speak up more in session, which is a criticism of the client's possibly culturally-based communication style. These brief anecdotes serve to demonstrate the destructive and demeaning effects of mental healthcare encounters on racial and ethnic minority populations when providers lack multicultural competence (MCC).

Sue et al.'s (1982) position paper on cross-cultural competencies serves as the base of research and theory on MCC in mental healthcare provision. In their paper, the authors defined multiculturally competent counselors as possessing the following broad characteristics in their work with racial and ethnic minorities: (1) awareness of their own assumptions about human behavior, values, and biases, (2) understanding and appreciation for their clients' differences in culture and worldview, and (3) development of effective interventions and skills for working with diverse clientele (Sue et al., 1982). The authors also emphasized that being multiculturally competent is an active, lifelong process for providers, without an endpoint. The most recent version of Sue et al.'s (1982) original model involves a total of 34 competencies of multiculturally competent counselors, each of which is organized as reflecting a combination of attitudes and beliefs, knowledge, and/or skills (Sue et al., 1998) (See Appendix B). For example, within the domain of attitudes and beliefs, the authors asserted that culturally competent providers should be aware of their own differences in cultural heritage (beliefs and attitudes), knowledgeable about their own heritage (knowledge), and able to seek consultation, obtain training, or refer clients to more qualified providers (skills). Sue et

al.'s (1982, 1998) model has been incorporated into the majority of graduate training programs in counseling psychology (Constantine & Ladany, 2001), and has informed the development of measurements of MCC (e.g., D'Andrea, Daniels, & Heck, 1991; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002**;** Sodowsky, Taffe, Gutkin, & Wise, 1994).

While Sue et al.'s (1982, 1998) model has been extoled for its content validity, researchers have also noted the lack of empirical studies on the competencies outlined by the model (Worthington, Soth-McNett, & Moreno, 2007). It has not been shown that providers who report they possess the multicultural competencies outlined by Sue et al. (1982, 1998) actually demonstrate MCC, as well as increased efficacy, in terms of improved health outcomes of clients (Ponterotto, Fuertes, & Chen, 2000). For example, providers' reported MCC has not been shown to correspond with their ability to construct case conceptualizations from a multicultural perspective (Constantine & Ladany, 2001; Ladany, Inman, Constantine, & Hofheinz, 1997). Self-report MCC measures have suggested indirect support of some competencies described in the model, such as demographic and training variables (e.g., Ponterotto, Rieger, Barrett, Sparks, Sanchez, & Magids, 1996; Pope-Davis & Dings, 1995) and worldview (Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). For example, Sodowsky et al. (1998) found that provider self-reports of multicultural skills, awareness, and knowledge increased with higher levels of multicultural training. Additionally, Tummala-Narra, Singer, Esposito, & Ash (2012) found that some individual factors, including a positive orientation to diversity, and systemic factors, such as access to institutional resources in the workplace, predicted

both higher self-perceived MCC and engagement in multicultural practices of providers. These findings suggest that providers who report possessing more of the competencies outlined by Sue et al. (1982) may have a more accepting view of diversity in general, and may have resources available to them in their healthcare setting to gain knowledge and skills in multicultural competent practice.

Sodowsky et al. (1998) also examined how demographic characteristics relate to MCC as a way to indirectly assess Sue et al.'s (1982) conceptualization of MCC. The authors found that European American providers had significantly lower scores on measures of MCC compared to the three other racial groups included in the study: Latinos, Asian Americans, and African Americans. Sodowsky et al. (1998) suggested that minority individuals had higher MCC scores because they possess heightened awareness of their own cultural differences due to their non-dominant power status in U.S. society. Providers who are members of minority groups may have more experience and practice in confronting multicultural issues, rendering them more aware, knowledgeable and skilled in competencies outlined by Sue et al. (1982; 1998) compared with their European American counterparts. While research has demonstrated significant relationships between demographic, training, and worldview variables and MCC, direct support of the competencies referred to in Sue et al.'s model (1982, 1998) is missing from the literature. One major impediment to obtaining evidence supporting the relevance of provider MCC, both in terms of how it relates to Sue et al.'s (1998) conceptualization and in terms of the efficacy of the provider, is the lack of viable assessment options.

Provider Self-report Measures of MCC

The vast majority of MCC research to date has used provider self-reports of MCC that were developed based on Sue et al.'s (1982, 1998) conceptualization of MCC. Following is a list of commonly used provider self-report scales: the Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea et al., 1991), the Multicultural Counseling Inventory (MCI; Sodowsky et al., 1994), the Multicultural Competency and Training Survey (MCCTS; Holcomb-McCoy & Myers, 1999), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2002), the Multicultural Counseling Awareness Scale–Form B, (MCAS-B; Ponterotto et al., 2002), and the California Brief Multicultural Competence Scale (CBSMCS; Gamst et al., 2004). Most of these scales were developed to assess the effectiveness of multicultural training programs. All of the above measures, with the exception of the MCCTS (Holcomb-McCoy & Myers, 1999), were found to have acceptable to good content, criterion, and construct validity and good reliability. The measures were all constructed to be Likert-type self-report scales and, for each measure, scales consist of as few as two to as many as five subscales. Compared with other provider self-report MCC measures, the CBMCS (Gamst et al., 2004) has been particularly well regarded as a sound measure of provider MCC. In contrast to scores on similar measures, scores on the CBMCS have not been found to significantly and positively correlate with measures of social-desirability (Gamst et al., 2004). Researchers have consistently found strong levels of reliability for the CBMCS, with scores ranging from 0.75 to 0.90 for various subscales (Gamst et al., 2004; Tummala-Narra et al., 2012). While provider self-report measures of MCC have been

important as initial steps in attempting to capture and quantify provider MCC, researchers have noted limitations of the measures.

First, there has been shown to be a lack of congruence among MCC self-report measures in what they assess (Pope-Davis & Dings, 1995; Ponterotto et al., 2000). While all of the provider self-report measures described above were developed based on Sue et al.'s (1982) tripartite model, the measures differ in the number of factors they assess. For example, only the CBMCS and the MCI both measure the same number of factors (i.e., four factors) (Gamst et al., 2004; Sodowsky et al., 1994). The MAKSS, MCCTS, MCKAS, and MCAS-B measure three, five, two, and one factor, respectfully (D'Andrea et al., 1991; Holcomb-McCoy & Myers, 1999). These findings call into question the idea that they are based on a unified theoretical framework. Further, Sue et al.'s model identified competencies across three core constructs: awareness, knowledge, and skills, which would most feasibly lead to a three-factor structure for all measures. Second, researchers have criticized existing measures of MCC for containing subscales that are positively correlated with measures of social desirability (Constantine & Ladany, 2001; Ponterotto et al., 2000; Sodowsky et al., 1994; Worthington et al., 2007). These findings suggest that providers may be unable to accurately assess their own MCC due to social pressures, rendering these self-reports of MCC largely uninformative. Relatedly, a common criticism of provider self-reports is that they are not representative of providers' actual behaviors, but rather reflect providers' visions about how they anticipate practicing. Providers' self-reported MCC has not shown to be correlated with observer

ratings of MCC (Worthington et al., 2000), exemplifying possible disconnect between providers' MCC and actual practice.

In an attempt to address the final criticism noted above, Tummala-Narra et al. (2012) paired measures of clinicians' self-reported MCC with measures of clinicians' self-reported engagement in multicultural practices. To measure engagement in multicultural practices, the authors developed the Clinicians' Multicultural Practices in Psychotherapy Scale (CMPPS; Tummala-Narra et al., 2012), a provider self-report assessing how often clinicians engaged in specific multicultural practices. For example, items included: "Sought consultation with other mental health professionals who have more knowledge and experience" and "Considered my client's first language and acculturation during initial assessment and/or psychological testing" (Tummala-Narra et al., 2012). A strength of this study included the use of a second self-report measure to potentially explore discrepancies between provider self-report of MCC and actual practices. However, the authors neglected to report the relationship between self-perceived MCC and self-perceived engagement in multicultural practices, which is an important and unanswered question in MCC research. Other limitations of the study were that the authors did not adequately establish validity and reliability of the CMPPS, and that by asking clinicians' to base their responses on the measure on a single racial and ethnic minority client, respondents may have self-selected clients with whom they felt particularly effective.

Rather than comparing across different types of self-reports by providers, it would be more informative to include the perspective of clients who are a key part of the

healthcare encounter. Tapping into clients' perceptions of provider MCC provides more direct information about the clients' experience in the healthcare setting, which is more closely related to their subsequent behaviors (i.e., adherence to treatment and health outcomes) (e.g., Polo, Alegría, & Sirkin, 2012). Recent research has begun to address the lack of client assessment of counselor MCC (e.g., Fuertes, Bartolomeo, & Nichols, 2001; Pope-Davis et al., 2002).

Client Measures of Provider MCC

Researchers have begun to recognize the importance of including consumer input in the measurement of provider MCC. For example, Constantine (2001, 2002) examined clients' perceptions of MCC by using a measure that has not been normed on a client population. To assess clients' perceptions, the author used the Cross-Cultural Counseling Inventory—Revised (CCCI-R; LaFramboise, Coleman, & Hernandez, 1991), which is designed for use by a supervisor in assessing the multicultural competence of the counselor in a cross-cultural counseling session. In using the CCCI-R to examine client perceptions of MCC, Constantine (2001) determined that racial and ethnic minority counselor trainees were rated as being more multiculturally competent than European American counselors. She also found that prior multicultural training of providers predicted observer-rated MCC, but self-reported MCC did not. Constantine (2002) found that ratings of counselor MCC by clients from racial and ethnic minority groups predicted significant variance in ratings of counseling satisfaction beyond that which was accounted for by general counseling competence ratings. While interesting, the generalizability of Constantine's (2001, 2002) findings is uncertain due to the use of a

measure not normed on a client population, and the use of highly educated participant clients from a major research university. Clients seeking services at university mental health centers are not representative of the majority of those seeking mental health services in the U.S.

Client-based MCC research has also commonly relied on samples of pseudo-clients rather than actual clients (Thompson, Worthington, & Atkinson, 1994; Worthington, et al., 2007). Pseudo-clients refer to participants who attend one or more sessions with an actual counselor for the purpose of the study, but do not typically see a counselor outside of the study and are not expected to continue counseling beyond the purposes of the study. For example, Thompson et al. (1994) examined the behaviors of 100 African American women who were exposed to either an African American or European American counselor who used verbal statements reflective of either a cultural or a universal content orientation. In the cultural content orientation, counselors made more statements acknowledging the unique cultural characteristics of the client. The researchers found that participants reported a greater willingness to return to counselors when exposed to the cultural as opposed to the universal content orientation. While these findings could potentially indicate that treatment adherence is related to an aspect of provider MCC, it is difficult to ascertain if the findings are generalizable to a real client population. The female participants in Thompson et al.'s (1994) study were not currently receiving or seeking mental health services. Rather, they were selected at random via telephone calls and were students at a predominantly White university. Rather than being

told they were going to engage in a counseling session, they were informed that they would be discussing a campus issue with a doctoral student.

Other authors' attempts at creating measures of client-perceived MCC have fallen short. Cornelius et al. (2004) developed the Cultural Competence Inventory (CCI), which the authors indicated was based on eight aspects of MCC in the social work literature. These eight components included: (1) communication ability/access to interpreters, (2) understanding of indigenous practices, (3) acceptance of cultural difference, (4) awareness of patient's culture, (5) respectful behaviors, (6) awareness of patient and provider values, (7) consumer involvement, and (8) community outreach (Cornelius et al., 2004). The authors performed principal components analysis (PCA) on the CCI and found that the scale likely measures four components. The results of the PCA indicated that items from the eight scales loaded on each of the four components, but no clear pattern of loading was observed (Cornelius et al., 2004; Ihorn, 2013). The authors did not provide interpretation of the four components or provide reliability estimates for the measure using the four-component structure. Finally, the authors acknowledged that other limitations of their study included its long length of 52-items, and a lack of samples from Asian Americans and Native Americans.

In a qualitative study, Pope-Davis et al. (2002) examined client perceptions of MCC using grounded theory. The authors argued for the need to allow a model of clients' experiences in cross-cultural counseling contexts to develop through a qualitative approach rather than forcing client perceptions into the preexisting model outlined by Sue et al. (1982, 1998) (e.g., awareness, knowledge, and skills), which was formulated to

describe counselor competencies, not client experiences. The authors determined that clients' self-identified needs, and how well they believed these needs were responded to, most significantly affected their experience of MCC. Factors such as clients' expectations of therapy, the salience of specific issues, including culture, for the client, and counselor processes, such as self-disclosure and equity of power in the relationship, affected the clients' experience of therapy in general and of counselor MCC (Pope-Davis et al., 2002). The authors noted that clients' experiences were not stagnant, but rather tended to change over time based on factors, such as life circumstances and the therapeutic process. In their review of the Pope-Davis et al. (2002) study, Constantine et al. (2002) noted the potential risk inherent in relying on clients to identify their needs in therapy, and asserted that the identification of key issues and how to address them should be collaborative, at least. Regardless of how their findings should be applied in practice, Pope-Davis et al.'s (2002) study underscored the dynamic and multifaceted nature of clients' experiences in the counseling relationship.

Davis (2007) conducted a mixed methods analysis of client, clinician, and administrator views of counselor MCC through use of concept mapping and cluster analysis in four children's mental health systems of care communities. A list of the 15 clusters of aggregate statements of cultural competencies are in Appendix C. Davis (2007) stressed the importance of allowing communities to self-define their achieved cultural competencies at the system-of-care community level. Within this framework, cultural competence was defined as "a shared understanding among community members of how policies, providers, services, and families will be respectful of and accountable

and responsive to one another within the complex and diverse context of each" (Davis, 2007, p. 377). Establishing reference points of MCC based on perceptions of members in individual systems of care, rather than on a pre-established, broad theoretical framework, allows for more site-specific incremental changes in an individual's system's development over time. While Davis (2007) never created a client measure based on the data, her research provided insight about the benefit of using research methodologies that involve the local community throughout the assessment process. The inclusion of multiple perspectives in assessing MCC provides richer information and a more collaborative approach to enhancing MCC in mental health care settings.

In response to the dearth of standardized client measures, Ihorn (2013) normed a client measure of MCC on a racially and ethnically diverse, and economically disadvantaged population of clients receiving mental healthcare in CHCs. Ihorn developed the Client Experience of Provider Counseling Competence Inventory – Client Version (CEPCCI-C; see Appendix D) based on Davis' (2007) (See Appendix C) and Sue et al.'s (1982, 1998) (See Appendix B) conceptualizations of MCC. The development of the CEPCCI-C was particularly unique in that it incorporated competencies of providers that were developed directly from the perspectives of consumers (Davis, 2007). The norming sample, individuals who receive care at CHCs, is likely representative of those who traditionally have received poor access to healthcare and/or poor treatment due to financial and geographic constraints, and are unjustly part of the mental health disparities statistics. In addition to establishing the psychometric properties of the client-based measure, Ihorn (2013) simultaneously collected data on

providers' self-reported MCC on a measure with parallel items (CEPCCI – Provider Version), and the CBMCS (see Appendix E), a measure with strong psychometric properties.

Ihorn (2013) found that the client-centered measure, the CEPCCI-C, had good reliability (alpha = 0.98) and all the items measured one factor: clients' general perception of their providers' MCC. Based on item loadings, Ihorn (2013) determined that the "Sensitivity to Consumers" subscale on the CBMCS, compared to its other subscales – Nonethnic Ability, Awareness of Cultural Barriers, and Multicultural Knowledge – most likely measured a construct that is closely related to the construct the CEPCCI-C assesses. This suggests that the items on the CEPCCI-C elicited clients' experience of how attuned the provider was to their cultural context based on cues inherent in the counseling relationship. That is, the components of MCC – awareness, knowledge, and skills – may be communicated to clients based on how the provider interacts with them. Ihorn (2013) also found a significant, positive relationship between providers' self-perception of their sensitivity toward their clients, providers' overall self-perception of their MCC, and client's perceptions of their providers' MCC. This suggests that providers may be accurate reporters of their own MCC. As multiple clients rated the same providers in her study, it would be worthy to investigate if some providers were found to be fundamentally more multiculturally competent than others, as perceived by clients. It is also unclear how client perceptions for a given provider may vary across clients.

In the first of a set of three studies, Hook, Davis, Owen, Worthington, and Utsey

(2013) developed a brief, 12-item client-based measure a provider's "cultural humility". The authors defined cultural humility as "the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client" (Hook et al., 2013, p. 354). They identified the items on the measure to load on two factors: positive other-oriented traits (e.g., showing interest in where the client is coming from) and negative other-oriented traits (e.g., making assumptions about client). Exploratory and confirmatory factor analyses were conducted and the measure was found to have good validity and reliability (alpha = 0.93).

In the second study, Hook et al. (2013) recruited 134 men and women participants, with representation from predominantly White, but also Black, Asian, Latino, and multiracial backgrounds, from a university counseling center and department clinic with who were currently in therapy. The authors examined the relationships between client perceptions of provider cultural humility, working alliance, and provider MCC. They found that cultural humility predicted developing a strong working alliance, as perceived by clients, while controlling for the effects of clients' perceptions of their providers' MCC, as measured by the CCCI-R (LaFromboise et al., 1991). The authors found that cultural humility accounted for more variance in working alliance beyond client perceptions of MCC, as measured by the CCCI-R. Finally, in their third study, Hook et al. (2013) recruited and surveyed 120 Black male participants attending therapy and found that clients' perceptions of cultural humility were positively associated with their perceived improvement to date in therapy, and that this relationship was mediated by working alliance. Taken together, these findings support the idea that the interpersonal

stance of providers – in addition to their awareness, knowledge, and skills – may enhance the client experience.

Current research on client experiences of provider MCC suggests that building on provider characteristics, such as their sensitivity to others, their interpersonal stance in therapy, and their tendency to join with the client to understand the clients' culture, may be crucial for improving diverse clients' experiences and outcomes in counseling. More research is needed to understand how clients and providers compare and contrast in terms of their perceptions of MCC in the client-provider relationship. Further, more information about how clients' experiences are affected by characteristics of themselves and providers, including race, ethnicity, and ethnic identity, and how these factors may affect experience of MCC and interpersonal dynamics, is needed.

Ethnic Identity

Research has not yet examined how clients and providers' development of, feelings about, or commitment to an ethnic identity may impact their experiences of multicultural competence (MCC) in the provider-client relationship. It seems plausible that possessing higher levels of ethnic identity would correlate with higher levels of self-reported MCC due to some shared qualities of the constructs. Awareness and knowledge about cultures is theoretically linked to exploration of one's own culture (Sue et al., 1982). Exploration of one's own culture is a key quality of ethnic identity. Far from a static construct, ethnic identity is a complex status that develops and changes over time and includes multiple dimensions (e.g., Ashmore, Deaux, & McLaughlin-Volpe, 2004; Phinney, 2003). Due to its complexity and fluidity, ethnic identity is challenging to define

and measure. The following section will provide a brief overview of the conceptualization and measurement of ethnic identity, and explore how the construct of ethnic identity relates to clients' perceptions of MCC.

Common components of ethnic identity described in the literature include self-categorization, commitment and attachment, exploration, and in-group attitudes (e.g., Erikson, 1968; Marcia, 1980; Tajfel, 1981; Tajfel & Turner, 1986; Phinney & Ong, 2007). Individuals have shown a tendency to use different ethnic labels depending on time and context (Portes & Rumbaut, 2001). Meaning and strength of the categorization to an individual has been shown to be more important than the category itself. For example, Fuligni, Witkow, & Garcia (2005) found that the salience of individuals' ethnic identity, rather than the identity label, had an enhanced effect on their academic achievement. Another process related to ethnic identity development is commitment, which is a sense of belonging to an ethnic group. While some have described it as the most critical characteristic of a well developed ethnic identity (e.g., Phinney & Ong, 2007), commitment alone has not been found to relate to a secure or achieved identity (Marcia, 80; Cokley, 2005). Exploration is an ongoing process of looking for information and having experiences that tends to strengthen the level of one's commitment to ethnic identity, and can increase or decrease at various stages of life (Phinney, 2006).

When conceptualizing ethnic identity, it is essential to consider the sociocultural context and how it may affect the process of development. In addition to self-categorization, commitment, and exploration, one's feelings about his or her ethnic group membership affect identity development. Positive feelings, or private regard, for one's

group, have been found to correspond with an achieved ethnic identity (Phinney, Cantu, & Kurtz, 1997; Roberts et al., 1999). Because minority groups have been subject to discrimination, individuals who identify with these groups may need to independently evaluate characteristics of their own group in order to develop private regard for their group, rather than relying on an internalization of external messages (Phinney, 1989).

When conceptualizing and measuring ethnic identity, it is important to distinguish it from racial identity. The constructs overlap in some ways. Racial and ethnic identity involve a sense of belonging, a process of exploring one's group, and relate to cultural behaviors and values. However, researchers have examined and measured racial and ethnic identity in distinct ways (Phinney & Ong, 2007). Racial identity research has predominantly examined how individuals respond to racism, and racial identity measures have focused on levels of internalized racism based on experiences (Helms, 2007). Ethnic identity research, in contrast, has focused on one's sense of belonging to a group defined by cultural heritage, including values and traditions (Phinney & Ong, 2007). Racial identity research includes group-specific measures, and has focused mainly on Black and White samples (Helms, 1990). Ethnic identity research, on the other hand, has been conducted with individuals from diverse racial and ethnic backgrounds, and measures exist that are not group-specific (Phinney, 1992).

No studies have specifically examined the relationship between levels of ethnic identity development and perceived or self-reported MCC in provider and client healthcare interactions. Some research suggests that strong (i.e., well developed) ethnic identity predicts same-ethnicity preference in social interactions and social preference

(Appiah, 2004; Ethier & Deaux, 1994). Minority individuals with high levels of ethnic identity have been found to have more friends of the same ethnicity compared to peers with lower levels of ethnic identity (Rosenthal & Feldman, 1992; Smith, Walker, Fields, Brookins, & Seay, 1999). More research is needed to understand how social preference translates to healthcare provider preference or perceptions of cultural competence.

Clients who have explored and committed to an ethnic identity may be more attuned to the nuances of their providers' behavior and language about culture, as compared to clients that have not engaged in these processes. For example, a client who has not actively reflected on the meaning of her culture may find a provider's questions about her cultural practices irrelevant or even off putting. A client who has engaged in exploring and committing to an ethnic identity, alternatively, might interpret the same question as showing respectful interest and cultural competence on the part of the provider. Clients with developed ethnic identity may also tend to notice and appreciate their providers' subtle skills and characteristics, such as an other-orientation (Hook et al., 2013), rather than focusing on more apparent, external characteristics, such as race, in their healthcare interactions.

In one study, Ladany, Brittan-Powell, & Pannu (1997) examined how psychology graduate student supervisee perceptions of their own and their supervisor's racial identity related to the supervisory working alliance and the supervisee's development of MCC. The supervisor and supervisee relationship is clearly distinct from the provider and client relationship, but there is some overlap in the dynamic. For example, supervisors inherently possess power and expertise over supervisees, with

varying degrees of collaboration. Ladany et al. (1997) used the Cultural Identity Attitude Scale (CIAS; Helms & Carter, 1990b) to measure the racial identity of supervisees who were "people of color", and the White Racial Identity Attitude Scale (WRIAS; Helms & Carter, 1990b) to assess White supervisee racial identity. The researchers found that supervisors with developed racial identities had a better working alliance, emotional connection, and increased collaboration with supervisees. This was especially true when supervisees also had a highly developed racial identity. In pairs where both supervisor and supervisee had highly developed racial identities, and in pairs where the supervisor had a highly developed racial identity and the supervisee had a less developed racial identity, the supervisor was effective in increasing the supervisee's MCC. This study examined racial identity rather than ethnic identity, and examined supervisor pairs rather than clients and providers. Nevertheless, due to the similarities of the constructs, it may be the case that providers and clients with developed ethnic identities are more able to form a positive working alliance with each other than providers and clients with less developed ethnic identities. Providers with developed ethnic identities may also be more apt to help clients reflect upon their cultural context and consider how these variables may be relevant in treatment than providers who have less developed ethnic identities.

Finally, it is important to note that there is debate about the differences in implications of ethnic identity development for different ethnic groups. Historical and present day sociocultural context and power imbalances among groups may have a significant impact on how ethnic identity development mediates and moderates psychological variables. Due in part to varying levels of ethnic salience for different

groups across family and community contexts (Phinney & Alipuria, 1990), the psychological and behavioral effects of ethnic identity development is challenging to predict. For example, one study showed that strong ethnic identity development related to higher levels of self-efficacy and lower levels of depression for African Americans, but that this same meditational pathway did not exist for Whites (Swenson & Prelow, 2005). As it relates to perceptions of MCC, it is likely that ethnic identity development will have differential effects for diverse clients.

Ethnic Identity Measurement

In addition to the complex task for researchers to reach a unified understanding of ethnic identity, there is the challenge of how to measure it. In an attempt to create a measure of ethnic identity that could be used with diverse populations, Phinney (1992) developed the Multigroup Ethnic Identity Measure (MEIM), which is composed of 14 items that assess three aspects of ethnic identity: (1) a sense of belonging (based on social identity theory; Tajfel & Turner, 1986), (2) ethnic identity achievement, including exploration and commitment (based on the empirical work of Marcia, 1980), and (3) ethnic behaviors or practices. The measure was normed on a large, racially and ethnically diverse sample of high school and college students. Reliability of the measure, as well as correlations among ethnic identity components, was higher for the college sample (alpha = 0.90) than the high school sample (alpha = 0.81), suggesting that ethnic identity may become more stable or secure with age (Phinney, 1992). For both the high school and college samples, ethnic identity appeared to have a single factor.

A number of studies of the 14-item MEIM have found a single-factor structure (Ponterotto, Gretchen, Utsey, Stracuzzi, & Saya, 2003; Reese, Vera, & Paikoff, 1998; Worrell, 2000). However, one large study of over 5000 ethnically diverse participants indicated a two-factor model for the MEIM (Phinney, 1992; Roberts et al., 1999). Through exploratory and confirmatory factor analysis, the researchers determined that two of the 14 items did not fit the model. The remaining 12 items loaded strongly on commitment (7 items) and exploration (5 items). The indication of exploration and commitment as the core processes of ethnic identity development aligned with Marcia's (1980) empirical work on identity development. Marcia (1980) found that a high amount of exploration of identities and a strong commitment to one tended to result in an achieved (well developed) identity status.

Other studies with White and Black adolescents have also found a similar two-factor structure for the MEIM (Spencer, Icard, Harachi, Cata- lano, & Oxford, 2000; Yancey, Aneshensel, & Driscoll, 2001). Based on a pilot study that used the 12-item MEIM (Roberts et al., 1999) to assess ethnic identity in a diverse sample of high school students in Southern California from four ethnic groups (Mexican Americans, African Americans, Vietnamese Americans, and Armenian Americans), Phinney and Baldelomar (2006) deleted two items that related to ethnic behaviors. The authors argued that despite correlating with aspects of ethnic identity, ethnic behaviors are conceptually distinct from the construct. Other revisions included changing the verb tense of items, such as changing items about exploration to make them applicable to both the past and present (e.g., from "I think about…" to "I have thought about…"). Finally, the authors added two

items to the exploration scale so that both scales could be weighted equally in analyses when examined together.

Phinney and Ong (2007) conducted a new study to determine the underlying factor structure of the revised 10-item ethnic identity measure, using exploratory followed by confirmatory factor analysis. They used the measure with two independent samples of college students from a predominantly minority urban public university in southern California. Based on these results and item loadings, the authors retained three items for the exploration factor and three items for the commitment factor. The resulting 6-item Multigroup Ethnic Identity Measure – Revised (MEIM-R; Phinney 2007; see Appendix G) was found to have a good representation of the latent structure of ethnic identity. The correlation between the two factors, exploration and commitment, was found to be 0.74. Both subscales showed good reliability, with alphas of 0.76 for exploration and 0.78 for commitment; for the combined 6-item scale, alpha was 0.81. The concise length of the MEIM-R allows it to be administered in conjunction with other measures that tap into different constructs.

Racial and Ethnic Match

"Racial and ethnic match" describes the match between self-labeled race or ethnic identity, usually as indicated on a demographic form, of two or more individuals. Racial or ethnic match has been studied in the literature primarily in terms of how it affects other psychological or social variables in relationships. Racial and ethnic match between clients and providers has been explored in counseling and medical research as it relates to clients' preference for providers, client satisfaction, and indicators of health outcomes. To

date, however, no research has examined the relationship between racial and ethnic match and perceived multicultural competence (MCC) of providers. In the medical literature, racial match between physician and patient has shown to be related to increased overall satisfaction of the healthcare experience and self-rated positive quality of care (Saha, Komaromy, Koepsel, & Bindman, 1999; Saha, Taggart, Komaromy, & Bindman, 2000). Other studies have suggested clients' preference for racially and ethnically matched counselors in the absence of other indicators of the cultural sensitivity of or shared attitudes of their counselors (e.g., Coleman, Wampold, & Casali, 1995; Lopez, Lopez, & Fong, 1991). It has been shown that other characteristics of providers, such as sharing values and personality traits, may be more important to clients than racial and ethnic match in their provider preferences (Atkinson, Furlong, & Poston, 1986). Taken together, these findings suggest that racial and ethnic match may be a relevant factor for client preferences at least in the absence of other information. In addition to client preference, other studies have examined how racial and ethnic match predicts health outcomes for the client – an arguably more important potential effect of match.

Scholars have referred to the cultural responsiveness hypothesis (Yeh, Eastman, & Cheung, 1994) as theoretical support for the potential benefits in health outcomes of client and provider ethnic and racial match. The cultural responsiveness hypothesis suggests that treatment efficacy improves when language and ethnic background of the provider and client are similar. It is argued that clients perceive their providers as more attuned to them given this match, and that providers tend to possess enhanced knowledge and skills when working with racially and ethnically similar clients (Sue, 1977). Evidence

for the cultural responsive hypothesis, as it relates to the issue of racial and ethnic match, are mixed. In a study examining thousands of children and adolescents in the Los Angeles mental health system, Yeh et al. (1994) found that racial and ethnic match was a predictor of service outcomes for adolescents, but not for children. They found that adolescents were less likely to drop out of treatment, attended more sessions, and had higher Global Assessment of Functioning (GAF) scores than their non-matched counterparts. However, when separating adolescents into ethnic groups, analyses revealed that only racial and ethnic minority groups showed benefits from matched dyads. This finding suggests that the majority or minority status of clients may moderate the effects of racial and ethnic match on health outcomes. Interestingly, language match between client and counselor was found to be significant predictor of dropout and number of sessions attended for Mexican Americans but not for Asian Americans. This last finding suggests it may be important to piece apart the effects of match for specific racial and ethnic groups.

In a similar study, Gamst et al. (2004) found no differences in GAF scores and client attendance based on client-provider racial and ethnic match when other variables (i.e., citizenship, trauma, referral source, language match, gender match, and diagnosis) were controlled. The authors did find, however, that ethnically matched African American children and adolescents needed fewer health center visits than their unmatched counterparts. In a meta-analysis examining seven studies of ethnic match and therapy, Maramba & Hall (2002) found that while racial and ethnic match was related to a lower dropout rate after the first session and an increase in number of sessions attended,

there were very small effect sizes. The authors concluded that racial and ethnic match, standing alone, was a relatively weak predictor of dropout and retention rates.

Studies on ethnic match in the mental health literature have been criticized for confounding variables (i.e., socioeconomic status, education, and diagnosis), use of pseudo-clients, and lack of diverse client samples (Flaskerud, 1986; Gamst et al., 2004). There is also a lack of coherence in the literature about how preferred language congruence between provider and client compares to or interacts with the effects of ethnic match on health outcomes. Finally, it is unclear if matched minority status predicts clients' perceptions of MCC and/or health outcomes. For example, does the shared experience of racism affect an Asian American client's perception of the MCC of his African American provider? Findings in this realm have implications for healthcare organizations and training institutions, including recruitment of students into healthcare fields, the training of students and professionals, and the hiring of providers.

Summary and Statement of Problem

There is evidence of mental healthcare disparities for racial and ethnic minorities in the U.S., including inferior treatment and poorer outcomes for these groups compared to European Americans. Researchers have proposed increased multicultural competence (MCC) of healthcare providers as one factor to potentially reduce healthcare disparities (HHS, 2011). The most widely accepted literature describes multiculturally competent providers as being aware of their biases about human behavior, showing appreciation for clients' differences in worldview, and possessing skills for working with culturally diverse clients (Sue et al., 1998). Assessment of these competencies has relied

predominantly on provider self-reports, and research has not yet examined the relationship between provider and client reports of provider MCC (Worthington et al., 2007). Current client measures are not accurate or reliable and have not been normed on culturally diverse client populations (e.g., Cornelius et al., 1994; LaFramboise et al., 1991). In order to understand if and how MCC relates to health disparities, researchers need to accurately and reliably quantify MCC. Ihorn (2013) paved the way in addressing this issue with her development of a psychometrically sound client measure of MCC normed on a diverse community mental health population. An important next step was to examine how client perspectives relate to provider self-reports of MCC when considering the experiences of multiple clients per provider.

The primary goal of the study was to extend Ihorn's (2013) research by examining the relationship between provider and client reports of provider MCC, including whether clients tend to rate the same provider similarly. A secondary goal of the study was to assess how ethnic identity development of the client and provider may impact client perceptions of provider MCC. Finally, the study sought to better understand how majority or minority status match between provider and client based on their identified race or ethnicity might impact client perceptions of provider MCC. Prior research has not investigated how these variables predict client perceptions of provider MCC.

Research Questions

The following research questions were formulated:

1. Do providers significantly differ from each other in multicultural competence, based on client ratings?

2. Is a statistically significant amount of variance in client ratings of provider multicultural competence accounted for by provider ratings of their own multicultural competence?

3a. Is a statistically significant amount of variance in client ratings of provider multicultural competence accounted for by provider ethnic identity development?

3b**.** Is a statistically significant amount of variance in client ratings of provider multicultural competence accounted for by client ethnic identity development?

4. Is a statistically significant amount of variance in client ratings of provider multicultural competence accounted for by the match between majority or minority status of the provider and client, based on client and provider identified race/ethnicity?

Chapter III: Method

The study consisted of two phases of data collection at two community mental health centers, Organizations A and B. Data collection was conducted in collaboration with Ihorn (2013). Ihorn (2013) conducted the first phase of data collection at Organization A, and this investigator extended data collection and introduced an additional measure at Organization B. For the current study, the data were used to examine the relationship between provider and client reports of provider multicultural competence, including whether clients tended to rate the same provider similarly in terms of their MCC. A secondary goal of the study was to assess variables that were hypothesized to impact client perceptions of provider MCC. These variables included ethnic identity development of client and provider, and majority and minority racial and ethnic match of providers and clients.

Organization Characteristics

The original data set from Organizations A and B included a total of 187 clients and 56 providers who completed at least part of the survey protocol. After any providers or clients without at least one corresponding client or provider matches were excluded, a total of 141 clients and 34 providers who completed at least part of the survey protocol remained. For these remaining client protocols, 36% were from Organization A and 64% were from Organization B. For remaining provider protocols, 47% were collected at Organization A and 53% were from Organization B.

The ethnic identity development measure used, the MEIM-R (Phinney & Ong, 2007), was only given to participants at Organization B. For analyses that included this

measure, only the 90 clients and 18 providers at Organization B were included. A summary of Organization Characteristics can be found in Table 1.

Based on a 2012 fact sheet provided by the organization, estimates indicate that clients at Organization A include representation from 40% Caucasian, 26% Hispanic, 25% African American, and 9% Other ethnic groups. Fifty-five percent of clients at Organization A have an annual income of between $0 and $5000 dollars, and 23% have an annual income of between $5000 and $10,000 dollars. Seventy-eight percent of clients at Organization A are over age 18.

At Organization B, as indicated in the organization's 2012 annual report, estimates suggest that clients include representation from 41% Hispanic, 33% Caucasian, 11% African American, and 15% Other ethnic groups. Fifty-eight percent of clients have an annual income of 100% or less of the poverty level, and 24% have an annual income of 101-150% of the poverty level. About 87% of clients at Organization B are over 18-years-old.

Participant Characteristics

Participants were adult clients who receive behavioral health services from one of two large community mental health systems, and the providers who work with them. Client and provider participants from eight different satellite sites at Organization A, and four sites at Organization B, participated in the study. Individual sites had their own manager(s), office staff, and providers, A summary of client and provider characteristics can be found in Tables 9 and 10 in Appendix H.

Table 1

Organization Characteristics

	Organization A	Organization B
Description	Local Mental Health Authority providing community-based behavioral health and developmental disabilities services to high need individuals	Nonprofit, Federally Qualified Community Health Center providing health care for uninsured and underinsured clients
Collection Method	For clients: Distribution by front desk administration; individual collection by researcher at group therapy meetings and in waiting room	For clients: Individual collection by researcher in waiting room or before group counseling session
	For providers: Collection at staff meetings	For providers: Collection at staff meetings
Number of Clients Participating	51	90
Number of Providers Participating	16	18

Note. Adapted from "Clients Perceptions of Community Mental Health Providers Multicultural Counseling Competence," (Unpublished doctoral dissertation) by S. M. Ihorn, 2013, University of Texas, Austin.

As shown in Table 9, client participants included both men and women, with more women than men participating. Over half of participating clients were White. About one third of total participants identified as Black or Hispanic. Both the median and mode educational attainment of the client sample was 12 years (i.e., the completion of 12th grade).

The most common client diagnoses included Anxiety, Bipolar Disorder, and, Depression, and a quarter of clients reported multiple diagnoses. The services most frequently sought by participants included Behavioral Health, Individual Counseling, Psychiatry Services, and Substance Abuse Services; many clients received assistance from the organization in multiple areas. A comparable number of clients reported having over 5 sessions with their identified providers as reported having fewer than 5 sessions with their providers over the course of treatment.

As shown in Table 10, providers who participated in the study included both men and women, with the majority of providers being female. Three quarters of providers identified being White; the remaining providers who chose to disclose their race or ethnicity identified as Hispanic, Black, or Multiracial. Most participating mental health providers had earned a master's degree, while a few held BA/BS and PhD/PsyD degrees. Most providers were licensed professional counselors or licensed clinical social workers.

Instrumentation

Client Experience of Provider Cultural Competence Inventory – Client Version (CEPCCI-C; Ihorn, 2013; Appendix D). The CEPCCI-C is a 38-item, Likert-scale (1-5) designed to measure the multicultural competence of providers. It was

developed based on linking descriptors of multicultural competence from Davis' (2007) study (see Appendix C) with guidelines from culturally competent practice established by Sue et al. (1998; see Appendix B). Ihorn (2013) conducted an exploratory factor analysis on the client data collected from 187 client participants at Organization A and B. The CEPCCI-C items loaded on a single factor, clients' general perception of their providers' MCC, and the measure demonstrated good internal consistency (alpha = 0.98). Clients' scores on this measure reflect their average score (between 1-4) across all items.

Client Experience of Provider Cultural Competence Inventory – Provider Version (CEPCCI-P) (Ihorn, 2013). The CEPCCI-P is a 38-item, Likert-scale (1-4) that contains the exact same items on the CEPCCI-C but words items from the provider perspective. For example, the first item on the CEPCCI-C is "My counselor is helpful" and the first item on the CEPCCI-P is "I am helpful to my clients". Providers' scores on this item reflect their average score (between 1-4) across all items. The measure was found to demonstrate good internal consistency (alpha = 0.95).

California Brief Multicultural Competence Scale (CBMCS; Gamst et al., 2004; Appendix E). The CBMCS is a 21-item, Likert-scale (1-4) designed to assess self-reported mental health practitioner multicultural competence, based on Sue et al.'s 1982 tripartite model of multicultural competence. It was developed by Gamst et al (2004) from four pre-existing measures of provider multicultural competence, including the Cross-Cultural Counseling Inventory—Revised (CCCI-R; LaFramboise, Coleman, & Hernandez, 1991), the Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D'Andrea et al., 1991), the Multicultural Counseling Awareness Scale–Form B, (MCAS-

B; Ponterotto et al., 2002), and the Multicultural Competency and Training Survey (MCCTS; Holcomb-McCoy & Myers, 1999). Gamst et al. (2004) found good internal consistency reliability for the measure, with alphas ranging from 0.75 to 0.90 across subscales. The CBMCS has also demonstrated strong construct validity with high levels of convergent validity with similar measures (Gamst, Liang, & Der-Karabetian, 2011). Scores on the CBMCS do not appear to correlate significantly with measures of social-desirability (Gamst et al., 2004).

Factor analysis suggests the CBMCS has a four-factor model, with each factor accounting for 59% of the total variance. The four factors assess the following areas of multicultural competence: Nonethnic Ability, Sensitivity to Consumers, Multicultural Knowledge, and Awareness of Cultural Barriers. Ihorn (2013) determined that the "Sensitivity to Consumers" subscale on the CBMCS likely measured a construct that is closely related to the construct the CEPCCI-C assesses (see Appendix I for comparison of items). Providers' scores on the CBMCS reflect their average score (between 1-4) across all items. Providers' scores on the CBMCS "Sensitivity to Consumers" subscale reflect their average score on items from this subscale only.

Multigroup Ethnic Identity Measure – Revised (MEIM-R; Phinney & Ong, 2007; Appendix G). The MEIM-R is a two-factor, 6-item, Likert- scale (1-4) that measures core aspects of group identity. The concise measure examines the strength and security of ethnic identity, and the degree to which has been achieved. The six items are preceded by an open-ended question eliciting the respondent's self-designated ethnic label, and conclude with a list of ethnic groups for the respondents to check to indicate

their own and their parents' ethnic backgrounds. The measure contains two factors, exploration of ethnic identity (3-items; alpha = .78) and commitment to ethnic identity (3 items; alpha = .76). The reliability of the combined 6-item scale is .81 and is a latent representation of ethnic identity. With an independent sample, the confirmatory factor analysis on the MEIM-R demonstrated an excellent fit with the data, with goodness-of-fit indices ranging from .96 to .98

Demographic Forms (Appendix F). The client demographic forms collected data on the following variables: race/ethnicity, gender, age, education level, type of service, number of sessions, diagnosis, and site. The provider demographic forms included information about race/ethnicity, gender, age, and degree type/licensure.

Procedure

Ethical compliance. This study procedure was developed in collaboration with Ihorn (2013). All participants were informed that their participation was voluntary, and that the purpose of the study was to improve understanding of how organizations can provide respectful and culturally sensitive mental health services to their clients. The ethical guidelines put forth by the APA and the University of Texas' "Policies and Procedures Governing Research with Human Subjects" were strictly adhered to. The ethics review board for each community mental health organization approved data collection for the study, and the ethical guidelines of each organization were adhered to.

Organizational recruitment. In order to respect organizational differences across sites, specific methods of data collection were developed collaboratively with administrators, managers, and staff at individual sites. Entry into both of the mental

health systems and separate sites was challenging due to their complex administrative structures and lack of resources to facilitate research endeavors. The researchers proposed the project, planned data collection, and answered questions at meetings with organization administrators and providers. Entry into individual sites was gained by email or phone contact with administrators and managers at sites, or by in-person visits to the sites. Communication with sites was difficult, particularly because administrators and providers in these systems had high work demands with minimal time and resources. Responding to and accommodating requests for research participation was, therefore, often not high priority. To lighten the burden on organization staff, the principal investigator and research assistant used hands-on data collection methods.

Client recruitment and data collection. Client data was obtained through contact with one of the researchers in the waiting room prior to their appointment or following a group counseling/support session, or it was obtained through contact with front desk staff at clients' appointment check-in. All clients were seeking services related to mental health. All clients were told that their participation was voluntary, and that their responses were confidential and private. They were told that they could fill in as much information as they felt comfortable with, and were free to direct questions or comments to the researchers.

Clients gave their completed forms directly to one of the researchers, or placed their forms in a sealed envelope, and then in a box at the front desk of the community mental health center. The principal investigator collected forms from the boxes at each of the sites twice a week during data collection. Due to the nature of the research collection,

exact numbers are not available, but it is estimated that the vast majority of clients who were approached agreed to participate in the research study.

Clients at Organization A were asked to complete the Client Experience of Provider Cultural Competence Inventory (CEPCCI-C; Ihorn, 2013) and a demographic form. At Organization B, clients were asked to complete the CEPCCI-C, demographic form, and the Multigroup Ethnic Identity Measure – Revised (MEIM-R; Phinney & Ong, 2007).

Provider recruitment and data collection. Researchers made contact with and collected data from providers at their sites' staff meetings. The research project was explained to providers, and questions and comments about the study itself and how the results would be used, were encouraged. Providers at Organization A were asked to complete the CEPCCI-P, the California Brief Multicultural Competence Scale (CBMCS), and a demographic form. Providers at Organization B were asked to complete the CEPCCI-P, the CBMCS, the MEIM-R, and a demographic form. For providers, these forms were only offered in English. All providers who were approached agreed to participate in the research study. Client and provider forms were linked using a numbering system, but all provider and client responses were kept confidential and de-identified to the greatest extent possible.

Variables

The variables included in the study were provider self-reported multicultural competence (MCC), as measured in three distinct ways, provider and client ethnic

identity development, and match between ethnic majority or minority status of the provider and client. Table 2 describes variable names with a description for each.

Hierarchical Linear Modeling

Hierarchical linear modeling (HLM) techniques were used to investigate the effects of the predictor variables on Client CEPCCI, which were assessed by research questions two through 5 (at end of chapter). The use of HLM aligned with the multi-level design of the study, as clients were sampled from different providers, and independent variables at both client and provider levels were examined. The use of HLM allowed for the inclusion of multiple random (providers, clients) and fixed factors (multicultural competence, ethnic identity development) at two levels (Bryk & Raudenbush, 1992). It also allowed for the separation of within-group effects from between-group effects for predictor variables – providing valid statistical inference for the nested data (Reise & Duan, 1999). Effects were examined at multiple levels to avoid misestimating standard errors. Unlike mixed effects ANOVA, HLM analyses are not restricted to equal cell sizes and categorically measured factors (Lee & Bryk, 1989).

Research Questions and Hypotheses

Research question 1. *Do providers significantly differ from each other in multicultural competence (MCC), based on client ratings?*

Hypotheses 1 and rationale. It was hypothesized that mean ratings of MCC, from clients' perspectives, would differ significantly across providers. The CEPCCI-C, used to measure client MCC, was created based on Sue et al.'s (1998) and Davis' (2007) statements of cultural competence. The competencies described by Sue et al. (1992,

Table 2

Description of Variables

Variable Name	Description
Client CEPCCI	Client average score on the Client Experience of Provider Cultural Competence Inventory (CEPCCI-C)
Provider CEPCCI	Provider average score on the Client Experience of Provider Cultural Competence Inventory – Provider Version (CEPCCI-P)
Provider CBMCS	Provider average score on the California Brief Multicultural Competence Scale (CBMCS)
Provider CBMCS Sensitivity	Provider average score on the CBMCS subscale of "Sensitivity to Consumers". This is a three-item subscale found to qualitatively fit with questions posed by the CEPCCI-C (Ihorn, 2013) (see Appendix I).
Client Ethnic Identity	Client average score on the Multigroup Ethnic Identity Measure – Revised (MEIM – R)
Provider Ethnic Identity	Provider average score on the Multigroup Ethnic Identity Measure – Revised (MEIM – R)
Ethnic Match	The match between majority or minority status of client and provider based on their self-labeled race/ethnicity (match vs. no match).

1998) and Davis (2007) reflect the general attitudes, knowledge, and skills of multiculturally competent providers. These competencies were expected to be present or not present for a provider regardless of the client with whom he or she interacted. For example, a provider who respects the indigenous, community-based helping practices of one client should arguably respect these practices for another client. It was expected that certain providers would be significantly more multiculturally competent, overall, compared to other providers, as reflected in their client MCC scores.

Research Question 2. *What is the impact of provider ratings of their own multicultural competence on the client ratings of provider multicultural competence?*

Hypothesis 2 and rationale. It was expected that a statistically significant amount of variance in provider means of client MCC would be accounted for by provider self-reported MCC. The CBMCS, which was one measure used to measure provider self-reported MCC, has been found to measure provider MCC accurately and consistently, and has not been shown to correlate with measures of social desirability (Gamst et al., 2004). The CBMCS and the CEPCCI-C share common origins, as both were developed based on Sue et al.'s (1982, 1998) theory of MCC. Ihorn (2013) conducted a Pearson product-moment correlation and found a significant, positive relationship between providers' self-perception of their sensitivity toward their clients, providers' overall self-perception of their MCC, and client's perceptions of their providers' MCC. This suggests that providers may be accurate reporters of their own MCC. Because providers are expected to behave in a similar and consistent manner in their counseling work, it was expected that their self-reporting accuracy will hold across multiple clients. As the

provider version of the CEPCCI-C contains the same items, reworded, as the Client CEPCCI-C, it is expected that client and provider responses on this measure will be similar.

It has been shown that clients are able to observe their providers' level of sensitivity to their context and needs (Hook et al., 2013), and Ihorn (2013) found that items on the CEPCCI-C load most closely to items on the "Sensitivity to Consumers" subscale of the CBMCS. Taken together, it is expected that the "Sensitivity to Consumers" subscale on the CBMCS will explain a significant amount of variance in client perceptions of provider MCC.

Another reason it was expected that providers would accurately report their MCC is that providers at Organizations A and B receive training in MCC. Sodowsky et al. (1998) found that provider self-reports of multicultural skills, awareness, and knowledge increased with higher levels of multicultural training. Providers in these settings also have chosen to work in healthcare settings that are community-focused and serve low-income, and racially and culturally diverse client populations. This suggests that providers in these settings may generally accept and value diversity. Tummala-Narra et al. (2012) found that positive orientation to diversity predicted both higher self-perceived MCC and engagement in multicultural practices of providers. Taken together, it is expected that providers' mean self-reported MCC will account for variance in providers' mean client MCC scores.

Research questions 3a and 3b. *What is the impact of provider (3a) and client (3b) ethnic identity development on client ratings of provider multicultural competence?*

Hypothesis 3a and rationale. It was expected that a statistically significant amount of variance in client ratings of provider MCC would be accounted for by provider ethnic identity development. It was expected that providers with higher levels of ethnic identity development would self-report and be perceived as having higher levels of MCC.

Providers with well developed ethnic identities, according to their scores on the MEIM-R (Phinney & Ong, 2007), have arguably gone through processes of exploration and commitment that are part of being multicultural competent. Providers with developed ethnic identities should be aware of their values and beliefs, and be cognizant of the fact that others (i.e., their clients) may possess different values and beliefs. Providers with developed ethnic identities will likely have reflected on areas of privilege or discrimination related to their ethnic group. Because of this, they may be more knowledgeable about discrimination faced by other groups. Providers who have developed ethnic identities are likely to have enhanced skills in working with diverse clients, due to their awareness and knowledge about their own ethnicity. This is congruent with Sue et al.'s (1982, 1998) theory of MCC, and fits with Ihorn's (2013) finding that sensitivity and openness to others is important in perceptions of MCC.

Hypothesis 3b and rationale. It was expected that client ethnic identity development would not account for a statistically significant amount of variance in client ratings of provider MCC. Client levels of ethnic identity were not expected to significantly affect their perceptions of provider MCC.

Clients with highly developed ethnic identities likely recognize, or even seek out, aspects of multicultural competence in the behaviors of or content expressed by their

providers. This was expected due to the attunement and understanding of cultural issues that accompanies ethnic identity exploration and commitment (Phinney & Ong, 2007). Clients with less developed ethnic identities were expected to rate the multicultural competence of their providers as high or low with more variable criteria that may not necessarily fit Sue et al.'s (1982, 1998) theory of MCC. It was expected that all clients, regardless of their ethnic identity development, would notice and respond to providers' general sense of openness, respect, and interest (Hook et al., 2013; Ihorn, 2013). Thus, it was not expected that client ethnic identity would significantly impact their ratings of providers.

Research question 4. *What is the impact of the match between majority or minority status of the provider and client, based on client and provider identified ethnicity, on client ratings of provider multicultural competence?*

Hypothesis 4 and rationale. It was expected that a statistically significant amount of variance in provider means of client MCC would be accounted for when majority or minority match status of race or ethnic label was considered.

Research has shown that clients show preference for racially and ethnically matched providers in the absence of other indicators of cultural sensitivity (Coleman et al., 1995; Lopez, Lopez, & Fong, 1991). Other studies have found that racial and ethnically matched clients have better health outcomes than their non-matched counterparts, including lower drop-out rates, better attendance, fewer visits needed, and higher GAF scores (Gamst et al., 2004; Yeh, Eastman, & Cheung, 1994). The effects of match have been explained by the cultural responsiveness hypothesis, which suggests that

clients tend to perceive their providers as more familiar with, knowledgeable about, and skilled in working with them given this match. While no studies thus far have examined match on client MCC specifically, it is hypothesized that clients may perceive racially and ethnically matched providers as more attuned to them.

Chapter IV: Results

The purpose of this chapter is to describe the relationships between client perceptions of provider multicultural competence (MCC) and the key study variables. The variables included provider self-reported MCC based on three measures, provider and client ethnic identity development, and match between ethnic majority or minority status of the provider and client.

Relationships Among Variables

Correlation. Correlational analyses were used to examine the relationship between Client CEPCCI and key variables, including Client Ethnic Identity, Provider CBMCS, Provider CBMCS Sensitivity, Client Ethnic Identity, and Provider Ethnic Identity (refer to Table 2 in Method chapter for description of variable names). First, the bivariate correlation coefficient between Client CEPCCI and Client Ethnic Identity was computed. These data were subsequently averaged to the provider level prior to compute correlation coefficients with respect to the provider-level variables (see Table 4).

Results indicated a significant, positive relationship between Client CEPCCI and Provider CBMCS Sensitivity. With $r^2 = .128$, approximately 13% of the variability in client perception could be accounted for by providers' self-perception of their sensitivity to consumers. This is considered a moderate strength of association (Gravetter & Wallnau, 2009). No relationship was found between Client CEPCCI and Provider CEPCCI or Provider CBMCS. Significant, strong, positive relationships were found among all three measures of provider MCC; the strongest relationship was between Provider CBMCS and Provider CBMCS Sensitivity. No significant relationships were

found between client and provider ratings of MCC and their reported levels of ethnic identity development on the MEIM-R.

In summary, clients tended to rate providers who self-reported higher scores on the "Sensitivity to Consumers" subscale of the CBMCS more positively, and this relationship was significant. In contrast, clients' ratings of their multicultural competence and their providers' self-rated multicultural competence on the CEPCCI-P or full CBMCS were not related. No relationship was found between how clients rated their providers' multicultural competence and their own ethnic identity development or their providers' ethnic identity development.

Descriptive Statistics

Descriptive statistics for the 141 clients and 34 providers included in the HLM analyses are reported in Table 3.

Table 3

Descriptive Statistics

Variable	n	Mean	Median	Standard Deviation	Range
Client CEPCCI	141	3.348	3.435	0.514	2.32
Provider CEPCCI	141	3.387	3.420	0.255	0.76
Provider CBMCS	141	3.097	3.100	0.250	1.04
Provider CBMCS Sensitivity	141	3.267	3.330	0.290	1
Client Ethnic Identity	90	2.867	2.830	0.685	3
Provider Ethnic Identity	90	2.830	3.000	0.568	1.83

Note. Values represent averaged score across measure items. CEPCCI, CBMCS , and MEIM-R measures were scored on a scale from 1 (Strongly Disagree) to 4 (Strongly Agree). Across measures, higher scores indicate higher level of multicultural competence or ethnic identity development.

Table 4

Correlation Matrix for Measures of Multicultural Competence and Ethnic Identity

Measure	Client CEPCCI	Provider CEPCCI	Provider CBMCS	Provider CBMCS Sensitivity	Client Ethnic Identity	Provider Ethnic Identity
Client CEPCCI	-					
Provider CEPCCI	.026	-				
Provider CBMCS	.125	.567**	-			
Provider CBMCS Sensitivity	.358*	.533**	.792**	-		
Client Ethnic Identity	.112	.053	.104	.125	-	
Provider Ethnic Identity	.183	-.024	.268	.159	.107	-

Note. Statistically significant correlation coefficients are indicated with * ($p < .05$) and ** ($p < .01$). N was 34 for client-level and 18 for provider-level comparisons.

Hierarchical Linear Modeling

Hierarchical linear modeling (HLM) techniques were used to investigate the between provider differences in multicultural competence, as measured by Client CEPCCI. HLM was also used to examine the effects of the predictor variables on Client CEPCCI. This allowed for the separation of within-group effects from between-group effects for predictor variables. SPSS Version 20 was the statistical software used. Client variables were group-centered and provider variables were uncentered, and the restricted maximum likelihood model was used. The unconditional model was run before examining the effects of explanatory variables.

Analysis and results for hypothesis #1. *It was hypothesized that mean ratings of multicultural competence, from clients' perspectives, would differ significantly across providers.*

Unconditional Model. The unconditional model yielded an estimate of the overall average of clients' perceptions of providers' multicultural competence (see Table 5). The grand mean estimate (across all providers) of Client CEPCCI was 3.3 with a standard error of 0.06. This shows a generally positive assessment of providers' multicultural competence by clients.

The unconditional model also provided an estimate of the intraclass correlation. The intraclass correlation describes the proportion of total outcome variance that is between providers, or the correlation between two randomly selected outcome scores within a randomly selected provider (Raudenbush & Bryk, 2002). The intraclass correlation (ϱ) was $\varrho = \tau_{00} / (\tau_{00} + \sigma^2) = 0.05/ (0.05 + 0.21) = .19$, which indicates that

about 19% of the Client CEPCCI variance was between providers.

A significance test for random effects was conducted to examine if the between-provider differences in CEPCCI-C were significantly different from zero. For variance tests, SPSS uses a Wald *z*-test, which is a ratio of the variance estimate divided by the standard error estimate. Significance tests of variances using this approach are interpreted after dividing the p-value from the output in half (i.e., as a one-tailed test; Snijders & Bosker, 2012). The Wald *z*-test for the level-2 variance component was found to be significant, as p = 0.058/2 = 0.029.

In summary, it was found that there were significant differences between providers in terms of how clients rated their multicultural competence. About 19% of variance in client perceptions of providers was between providers.

Table 5

Results from the Unconditional Model Fixed Effect

Fixed Effect	Coefficient	Standard Error	p value	
Avg. Provider mean, γ00	3.332	0.058	<0.001	
Random Effect	**Variance**	**Standard Error**	***Wald z***	**p**
Provider mean, *u*0*j*	0.0501	0.026	1.897	0.058
Level-1 effect, *ei*j	0.216	0.02689		

Analysis and results for hypothesis #2. *It was expected that a statistically significant amount of variance in provider means of client multicultural competence would be accounted for by provider self-reported multicultural competence.*

Provider self-reports. For Hypothesis #2, the client-level dependent variable was

Client CEPCCI, and the provider-level predictor variables were: 1) Provider CEPCCI, 2) Provider CBMCS, and 3) Provider CBMCS Sensitivity. A Mixed Model Analysis with SPSS version 20 was run *separately* for each predictor variable. The results for these HLM analyses are presented in Table 6. Provider CEPCCI explained a negligible amount of variance in Client CEPCCI ($t = 0.027$, $p = 0.928$). As Provider CEPCCI increases by one unit, Client CEPCCI increases by 0.006 points. Provider CBMCS explained more variance as compared to the Provider CEPCCI, but this amount was not statistically significant ($t = 0.749$, $p = 0.465$). As Provider CBMCS increases by one unit, Client CEPCCI increases by 0.17 points.

The relationship between Client CBMCS Sensitivity and Client CEPCCI was statistically significant ($t = 2.168$, $p = 0.037$). As Provider CBMCS Sensitivity increases by one unit, Client CEPCCI increases by 0.408 units. These findings suggest that only the three-item "Sensitivity to Consumers" subscale (see Appendix I) had a significant impact on Client CEPCCI for providers**.** Regression equations used for the unconditional and conditional models are found in Appendix J.

In summary, providers' self-reported sensitivity to clients' context significantly impacted clients' perceptions of their providers' multicultural competence. Providers' self-reported multicultural competence, as measured by average score across items on two measures of multicultural competence, did not have an impact on client perceptions. Thus, Hypothesis 2 was only partially supported.

Table 6

HLM Fixed Effects of Provider Self-Reports of MCC on Client CEPCCI

	Estimate	s.e.	df	t	p
Provider CEPCCI	0.006	0.233	29	0.027	0.978
Provider CBMCS	0.170	0.230	31	0.749	0.465
Provider CBMCS Sensitivity	0.408	0.188	33	2.168*	0.037

Analysis and results for hypotheses #3a and 3b.

Hypothesis 3a. *It was expected that a statistically significant amount of variance in client ratings of provider multicultural competence would be accounted for by provider ethnic identity development. It was expected that providers with higher levels of ethnic identity development would self-report and be perceived as having higher levels of multicultural competence.*

Hypothesis 3b. *It was expected that client ethnic identity development would not account for a statistically significant amount of variance in client ratings of provider multicultural competence. Client levels of ethnic identity were not expected to significantly affect their perceptions of provider multicultural competence.*

The results of the HLM analyses examining the effects of provider and client ethnic identity development on Client CEPCCI are shown in Table 7. The client-level dependent variable was Client CEPCCI. The client-level predictor variable was Client Ethnic Identity, and the provider-level predictor variable was Provider Ethnic Identity. A Mixed Model Analysis with SPSS version 20 was run separately for each predictor

variable. As Provider Ethnic Identity increases by one unit, Client CEPCCI decreases by 0.033 points. This difference is negligible (t = -0.373, p = 0.719). As Client Ethnic Identity increases by one unit, Client CEPCCI increases by 0.121 points. This difference is not statistically significant (t = 1.561, p = 0.122).

In summary, contrary to Hypothesis 3a, provider ethnic identity development did not impact client perceptions of their providers' multicultural competence. As predicted in Hypothesis 3b, client ethnic identity development did not impact clients' perceptions of their providers' multicultural competence.

Table 7

Fixed Effects of Client and Provider Ethnic Identity Development on Client CEPCCI

	Estimate	s.e.	df	t	p
Provider Ethnic Identity	-0.033	0.087	88	-0.373	0.719
Client Ethnic Identity	0.121	0.0477	88	1.561	0.122

Analysis and results for research question #4. *It was expected that a statistically significant amount of variance in provider means of client multicultural competence would be accounted for when majority or minority match status of race or ethnic label was considered.*

HLM was used to examine the effects of match of majority or minority race or ethnicity status of providers and their clients. Race or ethnicity for each provider and client was based on a) ethnic self-label reported by clients and providers on the MEIM-R, or, if the MEIM-R was not administered, on b) race/ethnicity reported on the

demographic form. It is worth noting that a total of 7 clients and providers provided a different ethnicity on the MEIM-R than they initially indicated on the demographic form, and it was their MEIM-R label that was used for the match vs. non-match categorization. One provider and five clients changed their reported ethnicity to "Mixed" or "Other" on the MEIM-R after self-labeling as "White" on the demographic form. One client changed their reported ethnicity from "Hispanic/Latino" on the demographic form to "Other" on the MEIM-R, and the another client changed from "Hispanic/Latino" on the demographic form to "Other" on the MEIM-R.

This client-level variable was group mean-centered, meaning individuals' scores were subtracted from their group mean. HLM analyses indicated that as the proportion of matches for each provider to their clients increases by one unit, Client CEPCCI score for providers increases by 0.248 points (see Table 8). Since $p = 0.011$, this relationship is statistically significant. In summary, the match between majority or minority status of self-labeled race or ethnicity had a significant impact on how clients rated their providers' multicultural competence.

Table 8

Fixed Effects of Ethnic Match on Client CEPCCI

	Estimate	s.e.	df	t	p
Ethnic Match	0.248	0.096	104	2.592	0.011

Additional HLM analyses. An additional HLM model with multiple predictors was run to determine how adding multiple predictors to the model at once would affect

the associations among variables. The predictor variables used in the conditional model were CBMCS Sensitivity, Client Ethnic Identity, and Provider Ethnic Identity. These predictors were used in the model because they were uncorrelated with each other, and are of primary interest for the study. Provider CBMCS was not added to the model because it is a global scale that contains the CBMCS Sensitivity subscale, and it is not desirable to have two scores from one measure in the same model. Provider CEPCCI was excluded from the model due to the lack of correlation found with Client CEPCCI , and strong correlation found with Provider CBMCS and CBMCS Sensitivity in the correlational analyses. Further, the CEPCCI-P has not yet been normed on a provider population. It would be suitable to better understand the factor structure of the measure before making hypotheses about how it interacts directly with an established measure of provider MCC.

The comparison null model for this conditional model was restricted to cases that could be directly compared (i.e., only matched cases that included client and provider ethnic identity scores, as well as provider CBMCS scores). As client and provider ethnic identity scores were only collected at Organization B, this reduced the sample of interest for CBMCS Sensitivity compared to the previous model run for this variable.

Likelihood ratio tests were run to compare the deviance (-2 log likelihood) of the two models. The deviance is a measure of lack of fit between model and data. Generally, when independent variables have a relationship to the dependent variable, the ability to predict the dependent variable accurately increases, and the deviance is expected to decrease (Snijders & Bosker, 1993). Using restricted maximum likelihood, the deviance

was computed for the null model (no predictor variables added) and for the model with the three predictor variables added. The deviance based on the restricted maximum likelihood estimation from the null model (123.02; 3 parameters) was found to be larger than the deviance computed after the three additional parameters were added to the model (126.36; 6 parameters). This indicated no statistical evidence that adding additional parameters, Client Ethnic Identity and Provider Ethnic Identity, along with Provider CBMCS Sensitivity, led to an improved fit of the model.

The deviance was also computed for both models using full maximum likelihood approach. Using full maximum likelihood, the deviance from the null model (118.847; 3 parameters) was larger than the deviance from the comparison model (116.2; 6 parameters), indicating some improvement in fit after adding the parameters. A chi-square test, which is the difference in deviances, with the number of degrees of freedom equal to the number of different parameters in the two models was not significant (x^2 = 2.647; df = 3; p = 0.449). Compared to the null model, the multiple parameter model did not show statistically significant improvement in model fit. Each of the three variables, CBMCS Sensitivity (t = 1.104, p = 0.273), Provider Ethnic Identity (t = -0.016, p = .987), and Client Ethnic Identity (t = 1.259, p = .211), was not found to explain a significant amount of variance in Client CEPCCI. When accounting for the effects of client and provider ethnic identity development, self-reported sensitivity to consumers by providers no longer explained a significant amount of variance in client perceptions of provider multicultural competence.

Summary

Taken together, the results showed that providers were significantly different from each other based on clients' ratings of their multicultural competence. It was also found that only one measure of provider self-reported multicultural competence included in the study – providers' score on the "Sensitivity to Consumers" subscale of the CBMCS – had a significant impact on how clients rated their providers' multicultural competence. Providers' self-report on the CEPCCI-P and the total score on the CBMCS did not have a significant effect on how providers' rated their multicultural competence. Client and provider ethnic identity development was not found to have a significant impact on ratings of provider multicultural competence. The proportion of match compared to non-match in majority and minority race or ethnicity status was found to have a significant effect on client ratings for providers.

Chapter V: Discussion

The primary purpose of this dissertation study was to examine the relationship between provider and client reports of provider multicultural competence, including whether clients tend to rate the same provider similarly. This study was part of a larger research focus initiated by Ihorn (2013) to improve the measurement and conceptualization of multicultural competence, and to examine the healthcare consumers' experience of multicultural competence. A particularly novel element of the current study was the use of Hierarchical Linear Modeling (HLM), which allowed for the examination of how multiple clients tended to rate them same provider. As anticipated, providers differed fundamentally in their multicultural competence, as assessed by clients. It was expected that providers' self-reported multicultural competence would account for a significant amount of variance in client ratings of multicultural competence. Providers' total score on the California Brief Multicultural Competence Scale (CBMCS) and Client Experience of Provider Counseling Competence Inventory – Provider Version (CEPCCI-P) did not account for a significant amount of variance in client ratings. However, the "Sensitivity to Consumers" subscale on the CBMCS did have a significant impact on client ratings. Clients rated providers who reported being more sensitive to their context and needs as more multicultural competent than others.

Secondary goals of the study were to examine how provider and client ethnic identity development and majority and minority match of race or ethnicity impact perceptions of provider multicultural competence. Contrary to what was expected, provider ethnic identity development was not related to higher client ratings of provider

multicultural competence. As hypothesized, client ethnic identity development did not account for a significant amount of variance in client perceptions of provider multicultural competence. Finally, the prediction that majority or minority match status of provider and client identified race or ethnicity would significantly impact client perceptions of provider multicultural competence was supported by this research.

Key Findings

Primarily, this study provided evidence that clients tend to view some providers as being more multiculturally competent than others. In view of that, what criteria did clients use when assessing providers' multicultural competence? A particularly noteworthy finding of this study was that providers' responses on the "Sensitivity to Consumers" subscale of the CBMCS predicted client perceptions of their providers' multicultural competence. Higher self-reported sensitivity to consumers was related to higher ratings of multicultural competence as perceived by clients. This finding provides strong preliminary evidence that clients are able to observe and interpret to what extent providers are considerate of their sociocultural context and needs. There are a few explanations for this phenomenon, and they will be discussed in the following three paragraphs.

First, the measure of multicultural competence completed by clients in the study was similar to that of the CBMCS Sensitivity subscale completed by providers. Ihorn (2013) determined that the "Sensitivity to Consumers" subscale on the CBMCS is most closely related to that which the CEPCCI-C assesses, compared to the other subscales. The other three constructs purportedly measured by the CBMCS are knowledge (e.g., "I

have an excellent ability to critique multicultural research), cultural awareness (e.g., "I can identify my reactions that are based on stereotypical beliefs about different ethnic groups"), and non-ethnic skill (e.g., "I have an excellent ability to assess, accurately, the mental health needs persons with disabilities"). While cultural knowledge, cultural awareness, and non-ethnic skill may be important to the quality of care a counselor provides, these abilities may not be as visible to the client. Further, providers may not be able to accurately report on these constructs compared to their sensitivity to clients.

A second explanation for the impact of provider self-reported sensitivity on clients' views is that this construct, in contrast to skill, knowledge, and awareness, may be more translatable from provider to client through verbal and nonverbal behaviors. For example, clients can likely detect whether or not a provider asks about barriers to treatment. Another example is that culturally sensitive providers likely clarify with clients that they are making sense, and ask for feedback. This "checking for understanding" behavior suggests the provider is making an effort to communicate in a way the client understands. The tripartite, broad construct of multicultural competence, as traditionally defined by Sue et al. (1998), may be, as a whole, intellectualized and detached from the client's actual experiences. Cultural sensitivity, relating to empathy and humility, is an important quality within the broader construct of multicultural competence, and may be more accessible, visible, and measurable to the client.

A third explanation for the congruence between client perception of multicultural competence and provider self-reported sensitivity can be found in research on cultural humility. This research posits that a culturally sensitive and humble interpersonal

approach of providers enhances clients' working alliance and perceived improvement in counseling. Cultural humility has been shown to positively affect clients' experiences in counseling to a greater extent than the effects of cultural awareness, knowledge, and skills (Hook et al., 2013). In the same vein, researchers have proposed the importance of multicultural *orientation*, a key component of competence, referring to specific disposition or virtues of providers that align with values of diversity as key to positive client experience (Owens, Tao, Leach, & Rodolfa, 2011). Individuals seeking healthcare in community health centers are likely to be facing multiple stressors. The community mental health client population, in particular, may align best with and feel respected by healthcare providers who are sensitive and adaptable to possible obstacles to treatment.

Another interesting finding of the dissertation study was that clients' perceptions of their providers' multicultural competence were *not* impacted by providers' overall ratings of multicultural competence on the CEPCCI-P or CBMCS. In other words, clients did not perceive providers who reported being more multiculturally competent, as assessed by these two measures, as more multiculturally competent than others. Possible explanations for this are provided. First, Ihorn (2013) found that more items from the CEPCCI-C loaded on the "Sensitivity to Consumers" subscale of the CBMCS compared to others subscales. It may be that only *some* of the items of the CEPCCI-C and CEPCCI-P, namely those loading strongly on sensitivity, were observable to clients. The items that did not load strongly on the "Sensitivity to Consumers" subscale may have been harder to observe or articulate by clients and providers. For example, the CEPCCI-C item, "My counselor understands my cultures" and the corresponding CEPCCI-P item, "I

understand my client's cultures", are arguably too subjective and amorphous to be either observed by clients or accurately reported on by providers. Provider and client respondents may have interpreted items on the CEPCCI-P and CEPCCI-C differently based on factors unrelated to the healthcare encounter (e.g., their personal definition of the meaning of the word, "cultures").

The discrepancy in psychometric properties and constructs of the measures is another possible explanation for the lack of congruence between client ratings on the CEPCCI-C and provider reports on the CEPCCI-P and CBMCS. It has not yet been determined what factors, or how many factors, the CEPCCI-P measures relating to multicultural competence. It is also unclear how the CEPCCI may relate to measures of other variables, such as social desirability or working alliance. Across the board, researchers have had a difficult time justifying the number of constructs that have been found to be measured based on their purported theoretical bases (e.g., Pope-Davis & Dings, 1995; Ponterotto et al., 2000). Ihorn (2013) hypothesized that three constructs would emerge from the CEPCCI-C based on Sue et al.'s (1992) tripartite theory, for example, but a single, unified construct was identified. The CBMCS as a full scale has consistently been found to have good psychometric properties (Gamst et al., 2004; Tummala-Narra et al., 2012); nevertheless, there is a lack of evidence that it taps into *client* perceptions of multicultural competence (Worthington et al., 2000).

It is notable that while Ihorn (2013) found a significant, moderate, positive relationship between provider total scores on the CBMCS and client scores on the CEPCCI-C, the current study found a weak, positive association. An explanation for this

discrepancy is that Ihorn used a random number generator to select clients to be matched to any given provider for her correlational analysis. In the current study, the ratings of all clients within a provider were taken into consideration in both the correlational and HLM analyses. As provider respondents were matched to about four client respondents, on average, choosing a single, random client for these providers eliminated the input of over three quarters of the total client respondents.

Implications of key findings. The finding that clients notice how sensitive providers' are to their sociocultural context has implications for theory, research, and practice. The traditional theoretical framework and measurement of multicultural competence has emphasized awareness, knowledge, and skills (Suet et al., 1982). Assessment of these competencies has relied heavily on provider self-report (e.g., Constantine & Ladany, 2001; Pope-Davis & Dings, 1995; Worthington, Mobley, Franks, & Tan, 2000). There has been a shift toward recognizing the import of consumer input in assessing multicultural competence of providers, as it relates to healthcare quality (NCQA, 2009). However, research has lagged behind this movement in establishing how clients view and assess multicultural competence, and developing psychometrically sound measures. The present study helps conceptualize multicultural competence as clients experience it, which is the first step toward better understanding how to measure and teach it.

Research on consumers' experience of multicultural competence from a community-based approach has indicated that consumers place significance on how in tune providers are with their self-identified needs (Davis, 2007; Pope-Davis et al., 2002)

and how culturally humble they are (Hook et al., 2013). The current study supported these findings that cultural sensitivity is observable and valued by clients. It is implicated that educators and researchers conceptualize training outcomes beyond a set mastery of knowledge and skills toward the continuous and dynamic process of an open and understanding approach. The current study findings suggest that it would be prudent to enhance our understanding of what culturally sensitive and humble behaviors look like to clients, how to measure them, and how to teach them.

Focusing on clients as individuals, being aware of institutional constraints and power imbalances, and adjusting communication and treatment to clients are tenets of cultural sensitivity (Hook et al., 2013). Cultural sensitivity is a core tenet within the realm of multicultural competence that should not be ignored. For training and education of healthcare practitioners, especially in the realm of community mental healthcare, knowledge and skill should *build* on cultural sensitivity. In this same vein, the potential emphasis on knowledge and skills *over or instead of* humility and flexibility in training and research increases the risk of stereotyping specific ethnic groups as possessing the same psychosocial tendencies. Tervalon and Murray-Garcia (1998) eloquently describe client-centered approaches to care: "only the patient is uniquely qualified to help the physician understand the intersection of race, religion, class, and so on in forming his (the patient's) identity, and to clarify the relevance and impact of this intersection on the present illness or wellness experience" (p. 121). It is the providers' thoughtful, considerate way of being with the client – empowering clients to share their context – that may be of fundamental importance when it comes to perceived cultural competence.

The current study focused on client respondents in the community-based healthcare setting, and the findings should be considered with respect to this context and population. Previous research on multicultural competence has examined behaviors of undergraduate students and consumers of university counseling services, a population with limited sociocultural diversity (e.g., Constantine, 2001). Due to the expansion of community mental healthcare and the presence of significant mental health disparities for culturally diverse individuals (HHS, 2011), it is important for the perceptions and behaviors of this population to be studied. Community-based research is necessary for accurately informing clinical practice in community settings (e.g., Pope-Davis, 2002; Smith, Chambers, & Bratini, 2009). In addition to helping advise best provider practices, research at the community level empowers community members to provide insight on assets and adaptive strengths of their milieu. Providers who are inquisitive and open to learning about the strengths of the community may also be more sensitive about the needs of its individual members.

Secondary Findings and Implications

This study provided preliminary evidence that shared majority or minority status based on identified race or ethnicity of clients and their providers predicts more positive ratings of provider multicultural competence; this supports the research hypothesis. Contrary to the research hypothesis, more developed ethnic identity of providers did not have any effect on how clients perceived their multicultural competence.

Racial and ethnic match. As hypothesized, majority and minority match status of provider and client, based on self-reported race and ethnicity on demographic forms,

was found to affect client perceptions of multicultural competence. Proportion of majority or minority match, based on self-labeled race or ethnicity of clients and providers, had a positive impact on client ratings of provider multicultural competence. This finding provides preliminary evidence that clients may view their providers differently – more culturally knowledgeable, skillful, and sensitive –when they share racial and ethnic majority or minority status with their providers. This supports research that has shown clients have preference for (e.g., Coleman, Wampold, & Casali, 1995; Lopez, Lopez, & Fong, 1991) and increased satisfaction with providers who share their race or ethnicity (Saha, Komaromy, Koepsel, & Bindman, 1999; Saha, Taggart, Komaromy, & Bindman, 2000). The information clients gather about the race or ethnicity of their provider, and whether they suspect to have shared socio-cultural experiences, may influence their perceptions of their provider. Clients that believe they share majority or minority status background with their provider may rate that provider as being more in tune with their cultural biases, needs, and context.

This significant finding about the effect of racial and ethnic match on perceptions of multicultural competence requires further examination due to the small sample size for providers who were not White in the study. Two times as many providers in the study self-labeled as White compared to any other race or ethnicity. Additionally, more than half of the client respondents in the study self-labeled as White. Therefore, more "matches" in the study tended to be between White clients and White providers rather than between individuals from Latino, Black, or other backgrounds. More research is

needed to piece apart the differences in multicultural competence compared to racial and ethnic based on a more racially and ethnically diverse provider sample.

Ethnic identity development. Ethnic identity development, specifically how much individuals had explored and committed to identification with an ethnic group, was not found to impact multicultural competence ratings in this study. There was a positive relationship found between ethnic identity and client ratings, but it was not significant. This finding was contrary to the hypothesis that provider ethnic identity development would have a positive impact on client ratings of their multicultural competence. As anticipated, client ethnic identity development and client perceptions of multicultural competence were not related. Ethnic identity development is a complex construct and the definition and measurement of it has been heavily debated in the literature. Researchers have argued that its conceptualization has been influenced by ideology and politics, in addition to science (Cokley, 2005). Additionally, age, time, and context affect reported ethnic identity development (Portes & Rumbaut, 2001; Phinney, 2006). Thus, one explanation for the lack of significant findings related to ethnic identity in the current study is the subjective, contextual, and elusive nature of the construct itself, especially when compared to a similarly fluid variable, multicultural competence. In the same vein, it is worth noting that the MEIM-R has been used predominantly with, and was normed on the adolescent and young adult populations. More research is necessary related to how ethnic identity development relates to other psychological variables later in the developmental lifespan. Finally, while self-report is necessary for measuring ethnic

identity due to its inherently personal qualities, it is also vulnerable to confounding factors such as social desirability or differences in question interpretation.

It is also possible that ethnic identity development of providers did not translate into behaviors observed and captured in the multicultural competence measure. Clients detected sensitivity of their providers, and not other aspects of multicultural competence. Thus, it makes sense that they might not have been able to perceive behaviors associated with a well-developed ethnic identity. It remains to be seen how ethnic identity translates into specific behaviors in the counseling relationship, for both the provider and client, and how it relates to multicultural competence. Provider factors potentially distinct from ethnic identity, such as capacity for empathy, warmth, and openness, may affect perceptions of cultural competence, or provider sensitivity, more than ethnic identity development.

Limitations

This dissertation study sought to improve understanding of the measurability, detectability, and impact of multicultural competence in provider-client dyads in the community mental health setting. This study was unique and innovative in sampling participants from the community health setting rather than the university setting. Due to the wide variety of educational, employment, criminal, psychological, language, and cultural backgrounds of clients in this setting, however, there was also a high amount of potentially confounding variables at play. It was beyond the scope of the study to control for many of these characteristics. The study did not assess, for example, the level of psychological distress clients were in when completing study measures (e.g., their Global

Assessment of Functioning scores), clients' past experiences with or attitudes toward mental health, or their preferred language. While the community health setting allowed for collection of a diverse sample of respondents, it also introduced many confounding variables related to client characteristics.

Another limitation of the study was sample size. There are unique challenges inherent in collecting data in a setting in which time, personnel, and financial constraints interact with high-need, overstressed client populations. The combination of a wide variety of client characteristics and limited sample size made examination of the impact of specific characteristics more difficult. Sample sizes for groups of participants representing different characteristics (e.g., clients with a GED) in the study were often too small to be compared statistically. Further, many clients reported holding multiple diagnoses and seeking multiple behavioral health services; this made it difficult to disentangle diagnoses and services across individuals. A smaller sample size of clients and providers also limited how many predictor variables could be added to the HLM models. A key facet of the study was to examine how multiple clients perceive the same provider, and because of this, many provider and clients were eliminated from the original data set that were lacking matches.

Another limitation relates to the statistical analyses conducted. When adding provider self-reported sensitivity, provider ethnic identity, and client ethnic identity to one hierarchical model simultaneously and examining how the parameters fit the data, the significant effect of self-reported sensitivity was not found. As there is not a theoretical basis for hypothesizing how these three variables interact in terms of their effects on

client perceived multicultural competence, it was more suitable to examine the effects of each variable independently for the current study. Nevertheless, the non-significant findings for the multiple-predictor model suggests that potential relationships between ethnic identity development and client perceptions of multicultural competence should be explored in future research. With a large sample of participants, it may have been more possible to piece apart the relationships between these variables.

A significant limitation of the current study was the lack of racial and ethnic diversity. While ethnic and racial minorities are overrepresented in the community health population, the majority of study participants indicated they were White. Additionally, Asian and Native Americans were significantly underrepresented in this sample. Based on the reported demographics of the clients served by the organizations in the study, it was expected that there would be more Hispanic and African American participant representation. In particular, there was a discrepancy in the percentage of Hispanic individuals purportedly served by the organizations, and the amount of data collected from this population for this study. While the two participating organizations indicated serving about 26% and 41% Hispanic individuals, respectfully, Hispanic participants represented only 13.7% and 14.4% in the study data for each organization. More information is required to understand why there were lower numbers of Hispanic and African American participants compared to Caucasian participants included in the study.

One possible explanation for the discrepancy is that Hispanic and African American individuals were less likely to agree to participate in the study compared to White individuals. Researchers approached most participants directly in waiting rooms,

and Hispanic and African American individuals may have been less comfortable with this approach compared to Caucasians. Another explanation is that, even though the measures were offered in Spanish, there may have been cultural or linguistic differences for Spanish-language dominant individuals that were not captured in the translated measures. Further, the translated measures have not been normed on Spanish speaking individuals. Due to these factors, perhaps more measures were not fully completed (and thus not used for the study) by Spanish speaking individuals compared to native English speakers. Regardless of the reasons for the lower-than-expected representation by certain racial and ethnic minority groups in the study, this proved to be a substantial limitation. The study, however, did capture rich cultural diversity in terms of including representation from diverse socioeconomic, educational, and diagnostic backgrounds.

As most of the providers in the study sample self-identified as White, it also would be informative to have had more diverse provider sample. The overrepresentation of White providers, however, may be more indicative of a real world phenomenon than reflecting a biased sample. There may be nuances across regional, cultural, racial, and ethnic groups in their perception or interpretation of culturally competent behaviors that did not emerge in this study due to limited representation of diverse groups.

Finally, the issues of ceiling effects and social desirability may have affected study findings. As is common in self-report measures of satisfaction, clients tended to rate their providers highly. The vast majority of average scores for clients' ratings on the CEPCCI-C fell between 3 and 4, indicating they tended to agree or strongly agree with positive statements about their providers. This resulted in a restricted variance of

responses. Although clients were informed that their responses were confidential and their providers would not have access to their ratings, it is suspected that clients may have erred on the size of positive reporting when describing their providers. Similarly, providers tended to rate themselves positively on traits of multicultural competence across measure. The theme of multicultural competence is an especially hot topic in healthcare provision at present, and there is pressure on providers to provide culturally competent care. Providers may have responded in an overly positive manner that reflected their ideal, rather than actual, attitudes, skills, and behaviors in this area.

Future Directions

The findings of this study begin to hone in on which aspects of multicultural competence are detected and valued by clients, and how clients and providers differ in their reports of multicultural competence. More research should be conducted to identify, more specifically, what behaviors of providers send messages of cultural sensitivity, humility, and respect to clients. In terms of possible revisions to the CEPCCI-C measure, including deleting items, focus groups that draw on the wisdom of community mental health consumers may be helpful in addition to quantitative research. In this vein, it is recommended that research continue to be conducted at the community level in order to provide clients a voice. It could be beneficial to gain more qualitative information about how clients interpret behaviors, styles, and "ways of being" of the same providers. Additional efforts should be made to elicit participation from racial and ethnic minority individuals within the community mental health setting.

It would also be interesting to compare clients' perceptions of providers in community health settings to those seeking healthcare in considerably dissimilar settings, including private practice and university counseling centers. As many clients seeking services through community mental health tend to be facing complex sociocultural stressors, this population may particularly value providers who consider their systemic context compared to populations seeking healthcare elsewhere. The organizations examined in the current study share many characteristics, and providers in these organizations may be more oriented toward multicultural issues compared to those who work in other settings. However, there also tends to be ample pressure and stress on providers in community healthcare due to strong demands for productivity (e.g., documenting billable hours), and sparser economic resources. It would be interesting to examine how providers in community mental health settings compared to those in other settings in terms of a) clients ratings of their multicultural competence, and b) the congruency between their self-reported multicultural competence and clients' perceptions. Factors such as time spent with clients, monthly productivity demands, billing documentation requirements, and salaries could be interesting provider-level variables to examine, in addition to client-level variables. More broadly, it could be beneficial to better understand how organizations can support the providers they employ in being more aware of and sensitive to the needs of their clients.

The current study adds to the literature base in conceptualizing and measuring multicultural competence from the client perspective. An important and logical next step is to examine how client outcomes are related to this construct. The push to train and

produce more multiculturally competent healthcare providers in this country is a response to the problem of mental health disparities for racially, ethnically, and socioeconomically diverse individuals. The provision of quality mental healthcare for all individuals is the ideal, and community mental health is the logical setting to focus attention. Therefore, the fundamental drive of research in multicultural competence research should be to understand what aspects of multicultural competence in providers lead to improved client outcomes (i.e., improved treatment adherence, decreased drop-out, improved working alliance, higher reported satisfaction, and so on). Community mental health providers lack time and resources, and tend to see many clients throughout the day. Cultural competence training and feedback that is focused and evidence-based would best fit with this population.

Summary

This study supports the existence of a disconnect between how clients and providers experience and assess provider multicultural competence. Clients may be able to observe and interpret specific qualities of a provider that relate to what researchers have described as multicultural competence (Sue et al., 1982), but not others. It is an important addition to the field of counseling psychology to find that clients and providers in community mental health settings are referencing different criteria or interpreting experiences differently when responding to questions about multicultural competence. Multicultural competence, like ethnic identity development, is a fluid construct that is impacted by political climate and ideology. As such, community-based research that draws on the consumer perspective is recommended rather than ascribing detached,

traditional paradigms to inform provider training and evaluation. The fast-paced, short-term, and under-staffed quality of the community mental health setting calls for the identification of practical, client-centered, community-based approaches to care. Ideally, these approaches should leave clients feeling that their cultural beliefs, values, and practices have been respected and not judged or pathologized. The current study provides a strong launching base for the implementation of culturally competent practice in community mental health.

Appendix A

APA Multicultural Guidelines (2003) Definitions of Ambiguous Terms

Culture is "the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, care taking practices, media, educational systems) and organizations" (APA, 2003, p. 7).

Race is "the category to which others assign individuals on the basis of physical characteristics, such as skin color or hair type, and the generalizations and stereotypes made as a result" (APA, 2003, p. 8).

Ethnicity is "the acceptance of the group mores and practices of one's culture of origin and the concomitant sense of belonging" (APA, 2003, p. 9).

Multiculturalism and **Diversity** are used interchangeably. They are defined as "dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions" (APA, 2001, p. 10).

Appendix B

Sue et al.'s 1998 Multicultural Counseling Competencies

COUNSELOR AWARENESS OF OWN ASSUMPTIONS, VALUES, AND BIASES

Beliefs and Attitudes

1. Culturally skilled counselors have moved from being culturally unaware to being aware and sensitive to their own cultural heritage and to valuing and respecting differences.
2. Culturally skilled counselors are aware of how their own cultural background and experiences, attitudes, and values and biases influence psychological processes.
3. Culturally skilled counselors are able to recognize the limits of their competencies and expertise.
4. Culturally skilled counselors are comfortable with differences that exist between themselves and clients in terms of race, ethnicity, culture, and beliefs.

Knowledge

1. Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions and biases of normality-abnormality and the process of counseling.
2. Culturally skilled counselors possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows them to acknowledge their own racist attitudes, beliefs, and feelings. Although this standard applies to all groups, for White counselors it may mean that they understand how they may have directly or indirectly benefitted from individual, institutional, and cultural racism (White identity development models).
3. Culturally skilled counselors possess knowledge about their social impact upon others. They are knowledgeable about communication style differences, how their

style may clash or facilitate the counseling process with minority clients, and how to anticipate the impact it may have on others.

Skills

1. Culturally skilled counselors seek out educational, consultative, and training experiences to enrich their understanding and effectiveness in working with culturally different populations. Being able to recognize the limits of their competencies, they (a) seek consultation, (b) seek further training or education, (c) refer out to more qualified individuals or resources, or (d) engage in a combination of these.
2. Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a nonracist identity.

UNDERSTANDING THE WORLDVIEW OF THE CULTURALLY DIFFERENT CLIENT

Beliefs and Attitudes

1. Culturally skilled counselors are aware of their negative emotional reactions toward other racial and ethnic groups that may prove detrimental to their clients in counseling. They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a nonjudgmental fashion.
2. Culturally skilled counselors are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups.

Knowledge

1. Culturally skilled counselors possess specific knowledge and information about the particular group that they are working with. They are aware of the life experiences, cultural heritage, and historical background of their culturally

different clients. This particular competency is strongly linked to the "minority identity development models" available in the literature.

2. Culturally skilled counselors understand how race, culture, ethnicity, and so forth may affect personality formation, vocational choices. manifestation of psychological disorders, help-seeking behavior, and the appropriateness or inappropriateness of counseling approaches.
3. Culturally skilled counselors understand and have knowledge about sociopolitical influences that impinge upon the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping, and powerlessness all leave major scars that may influence the counseling process.

Skills

1. Culturally skilled counselors should familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders of various ethnic and racial groups. They should actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills.
2. Culturally skilled counselors become actively involved with minority individuals outside the counseling setting (community events, social and political functions, celebrations, friendships, neighborhood groups, and so forth) so that their perspective of minorities is more than an academic or helping exercise.

DEVELOPING APPROPRIATE INTERVENTION STRATEGIES AND TECHNIQUES

Beliefs and Attitudes

1. Culturally skilled counselors respect clients' religious and/or spiritual beliefs and values about physical and mental functioning.
2. Culturally skilled counselors respect indigenous helping practices and respect minority community intrinsic help-giving networks.

3. Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling (monolingualism may be the culprit).

Knowledge

1. Culturally skilled counselors have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture bound, class bound, and monolingual) and how they may clash with the cultural values of various minority groups.
2. Culturally skilled counselors are aware of institutional barriers that prevent minorities from using mental health services.
3. Culturally skilled counselors have knowledge of the potential bias in assessment instruments and use procedures and interpret findings keeping in mind the cultural and linguistic characteristics of the clients.
4. Culturally skilled counselors have knowledge of minority family structures, hierarchies, values, and beliefs. They are knowledgeable about the community characteristics and the resources in the community as well as the family.
5. Culturally skilled counselors should be aware of relevant discriminatory practices at the social and community level that may be affecting the psychological welfare of the population being served.
6. The culturally skilled psychologist or counselor has knowledge of models of minority and majority identity, and understands how these models relate to the counseling relationship and the counseling process.

Skills

1. Culturally skilled counselors are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach to helping but recognize that helping styles and approaches may be culture bound. When they sense that their helping style is

limited and potentially inappropriate, they can anticipate and ameliorate its negative impact.

2. Culturally skilled counselors are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a "problem" stems from racism or bias in others (the concept of healthy paranoia) so that clients do not inappropriately blame themselves.
3. Culturally skilled counselors are not averse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally different clients when appropriate.
4. Culturally skilled counselors take responsibility for interacting in the language requested by the client; this may mean appropriate referral to outside resources. A serious problem arises when the linguistic skills of the counselor do not match the language of the client. This being the case, counselors should (a) seek a translator with cultural knowledge and appropriate professional background or (b) refer to a knowledgeable and competent bilingual counselor.
5. Culturally skilled counselors have training and expertise in the use of traditional assessment and testing instruments. They not only understand the technical aspects of the instruments but are also aware of the cultural limitations. This allows them to use test instruments for the welfare of the diverse clients.
6. Culturally skilled counselors should attend to as well as work to eliminate biases, prejudices, and discriminatory practices. They should be cognizant of sociopolitical contexts in conducting evaluations and providing interventions, and should develop sensitivity to issues of oppression, sexism, and racism.
7. Culturally skilled counselors take responsibility in educating their clients to the processes of psychological intervention, such as goals, expectations, legal rights, and the counselor's orientation.
8. The culturally skilled psychologist or counselor can tailor his or her relationship building strategies, intervention plans, and referral considerations to the particular

stage of identity development of the client, while taking into account his or her own level of racial identity development.

9. Culturally skilled counselors are able to engage in psychoeducational or systems intervention roles, in addition to their clinical ones. Although the conventional counseling and clinical roles are valuable, other roles such as the consultant, advocate, adviser, teacher, facilitator of indigenous healing, and so on may prove more culturally appropriate.

Appendix C

Davis' 2007 Statements of Cultural Competence

CLUSTER 1: SERVICE PROVIDER COMPETENCIES

- Providers take time to get to know and build rapport with children and families they serve
- Service providers welcome the involvement of an objective family advocate
- Providers don't assume families won't understand what's going on with the family or situation
- Service providers know when to offer empathic or sympathetic support to families
- Services are child centered and allow children to have a voice in what services they receive
- Providers work with and provide services to the entire family rather than only the identified child
- Service providers don't impose their own values and beliefs on families
- Providers are willing to ask questions and allow families to be experts on their own cultures

CLUSTER 2: FAMILY-CENTERED SERVICES

- Services provided are based on the specific needs of families
- Roles of each person involved in services are clear (parent, counselor, child)
- Services providers truly understand what's important to families
- Services and programs meet the scheduling needs of the family
- Services to families are nonjudgmental and affirming of the families' cultures and backgrounds
- Service provision involves mutual understanding between providers and families
- Services are family driven (families are in charge of their own services)

CLUSTER 3: PROVIDER-FAMILY INTERACTION

- Service providers truly support, value, and preserve the individual cultures of the families
- Service providers and families are able to use humor in their relationships
- Trusting relationships are built between providers and families

- Service providers and families truly work as a team
- Providers value and honor input from the whole family
- Families and service providers are not judgmental of one another
- Parents are kept informed of their child's treatment and progress
- Service providers use family-friendly language that is free of technical jargon
- Service providers respect parents' choices without being judgmental

CLUSTER 4: CULTURALLY-ACCOUNTABLE SYSTEM POLICIES

- Services are inclusive of all persons without discrimination
- A continuum of coordinated services and providers enables smooth service transitions for families
- The service systems support efforts to broaden services beyond "traditional" service provision
- Services lead to improving families' progress toward meeting their goals
- Agencies work together (combine resources, information, and efforts) to meet families' goals
- There is equal opportunity services for all individuals
- Consumers are not submitted to abusive workers (verbal abuse, physical management, environmental constraints)
- Service providers are educated about the cultural differences of families they are serving
- Culturally appropriate services are ensured to meet the needs of families
- Systems and service providers reflect ("look like") the diverse cultures in their community

CLUSTER 5: PROVIDER ACCOUNTABILITY TO FAMILIES

- Service plans are put in writing so everyone can be held accountable
- Providers think outside the box of their job description and extend themselves in serving families
- Service providers have a credible reputation for serving families
- Services are available for mental health and mental retardation dual diagnoses needs
- Care is developmentally appropriate and not diagnosis driven
- Providers make every effort to find help for families without passing the buck to another agency
- Providers actually do what they say they are going to do
- Providers can admit that they don't have the understanding necessary for working with a family

- Providers consider the culture of the whole person (spiritual, physical, financial, mental, family unit)

CLUSTER 6: CULTURALLY APPROPRIATE SERVICES

- Services to families are provided using a multidisciplinary approach
- Flexibility is built into the service system to provide unique or nontraditional services to meet family needs
- There is consistency in who provides services to families
- Services are individualized (not everyone is offered the exact same services in the exact same way)
- Services are provided within families' own communities
- Services are available to families regardless of families' financial resources
- Services and supports are strengths based and draw on the exiting resources of families

CLUSTER 7: GOVERNMENT OR AGENCY COMMUNITY INVOLVEMENT

- The government's understanding of the community's service needs is supported through appropriate funding allocation structures
- Decision-making bodies change services to meet the needs of the whole community
- Policy (legislated and agency) permits providers flexibility to do what's needed for families
- Organizations provide community-specific cultural competence training to employees at all levels
- There is interagency cultural and historical understanding
- Community ownership of services is valued by community members and supported by providers
- Practitioners can actually affect changes in the system of care
- The cultural demographics of those served reflect the community's population.

CLUSTER 8: AGENCY POLICIES

- Workers are given rapid due process for accusations made by consumers
- Agency policies allow employees to have case-related grief time
- Professional and direct-care staff receive equitable pay
- Staff are hired who have experienced mental health illnesses

- Services and systems are noncompetitive

CLUSTER 9: REMOVING RESTRICTIONS TO ACCESS

- "Red tape" is not a barrier to families accessing services
- Services to families remain consistent across political parties
- Employers are supportive of employees who have family members with special needs
- There is continuity of care for families over the long haul
- There are no more waiting lists
- People don't hear professionals make remarks based on ethnic origins
- Agency forms and documents are printed in the cultural language of families

CLUSTER 10: EDUCATION INVOLVEMENT AND EXPECTATIONS

- The educational system is prepared to be a positive participant.
- The educational needs of all children are met and supported
- Higher education institutions know their communities and can teach students about alternative types of referrals
- There is not an overrepresentation of children in alternative education
- Continuing education is offered to both families and professionals.

CLUSTER 11: FAMILY EMPOWERMENT

- Families are empowered by the strengths and differences of their culture
- Families are active in all aspects of services
- Families are invested in the service process
- Families have a lot of options for services
- Families view providers, policy makers, and agency administrators as helpful and motivating
- Family voice and choice are prioritized
- Families are given the time and consideration their situation deserves
- Opportunities are available for families to support and share information with one another
- Families feel they are treated with dignity and respect
- Families know that the service providers care
- Families feel listened to and heard by service providers
- Families are able to communicate in their own language with service providers.

- Families feel comfortable accessing services and asking questions of service providers.

CLUSTER 12: RESPECTFUL RESPONSIVENESS TO FAMILIES

- Families get a response when they make a request
- Families have a lot of options available when choosing service providers
- Families are happy to see providers
- Families are referred to as people and don't feel labeled or stigma associated with receiving services
- Families' time is respected
- Families are accurately informed of services and resources that are available to them
- Families and service providers are willing to share their cultures and beliefs with each other

CLUSTER 13: OUTCOMES AND ACCOMPLISHMENTS

- Families can access services and providers with no barriers (transportation, language, education, cost)
- Families get politically involved in advocating for change in government policies.
- Noticeable progress is made in child outcomes
- Kids are happy with themselves
- Children are allowed to be children
- Communication between parents and their children improves
- The elderly are valued
- There are ways to measure achievement
- Kids begin taking responsibility for their own behavior

CLUSTER 14: POSITIVE FAMILY AND PROVIDER REGARD

- People know how to appropriately respond to crisis situations
- Everyone is treated equally in the service process
- Services enhance family life
- Persons don't insult one another by trying to be too culturally polite
- Animosity is not present between systems and families

CLUSTER 15: RESPONSIVE FAMILY AND PROVIDER COMMUNICATION

- Families understand how to use impartial grievance procedures
- The needs of families are met
- Families are satisfied with the services they receive
- Families are educated about the organizations' cultures and mandates
- There is two-way respectful communication between children and service providers
- Parents and children are individually treated with respect.
- The line of communication is always open

Families are able to find resources on their own and use new resources to help themselves

Appendix D

Client Experience of Provider Cultural Competence Inventory

Please circle your response

1. My counselor is helpful.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

2. My counselor does not judge me.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

3. My counselor considers how discrimination might affect me (e.g. racial, ethnic, language, immigration status, sexuality, economic, political, etc.).
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

4. If I asked him/her, my counselor would be willing to involve my family members in my treatment.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

5. My counselor understands my culture.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

6. My counselor talks about my strengths.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

7. My counselor motivates me.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

8. I am comfortable talking with my counselor about our differences.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

9. My counselor speaks in a way that I understand.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

10. My counselor is aware of the barriers (money, transportation, child care, language, schedule, etc.) I may have faced to participate in treatment here.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

11. My counselor respects my culture.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

12. My counselor tells me about services and resources that are available to me.

Strongly Disagree *Disagree* *Agree* *Strongly Agree*

13. My counselor keeps me informed about my treatment and progress.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

14. My counselor explains to me how therapy works.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

15. My counselor respects my values and beliefs.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

16. If I asked him/her, my counselor would be willing to get ideas from someone in my community about how to best help me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

17. My counselor explains my legal rights to me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

18. I feel comfortable asking questions in therapy.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

19. My counselor really understands what is important to me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

20. My counselor supports me in accessing other resources or services I might need.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

21. My counselor respects and values my language(s) and the way that I speak.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

22. I feel comfortable with my counselor.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

23. If I asked him/her, my counselor would be willing to get ideas from someone in my religious or spiritual group about how to best help me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

24. My counselor is willing to ask me questions about my culture.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

25. I have a say about what goes on in my treatment.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

26. My counselor is responsive.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

27. My counselor uses the language I am most comfortable with.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

28. My counselor and I decide together what to work on in therapy.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

29. My counselor lets me be an expert about my own culture.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

30. My counselor and I work as a team.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

31. I trust my counselor.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

32. My counselor takes time to get to know me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

33. My counselor doesn't impose his/her own values and beliefs on me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

34. My counselor does what they say they will.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

35. I am satisfied with my counselor.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

36. My counselor is comfortable talking about our differences.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

37. My counselor values my culture.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

38. My counselor cares about me.
Strongly Disagree *Disagree* *Agree* *Strongly Agree*

Appendix E

California Brief Multicultural Competence Scale

Please circle your response.

1. I have an excellent ability to assess accurately the mental health needs of gay men.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

2. I have an excellent ability to assess accurately the mental health needs of lesbians.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

3. I have an excellent ability to assess accurately the mental health needs of persons with disabilities.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

4. I have an excellent ability to assess accurately the mental health needs of older adults.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

5. I have an excellent ability to assess accurately the mental health needs of men.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

6. I have an excellent ability to assess accurately the mental health needs of persons who come from very poor socioeconomic backgrounds.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

7. I have an excellent ability to assess accurately the mental health needs of women.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

8. I am aware that counselors frequently impose their own cultural values on minority clients.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

9. I am aware that being born a White person in this society carries with it certain advantages.
   Strongly Disagree *Disagree* *Agree* *Strongly Agree*

10. I am aware of institutional barriers which may inhibit minorities from using mental health services.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

11. I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.

Strongly Disagree *Disagree* *Agree* *Strongly Agree*

12. I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

13. I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

14. I have an excellent ability to critique multicultural research.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

15. I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons with different cultural/racial/ethnic backgrounds.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

16. I can discuss within group differences among ethnic groups (e.g., low socioeconomic status [SES] Puerto Rican client vs. high SES Puerto Rican client).
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

17. I can discuss research regarding mental health issues and culturally different populations.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

18. I am knowledgeable of acculturation models for various minority groups.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

19. My communication is appropriate for my clients.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

20. I am aware of institutional barriers that affect the client.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

21. I am aware of how my own values might affect my client.
    Strongly Disagree *Disagree* *Agree* *Strongly Agree*

Appendix F

Client and Provider Demographic Forms

CLIENT DEMOGRAPHIC FORM Date:

Identification Number _____

About how many sessions have you had with your counselor? _____

Gender (circle)

Male Female

Age _____

Highest Grade Completed in School _____

Sexual Orientation

Heterosexual (Straight) Gay or Lesbian Bisexual Other_____

Race/Ethnicity (circle as many as apply)

Hispanic/Latino Black or African American White

American Indian or Alaska Native Asian

Native Hawaiian or other Pacific Islander Other _____

Type of Service (circle)

Behavioral Health Medical Services Psychiatry Substance Use

Support Group Counseling (Individual) Counseling (Family)

Housing Services Other _____

Diagnosis (if any) _____

Site _____

PROVIDER DEMOGRAPHIC FORM Date:

Identification Number _____

Gender (circle)

Male Female

Age _____

Race/Ethnicity (circle as many as apply)

Hispanic/Latino Black or African American White

American Indian or Alaska Native Asian

Native Hawaiian or other Pacific Islander Other _____

Sexual Orientation

Heterosexual Gay or Lesbian Bisexual Other_____

Degree Type (circle)

BA/BS MA/MS PhD/PsyD MD Other _____

Licensure Type _____

Site _____

Appendix G

Multigroup Ethnic Identity Measure—Revised (MEIM—R)

In this country, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Hispanic or Latino, Black or African American, Asian American, Chinese, Filipino, American Indian, Mexican American, Caucasian or White, Italian American, and many others. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be _____

Please **CIRCLE one number after each statement** to indicate how much you agree or disagree with each statement.

1. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs. *(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree*

2. I have a strong sense of belonging to my own ethnic group.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

3. I understand pretty well what my ethnic group membership means to me.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

4. I have often done things that will help me understand my ethnic background better.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

5. I have often talked to other people in order to learn more about my ethnic group.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

6. I feel a strong attachment towards my own ethnic group.

(4) Strongly agree (3) Agree (2) Disagree (1) Strongly disagree

7. My ethnicity is (circle):

(1) Asian or Asian American, including Chinese, Japanese, and others

(2) Black or African American

(3) Hispanic or Latino, including Mexican American, Central American, and others

(4) White, Caucasian, Anglo, European American; not Hispanic

(5) American Indian/Native American

(6) Mixed; Parents are from two different groups

(7) Other (write in): _____

8. My father's ethnicity is (use numbers above) _____

9. My mother's ethnicity is (use numbers above) _____

Appendix H

Provider and Client Participant Characteristics

Table 9

Client Characteristics

	Organization A		Organization B	
Characteristic	**N**	**%**	**N**	**%**
Client Participants	51	36.2	90	63.9
Gender				
Female	32	62.7	58	64.4
Male	14	27.4	31	34.4
No Response	5	9.8	1	1.1
Sexual Orientation				
Bisexual	3	5.9	3	3.3
Heterosexual	37	72.5	80	88.9
Homosexual	3	5.9	4	4.4
No Response	8	15.7	3	3.3
Race/Ethnicity (Demographic Form)				
Asian	0	0	2	2.2
Black	9	17.6	12	13.3
Hispanic/ Latino	7	13.7	13	14.4
White	25	49	60	66.6
Other	1	2	1	1.1
Multiracial	2	3.9	2	2.2
No Response	7	13.7	0	0
Educational Attainment				
Did Not Complete High School	8	15.7	14	15.6
High School Diploma	12	23.5	30	33.3
GED	9	17.6	4	4.4
Some College/Associate Degree	12	23.5	22	24.4
Bachelor's Degree	2	3.9	15	16.7
Graduate Degree	0	0	4	4.4
No Response	8	15.7	1	1.1
Number of Sessions with Provider				
More than 5	30	58.8	37	41.1
Less than 5	1	1.9	53	58.9
No Response or Unsure	20	39.2	0	0

Service(s) Sought*				
Behavioral Health	11	–	67	–
Counseling (Family)	3	–	0	–
Counseling (Individual)	13	–	27	–
Housing Services	5	–	0	–
Medical Services	9	–	6	–
Psychiatry Services	12	–	20	–
Substance Abuse Services	29	–	1	–
Support Group	13	–	3	–
Other Services	2	–	0	–
Multiple Services	24	–	24	
No Response	7	13.7	1	1.1
Diagnosis*				
Anxiety Disorder	1	–	20	–
Attention-Deficit/Hyperactivity Disorder	0	–	7	–
Bipolar Disorder	11	–	25	–
Borderline Personality Disorder	0	–	2	–
Depression	7	–	27	–
Health Diagnosis	2	–	0	–
Posttraumatic Stress Disorder	2	–	11	–
Schizoaffective Disorder	1	–	14	–
Schizophrenia	1	–	0	–
Sleep Disorder	0	–	3	–
Substance Abuse	2	–	1	–
Tourette's	0	–	1	–
Multiple Diagnoses	9	–	26	–
No Response	29	56.9	19	21.1

*Percentages not included because many clients reported multiple services and diagnoses.

Table 10

Provider Characteristics

	Organization A		Organization B	
Characteristic	**N**	**%**	**N**	**%**
Providers	16	47.1	18	52.9
Gender				
Female	7	43.8	13	72.2
Male	8	50	5	27.8
No Response	1	6.2	0	0
Sexual Orientation				
Bisexual	–	–	0	0
Heterosexual	–	–	17	94.4
Homosexual	–	–	1	5.6
No Response	16	100	0	0
Race/Ethnicity				
Asian	0	0	0	0
Black	0	0	2	11.1
Hispanic/ Latino	1	6.2	2	11.1
White	13	81.2	13	72.2
Other	0	0	0	0
Multiracial	0	0	1	5.6
No Response	2	12.5	0	0
Ethnic Identity (MEIM-R)*				
Asian	–	–	0	0
Black	–	–	2	11.1
Hispanic/Latino	–	–	2	11.1
White	–	–	11	61.1
Other	–	–	2	2.2
Multiracial	–	–	1	5.6
Diff. Ethnic Group than Race/Ethnicity (Demo. Form)	–	–	2	11.1
Ethnic Group of Parent(s) Diff. than Respondent	–	–	1	5.6
Degree Type				
AA/AS	0	0	0	0
BA/BS	4	25	1	5.6
MA/MS/M.Ed.	11	68.7	13	72.2
PhD/PsyD	0	0	3	16.7
MD	0	0	1	5.6
No Response	1	6.2	0	0

Licensure Type (Multiple selected per client)				
Clinical Social Worker (LCSW)	5	–	7	38.9
Chemical Dependency Counselor (LCDC)	3	–	0	0
Marriage and Family Therapist (LMFT)	1	–	0	0
Professional Counselor (LPC)	6	–	3	16.7
Medical	0	–	2	11.1
Psychologist	0	–	3	16.7
Psychology and Mental Health Nurse Practitioner	0	–	1	5.6
Qualified Mental Health Professional (QMHP)	1	–	0	0
No Response	1	–	2	11.1

*MEIM-R not administered in Organization A

Appendix I

CBMCS and CEPCCI-C Item Comparison

Comparison of CBMCS and CEPCCI-C items

CBMCS "Sensitivity to Consumers" Subscale Items	CEPCCI-C Items
My communication is appropriate for my clients	My counselor speaks in a way that I understand. My counselor uses the language I am most comfortable with.
I am aware of institutional barriers that affect the client	My counselor considers how discrimination might affect me (e.g. racial, ethnic, language, immigration status, sexuality, economic, political, etc.). My counselor is aware of the barriers (money, transportation, child care, language, schedule, etc.) I may have faced to participate in treatment here.
I am aware of how my own values might affect my client	My counselor doesn't impose his/her own values and beliefs on me. My counselor respects my values and beliefs.

Note. Adapted from "Clients Perceptions of Community Mental Health Providers Multicultural Counseling Competence," (Unpublished doctoral dissertation) by S. M. Ihorn, 2013, University of Texas, Austin.

Appendix J

HLM Equations

Level-1 (client-level) model: ClientCEPCCIij = β0j + eij

ClientCEPCCIij is the score for client i within provider j,

β0 is the average score for provider j,

eij is the difference between a given client's score and the average score for that client's provider.

Level-2 (provider-level) model: β0j = γ00 + u0j

γ00 is the overall average for providers,

u0j is the difference between a given provider's mean and the overall ratings mean.

Figure 1. Equations for the level-1 and level-2 in the unconditional model.

For all conditional models,

Level-1: ClientCEPCCIij = β0j + eij

For Predictor Variable, Provider CEPCCI,

Level-2: β0j = γ00 + γ01(meanProviderCEPCCI)j + u0j

β0j is the average score for provider j,

meanProviderCEPCCIj is the explanatory variable "average Provider CEPCCI",

γ00 is the predicted client score for providers with the average Provider CEPCCI,

γ01 represents the expected change in average Client CEPCCI as the average Provider CEPCCI score increases by one point.

Provider CBMCS,

Level-2: β0j = γ00 + γ01(meanProviderCBMCS)j + u0j

Provider CBMCS Sensitivity,

Level-2: β0j = γ00 + γ01(meanProviderCBMCS_Sensitivity)j + u0j

Provider Ethnic Identity Development,

Level-2: β0j = γ00 + γ01(meanProviderEthnicIdentity)j + u0j

Client Ethnic Identity Development,

Level-2: β0j = γ00 + γ01(meanClientEthnicIdentity)j + u0j

Match of Ethnic Majority or Minority status of Client and Provider,

Level-2: β0j = γ00 + γ01(meanEthnicMatch)j + u0j

Figure 2. Equations for conditional models for predictor variables.

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