IVERS, NATHANIEL N., Ph.D. Mortality Salience and Worldview Defense: The Effect of Death Awareness and Self-Esteem on Multicultural Counseling Competence. (2009) Directed by Dr. Jane E. Myers. 212 pp.

The purpose of this study, based on Terror Management Theory (TMT; Solomon et al., 1991) and Multicultural Counseling Competency literature, was to investigate a) how increased death awareness affects counselors' self evaluations of their MCCs, b) how self esteem moderates the effects of death reminders on counselors' self evaluations of their MCCs, and c) how demographic variables affect counselors' self evaluations of their MCCs following death reminders.

141 master's and doctoral level counseling students enrolled in a CACREP-accredited counseling program in the Southeast or Southwest regions of the United States were randomly assigned to either a death awareness group (experimental group) or a control group. Participants in the death awareness group experienced increased death awareness prior to completing the Multicultural Counseling Inventory (MCI; Sodowsky, 1994); and participants in the control group completed the MCI prior to experiencing increased death awareness.

A one-way ANOVA was run to test the difference between groups. Results revealed that participants in the death awareness group self rated their MCCs (including the MCI Overall scale and the MCI Knowledge, MCI Skills, and MCI Relationship subscales) lower than did the control group. No differences between groups were revealed on the MCI Awareness subscale.

A multiple regression using the general linear model was run to analyze the effects of conscious death fear on counseling students' perceived MCCs. Results

indicated that death concern did not affect counseling students' self perceived MCCs. Also a series of linear regressions were run to understand the moderating effect of self esteem, multicultural training, and other demographic variables on counseling students' perceived MCCs follow increased death awareness. Results revealed that self esteem and multicultural training did not moderate the effect of increased death awareness on counseling students' self perceived MCCs. In partial support of the research hypotheses, results also revealed that, aside from graduate level (master's and doctoral students), demographic variables did not have a moderating effect on increased death awareness.

This study is a first step in a research agenda aimed at understanding the effect of increased death awareness on counselors' competence in working with diverse clients. This study contributes to the MCC and TMT bodies of literature, particularly, the practical application of TMT, and to the training of multiculturally competent counselors. It is anticipated that, through this study and future studies, effective training strategies that reduce the negative effects of increased death awareness on counseling students' MCCs can be developed and implemented in counselor training programs. Of course, before that can be accomplished, more research is needed.

MORTALITY SALIENCE AND WORLDVIEW DEFENSE: THE EFFECT OF

DEATH AWARENESS AND SELF-ESTEEM ON MULTICULTURAL

COUNSELING COMPETENCE

by

Nathaniel N. Ivers

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Approved by

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APPROVAL PAGE

This dissertation has been approved by the following committee of the Faculty of

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CHAPTER I

INTRODUCTION

The authors of Terror Management Theory (TMT; Solomon, Greenberg, & Pyszczynski, 1991) conjecture that people have an inherent fear associated with death. "People avoid this fear by maintaining faith in a cultural worldview that provides an explanation for existence, a set of standards for what is valuable, and the promise for either literal or symbolic immortality to those who live up to these standards" (Pyszczynski, Greenberg & Solomon, 2000, p. 157). TMT also states that if cultural worldviews provide protection or comfort against death fear, then reminding people about death likely increases the need for their cultural worldview (Solomon et al., 1991). Death reminders increase what the authors of TMT refer to as "mortality salience," which other authors have described in terms such as death concern or death awareness (e.g., Dickstein, 1972). In other words, when people are reminded of the inevitability of their own death, they experience anxiety which causes them to become increasingly aligned with their culture. Along with stronger support of cultural worldviews, people who become conscious of their mortality also may become less sensitive to worldviews that are different from their own. In a study analyzing the effect of death reminders on people's worldview defense, Arndt, Greenberg, Pyszczynski, and Solomon (1997) reported that when participants received subtle reminders about their mortality, they

became more accepting of people who espoused their cultural values and less sensitive and accepting of those who did not subscribe to their cultural worldview.

Indeed, if the TMT postulate is correct that mortality salience makes people less sensitive to diversity, it appears quite possible that counselors also could be affected by unconscious, subtle reminders of their eventual death. Particularly, it seems possible that counselors' ability to empathize with, understand, and work with diverse clientele, which Sue and associates (1982, 1992, 1998) operationalized in terms of multicultural counseling competencies (MCCs), could be adversely affected. If that is the case, then it is important that counselors learn ways to reduce the negative effects of mortality salience. Furthermore, if it is found that increased awareness of death negatively affects counselors' multicultural counseling competence, it will be important for counselor educators to address death-related issues in the training of future counselors both to increase their self-awareness and to enhance their multicultural counseling competence.

In this chapter, a rationale for a study analyzing the effects of increased death awareness on counseling students' multicultural counseling competence (MCC) is presented. To carry out that rationale, first, a statement of the problem is presented. Second, the purpose of the study is described. Third, research questions and hypotheses are presented. Fourth, the significance of the study to the counseling profession is described. Fifth, definitions of terms are provided. Sixth, the organization of the study is given.

Statement of the Problem

In this section, a brief statement of the research problem is presented. First, multicultural counseling literature, including a description of Sue et al.'s (1982, 1992, 1998) Tripartite model and pertinent research supporting the model are described. Second, the basic theoretical tenets of Terror Management Theory (TMT) and empirical research supporting those main tenets are discussed. Three main tenets of TMT, worldview defense, mortality salience, and self esteem, are emphasized in this review, and relationships between these constructs and Sue's Tripartite model are explored.

Multicultural Counseling Competence

In 1982, Sue, Bernier, Durran, Feinberg, Pedersen, Smith, et al. (1982) wrote a seminal article calling for counselors to receive multicultural training to more effectively meet the counseling needs of an increasingly diverse United States. Specifically, they argued that traditional counseling approaches and training were insufficient and oftentimes ineffective at meeting the needs of diverse clients. Sue et al., and Sue, Arredondo, and McDavis (1992) also argued that, because the United States is becoming increasingly diverse, the need for multiculturally competent counselors is imperative.

To expedite the process of incorporating multicultural training into mental health training programs, Sue et al. (1982) developed a framework for understanding MCC called the Tripartite model of multicultural counseling competence. In the Tripartite model, Sue et al. described MCC as a combination of multicultural knowledge, beliefs and attitudes (self awareness), and skills. Sue et al. argued that multiculturally competent counselors possess appropriate knowledge about diverse cultures, espouse culturally

sensitive beliefs and attitudes, and possess a broad range of culturally adaptable interpersonal and counseling skills.

Since their seminal article on multicultural counseling competence, other MCC models have been developed, including Cross's (1988) Model of Cultural Competence, Bennett's (1993) Developmental Model, Campenha-Bacote's (1994) Culturally Competent Model of Health Care, Beckett and Colleagues' (1997) Multicultural Communication Process Model, Lopez's (1997) Process Model of Cultural Competence, Castro's (1998) Three-Factor Model, Toporek's (2001) Multicultural Counseling Competency Assessment and Planning Model, and Sue's Multidimensional Model for Developing Cultural Competence (2001). Also, the tripartite model has been further expanded (e.g., Sue et al., 1992, 1998). Although alternative MCC models have received some attention, Sue et al.'s (1982, 1992, 1998) Tripartite model is still considered the most influential and accepted MCC model (Mollen, Ridley, & Hill, 2002). Also, the Tripartite model has set itself apart from other MCC models in that many of its tenets have received empirical validation (see Worthington et al., 2007).

MCC Empirical Research

A vast amount of empirical studies have analyzed the fundamental tenets of Sue et al.'s (1982, 1992, 1998) Tripartite model. Ponterotto et al. (2000) reviewed the empirical literature associated with the Tripartite model, and organized it into two main categories, including studies associated with cultural responsiveness and counseling outcome data, and studies using MCC self-report instruments. In this section, empirical studies associated with the Tripartite model are organized in that fashion.

Cultural Responsiveness and Counseling Outcomes. One tenet of Sue et al.'s (1992) Tripartite model that has been empirically validated is its cluster of competencies associated with "counselors' ability to understand, acknowledge, and address culture and race-related issues in sessions" (p. 642). Atkinson and Lowe (1995) and Ponterotto et al. reviewed empirical studies analyzing counseling outcome data based on cultural responsiveness. Together they reviewed nine different studies (Atkinson, Casas, & Abreu, 1992; Gim, Atkinson, & Kim, 1991; Pomales, Claiborn, & LaFromboise, 1986; Poston, Craine, & Atkinson, 1991; Sodowsky, 1991; Sodowsky, 1996; Thompson & Jenal, 1994; Thompson, Worthington, & Atkinson, 1994; Wade & Bernstein, 1991), and determined that culturally responsive counselors were more efficacious in working with diverse clients than were culturally unresponsive counselors. Specifically, studies reviewed by Atkinson and Lowe, and Ponterotto et al. indicated that culturally responsive counselors were more engaging to diverse clients (Thompson & Jenal) and were perceived as more credible (Sodowsky, 1996). Culturally responsive counseling also cultivated greater client satisfaction with counseling, increased client self-disclosure, and greater client eagerness to return for further counseling sessions. Since Atkinson and Lowe's and Ponterotto et al.'s reviews, other studies have analyzed the effect of MCC on counseling outcomes (Constantine, 2001; 2002; Kim, Li, & Liang, 2002; Pope-Davis, Toporek, Ortega-Villalobos, Ligiero, Brittan-Powell, Liu et al., 2002; Worthington, Mobley, Franks, & Tan, 2000).

Pope-Davis et al. (2002) Worthington et al. (2007), and Kim et al. (2002) analyzed clients' perceptions of counselors who addressed cultural issues in session.

Pope-Davis et al. and Worthington et al. reported that counselors who addressed racial or cultural issues in session were perceived by clients as more multiculturally competent than were counselors who did not address cultural or racial issues. Kim et al.'s study also supported the importance of addressing cultural issues, but added the importance of incorporating multicultural knowledge into treatment planning. In particular, they reported that Asian American clients rated their counselor/client working alliance more favorably when their counselor responded to them in "culturally congruent" ways.

Constantine (2001; 2002) also analyzed cultural responsiveness and client perceptions of counselors' MCC. Based on Sue et al.'s (1992) postulate that counselors with more exposure to cultural diversity are more multiculturally competent, Constantine analyzed the effect of race/ethnicity and multicultural training on observer ratings of counselors' MCC. Constantine hypothesized that racial/ethnic minority counselors would be more multiculturally competent than White counselors because they had supposedly been exposed to more cultural diversity. As expected, racial/ethnic minority counseling students were perceived by clients and observers as more multiculturally competent than were their White counterparts. Also, Constantine reported that multicultural training positively contributed to observer ratings of MCC.

Although these studies have demonstrated support for Sue et al.'s (1982, 1992, 1998) Tripartite model, they also have methodological limitations. Except for Constantine's (2001; 2002) and Pope Davis et al.'s (2002) studies, the existing research studies are analogue designs with pseudo-clients. Also, all the studies mentioned above suffer from low external validity, because they utilized convenience sampling to procure

participants. More empirical studies with real clients and different methodological designs including qualitative designs are needed to further understand the relationship between MCC and counseling outcomes (Worthington et al., 2007). Another methodological design, using self-report instruments to measure counselors' MCCs, has garnered significant attention in the MCC literature. According to Ponterotto et al. (2000), the use of MCC self-report instruments has generated the majority of the MCC empirical studies, and the most relevant studies. Research using MCC self-report instruments is detailed below.

Research using MCC Self-Report Instruments. In their review, Ponterotto et al. (2000) organized research using MCC self-report instruments into three broad categories: Competencies as Related to Demographic and Training Variables, Competencies Related to Case Conceptualization Skills, and Competencies Related to Hypothesized, Linked Constructs. In terms of Competencies as Related to Demographic and Training Variables, a number of demographic variables have been analyzed in relation to counselors' self-perceived MCCs, including race/ethnicity (see Ponterotto et al., 2000), age and gender (Ottavi, Pope-Davis, & Dings, 1994), educational/clinical variables (Ottavi et al.), and sexual orientation (Fassinger & Richie, 1997). Concerning multicultural training, pretest-posttest studies have been designed to test Sue et al.'s (1992; 1998) hypothesis that personal and education/training experiences with diversity yield higher levels of MCC. All of these studies, according to Ponterotto et al. (2000), reported significant gains after a multicultural counseling course (D'Andrea, Daniels, & Heck, 1991; Neville, Heppner, Louie, Thompson, Brooks, & Baker, 1996; Ponterotto, Rieger, Barrett, Harris, Sparks,

Sanchez et al., 1996; Robinson & Bradley, 1997; Sodowsky, 1996; Sodowsky,, Taffe, Gutkin, & Wise, 1994). However, these studies did not include outcome measures such as the ability to integrate MCC knowledge into case conceptualization.

A handful of studies have analyzed the relationship between MCC self-report instruments and other outcome measures of MCC, including written case conceptualization skills (Constantine & Ladany, 2000; Ladany, Inman, Constantine, & Hofheinz, 1997) and trained observer ratings (Worthington et al., 2000). Along with revealing that social desirability was highly correlated with MCC self report measures, Constantine and Ladany, and Ladany et al. revealed discrepancies between MCC self-report instruments and counselors' written case conceptualization abilities. Worthington et al. also revealed discrepancies between counselors' self evaluations and other outcome measures. They reported differences between MCC self-report measure ratings and trained observers' ratings of counselors' MCCs. Other studies, as described below, have examined MCCs in relation to a variety of psychological variables.

A host of MCC studies using MCC self-report instruments have analyzed and revealed correlations between MCC and other hypothetical variables, including racial identity development (Constantine, 2002; Ladany, Brittan-Powell, & Pannu, 1997; Ladany et al., 1997; Neville et al., 1996; Ottavi et al., 1994), racism attitudes (Constantine), social inadequacy (Sodowsky et al., 1998), locus of control variables (Sodowsky et al.), social desirability (Sodowsky et al.), attitudes about racial diversity, racism, and discrimination (Ponterotto & Alexander, 1996; Ponterotto, Buckard, Riger, Grieger, D'Onofrio, Dubuisson et al., 1995), empathy (Constantine et al., 2001), and

emotional intelligence (Constantine et al.). Although results of these studies have supported the Tripartite model and have expanded the MCC knowledge base, they also suffer from some of the same research limitations as other MCC research, such as low external validity.

While the literature reviewed here reveals extensive research on MCC, many of the studies suffer from empirical methodological limitations such as low external validity (e.g., use of convenience sampling), clinical application concerns (e.g., use of analogue designs), confounding variables (e.g., social desirability), and discrepancies between self-report measures and other outcome measures (e.g., written case conceptualization skills, trained observer ratings). In addition, Dickson and Jepsen (2007) noted that the application of this research to enhance counselor training is scarce and still a concern. Although we know some of the factors that enhance counselors' MCCs, studies using the competencies reveal a broad range of multicultural counseling awareness, knowledge, and skills among both students and professional counselors. New methods, grounded in theories supported by empirical studies, are needed to inform counselor training. One theory that offers promise both for helping counselors better understand their cultural worldviews and for shaping those worldviews is Terror Management Theory (TMT; Solomon et al., 1991).

Terror Management Theory

The theoretical underpinnings of TMT come from the seminal work of cultural anthropologist, Ernest Becker (1971; 1973; 1975). Becker (1973) stated that human beings are different from other living organisms in that they are self reflective creatures,

capable of understanding the fact that they will eventually die. Becker conjectured that this awareness of inevitable death can cultivate intense and deleterious feelings of fear and anxiety in people. However, people rarely experience completely the fear of death because their cultural worldviews help protect them against it. Becker stated that cultural worldviews protect against death fear by providing a) answers to existential questions (e.g., Where do I come from? What is my purpose? Where am I going?), b) promises about literal or symbolic immortality, and c) social roles and scripts for appropriate behavior, "the satisfaction of which allows [people] to view themselves as "beings of enduring significance living in a meaningful reality" (Pyszczynski, Greenberg, & Solomon, 2003, p. 16).

Because cultural worldviews create a buffer against death anxiety, when people experience death reminders, they tend to align themselves more closely with their cultural worldview and distance themselves from diverse cultural worldviews (Becker, 1975). This distancing occurs, according to Becker, because people unconsciously perceive dissimilar cultural worldviews as a threat to their own cultural worldview and, therefore, a threat to their self worth and immortality. Common reactions to diverse cultural worldviews, according to Becker, include belittling differing beliefs and values, converting people to one's own cultural worldview, assimilating useful aspects of other cultural worldviews into one's own, and killing people to prove the correctness of one's worldview. Although his postulates have been very influential to a variety of different professional disciplines, Becker never tested his hypotheses empirically.

TMT, which was derived from the above mentioned theoretical propositions of Becker (1971; 1973; 1975), was developed by Solomon, Greenberg, and Pyszczynski (1991) primarily as a means of empirically validating Becker's main postulates. The term "terror" in TMT was derived from Becker's idea of death anxiety, or the potentially paralyzing fear that individuals may experience if they become fully aware of their eventual death. The term "management" in TMT refers to people's unconscious strivings to manage or cope with the terror associated with inevitable death. These strivings are managed through four key mechanisms: mortality salience, self esteem, cultural worldview, and worldview defense.

Mortality salience refers to increased death awareness, or the realization of the inevitability of death. Self esteem is defined as a "sense of personal value that is obtained by believing a) in the validity of one's cultural worldview and b) that one is living up to the standards that are part of that worldview" (Pyszczynski, Solomon, Greenberg, & Arndt, 2004, pp. 436-437). Cultural worldview is defined as a "stable conception of reality that gives meaning to the social environment" (Renkema, Stapel, Maringer, & van Yperen, 2008, p. 554). Worldview defense refers to people's reactions to reminders of death in which they align themselves more closely with their cultural worldviews and denigrate dissimilar cultural worldviews.

To empirically validate Becker's (1971; 1973; 1975) main postulates, TMT researchers proposed two fundamental research hypotheses (Pyszczynski et al., 2003). The first hypothesis had two parts. First, "to the extent that cultural worldviews function [to moderate the potentially deleterious fear associated with mortality salience],

reminders of death should make people especially in need of the protection that their beliefs about the nature of reality [or cultural worldview] provides them" (Pyszczynski et al., p. 45). Second, "in response to mortality salience, people should be especially prone to derogate those who violate important cultural precepts and to venerate those who uphold them" (p. 45). The second TMT hypothesis stated that "self esteem should serve an anxiety-buffering function" against death reminders (Pyszczynski et al. p. 39). Since the development of those initial hypotheses, a variety of studies have been completed that support TMT's fundamental tenets. Research supporting each hypothesis is described below.

TMT Empirical Studies

In this section, studies related to death awareness and worldview defense are described first (hypothesis 1). These studies underscore the relationship between increased death awareness and worldview defense. Next, studies associated with self esteem as a moderator against worldview defense are reviewed (hypothesis 2).

Death Awareness and Worldview Defense. A variety of studies have tested the TMT hypothesis that death awareness causes people to align themselves more strongly with their cultural worldview and denigrate dissimilar cultural worldviews. The first series of studies designed to analyze that proposition was completed by Rosenblatt, Greenberg, Solomon, Pyszczynski, and Lyon (1989). They completed six separate studies and found that, compared to participants who had not received death reminders, participants who had received death reminders allotted higher punishments to people whose behavior disobeyed culturally-derived moral standards of conduct. Participants

who received death reminders, compared with participants who did not, also gave a significantly higher reward to people who upheld their cultural values. Since Rosenblatt et al.'s study, other studies have demonstrated worldview defense following reminders of death.

Greenberg, Pyszczynski, Solomon, Rosenblatt, Veeder, Kirkland et al. (1990) furthered the work done by Rosenblatt et al. by analyzing participants reactions to in-group and out-group members—in this case, religiously similar and religiously different members. Christian participants who received death reminders rated fellow Christians more positively and Jewish people more negatively than did participants who did not receive death reminders. Also, regarding negative stereotypes, Christian participants who received death reminders espoused negative Jewish stereotypes more readily than did participants who did not receive death reminders. Greenberg et al. stated that findings of the study were consistent with the hypothesis that positive reactions to in-group members and negative reactions to out-group members occur when people experience reminders of their death.

Other studies also have lent support to TMT's hypothesis that death reminders lead to worldview defenses. In particular, Nelson, Moore, Olivetti, and Scott (1997) and Schimel, Simon, Greenberg, Pyszczynski, Solomon, Waxmonsky, et al. (1999) reported that, compared to participants who did not receive death reminders, participants who received death reminders were more likely to espouse prejudicial and stereotypic beliefs and attitudes toward culturally diverse individuals. Along with attitudinal reactions to death reminders, behavioral reactions to diversity after death reminders also have

occurred (Ochsmann & Mathy, 1994; McGregor, Lieberman, Greenberg, Solomon, Arndt, & Simon, 1998).

Ochsmann and Mathy (1994) stated that along with the effect of increased prejudicial and stereotypic beliefs and attitudes toward cultural diversity, death reminders also affect participants' behaviors toward culturally diverse people. Specifically, in a series of two studies, they reported that after receiving death reminders, participants were more likely to sit next to culturally similar individuals (ethnically and nationally similar) than culturally different (ethnically and nationally diverse) individuals. In some instances, aggressive responses also have occurred.

McGregor et al. (1998) analyzed aggressive reactions associated with death reminders. Participants' were either given a death reaction prompt or a control prompt, and then were asked to read a political statement that contradicted their political views. They were told that the statement was written by another participant. Participants then were asked to decide how much hot sauce to give to the participant who supposedly wrote the contradicting political statement. Participants who were given death reminders allocated significantly more hot sauce to participants who espoused political views that contradicted their own than did participants who were not given death reminders.

In the studies cited above, participants exhibited prejudicial, stereotypic, discriminatory, and aggressive reactions following death reminders toward people who espoused different cultural worldviews. They also exhibited more favorable reactions to culturally similar people. These studies also reported negative reactions following mortality salience for a broad range of cultural worldview differences, including

differences related to beliefs about appropriate moral conduct (Rosenblatt et al., 1989),

religious differences (Greenberg et al., 1990), national identity differences (Ochsmann &

Mathy, 1994), ethnic/racial differences (Ochsmann & Mathy, 1994), and political

differences (McGregor et al., 1998). TMT research also has highlighted factors that

moderate or buffer against the effects of death reminders. As described in TMT's second

hypothesis, high self esteem has been found to be a buffering agent against the negative

effects of death reminders (see Pyszczynski, Greenberg, Solomon, & Arndt, 2004 for a

complete review).

     Self Esteem as a Moderating Factor. A variety of studies have analyzed the effect

of self esteem on people's reactions to general anxiety and death anxiety specifically

(e.g., Greenberg, Solomon, Pyszczynski, Solomon, & McGregor, 1997; Harmon-Jones,

Simon, Greenberg, Pyszczynski, Solomon, & McGregor, 1997). Greenberg et al.

completed three separate studies to understand the effect of self esteem on anxiety. In all

three studies, participants who received self esteem boosts experienced significantly less

anxiety following threatening stimuli than did participants who did not receive a self

esteem boost. Along with buffering against general anxiety, self esteem has been shown

to buffer against the anxiety produced by mortality salience concerns.

     Harmon-Jones et al. (1997) completed two studies to analyze the effect of self

esteem on reactions to reminders of death. In the first study, participants who received

self esteem boosts and reminders of death were less likely than were participants who did

not receive self esteem boosts to demonstrate pro-U.S. bias in their evaluations of and

reactions to anti-U.S. and pro-U.S. essays. In the second study, Harmon-Jones et al.

measured self esteem using the Rosenberg Self Esteem Scale (Rosenberg, 1965).

Participants who had high self esteem were less defensive about their worldviews than

were participants who had moderate self esteem. Results of these studies reveal the

buffering qualities of bolstered and dispositional self esteem on participants' reactions to

death reminders.

These studies on self esteem have lent support to the TMT hypothesis that self

esteem provides protection against the negative reactions associated with death

reminders. The studies demonstrated that experimentally bolstered self esteem minimizes

anxiety associated with threatening events, and experimentally bolstered self esteem and

dispositional self esteem assuage negative reactions consistent with heightened

worldview defense.

In essence, TMT researchers have provided support for their hypothesis that

following death reminders, people are more likely to derogate those who threaten their

cultural worldviews and venerate those who uphold them. TMT researchers also have

provided support for the hypothesis that self esteem acts as a buffering agent against

negative reactions associated with death reminders.

While the TMT literature is replete with evidence that death reminders negatively

affect people's attitudes toward, beliefs about, and interactions with diversity, there are

no studies on the effect of death reminders on counselors' MCCs. Further, the effect of

self esteem on this relationship has not been examined. This appears to be an important

gap in both the TMT and MCC literature that needs to be filled because, if counselors are

susceptible to worldview defense after receiving innocuous reminders of death, and if

lower self esteem contributes to this outcome, counselors may experience negative worldview defenses such as prejudicial, stereotypic, judgmental, discriminatory, and aggressive reactions to diverse clients. Raising awareness of this process through counselor training may increase the level of multicultural competence among practicing counselors and ultimately improve counseling services to diverse clients.

Purpose of the Study

The purpose of this study was to fill the gap between the MCC literature and the TMT literature by investigating a) how increased death awareness affects counselors' self evaluations of their MCCs, b) how self esteem moderates the effects of death reminders on counselors self evaluations of their MCCs, and c) how demographic variables such as race/ethnicity, age, religious affiliation, sexual orientation, years of counseling training, and previous multicultural training affect counselors' self evaluations of their MCCs following death reminders. This study contributes to the MCC body of literature associated with hypothetical constructs that affect counselors' multicultural counseling competence. It also contributes to the literature pertaining to the training of multiculturally competent counselors. Finally, it expands the practical applications of TMT.

Research Questions

The main issue addressed in this study is the need to increase multicultural counseling competence among counselor trainees and professional counselors. As an initial step, the current study examined MCC among counselor trainees and attempted to

determine factors which can influence the development of MCC during counselor

training. To that end, the following research questions were addressed in this study:

1. What is the effect of increased death awareness on counseling students' perceived

   multicultural counseling competence?

2. Does self esteem moderate the effects of increased death awareness on counseling

   students' perceived multicultural counseling competence?

3. After controlling for the effects of self esteem, how do demographic variables,

   such as race/ethnicity, age, religious affiliation, sexual orientation, years of

   counseling training, and previous multicultural training predict counseling

   students' perceived MCCs following increased death awareness?

<div align="center">Significance of the Study</div>

The demographic makeup of the United States is becoming increasingly

multicultural and multilingual (Sue et al., 1992). In 2004, the U.S. population was

approximately 293.6 million, with 236 million Whites, 41.3 million Latinos/as, 37.5

million Blacks, 12.3 million Asians, and 2.8 million Native Americans and Alaskan

Natives. By the year 2050, ethnic minorities will represent approximately half the total

population of the United States (U.S. Census, 2004; Lum, 2007). With this exponential

increase in diversity in the United States, it is important that counselors recognize factors

that affect their knowledge about, beliefs and attitudes toward, and interactions with

diverse clients. It also is important that counselor educators develop more effective

strategies for training multiculturally competent counselors.

Many studies have shed light on factors that affect counselors' MCCs; however, no studies have examined MCCs in relation to TMT. Specifically, no studies have analyzed the effect of death reminders on counseling students' perceived MCCs, or the moderating effect of self esteem on counseling students' reactions to death reminders. This gap in the literature is significant because, based on previous TMT studies, death reminders cultivate reactions that are diametrically opposite of MCC postulates.

For example, in the Tripartite model, Sue et al. (1998) stated that multiculturally competent counselors are "comfortable with differences that exist between themselves and clients in race, ethnicity, culture, and beliefs" (p.38). They also stated that "[counselors] are able to contrast their own beliefs and attitudes with culturally different clients in a nonjudgmental fashion" (p. 39). Based on the TMT research, worldview defense is inversely related to multiculturally competent beliefs and attitudes, because after death reminders, participants exhibited prejudicial, judgmental, and stereotypic reactions to diversity.

Regarding multicultural skills, Sue et al. (1998) stated that counselors become actively involved with minority individuals . . ." and have the capacity to be culturally responsive to diverse clients (p. 40). However, TMT researchers have demonstrated that after death reminders, people are more likely to avoid interactions with culturally diverse individuals (Ochsmann & Mathy, 1994) and even may react aggressively toward people who hold contradicting cultural values and beliefs (McGregor et al., 1998).

Indeed, if counselors are found to exhibit worldview defenses following death reminders, then it is important that counselors and counselor educators learn ways to

reduce the negative effects of mortality salience. Furthermore, if counselors' self esteem is found to have a buffering effect on worldview defense following death reminders, helping counselors enhance their self esteem could be an important focus of multicultural counselor training. In essence, the results of this study have the potential to increase the MCC knowledge base, particularly in regard to cultural worldviews and worldview defense. Ultimately, results of this study have the potential to influence the multicultural training practices of counselor educators.

<div align="center">Definition of Terms</div>

Death Awareness refers to a conscious recognition of one's inevitable death.

Death concern is "conceptualized as conscious contemplation of the reality of death and negative evaluation of that reality" (Dickstein, 1972, 564).

Worldview is the way in which "people perceive their relationship to the world (nature, other people, institutions, and so on)" (Sue et al., 1998, p. 18).

Mortality Salience refers to reminders of death (Pyszczynski et al., 2003). It may be operationalized in terms of death concern (Dickstein, 1972) and death awareness. In this manuscript, "mortality salience," "death reminders," and "increased death awareness" are used interchangeably.

Multicultural Counseling is "any counseling relationship in which one or more of the participants differ with respect to cultural background, values, and lifestyles" (Sue et al., 1982, pp. 47).

Multicultural Counseling Competence is the combination of multicultural knowledge, awareness, and skills (Sue et al., 1992).

Self Esteem is a "sense of personal value that is obtained by believing a) in the validity of one's cultural worldview and b) that one is living up to the standards that are part of that worldview" (Pyszczynski et al., 2004, pp. 436-437).

Worldview Defense is a reaction to mortality salience in which people align themselves more strongly to their cultural beliefs and people who support their worldviews, and denigrate or belittle cultures and people who hold differing cultural worldviews (Harmon-Jones et al., 1997).

<p align="center">Organization of the Study</p>

This study is presented in five chapters. The first chapter provided a brief statement of the problem by presenting multicultural counseling literature, including a description of Sue et al.'s (1982, 1992, 1998) Tripartite model of MCC and pertinent research supporting the model, an introduction to the basic theoretical tenets of Terror Management Theory and empirical research supporting its main tenets., and pertinent gaps in the MCC and TMT literature. This overview was followed by descriptions about the purpose of the study, research questions, the significance of the study, and finally, the organization of the study.

The second chapter provides an extensive review of related literature. In the first section of the review, multicultural counseling competency definitions and models are described, and pertinent MCC studies are presented and critiqued. Also, strategies for assessing MCC are explored. In the second section, theoretical underpinnings of TMT are described, major constructs including mortality salience, self esteem, and worldview defense are examined, and pertinent literature supporting TMT is reviewed and analyzed.

In the third chapter, the methodology used in the study is described, including participants, sampling method, instruments, and data analyses. In the fourth chapter, results of the data analyses are presented. Finally, in chapter five, a discussion of the results of the study are provided, including implications for the training of counselors, limitations of the study, and recommendations for further research.

CHAPTER II

LITERATURE REVIEW

In chapter I, the rationale for a study of the relationship between Terror

Management Theory (TMT) and multicultural counseling competence (MCC) was

presented. In order to better understand the relationship between MCC and TMT—

specifically, the implications of increased death awareness on counselors' MCCs—a

review of pertinent literature on those topics is provided in this chapter. The review is

broken into two main sections: multicultural counseling competence and Terror

Management Theory. In the first section, MCCs are defined, the evolution of the

competencies is described, and the empirical research related to MCCs is analyzed. In the

second section, the fundamental tenets of TMT, including mortality salience and self

esteem are outlined, and research on TMT is analyzed and critiqued. The chapter

concludes with a summary of this literature and the need for further studies based on

identified gaps in the knowledge base.

Multicultural Counseling Competencies

In 1982, Sue, Bernier, Durran, Feinberg, Pedersen, Smith, et al. (1982) presented

a seminal article calling for counselors to receive multicultural training to more

effectively meet the counseling needs of an increasingly diverse United States. They

argued that traditional counseling approaches and training were insufficient and

oftentimes ineffective at meeting the needs of diverse clients, and that, because the

United States is becoming increasingly diverse, the need for multiculturally competent counselors is imperative. To expedite multicultural counseling training in the helping professions, Sue et al. proposed a definition and model of MCC, and they called for a greater focus on MCC empirical research.

Sue et al. (1982) stated that multiculturally competent counselors are those who have moved from cultural unawareness to cultural awareness and are sensitive to how their culture—specifically, their values, beliefs, and biases—affect their work with culturally diverse clients. They also stated that multiculturally competent counselors are aware of sociopolitical factors that affect minority clients, have knowledge and understanding of their diverse clients' cultural group, and are capable of utilizing a broad range of culturally appropriate nonverbal and verbal responses when working with diverse clients. Fundamentally, they defined MCC as the combination of multicultural knowledge, beliefs and attitudes, and skills. They also limited their definition of multicultural counseling to include only factors of race and ethnicity. Since their seminal article, other definitions and models of MCC have been proposed and expanded, and empirical studies supporting the basic tenets of MCC have been produced. In this section, MCC definitions, models, and research are described and critically analyzed.

Definitions of Multicultural Counseling Competence

Along with Sue et al.'s (1982) definition, wherein MCC was defined as multicultural knowledge, beliefs and attitudes, and skills, various other definitions of MCC have been proposed, many of which are very similar to Sue et al.'s definition (e.g., Holcomb-McCoy & Myers, 1999; Pope-Davis & Dings, 1995; S. Sue, 1998); however,

an agreed upon and consistent definition of MCC is still unavailable (Monk, Winslade, & Sinclair, 2008; Ponterotto & Casas, 1987; Pope-Davis, Reynolds, Dings, & Nielson, 1995; Ridley & Kleiner, 2003). In this section, definitions of MCC are presented and critiqued. First, because of their similarities to Sue et al.'s MCC definition, Holcomb-McCoy and Myers' (1999) definition, Pope-Davis and Dings' (1995) definition, and S. Sue's (1998) definition are discussed. Second, Constantine and Ladany's (2001) and D. W. Sue's expanded definitions are presented. Third, Sue, Arredondo, and McDavis' (1992) refinements of Sue et al.'s (1982) MCC definition is presented. Fourth, a critique of the MCC definitions is given.

Holcomb-McCoy and Myers' (1999) Definition

Holcomb-McCoy and Myers (1999) drew from the works of Abernethy (1995), Ponterotto and Casas (1987), and Sue et al. (1992) to define MCC. They stated that "multiculturally competent counselors are professionals who possess the necessary skills to work effectively with clients from various cultural/ethnic backgrounds" (p. 294). They also stated that multiculturally competent counselors are (a) aware of their "personal worldviews" and how they are products of "cultural conditioning," (b) have knowledge regarding the worldviews of their culturally diverse clients, and (c) have counseling skills necessary for working with diverse clients (p. 294). In essence, they defined MCC as an interconnection of knowledge about cultural diversity, recognition of culturally constructed beliefs and attitudes, and the possession of multicultural counseling skills.

Pope-Davis and Dings' (1995) Definition

Pope-Davis and Dings (1995) presented a similar definition as Holcomb-McCoy and Myers' definition, in that it also contained the combination of multicultural knowledge, awareness, and skills. They stated that multicultural counseling competence is based on three basic factors: "(a) understanding the different experiences of members of various cultural groups, (b) understanding the barriers to communication across cultures that exist as a result of these differences, and (c) possessing a specific set of abilities that can potentially make a counselor culturally skilled" (p. 288). Pope-Davis and Dings also differed from Sue et al. (1982) as they broadened the definition of multiculturalism to include not only race and ethnicity, but also regional and national origin, socioeconomic status, sexual orientation, gender, and language.

S. Sue's (1998) Definition

S. Sue (1998) also provided a definition of MCC that was similar to Holcomb-McCoy and Myers' (1999) and Pope-Davis and Dings' (1995) definitions. He stated that multiculturally competent counselors are those who recognize and appreciate diverse cultural groups and can efficaciously work with them. He also stated that counselors are multiculturally competent when they possess the necessary cultural knowledge and counseling skills to help diverse clients effectively.

Constantine and Ladany's (2001) Definition

Constantine and Ladany (2001) expanded the MCC definitions proposed by Sue et al. (1982), Holcomb-McCoy and Myers (1999), Pope-Davis and Dings (1995) and S. Sue (1998). In particular, they stated that MCC consisted of six dimensions: "(a)

counselor self-awareness, (b) general knowledge about multicultural issues, (c) multicultural counseling self-efficacy, (d) understanding of unique client variables, (e) an effective counseling working alliance, and (f) multicultural counseling skills" (p. 490). Constantine and Ladany reported that counselors degree of multicultural counseling competence depends on the "level at which the six dimensions are achieved" (p. 490). As can be seen, the combination of multicultural knowledge, awareness, and skills is included in Constantine and Ladany's definition; however, they included unique additions to the definition of MCC as well, including counseling self-efficacy, understanding of unique client variables, and an effective counseling working alliance.

Constantine and Ladany (2001) described multicultural counseling self-efficacy as counselors' confidence about their ability to perform multicultural counseling skills appropriately and effectively. They differentiated between self efficacy and self-perceptions, stating that self-efficacy was directly associated with beliefs about one's counseling behaviors (skills); whereas, self-perceptions described counselors' beliefs about their multicultural knowledge and awareness. Constantine and Ladany described the dimension of understanding of unique client variables as a counselor's ability to understand how multiple variables interact to influence a client. The variables that they cited were personal factors (e.g., "cultural group membership, background, socialization, personality traits, and values") and situational factors (e.g., "clients' presenting concerns, therapeutic expectations, motivation to change, and willingness to self-disclose"). Finally, Constantine and Ladany described the dimension of effective counseling working alliance as the "extent to which multicultural issues can be addressed within the

counseling dyad. They stated that counselors' and clients' ability to discuss issues related to multiculturalism illustrates the strength of the counseling working alliance.

D.W. Sue's (2001) Definition

Similar to Constantine and Ladany (2001), D. W. Sue (2001) expanded upon the fundamental definition of MCC as counselors' possession of multicultural knowledge, awareness, and skills. He also prefaced his definition with a caveat, stating that, because the term is continually evolving, he was unsure about whether a unified definition of MCC could be developed. Nonetheless, he offered a working definition of it as follows:

> Cultural competence is the ability to engage in actions or create conditions that maximize the optimal development of client and client systems. Multicultural counseling competence is defined as the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on the behalf of clients from diverse backgrounds), and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups (p. 802).

As other MCC theorists proposed, D. W. Sue stated that MCC is the acquisition of multicultural knowledge, awareness, and skills; however, he also reported that MCC includes an element of advocacy at the organizational and societal levels. Since 1982, even though many similar and expanded definitions of MCC have been proposed, the most widely accepted definition is still Sue et al.'s (1982; 1992) definition of MCC.

Sue et al.'s (1982, 1992) Definitions

As mentioned previously, Sue et al. (1982) described multicultural counseling competence as the possession of multicultural knowledge, skills, and beliefs and attitudes, and they limited their definition of multicultural counseling to include only

factors of race and ethnicity. In 1992, Sue et al. (1992) expanded the definition of MCC to include three broad areas that included (a) racial and cultural awareness of self and others, (b) understanding different cultural worldviews, beliefs, attitudes, and values, and how they inform case conceptualization and treatment planning, and (c) use of appropriate intervention strategies that are sensitive to cultural and contextual factors. Also, Sue et al. (1992) expanded the definition of multiculturalism from racial and ethnic differences to also include other aspects of diversity, including gender, sexual orientation, socioeconomic status, and physical disability. Sue et al.'s MCC definition also has undergone conceptual critiques. Many of the critiques also apply to other MCC definitions. In the following section, critiques of MCC definitions are presented.

Critique of the MCC Definitions

Aside from Sue et al.'s (1982; 1992) and D. W. Sue's (2001) MCC definitions, the definitions presented in this section have not received critical attention in the literature. In the following paragraphs, critiques of Sue et al.'s (1982; 1992) MCC definition are given, and a description of how those critiques apply to the other MCC definitions is presented.

Although widely accepted, many authors have found Sue et al.'s (1982; 1992) definition of MCC to be insufficient (Constantine & Ladany, 2000; Mollen, Ridley, & Hill, 2003; Ridley, 2008; Ridley & Kleiner, 2003). Constantine and Ladany stated that "counselors and counseling psychologists may wish to consider whether the current definition of *multicultural counseling competence* [knowledge, beliefs and attitudes, and skills] sufficiently captures its presumed meaning" (p. 162). Also, Ridley pointed out that

although Sue et al.'s characterization of multicultural competence is descriptive and aspirational it lacks instruction on how counselors can behave competently. Pope-Davis and Dings (1995) claimed that although Sue et al.'s definition was a step in the right direction, it lacks guidance about how counselors should be trained to become multiculturally competent. Specifically, they expressed that Sue et al.'s description of multicultural counseling competence does not adequately describe the particular counseling abilities that are necessary to be able to work effectively with diverse clients.

As mentioned earlier, many of the criticisms leveled by Ridley and Kleiner (2003) about Sue et al.'s definitions could apply also to the other MCC definitions. In particular, Ridley and Kleiner's critique that Sue et al.'s (1982, 1992) definitions are descriptive and not prescriptive appears to be applicable to the other definitions. To further demonstrate how Ridley and Kleiner's main points of criticism of Sue et al.'s definitions apply to other MCC definitions, D. W. Sue's (2001) definition is critiqued below.

Ridley and Kleiner stated that Sue et al.'s (1982, 1992) definitions were descriptive, yet did not provide prescriptive details about how counselor educators could assess competence. In particular, similar to Sue et al.'s definitions, D. W. Sue's (2001) definition leaves many similar questions unanswered (Monk, Winslade, & Sinclair, 2008) such as, what aspects of awareness, knowledge, and skills are needed to function effectively in a pluralistic society? What does it mean to "function effectively" in a pluralistic society? Other broad questions that remain to be answered using D. W. Sue's (2001) definition include "What is cultural competence? Does it entail only culture, race, and ethnicity, or is it more encompassing? Is it desirable for clinicians, clients, and/or

laypersons? Does it vary depending on to whom we are referring?" Is there a difference between competence and competencies? Is there a distinction between cultural competence and multicultural counseling competence?" (Ridley, Baker, & Hill, 2001, p. 823).

According to Ridley (2008), a consistent and unified definition of multicultural counseling competence is needed in order for the multicultural counseling field to continue to move forward. However, as mentioned above, a consistent and unified definition is still unavailable. Upon review and analysis of the existing definitions of MCC, Sue et al.'s (1992) MCC definition, although imperfect and not universally agreed upon, is the most widely accepted and utilized definition for multicultural counseling competence in the multicultural literature, and therefore, has been the foundation for multicultural counseling competency models (e.g., Sue et al., 1982; Sue et al., 1992; Sue et al., 1998; Sue, 2001), multicultural counseling competency assessment instruments, and empirical articles. Therefore, in this chapter, multicultural counseling competence is defined based on Sue et al.'s (1992) conceptualization of it, wherein multicultural counseling competence is described as the attainment of multicultural knowledge, awareness, and skills.

With a working definition of multicultural counseling competence given, multicultural counseling competency models are now discussed. As is the case with the definition of multicultural counseling competence, there are a wide range of multicultural counseling competency models that have been proposed. Each model is discussed in

detail. After describing the models, empirical research related to the multicultural

counseling competencies is reviewed and critiqued.

<p align="center">*Multicultural Counseling Competency Models*</p>

A variety of models have been proposed to explain multicultural counseling

competencies, including Bennett's (1993) Developmental Model, Campenha-Bacote's

(1994) Culturally Competent Model of Health Care, Beckett, Dungee-Anderson, Cox,

and Daly's (1997) Multicultural Communication Process Model, Lopez's (1997) Process

Model of Cultural Competence, Castro's (1998) Three-Factor Model, Cross's (1988)

Model of Cultural Competence, Toporek and Reza's (2001) Multicultural Counseling

Competency Assessment and Planning Model, Sue et al.'s (1982; 1992; 1998) tripartite

model, and Sue's (2001) Multidimensional Model for Developing Cultural Competence

(MDCC) (Mollen et al., 2003).

In a chapter in the *Handbook of Multicultural Competencies in Counseling and

Psychology*, Mollen et al. (2003) reviewed and evaluated existing models of multicultural

counseling competencies using predetermined criteria. They stated that clear and logical

criteria were not available for the process, so they established their own criteria based on

the following questions "What are the critical factors that we use to gauge models'

effectiveness? How do the models further stimulate the conversation among researchers,

scholars, and practitioners? How do these new models improve on existing models?" (p.

22). The criteria that they developed included the following (a) "*A model is characterized

by clarity and coherence*," (b) "*A model is descriptive as well as prescriptive*," (c) "*A

model makes a unique contribution*," (d) "*A model includes critical facets*," (e) "*A model*

can be validated," and (f) "*A model strikes a balance between simplicity and complexity*" (pp. 22-23). They also divided the multicultural counseling competency models into two groups—secondary models and major models. They distinguished major models from secondary models on the basis of the models' elaboration and influence on the profession. Mollen et al. categorized Sue et al.'s (1982; 1992) tripartite model of Multicultural Counseling Competencies and Sue's (2001) MDCC as major models. They categorized the remaining models as secondary models. In this section, for organization purposes, secondary models are reviewed and analyzed first based on Mollen et al.'s criteria, followed by a review and critique of major models, including Sue et al.'s (1982; 1992; 1998) tripartite model and Sue's (2001) MDCC.

Secondary models are discussed in chronological order. The models include Cross's (1988) Model of Cultural Competence, Bennett's (1993) Developmental Model, Campenha-Bacote's (1994) Culturally Competent Model of Health Care, Beckett and Colleagues' (1997) Multicultural Communication Process Model, Lopez's (1997) Process Model of Cultural Competence, Castro's (1998) Three-Factor Model, and Toporek and Reza's (2001) Multicultural Counseling Competency Assessment and Planning Model. After reviewing those models, a critique of the secondary models is presented. Mollen et al. (2003) did not critique the secondary models individually, because the models had similar strengths and limitations; therefore, in this section, secondary models also are critiqued together.

Cross's (1988) Model of Cultural Competence

Cross's (1988) Model of Cultural Competence was originally developed to conceptualize cultural competence within organizations. However, it also has been utilized to describe counselors' cultural competence. Cross described a six stage model of cultural competence. The stages include (a) cultural destructiveness, (b) cultural incapacity, (c) cultural blindness, (d) cultural precompetence, (e) basic cultural competency, and (f) advanced cultural competency. In the cultural destructiveness stage, organizations or individuals harbor beliefs about their cultural superiority over other cultures. In the cultural incapacity stage, segregation of cultural groups is believed in or promoted. In the cultural blindness stage, activities of individuals and organizations are ethnocentric to the point that only those affiliated with that culture, or those who have assimilated that culture's beliefs, behaviors, and values are able to benefit from services. In the cultural precompetence stage, organizations attempt to address diversity issues through promotion and hiring, and individuals begin to engage in sensitivity training. In the cultural competency stage, feedback from diverse communities is sought, and an attempt to understand how to provide effective services to diverse clients is explored. In the cultural competency stage, advocacy on behalf of diverse clients is pursued.

Bennett's (1993) Developmental Model

Bennett (1993) proposed a six-stage developmental model of multicultural counseling competence, wherein individuals move from ethnocentrism to ethnorelativism. Bennett described three stages of ethnocentrism (denial, defense, minimalization) and three stages of ethnorelativism (acceptance, adoption, and

integration). People in the denial stage do not accept or believe that there are cultural differences. People in the defense stage acknowledge that there are cultural differences, and defend against differences by evaluating those differences negatively. Furthermore, people in the defense stage often exhibit dualistic (us/them) thinking and frequently espouse negative stereotyping of others. People in the minimization stage also recognize differences, but tend to minimize them. People in the acceptance stage recognize differences and appreciate them. Bennett called the acceptance stage the beginning of cultural relativism and the point where people are able to evaluate differences based on contextual factors. People in the adoption stage, also termed the adaptation stage, not only accept and value cultural differences, but also develop new communication skills to be able to effectively communicate, understand, and relate to other cultures and cultural boundaries. People in the integration stage cultivate an identity that is not principally based on one specific culture. Furthermore, they are able to integrate multiple frames of reference or perspectives to evaluate contexts.

Campenha-Bacote's (1994) Culturally Competent Model of Health Care

Campenha-Bacote (1994) developed a culturally competent model of health care wherein cultural competence was defined as the ability for health care workers to give culturally appropriate assessments and interventions. The model consists of four components: cultural awareness, cultural knowledge, cultural skills, and cultural encounters. Campenha-Bacote described cultural awareness as health care workers' ability to become more sensitive to different cultural worldviews and behaviors. In particular, the author stated that the acquirement of cultural awareness begins with

professionals recognizing and examining their own prejudices and biases, and

understanding how their prejudices and biases affect their cross-cultural interactions.

Campenha-Bacote described cultural knowledge as health care professionals'

understanding of different cultures' belief systems regarding illness, as well as

information regarding their general worldviews. Campenha-Bacote described cultural

skills as the ability of professionals to conduct a cultural assessment without judging

them in stereotypical ways. Finally, Campenha-Bacote described cultural encounter as

professionals' ability to interact with diverse cultural groups.

Beckett and Colleagues' (1997) Multicultural Communication Process Model (MCCPM)

Beckett, Dungee-Anderson, Cox, and Daly (1997) developed a two-tiered model

called the Multicultural Communication Process Model (MCCPM). In the first tier,

practitioners utilize the model to facilitate personal growth in multicultural knowledge. In

the second tier, they use the model to work more effectively with diverse clients. Becket

et al. described eight nonlinear or non-sequential components to their model. They

include (a) know self, (b) acknowledge cultural differences, (c) know other cultures, (d)

identify and value differences, (e) identify and avoid stereotypes, (f) empathize with

persons from other cultures, (g) adapt rather than adopt, and (h) acquire recovery skills.

Lopez's (1997) Process Model of Cultural Competence

Lopez (1977) promoted a model of cultural competence that he said would be

applicable to both clinicians and supervisors. He described four domains whereby

counselors and supervisors could demonstrate cultural competence including

engagement, assessment, theory, and methods. In the engagement domain, counselors

gain clients' desire to engage in therapy by cultivating a positive working environment through the use of culture-specific styles of communication and treatment goals. In the assessment domain, counselors use formal and/or informal assessments to better understand clients' problems. In this process, counselors balance between mainstream norms of behavior and culture-specific norms to understand clients' problems. The theory model states that counselors and clients may possess different models or beliefs about the clients' problems, and counselors must be able to balance between their mainstream models and clients' models to understand and explain the presenting problem. The methods domain refers to counselors being able to provide culturally competent interventions. To better explain that point, Lopez stated three important aspects of culturally competent treatment. First, for the treatment to be culturally competent, it must be individualized. Second, it encompasses a wide variety of possible treatment interventions. Third, treatment interventions must fit clients' cultural belief system.

Castro's (1998) Three-Factor Model

Castro's (1998) Three-Factor Model consists of a six level continuum (from –3 to +3) of "capacity for cultural competence" with the positive levels constituting the Three-Factor Model. Castro stated that the model enables counselors to conduct more culturally appropriate assessments and treatments, and to improve their overall cultural competence. The levels include cultural destructiveness, wherein counselors feel a sense of cultural superiority toward their culturally diverse clients (–3), an emphasis on separate but equal treatment of clients (–2), an emphasis on the similarities among cultural groups and equal treatment of culturally diverse clients (–1), an emphasis on understanding and

appreciating sociocultural factors affecting the client (+1), an ability to understand and integrate a variety of cultural and therapeutic variables that affect clients in order to develop an effective treatment intervention (+2), and cultural proficiency, in which counselors are committed to lifelong learning and effectiveness in designing and implementing culturally appropriate treatment plans and interventions.

Toporek's (2001) Multicultural Counseling Competency Assessment and Planning Model

Toporek (2001) developed a model called the multicultural counseling competency assessment and planning model (MCCAP). This model incorporates the basic structure of Sue et al.'s (1992) multicultural counseling competence model (described in detail later) in which multicultural counseling competencies are categorized into three areas: awareness of one's assumptions and beliefs, knowledge of clients' worldview, and development of culturally appropriate interventions. Toporek expanded Sue et al.'s model, stating that multicultural counseling competence is more complex than Sue et al.'s model illustrates. Toporek added three dimensions to the model, contexts, modes of change, and process for assessment and planning, with each dimension containing three items. The three contexts include personal, professional, and institutional contexts. The three modes of change include cognitive, affective, and behavioral modes of change. The three areas of assessment and planning include assessment, needs, and goals.

With regard to the contexts, the *personal context* refers to counselors' ability to incorporate multicultural knowledge, awareness, and skills into their personal lives. Toporek purported that when counselors are not able to be multiculturally competent in

their personal lives, they may become less able to be multiculturally competent in their professional or counseling roles. The *professional context* refers to counselors' formal role in the profession. The *institutional context* refers to counselors' membership in a particular organization. Toporek said that "implications of being multiculturally competent are different when one is in a position of power institutionally (e.g., administrative position)" (p. 20), and when in certain positions, advocacy and policy making should be done in a way that does not adversely affect people of color.

The modes of change refer to how multiculturally competent counselors are trained. Toporek purported that the majority of multicultural counseling focuses on cognitive change (gaining knowledge and different perceptions), and ignores the importance of affective change (changing feelings or emotions related to multicultural issues) and behavioral change (changing actions and reactions). In her model, Toporek said that each mode of change should be addressed in order for multicultural counseling competence to be attained. With regard to assessment and planning, the reason for *assessment* is to gain a thorough evaluation of counselors' multicultural competence. The *needs* refer to the aspects of multicultural competence that are in need of developing further, and *goals* are used to formulate a strategic plan to help counselors improve their multicultural competence.

Critique of the Secondary MCC Models

Using their predetermined criteria for reviewing and critiquing multicultural counseling competency models, Mollen et al. (2003) stated that the secondary models have added to the conversation about the importance of multicultural counseling

competence by extending the multicultural counseling competence conversation to other professions (e.g., health care, social work) and to specific populations (e.g., African Americans). They also stated that the secondary models varied in complexity from very complex to overly simplistic. Mollen et al. described Toporek's (2001) model as very detailed and intricate, and Bennett's (1993) model as overly simplistic regarding the construct of multicultural competence. Regarding directedness, Mollen et al. stated that the majority of the secondary models are direct in that they state actions that need to be exhibited (e.g., advocacy, avoiding stereotypes); however, for the most part, "they do not provide concrete guidance in how to achieve these ends" (p. 33). According to Mollen et al., Lopez's (1997) model is more direct than the other models, in that it provides case vignettes that help readers understand how his model can be applied in practice. However, Mollen et al. stated that Lopez's description of the four domains of multicultural counseling competence is descriptive, but not prescriptive, which affects researchers' ability to understand which behaviors, according to his model, describe multicultural competence. Possibly most significant, Mollen et al. stated that the secondary models have not been subjected to empirical validation studies which, they argued, impedes their ability to verify accurately the models' effectiveness in explaining multicultural counseling competence. As is described in the review of Sue et al.'s (1982; 1992; 1998) tripartite Model, empirical validation is one of the main factors that differentiates the tripartite model and the secondary models.

Mollen et al. (2003) also reviewed and critiqued "major models" of multicultural counseling competence according to the same criteria they used to critique the secondary

models. In this section, Sue et al.'s (1982; 1992; 1998) Tripartite Model of Multicultural Counseling Competencies and Sue's (2001) expansion of the tripartite model called the Multidimensional Model of Developing Cultural Competence are described, supporting research is explored, and limitations are examined.

Sue et al.'s (1982; 1992; 1998) Tripartite Model

Sue et al. (1982) first presented their tripartite model in a seminal article on multicultural counseling competencies which was published in *The Counseling Psychologist*. They described the impetus for this model in terms of three main goals: (a) to challenge common "myths and misunderstandings" around multicultural counseling; (b) to initiate the task of defining the term "cross-cultural counseling;" and (c) to establish and recommend the adoption of specific competencies for cross-cultural counseling by the American Psychological Association as guidelines for accreditation criteria. The cross-cultural counseling competencies outlined by Sue et al., with some revisions and additions (Sue et al., 1992; Sue et al., 1998), has become the most widely utilized model for understanding and measuring counselors' efficaciousness in working with diverse clients (Worthington, Soth-McNett, & Moreno, 2007; Mollen et al., 2003; Ridley & Kleiner, 2003). Furthermore, Sue et al.'s tripartite model has been embraced by six separate divisions of the American Counseling Association (ACA) and two divisions of the American Psychological Association (APA). In this section, components of the model are described; the definition and refinement of the model is discussed; research using the model is described and critiqued; and the relationship between multicultural counseling competence and Terror Management Theory is discussed.

Components of the Tripartite Model. Sue et al. (1982) stated that "cross-cultural counseling competencies" were sorely needed in the "human services professions" because traditional counseling has "failed to meet the particular mental health needs of ethnic minorities" (p. 48). They also stated that the majority of graduate programs did not give enough attention to the unique mental health issues of diverse clients. They stated that this inattention on the part of graduate programs has resulted in counselors lacking awareness and understanding about the cultural values and beliefs of minority cultures and how they experience life in an "oppressive society." Sue et al. purported that one of the most important ways in which counselors can be trained to be more culturally competent is through the creation and adoption of a multicultural counseling competence model that could be utilized to identify and assess counselors' competencies. Therefore, they proposed their tripartite model, which is called such because of its "tripartite" framework of knowledge, beliefs and attitudes, and skills.

Sue et al. (1982) defined cross-cultural counseling as "any counseling relationship in which one or more of the participants differ with respect to cultural background, values, and lifestyles" (p. 47). Sue et al. stated that the majority of the time, cross cultural counseling occurs with a White counselor and a minority client. However, Sue et al. also considered cross-cultural counseling to include situations in which the counseling relationship consists of individuals who are affiliated with different minority cultures or where the person affiliated with a minority group is the counselor and the person affiliated with the majority group is the client. They also stated that cross cultural counseling is not necessarily limited to race, but also related to differences related to sex,

sexual orientation, socioeconomic factors, religious orientation, and age. However, as mentioned above, in their actual tripartite model Sue et al. (1982) restricted multicultural counseling competence to include only racial and ethnic factors.

In describing and defining multicultural counseling competence, a number of terms were used by Sue et al. (1982) but were not defined. These terms were later defined by Sue et al. (1998). They include *multiculturalism*, *culture*, *race, ethnicity, diversity, minority*, *majority, multicultural counseling/therapy*, and *worldview*. Sue et al. (1998) stated that multiculturalism was continually evolving, but provided a working definition of it that included 10 major characteristics. They stated that multiculturalism

1. cultivates the valuing of cultural pluralism, diversity, and tolerance, and the push to overcome ethnocentrism;

2. promotes social justice "(an activist orientation and a commitment to change social conditions that deny equal access and opportunities)" cultural democracy, and equity (p. 6);

3. supports the acquirement of attitudes, knowledge, and skills necessary to "function in a pluralistic democratic society and to interact, negotiate, and communicate with people of diverse backgrounds" (p. 5);

4. refers to more than solely race, class, gender, and ethnicity, but also includes "diversity in religion, national origin, sexual orientation, ability and disability, age, geographic origin, and so forth" (p. 5);

5. cultivates the celebration of achievements and contributions of diverse cultures, a desire to understand both the positive and negative aspects of cultural groups, and

an active involvement in understanding the history, conditions, and social realties of diverse cultural groups;

6. challenges individuals to "study multiple cultures, to develop multiple perspectives," and to teach others how to "integrate broad and conflicting bodies of information to arrive at sound judgments" (p. 5);

7. cultivates respect for other perspectives, engagement in social justice practices, and an investigation and understanding of power differences, privilege, and the distribution of resources, along with rights and responsibilities;

8. produces a commitment to "'change' at the individual, organizational, and societal levels,'" and encourages people to promote new practices, theories, policies, and organizational structures that are more "responsive" to all groups (p. 6);

9. promotes ownership of "painful realities about oneself, [one's] group, and [one's] society," that may create feelings of discomfort and tension (p. 6);

10. includes the goal of achieving "positive individual, community, and societal outcomes because it values inclusion, cooperation, and movement toward mutually shared goals" (p. 6).

Sue et al. (1998) also defined terms associated with multiculturalism, including *culture*, *race*, *ethnicity*, *diversity*, *minority*, *majority*, and *multicultural counseling/therapy*. They provided two definitions of culture including Cross, Bazron, Dennis, and Isaacs' (1989) definition, wherein culture is defined as "an integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs,

values, and institutions of a racial, ethnic, religious, or social group" (p. iv); and Linton's (1945) definition wherein culture is defined as "the configuration of learned behavior and results of behavior whose components and elements are shared and transmitted by members of a particular society" (p. 7). Sue et al. purported that Linton's definition was possibly the most succinct. They also elaborated on that definition by differentiating between culture and race or ethnicity, and stated that every society that "shares and transmits behaviors to its members possesses a culture" (p. 7).

Sue et al. (1998) described a variety of definitions that have been proposed for *race*, including biological and social definitions. Regarding biological definitions, Sue et al. referenced a definition of race based on a biological/hereditary classification, in which race is broken down into three main groups: Caucasoid, Mongoloid, and Negroid. They also referenced Krogman (1945) who defined race as "a subgroup of peoples possessing a definite combination of physical characteristics of genetic origin, the combination of which to varying degrees distinguishes the subgroup from other subgroups of mankind" (p. 49). Sue et al. pointed out a variety of problems with biological definitions of race, including the fact that there are more within group differences than between group differences. They also stated that because of migrations, invasions, and exploration, a "common gene pool" has not existed for a very long time, making it unlikely for people to be biologically or genetically associated with a definitive racial group.

With regard to social definitions, Sue et al. (1998) referenced Feagin (1989) who stated that "external societal definitions of race have often resulted in ideological racism, which links physical characteristics of groups (usually skin color) to major psychological

traits" (p. 9). They described two seemingly contradictory societal definitions of race—the "one drop rule," which labeled people who had even one drop of Black blood as Black, and a U.S. government regulation that excludes people from being Native American unless 25% of their blood is Native American—as examples of how societal definitions of race are relative and often used politically to oppress or exclude. While recognizing the problems associated with definitions of race, Sue et al. acknowledged the importance of racial identities, "in which groups define themselves racially by certain physical features" and the social meanings and beliefs those identifications create (p. 9). Rather than propose or adopt a specific definition of race, Sue et al. referred to five basic groupings to describe racial distinctions in the United States: African Americans, Asian Americans/Pacific Islanders, Latino-Hispanic Americans, Native Americans, and White Americans.

Sue et al. (1998) stated that *diversity* "speaks to the presence or absence of numerical symmetry" of differences within society (p. 10). They stated that diversity includes differences in race, ethnicity, sexual orientation, gender, age, religion, physical disability, and so forth. They also said that diversity was different than multiculturalism, in that diversity refers to a numerical value and multiculturalism refers to equity within contexts. To expound on the difference between diversity and multiculturalism, Sue et al. said that there could be a racially diverse workforce (many different races working at an institution), but it might not be multicultural because upper management is filled with only one racial group.

Sue et al. (1998) also provided definitions of *minority* and *majority*. They used a

definition of *minority* proposed by Wirth (1945) who defined it as " a group of people

who, because of physical or cultural characteristics, are singled out from the others in

society in which they live for differential and unequal treatment, and who therefore

regard themselves as objects of collective discrimination" (p. 347). They defined *majority*

as "the group that (a) holds the balance of economic, social, and political power; (b)

controls the gateways to power and privilege; and (c) determines which groups will be

allowed access to the benefits, privileges, and opportunities of the society" (p. 12).

With multiculturalism and its accompanying terms defined, Sue et al. (1998)

defined multicultural counseling/therapy (MCT), which is similar to and an extension of

Sue et al. (1982) definition of cross-cultural counseling. Sue et al. (1998) stated that the

term "cross-cultural counseling" had become "progressively less popular" and was

therefore replaced by the term multicultural counseling/therapy. However, they did not

state how or why the term "cross-cultural counseling" became less popular than the term

multicultural counseling/therapy. Sue et al. (1998) defined MCT "'as a metatheoretical

approach that (a) recognizes that all modes and theories of helping arise from a particular

cultural context; (b) refers specifically to a helping relationship in which two or more of

the participants are of different cultural backgrounds; (c) includes any counseling

combination that fulfills the definition of 'culture;' (d) recognizes the use of both

Western and non-Western approaches to helping; and (e) is characterized by the helping

professional's culturally appropriate awareness, knowledge, and skills'" (p. 13).

Sue et al. (1982) also referred to people's worldviews when describing cross-cultural competencies, but did not provide a definition of *worldview*. Sue et al. (1998) defined *worldview* as the way in which "people perceive their relationship to the world (nature, other people, institutions, and so on) (p. 18). They also described other multicultural researchers' definitions of worldviews (e.g., Sue, 1977, 1978; Ivey, Ivey, & Simek-Morgan, 1993). Sue (1977, 1978) stated that *worldviews* are highly correlated with people's cultural upbringing, sociopolitical history, and their life experiences. Ivey et al. stated that *worldviews* represent people's philosophy of life and how they believe the world works.

Description of the Tripartite Model. The model proposed by Sue et al. (1982) describes multicultural counseling competencies associated with the four main diversity groups in the United States: African Americans, Asian Americans, Latinos/Latinas/Hispanics, and Native American/Alaskan Natives. The model also includes three basic categories: multicultural knowledge, beliefs/attitudes, and skills which, in sum, are comprised of 11 multicultural counseling competencies, including four aspects of multicultural counseling knowledge, four multicultural counseling beliefs/attitudes, and three multicultural counseling skills. The following is a detailed description of each competency, organized by the MCC categories (Knowledge, Beliefs/Attitudes, and Skills) in which each competency falls.

As mentioned above, with regard to Knowledge, Sue et al. (1982) described four aspects of multicultural knowledge counselors should possess. First, they stated that "the culturally skilled [counselor] will have a good understanding of the sociopolitical

system's operation in the United States with respect to its treatment of minorities" (p. 49). Specifically, Sue et al. explained this knowledge as the ability of counselors to understand the oppressive elements present in the mental health field and recognize how "cultural racism" affects the identity and worldview development of ethnic minorities (p. 50).

Second, Sue et al. stated that the "culturally skilled [counselor] must possess specific knowledge and information about the particular group he/she is working with" (p. 49). They explained that counselors who have an in-depth knowledge of the cultural beliefs, practices, and worldviews of their clients can be more effective helpers than those counselors who do not possess that knowledge (Sue et al.).

Third, Sue et al. (1982) stated that the "culturally skilled [counselor] must have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy" (p. 49). They said that this "clear and explicit knowledge and understanding" included "language factors, culture-bound values, and class-bound values" (p. 50). They also stated that it included a counselor's clear understanding of value assumptions inherent in particular counseling theories and how they interact and work with the values and beliefs of diverse clients.

Fourth, Sue et al. (1982) said that multiculturally knowledgeable counselors are "aware of institutional barriers which prevent minorities from using mental health services" (p. 49). They elaborated on that point by describing barriers to mental health services for minorities, including the locations of mental health agencies, the decor (formal or informal) of the mental health facilities, advertising issues (e.g., languages

used), the presence (or lack thereof) of minority helping professionals, hours of operation, the organizational climate of the mental health agency, the services rendered by mental health agencies, and the beliefs and attitudes of mental health professionals.

Sue et al. (1982) also described four Beliefs/Attitudes that multiculturally competent counselors should possess. First, they stated that the "culturally skilled [counselor] is one who has moved from being culturally unaware to being aware and sensitive to his/her own cultural heritage and to valuing and respecting differences" (p. 49). To expound on and further explicate that characteristic, Sue et al. stated that multiculturally competent counselors have shifted from ethnocentric attitudes to respecting cultural differences and viewing them "as equally valuable and legitimate as their own" (p. 50). Additionally, they stated that culturally aware counselors are less likely to impose their values onto culturally diverse clients.

Second, Sue et al. (1982) stated that a "culturally skilled [counselor] is aware of his/her own values and biases and how they may affect minority clients" (p. 49). They said that multiculturally competent counselors are aware of and attempt to avoid biases, prejudices, and inappropriate labeling and stereotyping. They also expressed that multiculturally competent counselors monitor their work with diverse clients through education, consultation, and supervision.

Third, Sue et al. (1982) stated that a "culturally skilled [counselor] is one who is comfortable with differences that exist between the counselor and client in terms of race and beliefs" (p. 49). They expounded on that stating that rather than being "color blind,"

multiculturally competent counselors recognize that regardless of differences, individuals are equally human, and therefore, important.

Fourth, Sue et al. (1982) stated that the "culturally skilled [counselor] is sensitive to circumstances (personal biases, stage of ethnic identity, sociopolitical influences, etc.) which may dictate referral of the minority client to a member of his/her own race/culture" (p. 49). Specifically, they said that multiculturally competent counselors recognize their limitations to providing appropriate counseling services to diverse clients and are not afraid to refer them to another, more competent counselor in that area of cultural expertise.

Lastly, Sue et al. (1982) described three multicultural skills that counselors should possess in order to effectively work with diverse clients. First, they stated that "culturally skilled [counselors] must be able to generate a wide variety of verbal and nonverbal responses" (p. 49). Specifically, they suggested that counselors working with diverse clients should expand their repertoire of counseling responses, because minority clients may respond differently to traditional counseling approaches.

Second, Sue et al. (1982) stated that the "'culturally skilled [counselor] must be able to send and receive both verbal and non-verbal messages accurately and 'appropriately'" (p. 49). To expound on that, Sue et al. stated that being able to "receive," or in other words, accurately understand diverse clients' verbal and nonverbal messages is extremely important. They also stated that being able to communicate to diverse clients using their preferred or prized communication styles can be helpful in counseling. As they pointed out, some cultures prize subtleness and indirectness; whereas, others prize

the opposite—directness and confrontation. Hence, counselors who are able to recognize

different preferences in communication styles and have the skills to utilize those

preferred styles, are more likely to be effective counselors to their culturally diverse

clients.

Third, Sue et al. (1982) stated that the "culturally skilled [counselor] is able to

exercise institutional intervention skills on behalf of his/her client when appropriate" (p.

49). In essence, Sue et al. described this multicultural skill as an ability for counselors to

understand their minority clients' problems systemically, and to discard or expand their

traditional counseling role to include roles such as "consultant, change agent,

ombudsman, and outreach coordinator" (p. 51).

Although Sue et al.'s (1982) has been the most accepted and most utilized MCC

model, it also has undergone a number of refinements. In the following paragraphs

refinements of the tripartite model are described, including Sue et al.'s (1992; 1998)

refinements, and Sue's (2001) refinement.

Refinement of the Tripartite Model. Ten years after Sue et al.'s (1982) seminal

article on multicultural counseling competencies was published, Sue et al. (1992) wrote

an article that was published conjointly in the *Journal of Counseling and Development*

and the *Journal of Multicultural Counseling and Development* challenging the American

Association for Counseling and Development (currently the American Counseling

Association) and the counseling profession in general to adopt specific multicultural

counseling competencies in their accreditation criteria. They also expanded the 1982

model from 11 competencies to 31 competencies, while keeping the basic tripartite

framework of Knowledge, Beliefs and Attitudes, and Skills, to include an overarching

emphasis on counselor awareness. They described the model as a 3 (Categories) X 3

(Dimensions) matrix of MCCs. The categories included (a) "counselor awareness of own

assumptions, values, and biases;" (b) "understanding the worldview of the culturally

different client;" and (c) "developing appropriate intervention strategies and techniques"

(p. 481). These characteristics each included three dimensions, or the original tripartite

framework of (a) beliefs and attitudes, (b) knowledge, and (c) skills.

Four years after Sue et al.'s (1992) expansion of the multicultural counseling

competencies, Arredondo, Toporek, Brown, Jones, Locke, Sanchez et al. (1996), by the

direction of the then President (1994-1995) of the Association for Multicultural

Counseling and Development (AMCD), Marlene Rutherford-Rhodes, published an article

in the *Journal of Multicultural Counseling and Development* in which they

operationalized the 31 competencies. Under each of the 31 competencies, explanatory

statements describing specific behaviors and objectives that counselors should meet in

order to be considered multiculturally competent were provided.

Six years after the 1992 expansion of the model, Sue et al. (1998) expanded the

tripartite model again from 31 competencies to 34 competencies. The three additions

were all under Dimension 3, "developing appropriate intervention strategies and

techniques." The first addition was added to the Knowledge category, which stated that

"[t]he 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" (p. 41). The other two additional competencies

were added to the Skills category. They stated that "[t]he 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" and that "[c]ulturally 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, advisor, teacher, facilitator of indigenous healing, and so on may prove more culturally appropriate" (p. 42). Since 1998, the tripartite model has been further expanded by Sue (2001). Sue described the model as the multidimensional model, and Mollen et al. (2003) categorized it as a "major model" of MCC. In the following paragraphs, Sue's (2001) Multidimensional Model for Developing Cultural Competence (MDCC) is described.

Sue's (2001) Multidimensional Model for Developing Cultural Competence

Three years after Sue et al.'s (1998) additions to the tripartite model, Sue (2001) again expanded on the model and called it the Multidimensional Model for Developing Cultural Competence (MDCC). Sue developed the MDCC as a response to what he described as barriers to the adoption of multicultural competence guidelines in the helping professions. He listed these barriers as (a) "beliefs in the universality of psychological laws and theories," (b) beliefs in "the invisibility of monoculturalism," (c) "differences over defining cultural competence," and (d) "the lack of a conceptual framework for organizing its multifaceted dimensions" (pp. 790-791). Compared with tripartite model, the MDCC includes a greater focus on social justice. Sue (2001) did not

specifically define social justice; however, Sue et al. (1998) defined it as an activist

orientation and a commitment to change social conditions that deny equal access and

opportunities," "cultural democracy," and equity (p. 6).

In the MDCC model, Sue (2001) also expanded the tripartite model from the 3

(Characteristics) X 3 (Dimensions) matrix to a 3 (Awareness, Knowledge, Skills) X 4

(Individual, Professional, Organizational, and Societal) X 5 (African American, Asian

American, Latino/Hispanic American, Native American, and European American)

design. The 3 X 4 X 5 includes three primary dimensions: (a) specific racial/group

perspectives, (b) components of cultural competence, and (c) foci of cultural competence.

Using the model, Sue defined cultural competence as the "multifactorial combination and

intersection of these three dimensions" (Mollen et al., 2003, p. 26). Now that the basic

tenets of Sue et al.'s (1982; 1992; 1998) tripartite model and Sue's (2001) MDCC have

been described. A critique of the tripartite model and the MDCC are presented.

Critique of Sue et al.'s (1982; 1992; 1998) Tripartite Model

Mollen et al. (2003) reviewed and critiqued Sue et al.'s tripartite model based on

their criteria, which included the following: (a) characterized by clarity and coherence,

(b) descriptive as well as prescriptive, (c) makes a unique contribution, (d) includes

critical facets, (e) strikes a balance between simplicity and complexity, (f) able to validate

via quantitative and/or qualitative research. They also reviewed and critiqued Sue's

(2001) MDCC. The same basic critiques that Mollen et al. leveled against the tripartite

model apply to the MDCC, except for the comments associated with the empirical

validation criterion. For that criterion, Mollen et al. stated that because of its relative

newness to the counseling field, the MDCC has not been subjected to empirical scrutiny. Hence, it faces the same limitation as the secondary models, in that it is difficult to adequately critique and validate without empirical research. In the following paragraphs, Mollen et al.'s critique of the tripartite model is discussed using their aforementioned criteria for evaluating models.

Concerning clarity and comprehensibility, Mollen et al. said, although the model is sound in its rationale and development, it is not always clear and comprehensible in regard to its definitions and clarifications of terms. Specifically, Mollen et al. stated that "words and phrases such as *culturally skilled*, *culturally competent*, and *cultural competency* are used interchangeably" (p. 24). They also stated that the terms *competent* and *competencies* are not sufficiently operationalized, which obfuscates the actual meaning of cultural competence.

With respect to description and prescription, Mollen et al. (2003) stated that Sue et al. (1982; 1992) provided descriptions about multicultural knowledge, beliefs and attitudes, and skills, but did not give readers prescriptive details. To help readers understand the model's lack of prescription, Mollen et al. provided examples of questions that they believed are not answered by the tripartite model, which include: "How do culturally skilled counselors recognize the limits of their competencies and expertise? What underlying mechanisms need to be developed and strengthened so that counselors are aware of their limitations? [W]hat course of action do counselors take once they have gained this type of awareness?" (p. 24). Mollen et al. stated that without more

prescriptive elements, the tripartite model provides insufficient guidance about how counselors can achieve multicultural counseling competence.

Regarding the criterion of making a unique contribution, Mollen et al. stated that Sue et al.'s (1982; 1992) tripartite model has significantly influenced the profession's focus on research and training related to multicultural counseling. Specifically, Mollen et al. stated that since Sue et al.'s (1982) article, there has been a surge of publications, books, presentations, and monographs related to multicultural counseling competence. They also stated that it has impacted professional ethics codes and influenced counseling training programs and accreditation criteria.

Based on the criterion of including critical facets, Mollen et al. (2003) critiqued the model for focusing almost exclusively on knowledge, skills, and beliefs and attitudes. They cited Constantine and Ladany (2000) who purported that the "historical definition" of multicultural counseling competence coined by Sue et al. (1982; 1992) has gone unchallenged. Mollen et al. also stated that other critical facets that have been proposed by researchers, such as the influence of the therapeutic relationship (Sodowsky, Taffe, Gutkin, & Wise, 1994) and racial identity development (Holcomb-McCoy & Myers, 1999) have not been added to the model. Furthermore, Mollen et al. questioned Sue et al.'s decision to focus their model exclusively on "visibly recognizable ethnic minorities" (p. 25). They stated that many of those individuals who indeed belong to one of the four minority groups described by Sue et al. have other important aspects of their identity (e.g., religious, sexual orientation) that are as salient and influential as ethnicity or race. Furthermore, they stated that many individuals may not "fall neatly into one of the four

designated ethnic categories" (p. 25). For example, some might be biracial or multiracial, or they may be associated with an ethnic minority group that does not belong to one of the four major ethnic groups yet they still experience prejudice and discrimination.

Mollen et al. (2003) also questioned the tripartite model based on the criterion of simplicity and complexity. They stated that the tripartite model is an oversimplification of the construct of multicultural counseling competence, and although it has provided a basis for understanding the construct, its oversimplification is problematic. They cited other scholars who also felt the tripartite model was too simplistic. Wood and Power (1987) stated that competence involves more than knowledge and skills, and therefore, needs to be more comprehensive. Lester (2000) stated that the tripartite model is inadequate as a full representation of multicultural counseling competence. Pope and Brown (1996) conjectured that emotional competence, based on managing emotions, sensitive clinical issues, self-care, and personal biases should be included in a model of counseling competence. Similar to Pope and Brown, Welfel (1998) stated that considerations such as diligence and burnout management are important aspects of competence. Lastly, Sodowsky et al. (1994) described the inclusion of the therapeutic relationship as a facet of multicultural counseling competence. Mollen et al. purported that Sue et al. (1982; 1992) have ignored other sources on the topic of multicultural counseling competence.

Possibly the biggest difference between Sue et al.'s (1982; 1992; 1998) tripartite model and other models (including Sue's (2001) MDCC) is its empirical support. Mollen et al. (2003) stated that the tripartite model has been "subjected to a wide degree of

empirical testing, some of which has lent considerable support" to the model (p 25).

Nevertheless, they reported that further research is needed on the model. Specifically,

they called for research using grounded theory and consensual qualitative design. In the

following section, empirical research related to the tripartite model is presented and

discussed.

Empirical Research Associated with the Tripartite Model

The direct empirical research related to Sue et al.'s (1982, 1992, 1998) tripartite

model, although more robust than that of the other MCC models, is rather limited

(Ponterotto et al., 2000). In a review of the empirical literature associated with the

tripartite model, Ponterotto et al. searched and pulled related articles from eight

counseling and counseling psychology journals from the years 1991 through 1998. The

articles included *Journal of Counseling Psychology*, *The Counseling Psychologist*,

Journal of Counseling and Development, *Journal of Multicultural Counseling and*

Development, *Profesional Psychology: Research and Practice, American Psychologist*,

Psychotherapy, and the *Journal of Consulting and Clinical Psychology*. They also drew

from a previous review of multicultural counseling competence done be Atkinson and

Lowe (1995). After analyzing the research related to the tripartite model, Ponterotto et al.

stated that the studies could be organized into two general categories—studies analyzing

counseling outcome data based on counselors' cultural responsiveness, and studies that

analyzed correlates of multicultural counseling competencies using operationalized

assessments based on Sue's (1991) tripartite model. In this review of empirical research

supporting the tripartite model, studies are organized using the above mentioned

categories proposed by Ponterotto et al.

MCC Counseling Outcome Data and Cultural Responsiveness

Regarding research on counseling outcome data and cultural responsiveness,

Ponterotto et al. (2000) stated that articles measuring counselors' cultural responsiveness

in counseling support aspects of Sue et al.'s (1992) tripartite model. Specifically, they

stated that Sue et al.'s (1992; 1998) cluster of competencies associated with "counselors'

ability to understand, acknowledge, and address culture and race-related issues in

sessions" was supported by research measuring cultural responsiveness (p. 642).

Ponterotto et al. described nine articles that analyzed client responses to culturally

responsive counselors. Seven of the articles came from Atkinson and Lowe's (1995)

integrative review of multicultural counseling (Atkinson, Casas, & Abreu, 1992; Gim,

Atkinson, & Kim, 1991; Pomales, Claiborn, & LaFromboise, 1986; Poston, Craine, &

Atkinson, 1991; Sodowsky, 1991; Thompson, Worthington, & Atkinson, 1994; Wade &

Bernstein, 1991), and the remaining two articles they found themselves (Sodowsky,

1996; Thompson & Jenal, 1994). Atkinson and Lowe defined cultural responsiveness as

counselor responses "that acknowledge the existence of, show interest in, demonstrate

knowledge of, and express appreciation for the client's ethnicity and culture and that

place the client's problem in a cultural context" (p. 402). They stated that, overall, the

results of the seven articles they reviewed indicated that counselors who exhibit "cultural

responsiveness" are perceived by their diverse clients as more credible. They also

reported that culturally responsive counseling results in greater satisfaction with

counseling, increased client self-disclosure, and greater client eagerness to return for further counseling sessions.

The other two articles reviewed by Ponterotto et al. (2000) also support the part of Sue et al.'s (1992, 1998) tripartite model that states that counselors who exhibit the ability to understand, acknowledge, and address culture and race-related issues in counseling are more credible and effective counselors with diverse clients. Thompson and Jenal (1994) for example, used a qualitative design (modified grounded theory analysis) to analyze 24 African American college student client responses to counselors (two Black and two White) who exhibited a universalistic or avoidant posture regarding race and race-related issues. Thompson and Jenal arrived at a coding theme of "quality of interaction" which was illustrated by four different interactions: smooth, exacerbated, constricted, and disjunctive. Overall, Thompson and Jenal found that clients who faced a race-avoidant counselor tended to have more difficulty engaging with them.

Sodowsky (1996) examined whether counselors who used "culturally consistent counseling tasks" would be evaluated as more multiculturally competent than those who did not use those tasks. 38 master's and doctoral students in counseling and school psychology programs who were taking a multicultural counseling course volunteered to participate in the study. Participants were randomly assigned to watch one of two tapes, one showing a culturally consistent counselor and the other showing a culturally discrepant counselor. After watching the tapes, the students rated the counselors' performance using a revised Multicultural Counseling Inventory (MCI) (the original first person language was substituted for third person language). The results indicated that the

culturally consistent counselor demonstrated superior multicultural counseling competencies than the culturally discrepant counselor. Sodowsky (1996) stated that the results of the study provided evidence to support the hypothesis that there is a relationship between "perceived multicultural counseling competencies and perceived counselor credibility" (p. 312).

Since Ponterotto et al.'s (2000) review, other studies have been done to support the proposition posited by Sue et al. (1991) that counselors who understand, acknowledge, and address culture and race-related issues in session are more credible and effective with diverse clients. Specifically, Constantine (2001; 2002), Worthington, Mobley, Franks, & Tan (2000), Pope-Davis, Toporek, Ortega-Villalobos, Ligiero, Brittan-Powell, Liu et al. (2002), and Kim, Li, and Liang (2002) studied aspects of multicultural counseling competence and its affects on counseling process and the counseling relationship.

Constantine (2001) analyzed transcribed intake sessions of 52 counseling sessions done by 52 counselors-in-training to better understand the influence of "(a) counselor and client race or ethnicity, (b) counselor-client racial or ethnic match, (c) previous academic training in multicultural counseling, and (d) self-reported multicultural counseling competence to observer ratings of trainees' multicultural counseling competence" (p. 456). Results revealed that Black and Latino counselors were rated by outside observers using the CCCI-R (LaFromboise et al., 1991) to be significantly more multiculturally competent than their White counterparts. Results also revealed that racial or ethnic counselor/client matches did not contribute significantly to observer ratings of

multicultural counseling competence. Results further indicated that multicultural training is positively predictive of observer-rated multicultural competence. However, no relationship was found between self-perceived multicultural counseling competence as measured by the MCI and observer-rated multicultural counseling competence. Constantine stated that the study contributes several implications for the training and practice of multiculturally competent counselors. In particular, she stated that the study further highlights other factors (e.g., race and ethnicity) along with multicultural training that influence counselors' multicultural counseling competence.

Constantine (2002) also evaluated counselors' multicultural counseling competence based on client perceptions. She asked 112 college students of color to describe or evaluate their attitudes toward counseling, their counselor's general counseling competence using the Counselor Rating Form – Short (CRF-S; Corrigan & Schmidt, 1983), their satisfaction with counseling, and ratings of their counselor's multicultural counseling competence using a revised client friendly version of the CCCI-R. Among other things, results revealed that ethnic and racial minority clients' ratings of their counselors' multicultural counseling competence influenced their overall satisfaction with counseling. Constantine stated that this result appears to "corroborate the long-held assertion that counselors' multicultural counseling competencies are especially vital to clients of color" (p. 260).

Worthington et al. (2000) analyzed the convergent validity of self-report and observer-rated measures of multicultural counseling competence. 38 practicing professional counselors and 17 counselors-in-training were shown a videotaped

simulation of a Mexican-American client who was struggling with adjustment difficulties in her first year of college. During predetermined pauses in the videotape, participants were asked to respond verbally to the client as if they were counseling her. Responses were recorded, transcribed, and evaluated by trained raters using the CCCI-R. After watching the videotape, participants completed a set of scales including the Multicultural Counseling Inventory (MCI), a self-report instrument that measures multicultural counseling competence. Among other things, Worthington et al. found no correlation between self-report measures of multicultural counseling competence and observer-rated multicultural counseling competence. Furthermore, they found that participants who more frequently used references to racial or cultural elements in their verbal responses to the videotape were rated as more multiculturally competent than those who did not. As is the case with many of the other studies looking at client responses and counseling outcomes, Worthington et al.'s study is limited by its use of an analogue counseling situation.

Pope-Davis et al. (2002) also analyzed clients' perspectives of counselors' multicultural counseling competencies using qualitative interviews and grounded theory. 10 undergraduate students (nine females; one male) participated as clients in the study. Pope Davis et al. discovered an "emergent theoretical model of clients' experiences of their counselor's cultural competence" that suggested a "dynamic interaction of many factors" (p. 368). Specifically, they found that clients' perceptions regarding the effectiveness of their counseling experience depended on a combination of client characteristics and counselor characteristics. Also,the results of the study supported the

assertion that counselors who address racial or cultural issues in counseling are perceived by clients as more culturally competent.

Finally, Kim, Li, and Liang (2002) analyzed Asian-American client responses to culturally congruent and culturally incongruent counseling responses. Kim et al. described culturally congruent responses as those that emphasized immediate resolutions of problems and incongruent responses as those that emphasized the attainment of insight. They found that Asian American clients rated the counselor/client working alliance as higher when the counselor emphasized the culturally congruent response.

In summary, Ponterotto et al.'s (2000) review, Atkinson and Lowe's (1995) review, and subsequent articles have lent strong support for Sue et al.'s (1992; 1998) cluster of competencies that states that multiculturally competent counselors understand, acknowledge, and address cultural and racial issues in counseling. More empirical studies with real clients and different methodological designs including qualitative designs are needed to further understand the relationship between MCC and counseling outcomes (Worthington et al., 2007). Another methodological design, using self-report instruments to measure counselors' MCCs, has received attention in the MCC literature. According to Ponterotto et al. (2000), the use of MCC self-report instruments has generated the most relevant MCC studies. Research using MCC self-report instruments is detailed below.

Research Using MCC Self-Report Instruments

The majority of the empirical studies on the tripartite model have been done using MCC self-report assessment instruments (Ponterotto et al., 2000; Worthington et al., 2007). Ponterotto et al. stated that the most relevant MCC research has been done using

instruments that were designed to "operationalize the model" (Ponterotto et al., p. 643).
See Hays (2008) for a current and thorough review and critique of these instruments. The
MCC instruments include the Cross-Cultural Counseling Inventory – Revised (CCCI-R;
LaFromboise, Coleman, & Hernandez, 1991), the Multicultural Counseling Inventory
(MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), the Multicultural Awareness-
Knowledge-and-Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991; Kim,
Cartwright, Asay, & D'Andrea, 2003), the Multicultural Counseling Knowledge and
Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002;
Ponterotto, Sanchez, & Magids, 1991), and the Multicultural Counseling Competence
and Training Survey (MCCTS, Holcomb-McCoy & Myers, 1999). All of these
instruments are based generally on the tripartite model.

Worthington et al. (2007), as part of a 25 year content analysis of multicultural
counseling competence literature, grouped correlates of self-report multicultural
counseling competency instruments into nine distinct categories: (a) demographics, (b)
attitudes, (c) personality, (d) identity, (e) theoretical orientation, (f) multicultural
counseling training, (g) cross-cultural contact, (h) clinical experience, and (i) social
desirability. Ponterotto et al. (2000) grouped MCC research using self-report instruments
into three broad categories: Competencies as Related to Demographic and Training
Variables, Competencies Related to Case Conceptualization Skills, and Competencies
Related to Hypothesized, Linked Constructs. As shall be demonstrated, the categories
outlined by Ponterotto et al. subsume the categories outlined by Worthington et al. In this
section, Ponterotto et al.'s general categories are used as an organizer.

Competencies as Related to Demographic and Training Variables. To introduce

the category of Competencies as Related to Demographic and Training Variables,

Ponterotto et al. (2000) stated that throughout the tripartite model, Sue et al.'s (1992;

1998) made references to the idea that "personal and education/training experiences with

diversity will yield higher competency levels" (p. 643). Specifically, Sue et al. (1998)

stated under the "Skill" competency category of "Understanding the Worldview of the

Culturally Different Client" that "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" (p. 40).

Extrapolating from that, Ponterotto et al. conjectured that because diverse counselors

often have more personal experiences with culturally diverse individuals outside of the

counseling setting, they would score higher on measures of multicultural counseling

competence. In fact, according to Ponterotto et al., in the majority of research studies

analyzing the relationship between multicultural counseling competence and

race/ethnicity, counselors-of-color scored higher than their European American

counterparts across a variety instruments and subscales (Ponterotto, Rieger, Barrett,

Harris, Sparks, Sancez et al., 1996; Pope-Davis, Dings, & Ottavi, 1995; Pope-Davis &

Ottavi, 1994; Pope-Davis, Reynolds, Dings, & Nielson, 1995; Sodowsky, 1996;

Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998).

Regarding multicultural counseling training, Ponterotto et al. (2000) pointed out

that a number of articles have employed a pretest-posttest design to analyze the

effectiveness of multicultural counseling courses on counselors' development of

multicultural counseling competencies. All of these studies have reported significant

gains after a multicultural counseling course (D'Andrea et al., 1991; Neville et al., 1996;

Ponterotto et al., 1996; Robinson & Bradley, 1997; Sodowsky, 1996; Sodowsky et al.,

1994). However, these studies did not include outcome measures, such as the ability to

integrate multicultural knowledge into case conceptualization.

Competencies Related to Case Conceptualization Skills. Concerning the category

of Competencies Related to Case Conceptualization Skills, Ponterotto et al. (2000)

described articles that have shed light on potential limitations of using MCC self-report

instruments. Specifically, Constantine and Ladany (2000), Ladany, Inman, Constantine,

& Hofheinz (1997), and Worthington et al. (2000) revealed discrepancies between MCC

self-report instruments and other measures of multicultural counseling competencies.

Constantine and Ladany as well as Ladany et al. reported that MCC self-report measures

were not correlated with counselors' written case conceptualization ability as measured

by trained raters. Constantine and Ladany also found that select subscales of self-report

instruments were significantly correlated with a social desirability measure.

Ponterotto et al (2000). stated that "these studies raise important concerns

regarding the construct validity of the self-report competency measures" (p. 644). As

described earlier, Worthington et al. (2000) reported differences between counselors'

self-evaluations of their multicultural counseling competencies as measured by the MCI

and trained observers' ratings of their multicultural counseling competence. Other studies

have examined MCC in relation to a variety of psychological variables as described below.

Competencies Related to Hypothesized, Linked Constructs. Concerning the category of Hypothesized, Linked Constructs, Ponterotto et al. (2000) described a number of studies that used MCC self-report instruments to analyze the relationship between multicultural counseling competencies and other psychological variables, including "racial identity development, expanded worldview, acknowledgement of oppressive conditions for some minority clients, and a general nonracist personal stance" (p. 644). Concerning racial identity development, Ponterotto et al. described four studies that reported significant relationships between multicultural counseling competencies and racial identity attitudes (Ladany, Brittan-Powell, & Pannu, 1997; Ladany et al., 1997; Neville et al., 1996; Ottavi et al., 1994).

Ottavi et al. (1994) analyzed the relationship between multicultural counseling competencies and racial identity attitudes. They measured multicultural counseling competencies and racial identity attitudes using the MCI (Sodowsky et al., 1994) and the White Racial Identity Attitude Scale (WRIAS; Helms & Carter, 1990), respectively. They also analyzed the relationship between multicultural counseling competencies and educational level, clinical experience, age, and gender. Results indicated that White racial identity attitudes, educational level, and clinical experience were moderately correlated with multicultural counseling competencies. Results from a regression analysis indicated that White racial identity attitudes were more predictive of multicultural counseling competence than gender, age, educational level, or clinical experience. Specifically,

Ottavi et al. reported that Pseudo-Independence, a higher status racial identity attitude, contributed significantly to the variance of all four MCI scales (Knowledge, Awareness, Skills, Relationships). They also reported that Autonomy, another higher status racial identity attitude, contributed significantly to the variance of the Knowledge subscale.

Neville et al. (1996) also analyzed the relationship between White racial identity attitudes using the WRIAS and multicultural counseling competencies. However, rather than using the MCI to measure multicultural counseling competencies, Neville et al. used the Multicultural Awareness, Knowledge, and Skills Survey. Similar to the results reported by Ottavi et al. (1994), Neville et al. found that racial identity attitude development contributed significantly to the variance of multicultural counseling competency scores. Specifically, they found that lower-level racial identity attitudes (Contact, Disintegration) correlated negatively with aspects of multicultural counseling competence, and higher levels of racial identity attitude development (Autonomy, Pseudo-Independence) correlated positively with aspects of multicultural counseling competence.

Ladany et al. (1997), using a modified self-report version of the Cross-Cultural Counseling Inventory-Revised (CCCI-R), the WRIAS, and the Cultural Identity Attitude Scale (CIAS), analyzed the relationship between multicultural counseling competence and racial identity attitudes. Results from White participants indicated that Pseudo-Independence attitudes contributed significantly to multicultural counseling competence scores. For diverse participants, the Dissonance and Awareness subscales of the CIAS contributed significantly to the variance in multicultural counseling competence scores.

Ladany, Brittan-Powell, and Pannu (1997) also used a modified self-report CCCI-R, the WRIAS, and the CIAS to analyze the relationship between racial identity attitudes and multicultural counseling competence. However, in this study, they focused on supervisors' and supervisees' racial identity attitudes and how they affected supervisees' multicultural development. Results indicated that supervisors who held higher or equally high statuses of racial identity attitude development with their supervisees exerted a more positive influence on supervisees' multicultural development than supervisors who had low racial identity attitude statuses.

After Ponterotto et al.'s (2000) review had been published, Constantine (2002) also analyzed the effects of "racism attitudes," multicultural training, and White Racial Identity Attitudes on participants' self-report of their multicultural counseling competencies. Participants consisted of school counselors-in-training who were administered the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2000) to measure their multicultural counseling competencies, the New Racism Scale (NRS; Jacobson, 1985), the White Racial Identity Attitude Scale (WRIAS; Helms & Carter, 1990), and a brief demographic questionnaire. As predicted by her hypothesis, results indicated a correlation between higher levels of racism attitudes and lower levels of multicultural counseling competence. Furthermore, lower levels of White Racial Identity Attitudes (higher disintegration racial identity attitudes) were correlated with lower levels of multicultural counseling competence.

Concerning other correlates of multicultural counseling competence, Sodowsky et al. (1998) analyzed the relationship between multicultural counseling competence and

other psychological variables, including feelings of social inadequacy, locus of control variables, social desirability, race, and multicultural training. The construct of social inadequacy was operationalized using the Revised Janis-Field Feelings of (Social) Inadequacy Scale (Eagly, 1967). The Revised Janis-Field Feelings of (Social) Inadequacy Scale "has been used to study one's susceptibility to favorable or unfavorable information and social influence and one's improvisation and attitude changes as an effect of situational variables" (Sodowsky et al., 1998, p. 258). The locus of control variable was operationalized using the Locus of control Race Ideology factor (Gurin, Gurin, Lao, & Beattle, 1969). This instrument measures people's beliefs about the "operation of personal and external forces" in the context of the race situation in the United States" (Sodowsky et al., p. 258). The Multicultural Social Desirability Scale (Sodowsky, O'Dell, Hagemoser, Kwan, & Tonemah, 1993), and the Multicultural Counseling Inventory (Sodowsky et al., 1994) also were used to measure social desirability and multicultural counseling competencies, respectively.

Results of the study indicated that, after multicultural social desirability and race were controlled for, feelings of social inadequacy and locus of control racial ideology were individually and collectively significant contributors to the variance in multicultural counseling competency scores. Specifically, a negative correlation was found between multicultural counseling competency scores and scores on Feelings of Social Inadequacy, indicating that counselors who feel more socially inadequate are less likely to rate themselves as multiculturally competent. A negative correlation between locus of control racial ideology and multicultural counseling competency scores also was found,

indicating that individuals with higher internal locus of control racial ideology scored lower on multicultural counseling competencies. Sodowsky et al. (1998) conjectured that the results indicate a need for counselor educators to impress upon their students the belief in "personal control over their individual endeavors" as well as a "recognition of alternative worldviews of minority groups" that could cultivate "innovative counselor behaviors as well as advocacy" (p. 262). Furthermore, results of the study indicated that increased multicultural training improved multicultural counseling competency scores.

Attitudes about racial diversity and discrimination also have been studied in relation to multicultural counseling competence. As part of the development and initial validation of the Quick Discrimination Index (QDI), Ponterotto, Burkard, Rieger, Grieger, D'Onofrio, Dubuisson, et al., (1995), analyzed the correlation between racial diversity attitudes and multicultural counseling competence. Using the Multicultural Counseling Awareness Scale (MCAS; Ponterotto, Rieger, Barrett, Harris, Sparks, Sanchez et al., 1996) to measure multicultural counseling competence and the QDI to measure racial diversity attitudes, Ponterotto et al. found a significant correlation between racial identity attitudes and multicultural counseling competence. Specifically, they found a significant correlation between the Knowledge/Skills subscale of the MCAS and the General (Cognitive) subscale of the QDI, the Knowledge Skills subscale of the MCAS and the Affective Attitudes subscale of the QDI, the Awareness subscale of the MCAS and the General (Cognitive) subscale of the QDI, and the Awareness subscale of the MCAS and the General Attitudes regarding Women's Equity Issues subscale of the QDI.

Ponterotto and Alexander (1996) also studied the relationship between discrimination, subtle racism, and multicultural counseling competence. As expected, they found that racist attitudes and discriminatory beliefs negatively correlated with self-report scores of multicultural counseling competence.

Since Ponterotto et al.'s (2000) review of the multicultural counseling competency literature, other researchers have studied the relationship between multicultural counseling competence and select variables. In particular, Constantine and associates (e.g., Constantine & Gainor, 2001; Constantine, 2001) have looked at the relationship between the following variables and multicultural counseling competence: emotional intelligence, empathy, and theoretical orientation.

Constantine et al. (2001) analyzed the relationship among multicultural counseling competence, empathy, and emotional intelligence. They measured multicultural counseling competence, empathy, and emotional intelligence using the the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al., 2000), the Interpersonal Reactivity Index (IRI; Davis, 1980), and the Emotional Intelligence Scale (EIS; Schutte, Malouff, Hall, Haggerty, Cooper, Golden et al., 1998), respectively. These instruments were administered to 106 school counselors who volunteered to participate in the study. Results indicated that previous multicultural training, empathy, and emotional intelligence scores accounted for significant variance on the Knowledge scale of the MCKAS. However, multicultural training, empathy, and emotional intelligence did not significantly account for variance on the Awareness scale of the MCKAS.

Constantine (2001) also analyzed the relationship between empathy, previous multicultural training, and multicultural counseling competence. Additionally, after accounting for multicultural training, Constantine analyzed the relationship between counselors' theoretical orientations and multicultural counseling competence. As was the case in the previously study, results indicated that higher levels of multicultural training were related to higher levels multicultural counseling competence. Also, similar to the previous study, high empathy scores were correlated with higher levels of multicultural counseling competence. After controlling for multicultural training, results indicated that school counselor trainees' theoretical orientations were correlated with multicultural counseling competence. Specifically, results indicated that participants who described their orientation as eclectic/integrative reported significantly higher levels of multicultural counseling competence, compared with those who described their theoretical orientations as psychodynamic or cognitive-behavioral.

As was demonstrated, a variety of psychological variables have been shown to be related to self-perceived MCCs, including racial identity development, expanded worldview, awareness of oppressive conditions, racial attitudes, multicultural training, empathy, emotional intelligence, demographic variables (race, gender), and theoretical orientation. Although results of these studies provide support for the tripartite model and have expanded the MCC knowledge base, they also suffer from some of the same research limitations as other MCC research, such as low external validity.

While the MCC literature reviewed here reveals extensive research supporting the tripartite model, many of the studies were constrained by methodological limitations such

as low external validity (e.g., use of convenience sampling), clinical application concerns (e.g., use of analogue designs), confounding variables (e.g., social desirability), and discrepancies between self-report measures and other outcome measures (e.g., written case conceptualization skills, trained observer ratings). In addition, Dickson and Jepsen (2007) reported that the application of this research to enhance counselor training is scarce and still a concern. New methods, grounded in theories supported by empirical studies, are needed to inform counselor training.

Summary of Multicultural Counseling Competency Literature

In this section, definitions of MCC, models of MCC, and empirical research supporting postulates of MCC were reviewed and critiqued. Although a universally agreed upon definition of MCC is yet to be developed, Sue et al.'s (1992) definition, wherein multicultural counseling competence is defined as counselors multicultural knowledge, skills, and beliefs and attitudes, has been widely accepted and empirically supported. Nevertheless, critiques of Sue et al.'s definition have demonstrated limitations. In particular, Ridley and Kleiner (2003) proposed that the definition lacks clarity and prescription, which hinders counselors' and counselor educators' ability to understand exactly what multicultural counseling competence looks like in application.

Regarding multicultural counseling models, Sue et al.'s (1982; 1992; 1998) tripartite model is the mostly widely accepted model of multicultural counseling competence in the counseling field. However, it also has its limitations. In particular, Mollen et al. (2003) stated that, although the model is sound in its rationale and development, it is not clear and comprehensible in some areas. Mollen et al. also stated

that the model does not provide prescriptive details or an understanding of, for example, what multicultural competence looks like in practice. Conversely, Mollen et al. purported that the tripartite model sets itself apart from other multicultural counseling competency models in that it has spawned empirical research that supports many of its postulates.

A number of empirical studies have been completed that support some of the tripartite model's basic tenets. In the tripartite model, for example, Sue et al. (1982; 1992; 1998) conjectured that multiculturally trained counselors are more likely to be responsive to diverse clients' needs. Empirical studies (mostly analogue designs) demonstrated that counselors who exhibited multicultural skills in session were more likely to receive positive feedback from session observers and participating clients about their overall effectiveness, compared with counselors who did not demonstrate multicultural skills. Empirical studies using self-report instruments also have found that multicultural training improves participants' conceptualization skills of diverse clients and their general multicultural skills, knowledge, awareness, and relationship skills. Furthermore, research analyzing the correlation between multicultural counseling competence and other psychological variables (e.g., racial identity development, racism attitudes, discrimination, empathy, emotional intelligence, case conceptualization skills, multicultural training, demographic variables) has provided results indicating relationships between multicultural counseling competence and those variables in the expected directions (based on the tripartite model).

While the MCC literature reviewed here reveals extensive research supporting the tripartite model, many of the studies suffer from methodological limitations such as low

external validity (e.g., use of convenience sampling), clinical application concerns (e.g., use of analogue designs), confounding variables (e.g., social desirability), and discrepancies between self-report measures and other outcome measures (e.g., written case conceptualization skills, trained observer ratings). In addition, Dickson and Jepsen (2007) noted that the application of this research to enhance counselor training is scarce and still a concern. Although we know some of the factors that enhance counselors' MCCs, studies using the competencies reveal a broad range of multicultural counseling awareness, knowledge, and skills among both students and professional counselors. New methods, grounded in theories supported by empirical studies, are needed to inform counselor training. One theory that offers promise both for helping counselors better understand their cultural worldviews and for shaping those worldviews is Terror Management Theory (TMT; Solomon et al., 1991). In the following section, TMT is described and critiqued, and pertinent empirical studies related to it are reviewed.

Terror Management Theory

The theoretical underpinnings of Terror Management Theory (TMT) come from the seminal work of cultural anthropologist, Ernest Becker. In particular, TMT pulls from the following works by Becker: *The Denial of Death* (1973; the culmination of Becker's life's work and 1974 Pulitzer Prize winner) *Escape from Evil* (1975), and *The Birth and Death of Meaning* (1962/1971; Pyszczynski, Solomon, & Greenberg, 2003). In these works, Becker expanded upon and weaved together the thoughts and theories of various theorists from a variety of different disciplines, including Charles Darwin (Evoluntionary Biology), Søren Kierkegaard (Theology), Sigmund Freud (Psychoanalysis), Otto Rank

(Psychoanalysis), Erving Goffman (Sociology), Erich Fromm (Social Psychology), and Ervin Yalom (Psychiatry) (Pyszczynski et al.). In this section, pertinent TMT literature is reviewed. First, the philosophical underpinnings of TMT, based on the works of Becker, are presented. Second, key terms used in TMT are discussed. Third, core TMT propositions, implications, and hypotheses are described. Fourth, pertinent empirical studies supporting TMT's major hypotheses and tenets are reviewed. Fourth, the relationship between TMT and MCC is described.

Theoretical Underpinnings of Terror Management Theory

Becker (1973), summarizing the philosophies of Kierkegaard, stated that human beings are similar to other living organisms in that they are equipped with a biological need for self preservation. He also stated that humans are unique, because they are the only living organisms who have the ability to reflect upon their own existence. This self reflective ability gives humans the unique capacity to comprehend the finitude of their mortal condition which, according to Becker, potentially cultivates in people intense and deleterious feelings of fear and anxiety. Becker referred to this fear as annihilation anxiety. He also said that people rarely experience directly the effects of annihilation anxiety, because culture, as well as other factors, mitigates its effects by creating for people a more sanguine and convincing reality—one in which people can feel that they are "beings of enduring significance living in a meaningful reality" (Pyszczynski et al., p. 16).

Becker (1975) defined culture in terms of death awareness. Specifically, he stated that culture is a human creation organized around accepted values about what brings

meaning and beliefs about the nature of reality that are shared within groups of people to mitigate the fear associated with an awareness of one's eventual death (Pyszcznski et al., 2003). Becker stated that culture mitigates the effects of death anxiety in a variety of ways. First, he stated that culture provides its members with a belief system that answers universal existential questions (e.g., Where did I come from; Why am I here; Where am I going?). Answers to these questions, according to Becker, confer upon people a sense of meaning and significance about life. Second, Becker stated that culture offers answers to people concerning literal and/or symbolic immortality. Regarding literal immortality, Becker stated that culture often provides its members with descriptions and promises of an afterlife. This belief in an afterlife helps minimize anxiety associated with death awareness. Regarding symbolic afterlife, Becker stated that culture provides people with an unconscious belief that if they accomplish great things they set themselves apart from others, which allows them to think that they have transcended the bonds of humanity and ultimately immunized themselves to the human condition of eventual death. Third, Becker stated that culture provides people with social roles and scripts for appropriate conduct which, when satisfied, allows people to perceive themselves as valuable members of a meaningful reality. This valuing of self, according to Becker, cultivates self esteem (a major tenet of TMT)—which buffers against the fear associated with eventual death.

Because culture creates a buffer against death anxiety, Becker (1975) conjectured that when people experience death reminders, they align themselves more closely with their culture and cultural beliefs. Becker also stated that differing cultural beliefs are

perceived by people as threats to their culture and, ultimately, a threat to their self worth and immortality. He described four common reactions that occur when people encounter the culturally diverse: (a) *derogation* (belittling differing beliefs or disparaging those who are different), (b) *conversion* (attempting to convert people to the "correct" culture), (c) *assimilation/accommodation* (integrating useful aspects of another culture into one's own culture, which helps to minimize the threat), (d) *annihilation* (attempting to prove the correctness of one's culture by killing people who espouse a different cultural view. "If I can kill you, then you're wrong") (Rector, 2008, p. 2).

Although his postulates have been very influential to a variety of different professional disciplines, Becker never tested his hypotheses empirically. TMT, which was derived from the above mentioned theoretical propositions of Becker (1971; 1973; 1975), was developed by Solomon, Greenberg, and Pyszczynski (1991) primarily as a means of empirically validating Becker's main postulates. The term "terror" in TMT was derived from Becker's idea of death anxiety, or the potentially paralyzing fear that individuals may experience if they become fully aware of their eventual death. The term "management" in TMT refers to people's unconscious strivings to manage or cope with the terror associated with inevitable death. These strivings are managed through four key mechanisms: mortality salience, self esteem, cultural worldview, and worldview defense. In the following section, major tenets of TMT are described and analyzed.

Key Tenets of TMT

TMT was developed by Solomon, Greenberg, and Pyszcznski (1991). It was derived from and inspired by the seminal works of Ernest Becker. Four important

psychological mechanisms described in TMT include mortality salience, cultural worldview, worldview defense, and self esteem.

Mortality salience refers to increased death awareness, or the realization of the inevitability of death. TMT theorists have demonstrated that mortality salience can occur in a number of different settings and situations, from watching a tragic accident (Nelson, Moore, Olivetti, & Scott, 1997) to walking by a funeral home (Pyszczynski, Wicklund, Floresku, Gauch, Koch, Solomon et al., 1996). As described in the previous section, Becker (1973) stated that death awareness cultivates intense feelings of fear in people, and people's cultural worldviews help protect them against that fear.

Cultural worldview was defined by TMT theorists as a "stable conception of reality that gives meaning to the social environment" (Renkema, Stapel, Maringer, & van Yperen, 2008, p. 554). Because cultural worldviews protect people against fear and anxiety associated with mortality salience, people often try to protect their cultural worldviews. One way they do that, according to TMT, is through a reaction called worldview defense.

Worldview defense, according to TMT, occurs after people have experienced mortality salience. It describes people's tendency to align themselves more closely to culturally similar people and disparage those who have different cultural worldviews. Common worldview defenses include preferential treatment towards and ethnocentric beliefs and attitudes about culturally similar people and worldviews, and prejudice, stereotyping, discrimination, and aggression toward culturally diverse people. Although no studies have analyzed counselors' reactions following increased death awareness, they

too may be susceptible to prejudicial, discriminatory, stereotypic, and aggressive reactions following death awareness. This is important because worldview defenses are diametrically opposite of multicultural counseling competence. In the section entitled Empirical Studies Associated with TMT, studies supporting TMT hypothesis that increased death awareness cultivates worldview defenses is analyzed. Along with cultural worldviews, self esteem, a cultural product, according to TMT, helps assuage people's worldview defense.

Pyszczynski, Greenberg, Solomon, Arndt, and Schimel (2004) defined self esteem as a "sense of personal value that is obtained by believing (a) in the validity of one's cultural worldview and (b) that one is living up to the standards that are part of that worldview" (pp. 436-437). Self esteem has been found to moderate the effects of mortality salience (Pyszczynski et al.). Persons with high self esteem, according to empirical studies, are less likely to disparage and discriminate against culturally diverse people following reminders of death; whereas, those with low self esteem are more likely to perceive diverse cultures as threatening.

As noted above, mortality salience, cultural worldview, worldview defense, and self esteem are core TMT propositions. These concepts are integral to understanding TMT and the relationship between TMT and MCC. To better understand this relationship, it is essential to review the implications of TMT for cross cultural equanimity and the hypotheses underlying TMT which have been the basis of numerous empirical investigations to establish the validity of the theory.

Core TMT Propositions, Implications, and Hypotheses

The core proposition of TMT is that cultures "allow people to control the ever-present terror of death by convincing them that they are beings of enduring significance living in a meaningful reality" (i.e., self esteem; Pyszczynski et al., 2003, p. 16). The core implication of TMT, therefore, is that in order for people to "maintain psychological equanimity throughout their lives [they] must sustain faith in a culturally derived worldview that imbues reality with order, stability, meaning, and permanence; and [the] belief that one is a significant contributor to this meaningful reality" (Pyszcznski et al., pp. 16-17). To support that proposition and implication, TMT theorists created two fundamental research hypotheses that have influenced over 300 empirical studies (Rector, 2008).

The first TMT hypothesis has two parts, with the first part stating that "to the extent that cultural worldviews function to [moderate the potentially deleterious fear associated with mortality salience], reminders of death should make people especially in need of the protection that their beliefs about the nature of reality provide them" (Pyszcznski et al., p. 45). The second part of the hypothesis stated that "in response to mortality salience, people should be especially prone to derogate those who violate important cultural precepts and to venerate those who uphold them" (p. 45). The second TMT hypothesis stated that "self esteem should serve an anxiety-buffering function" against mortality salience (Pyszcznski et al., 2003, p. 39). As mentioned earlier, these two hypotheses have influenced over 300 empirical studies.

Empirical Studies Associated with TMT

In this section, empirical research associated with TMT's basic postulates are reviewed and analyzed. Specifically, research associated with above mentioned hypotheses is reviewed. First, studies associated with the effect of mortality salience on worldview defense (hypothesis 1) are described and analyzed. This section, labeled Death Awareness and Worldview Defense, is organized with the following categories: death awareness and moral transgressions, death awareness in everyday situations, death awareness and prejudice, and death awareness and aggression. Second, studies associated with factors that mitigate or bolster worldview defense, including distraction and delay and self esteem (hypothesis 2) are discussed and analyzed.

Mortality Salience and Worldview Defense

TMT has inspired a host of empirical studies associated with the effect of mortality salience on people's worldview defense. In this section, studies related to death awareness and moral transgressions are described first. Next, studies associated with death awareness in everyday situations, death awareness and prejudice, and death awareness and aggression are reviewed.

Death Awareness and Moral Transgressions. To initiate an empirical analysis of the effect mortality salience on people's reactions to diversity, Rosenblatt, Greenberg, Solomon, Pyszczynski, and Lyon (1989) proposed the following hypothesis: "When people are reminded of their own mortality, they are especially motivated to maintain their cultural anxiety-buffer, and thus are especially punitive toward those who violate it

and especially benevolent toward those who uphold it" (p. 682). To test that hypothesis, Rosenblatt et al. completed six separate experiments.

In the first experiment, Rosenblatt et al. (1989) asked 22 municipal court judges to set bond for an alleged prostitute based on the information they normally would have to make that decision. Rosenblatt et al. stated that municipal court judges were specifically solicited for this experiment to increase the study's generalizability, and because judges are trained to make objective decisions based on the law. The charge of prostitution was chosen because "it emphasized the moral nature of the crime," and because prostitution is widely considered a deviation from culturally appropriate practices (p. 682). Half of the judges were given a mortality salience prompt, and the other half were not. The mortality salience prompt was accomplished by having half the judges complete the Mortality Attitudes Personality Survey, which consists of two open-ended questions: What will happen to them when they die, and what emotions that thought engenders in them. After completing the mortality salience prompt, participants were then asked to complete the Multiple Affect Adjective Check List (MAACL; Zuckerman & Lubin, 1965). The group of judges who did not receive a mortality salience prompt also completed the MAACL. The MAACL was utilized to assess for positive affect, hostility, depression, and anxiety. After completing the MAACL, the judges were handed the case brief and the bond assessment forms, and asked to set bond.

Results of the study indicated that judges who experienced reminders of the inevitability of their death gave the defendant a "much higher bond than did judges in the control condition (Ms = \$455 and \$50, respectively)" (Rosenblatt et al., 1989, p. 682).

Results also indicated no differences between the two groups of judges on the MAACL. Rosenblatt et al. explained the results using TMT. Specifically, they stated that transgressions against culturally-derived moral principles (e.g., prostitution) unconsciously "threaten the integrity of the anxiety buffer (i.e., culture) and thus engender negative reactions toward the transgressor" (p. 683). Therefore, according to Rosenblatt et al., having people think about their own death, "presumably increased their need for faith in their values, and thus increased their desire to punish the moral transgressor" (p. 683).

Rosenblatt et al.'s (1989) second experiment was identical to the first with the exception of a few procedures. First, undergraduate college students were utilized as participants rather than municipal court judges. Second, materials for the experiment were administered during the student's class period. Third, because the students did not know as much about the law as the municipal court judges did, subjects were provided with a written description of the bond-setting process and definitions of legal terminology. Specifically, subjects were told that a bond for a prostitution offense usually ranges from $0 to $999. Fourth, subjects were administered a measure of attitude toward prostitution. The distribution of scores was divided into thirds and students with the most positive and most negative attitudes toward prostitution were chosen to participate in the study. Also, to control for subjects' attitudes toward the experimenter, after the experimenter left the room, subjects completed the Interpersonal Judgment Scale (IJS; Byrne, 1971), which asked subjects to rate how well they liked the experimenter and how likely they would be to participate again in a study administered by that experimenter.

The IJS also asked subjects to rate their view of the experimenter's knowledge, intelligence, morality, and ability to adjust.

Results of the experiment were similar to those of the first experiment in that subjects who were given the mortality salience prompt allotted a higher bond for prostitution (Ms = $283 and $132, respectively) than those who were not given the mortality salience prompt. Results also indicated that, after mortality salience, subjects who had more negative attitudes toward prostitution allotted higher bonds than did those who had negative attitudes toward prostitution and who did not receive the mortality salience prompt. Results also indicated that mortality salience had no effect on subjects who had more favorable attitudes toward prostitution. Also, no effect was indicated between subjects' views of the experimenter and the amount they allotted for the bond. Rosenblatt et al. (1989) purported that the results of the study indicated that "increasing the salience of mortality does not lead subjects to derogate just any target" (p. 684). Rosentblatt et al. explained that mortality salience only affected the bond allotment of subjects who thought that prostitution was immoral because it was perceived as a threat to their culturally-derived moral standards of conduct. Conversely, for those who did not view prostitution as immoral, the salience of mortality had no effect, because the act of prostitution was not seen as a threat to their culturally-derived moral standards of conduct.

A third experiment was completed by Rosenblatt et al. (1989) to analyze the TMT tenet that mortality salience not only increases people's desire to punish those who transgress culturally-derived standards of conduct, but also increases people's desire to

reward those who personify their cultural values. Rosenblatt et al. stated that when people uphold cultural values, it cultivates a sense of "consensual validation" for one's cultural worldview (p. 684). Therefore, they hypothesized that people who experience mortality salience will react more positively to those who uphold their cultural values. The same procedures used in experiment two were utilized in experiment three, save the following differences. First, the IJS was not utilized in experiment three. Second, in addition to asking participants to allot a bond amount for prostitution, they also were asked to recommend a monetary reward (between $50 and $10,000) to a woman who purportedly helped police arrest a criminal who allegedly had mugged (sometimes violently) a handful of people. As in experiment 1 and 2, half of the subjects were given a packet of questionnaires containing a mortality salience prompt, and the other half were given questionnaires without the mortality salience prompt.

Results of the study supported the findings from experiments 1 and 2 that participants in the mortality-salient condition recommended a higher bond for an alleged prostitution offense than did participants in the control group. Results also indicated that participants in the mortality-salient condition recommended a higher monetary reward to the woman who allegedly helped police apprehend a criminal than did participants in the control group (Ms = $3,478 and $1,112, respectively). Thus, the experiment replicated findings that support TMT's tenet that individuals who experience reminders of death become more likely to derogate those whose behavior contradicts their own cultural values, and reward individuals who uphold their cultural values.

Experiment 4, completed by Rosenblatt et al. (1989) was performed to rule out alternative explanations for the results given in Experiments 1, 2, and 3. Rosenblatt et al. stated that one alternative explanation was that the mortality salience prompts elicited heightened self awareness in participants, which possibly explains the results rather than mortality salience. Therefore, in this study, a self awareness manipulation (a mirror) was included. Another alternative explanation, according to Rosenblatt et al. was that arousal could explain the results rather than mortality salience. Therefore, in this study, along with allotting a bond amount for a prostitute, participants were asked to rate "how much they liked five generally pleasant events and five generally unpleasant events" (p. 685). Rosenblatt conjectured that the mortality-salient condition would elicit a significant effect only toward things that threatened or bolstered people's cultural worldview; therefore, pleasant and unpleasant event ratings should not be affected.

As was found in the previous three studies, a main effect was found between subjects in the mortality-salient condition and the control condition, with participants in the mortality-salient condition setting higher bonds for prostitution than the subjects in the control group (Ms = \$537.84 and \$102.34, respectively). Results also indicated that people who were given the high self awareness manipulation were no more likely to set higher bonds than the self awareness control group subjects. Furthermore, results indicated no difference between subjects in the mortality-salient condition and control subjects on ratings of pleasant and unpleasant events. Rosenblatt et al. concluded from the results that TMT is a better explanation for the results than self awareness explanations or arousal amplification explanations.

Nevertheless, to measure and analyze more reliably the effect of arousal, experiment 5 was completed. In this study, subjects' physiological arousal was measured by a Grass Instruments Company physiograph, which measures people's pulse rate, pulse volume, and skin resistance. Similar to the previous studies, mortality-salient subjects set higher bonds for prostitution than did control subjects. Also, no differences were found between the pre-mortality salience prompt and the after-mortality salience prompt regarding physiological arousal, indicating that arousal had no effect on participants' bond allotment for prostitution.

In experiment 6, Rosenblatt et al. (1989) used a different mortality salience prompt to determine whether subjects would allot higher bonds for alleged prostitution. In this case, subjects in the mortality-salient condition were administered Boyar's (1964) Fear of Death Scale, and subjects in the control condition were administered the A-Trait form of the State-Trait Anxiety Inventory (Speilberger et al., 1970). Results indicated that subjects in the mortality-salient condition recommended a significantly higher bond than did subjects in the control condition (Ms = 400.33 and $99.94, respectively), indicating that the effects found in the previous five experiments were not due to the "particular features of the open-ended death questionnaire, but rather to requiring the subjects to think about their own deaths" (p. 688).

In summary, the six experiments completed by Rosenblatt et al. (1989) provide support for several TMT-derived postulates. First, people who receive reminders of their death align themselves more closely with people who uphold their values (as shown by participants in the mortality-salient condition giving higher monetary rewards to the lady

who turned in a criminal). Second, reminders of death increase people's sense of threat related to people who behave contrary to their cultural values (as demonstrated by participants in the mortality-salient condition setting higher bail amounts for prostitution). Rosenblatt et al. explained these results in terms of TMT, stating that as people receive reminders of their death, they have an unconscious desire to bolster their cultural worldview, because their cultural worldview provides protection against the fear of death. Rosenblatt et al. said that they protect themselves by aligning themselves more closely with their cultural values and disparaging things (e.g., people, behaviors) that run contrary to their values.

Greenberg, Pyszczynski, Solomon, Rosenblatt, Veeder, Kirkland, et al. (1990) decided to further the work done by Rosenblatt et al. (1989) through three studies that assessed "whether similar effects could be shown for reactions to targets who bolster or threaten the cultural worldview in other ways" (p. 309). In study 1, Greenberg et al. analyzed participants' reactions to people of religiously similar and religiously different backgrounds. In study 2, they analyzed participants' reactions to attitudinally similar and attitudinally different people. Finally, in study 3, Greenberg et al. analyzed participants' reactions to people who explicitly criticized or praised their culture. The same mortality salience manipulation that was used in the first five experiments completed by Rosenblatt et al. was used in these three studies.

In study 1, Greenberg et al. (1990) analyzed the TMT-derived hypothesis that, under the mortality-salient condition, subjects would rate in-group members more positively than out-group members. In this case, in-group and out-group members were

operationalized as Christians and Jews, respectively. 46 Christian undergraduate

psychology students participated in the study. Half of the participants were assigned to

the mortality-salient condition, and the other half to the control condition. Results of the

study indicated that participants in the mortality-salient condition rated Christians more

positively (as measured by the Interpersonal Judgment Scale), and rated Jews more

negatively than participants who did not receive death reminders. However, regarding

negative, stereotypic ratings of Jews, participants in the mortality-salient condition rated

Jews more negatively only when they were asked to rate the Christian first. However,

regarding positive traits, participants in the mortality-salient condition rated Christians

more positively regardless of order. According to Greenberg et al., "these findings are

consistent with the notion that positive reactions to in-group members and negative

reactions to out-group members are mediated by the implications that such individuals

have for the individual's cultural anxiety-buffer" (p. 312).

In an attempt to generalize the effects of mortality salience beyond religious

affiliation, Greenberg et al. (1990) completed study 2, which was designed to analyze the

effect mortality salience has on people's ratings of similar and dissimilar others.

Specifically, Greenberg et al. desired to analyze whether participants, under the

mortality-salient condition who rated themselves as highly authoritarian, would rate

dissimilar others more negatively than participants with low authoritarian attitudes. Half

of the participants were given a mortality salience prompt, and the other half was given a

prompt to discuss their favorite ethnic food. After those prompts, participants were

randomly assigned to either analyze similar or dissimilar bogus attitude surveys of

another participant. Next, participants were asked to fill out a questionnaire that measured their attractiveness to the target based on their attitude survey.

Results of the study indicated that participants with high authoritarian attitudes were much more likely than participants with low authoritarian attitudes to rate negatively those who had dissimilar attitudes. Furthermore, participants with high authoritarian attitudes who had received the mortality salient prompt, were more likely to give higher negative ratings to dissimilar others than participants with high authoritarian attitudes who were given the favorite ethnic food prompt. Results also indicated no difference between participants with low authoritarian attitudes regardless of whether they were given the mortality salience prompt or favorite ethnic food prompt. Greenberg et al. conjectured that this result may have occurred because "in the worldviews of low authoritarians, open-mindedness and tolerance of different opinions are highly valued;" therefore, it is possible that dissimilar attitudinal values were not seen as a threat to their cultural value system (p. 315). Greenberg et al. also conjectured that a more convincing cultural worldview disparity would have produced more negative reactions in low authoritarians in the mortality-salient condition.

Greenberg et al. (1990) stated that Rosenblatt et al.'s (1989) studies and their own first two studies demonstrated the effects of mortality salience on people's reactions to individuals who *indirectly* validated or threatened their cultural worldviews; however, no studies had analyzed mortality salience's effect on a *direct* validation or threat to cultural worldviews. In their third study, Greenberg et al. studied the effect of mortality salience on participants' reactions to direct validations or threats to their cultural worldviews. In

particular, participants were asked to react to foreigners' favorable, mixed, or unfavorable views of the United States. Participants consisted of 70 male and 81 female American introductory psychology students. As in the other studies, half of the participants were assigned to the mortality-salient condition, and the other half was assigned to the control condition, in which they were asked to describe the emotions that food arouses in them. After being subjected to the mortality-salient or control conditions, participants were asked to evaluate essays that contained favorable opinions about the United States, mixed opinions about the United States, and unfavorable opinions about the United States. As expected, participants in the mortality-salient condition rated the author of the favorable U.S. essay as more likeable than did participants in the control condition. Participants in the mortality-salient condition rated the author of the unfavorable U.S. essay significantly more negatively than did participants in the control condition.

The three studies completed by Greenberg et al. (1990) provide further support for TMT's tenet that mortality salience creates a need for worldview defense. In particular, Greenberg et al. were able to demonstrate that after experimentally manipulating mortality salience, participants are more likely to rate positively individuals who held similar religious views, similar attitudinal preferences, and similar political values. They also demonstrated that participants in the mortality-salient condition were more likely to react negatively to those who held different religious views, who had different attitudinal preferences, and who held different political values. However, a question that had not been answered to this point was whether mortality salience effects could occur outside of the research laboratory. In other words, in everyday life, could

people experience sufficient reminders of their death to engender a need to guard against it via worldview defense? To answer that question, Pyszczynski et al. (1996) analyzed participants' reactions to cultural similarities and differences after being exposed to viewing a funeral home from 100 meters away.

Death Awareness and Worldview Defense in Everyday Life. To provide support for the hypothesis that reminders of mortality encountered in everyday life could affect people's worldview defense, Pyszczynski et al. (1996) investigated participants' reactions after walking by a funeral parlor. Pyszczynski et al. aimed to understand how mortality salience affected people's desire for consensus about their culturally relevant beliefs and analyze mortality salience in daily life (away from the research laboratory). Pyszczynski et al. studied the hypothesis that "mortality salience increases the desire to perceive high consensus for one's culturally relevant attitudes" (p. 333). 64 German men and women participated in the study. They were randomly assigned to one of three groups—a group that was interviewed walking 100 meters in front of a funeral parlor, a group that was interviewed walking directly in front of the funeral parlor, and a group that was interviewed walking 100 meters after the funeral parlor. All participants were asked critical political questions: "Are you for or against a change in the constitution to restrict the immigration of asylum-seekers? And "What percentage of German citizens do you think share your opinion?"

Results of the study provided some support for the hypothesis that mortality salience would lead to exaggerated estimates of consensus. Specifically, participants under the mortality-salient condition, who expressed opposition to changing the

constitution, exhibited higher consensus beliefs than participants in the control condition. Pyszczynski et al. (1996) conjectured that this result might reflect an increased "need for protection provided by subjects' cultural worldviews. "Seeing others as agreeing with oneself implies that one's own attitude is valid and correct" (p. 334).

The second study performed by Pyszczynski et al. (1996) was similar to study 1, in that participants were interviewed either in front of a funeral home or 100 meters before or after it. This study varied from study 1 in that it was performed in the United States and the questions that investigators asked participants were different. In this case, participants were asked to give their opinion regarding the teaching of Christian values in the public schools, and their opinion about what percentage of people held that same view. This particular topic in question was chosen by the investigators because it was considered a controversial and salient topic that had recently received a lot of attention in that area. Results of the study indicated that participants in the mortality-salient condition who also agreed that Christian values should be taught in the public schools, were more likely to overestimate consensus, compared with participants in the control condition who agreed that Christian values should be taught in the public schools. Pyszczynski et al. stated that the results supported their hypothesis that mortality salience creates a need for people to feel consensual validation for their worldviews. Furthermore, and perhaps more significantly, Pyszczynski et al. demonstrated that reminders of death and its effects on people are prevalent in everyday life, and not just in laboratory settings.

Death Awareness and Prejudice. As part of the general worldview defense, TMT researchers have found that people who have received reminders of their death are more

likely to react prejudicially toward dissimilar others. Specifically, Greenberg et al.'s (1990) study 1, which was reviewed earlier, demonstrated prejudicial reactions of participants after being reminded of death. Participants who had been reminded of death were more likely to evaluate favorably individuals who espoused similar religious values. After receiving death reminders, participants also were more likely to evaluate unfavorably individuals who purportedly held dissimilar religious values. Other studies also have analyzed the prejudicial reactions of people after receiving reminders of their death (e.g., Nelson, Moore, Olivetti, & Scott, 1997; Ochsmann & Mathy, 1994; Schimel, Simon, Greenberg, Pyszczynski, Solomon, Waxmonksy, et al., 1999).

Nelson et al. (1997) hypothesized that participants who experienced reminders of their death would be more likely to react negatively to different cultures. To induce a mortality salient reaction, half of the participants watched a video depiction of a gory car accident, and the other half watched a video depicting driving safety tips. After experiencing either the mortality-salient condition or the control condition, participants were read a scenario about a driver who had a car accident and was suing either an American or a Japanese car company. Nelson et al. hypothesized that, because participants were all American, those in the mortality-salient condition, compared with participants in the control condition, would be more likely to cast blame for the accident on the Japanese car company. As expected, results of the study supported the hypothesis; participants who were given reminders of their death were more likely to blame the car company for the accident if it was the Japanese car company.

Schimel et al. (1999) analyzed the relationship between stereotypic behaviors and mortality salience. In a series of studies, they hypothesized that because, according to TMT, stereotypic thinking functions as a protection against mortality salience, people who receive reminders of death would exhibit more stereotypic thinking and behaviors than would those who did not receive death reminders. In study 1, German participants were administered either a control or mortality salience prompt. After that, they were asked to express their beliefs about how many people of a diverse culture matched a particular stereotype. Results indicated that participants in the mortality-salient condition exhibited more stereotypic beliefs than did participants in the control condition.

In study 2, Schimel et al. (1999) used a different measure of stereotypic thinking that asked participants to write reasons for stereotype-consistent and stereotype-inconsistent behaviors. Schimel et al. postulated that longer explanations for stereotype-inconsistent behavior would infer the possibility that the participant held stereotypic beliefs. Also, rather than analyzing people's stereotypic thinking regarding nationality or ethnicity, they looked at gender role stereotypes. Similar to the results of study 1, these results indicated that participants who received reminders of death, were more likely to subscribe to stereotypical gender roles as evidenced by writing lengthier explanations for stereotype-inconsistent behavior.

In study 3, participants' evaluations of stereotypic-consistent and stereotypic-inconsistent behaviors of dissimilar others was analyzed. As in the previous study, participants were randomly assigned to either a control condition or a mortality-salient condition. After receiving either the mortality salience prompt or the control prompt,

participants were asked to evaluate essays that were purportedly written by Black or White authors. Results of the study indicated that White participants were more likely to evaluate favorably the behavior of the Black person if his behavior was stereotype-inconsistent. However, under the mortality salient condition, participants were more likely to evaluate favorably the Black person who exhibited stereotype-consistent behavior. Schimel et al. stated that stereotypes, "as part of the cultural worldview, serve a terror management function" (p. 915).

Ochsmann and Mathy (1994), in an unpublished manuscript (as cited in Pyszczynski et al., 2003), also analyzed people's prejudicial reactions after receiving reminders of death. Ochsmann and Mathy completed two studies that assessed the effects of mortality salience on German participants' beliefs and actions. In the first study, German students were assigned to either a control or mortality-salient condition. Results indicated that participants in the control condition did not discriminate between Turkish and German targets. However, in the mortality-salient condition, participants rated German targets more positively and Turkish targets more negatively.

In their second study, Ochsmann and Mathy (1994) analyzed participants' prejudicial behaviors associated with mortality salience. German student participants were given a packet of questionnaires containing bogus personality assessments. Half of the participants received packets containing a mortality salience prompt, and the other half received a control questionnaire in their packets. Participants were told that after they completed the questionnaires, they were to enter a waiting room to collect a modest remuneration for their participation in the study. In the waiting room, a row of nine chairs

were set up with a German confederate sitting in the middle. Unbeknownst to the

participants, this confederate was associated with the study, and either dressed to appear

as a mainstream German or as a Turkish individual. Ochsmann and Mathy hypothesized

that participants who received reminders of their death would sit farther away from the

Turkish individual than participants who did not receive death reminders. Results

supported that hypothesis. In particular, participants in the control condition sat the same

distance away from the confederate regardless of whether she appeared Turkish or

German. In the mortality-salient condition, participants "sat closer to the German target

and farther away from the Turkish target" (p. 74).

Pyszczynski et al. (2003) stated that Ochsmann and Mathy's (1994) second study

was of particular importance because it demonstrated "behavioral responses to mortality

salience in addition to the attitudinal differences obtained in prior studies" (p. 74). In

essence, results indicated that people who receive reminders of death not only dislike

those who espouse differing cultural worldviews, but also attempt to physically distance

themselves from diversity (Pyszczynski et al.). In some instances, aggressive responses

also occurred.

Death Awareness and Aggression. Along with demonstrating prejudicial

behavioral responses to dissimilar others, TMT researchers have found empirical

evidence supporting the postulate that when people are reminded of their death, they are

more prone to exhibit aggressive behavior toward people who espouse different cultural

worldviews. McGregor, Lieberman, Greenberg, Solomon, Arndt, & Simon (1998)

analyzed participants' aggressive behavioral reactions to a perceived worldview defense.

Participants were recruited on the basis of having either strong liberal or strong conservative political views. Participants were first asked to sit in an individual cubicle and write a brief essay outlining their political views. The essays were collected, and participants were told that their essays would be distributed to other participants in the study. After the collection of essays, participants were asked to complete a bogus personality inventory and either a mortality salience prompt or a control prompt. After receiving one of the two prompts, participants were given an essay that was purportedly written by another participant. However, the distributed essays actually had been prepared earlier by investigators. One of the essays was designed to conflict with conservative values and the other with liberal values. Half of the participants read essays that conflicted with their political values, and the other half read essays that supported their political values.

After reading the essay, participants were told that the first study was over, and were asked to participate in a second study. Among other things, in this study, participants were asked to choose how much hot sauce to give to the participant whose essay they had read. They also were led to believe that the other participant would have to consume whatever amount of hot sauce they chose to give him or her. This was the aggression manipulation. Participants in the mortality-salient condition allocated significantly more hot sauce to participants who espoused contradictory political views than did participants in the control condition (26.31 g and 17.56 g, respectively). During the debriefing process, McGregor et al. reported that participants were conscious of the fact that they were giving the other participant a painful dose of hot sauce. McGregor

stated that results of the study add support to the TMT proposition that reminders of death engender not only negative reactions but also physical aggression toward people who subscribe to dissimilar and contradicting worldviews.

The studies reviewed in this section provide support for the TMT proposal that reminders of death affect people's beliefs about and reactions to differing cultural worldviews. In particular, these studies demonstrated that participants who receive reminders of death are more likely to castigate people whose behaviors contradict their own culturally prescribed standards of conduct (e.g., prostitution), act prejudicially to those who hold differing cultural values or affiliations (e.g., religious affiliations, attitudinal preferences, political views), and act aggressively to those who hold differing and contradictory cultural worldviews. These studies also demonstrated that, after receiving reminders of death, people are more likely to align themselves more closely to their cultural worldviews and act preferentially toward others who hold those worldviews. Participants who received death reminders also were more likely to reward participants who upheld their worldviews, sit by those who appeared more like them, and rate more positively those who appeared more like them. Although no studies have analyzed counselors' reactions to increased death awareness, if counselors also are susceptible to worldview defense after receiving innocuous reminders of death, they too may experience negative worldview defenses such as prejudicial, stereotypic, judgmental, discriminatory, and aggressive reactions to diverse clients. Along with demonstrating the effect of death awareness on people's evaluations of and reactions to cultural similarities and culturally differences, TMT theorists have uncovered factors that bolster and mitigate

worldview defenses following increased death awareness. In the following section, delay and distraction's bolstering effect and self esteem's mitigating effect on people's reactions following death reminders is analyzed.

Bolstering and Mitigating Factors

TMT researchers have shed light on variables that bolster or moderate the effects of mortality salience. Regarding the bolstering factors, delaying and/or distracting participants after a mortality-salient prompt yields a greater worldview defense reaction than does giving participants the dependent measure subsequent to the mortality salience prompt. Regarding mitigating factors, high self esteem helps mitigate the effects of mortality salience on worldview defense. In this section, first, studies related to delay and distraction are described. Second, studies related to the moderating effect of self esteem on worldview defense are described.

Delay and Distraction as a Bolster to Worldview Defense. Greenberg, Pyszczynski, Solomon, Simon, and Breus (1994) devised studies to analyze the effects of delay and distraction on worldview defense following a mortality salience prompt. In study 1, participants were randomly assigned to one of three conditions—a control condition, a typical mortality-salient condition, and a more prolonged and extensive mortality-salient condition. Greenberg et al. hypothesized that "a more prolonged and extensive consideration of mortality than that employed in previous studies would attenuate" the typical mortality salience effect (Pyszczynski et al., 2003, p. 56). In this study, participants were asked to evaluate foreign students who wrote either a pro-American or anti-American essay. Results indicated that participants in the typical

mortality-salient condition demonstrated a significantly higher preference for the foreign

student who wrote the pro-American essay than did participants in the control study.

Furthermore, participants in the more prolonged and extensive mortality-salient condition

exhibited significantly lower preferences for the pro-American essay than did participant

in the typical mortality-salient condition. Pyszczynski et al. stated that the lower mortality

salience effect exhibited by those in the more prolonged and extensive mortality-salient

condition could be explained by proximal and distal defenses. They stated that when

reminders of mortality are clearly in people's awareness, proximal psychological

defenses are activated which temporarily provide protection against the deleterious fear

of death. However, "once the problem of death is out of focal attention but while it is still

highly accessible, terror management concerns are addressed by distal defenses" or, in

other words, through worldview defenses (p. 56).

In study 2, Greenberg et al. (1994) analyzed the effect of distracting people from

the thought of death and the effect of having participants focus on death after the

mortality salience prompt. Participants were assigned to three different groups. In the first

group, participants were distracted after the mortality-salient prompt by completing a 3-

minute crossword puzzle that contained "television-related" words (e.g., media). In the

second group, participants were also given a 3-minute crossword puzzle after the

mortality-salient prompt, but the crossword puzzle contained death-related words (e.g.,

coffin, graveyard). In the third group, after the mortality salience prompt, participants

were asked to write down whatever came to mind for three minutes. Participants who

received a distraction from thoughts of death were more likely to exhibit worldview

defenses than were participants who were not distracted from thoughts of death. TMT researchers also have discovered that self esteem acts as a buffer against the anxiety engendered by reminders of death.

Self Esteem as a Buffer against Anxiety. A series of empirical studies have been completed to test the hypothesis proposed by TMT that self esteem is an anxiety-buffering agent, and it helps quell the effects of mortality salience. In this review, studies completed by Greenberg, Solomon, Pyszczynski, Rosenblatt, Burling, Lyon, et al. (1992), Harmon-Jones, Simon, Greenberg, Pyszczynski, Solomon, and McGregor (1997), and Arndt and Greenberg (1999) are analyzed.

Greenberg et al. (1992) completed three different studies to better understand the effect of self esteem on anxiety. In the first study, they hypothesized that the bolstering of participants self esteem would reduce their anxiety in response to a perceived threat. To test that hypothesis, they randomly assigned 52 participants to either a group who viewed a "threatening" video or a group who viewed a "non-threatening" video (mortality salience variable). Before viewing the video, however, participants were given individual results from a bogus (made up) personality assessment instrument that they had taken previously. Feedback from the bogus instrument was "highly general in nature so that it could plausibly apply to all subjects" (p. 915). Half of the participants in the group that would view the "threatening" video were given "neutral feedback," and the other half of the participants were given "positive feedback." The neutral feedback stated the following: "While you have some personality weaknesses, you are generally able to compensate for them" and "Some of your aspirations may be a bit unrealistic" (p. 915).

The positive feedback stated the following: "While you may feel that you have some personality weaknesses, your personality is fundamentally strong" and "Most of your aspirations tend to be pretty realistic" (p. 915). After reviewing their bogus personality results and reviewing the "threatening" video, participants completed the A-State form of the State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970). This was done to measure participants' levels of anxiety. Results of the study indicated that "increased-self-esteem subjects showed less anxiety in response to threat than did neutral self-esteem subjects" (p. 916) which, according to Greenberg et al., provides support for the proposition that self esteem helps reduce people's anxiety in threatening situations.

In study 2, Greenberg et al. (1992) aimed to understand whether self esteem would also be a buffer against a more personal, yet non-life-threatening situation—in this case, electric shock. Greenberg et al. stated that a different measure of self esteem and anxiety were utilized in this study so that they could provide converging evidence of self esteem's general anxiety-reducing qualities. Self esteem was operationalized by giving participants bogus feedback on a verbal intelligence instrument. Anxiety was operationalized using a measure of physical arousal (skin conductance). Greenberg et al. stated that measuring anxiety by physical arousal was beneficial because it is "less prone to reporting bias" (p. 916). Similar to study 1, Greenberg et al. hypothesized that enhanced self esteem would reduce the effects of anxiety on participants. Results indicated that subjects who were given positive feedback regarding their verbal intelligence had lower physical arousal compared with participants who received neutral feedback about their verbal intelligence. Although the results provided support for their

hypothesis, Greenberg et al. pointed out that giving people self esteem enhancers by way of personality or intelligence feedback may not measure self esteem, but rather it might measure positive and negative affect. To test that possibility, Greenberg et al. performed a third study.

In the third study Greenberg et al. (1992) performed basically the same procedure as they had performed in study 2. However, in this study, participants were asked to complete the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988) to assess the mediating effect that affect has on people's response to anxiety. Similar to the previous study, results indicated that, compared with participants who received positive feedback about their verbal intelligence, participants who had received neutral feedback regarding their verbal intelligence experienced significantly greater arousal toward the threat of receiving mild electric shocks. Furthermore, regarding the mediating effects of positive or negative affect, results did not support the possibility that positive affect is a mediating factor between self esteem and reduced anxiety responses.

Thus far, the studies reviewed regarding self esteem have lent support for TMT's proposition that self esteem provides a buffer against different anxiety-producing threats, and that it reduces the influence of mortality salience on people. However, these studies did not shed light on specific reactions associated with mortality salience that self esteem might buffer against. In particular, these studies did not address the effect self esteem has on worldview defense. The following studies aimed to shed light on the relationship between high self esteem and the need to defend one's worldview.

Harmon-Jones et al. (1997) posited that because self esteem protects against the anxiety produced by mortality concerns, then it should also reduce people's worldview defense, a common reaction to mortality salience. Harmon-Jones et al. described worldview defense as a reaction to mortality salience in which people align themselves more strongly to their cultural beliefs and people who support their worldviews, and denigrate or belittle cultures and people who hold differing cultural worldviews. To test their hypothesis, Harmon-Jones manipulated participants' self esteem in the same manner as Greenberg et al.'s (1992, Study 1) did, wherein participants were given a made up personality inventory with bogus "positive feedback" and "neutral feedback." After receiving the bogus feedback, participants were asked to either write about their own mortality (thoughts about their own death) or about a neutral subject (watching television). After completing either the mortality question or the neutral question, participants were asked to read, evaluate, and express their reactions to two different essays concerning "foreigners' views of the U.S. and Americans" (p. 26). One of the essays was pro U.S., and the other one was anti-U.S. Among other things, results of the study indicated that participants who received experimentally enhanced self esteem and who also experienced mortality salience were less likely to demonstrate pro-U.S. bias in their evaluation and reactions to the essays, compared with participants who received neutral feedback about their personalities and who experienced mortality salience.

Harmon-Jones et al. (1997) also completed a second study in which they measured dispositional self esteem using the Rosenberg Self-Esteem Scale (Rosenberg, 1965). Principally, they aimed to evaluate whether dispositional self esteem would

provide similar protection against worldview defense as did experimentally enhanced self esteem in the first study. Other than a different self esteem manipulation, the procedures in study 2 were identical to that of study 1. Results also were similar to the results presented in study 1 in that people who had high dispositional self esteem were less defensive about their worldviews than those who had moderate dispositional self esteem, indicating that dispositional self esteem creates a buffer against the effects of mortality salience, particularly the reaction of worldview defense.

Arndt and Greenberg (1999) also studied the effects of enhanced self esteem on participants' reactions to worldview threats after mortality salience. Similar to the first study completed by Harmon-Jones et al. (1997), Arndt and Greenberg administered bogus personality tests with accompanying bogus feedback to participants to manipulate self esteem. In this case, however, Arndt and Greenberg manipulated the personality results to give participants specific feedback related to the likelihood of them being successful in either their college major or another domain in their life. Participants were also given a mortality salience prompt wherein they were asked to write about their feelings related to the thought of inevitable death, and specifically, what they thought would happen when they die. As in Harmon-Jones et al.'s study, some participants were given a neutral prompt instead of a mortality salience prompt. In this case they were asked to write about two questions regarding dental pain. After completing either the mortality salience or neutral prompt, participants were asked to read two essays. One essay contained anti-U.S. rhetoric in it, and the other contained anti-major or anti-domain of life rhetoric in it. Similar to the results described by Harmon-Jones et al., Arndt and

Greenberg found that, after mortality salience, participants who were given neutral feedback about their personality, belittled the anti-U.S. essays; whereas, participants who received positive personality feedback did not. Conversely, regardless of positive or neutral personality feedback, participants who read the anti-major or anti-domain of life essay, derogated those essays. Arndt and Greenberg stated that "these findings indicate that when a target threatens a dimension on which a self esteem boost is predicated, such a boost will not deter derogation following mortality salience" (p. 1331). On a different note, regarding the neutral and mortality salience prompts, participants who were asked to write about dental pain, were not found to experience heightened worldview defense compared with those who were given the mortality salience prompt, lending evidence to the fact that thoughts of uncomfortable pain do not in themselves bring about worldview defense reactions.

The studies mentioned in this section on self esteem, along with other similar studies (for a more expansive review of TMT research related to self esteem see Pyszczynski, 2004) lend support to the TMT hypothesis that self esteem provides protection against the negative reactions associated with mortality salience. In particular, these studies demonstrated that self esteem can act as a general anxiety buffer against thoughts of death, and it can assuage reactions consistent with heightened worldview defense.

Summary of Terror Management Theory

In this section, the basic tenets of Terror Management Theory have been described. Additionally, relevant empirical studies supporting the fundamental tenets of

TMT have been reviewed. As a synopsis, TMT posits that all human beings have an innate and potentially paralyzing fear of death that is masked by cultural worldviews. When people receive reminders of their death (e.g., mortality salience), they unconsciously attempt to align themselves more closely with their cultural worldview and separate themselves from contradictions or threats to their cultural worldview (worldview defense). TMT theorists also conjecture that delay and distraction bolsters the effect of mortality salience on people's worldview defense, and self esteem moderates the effects of mortality salience on people's worldview defense.

A host of empirical studies have provided support for the above mentioned hypotheses. In particular, empirical studies have demonstrated that people who receive reminders of their death are more likely to support and evaluate positively those who espouse similar cultural worldviews. Moreover, they are more likely to denigrate those who espouse different cultural worldviews. In particular, empirical studies have demonstrated that people who have received reminders of their death are more likely than those who have not received death reminders to penalize, exhibit prejudicial beliefs toward, espouse racial/ethnic and gender stereotypes about, and act aggressively toward culturally different others. TMT researchers also have demonstrated that self esteem moderates the effects of death awareness.

While the TMT literature is replete with evidence that death reminders negatively affect people's attitudes toward, beliefs about, and interactions with diversity, there are no studies on the effect of death reminders on counselors' MCCs. This appears to be an important gap in both the TMT and MCC literature that needs to be filled because, if

counselors are susceptible to worldview defense after receiving innocuous reminders of death, they too may experience negative worldview defenses such as prejudicial, stereotypic, judgmental, discriminatory, and aggressive reactions to diverse clients. If counselors are found to exhibit worldview defenses following death reminders, then it is important that counselors and counselor educators learn ways to reduce the negative effects of mortality salience. Furthermore, if counselors' self esteem is found to have a buffering effect on worldview defense following death reminders, helping counselors enhance their self esteem could be an important focus of multicultural counselor training.

Chapter II Summary

In this chapter, conceptual literature and empirical studies pertaining to multicultural counseling competence and Terror Management Theory were critically analyzed and reviewed. This was done in order to illustrate the relationship between multicultural counseling competence and Terror Management Theory—specifically, the implications of increased death awareness on counselors' multicultural counseling competence. This review also was undertaken to demonstrate a gap in the literature that supports a rationale for the present study. Review of the multicultural counseling literature revealed studies (although few in number) that provided support for the hypothesis that multicultural counseling training positively affects counselors' effectiveness in working with diverse clients. Additionally, the multicultural counseling literature revealed factors that affect counselors' multicultural counseling competence, including demographic variables (e.g., race, gender), empathy, emotional intelligence, case conceptualization skills, racial identity development, racism attitudes, and

discrimination. Although many studies have shed light on factors that affect counselors' MCCs, no studies have studied MCCs in relation to TMT. Specifically, no studies have analyzed the effect of death reminders on counseling students' perceived MCCs, or the moderating effect of self esteem on counseling students' reactions to death reminders. This gap in the literature is significant because, based on previous TMT studies, death reminders cultivate reactions that are diametrically opposite of MCC postulates.

Literature pertaining to Terror Management Theory has revealed that increased death awareness (e.g., mortality salience) cultivate in people a desire to align themselves more closely with culturally similar others and disparage those who are culturally dissimilar. In particular, TMT researchers demonstrated that people who received reminders of their death are more likely than those who had not received death reminders to penalize, exhibit prejudicial beliefs toward, espouse racial/ethnic and gender stereotypes about, and act aggressively toward culturally different others. In other words, a host of TMT research has demonstrated that after receiving reminders of death, people become less multiculturally competent. Currently, no study has analyzed the effect of increased death awareness on counselors' perceived multicultural counseling competence, nor are there studies examining the possible mitigating effect of self esteem on this process.

CHAPTER III

METHODOLOGY

A review of related literature presented in Chapter II supports a rationale and need

for a study that analyzes the effect of death awareness on counseling students' self

perceived multicultural counseling competencies (MCCs). The literature review also

supports a need to measure the moderating effect of self esteem on counseling students'

self perceived MCCs following an increase in death awareness. In this chapter, the

methodology for a study to address this gap in the literature is described, including

research questions and hypotheses, participants, instrumentation, procedures, data

analysis, and limitations.

Research Questions and Hypotheses

Research hypotheses presented in this section are based on the research questions

that were first presented in Chapter I. In this section, research questions are provided, and

research hypotheses associated with those questions are given.

Research Question 1: What is the effect of death awareness on counseling students'

perceived multicultural counseling competence?

Hypothesis 1a: Counseling students who complete a death awareness

questionnaire before rating their multicultural counseling competencies will rate

themselves lower on multicultural counseling competencies than will counseling

students who do not complete a death awareness questionnaire before rating their multicultural counseling competence.

Hypothesis 1b: Counseling students with high death concerns will rate their multicultural counseling competencies lower than will counseling students with low death concerns.

Research Question 2: Does self esteem moderate the effects of death awareness on counseling students' perceived multicultural counseling competence?

Hypothesis 2: Following completion of a death awareness questionnaire, students with high self esteem will rate themselves higher on multicultural counseling competencies than will students with moderate or low self esteem.

Research Question 3: After controlling for the effects of self esteem, how do demographic variables, such as race/ethnicity, age, religious affiliation, sexual orientation, years of counseling training, and previous multicultural training predict counseling students' perceived MCCs following completion of a death awareness questionnaire?

Hypothesis 3a: Multicultural training will moderate the effect of increased death awareness on counseling students' perceived multicultural counseling competence, such that, following completion of a death awareness scale, counseling students who have had multicultural training will rate themselves higher on their multicultural counseling competence than will counseling students who have not had multicultural training.

Hypothesis 3b: Other than multicultural training, demographic variables will not predict counseling students' ratings of multicultural counseling competence following the completion of a death awareness questionnaire.

Population and Participants

The population of interest in this study includes counseling students in entry-level and doctoral counselor education training programs. Only CACREP-accredited counseling programs were included, as these programs require multicultural counseling as part of the core counselor preparation curriculum. Based on a power analysis using G*Power, 180 to 200 participants were desired. Because of constraints in recruiting participants, 141 master's level and doctoral level counseling students matriculating in counseling programs located in the Southeast and Southwest regions of the United States participated in the study.

Instrumentation

Participants completed a packet of instruments that included the Death Concern Scale (DCS; Dickstein, 1972), the Rosenberg Self Esteem Scale (RSES; Rosenberg, 1965, 1989), the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), the Literary Preference Questionnaire (LPQ), and a demographic questionnaire. Except for the RSES and the demographic questionnaire, which always were administered first and last, respectively, the order of instrumentation varied. In this section, first, the RSES is described, followed by the DCS, LPQ, and the MCI.

Rosenberg Self Esteem Scale

Rosenberg (1989) developed the Rosenberg Self Esteem Scale (RSES) to measure self esteem. He defined self esteem as a positive or negative evaluation of self. The RSES is a unidimensional, 10-item instrument that originally was scored on Guttman scale; however, now it is more commonly scored on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). In this study, the Likert scale was utilized. The total self esteem score, which ranges from 10 to 40, is calculated by summing the items. Higher scores represent higher self esteem and lower scores represent lower self esteem. The unit of analysis for this study is the total score.

The psychometric properties of the RSES are generally sound. Depending on the study, the internal consistency has ranged from .77 to .88, and the test-retest correlations have ranged from .82 to .88 (Blascovich & Tomaka, 1991; Rosenberg, 1989). Regarding construct validity, some studies have revealed a unidimensional structure of self esteem based on the RSES (Rosenberg, 1965; Corwyn, 2000), and others have demonstrated a bidimensional structure (Bagley, Bolitho, & Bertrand, 1997) consisting of self-confidence and self-deprecation. Concerning convergent validity, Kahle (1976) reported that the Likert scoring version of the RSES was highly correlated with the Feelings of Inadequacy Scale (r = .75), and the Self Description Inventory (r = .64).

The Rosenberg Self Esteem Scale was used in this study to measure counseling students' self esteem. This was done to examine the moderating effects of self esteem on counseling students' self evaluations of multicultural counseling competence after experiencing increased death awareness.

Literary Preference Questionnaire

In three separate studies, Greenberg, Pyszczynski, Solomon, Simon, and Breus (1994) demonstrated that the effects of death awareness (e.g., worldview defense) are more pronounced when thoughts of death are pushed to the fringes of conscious awareness. To do that, Greenberg et al. and most TMT studies completed after Greenberg et al.'s study, have included an approximately three-minute distraction prompt following reminders of death. One particular method that has been used to distract participants is the Literary Preference Questionnaire (LPQ; Cohen, Ogilvie, Solomon, Greenberg, & Pyszczynski, 2005). In this method, participants are asked to read a short literary passage and answer two opinion questions about the passage. The questions include, "How do you feel about the overall descriptive qualities of the story" and "Do you think the author of this story is male or female?" The LPQ was used in this study to distract participants from thinking consciously about their death.

Death Concern Scale

The Death Concern Scale (DCS) was developed by Dickstein (1972) to measure people's concern about death. Dickstein operationalized death concern as "conscious contemplation of the reality of death and negative evaluation of that reality" (p. 564). The DCS consists of 30 items. The first 11 items contain response alternatives ranging from one (never) to four (often) on a Likert-type scale. The remaining 19 items contain different response alternatives ranging from one (I strongly disagree) to four (I strongly agree) on a Likert-type scale. Scores are derived additively, with some items requiring reverse scoring. Total scores potentially range from 30 to 120. Scores of 85 or higher

represent high death concerns and scores of 65.5 or lower represent low death concerns. The unit of analysis for this study is the total score.

Concerning psychometric properties, Dickstein (1972) reported that the DCS has strong internal consistency (α = .85), good test-retest reliability (r = .87), and good corrected split-half reliabilities (r > .84). Dickstein also reported that the DCS possesses convergent validity, as it was found to be moderately correlated in the expected directions with other measures of anxiety, including the Manifest Anxiety Scale (MAS; Taylor, 1953), the State-Trait Anxiety Inventory (STAI; Levitt, 1967; Spielberger, Gorsuch, & Lushene, 1970), the Repression-Sensitization Scale (R-S; Byrne, 1961; Byrne, Barry, & Nelson, 1963), and the Internal-External Scale (I-E; Rotter, 1966). Dickstein stated that moderate correlations were expected between the DCS and measures of anxiety because, although similar, death concern and general anxiety are different constructs.

In subsequent studies, the construct validity of the DCS was investigated. Klug and Boss (1977) and Hammer and Brookings (1987) analyzed the construct validity of the DCS by investigating its factor structure. Klug and Boss, and Hammer and Brookings ran a principle component factor analysis (oblique rotation) and an item factor analysis (oblimin rotation), respectively. Results of each study indicated that the DCS contains two moderately correlated components (r = .42; Klug & Boss; r = .22; Hammer & Brookings): Conscious Contemplation of Death and Negative Evaluations of Death. These two components support Dickstein's definition of death concern that it is a combination of negative evaluations and conscious contemplation about death.

In this study, the DCS had two purposes. First, it served as a death awareness prompt, because completing the survey allowed participants to answer questions that reminded them of their eventual death (e.g., "I think about my own death;" "The knowledge that I will surely die does not in any way affect the conduct of my life;" Dickstein, p. 565). Second, its total score, which measures counseling students' death awareness as defined as negative evaluations of death and the degree of conscious contemplation about death, was used to assess its affect on counseling students' self-perceived MCCs.

Multicultural Counseling Inventory

The Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994) was developed to "operationalize some of the proposed constructs of multicultural counseling competencies" (e.g., multicultural knowledge, awareness, and skills; p 139) and uncover other potential dimensions of MCC. It consists of 40 items that are scored on a 4-point Likert scale ranging from 1 (very inaccurate) to 4 (very accurate). The MCI has acceptable overall internal consistency ($\alpha = .90$) and good criterion-related validity based on the fact that counselors with more multicultural counseling experience score higher than do counselors with less multicultural counseling experience (Hays, 2008). Also, according to Hays, the MCI contains adequate construct validity based on the fact that the factor structure of the MCI accounts for 37% of the total variance. The MCI is scored by summing the items. Higher scores represent higher multicultural counseling competence for both the overall score and the individual factor scores.

Concerning construct validity, exploratory factor analysis using oblique rotations and LISREL confirmatory factor analysis measuring the structure's goodness of fit revealed a four factor structure for the MCI that accounted for 37% of the total variance (Hays, 2008). Based on item groupings, factors were labeled Multicultural Counseling Skills, Multicultural Counseling Awareness, Multicultural Counseling Relationship, and Multicultural Counseling Knowledge. Three of the factors parallel Sue et al.'s (1982, 1992) model of multicultural counseling competence (Knowledge, Awareness, and Skills) and the Relationship factor, expands upon it.

Multicultural Counseling Skills (factor 1) consists of eleven items with an internal consistency (Cronbach's Alpha) of .81. Multicultural counseling skills items refer to "success with retention of minority clients, recognition of and recovery from cultural mistakes, use of nontraditional methods of assessment, counselor self-monitoring, and tailoring structured versus unstructured therapy to the needs of minority clients" (Sodowsky et al., 1994, p. 141).

Multicultural Counseling Awareness (factor 2) consists of ten items that have an internal consistency (Cronbach's Alpha) of .80. According to Sodowsky et al. (1994), multicultural counseling awareness suggests "proactive sensitivity and responsiveness, extensive multicultural interactions and life experiences, broad-based cultural understanding, advocacy within institutions, enjoyment of multiculturalism, and an increase in minority caseload" (p. 142).

Multicultural Counseling Relationship (factor 3) consists of eight items that have an internal consistency (Cronbach's Alpha) of .67. Sodowsky et al. (1994)

operationalized multicultural counseling relationship as counselors' interactional abilities with diverse clients, such as the counselors' "trustworthiness, comfort level, stereotypes of the minority client, and worldview" (p. 142).

Multicultural Counseling Knowledge contains 11 items that have an internal consistency (Cronbach's Alpha) of .80. Sodowsky et al. (1994) described multicultural counseling knowledge in terms of counselors' knowledge of "culturally relevant case conceptualization and treatment strategies, cultural information, and multicultural counseling research" (p. 142).

In this study, the MCI was used to measure counseling students' self perceived MCCs. The total multicultural counseling competency score as well as the individual factor scores of multicultural knowledge, awareness, skills, and relationship were examined.

Demographic Questionnaire

A demographic questionnaire developed by this researcher was administered to participants to obtain the following demographic information: race/ethnicity, age, religious affiliation, sexual orientation, years of counseling training, and previous multicultural training. A copy of the demographic questionnaire is provided in Appendix A. Other studies have included the following demographic variables in their analyses of MCC or TMT: race/ethnicity (Constantine, 2001; Sodowsky, Kuo-Jackson, Frey Richardson, & Tiongson Corey, 1998), age and gender (Ottavi et al., 1994), religious affiliation (Greenberg et al., 1990), years of counseling training (Ottavi et al.),

multicultural training (Sodowsky et al., 1998; Constantine, 2002), and sexual orientation (Fassinger & Richie, 1997).

<center>Procedures</center>

After acquiring approval from The University of North Carolina Institutional Review Board (IRB), this researcher contacted by email department chairpersons or professors of the following CACREP accredited counseling programs to request permission to recruit counseling students for participation in the study: The University of North Carolina at Charlotte (UNCC), Wake Forest University (WFU), Clemson University, Virginia Tech University, Florida International University, North Carolina Central University, and The University of Texas at San Antonio. When the researcher requested permission from department chairpersons and professors to recruit their students, he provided them with an informed consent form approved by the IRB that included a description of the study, benefits and risks of participation in the study, and an estimate of the time required to administer the study (20-25 minutes). Students in the classrooms who did not wish to participate were offered an alternative assignment approved in advance by the instructor. The informed consent form for the study is included in Appendix B.

After receiving IRB approval and permission from the department chairpersons or individual counseling professors at the above mentioned university counseling programs, the researcher either recruited and administered the study himself to counseling students, or he mailed packets and instructions for recruitment and administration of the study to proxy administrators to recruit students and administer the study. Administration of the

study consisted in reading a recruitment script (included in Appendix C) and handing out research packets to participants that contained the five instruments described above, a demographic questionnaire, and a copy of an IRB approved informed consent form. The order of administration of instruments varied, and participants were asked to complete the instruments and questionnaire in the order in which they were provided in the packet. Half the student participants were randomly assigned to complete the MCI before completing the DCS (Control Group), and the other half were randomly assigned to complete DCS before completing the MCI (Death Awareness Group).

The informed consent included in the packet contained a description of the study, benefits and risks of participation in the study, approximate time required for administration of the study, and contact information in case of questions or concerns related to the research. The informed consent also stated that the participation is voluntary, participants may withdraw from the study at any time, and participation would not influence their standing in the course. The informed consent form also indicated that instructors reserved the right to assign alternative assignments to those who did not participate in the study if the study was administered during class time. After completing the research packet, participants were asked to turn it in to the researcher.

Pilot Study

Before completing the main study, a pilot study was run to test the procedures of the main study. More specifically, the pilot study was run to get a sense for a) how increased death awareness affects counselors' self evaluations of their MCCs, b) how self esteem moderates the effects of death awareness on counselors' self evaluations of

their MCCs, and c) how demographic variables such as race/ethnicity, age, religious affiliation, sexual orientation, years of counseling training, gender, and previous multicultural training predict counselors' self evaluations of their MCCs following death reminders. In this section, research questions and hypotheses, procedures, data analyses, results, and discussion associated with the pilot study is presented.

Research Questions and Hypotheses

The same research questions and hypotheses described in the main study were used in the pilot study. Research questions and their accompanying hypotheses are included in this section. They included the following:

Research Question 1: What is the effect of death awareness on counseling students' perceived multicultural counseling competence?

Hypothesis 1a: Counseling students who complete a death awareness questionnaire before rating their multicultural counseling competencies will rate themselves lower on multicultural counseling competencies than will counseling students who do not complete a death awareness questionnaire before rating their multicultural counseling competence.

Hypothesis 1b: Counseling students with high death concerns will rate their multicultural counseling competencies lower than will counseling students with low death concerns.

Research Question 2: Does self esteem moderate the effects of death awareness on counseling students' perceived multicultural counseling competence?

Hypothesis 2: Following completion of a death awareness questionnaire, students with high self esteem will rate themselves higher on multicultural counseling competencies than will students with moderate or low self esteem.

Research Question 3: After controlling for the effects of self esteem, how do demographic variables, such as race/ethnicity, age, religious affiliation, sexual orientation, years of counseling training, and previous multicultural training predict counseling students' perceived MCCs following completion of a death awareness questionnaire?

Hypothesis 3a: Multicultural training will moderate the effect of increased death awareness on counseling students' perceived multicultural counseling competence, such that, following completion of a death awareness scale, counseling students who have had multicultural training will rate themselves higher on their multicultural counseling competence than will counseling students who have not had multicultural training.

Hypothesis 3b: Other than multicultural training, demographic variables will not predict counseling students' ratings of multicultural counseling competence following the completion of a death awareness questionnaire.

Procedures

79 counseling student participants recruited from the UNCG Department of Counseling and Educational Development took part in the pilot study. Permission was granted to recruit UNCG counseling students for the study by the UNCG IRB, the department chair of the UNCG Department of Counseling and Educational Development,

and the professors in whose classrooms the study was administered. Administration of the study was done in intact classrooms during classroom hours, and it took approximately 20-30 minutes to complete. Participants were read a recruitment script (included in Appendix D), given an informed consent form (included in Appendix E) and administered a packet of assessments containing the RSES, LPQ, DCS, MCI, and a brief demographic questionnaire. The demographic questionnaire for the pilot study is included in Appendix F. The order of administration was varied, and participants were asked to complete the instrument and questionnaires in the order in which they were provided in the packet. Half the student participants were randomly assigned to complete the MCI before completing the DCS. The other half were randomly assigned to complete DCS before completing the MCI.

Data Analyses

Data were analyzed using a one-way analysis of variance (ANOVA) and a series of linear regressions using a General Linear Model. Missing data were treated using linear interpolation. The one-way ANOVA was run to test hypothesis 1a that counseling students who complete a death awareness questionnaire before rating their multicultural counseling competencies will rate themselves lower on MCCs than will counseling students who do not complete a death awareness questionnaire before rating their MCCs. Linear regressions were run to test the remaining hypotheses that death concern, self esteem, and demographic variables moderate the effect of counseling students' self-evaluations of their MCCs.

Results

Demographics

Participants were 79 current master's and doctoral students (62 master's, 17 doctoral) enrolled in the UNCG Department of Counseling and Educational Development. They were predominately female (71 females, 8 males), Caucasian (N =62) and heterosexual (N=70), and their ages ranged from 21-years-old to 69-years-old (Mean = 28; Standard Deviation = 9.17). African Americans (N=12), Asians or Pacific Islanders (N=3), and one bi/multiracial individual (N=1) also were represented in the sample. Along with those who identified as heterosexual, five participants identified as bisexual, two identified as lesbian, and one identified as gay. A variety of religious affiliations also were represented in the sample including Protestant (N=35), unaffiliated (N=22), Catholic (N=5), Evangelical (N=3), Jewish (Non-Orthodox; N=2), Islamic/Muslim (N=1), and Other (N=9).

Regarding counseling training, 13 participants had not yet completed a semester of counseling training, 16 had completed one semester, seven had completed two semesters, 23 had completed three semesters, three had completed four semesters, and 17 had completed more than four semesters. Concerning multicultural training, all participants had either completed a course in multicultural counseling or were currently enrolled in a multicultural counseling course (N = 52 and 27, respectively). Participants who currently were enrolled in a multicultural course had completed 14 weeks of the 15 week course when they participated in the study.

Descriptive Statistics

Ranges, means, standard deviations, and reliability (internal consistency) were

completed for each scale and subscale in order to analyze the consistency of the scales

and subscales, as well as the variability of scores. The following table (Table 1) illustrates

the ranges, means, standard deviations, and reliabilities (internal consistency) of the

following scales and subscales: the RSES, DCS, MCI, MCI Skills, MCI Awareness, MCI

Relationship, and MCI Knowledge.

Table 1

Descriptive Statistics

Scale and Subscales	Range		Mean	SD	Reliability α
	Minimum	Maximum			
RSES	16	40	34.20	4.16	.860
DCS	50	95	70.13	10.50	.857
MCI	85	152	120.75	12.54	.883
MCI Skills	26.50	44	34.42	4.270	.796
MCI Awareness	18	40	28.31	4.82	.759
MCI Relationship	13	31	23.68	3.65	.745
MCI Knowledge	25	44	34.34	4.14	.803

As illustrated in Table 1, means and ranges indicate truncated ranges for the

overall scores on the RSES and MCI. For this sample, the mean for the overall RSES

score was 34.202, which indicates that the majority of participants had high self esteem.

The mean for the MCI overall score was 120.747, which also reveals that the majority of

participants scored high on their MCCs. Mean scores on MCI subscales also reveal

potentially shortened ranges and negatively skewed scores. Concerning reliability, the

internal consistency of the scales and subscales ranged from .745 to .883, indicating good or adequate internal consistency for each scale and subscale.

These descriptive analyses, showing scale and subscale ranges, means, and standard deviations are potentially important because they may provide explanations for the results of the statistical analyses. In the following section, statistical analyses, including a one-way ANOVA and a series of linear regressions are described.

Analyses

As described in the procedures section, a one-way ANOVA and a series of linear regressions were run to test the research hypotheses. In this section, results of the one-way ANOVA and the series of linear regressions are illustrated.

One-Way ANOVA. In order to evaluate Hypothesis 1a, a one-way ANOVA was run. Results of the analysis indicated no difference in MCI scores (including the MCI Overall score and the MCI Skills, MCI, Awareness, MCI Relationship, and MCI Knowledge subscales) between student participants who experienced increased death awareness prior to completing the MCI and students who completed the MCI before experiencing increased death awareness. Tables 2 and 3 illustrate the comparison between the two groups based on order of administration. Table 2 compares descriptive statistics of the two groups, and Table 3 illustrates the results of the one-way ANOVA.

Table 2

Order of Administration: Means, Standard Deviations, and Range

		N	Mean	SD	Minimum	Maximum
MCI Overall	MCI First	40	121.12	13.35	85.00	151.00

	DCS First	39	120.37	11.83	96.50	152.00
	Total	79	120.75	12.54	85.00	152.00
MCI Knowledge	MCI First	40	34.36	4.45	26.00	43.00
	DCS First	39	34.31	3.86	25.00	44.00
	Total	79	34.34	4.14	25.00	44.00
MCI Skills	MCI First	40	34.63	4.36	27.00	44.00
	DCS First	39	34.20	4.22	26.50	44.00
	Total	79	34.42	4.27	26.50	44.00
MCI Relationship	MCI First	40	23.98	3.79	14.00	31.00
	DCS First	39	23.38	3.51	13.00	31.00
	Total	79	23.68	3.65	13.00	31.00
MCI Awareness	MCI First	40	28.15	4.75	18.00	37.00
	DCS First	39	28.47	4.95	19.00	40.00
	Total	79	28.31	4.82	18.00	40.00

Table 3

Order of Administration: One-Way ANOVA Results

		Sum of Squares	df	Mean Square	F	Sig.
MCI Overall	Between	11.082	1	11.082	.070	.793
	Within	12263.146	77	159.262		
	Total	12274.228	78			
MCI Knowledge	Between	.042	1	.042	.002	.961
	Within	1336.874	77	17.362		
	Total	1336.916	78			
MCI Skills	Between	3.767	1	3.767	.205	.652
	Within	1417.712	77	18.412		
	Total	1421.479	78			
MCI Relationship	Between	6.883	1	6.883	.514	.475
	Within	1030.206	77	13.379		
	Total	1037.089	78			
MCI Awareness	Between	2.078	1	2.078	.088	.767
	Within	1810.574	77	23.514		
	Total	1812.652	78			

As illustrated in these tables, there was no significant difference in MCC scores between the group who took the DCS first and the group who took the MCI first. After completing the one-way ANOVA, a series of linear regressions were run to test the effect of self esteem, death concern, and demographic variables on participants' MCC self evaluations following increased death awareness.

Series of Linear Regressions. A series of linear regressions were run to test hypotheses 1b, 2, 3a, and 3b. Specifically, regressions were run to test the moderating effect of death concern, self esteem, and demographic variables (e.g., race/ethnicity, gender, religious affiliation, sexual orientation, multicultural training, counseling training) on counseling students' self-perceived MCCs following increased death awareness. Results of the analyses indicated that, although self esteem and death concern influenced in the expected directions participants' self evaluations of MCCs following increased death awareness, the results were not significant. The regression equation predicting MCI overall scores from self esteem and order of operation is $\hat{Y} = 108.511 + 11.133(\text{Order of Operation}) + .368 (\text{Overall Self Esteem}) + -.347 (\text{Self Esteem*Order of Operation})$. As expected, race/ethnicity, religious affiliation, counseling training, sexual/affectional orientation, and age did not moderate the effect of increased death awareness on participants' evaluations of their MCCs. Unexpectedly, results revealed that multicultural training did not moderate the effects of increased death awareness on MCCs. Tables 4, 5, and 6 illustrate the moderating effects of self esteem, death concern, and multicultural training.

Table 4

Moderating Effect of Self Esteem

Dependent Variable	Equations	Significance		
		Order	RSES	RSES*Order
MCI Overall	$\hat{Y}$ = 108.511 + 11.133(Order) + .368 (RSES) + -.347 (RSES*Order)	.416	.648	.818
MCI Skills	$\hat{Y}$ = 31.679 + -3.470 (Order) + .086 (RSES) + .089 (RSES*Order)	.675	.573	.711
MCI Awareness	$\hat{Y}$ = 24.824 + 11.315 (Order) + .097 (RSES) + .097 (RSES*Order)	.227	.574	.237
MCI Relationships	$\hat{Y}$ = 18.911 + -1.661 (Order) + .148 (RSES) + .032 (RSES*Order)	.812	.255	.877
MCI Knowledge	$\hat{Y}$ = 33.097 + 4.949 (Order) + .037 (RSES) + -.146 (RSES*Order)	.540	.805	.533

Table 5

Moderating Effect of Death Concern

Dependent Variable	Equations	Significance		
		Order	DCS	DCS*Order
MCI Overall	$\hat{Y}$ = 134.083 + 3.35 (Order) + -.186 (DCS) + -.056 (DCS*Order)	.865	.297	.840
MCI Skills	$\hat{Y}$ = 38.117 + 1.168 (Order) + -.05 (DCS) + -.022 (DCS*Order)	.862	.411	.815
MCI Awareness	$\hat{Y}$ = 28.146 + 5.202 (Order) + .00005 (DCS) + -.069 (DCS*Order)	.497	.999	.521
MCI Relationships	$\hat{Y}$ = 26.832 + 2.921 (Order) + -.041 (DCS) + -.049 (DCS*Order)	.608	.426	.539
MCI Knowledge	$\hat{Y}$ = 40.988 + -5.941 (Order) + -.095 (DCS) + .085 (DCS*Order)	.361	.107	.355

Table 6

Moderating Effect of Multicultural Training (MT)

Dependent	Equations	Significance

Variable		MT	Order	MT*Order
MCI Overall	$\hat{Y} = 121.704 + -.903$ (MT) + -.284 (Order) + -.563 (MT*Order)	.675	.936	.853
MCI Skills	$\hat{Y} = 35.556 + -1.419$ (MT) + .164 (Order) + -.703 (MT*Order)	.038	.882	.459
MCI Awareness	$\hat{Y} = 27.667 + .744$ (MT) + .693 (Order) + -.584 (MT*Order)	.370	.611	.616
MCI Relationships	$\hat{Y} = 24.333 + -.551$ (MT) + -1.213 (Order) + .92 (MT*Order)	.377	.238	.295
MCI Knowledge	$\hat{Y} = 34.148 + .323$ (MT) + .072 (Order) + -.195 (MT*Order)	.651	.951	.846

Discussion

Results of the study were surprising and unexpected based on previous research

that has revealed differences in reactions to diversity between groups who experienced

increased death awareness and groups who did not experience increased death awareness.

It may be possible that the research hypotheses in this study were not supported because

of methodological and sampling limitations. Possible limitations included a homogeneous

sample of participants and the subtleness of the death awareness prompt.

Concerning the possible homogenous sample limitation, as mentioned in the

results section, all the students were UNCG counseling students, and the majority of the

participants were Caucasians, females, heterosexual, and protestant. All participants also

had either completed a multicultural course or were currently taking one. Furthermore,

analysis of means and ranges revealed a truncated range in MCI scores and RSES scores.

In fact, the vast majority of participants received a score of 30 or higher (72 of 79

participants) on the RSES. This lack of variability in the sampling group may have

affected the results of the study. To correct for this limitation, in the larger study, a more

heterogeneous group of participants was sought by recruiting counseling students from multiple university counseling programs that have differing demographic compositions.

Regarding the DCS, it may be possible that the increased death awareness that the DCS elicited was too subtle. If the DCS did, in fact, cultivate more subtle death anxiety than other methods, it may be appropriate to remove the LPQ from the larger study. The LPQ was utilized as a brief distraction so that, as the TMT research has demonstrated, death awareness could move to the fringes of the unconscious where worldview defenses are more likely to occur. However, the DCS may elicit subtle death anxiety that already is on the fringes of the unconscious. A distraction may eliminate the effect altogether. Another option is to utilize a more salient death awareness prompt. The limitation in that is receiving prompt IRB approval.

Based on the pilot study, changes to the larger study were made. First, because administration time for the pilot study ranged from 20-30 minutes, participants will be told that the study takes approximately 20-25 minutes to complete. Second, the LPQ may be removed from the study or the DCS may be replaced with a more salient death awareness prompt. Other than that, procedures described in the pilot study will be followed in the larger study.

Data Analysis

Table 7

Hypotheses, Instruments, and Data Analyses

Hypotheses	Instruments and Scales	Data Analyses

1a: Counseling students who complete a death awareness questionnaire before rating their multicultural counseling competencies will rate themselves lower on multicultural counseling competencies than will counseling students who do not complete a death awareness questionnaire before rating their multicultural counseling competence.	DCS
	
	    Order of administration
	
	MCI
	
	    Multicultural Skills
	    Multicultural Awareness
	    Multicultural Relationship
	    Multicultural Knowledge
		One-way ANOVA

1b: Counseling students with high death concerns will rate their multicultural counseling competencies lower than will counseling students with low death concerns.	DCS
	
	    Overall Score
	
	MCI
	
	    Multicultural Skills
	    Multicultural Awareness
	    Multicultural Relationship
	    Multicultural Knowledge
		Multiple Regression using the General Linear Model

2: Following completion of a death awareness questionnaire, students with high self esteem will rate themselves higher on multicultural counseling competencies than will students with moderate or low self esteem.	DCS
	
	RSES
	
	    Overall Score
	
	MCI
	
	    Multicultural Skills
	    Multicultural Awareness
	    Multicultural Relationship
	    Multicultural Knowledge
		Series of linear regressions using the General Linear Model

3a: Multicultural training will moderate the effect of increased death awareness on counseling students' perceived multicultural counseling competence, such that, following completion of a death awareness scale, counseling students who have had multicultural training will rate themselves higher on their	Demographic Questionnaire
	
	    Multicultural Training
	    Question
	
	DCS
	
	MCI
	
	    Multicultural Skills
	    Multicultural Awareness
		Series of linear regressions using the General Linear Model

multicultural counseling competence than will counseling students who have not had multicultural training.	Multicultural Relationship Multicultural Knowledge	
3b: Other than multicultural training, demographic variables will not predict counseling students' ratings of multicultural counseling competence following the completion of a death awareness questionnaire.	Demographic Questionnaire DCS MCI Multicultural Skills Multicultural Awareness Multicultural Relationship Multicultural Knowledge	Series of Linear Regressions using the General Linear Model

After completing data collection, descriptive statistics, psychometric checks, an analysis of missing data, one-way analyses of variance, and a series of linear regressions were run using SPSS 14.0 (SPSS, Inc, 2005). First, descriptive statistics of the variables included in the demographic questionnaire were run to understand the demographic makeup of the sample. Also, descriptive statistics and a test of internal consistency were run for the DCS, RSES, and MCI. Next, an analysis of missing data was completed. Any missing data was treated using linear interpolation. Finally, data analyses investigating the research questions were run. In this section, research hypotheses are presented and specific analyses that were used for testing each hypothesis is provided.

Hypothesis 1a (Counseling students who receive death reminders before rating their multicultural counseling competence will rate themselves lower on multicultural counseling competencies than will counseling students who do not receive death reminders before rating their multicultural counseling competencies) was tested using a one-way analysis of variance (one-way ANOVA). This analysis assessed the difference

in self-reported MCC scores between counseling students who received death reminders before completing the MCI and counseling students who completed the MCI before receiving death reminders. In essence, the analysis investigated the effect of death reminders on counseling students' self-reported MCCs.

Hypothesis 1b (Counseling students with high death concerns will rate their multicultural counseling competencies lower than will counseling students with low death concerns) was measured using a multiple regression. Counseling students' MCCs (overall score and all four factor scores) served as criterion variables, and death concern served as a predictor variable.

Hypothesis 2 (Following death reminders, students with high self esteem will rate themselves higher on multicultural counseling competencies than will students with moderate or low self esteem) was investigated using a series of linear regressions (Note: Before analyzing each interaction effect, a full regression model was run which included self esteem and demographic variables). The order of administration of the MCI and DCS served as the predictor variable (death reminders). Self esteem served as a moderating variable, and MCC scores (overall score and factor specific scores) served as criterion variables.

Hypotheses 3a and 3b (3a: Multicultural training will moderate the effect of death reminders on counseling students' perceived multicultural counseling competence, such that, following death reminders counseling students who have had multicultural training will rate themselves higher on their multicultural counseling competence than will counseling students who have not had multicultural training; 3b: Other than multicultural

training, demographic variables will not predict counseling students' ratings of

multicultural counseling competence following death reminders) was tested using a series

of linear regressions. The order of administration of the MCI and DCS served as the

predictor variable. Demographic variables (race/ethnicity, age, religious affiliation,

sexual orientation, years of counseling training, and previous multicultural training)

served as moderating variables, and MCC scores (overall MCC score and factor specific

scores) served as criterion variables.

As described in Chapter I and Chapter II, the results of this study are important

because they shed light on the effect of increased death awareness on counseling

students' self-reported MCCs. Furthermore, results provide information about the

moderating effects of self esteem and other demographic variables on counseling

students' self-reported MCCs following death reminders. These results are important

because they have the potential to increase the MCC knowledge base, particularly in

regard to cultural worldviews and worldview defense. Ultimately, results of this study

have the potential to influence the multicultural training practices of counselor educators.

CHAPTER IV

RESULTS

In this chapter, results of the study analyzing the effect of increased death awareness and the moderating effect of self esteem on counseling students' self-perceived multicultural counseling competence are presented. First, participant demographics are reported, followed by descriptive statistics and reliabilities, hypothesis testing, post hoc findings, and a summary of results.

Resulting Sample

Participants were 141 current master's and doctoral level students (128 master's, 13 doctoral) enrolled in counseling programs (seven programs altogether) located in the southeast or southwest region of the United States. As shown in Table 8, participants self identified predominately as female (112 females, 29 males), Caucasian (78 Caucasian, 35 African American, 19 Hispanic/Latino/Latina, 3 Asian or Pacific Islander, 2 Bi/multiracial, and 4 Other), and heterosexual (133 Heterosexual, 4 Gay, 3 Lesbian, 1 Bisexual). Participants' ages ranged from 22 to 53 with a mean of 28.39 and a standard deviation of 4.77.

Regarding religious affiliations, participants self identified as Protestant (N=47), Catholic (N=28), Evangelical (N=8), Buddhist (N=2), Jewish (Unorthodox; N=2), Hindu (N=1), and Unaffiliated with Any Particular Organized Religion (N=16). A host of participants also chose "Other" to describe their religious affiliation, which included

specifiers such as Christian, Baptist, Unitarian, Nondenominational, Agnostic, and

Spiritual.

Concerning counselor training and multicultural training, the majority of

participants reported that they had completed more than four semesters/quarters of formal

counseling training (N=64). The next highest response was one semester (N=32),

followed by three semesters (N=22), two semesters (N=11), four semesters (N=9), and

zero semesters (N=3). With regard to multicultural training, 101 participants reported

having completed a multicultural course, 22 participants stated that they currently were

enrolled in a multicultural course, and 18 participants reported that they had not taken a

multicultural course.

Table 8

Demographic Information

Demographic Category	Demographic Variables	N	%
Graduate Level	Master's Level	128	90.8
	Doctoral Level	13	9.2
Gender	Female	112	79.4
	Male	29	20.6
Race/Ethnicity	Caucasian	78	55.3
	African American	35	24.8
	Hispanic/Latino/Latina	19	13.5
	Asian or Pacific Islander	3	2.1
	Bi/Multicultural	2	1.4
	Other	4	2.8
Sexual/Affectional Orientation	Heterosexual	133	94.3
	Gay	4	2.8
	Lesbian	3	2.1
	Bisexual	1	0.7
Religious Affiliation	Protestant	47	33.8
	Catholic	28	20.1

	Evangelical	8	5.8
	Buddhist	2	1.4
	Jewish (Unorthodox)	2	1.4
	Hindu	1	0.7
	Unaffiliated with Religious Affiliation	16	11.5
	Other	35	25.2
Counseling Training	Zero	3	2.1
	One	32	22.7
	Two	11	7.8
	Three	22	15.6
	Four	9	6.4
	More than Four	64	45.4
Multicultural Training Course	Yes, Completed a Multicultural Course	101	71.6
	No	18	12.8
	Currently Enrolled in a Multicultural Course	22	15.6

Descriptive Statistics and Reliabilities

Table 9 presents descriptive statistics, including ranges, means, standard deviations, and reliabilities (internal consistency) of the following scales and subscales: RSES, DCS, MCI, MCI Skills, MCI Awareness, MCI Relationship, and MCI Knowledge. Regarding the RSES, the overall scale ranges from 10 to 40. In this study, RSES scores ranged from 21 to 40 with a mean and standard deviation of 34.66 and 4.06, respectively. Based on a similar study Harmon-Jones et al. (1997) that utilized the RSES to assess self esteem's moderating effect following increased death awareness, it appears that the mean and range of scores, although negatively skewed, may be adequate for this study. Harmon-Jones et al. used the RSES to study the moderating effect of self esteem on college students' reactions to culturally different beliefs following increased death awareness. They determined arbitrary cutoff scores of low, moderate, and high self

esteem, wherein RSES scores ranging from 28 to 32 represented moderate self esteem, and scores from 36 to 40 represented high self esteem. Participants who scored below 28 were considered to have low self esteem and were excluded from the study. Although this study did not use cutoff scores to indicate low, moderate, and high self esteem, ranges of overall RSES scores were similar. Concerning reliability, the RSES had an internal consistency (Cronbach's Alpha) of .861. Blascovich & Tomaka (1991) reported that the internal consistency of the RSES ranged from .77 to .88, which held true for the current sample.

Regarding the DCS, possible scores range from 30 to 120. In this study, scores ranged from 47 to 105 with a mean overall score of 68.75 and a standard deviation of 11.54. Normative data, provided by Dickstein (1972), indicates that these results are similar to other studies that used the DCS. Dickstein, for example, provided descriptive data from four studies in which DCS means ranged from 70.53 to 74.54; standard deviations ranged from 11.02 to 12.61; minimum scores ranged from 33 to 45; and maximum scores ranged from 98 to 111. It appears that DCS descriptive data falls close to or within those distributions. The internal consistency (Cronbach's Alpha) of the DCS, in this study, was .871, which is similar to previous studies completed by Dickstein, wherein internal consistencies of the DCS ranged from .859 to .879.

Concerning the MCI, overall scores can range from 40 to 160. In this study, overall scores ranged from 89 to 149 with a mean score of 121.22 and a standard deviation of 11.45. The internal consistency (Cronbach's Alpha) of the MCI was .832. Sodowsky, Kuo-Jackson, Richardson, and Corey (1998) reported a similar mean and

standard deviation with a sample of 176 counselors (M = 128.99; SD = 12.24), which may indicate that the measure is not normally distributed. Hays (2008) reported that the internal consistency (Cronbach's Alpha) of the MCI was .90; however, other studies have reported internal consistencies closer to that of this sample (e.g., .87; Sodowsky et al.; .88; Sodowsky et al., 1994).

With regard to the MCI Skills subscale, possible scores can range from 11 to 44. In this study, scores ranged from 21 to 44 with a mean of 34.32 and a standard deviation of 3.99. These results, particularly the mean score, indicate that the majority of the participants in this sample reported high multicultural counseling skills. Sodowsky et al. (1998) reported a similar mean and standard deviation (M = 38.56; SD = 3.63) with a sample of 176 practicing counselors. The internal consistency (Cronbach's Alpha) for the MCI Skills subscale for this study was .745, which is lower than that which Sodowsky (1994) reported (α = .81).

For the MCI Awareness subscale, scores can range from 10 to 40. In this study, scores ranged from 16 to 40 with a mean of 28.39 and a standard deviation of 4.77. This distribution more closely resembles a normal distribution than did the MCI Overall score or Skills subscore. Sodowsky et al. (1998) reported a MCI Awareness subscale mean score of 31.47 and a standard deviation of 4.44 which, again, appears negatively skewed. The internal consistency (Cronbach's Alpha) of the MCI Awareness subscale for this study was .727. This was lower than the internal consistency (Cronbach's Alpha) reported by Sodowsky (1994) for the MCI Awareness subscale (α = .80).

Regarding the MCI Relationship subscale, scores can range from 8 to 32. For this sample, MCI Relationship scores ranged from 16 to 31 with a mean of 24.21 and a standard deviation of 3.24. Roysircar Sodowsky et al. (1998) reported a similar mean and standard deviation (25.68 and 3.10, respectively). The internal consistency of the MCI Relationship was .639, which is similar to previously reported internal consistencies (Cronbach's Alpha) of the MCI Relationship scale (.67; Sodowsky et al., 1994; .62; Sodowsky et al.).

Concerning the MCI Knowledge subscale, scores can range from 11 to 44. In this sample, scores ranged from 26 to 43 with a mean of 34.31 and a standard deviation of 3.62. The internal consistency of the subscale was .69. Roysircar Sodowsky et al. (1998) reported a similar mean and standard deviation (Mean = 33.29; SD = 3.83). The internal consistency (Cronbach's Alpha) of the MCI Knowledge score for the current sample is lower than previously reported internal consistencies. For example, Sodowsky et al. (1994) reported an internal consistency of .80 for the MCI Knowledge subscale.

Table 9

Descriptive Statistics

Scales and Subscales	Range		Mean	SD	Reliability α
	Minimum	Maximum			
RSES	21	40	34.66	4.06	.861
DCS	47	105	68.75	11.54	.871
MCI	89	149	121.22	11.45	.832
MCI Skills	21	44	34.32	3.99	.745
MCI Awareness	16	40	28.39	4.77	.727
MCI Relationship	16	31	24.21	3.24	.639

MCI Knowledge	26	43	34.31	3.62	.690

Hypothesis Testing

In this section, research hypotheses are presented, a description of how these hypotheses were tested is described, the results of the analyses is presented, and a conclusion about each hypothesis is given.

Hypothesis 1a Results

Hypothesis 1a stated the following: Counseling students who complete a death awareness questionnaire before rating their multicultural counseling competencies will rate themselves lower on multicultural counseling competencies than will counseling students who do not complete a death awareness questionnaire before rating their multicultural counseling competence. To test this hypothesis, a one-way analysis of variance (ANOVA) was run. This analysis assessed the difference in self-reported MCC scores and subscale scores between counseling students who received death reminders before completing the MCI and counseling students who completed the MCI before receiving death reminders.

As described in Table 10, 67 participants (control group; 48.5%) were randomly assigned to complete the MCI before completing the DCS, and 74 participants (death awareness group; 52.4%) were randomly assigned to complete the DCS before completing the MCI. The MCI Overall mean and standard deviation scores for the control group were 124.54 and 11.71, respectively. For the death awareness group, the MCI Overall mean and standard deviation scores were 118.22 and 10.41, respectively. The difference between the means of the control and death awareness groups was 6.32 points.

Regarding MCI subscale scores, the control group had mean scores of 35.06, 35.37, 24.96, and 29.16 on the MCI Knowledge, Skills, Relationship, and Awareness subscales, respectively. The death awareness group had mean scores of 33.64, 33.37, 23.53, and 27.69 on the MCI Knowledge, Skills, Relationship, and Awareness subscales, respectively. As illustrated in Table 10, the death awareness group's mean score was lower than that of the control group on each MCI subscale.

Table 10

Order of Administration: Means, Standard Deviations, and Range

		N	Mean	SD	Minimum	Maximum
MCI Overall	MCI First	67	124.54	11.71	103	149
	DCS First	74	118.22	10.41	89	147
	Total	141	121.22	11.45	89	149
MCI Knowledge	MCI First	67	35.06	3.61	26	42
	DCS First	74	33.64	3.51	26	43
	Total	141	34.31	3.62	26	43
MCI Skills	MCI First	67	35.37	3.74	28.5	44
	DCS First	74	33.37	3.99	21	42
	Total	141	34.32	.3.99	21	44
MCI Relationship	MCI First	67	24.96	3.28	17	31
	DCS First	74	23.53	3.07	16	31
	Total	141	24.21	3.24	16	31
MCI Awareness	MCI First	67	29.16	4.86	20	40
	DCS First	74	27.69	4.61	16	39.5
	Total	141	28.39	4.77	16	40

Results of the one-way ANOVA, as illustrated in Table 11, indicate a statistically significant difference in MCI Overall scores between participants who experienced increased death awareness prior to completing the MCI (death awareness group) and participants who completed the MCI prior to experiencing increased death awareness (control group; $F(1,139)=11.485, p=.001, \eta^2=.076$). Regarding the subscales of the MCI, results also indicated statistically significant differences in MCI Skills ($F(1,139)=9.32, p=.003, \eta^2=.063$), MCI Knowledge ($F(1,139)=5.623, p=.019, , \eta^2=.039$), and MCI Relationship ($F(1,139)=7.117, p=.009, \eta^2=.049$) scores between the death awareness group and the control group. No difference in MCI Awareness scores between groups was revealed.

Table 11

Order of Administration: One-Way ANOVA Results

		Sum of Squares	df	Mean Square	F	Sig.
MCI Overall	Between	1400. 93	1	1400.933	11.485	.001
	Within	16955.37	139	121.981		
	Total	18356.31	140			
MCI Knowledge	Between	71.36	1	71.360	5.623	.019
	Within	1763.91	139	12.69		
	Total	1835.27	140			
MCI Skills	Between	139.82	1	139.82	9.32	.003
	Within	2085.27	139	15.00		
	Total	2225.08	140			
MCI Relationship	Between	71.724	1	71.72	7.12	.009
	Within	1400.81	139	10.08		
	Total	1472.54	140			
MCI Awareness	Between	75.48	1	75.48	3.37	.069
	Within	3112.88	139	22.40		
	Total	3188.37	140			

Results of the one-way ANOVA support Hypothesis 1a; participants who experienced increased death awareness prior to completing the MCI, rated themselves lower on their MCCs compared with participants who did not experience increased death awareness before completing the MCI. This held true for the MCI Overall score and three of the four MCI subscales, including MCI Skills, MCI Knowledge, and MCI Relationship. Although the mean score for the death awareness group also was lower than that of the control group on the MCI Awareness subscale, the difference was not statistically significant. Aside from the MCI Awareness subscale, these results indicate that increased death awareness has a negative effect on counseling students' self perceived MCCs.

Hypothesis 1b Results

Hypothesis 1b stated that counseling students with high death concerns will rate their multicultural counseling competencies lower than will counseling students with low death concerns. To test this hypothesis, a multiple regression was run using a General Linear Model. As illustrated in Table 12, no significant difference in MCC mean scores was found between participants with high death concerns and participants with low death concerns. Therefore, the hypothesis was not supported.

Table 12

Effect of Death Concern on MCCs

Dependent Variable	F Values	Significance
MCI Overall	F(44,96)=1.383	.095
MCI Skills	F(44,96)=1.098	.346
MCI Awareness	F(44,96)=1.196	.232

MCI Relationships	F(44,96)=1.120	.318
MCI Knowledge	F(44,96)=1.090	.357

Hypothesis 2 Results

Hypothesis 2 stated that, following death reminders, students with high self esteem will rate themselves higher on multicultural counseling competencies than will students with moderate or low self esteem. This hypothesis was investigated using a series of linear regressions using a General Linear Model. The order of administration of the MCI and DCS (Order) served as the predictor variable (death reminders), self esteem (RSES) served as a moderating variable, and MCC scores (overall score and subscale scores) served as criterion variables. Table 13 illustrates the results of the analysis.

Table 13

Moderating Effect (Interaction) of Self Esteem and Order

Dependent Variable	F Values and **Significance**		
	Order	RSES	RSES*Order
MCI Overall	F(1,108)=6.409 **.013**	F(18,108)=1.442 **.127**	F(13,108)=.511 **.914**
MCI Skills	F(1,108)=4.834 **.030**	F(18,108)=1.429 **.133**	F(13,108)=.670 **.788**
MCI Awareness	F(1,108)=2.000 **.110**	F(18,108)=.674 **.830**	F(13,108)=.973 **.483**
MCI Relationships	F(1,108)=4.540 **.035**	F(18,108)=2.233 **.006**	F(13,108)=.779 **.681**
MCI Knowledge	F(1,108)=2.203 **.141**	F(18,108)=1.511 **.100**	F(13,108)=.448 **.948**

As described in Table 13, the interaction of order of administration (e.g., control group; death awareness group) and self esteem did not significantly predict MCI Overall scores or subscale scores. Thus, no moderating effect of self esteem on participants' self

perceived MCCs was found following increased death awareness. In other words, higher

self esteem did not appear to buffer the negative effects of increased death awareness on

counseling students' multicultural counseling competence. Therefore, hypothesis 2 was

not supported.

Hypothesis 3a Results

Hypothesis 3a stated that multicultural training will moderate the effect of death

reminders on counseling students' self perceived multicultural counseling competence,

such that, following death reminders counseling students who have had multicultural

training will rate themselves higher on their multicultural counseling competence than

will counseling students who have not had multicultural training. This hypothesis was

analyzed using a series of linear regressions using a General Linear Model. In the

analysis, order of administration (e.g., MCI First; DCS First) served as a predictor

variable, multicultural training served as a moderating variable, and MCI Overall score

and subscale scores served as criterion variables. Table 14 illustrates the results of the

analyses. As illustrated in Table 14, no moderating effect of multicultural training on

participants self-reported MCCs was revealed. Therefore, hypothesis 3a was not

supported. These results indicate that, regardless of multicultural training, participants

who received death reminders prior to completing the MCI rated themselves lower on

their multicultural counseling competence than did participants who did not receive death

reminders prior to completing the MCI.

Table 14

Moderating Effect (Interaction) of Multicultural Training (MT) and Order

Dependent Variable	F Values and **Significance**		
	Order	MT	MT*Order
MCI Overall	F(1,135)=7.947 **.006**	F(2,135)=1.001 **.370**	F(2,135)=.785 **.458**
MCI Skills	F(1,135)=9.724 **.002**	F(2,135)=1.941 **.148**	F(2,135)=1.563 **.213**
MCI Awareness	F(1,135)=2.271 **.134**	F(2,135)=2.423 **.093**	F(2,135)=.195 **.823**
MCI Relationships	F(1,135)=3.089 **.081**	F(2,135)=1.154 **.318**	F(2,135)=.306 **.737**
MCI Knowledge	F(1,135)=3.459 **.065**	F(2,135)=3.369 **.037**	F(2,135)=.400 **.671**

Hypothesis 3b Results

Hypothesis 3b stated that other than multicultural training, demographic variables will not predict counseling students' ratings of multicultural counseling competence following death reminders. This was tested using a series of linear regressions with the General Linear Model. The order of administration of the MCI and DCS served as the predictor variable. Demographic variables (gender, race/ethnicity, age, religious affiliation, sexual orientation, years of counseling training, and graduate level) served as moderating variables, and MCC scores (overall MCC score and subscale scores) served as criterion variables. As illustrated in Tables 15-19, results revealed, with one exception, that demographic variables did not have a moderating effect on participants' self perceived MCCs following increased death awareness, which supports hypothesis 3b. However, graduate level (master's, doctoral) had a moderating effect on participants' self perceived multicultural counseling knowledge following increased death awareness (*p=.004)*, which does not support hypothesis 3b.

Table 15

Moderating Effect (Interaction) of Demographic Variables (Dependent Variable: MCI Overall)

Demographic Variable	F Values and **Significance**		
	Order	Demographic Variable	Interaction
Gender	F(1,137)=4.821 **.030**	F(1,137)=.235 **.628**	F(1,137)=.487 **.486**
Race/Ethnicity	F(1,129)=2.122 **.148**	F(5,129)=7.074 **.000**	F(5,129)=.887 **.492**
Age	F(1,97)=7.176 **.009**	F(28,97)=.947 **.549**	F(14,97)=1.296 **.224**
Religious Affiliation	F(1,125)=9.653 **.002**	F(7,125)=1.728 **.108**	F(5,125)=.412 **.840**
Sexual Orientation	F(1,135)=3.473 **.065**	F(3,135)=2.510 **.061**	F(1,135)=.847 **.359**
Counseling Training	F(1,129)=9.327 **.003**	F(5,129)=2.281 **.050**	F(5,129)=.583 **.713**
Graduate Level	F(1,137)=8.466 **.004**	F(1,137)=2.451=**.120**	F(1,137)=1.439 **.232**

Table 16

Moderating Effect (Interaction) of Demographic Variables (Dependent Variable: MCI Knowledge)

Demographic Variable	F Values and **Significance**		
	Order	Demographic Variable	Interaction
Gender	F(1,137)=1.904 **.170**	F(1,137)=.011 **.918**	F(1,137)=.649 **.422**
Race/Ethnicity	F(1,129)=.436 **.510**	F(5,129)=1.714 **.136**	F(5,129)=.879 **.497**
Age	F(1,97)=5.576 **.020**	F(28,97)=1.447 **.095**	F(14,97)=.870 **.593**
Religious Affiliation	F(1,125)=6.946 **.009**	F(7,125)=.991 **.441**	F(5,125)=.412 **.840**
Sexual Orientation	F(1,135)=1.471 **.227**	F(3,135)=1.900 **.133**	F(1,135)=.323 **.571**
Counseling Training	F(1,129)=7.181 **.008**	F(5,129)=2.058 **.075**	F(5,129)=.692 **.630**
Graduate Level	F(1,137)=14.431 **.000**	F(1,137)=1.283 **.259**	F(1,137)=8.746 **.004**

Table 17

Moderating Effect (Interaction) of Demographic Variables (Dependent Variable: MCI Skills)

Demographic Variable	F Values and **Significance**		
	Order	Demographic Variable	Interaction

Gender	F(1,137)=3.832 **.052**	F(1,137)=.658 **.419**	F(1,137)=.349 **.556**
Race/Ethnicity	F(1,129)=1.865 **.174**	F(5,129)=3.204 **.009**	F(5,129)=.873 **.501**
Age	F(1,97)=4.377 **.039**	F(28,97)=1.047 **.418**	F(14,97)=.664 **.803**
Religious Affiliation	F(1,125)=5.126 **.025**	F(7,125)=.983 **.447**	F(5,125)=.270 **.926**
Sexual Orientation	F(1,135)=2.357 **.127**	F(3,135)=1.897 **.133**	F(1,135)=.481 **.489**
Counseling Training	F(1,129)=7.687 **.006**	F(5,129)=2.780 **.020**	F(5,129)=.708 **.619**
Graduate Level	F(1,137)=4.630 **.033**	F(1,137)=12.192 **.001**	F(1,137)=.077 **.782**

Table 18

Moderating Effect (Interaction) of Demographic Variables (Dependent Variable: MCI Relationship)

Demographic Variable	F Values and **Significance**		
	Order	Demographic Variable	Interaction
Gender	F(1,137)=6.645 **.011**	F(1,137)=2.322 **.130**	F(1,137)=.243 **.623**
Race/Ethnicity	F(1,129)=.391 **.533**	F(5,129)=6.311 **.000**	F(5,129)=1.139 **.343**
Age	F(1,97)=9.294 **.003**	F(28,97)=.434 **.993**	F(14,97)=1.120 **.350**
Religious Affiliation	F(1,125)=6.934 **.010**	F(1,125)=2.705 **.012**	F(5,125)=.625 **.681**
Sexual Orientation	F(1,135)=3.693 **.057**	F(3,135)=1.943 **.126**	F(1,135)=1.337 **.250**
Counseling Training	F(1,129)=.572 **.451**	F(5,129)=.635 **.674**	F(5,129)=1.074 **.378**
Graduate Level	F(1,137)=5.608 **.019**	F(1,137)=2.095 **.150**	F(1,137)=1.501 **.223**

Table 19

Moderating Effect (Interaction) of Demographic Variables (Dependent Variable: MCI Awareness)

Demographic Variable	F Values and **Significance**		
	Order	Demographic Variable	Interaction
Gender	F(1,137)=.595 **.442**	F(1,137)=2.004 **.159**	F(1,137)=.764 **.384**
Race/Ethnicity	F(1,129)=1.438 **.233**	F(5,129)=4.689 **.001**	F(5,129)=.936 **.460**
Age	F(1,97)=.419 **.519**	F(28,97)=1.053 **.411**	F(14,97)=1.477 **.134**
Religious Affiliation	F(1,125)=2.567 **.112**	F(7,125)=1.180 **.319**	F(5,125)=.207 **.959**
Sexual Orientation	F(1,135)=.745 **.390**	F(3,135)=2.650 **.051**	F(1,135)=.132 **.717**
Counseling Training	F(1,129)=5.532 **.020**	F(5,129)=2.237 **.054**	F(5,129)=.578 **.717**
Graduate Level	F(1,137)=.508 **.477**	F(1,137)=1.037 **.310**	F(1,137)=.171 **.680**

These results mean a few things. First, they indicate that, regardless of age, race/ethnicity, religious affiliation, sexual orientation, gender, and years of counseling training, participants who receive increased death awareness before rating their MCCs are more likely to rate their MCCs lower than are participants who do not experience increased death awareness prior to rating their MCCs. Second, results indicate that master's level counseling student participants may be less affected by increased death awareness, at least in their assessment of their multicultural knowledge, than are doctoral level counseling student participants following death awareness (See Figure 1). One explanation for this may be that the lower number of doctoral participants in the study may have made their perceived MCC Knowledge mean scores more susceptible to extreme scores. Figure 1 illustrates the interaction effect between order of administration and graduate level.

Figure 1

Moderating Effect of Graduate Level (Master's and Doctoral)
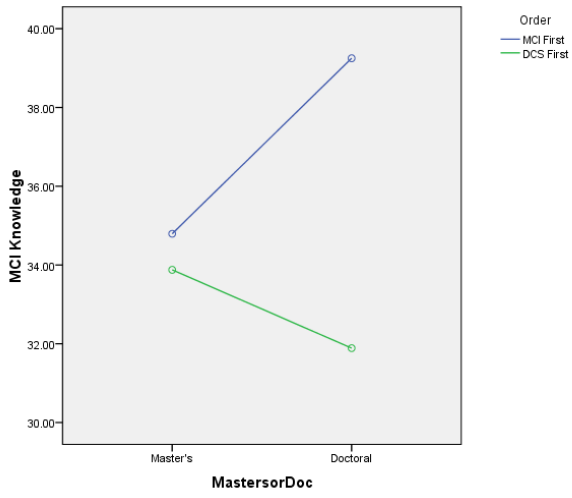
Post Hoc Analyses

After testing the research hypotheses, two post hoc analyses were run to determine if race/ethnicity and religious affiliation had an effect on counseling students' self perceived MCCs. For both analyses, some groups were not included because of low sample sizes. Concerning race/ethnicity, Caucasians, African-Americans, and Hispanics/Latinos/Latinas were included. Regarding religious affiliation, Protestants and Catholics were included. A one-way ANOVAs followed by a Bonferonni comparison were run to analyze differences in MCCs among race/ethnic groups, and an independent t test was run to determine the difference in MCCs between those who identified as Protestant and those who identified as Catholic.

Regarding race/ethnicity, first, descriptive statistics, as illustrated in Table 20, were run. For MCI Overall scores, African Americans (N=35) had a mean score of 121.52, Caucasians (N=78) had a mean score of 118.53, and Hispanics/Latinos/Latinas (N=19) had a mean score of 132.08. For MCI Awareness, African Americans had a mean score of 28.94, Caucasians had a mean score of 27.07, and Hispanics/Latino/Latinas had a mean score of 32.24. For MCI Relationship subscale scores, African Americans had a mean score of 24.33, Caucasians had a mean score of 23.69, and Hispanics/Latinos/Latinas had a mean score of 26.74. For MCI Skills, African Americans had a mean score of 34.21, Caucasians had a mean score of 33.84, and Hispanics/Latinos/Latinas had a mean score of 36.95. For MCI Knowledge, African Americans had a mean score of 34.04, Caucasians had a mean score of 33.93, and Hispanics/Latinos/Latinas had a mean score of 36.16.

A one-way ANOVA, as illustrated in Table 20, indicated a difference in groups regarding MCI overall scores (*F(5,135)=5.549, p=.000*), MCI Awareness (*F(5,135)=4.408, p=.001*), and MCI Relationship (*F(5,135)=5.314, p=.000*). No difference was found, however, regarding MCI Knowledge ((*F(5,135)=1.730, p=.132*) and MCI Skills (*F(5,135)=2.173, p=.061*). For the one-way ANOVA, descriptive statistics were run.

Table 20

Comparison of Race/Ethnic Groups' MCCs

Dependent Variable	Groups	Means	Standard Deviations	F	Sig.
MCI Overall	African American	121.52	11.63	5.55	.000
	Caucasian	118.53	10.30		
	Hispanic/Latino/Latina	132.08	10.56		
MCI Knowledge	African American	34.04	3.40	1.73	.132
	Caucasian	33.93	3.41		
	Hispanic/Latino/Latina	36.16	4.68		
MCI Skills	African American	34.21	4.03	2.17	.061
	Caucasian	33.85	4.01		
	Hispanic/Latino/Latina	32.67	3.36		
MCI Relationships	African American	24.33	3.28	5.31	.000
	Caucasian	23.69	2.97		
	Hispanic/Latino/Latina	26.74	3.00		
MCI Awareness	African American	28.94	4.70	4.41	.001
	Caucasian	27.07	4.40		
	Hispanic/Latino/Latina	32.24	4.44		

A Bonferonni comparison shed light on differences in self reported MCCs between those who identified as African Americans, Caucasians, and Hispanics/Latinos/Latinas. Concerning MCI Overall scores, Hispanic/Latino/Latina counseling students scored higher on average than did African American students and Caucasian students (p = .01 and p = .000, respectively). Concerning MCI Awareness, no

difference was found between African American students and Hispanic/Latino/Latina

students; however, results indicated that Caucasian students reported lower MCI

Awareness than did Hispanic/Latino/Latina students (p = .000). Regarding MCI

Relationship, again, no difference was indicated between African Americans and

Hispanics/Latinos/Latinas; however, Hispanic/Latino/Latina students self reported higher

MCI Relationship skills than did Caucasian students (p = .002). The same held true for

MCI skills. The only mean difference was between Caucasians and

Hispanics/Latinos/Latinas, with Hispanics/Latinos/Latinas reporting higher MCI Skills

than did Caucasians (p = 035). No difference between groups was revealed on the MCI

Knowledge subscale.

Concerning the second post hoc analysis, an independent t test was run to analyze

the difference in self reported MCCs between those who identified as Catholics and those

who identified as Protestants. Results of the independent t test, as illustrated in Table 17,

revealed differences between Catholics and Protestants regarding MCI overall scores (*p*

= .026) and MCI Relationship scores (p=.050). For the MCI Overall scale, Catholics self

reported higher MCCs than did Protestants (M = 125.70; SD = 11.48 and M = 120.05; SD

= 9.74, respectively). This also held true for the MCI Relationship subscale (M = 25.57;

SD 2.94; M = 24.17; SD = 2.96, respectively).

Table 21

Comparison between Religious Affiliation and MCCs

Dependent Variable	Group	Means	Standard Deviations	t-value	Sig (2-tailed)
MCI Overall	Catholic	125.70	11.48	2.27	.026

	Protestant	120.05	9.74		
MCI Knowledge	Catholic	34.96	4.09	1.18	.241
	Protestant	33.99	3.02		
MCI Skills	Catholic	35.68	3.51	1.86	.067
	Protestant	34.13	3.47		
MCI Relationships	Catholic	25.57	2.94	1.99	.050
	Protestant	24.17	2.96		
MCI Awareness	Catholic	29.48	4.87	1.54	.129
	Protestant	27.76	4.62		

Summary of Results

In this chapter, results of a study analyzing the effect of increased death awareness and the moderating effect of self esteem on counseling students' self perceived multicultural counseling competence were presented. Results supported hypothesis 1a that counseling students who complete a death awareness questionnaire before rating their MCCs will rate themselves lower on MCCs than will counseling students who do not complete a death awareness questionnaire before rating their MCCs. Results of the study also partially supported hypothesis 3b that demographic variables would not moderate the effect of increased death awareness on participants' self perceived multicultural counseling competence.

Not all results supported the research hypothesis. Hypothesis 2, for example, stated that self esteem would moderate the effects of increased death awareness on counseling students self perceived MCCs. This was not supported. Hypothesis 1a, which stated that death concern would affect counseling students' self perceived MCCs also was not supported. Moreover, graduate level (master's or doctoral level) had a moderating effect on counseling students' self perceived multicultural counseling knowledge

following increased death awareness, such that master's students appeared less affected by increased death awareness than were doctoral students. This did not support hypothesis 3b.

Two post hoc analyses also were run, which indicated that Hispanic/Latino/Latina counseling students perceived their overall MCCs higher than did African American and Caucasian counseling students. Also, concerning MCI subscale scores, Hispanic/Latino/Latina students self reported higher MCI Skills, MCI Awareness, and MCI Relationship scores than did Caucasian students. For the second post hoc analysis, a difference in MCI Overall scores and MCI Relationship scores was found between self identified Catholic and Protestant students, with Catholic students self reporting higher MCI Overall and MCI Relationship scores. Discussion and implications of the results described in Chapter IV are presented in Chapter V.

CHAPTER V

DISCUSSION

In Chapter IV, results associated with the effect of increased death awareness and the moderating effect of self esteem were presented. In this chapter, results outlined in Chapter IV are discussed. First, a discussion of sample demographics is provided. Second, descriptive and reliability statistics of the instruments are discussed. Third, results of hypothesis testing are analyzed and discussed. Finally, potential limitations of the study and implications for counselor education and counseling praxis are provided, followed by recommendations for future research.

Discussion

In this section discussion related to the results described in Chapter IV is presented. First, noteworthy results associated with the participant sample are discussed. Second, discussion of the descriptive statistics and reliability coefficients of the instruments is provided. Third, hypothesis testing is described for each research hypothesis.

Participant Sample

As described in Chapters III and IV, participants were 141 master's and doctoral level counseling students enrolled in CACREP-accredited counseling programs. Participants for the study were recruited from various counseling programs at universities located in the Southeast and Southwest regions of the United States. As noted in Chapter

IV, the majority of counseling students were female, Caucasian, heterosexual, and Protestant or Catholic. Concerning training, the majority of the students were master's level students, and they had completed a multicultural counseling course. Based on a power analysis (analyzed using G*Power) described in Chapter III, a sample between 180-200 participants was desired; however, because of constraints associated with participant recruitment (e.g., getting permission to enter classrooms to recruit participants), only 141 counseling students participated in the study. This is a potential limitation of the sample and should be considered when interpreting the results.

Regarding convenience sampling and voluntary participation, because participants were not a random-sample of counseling students in the United States, the external validity of the study may be limited. To improve the generalizability of the study, the researcher requested counseling student participation from a variety of different universities in the Southeast and Southwest regions of the United States; nevertheless, because of potential limitations regarding the generalizability of the study, results should be interpreted with caution.

In particular, a large number of students self identified as female, Caucasian, heterosexual, Christian (e.g., Protestant, Catholic), and master's students. These overrepresentations of certain demographic groups in this study may or may not be consistent with the makeup of students at counseling programs throughout the United States. Smaller percentages of certain demographics, such as, males, gay, lesbian, and bisexual students, doctoral level students, and certain racially/ethnically diverse groups, may further minimize the generalizability of the results of the study to those populations.

Instruments

As described in Chapter III, three self-report instruments were utilized in the study along with a brief demographic questionnaire and the Literary Preference Questionnaire (LPQ). The self report instruments included Rosenberg's Self Esteem Scale (RSES), the Death Concern Scale (DCS), and the Multicultural Counseling Inventory (MCI). For the MCI, the overall scale and its four subscales (Multicultural Knowledge, Multicultural Awareness, Multicultural Skills, and Multicultural Relationship) were included as dependent variables in the study. In this section, noteworthy descriptive statistics and reliability coefficients associated with these measures is discussed.

Regarding reliability, the RSES, DCS, and MCI appeared to have adequate internal consistency based on norming groups. Two MCI subscales, the Multicultural Relationship subscale and the Multicultural Knowledge subscale, however, suffered from lower internal consistency (.639 and .690, respectively). For the Multicultural Relationship subscale, other similar studies reported comparable internal consistencies, which may indicate that this subscale inherently suffers from lower internal consistency. This may be due to a fewer number of items (n =8) or to unique characteristics of the current sample. Differential multicultural training across counseling programs, which was not held constant in this study, also may contribute to lower internal consistencies of the MCI Reliability and MCI Knowledge subscales.

For the Multicultural Knowledge subscale, an internal consistency (.690) was somewhat lower than internal consistencies reported in other similar studies. This lower internal consistency may have affected the results of the study.

Concerning descriptive statistics (e.g., Means, Standard Deviations, Ranges), the RSES and MCI overall scale and MCI Knowledge, Relationship, and Skills subscales, appeared to have distributions that were negatively skewed. Based on similar studies that used the RSES and the MCI, it appears that higher means and truncated ranges are common with these instruments. Nevertheless, these truncated ranges may have impacted the results of the study.

<div align="center">Hypothesis Testing</div>

Five hypotheses were presented in this study (Hypothesis 1a, 1b, 2, 2a, and 2b). In Chapter IV, results testing these five hypotheses were proposed. In this section, discussion of the results associated with each hypothesis is discussed.

Hypothesis 1a

Hypothesis 1a stated that counseling students who complete a death awareness questionnaire before rating their multicultural counseling competencies will rate themselves lower on multicultural counseling competencies than will counseling students who do not complete a death awareness questionnaire before rating their multicultural counseling competence. Results indicated support for Hypothesis 1a, except for on the MCI Awareness subscale. This result appears to indicate that experiencing increased death awareness negatively affects counseling students' self perceptions of their multicultural counseling competence, such that they rate their MCCs lower than do

counseling students who self rate their MCCs prior to experiencing increased death

awareness. This appears to hold true for overall MCCs, as well as for the MCC

relationship skills, MCC skills, and MCC knowledge.

A possible alternative explanation for these results is that the order of

administration of the MCI affected participants' ratings of their MCCs. As described in

Chapter III, the death awareness group completed the MCI after completing the RSES

and the DCS, and the control group completed the MCI after completing the RSES and

before completing the DCS. It is possible that other factors, possibly, fatigue may explain

mean differences, but it does not account for why a lower MCC Relationship score was

revealed.

Concerning MCC relationship skills, results supporting Hypothesis 1a may be

explainable using Terror Management Theory (TMT). Roysircar (2003) stated that

counseling students who are multiculturally competent regarding their multicultural

relationship skills possess the following qualities: They are "comfortable with minority

client's differences; "confident in facing personal limitations;" "sensitive to client

mistrust;" "understand countertransference and/or defensive reactions with minority

clients;" "sensitive to difficulties based on cognitive style;" "strive to avoid stereotyped

and biased case conceptualization;" "understand minority client-majority group

comparisons;" and "know how differences in worldview affect counseling" (p. 20).

Terror Management theorists suggest that following increased death awareness, people

are more inclined to feel uncomfortable with minority differences, are less sensitive

toward dissimilar others, and less understanding of diversity. They also are more likely to

espouse stereotypic, biased views of diverse clients; and they are less likely to understand or validate different cultural worldviews than are people who do not experience increased death awareness. Another explanation for the results indicating a difference between the death awareness group and the control group regarding MCC relationship skills is that the lower internal consistency of the MCI Relationship subscale affected the results.

Regarding Multicultural Knowledge and Multicultural Skills, it is somewhat less clear why increased death awareness affected participants' self-perceived multicultural knowledge and skills. As noted in Chapter III, Sodowsky (1994) stated that Multicultural Knowledge is operationalized in terms of counselors' knowledge of "culturally relevant case conceptualization and treatment strategies, cultural information, and multicultural counseling research" (p. 142). Sodowsky operationalized Multicultural Skills in terms of "success with retention of minority clients, recognition of and recovery from cultural mistakes, use of nontraditional methods of assessment, counselor self-monitoring, and tailoring structured versus unstructured therapy to the needs of minority clients" (p. 141). How exactly increased death awareness, for example, negatively affected participants' perceptions of their history of success with retention of minority clients or their perceived knowledge of multicultural counseling research is unclear. One explanation might be that increased death awareness which, according to TMT cultivates a closer alignment with one's own culture and disparagement of differing worldviews, may affect counseling students' self efficacy associated with multicultural issues, thereby contributing to a lower self-perceived overall multicultural counseling competence, including multicultural knowledge and skills. Constantine (2001) conjectured that, self report MCC instruments,

rather than measuring multicultural counseling competence may, in fact, measure counseling students' self efficacy associated with multicultural counseling.

Reasons for a non-statistically significant difference between the death awareness group and the control group on the MCI Awareness subscale also are unclear. However, it may be possible that the sample size of 141 participants rather than 180 to 210 may have contributed to the non-significant result. A larger sample size may have supported a difference between groups regarding Multicultural Awareness, if in fact there is a difference.

Effect sizes were computed for statistically significant analyses. For all four analyses, low effect sizes were calculated (from .039 to .076). This is somewhat puzzling, because other TMT studies (e.g., Rosenblatt et al., 1989; Greenberg et al., 1990) revealed larger mean differences between control groups and the mortality-salient groups. It is possible that low effect sizes can be explained by instrumentation. In this study and in other similar studies, the MCI Overall score and subscale scores appeared to have negatively skewed, truncated distributions, which creates lower variability. Lower variability may explain the low effect sizes.

Hypothesis 1b

Hypothesis 1b stated that counseling students with high death concerns will rate their multicultural counseling competencies lower than will counseling students with low death concerns. Results of a multiple regression did not support this hypothesis. No difference in self-rated MCC scores was found between high death concern and low death concern participants. Although this result is puzzling in relation to TMT's

proposition that death fear cultivates worldview defense, there may be an explanation for the result based on TMT. Rosenblatt et al. (1989), in one of their six experiments, compared the effect of anxiety, as measured by the A-Trait form of the State-Trait Anxiety Inventory (Spielberger et al., 1970) on participants' reactions to diversity. They found that anxiety did not significantly affect participants' reactions to diversity. In fact, people who received subtle death reminders, reacted more negatively toward diversity than did people who rated themselves as having either state or trait anxiety. In norming the DCS, Dickstein (1970) ran a convergent validity analysis of the DCS with the State-Trait Anxiety Inventory. He found that anxiety and death concern were positively related, albeit somewhat different constructs. Based on the results of this study and those of Rosenblatt et al.'s study, it appears that state or trait anxiety and anxiety engendered by conscious death concern do not significantly influence attitudes toward diversity and self-perceived MCCs. Some TMT theorists would probably state that death fear that is raised to the fringes of the unconscious elicits worldview defenses more so than does a "conscious contemplation of the reality of death and negative evaluation of that reality" (death concern; Dickstein, p. 564; Greenberg et al., 1994).

Hypothesis 2

Hypothesis 2 proposed that, following death reminders, students with high self esteem will rate themselves higher on multicultural counseling competencies than will students with moderate or low self esteem. Results did not support this hypothesis. Contrary to the hypothesis and TMT literature, no moderating effect of self esteem on counseling students' self perceived MCCs following increased death awareness was

found. It is possible that, because self esteem scores in the sample were not normally

distributed and, in fact, negatively skewed, there was not sufficient variability in self

esteem scores for a moderating effect to occur. Further studies of increased death

awareness on counseling students, possibly with different measures of self esteem, could

possibly shed light on this result. Also, it may be possible that, using the RSES with

clearly delineated contrasted groups would yield different results. For example, Harmon-

Jones et al. (1997) analyzed the moderating effects of self esteem on increased death

awareness using the RSES. They contrasted high and moderate self esteem using RSES

percentile scores. High self esteem represented participants who scored above the 75th

percentile on the RSES (greater than 36), and moderate self esteem represented

participants who scored between the 25th and 50th percentile on the RSES (28-32). Future

studies analyzing the moderating effect of self esteem on increased death awareness may

consider using contrasted groups similar to that. Including a low self esteem group,

possibly those who score below the 25th percentile, also could yield important findings.

Hypothesis 3a

Hypothesis 3a stated that multicultural training will moderate the effect of death

reminders on counseling students' self perceived multicultural counseling competence,

such that, following death reminders counseling students who have had multicultural

training will rate themselves higher on their multicultural counseling competence than

will counseling students who have not had multicultural training. Similar to hypothesis 2,

results of the study did not support hypothesis 3a. Thus, regardless of multicultural

counseling training, increased death awareness appears to negatively affect counseling

students' self perceived MCCs. If this result is not due to potential limitations of the study, it is important, because it infers that multicultural training may be insufficient in moderating the negative effects of increased death awareness. In the Implications section of this chapter, more on how this study may inform multicultural training is proposed.

Alternatively, there are possible limitations of the sample size that might explain why the hypothesis was not supported. For example, the vast majority of participants reported having completed a multicultural counseling course (71.6%). Only 12.8% of participants reported that they had not taken a multicultural counseling course, and 15.6% reported that they currently were enrolled in a multicultural counseling course. It may be possible that more equitably sized groups would have provided different results.

Hypothesis 3b

Hypothesis 3b stated that other than multicultural training, demographic variables will not predict counseling students' ratings of multicultural counseling competence following death reminders. The other demographic variables gathered in this study were gender, race/ethnicity, age, religious affiliation, sexual orientation, years of counseling training, and graduate level (master's and doctoral). For the most part, results of the study supported the hypothesis. Other than graduate level, no moderating effect of demographic variables on participants' self perceived MCCs was indicated following increased death awareness. Results revealed that graduate level had a moderating effect on counseling students' self perceived multicultural knowledge following increased death awareness. In particular, master's level students were found to be less affected on their MCC Knowledge self ratings than were doctoral students. This is a peculiar result, and difficult

to explain. It may be that, because only 9.2% of the sample was made up of doctoral students, they were more susceptible to the influence of extreme scores. Or, the results may be due to a higher level of both training and experience, or some other factors unique to doctoral students, or to this sample of doctoral students. Because doctoral students are future counselor educators, further examination of their MCC with larger samples is clearly needed to better understand the current finding.

Post Hoc Analyses

As presented in Chapter IV, two post hoc analyses were run to understand the difference in self perceived MCCs between racial/ethnic groups and religious affiliations. Based on sample size, the post hoc analysis for racial/ethnic groups included only African Americans, Caucasians, and Hispanics/Latinos/Latinas. The post hoc analysis for religious affiliation included only Catholics and Protestants. First, racial/ethnicity group differences are discussed, followed by religious affiliation differences.

As demonstrated in Chapter IV, a significant difference regarding overall MCC was reported between African Americans, Caucasians, and Hispanics/Latinos/Latinas, with Hispanic/Latino/Latina counseling students reporting higher overall MCCs than did African Americans or Caucasians. Regarding specific MCCs, Hispanic/Latino/Latina students reported higher multicultural skills, multicultural relationship skills, and multicultural awareness than did Caucasian students. No differences between African American students and Caucasian students were revealed.

These post hoc findings replicate, to some extent, previous studies that have analyzed the difference between racial/ethnic groups and multicultural counseling

competence. Constantine (2001, 2002), for example, reported that minority students self rated their MCCs higher than did Caucasian students. She explained these results in terms of exposure to cultural diversity, stating that minority students, because they have to interact with a diverse, majority society on a daily basis, have more cross cultural interactions. This exposure, according to Sue et al. (e.g., Tripartite model; 1992; 1998), enhances multicultural counseling competence. More exposure to different cultures may explain, to some extent, why Hispanic/Latino/Latina students reported higher MCCs than did Caucasian students.

Increased exposure to cultural diversity also may partially explain why Hispanic/Latino/Latina counseling students reported higher overall MCCs than did African American counseling students. Along with exposure to multicultural interactions, Latinos/as residing in the United States oftentimes are exposed to bilingual contexts (Santiago-Rivera & Altarriba, 2002). It is quite common, for example, for Latino/a children to speak English at school and with their friends, and speak Spanish at home with their family. A study that analyzes the affect of bi/multilingualism on self perceived MCCs would be very helpful in shedding light on these racial/ethnic group differences in self perceived MCCs.

Regarding religious affiliation, as presented in Chapter IV, a difference between Protestants and Catholics on self-perceived overall MCCs and MCC relationship skills was revealed. It is possible that differences between Protestants and Catholics may explain why Catholics rated their MCCs higher than Protestants; however, it may be more likely that a mediating variable, race/ethnicity, played a role in this result. Of the

participants who identified as Catholic, 46% also identified as Hispanic/Latino/Latina, and 74% of those who identified as Protestants identified as Caucasian. As described earlier, Hispanic/Latino/Latina counseling students rated themselves higher on their overall MCCs and on their MCC relationship skills than did Caucasian students.

Summary of Discussion of Results

The major finding of this study was that hypothesis 1a was partially supported. This indicates that increased death awareness may negatively affect counseling students' perceived multicultural counseling competence, at least with respect to overall MCCs, MCC knowledge, MCC skills, and MCC relationship skills. Of course, with any findings, there are alternative explanations for the difference in means. One alternative explanation is that the different orders of administration of the instruments may have influenced the mean difference. This is unlikely, however, based on past TMT literature (e.g., Rosenblatt et al., 1989). Rosenblatt et al. also used a Likert type scale to elicit increased death awareness in experimental group participants. However, for the control group, they used an anxiety assessment rather than changing the order of administration. Results of their study revealed a significant mean difference related to worldview defense between the control group and the experimental group, and the order of administration of the criterion variable was the same for both groups.

Another finding was that Hypotheses 2 and 3b, which proposed that self esteem and multicultural training would have a moderating or buffering effect on counseling students' self perceived MCCs following death awareness, were not supported. These findings seem to indicate that, irrespective of multicultural training or self esteem level,

increased death awareness can negatively affect counseling students' perceived MCCs, a finding which provides support for some of the basic tenets of TMT. It also may be possible that, because the majority of the participants self reported high self esteem and reported having taken a multicultural counseling course, the variability was impacted, thus, affecting the results.

Another important finding was that conscious contemplations and negative anxiety toward death (death concern), as measured by the DCS, did not affect counseling students' MCCs. This finding is important because it may shed light on how reactions to conscious and unconscious death fear differ.

Hypothesis 3b was partially supported. Other demographic variables, including race/ethnicity, gender, age, sexual orientation, religious affiliation, and semesters/quarters of counselor training, did not have a moderating effect on counseling students' perceive MCCs following increased death awareness. Interestingly, however, findings indicated that graduate level moderated the effects of increased death awareness on counseling students' self perceived MCC Knowledge, such that, master's level students were less affected by increased death awareness than were doctoral students. It may be possible that master's students are less affected by increased death awareness with regard to their multicultural knowledge; however, it appears more likely that, because there were fewer doctoral students in the sample, their MCC knowledge scores may have been influenced by extreme scores.

Limitations of the Study

A variety of potential limitations were inherent in this study that merit consideration when interpreting the results. These potential limitations include sampling, instrumentation, and statistical analysis limitations. First, as described earlier in the chapter, results may have been influenced by convenience sampling. Because the participant sample of this study may or may not be representative of counseling students throughout the United States, the external validity of the study may be limited. As noted, to improve the generalizability of the study, the researcher recruited counseling student participants from a variety of different universities in the Southeast and Southwest regions of the United States.

Also, concerning convenience sampling, results may have been influenced by a potentially homogenous sample. Homogeneous samples can be problematic because they often generate false-negative results. To defend against that possibility, the researcher requested counseling student participation from universities with diverse demographics, including Historically Black Colleges and Universities (HBCU) and Hispanic Serving Institutions (HSIs).

As noted earlier in this chapter, a large number of participants in this study self identified as female, Caucasian, heterosexual, Christian (e.g., Protestant, Catholic), and master's students. These overrepresentations of certain demographic groups in this study may or may not be consistent with the makeup of students at counseling programs throughout the United States. Smaller percentages of certain demographics, such as, males, gay, lesbian, and bisexual students, doctoral level students, and certain

racially/ethnically diverse groups, may further minimize the generalizability of the results of the study to those populations.

Second, the results of the study may have been influenced by limitations associated with instrumentation. First, the MCI, DCS, and the RSES are self report instruments. A potential limitation of self report instruments is that they often are susceptible to social desirability effects. Also, specific to the MCI, some participants, particularly those who have not taken a multicultural course, may not have enough knowledge or experience to adequately evaluate their MCCs. Also, as described in Chapter II, self report instruments, such as the MCI may not accurately measure the construct it purports to measure. Constantine and Ladany (2000) demonstrated that self-report measures of MCCs did not correlate with multicultural written case conceptualization skills. Because of these potential limitations when using self report instruments, results should be interpreted with some degree of caution. Also, as described earlier, results of the study may be influenced by the truncated ranges of the RSES and the MCI. These ranges reduce variability which, in turn, reduces the potential for significant results.

Third, data analysis may create a potential limitation. When a series of linear regressions are run on a set of related variables, the likelihood for a Type I Error is enhanced (Myers, 1979; as cited in Howell, 2007). Because the results of the series of linear regressions were largely non-significant in this study, it did not appear necessary to make a correction, such as a Bonferonni.

Implications of the Study

The results of this study have implications for counselor education, counseling practice, and further research. First, implications for counselor education are discussed, followed by implications for counseling practice, and future research.

Implications for Counselor Education

The findings of this study appear to have important implications for counselor education, particularly with respect to the training of multiculturally competent counselors. As described in Chapters I and II, this is the first study to assess counseling students' reactions to self perceived MCCs. It also is the first study to analyze the connection between Terror Management Theory and multicultural counseling theory. Because it appears, based on this study, that increased death awareness affects counseling students negatively regarding their self perceived MCCs, counselor educators may need to develop strategies to reduce the negative reactions associated with increased death awareness in their students.

One way in which counselor educators might reduce the affects of death reminders is by helping counseling students increase their conscious death awareness, or in other words, bringing the covert, or unconscious anxiety of death to the overt, or conscious level, where it can be addressed. Lykins, Segeratrom, Averill, and Evans' (2007) reported that, opposed to the short-term and subtle reminders of death that cultivate rather extrinsic motivations of vanity and egotism in participants, more in-depth familiarity or awareness of mortality promotes intrinsic goal-orientation, greater motivation to serve others, and stronger desires to develop close relationships in its

participants. Hence, it appears that if counselor educators can help counselors-in-training become more consciously aware of the inevitability of their own death, they may be able to help them quell or cope with some of the adverse affects of unconscious death anxiety, and enhance their multicultural counseling competence.

Another possible implication of this study for counselor educators is that it connects TMT with multicultural counseling theory. Sue et al. (1982; 1992; 1998) stated that, in order for counselors to be multiculturally competent, they need to have multicultural knowledge, skills, and beliefs and attitudes (awareness). Sue et al. (1998) stated that one aspect of multicultural awareness is recognizing one's own prejudices and biases. TMT provides a theoretical basis, or explanation for the etiology of underlying biases and prejudices, and has empirical studies that support it. As described in Chapter I and II, TMT proposes that people unconsciously perceive different cultural worldviews as threats to their immortality, which cultivates in them unconscious biases, beliefs, and reactions toward diversity. Counselor educators may be able to utilize TMT as one framework for better understanding the development of multicultural competence in counseling students. Along with implications for counselor training, findings of this study also may influence counseling practice.

Implications for Counseling Practice

The results of this study also may have implications for counseling practice. As described in the previous section, one potential implication of this research is that it may eventually help counseling students develop a more in-depth familiarity or awareness of mortality which, in turn, may help them increase their MCCs. Although some exploration

of the inevitability of death may be possible in a classroom setting, individual and group counseling also may help counseling students develop a more in-depth familiarity with mortality. Existential approaches, in particular, approaches in which clients process fundamental questions about existence (e.g., What is the purpose of my life? Where am I going after I die? What makes me meaningful?) may help cultivate in counseling students a healthier awareness of mortality, and increased MCCs as they graduate and become professional counselors.

Also, related to counseling practice, if unconscious anxiety associated with death can affect counseling students' reactions toward differences, it also may be useful for counselors in the conceptualization of client behaviors. As demonstrated in Chapters I and II, TMT researchers have analyzed the effects of increased death awareness on a wide range of diverse groups (e.g., municipal judges, social work students, college students, diverse racial/ethnic groups, middle-aged adults). They have found in many cases that, compared with control groups, participants who received death reminders (regardless of demographic makeup) were more likely to defend their worldviews through aligning themselves more closely to their cultural values and disparaging dissimilar cultural values. Counselors who work with clients who exhibit xenophobic, prejudicial views toward dissimilar others or clients who have existential concerns, may benefit from understanding TMT.

Implications for Future Research

The results of this study, although potentially important, need further quantitative and qualitative support. As described earlier in this chapter, this is the first study in which

increased death awareness has been studied with counseling students and compared with multicultural counseling competence. More research that sheds light on the connection between existential, unconscious death fear and counseling students' ability to work with diverse clients is needed. In this section, future research that can further our understanding of the impact of unconscious death fear on counselor education and counseling practice is discussed.

Replication of the findings in this study is important. This may include similar procedures as were used in the current study, with some variability. First, studies with different sampling demographics are discussed, followed by a discussion of different independent and dependent variable measures, and studies associated with the curvilinear effect of death awareness. As mentioned in the limitations section of this chapter, the generalizability of the study is limited. Future studies with counseling student participants from various regions of the United States, may bolster the study's generalizability. Similarly, because the current study had low numbers of certain populations (e.g., Asian Americans, Gays and Lesbians, Buddhists, doctoral students), future studies with more representation from these diverse groups would be helpful.

The current study also was limited to counseling student participants. Future studies could analyze the effect of increased death awareness on practicing counselors and counselor educators. Future studies also could compare counseling students, practicing counselors, and counselor educators on their self perceived MCCs following increased death awareness. Comparing different counseling tracks, such as school counseling, college counseling, and mental health counseling students also may be

enlightening. Furthermore, based on the finding of this study that master's level students were less affected by increased death awareness than were doctoral students, a study with more equitable samples of master's and doctoral students could provide clearer answers to the meaning of this finding.

Concerning independent variables, because self esteem, as measured by the RSES, was not found in this study to have a moderating effect on counseling students' self perceived MCCs following increased death awareness, in future studies, other self esteem instruments may be useful. This may shed light on whether self esteem does in fact have a moderating effect on counseling students' reactions to increased death awareness.

Different methods of eliciting increased death awareness also may be helpful in furthering our understanding of the effects of unconscious death fear on counseling students' reactions to diversity. Ultimately, for this line of research to have practical implications, research will need to demonstrate that increased death awareness occurs outside of the laboratory, in real life situations. As reviewed in Chapter II, Pyszczynski et al. (1996) demonstrated that participants who walked by a funeral home were more likely than those who did not walk by the funeral home to exhibit defensive behaviors regarding their worldview. A study similar to that with counselors, wherein increased death awareness is elicited via everyday situations would be valuable to understanding whether increased death awareness can affect counselors' interactions with diverse clients in real life.

Concerning dependent variables, because of the limitations of self report instruments and specifically MCC self report instruments, future researchers, who assess the effect of increased death awareness on MCCs, should consider utilizing different MCC measures. One possible procedure, based on Constantine and Ladany's (2000) study, is to assess participants' written case conceptualization skills of diverse clients following increased death awareness. These written case conceptualizations could be reviewed by trained raters. Another possibility is to have trained observers rate participants' counseling skills with diverse clients (possibly actors) following increased death awareness. Another possibility is to assess how specific constructs related to MCCs (e.g., racial identity development, racial attitudes, discrimination) are affected by increased death awareness. To possibly get away from analogue studies, a study using outcome measures, such as ratings of counselors' effectiveness by diverse clients could be designed . Possibly, one group of counselors could be given an increased death awareness prompt (possibly a picture in the counseling office) before or during the counseling session(s) with the diverse clients, and the other group could receive another prompt, or not one at all. It would be interested to assess whether client ratings would differ between groups.

Finally, in the Implications for Counselor Education section of this chapter, Lykins et al.'s (2007) report of a curvilinear effect of increased death awareness was mentioned. They said that subtle reminders of death elicited negative reactions toward diversity, but more in-depth familiarity or acceptance of the inevitability of death cultivated more motivation to serve others. Future studies that replicate these findings

with counselors, counseling students, and counselor educators could help improve our understanding of how to develop strategies to reduce the negative effects of increased death awareness on counseling students', counselors', and counselor educators' MCCs.

Conclusion

In this chapter, results of a study analyzing the effect of increased death awareness and the moderating effect of self esteem on counseling students' self perceived MCCs were discussed. A total of 141 master's and doctoral level counseling students, enrolled in a CACREP-accredited counseling program in the Southeast or Southwest region of the United States, participated in the study. Results of the study revealed that, aside from multicultural awareness, counseling students who experienced increased death awareness prior to self rating their MCCs, rated their MCCs lower than did counseling students who did not receive death reminders prior to rating their MCCs (Hypothesis 1a). Results also indicated that self esteem and multicultural training did not moderate the effects of increased death awareness on counseling students' ratings of their MCCs (Hypothesis 2 and 3a, respectively); and conscious death concern did not affect counseling students' self perceived MCCs (Hypothesis 1b). Results also revealed that, except for graduate level (master's and doctoral), demographic variables (e.g., race/ethnicity, gender, age, sexual orientation, semesters/quarters of counseling training, and religious affiliation) did not moderate the effect of increased death awareness on counseling students' self perceived MCCs (Hypothesis 3b).

These results, in particular the results supporting Hypothesis 1a, are important to counselor education and counseling because they shed light on the effect of increased

death awareness on counseling students' competence in working with diverse clients. This is important because, as mentioned in Chapter I, the demographic makeup of the United States is becoming increasingly diverse, leading to an increased need for multiculturally competent counselors. This study is the first step in a series of studies that will analyze the effect of increased death awareness on counselors' competence in working with diverse clients. It is anticipated that, through this study and future studies, effective training strategies that reduce the negative effects of increased death awareness on counseling students' MCCs can be developed and implemented in counselor training programs. Of course, before that can be accomplished, more research is needed.

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APPENDIX A: DEMOGRAPHIC QUESTIONNAIRE

1 Age: _____

2 Gender: Female _____ Male _____ Transgender _____ Transsexual _____

3 What race/ethnicity would best describe you?

    a. African American
    b. Caucasian
    c. Asian or Pacific Islander
    d. Hispanic/Latino/Latina
    e. Native American
    f. Bi/multiracial, Please specify: _____
    g. Other (specify) _____

4 What religious affiliation best describes you?

    a. Catholic   b. Protestant
    c. Evangelical   d. LDS
    e. Buddhist   f. Jewish (Non-Orthodox)
    g. Jewish (Orthodox)   h. Islamic / Muslim
    i. Hindu   j. Unaffiliated with any particular organized religion
    k. Other (specify) _____

5 How many semesters/quarters of formal counseling training have you completed?

    a. 0   b. 1
    c. 2   d. 3
    e. 4   f. More than 4

6 Are you a master's level or doctoral level counseling student?

    a. Master's level
    b. Doctoral level

7 Have you completed a graduate-level multicultural counseling course?

    a. Yes
    b. No
    c. I currently am taking a multicultural counseling course

8 What is your sexual/affectional orientation?

    a. Lesbian
    b. Gay
    c. Bisexual
    d. Heterosexual

APPENDIX B: INFORMED CONSENT FORM

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO
CONSENT TO ACT AS A HUMAN PARTICIPANT: LONG FORM

Project Title: *Mortality Salience and Worldview Defense: The Effect of Death Awareness and Self Esteem on Multicultural Counseling Competence*

Project Director: Nathaniel N. Ivers & Jane E. Myers

DESCRIPTION AND EXPLANATION OF PROCEDURES

The purpose of this study is to assess the effect of death awareness and the moderating effect of self esteem on counseling students' self perceived multicultural counseling competence. The project involves participants completing four instruments: The Multicultural Counseling Inventory (MCI), the Death Concern Scale (DCS), Rosenberg's Self Esteem Scale (RSES), and the Literary Preference Questionnaire (LPQ). Participants also will complete a brief demographic questionnaire. Participants will be given a packet containing these instruments and will be asked to complete them in the order in which they come. Approximately 20-25 minutes will be needed to complete the project.

REASON FOR SELECTING PARTICIPANTS: The reason you are being asked to participate in this study is because you are either a full-time or part-time graduate student enrolled in a counseling program.

RISKS AND DISCOMFORTS: Because the focus of this project concerns potentially uncomfortable issues (e.g., values and beliefs about diversity, death awareness), you may experience some feelings of discomfort as you participate in this project. If uncomfortable feelings arise as a result of this project, you may consider meeting with a counselor at your university counseling center.

POTENTIAL BENEFITS: By participating in this project, you will contribute to the multicultural counseling competency knowledge base, thus helping to develop more effective ways of training multiculturally competent counselors.

POTENTIAL BENEFITS TO SOCIETY: This study may benefit society by increasing the multicultural counseling competency knowledge base, thus potentially helping to develop more effective ways of training multiculturally competent counselors who can provide efficacious counseling services to an increasingly diverse society.

CONFIDENTIALITY: All information obtained in this study is strictly confidential unless disclosure is required by law. No identifying information will be collected in the study.

CONSENT: By completing the questionnaires, you are acknowledging that you understand the procedures and any risks and benefits involved in this research. You are free to refuse to participate or to withdraw your participation in the project at anytime without penalty or prejudice. Your participation is entirely voluntary; however, if this study is being administered during class time, students in the classroom who do not wish to participate will be offered an alternative assignment approved in advance by the instructor. Your privacy will be protected because you will not be identified by name as a participant in this project.

The University of North Carolina at Greensboro Institutional Review Board, which ensures that research involving people follows federal regulations, has approved the research and this consent form. If you have any concerns about your rights or how you are being treated, please contact Mr. Eric Allen in the Office of Research and Compliance at UNCG at (336) 256-1482. Questions about this project or your benefits or risks associated with being in this study can be answered by Mr. Nathaniel Ivers by calling 336-972-2022 or Dr. Jane Myers by calling 336-334-3429. Any new information that develops during the project will be provided to you if the information might affect your willingness to continue participation in the project.

By completing the questionnaires, you are agreeing to participate in the project described to you.

APPENDIX C: RECRUITMENT SCRIPT

The reason you are being asked to participate in this study is because you are either a full-time or part-time graduate student enrolled in a counseling program. The purpose of this study is to assess the effect of death awareness and the moderating effect of self esteem on counseling students' self perceived multicultural counseling competence. Participation in the study involves completing four instruments: The Multicultural Counseling Inventory (MCI), the Death Concern Scale (DCS), Rosenberg's Self Esteem Scale (RSES), and the Literary Preference Questionnaire (LPQ). Participants also will complete a brief demographic questionnaire. If you choose to participate, you will be given a packet containing these instruments and will be asked to complete them in the order in which they come. Approximately 20-25 minutes will be needed to complete the project.

This research is potentially important because the United States is becoming increasingly diverse, and in order for counselors to meet the counseling needs of this diverse society, more effective multicultural training techniques are needed. By participating in this project, you will contribute to the multicultural counseling competency knowledge base, thus helping to develop more effective ways of training multiculturally competent counselors.

There are no anticipated risks involved in participating in this study; however, because the focus of this project concerns potentially uncomfortable issues, such as values and beliefs about diversity and death awareness, you may experience some discomfort. If uncomfortable feelings arise as a result of this project, you may consider meeting with a counselor at your university counseling center.

All information obtained in this study is strictly confidential unless disclosure is required by law. No identifying information will be collected in the study; therefore, your identity cannot be linked to the data gathered.

Along with a packet of questionnaires, you will be given a copy of the informed consent form for this project. The University of North Carolina at Greensboro Institutional Review Board, which ensures that research involving people follows federal regulations, has approved this research and this consent form. By completing the questionnaires, you are acknowledging that you understand the procedures and any risks and benefits involved in this research. You are free to refuse to participate or to withdraw your participation in the project at any time without penalty or prejudice. Your participation is entirely voluntary; however, if administration of this project is during class time, and you do not wish to participate, you will be offered an alternative assignment approved in advance by your instructor.

Are there any questions?

APPENDIX D: RECRUITMENT SCRIPT (PILOT STUDY)

The reason you are being asked to participate in this study is because you are either a full-time or part-time graduate student enrolled in the counseling or counseling and counselor education program at UNCG. The purpose of this study is to assess the effect of death awareness and the moderating effect of self esteem on counseling students' self perceived multicultural counseling competence. Participation in the study involves completing four paper-and-pencil instruments: The Multicultural Counseling Inventory (MCI), the Death Concern Scale (DCS), Rosenberg's Self Esteem Scale (RSES), and the Literary Preference Questionnaire (LPQ). Participants also will complete a brief demographic questionnaire. If you choose to participate, you will be given a packet containing these instruments and will be asked to complete them in the order in which they come. Approximately 30 minutes will be needed to complete the project.

This research is potentially important because it aims to contribute to the multicultural counseling competency knowledge base, thus informing multicultural counseling and training. The United States is becoming increasingly diverse, and in order for counselors to meet the counseling needs of this diverse society, more effective multicultural training techniques are needed. By participating in this project, you will contribute to the multicultural counseling competency knowledge base, thus helping to develop more effective ways of training multiculturally competent counselors.

There are no risks involved in participating in this study; however, because the focus of this project concerns potentially uncomfortable issues, such as values and beliefs about diversity and death awareness, you may experience some discomfort. If uncomfortable feelings arise as a result of this project, you may consider meeting, free of charge, with a counselor at the UNCG Counseling and Testing Center (CTC).

All information obtained in this study is strictly confidential unless disclosure is required by law. No identifying information will be collected in the study; therefore, your identity cannot be linked to the data gathered.

Along with a packet of questionnaires, you will be given a copy of the informed consent form for this project. The University of North Carolina at Greensboro Institutional Review Board, which ensures that research involving people follows federal regulations, has approved this research and this consent form. By completing the questionnaires, you are acknowledging that you understand the procedures and any risks and benefits involved in this research. You are free to refuse to participate or to withdraw your participation in the project at any time without penalty or prejudice. Your participation is entirely voluntary; however, if you do not wish to participate, you will be offered an alternative assignment approved in advance by your instructor.

Are there any questions?

APPENDIX E: INFORMED CONSENT FORM (PILOT STUDY)

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO
CONSENT TO ACT AS A HUMAN PARTICIPANT: LONG FORM

Project Title: *Mortality Salience and Worldview Defense: The Effect of Death Awareness on Multicultural Counseling Competence*

Project Director: <u>Nathaniel N. Ivers & Jane E. Myers</u>

Participant's Name:

_____

DESCRIPTION AND EXPLANATION OF PROCEDURES

The purpose of this study is to assess the effect of death awareness and the moderating effect of self esteem on counseling students' self perceived multicultural counseling competence. The project involves participants completing four paper-and-pencil instruments: The Multicultural Counseling Inventory (MCI), the Death Concern Scale (DCS), Rosenberg's Self Esteem Scale (RSES), and the Literary Preference Questionnaire (LPQ). Participants also will complete a brief demographic questionnaire. Participants will be given a packet containing these instruments and will be asked to complete them in the order in which they come. Approximately 30 minutes will be needed to complete the project.

REASON FOR SELECTING PARTICIPANTS: The reason you are being asked to participate in this study is because you are either a full-time or part-time graduate student enrolled in the counseling or counseling and counselor education program at UNCG.

RISKS AND DISCOMFORTS: Because the focus of this project concerns potentially uncomfortable issues (e.g., values and beliefs about diversity, death awareness), you may experience some feelings of discomfort as you participate in this project. If uncomfortable feelings arise as a result of this project, you may consider meeting, free of charge, with a college counselor at the UNCG Counseling and Testing Center (CTC).

POTENTIAL BENEFITS: By participating in this project, you will contribute to the multicultural counseling competency knowledge base, thus helping to develop more effective ways of training multiculturally competent counselors.

POTENTIAL BENEFITS TO SOCIETY: This study may benefit society by increasing the multicultural counseling competency knowledge base, thus potentially helping to develop more effective ways of training multiculturally competent counselors who can provide efficacious counseling services to an increasingly diverse society.

COMPENSATION/TREATMENT FOR INJURY: There are no risks for participation in this study; however, if feelings of discomfort arise from beliefs, values, or thoughts about diversity or death awareness, participants may seek counseling services free of charge from the UNCG Counseling and Testing Center.

CONFIDENTIALITY: All information obtained in this study is strictly confidential unless disclosure is required by law. Except for participants' name and signature on this informed consent form, no identifying information will be collected in the study. Informed consent forms and other data will be stored in a locked filing cabinet behind locked doors in Dr. Jane Myers' UNCG office.

CONSENT: By signing this consent form, you are acknowledging that you understand the procedures and any risks and benefits involved in this research. You are free to refuse to participate or to withdraw your participation in the project at anytime without penalty or prejudice. Your participation is entirely voluntary; however, students in the classroom who do not wish to participate will be offered an alternative assignment approved in advance by the instructor. Your privacy will be protected because you will not be identified by name as a participant in this project.

The University of North Carolina at Greensboro Institutional Review Board, which ensures that research involving people follows federal regulations, has approved the research and this consent form. If you have any concerns about your rights or how you are being treated, please contact Mr. Eric Allen in the Office of Research and Compliance at UNCG at (336) 256-1482. Questions about this project or your benefits or risks associated with being in this study can be answered by itself will be answered by Mr. Nathaniel Ivers by calling 336-972-2022 or Dr. Jane Myers by calling 336-334-3429. Any new information that develops during the project will be provided to you if the information might affect your willingness to continue participation in the project.

By signing this form, you are agreeing to participate in the project described to you by Mr. Ivers.

_____
Participant's Name

_____   _____
Participant's Signature   Date

APPENDIX F: DEMOGRAPHIC QUESTIONNAIRE (PILOT STUDY)

1 Age: _____

2 Gender: Female _____ Male _____

3 What race/ethnicity would best describe you?

      a. African American
      b. Caucasian
      c. Asian or Pacific Islander
      d. Hispanic/Latino/Latina
      e. Native American
      f. Bi/multiracial, Please specify:

          _____

      g. Other (specify) _____

4 What religious affiliation best describes you?

      a. Catholic
      b. Protestant
      c. Evangelical
      d. LDS
      e. Buddhist
      f. Jewish (Non-Orthodox)
      g. Jewish (Orthodox)
      h. Islamic/Muslim
      i. Hindu
      j. Unaffiliated with any particular organized religion
      k. Other (specify) _____

5 How many semesters/quarters of formal counseling training have you completed?

      a. 0
      b. 1
      c. 2
      d. 3
      e. 4
      f. More than 4

6 Are you a master's level or doctoral level counseling student?

      a. Master's level
      b. Doctoral level

7   Have you completed a graduate-level multicultural counseling course?

    a. Yes
    b. No
    c. I currently am taking a multicultural counseling course

8   What is your sexual/affectional orientation?

    a. Lesbian
    b. Gay
    c. Bisexual
    d. Heterosexual
    e. Transgender
    f. Transsexual