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Client Outcome: An Exploratory Investigation of Multicultural Competence and the Working Alliance

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CLIENT OUTCOME: AN EXPLORATORY INVESTIGATION OF MULTICULTURAL COMPETENCE AND THE WORKING ALLIANCE

by

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ABSTRACT

Early termination and low retention of clients is a common problem in counseling, with between 65%-80% of clients terminating treatment before the 10th session (Garfield, 1994; Lambert, 2013). Researchers (Lampropoulous, Schneider, & Spengler, 2009; Owen, Smith, & Rodolfa, 2009) have found that predictors of early termination include client age, race, socioeconomic status, and level of perceived distress. Furthermore, racial and ethnic minorities underutilize mental health services and have low retention when engaged in services, highlighting the need for counseling professionals to empirically explore factors that may be contributing to client engagement of the counseling process. Exploration of multicultural competence and working alliances may increase understanding of the therapeutic factors that influence client outcomes. The purpose of this research study was to investigate relationships between multicultural competence, working alliance, and client outcomes as perceived by counselors-in-training and their clients (N = 191; n = 72 counselors'-in-training, n = 119 clients). The Tripartite Model of Multicultural Counseling (Arredondo et al., 1996) was used as the primary theoretical framework in which the study is grounded. This investigation explored clients' perceptions of their counselors'-in-training ' multicultural competence as measured by the *Cross-Cultural Counseling Inventory* ([CCCI-R]; LaFromboise, Coleman, & Hernandez, 1991), the working alliance as measured by the *Working Alliance Inventory- Short Revision* ([WAI-S]; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989) and prediction on client outcome as measured by the *Outcome Questionnaire 45.2* ([OQ 45.2]; Lambert & Burlingame, 1996), after controlling for social desirability (as measured by the (Social Desirability Scale-Short Form [SDS; Reynolds,1982]). This investigation also examined if there were any differences in clients' and counselors'-in-training perceptions on multicultural competence (as

measured by the CCCI-R) or the working alliance (as measured by the WAI-S). Results from the investigation indicated that counselors'-in-training perceptions of their multicultural competence was a predictor of client outcomes. However, counselors'-in-training perceptions of the working alliance or clients' perceptions of their counselors'-in-training multicultural competence and the working alliance were not predictors of client outcomes. Positive relationships between clients' and counselors'-in-training perceptions of counselors'-in-training multicultural competence and the working alliance were found. The results of this investigation contribute to a gap in the counseling literature on multicultural competence, the working alliance, and client outcomes. A review of the literature on the constructs of interest, research methodology, data analysis, results and implications are discussed.

Keywords: client outcome, multicultural competence, working alliance, counselor education

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CHAPTER ONE: INTRODUCTION

The purpose of this research study was to investigate the relationship between multicultural competence, the working alliance, and client outcomes. The research questions for this study focused on clients' and counselors'-in-training perceptions of multicultural competence as measured by the *Cross-Cultural Counseling Inventory* (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991), the working alliance as measured by the *Working Alliance Inventory-Short Revision* (WAI-S; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989) and prediction on client outcome post-test scores, while controlling for client outcome pre-test scores, as measured by the *Outcome Questionnaire 45.2* (OQ 45.2; Lambert & Burlingame, 1996). Specifically, this study examined the relationships between clients' and counselors'-in-training perceptions on multicultural competence, the working alliance and client outcome.

Background of Study

Ethnic and racial minority populations continue to increase in the United States. According the U.S Bureau of Census (2012), an estimated 316 million-plus persons are living in the United States, with close to 80% identifying as being White. However, major demographic shifts are anticipated in the U.S. over the next 30 years, with minorities comprising the majority of the population. As demographics continue to shift in the U.S., counselors will have the opportunity to provide counseling services to a wide range of clients. As a result, counselors'-in-training need to be well prepared to work with clients from diverse populations. Specifically, counselors'-in-training need to be knowledgeable and aware of their own cultural background and personal biases, aware of their clients' worldview, and able to research and integrate culturally relevant and appropriate interventions in their work with clients (American Counseling Association [ACA], 2014; Sue & Sue, 2013).

Two key factors, the working alliance and multicultural competence are critical when working with clients from diverse backgrounds (Baldwin, Wampold, & Imel, 2007; Constantine, 2001; Horvath & Greenberg, 1994). For the purpose of the investigation, multicultural competence refers to a "counselors' cultural awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and client groups" (ACA, 2014, p. 20). Multicultural Competence is paramount for counselors'-in-training when working with diverse clients in a therapeutic environment (Sue & Sue, 2013). For example, researchers (Griner & Smith, 2006) conducted a meta-analysis (k = 76) evaluating the influence of counselors demonstrating cultural sensitivity in session (i.e., conducting sessions in clients' native language). Results indicated positive effects (d = .76) on client symptom improvement and client satisfaction with counseling.

Similar to multicultural competence, the working alliance between clients and counselors has been identified as a key factor in client outcomes, regardless of treatment modality or therapeutic setting (Bachelor, 2013). For this investigation, the working alliance is defined as the extent of agreement between counselors and clients on the tasks, bond, and goals within a counseling session (Horvath & Greenberg, 1989). Although both multicultural competence and the working alliance have been positively associated with positive therapeutic outcomes, limited empirical research exists investigating these constructs from the clients' perspective (Bachelor, 2013; Worthington, Soth-McNett, & Moreno, 2007). In response to the limited empirical evidence, this investigation explored perceived multicultural competence and the working alliance from both clients and counselors'-in-training. Additionally, this investigation explored the predictive ability of multicultural compeatence and the working alliance on client outcomes.

For the investigation, client outcome is defined as symptomatic distress, quality of interpersonal relationships, and perceived social role in their daily lives (Lambert & Burlingame, 1996).

Statement of the Problem

Racial and ethnic minorities have limited access to mental health services and are less likely than majority populations to seek mental health services due to a variety of barriers (e.g. cost, lack of availability, societal stigma, language barriers, etc.; Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2008). Constantine (2002) and Day-Vines and colleagues (2007) have indicated that an understanding of clients' cultural backgrounds enables counseling professionals to better understand, empathize, and provide services to clients from diverse backgrounds. Suggestions of how to increase retention of minority clients include utilizing culturally sensitive approaches (e.g. multicultural competence) and fostering a safe therapeutic environment utilizing the working alliance so that clients feel comfortable (Ponterotto, 2001). Multicultural competence and the working alliance are therapeutic factors that influence client outcome, although empirical evidence is limited.

Influencing client outcomes is a primary goal for counselors; however, gaps in empirical research exist related to the relationship between client outcome, counselor characteristics/skills, and the working alliance. Specifically, little is known regarding the influence of multicultural competence (as perceived by both client and counselor) on client outcomes (Hays & Erford, 2014; Katz & Hoyt, 2014). Although developing multicultural competence has been the focus of considerable empirical research, the majority of studies have focused on trainee self-report of multicultural competence, failing to account for clients' perceptions of trainees' competencies (Constantine, 2001; Fuertes, Stacuzzi, Bennett, Scheinholtz, & Mislowack, 2006). Furthermore, little is known about relationships between counselor and client perceptions of multicultural

competence and the working alliance and the relative influences on positive client outcomes (Hatcher & Barends, 1996; Horvath & Bedi, 2002). Thus, the purpose of this investigation was to explore the relationship between multicultural competence and the working alliance on client outcome.

Significance

Early termination and low retention of clients is a common problem in counseling, with between 65%-80% of clients terminating treatment before the 10th session (Garfield, 1994; Lambert, 2013). Researchers (Lampropoulous, Schneider, & Spengler, 2009; Owen, Smith, & Rodolfa, 2009) have found that predictors of early termination include client age, race, socioeconomic status, and level of perceived distress. In addition to early termination and dropout rates, racial and ethnic minorities underutilize mental health services**,** highlighting the need for counseling professionals to empirically explore factors that may be contributing to effectiveness of the counseling process. Exploration of multicultural competence and working alliances may increase understanding of the therapeutic factors that may influence client outcomes.

Research has been conducted on the exploration of multicultural competence; however, research is limited to primarily self-report measures from counselors, failing to include client perceptions of their counselors' ability to demonstrate multicultural competence. Results from a 2005 content analysis of multicultural-centered articles (k = 102) within the *Journal of Counseling and Development* indicated that only eight percent of articles provided a dedicated discussion to multicultural competence and only 42% of articles were grounded in empirical research (Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005). Similarly, Worthington, Soth-McNett, and Moreno, (2007) conducted a 20-year content analysis of empirical articles (k =

75) on multicultural competence, concluding that only 3.7% of the studies used independent observers to provide assessment of counselors' multicultural counseling skills, and the majority of the clients used in the samples of these studies were college students (Worthington et al., 2007). In sum, substantial gaps exist in research on the relationships between multicultural competence, the working alliance, and client outcomes.

Additionally, client involvement may be the most important determinant in client outcome (Bohart & Tallan, 2010). For example, clients' perceptions of the working alliance and empathy have been shown to have stronger influences on outcome than counselors' perceptions of the same constructs (Busseri & Tyler, 2004; Long, 2001). Despite the importance of clients' perception in counseling outcomes, clients are the "most neglected factor in treatment outcome" (Bohart & Tallman, 2010, p. 84), with limited measurement of their perceptions of treatment. This investigation sought to increase understanding of the therapeutic process by exploring the working alliance and multicultural competence from both client and counselor perspectives. Furthermore, although research has been conducted on the relationship between working alliance and client outcomes, little is known regarding the influence of multicultural competence.

Constructs

The research study focused on the exploration of three major constructs within the counseling profession: (a) client outcome, (b) multicultural competence, and (c) the working alliance. A brief introduction on each construct is discussed below.

Client Outcome

Hans Eysneck (1952) conducted the first empirical evaluation on the efficacy of psychotherapy (N = 19) and concluded that, overall, psychotherapy is not effective or needed. Though Esyeneck's critique was controversial, it ignited the need for further research on client

outcomes. In 1977, Smith conducted the first extensive meta-analysis on psychotherapy client outcomes studies ($k = 400$). Contrary to Eysneck's study, Smith concluded that individuals who receive counseling are better off than untreated individuals. Overall, research on client outcome demonstrates that counseling has a positive effect on decreasing clients' psychological distress (Lambert et al., 2013). For the investigation, client outcome is defined as levels of symptomatic distress, interpersonal relationships, and social role (Lambert et al., 2013). Symptomatic Distress (SD) refers to the severity of clinical symptoms (e.g. symptoms of depression) a client is reporting. Interpersonal Relations (IR) refers to the client's level of satisfaction and quality of life with intimate relationships in their life. Social Role (SR) refers to the level of client's satisfaction or distress with areas of social roles at work, family, and leisure time.

A variety of therapeutic factors can influence client outcomes. The Common Factors Model (CFM; Rosenzwig, 1936) suggests that there are sets of therapeutic variables that overlap in all counseling services, which contribute to the type of outcome in counseling. The CFM model is categorized into extratherapeutic factors (e.g. social support, spontaneous remission), expectancy (clients' hope and expectation for change), specific techniques (e.g. hypnosis, biofeedback), and common factors (e.g. empathy, warmth, congruence, and therapeutic relationship) (Lambert & Barley, 2001). Frank and Frank (1991) suggested a fourth element to the CFM, called treatment coherency. Treatment coherency refers to the matching process in counseling (e.g., matching the clients' cultural values such as language and incorporating that into counseling; Scheel & Conoley, 2012). Researchers (Lei & Duran, 2014; Norcross & Lambert, 2011; Malin & Pros, 2014) have indicated that the therapeutic relationship and empathy have the most influence on client outcome. Specifically, client perceptions about the therapeutic relationship and counselor empathy contributed the greatest amount of explained

variance in client outcome (Norcross & Lambert, 2011), highlighting the importance of client involvement in counseling and in research.

Multicultural Competence

Multicultural competence refers to a counselor's cultural awareness and knowledge about self and others, and how this awareness and knowledge are applied effectively in practice with clients and client groups (ACA, 2014). The Tripartite Model conceptualizes multicultural competence as knowledge, skills and awareness and is the preeminent model in the counseling field (Abreu, Chung, & Atkinson, 2000; Arredondo, et al., 2005; Watson, Herlihy, & Pierce, 2006). The TM model was used as the theoretical framework for the investigation. Multicultural awareness refers to counselors' awareness of their own cultural worldview and biases. Multicultural knowledge refers to counselors' knowledge about various cultural norms and values than can affect the counseling process. Multicultural skills refers to counselors' ability to form a working alliance with clients of various cultures and utilize culturally appropriate interventions.

Research has been conducted on understanding and exploring multicultural competence for counselors; however, the majority of research conducted on multicultural competence has utilized counselor self-report measures (Constantine & Landany, 2001; Worthington et al., 2007). Self-report multicultural measures have been criticized for being prone to social desirability and having tendencies to measure anticipated behaviors of multicultural competence rather than actual demonstrated behaviors and attitudes of multicultural competence (Constantine & Landany, 2001; Worthington, Mobley, Franks, & Tan, 2000). Therefore, there is a strong need for research investigating multicultural competence from clients perspectives, to better understand demonstrated competency rather than perceived

competency. The investigation sought to explore multicultural competence from client and counselor perspectives to contribute to the empirical literature and to increase understanding of similarities and differences between client and counselor perceptions.

Working Alliance

The term *therapeutic alliance* was coined by Rogers (1957) and was characterized as a client-centered approach. Rogers defined the counseling relationship as the counselors' ability to be authentic, and to show empathy and unconditional positive regard towards their client. Since Rogers' definition, the idea of the therapeutic alliance has been expanded to include the clients' responsibility in forming relationships, and is now known as the working alliance. In 1965, Greenson coined the term working alliance. For the purpose of this investigation, the working alliance is defined as the extent of agreement between counselors'-in-training and client on the goals, tasks, and bond in session (Horvath & Greenberg, 1989). Goals are the agreed-upon objectives between client and counselor to work on in counseling (Tracey & Kovocivic, 1989). Tasks are the agreed-upon behaviors within counseling in order to achieve the desired outcome goals (Bordin, 1980). Bond is the level of empathy or attachment clients and counselors perceive (Bordin, 1980). This conceptualization of the counseling relationship emphasizes the importance of mutuality in counseling. Essentially, the mutual definition of the working alliance highlights the importance of exploring client and counselor perceptions in session.

Considerable research has been conducted on the working alliance in relation to clients' and counselors'-in-training perceptions and client outcome. There have been several self-report alliance measures for clients and counselors to rate their perceptions (e.g. *Penn Helping Alliance Inventory-Revised* [HAQ-R], Alexander & Luborsky, 1986; *The Working Alliance Inventory*, short form [WAI-S], Tracey & Kovocivic, 1989). Research has shown consistent similarities and

differences between clients' and counselors' perceptions of the working alliance (Bachelor, 2013; Fitzpatrick, Iwakabe, & Stalikas, 2005; Hatcher, Barrends, Hansell, & Gutfreund, 1995). In addition, the working alliance is often researched within the counseling field and has been identified as a key factor in positive client outcomes, despite choice of treatment modality or counseling setting (Bachelor, 2013). Overall, the working alliance is highly rated by clients and counselors (Tyron, Blackwell, & Hammel, 2008), and is a consistent predictor of counseling outcomes (Baldwin et al., 2007; Norcross & Lambert, 2011).

Relationship between Multicultural Competence, Working Alliance, and Client Outcome

Norcross and Lambert (2011) conducted a meta-analysis ($k = 24$) on influential factors in counseling relationships. Their results indicate that the therapeutic relationship has the same, if not more, impact on client outcome than treatment method alone (Norcross & Lambert, 2011). The authors acknowledge that the therapeutic relationship is not an intervention of its own, but is in combination with other factors such as counselors' characteristics or clients' motivation in session that contribute to client outcome. Contrastingly, Bachelor and Horvath (1999) and Drisko (2013) have found that at times the therapeutic relationship does not have significant impact on client outcome. In addition, there are also discrepancies in results as to what extent multicultural competence may predict change in client outcome and the quality of the working alliance. For example, Owen, Jordan, Turner, Davis, Hook, and Leach (2014) conducted a quantitative analysis analyzing the relationship between clients' ($n = 45$) perceptions of counselors' cultural humility and client outcomes. Cultural humility refers to a counselors' ability to allow the client to be the expert in their cultural identify and maintain a respectful relationship (Owen et al., 2014). Client outcomes were measured using the *Patient's Estimate of Improvemen*t (PEI; Hatcher & Barrends, 1996). A correlational analysis indicated clients' perceptions of their

counselors' cultural humility was positively correlated with client outcomes ($r = .33$, $p < .05$). Contrastingly, Owen et al., (2011) found that multicultural competence was unrelated to counseling outcomes. Lastly, in relation to the working alliance, the research of Fuertes and Brobost (2002) indicated that counselors who were rated as demonstrating multicultural competence in session were also rated as demonstrating increased empathy in session. These aforementioned studies are reviewed in depth in Chapter Two. Therefore, further research is needed to increase understanding as to how multicultural competence influences the quality of the working alliance and predicts client outcomes, accounting for both clients' and counselors'-in-training perceptions.

Operational Definitions

The operational definitions of each core term are provided below. These definitions are divided into two sections: (a) location; and (b) constructs.

Location Terms

Practicum. A required course held at community counseling clinic at a large southeastern region university for masters' level counselors. The practicum course provides counselors'-in-training with two practicum experiences over the course of two semesters, in which they practice counseling skills by providing individual, couples and family counseling to members of the community.

Construct Terms

Client Outcome. Measuring and comparing a client's status at repeated points in therapy of their level of symptomatic distress, quality of interpersonal relationships, and perceived social role in their daily lives (Lambert & Burlingame, 1996).

Multicultural Competence. A counselor's acquisition of cultural awareness, knowledge, and skill in working with diverse populations (Arredondo et al., 1996).

Working Alliance. The extent of agreement between clients and counselors on the goals, tasks (how to accomplish goals), and bond (development of personal bond between client and counselor); (Horvath & Greenberg, 1989).

Research Questions

The purpose of this investigation was to explore the relationships between both clients' and counselors'-in-training perceptions of multicultural competence and the working alliance on client outcomes. The population for this sample was masters students enrolled in Practicum at the university and adult clients who were receiving services at the university counseling center from Practicum students. This investigation was guided by four research questions, provided below.

Research Question One

Does counselors'-in-training multicultural competence and working alliance (as perceived by clients) predict client outcome, while controlling for social desirability from the clients' perspective?

Research Question Two

Does counselors'-in-training multicultural competence and working alliance (as perceived by counselors) predict client outcome, while controlling for social desirability from the counselors'-in-training perspective?

Research Question Three

What differences exist between client and counselors'-in-training perceptions of counselors'-in-training multicultural competence and working alliance, while controlling for social desirability?

Research Question Four

What relationships exist between the demographic variables (e.g. age, gender, ethnicity) and multicultural competence, the working alliance, and client outcome?

Methodology

Research Design

A correlational research design was used to examine the research questions. Correlational research strives to see the extent of the relationship between variables: low, moderate, or high relationship (Gall, Gall, & Borg, 2007). Correlational research design is used when researchers want to explore the relationship between different variables at the same point in time or different points of time and to predict outcome scores on a selected population (Gall et al., 2007). The study aimed to explore the extent to which multicultural competence and the working alliance predict change in clients' outcome through quantitative measures. In addition, the study sought to explore how clients and counselors-in-training perceive multicultural competence and the working alliance.

Population and Sampling

A convenience sample refers to when the researcher has a sample readily available (Tabachnick & Fidell, 2013). The principal investigator of this study was a staff member at the community counseling clinic in which data was collected. Therefore, this study used a convenience sample due to the accessibility of the population for the principal investigator.

The population for this study included masters-level Counselor Education students enrolled in Practicum I or II courses at a university counseling center in the southeastern United States. In addition, the population included adult clients (over the age of 18) receiving counseling services from Practicum I or II counselors at the clinic over the course of two semesters.

It is also important to consider power when making sample size determinations. Power is the level of probability that a statistical test correctly rejects the null hypothesis when the null hypothesis is false (Tabachnick & Fidell, 2013). In order to decrease chances of Type I error (when the null hypothesis is true, but is rejected), Cohen (1998) suggests a determination of significance at the .05 alpha level and an adequate power of .80 is necessary.The data analysis in the study utilized multivariate statistics, including hierarchical multiple regression and multivariate analysis of covariance (MANCOVA) with repeated measures between groups. Following the recommendations of Balkin and Shepris (2011), G*Power free statistical software was used to determine appropriate sample size. Given the parameters of the hierarchical regression in this investigation (i.e., total of five predictor variables: two controlled variables – social desirability and client outcome pretest score, and three more variables – multicultural competence, working alliance, and client outcome post-test score), a prior analysis was conducted, using G*power, with the significance level at.05, desired power at .8, and effect size at .13 (Cohen, 1998). The G*power analysis revealed the study required a minimum of 105 total participants. In addition, given the parameters in this investigation of repeated measures), a prior analysis was conducted using G*power with the significance level at .05, desired power at .80, and effect size at .13 (Cohen, 1998). This revealed the study required a total sample size of 194 participants. Therefore, the desired sample size for this investigation was 250 in order to reduce Type I error and increase the

likelihood of generalizability (Balkin & Sheperis, 2011). The total sample size for this investigation (N = 191) met the criteria for hierarchical regression suggested power but not for repeated measures MANCOVA. Thus, a limitation of this investigation was the sample size. Lastly, limited data exists on response rates when assessing clients and counselors; however, given that the university counseling center is a research clinic, 80-90% response rate was anticipated, and met.

Data Collection Procedures

This investigation took place at a university counseling clinic located in the southeastern region of the U.S., a clinic that conducts research and provides free counseling services to community members. Permission to conduct research at the university counseling clinic was obtained from the clinical director, counselor education program coordinator, and the Institutional Review Board at the university. Recruitment began during Practicum orientation, given by the researcher during the first week of practicum class in each of two semesters. The researcher provided counselors with an explanation of research during their first week of Practicum class, prior to seeing clients. The researcher also verbally explained the purpose of the study and voluntary participation of the study to the masters' level counselors, emphasizing that completing surveys would not affect their grades and the instructor would not know whether they completed the surveys or not. Counselors provided their clients with an explanation of research prior to beginning the first counseling session. The explanation emphasized that if clients chose to not participate in the study, they could still receive counseling services.

Instrumentation

There are a total of four constructs in this investigation: (a) client outcome (symptomatic distress, social role, interpersonal relationships), (b) multicultural competence, (c) the working alliance (bond, level, task), and (d) social desirability. This quantitative investigation used five instruments to investigate these constructs: (1) *Demographic Questionnaire* (DQ), (2) the *Cross-Cultural Counseling Inventory* (CCCI-R; LaFromboise et al., 1991) (3) *Working Alliance Inventory- Short Revision* (WAI-S; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989), (4) *Outcome Questionnaire 45.2* (OQ 45.2; Lambert & Burlingame, 1996), and (5) *Social Desirability Scale-Short Form* (SDS; Reynolds,1982). Clients and counselors completed the OQ 45.2, WAI-S, CCCI-R and the SDS during the third session. Clients completed the OQ 45.2 during their first and third counseling sessions.

Demographic Questionnaire. A demographic questionnaire was developed by the researcher to determine age, ethnicity, gender, and counseling session number for both client and counselor. In addition, the demographic questionnaire of the counselor determined practicum level and multicultural counseling course history.

Cross Cultural Competency Inventory-Revised (CCCI-R; LaFromboise et al., 1991). The CCCI was developed based on the multicultural competencies defined by the Education and Training Committee of Division 17 of the American Psychological Association (Sue, Arredondo, & McDavis, 1982). The CCCI-R is a 20-item assessment intended for observer report of a counselors' level of cultural awareness, knowledge, and skill. The 20 items are rated on a 6-point Likert scale ranging from one to six (1=*"strongly disagree"* to 6=*"strongly agree"*). Reported overall internal consistency on the CCCI-R is .93 (LaFrombise et al., 1991). Overall internal consistency for the CCCI-R scale is .95. This investigation adapted the CCCI-R from its observer

report version to a self-report version for clients and counselors to complete, following the format of other researchers (e.g. Fuertes & Brobost, 2002; Owen, Leach, Wampold, & Rodolfa, 2011) who have adapted the scale. For example, an observer report item on the CCCI-R states "Counselor is comfortable with differences between counselor and client." For this investigation that item was adapted for the counselor's version to read, "I am comfortable with differences between myself and my client," and the client's version to read, "Counselor is comfortable with differences between myself and them."

Working Alliance Inventory-Short Revision (WAI-S; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989). The WAI-S is a shortened version from the original 36-item scale developed by Horvath and Greenberg (1989). The WAI-S is a 12-item Likert scale intended to measure the strength of the therapeutic relationship as perceived by client and counselor. WAI-S has three subscales: (a) goals, (b) tasks, and (c) bonds. The WAI client version yields an overall strong internal consistency for WAI-S total score ($\alpha = 98$), task subscale ($\alpha = .90$), bond subscale ($\alpha = .92$), and goal subscale ($\alpha = .90$). In addition, the WAI counselor version yields an overall strong internal consistency for WAI-S total score ($\alpha = .95$), task subscale ($\alpha = .83$), bond subscale ($\alpha = .91$), and goal subscale ($\alpha = 88$). Reported overall internal consistency of the WAI-S is .95 and internal consistency for the three subscales is above .80 (Tracey & Kovocivic, 1989).

Outcome Questionnaire 45.2 (OQ45.2; Lambert & Burlingame, 1996). The OQ 45.2 is a 45 item Likert scale intended to measure clients' status. The OQ 45.2 is given multiple times throughout treatment to measure progress. OQ 45.2 has three subscales: (a) symptomatic distress, (b) interpersonal relationships, and (c) social roles. The Symptomatic Distress (SD) subscale is made of criteria from common diagnoses such as anxiety, depression, and substance use. The Interpersonal Relations (IR) subscale is made of items that explore a client's level of

satisfaction and quality of life with intimate relationships in their life. The Social Role (SR) is a subscale that measures a client's satisfaction and distress level with areas of social roles at work, family, and leisure time. Reported overall internal consistency of the OQ 45.2 is .93 and internal consistency for three subscales is above .70 (Lambert & Burlingame, 1996).

Reynolds Marlowe-Crown Social Desirability Scale-Short Form A (SDS; Reynolds, 1982). The SDS is a shortened version from the original *Marlow-Crowne Social Desirability Scale* (MCSDS; Crowne & Marlow, 1960). The SDS-short-form A is a 10-item dichotomous True/False scale intended to measure the likelihood of an individual to respond in a way on an instrument that is socially desirability When the SDS- short form A was correlated with the original SDS scale, results indicated a high correlation (r = .91), yielding strong concurrent validity. In addition, internal consistency was measured using the Kuder-Richardson 20-reliability formula; results indicated strong internal consistency ($r_{KR\text{-}20}$ =. 74); (Reynolds,1982).

Data Analysis

To explore research questions one and two, hierarchical multiple regression was used. Standard multiple regression analysis is commonly used in social science research when researchers want to determine the most appropriate predictors for their analysis that may be supportive of a theory (Gall et al., 2007). Alternatively, researchers who are interested in determining the most explained variance in the dependent variable (e.g. client outcome) with the least possible number of predictors chose hierarchical multiple regression to determine the highest quality predictor (Tabachinik & Fidell, 2013). Hierarchical regression (also known as sequential regression) is an appropriate analysis when the researcher has a basis of research or theory of how to assign entry order of variables. Essentially, instead of having statistical software choose the order of variable entry, the entry is chosen by the researcher based on previous

research or theory. All of the data was analyzed using the *Statistical Package for Social Sciences* (SPSS, Version 22).

To explore research question three, a repeated measured Multivariate Analysis of Covariance (MANCOVA) was conducted. Tabachnick and Fidell (2013) suggest utilizing a repeated measures MANCOVA when a researcher has two or more groups of participants that are measured on several different scales at the same time. Specifically, Tabachnick and Fidell (2013) recommend using a repeated measures MANCOVA to explore the mean patterns on the scales between two groups (e.g. differences in mean scores between WAI, CCCI-R, and SDS measurements in counselors-in-training and clients). Counselors and clients both completed three different assessments at the same time, CCCI-R, WAI-R, and SDS. The dependent variables in this repeated measures MANCOVA were client total score on multicultural competence, the working alliance, and social desirability. In addition, the dependent variables in this repeated measures MANCOVA were counselor total score on multicultural competence, the working alliance, and social desirability. This repeated measures MANCOVA utilized social desirability as the covariate and analyzed the patterns of means on the CCCI-R and WAI-R between clients and counselors. Lastly, for research question four, Pearson product correlation two tailed was used to explore the relationship between demographics variables (e.g. age, gender, ethnicity) and the working alliance, multicultural competence, and the working alliance.

Ethical Considerations

The following ethical considerations were relevant to this investigation:

1. Data was collected with minimal information (e.g. only initials were of clients and counselors were requested).
2. Participation in this study was voluntary and participation did not influence practicum students' class grades or availability of counseling sessions to adult clients.
3. All participants were informed of their rights to participate or withdraw from the study verbally and through an explanation of research obtained with approval from the Institutional Review Board (IRB).
4. Permission to use the five instruments in this investigation was obtained from the developers.
5. This study was conducted once approval from the dissertation chair and all committee members was obtained.

Limitations

Limitations for this investigation are listed below:

1. This study was geared towards counselors'-in-training; therefore, a limitation of this study was that all types of counseling professionals were *not* included.
2. The Cross-Cultural-Inventory-Revised scale was adapted for use for counselors and clients, thus its adaptation could be a threat to internal consistency.
3. Some of the data collection instruments in this study were self-report; therefore, participants may have responded in a biased manner.
4. Participants may be subject to tester fatigue, experience testing fatigue, and lose concentration while completing instrumentation after their counseling.

5. Generalizability to populations other than novice counselors or clients within a university setting is low.

Summary of Results

The purpose of this investigation was to explore relationships between multicultural competence, the working alliance, and predicting client outcomes from both clients and counselors-in-training perceptions. The results of this investigation contribute to a gap in the counseling literature on multicultural competence, the working alliance, and client outcomes. Preliminary analysis through A Pearson Product two tailed correlation identified the following significant relationships: (a) a positive relationship between clients' perceptions of counselors'-in-training multicultural competence and the working alliance (b) significant positive relationship between counselors'-in-training perceptions of their multicultural competence and the working alliance (c) a positive relationship between client and counselors perceptions of the working alliance, (d) a positive relationship between social desirability scores on counselors'-in-training CCCI-R responses, (e) negative relationships between clients social desirability scores total both client outcome OQ 45.2 pre-test and post- tests, and (f) positive relationships between the OQ 45.2 pre and post test scores).

In order to analyze the four research questions the following three statistical analysis were used: (a) hierarchical regression, (b) repeated measures MANCOVA, and (c) Pearson Product two tailed correlation. The first results from the hierarchical regression indicated that clients' perception of the working alliance and multicultural competence were not significant predictors of client outcome, after controlling for clients' social desirability scores and client outcome pre-test scores (R^2 = .789). Next, results from the second hierarchical regression indicated that counselors'-in-training perceptions of the working alliance and multicultural

competence were found as a whole model to be significant predictors of client outcome, after controlling for counselors'-in-training social desirability scores and clients outcome pre-test scores (R^2 = .796). Further inspection of coefficients revealed that counselors'-in-training perceptions of their multicultural competence was the significant predictor of client outcome. Third, results from the repeated measures MANCOVA indicated that there were differences between client and counselors'-in-training perceptions of the working alliance and multicultural competence. Observed power to detect these differences was .817 and the effect size was .082, indicating a small effect size (Cohen, 1992). Further univariate tests indicated that after controlling for social desirability, there were no differences between client and counselors'-in-training multicultural perceptions. However, univariate tests revealed that after controlling for SDS, there were differences between client and counselors'-in-training working alliance perceptions. Furthermore, upon exploration of the mean scores between clients and counselors-in-training, it appears that clients rated their counselors'-in-training multicultural competence and the working alliance higher than counselors-in-training rated their multicultural competence and the working alliance. Fourth, results from the Pearson Product two tailed correlation on clients' demographics revealed significant relationships between clients' age and client outcome post test scores. Lastly, Pearson-Product two-tailed correlation on counselors'-in-training demographic data indicated counselors'-in-training age had a significant positive relationship with their perceptions of their multicultural competence and the working alliance; counselors'-in-training ethnicity had a negative relationships with their perceptions of their multicultural competence and the working alliance.

Contribution of the Study

The purpose of this investigation was to explore relationships between multicultural competence, the working alliance, and prediction on client outcome. The aim of this study was to highlight the value of the clients' perceptions on counseling topics they are often not asked about. Identifying relationships between multicultural competence, the working alliance, and client outcomes provides counselors with understanding and insights into clients' perceptions about the counseling process. Counselor educators may benefit by increasing their understanding of how their counselors'-in-training are relating to their clients in session. Specifically, counselor educators may be inclined in supervision to help their developing counselors enhance their rapport building and multicultural competency skills. Furthermore, this investigation utilized the only observer report scale for multicultural competence and investigated the psychometric properties with a sample of masters' level counselors'-in-training and adult clients. Overall, the results from this investigation contributed to a gap in the literature of exploring the extent to which multicultural competence and the working alliance predicting client outcome.

Chapter Summary

This chapter provided an introduction to the study including the background of the study, statement of the problem, significance of the study, and an overview of theoretical constructs. In addition, this chapter presented the gap in the literature and the need for empirical investigations on client outcome, multicultural competence, the working alliance. As multicultural competence and the working alliance continue to increase in prevalence in the counseling field, it is important to investigate to what extent these constructs predict client outcome. In the following chapters, a review of the literature and empirical support for the constructs will be provided, and a discssion of the research methodology for this study will are highlighted.

CHAPTER TWO: LITERATURE REVIEW

Chapter Two includes a review of the literature supporting the primary constructs of this investigation: (a) multicultural competence, (b) the working alliance, (c) and client outcomes. The Tripartite Model of Multicultural Counseling (Arredondo et al., 1996) was used as the primary theoretical framework on which the study is grounded. This literature review supports the rationale and merit of an investigation focused on exploring relationships between client and counselor perceptions of multicultural competence, the working alliance, and client outcome. In this Chapter, an overview of the Tripartite Model is provided, reviews of the origins and foundations for the working alliance and client outcome are discussed, and reviews of evidence supporting client and counselor perceptions are highlighted. Lastly, a section on relationships between the constructs is included.

Rationale for the Investigation

Ethnic and racial minority populations continue to increase in the United States. According the U.S Bureau of Census (2012), population estimates indicate that of the more than 316 million persons living in the United States, close to 80% of individuals identify as White. However, major demographic shifts are anticipated in the U.S. over the next 30 years, with minorities comprising the majority of the population. Shifting demographics highlight the urgency for counselors to be well prepared in working with clients from diverse backgrounds.

Specifically, counselors need to be aware and knowledgeable of their cultural background and personal biases, aware of their clients' worldview, and able to research and integrate culturally relevant and appropriate interventions in their work with clients (ACA, 2014; Sue & Sue, 2013). Further, early termination and low retention of clients are common problems in counseling, with 65%-80% of clients terminating treatment before the 10th session (Garfield

1994; Lambert, 2013). Researchers (Lampropoulous et al., 2009; Owen et al., 2009) have found that predictors of early termination include client age, race, socioeconomic status. Specifically, racial and ethnic minorities have limited access to mental health services and are less likely than majority populations to seek mental health services due to a variety of barriers (e.g. cost, lack of availability, societal stigma, and language barriers; Scheppers et al., 2008). Researchers (Constantine, 2002; Day-Vines et al., 2007) have indicated understanding clients' cultural backgrounds enables counseling professionals to better understand, empathize with, and provide services to clients from diverse backgrounds. Suggestions of how to increase retention of minority clients include utilizing culturally sensitive approaches (e.g. cultural competencies), and fostering a safe therapeutic environment, utilizing the working alliances, so that clients feel comfortable (Ponterotto, 2001). Multicultural competence and the working alliance are therapeutic factors that may influence client outcome, although empirical evidence is limited, emphasizing the need for this investigation.

Client involvement is a determinant in client outcome. For example, clients' perceptions of the working alliance and empathy have a higher influence on outcome than counselors' perception (Busseri & Tyler, 2004; Long 2001). In addition to the working alliance, research has been conducted multicultural competence; however, the research is limited to counselor or supervisor perceptions, failing to include clients' perceptions. In a 10-year content analysis of multicultural-centered articles (k = 102) from the *Journal of Counseling and Development*, the authors concluded that only 8% of articles provided a dedicated discussion of multicultural competence and only 42% of articles had an empirical approach (Arredondo et al., 2005). Similarly, Worthington and colleagues (2007) conducted a 20-year content analysis of empirical articles (k = 75) on multicultural competence. The authors concluded that only 3.7% of the

studies used independent observers to provide assessment of counselors' multicultural counseling skills, and the majority of the clients used in these studies were college students (Worthington et al., 2007). Therefore, gaps in the literature exit related to multicultural competence, the working alliance, and clients' perceptions. Despite the importance of clients' perceptions in counseling outcomes, clients are the "most neglected factor in treatment outcome" in empirical research (Bohart & Tallman, 2010, p. 84). Therefore, the purpose of the investigation is to explore client outcomes and perspectives from both clients and counselors on multicultural competence, and the working alliance, to increase understanding on the relationships between constructs from multiple perspectives.

Origins of Multicultural Counseling

Multicultural counseling is defined as "counseling that recognizes diversity and embraces approaches that support the worth, dignity, potential, and uniqueness, of individuals within their historical, cultural, economic, political, and psychosocial contexts" (ACA, 2014, p. 21). In order to understand current definitions of multicultural counseling, a brief review of the origins and history is provided.

The counseling profession was established in the early 1950s; however, three decades passed before scholars and educators embraced the need to focus on multicultural issues for counselor trainees and clients. In the early 1980s, there was a movement for the inclusion of working with clients from ethnic minority backgrounds into the ACA's Code of Ethics (ACA, 2014). In 1982, Dr. Derald Wang Sue presented a landmark paper asserting that psychology and counseling professionals needed to obtain multicultural competence (Sue et al., 1982; Watson et al., 2006). Dr. Sue's landmark paper was endorsed by the Education and Training Committee of the American Psychological Association's Division of Counseling Psychology (Division 17); it

outlined 11 characteristics of multicultural competence, categorized into three dimensions: beliefs/attitudes, knowledge, and skill (Sue et al., 1982).

In 1992, Sue, Arredondo, and McDavis selected members of the Association for Multicultural Counseling and Development (AMCD; Sue, et al., 1982) developed the initial draft of multicultural competencies.In 1992, AMCD proposed an outline of 31 multicultural competencies to be included in accreditation criteria. In 1996, Arredondo and colleagues presented a paper outlining the Tripartite Model of Multicultural Counseling that categorized multicultural competence into three parts: awareness, knowledge, and skills (Arredondo et al., 1996). Fundamentally, the tripartite model characterizes a culturally competent counselor to engage in self-exploration of their beliefs/attitudes, increase their knowledge of the needs of multicultural populations, and engage in culturally sensitive counseling skills.

Multicultural counseling is accepted as the fourth force in counseling (Pedersen, 1991) and continues to pick up momentum within the counseling field. The ACA and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) are professional organizations that provide a set of ethical guidelines and accreditation standards for counseling professionals, including guidelines and standards that support the importance of and necessity for counselors to be culturally competent. For example, the ACA Code of Ethics (2014) states, "Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy. Counselors respect differing views toward disclosure of information" (*Standard B.1.*, p. 6). Another example of the importance of multicultural competence within the ACA ethical guideline states, "Multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population"

(Standard C.2.a., p. 8). Similarly, a CACREP (2009) standard states, "Counselor educators infuse material related to multiculturalism/diversity into all courses and workshops for the development of professional counselors" (*Standard F.7.c*., p. 14). These professional emphases on the importance of multicultural competence throughout the counseling profession highlight the importance of this investigation.

Multicultural Competence Models

Several models were developed to conceptualize multicultural competence in the counseling profession including: (a) *Coping with Diversity Model* (Coleman, 1995), (b) *Alternative Conceptualization of Multicultural Competence* (Constantine & Ladany, 2002, (c) the *Counselor Wisdom Paradigm* (Hanna, Bemak, & Chung, 1999), (d) the Model of Multicultural Understanding (Locke, 1992), (e) the *Worldview and Change Model* (Treviño, 1996), and (f) the Tripartite Model (Sue, Arredondo, & McDavis, 1992). Within each model, scholars identify characteristics of a culturally competent counselor. Multicultural models are based on either a stage approach or a characteristic approach. Stage models (e.g., Coping with Diversity Counseling Model; Coleman, 1995) emphasize developmental stages counselors must go through to multicultural competence (Mollen, Ridley, & Hill, 2003). Characteristic models (e.g., Tripartite Model) emphasize principles counselors can follow to enhance their multicultural competence (Mollen et al., 2003). The Tripartite Model is a characteristic model that is often used to conceptualize multicultural competence within the literature for counselor trainees and mental health professionals (Arredondo et al., 1996; Constantine & Ladany, 2000; Holcomb-McCoy, 2001; Sue, 2001). Thus, the Tripartite Model was used as the theoretical framework for this investigation and is discussed here in detail.

The Tripartite Model

The Tripartite Model (TM) was developed in the 1980s in a landmark paper discussing the need for counselors to be multiculturally competent (Sue et al., 1982). The TM was developed to address the needs of ethnic minority populations and clients who experienced sociopolitical oppression. The foundation of the TM can be categorized into three factors: awareness, knowledge, and skills. The first factor in the TM, multicultural awareness, refers to a counselor's awareness of their own cultural worldview and biases. Counselors who are culturally aware have insight on how their cultural biases influence the counseling process, are comfortable with clients' culture, and respect the clients' religion and culture (Sue et al., 1992). The second area, multicultural knowledge, refers to a counselor's knowledge about various cultural norms and values that affect the counseling process. Counselors demonstrating cultural knowledge understand how cultural norms influence personality and manifestations of psychological symptomatology. In addition, counseling professionals have a responsibility to know how sociopolitical issues such as racism and discrimination affect clients and themselves (Sue et al., 1992). Lastly, multicultural skills refer to a counselor's ability to form a working alliance with clients of various cultures and utilize culturally appropriate interventions. Multicultural skills are demonstrated behaviorally, such as when counselors actively seek out culturally sensitive educational workshops to enhance their training and proficiency in multicultural counseling, or when counselors practice culturally sensitive counseling strategies (e.g. conducting the session in the language preferred by their client); (Sue et al., 1992).

The TM was revised three times to include: (a) Multicultural Competencies (Sue et al., 1992), (b) the Operationalization of the Multicultural Competencies (Arredondo et al., 1996), and (c) the Multidimensional Model of Cultural Competence (MDCC; Sue, 2001). In 1992, Sue

and colleagues organized the TM model into a three-by-three table: counselor awareness of own assumptions/values/biases, understanding the worldview and developing appropriate intervention strategies of the culturally different clients, and dimensions of beliefs and attitudes, knowledge, and skills.

In 1996, Arredondo and colleagues elaborated on the three-by-three factors. They operationalized the multicultural competencies by utilizing aspects of Arredondo's and Glauner's (1992) Dimensions of Personal Identity Model, which emphasizes dimensions of a personality that all individuals possess. The multicultural competencies were operationalized into three ABC dimensions: (1) A – a description of physical and innate characteristics (e.g. accents, height, etc.), and how individuals may be judged based on these characteristics, (2) B – the consequences of experiencing A and C dimensions, and (3) C – the impact sociopolitical and socio-ecological events have on an individuals' worldview. Essentially, within this model, a culturally competent counselor is able to consider how the A, B, and C dimensions influence themselves and their clients. In addition, culturally competent counselors seek out self-exploration opportunities that enhance their knowledge, skills, and awareness.

Together, the multicultural competencies presented by Sue and colleagues (1982), and Arredondo and colleagues (1996) focused on five minority populations (e.g. African-American, Asian-American, European-American, Hispanic/Latino, and Native American). In 2001, Sue presented a revised, more inclusive, model of multicultural competencies called the Multidimensional Model of Cultural Competence (MDCC). The MDCC expanded the model into a three-by-four-by five factor model. Each of the factors within the MDCC incorporated one of three dimensions, Racial and Culture-Specific Attributes of Competence, Components of Cultural Competence, and Foci of Cultural Competence. While the MDCC included the five

minority populations, it also included culturally specific characteristics that were not just related to race/ethnicity. For example, Sue (2001) suggested that a culturally skilled counselor takes into account a clients' individual personality, age, and gender in combination with their ethnic identity. In addition, a culturally competent counselor using the MDCC as guidance takes an advocacy role and intervenes within the clients' systematic environment (society, organizations, work, etc.; Sue, 2001).

Limitations of the Tripartite Model. Although the TM provides the foundational framework for multicultural counseling, several limitations exist. For one, the TM has been widely used to develop assessments to measure multicultural counseling competencies based on multicultural awareness, skills, and knowledge, even though research does not support the three factor structure. Popular assessments include The *Cross-Cultural Counseling Inventory Revised* (CCCI-R; LaFromboise et al., 1991), the *Multicultural Counseling Awareness Scale-Form B* (MCAS:B; Ponterotto, Sanchez, & Magids, 1991), and *Multicultural Counseling Inventory* (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994). Constantine, Gloria, and Ladany (2002) analyzed the factor structure of the three self-report multicultural competence scales (using a principal-components factor analysis) to determine whether the three TM factors underlying the self-report measures were present. Results indicated that the multicultural competence self-report measures did not support a three-factor structure, with only two factors meeting the Kaiser-Guttman criterion of eigenvalue greater than 1. Weinrach and Thomas (2002) also asserted that the TM lacked empirical support for how its competencies were developed. Furthermore, Weinrach and Thomas (2002) noted that the TM's underlying assumptions and beliefs about race are not inclusive of other influential factors such as gender or age. Despite the limitations of the TM, the model remains the foundation of conceptualizing multicultural

competence within the counseling literature and is the foundation of empirical research conducted to date.

Empirical Evidence on Multicultural Competence

Research on multicultural competence emphasizes racial and ethnic minorities as the primary indicator of diversity (Constantine & Ladany, 2001; Pope-Davis & Coleman, 1994); therefore, an overview of empirical research of ethnic and racial minority counselor and client perceptions is provided. Coleman, Wampold, and Casali (1995) conducted a meta-analysis (k = 21) of research focused on ethnic minorities' perceptions and preferences for ethnically similar counselors. Results from the large effect size (d = .73) and chi-square test of homogeneity ($\chi 2$ [1, N = 18] = 316.62, p < .001) indicated that participants strongly preferred counselors from similar ethnic/racial backgrounds as themselves. However, a small effect size (d = .20) and chi-square homogeneity test ($\chi 2$ [1, N = 22] = 54.49, p < .002) reveals that there was small difference between ethnic/racial backgrounds on how clients rated the overall competencies of their counselors Q54.49, *df* 41, (d = .20, p < .001). Similarly, Cabral and Smith (2011) conducted a meta-analysis (k = 152) investigating clients' preferences and outcomes of working with counselors who are racially/ethnically similar. The authors drew three conclusions from the meta-analysis. First, across 52 studies of preference, there was a moderate effect size of .63 (*SE* = .08, p < .001) for clients having a preference for counselors from similar racial/ethnic backgrounds. Second, across 81 studies of clients' perceptions, a small effect size was .32 (*SE* = .07, p < .001)), indicating the tendency for clients to view counselors of similar race/ethnicity more positively than other counselors. Lastly, across 53 studies of client outcome, results indicated there were no differences, .09 (*SE* = 0.02, p < .001) in client outcomes when client and counselors were from similar racial/ethnic backgrounds. Collectively, the effect sizes in

Cabral and Smiths' (2011) study indicate that the influence of racial/ethnic matching of client and counselor is highly variable; therefore, inconclusive regarding the importance of clients and counselors coming from similar racial/ethnic backgrounds.

In summary, the results from the meta-analyses of Coleman and colleagues (1995) and Cabral and Smith (2011) indicate that while clients may prefer to be paired with counselors who are of similar race/ethnicity, the matched pairing had little influence on clients' perceptions of their counselors' competencies or on client outcomes related to treatment. Results from existing empirical investigations identify the need to further investigate relationships between other variables that may influence client outcomes.

Research focused on the relationships between clients' and counselors' ethnic and racial backgrounds is extensive; however, limited research examines the relationships between multicultural competence and variables such as the working alliance and client outcome. Furthermore, since the development of the multicultural competencies, there has been considerable empirical research on trainee self- report multicultural competence; however, gaps remain in accounting for clients' perceptions of trainees' competencies (Constantine, 2001; Fuertes et al., 2007). Finally, little is known about relationships between counselor and client perceptions of multicultural competence and the relative influence on the working alliance or positive client outcomes (Hatcher & Barends; 1996; Horvath & Bedi, 2002). The few empirical investigations that have highlighted this relationship are discussed.

Fuertes and Brobst (2002) examined the role of multicultural competence from the perspective of the client. Participants in this investigation included masters and doctoral students (N = 85) who were surveyed over two months about their experiences in counseling. Participants varied in their timing of having received counseling; 54 reported currently

receiving counseling, and 31 reporting having received counseling recently. However, the authors do not distinguish how recently those 31 participants received counseling. Participants identified themselves as predominantly Euro-American (*n* = 49), Hispanic-American (*n* = 18), Asian-American (*n* = 9), and Indian-American (*n* = 1). Participants were also asked to identify their counselors' racial/ethnic background (*N* = 85). Participants identified their counselors' race as predominantly Euro-American (*n* = 64), Hispanic (*n* = 3), African-American (*n* = 2), and 16 respondents did not indicate their counselors' race.

Participants in this investigation completed five measurements after a counseling class; as an incentive for participating they were told they would be included in a $25 raffle at their university bookstore. The CCI-R (CCCI-R; LaFromboise et al., 1991) measurement was used to assess perceptions of their counselor's multicultural competency. Counselors' multicultural competence was measured by multicultural awareness, knowledge, and skills (LaFromboise et al., 1991). A strong internal consistency was reported for the CCCI-R adapted version (α =.93). The CRF-S (CRF-S; Corrigan & Schmidt, 1983) is a 12-item assessment that was used to assess counselor attractiveness (client's liking/admiration toward counselor), expertness (clients' belief of counselor's knowledge and skills in problem solving), and trustworthiness (clients' perception of counselor's openness). Confirmatory factor analysis yielded evidence of strong construct validity as evidenced by split-half reliabilities ranging between .85 to .91 and internal consistency (α =.94). The *Barrett-Lennard Relationship Inventory* (Barrett-Lenard, 1962) is a 16-item assessment that was used to assess clients' perceptions of counselor empathy, with a reported strong internal consistency (α =.88). The *Miville-Guzman Universality-Diversity Scale-Short* (M-Guds;, & Fuertes, Miville, Mohr, Sedlacek Gretchen, 2000) is a 45-item scale that was used to assess multicultural self-awareness. The M-Guds assessment was reported to have

strong internal consistency (α =.79). Lastly, the *Counselor Evaluation Inventory* (CEI; Linden, Stone, & Shertzer, 1965) is a 5-item subscale that was used to measure client satisfaction in counseling, with a strong reported internal consistency (α =.95).

A bivariate correlation was run among the following variables: client satisfaction, number of sessions completed, clients' multicultural awareness, counselors' multicultural competence, and counselors' empathy. Positive significant correlations ($p < .01$, two tailed) were found between clients' satisfaction and clients' perceptions of general counseling skills (e.g. trustworthiness, attractiveness etc.; $r = .84$), between clients' satisfaction and perception of counselor empathy ($r = .55$), and between clients' satisfaction and overall perceptions of counselors multicultural competence ($r = .79$). Client perception of counselors' multicultural competence was also correlated with counselor attractiveness, trustworthiness, expertness ($r = .72$) and empathy ($r = .55$). Essentially, results from correlations indicated an overall positive correlation between clients' perceptions of their counselors' multicultural competence, general counseling skills, and empathy.

A hierarchical regression analysis was used to analyze four predictor variables on client satisfaction: counselors' multicultural competence, attractiveness, trustworthiness, expertness. This hierarchical regression was entered in three steps: (a) client multicultural awareness; (b) clients' ratings of counselors' empathy, attractiveness, expertness, and trustworthiness (entered simultaneously); and (c) clients' perceptions of counselors' multicultural competence. The model summary table was not presented in the study, and *F* statistics were not reported. The adjusted ΔR^2 at steps one through three were .07, .76, and .80 respectively ($p < .05$ for step 1, $p < .001$ for steps two and three). Overall, the summary of the regression analysis indicated that 80% of the variance in clients' satisfaction with their counselors was predicted by the four

variables. In addition, Fuertes and Brobst (2002) examined potential possible differences between Euro Americans and ethnic minority clients' level of satisfaction with their counselors, using the same variables and three steps as reported in the previous model. Again, *F* statistics were not provided in the results table. The adjusted ΔR^2 at steps one through three for Euro American clients ($n = 49$) were .06, .82, and .84 respectively ($p > .05$ for step one, $p < .001$ for step two, and $p < .05$ for step three). The adjusted ΔR2 at steps one through three for ethnic minority clients ($n = 36$) were .07, .68, and .84 respectively ($p > .05$ for step one, $p < .001$ for step two, and $p < .05$ for step three). Results from the first regression and second regression indicate that both Euro-American and ethnic minority clients perceived general counseling skills (e.g. trustworthiness, empathy) to be of importance. However, counselors' multicultural competence was only significant for ethnic minority clients.

In summary, Fuertes and Brobost (2002) results indicated strong positive correlations between clients' perceptions of their counselors' multicultural competence, general counseling skills, and empathy. In addition, results revealed that when the overall sample of participants was divided into subsamples of Euro American and ethnic minority clients, the counselors' multicultural competence explained a significant amount of variance for the ethnic minority sample. Two limitations of this investigation included a small sample size and that *F* statistics were not provided in the output table, making it impossible to accurately report the full hierarchical regression output. However, results from this investigation suggest the important role multicultural competence can have within the counseling relationship and with minority client satisfaction with counseling.

In a qualitative investigation, Pope-Davis et al., (2002) conducted a grounded theory design interviewing 10 undergraduate students who had received counseling (N = 10; 9 women, 1 man) from a large East Coast university who received course credit for participating in the study. The purpose of this investigation was to increase understanding of clients' perceptions and experiences in counseling of cross-cultural dyads and create a grounded theory model of clients' perspectives on multicultural competence. A common theme found was this: If a client thought it was important for a counselor to include cultural components within a counseling setting, then culture would influence their counseling sessions. A common theme that was found is that it was incorporating culturally relevant components into counseling was importance to clients only if they self-identified their culture as a core value in their life. Second, counselors who incorporated aspects of the client's culture in session were viewed as more culturally competent than counselors who did not. While this investigation had a limited sample size, it is of major importance because it is one of the few qualitative studies on multicultural competence from the clients' perspectives. Findings from this qualitative investigation are similar to Fuertes and Brobost et al. (2002), which found that clients' perceptions of their own culture, and whether they hold aspects of their culture as a core value, is interconnected with how culture is incorporated throughout the counseling process.

Limitations in Empirical Evidence on Multicultural Competence

Worthington and colleagues (2007) conducted a 20-year content analysis of empirical articles (k = 75) on multicultural competence. The authors concluded that the majority of the studies utilized self-report assessments with intrapersonal variables (e.g. counselor race/ethnicity), and only 3.7% of the studies used observer/independent report assessments (Worthington et al., 2007). The only observer report multicultural competence scale that exists

is the CCCI-R (LaFromboise et al., 1991). The CCCI-R is intended for supervisors to rate their supervisees' multicultural competence; therefore, no observer report currently exits that was made specifically for client ratings of their counselors' multicultural competence. In addition, the analysis indicated that the majority of the clients used in multicultural counseling research samples are college students, highlighting the need for more diverse samples (Worthington et al., 2007). Similarly, Arredondo and colleagues (2005) conducted a 10 year content analysis of multicultural-centered articles (k = 102) in the *Journal of Counseling and Development*. The authors concluded that only eight percent of articles provided a dedicated discussion to multicultural competence and less than half (42%) were empirical articles. Thus, an increase in empirical evidence is needed on observer reports of counselor's multicultural counseling skills, from a diverse population of clients.

Overall, since the development of multicultural competence, there have been different approaches to measure and assess the multicultural competence of counselors. Pope-Davis and Coleman (1994), Constantine and Ladany (2001), and Worthington and colleagues (2007) identify four themes from multicultural counseling research: (a) most of the assessments stem from the Tripartite Model presented by Sue and colleagues (1992); (Coleman et al., 1995; LaFromboise & Foster, 1992; Ponterotto et al., 2007); (b) psychometric properties of these assessments need further investigation; (c) there is a lack of client outcome studies that measure the validity of multicultural assessments' impact on client improvement; and (d) the majority of multicultural competence research focuses on demographic variables of race and ethnicity. In order for multicultural competence research to reach further sophistication, professional counseling organizations and scholars (ACA, 2014; Bachelor, 2013; CACREP, 2009; Okiishi, Lambert, Nielsen, & Ogles, 2003; Owen et al., 2011) recommend exploring other variables that

contribute to the multicultural counseling process, such as client outcome and the working alliance.

Origins of the Working Alliance

The term "therapeutic alliance" was coined by Rogers (1957) and was characterized as a client-centered approach. Rogers (1957) defined the counseling relationship as the counselors' ability to be authentic, and to show empathy and unconditional positive regard towards their client. Since Rogers' definition, the idea of the therapeutic alliance has been expanded to include the clients' responsibility in forming relationships. This expansion is known as the working alliance. In 1956, Zetzel elaborated on Freud's (1912) concept of transference to highlight the benefit of incorporating client-therapist relationship within counseling. In 1965, Greenson coined the term working alliance in a journal article titled *The Working Alliance and Transference of Neurosis.* In this article, Greenson (1965) elaborated on Zetzel's (1956) clarification of transference, to include collaboration between counselor and client involving three concepts: transference, the working alliance, and the real relationship.

Although there is no single definition of the working alliance, researchers have adopted Bordin's (1980) definition (Al-Damarki & Kivlinghan, 1993; Baldwin et al., 2007; Horvath & Greenberg, 1989). For the purpose of this investigation, the working alliance is defined as the extent of agreement between counselors and client on the goals, tasks, and bond in session (Horvath & Greenberg, 1989). Goals are the agreed-upon objectives between client and counselor to work on in counseling (Tracey & Kovocivic, 1989). Tasks are the agreed-upon behaviors within counseling in order to achieve the desired outcome (Bordin, 1980). Bond is the level of empathy or attachment clients and counselors perceive (Bordin, 1980). This

conceptualization of the counseling relationship emphasizes the importance of mutuality in counseling and supports the importance of exploring client and counselor perceptions in session.

Empirical Evidence on the Working Alliance

Considerable research focuses on the working alliance. Hatcher, Barends, Hansell, and Gutfreund (1995) investigated the extent to which clients and counselors agree on the strength of the working alliance. Participants for this investigation were recruited from a psychological training facility for clinical psychology and social work interns. Administrative clinic staff collected data from 1989-1993. The sample (N = 182) included clients (n = 144; n = 45 males, 99 females) who completed from under one month to five years of counseling, and their counselors (n = 38; 24 female, 14 male), with clinical experience ranging between eight months to eight years. Demographic information such as race/ethnicity and age were not reported.

Both clients and their counselors completed three working alliance measures. First was the *Penn Helping Alliance Inventory-Revised* (HAQ-R; Alexander & Luborsky, 1986), a seven-item self-report assessment rated on a six-point Likert-type scale. Second was *The Working Alliance Inventory*, short form (WAI-S; Tracey, & Kovocivic, 1989) is a 12-item seven-point Likert scale with three subscales (goals, tasks, bonds). The WAI-S is a shortened version of the original WAI 36-item version (Horvath & Greenberg, 1989). Third was the *California Psychotherapy Alliance Scales* (CALPAS; Gaston & Marmar, unpublished manuscript, 1991), with both client and counselor versions. It consists of a 24-item scale measured on a seven-point Likert scale with four subscales: Patient Working Capacity, Patient Commitment, Working Strategy Consensus, and Therapist Understanding. In addition, the *Quality of Life Inventory* (QOL; Mayman, 1990) is a 12 domain scale used to measure pre-therapy index of client

symptomatology. Validity of the QOL scale yielded a strong internal consistency with the clinic sample (α = .84; Hatcher et al., 1995).

A nested research design was used in this investigation because it is a common design used in working alliance studies in which one counselors has several clients, enabling researchers to separate variances due to individual counselors from variance due to clients (Hatcher et al., 1995). Various models were analyzed with confirmatory factor analysis for clients' and counselors' ratings of the working alliance, results confirmed a three factor model (χ^2 [4] = 7.19, p > .13; GFI = .98; RMSR = .02; CFI = 1.0). When counselors' and clients' perceptions were combined within the three working alliance assessments, results indicated that the HAQ-R scale accounted for 44% of clients' and 27% of counselors' variance. In addition, the HAQ-R scale yielded the strongest shared view between counselors (38% variance) and clients (28% variance). The WAI-S score accounted best for clients' and counselors' individual perceptions of the working alliance, accounting for 56% of counselors' views and 43% of clients' views. Overall, results indicated that clients and counselors agree on helpfulness (e.g. clients' belief that their counselor is helping them) and clarification about goals and tasks in counseling. Individually, results indicated that helpfulness plays a larger role for clients than counselors, and that quality of the bond formed with counselors plays a larger role for counselors than clients.

In summary, results from this investigation indicate that clients and their counselors agree upon aspects of the working alliance that are characterized by helpfulness and agreement upon goals and tasks. Specifically, clients tend to view helpfulness as more important and counselors tend to view the quality of the bond formed in counseling as more important. In addition, the results of the factor loadings indicate that the WAI-S is a strong representation of counselors' views, whereas two features of the clients' views are represented in the WAI-S and HAQ-R.

Overall, Hatcher and colleagues (1995) began a trend in empirical investigations on the working alliance and indicated that there were differences and similarities among clients' and counselors' perceptions of the working alliance.

Fitzpatrick, Iwakabe, and Stalikas (2005) investigated clients' and counselors'-in-training perceptions of the working alliance over the course of counseling and related those perceptions to session-level counseling factors. The sample for this investigation included 48 client-counselor dyads. Clients (n = 48; 39 female, 9 male, an average age of M = 30, SD = 10.31) were college students enrolled in a human science undergraduate program at a large Canadian University. The human science course had an experiential component in which students could choose to attend counseling and be randomly assigned to counselors. Length of counseling treatment ranged between 9 to 16 sessions (M = 14.3, SD = 1.5). Counselors (n = 45; 7 men, 38 women, with an average age of M = 31, SD = 9.05) were master's level trainees in their first practicum course in a counseling psychology program. They were from a different university than their clients.

Clients and counselors completed three assessment measures in this study. The first assessment, the *Session Impact Scale* (SIS; Elliot & Wexler, 1994) was a 22-item scale with a five-point anchored rating scale (*1 = not at all; 5 = very much*) measuring client ratings of positive or negative aspects of counseling outcome using three subscales: Tasks (positive phenomenon such as making progress on assignments assigned to improve problems), Relationship (related to clients' feelings of being understood/supportive), and Hindering (related to clients' feeling misunderstood or bothersome). The second assessment completed was the WAI (Horvath & Greenberg, 1989), a self-report measure where items are measured on a 7-point Likert scale (*1 = never, 7 =always*). Lastly, clients completed the *Target Complaints Scale*

(TCS; Battle et al, 1966), in which they identified three problems they wanted to address in counseling. The internal consistencies of the SIS, WAI, and TCS were not reported for the client-counseling dyads. Clients and counselors would complete the SIS after each session and the WAI after every second or third session. In order to account for differences in clients' and counselors' perceptions of the working alliance, Fitzpatrick and colleagues (2005) completed absolute divergence by taking the absolute value of client-rated alliance scores and subtracting them from counselor-rated alliance scores for the same session. Also, relative divergence scores were used to analyze differences in clients' and counselors' scores; they were calculated by standardizing each score of the WAI within each participant over the course of treatment and subtracting counselors' scores' from clients' scores for each session.

To analyze how clients' and counselors' perspectives on the working alliance related to aspects of counseling factors, partial correlation coefficients were conducted comparing the WAI to the SIS score for the same session. A Bonferroni adjustment was conducted, setting the experiment wise error at .05, $p < .0005$; comparison of scores yielded that there was no absolute or negative divergence between counselors' and clients' perspectives. In addition, the alliance was significantly related to how whether clients' rated their counseling session experience as positive or negative. Next, a first-order Pearson correlation coefficient analysis was conducted to explored whether clients' and counselors' ratings of the alliance early on in counseling would be related to clients' progress early on in session. Fitzpatrick and colleagues (2005) defined an early session as the second-third-fourth session, a later session as fourth-third-second to last, and middle phase as close to the midpoint of interval of counseling as possible. Results indicated that clients' ratings on the Task subscale of the alliance were positively correlated both early and later in counseling, with two helpful subscales (Task and Relationship) on the SIS both early

(WAI Task-SIS Task, r = .61; WAI Goal-SIS Relationship, r = .61) and later (WAI Task-SIS Task, r = .54; WAI Goal-SIS Relationship, r = .53). This essentially means that a strong working alliance was related to clients' rating their counseling session as a helpful/positive experience. Client rated Bond was correlated with session impact during early (r = .62) and middle phases (r = .49) in counseling with the Relationship subscale of the SIS. Also of importance to note is that counselor-rated alliance dimensions did not correlate with client-rated session impact during early, middle, or late phase of counseling.

Overall, examination of the means and standard deviations of WAI scores indicate that clients rated aspects of the working alliance higher than their counselors. Inspection of divergence scores specifically indicates that clients rated the alliance slightly higher for Task (73%-77%) and Goal (67%-75%) than Bond (58%-65%). Lastly, Fitzpatrick and colleagues (2005) conducted two multivariate analyses of variance (MANOVAs) to explore how clients' and counselors' perception ratings of the alliance develop over the counseling process. The two MANOVAs included two within-subject factors: phase (early-middle-later) and WAI subscale scores (Task-Goal-Bond). The authors used the robust Pillai's formula to trace the differences in F statistics. Results indicated that divergence of scores did not change significantly over the three phases of counseling, $F_{(2, 56)} = 0.56$, $p > .05$; Pillai's trace = .024, and no interaction between the three phases of counseling and WAI subscales, $F_{(2, 46)} = 1.47$, $p > .05$; Pillai's trace = 1.20. However, absolute divergence was statistically significant between the WAI subscales, $F_{(2 ,46)} = 6.57$, $p < .05$; Pillail's trace = .222. Due to the significance, a post hoc pairwise comparison was conducted with Boneferroni adjustment carried out to set the experiment wise error rate at .05 (alpha level .0005). Results yielded differences between clients' and counselors' perceptions on the Bond scale was statistically smaller than the Task (p = .02) and Goal (p

= .02), with no differences between Task and Goal subscales (p = .06) subscales. In addition, results from the MANOVA indicated no differences between clients' and counselors' perceptions of the alliance over the three phases of counseling on the three subscales, $F_{(2, 46)}$ = .0326, p > .05; Pillail's trace; .014. Overall, no differences were shown between the three subscales of the WAI, $F_{(2,46)}$ = 2.134, p > .05; Pillai's trace = .085. The combined interaction of the three phases of counseling and three subscales was also not significant, $F_{(2, 46)}$ = 1.288, p > .05. Essentially there were no differences between clients' and counselors' perceptions of the working alliance over the three phases of counseling.

In addition, to explore clients' and counselors' perceptions of the working alliance more in-depth, Fitzpatrick and colleagues (2005) conducted another MANOVA with two within-subject design factors. The two factors were phases of counseling (early-middle-late) and WAI subscales (Task, Bond, Goal). Results indicated as a whole, client-rated alliance would increase over time, $F_{(2, 46)}$ = 3.51, p < .05; Pillai's trace = .132) and clients' ratings on the three subscales were significantly different, $F_{(2, 46)}$ = 8.53, p < .05; Pillai's trace = .271). Post hoc analysis with Bonferroni adjustment at .0005 indicated there was no difference between Task and Bond subscales (p = .83). Overall, there was no significant interaction between the three phases of counseling and WAI subscales for clients, $F_{(2, 46)}$ = 0.44, p > .78; Pillai's trace = .04). In comparison, counselor-related alliance scores were similar to those of client-rated alliance scores. Results indicated there was a statistically significant change in alliance scores over time $F_{(2, 46)}$ = 8.38, p < .05; Pillai's trace = .27) and the ratings on the subscale scores were significantly different, $F_{(2, 46)}$ = 39.78, p < .05; Pillai's trace = .148). Post hoc analysis with Bonferroni adjustment showed bond subscale was significantly higher than task and bond (p = .01). Overall, the MANOVA indicated there was no statistically significant interaction between

three phases of counseling and three WAI subscales for counselors, $F_{(2, 46)} = 1.90$, $p > .05$; Pillai's trace = .15).

In summary, results from Fitzpatrick and colleagues (2005) indicate that clients' own perceptions of the working alliance of tasks and goals was most related to positive aspects of counseling. In addition, there were differences between client- and counselor-rated scores of the working alliance, with clients rating the relationship slightly higher. Essentially, this indicates that a strong working alliance is of importance to clients. A major limitation of this investigation included the differences in the length of treatment, ranging between four to fourteen sessions. The large variability in amount of sessions did not provide a full spectrum of what the working alliance may have really looked like if all clients had the same number of later sessions. Results from this investigation warrant further research on exploring aspects of the counseling process that would be most beneficial in helping clients. Overall, this study is of relevance for this investigation due to similarities in sampled counselors'-in-training.

Limitations on Working Alliance Research

The working alliance is often researched within the counseling field and is identified as a key factor in positive client outcomes regardless of treatment modality or counseling setting (Bachelor, 2013). However, discrepancies exist between client and counselor perceptions of strong working alliances (Bachelor & Horvath, 1999; Tyron et al., 2007). An increase in research in different settings is needed to increase understanding about counselors' and clients' perceptions of the therapeutic alliance (Bachelor, 2013). Martin, Garske, and Davis (2000) conducted a meta-analysis (k = 79 articles) of underlying patterns that exist between the working alliance and client outcome. These 79 studies had been conducted over an 18-year span, with 30 studies available before 1990 and 49 studies available between 1990 and 1996. Of these studies,

58 were from published sources and 21 were unpublished doctoral dissertations or master's theses. The mean sample size was 60.39 patients (*SD* = 64.64), and the average length of treatment was 22.18 sessions (*SD* = 18.76). Approximately two thirds of the patients were female. The mean number of counselors per study was 20.22 (*SD* = 19.99), and the average amount of therapist experience was 8.10 years (*SD* = 5.23). The WAI scale was used most often in the sample of studies (*n* = 22), followed by the CPAS (*n* = 16), *the Pennsylvania Scales* (*n* =12), *the Vanderbilt Scales* (*n* = 9), *the Toronto Scales* (*n* = 5), and the *Therapeutic Bond Scales* (*n* = 3). In the studies, patients were the most common rater of the alliance (*n* = 37), followed by counselors (*n* = 26), and observers (*n* = 25). Results indicated overall reliability of over 60 scales was above .70 and internal consistency was above .80. Thus, no difference was found in the ability of one scale to better predict change in client outcome. In addition, overall, authors concluded that the correlation between client and therapist alliance is moderate with client outcome (*r* = .22). Overall, this meta-analysis supports the use of the WAI scale for this investigation and emphasizes the need for larger sample sizes of counselors.

In addition to the working alliance and multicultural competence, the ACA Code of Ethics (ACA, 2014) and CACREP (2009) emphasize the importance of counselors' roles and ethical responsibilities in engaging in research that measures client outcomes. Aside from the need to increase understanding between the differences in perceptions between clients and counselors (about counselors' multicultural competence and the working alliance), there is a need to investigate the extent to which these two constructs predict client outcome. This investigated three components (multicultural competence, working alliance, and client outcome) that are significant within the counseling field, but that need further empirical research to help counselors and counselor educators increase their understanding of these subjective constructs.

Client Outcome

Client outcome refers to measuring and comparing a client's status at repeated points in counseling on their level of symptomatic distress, quality of interpersonal relationships, and perceived social role in their daily lives (Lambert & Burlingame, 1996). Symptomatic Distress (SD) refers to the severity of clinical symptoms (e.g. symptoms of depression) a client is reporting (Lambert & Burlingame, 1996). Interpersonal Relations (IR) refers to the client's level of satisfaction and quality of life with intimate relationships in their life (Lambert & Burlingame, 1996). Social Role (SR) refers to the level of client's satisfaction or distress with areas of social roles at work, family, and leisure time (Lambert & Burlingame, 1996).

Factors Associated with Client Outcome

A variety of therapeutic factors can influence client outcomes. The common factors model (Rosenzwig, 1936) suggests there is a set of therapeutic variables that overlap in all counseling services, and that contribute to the type of outcome in counseling. The common factors model is generally categorized into extratherapeutic factors (e.g. social support, spontaneous remission), expectancy (clients' hope and expectation for change), specific techniques (e.g. hypnosis, biofeedback), and common factors (e.g. empathy, warmth, congruence, and therapeutic relationship); (Lambert & Barley, 2001). In 1991, Frank and Frank added a fourth element to the common factors model called treatment coherency. Treatment coherency refers to the matching process in counseling (e.g. matching the clients' cultural values such as language and incorporating that into counseling; Scheel & Conoley, 2012). From the therapeutic factors discussed, the therapeutic relationship and empathy have been found to have the most influence on client outcome. Principally, client perception about the therapeutic relationship and counselor empathy has the most explained variance in client outcome (Norcross

& Lambert, 2011). The aforementioned research on client outcomes and the common factors model highlights the importance of client involvement in counseling and in research.

Empirical Evidence on Client Outcome

Investigating the efficacy of psychotherapy can be traced to 1952. Eysneck (1952) conducted an evaluation of 19 studies in psychotherapy and concluded that, overall, psychotherapy is not effective and that neurotic clients can get better on their own. Though Esyeneck's critique was controversial, it ignited the conversation for further research on client outcomes. Smith (1977) conducted the first extensive meta-analysis on psychotherapy client outcomes studies (k = 400) and, contrary to Eysneck's study, concluded that individuals who receive counseling are better off than untreated individuals. Smith highlighted that the most important component in reviewing client outcomes studies was looking at the effect size. After reviewing 400 client outcome studies, Smith (1997) concluded that an effect size of .75 was a determining factor of efficacious psychotherapy.

In a study examining the overall outcome of counseling, Okiishi, Lambert, Nielsen, and Ogles (2003) examined speed of improvement for clients (n = 1841) and counselors (n = 91) over a two-and-a-half-year period in a university counseling center using the *Outcome Questionnaire 45.2* (OQ 45.2; Lambert & Burlingame, 1996). The OQ 45.2 is a 45 item self-report assessment developed to assess client outcomes throughout the counseling process (Lambert & Burlingame, 1996). The OQ 45.2 is a well-established assessment that has been validated across several diverse clinical populations (Okiishi et al., 2003). Hierarchical Linear Modeling indicated significant difference between clients and counselors on both their OQ scores (HLM intercept; b = 73.80, $p < 0.001$) and in their rates of improvement (HLM slope; b = -0.79, < 0.001). These results indicated varied results, with some clients reported functioning

clinically significantly better at termination of counseling while some clients reported functioning clinically significantly worse (Okiishi et al., 2003). Overall, these investigations highlight the need to explore the extra-therapeutic variables that can contribute to clients' functioning in counseling.

To assess the extent of change in client outcomes receiving counseling in various university settings, Vermeersch et al. (2004) utilized the OQ 45.2 (Lambert & Burlingame, 1996). Vermeersch et al. (2004) were interested in exploring the OQ 45.2 sensitivity to change: the degree to which an assessment accurately represents change in clients in counseling (Hill & Lambert, 2004). For this investigation, Vermeerch et al. (2004) utilized two criteria: (a) client change on an item, subscale, or total score based on the theoretical foundations of OQ 45.2; and (b) change on an item, subscale, or total score when compared to a control group of untreated individuals. Data for this investigation included treated and untreated individuals. The experimental sample data was archival data that consisted of 5,553 counseling center clients who received counseling from predominantly Caucasian female counselors (n = 527) across 40 university counseling centers within the United States. The average number of sessions completed by clients was three and average pre-treatment OQ total score was 70. The control group consisted of undergraduate students (n = 248) enrolled in a psychology course located at a large western university. The undergraduate students consisted primarily of 21-year-old female Caucasians who completed the OQ 45.2 assessments weekly, bi-weekly, or monthly over a three-month period.

The OQ 45.2 internal consistency estimates for the total score, symptomatic distress subscale, interpersonal relations subscale, and social role subscale yielded a strong internal consistency for the control group .90, .87, .68, and .51, and the counseling center sample (.92, .90, .74, and .66). The OQ 45.2 assessment was completed via paper-and-pencil format and completed at least two times by the control and experimental group. Statistical Analysis Software (SAS) used a multilevel procedure to compare the scores of both groups. In order to obtain cross-study comparisons related to effect size and sample, the Ray and Sahdish's (1996) total score formula was used. The comparisons of slopes and effect sizes between the experimental and control group were the main interests of this study. The OQ total score for clients showed consistency with a downward sloping (-2.38) response and stability in scores for the non-clinical sample (-.53). In addition, the effect size when comparing clients and the non-clinical sample was moderate (d = .59). Lastly, the three subscales demonstrated downward sloping scores for clients (SD slope = -1.67, IR slope = -0.36, and SR = -.032) and relatively stable slope for clients (SD slope = -.4388, IR = -.0618, and SR = -.028). Lastly, the effect sizes when comparing clients and the non-clinical sample ranged from moderate to high (SD d = .60, IR d = .37, and SR d = .44). Overall, the results from this investigation provide support for the use of the OQ 45.2 total score as the most appropriate indicator of client change in counseling; it also promotes further research on subscale scores.

In an investigation analyzing client improvement, Hayes, Owen, and Bieschke (2014) explored counselors' factors in client improvement with racial/ethnic minority clients. They used archival data from a mid-Atlantic university counseling center, searching through a seven-year period (2004-2011). The sample included counseling graduate students in training (n = 36) and clients (n = 238). Practicum counselors included doctoral or masters level students,

predominantly female (n = 32) and white (n = 34). The client sample consisted of students, 79.4% women 20.6% men; 64.9% European American, 10.1% African American, 7.9% Hispanic/Latino, 2.6% multiethnic, and 1.3% other. Clients were seen on average for five sessions, and counselors saw between four and 13 clients. Clients completed the OQ 45.2 before each counseling session. Hayes et al. used two multilevel models in which clients (Level 1) were nested within counselors (Level 2).

The first model explored whether race/ethnicity was a predictor of OQ 45.2 post-scores, while controlling for OQ 45.2 pre scores and counselor race/ethnicity. The second multilevel model explored the association between client race/ethnicity and OQ 45.2 scores with all counselors. Hayes et al. (2014) used the reliable change index of 14 points from pre to post treatment scores on the OQ 45.2 as an indicator of client improvement. Descriptive information revealed that racial/ethnic minority (REM) clients were seen for an average of five sessions and had an initial OQ 45.2 score of M = 61.35, SD = 24.12, final OQ 45.2 score M = 51.93, SD = 26.64, with 31.3% showing improvement, 65% no change in scores, and 3.8% deteriorating. In comparison White clients were seen an average of five sessions, with an initial OQ score of M= 56.07, SD = 20.43 and final OQ 45.2 score M = 47.43, SD = 23.42; with 31.8% client improvement, 62.8% no change and 5.4% deteriorating. Results from the first multilevel model indicated no significant difference between REM and White clients in post-treatment OQ 45.2 scores improvement (HLM intercept; b = 50.47, $p < 0.001$). Results from the second multilevel model indicated that some differences in the association between client race and ethnicity with all counselors in post treatment OQ 45.2 scores existed HLM intercept; b = 48.91 $p < 0.001$. In a post hoc analysis, Hays et al. (2014) treated client race/ethnicity as a random factor to see what extent client race or ethnicity accounted for the variance in treatment outcomes. Results of the

post hoc test indicated that client race/ethnicity accounted for 19.1% of the variance in treatment outcomes, indicating that some counselors produced better outcomes than some other counselors, and clients' ethnicity has a partial role in this. In addition, Hays et al., (2014) were interested in exploring the extent to which the random factor. Results from random effects in counselor variance in outcomes in model 1 fixed was 22.99 in comparison to model two was 18.59. Model two indicates that when client race/ethnicity was not controlled for and treated as a random effect, client race/ethnicity still accounted for nearly 19% of the variance in treatment outcomes.

Overall, Hays et al. (2014) indicated that there was no significant difference in client outcome scores between REM and white clients. In addition, counselors'-in-training varied in their level of effectiveness in client improvement; the variability in improvement was due partially to clients' REM status. Essentially, some of counselors' clients who were REM showed decreases in their clinical distress while others did not. A limitation is the small sample of counselors in comparison to clients. Overall, Hays et al.'s (2014) findings indicated that further research needs to look at other variables that may contribute to client outcome other than clients' REM, such as the working alliance and multicultural competence.

In a study exploring the level of effectiveness in treatment from counselors'-in-training, Nyman, Nafziger, and Smith (2010) examined client (N = 264) outcome data. Clients were students in college (67% female, 33% male; a minimum of six counseling sessions; and majority White with 91%). Clients completed two assessments to measure symptomology and interpersonal problems; the *College Adjustment Scale* (CAS) and the *Outcome Questionnaire 45.2*. Clients completed the CAS and OQ 45.2 prior to their intake session. After the intake, clients completed the OQ 45.2 every third session and the CAS every sixth session. Data was collected over a three-year period, with counselors (five doctoral students, nine interns, and 18

practicum students) receiving multilevel supervision: counseling staff supervised interns and first-semester practicum students, and interns supervised second-semester practicum students.

First, Nyman et al., (2010) conducted a MANOVA, using intake scores on the CAS and OQ 45.2, to see if there were any initial differences in symptomology among practicum students, interns, and licensed staff professionals. Results revealed there were differences in symptomatology among the clients from the three levels from intake to follow-up sessions (Wilks's lambda = .74; $F_{(6, 167)} = 9.7$, $p < 001$). On the other hand, there were no statistically differences when comparing counselors training level (Wilks's lambda = .92; $F_{(12,234)} = 1.23$, $p > .001$). Further, Nyman et al., (2010) conducted a chi-square analysis from the counselor-training levels on client outcome and results indicated that there was no statistical difference in client outcomes by counselor training level; $X^2(6, N = 264) = 4.4$, $p > .001$. They categorized clients into four groups and utilized Lambert & Burlingame's (1996) suggestion of cut-off score of 63, with a reliable change index of 14 to determine client symptomatology improvement. Results indicated that the majority of clients' symptomology were unchanged (47%), 21% of clients improved, 20% of clients recovered, and 12% of clients' symptomology.

Overall, Nyman et al. (2010) found that counselor-training level did not have a statistical significance on client outcome. In addition, they found that clients' symptomology varied amongst no changes, symptom improvement, or even deterioration across the spectrum of counseling staff, interns, and practicum students. Some limitations of this investigation include the small sample size of clients, and little exploration of extraneous variables that may have contributed to client outcome. However, results from this investigation provide support for the use of practicum counselors as the sample of counselors in this investigation. It also supports the use of the OQ 45.2 to measure client symptomology.

In order to explore client outcomes, Llagan, Vinson, Sharp, Harvice, and Hagan (2014) controlled for clients' readiness to change. They utilized a college counseling center to compare counselors'-in-training with counseling staff. Clients over the age of 18 (N = 331) were recruited from a college counseling center in the Southeast over a two-year period. Majority of clients were female (70%) with 30% male; they were seen for an average of three to five sessions. Counselors (N = 28) included 12 professional counselors (licensed, or working towards licensure, social workers, or psychologists), and 16 supervised masters or doctoral graduate students enrolled in counseling or psychology programs. Clients completed a self-report readiness to change questionnaire on the counseling intake form and the OQ 45.2 prior to each counseling session. There were mean differences of 13.27 (SE = 0.95) for both counseling professionals and counselors'-in-training; specifically, the mean for counselors'-in-training clients (M = 14.64) was slightly higher than clients from counseling professional staff (M = 11.56). However, when Llagan et al. controlled for clients' readiness to change and attendance, there were no significant differences $F(1, 323) = 1.82$, $p > .05$ between counselors'-in-training and counseling professionals' client outcomes. Though this study may have limited generalizability, results provide further support to use practicum counselors in this investigation; it shows a lack of significant difference in client outcome improvement between counselors'-in-training and other counseling professionals.

Limitations on Client Outcome Research

Utilizing outcome assessments to measure client improvement is one way to show clients and their counselors how clients' symptoms are changing throughout the counseling process. However, there is limited focus within the counseling research on investigating client outcomes (Garcia, Cartwright, Winston, & Borzuchowska, 2003; Wester, 2007). Winter and colleagues (2013) conducted a systematic review of the literature on counseling and psychotherapy on suicide prevention from 1981-2008. Results indicated that only 67 studies were published relating to outcome studies in this area (Winter, Bradshaw, Bunn, & Wellsted, 2013). That is, on average only two studies published per year investigated client outcome. Similarly, in a meta-analysis comparing counseling for adults with depression from 1966-2007, only 53 articles were found that measured counseling related outcomes (e.g. cognitive behavioral counseling, problem-solving counseling etc; Cujipers, van Straten, Andersson, & van open, 2008). Thus, over three decades, that would average about one publication per year on client outcomes. While these meta-analyses are specific to adults with depression and suicide prevention, they highlight the limited research in client outcome research over three decades.

Empirical Relationship between Major Constructs

In addition to the individual contributions of the three aforementioned constructs (i.e. multicultural competence, working alliance, and client outcomes), each of these factors has been researched in combination with one another. The following section will discuss the limited empirical studies on the relationships between the constructs, including: (a) Multicultural Competence and the Working Alliance, (b) Multicultural Competence and Client outcome, and (c) Working Alliance and Client Outcome.

Multicultural Competence and the Working Alliance

Fuertes and colleagues (2007) examined what role multicultural competence played with how clients rated the working alliance and their satisfaction in counseling. The sample (N = 51) included counselor-client dyads at university counseling centers who had completed at least three counseling sessions. Within the counselor sample, there were 27 women, 24 men, with an average age of 32 (SD = 7.9). Participants from the counselor sample identified as Euro-Americans (n = 34), Asian-American (n = 12), African-American (n =4) and Hispanic (n = 1). The client sample consisted primarily of college students, with 36 women, 15 men, with an average age of 27 (SD = 7.3). Participants from the client sample identified as Asian-American (n = 17), African-American (n = 14), Euro-American (n = 12), and Hispanic (n = 8). Fuertes and colleagues (2007) measured counselors' multicultural competence using the Cross Cultural Counseling Inventory (CCCI-R; LaFromboise et al., 1991). The CCCI-R is a 20-item scale grounded in the Tripartite Model that is designed to measure a counselors' cultural awareness, knowledge, and skills. The CCCI-R was intended for third-person observer report; however, it was adapted for use with counselors and clients. Examples of items include: "Therapist is aware of his or her own cultural heritage." This statement was adapted for the client as: "My therapist is aware of his or her own cultural heritage" and for the counselor as: "I am aware of my own cultural heritage." Results indicated good internal consistency for the client CCCI-R form (α =.93) and counselor CCCI-R form (α = .90). In addition, the working alliance was measured using the Working Alliance Inventory-Short (WAI-S; Tracey & Kovocivic, 1989). The WAI-S is a 12-item tool that measures client-counselor bond and agreement on tasks and goals in session. Results indicated strong internal consistency with client WAI-S form (α =.94) and counselor WAI-S form (α =.90). Client satisfaction in counseling was measured using a 5-item

subscale from the Counseling Evaluation Inventory (Linden et al., 1965), with a reported strong internal consistency (α =.95). Results indicated significant differences between clients' (*M* = 91.39, *SD* = 18.58) and counselors' ratings (*M* = 99.29, *SD* = 9.22) of counselors' multicultural competence, with counselors' ratings higher than client ratings ($t[52] = 2.47$, $p < .01$). However, no significant differences appeared between the working alliance for clients (*M* = 63.30, *SD* = 14.19) or counselors (*M* = 63.66, *SD* = 9.41). Moderate significant relationships were seen between clients' and counselors' ratings of counselors' multicultural competence skills and client and counselor satisfaction in counseling (*d* = .60). A small correlation (*d* = .02) was found for combined scores between clients' ratings of counselors' expertness, attractiveness, and trustworthiness when compared with counselors' ratings of the working alliance and multicultural competence.

In summary, Fuertes and colleagues (2007) found both similarities and differences in client and counselor perceptions of multicultural competence and the working alliance.-In general, when clients' and counselors' perceptions were combined, counselors' perceptions of their own multicultural competence were the only variable not significantly associated with counseling satisfaction or counselors' competencies. A major limitation in this investigation was the incomplete reporting of results and description of sample and methods, making it impossible to compare the authors' conclusions and results to previous research. Overall, this study's findings identify the importance of further exploring clients' and counselors' perceptions of multicultural competence and the working alliance.

Multicultural Competence and Client Outcome

Owen, Leach, Wampold, and Rodolfa (2011) sampled college student clients (N = 143) and counselors (N = 31) who had completed a minimum of three counseling sessions from a university counseling center in order to compare differences between clients' and counselors' ratings of counselors' multicultural competence. Clients were asked to identify the demographic data of their counselors, therefore minimal information was reported. Clients' identified their counselors as predominantly White/European-American. Similarly, clients identified their race/ethnicity as predominantly White/European-American (54.5%), with a smaller number of diverse clients including Asian-American (14.7%), Hispanic (14%), multiracial (13.3%), African-Americans (2.8%), and Native American (0.5%). Clients who had completed a minimum of three sessions were sent electronic surveys at the end of the academic semester.

Owen and colleagues (2011) utilized three measures to explore multicultural competence, client outcome, and clients' pre-therapy emotional and interpersonal state. The CCCI-R (LaFromboise et al., 1991) was modified similarly as in the aforementioned studies, and yielded a strong internal consistency (α = .95). The *Schwartz Outcome Scale-10* (SOS-10; Blais et al., 1999) is 10-item counseling outcome assessment that measures clients' psychological well-being over a one-week time period. The internal consistency of the SOS-10 for the sample of this study was strong (α = .95). Clients' perception of their pre-therapy functioning was based on three questions which yielded a strong internal consistency (α = .73). The researchers divided their sample into two levels: client level one was treated as nested within counselor level two. Preliminary analysis explored race/ethnicity on clients' perceptions of their counselors' multicultural competences. Results indicated there were no differences in clients' perceptions of their counselors multicultural competence (γ= -0.06, SE = .21, p > .05), or

counselors 'perceptions of their multicultural competences (γ = -.06, *SE* = .23, $p > .05$), or the interaction between clients' and counselors' race/ethnicity (γ = 0.02, *SE* = .23, $p > .05$). Furthermore, the effect size of the CCCI-R scores between the four counseling dyads (counselor-racial ethnic minority and client-racial ethnic minority, counselor-racial ethnic minority and client-White, counselor-White and counselor racial ethnic minority, and counselor-White and client-White) indicated no effect (*M* = 5.06, *SD* = .67, *d* = -.05). Essentially, results from the preliminary analysis and effect size determined there were no significant differences between clients' perceptions of their counselors' multicultural competence. These effect sizes for the four client-counselors dyads ranged from medium to large and revealed that little variability was seen in the perceptions of clients' and counselors' multicultural competence when race/ethnicity was taken into account.

Owen and colleagues (2011) conducted a second preliminary analysis to measure the variability in counseling outcomes and clients' perceptions of counselors' multicultural competence. The researchers conducted three multilevel models with an Intraclass correlations (ICC), to quantify the degree to which clients relate to each other in treatment outcome and their perceptions of their counselors' multicultural competence. In the first ICC, clients' SOS-10 scores were the dependent variable and clients' perceptions of their pre-therapy functioning were the independent variable. Results from the first ICC model indicated that predicting client outcomes (as measured by the SOS-10) was statistically significant (ICC = .085; χ^2 (29) = 42. 52, $p < .05$). Essentially, counselors accounted for approximately 8.5% of the variance in client outcomes. In the second ICC, clients' CCCI-R scores were compared with client outcomes. Results indicated that there was no significant difference in how clients rated their counselors' multicultural competence based on the revised CCCI-R (ICC = .00001; χ^2 [30] = 16.79, $p > .05$).

Essentially, clients who had symptom improvement in session did not necessarily rate their counselors as being more multicultural competence.

Lastly, a third model explored whether clients' perceptions of their counselors' multicultural competence would account for the variance in client outcomes. To test this, the researchers replicated the first ICC model, yet included the interaction between clients' and counselors' race/ethnicity as predictor variables. Overall, the third ICC model indicated that when the other Level 2 variables were added, the proportion of variance accounted for by the counselor did not change in comparison to the baseline model (ICC = .085). Collectively, the results from the third ICC model indicated that clients' perceptions of counselors' multicultural competence is unrelated to clients' counseling outcomes.

Owen and colleagues (2011) explored multicultural competence, client outcome, and clients' pre-therapy emotional and interpersonal state. Results indicated that there were no significant differences between clients' perceptions of their counselors' multicultural competence, regardless of REM status. In addition, results from the collective ICC models indicate that clients' perceptions of their counselors' multicultural competence was unrelated to clients' counseling outcomes. Owen and colleagues (2011) have made a significant contribution to the literature of multicultural competence and client outcomes. Lastly, because clients' perceptions of their counselors' multicultural competence did not vary based on their counselors' race/ethnicity, this investigation is needed to explore multicultural competence in combination with other predictor variables (such as the working alliance).

More recently, Bachelor (2013) conducted an investigation to better understand how clients (n = 176; 125 women; 51 men) and counselors (n = 133) perceive the working alliance. Clients were recruited from two university consultation services (n = 100), private practice

clinics (*n* = 44) and community agencies (*n* = 32). Participating counselors consisted of counseling psychology practicum students (*n* = 35), licensed psychologists (*n* = 19), licensed social worker (*n* = 1), nurse practitioner (*n* = 1), and undergraduate volunteers (*n* = 5). No specific racial/ethnic demographic information of clients was provided, counselors were identified as predominantly White. Clients and their counselors completed three different assessments to measure the counseling relationship: The *Helping Alliance Questionnaire* (Alexander & Luborsky, 1986), the *Working Alliance Inventory*, WAI-S (Tracey & Kovocivic, 1999), *California Psychotherapy Alliance Scales* (CALPAS; Gaston & Marmar, unpublished manuscript, 1991). The total score for the three scales yielded strong internal consistency, ranging from 0.85 to 0.90 and from 0.90 to 0.94.

Bachelor (2013) explored the working alliance in relation to client outcome. Four counselor and four client rater outcome measures were used. Three measures were completed by both counselors and clients: the Global Rating Scale (GRS; Green, Gleser, Stone, & Seifert, 1975), a single item scale measuring overall helpfulness of counseling on a nine-point Likert scale, the Post-Therapy Rating Scale (PRS; Nicols & Beck, 1960), a four-item five-point Likert scale that assesses change, and the Target Complaints Method (TC; Battle et al., 1966), a pre- and post-therapy assessment that lists problems for which clients seek help (rated on a six-point severity scale). Lastly, clients' overall level of functioning was completed by counselors, before and after counseling, using the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976) on a scale ranging from 1-100. Clients rated their perceived psychological distress on a 29-item four-point measure called Psychiatric Symptom Index (PSI; Boyer, Préville, Légaré, & Valois, 1993). Bachelor (2013) reported strong internal consistencies for all total alpha scores of the measures ranging from 0.85 to 0.91.

Bachelor (2013) conducted a principal component analysis (PCA) on the alliance scales in order to characterize aspects of the working alliance relationship. Results from the PCA specified six factors for clients, accounting for 46% of the total item variance, and four factors for counselors, resulting in 55.1% of the total item variance. Bachelor (2013) conducted a Pearson-product moment correlation to explore the relationship between clients' and counselors' alliance, based upon ratings of 91 counseling dyads. Collaboratively, clients and counselors viewed the working alliance in four basic components: Collaborative Work Relationship (r = .32), Productive Work (r = .42), Active Commitment (r = .42), and Agreement on Goals (r = .39). However, there was no significant correlation (r = .12) among clients' and counselors' perceptions of the bond formed in counseling. Results suggest that clients and counselors identify different aspects of the working alliance as important.

Bachelor (2013) also explored the relationship between the working alliance and counseling outcomes. A Pearson-product moment correlation was conducted to explore the relationship between the working alliance and client outcomes. Results indicated that four out of the six factors for clients' perceptions on the working alliance correlated low to moderately with client outcome measures: (a) Collaborative Work Relationship (correlations ranging between r = .29 and 37), (b) Productive Work (r = .36), (c) Active Commitment (r = .24), Bond (r = .24), and (d) Agreement on Goals/Tasks (with correlations ranging between r =.24 and .29). In addition, results indicated that three out of the four factors for counselors' perceptions ranged in low to moderate correlations with client outcome: Collaborative Work Relationship (with correlations ranging between r = .23 and .33), Counselor Confidence and Dedication (with correlations ranging between r = .24 and.46), and Client Commitment and Confidence (with correlations ranging between r = .24 and .46).

Bachelor's (2013) investigation utilized several working alliance and client outcome measures to explore clients' and counselors' perceptions between the working alliance and its relation to client outcome. In summary, results from investigation indicated that clients and counselors perceive the working alliance differently in multi-faceted components. It implies that counselors can expect their clients to view the working alliance differently than them. In addition, results from this investigation indicate that the working alliance is low to moderately correlated with client outcome, from both clients' and counselors' perceptions. Limitations of this investigation include the homogenous sample of predominately White participants, making the implications difficult to generalize to minority populations. Additionally, the plethora of assessments participants had to complete may have contributed to response error due to susceptibility of testing fatigue. This investigation intends to recruit a more diverse sample and utilize one assessment to measure the working alliance and client outcomes.

In sum, results from these investigations identified that clients' and counselors' perceptions of the working alliance and multicultural competence have similarities and differences. Further, their perceptions may have different relationships on their counseling process and in their counseling outcomes. However, further research is needed to increase understanding as to how multicultural competence influences the quality of the working alliance and predicts client outcomes, accounting for both clients' and counselors' perceptions. The present study aimed to add to this future research in order for counseling professionals to increase their awareness of their clients' perspectives and understand predictors of their client outcomes.

Chapter Summary

This chapter provides an overview of the origins and foundations of multicultural competence, the working alliance, and client outcome, highlighting the importance of clients and counselors perceptions. Relationships between the variables were addressed in order to provide an empirical connection in support for this investigation, the research design, and how the constructs of multicultural counseling and the working alliance will enhance understanding of client outcomes. The empirical studies reviewed in this chapter provide support for the importance of client and counselor perceptions in counseling. Although empirical support exists on therapeutic factors and their contributions to client outcome, wide gaps remain on the relationships between multicultural competence and the working alliance, and how they predict client outcome.

CHAPTER THREE: METHODOLOGY

Chapter Three presents the research design, methods and procedures for the study. The purpose of this research study was to investigate the relationships between multicultural competence, working alliance, and client outcomes as perceived by counselors and clients. The research question guiding the investigation concerns clients' perceptions of multicultural competence as measured by the *Cross-Cultural Counseling Inventory* (CCCI-R; LaFromboise et al., 1991), the working alliance as measured by the *Working Alliance Inventory-Short Revision* (WAI-S; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989), and predicting client outcomes as measured by the *Outcome Questionnaire 45.2* (OQ 45.2; Lambert & Burlingame, 1996), after controlling for social desirability (as measured by the (*Social Desirability Scale-Short Form* [SDS; Reynolds,1982]). In addition, this investigation examined if there are any differences in clients' and counselors'-in-training perceptions of multicultural competence (as measured by the CCCI-R) or the working alliance (as measured by the WAI-S).

The study utilized a descriptive, correlational research design (Gall et al., 2007) in order to understand the relationship between multicultural competence, the working alliance, and client outcomes. The purpose of this chapter is to describe the research methodology for the investigation, including: (a) population and sampling, (b) data collection procedures, (c) instrumentation, (d) research design, (e) research questions, (f) data analysis, (g) ethical considerations, and (h) study limitations.

Population and Sampling

The population for this study included masters-level Counselor Education students enrolled in Practicum I or II courses at a university counseling center in the southeastern United States. In addition, the population included adult clients (over the age of 18) receiving

counseling services from Practicum I or II counselors at the center over the course of two semesters. The practicum course takes place at the university counseling clinic. Students see between 2-3 clients per week for one hour once a week. Each practicum course has on average six to seven counselors-in-training. During the two semesters of data collection points, there were two sections of practicum per day (Monday-Thursday) and one section per day (Friday and Saturday). It is general practice within the clinic for clients to be given clinic assessments such as the psychosocial assessment during the first session of counseling. A convenience sample refers to when the researcher has a sample readily available (Tabachnick & Fidell, 2013). The researcher of this study was a staff member at the community counseling clinic in which data was collected. Therefore, this study used a convenience sample due to the accessibility of the population for the principal investigator. It is also important to consider power when making sample size determinations. Power is the level of probability that a statistical test correctly rejects the null hypothesis when the null hypothesis is false (Tabachnick & Fidell, 2013). In order to decrease chances of Type I error (when the null hypothesis is true, but is rejected), Cohen (1998) suggests a determination of significance at the .05 alpha level and an adequate power of .80 is necessary; therefore were the desired alpha level and power for the investigation. The data analysis in the study utilized multivariate statistics, including hierarchical multiple regression and multivariate analysis of covariance (MANCOVA) with repeated measures between groups. Following the recommendations of Balkin and Shepris (2011), G*Power free statistical software was used to determine appropriate sample size. Given the parameters of the hierarchical regression in this investigation (i.e., total of five predictor variables: two controlled variables – social desirability and client outcome pretest score, and three more variables – multicultural

competence, working alliance, and client outcome post-test score), a prior analysis was conducted, using G*power, with the significance level at.05, desired power at .8, and effect size at .13 (Cohen, 1998). This revealed the study required a minimum of 105 total participants. In addition, given the parameters in this investigation of repeated measures MANCOVA between factors (i.e., with two groups; clients and counselors; and three measures: CCCI-R, WAI-S and SDS), a prior analysis was conducted using G*power with the significance level at .05, desired power at .80, and effect size at .13 (Cohen, 1998). G*power analysis revealed the study required a total sample size of 194 participants. Therefore, the desired sample size for this investigation was 250 in order to reduce Type I error and increase the likelihood of generalizability (Balkin & Sheperis, 2011). The total sample size for this investigation (N = 191) met the criteria for hierarchical regression suggested power but not for repeated measures MANCOVA. Thus, a limitation of this investigation was the sample size. Lastly, limited data exists on response rates when assessing clients and counselors; however, given that the university counseling center is a research clinic, 80-90% response rate was anticipated, and met.

Data Collection Procedures

This study took place at a university counseling center in the southeastern United States. The counselors were masters' level counseling students enrolled in practicums which took place at the university counseling center. Permission to conduct research at the university counseling center was obtained from the clinical director and the Institutional Review Board (IRB) at the university.

Recruitment of practicum level counselors occurred during practicum orientation held at the beginning of each semester. There, the researcher of this investigation explained the purpose

and voluntary nature of the study to the practicum students. The researcher emphasized that completion of surveys would not affect the counselors'-in-training grades and the instructor would not know whether the counselor filled the surveys out or not. Counselors were instructed on how to present the summary explanation of research to their clients, and shown where the assessments were located within the university counseling center. In order for clients to have easy access to the assessments, the researcher placed them inside the practicum room next to the other assessments typically given to clients being seen at the clinic. The assessments were located inside the practicum room of the clinic labeled next to the other assessments typically given to clients in order. Counselors received small tokens (a mechanical pencil and small piece of candy) from the researcher during the practicum orientation as an incentive to complete the surveys. Clients received no incentive to complete the surveys.

Provisions to ensure privacy were taken into account throughout all data collection procedures. All counselors and clients were given the summary explanation of research form prior to completing the surveys. Clients were informed that research participation was completely voluntary and did not affect their ability to receive free counseling services. There were minimal risks to clients and counselors, including the potential inconvenience of using five to seven minutes of time during the first and third weeks of counseling sessions. Potential benefits to both counselor and client were to reflect on the counseling relationship and consider the therapeutic alliance and multicultural competencies early in the relationship. Provisions to maintain confidentiality of data have been adapted from the suggestions of Gall, Gall, & Borg, (2007):

1. A unique identifier was given to each participant and was numbered from 1000-1073. The principal investigator assigned numbers based on alphabetical order of the first name of the

counselor (e.g., the name "Anna" would receive 1000, the name "Ben" would receive 1001, etc.).

2. Clients and counselors were linked by their assigned number, for example if JN completed survey 1 she was given number 1000 and her counselor RP was coded as 2000.

3. Participants' initials were kept in a password-protected document on the researcher's password-protected computer, located in a locked office inside the university counseling center. The clinic has security cameras and is only accessible through a code-protected entrance. The researcher had access to all surveys. Practicum students and their supervisors only had access to the OQ 45.2 assessments and electronic scores for clinical purposes. This information was used to ensure that counselor and client information was matched with appropriate individuals, and also so the investigators could add the final OQ 45.2 scores to the data for each participant.

4. The assigned completed surveys were kept separate from the names database in a locked filing cabinet in the university counseling center, and data entered into SPSS were kept in a password-protected document.

5. The database containing associated client and counselors'-in-training information was deleted from the researcher's computer by the end of the spring 2015 term (once the researcher analyzed the data and graduated from the university).

Instrumentation

This quantitative investigation used a total of five instruments. The instruments were administered at the university counseling center; clients and counselors completed the surveys during the counseling sessions. Clients were asked to fill out the *Outcome Questionnaire 45.2* (OQ 45.2; Lambert & Burlingame, 1996) during their first and third session. In addition, both

clients and counselors completed the following assessments during their third counseling session: *Demographic form, Cross-Cultural Counseling Inventory* (CCCI-R; LaFromboise et al.,1991), *Working Alliance Inventory-Short Revision* (WAI-S; Horvath & Greenberg; Tracey & Kovocivic, 1989), and *Social Desirability Scale-Short Form* (SDS, Reynolds, 1982).

The researcher had instructed counselors-in-training to provide clients with their OQ 45.2 assessments during their first and third session. In addition, clients and counselors-in-training were instructed complete the demographic questionnaire, CCCI-R, WAI-S, and SDS after their third session was completed. The researcher chose the third research session as a data collection point for three reasons. First, the researcher had conducted preliminary analysis on adult client retention rates in the community counseling clinic using scheduling software used by the clinic called Titanium. Results from the preliminary analysis that after the fourth counseling session client retention rate drops by 60%. Essentially, after the third session 60% of adult clients do not continue counseling. Thus, in order to increase the likelihood of obtaining an adequate sample size, the researcher chose between the first and third sessions to collect sate. Second, the third session was chosen because the OQ 45.2 assessment is designed to be given on a weekly basis in order to measure client progress (Lambert & Burlingame, 1996). Thus, client progress can be seen from one session to the next, including progress from first to third session. Lastly, the working alliance is generally measured between the first and fifth session (Horvath & Bedi, 2002) and has been shown to stay relatively stable over the course of counseling from first session to last (Fitzpatrick et al., 2005). Overall, the third session was an appropriate data collection point for this investigation. Upon completion, clients placed the surveys (demographic survey, CCCI-R, WAI, and SDS) in the researcher's locked box in the university counseling center to maintain confidentiality. The researcher was the only one had a key to this locked box

and counselors did not have access to the assessment scores. Currently, the OQ 45.2 is administered at the university counseling center by counselors to assess client outcomes; therefore, current practices were maintained, allowing counselors and their supervisors' access to the scores. Counselors placed the OQ 45.2 assessment in a box (this was separate from the box that contained the Demographic, CCCI-R, WAI-S, and SDS surveys) inside a locked room in the counseling center. At the end of each counseling week, the researcher took the OQ 45.2 surveys and research assessments from the locked box, and transferred them to the locked cabinet within her office inside the university counseling center. A total of five instruments were used in this investigation; they will be described in detail.

Demographic Questionnaire

A demographics questionnaire was developed by the researcher to determine age, ethnicity, gender, and counseling session number for both client and counselor. In addition, the demographic questionnaire of the counselor determined practicum level and multicultural counseling course history. As noted, both the counselor and client completed the demographic questionnaire.

Outcome Questionnaire 45.2

In order to measure client outcome, the *Outcome Questionnaire 45.2* (OQ 45.2; Lambert & Burlingame, 1996) was used. The OQ 45.2 was developed for repeated measurement of adult clients' status through the course of counseling and termination. The OQ 45.2 is foundationally based on Lambert's three-part organizational scheme for client outcome measurement, suggesting three areas of clients' status be explored: (a) symptomatic distress, (b) interpersonal relationships, and (c) social roles. The symptom distress (SD) subscale is made of criteria from common diagnoses such as anxiety, depression, and substance use (e.g. "I feel blue"). The

interpersonal relations (IR) subscale explores a client's level of satisfaction and quality of life with intimate relationships in their life (e.g. "I feel lonely"). The social role (SR) subscale measures a client's satisfaction and distress level with areas of social roles at work, family, and leisure time (e.g. "I have too many disagreements at work/school").

The OQ 45.2 has 45 items rated on a five-point Likert scale ranging from 0-4 (0 = *almost always* to 4 = *never*). The total score ranges from 0-180 and is calculated by adding the client's responses on all items and the reverse scores of nine items (1, 12, 13, 20, 21, 24, 31, 37 and 43). The total score is interpreted as the higher the score, the more distress the client has. The total score cut off score is set at 63, indicating scores of clinical significance (Lambert & Burlingame, 1996). In the case of the OQ 45.2 scores, scores are expected to lower over time as clients improve in counseling (Lambert & Burlingame, 1996). In order to assess whether multicultural competence or the working alliance predicted client outcome, the pre-test score of the OQ 45.2 were controlled for and the post-test third session OQ 45.2 score was the dependent variable.

Psychometric data for the OQ 45. 2 was collected using diverse samples including undergraduate, clinical, employee assisted programs, and community agencies. The samples included diverse representation of males/females, and ethnicities ranged from Caucasian, African-American, Latino and Other. Minimal differences were found among the total scores of Caucasians (n = 1,931), African-American (n = 274), Latino (n = 36), and other (n = 37) populations. The test-retest reliability results indicated stable scores over time for the total score (r = .84), and three subscales SD (r = .78), IR (r = .80) and SR (r = .84). Reported overall internal consistency was strong for OQ total score (α = 93) and three subscales (α = .70 or above; Lambert & Burlingame, 1996). In addition, to support the validity of the OQ 45.2, concurrent and criterion validity were used. Concurrent validity is achieved when researchers correlate a

measure with a previously validated measure to show that the test is measuring the construct it purports to measure (Reynolds, Livington, & Wilson, 2010). The OQ 45.2 was correlated with nine similar assessments such as the *Beck Depression Inventory* (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the *Symptom Checklist-90r*. Overall, the correlations between the OQ 45.2 scales and related measures was statistically significant ($p < .05$) for the OQ Total and domains of IR ($r = 0.71$), SR ($r = .70$), and SD ($r = 0.94$).

Overall, the OQ 45.2 was selected for this investigation because it has been used in various settings, including community clinics in a university setting similar to the one in this investigation (Gregersen, Nebeker, Seely, & Lambert, M. J. (2004). et al., 2004; Wolgast, Lambert, & Puschner, 2003) and the overall validity and reliability of the scale has been shown. Most importantly to note, Lambert and colleagues (2013) do not recommend using subscale scores independently as indicators of reliable change. The Reliable Change Index (RCI) for the OQ 45.2 total score is 14. The SD, IR, and SR subscales have been shown to be highly correlated, meaning that as clients change scores on one subscale, they are likely to change scores in the same direction on the other two subscales (Lambert et al., 2013). Thus, this investigation utilized the Total Score of the OQ 45.2.

Working Alliance Inventory- Short Revision

In order to measure clients' perceptions and counselors'-in-training perceptions about the working alliance relationship in counseling, the *Working Alliance Inventory- Short Revision* (WAI-S; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989) was used. The WAI-S is a shortened version from the original 36-item *Working Alliance Invent*ory developed by Horvath and Greenberg (WAI; 1989). The original WAI has been shown to have strong internal consistency ($\alpha = .93$) and acceptable convergent and predictive validity (Horvath & Greenberg,

1989).The basis of the WAI originated from Bordin's (1979) definition of the working alliance: the extent of agreement between clients and counselors on the goals, tasks, and bond (personal bond between client and counselor) (Horvath & Greenberg, 1989).

The WAI-S is a 12-item scale intended to measure the strength of the therapeutic relationship as perceived by client and counselor. WAI-S has three subscales: goal, task, and bond. Each item on the WAI-S is rated on a seven-point Likert scale ranging from 1 to 7 (1 = *never* to 7 = *always*). A sample item from the client version is "I am confident in my counselors' ability to help me" and a sample item from the counselor version is "I am confident in my ability to help this client." Total scores range from 12-84, with higher scores indicating stronger working alliance.

Confirmatory factor analysis (CFA) was conducted on both client and counselor versions of the WAI-S. The WAI-S was given to 124 pairs of clients (n = 84; 53 women and 31 men with an average age of 22) and counselors (n = 15; seven women and eight men) at a large university counseling center after the first counseling session (Tracey & Kovocivic, 1989). The client version indicated an overall strong internal consistency with total score (α = 98), task subscale (α = .90), bond subscale (α = .92), and goal subscale (α = .90). The counselor version indicated an overall strong internal consistency with total score (α = .95), task subscale (α = .83) bond subscale (α = .91), and goal subscale (α = 88). Overall internal consistency was strong for the WAI-S (α = .95) and for the three subscales (α = .80 or above; Tracey & Kovocivic, 1989).

Overall, the WAI-S was chosen for the investigation for the following reasons: (a) strong internal consistency shown for both client and counselor versions, (b) the WAI or WAI-S is the most commonly used scale in empirical investigations to explore the counseling relationship (Martin, Garske, & Davis, 2000; Tyron et al., 2007), and (c) several empirical investigations

have used the WAI-S in exploring the working alliance in relation to client outcome (Bachelor, 2013; Fitzpatrick et al., 2005; Hatcher et al., 1995; Marmarosh & Kivlighan, 2012). Lastly, Tracey and Kovocivic (1989) indicate that while a researcher can utilize subscale scores, the primary contribution of the WAI-S is measurement of the general alliance, found by analyzing the total score. The primary focus of this investigation was measuring the overall working alliance, therefore WAI-S total score was used for both clients and counselors.

Cross-Cultural Competency Inventory-Revised

In order to measure client and counselor perceptions of counselor multicultural competence, the *Cross-Cultural Competency Inventory-Revised* (CCCI-R; LaFromboise et al., 1991) was used in this investigation. The CCCI-R is a revised version of the original *Cross Cultural Competency Inventory* (CCCI; Hernandez & LaFromboise, 1985). The CCCI-R was developed based on the multicultural competencies defined by the Education and Training Committee of Division 17 of the American Psychological Association (Sue et al., 1982). The CCCI-R is a 20-item assessment intended for observer report of a counselors' level of cultural awareness, knowledge, and skill. The 20 items are rated on a 6-point Likert scale ranging from one to six (*1 "strongly disagree" to 6 "strongly agree"*). Although the CCCI-R was developed to be completed by supervisors, it has been adapted to be completed by counselors and clients. A sample item of the client version on the CCCI-R is "My counselor is aware of his or her own cultural heritage" and a sample of counselor item on the CCCI-R is "I am aware of my own cultural heritage." Total score ranges from 0-120, with a higher score indicating higher multicultural competency.

LaFromboise, Coleman, and Hernandez (1991) investigated the reliability and validity of the CCCI-R with three studies. In the first study, the content validity was measured: did the 20 items on the CCCI-R represent the multicultural competencies defined in the Division 17 report? Eight educational and counseling psychology doctoral students were recruited as raters in the content validity study. Results indicated an overall level of agreement of 80% with an inter-rater reliability at .58, $p < .001$. In a second study of the CCCI-R, LaFromboise and colleagues (1991) report that multiple raters and multiple stimulus tapes measured reliability. Expert raters ($n = 3$; two males, one female) viewed 15-20 minute videotaped counseling sessions and rated the sessions using the CCCI-R, with an overall reliability of the ratings of the three raters yielding at .78. Lastly, in a third study, the factor structure of the CCCI-R was measured. University students ($n = 86$) participated as raters of a counseling interview with an Anglo-American female counselor being evaluated by her faculty supervisor. Participants were encouraged to put themselves in the place of the client while viewing a seven-minute video of a counseling session; they completed the CCCI-R immediately after. The 20-item scale yielded an overall internal consistency coefficient alpha of .95, with an inter-item between .18 and .73.

Overall, the CCCI-R assessment was used for this investigation for the following reasons: (a) this is the only observer report scale of counselor's multicultural competence in existence, (b) overall strong internal consistency and inter-rater reliability was yielded, (c) the multicultural theoretical basis of the CCCI-R is representative of the multicultural theoretical basis of this investigation, and (d) several researchers (Fuertes et al., 2006 Owen et al., 2011) have adapted the CCCI-R to be completed by counselors and their clients. Lastly, LaFromboise et al. (1991) originally fit the CCCI-R on a three-factor solution that loaded on Cross-Cultural Counseling Skill, Socio-Political Awareness, and Cultural Sensitivity. However, an initial factor analysis

yielded that 19 out of the 20 items only loaded on a single factor, which accounted for a low percentage of explained variance (51%,cut off of 0.55). Due to the factors of the CCCI-R loading into one factor, the CCCI-R yields one total score, ranging from 0-120. Therefore, this investigation used CCCI-R total score.

Reynolds Marlow-Crown Social Desirability Scale-Short Form A

In order to measure social desirability in this study, the *Reynolds Marlow-Crown Social Desirability Scale-Short Form A* (SDS; Reynolds, 1982) was used. The SDS is a shortened version from the original *Marlow Crowne Social Desirability Scale* (MCSDS; Crowne & Marlow, 1960). Scoring ranges from 0-11, with the higher the score indicating participants likelihood of answering in a socially desirable manner in order to avoid disapproval from others. Crowne and Marlow (1960) considered social desirability to be based on statistical deviance and developed MCSDS scale items with a panel of 10 psychology faculty and graduate students. The 10 expert raters screened items for social desirability that were developed based on existing personality measures (e.g. *Minnesota Multiphasic Personality Inventory*). The SDS-short form A is a 11-item dichotomous True/False scale intended to measure the likelihood of an individual to respond in a way on an instrument that is socially acceptable. A sample item is "I'm always willing to admit it when I make a mistake." When the SDS-short form A was correlated with the original SDS scale, results indicated a high correlation (r = .91), yielding strong concurrent validity. In addition, internal consistency was measured using the Kuder-Richardson formula 20-reliability formula; results indicated strong internal consistency ($r_{KR\text{-}20}$ =. 74); (Reynolds, 1981).

Considerable research has been conducted on understanding and exploring multicultural competence for counselors; however, the majority of research conducted on multicultural competence has utilized counselor self-report measures (Constantine & Landany, 2001; Worthington et al., 2007). A social desirability scale was used in this investigation because self-report multicultural measures have been criticized for being prone to social desirability and having tendencies to measure anticipated behaviors of multicultural competence rather than actual demonstrated behaviors and attitudes of multicultural competence (Constantine & Ladany, 2001; Mobley, Franks, & Tan, 2000). Specifically, the SDS-short form A was used because the assessment showed strong internal consistency.

Research Design

A correlational research design was used to examine the noted research questions. Correlational research strives to see the extent of the relationship between variables: low, moderate, or high relationship (Gall et al., 2007). Correlational research designs are used when researchers want to explore the relationship between different variables at the same point in time or different point of time, and to predict outcome scores on a said population (Gall et al., 2007). This study focused on exploring the extent to which multicultural competence and the working alliance predict client outcomes, and exploring how clients and counselors perceive multicultural competence and the working alliance.

Threats to Validity

Correlational research designs are commonly threatened by three types of validity: (a) construct; (b) internal; and (c) external. Validity refers to the quality or soundness of a research study. Ways to mitigate construct, internal, and external validity will be discussed.

Addressing Construct Validity. Construct validity refers to the extent to which an assessment measures the desired construct (Gall et al., 2007). To support the construct validity of this investigation, the researcher provided concise operationalized definitions of each construct based on empirical research and theoretical foundations. In addition, reliability of each measurement was analyzed.

Addressing Internal Validity.

Internal validity is the described process of ensuring that the constructs the researcher intends to measure represent the ones affecting the results of the investigation (Tabachnick & Fidell, 2013). Internal validity is threatened when the researcher does not control for extraneous variables. Extraneous variables are any variables other than the designated predictor variable that can influence investigations outcome (Gall et al., 2007). Potential threats to internal validity of this investigation will be discussed: (a) testing fatigue, (b) testing effects, and (c) instrumentation. In addition, ways to mitigate the extraneous variable will be addressed.

Testing fatigue. Testing fatigue refers to the threat that participants may alter their responses on instrumentation due to tester fatigue (e.g. getting bored or tired); (Gall et al., 2007). Therefore, the researcher chose the revised shortened version of instruments if possible, to shorten the time that participants take to fill them out.

Testing effects. When researchers administer similar pre-tests and post-tests, participants may show improvement due to their familiarity with the test (Gall et al., 2007). Therefore, careful consideration was given as to when assessments would be completed. The OQ 45.2 is the only assessment to be given as pre and posttest in this study. Also, the OQ 45.2 is recommended to be given on a weekly basis (Lambert & Burlingame, 1996).

Instrumentation. An inherent threat to internal validity is the possibility that the measurement chosen to represent a construct does not in fact measure that construct (Gall et al., 2007). In order to minimize threats to instrumentation validity, the researcher chose instruments that have been reviewed for their construct validity and have been used with similar populations/environment.

Addressing External Validity.

External validity is the extent to which the results of an investigation can be generalized to a population and environment beyond the scope in which it was studied (Gall et al., 2007). Common types of external validity within correlational research include population validity and ecological validity.

Population validity. Population validity refers to the extent to which results from an investigation can be generalized from the sample studied (e.g., masters counseling students) to a larger population (e.g., private practice practitioners); (Gall et al., 2007). In order to maintain the scope of population validity, the researcher generalized findings within the population of master students in the counselor educations programs with similar demographic characteristics.

Ecological validity. Ecological validity refers to the extent to which results from an investigation can be generalized to an environment outside of that studied within the

investigation (Gall et al., 2007). In order to maintain the scope of ecological validity, the researcher generalized findings within the university counseling center environment.

Research Questions

The purpose of this research investigation is to explore the relationship between both client and counselor perceptions of multicultural competence and the working alliance on predicting client outcomes. In addition, this investigation explored the mean differences between clients and counselors perceptions of multicultural competence and the working alliance.

Research Question One

Does counselors'-in-training multicultural competence and working alliance (as perceived by clients) predict client outcome, while controlling for social desirability?

Research Question Two

Does counselors'-in-training multicultural competence and working alliance (as perceived by counselors) predict client outcome, while controlling for social desirability?

Research Question Three

What differences exist between client and counselor perceptions of counselors'-in-training multicultural competence and working alliance, while controlling for social desirability?

Research Question Four

What relationships exist between the demographic variables (e.g. age, gender, and ethnicity) and multicultural competence, the working alliance, and client outcome?

Data Analysis

To explore research questions one and two, a hierarchical multiple regression was used. Standard multiple regression analysis is commonly used in social science research when researchers want to determine the most appropriate predictors for their analysis that may be supportive of a theory (Gall et al., 2007). Alternatively, to multiple regression, researchers who are interested in determining the most explained variance in the dependent variable (e.g. client outcome) with the least possible number of predictors chose the approach of hierarchical multiple regression (Tabachnik & Fidell, 2013).

Hierarchical regression (also known as sequential regression) is an appropriate analysis when the researcher has a basis of research or theory of how to assign entry order of variables. Essentially, instead of having SPSS choose the order of variable entry, the entry is chosen by the researcher based on previous research or theory. IBM SPSS package software was used to analyze the hierarchical regression.

To explore research question three, a repeated measures Multivariate Analysis of Covariance (MANCOVA) was conducted. Tabachnick and Fidell (2013) suggest utilizing a repeated measures MANCOVA when a researcher has two or more groups of participants who are measured on several different scales at the same time. Specifically, Tabachnick and Fidell (2013) recommend using a repeated measures MANCOVA to explore the mean patterns on the scales between two groups (e.g. differences in mean scores between WAI, CCCI-R, and SDS measurements in counselors-in-training and clients). Counselors and clients both completed three different assessments at the same time, CCCI-R, WAI-R, and SDS. The dependent variables in this repeated measures MANCOVA were client total score on multicultural competence, the working alliance, and social desirability. This repeated measures MANCOVA

utilized social desirability as the covariate and analyzed the patterns of means on the CCCI-R and WAI-R between clients and counselors.

Lastly, to explore research question four, a Pearson-product correlational two-tailed was used to explore the relationships between demographic variables (e.g. age, gender, ethnicity) and the working alliance, multicultural competence, and client outcome. Tabachnick and Fidell (2013) recommend using correlational analysis when a researcher wants to describe the strength and direction of a relationship between two variables (multicultural competence and working alliance).

Ethical Considerations

The following ethical considerations were relevant for this investigation:

1. Data was collected with minimal information.
2. Participation in this study was voluntary and participation did not influence practicum students' class grades or the adult clients' access to counseling.
3. All participants were verbally informed of their right to participate or withdraw from the study, and given an explanation of research obtained with approval from the Institutional Review Board (IRB) at a large university located in the southeastern region of the U.S.
4. Permission to use the five instruments in this investigation was obtained from the developers.
5. This study was conducted once approval from the dissertation chair and all committee members was obtained.

Limitations

All research has limitations. Potential limitations for the investigation included:

1. Counselors'-in-training included in the sample may see more than one client. Essentially, each counselors'-in-training perceptions of the working alliance or their level of multicultural competencies may be measured up to three times. Thus, a limitation of this investigation may result in the violation of test independence.
2. This study was geared towards counselors'-in-training. Therefore, a limitation of this study was that all experience levels of counseling professionals are *not* included.
3. The Cross-Cultural-Inventory-Revised scale was adapted for use for counselors and clients, thus its adaptation could be a threat to internal consistency.
4. Some of the data collection instruments in this study were self-report; therefore, participants may have responded in a biased manner.
5. Participants may have been subject to tester fatigue and experience testing fatigue and lose concentration while completing instrumentation after their counseling.
6. Generalizability to populations other than novice counselors or clients within a university setting is low.

Chapter Summary

Chapter Three reviewed the research methodology used to investigate the relationship between multicultural competence (as measured by the *Cross-Cultural Counseling Inventory* (CCCI-R; LaFromboise et al., 1991), the working alliance (as measured by the *Working Alliance Inventory-Short Revision* (WAI-S; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989), and client outcome (as measured by the *Outcome Questionnaire 45.2* (OQ-4545.2; Lambert & Burlingame, 1996). This chapter provided details on research design, sampling procedures,

population sampling, and research questions. Lastly, ethical considerations and limitations were reviewed.

CHAPTER FOUR: RESULTS

Chapter Four presents the results of the investigated research questions. The purpose of this research study was to explore clients' and counselors'-in-training perceptions of multicultural competence (as measured by the *Cross-Cultural Counseling Inventory* [CCCI-R] LaFromboise et al.,1991) and the working alliance (as measured by the *Working Alliance Inventory- Short Revision* [WAI-S]; Horvath & Greenberg; Tracey & Kovocivic, 1989), in relation to client outcome (as measured by the *Questionnaire 45.2* [OQ 45.2]; Lambert & Burlingame, 1996). A correlational research design was used to identify the relationships between multicultural competence, the working alliance, and client outcome. In addition, this investigation explored the relationships between client outcome and adult client demographic information (i.e., gender, ethnicity, age). The research questions were analyzed using hierarchical regressions and repeated measures multivariate analysis of co-variance. This chapter details: (a) preliminary statistics; (b) descriptive results; (c) instrument data; and (d) data analyses for each research question.

Sampling and Data Collection Procedures

The researcher obtained approval from their dissertation committee, the clinical director of the community counseling clinic, and the university Institutional Review Board (IRB). The population for this study included masters-level Counselor Education students enrolled in a Practicum I or II course at a community counseling clinic in the southeastern United States. In addition, the population included adult clients (over the age of 18) receiving counseling services from Practicum I or II counselors at the center over the course of two semesters. The principal investigator of this study was a staff member at the community counseling clinic in which data

was collected. Therefore, this study used a convenience sample due to the accessibility of the population for the principal investigator. Data was collected for this investigation over the Summer and Spring semesters in 2014.

Recruitment of practicum level counselors occurred during practicum orientation held at the beginning of each semester, in which the researcher explained the purpose and voluntary nature of the study to the counseling student participants. The researcher emphasized that completion of surveys would not affect the students' grades and the instructor would not know whether they participated in the study or not. Participants were instructed on how to present the summary explanation of research to their clients, explaining that research participation was completely voluntary and did not affect their ability to receive free counseling services. Details regarding instrumentation is provided in the following sections. Provisions to ensure privacy were taken into account throughout all data collection procedures. All participants were given the summary explanation of research form prior to completing the surveys. There were minimal risks to clients and counselors, including the potential inconvenience of using five to seven minutes of time during the first and third weeks of counseling sessions. Potential benefits to both counselor and client were to reflect on the counseling relationship and consider the therapeutic alliance and multicultural competencies early in the relationship. Counseling student participants received small tokens (a mechanical pencil and small piece of candy) as an incentive to complete the surveys, client participants received no incentive to complete the surveys.

Descriptive Data Results

Descriptive statistics are provided to explore specific characteristics of the data that was collected to gain a better understanding of the participants and instruments used in this investigation.

Response Rates

Participants were recruited from a community counseling clinic located in a university in the southeastern region of the United States. A total of 146 clients (e.g. over the age of 18, receiving counseling services from practicum students) and 85 counselors (e.g. students enrolled in Practicum) met criteria to participate in this investigation (N = 231). One hundred and thirty one clients completed the assessments and 75 counselors, yielding a response rate of 89% for clients and 88% for counselors-in-training. Cases were removed that met the following exclusion criteria: (a) same clients completing the assessments more than once, (b) had more than 40% of assessments not completed, or (c) were identified as extreme outliers by SPSS in inspection of the box plots(Tabachnick & Fidell, 2013; Pallant, 2010). The total usable sample yielded a response rate of 78% (n = 119) for clients and 84% (n = 72) for counselors-in-training, totaling 191 total participants. Data screening procedures are discussed in the preliminary analysis section of this chapter.

Clients Demographics

The descriptive data and measures of central tendency are provided for all client participants (N = 119) in the study (See Table 1). The majority of participants identified as female (n = 71, 59.7%), compared to those who identified as male (n = 48, 40.3%). The majority of participants were between the ages of 18-30 (n = 56, 47.1%), followed by those between the ages of 31-40 (n = 27, 22.7%), those between the ages of 41-50 (n = 22, 18.5%), those between

the ages of 51-60 (*n* = 12, 10.1%), and those between the ages of 61-65 (*n* = 2, 1.7%). Ethnicity and race of client participants were primarily Caucasian (53.8%) African American (non-Hispanic) (17.6%), Hispanic/Latino (16.8%), Biracial/Multiracial (5.9%), Other ,(3.4%), American Indian (1.7%), and Asian (.8%).

Table 1 *Client Demographics*

Demographic	Total (*n*)	Percentage
Gender		
Female	71	59.7%
Male	48	40.3%
Age		
18 – 30	56	40.3%
31 – 40	27	47.1%
41 – 50	22	18.5%
51 – 60	12	10.1%
61 – 65	2	1.7%
Ethnicity		
Caucasian	64	53.8%
African American (non-Hispanic)	21	17.6%
Hispanic/Latino	20	16.8%
Biracial/Multiracial	7	5.9%
Other	4	3.4%
American Indian	2	1.7%
Asian	1	.8%

Counselors-in-training' Demographics

The descriptive data and measures of central tendency are provided for the counselor population (*N* = 72) in this study (See Table 2). The majority of participants identified as female (*n* = 61, 84.7%), compared to those who identified as male (*n* = 11, 15.3%). The majority of participants were between the ages of 21-26 (*n* = 54, 75%), followed by those between the ages of 27-37 (*n* = 18, 25%). Ethnicity and race of client participants were Caucasian (66.7%), Biracial/Multiracial (11.1%), African American/Black (9.7%), Hispanic/Latino (9.7%), Asian

(1.4%), and Other (1.4%). Lastly, the majority of practicum students reported having taken or were taking a Multicultural Course (*n* = 70, 97.2%), compared to those who reported not having taken or currently taken a Multicultural Course (*n* = 2, 2.8%).

Table 2 *Counselor Demographics*

Demographic	Total (*n*)	Percentage
Gender		
Female	61	84.7%
Male	11	15.3%
Age		
21 – 26	54	75%
27 – 37	18	25%
Ethnicity		
Caucasian	48	66.7%
Biracial/Multiracial	8	11.1%
African American (non-Hispanic)	7	9.7%
Hispanic/Latino	7	9.7%
Asian	1	1.4%
Other	1	1.4%
Multicultural Course		
Yes	70	97.2%
No	2	2.8%

Data Analysis

The following section reviews the results of the analyses for the four research questions. All of the data was analyzed using the *Statistical Package for Social Sciences* (SPSS, Version 22). To confirm that 95% of the variance of the relationship between the variables was not due to sampling error and to the actual relationship between the variables, an alpha level of .05 was set (Fraenkel, Wallen, & Hyun, 2011). In addition, In order to decrease chances of Type I error (when the null hypothesis is true, but is rejected) when using multivariate analysis, Cohen (1998)

suggests a determination of significance at the .05 alpha level and an adequate power of .80 is necessary; therefore were the desired alpha level and power for the investigation.

Statistical Assumptions and Data Screening

Several preliminary analyses were conducted to ensure the sample was fit to be analyzed. Descriptive statistics were run to find out what percentage of values were missing from each variable (Pallant, 2010). Some clients or counselors'-in-training had 40% or more of their assessments not completed at random sections of their assessments. Tabachnick and Fidell (2013) suggest that when data is missing at random (MAR) from different variables and from a relatively small sample, deletion of cases is acceptable. Thus, leading to the removal of six clients and three counselors-in-training from this investigation. The data was missing at random due to participants not completing entire portions of an assessment that was on back of the page or the second portion of assessment that was stapled to the packet. The rest of the client and counselors-in-training sample did not have any missing data. In order to reduce the likelihood of violating the assumption of independence, clients were used as a static variable. A static variable within this data set is defined as a variable that only has one independent observation. It is possible for the same client to have received services at the community counseling clinic during the two semesters in which the researcher collected the data. If the same client made an observation of multiple counselors'-in-training multicultural competence and working alliances, potential for the observations to not be independent of each other was increased, thus violating the assumption of independence (Tabachnick & Fidell, 2013). Thus, if the same client had multiple ratings on assessments, they were removed from the data set, resulting in the removal of three clients.

Outliers were screened for among the constructs. An exploration of the box plot for the CCIR scores of clients indicated two extreme outliers, a review of the 5% trimmed mean of these values indicated two different mean values when compared to the original mean, and that Mahalanobis distances were above 20.52. Therefore, the two identified extreme cases outliers of client cases were removed due to their potential of skewing the results of data analysis (Tabachnick & Fidell, 2013). Overall, data cleaning procedures resulted in the removal of 12 clients and 3 counselors-in-training, yielding a total sample size of 191 (clients, n = 119; counselors-in-training, n = 72).

Instrumentation

This quantitative investigation used a total of five instruments. The instruments were administered at the community counseling clinic and clients and counselors-in-training completed the surveys during the counseling sessions. Clients were asked to fill out the *Outcome Questionnaire 45.2* (OQ 45.2; Lambert & Burlingame, 1996) during their first and third session. In addition, both clients and counselors-in-training completed the following assessments during their third counseling session: *Demographic form, Cross-Cultural Counseling Inventory* (CCCI-R; LaFromboise et al.,1991), *Working Alliance Inventory- Short Revision* (WAI-S; Horvath & Greenberg; Tracey & Kovocivic, 1989), and *Social Desirability Scale-Short Form* (SDS, Reynolds,1982).

Demographic Questionnaire

A demographics questionnaire was developed by the researcher to determine age, ethnicity, gender, and number of counseling session for both clients and counselors-in-training. In addition, the demographic questionnaire for the counselor determined the practicum level and multicultural counseling course history.

Client Outcome

The *Outcome Questionnaire 45.2* ([OQ 45.2]; Lambert & Burlingame, 1996) is a 45 item self report instrument that (OQ 45.2; Lambert & Burlingame, 1996) is intended to measure client functioning and outcome (n = 119). The scale utilizes a five-point Likert scale response (e.g., 0 = *never*, 1 = *rarely*, 2 = *sometimes*, 3 = *frequently*, 4 = *almost always*). Total scores on the OQ 45.2 consisted of the sum of scores of three subscales (e.g., symptomatic distress, interpersonal relationships, social roles) and the reverse scores of nine items (e.g. 1, 12, 13, 20, 21, 24, 31, 37 and 43). The total score ranges from 0-180 and are interpreted as the higher the score, the more distress the client has. The total score cut off is set at 63, indicating scores above 63 indicate clinical significance (Lambert & Burlingame, 1996). In the case of the OQ 45.2, scores are expected to lower over time as client's functioning improves (Lambert et al., 1996). Lambert and colleagues (2013) indicate that a 14 point decrease in OQ 45.2 scores from one counseling session to the next indicate clinical change, or decreases in client distress, a term coined as the Reliable Change Index (RCI) for the OQ 45.2. Total outcome scores for clients on the OQ 45.2 pretest, completed on the first session were: (M = 69.37, *Mdn* = 64, *Mod*e = 70, SD = 25.009). Total outcome scores for clients on the OQ 45.2 post test scores, completed on the third session, were the following: (M = 63.73, *Mdn* = 58, *Mode* = 49, SD = 27.56). Analysis of the RCI for the OQ 45.2 pre-test and post-test scores indicated that clients distress level lowered by seven points from first session to third session, indicating non-clinically significant levels of change between sessions. The reliability of the OQ 45.2 was calculated using Cronbach's alpha and results indicated the OQ 45.2 pre and posttest assessments had good reliability (e.g. OQ 45.2 pretest score α = .82, OQ 45.2 post test score α = .83) for the sample in the current investigation. Lastly, the three OQ subscale scores had an internal consistency above .70.

Working Alliance

In order to measure clients' perceptions and counselors'-in-training perceptions about the working alliance relationship in counseling, the 12 item *Working Alliance Inventory-Short Revision* (WAI-S; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989***)*** was used. The scale utilizes a seven point Likert scale response (e.g. 1 = *never* and 7 = *always*). Total scores for the WAI-S are calculated by summing the scores of three subscales (e.g. goal, task, bond). Total scores range from 12-84, with higher scores indicating stronger working alliances. Total WAI-S scores for clients were the following: (*M* = 64.63, *Mdn* = 75, *Mode* = 84, *SD* = 8.). Total WAI-S scores for counselors-in-training were the following: (*M* = 59.40, *Mdn* = 64, *Mode* = 70, *SD* = 7.61). In analyzing the average scores of clients and counselors-in-training, clients rated the working alliance higher than counselors-in-training by an average of five points. Lastly, the reliability of the WAI-S was calculated using Cronbach's alpha and results indicated the WAI-S assessment had good reliability for both clients (α = .82) and counselors-in-training (α = .81) in the sample. Lastly, the three WAI-S subscales had an internal consistency above .70.

Multicultural Competence

The *Cross Cultural Competence Inventory-Revised* (CCCI-R; LaFromboise et al., 1999) was used in order to measure client and counselor perceptions of counselors'-in-training multicultural competence in this investigation. The CCCI-R is a 20-item assessment intended for observer report of a counselors' level of cultural awareness, knowledge, and skill. The scale utilizes a six point Likert scale response (e.g. 1 = *strongly disagree* and 6 = *strongly agree*). The scale items were adapted for clients and counselors-in-training to complete the assessment in this investigation. Total scores range from 0-120 and are calculated by summing up the 20 items, the higher the score indicating higher cultural competency. The total score for clients CCCI-R

ratings of their counselors'-in-training multicultural competence on the third counseling session were: (*M* = 102.81, *Mdn* = 102, *Mode* = 100, *SD* = 10.42). The total scores for counselors-in-training CCCI-R ratings of their own multicultural competence on the third session were: (*M* = 96.98, *Mdn* = 97, *Mode* = 96, *SD* = 7.66). Analysis of the mean scores between clients and counselors-in-training indicated that clients rated their counselors'-in-training multicultural competence higher than counselors-in-training rated themselves by an average of seven points. Lastly, the reliability of the CCCI-R was calculated using Cronbach's alpha and results indicated the CCCI-R had high reliability for clients (α = .929) and good reliability counselors-in-training (α = .85) in the sample.

Social Desirability

The *Reynolds Marlowe-Crown Social Desirability Scale-Short Form A* (SDS; Reynolds, 1982***)*** was used to measure social desirability in this study**.** The SDS is an 11 item dichotomous (e.g., 0 = *True*, 1 = *False*) scale intended to measure the likelihood of an individual to respond in a way on an instrument that is socially acceptable. Scoring ranges from 0-11, with the higher the score indicating participants likelihood of answering in a socially desirable manner in order to avoid disapproval from others. Total SDS scores for clients were: (*M* = 5.74, *Mdn* = 6, *Mode* = 6, SD = 2.27). Total SDS scores for counselors-in-training were: (*M* = 5.71, *Mdn* = 6, *Mode* = 8, *SD* = 2.66). Analysis of the means for both clients and counselors-in-training total SDS scores indicated that both clients and counselors-in-training had a moderate likelihood of answering in a socially desirable manner. Lastly, the reliability of the SDS was calculated using Cronbach alpha and results indicated the CCCI-R SDS had acceptable reliability for clients (α = .60) and good reliability counselors-in-training (α = .73). A summary of all instrument reliability levels is provided below in Table 3.

Table 3 *Summary Instrument Reliability Levels*

Scale	Cronbach's Alpha
OQ 45.2 First Session	.82
OQ 45.2 Third Session	.83
CCCI-R Client Version	.93
CCCI-R Counselor Version	.85
WAI-S Client Version	.82
WAI-S Counselor Version	.81
SDS Client	.60
SDS Counselor	.73

Research Questions and Data Analysis

The purpose of this study was to explore the relationships between multicultural competence, working alliance and client outcome. The following section provides description of data analysis and the results from the exploratory research questions. Hierarchical multiple regression, repeated measures MANCOVA, and Pearson product correlation were used in the data analysis. Prior to beginning multivariate analysis, Tabachnick and Fidell (2013) recommend conducting a correlation analysis to explore the relationships between variables in order to provide rationale to analyze the variables together. A Pearson Product two tailed correlation identified the following significant relationships: (a) a positive relationship between clients' perceptions of counselors'-in-training multicultural competence and the working alliance (r = .571, p <.01, 32.60% variance explained), (b) significant positive relationship between counselors'-in-training perceptions of their multicultural competence and the working alliance (r = .623, p < .01, 38.81% variance explained), (c) a positive relationship between client and counselors perceptions of the working alliance (r = .199, p < .05, 4.0% variance explained) (d) a

positive relationship between social desirability scores on counselors'-in-training CCCI-R responses (r = .233, p < .05, .5.4% of variance explained), (e) negative relationships between clients social desirability scores total both client outcome OQ 45.2 pre-test (r = -.233, p < .05, 5.4% of variance explained) and post- tests (r = -.277, p <.01, 7.6% of variance explained), and (f) positive relationships between the OQ 45.2 pre and post test scores (r = .884, p < .01, 78.1% of variance explained). The following relationships had a large effect size (Cohen, 1988): (1) Clients' perceptions of their counselors'-in-training multicultural competence and the working alliance; (2) OQ 45.2 pre and post test scores; and (3) Clients' and counselors'-in-training perceptions of the working alliance. The following relationships had a medium effect size: (1) relationship between social desirability scores on counselors' CCCI-R responses; (2) Clients social desirability scores on both OQ 45.2 pre and post test score; and (3) Clients' and counselors'-in-training perceptions of multicultural competence and the working alliance. Overall, there were relationships between most of the variables within this investigation.

A hierarchical regression is used when the researcher has a theoretical basis to specify the order as to which the independent variables are entered (Pallant, 2010). In the following analyses, social desirability and OQ 45.2 pre-test scores were used as the control variables. It is common practice within social sciences to use pre-test scores as a control variable and post-test scores as a dependent measure in order to reduce error variance and to create more powerful tests for data analysis (Tabachnick & Fidell, 2013). Also, social desirability was used as a control variable due to the strong likelihood of participants to respond in a socially desirable manner on self-report measures (DeVellis, 2003; Gall et al., 2007, 2011; Pike 1999). In addition, social desirability and OQ 45.2 were used as control variables because a review of Pearson Product correlation matrix revealed that there was a relationship between social desirability scores,

counselors'-in-training multicultural competence scores, and clients OQ 45.2 scores. Therefore, OQ 45.2 pre-test score and social desirability scores of both clients and counselors-in-training were entered in block one.

Next, depending on the research question, either total scores of client or counselors-in-training CCCI-R and WAI-S scores were entered in block two due to the research linking the relationship between working alliance and client outcomes (Hatcher et al., 1995; Norcross & Lambert, 2011). In addition, CCCI-R and WAI-R scores were entered in block two due to results of correlational analysis revealing that there were significant relationships between clients' and counselors'-in-training perceptions of counselors'-in-training multicultural competence and the working alliance.

Preliminary analyses were conducted on all data from clients and counselors-in-training to check for statistical assumptions. As previously indicated, clients were kept as static variable to reduce the likelihood of violating independence. However, the assumption of independence was violated due to some counselors-in-training (n = 45; counselors-in-training filled out assessments twice, 2 counselors-in-training filled out assessments three times) having multiple ratings on the same assessment. A violation of independence can increase the standard error of slopes of variables (Tabachnick & Fidell, 2013), however, is a highly common limitation within social science research (Constantine, 2007). An analysis of the normal probability Q-Q plot, standardized residuals, and scatterplot indicated that the assumptions of normality, linearity, and homoscedasticity were met (See Figures 1-10 below). Multicollinearity was checked for through exploration of the correlations matrix and coefficients table as correlations between independent variables should be below .7 to retain all variables, unless dealing with a repeated measures (e.g. OQ pre and post test scores) (Tabachinick & Fidell, 2013). Repeated measures are expected to be

highly correlated with themselves and may have a correlation above .7 (Tabachnick and Fidell, 2013). The correlations of the repeated measure OQ 45.2 were expected to be above .7, and the rest of the independent variables were below .7 (See Table 4). Multicollinearity was further explored through assessment of tolerance values being smaller than .10) or VIF larger than 10 and Mahalanobis distances scores greater than 20.52 (Tabachnick & Fidell, 2013). After exploration of the correlation matrix/coefficients, tolerance values, VIFs, and mahalanobis distance, the researcher concluded that the assumption of multicollinearity was not violated.

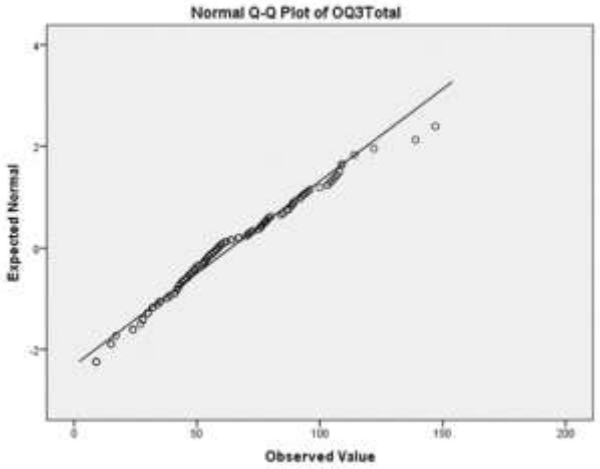

Figure 1: Outcome Questionnaire Post-Test Plot

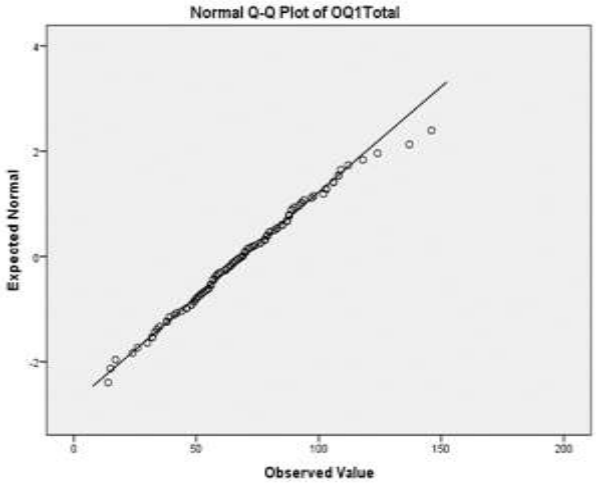

Figure 2: Outcome Questionnaire Pre-Test Plot

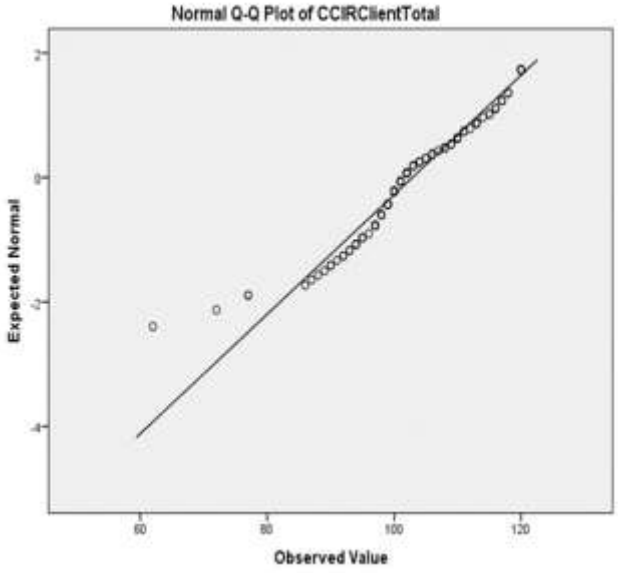

Figure 3: Client Cross Cultural Inventory Plot

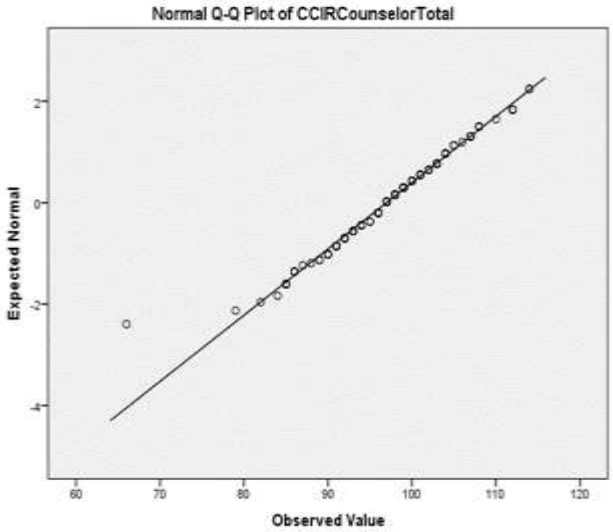

Figure 4: Client Cross Cultural Inventory Revised Plot

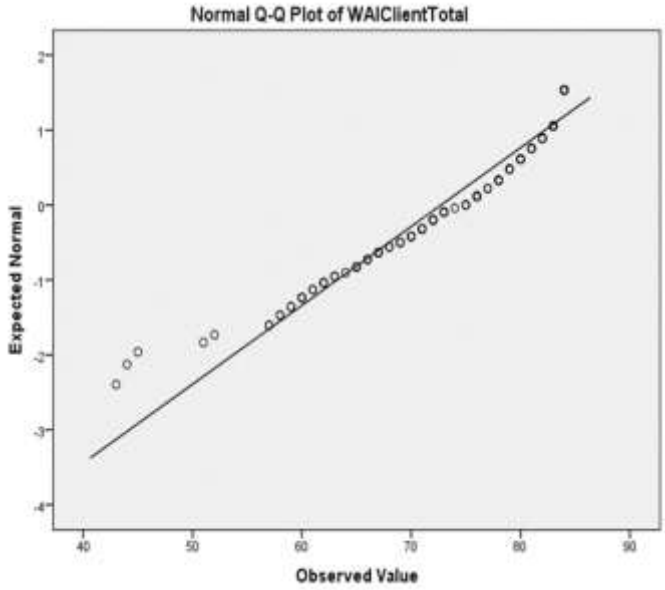

Figure 5: Client Working Alliance Plot

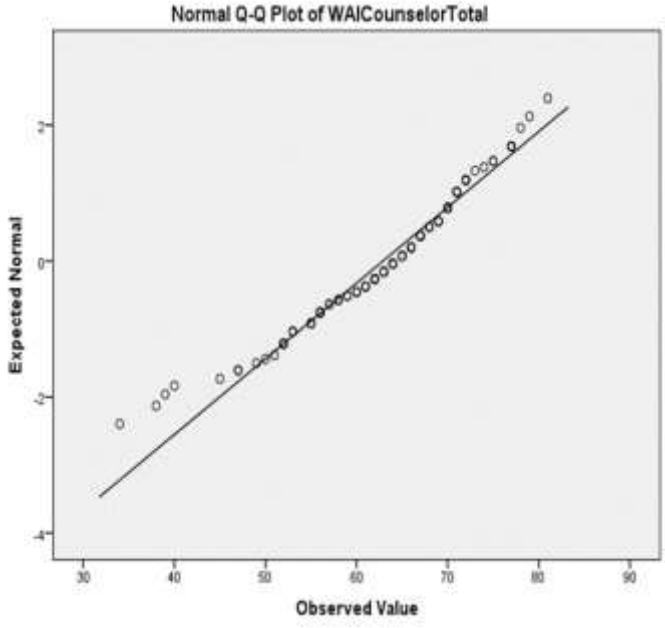

Figure 6: Working Alliance Counselor Plot

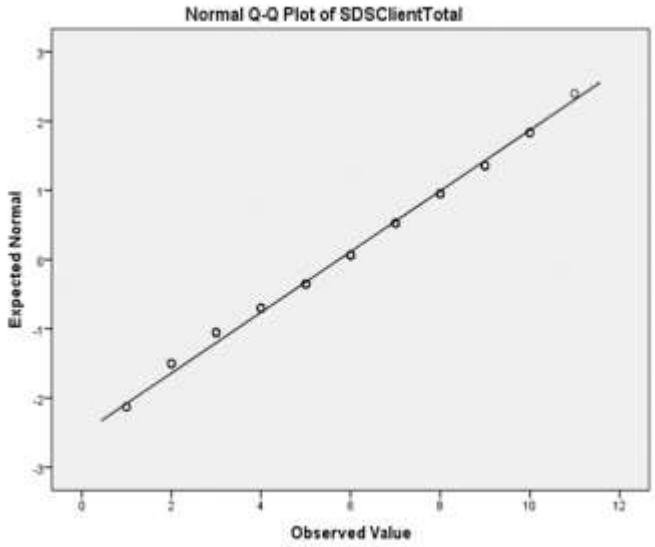

Figure 7: Social Desirability Client Plot

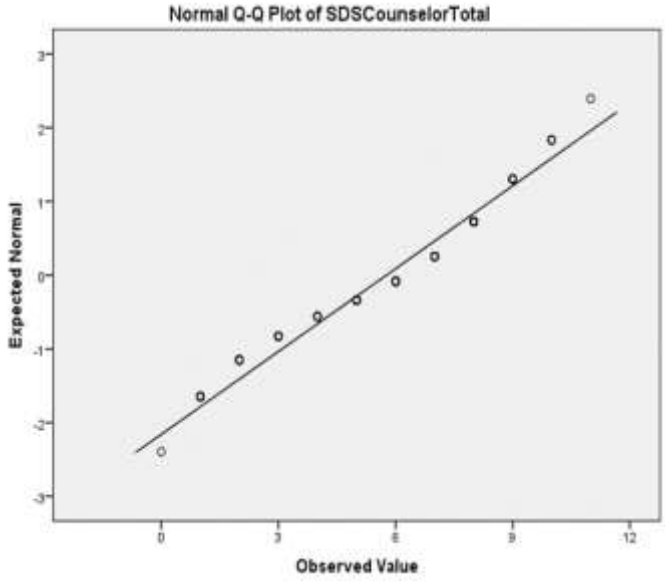

Figure 8: Social Desirability Counselor Plot

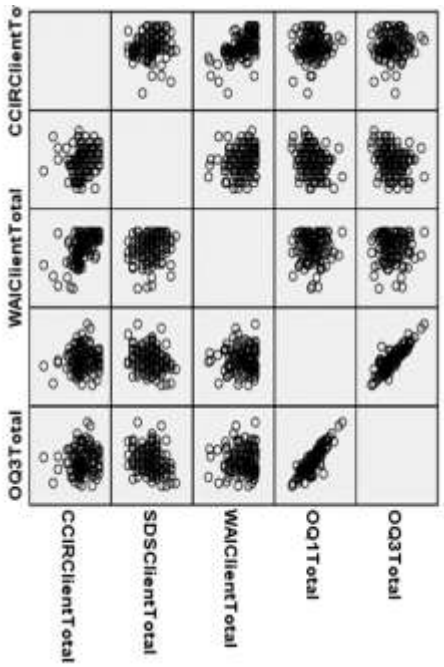

Figure 9: Client Scatterplot Matrix

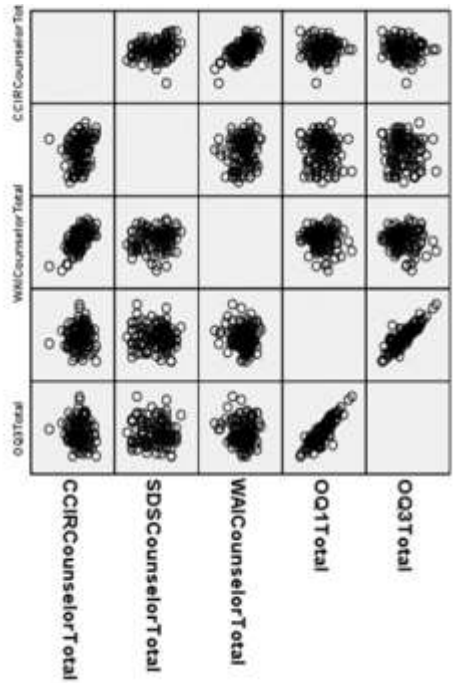

Figure 10: Counselor Scatterplot Matrix

Table 4 *Correlations*

		CCIR Client	CCIR Couns	WAI Cliet	WAI Couns	SDS Client	SDS Couns	OQ1	OQ3
CCIR Client	Pearson Correlation	1	.166	.571**	.106	.168	-.058	.094	.113
	Sig. (2-tailed)		.072	.000	.251	.067	.533	.307	.222
	N	119	119	119	119	119	119	119	119
CCIR Couns	Pearson Correlation	.166	1	.134	.623**	-.033	.233*	.025	-.091
	Sig. (2-tailed)	.072		.145	.000	.720	.011	.784	.327
	N	119	119	119	119	119	119	119	119
WAI Client	Pearson Correlation	.571**	.134	1	.199*	.164	-.119	.033	.013
	Sig. (2-tailed)	.000	.145		.030	.074	.196	.724	.888
	N	119	119	119	119	119	119	119	119
WAI Couns	Pearson Correlation	.106	.623**	.199*	1	-.009	.179	-.061	-.075
	Sig. (2-tailed)	.251	.000	.030		.922	.051	.513	.415
	N	119	119	119	119	119	119	119	119
SDSClient	Pearson Correlation	.168	-.033	.164	-.009	1	.022	-.233*	-.277**
	Sig. (2-tailed)	.067	.720	.074	.922		.813	.011	.002
	N	119	119	119	119	119	119	119	119
SDSCouns	Pearson Correlation	-.058	.233*	-.119	.179	.022	1	-.077	-.055
	Sig. (2-tailed)	.533	.011	.196	.051	.813		.406	.554
	N	119	119	119	119	119	119	119	119

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Research Question One

The first research question explored: Does counselors'-in-training multicultural competence and working alliance predict client outcome, while controlling for social desirability from the clients' perspective?

Hierarchical multiple regression was used to assess the extent to which the two control measures (CCCIR and WAI-S) predicted client outcome (OQ 45.2 posttest), after controlling for the influence of social desirability (SDS) and client outcome pre-test scores (OQ 45.2 pretest). As previously described, preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity (See Figures 1-10). Client outcome OQ 45.2 pre-test score and SDS were entered in Step one, explaining 78.6% ($F_{(2, 116)} = 213.3$; $p < .001$) of the variance in client outcome OQ 45.2 posttest scores (See Table 5). After entry of CCIR and WAI scores at Step two, the total variance explained by the model as a whole was 78.9%, ($F_{(4, 114)} = 106.80$; $p < .001$) (See Table 5). The introduction of CCCIR and WAI-S only explained an additional variance of .3%, after controlling for client pre-test score and social desirability (R^2 change = .003; $F_{(2, 114)} = .851$; $p > .05$) (See Table 5). In the final model, only one of the four predictor variables was statistically significant, client outcome pre-test score ($b = .859$, $p < .001$) (See Table 6). The final model indicates large effect size ($R^2 = .789$) (Cohen, 1992). The regression equation produced from this final model was: OQ 45.2 post-test score = .947 (OQ 45.2 pretest score) - .991 (social desirability total) + .183(multicultural competence) - .119 (working alliance) (Table 6).

Table 5 *Clients Perceptions Model Summary*

Model	*R*	R^2	Adjusted R^2	*SE*	Change Statistics				
					R^2 Change	*F*	*df*1	*df*2	*p*
1	.887[a]	.786	.782	12.85134	.786	213.261	2	116	.000
2	.888[b]	.789	.782	12.86790	.003	.851	2	114	.430

Table 6 *Coefficients Summary*

		Unstandardized Coefficients		Standardized Coefficients	Values	Sig.
		B	*SE B*	*B*	*t*	*p*
	(Constant)	2.772	5.194		.534	.595
1	OQ1Total	.954	.049	.866	19.616	.000
	SDSTotal	-.913	.534	-.076	-1.711	.090
	(Constant)	-6.396	12.398		-.516	.607
	OQ1Total	.947	.049	.859	19.250	.000
2	SDSTotal	-.991	.547	-.082	-1.813	.073
	CCCIRTotal	.183	.140	.069	1.303	.195
	WAITotal	-.119	.152	-.041	-.781	.436

Research Question Two

The second research question explored: Does counselors'-in-training multicultural competence and working alliance predict client outcome, while controlling for social desirability from the counselors'-in-training perspective?

Hierarchical multiple regression was used to assess the ability of two control measures (CCCIR and WAI-S) to predict client outcome (OQ 45.2 posttest), after controlling the influence of social desirability (SDS) and client outcome pre-test scores (OQ 45.2 pretest). As previously described, preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity (See Figures 1-10). However a limitation of this hierarchical regression is that the assumption of independence may have been violated due to some counselors-in-training (n = 45) having multiple ratings on the same assessment.

Client outcome pre-test score and counselors-in-training SDS total scores were entered in Step one, explaining 78.1% of the variance ($F_{(2.116)} = 206.60$; $p < .001$) in client outcome OQ 45.2 post test scores (See Table 7). After entry of CCCI-R and WAI scale at Step two, the total variance explained by the model as a whole was 79.6% ($F_{(4,114)} = 111.38$; $p < .05$) (See Table 7). The introduction of CCCI-R and WAI-S explained additional variance of 1.5%, after controlling for client pre-test score and social desirability (R^2 change = .015; $F_{(2, 114)} = 4.32$; $p < .05$) (Table 6). In the final model, two of the four predictor variables were statistically significant, client outcome pre-test score (b = .894, $p < .001$), and CCIR (b = -.157, $p < .05$) (See Table 8). The final model indicates a large effect size (R^2 =.796) (Cohen, 1992). The final regression equation produced from this model was: OQ 45.2 post test score = .985 (OQ 45.2 pre-test score) + .282 (social desirability) - .563 (multicultural competence) + .192 (working alliance) (See Table 8).

Table 7 *Counselors-in-training' Perceptions Model Summary*

Model	*R*	R^2	Adjusted R^2	*SE* of the Estimate	Change Statistics				
					R^2 Change	*F*	*df*1	*df*2	*p*
1	.884[a]	.781	.777	13.01248	.781	206.585	2	116	.000
2	.892[b]	.796	.789	12.65437	.015	4.329	2	114	.015

Table 8 *Coefficients Summary*

Model		Unstandardized Coefficients		Standardized Coefficients	Values	Sig.
		B	*SE B*	*β*	*t*	*P*
1	(Constant)	-3.889	4.551		-.855	.395
	OQ1Total	.974	.048	.884	20.258	.000
	SDSTotal	.012	.450	.001	.026	.980
2	(Constant)	36.308	15.112		2.403	.018
	OQ1Total	.985	.047	.894	20.946	.000
	SDSTotal	.282	.451	.027	.625	.533
	CCCIRTotal	-.563	.198	-.157	-2.846	.005
	WAITotal	.192	.167	.062	1.149	.253

a. Dependent Variable: OQ3Total

Research Question Three

The third research question was: What differences exist between clients' and counselors'-in-training perceptions of counselors'-in-training multicultural competence and working alliance, while controlling for social desirability?

The repeated measures MANCOVA was utilized to explore differences in mean values of client perception of their counselors'-in-training multicultural competence (as measured by the CCCI-R) and mean values of counselors'-in-training perceived mutlicultural competence (as measured by the CCCI-R), while controlling for social desirability (as measured by the SDS). In addition, the MANCOVA explored if the mean value of clients' perception of the therapeutic relationship (as measured by the WAI-S) differs from the mean value of the counselors'-in-training perception of the therapeutic relationship (as measured by the WAI-S), while controlling for social desirability (as measured by the SDS). Social desirability was used as a control variable due to the likelihood of participants to on self-report measures to respond in a socially desirable manner (DeVellis, 2003; Gall et al., 2007; Pike 1999).

Prior to beginning data analysis, the assumptions of sample size, normality, extreme outliers, linearity, multicollinearity, and homogeneity of variance were inspected (See Figures 1-10). Tabacknick and Fidell (2013) recommended that the minimum sample size to conduct a MANOVA are 10 or more cases per dependent variables, which were met in this study (N = 191). Visual exploration of box plots indicated no extreme outliers within the sample. In addition, to screen for outliers, a test of Mahalanobis distance client one case indicated the presence of a multivariate outlier, by having an exceedingly critical value (24.32), indicating the presence of a multivariate outlier. Due to the minimal value of exceeding acceptable condition (less than 2), the researcher did not remove the singular outlier. Further, a visual exploration of

the dependent variables on a scatterplot indicated linearity.

Perceptions of the working alliance, counselors'-in-training multicultural competence, and likelihood of individuals to respond in a socially desirable manner were measured for both clients and counselors-in-training on the third counseling session. A repeated measures MANCOVA confirmed that there were significant differences between client and counselors-in-training perceptions of the working alliance and multicultural competence (Wilks' $\lambda = .918$, $F_{(2, 115)} = 5.20$, $p < .05$ partial $\eta^2 = .082$). Univariate tests indicated that after controlling for social desirability, there were no differences between client and counselors'-in-training CCCIR perceptions ($F_{(1, 116)} = 2.670$, $p > .05$, partial $\eta^2 = .023$), though univariate tests revealed that after controlling for SDS, there were significant differences between client and counselors'-in-training WAI-S perceptions $F_{(1, 116)} = 10.40$, $p < .05$, partial $\eta^2 = .082$). Observed power to detect these differences was .817 and the effect size was .082, indicating a small effect size (Cohen, 1992). Lastly, upon exploration of the mean scores between clients and counselors-in-training, it appears that clients rated their counselors'-in-training multicultural competence ($M = 102.87$, $SD = 9.50$) and the working alliance ($M = 74.73$, $SD = 9.50$) higher than counselors-in-training rated their multicultural competence ($M = 96.88$, $SD = 7.66$) and the working alliance ($M = 64.91$, $SD = 8.97$) (See Table 9).

Table 9 *CCCIR and WAI Estimates*

Measure	Raters	*M*	*SD*	95% Confidence Interval	
				Lower Bound	Upper Bound
CCCIR	Clients	102.874[a]	10.41	100.997	104.751
	Counselors	96.983[a]	7.66	95.620	98.346
WAI	Clients	72.739[a]	9.50	71.035	74.444
	Counselors	62.908[a]	8.97	61.291	64.525

a. Covariates appearing in the model are evaluated at the following values: SDSClientTotal = 5.7395, SDSCounselorTotal = 5.7647.

Research Question Four

The fourth research question was: What relationships exist between clients' and counselors'-in-training demographic variables (e.g. age, gender, ethnicity) and multicultural competence, the working alliance, and client outcomes?

A Pearson-Product two-tailed correlation was conducted to inspect the relationships between clients and demographic variables and counselors'-in-training multicultural competence, the working alliance, and client outcomes. The results revealed that the only significant relationship from the clients' demographics was with age and client outcome post test scores ($r = .197$, $p < .05$, 3.8% of variance explained) (See Table 10). In a Pearson-Product two-tailed correlation was conducted to inspect the relationship between counselors'-in-training' demographic variables and counselors'-in-training multicultural competence, the working alliance, and client outcomes. The results indicated counselors'-in-training age had a significant positive relationship with their perceptions of their multicultural competence ($r = .243$, $p < .01$, 5.9% of variance explained) and the working alliance ($r = .207$, $p < .05$, 4.2% of variance explained). In addition, counselors'-in-training ethnicity had a significant negative relationship with their perceptions of their multicultural competence ($r = -.263$, $p < .05$, 6.9% of variance

explained) and the working alliance (r = -.345, p < .05, 11.9% of variance explained); (See Table 11). The following relationships from research question four had a medium effect size (Cohen, 1988): (1) clients' age and client outcome OQ 45.2 post test scores; (2) counselors' age and their multicultural competence and the working alliance; and (3) counselors' ethnicity and their multicultural perception. Lastly, counselors'-in-training ethnicity and their perceptions with their multicultural and the working alliance had a large effect (Cohen, 1988).

Table 10 *Summary of Client Demographic Correlations*

		Age	Gender	Ethnicity	CCCIR	SDS	WAI	OQ1	OQ3
Age	Pearson Correlation	1	.066	.130	.033	-.026	.015	.088	.182*
	Sig. (2-tailed)		.477	.160	.722	.777	.873	.339	.047
	N	119	119	119	119	119	119	119	119
Gender	Pearson Correlation	.066	1	.086	.069	-.064	.081	-.007	.013
	Sig. (2-tailed)	.477		.352	.453	.488	.384	.940	.888
	N	119	119	119	119	119	119	119	119
Ethnicity	Pearson Correlation	.130	.086	1	.019	.049	-.084	-.025	.018
	Sig. (2-tailed)	.160	.352		.836	.600	.362	.791	.844
	N	119	119	119	119	119	119	119	119

*. Correlation is significant at the 0.05 level (2-tailed).
** Correlation is significant at the 0.01 level (2-tailed)

Table 11 *Summary of Counselor Demographic Correlations*

		Age	Ethnicity	Gender	CCCIR	SDS	WAI	OQ1	OQ3
Age	Pearson Correlation	1	-.010	.207*	.243**	-.018	.207*	.101	.125
	Sig. (2-tailed)		.918	.024	.008	.846	.024	.273	.177
	N	119	119	119	119	119	119	119	119
Ethnicity	Pearson Correlation	-.010	1	-.103	-.263**	-.159	-.345**	-.044	-.050
	Sig. (2-tailed)	.918		.265	.004	.084	.000	.635	.593
	N	119	119	119	119	119	119	119	119
Gender	Pearson Correlation	.207*	-.103	1	.110	-.004	.021	-.059	-.005
	Sig. (2-tailed)	.024	.265		.232	.961	.821	.526	.961
	N	119	119	119	119	119	119	119	119

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

Summary of Results

The purpose of this investigation was to explore relationships between multicultural competence, the working alliance, and predicting client outcomes from both clients' and counselors'-in-training perceptions. The results of this investigation contribute to a gap in the counseling literature on multicultural competence, the working alliance, and client outcomes. Preliminary analysis through A Pearson Product two-tailed correlation identified the following significant relationships: (a) a positive relationship between clients' perceptions of counselors'-in-training multicultural competence and the working alliance (b) significant positive relationship between counselors'-in-training perceptions of their multicultural competence and

the working alliance (c) a positive relationship between client and counselors perceptions of the working alliance, (d) a positive relationship between social desirability scores on counselors'-in-training CCCI-R responses, (e) negative relationships between clients social desirability scores total both client outcome OQ 45.2 pre-test and post- tests, and (f) positive relationships between the OQ 45.2 pre and post test scores).

In order to analyze the four research questions the following three statistical analysis were used: (a) hierarchical regression, (b) repeated measures MANCOVA, and (c) Pearson Product two-tailed correlation. The first results from the hierarchical regression indicated that clients' perception of the working alliance and multicultural competence were not significant predictors of client outcome, after controlling for clients' social desirability scores and client outcome pre-test scores (R^2 = .789). Next, results from the second hierarchical regression indicated that counselors'-in-training perceptions of the working alliance and multicultural competence were found as a whole model to be significant predictors of client outcome, after controlling for counselors'-in-training social desirability scores and clients outcome pre-test scores (R^2 = .796). Further inspection of coefficients revealed that counselors'-in-training perceptions of their multicultural competence was the significant predictor of client outcome. Third, results from the repeated measures MANCOVA indicated that there were differences between client and counselors'-in-training perceptions of the working alliance and multicultural competence. Observed power to detect these differences was .817 and the effect size was .082, indicating a small effect size (Cohen, 1992). Further univariate tests indicated that after controlling for social desirability, there were no differences between client and counselors'-in-training multicultural perceptions. However, univariate tests revealed that after controlling for SDS, there were differences between client and counselors'-in-training working alliance

perceptions. Furthermore, upon exploration of the mean scores between clients and counselors-in-training, it appears that clients rated their counselors'-in-training multicultural competence and the working alliance higher than counselors-in-training rated their multicultural competence and the working alliance. Fourth, results from the Pearson Product two tailed correlation on clients' demographics revealed significant relationships between clients' age and client outcome post test scores. Lastly, Pearson-Product two-tailed correlation on counselors'-in-training demographic data indicated counselors'-in-training age had a significant positive relationship with their perceptions of their multicultural competence and the working alliance; counselors'-in-training ethnicity had a negative relationships with their perceptions of their multicultural competence and the working alliance.

Chapter Summary

Chapter Four presented the results of the data analyses which included: (a) descriptive analysis, (b) Pearson's correlations, (c) hierarchical multiple regressions, and (d) repeated measures analysis of co-variance. Chapter Five continues with a discussion of the results, offering implications for practicing practicum counselors, counselor educators, and recommendations for future research.

CHAPTER FIVE: CONCLUSIONS

The purpose of Chapter Five is to provide an overview of the study, research methodology, and a discussion of the results. Specifically, results are discussed and compared with other findings presented in Chapter Two. This Chapter Five (a) reviews results of the main research hypothesis; (b) identifies limitations of the study (e.g. research design, sampling, instrumentation); (c) provides recommendations for future research; and (d) presents implications for counselors and counselor educators.

Summary of Study

The purpose of this research study was to explore the relationship between multicultural competence, the working alliance, and client outcomes. This investigation was focused on clients' and counselors'-in-training perceptions of multicultural competence (as measured by the *Cross-Cultural Counseling Inventory* [CCCI-R; LaFromboise, Coleman, & Hernandez, 1991]), the working alliance (as measured by the *Working Alliance Inventory-Short Revision* [WAI-S; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989]) and prediction on client outcome (as measured by *the Outcome Questionnaire 45.2* [OQ 45.2; Lambert & Burlingame, 1996]), after controlling for social desirability (as measured by the (*Social Desirability Scale-Short Form* [SDS; Reynolds,1982]).

The following section elaborates on the results of the data analysis described in Chapter Four. Specifically, a review on the descriptive data and instrumentation are presented. In addition, the results of data analyses are compared to research investigations found in Chapter Two, focused on multicultural competence, the working alliance, client outcomes, and the relationships between these constructs.

Sampling and Procedures

This investigation was approved by the Institutional Review Board (IRB) from a large southeastern university. Participants were recruited from a university community counseling clinic over the Summer 2014 and Fall 2014 semesters. A total of 146 clients (e.g. over the age of 18, receiving counseling services from practicum students, etc.) and 85 counselors-in-training (e.g. students enrolled in practicum) met criteria to participate in this investigation (N = 231). 131 clients completed the assessments and 75 counselors-in-training, yielding a response rate of 89% for clients and 88% for counselors-in-training (N = 206). Cases were removed due to meeting the following exclusion criteria: (a) cases of clients completing the assessments more than once, (b) more than 40% of their assessments not completed at random, or (c) were identified as extreme outliers (Pallant, 2010; Tabachnick & Fidell, 2013). The final sample yielded a response rate of 78% (n = 119) for clients and 84% (n = 72) for counselors-in-training. The final sample included 191 total participants, yielding a total sample response rate of 82%.

Participants

Counselors'-in-training in this investigation were masters' level counselor education students enrolled in Practicum I or II course. The clients in this investigation were members from the community who were adult clients over the age of 18 receiving services from Practicum level I or II counselors'-in-training at a university community counseling center in the southeastern region.

Clients Demographics

The descriptive data and measures of central tendency are provided for all client participants (*N* = 119) in the study. The majority of participants identified as female (*n* = 71, 59.7%), compared to those who identified as male (*n* = 48, 40.3%). The majority of participants were between the ages of 18-30 (*n* = 56, 47.1%), followed by those between the ages of 31-40 (*n* = 27, 22.7%), those between the ages of 41-50 (*n* = 22, 18.5%), those between the ages of 51-60 (*n* = 12, 10.1%), and those between the ages of 61-65 (*n* = 2, 1.7%). Ethnicity and race of client participants were primarily Caucasian (53.8%) African American (non-Hispanic) (17.6%), Hispanic/Latino (16.8%), Biracial/Multiracial (5.9%), Other, (3.4%), American Indian (1.7%), and Asian (.8%).

Counselor Demographics

The descriptive data and measures of central tendency are provided for the counselor population (*N* = 72) in this study. The majority of participants identified as female (*n* = 61, 84.7%), compared to those who identified as male (*n* = 11, 15.3%). The majority of participants were between the ages of 21-26 (*n* = 54, 75%), followed by those between the ages of 27-37 (*n* = 18, 25%). Ethnicity and race of counselor participants were Caucasian (66.7%), Biracial/Multiracial (11.1%), African American/Black (9.7%), Hispanic/Latino (9.7%), Asian (1.4%), and Other (1.4%). Lastly, the majority of counseling students reported having taken or were currently taking a Multicultural Course (*n* = 70, 97.2%), compared to those who reported not having taken or currently taken a Multicultural Course (*n* = 2, 2.8%).

The majority of the demographic characteristics within this investigation (e.g. age, gender, and race) are consistent with multicultural, working alliance, and client outcome literature for clients and counselors-in-training (e.g. Bachelor, 2013, Hatcher, Barends, Hansell, & Gutfreund, 1995; Fitzpatrick, Iwakabe, and Stalikas 2005; Fuertes & Brobst, 2002; Nyman, Nafziger, & Smith, 2010). However, the client sample population for this investigation is different than the majority of studies, in that it is a community based population rather than college based population. The majority of research investigating similar constructs have utilized a college student client population (e.g. Hayes, Owen, & Bieschke, 2014; Owen et al., 2011; Pope-Davis, 2002). While student status was not collected for this dissertation, within the university counseling clinic in which the study was conducted, students are screened out for and referred to a college counseling clinic on campus. Further, the over 50% of the age of client participants was over 31 years of age highlighting that participants were not of typical college age students (i.e., 18-23).

Instrumentation

There were four primary constructs in this investigation: (a) client outcome (symptomatic distress, social role, interpersonal relationships), (b) multicultural competence, (c) the working alliance (bond, level, task), and (d) social desirability. This quantitative investigation used five instruments to investigate these constructs: (1) *Demographic Questionnaire*; (2) the *Cross-Cultural Counseling Inventory* ([CCCI-R]; LaFromboise, Coleman, & Hernandez, 1991), (3) *Working Alliance Inventory-Short Revision* ([WAI-S]; Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989), (4) *the Outcome Questionnaire 45.2* [OQ 45.2]; Lambert & Burlingame, 1996) and (5) *Social Desirability Scale-Short Form* ([SDS]; Reynolds, 1982).Clients completed the OQ 45.2 during their first and third counseling sessions. In addition, both clients and

counselors-in-training completed the OQ 45.2, WAI-S, CCCI-R and the SDS during the third session.

Client Outcome

The *Outcome Questionnaire 45.2* ([OQ 45.2]; Lambert & Burlingame, 1996) is a 45-item scale that (OQ 45.2; Lambert & Burlingame, 1996) was completed by the clients to measure client outcome. Total scores on the OQ 45.2 consisted of the sum of scores of three subscales (e.g., symptomatic distress, interpersonal relationships, social roles) and the reverse scores of nine items (e.g. 1, 12, 13, 20, 21, 24, 31, 37 and 43). In the case of the OQ 45.2, scores are expected to lower over time as clients improve in counseling (Lambert et al., 1996). Total outcome scores for clients on the OQ 45.2 pretest, completed on the first session were: (*M* = 69.37, *Mdn* = 64, *Mod*e = 70, *SD* = 25.009). Total outcome scores for clients on the OQ 45.2 post test scores, completed on the third session, were the following: (*M* = 63.73, *Mdn* = 58, *Mode* = 49, *SD* = 27.56). Analysis of the mean score differences of OQ 45.2 pre-test and post-test scores indicated that clients distress level lowered by seven points from first session to third session. The reported means are similar to other investigations using the OQ 45.2 to measure client outcome. For example, Hayes, Owen, and Bieschke,(2014) reported OQ 45.2 first session scores (*M* = 61.35, *SD* = 24.12) and final session OQ 45.2 scores (*M* = 51.93, *SD* = 24.13) scores indicated clients were just below the total cut off score of 63 indicating clinical significance (Lambert & Burlingame, 1996). Similarly, Nyman, Nafziger, and Smith (2010) reported OQ 45.2 first session score (*M* = 78.4, *SD* = 23.6) and OQ 45.2 last session score (*M* = 69.4, *SD* = 21.1) were right above the cut off score indicating clinical significance. Thus, the averages OQ 45.2 scores from the current investigation were congruent with other investigations who clients had distress.

Working Alliance

The 12 item *Working Alliance Inventory Short Form* ([WAI-S] Horvath & Greenberg, 1989; Tracey & Kovocivic, 1989) was used in order to measure client and counselor perceptions about the working alliance relationship in counseling. Total WAI-S scores for clients were the following: (*M* = 64.63, *Mdn* = 75, *Mode* = 84, *SD* = 8.). Total WAI-S scores for counselors-in-training were the following: (*M* = 59.40, *Mdn* = 64, *Mode* = 70, *SD* = 7.61). The reported mean scores on the WAI-S were consistent with other research. For example, Okiishi, Lambert, Nielsen, and Olges (2003) investigated the mean score for clients and counselors-in-training on the working alliance during the initial first session and scores indicated high ratings (*M* = 73.00, *SD* = 18.57). In addition, Fuertes and colleagues (2007) clients' reported score (*M* = 63.30, *SD* = 14.19), and counselors-in-training (*M* = 63.66 *SD* = 9.41) were similar to averages in the current study. Similarly Wei and Heppner (2005) clients scores (*M* = 64.16, *SD* = 5.94) and counselors-in-training (*M* = 69.03, *SD* = 10.53) were similar to the current study. Thus, the clients and counselors perceptions of rating the working alliance as high are congruent with other investigations.

Multicultural Competence

The *Cross Cultural Competence Inventory-Revised* (CCCI-R; LaFromboise et al., 1999) was used to measure client and counselor perceptions of counselors'-in-training multicultural competence in this investigation The total score for clients CCCI-R ratings of their counselors'-in-training multicultural competence on the third counseling session were: (*M* = 102.81, *Mdn* = 102, *Mode* = 100, *SD* = 10.42). The total score for counselors-in-training CCCI-R ratings of their own multicultural competence on the third session were: (*M* = 96.98, *Mdn* = 97, *Mode* = 96, *SD* = 7.66). Lastly, the reliability of the CCCI-R was calculated using Cronbach alpha and results

indicated the CCCI-R had high reliability for clients (α = .929) and good reliability counselors-in-training (α = .85). The reported mean CCCI-R scores are consistent with other research investigations that have used the CCCI-R to measure multicultural competence. For example, Fuertes and Brobst (2002) reported client scores were indicated of high ratings (*M* = 97.39, *SD* = 14.58). Similarily, Constantine (2002) client scores were indicative of high ratings (*M* = 100.00, *SD* = 12.42). In addition, Constantine and Ladany (2002) reported counselors scores were indicative of high ratings (*M* = 95.56, *SD* = 9.3). Lastly, Fuertes and colleagues (2007) clients reported scores (*M* = 91.39, *SD* = 18.58) and their counselors (*M* = 99.29, *SD* = 9.22) were indicative of similar ratings. Thus, the averages on the CCCI-R scores were consistent with similar investigations.

Social Desirability

The *Reynolds Marlowe-Crown Social Desirability Scale-Short Form A* (SDS; Reynolds,1982) was used to measure social desirability in this study. The SDS is an 11 item dichotomous (e.g. 0 = True, 1 = False) scale intended to measure the likelihood of an individual to respond in a way on an instrument that is socially acceptable. Scoring ranges from 0-11, with the higher the score indicating participants likelihood of answering in a socially desirable manner in order to avoid disapproval from others. Total SDS scores for clients were: (*M* = 5.74, *Mdn* = 6, *Mode* = 6, SD = 2.27). Total SDS scores for counselors were: (*M* = 5.71, *Mdn* = 6, *Mode* = 8, *SD* = 2.66). The reliability of the SDS was calculated using Cronbach alpha and results indicated the SDS had acceptable reliability for clients (α = .60) and good reliability counselors-in-training (α = .73). The majority of participants in existing literature typically fall within the average range (*M* = 4.81), indicating an average degree of conformity (Reynolds, 1982). The mean scores for this investigation are slightly higher than the mean scores in previous research, however, still fall

within the middle range of scores for the SDS assessment, indicating clients' and counselors'-in-training having an average concern to be socially desirable. In sum, overall, participants' average scores on all instruments fell within similar ranges with previous research, indicating that the sample was responding to instruments in similar ways are participants in other studies.

Summary of Results and Conclusions

The following section discusses the results and conclusions of each research question. In addition, the results will be critiqued and compared to similar research studies, including those studies outlined in Chapter Two.

To explore research questions one and two, hierarchical multiple regression was used. Standard multiple regression analysis is commonly used in social science research when researchers want to determine the most appropriate predictors for their analysis that may be supportive of a theory (Gall et al., 2007). Alternatively, to multiple regression, researchers who are interested in determining the most explained variance in the dependent variable (e.g. client outcome) with the least possible number of predictors chose the approach of hierarchical multiple regression (Tabachnik & Fidell, 2013).

Hierarchical regression (also known as sequential regression) is an appropriate analysis when the researcher has a basis of research or theory of how to assign entry order of variables. Essentially, instead of having SPSS choose the order of variable entry, the entry is chosen by the researcher based on previous research or theory. IBM SPSS package software was used to analyze the hierarchical regression. A hierarchical regression is used when the researcher has a theoretical basis to specify the order as to which the independent variables are entered (Pallant, 2010). In the following analyses, social desirability and OQ 45.2 pre-test scores were used as the control variables. It is common practice within social sciences to use pre-test scores as a control

variable and post-test scores as a dependent measure in order to reduce error variance and to create more powerful tests for data analysis (Tabachnick & Fidell, 2013). Also, social desirability was used as a control variable due to the strong likelihood of participants to respond in a socially desirable manner on self-report measures (DeVellis, 2003; Gall et al., 2007, 2011; Pike 1999). In addition, social desirability and OQ 45.2 were used as control variables because a review of Pearson Product correlation matrix revealed that there was a relationship between social desirability scores, counselors'-in-training multicultural competence scores, and clients OQ 45.2 scores.

Lastly, though clients' age showed to have a positive correlation with client outcome OQ 45.2 pre and post test scores, and counselors' age showed to have a positive correlation with counselors'-in-training perceptions of their multicultural competence and the working alliance, these variables were not included in block one due to lack of theoretical support for this demographic characteristic. For example, Worthington and colleagues (2007) conducted a 20-year content analysis of empirical articles (k = 75) on multicultural competence. The authors concluded that the majority of the studies utilized self-report assessments with intrapersonal variables (e.g. counselor race/ethnicity), and only 3.7% of the studies used observer/independent report assessments (Worthington et al., 2007). In addition, based off of all the investigations reviewed in Chapter Two, age was not used as an interpersonal variable. Thus, SDS and OQ 45.2 pre-test were the constructs controlled for in block one.

Next, depending on the research question, either total scores of client or counselors-in-training CCCI-R and WAI-S scores were entered in block two due to the research linking the relationship between working alliance and client outcomes (Hatcher et al., 1995; Norcross & Lambert, 2011). In addition, CCCI-R and WAI-R scores were entered in block two due to

results of correlational analysis revealing that there were significant relationships between clients' and counselors'-in-training perceptions of counselors'-in-training multicultural competence and the working alliance.

Research Question One

The first research question explored: Does counselors'-in-training multicultural competence and working alliance predict client outcome, while controlling for social desirability from the clients' perspective?

Hierarchical multiple regression was used to assess the extent to which the two control measures (CCCIR and WAI-S) predicted client outcome (OQ 45.2 post test), after controlling for the influence of social desirability (SDS) and client outcome pre-test scores (OQ 45.2 pre test). Client outcome OQ 45.2 pre-test score and SDS were entered in Step one, explaining 78.6% ($F_{(2, 116)} = 213.3$; $p < .001$) of the variance in client outcome OQ 45.2 posttest scores (Table 4). After entry of CCIR and WAI scores at Step two the total variance explained by the model as a whole was 78.9%, ($F_{(4, 114)} = 106.80$; $p < .001$). The introduction of CCCIR and WAI-S only explained an additional variance of .3%, after controlling for client pre-test score and social desirability (R^2 change = .003; $F_{(2, 114)} = .851$; $p > .05$) (*See Table 4*). In the final model, only one of the four predictor variables was statistically significant, client outcome pre-test score ($b = .859$, $p < .001$). The final model indicates large effect size ($R^2 = .789$) (Cohen, 1992). The regression equation produced from this final model was: OQ 45.2 post-test score = .947 (OQ 45.2 pretest score) - .991 (social desirability total) + .183(multicultural competence) - .119 (working alliance). See *Table 5* for full display of results.

Research Question Two

The second research question explored: Does counselors'-in-training multicultural competence and working alliance predict client outcome, while controlling for social desirability from the counselors'-in-training perspective?

Hierarchical multiple regression was used to assess the ability of two control measures (CCC-IR and WAI-S) to predict client outcome (OQ 45.2 post test), after controlling the influence of social desirability (SDS) and client outcome pre-test scores (OQ 45.2 pre test). As previously described, preliminary analyses were conducted to ensure no violation of the assumptions of normality, linearity, multicollinearity (See figures 1-10). However a limitation of this hierarchical regression is that the assumption of independence may have been violated due to some counselors-in-training (n = 45) having multiple ratings on the same assessment.

Client outcome pre-test score and counselors-in-training SDS total scores were entered in Step one, explaining 78.1% of the variance ($F_{(2.116)} = 206.60$; $p < .001$) in client outcome OQ 45.2 post test scores (*See Table 6*). After entry of CCCI-R and WAI scale at Step two, the total variance explained by the model as a whole was 79.6% ($F_{(4,114)} = 111.38$; $p < .05$) (Table 6). The introduction of CCCI-R and WAI-S explained additional variance of 1.5%, after controlling for client pre-test OQ.45 score and social desirability (R^2 change = .015; $F_{(2, 114)} = 4.32$; $p < .05$) (Table 6). In the final model, two of the four predictor variables were statistically significant, client outcome pre-test score (b = .894, $p < .001$), and multicultural competence (b = -.157, $p < .05$) (Table 7). The final model indicates a large effect size (R^2 =.796) (Cohen, 1992). The final regression equation produced from this model was: OQ 45.2 post test score = .985 (OQ 45.2 pre-test score) + .282 (social desirability) - .563 (multicultural competence) + .192 (working alliance) (Table 7).

Comparison of Results from Research Questions One and Two with Previous Literature

Research questions one and two indicated that clients' perspective of their counselors'-in-training multicultural competence and the working alliance did not predict client outcome on OQ 45.2 post-test scores (R^2 = .789), while counselors'-in-training perspectives do (R^2 = .796). More specifically, counselors'-in-training perspective of their multicultural competence was a significant predictor of client outcome post-test scores, after controlling for client outcome pre-test scores and counselors'-in-training SDS scores. Few published studies were identified that examined clients' and counselors'-in-training perspectives on counselors'-in-training multicultural competence and client outcome. Owen, Leach, Wampold, & Rodolfa (2011) sampled college student clients (N = 143) and counselors (N = 31) who had completed a minimum of three counseling sessions from a university counseling center in order to compare differences between clients' and counselors'-in-training ratings of counselors'-in-training multicultural competence. Results from intra class correlation analysis indicated that counselors'-in-training accounted for 8.5% (ICC = .085) of the variance in client outcomes while clients' perceptions of counselors'-in-training multicultural competence were not related to clients' counseling outcomes, which is consistent with the findings from this investigation that clients' perceptions of their counselors'-in-training multicultural competence did not predict client outcome.

Results from research questions one and two also revealed that the working alliance from both clients' and counselors-in-training perceptions did not predict client outcome. The results from this investigation on the working alliance and client outcome are incongruent with previous research that indicates a strong association between the working alliance and client outcomes (Norcross, 2011). For example, in 2011, Horvath, Del Re, Flückiger and Symonds conducted a

meta-analysis (k = 201) from the years 2001-2009 on research exploring the relationship between the therapeutic relationship and client outcomes for individual therapy. Results from the meta-analysis revealed that in 190 articles there was a robust relationship between the alliance and treatment outcome (r = .275; d = .25-.30) and that the probability of the working alliance being associated with client outcomes was statistically significant (p < .01), regardless of treatment outcome, from the perspective of clients or counselors; which is inconsistent with results from this investigation on clients or counselors'-in-training perceptions of the working alliance being significant predictors of client outcome.

Preliminary correlational analysis from research questions one and two also indicated that there were no significant relationships between client and counselors-in-training perceptions of counselors-in-training multicultural competence, the working alliance and client outcomes. Previous research exploring the relationship between multicultural competence and client outcomes are limited due to the lack of client outcome studies that measure the validity of multicultural assessments' impact on client improvement (Pope-Davis &Coleman 1994, Constantine & Ladany, 2001; Worthington et al., 2007). However, there are many research studies that explore the relationship between the working alliance and client outcomes (Horvath & Bedi, 2002; Norcross, 2011). For example, Martin, Garske, and Davis (2000) conducted a meta-analysis (k = 79 articles) of underlying patterns that exist between the working alliance and client outcome. These 79 studies had been conducted over an 18-year span, with 30 studies available before 1990 and 49 studies available between 1990 and 1996. The authors concluded that the correlation between client and therapist alliance is moderate with client outcome (r = .22). Furthermore, Bachelor (2013) conducted an investigation to better understand how clients (n = 176; 125 women; 51 men) and counselors (n = 133) perceive the working alliance. Results

indicated that four out of the six factors for clients' perceptions on the working alliance correlated low to moderately with client outcome measures: (a) Collaborative Work Relationship (correlations ranging between *r* = .29 and 37), (b) Productive Work (*r* = .36), (c) Active Commitment (*r* = .24), Bond (*r* = .24), and (d) Agreement on Goals/Tasks (with correlations ranging between *r* =.24 and .29). In addition, results indicated that three out of the four factors for counselors'-in-training perceptions ranged in low to moderate correlations with client outcome: Collaborative Work Relationship (with correlations ranging between *r* = .23 and .33), Counselor Confidence and Dedication (with correlations ranging between *r* = .24 and.46), and Client Commitment and Confidence (with correlations ranging between *r* = .24 and .46). The findings from previous research (e.g. Bachelor, 2013; Martin, Garske, and Davis) are incongruent with the results from this investigation that did not find a significant relationship between clients' and counselors'-in-training perceptions of the working alliance and client outcome. Possibilities for the incongruences of the findings from this investigation and the aforementioned investigations are highlighted in the implications section of this chapter.

Research Question Three

The third research question was: What differences exist between client and counselor perceptions of counselors'-in-training multicultural competence and working alliance, while controlling for social desirability?

A repeated measures MANCOVA was utilized to explore differences in mean values of clients' perception of their counselors'-in-training multicultural competence (as measured by the CCCI-R and mean values of counselors-in-training perceived multicultural competence (as measured by the CCCI-R), while controlling for social desirability (as measured by the SDS). In addition, the MANCOVA explored if the mean value of client perception of the therapeutic

relationship (as measured by the WAI-S) differed from the mean value of the counselor's perception of the therapeutic relationship (as measured by the WAI-S), while controlling for social desirability (as measured by the SDS). Prior to beginning data analysis, the assumptions of sample size, normality, outliers, linearity, multicollinearity, and homogeneity of variance were inspected, and no violations were indicated. A repeated measures MANCOVA confirmed that there were significant differences between client and counselors'-in-training perceptions of the working alliance and multicultural competence (Wilks' $\lambda = .918$, $F_{(2, 115)} = 5.20$, $p < .05$ partial $\eta^2 = .082$). Univariate tests indicated that after controlling for social desirability, there were no differences between client and counselors-in-training CCCIR perceptions ($F_{(1, 116)} = 2.670$, $p > .05$, partial $\eta^2 = .023$), but that there were significant differences between client and counselors-in-training WAI perceptions $F_{(1, 116)} = 10.40$, $p < .05$, partial $\eta^2 = .082$). Observed power to detect these differences was .817 and the effect size was .082, indicating large power and small effect (Cohen, 1992). Lastly, upon inspection of the mean scores between clients and counselors-in-training, it appears that clients rated their counselors-in-training multicultural competence ($M = 102.87$, $SD = 9.50$) and the working alliance ($M = 74.73$, $SD = 9.50$) higher than counselors-in-training rated their multicultural competence ($M = 96.88$, $SD = 7.66$) and the working alliance ($M = 64.91$, $SD = 8.97$).

Results of this investigation contribute to the mixed findings of differences in perceptions between counselors-in-training and clients. For example, Fuertes and colleagues (2007) examined how clients and counselors'-in-training rated their counselors'-in-training multicultural competence. Results indicated differences between clients' and counselors'-in-training ratings of counselors'-in-training multicultural competence, with counselors'-in-training ratings higher than client ratings ($t(52) = 2.47$, $p < .01$), consistent with results from this investigation.

However, no differences appeared between the working alliance for clients (M = 63.30, M = 14.19) or (M = 63.66, SD = 9.41). Contrastingly, this investigation found no differences between clients' and counselors'-in-training ratings of counselors'-in-training multicultural competence had differences in client and counselors'-in-training perceptions of the working alliance. Similarly, Fitzpatrick and colleagues (2005) found results consistent with this investigation; results from a MANOVA indicated no differences between clients' and counselors'-in-training perceptions of the alliance from 1st session to last session of counseling on the three subscales, ($F_{(2, 46)}$ = .0326, p > .05; Pillail's trace; .014). Overall, no differences were shown between the three subscales of the WAI, ($F_{(2,46)}$ = 2.134, p > .05; Pillai's trace = .085). Essentially, Fuertes and colleagues (2007) found that the working alliance from clients and counselors-in-training perceptions did not significantly change from 1st session last session. Overall, further investigations are needed to help clarify the perceptions of clients and counselors'-in-training on the working alliance and multicultural competence. Possibilities for differences in perceptions between clients' and counselors'-in-training are discussed in the implications sections of this chapter.

Research Question Four

The fourth research question was: What relationships exist between clients' and counselors'-in-training demographic variables (e.g. age, gender, ethnicity) and multicultural competence, the working alliance, and client outcomes? A Pearson-Product two-tailed correlation was conducted to inspect the relationships between clients and demographic variables and counselors'-in-training multicultural competence, the working alliance, and client outcomes. The results revealed that the only significant relationship from the clients' demographics was with age and client outcome post test scores (r = .197, p < .05, 3.8% of variance explained). In a

Pearson-Product two-tailed correlation was conducted to inspect the relationship between counselors'-in-training' demographic variables and counselors'-in-training multicultural competence, the working alliance, and client outcomes. The results indicated counselors'-in-training age had a significant positive relationship with their perceptions of their multicultural competence (r = .243, p < .01, 5.9% of variance explained) and the working alliance (r = .207, p < .05, 4.2% of variance explained). In addition, counselors'-in-training ethnicity had a significant negative relationship with their perceptions of their multicultural competence (r = -.263, p < .05, 6.9% of variance explained) and the working alliance (r = -.345, p < .05, 11.9% of variance explained). The following relationships from research question four had a medium effect size (Cohen, 1988): (1) clients' age and client outcome OQ 45.2 post test scores; (2) counselors' age and their multicultural competence and the working alliance; and (3) counselors' ethnicity and their multicultural perception. Lastly, counselors'-in-training ethnicity and their perceptions with their multicultural and the working alliance had a large effect (Cohen, 1988). The majority of multicultural counseling literature solely focuses on analyzing race/ethnicity as demographic characteristics, (Worthington et al., 2007). Results from this study suggest that small positive relationships exist between age and client outcome. In sum, clients and counselors'-in-training age appear to have a positive relationship with some of the constructs in this investigation.

Limitations

Every investigation contains limitations. While efforts have been made to minimize as many limitations as possible in this investigation, the following section discusses the limitations that were present in this investigation: (a) research design, (b) sampling, and (c) instrumentation.

Research Design

Limitations in the research design of the current investigation include potential threats to internal and external validity within this investigation. An inherent threat of correlational research designs is that correlation does not imply causation (Tabachnick & Fidell, 2013). Therefore, this investigation can be conceptualized as a preliminary exploration of client outcome, multicultural competence, and the working alliance. Potential threats to internal validity of this investigation are discussed such as testing fatigue and data analysis. Testing fatigue refers to the threat that participants may alter their responses on instrumentation due to tester fatigue (e.g. getting bored or tired); (Gall et al., 2007). Therefore, the researcher chose the revised shortened version of instruments if possible, to shorten the time that participants take to fill them out. However, six clients and three counselors may have suffered from testing fatigue in this investigation when they did not complete 40% or more sections of the assessment packet at random; leading to the removal of these cases as a potential limitation of this investigation. Lastly, another threat to validity in this investigation was the use of self-report data. A concern in self-report instruments may be the likelihood of individuals to respond in a socially desirable manner (Gall et al., 2007). In order to minimize the effects of this limitations, the researcher included observer report to compare participants self-reports, as well as utilized the short form of the *Marlowe-Crowne Social Desirability Scale* (Reynolds, 1982).

Another limitation of the research design was the potential violation of independence due to the same participant completing the same assessment multiple times. While the researcher took steps to ensure observations were independent (e.g. making clients a static variable), the counselors'-in-training population had 12 individuals who completed the assessments twice. A violation of independence can increase the standard error of slopes of variables (Tabachnick &

Fidell, 2013); however, it is a highly common limitation within social science research (Constantine, 2007). In addition, another limitation of this investigation was that the multicultural competence and working alliance were collected in a cross-sectional manner (e.g only in the third counseling session), thus, if data were collected in a longitudinal manner, in intervals, results may have been different if another time frame was chosen (Gall et al., 2007). Lastly, power in this investigation was a limitation for the repeated measure MANCOVA due to not reaching the suggested G*power total sample size of 194. Finally, the chosen form of data analysis may have been a limitation. The researcher controlled the order in which constructs were entered into the hierarchical multiple regressions, which may have affected the significance of results (Gall et al., 2007). However, the researcher took careful consideration in choosing the order in which constructs were entered by using a theoretical basis and exploring the relationships between the constructs using correlational analysis prior to performing data analysis.

External validity is the extent to which the results of an investigation can be generalized to a population and environment beyond the scope in which it was studied (Gall et al., 2007). Common threats to external validity within correlational research include population validity. Population validity refers to the extent to which results from an investigation can be generalized from the sample studied (e.g., masters counseling students) to a larger population (e.g., private practice practitioners); (Gall et al., 2007). In order to maintain the scope of population validity, the researcher generalized findings within the population of master students in the counselor educations programs with similar demographic characteristics.

Sampling

This investigation utilized a convenience sample, which inherently brings limitations. A common issue with convenience samples is the lack of diversity of within the population or loaction, limiting its potential of generalizability (Tabachnick & Fidell, 2013). This study was geared towards counselors'-in-training within a community counseling center at a large southeastern region university in the U.S; therefore, a limitation of this study was that all types of counseling professionals were *not* included. Also, generalizability of findings to populations other than novice counselors or clients outside of a community counseling center setting are low. In addition, selection bias was a limitation of this investigation. Self-selection bias is when participants choose to not participate in an investigation that can have different characteristics (e.g. ethnicity, age, multicultural experiences) from those participants who do participate (Gall et al., 2007). However, given the high response rate of 78% (n = 119) for clients and 84% (n = 72) for counselors, the researcher concludes that the limitation of self-selection bias was minimal.

Instrumentation

The assessments used within this investigation was another limitation of the study. First, the CCCI-R assessment was minimally adapted for use for counselors and clients, however, the adaptation could be threat to internal consistency. Lastly, the data collection instruments in this study were self-report; therefore, participants may have responded in a biased manner. Overall, the researcher used assessments commonly used to measure the constructs and found good reliability with both client and counselor samples.

Despite the limitations of this investigation, the diversity of the adult client population and results from this investigation contribute to the limited literature on the relationships between multicultural competence, the working alliance and client outcome. The majority of the demographic characteristics within this investigation (e.g. age, gender, and race) are consistent with multicultural, working alliance, and client outcome literature for clients and counselors-in-training (e.g. Bachelor, 2013, Hatcher, Barends, Hansell, & Gutfreund, 1995; Fitzpatrick, Iwakabe, and Stalikas 2005; Fuertes & Brobst, 2002; Nyman, Nafziger, & Smith, 2010). However, the client sample population for this investigation is different than the majority of studies, in that it is a community based population rather than college based population. The majority of research investigating similar constructs have utilized a college student client population (e.g. Hayes, Owen, & Bieschke, 2014; Owen et al., 2011; Pope-Davis, 2002). While student status was not collected for this investigation, within the university counseling clinic in which the study was conducted, students are screened out for and referred to a college counseling clinic on campus. Further, over 50% of the age of client participants was over 31 years of age highlighting that participants were not of typical college age students (i.e., 18-23). Thus, results from this investigation contribute to the limited research on community based populations.

Utilizing outcome assessments to measure client improvement is one way to show clients and their counselors how clients' symptoms are changing throughout the counseling process. However, there is limited focus within the counseling research on investigating client outcomes (Garcia, Cartwright, Winston, & Borzuchowska, 2003; Wester, 2007). Winter and colleagues (2013) conducted a systematic review of the literature on counseling and psychotherapy on suicide prevention from 1981-2008. Results indicated that only 67 studies were published relating to outcome studies in this area (Winter, Bradshaw, Bunn, & Wellsted, 2013). That is, on

average only two studies published per year investigated client outcome. Similarly, in a meta-analysis comparing counseling for adults with depression from 1966-2007, only 53 articles were found that measured counseling related outcomes (e.g. cognitive behavioral counseling, problem-solving counseling etc; Cujipers, van Straten, Andersson, & van open, 2008). Thus, over three decades, that would average about one publication per year on client outcomes. While these meta-analyses are specific to adults with depression and suicide prevention, they highlight the limited research in client outcome research over three decades. Therefore, this investigation also contributed to the limited client outcome research within counseling.

Overall, since the development of multicultural competence, there have been different approaches to measure and assess the multicultural competence of counselors. Pope-Davis and Coleman (1994), Constantine and Ladany (2001), and Worthington and colleagues (2007) identify four themes from multicultural counseling research: (a) most of the assessments stem from the Tripartite Model presented by Sue and colleagues (1992); (Coleman et al., 1995; LaFromboise & Foster, 1992; Ponterotto et al., 2007); (b) psychometric properties of these assessments need further investigation; (c) there is a lack of client outcome studies that measure the validity of multicultural assessments' impact on client improvement; and (d) the majority of multicultural competence research focuses on demographic variables of race and ethnicity. In order for multicultural competence research to reach further sophistication, professional counseling organizations and scholars (ACA, 2014; Bachelor, 2013; CACREP, 2009; Okiishi, Lambert, Nielsen, & Ogles, 2003; Owen et al., 2011) recommend exploring other variables similar to this investigation that contribute to the multicultural counseling process, such as client outcome and the working alliance. Lastly, given some of the limitations of the current study, several recommendations are provided for future research.

Recommendations for Future Research

The researcher identifies several potential recommendations for future research from this current investigation. First, future researchers can extend and replicate this study with larger and more diverse samples. This investigation is limited to the generalizability of counselors'-in-training within which the university and community counseling clinic the investigation took place in. Thus, future researchers can explore the perceptions of counselors'-in-training that have completed their training programs to see how results may differ. Second, future researchers can increase data collection points for assessing client outcome (i.e., 1st, 5th, 10th and 15th sessions) to determine if and when clinically significant change in client outcomes occurs. The OQ 45.2 total score cut off is set at 63, indicating scores above 63 indicate clinical significance (Lambert & Burlingame, 1996). In the case of the OQ 45.2, scores are expected to lower over time as client's functioning improves (Lambert et al., 1996). Lambert and colleagues (2013) indicate that a 14 point decrease in OQ 45.2 scores from one counseling session to the next indicate clinical change, or decreases in client distress, a term coined as the Reliable Change Index (RCI) for the OQ 45.2. Total outcome scores for clients on the OQ 45.2 pretest, completed on the first session were: (M = 69.37, Mdn = 64, Mode = 70, SD = 25.009). Total outcome scores for clients on the OQ 45.2 post test scores, completed on the third session, were the following: (M = 63.73, Mdn = 58, Mode = 49, SD = 27.56). Analysis of the RCI for the OQ 45.2 pre-test and post-test scores indicated that clients distress level lowered by seven points from first session to third session, indicating non-clinically significant levels of change between sessions. Thus, this client population began the first session with just meeting the criteria for clinical significance distress and in three sessions did not reach measurable clinically significant levels of change, according to the RCI. Therefore, further research is needed on community based populations with different

levels of distress in order to see if CCCI-R and WAI-S would be predictive of client outcome. Additionally, researchers can compare the perceptions of clients and counselors on the working alliance and multicultural competence at different points in counseling in order to see patterns of the quality of the counseling relationship or multicultural competence skills.

Further recommendations for future research include implementing a research approach in which supervisors, counselors, and clients rate the counselors'-in-training multicultural competence and the working alliance. In doing so, counselors will be able to receive feedback from different observers on their developing skills. Fourth, further investigations can implement a mixed method design (e.g. qualitative and quantitative) to explore factors that influence client outcome for brief therapy. This current investigation found that clients' perceptions of multicultural competence and WAI were not predictors of client outcome, through quantitative measures. Utilizing a qualitative component may help counselors and counselor educators gain further insight into what clients' perceive a culturally sensitive counselors would look like or what a positive working alliance looks like. Lastly, a future recommendation for research would be to perform a confirmatory factor analysis (CFA) on the CCCI-R with the client and counselor population from this sample. The only observer report multicultural competence scale that exists is the CCCI-R (LaFromboise et al., 1991). The CCCI-R is intended for supervisors to rate their supervisees' multicultural competence; therefore, no observer report currently exits that was made specifically for client ratings of their counselors'-in-training multicultural competence. Conducting a CFA on the CCCI-R with the populations from this investigation will contribute to the gap in the literature on the psychometric properties of the adapted CCCI-R.

Implications

The purpose of this investigation was to explore relationships between multicultural competence, the working alliance, and predicting client outcome. Implications of the results of this investigation for counselors and counselor educators will be discussed next.

Counseling Implications

Early termination and low retention of clients is a common problem in counseling, with between 65%-80% of clients terminating treatment before the 10th session (Garfield, 1994; Lambert, 2013). Researchers (Lampropoulous, Schneider, & Spengler, 2009; Owen, Smith, & Rodolfa, 2009) have found that predictors of early termination include client age, race, socioeconomic status, and level of perceived distress. In addition to early termination and dropout rates, racial and ethnic minorities underutilize mental health services, highlighting the need for counseling professionals to empirically explore factors that may be contributing to effectiveness of the counseling process. Exploration of multicultural competence and working alliances may increase understanding of the therapeutic factors that influence client outcomes.

Identifying relationships between multicultural competence, the working alliance, and client outcomes provides counselors with understanding and insights into clients' perceptions about the counseling process. In contrast to previous research, clients' perceptions of their counselors'-in-training multicultural competence and the working alliance were not predictors of client outcomes in the current investigation. Potential explanations for this non-significant finding include the cross sectional research design on the constructs of multicultural competence and the working alliance. In a cross sectional research design, the researcher looks at a *snapshot* of constructs at one point in time (Gall et al., 2007). In this investigation, multicultural competence and the WAI were assessed during the third session for both clients' and counselors.

Thus, assessing multicultural competence and WAI during the third session may not have been enough time for clients to evaluate their counseling relationship or their counselors'-in-training multicultural competence. For example, Fitzpatrick, Iwakabe, and Stalikas (2005) explored clients' perceptions of the working alliance utilizing the WAI-S over three phases of counseling (e.g. early; 2-4 sessions, middle; midpoint, late; fourth, third or second to last). Fitzpatrick and colleagues (2005) conducted a MANOVA with two within-subject design factors. The two factors were phases of counseling (early-middle-late) and WAI subscales (Task, Bond, Goal). Results indicated as a whole, client-rated alliance increased over time, ($F_{(2, 46)} = 3.51$, $p < .05$; Pillai's trace = .132). Thus, results of this analysis may have been different if multicultural competence and the WAI were measured over time.

Another possible explanation of CCCI-R and WAI-S not being predictors on client outcome from clients' perspective is that these two assessments may not be representative of how this client population defined the working alliance and multicultural competence. The basis of the WAI-S originated from Bordin's (1979) definition of the working alliance including three terms: the extent of agreement between clients and counselors on the goals, tasks, and bond (personal bond between client and counselor); (Horvath & Greenberg, 1989). Similarly defined, The CCCI-R was developed based on the tripartite model (TM) of multicultural competencies (e.g. knowledge, skills, and awareness); (Sue et al., 1982). Weinrach and Thomas (2002) noted that the TM's underlying assumptions and beliefs about race are not inclusive of other influential factors such as gender or age. Thus, clients may have different values than those defined in these assessments that may not have been addressed due to the nature of the location in which this investigation took place. For example, it is general practice within the clinic this study was conducted in, for clients to be given clinic assessments such as the psychosocial assessment to

complete during the first three sessions of counseling. The counseling sessions at the clinic the investigation took place are approximately 50 minutes and the typical clinical assessments given by the counselor (e.g. psychosocial) may not meet the expectation that the client had of just engaging in *talk therapy*. Therefore, if clients value oral communication they may have viewed the assessments as a form of hindering their working alliance. Another characteristic of the clinic in which this investigation took place is that it is not a crisis center and clients do not have access to their counselors-in-training 24/7. If clients value proximity and availability in order to make progress on their goals, the client may have answered *never* on item number 12 "I believe the way my counselor and I are working with my problem is correct". Thus, it is of importance for counselors to check in with their clients about their assumptions, expectations, and values in counseling.

Given that after controlling for clients social desirability responses and OQ 45.2 pre-test scores, perceptions of clients views on the working alliance and counselors'-in-training multicultural competence only explained .03% of the variance in clients OQ 45.2 posttest outcome scores, it is important for counselors'-in-training to explore what aspects of the counseling process are important to clients before engaging in therapeutic interventions. For example, in a qualitative investigation, Pope-Davis et al., (2002) conducted a grounded theory design interviewing 10 undergraduate students who had received counseling (N = 10; 9 women, 1 man) from a large East Coast university who received course credit for participating in the study. The purpose of Pope-Davis' and colleagues (2002) investigation was to increase understanding of clients' perceptions and experiences in counseling of cross-cultural dyads and create a grounded theory model of clients' perspectives on multicultural competence. A common theme found among participants was that incorporating culturally relevant components

into counseling was importance to clients only if they self-identified their culture as a core value in their life. Thus, it is important for counselors'-in-training to explore their clients' core values in session to increase understanding of their clients values and expectations in counseling.

While counselors'-in-training and the working alliance did not predict client outcomes, correlational analysis indicated significant positive relationship between the working alliance and multicultural competence for clients. Implications for counselors include acknowledging and reflecting on the importance of the relationship between multicultural competence and the working alliance in counseling. For example, Owen et al., (2011) explored how clients' perceptions (N = 232) of microagressions towards their counselors (N = 29) would effect therapy and whether the working alliance would mediate it. Microagressions are common insults and injustices (intentional or unintentional) that communicate humiliating or embarrassing messages to an individual or persons of a particular group (Ponterotto et al., 2001). Results indicated that the working alliance was a moderator (B = 0.45, SE = .08, p < .001, = .37). Essentially, clients who perceived the working alliance to be of better quality had improved counseling outcomes. In addition, if clients had negative views about microagressions towards their counselors, these were moderated by the working alliance. Given the association between multicultural competence and the working alliance indicated in this investigation and Owen et al., (2011), counselors can explore how their clients view the relationship between the working alliance and multicultural competence in session. For example, counselors'-in-training can ask clients early on in counseling probing points to promote discussion on the working alliance such as "What are you looking for in a counseling relationship?" or on multicultural competence such as "Please tell me a little bit about your culture."

Contrastingly from the first hierarchical regression, results from the second hierarchical regression indicated that counselors'-in-training perceptions of their multicultural competence were a predictor of client outcome. However, counselors'-in-training perceptions of the working alliance was not a predictor of client outcome; indicating that if a counselor perceives themselves to be multiculturally competent, this may have a relationship with the clients' outcome in counseling. Potential explanations of this finding include that counselors who have higher senses of multicultural competence, may also be more empathic, sensitive and open to engaging in deeper dialogues with their clients, influence change. Further, researchers (Barden & Greene, 2014) have suggested that measuring multicultural competence is similar to measuring multicultural self-efficacy, or a counselor's belief in their ability to successfully counsel someone from a different cultural background than their own. Self-efficacy has been found to have direct associations with effective counseling, therefore, participants in the current study may have been more efficacious, and therefore more able to influence change in their client's outcome. Thus, counselors'-in-training are encouraged to self-reflect on how they view their multicultural self-efficacy. Counselors'-in-training can utilize the CCCI-R assessment to gauge their multicultural competence with a particular client and reflect on their responses. For example, if a counselors'-in-training find themselves answering *strongly disagree* on item number 16 "I am at ease talking with this client," of the CCCI-R, they can reflect and ask themselves "What would help me feel more comfortable talking with this client?"

Results from this investigation identify how clients and counselors'-in-training may perceive aspects of the working alliance differently. Results indicated that there were differences between clients' and counselors'-in-training perceptions of the working alliance and multicultural competence, after controlling for social desirability, Counselors may want to utilize

assessments such as the CCCI-R and WAI-S in session to facilitate discussions on these topics in an effort to increase the bond and alliance between themselves and their clients. For example, if counselors see that their client *strongly disagrees* with the CCCI-R assessment question 20 "My counselor acknowledges and is comfortable with cultural differences", counselors can utilize this as a discussion point to address any cultural differences that may be interfering with the counseling process. Similarly, if clients answer *never* on number 12 of the WAI assessment "I believe the way my counselor and I are working with my problem is correct," counselors can use this as a point of discussion to ask the client what is working or not working in counseling.

Interestingly, relationships between demographic variables and the constructs of interest in the current study were primarily non-significant, however, positive relationships were found between clients' age and client outcome. In addition counselors'-in-training age had a significant positive relationship with their perceptions of their multicultural competence and the working alliance. Counselors can take into account how their clients view themselves at the age group they are in and how that relates to their distress in counseling. For counselors, there may be a correlation between their salience of their ethnic identity and the working alliance as they get older. Researchers have suggested that as individuals develop through their life stages and attain new experiences that promote growth in their cognitive/problem solving thinking that, individuals begin to feel salient in who they are as person and roles they play in the world (Branch, 2001; Meeus, 2011). However, further analysis is needed to explore what specific age groups had these results. Specifically, within the counseling literature race/ethnicity are the most commonly used exploration variables (Worthington et al., 2007); highlighting the need for diversification in research variables (e.g. age).

Counselor Education Implications

Results from this investigation indicated that counselors'-in-training perceptions of their multicultural competence in predicting client outcomes. Specifically, results identified that after controlling for social desirability and client outcome post-test scores, counselors'-in-training perceptions of their multicultural competence explained 1.5% of the variance. Though counselors'-in-training multicultural competence was found to explain a small portion of variance in client outcomes, this investigation also found: a) a positive relationship between clients' perceptions of counselors'-in-training multicultural competence and the working alliance (b) significant positive relationship between counselors'-in-training perceptions of their multicultural competence and the working alliance (c) a positive relationship between client and counselors perceptions of the working alliance. Thus, implications for counselor educators include engaging their counselors'-in-training in discussions about their views on their multicultural competence skills and working alliance with clients. Counselor educators can utilize client and counselors responses on the CCCI-R and WAI-S as points of reflection in supervision. For example, if counselors'-in-training responnd with *often* on question number four of the WAI-S assessment "I have doubts about what we are trying to accomplish in counseling", counselor educators can ask their supervisees to elaborate on what doubts they are having.

In this investigation there were also relationships found between social desirability and counselors'-in-training perceptions of their CCCI-R responses. When individuals respond in a socially desirable manner they may feel pressured to answer in a way society wants them to in order to be accepted (DeVellis, 2013); or in favor of how counselors'-in-training think they are supposed to appear to researchers/supervisors as a counselor who has multicultural competence. Currently, counselors'-in-training are expected to receive curriculum that emphasizes the

importance of multicultural competence throughout their masters programs (CACREP, 2009). For example, ACA ethical guideline states, "Multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counselor in working with a diverse client population" (Standard C.2.a., p. 8). Thus, counselors'-in-training may feel pressure to answer as if they perceive themselves to have high multicultural competence in order to live up to their expected standards of what a counselor who has multicultural competence looks like. Given that a significant relationship was found between counselors'-in-training SDS responses and their CCCI-R responses, counselor educators can explore how counselors'-in-training perceive what a multiculturally competent counselors is *suppose* to look like.

In addition to significant relationships found between counselors'-in-training CCCI-R responses and social desirability, this investigation also found significant relationships between clients' social desirability responses and their client outcome OQ 45.2 pre and post test scores. Overall, findings that participants in this investigation responded in a socially desirable manner is consistent with the concern in social science research for participants to respond in a socially desirable manner on self-report (DeVellis, 2003; Gall et al., 2007, 2011; Pike 1999). For example, Constantine and Ladany (2002) investigated the relationship between multicultural competency scales and social desirability of 135 counseling professionals and masters/bachelor counseling student; results indicated a significant positive relationship between the counselors CCCI-R high total score responses and social desirability ($r = .50$, $p < .01$). Thus, when counselor educators engage in research they can consider incorporating a social desirability scale in their investigations.

Additional implication for counselor educators includes conducting research on factors that influence clinically significant changes in client outcome. Given that close to 80% of the variance in post test scores were accounted for by OQ 45.2 pre-test scores on client outcomes and social desirability responses, counselor educators are encouraged to focus their training of counselors on extratherapeutic factors that are evidenced based. A variety of therapeutic factors can influence client outcomes. The common factors model (Rosenzwig, 1936) suggests there is a set of therapeutic variables that overlap in all counseling services, and that contribute to the type of outcome in counseling. The common factors model is generally categorized into extratherapeutic factors (e.g. social support, spontaneous remission), expectancy (clients' hope and expectation for change), specific techniques (e.g. hypnosis, biofeedback), and common factors (e.g. empathy, warmth, congruence, and therapeutic relationship) (Lambert & Barley, 2001; Norcorss & Lamber, 2011). The common factors model and the findings from this investigation that clients' perceptions were not predictive of client outcome highlight the need for further research on what variables within the counseling process predict client outcome.

Chapter Summary

Chapter Five critiqued and compared results from the current investigation with existing research in the counseling field. The results of this study should be interpreted within the scope and limitations identified. Overall, the results from this investigation contributed to a gap in the literature of exploring the extent to which multicultural competence and the working alliance predict client outcome. Implications and suggestions for future research were discussed.

APPENDIX A: IRB APPROVAL LETTER

University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1**
FWA00000351, IRB00001138

To: **Jessica Gonzalez** and Co-PI: **Sejal Barden**

Date: **May 09, 2014**

Dear Researcher:

On 5/9/2014, the IRB approved the following activity as human participant research that is exempt from regulation:

Type of Review:	Exempt Determination
Project Title:	Client outcome: An exploratory investigation of the cultural competencies and the therapeutic alliance
Investigator:	Jessica Gonzalez
IRB Number:	SBE-14-10263
Funding Agency:	
Grant Title:	
Research ID:	N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Kanille Chap

IRB Coordinator

APPENDIX B: CLIENT EXPLAINATION OF RESEARCH

University of Central Florida

Department of Child, Family, and Community Sciences

Counselor Education Program

Explanation of Research for Clients

Title of Study:

Client outcome: An exploratory investigation of the cultural competencies and the therapeutic alliance

Principal Investigator: Jessica Gonzalez, M.S.; Co-Investigator and Faculty Advisor: Sejal Barden, Ph.D

Dear Client,

My name is Jessica Gonzalez, and I am the Clinical Administrator in the Community Counseling and research Center and a doctoral student in the Counselor Education program. Dr. Barden and I are working on a research study investigating the cultural competencies for counselors-in-trainings, which is assessed during Practicum, in relation to the therapeutic and client outcome. You are being asked to participate in this study because you are a client at the Community Counseling and Research. Approval to conduct this study was obtained through the University of Central Florida Institutional Review Board. Additionally, we have the permission of the Counselor Education Program at the University of Central Florida to conduct this research study. **You must be 18 years or older to participate in this study.**

Purpose of the study

The purpose of this study is to investigate client outcome during the Practicum experience and compare results to cultural competencies and the therapeutic alliance, forms will be given at first, third, and fifth counseling session for each client.

Procedures

- If you agree to participate in this study you will be asked to fill out the working alliance inventory (WAI; Horvath & Greenberg, 1989) and the cross-cultural counseling inventory (CCCI-R; Hernandez & Lafromboise, 1983) and social desirability scale-short form (Reynolds & Garbasi, 1982) during your *third and fifth* session along with your counselor, along with the outcome questionnaire (OQ45.2; Lambert & Burlingame, 1996) during your *first, third, and fifth session.*

- On your third and fifth visit you fill out an additional three forms (WAI, CCCI-R, and social desirability scale), which you will be asked to place in an envelope and leave in a designated box.

- The OQ 45.2 will be collected by your counselor and placed in a box located within the CCRC practicum room and then collected by the Principal Investigator and put in a locket cabinet inside the CCRC.

- The counselor will also fill a WAI, CCCI-R and social desirability form out on EACH client after the third and fifth session and place it in the box.

- All information is confidential and only the primary investigator and other approved investigators have access to the WAI, CCCI-R and social desirability form. Your counselor and their supervisor will only have access to the OQ 45.2 for clinical purposes.

- Your identity and responses are confidential (identifiers or identification numbers are only available to the primary investigator and other approved investigators).

UCF University of Central Florida IRB
IRB NUMBER: SBE-14-10263
IRB APPROVAL DATE: 5/9/2014

- It will take 5 - 7 minutes to fill forms at the end of your session and you will only be asked to complete the data collection instruments during your first third and fifth session.

Risks

There are no known risks or discomforts associated with participation with this study. However, you may be inconvenienced by taking the extra time to complete the questionnaire.

Benefits

There may not be direct benefits to you for participating in this study; however, it is hoped that our participation will lead to knowledge that may help other counseling professionals and contribute to the counseling literature.

Cost/compensation

You will not receive any compensation for participating in this study.

Confidentiality

Your participation in this study is confidential. Your name or other identifying information will be collected; however your names are associated with your assigned numbers and your counselor's assigned numbers in a password-protected document that only Jessica Gonzalez has access. Your counselors will fill assessments out on each client. The documents containing your names will be destroyed and data will be matched to your assessments through the random numbers you were assigned and not through your name. All information will be stored in locked cabinets in the primary investigator's office and computer. The data collected will be used for statistical analyses and no individuals will be identifiable from the pooled data. The information obtained from this research may be used in future research and published. However, your right to privacy will be retained. All data will be presented in group format and no individuals will be identifiable from your data. **Your counselor and their supervisor will only have access to the OQ 45.2 responses for clinical purposes but will NOT have access to your responses on other forms and will not be able to connect you to the data responses.**

Voluntary Participation

Your participation in this research project is entirely voluntary. You do not have to participate. You do not have to answer any question(s) that you do not wish to answer. Please be advised that you may choose not to participate in the study, and may withdraw from the study at any time without consequence. Your instructor or academic program will not be notified of whether or not you participated.

If you have any questions or comments about this research, please contact Jessica Gonzalez at jessgo43@knights.ucf.edu; 407-823-4778 or Dr. Sejal Barden sejal.barden@ucf.edu University of Central Florida, College of Education and Human Performance, Counselor Education Program Orlando, FL.

Questions or concerns about research participants' rights may be directed to the UCF IRB Office, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL, 32826-3246. The telephone numbers are 407-823-2910 or 407-882-2012.

Sincerely,

Jessica Gonzalez, M.S.

I understand my rights as a research participant, and I understand what the study is about and how and why it is being done. By completing the data collection instruments, I consent to participate in this research study.

APPENDIX C: COUNSELOR EXPLAINATION OF RESEARCH

University of Central Florida

Department of Child, Family, and Community Sciences

Counselor Education Program

Explanation of Research for Counselors

Title of Study:

Client outcome: An exploratory investigation of the cultural competencies and the therapeutic alliance

Principal Investigator: Jessica Gonzalez, M.S.; Co-Investigator and Faculty Advisor: Sejal Barden, Ph.D

Dear Counselor,

My name is Jessica Gonzalez, and I am the Clinical Administrator in the Community Counseling and research Center and a doctoral student in the Counselor Education program. Dr. Barden and I are working on a research study investigating the cultural competencies for counselors-in-trainings, which is assessed during Practicum, in relation to the therapeutic and client outcome. You are being asked to participate in this study because you are a Masters-level Counselor in the Counselor Education program at the University of Central Florida. Approval to conduct this study was obtained through the University of Central Florida Institutional Review Board. Additionally, we have the permission of the Counselor Education Program at the University of Central Florida to conduct this research study. **You must be 18 years or older to participate in this study.**

Purpose of the study

The purpose of this study is to investigate client outcome during the Practicum experience and compare results to cultural competencies and the therapeutic alliance, which will be measured at the third and fifth counseling session for each client.

Procedures

- If you agree to participate in this study you will be asked to fill out the working alliance inventory (WAI; Horvath & Greenberg, 1989) and the cross-cultural counseling inventory (CCCI-R; Hernandez & Lafromboise, 1983) and social desirability scale-short form (Reynolds & Garbasi, 1982) during your *third and fifth* session along with your client.
- Once you fill out the first three forms (WAI, CCCI-R, and social desirability scale), you will be asked to place it in an envelope and leave it in a designated box.
- Once your client completes OQ45.2 you will put the form inside the practicum room (192h) located inside the CCRC inside the designated box for OQ-45.2 scores, this box is separate from the WAI, CCCI-R, and social desirability form.
- All information is confidential and only the primary investigator and other approved investigators have access to the forms.
- Your identity and responses are confidential (identifiers or identification numbers are only available to the primary investigator and other approved investigators).
- It will take 5 - 7 minutes to fill forms at the end of your session and you will only be asked to complete the data collection instruments during your third and fifth session.

Risks

There are no known risks or discomforts associated with participation with this study. However, you may be inconvenienced by taking the extra time to complete the questionnaire.

Benefits

There may not be direct benefits to you for participating in this study; however, it is hoped that our participation will lead to knowledge that may help other counseling professionals and contribute to the counseling literature.

Cost/compensation

You will not receive any money for participating in this study; however, you will receive a small token of appreciation for your time and participation. In addition, counselors will not receive extra credit or alternative assignments for their participation in this study.

Confidentiality

Your participation in this study is confidential. Your name or other identifying information will be collected; however your names are associated with your assigned numbers and your counselor's assigned numbers in a password-protected document that only Jessica Gonzalez has access. As the counselor, you will fill assessments out on each client. The documents containing your names will be destroyed and data will be matched to your assessments through the random numbers you were assigned and not through your name. All information will be stored in locked cabinets in the primary investigator's office and computer. The data collected will be used for statistical analyses and no individuals will be identifiable from the pooled data. The information obtained from this research may be used in future research and published. However, your right to privacy will be retained. All data will be presented in group format and no individuals will be identifiable from your data. **Your instructor will not have access to your responses and will not be able to connect you to the data responses.**

Voluntary Participation

Your participation in this research project is entirely voluntary. You do not have to participate. You do not have to answer any question(s) that you do not wish to answer. Please be advised that you may choose not to participate in the study, and may withdraw from the study at any time without consequence. Your instructor or academic program will not be notified of whether or not you participated.

If you have any questions or comments about this research, please contact Jessica Gonzalez at jessgo43@knights.ucf.edu; 407-823-4778 or Dr. Sejal Barden sejal.barden@ucf.edu University of Central Florida, College of Education and Human Performance, Counselor Education Program Orlando, FL.

Questions or concerns about research participants' rights may be directed to the UCF IRB Office, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL, 32826-3246. The telephone numbers are 407-823-2910 or 407-882-2012.

Sincerely,

Jessica Gonzalez, M.S.

I understand my rights as a research participant, and I understand what the study is about and how and why it is being done. By completing the data collection instruments, I consent to participate in this research study.

APPENDIX D: CLIENT DEMOGRAPHIC, CROSS CULTURAL COUNSELING INVENTORY REVISED, SOSCIAL DESIRABILITY FORMS

Cross-Cultural Counseling Inventory-Revised (Client version)
(Adapted from ©Alexis Hernandez and Teresa LaFromboise, 1983)

Client Initials:_____ **Counselor Name:**_____ **Session#:**_____

Client Demographics: Age:_____ **Gender:**_____
Ethnicity: (a)African American/Black (non-Hispanic) ____; (b)American Indian ____; (c)Asian ____; (d)Biracial/Multiracial ____; (e)Caucasian ____; (f)Hispanic/Latino____; (g)Pacific Islander ____; (h) Other___

Directions: The purpose of this inventory is to measure your perceptions about the Cross Cultural Competency of your counselor. Please circle only one response of the appropriate rating scale in each statement. Be sure to check every scale even though you may not feel that you have insufficient data on which to make a judgment-**please do not omit any.**

1. My counselor is aware of his or her own cultural heritage.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
2. My counselor values and respects cultural differences.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
3. My counselor is aware of how their own values might affect this client.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
4. My counselor is comfortable with differences between counselor and client.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
5. My counselor is willing to suggest referral when cultural differences are extensive.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
6. My counselor understands the current socio-political system and its impact on me.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
7. My counselor demonstrates knowledge about my culture.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
8. My counselor has a clear understanding of counseling and therapy process.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
9. My counselor is aware of institutional barriers which might affect my circumstances.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
10. My counselor elicits a variety of verbal and non-verbal responses from me.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
11.My counselor accurately sends and receives a variety of verbal and non-verbal messages.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
12. My counselor is able to suggest institutional intervention skills that favor me.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree

Please Continue on Next Page

13. My counselor sends messages that are appropriate to the communication of me.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
14. My counselor attempts to perceive the presenting problem within the context of the my cultural experience, values, and/or lifestyle.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
15. My counselor presents his or her own values to me.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
16. My counselor is at ease talking with this me.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
17.My counselor recognizes those limits determined by the cultural differences between client and counselor.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
18. My counselor appreciates my social status an ethnic minority.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
19. My counselor is aware of the professional and ethical responsibilities of a counselor.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
20. My counselor acknowledges and is comfortable with cultural differences.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree

Reynolds Short Form of the Marlowe-Crowne Social Desirability Scale

(Reynolds & Gerbasi, 1982)

Directions: Please circle one response to the following statements.

1 .It is sometimes hard for me to go on with my work if I am not encouraged	True	False
2. I sometimes feel resentful when I don't get my way	True	False
3. No matter who I'm talking to, I'm always a good listener.	True	False
4. There have been occasions when I took advantage of someone	True	False
5 .I'm always willing to admit it when I make a mistake.	True	False
6. I sometimes try to get even rather than forgive and forget	True	False
7. I am always courteous, even to people who are disagreeable.	True	False
8. I have never been irked when people express ideas very different from my own.	True	False
9. There have been times when I was quite jealous of the good fortune of others.	True	False
10. I am sometimes irritated by people who ask favors of me.	True	False
11. I have never deliberately said something that hurt someone's feelings.	True	False

Thank you for your Participation!

APPENDIX E: COUNSELOR DEMOGRAPHICS, CROSS CULTURAL COUNSELING INVENTORY REVISED, SOCIAL DESIRABLITY FORMS

Cross-Cultural Counseling Inventory-Revised (Counselor version)
(Adapted from Hernandez & LaFromboise, 1983)

Counselor Name:_____ **Client Initials:** _____ **Todays Date:**_____

Have you taken or are currently enrolled in a Multicultural Counseling Course? Yes____No_____

Counselor Demographics: **Prac I or II:**_____ **Age:**_____ **Gender:**_____

Ethnicity: (a)African American/Black (non-Hispanic) ____; (b)American Indian ____; (c)Asian ____;

(d)Biracial/Multiracial ____; (e)Caucasian ____; (f)Hispanic/Latino____; (g)Pacific Islander ____; (h) Other___

Directions: The purpose of this inventory is to measure your perceptions about the Cross Cultural Competency with this client. Please circle only one response of the appropriate rating scale in each statement. Be sure to check every scale even though you may not feel that you have insufficient data on which to make judgment-**please do not omit any.**

1. I am aware of my own cultural heritage.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
2. I value and respect cultural differences.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
3. I am aware of how my own values might affect this client.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
4. I am comfortable with differences between myself and client.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
5. I am willing to suggest referral when cultural differences are extensive.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
6. I understand the current socio-political system and its impact on the client.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
7. I demonstrate knowledge about client's culture.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
8. I have a clear understanding of counseling and therapy process.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
9. I am aware of institutional barriers which might affect client's circumstances.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
10. I elicit a variety of verbal and non-verbal responses from the client.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
11. I accurately send and receive a variety of verbal and non-verbal messages.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**
12. I am able to suggest institutional intervention skills that favor the client.	**strongly disagree**	**disagree**	**slightly disagree**	**slightly agree**	**agree**	**strongly agree**

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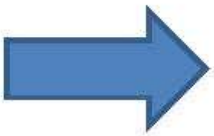

13. I send messages that are appropriate to the communication of the client.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
14. I attempt to perceive the presenting problem within the context of the client's cultural experience, values, and/or lifestyle.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
15. I present my own values to the client.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
16. I am at ease talking with this client.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
17. I recognize those limits determined by the cultural differences between client and myself.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
18. I appreciate the client's social status.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
19. I am aware of the professional and ethical responsibilities of a counselor.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree
20. I acknowledge and am comfortable with cultural differences.	strongly disagree	disagree	slightly disagree	slightly agree	agree	strongly agree

Reynolds Short Form of the Marlowe-Crowne Social Desirability Scale
(Reynolds & Gerbasi, 1982)

Directions: Please circle one response to the following statements.

1. It is sometimes hard for me to go on with my work if I am not encouraged	True	False
2. I sometimes feel resentful when I don't get my way	True	False
3. No matter who I'm talking to, I'm always a good listener.	True	False
4. There have been occasions when I took advantage of someone	True	False
5. I'm always willing to admit it when I make a mistake.	True	False
6. I sometimes try to get even rather than forgive and forget	True	False
7. I am always courteous, even to people who are disagreeable.	True	False
8. I have never been irked when people express ideas very different from my own.	True	False
9. There have been times when I was quite jealous of the good fortune of others.	True	False
10. I am sometimes irritated by people who ask favors of me.	True	False
11. I have never deliberately said something that hurt someone's feelings.	True	False

Please Continue on Next Page

APPENDIX F: CLIENT WORKING ALLIANCE INVETORY SHORT FORM

WAI Client

Working Alliance Inventory - Client (Short Form-Revised)

Your Initials (*Client*): _____ **Today's Date:** _____

Your Counselor's Name: _____

Using the 7-point Likert scale provided, please indicate the degree to which you agree or disagree with each statement about your counselor and your counseling experience. This assessment is for research purposes only, and **your counselor will not have access to this information**.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

Your Rating	Statements
	1. My counselor and I agree about the things I will need to do in counseling to help improve my situation.
	2. What I am doing in counseling gives me new ways of looking at my problem.
	3. I believe my counselor likes me.
	4. My counselor does not understand what I am trying to accomplish in counseling.
	5. I am confident in my counselor's ability to help me.
	6. My counselor and I are working towards mutually agreed upon goals.
	7. I feel that my counselor appreciates me.
	8. We agree on what is important for me to work on.
	9. My counselor and I trust one another.
	10. My counselor and I have different ideas on what my problems are.
	11. My counselor and I have established a good understanding of the kind of changes that would be good for me.
	12. I believe the way my counselor and I are working with my problem is correct.

Horvath A. O., & Greenberg L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36,* 223-233.

Thank you for your participation!

Please place this completed form in box.

APPENDIX G: COUNSELOR WORKING ALLIANCE INVETORY SHORT FORM

Working Alliance Inventory - Counselor (Short Form-Revised)

Your Name (*Counselor*): _____ **Today's Date:** _____

Your Client's initials: _____

Using the 7-point Likert scale provided, please indicate the degree to which you agree or disagree with each statement about your client. This assessment is for research purposes only, and **your client & supervisor will not have access to this information**.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

Your Rating	Statements
	1. My client and I agree about the steps to be taken to improve his/her situation.
	2. My client and I both feel confident about the usefulness of our current activity in counseling.
	3. I believe my client likes me.
	4. I have doubts about what we are trying to accomplish in counseling.
	5. I am confident in my ability to help my client.
	6. We are working towards mutually agreed upon goals.
	7. I appreciate my client as a person.
	8. We agree on what is important for my client to work on.
	9. My client and I have built a mutual trust.
	10. My client and I have different ideas on what his/her real problems are.
	11. We have established a good understanding between us of the kind of changes that would be good for my client.
	12. My client believes the way we are working with his/her problem is correct.

Horvath A. O., & Greenberg L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36,* 223-233.

Thank you for your participation! Please place this completed form in Jessica Gonzalez's mailbox.

APPENDIX H: OUTCOME QUESTIONNAIRE

Outcome Questionnaire (OQ®-45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name:_____ Age:____ yrs.

Sex

ID#_____ M☐ F☐

Session #_____ Date__/__/__

		Never	Rarely	Sometimes	Frequently	Almost Always	SD IR SR DO NOT MARK BELOW
1.	I get along well with others.	☐4	☐3	☐2	☐1	☐0	
2.	I tire quickly.	☐0	☐1	☐2	☐3	☐4	
3.	I feel no interest in things.	☐0	☐1	☐2	☐3	☐4	
4.	I feel stressed at work/school.	☐0	☐1	☐2	☐3	☐4	
5.	I blame myself for things.	☐0	☐1	☐2	☐3	☐4	
6.	I feel irritated.	☐0	☐1	☐2	☐3	☐4	
7.	I feel unhappy in my marriage/significant relationship.	☐0	☐1	☐2	☐3	☐4	
8.	I have thoughts of ending my life.	☐0	☐1	☐2	☐3	☐4	
9.	I feel weak.	☐0	☐1	☐2	☐3	☐4	
10.	I feel fearful.	☐0	☐1	☐2	☐3	☐4	
11.	After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	☐0	☐1	☐2	☐3	☐4	
12.	I find my work/school satisfying.	☐4	☐3	☐2	☐1	☐0	
13.	I am a happy person.	☐4	☐3	☐2	☐1	☐0	
14.	I work/study too much.	☐0	☐1	☐2	☐3	☐4	
15.	I feel worthless.	☐0	☐1	☐2	☐3	☐4	
16.	I am concerned about family troubles.	☐0	☐1	☐2	☐3	☐4	
17.	I have an unfulfilling sex life.	☐0	☐1	☐2	☐3	☐4	
18.	I feel lonely.	☐0	☐1	☐2	☐3	☐4	
19.	I have frequent arguments.	☐0	☐1	☐2	☐3	☐4	
20.	I feel loved and wanted.	☐4	☐3	☐2	☐1	☐0	
21.	I enjoy my spare time.	☐4	☐3	☐2	☐1	☐0	
22.	I have difficulty concentrating.	☐0	☐1	☐2	☐3	☐4	
23.	I feel hopeless about the future.	☐0	☐1	☐2	☐3	☐4	
24.	I like myself.	☐4	☐3	☐2	☐1	☐0	
25.	Disturbing thoughts come into my mind that I cannot get rid of.	☐0	☐1	☐2	☐3	☐4	
26.	I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4	
27.	I have an upset stomach.	☐0	☐1	☐2	☐3	☐4	
28.	I am not working/studying as well as I used to.	☐0	☐1	☐2	☐3	☐4	
29.	My heart pounds too much.	☐0	☐1	☐2	☐3	☐4	
30.	I have trouble getting along with friends and close acquaintances.	☐0	☐1	☐2	☐3	☐4	
31.	I am satisfied with my life.	☐4	☐3	☐2	☐1	☐0	
32.	I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")	☐0	☐1	☐2	☐3	☐4	
33.	I feel that something bad is going to happen.	☐0	☐1	☐2	☐3	☐4	
34.	I have sore muscles.	☐0	☐1	☐2	☐3	☐4	
35.	I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.	☐0	☐1	☐2	☐3	☐4	
36.	I feel nervous.	☐0	☐1	☐2	☐3	☐4	
37.	I feel my love relationships are full and complete.	☐4	☐3	☐2	☐1	☐0	
38.	I feel that I am not doing well at work/school.	☐0	☐1	☐2	☐3	☐4	
39.	I have too many disagreements at work/school.	☐0	☐1	☐2	☐3	☐4	
40.	I feel something is wrong with my mind.	☐0	☐1	☐2	☐3	☐4	
41.	I have trouble falling asleep or staying asleep.	☐0	☐1	☐2	☐3	☐4	
42.	I feel blue.	☐0	☐1	☐2	☐3	☐4	
43.	I am satisfied with my relationships with others.	☐4	☐3	☐2	☐1	☐0	
44.	I feel angry enough at work/school to do something I might regret.	☐0	☐1	☐2	☐3	☐4	
45.	I have headaches.	☐0	☐1	☐2	☐3	☐4	

+ +

Total=

For More Information Contact:
AMERICAN PROFESSIONAL CREDENTIALING SERVICES LLC
E-MAIL: APCS@KROLS.COM
WEB: WWW.OQMANUAL.COM
TOLL-FREE: 1-888-MH SCORE (1-888-647-2673)
FAX/VOICE: 1-973-366-8665

LIST OF REFERENCES

Abreu, J. M., Chung, R., & Atkinson, D. R. (2000). Multicultural counseling training: Past, present, and future directions. *The Counseling Psychologist*, (5), 641.

Alexander, L. B., & Luborsky, L. (1986). The Penn Helping Alliance Scales. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325-366). New York: Guilford Press.

American Counseling Association (2014). *ACA Code of Ethics.* Alexandria, VA: Author.

Arredondo, P., Rosen, D. C., Rice, T., Perez, P., & Tovar-Gamero, Z. G. (2005). Multicultural counseling- A 10-year content analysis of the Journal of Counseling & Development. *Journal of Counseling & Development,* 8*3*(2), 155-161.

Arredondo, P., Toporek, M. S., Brown, S., Jones, J., Locke, D. C., Sanchez, J. and Stadler, H. (1996). *Operationalization of the Multicultural Counseling Competencies*. AMCD: Alexandria, VA.

Arredondo, P., & Glauner, T. (1992). *Personal dimensions of identity model*. Boston: Empowerment Workshops.

Atkinson, D., & Israel, T. (2003). The future of multicultural counseling competence. In D. Pope-Davis, H. Coleman, W. Liu, & R. Toporek (Eds.), *Handbook of multicultural competencies in counseling & psychology.* (pp. 591-607). Thousand Oaks, CA: SAGE Publications, Inc.

Bachelor, A. (2013). Clients' and therapists' views of the therapeutic alliance: Similarities, differences and relationship to therapy outcome. *Clinical Psychology & Psychotherapy*, *20*(2), 118-135.

Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B.L. Duncan S. D. Miller (Eds.). *The heart and soul of change: What works in therapy* (pp. 133-178). Washington, DC US: American Psychological Association.

Baldwin, S., Wampold, B., & Imel, Z. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842-852.

Barden, S. M., & Cashwell, C. (2014). International immersion in counselor education: A consensual qualitative research investigation. *Journal of Multicultural Counseling and Development, 42*, 42-60. DOI: 10.1002/j.2161-1912.2014.00043.x

Barden, S. M., & Greene, J. (2014). An investigation of multicultural counseling self-efficacy and multicultural counseling competence for counselors'-in-training. *International Journal for the Advancement of Counseling*, 1-13. DOI 10.1007/s10447-014-9224-1

Balkin, R. S., & Sheperis, C. J. (2011). Evaluating and reporting statistical power in counseling research. *Journal of Counseling & Development, 89*(3), 268-272.

Beck, A.T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961) An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Blais, M. A., Lenderking, W. R., Baer, L., deLorell, A., Peets, K., Leahy, L., & Burns, C. (1999). Development and initial validation of a brief mental health outcome measure. *Journal of Personality Assessment, 73*, 359–373.

Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, M. A. Hubble (Eds.) *The heart and soul of change: Delivering what works in therapy (2nd ed.)* (pp. 83-

111). Washington, DC, US:

Branch, C. (2001). The many faces of self: ego and ethnic identities. *The Journal of Genetic Psychology*, *162*(4), 412-429.

Busseri, M. A., & Tyler, J. D. (2003). Interchangeability of the working alliance inventory and working alliance inventory, short form. *Psychological Assessment*, *15*(2), 193-197.

Cabral, R., & Smith, T. (2011). Racial/Ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*(4), 537-554.

Carlson, M.H., Brack, C.J., Layro, R., Cohen, R., & Kirkscey, M. (1999) An exploratory study of multicultural competence of counselors in training, *The Clinical Supervisor, 17*(2),75-87.

Cohen, J. (1994). The earth is round ($p < .05$). American Psychologist, *49*(12), 997-1003.

Cohen, J. (1992). A power primer. *Psychological Bulletin*, *112*, 155-159.

Coleman, H. L. K., Wampold, B. E., & Casali, S. L. (1995). Ethnic minorities' ratings of ethnically similar and European American counselors: A meta-analysis. *Journal of Counseling Psychology, 42*, 55-64.

Constantine, M. G., & Ladany, N. (2000). Self-report multicultural counseling competence scales: Their relation to social desirability attitudes and multicultural case conceptualization ability. *Journal of Counseling Psychology, 47*, 155-164.

Constantine, M. G. (2001). Predictors of observer ratings of multicultural counseling competence in Black, Latino, and White American trainees. *Journal of Counseling Psychology*, *48*(4), 456-462.

Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic

minority clients' attitudes toward counseling and ratings of their therapists' general and multicultural counseling competence. *Journal of Counseling Psychology*, *49*(2), 255-263.

Constantine, M. G., Gloria, A. M., & Ladany, N. (2002). The factor structure underlying three self-report multicultural counseling competence scales. *Cultural Diversity and Ethnic Minority Psychology*, 8, 334-345.

Constantine, M. G., (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology*, *54*(1), 1-16.

Cuijpers, P., van Straten, A., Andersson, G., & van Oppen, P. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of Consulting And Clinical Psychology*, *76*(6), 909-922.

Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development*, *85*(4), 401-409.

DeVellis, R.F. (2003). *Scale development Theory and applications* (2nd ed). Thousand Oaks, CA: Sage Publications.

Drisko, J. (2013). The common factors model: Its place in clinical practice and research. *Smith College Studies in Social Work (Haworth)*, *83*(4), 398-413.

Endicott, J., Spitzer, R., Fleiss, J., & Cohen, J. (1976). The Global Assessment Scale. *Archives of General Psychiatry, 33*, 766–771.

Eysenck, H. J. (1952). The effects of psychotherapy- an evaluation. *Journal of Consulting Psychology*, *16*(5), 319-324.

Fitzpatrick, M. R., Iwakabe, S., & Stalikas, A. (2005). Perspective divergence in the

working alliance. *Psychotherapy Research*, *15* (1-2*)*, 69-79.

Frank, J. D. & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University.

Fraenkel, J., Wallen, N., Hyun, H. (2011). *How to design and evaluate research in education.* (8th ed.). New York, NY: McGraw-Hill Companies, Inc.

Freud, S. (1912). *The dynamics of transference*. Reprinted (1953–1974) in the Standard Edition of the Complete Psychological Works of Sigmund Freud (trans. and ed.J. Strachey), (Vol 12), (pp. 97–108). London: Hogarth Press.

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholz, J., Mislowack, A., Hersh, M., & Cheng, D. (2007). 'Therapist Multicultural Competency: A Study of Therapy Dyads': Correction. Psychotherapy: *Theory, Research, Practice, Training*, *44*(1), 13.

Fuertes, J. N., & Brobst, K. (2002). Clients' ratings of counselor multicultural competency. *Cultural Diversity & Ethnic Minority Psychology*, *8*(3), 214-23.

Fuertes, J. N., Miville, M. L., Mohr, J. J., Sedlacek, W. E., & Gretchen, D. (2000). Factor structure and short form of the Miville-Guzman Universality Diversity Scale. *Measurement and Evaluation in Counseling and Development*, *33*, 157–169.

Gall, M. D., Gall J. P., & Borg, W. R. (2007*). Educational Research: An Introduction* (8th ed.). Boston: MA: Allyn & Bacon.

Greenson, R. R. (1965). The working alliance and the transference neuroses. *Psychoanalysis Quarterly, 34,* 155-181.

Gregersen, A. T., Nebeker, R. S., Seely, K. I., & Lambert, M. J. (2004). Social validation of the Outcome Questionnaire: An assessment of Asian and Pacific Islander college students. *Journal of Multicultural Counseling and Development, 33(2),*194-205.

Hanna, F. J., Bemak, F., & Chung, R. C. (1999). Toward a new paradigm for multicultural counseling. *Journal of Counseling and Development*, *77*, 125-134.

Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology*, *64*(6), 1326-1336.

Hays, D. G. (2008). Assessing multicultural competence in counselor trainees: A review of instrumentation and future directions. *Journal of Counseling & Development*, *86*(1), 95-101.

Hays, D. G., & Erford, B. T. (2009). *Developing Multicultural Counseling Competency: A Systems Approach*. Prentice Hall.

Hill, C. E., & Corbett, M. M. (1993). A perspective on the history of process and outcome research in counseling psychology. *Journal of Counseling Psychology*, *40*(1), 3.

Holcomb-McCoy, C.C. (2001). Exploring the self-perceived multicultural competence of elementary school counselors. *Professional School Counseling, 4*, 195-201.

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. r., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353-366.

Horvath, A. O., & Bedi, R. P. (2002). The Alliance. In J. Norcross (Ed.), *Psychotherapy Relationships That Work: Therapist Contributions and Responsiveness to Patients* (pp. 37-70). New York: Oxford University Press. Psychotherapy. Oxford, New York.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and clinical psychology*, *61*(4), 561-573.

Horvath, A. O., & Greenberg, L. S., (1989). Development and validation of the working

alliance inventory. *Journal of Counseling Psychology, 36*(2), 223-233.

LaFromboise, T. D., Coleman, H. L., & Hernandez, A. (1991). Development and factor structure of the Cross-Cultural Counseling Inventory—Revised. *Professional Psychology: Research and Practice, 22*(5), 380-388.

Lambert, M. J., Kahler, M., Harmon, C., Burlingame, G. M., Kenichi, S., & White, M. W. (2013). *Administration and scoring manual OQ 45.2 Outcome Questionnaire*. Salt Lake City, Utah: OQ Measures L.L.C.

Lambert, M.J. & Asay, T. A (2004). *Clinically significant change*. In D. Charman (Ed.). Core Processes in brief psychodynamic psychotherapy: Advancing effective practice (pp. 309-322). Mahwah, NJ: Lawrence Erlbaum.

Lei Y, Duan C. Relationship between therapist empathy and client-perceived working alliance in China: A multilevel modelling analysis. *Counselling Psychology Quarterly* [serial online]. (2014), *27*(2), 200-215. Available from: Professional Development Collection, Ipswich, MA. Accessed January 21, 2015.Malin, A. J., & Pos, A. E. (2014). The impact of early empathy on alliance building, emotional processing, and outcome during experiential treatment of depression. *Psychotherapy Research: Journal Of The Society For Psychotherapy Research*, 1-15.

Locke, D.C. (1992). *Increasing multicultural understanding: A comprehensive model*. Thousand Oaks, CA: Sage.

Long, J. R. (2001). Goal agreement and early therapeutic change. *Psychotherapy- Theory, Research, Practice, and Training, 38*, 219–232.

Marmarosh, C., & Kivlighan, D. (2012). Relationships among client and counselor agreement about the working alliance, session evaluations, and change in client

symptoms using response surface analysis. *Journal of Counseling Psychology*, *59*(3), 352-367.

Martin, D. J., Garske, J. P., & Davis, M. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*(3), 438-450.

Meeus, Wim. (2011). The study of adolescent identity formation 2000-2010: a review of longitudinal research. *In Journal of Research on Adolescence*, *21*(1), 84.

McAuliffe, G. & Eriksen, K. (2002). *Teaching strategies for constructivist and developmental counselor education*. Westport, Connecticut: Bergin & Garvey.

Mollen, D., Ridley, C., & Hill, C. (2003). *Models of multicultural couneling competence: A critical evaluation.* In D. Pope-Davis, H. Coleman, W. Liu, & R. Toporek (Eds.), Handbook of multicultural competencies in counseling & psychology. (pp. 21-38). Thousand Oaks, CA: SAGE Publications, Inc.

Norcross, J. C. (2011). *Psychotherapy relationships that work: Evidence- based responsiveness / edited by John C. Norcross*. New York: Oxford University Press.[Electronic Source].

Okiishi, J., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An empirical analysis of therapist effects. *Clinical Psychology and Psychotherapy*, *10*(6), 361-373.

Owen, J., Jordan II, T. A., Turner, D., Davis, D. E., Hook, J. N., & Leach, M. M. (2014). Therapists' Multicultural Orientation: Client Perceptions of Cultural Humility, Spiritual/Religious Commitment, and Therapy Outcomes. *Journal of Psychology and Theology*, *42*(1), 91-98.

Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Client and therapist

variability in clients' perceptions of their therapists' multicultural competencies. *Journal of Counseling Psychology, 58*(1), 1-9.

Pedersen, P. B. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development, 70,* 6-12.

Pike, G.R. (1999). The constant error of the halo in educational outcomes research. *Higher Education, 40,* 61-86.

Pope-Davis, D., Coleman, H., Liu, W., & Toporek, R. (2003). *Handbook of multicultural competencies in counseling & psychology*. Thousand Oaks, CA: SAGE Publications, Inc.

Pope-Davis, D. B., Toporek, R. L., Ortega-Villalobos, L. D., Ligiero, D., Brittan-Powell, S., Liu, W. M., et al. (2002). Client perspectives of multicultural counseling competence: A qualitative examination. *The Counseling Psychologist , 30*(3), 355–393.

Pope-Davis, D. B., Liu, W. M., Toporek, R. L., & Brittan-Powell, C. S. (2001). What's missing from multicultural competency research: Review, introspection, and recommendations. *Cultural Diversity and Ethnic Minority Psychology*, *7*(2), 121-138.

Ponterotto, J. G. (2001). *Handbook of multicultural counseling / editors, Joseph G. Ponterotto ... [et al]*. Thousand Oaks, CA: SAGE Publications.

Ponterotto, J. G., Sanchez, C. M., & Magids, D. (1991). *Initial development of the Multicultural Counseling Awareness Scale*. Paper presented at the annual meeting of the American Psychological Association, San Francisco.

Reynolds & Gerbasi, Development of reliable & valid short forms of the MCSDS. (1992) *Journal of Clinical Psychology*, *38,* 119-25.

Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic

personality change. *Journal of Consulting and Clinical Psychology, 22,* 95-103.

Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American Journal of Orthopsychiatry*, *6*(3), 412–415.

Scheel, M. J., & Conoley, C. W. (2012). *Psychotherapy process and outcome research in counseling psychology*. In N. A. Fouad, J. A. Carter, L. M. Subich (Eds.) , APA handbook of counseling psychology, (Vol. 1), Theories, research, and methodology.

Smith M., Glass, G. & Miller, T. (1980). *The benefits of psychotherapy*. Baltimore, MD: John Hopkins University Press.

Smith, M. & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *32*(9), 752–760.

Sodowsky, G.R., Taffe, R.C., Gutkin, T., & Wise, S.L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of multicultural competencies. *Journal of Counseling Psychology*, *41*, 137-148.

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). Hoboken, NJ: John Wiley & Sons, Inc. (S. & S.)

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies standards: A call to the profession. *Journal of Multicultural Counseling and Development*, *20*, 64-88.

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, *10*, 45–52.

Tabachnick, B. G., & Fidell, L. S. (2013). *Using multivariate statistics* (6th ed.). Boston, MA: Allyn & Bacon.

Tracey, J. T. & Kokotovic, M. A. (1989). Factor Structure of the Working Alliance Inventory. *A Journal of Consulting and Clinical Psychology*. *1*(3), 207-210.

Treviño, J. G. (1996). Worldview: Change in cross-cultural counseling. *The Counseling Psychologist, 24*, 198-215.

Tyron, G. S., Blackwell, S. C., & Hammel, E. F. (2008) The magnitude of client and therapist working alliance ratings. *Psychotherapy Theory, Research, Practice, Training*, *45*(4), 546-551.

U.S. Bureau of the Census. (2012). *U.S. census bureau projections show a slower growing, older, more diverse nation a half century from now*. Retrieved from https://www.census.gov/newsroom/releases/archives/population/cb12-243.html

U.S. Bureau of the Census. (2012). *State and county quick facts*. Retrieved from http://quickfacts.census.gov.

Watson, Z. P., Herlihy, B., & Pierce, L. (2006). Forging the link between multicultural competence and ethical counseling practice: A historical perspective. *Counseling & Values*, *50*(2), 99-107.

Weinrach, S. G., & Thomas, K. R. (2002). A critical analysis of the multicultural counseling competencies: Implications for the practice of mental health counseling. *Journal of Mental Health Counseling*, *24*(1), 20-35.

Wester, K. L. (2007). Teaching research integrity in the field of counseling. *Counselor Education & Supervision, 46*, 199–211.

Wei, M., & Heppner, P. P. (2005). Counselor and Client Predictors of the Initial Working

Alliance: A Replication and Extension to Taiwanese Client-Counselor Dyads. *The Counseling Psychologist*, *33*(1), 51-71. doi:10.1177/0011000004268636

Winter, D., Bradshaw, S., Bunn, F., & Wellsted, D. (2013). A systematic review of the literature on counseling and psychotherapy for prevention of suicide: 1. Quantitative outcome process studies. *Counseling & Psychotherapy Research*, *12*(3), 164-183.

Wolgast, B. M., Lambert, M. J., & Puschner, B. (2003). The dose-response relationship in a college counseling center: Implications for setting session limits. *Journal of College Student Psychotherapy*, *8*, 15-29.

Worthington, R. L., Soth-McNett, A. M., & Moreno, M. V. (2007). Multicultural Counseling competencies research: A 20-year content analysis. *Journal of Counseling Psychology*, *54*(4), 351-361.

Worthington, R. L., Mobley, M., Franks, R. P., & Tan, J. (2000). Multicultural counseling competencies: Verbal content, counselor attributions, and social desirability. *Journal of Counseling Psychology*, *47*(4), 460-468.

Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis*, *37*, 369-376.