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The Mediating Effect of Color-blind Racial Ideology on the Relationship Between Multicultural Counseling Competence And Empathy

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THE MEDIATING EFFECT OF COLOR-BLIND RACIAL IDEOLOGY ON THE RELATIONSHIP BETWEEN MULTICULTURAL COUNSELING COMPETENCE AND EMPATHY

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ABSTRACT

Multicultural counseling competence is the extent to which a therapist can effectively work with clients from cultural groups which differ from their own, and is expressed through skills, knowledge, and awareness (Sue, 1998; Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vasquez-Nuttall, 1982; Sue, Arredondo, & McDavis, 1992). Color-blind racial ideology is the belief that either emphasizes sameness among all individuals, known as *color-evasion color-blind racial attitudes,* or emphasizes that all individuals have the same opportunity for success, known as *power-evasion color-blind racial attitudes* (Carr, 1997; Neville, Lilly, Duran, Lee, & Browne, 2000; Neville, Awad, Brooks, Flores, & Bluemel, 2013). A significant positive relationship has been found between therapist multicultural counseling competence and color-blind racial attitudes (Johnson & Williams, 2015). Additionally, lower levels of multicultural counseling competence are predictive of poorer ratings of empathy, while higher levels of color-blind racial attitudes are predictive of poorer ratings of empathy (e.g., Burkard & Knox, 2004; Fuertes & Brobst, 2002).

This study examined if therapist color-blind racial attitudes mediate the relationship between therapist-reported multicultural counseling competence and therapist-rated empathy. Participants were licensed practitioners and masters and doctoral-level trainees under supervision. Participants completed a measure assessing

multicultural counseling competence, two measures assessing color-blind racial attitudes, and a measure assessing ratings of empathy. Results found partial mediation of color-evasion color-blindness on the relationship between multicultural awareness and empathy expressed toward an African-American male client. There was no mediated effect when respondents rated their general empathy. Results and future directions are also discussed.

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INTRODUCTION

Clinician multicultural counseling competence is conceptualized using a tripartite model providing clinicians with a series of guidelines for ethically competent practice with diverse clients in therapy (Sue et al., 1982; Sue et al., 1992). Multiculturally competent therapy is an ethical imperative because lower levels of multicultural counseling competence often result in negative experiences, particularly for racial and ethnic minority clients, as well as for other marginalized clients (Fisher, 2014; Tao et al., 2015). Color-blind racial ideology is the belief that race should not and does not matter, a belief which can be expressed as either emphasizing sameness among all individuals (known as *color-evasion color-blind racial attitudes*) or by emphasizing that all individuals have the same opportunity for success (known as *power-evasion color-blind racial attitudes*; Carr, 1997; Neville et al., 2000; Neville et al., 2013). Research has established a relationship between multicultural counseling competence and color-blind racial attitudes among therapists (e.g., Johnson & Williams, 2015). One construct,

empathy, has been found to be influenced by therapist multicultural counseling competence and color-blind racial attitudes (e.g., Burkard & Knox, 2004; Constantine, 2001b).

The purpose of this proposal is to put forward a study examining the mediating effects of color-blind racial ideology on the relationship between multicultural counseling competence and empathy. Chapter I introduces theoretical and empirical literature on multicultural counseling competence, color-blind racial ideology, and empathy. The second chapter will critically review empirical studies on multicultural counseling competence, color-blind racial attitudes, and empathy, and the relationships between these constructs. A gap in the literature and rationale for a study is identified. The third chapter outlines a proposed study including methods, measures, and data analysis.

Multicultural Counseling Competence

Multicultural counseling relationships are any counseling relationships where the participants differ with respect to their cultures, most often the therapist being from a privileged culture and client being from an oppressed culture (Sue et al., 1982). Multicultural counseling competence is a therapist's ability to work effectively with other cultural groups, in addition to appreciating and recognizing other cultural groups (Sue, 1998; Sue et al., 2009). Issues such as a therapist's inability to understand a client's situation, difficulties, or strengths, empathize with and understand a client's worldview, or integrate culturally relevant techniques into therapy occur when there is minimal assumed similarity between the client and counselor in terms of their cultures and cultural meanings (Sue et al., 1982). Although there is some evidence that general counseling competence and multicultural counseling competence overlap (e.g., Coleman, 1998),

evidence on this finding is mixed (e.g., Cates, Schaefle, Smaby, Maddux, & LeBeauf, 2007). As such, psychologists must engage in continuing education, and training programs must offer courses and other learning tools to facilitate development of multicultural counseling competence.

Theory and research on multicultural counseling competence has typically situated the construct across three dimensions (attitudes/beliefs, knowledge, and skills; Sue et al., 1982; Sue et al., 1992). In terms of multicultural attitudes and beliefs, multiculturally competent therapists maintain awareness of their values and biases that are sensitive to their own cultural identities, are respectful of cultural differences, and are comfortable with differences existing between clients and themselves (Sue et al., 1982). Examination of one's attitudes and beliefs is the first step toward awareness, which is accomplished by introspection and reflective self-evaluation (Sodowsky, Taffe, Gutkin, & Wise, 1994). According to Smith, Soto, Griner, and Trimble (2016), therapists without awareness might unintentionally project their own cultural values and assumptions onto racial and ethnic minority clients, fail to recognize how their own actions are perceived by racial and ethnic minority clients, and misinterpret racial and ethnic minority client actions or intentions.

In terms of multicultural knowledge, a multiculturally competent therapist should have a comprehensive understanding of the sociopolitical reality in the United States with respect to how racial and ethnic minority people are treated and the barriers racial and ethnic minority people face in terms of accessing mental health services (Sue et al., 1982). Competent therapists also possess knowledge and information about cultural groups they work with as well as knowledge and understanding of general characteristics

of counseling (Sue et al., 1982). Multicultural knowledge is important because, without it, counselors are not able to accurately contextualize or interpret the meanings of actions or perceptions from other cultures (Smith et al., 2016). Culturally competent therapists place their client in the proper cultural context, and work to generalize their client's experiences to their client's cultural worldviews (Sue, 1998).

Therapists who utilize multiculturally competent skills generate, send, and receive a variety of verbal and nonverbal responses in culturally appropriate ways, as well as exercise institutional intervention skills, such as outreach or consulting, when appropriate (Sue et al., 1982). Skills are important for a counselor to adapt clinical work to the needs of culturally diverse clients (Smith et al., 2016). Multiculturally competent therapists should develop intervention strategies and techniques which are proficient with a client's culture (Sue et al., 1992). Integrating multiculturally-appropriate skills into therapy appears challenging for most therapists; there is evidence that therapists and students are often able to identify appropriate practices but struggle to actually implement these practices into therapy (e.g., Hansen et al., 2006; Sehgal et al., 2011).

Ethical implications of multicultural counseling competence. Multicultural counseling competence is an important part of practicing ethically and effectively (Arredondo & Toporek, 2004; Fisher, 2014). A therapist who does not practice competently is at risk for providing ineffective, potentially harmful therapy for racial and ethnic minority clients (Sue et al., 1992). Furthermore, Coleman (2004) argues that therapists expanding their abilities to meet client needs are acting out of a commitment to social justice. Many professional organizations have established standards and benchmarks for multiculturally competent practice (e.g., Arredondo, Toporek, Brown,

Jones Locke, Sanchez, & Stadler, 1996; Middleton, Rollins, Sanderson, Leung, Harley, Ebener, and Leal-Idrogo, 2000; National Association of Social Workers, 2007; Singh, Merchant, Skudrzyk, & Ingene, 2012;).

The American Psychological Association (APA) has also published guidelines, *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (herein referred to as the *Multicultural Guidelines*; 2003). The APA *Multicultural Guidelines* are organized into five different categories: (1) commitment to cultural awareness and knowledge of self and others, (2) education, (3) research, (4) practice, and (5) organizational change and policy development (2003). In summary, therapist multicultural counseling competence is imperative for ethical practice. In response to a sizeable amount of scholarship on the ethical importance of multiculturally competent practice, many professional organizations have implemented guidelines for multiculturally competent practice.

Importance of multicultural counseling competence. Multicultural counseling competence is important for mental health research and practice, as competencies are skills which raise awareness to a cultural-environmental-contextual perspective of mental health (Sue et al., 1982). Without multicultural counseling competence, research findings risk being influenced by Western-based values; for example, bias, implicit or explicit racist attitudes, or prejudices may influence a researcher's view of pathology or psychosis, two constructs that have historically been viewed differently based on a client's racial or ethnic identity. (Sue et al., 1982). Furthermore, racial and ethnic minority clients risk being described as deficient or may terminate therapy prematurely due to cultural variations in communication, leading to misunderstandings between the

therapist and client (Owen, Imel, Adelson, & Rodolfa, 2012; Owen et al., 2017; Sue et al., 1982).

The study of therapist multicultural counseling competence is important given the evidence of racial and ethnic minority clients having difficult experiences in therapy. Racial and ethnic minority clients are less likely to initiate treatment (e.g., Akincigil et al., 2012; Zane et al., 2005) and are more likely to terminate therapy prematurely (e.g., Owen et al., 2012; Owen et al., 2017). Furthermore, therapist effectiveness is partially explained by a client's racial and ethnic minority status; specifically, therapists at times are less effective with racial and ethnic minority clients than with Caucasian clients (e.g., Hayes, Owen, & Bieschke, 2015; Imel et al., 2011). In sum, racial and ethnic minority clients appear vulnerable to poor, ineffective therapy; the role therapist multicultural counseling competence has in these experiences is worthy of further assessment.

Predictors of multicultural counseling competence. Understanding predictors of multicultural counseling competence is important when studying multicultural counseling competence. There are several aspects of training, such as the number of multicultural courses taken or number of racial and ethnic minority clients seen, which predict a therapist's multicultural counseling competence. Additionally, a therapist's racial group membership or attitudes toward race and ethnicity can predict how culturally competent a therapist is. A review of predictors of multicultural counseling competence is important, given that these predictors can act as confounding variables in multicultural counseling competence research. What follows is an introduction to research on predictors of multicultural counseling competence.

Academic training programs in psychology and counseling play an important role in student development of multicultural counseling competence. There is evidence that multicultural counseling competence increases over the course of a semester enrolled in a multicultural course (e.g., Cartwright, Daniels, & Zhang, 2008; Estrada, Durlak, & Juarez, 2002; Malott, 2010), that training programs focusing on students' attitudes toward diversity might facilitate the development of multicultural counseling competence (Reynolds & Rivera, 2012), and that higher levels of overall multicultural training are associated with higher levels of multicultural counseling competence (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006).

A consistent finding across the literature has been that having a more diverse caseload is predictive of higher levels of self-reported multicultural counseling competence, both for mental health professionals and students in training (e.g., Arthur & Januszkowski, 2001; Bellini, 2002; Lee & Khawaja, 2013; Pope-Davis, Prieto, Whitaker, & Pope-Davis, 1993). Additionally, the amount of multicultural coursework (e.g., Arthur & Januszkowski, 2001; Bellini, 2002; Constantine, 2001a; Constantine & Yeh, 2001; Pope-Davis et al., 1993) and experiential activities designed to facilitate interactions with racial and ethnic minorities in educational settings (e.g., Coleman, Morris, & Norton, 2006; Lee, Rosen, & McWhirter, 2014; Roysircar, Gard, Hubbell, & Ortega, 2005) have all been found to improve multicultural counseling competency during training. Higher degrees of openness to diversity (Tummala-Narra, Singer, Li, Esposito, & Ash, 2012), greater acceptance of similarities and differences of others (Munley, Lidderdale, Thiagarajan, & Null, 2004), and more frequent critical incidents (meaningful emotional or behavioral interpersonal experiences with minorities; Delsignore, Petrova, Harper,

Stowe, Mu'min, & Middleton, 2010) are also significantly predictive of multicultural counseling competence.

Racial group membership appears to predict higher scores of multicultural counseling competence. Many studies assessing self-reported multicultural counseling competence have found racial and ethnic minority participants report higher overall competence as well as dimensions of competence compared to White participants (e.g., Bellini, 2002; Chao, Wei, Good, & Flores, 2011; Hill et al., 2013; Holcomb-McCoy & Myers, 1999; Lassiter & Chang, 2006; Pope-Davis & Ottavi, 1994; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). There is also evidence that racial and ethnic minority participants in research on multicultural counseling competence identify more critical incidents in training (Coleman, 2006) and have more positive attitudes toward racial diversity and multiculturalism (Dickson, Jepsen, & Barbee, 2008) compared to White participants. Overall, these findings suggest White trainees and practitioners are likely to report lower-levels of multicultural counseling competence compared to racial and ethnic minority trainees and practitioners.

In summary, completing multicultural coursework, interacting with racial and ethnic minority clients, belonging to a racial and ethnic minority group, and having positive attitudes toward diversity are all predictive of greater multicultural counseling competence. The conclusion that multicultural counseling competence is honed through coursework is significant, given the mixed evidence on how well training programs integrate multiculturally-focused training into their curricula (e.g., Allison, Crawford, Echemendia, Robinson, & Knepp, 1994; Inman, Meza, Brown, & Hargrove, 2004; Ponterotto, 1997). The various predictors of multicultural counseling competence are

important for investigations in multicultural counseling competence, as these predictors are likely to influence results. For the purpose of the current study, these predictors will be considered potential covariates of multicultural counseling competence.

Multicultural counseling competence and therapeutic processes and outcomes. There is mixed evidence that racial and ethnic minority clients have poorer therapy outcomes compared to Caucasian clients (Bryan, Dersch, Shumway, & Arredondo, 2004). Therapy outcome research has traditionally been the study of how effective therapy is for clients, and therapy process research has examined events occurring within the therapeutic encounter, such as working alliance (the strength of the relationship between the counselor and client) and the interaction of the counselor and client (Heppner, Wampold, Owen, Thompson, & Wang, 2016). Some investigations have concluded that, when racial and ethnic minority clients have poorer outcomes compared to Caucasian clients, it is due to a lack of therapist multicultural counseling competence (e.g., Owen, Leach, Wampold, & Rodolfa, 2011b; Tao et al., 2015). What follows is an introduction to the literature examining the role multicultural counseling competence has on therapy processes and outcomes.

Cultural components in the therapy room, such as the client's racial identity and the degree to which a therapist responds to a client's racial identity, are significant influences on therapy processes and outcomes, particularly working alliance (the strength of the relationship between the counselor and client) and empathy (the counselor's ability to understand thoughts, feelings, and struggles of clients; e.g., Kim & Atkinson, 2002; Kim, Li, & Liang, 2002; Kim, Ng, & Ahn, 2009; Li & Kim, 2004). In addition to these findings, there is evidence that when therapists address racial and cultural differences,

they are rated as more culturally competent by their clients (Li, Kim, & O'Brien, 2007). Furthermore, there is some evidence of a relationship between the degree to which a therapist and client share a racial and ethnic identity and therapy processes and outcomes, as well as attrition rate (e.g., Flaskerud & Liu, 1991; Ibaraki & Hall, 2014), although some studies have found no relationship (e.g., Cabral & Smith, 2011; Presnell, Harris, & Scogin, 2012; Ruglass et al., 2014). Summarized, the racial and ethnic identities of a client and therapist might have some effect on therapy processes and outcomes, although this is not always the case.

Therapist multicultural counseling competence appears to influence client ratings of counselor empathy, trustworthiness, and working alliance (e.g., Fuertes & Brobst, 2002; Fuertes, Stracuzzi, Bennett, Scheinholtz, Mislowack, Hersh, & Cheng, 2006; Sarmiento, 2012; Wang & Kim, 2010), satisfaction with counseling (e.g., Constantine, 2002), and psychological well-being (Dillon, Odera, Fons-Scheyd, Sheu, Ebersole, & Spanierman, 2016). These empirical findings are consistent with research in other disciplines of mental health, such as rehabilitation counseling (e.g., Bellini, 2003; Matrone & Leahy, 2005). Furthermore, Constantine (2000) found that therapists with higher levels of self-reported ratings of empathy exhibited higher levels of multicultural counseling knowledge and awareness. Taken together, there appears to be a correlational relationship between therapist multicultural counseling competence and therapist empathy.

In addition to multicultural counseling competence, parallel multicultural constructs (therapist cultural humility and therapist multicultural orientation) also influence therapy processes and outcomes (e.g., Hook, Davis, Owen, Worthington Jr., &

Utsey, 2013; Owen, Tao, Leach, & Rodolfa, 2011c; Owen, Jordan, Turner, Davis, Hook, & Leach, 2014a). Specifically, client perceptions of therapist cultural humility (an interpersonal stance that is other-oriented rather than self-focused) influences client ratings of working alliance as well as improvement in therapy (Hook et al., 2013). Furthermore, client perceptions of therapist multicultural orientation (how a therapist interacts with a client on an interpersonal level) affect client perceptions of the therapeutic alliance and improvement in psychological functioning (e.g., Owen et al., 2011c; Owen et al., 2014a). These conclusions provide additional evidence of a relationship between the race/ethnicity of both the therapist and client and therapy processes and outcomes.

To summarize, there is evidence to suggest that therapy processes and outcomes can be both positively and negatively influenced by therapist multicultural counseling competence, as well as by cultural humility and cultural orientation, two constructs related to multicultural counseling competence. Although results of quantitative studies suggest the relationship between multicultural counseling competence and therapy processes and outcomes is unclear, this lack of clarity might be explained by findings from Pope-Davis et al.'s (2002) qualitative study on client perceptions of multicultural counseling competence. Pope-Davis et al. (2002) found that clients perceived a varying degree of multicultural counseling competence in therapists, and that perceptions of competence were partially dependent on the needs of the client and the client's presenting concerns, as well as the extent to which clients perceived their therapists were able to meet their needs.

In review, therapist multicultural counseling competence is an ethical imperative. A therapist not practicing culturally competent therapy risks harming the client, in addition to practicing unethically. There are many predictors of therapist multicultural counseling competence, including the racial and ethnic identities of the therapist, a therapist's amount of multicultural training, and the number of clients identifying as a racial and ethnic minority on the therapist's caseload. Therapist multicultural counseling competence can improve or harm therapy processes and outcomes for racial and ethnic minority clients. One construct which has been found to have a positive, correlational relationship with multicultural counseling competence is color-blind racial ideology. What follows is an introduction to theory and empirical research on color-blind racial ideology.

Color-Blind Racial Ideology

The *Multicultural Guidelines* (APA, 2003) are a call for therapists to maintain adequate multicultural skills, knowledge, and awareness. Awareness, in particular, involves a therapist's ability to recognize and be aware of his or her biases, and how these biases might adversely impact his or her racial and ethnic minority clients (Carr, 1997; Gushue & Carter, 2000). Therapists demonstrate poor awareness of their biases or privileges when they fail to acknowledge sociopolitical realities and oppression their racial and ethnic minority clients experience. The extent to which therapists view or do not view color, otherwise known as their color-blind racial attitudes, is an important construct to understand when assessing multicultural counseling competence.

Carr (1997) argues that color-blind racial attitudes in the United States have led to greater institutional oppression in an attempt to minimize overt racism. In its simplest

terms, color-blind racial ideology is the belief that either emphasizes sameness among all individuals, known as *color-evasion color-blind racial attitudes,* or emphasizes that all individuals have the same opportunity for success, known as *power-evasion color-blind racial attitudes* (Carr, 1997; Neville et al., 2000; Neville et al., 2013). Jones (2014) identifies four core beliefs of a color-blind approach to race: (a) skin color is artificial and is not relevant to personal characteristics, ability, or worth, (b) in merit-based societies, skin color is not relevant to judgement and fairness, (c) judgements of merit and fairness are flawed if race is taken into account, and (d) the best way to avoid discriminating by race when interacting with people is to ignore skin color altogether. A color-blind society sees individuals move upwards and downwards based on individual characteristics alone, and not on societal barriers faced by people of color (Jones, 2014).

There are two dimensions of color-blind racial ideology: *color-evasion* and *power-evasion* (Frankenberg, 1993; Neville et al., 2013). *Color-evasion* color-blind racial ideology is characterized as a denial of racial differences by emphasizing sameness; a person may not see "race", per say, and maintain that all individuals are the same (Neville et al., 2013). According to Neville et al. (2013), the color-evasion color-blind individual uses this type of color-blind racial ideology to suppress discomfort they may experience around people of color. *Power-evasion* color-blind racial ideology consists of denying racism exists by emphasizing a belief that all individuals have the same opportunities in society (Neville et al., 2013). This dimension of color-blind racial ideology minimizes blatant racial issues, institutional racism, and White privilege, and seeks to legitimize ideology and public policy which justifies racial status quo (Neville et al., 2013).

It is hypothesized that individuals hold color-blind views when they believe the best way to address inequality is to stop paying attention to race altogether (Babbit, Toosi, & Sommers, 2014). Furthermore, holding a color-blind approach to race allows an individual to be neutral and objective when confronted with accusations of being racist, and absolves them of responsibility for obstructing the rights of other racial groups in that group's pursuit of equality (Jones, 2014); as Gullett and West (2014) say, "Attempting to appear color blind to race is one way to manage the concern of trying to appear unprejudiced" (p. 72). Apfelbaum, Sommers, and Norton (2008) examined the extent to which White participants regulate prejudice in social interactions, finding that White participants adhered to color-blind racial attitudes when concerned with appearing biased. In sum, some people may use color-blind racial attitudes strategically to mask underlying prejudice.

Color-blind racial attitudes might also be used to justify opposition to policies and practices seeking to equalize opportunity for different races, as well for eliminating these policies (Awad, Cokley, & Ravitch, 2005; Babbitt et al., 2014; Mazzocco, Cooper, & Flint, 2011). Oh, Choi, Neville, Anderson, and Landrum-Brown (2010) found that Whites adhering to more color-blind racial attitudes were more likely to view affirmative action policies in higher education as unfair and detrimental to Whites. Babbitt et al. (2014) further state that individuals espousing color-blind racial attitudes might do so to protect their own privileges and preserve the status quo. In summary, people adhere to color-blind racial attitudes in order to protect themselves from appearing prejudice as well as protect their own privileges.

There are many consequences to people who adhere to color-blind racial attitudes. In schools, both students and teachers holding higher color-blind racial attitudes are more likely to attribute racial bullying to ordinary misconduct (Apfelbaum, Pauker, Sommers, & Ambady, 2010). These results are alarming given the conclusion by Babbitt et al. (2014), who, in discussing why people hold color-blind racial attitudes, write that adopting color-blind views in childhood typically leads to avoidance, ignorance, and complicity in race-based disparities in adulthood. Adhering to color-blind racial attitudes also results in less friendly nonverbal behavior among Whites (Apfelbaum et al., 2008). Furthermore, African-Americans adhering to color-blind racial attitudes tend to internalize racist stereotypes of themselves, believe in the existence of inferior and superior social groups, and blame themselves for disparities in economic and social capital (Neville, Coleman, Falconer, & Holmes, 2005). Among therapists, color-blind racial attitudes influence perceptions of client symptom severity and ability to empathize with racial and ethnic minority clients (Gushue, 2004). In sum, individuals who hold high color-blind racial attitudes are more likely to exhibit both overt and implicit bias toward racial and ethnic minority people.

Another consequence of adherence to color-blind racial attitudes is its influence on a person's capacity for empathy. Tettegah (2014) wrote that adhering to color-blind racial attitudes causes individuals to hold empathy towards some racial groups and not others, a phenomenon Tettegah refers to as the *masking phenomenon*. According to Tettegah (2014), individuals adhering to color-blind racial attitudes view empathy as an *equal-opportunity behavior*. This means that a person holding high color-blind racial attitudes often holds equally empathic attitudes toward individuals regardless of race,

which has consequences for therapists. For example, the masking phenomenon means that a racial and ethnic minority client who experiences depression due to an act of oppression will receive the same amount of empathy from a therapist with high levels of color-blind racial attitudes compared to a White client who experiences depression but not because of oppression. This conclusion is important given the previously discussed empirical findings that therapist multicultural counseling competence influences their perceived empathy in therapy. There is a significant relationship between color-blind racial attitudes among therapists and the degree to which they rate themselves as empathic. Specifically, therapists with higher color-blind racial attitudes rate themselves as holding less empathic attitudes toward clients (Burkard and Knox, 2004).

A related construct of color-blind racial attitudes are racial microaggressions. Racial microaggressions are brief, intentional or unintentional behaviors which send denigrating messages to racial and ethnic minority individuals, and color-blindness is a form of microaggression in that it does not acknowledge a person of color's racialized experiences (Neville et al., 2013; Sue et al., 2007). Therapist microaggressions have a negative impact on the working alliance between a therapist and client (e.g., Constantine, 2007; Owen, Tao, Imel, Wampold, & Rodolfa, 2014b; Owen, Tao, & Rodolfa, 2010) as well as how effective therapy is at resolving client presenting concerns (Owen, Imel, Tao, Wampold, Smith, & Rodolfa, 2011a). To conclude, color-blind microaggressions represent a related construct of color-blind racial ideology, and are harmful to therapy processes.

In summary, people holding color-blind racial attitudes believe that a person's race does not matter in terms of that person's ability to move upwards in society, instead

attributing this inability to move upward to an individual's characteristics alone. Most individuals hold color-blind racial attitudes when they are confronted with accusations of being prejudiced, and believe the best way to address inequality is to stop paying attention to race altogether. People holding high color-blind racial attitudes are likely to exhibit both overt and covert bias toward people of different racial and ethnic identities. There are also implications for attributing empathy towards racial and ethnic minority individuals, an important consideration given the previously reviewed literature on empathy and multicultural counseling competence. What follows is an introduction to the construct of empathy and how empathy is expressed therapeutically.

Empathy

Although there is no consensual, agreed upon definition of empathy, Batson (2009) identified eight psychological states describing the experience of empathy: (1) knowing a person's internal state, including thoughts and feelings, (2) posturing or matching the behavior of another person, (3) feeling as another person feels, (4) projecting oneself into another's situation, (5) imagining how another person is feeling or thinking, (6) imagining how one would feel in another person's situation, (7) being distressed when witnessing another person's suffering, and (8) feeling for another person when they are suffering. Neuroscience research identifies empathy as being an emotional stimulation consistent with another person's emotions, the ability to perspective take, and the ability to regulate one's emotional experience in order to offer compassion to another distressed person (Decety & Lamm, 2009; Eisenberg & Eggum, 2009; Shamay-Tsoory, 2009). Additionally, empathy can be expressed *affectively* (the ability to match the

emotions of another person with the same emotions) and *cognitively* (the ability to assume another person's perspective; Davis, 1983).

In psychotherapy, the most concise definition of empathy comes from Carl Rogers, who defined empathy as therapists sensitive ability and willingness to understand the thoughts, feelings, and struggles of their clients from the client's point of view (1980). Empathy, in this sense, requires the therapist to be sensitive to the changing felt meanings experienced by the client, and sensing meanings to which the client is minimally aware of (Rogers, 1980). Empathy is expressed therapeutically in three different ways: *empathic rapport*, *communicative attunement*, or *person empathy* (Elliot, Bohart, Watson, & Greenberg, 2011; Elliot, Watson, Goldman, & Greenberg, 2003). *Empathic rapport* is expressed when a therapist exhibits compassion toward his or her client and demonstrates an effort to understand his or her client's experiences (Elliot et al., 2011). *Communicative attunement* is a therapist's effort to be attuned to the client's communications and unfolding experiences (Elliot et al., 2011). Finally, *person empathy* is the sustained effort on behalf of a therapist to understand a client's present and historical experiences which form the background of a client's current experiencing (Elliot et al., 2003; Elliot et al., 2011).

Psychotherapy researchers have typically situated empathy as being a general ability of therapists to be sensitive to moment-to-moment experiences in therapy, often occurring as a multistage interpersonal process (e.g., Buie, 1981; Duan & Hill, 1996). Psychotherapy empathy is measured in four ways: empathy rated by nonparticipant raters (*expressed empathy*), client-rated empathy (*received empathy*), therapists' rating of their own empathy (*empathic resonance*), and the congruence between therapist and client

empathic perceptions of the client (known as *empathic accuracy*; Elliot et al., 2003). Empathy training can help individuals learn better empathy skills and overall helping skills (Hill et al., 2008; van Berkhout & Malouff, 2016).

Client ratings of therapist empathy typically are the strongest predictor of therapy outcomes, with many empirical studies and meta-analyses finding that client-rated empathy and observer-rated empathy were better than therapist-rated empathy at predicting successful therapy outcomes (e.g., Burns & Nolen-Hoeksema, 1992; Elkin et al., 2014; Elliot et al., 2011; Mlotek, 2013;). Initial research on therapist-rated empathy is mixed, with some empirical studies concluding that therapist-rated empathy did not predict successful client outcomes (e.g., Barrett-Lennard, 1981; Gurman, 1977; Lesser, 1961;) and some studies concluding that therapist-rated empathy did predict client outcomes (e.g., Cartwright & Lerner, 1963). However, Bohart, Elliot, Greenberg, & Watson (2002), in a meta-analysis examining therapist-rated, client-rated, and observer-rated empathy, found evidence that therapist-ratings of empathy did correlate with client outcomes. Specifically, Bohart et al. concluded that the more empathic therapists rated themselves, the better client outcomes they reported.

In terms of multiculturalism and diversity, there is evidence that therapists are capable of empathizing with clients who have different life experiences than their own (Hatcher et al., 2005). This is an important finding considering that multicultural counseling competence is predicated on perceived cultural differences between a therapist and client. Furthermore, holding attitudes toward race and ethnicity which are more accepting of similarities and differences of others has been found to positively

correlate with higher levels of empathy (Miville, Carlozzi, Gushue, Schara, & Ueda, 2006).

Spanierman and Heppner (2004), in seeking to conceptualize a tripartite model of the cognitive, affective, and behavioral costs of racisms to Whites, identified White Empathic Reactions as one of three factors in the Psychosocial Costs of Racism to Whites Scale (PCRW). The White Empathic Reactions Toward Racism factor of the PCRW assesses emotions such as anger or sadness in response to racism; higher scores indicate higher levels of anger or sadness in response to racism (Spanierman & Heppner, 2004). White empathy toward racism is predictive of lower color-blind racial attitudes and higher openness and appreciation for diversity (Spanierman & Heppner, 2004; Spanierman, Todd, & Anderson, 2009). Furthermore, higher scores of White empathy are predictive of self-reported multicultural knowledge and supervisor ratings of multicultural counseling competence (Spanierman, Poteat, Wang, & Oh, 2008). The dimension of empathy found in the psychosocial costs of racism to Whites appears to be consistent with therapist-rated empathy; in fact, the Spanierman et al. (2008) article uses a sample of therapists, who, although not directly rating how empathic they view themselves, do complete a measure producing a factor pertaining to perceived empathy.

In sum, empathy appears sensitive to cultural differences between a therapist and a client. Holding a positive, accepting attitude toward cultural differences can help therapists be more empathic toward clients with cultural identities differing from their own. Although this is an important consideration for multiculturally competent therapy, further investigation into the relationship between multicultural counseling competence and empathy is needed.

Relationship Between Constructs of Interest

Thus far, the constructs of multicultural counseling competence, color-blind racial ideology, and empathy have been introduced. Empirical research has found relationships between these three constructs. The following section outlines the relationships between multicultural counseling competence, color-blind racial ideology, and empathy, and identifies a gap in the research in need of examination.

Relationship between color-blind racial ideology and multicultural counseling competence. Many empirical studies have examined the differences between endorsing color-blind racial attitudes versus multicultural attitudes, as well as the effects these attitudes have on interactions with others. In this sense, multicultural attitudes refer to one's appreciation of group differences, and not the Attitude dimension of multicultural counseling competence. However, both constructs are rooted in the theory that one's awareness of diversity and multiculturalism is important. Overall, multicultural attitudes are endorsed by racial and ethnic minority individuals more frequently compared to White individuals (Ryan, Hunt, Weible, Peterson, & Casas, 2007). Furthermore, Correll, Park, and Smith (2008) concluded that color-blind attitudes resulted in greater prejudice compared to multicultural attitudes among White individuals. Richeson and Nussbaum (2004) compared color-blind attitudes to multicultural attitudes among White college students, finding that greater color-blind attitudes were associated with greater racial attitude biases. Furthermore, White individuals holding attitudes toward race and ethnicity which are more favorable toward multiculturalism than color-blindness are more likely to socially engage with racial and ethnic minority individuals (Plaut, Thomas, & Goren, 2009). In sum, people holding

lower levels of color-blind attitudes are more likely to hold more multiculturally-accepting attitudes.

There is evidence that multicultural training among psychology trainees affects student color-blind racial attitudes, and that color-blind attitudes are related to dimensions of multicultural counseling competence (Johnson & Williams, 2015). Chao et al. (2011) found that students holding lower color-blind racial attitudes were more likely to report higher multicultural awareness, regardless of level of training and student race/ethnicity, while Chao (2013) found that limited multicultural training and high levels of color-blind racial attitudes predicted low scores of multicultural counseling competence. Furthermore, higher color-blind attitudes are predictive of lower self-reported multicultural awareness, knowledge, and case-conceptualization ability (Neville, Spanierman, & Doan, 2006; Penn & Post, 2012). These conclusions are significant because they show how sensitive therapist multicultural counseling competence is to broader constructs not just related to mental health professionals. Greater color-blind racial attitudes might begin to take shape in a person's perceptions of race and diversity before any multicultural counseling training is implemented. Identifying and being aware of color-blind racial attitudes is an important component to developing greater multicultural counseling competence. In summary, there appears to be a relationship between the color-blind racial attitudes held by mental health practitioners and practitioners in training and their reported multicultural counseling competence. What is unknown is the extent to which color-blind racial attitudes held by mental health practitioners and practitioners in training influence or act as a mediator of the relationship between practitioner multicultural counseling competence and empathy. Research in this

area is important, given that increasing awareness of color-blind racial attitudes among therapists and trainees can have a positive effect on multicultural counseling competence and, subsequently, capacity for empathy.

Statement of the Problem

Research has determined a positive correlation between therapist multicultural counseling competence and color-blind racial attitudes. Specifically, therapists reporting higher degrees of color-blind racial attitudes also report lower levels of self-reported multicultural counseling competence. Research on multicultural counseling competence and the therapy process of empathy has determined that lower therapist-rated multicultural counseling competence is associated with lower levels of therapist-reported empathy. Furthermore, research on therapist color-blind racial attitudes and the therapy process of empathy has concluded that therapists holding higher color-blind racial attitudes are more likely to rate themselves as being less empathic compared to therapists holding lower degrees of color-blind racial attitudes. To date, there has been no research on the extent to which color-blind racial attitudes held by therapists mediate the relationship between therapist self-reported multicultural counseling competence and reported empathy. In addition to the primary research question, the review of literature on empathy concluded that empathy, assessed with the context of multicultural counseling, has been assessed as global empathy; there is no such theoretical or empirical research which has examined whether empathy is different when expressed globally as opposed towards a client with a racial and ethnic minority identity. Specifically, empathy has never been measured in the context of a therapist's capacity for empathy toward a racial and ethnic minority client.

Significance of the Problem

Therapist multicultural counseling competence is an ethical imperative for clinicians. The study of multicultural counseling competence is important because without it, racial and ethnic minority clients risk being mistreated by mental health practitioners, which might result in harmful or ineffective therapy, as well as premature termination of therapy. The potential for providing harmful, ineffective therapy as a result of culturally incompetent practice is certainly an important consideration, given the evidence that racial and ethnic minority clients are less likely to initiate counseling compared to White clients and are more likely to prematurely terminate therapy compared to White clients. Additionally, empathy research has not utilized methods of assessing whether empathy exists in the context of a therapist's capacity to empathize with a racial and ethnic minority client. Specifically, there has not been research into whether therapeutic global empathy differs from empathy measured in the context of being shown toward a racial and ethnic minority client.

Purpose of the Study

The purpose of the study is to test for mediation effects of therapist color-blind racial attitudes on the relationship between therapist-rated multicultural counseling competence and therapist ratings of empathy. A secondary aim of the study will be to collect preliminary data into whether therapeutic empathy expressed globally differs from empathy expressed towards a racial and ethnic minority-identified client.

Significance of the Study

This study will fill a gap in the literature, in that it will test mediation effects of color-blind racial attitudes on the relationship between therapist multicultural counseling

competence and therapist ratings of empathy. Results of this study will provide guidance for therapists, educators, and supervisors in terms of addressing and raising awareness to issues of biases rooted in color-blindness, with the goal of honing and improving multicultural counseling competence. Additionally, the study will provide preliminary insight into whether empathy assessed in a specific context of therapeutic empathy toward racial and ethnic minority clients differs from empathy assessed globally.

CHAPER 2

REVIEW OF RELEVANT LITERATURE

The purpose of this chapter is to provide a review of empirical literature related to multicultural counseling competence, color-blind racial ideology, and therapy processes and outcomes. First, research on multicultural counseling competence will be reviewed, including measurement of multicultural counseling competence, multicultural counseling competence and therapy process and outcome research, and related multicultural counseling constructs and therapy processes and outcome research. Second, research on color-blind racial ideology will be reviewed, including measurement of color-blind racial attitudes and color-blind racial attitudes and therapy outcome and process research. Third, research on therapist-rated empathy will be reviewed. Fourth, research on the relationships between these three constructs will be reviewed. Specifically, the review will demonstrate a relationship between lower levels of multicultural counseling competence and higher levels of color-blind racial attitudes, and that lower levels of multicultural counseling competence and higher levels of color-blind racial attitudes independently predict lower scores of therapist-rated empathy. A gap in the literature will be identified, and a proposed empirical study will be presented.

Multicultural Counseling Competence

Therapist multicultural counseling competence is a therapist's capability to effectively work with cultural groups differing from a therapist's own cultural group (Sue, 1998; Sue et al., 2009). Theory and research on multicultural counseling competence conceptualizes competence across three dimensions: attitudes/beliefs, knowledge, and skills (APA, 2003; Smith et al., 2016; Sue et al., 1982; Sue et al., 1992). Multicultural counseling competence is an ethical imperative; therapists not practicing competently risk providing ineffective and harmful therapy (Arredondo & Toporek, 2004; Fisher, 2014; Sue et al., 1992). The study of therapist multicultural counseling competence is important, as racial and ethnic minority clients are less likely than White clients to initiate treatment (e.g., Akincigil et al., 2012) and are more likely to terminate therapy prematurely (e.g., Owen et al., 2012). What follows is a review of general literature on multicultural counseling competence, followed by the role of multicultural counseling competence on therapy processes and outcomes. First, a review of instrumentation is warranted to better inform a comprehensive analysis of literature on multicultural counseling competence.

Measurement of multicultural counseling competence. Multicultural counseling competence instruments assess competence by giving an overall score of competence based on questions rating skills, awareness, and knowledge, consistent with the tripartite framework of multicultural counseling competence introduced by Sue et al. (1982). Many reviews and analyses of multicultural counseling competence instrumentation (e.g., Constantine, Gloria, & Ladany, 2002; Dunn, Smith, & Montoya, 2006; Kitaoka, 2005; Ponterotto, Rieger, Barrett, & Sparks, 1994) have identified four

major instruments used in research on multicultural counseling competence: the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002), the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised (MAKSS-CE-R; Kim, Cartwright, Asay, & D'Andrea, 2003), the Cross-Cultural Counseling Inventory – Revised (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991), and the Multicultural Counseling Inventory (MCI; Sodowsky et al., 1994). Three of these instruments, the MCKAS, MCI, and MAKSS-CE-R, are self-report instruments of multicultural counseling competence, where respondents rate their multicultural counseling competence. The CCCI-R assesses therapist multicultural counseling competence using a third-party rating of multicultural counseling competence, allowing for supervisors or clients to rate therapists on their multicultural counseling competence.

Although three of the four previously mentioned instruments are self-report assessments of multicultural counseling competence, they differ in how they assess respondent perceptions of their multicultural counseling competence. The MCI assesses multicultural counseling competence by providing a global score of overall multicultural counseling competence and scores on four subscales: Multicultural Skills, Multicultural Awareness, Multicultural Knowledge, and Multicultural Relationship (Sodowsky et al., 1994). The MCKAS is an instrument assessing multicultural knowledge and awareness, and is a revision of the Multicultural Counseling Awareness Scale (MCAS; Ponterotto, Rieger, Barrett, Harris, & Sparks, 1996). The original MCAS assessed multicultural counseling competence across two subscales, the Knowledge/Skills subscales and the Awareness subscale; Ponterotto et al. (1996) acknowledge their confirmatory factor

analysis conflicts with the tripartite model of multicultural counseling competence presented by Sue et al. (1982) and Sue et al. (1992). In their 2002 revision, Ponterotto et al. found a proposed one- and two-factor confirmatory factor analysis to be poor fits, and, after creating item parcels for each factor, found two factors (Knowledge and Awareness).

The MAKSS-CE-R assesses multicultural counseling competence by providing a global score of multicultural counseling competence as well as scores on three subscales: Multicultural Awareness, Multicultural Knowledge, and Multicultural Skills (Kim et al., 2003). The MAKSS-CE-R is a revision of the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition (MAKSS-CE; D'Andrea, Daniels, & Heck, 1991). Critiques of the original MAKSS-CE concluded that the original instrument was in need of further confirmatory factor analyses and assessments of criterion validity (e.g., Ponterotto et al., 1994; Ponterotto & Alexander, 1996; Pope-Davis & Dings, 1995). In response to the criticism, Kim et al. designed a revision using exploratory and confirmatory factor analysis to support a three factor structure.

In sum, the MAKSS-CE-R, MCI, and MCKAS are self-report measure giving a global score of multicultural counseling competence in addition to scale scores on multicultural awareness, knowledge, skills, and relationships. The CCCI-R (LaFramboise et al., 1991) is the only observer-rated assessment of multicultural counseling competence. Although the present investigation is not utilizing third-party ratings of multicultural counseling competence, a brief review of the CCCI-R is warranted. The CCCI-R has been used by third-party raters or clients to rate observed multicultural counseling competence in therapists or trainees. Although the CCCI-R does

provide a measure of competence which differs from self-report instruments, it is not without limitations. Worthington, Mobley, Franks, and Tan (2000) concluded that observer-ratings of multicultural counseling competence may not be preferable to self-report measures, in that observer-ratings of competence are sensitive to the verbal content of sessions. Specifically, clinicians who simply discuss multicultural issues were rated as being more competent than clinicians who did not; however, such discussion does not necessarily mean that a clinician is practicing competently (Worthington et al.).

In conclusion, the three self-report multicultural counseling competence instruments exhibit moderate to strong psychometric properties and factor structures. However, all three have different subscales and measure multicultural counseling competence differently. The MCI included a fourth subscale, the Relationship subscale, while the MCKAS lacks a Skills subscale, both of which are inconsistent with the tripartite framework of multicultural counseling competence conceptualized by Sue et al. (1982) and Sue et al. (1992). Of the three self-report instruments of multicultural counseling competence, only the MAKSS-CE-R offers a factor structure consistent with the tripartite model of multicultural counseling competence, giving scores of overall competence in addition to scores on multicultural knowledge, awareness, and skills. The factor structure, psychometric properties, and consistency with the tripartite model of multicultural counseling competence make the MAKSS-CE-R the best choice for the present investigation.

An important construct which is often assessed in studying multicultural counseling competence is multicultural social desirability, which is the tendency for an individual to state they socially and personally always have positive interactions with

minorities and favor policies expanding diversity. There is some empirical evidence from studies which have exclusively assessed the relationship between self-reported competence and social desirability, finding significant relationships between social desirability scores and overall multicultural counseling competence scores (e.g., Constantine & Ladany, 2000; Sodowsky et al., 1998). Furthermore, Constantine and Ladany (2000) found that higher social desirability scores were significantly related to higher multicultural knowledge and lower multicultural awareness, as measured by the CCCI-R, the original MAKSS, the MCI, and the MCKAS. Recently, however, Tracey (2016), in reviewing the landscape of empirical research on socially desirable responding, concluded that the low-stakes nature of counseling psychology research on multicultural counseling competence is more attributable to impression management, or the act of presenting oneself in a manner tailored to an audience. Thus, some of the conclusions reached in research on social desirability and multicultural counseling competence may be better explained by impression management, which is the act of trying to impress someone, and a type of social desirability. This is a significant finding for the present study, as social desirability attitudes will not be a variable studied, given the recently raised uncertainty regarding the role this construct has in counseling psychology research.

One of the most widely used measures of impression management is the Balanced Inventory of Desirable Responding (BIDR; Paulhus, 1990). The BIDR is comprised of two subscales: the Self-Deception subscale and the Impression Management subscale (IM subscale). The Impression Management subscale of the BIDR assesses a respondent's tendency to over-report their performance of desirable behaviors and underreport their performance of undesirable behaviors (Paulhus, 1990). The Impression Management

subscale of the BIDR has been found to be a strong measure of attempts to present oneself towards others (e.g., Li & Bagger, 2007; Miller & Ruggs, 2014). Because the IM subscale of the BIDR has been found to adequately assess impression management, it was chosen to be a covariate in the present study.

Perceived versus demonstrated multicultural counseling competence. The study of multicultural counseling competence is important. As mentioned previously, many empirical studies have concluded that practitioners consistently over-estimate their self-ratings of multicultural counseling competence. Hansen et al. (2006) reviewed multicultural counseling competence literature and identified 52 specific multicultural counseling competencies, which was developed into a questionnaire. The authors do not provide specific information about how these final 52 competencies were identified, only citing comprehensive conversations between authors and consultation with two identified experts in the field of multicultural counseling. Example competencies from the questionnaire include, "Show respect for a client's worldview", "use racially/ethnically sensitive data-gathering techniques", and "regularly evaluate one's own multicultural competence". In the questionnaire, the authors had respondents rate how frequently they practiced a competency and how important they identified a competency to be. The final sample in Hansen et al.'s study was comprised of 149 practicing psychologists, of whom 92.7% identified as White, 2% identified as Hispanic, 1.3% identified as Asian, 1.3% identified as African American, and 2.7% identified as multiracial/biracial. Participants also rated their multicultural counseling competence on a Likert-type scale of 1 (*not at all competent*) to 5 (*extremely competent*).

The authors first identified 7 of the competencies as being considered "universally practiced" by concluding that 80% of the sample had rated these competencies as a 4 or 5 on the Likert-type scale. The competencies considered to be universally practiced involved respecting a client's worldview, being aware of bias, establishing rapport in culturally sensitive ways, and considering a client's race and ethnicity when diagnosing. However, Hansen et al. (2006) also found a similar competence, making a culture-specific diagnosis, to be never or rarely used by over 50% of the sample. Hansen et al. also ran a test of significance between ratings of a competence's importance and how frequently the competence was practiced; ratings of how frequently a competence was practiced were significantly lower than ratings of a competence's importance.

The findings by Hansen et al. (2006) illustrate that practitioners are capable of identifying therapy practices consistent with competent multicultural counseling practice, but do not always engage in these practices. Building off these results, Cartwright et al. (2008) assessed multicultural counseling competence by having 31 participants complete the MAKSS-CE-R and having two raters view a video of participants in a role-play counseling session, rating competence using the Multicultural Counseling Assessment Survey Form (MCAS), an observer-rating instrument of multicultural counseling competence. Participants in the Cartwright et al. study were enrolled in a counseling graduate program; 22 identified as Asian/Pacific Islander, 6 identified as White, 1 identified as Latino/Latina, and 2 did not provide their racial identity. Using *t*-test analysis, Cartwright et al. found that observer ratings of multicultural counseling competence were significantly lower than self-ratings of multicultural counseling competence (Awareness, $t = -6.09$; Knowledge, $t = -7.92$; Skills, $t = -2.64$). In sum, the

Cartwright et al. study builds on the previous study by Hansen et al. (2006) by further demonstrating a gap between perceptions of competence and third-party rated competence.

Further building on this literature is Sehgal et al. (2011), who assessed demonstrated versus self-rated multicultural counseling competence. The authors developed a measure of demonstrated multicultural counseling competence, which assessed multicultural counseling competence two ways: a participant's ability to identify appropriate interventions (categorized as demonstrated multicultural counseling competence – Should) and a participant's willingness to use an intervention with a racial and ethnic minority client (categorized as demonstrated multicultural counseling competence – Would). Sehgal et al. administered the measure of demonstrated multicultural counseling competence – Should and demonstrated multicultural counseling competence – Would to a sample of 102 graduate students in APA-accredited psychology graduate programs and 53 psychologists. Of the 102 graduate students, 69 identified as White, 14 identified as Asian American, 7 identified as Latino/Latina, 3 identified as African American, 3 identified as biracial, 2 identified as Native American, and 2 identified as Arab American. Among the 53 psychologists, 30 identified as White, 9 identified as Latino/a, 6 identified as African American, 4 identified as Asian American, 2 identified as Native American, and 2 identified as Arab American.

Sehgal et al. (2011) found Cronbach's alpha for their measure of multicultural counseling competence to be .83. Participants read four clinical vignettes featuring racial and ethnic minority clients and asked to rate how appropriate or inappropriate an intervention would be (which represented the Should subscale of the measure), and then

rate how likely they were to perform the intervention (which represented the Would subscale of the measure). Using a repeated measures ANOVA, the authors found mean scores on the Should subscale of the measure to be significantly higher compared to mean scores of the Would subscale of the measure among all participants. While the difference between Would and Should subscales were significant for both practitioners and students, the difference was smaller for practitioners; this finding is likely a product of the greater amount of multicultural training practitioners are likely to report.

In sum, there is substantial empirical evidence that both mental health professionals and graduate students in mental health programs are likely to report higher levels of multicultural counseling competence compared to the level of competence they are likely exhibiting. This might complicate the study of multicultural counseling competence, as many empirical studies often rely on self-report ratings of multicultural counseling competence. Regardless, these findings certainly point to further assessment and a better understanding of multicultural counseling competence. What follows is a review of literature examining the personal and professional characteristics associated with multicultural counseling competence among mental health professionals and graduate students.

Personal and professional characteristics associated with multicultural counseling competence. Attitudes toward diversity and other personality characteristics appear to be related to a clinician's multicultural counseling competence. Tummala-Narra et al. (2012) examined individual and systemic factors associated with perceptions of multicultural counseling competence. Using a sample of 196 licensed mental health clinicians, Tummala-Narra et al. gathered demographic data and information about access

to multicultural resources at a clinician's agency or place of employment. Additionally, the authors administered a measure of attitudes toward diversity. Tummala-Narra et al. assessed multicultural counseling competence by administering the California Brief Multicultural Competence Scale, and developed a measure of self-perceived frequency of implementation of multicultural practices in psychotherapy.

Tummala-Narra et al. (2012) utilized regression models to assess the extent to which attitudes toward diversity and access to resources predicted self-perceived multicultural counseling competence and implementation of practice. Results indicated that more accepting attitudes toward diversity were positively associated with greater self-perceived multicultural competence and with more frequent implementation of multicultural practices. Furthermore, greater access to multicultural resources and satisfaction with multicultural workshops were also associated with greater self-reported competence and implementation. In sum, being more accepting of and open to diversity, being more satisfied with multicultural training, and having access to resources are all predictive of greater self-perceived multicultural counseling competence and better implementation of multicultural practices in therapy.

Reynolds and Rivera (2012), building on the literature examining characteristics of therapists practicing competently, examined attitudes and psychological factors that influence self-reported multicultural counseling competence. The authors examined two measures assessing personality characteristics, a measure of self-esteem, a measure assessing attitudes toward racial minority groups, and the MCKAS for a sample of 129 graduate students enrolled in master's level counseling programs.

Using two separate hierarchical regressions, with multicultural knowledge and multicultural awareness as the outcome variables, Reynolds and Rivera (2012) found that higher levels of self-esteem, openness to change, and comfort with ambiguity were not significant predictors of awareness or knowledge; however, attitudes toward diversity and equality was a significant predictor of both multicultural knowledge and awareness. This finding is consistent with previously discussed literature, in that being more open to and accepting of diversity is positively associated with greater self-perceived multicultural counseling competence.

In sum, the conclusions that practitioners tend to view themselves as being more competent than what is observed is also significant, given the fact that much of the multicultural counseling research has relied on self-report measures of multicultural counseling competence. The research on personality characteristics illustrate that practicing multicultural competent therapy requires a person to be open and accepting of cultural similarities and differences of others. This parallels broader theoretical literature on multicultural counseling competence; specifically, that greater awareness of personal biases is important to honing one's multicultural counseling competence. The extent to which a person holds color-blind racial attitudes is also relevant to awareness. What follows is a review of literature on color-blind racial ideology.

Color-Blind Racial Ideology

Color-blind racial ideology is the belief that race should not and does not matter, and that individuals move upward or downward in society based on individual characteristics alone (Neville et al., 2000; Jones, 2014). Many people hold color-blind racial attitudes in an attempt to be neutral or objective when confronted with accusations

of racism or because they simply believe that not "seeing color" is the best way to address inequality (Babbitt et al., 2014; Jones, 2014). There are two dimensions of color-blind racial attitudes: *color-evasion*, which is a denial of racial differences by emphasizing sameness, and *power-evasion*, which is a denial of racism altogether and a belief that all individuals have the same opportunities for upward mobility in society (Frankenberg, 1993; Neville et al., 2013). What follows is a review of literature examining the broader construct of color-blind racial ideology and the relationship between therapist color-blind racial attitudes and therapy processes and outcomes. First, a brief review of instrumentation assessing color-blind racial attitudes is warranted.

Measurement of color-blind racial ideology. Awad and Jackson (2014), in their review of the measurement of color-blind racial attitudes, discuss how the measurement of racial attitudes has shifted as society has shifted in how racial attitudes are expressed. In contemporary society, overt and explicit expressions of negative attitudes about race have become less acceptable, which necessitates a shift in the measurement of racial attitudes (Awad & Jackson). As a result of this shift, measurement of color-blind racial attitudes has become different from measuring other forms of prejudice and racism.

There are many instruments available to assess color-blind racial attitudes. A widely used measure of color-blind racial attitudes is the Color-Blind Racial Attitudes Scale (CoBRAS; Neville et al., 2000). The CoBRAS is a self-report instrument which assesses color-blind racial attitudes across three subscales: *Racial Privilege* (the extent to which a person denies the existence of White privilege), *Institutional Discrimination* (the extent to which a person is aware of institutional discrimination), and *Blatant Racial Issues* (the extent to which a person is unaware of prevalent racial discrimination; Neville

et al., 2000). Despite the three-factor structure of the CoBRAS, Neville et al. (2000) concluded that the CoBRAS was not an adequate measure of color-evasion color-blind racial ideology. Although the CoBRAS is an adequate measure of power-evasion color-blind racial attitudes, many empirical studies have used the CoBRAS as a measure of overall color-blindness. The rationale for the use of the CoBRAS is not addressed in any of the literature reviewed in this present investigation, nor is there any mention of the CoBRAS being an adequate measure of power-evasion color-blindness as a limitation. Despite this, Awad and Jackson (2014), in their review of color-blind racial attitude instrumentation, identify the Color-Blindness Subscale of the Intergroup Ideologies Measure (Rosenthal & Levy, 2012), a measure of Polyculturalism, as an adequate measure of color-evasion color-blind racial attitudes.

In sum, the two dimensions of color-blind racial attitudes, color-evasion and power-evasion, present a challenge in the measurement of color-blind racial attitudes. To date, no measure is available which adequately measures both color-evasion and power-evasion color-blind racial attitudes. Furthermore, the rationale for empirical studies to use the CoBRAS to assess global color-blindness is unclear. Consistent with previous research, the present investigation will utilize the CoBRAS as a measure of power-evasion color-blind racial attitudes. Furthermore, based on the review by Awad and Jackson (2014), the Color-Blindness subscale of the Intergroup Ideologies Measure will be used as a measure of color-evasion color-blind racial attitudes. What follows is a review of literature assessing the consequences of holding higher levels of color-blind racial attitudes.

Consequences of holding color-blind racial attitudes. As mentioned previously, there are many consequences to holding higher levels of color-blind racial attitudes. Neville et al. (2006) assessed the extent to which color-blind racial attitudes held by African Americans predicted psychological false consciousness (held beliefs by marginalized people which are contrary to their personal or social interest and contributes to the maintenance of their disadvantaged position in a group). Specifically, Neville et al. were interested in assessing the extent to which color-blind attitudes among participants predicted social dominance orientation (the degree to which people justify their social roles), victim blame beliefs about social inequities (the degree to which people attribute blame for inequity), and lower racial identity (the degree to which people internalize oppression).

Neville et al. (2006) administered the CoBRAS and individual measures of social dominance orientation, victim blame beliefs, and lower racial identity to a sample of 211 African American adults. Neville et al. found significant, positive correlations between the CoBRAS and three measure of psychological false consciousness using bivariate correlations. Specifically, scores on the CoBRAS was positively correlated with scores of internalized oppression (r = .20), victim blame beliefs (r = .31), and social dominance orientation (r = .40). In sum, these findings suggest that African Americans adopting greater color-blind racial attitudes are more likely to internalize racist attitudes about African Americans, attribute social injustices to the victims of these injustices, and adopt anti-egalitarian beliefs to justify inequality. The findings by Neville et al. are important to understanding that color-blind racial attitudes are not specific to White individuals; people of all racial and ethnic identities can hold them.

Another important consequence of holding greater color-blind racial attitudes is specific to the mental health field. Gushue (2007) examined the extent to which White psychology trainees' color-blind racial attitudes influenced their perceptions of symptom severity for White and African American clients. Gushue administered the CoBRAS, a measure of symptom severity, and a fictitious intake report to a sample of 158 graduate students in clinical and counseling psychology graduate programs across seven universities. Half of the sample received a fictitious intake report with an African American client and half received a report with a White client.

Using hierarchical regression, Gushue (2007) found the client's race in the intake report accounted for significant variance of symptom perceptions; specifically, the White client was rated as being more symptomatic compared to the African American client. Furthermore, participant color-blind racial attitudes accounted for a significant portion of remaining variance after accounting for client race; specifically, participants with higher color-blind racial attitudes attributed higher ratings of symptom severity to clients. Finally, an interaction effect indicated that color-blind racial attitudes were positively related to symptom ratings for the African American client, and not the White client.

In sum, the findings by Gushue (2007) indicate that color-blind racial attitudes influence perceptions of client symptom severity for African American clients. These findings are certainly alarming given the previously reviewed literature on the experiences of racial and ethnic minority clients in therapy; specifically, that racial and ethnic minority clients are less likely to initiate treatment and are more likely to terminate prematurely. In conclusion, greater clinician color-blind racial attitudes are likely to influence many aspects of a client's experience in therapy. Therefore, further exploration

of this construct is warranted. What follows is a review of the construct of empathy, which is a therapy process that may be influenced by color-blind racial attitudes.

Empathy

Empathy is the ability to take the perspective of another person, identifying with the emotions another person is experiencing, and understanding another person's point of view (Batson, 2009; Rogers, 1980). In psychotherapy, empathy is the ability and willingness of a therapist to understand the thoughts, feelings, and struggles of their clients (Rogers, 1980). People express empathy in two ways: they might match the emotions of another person with emotions of their own (known as *affective empathy*), or they might try and assume another person's perspective (known as *cognitive empathy*; Davis, 1983). In psychotherapy, empathy can be expressed three different ways: *empathic rapport*, *communicative attunement*, or *person empathy* (Elliot et al., 2011; Elliot et al., 2003). Many psychotherapy researchers conceptualize empathy as being an ability sensitive to moment-to-moment therapy process (e.g., Buie, 1981; Duan & Hill, 1996).

There has been an extensive amount of research on the role of therapist empathy in predicting therapy outcomes and processes. Bohart et al. (2002) conducted a meta-analysis looking to assess general associations between therapist empathy and therapy outcomes. Specific questions in the meta-analysis sought to assess the degree to which different forms of therapy moderate the relationship between therapy outcomes and therapist empathy, the degree to which different types of empathy moderate the relationship between therapy outcomes and empathy, and how different sample and study characteristics, such as sample size or type of treatment modality, moderate the

relationship between therapist empathy and therapy outcomes (Bohart et al.). Bohart et al. gathered empirical studies which assessed client-rated, observer-rated, and therapist-rated empathy; however, the authors do not specify the number of studies reviewed which examined therapist-rated empathy.

Forty-seven total studies were reviewed in the meta-analysis by Bohart et al. (2002). The authors found that therapist-rated empathy had a significant mean *r* of 0.18, although this was lower than observer-rated empathy (significant mean *r* of 0.23) and client-rated empathy (significant mean *r* of 0.25). The conclusions from Bohart et al. suggest that therapist-rated empathy is an adequate measure of empathy in therapy outcome research, although this measure of empathy is not as strong as measuring empathy using client-rated empathy or observer-rated empathy measures. Furthermore, Bohart et al. concluded that therapist-rated empathy is a significant predictor of better therapy outcomes; specifically, the higher therapists rate themselves in terms of being empathic, the better outcomes are reported for their clients.

Relationship Between Multicultural Counseling Competence and Color-Blind Racial Attitudes.

There is a statistical relationship between scores on measures of multicultural counseling competence and scores on measures of color-blind racial attitudes. Neville et al. (2006) examined the relationship between therapist color-blind attitudes and self-reported multicultural counseling competencies in a sample of 79 therapists and 51 counseling graduate students. Of the 79 therapists, 60 identified as White, 10 identified as African American, 2 identified as Asian American, 2 identified as Latino/a, 1 identified as Native American, and 3 gave no response. Among the 51 counseling

graduate students, 20 identified as White, 20 identified as African American, 5 identified as Asian American, 1 identified as Latino/a, 2 identified as Native American, and 3 identified as unknown. The CoBRAS was used to assess participant color-blind racial attitudes, and an open-ended inquiry was provided for participants to qualitatively define color-blindness. Multicultural counseling competence was assessed using the MCKAS and a multicultural case conceptualization task. Results indicated that participants collectively espousing higher color-blind attitudes reported lower multicultural awareness and knowledge, as well as overall scores on multicultural counseling competence. Multicultural awareness and knowledge had a significant negative correlation with scores on the CoBRAS; specifically, the higher CoBRAS scores a participant had, the lower scores on MCKAS Awareness and Knowledge subscales. Furthermore, 84% of Neville et al.'s (2006) sample described themselves as not being color-blind, although this was only measured by having participants answer the question, "Are you color-blind when it comes to race". Overall, Neville et al. (2006) found empirical evidence of a specific relationship between color-blind racial attitudes and therapist multicultural counseling competence; specifically, that higher color-blind racial attitudes are predictive of lower multicultural awareness and knowledge.

An important empirical finding regarding the relationship between multicultural counseling competence and color-blind racial attitudes is the role multicultural training plays in moderating their relationship. Chao et al. (2011), in a sample of 370 psychology trainees, conducted regression analyses to determine the extent to which multicultural counseling training moderated the relationship between color-blind racial attitudes and self-reported multicultural counseling competence. In their analyses, Chao et al.

followed what Sodowsky et al. (1998) used to determine multicultural training; specifically, participants were awarded scores based on the amount of multicultural coursework and multicultural research completed or multicultural workshops attended. The authors found that the more multicultural training a participant had, the stronger the relationship was between color-blindness and multicultural knowledge. These results suggest that when a trainee holds higher levels of color-blind racial attitudes, multicultural training can influence their attitudes' effect on multicultural counseling competence.

Chao (2013) found the association between race/ethnicity and multicultural counseling competence was significant among participant with higher levels of multicultural training who also held high color-blind racial attitudes. The authors administered the CoBRAS and MCKAS to a sample of 259 school counselors, using hierarchical multiple regression to test for mediation and moderation. This finding suggests that, even if people have a high degree of multicultural training, a variable which has been found to be predictive of multicultural counseling competence, the extent to which they hold color-blind racial attitudes significantly affects the relationship between their amount of multicultural training and their reported multicultural counseling competence.

This is a significant conclusion, given the empirical evidence suggesting a strong relationship between race/ethnicity and self-reported multicultural counseling competence; Chao (2013) essentially finds that color-blind racial attitudes mediate this relationship. Finally, results suggested that participants reporting limited multicultural training and high levels of color-blind racial attitudes reported the lowest levels of

multicultural counseling competence (Chao, 2013). In summary, multicultural training appears to influence the effect of color-blind racial attitudes on a trainee's multicultural knowledge, which is notable given the previously discussed literature identifying multicultural training as a key factor in therapist multicultural counseling competency development. This is an important consideration for the present investigation, as both practitioners and graduate student trainees will be recruited for participation.

In sum, there appears to be a relationship between color-blind racial attitudes and multicultural counseling competence. Specifically, the lower degree to which a therapist holds color-blind racial attitudes, the higher multicultural counseling competence they will report. This conclusion is significant, given the previously discussed literature on the relationship between multicultural counseling competence and empathy, as well as color-blind racial attitudes and empathy.

In sum, there appears to be a relationship between color-blind racial attitudes and multicultural counseling competence; greater color-blind racial attitudes are predictive of lower multicultural counseling competence, while lower color-blind racial attitudes is predictive of greater multicultural counseling competence. What follows is a review of literature examining the relationship therapy processes and outcomes has with multicultural counseling competence and color-blind racial attitudes.

Relationship Between Constructs of Interest and Therapy Processes and Outcomes

Therapy process and outcome research is important to understanding how clinicians can better deliver therapy to clients. This is particularly true in cross-cultural counseling relationships, where clinician multicultural counseling competence plays a role in the processes and outcomes of therapy. The following section will review

literature on the relationship between therapist multicultural counseling competence and therapy processes and outcomes, color-blind racial attitudes and therapy processes and outcomes, and different dimensions of empathy and therapy processes and outcomes.

Therapist multicultural counseling competence and therapy outcomes, processes, and empathy. Assessing the effect of therapist multicultural counseling competence on successful client outcomes in treatment has been a topic of much focus in the counseling literature. A 2015 meta-analysis by Tao et al. sought to determine the relationship of multicultural counseling competence to therapy processes and outcomes. Tao et al. (2015) also sought to determine the heterogeneity of associations between therapist multicultural counseling competence and therapy processes and outcomes, and used moderator analysis to test for potential sources of variability including type of outcome measure (such as alliance versus satisfaction), type of multicultural counseling competence measure, demographics, and clinical setting. The inclusion criteria for the meta-analysis by Tao et al. were as follows: the study included a client rating of therapist multicultural counseling competence or related construct, the data were gathered from ratings of actual counseling sessions, and the study presented values allowing for a calculation of a Pearson correlation coefficient between multicultural counseling competence and therapy processes and outcomes.

Eighteen empirical studies were included in the final meta-analysis by Tao et al (2015); thirteen are included in this present review. Tao et al. found that perceptions of therapist multicultural counseling competence accounted for a significant 8.4% of the variance in overall therapy outcomes; furthermore, other aspects of therapy, such as working alliance and perceived counselor empathy, were also significantly influenced by

perceptions of multicultural counseling competence. Results from the Tao et al. meta-analysis indicate that therapist multicultural counseling competence influences therapy processes and outcomes. What follows is a review of early research on multicultural counseling competence and therapy processes and outcomes.

Early research on multicultural counseling competence and therapy processes and outcomes. Constantine (2000) administered the MCKAS and the Empathic Concern and Perspective-Taking subscales of the Interpersonal Reactivity Index (IRI), and a measure of empathy, to a sample of 124 therapists, 103 of whom identified as White, 10 identified as Latino, 4 identified as African-American, 4 identified as Asian-American, and 1 identified as biracial. Using forced-entry regression analysis, Constantine found that affective and cognitive empathy made significant contributions of 17% of variance to scores on the Knowledge subscale and 14% of the variance on scores of the Awareness subscale of the MCKAS. These findings suggest that the degree to which a therapist rates themselves as being cognitively or affectively empathic toward others significantly contributes to the degree to which they rate their multicultural knowledge and awareness. One limitation of Constantine's study was that it did not examine multicultural skills, and did not examine how these two types of empathy explain total scores on the MCKAS.

Constantine (2001b) also examined the relationship between affective and cognitive empathy and multicultural counseling competence by administering the Perspective-Taking and Empathic Concern subscales of the IRI to a sample of 132 therapists, 100 of whom identified as White, 11 identified as African American, 8 identified as Asian American, 8 identified as Latino/a American, 2 identified as biracial, and 1 identified as American Indian. In addition, Constantine had participants complete a

multicultural case-conceptualization exercise. This case conceptualization exercise had participants conceptualize cases two separate ways: first, participants conceptualized cases based on their beliefs of the factors contributing to the client's presenting concern (ratings of etiology), and second, participants conceptualized cases based on what they believed to be the best interventions for the client (treatment ratings). Constantine had two raters score responses based on a system examining a participant's ability to offer alternative interpretations of a client's presenting problem and a participant's ability to develop associations between interpretations.

Constantine (2001b) utilized two hierarchical regressions, with multicultural case conceptualization ability ratings as a criterion variable. Constantine found that cognitive and affective empathy added significant variance to ratings of multicultural case conceptualization related to etiology, although affective empathy was the only type of empathy to positively add to multicultural case conceptualization ratings related to etiology. Furthermore, Constantine found that both cognitive and affective empathy had significant positive contributions of 18% of variance to treatment ratings. These findings indicate that therapists who rate themselves as high in cognitive and affective empathy are likely to have stronger multicultural case conceptualization skills.

Constantine (2002) assessed the degree to which client-rated multicultural counseling competence predicted client ratings of their therapists' attractiveness, expertness, and trustworthiness, in addition to their overall satisfaction with counseling; these constructs differ from therapy outcome measured, in that they do not assess client psychological functioning. Using a sample of 112 racial and ethnic minority client participants at university counseling centers, Constantine administered the CCCI-R to

assess client-rated multicultural counseling competence, the Counselor Rating Form – Short to assess therapist attractiveness, expertness, and trustworthiness, and the Client Satisfaction Questionnaire to assess satisfaction with therapy. Using a test of mediation in hierarchical multiple regression, Constantine found that client-rated therapist multicultural counseling competence mediated the relationship between ratings of general counseling competence and client satisfaction with counseling, meaning a certain degree of satisfaction with counseling that was explained by a client's rating of the general counseling competence of his or her therapist was also explained by his or her perception of the multicultural counseling competence of his or her therapist. Taken together, these results suggest that client-rated multicultural counseling competence to some degree has an effect on racial and ethnic minority clients' satisfaction with counseling.

Fuertes and Brobst (2002) assessed the role client-rated multicultural counseling competence has on satisfaction with counseling services, counselor attractiveness, expertness, and trustworthiness, and the degree to which the client perceived their counselor as being empathic. Client-rated empathy was assessed using the Empathic Understanding subscale of the Barrett-Lennard Relationship Inventory, while client-rated multicultural counseling competence was assessed using the CCCI-R. Eighty-five graduate students, 54 of whom were currently being seen for counseling while 31 reported previous counseling experience, completed these two measures of their experiences in counseling; the authors do not describe where participants received counseling services. Forty-nine participants identified as Caucasian, 18 Latino/a, 9 identified as Asian American, 8 as African American, and 1 American Indian. Bivariate correlations found that perceptions of therapist multicultural counseling competence was

significantly correlated with client satisfaction with counseling (.79), ratings of counselor attractiveness, expertness, and trustworthiness (.72), and client-rated empathy (.55). Furthermore, among racial and ethnic minority participants, hierarchical regression analysis found that client-rated multicultural counseling competence significantly predicted satisfaction with counseling, contributing an additional 16% of unique variance to ratings of satisfaction. What follows is a review of literature on therapist multicultural counseling competence and outcomes within the last ten years.

Recent research on multicultural counseling competence and therapy processes and outcomes. Building off of previous research, Fuertes et al. (2006) used a dyadic data analysis comprised of 51 dyads (one counselor to one client from a university counseling center) to assess multicultural counseling competence and outcomes. Similar to Fuertes and Brobst (2002), Fuertes et al. utilized the CCCI-R to assess client-rated multicultural counseling competence and the Empathic Understanding subscale of the Barrett-Lennard Relationship Inventory. Similar to Fuertes and Brobst (2002), Fuertes et al. found a significant positive relationship between client ratings of therapist multicultural counseling competence and ratings of therapist empathy, finding a bivariate correlation of .81. The results from Fuertes et al. represent an extension of the results from Fuertes and Brobst.

Wang and Kim (2010) used an analogue research design to assess the extent to which client-rated therapist multicultural counseling competence, particularly multicultural counseling skills, predicts client perceptions of therapist empathy. The independent variables in Wang and Kim's analogue research design were supportive counseling rooted in multicultural counseling competence or supportive counseling alone.

Wang and Kim administered the Empathic Understanding subscale of the Barrett-Lennard Relationship Inventory to a sample of 113 Asian American college students. To assess multicultural counseling competence, the authors developed a seven-item scale designed to measure the presence of culturally competent skills. Fifty-five participants viewed a video of a counseling session where the counselor exhibited strong multicultural counseling skills and 58 viewed a video a counseling session where the counselor provided supportive therapy only. Participants were instructed to rate the counselor's demonstrated empathy in their respective video. To compare scores between the two videos, Wang and Kim used independent sample t-tests, finding that therapists in the multicultural condition were rated as being significantly more empathic compared to counselors in the supportive only condition. In sum, the results by Wang and Kim provide evidence that culturally competent practice is important for observable empathy.

A more recent study of multicultural counseling competence and therapy outcomes was a study by Dillon et al. (2016), who assessed client and counselor reports of counselor multicultural counseling competence across four sessions. Dillon et al. used a one-with-many dyadic method of data analysis, which posits that client and therapist perceptions of counseling processes vary as a function of the perceiver (client), the partner (therapist), and the relationship between perceiver and partner; this allows researchers to estimate variance associated with the perceiver and partner. The sample consisted of 133 racial and ethnic minority clients attending therapy at a university counseling center, who were nested within a therapist-client dyad of 22 counselors, 37.5% of whom identified as White; participants completed the CCCI-R and a measure assessing psychological well-being. Results from the study by Dillon et al. found

differences between therapists in terms of their client-rated multicultural counseling competence; in other words, some therapists demonstrated higher levels of competence compared to others. Furthermore, there was a relationship between improvement in client psychological well-being and higher ratings of therapist multicultural counseling competence. In sum, the results from Dillon et al. indicate a relationship between client perceptions of multicultural counseling competence and therapy outcome.

Whereas Dillon et al. (2016) found a relationship between therapist multicultural counseling competence and therapy outcomes, Owen et al. (2011b) had previously tested whether therapists rated by their clients as having higher multicultural counseling competence would have better therapy outcomes compared to therapists with lower rated multicultural counseling competence. Owen et al. administered the CCCI-R and a measure of psychological well-being to a sample of 143 clients, 78 of whom identified as White and 65 of whom identified as racial and ethnic minorities; the 143 participants saw a total of 31 therapists, 22 of whom identified as White. Using hierarchical linear modeling, Owen et al. preliminarily found that perceptions of therapist multicultural counseling competence did not significantly differ based on the race of the client, therapist, or the interaction between client and therapist racial and ethnicity status; furthermore, there was no significant main effect of client-rated therapist multicultural counseling competence on client outcomes. However, Owen et al. did identify a positive relationship between client outcomes and client-rated multicultural counseling competence when measured within particular therapist-client dyads. In other words, results suggested a positive association between client-rated multicultural counseling competence and client outcomes when the analysis examined these variables within the

context of each therapist's clients participating in the study. In sum, although the Owen et al. results initially concluded no relationship between multicultural counseling competence and therapy outcomes, this appears to be the product of data analysis procedure; when analyzed at the individual therapist level, competence did determine outcomes.

To summarize, there has been a substantial amount of empirical research done to assess the degree to which client-rated therapist multicultural counseling competence predicts therapy outcomes; particularly, research has consistently demonstrated that therapists with higher ratings of multicultural counseling competence will consistently be rated as demonstrating higher levels of empathy toward clients. A strength of these studies has been the use of advanced statistical analyses to determine these relationships, including hierarchical linear modeling and dyadic methods of data analysis. In addition to therapist multicultural counseling competence, other aspects of client and therapist race have been shown to influence therapy processes and outcomes. What follows is a review of literature examining shared cultural values between a therapist and client, and their relationship to therapy processes and outcomes.

Shared cultural values/worldviews and therapy outcomes, processes, and empathy. A client's perception of the extent to which their therapist shares their worldview influences a client's perception of their therapists' multicultural counseling competence, as well as therapy processes and outcomes. Kim et al. (2002) assessed the degree to which Asian American clients adhered to Asian cultural values predicted client perceptions of the counseling process and therapist multicultural counseling competence, using an analogue research design. Clients in this study met with a European American

female therapist, with clients identifying a career counseling concern; the therapist then either focused on immediate resolution of the problem or helping the client attain insight into the problem, and either encouraged clients to express cognitions rather than emotions, or emotions rather than cognitions (Kim et al.). In a sample of 78 Asian American clients at a university counseling center, Kim et al. utilized a quasi-intervention analogue research design, meaning the authors tested multiple independent variables and multiple dependent variables, and a 2 (high and low client adherence to Asian cultural values) x 2 (immediate resolution of the problem and insight attainment) x 2 (counselor emphasis of client expression) factorial design.

Client-rated empathy in the study by Kim et al. (2002) was assessed using the Empathic Understanding subscale of the Barrett-Lennard Relationship Inventory, while client-rated multicultural counseling competence was assessed using the CCCI-R. Results from the Kim et al. study indicated that clients with high adherence to Asian cultural values perceived the counselor emphasizing expression of emotions as being more culturally competent than the counselor emphasizing expression of cognitions. Furthermore, Asian American clients with high adherence to Asian cultural values perceived greater empathic understanding than did clients with low adherence to Asian cultural values, regardless of whether their therapist encouraged cognition or emotion, and regardless if the counselor emphasized immediate resolution or encouraged insight exploration (Kim et al.). In sum, these results suggest that Asian American clients with high adherence to Asian cultural values perceived greater counselor empathy overall than clients with low adherence to Asian cultural values, and rated higher multicultural

counseling competence in counselors who encouraged emotional expression than expression of cognitions.

Similarly to the study by Kim et al. (2002), Kim and Atkinson (2002) used an analogue research design to investigate the relationship between adherence to Asian values among Asian American clients and their ratings of their therapist's multicultural counseling competence and capacity for empathy. Kim and Atkinson used a 2 x 2 x 2 factorial design, with client adherence to Asian cultural values (low and high), therapist expression of cultural values (Asian cultural values and U.S. cultural values), and counselor ethnicity (Asian American and European American). A sample of 112 Asian American undergraduate students were administered the CCCI-R to assess ratings of therapist multicultural counseling competence and the Empathic Understanding subscale of the Barrett-Lennard Relationship Inventory to assess client ratings of empathy. Participants attended a career counseling session with a counselor who expressed either low or high Asian cultural values.

Using a 2 x 2 x 2 multivariate analysis of covariance, Kim and Atkinson (2002) found that clients with high adherence to Asian cultural values who met with an Asian American counselor had significantly higher ratings of empathic understanding compared to clients with low adherence to Asian cultural values. Furthermore, among clients who saw a European American counselor, clients with low adherence to Asian cultural values rated empathic understanding as significantly higher compared to clients with high adherence to Asian cultural values. In sum, the results from Kim and Atkinson demonstrate that empathy is sensitive to cultural components in the therapy room.

Li and Kim (2004) assessed the degree to which counseling style (operationalized as either directive or nondirective) and adherence to Asian cultural values predicted client-rated counselor effectiveness, working alliance, session depth, empathic understanding, and multicultural counseling competence. Participants were 52 Asian American students who were clients at a university counseling center, with 7 European American and 1 Hispanic counselor. Client-rated empathy was assessed using the Empathic Understanding subscale of the Barrett-Lennard Relationship Inventory, while multicultural counseling competence was assessed using the CCCI-R. Li and Kim also used an analogue method, with client-rated empathy and multicultural counseling competence included as dependent variables and client adherence to Asian cultural values and counseling style as independent variables.

Clients in the Li and Kim (2004) study were placed into groups indicating either low or high adherence to Asian cultural values. Using hierarchical regression, Li and Kim found that clients with high adherence to Asian cultural values in the direct counseling condition rated their counselors as being more empathic and more multiculturally competent than did clients in the indirect counseling condition. These findings suggest that client-rated counselor empathy and multicultural counseling competence might be somewhat dependent on the degree to which the client and counselor share cultural values.

Kim et al. (2009) assessed the extent to which therapist multicultural counseling competence, therapist credibility and empathy, working alliance, and the likelihood of recommending the therapist to others was predicted by the degree to which the client perceived a match between the therapist and client about the etiology of the presenting

problem. The sample was 61 Asian American clients at a university counseling center. Client-rated empathy was assessed using the Empathic Understanding subscale of the Barrett-Lennard Relationship Inventory, and multicultural counseling competence was assessed using the CCCI-R. Using hierarchical multiple regression, client-rated multicultural counseling competence and empathic understanding as dependent variables, Kim et al. (2009) found that client-therapist match on belief about problem etiology was a significant positive predictor of client-rated multicultural counseling competence and empathic understanding. In sum, results from Kim et al. suggest that clients who perceive a similarly shared worldview with their therapist will rate their counselor as having higher multicultural counseling competence and as being more empathic than clients who do not perceive a shared worldview with their therapist.

In addition to shared cultural values influencing therapy processes and outcomes, related multicultural counseling constructs which have been found to be similar to therapist multicultural counseling competence also influence therapy processes and outcomes. What follows is a review of literature on the relationship between related multicultural constructs and therapy processes and outcomes.

Related multicultural counseling constructs and therapy outcomes, processes, and empathy. There has been considerable research on the extent to which multicultural counseling competence, in addition to related multicultural counseling constructs, predicts therapy outcomes and processes, particularly empathy. Therapy processes and outcomes have been found to be influenced by related multicultural constructs, such as cultural humility and therapist multicultural orientation.

Owen et al. (2011c) operationalize multicultural orientation as a way of being with a client, primarily guided by the saliency of a therapist's cultural identity. A strong relationship between multicultural orientation and client-rated multicultural counseling competence has been demonstrated (Owen et al.). Owen et al. concluded that client perceptions of therapists' multicultural orientations were positively related to client perceptions of working alliance. One hundred seventy-six clients from a university counseling center were administered a modified version of the CCCI-R to assess for perceptions of therapist multicultural orientation, a measure of psychological well-being, a measure of therapeutic alliance, and a measure assessing the relational bond between a client and therapist. The authors grouped the clients by race/ethnicity, with 95 identifying as White and 81 identifying as racial and ethnic minority, and used this grouping as a predictor variable. Using multiple mediation analysis with bootstrapping methods, Owen et al. found that client perception of the working alliance was a statistically significant mediator for the relationship between perceptions of therapist multicultural orientation and client psychological well-being, suggesting that working alliance is an important factor in the gains a client makes in therapy, and that multicultural orientation plays a role in facilitating positive working alliance.

Another related multicultural construct, cultural humility, has been found to influence therapy processes. Hook et al. (2013) operationalize cultural humility as an interpersonal stance that is other-oriented rather than self-focused, involving respect and lack of superiority toward an individual's cultural experience and cultural background, meaning that a person does not believe his or her culture is superior to a different culture. Across three studies, Hook et al. sought to assess the importance of cultural humility as a

construct, develop a measure of cultural humility, and assess the relationship between client ratings of therapist cultural humility and working alliance. In study 1, Hook et al. administered a measure of working alliance and a preliminary 36-item measure corresponding with their theoretical conceptualization of cultural humility to a sample of 472 college students who had previously attended therapy, conducting hierarchical regression analysis. Hook et al. concluded that client perceptions of therapist cultural humility predicted working alliance while accounting for the severity of the client's presenting concern. Specifically, higher ratings of cultural humility were associated with positive perceptions of working alliance, while lower ratings of cultural humility were associated with negative perceptions of working alliance. The second study by Hook et al. replicated the first study, but instead used a sample of 134 adults who were presently in therapy, finding similar results. Additionally, the authors administered the CCCI-R, and found that client perceptions of therapist multicultural counseling competence were a significant predictor of working alliance.

In the third of three studies by Hook et al. (2013), the researchers administered the same measures of client-rated cultural humility and working alliance, in addition to a measure of client-rated improvement in therapy, to a sample of 120 African American adults currently attending therapy. Hook et al. sought to determine the extent to which working alliance mediated the relationship between cultural humility and improvement in therapy. Using a test of mediation, Hook et al. found working alliance to fully mediate the positive relationship between client perceptions of cultural humility and improvement in therapy. One limitation of this third study by Hook et al. is that the authors did not administer the measure of improvement in therapy multiple times; instead of

administering a measure of improvement in therapy at multiple points, it was only administered at one point in time.

Owen et al. (2014a) also assessed cultural humility, this time examining the extent to which client-rated cultural humility predicted therapy outcomes, with outcomes being assessed using a measure of patient estimation of improvement in therapy. Owen et al. administered a measure of client-rated therapist cultural humility and a measure assessing client-rated improvement in therapy to a sample of 45 clients, 34 of whom identified as a racial and ethnic minority client, at a university counseling center. Using a cross-sectional research design, the authors conducted regression analysis and concluded that client-rated cultural humility was positively related to therapy outcome, meaning that the more clients rated their therapists as exhibiting cultural humility, the greater improvement in therapy was reported (Owen et al.).

In sum, these results highlight the role culture has on therapy processes and outcomes. Specifically, Hook et al. (2013) reported a positive relationship between multicultural counseling competence and cultural humility. Additionally, the previously reviewed literature on therapist multicultural counseling competence and therapy processes and outcomes conclude that therapy processes and outcomes are influenced by therapist multicultural counseling competence. Thus, further examination of therapist multicultural counseling competence and therapy processes and outcomes is warranted.

Color-blind racial attitudes and therapy outcomes, processes, and empathy. Although there has been substantially less research examining the relationship between color-blind racial attitudes and therapy processes and outcomes compared to that of multicultural counseling competence, Burkard and Knox (2004) examined the degree to

which color-blind racial attitudes influence therapists' empathy and attribution of client responsibility. Burkard and Knox administered the CoBRAS to assess for color-blind racial attitudes, while the Empathic Concerns and Perspective-Taking subscales of the Interpersonal Reactivity Index were used to assess therapist empathy.

Four clinical vignettes were designed to experimentally manipulate the race of the client and the client's attribution for the cause of his or her problem; Burkard and Knox (2004) utilized analyses of covariance (ANCOVAs) to determine the degree of differences in empathy among 247 psychologists from high, moderate, and low levels of color-blind racial attitudes. Results indicated that therapist levels of color-blind racial attitudes significantly influenced ratings of empathy; using pairwise comparisons, Burkard and Knox found that therapists with high color-blind racial attitudes rated themselves as less empathic compared to therapists with low color-blind racial attitudes. Additionally, Burkard and Knox found no significant differences between client race/ethnicity in each vignette. In sum, the results from Burkard and Knox suggest that therapist's ability to empathize with clients predict their level of color-blind racial attitudes, regardless of client race.

Related color-blind racial constructs and therapy processes and outcomes. As mentioned previously, racial microaggressions are brief, intentional or unintentional behaviors which send denigrating messages to racial and ethnic minority individuals, and color-blindness is a form of microaggression in that it does not acknowledge a person of color's racialized experiences (Neville et al., 2013; Sue et al., 2007). Color-blind racial microaggressions represent a form of multicultural counseling incompetence, as fostering

a sense of racial self-awareness in training programs is a prerequisite for minimizing microaggressions and practicing competently (Sue et al., 2007).

Constantine (2007) assessed the relationship between client perceptions of therapist racial microaggressions and perceived working alliance and satisfaction with counseling. Participants in the study by Constantine were 40 African American students at a university counseling center assigned to 19 White counselors. Client participants completed a measure of perceived racial microaggressions, an assessment of working alliance, counselor trustworthiness, expertness, and attractiveness, and a satisfaction questionnaire, while therapist participants completed the CCCI-R to assess for multicultural counseling competence. Using structural equation modeling, Constantine (2007) found a significant, negative path between perceived racial microaggressions and therapeutic working alliance, suggesting that perceived microaggressions were associated with lower levels of working alliance. Furthermore, Constantine found that clients perceiving microaggressions from their therapist reported lower satisfaction with counseling.

Owen et al. (2014b) also assessed the relationship between client perceptions of therapist racial microaggressions and perceptions of working alliance. Building off the study by Constantine (2007), Owen et al administered a measure assessing client perceptions of therapist microaggressions and a measure of working alliance to a sample of 120 clients at a university counseling center. Furthermore, Owen et al. grouped these clients within dyads of 33 therapists, allowing for multilevel modeling of data analysis. Using this method of analysis, Owen et al. found that clients reporting stronger alliances with their therapist reported fewer microaggressions. Furthermore, the dyadic analysis of

data found that dyads where the client and therapist had discussed the microaggression had higher ratings of working alliance compared to dyads that did not discuss the microaggression.

In addition to the above-mentioned relationships between therapist microaggressions and client-rated working alliance, Owen et al. (2011a) concluded that working alliance mediates the relationship between therapist microaggressions and therapy outcomes. Owen et al. administered a measure assessing client perceptions of working alliance, perceptions of therapist microaggressions, and a measure of psychological well-being to a sample of 245 university counseling center clients. Using regression analysis, Owen et al. found that clients who reported a greater number of microaggressions also reported poorer psychological well-being. Furthermore, Owen et al. found that the working alliance described by the client mediated this relationship between microaggressions and psychological well-being. In sum, these results from Constantine (2007) and Owen et al. suggest that therapy processes are affected by therapist microaggressions. This suggests that further assessment of therapy processes and how they can be harmed.

Empathy and therapy processes and outcomes. As previously discussed, therapeutic empathy represents a type of therapy process which can help or hinder successful outcomes in therapy. However, therapist empathy also has a relationship between other therapy processes as well. Given the previously reviewed literature on the relationship between multicultural counseling competence, color-blind racial attitudes, and empathy, further exploration into the nature of these relationships is warranted, particularly how they related to therapy process and outcome research. What follows is a

select review of literature on the three different assessments of empathy (client-rated, observer-rated, and therapist-rated), and their relationship to therapy processes and outcomes.

Client-rated empathy and therapy processes and outcomes. As mentioned previously, client-rated empathy has been shown to be a strong predictor of therapy processes and outcomes. Burns and Nolen-Hoeksema (1992) utilized structural equation modeling to assess the extent to which client-ratings of therapist empathy predicted clinical improvement in therapy. Burns and Nolen-Hoeksema administered the Beck Depression Inventory (BDI), an instrument which measures symptoms of depression, and the Empathy Scale, a 10-item questionnaire where respondents rate how warm, caring, and empathic their therapist is. Participants in the study by Burns and Nolen-Hoeksema were 185 clients who were being treated for mood disorders at an outpatient mental health clinic. Participants were administered the BDI at the beginning of a twelve-week treatment module, and then re-administered the BDI and administered the Empathy Scale following the twelve-week treatment module.

Using a structural equation analysis, Burns and Nolen-Hoeksema (1988) found that ratings of empathy significantly predicted scores on the BDI; specifically, regression coefficients ranged from -1.15 to -1.38, indicating that higher levels of empathy lead to improved scores on the BDI. The authors conclude that therapeutic empathy had a direct effect on improvement in therapy. The findings by Burns and Nolen-Hoeksema provide empirical evidence that client-rated empathy significantly predicts a measure of therapy outcome.

Observer-rated empathy and therapy processes and outcomes. As mentioned previously, the Bohart et al. (2002) meta-analysis found that observer-rated empathy is predictor of therapy outcomes, although not as strongly as client-rated. Mlotek (2013), using archival data of client self-report measures of outcomes and observer-ratings of empathy, sought to assess the degree to which empathy improved outcomes over the course of treatment. The data used by Mlotek was taken from a previous study assessing outcomes from clients being treated for a trauma; these clients were administered an outcome measure assessing the impact of trauma on functioning and an outcome measure assessing the degree of negative feelings, unmet needs, and feelings of worthlessness. Additionally, clients completed a measure of the extent to which they engaged in therapy. Clients were administered these outcome measures before treatment, during treatment (at the 8th session), post-treatment, and 6 months following treatment. Client treatment sessions were videotaped.

Participants in the study by Mlotek (2013) were 45 adult clients receiving mental health treatment for trauma; the mean age for the sample was 45.62. Racial and ethnic data was unavailable. Mlotek trained two raters who viewed 37 of 45 initial therapy sessions available via videotape; 8 were eliminated due to a technical error. Raters provided observer ratings of empathy using a measure of expressed empathy. Using regression analysis, Mlotek found that higher levels of observer-rated empathy predicted higher levels of engagement in therapy and a greater reduction of trauma symptoms post-treatment.

Also assessing the role of observer-rated therapist empathy on therapy outcomes is Elkin et al. (2014), who conducted a larger study of dimensions of therapist

responsiveness and patient early engagement in therapy. Participants in the Elkin et al. study were 72 patients receiving either cognitive-behavioral therapy or interpersonal therapy for Major Depressive Disorder; patient race and ethnicity demographics were not provided. As part of the larger study, patients completed a measure of measure of depression at pre-screening and two weeks after initiating treatments. In addition to having patients complete a measure of depression, raters completed the full scale Barrett-Lennard Relationship Inventory.

Using regression analysis, Elkin et al. (2014) found that higher scores on the initial administration of the measure of depression were related to lower scores on the Barrett-Lennard Relationship Inventory, suggesting that the more depressed a patient was, the lower their therapist was rated as being empathic. However, Elkin et al. did not find a significant main effect scores on the Barrett-Lennard Relationship Inventory predicting scores on the follow-up administration of the measure assessing depression. This finding suggests that observer-rating of empathy was not a predictor of a measure of therapy outcome.

In short, observer-rated empathy has been shown to be an adequate predictor of therapy processes and outcomes, although not as strong as client-rated empathy. What follows is a brief review of literature examining therapist-rated empathy and therapy processes and outcomes.

Therapist-rated empathy and therapy processes and outcomes. As mentioned previously, therapist-rated empathy is one of three ways to assess empathy, with observer-rated and client-rated empathy being stronger predictors of counseling outcomes compared to therapist-rated empathy. Lesser (1961) tested for a relationship between a

client's progress in counseling and a counselor's rating of empathy. Therapist-rated empathy in the study by Lesser was measured using an instrument derived from having four raters rate statements describing the following: descriptions of a therapeutic relationship, characteristics of an "expert" therapist, and effective therapeutic treatments. Twelve statements were rated as being characteristic of "empathic understanding", and were used in the scale; however, no psychometric properties of this scale were provided. Counseling progress was assessed by having a client sort statements about themselves, and then sorting the same statements about "an ideal person". Lesser does not provide examples of these statements. Upon terminating therapy, clients again sorted statements about themselves, and then sorted the same statements about their ideal person.

Participants in the study by Lesser (1961) were 22 students attending therapy services at a university counseling center; no demographic information was provided. Using rank order *t*-tests, Lesser concluded no relationship between counseling progress and therapist-rated empathy. There was a negative, nonsignificant correlation between ratings of counseling progress and therapist ratings of their empathy. The findings by Lesser highlight early conclusions about therapist-ratings of empathy not having a relationship with therapy outcomes. However, the psychometric properties of the instruments used in Lesser's study are unknown, and the sample size is comparatively small from other studies in counseling psychology research, which raises doubts about the validity of the results.

Also exploring the relationship between therapist-rated empathy and therapy outcome is a study by Cartwright and Lerner (1963), using a sample of 28 clients in a university counseling center. Cartwright and Lerner assessed improvement in therapy

using ratings by therapists at two different points of therapy (beginning and end); these ratings assessed a therapist's perceptions of a client's overall improvement in therapy. Empathy was assessed by using information provided by both the client and therapists. A client provided 10 self-descriptions of how they "see [themselves]", then their therapist, presented with a list including these 10 self-descriptions, attempted to predict the client's self-description. This process was performed at the beginning and end of therapy. Cartwright and Lerner reasoned that this process measured empathic understanding.

Cartwright and Lerner (1963) performed a test of significance on the differences between scores before and after therapy. Results showed no significant difference between clients who improved in therapy and clients who did not improve in therapy in terms of therapist self-reported empathy. However, among improved cases only, there was a significantly higher rating of self-reported empathy at the second administration of the instrument, meaning that therapists rated themselves as being more empathic at the end of therapy among clients who reported improvement in therapy. In sum, the results from Cartwright and Lerner appear mixed, with some indication that therapist-rated empathy is associated with improvement in therapy. However, the instrumentation assessing empathy is suspect, with no psychometrics provided. Therefore, further investigation into a relationship between these constructs is warranted.

In sum, empathy can be measured using ratings from clients, observers, and self-report measures completed by therapists. Although early research as to how strong these three types of empathy measurement are at accurately measuring empathy have found limited evidence that therapist-rated empathy was an accurate predictor of empathy, a meta-analysis by Bohart et al. (2002) concluded that therapist-rated empathy is a good

predictor of empathy, although not as strong as client-rated empathy and observer-rated empathy. Furthermore, outcome research that has looked at therapist empathy has concluded that better ratings of therapist-rated empathy predicts better outcomes in therapy, a significant finding given the previous research discussed on relationships between therapy outcomes and both therapist multicultural counseling competence and color-blind racial attitudes. Nonetheless, the role of empathy in counseling is important, as it facilitates improvement in both the process of therapy and therapy outcome. Furthermore, these relationships between the three different types of measured empathy and therapy process and outcome research are significant given the previously reviewed research establishing relationships between therapy processes and outcomes and both multicultural counseling competence and color-blind racial attitudes. These relationships suggest further assessment between the constructs is warranted.

The construct of empathy is also part of a conceptualization of racism; specifically, it is measured within the context of the theory of Psychosocial Costs of Racism to Whites. Literature on this construct has examined the role empathy has in how a person experiences psychosocial costs of racisms. Furthermore, given that assessment of this construct is self-report, it represents a type of self-reported empathy, similar to therapist-rated empathy. What follows is a review of literature on a parallel type of self-rated empathy and multicultural counseling competence.

Related construct of empathy and multicultural counseling competence. Spanierman and Heppner (2004) conceptualized a tripartite model examining the cognitive, affective, and behavioral costs of racism to Whites, naming this construct Psychosocial Costs of Racism to Whites. In developing a scale to assess dimensions of

Psychosocial Costs of Racism to Whites, the authors uncovered a factor related to empathy, named The White Empathic Reactions Toward Racism. This factor assesses emotions in response to racism; higher scores indicate higher levels of sadness or anger in response to racism. The construct of empathic reactions toward racism appears consistent with the cognitive, perspective-taking aspect of racism, and is consistent with self-report measures of empathy.

Spanierman et al. (2009), adding to the Psychosocial Costs of Racism literature, examined this construct among college freshmen. Specifically, the authors were interested in examining different factors, such as diversity attitudes and diversity activities during the academic year, which predict Psychosocial Costs of Racism. Spanierman et al. administered the Psychosocial Costs of Racism to Whites Scale to a sample of 287 White college freshmen at the beginning of an academic year and at the end of an academic year. In addition to assessing for Psychosocial Costs of Racism, the authors had participants provide a number of interracial friendships they had, and administered a measure assessing one's openness and appreciation of cultural diversity and a measure assessing awareness of racial privilege. Additionally, at the end of the academic year follow-up, participants provided the number of diversity-related courses they had taken and the number of diversity-related activities they had participated in.

Using multinomial logistic regression, the authors found that the more open and appreciative of cultural diversity a person was, the higher their empathic reactions toward racism would be. This finding suggests that the more open and accepting of diversity a person is, the more likely they are to be empathic toward people experiencing racism and discrimination. This finding is important given the previously reviewed literature on the

relationships between empathy and both multicultural counseling competence and color-blind racial attitudes.

There is also evidence of a relationship between the related empathy found in Psychosocial Costs of Racism to Whites, color-blind racial attitudes, and multicultural counseling competence. Spanierman et al. (2008) assessed the extent to which different dimensions of Psychosocial Costs of Racism to Whites predicted observed and demonstrated, observed, and self-rated multicultural counseling competence among White trainees in graduate psychology programs across two studies. Spanierman et al. administered the Psychosocial Costs of Racism Scale, a short form of the CoBRAS to assess for color-blind racial attitudes, the MCKAS to assess self-reported multicultural counseling competence, the CCCI-R to assess observer-rated multicultural counseling competence, and a case conceptualization task to measure demonstrated multicultural counseling competence.

In the first study, Spanierman et al. (2008) tested the extent to which the Psychosocial Costs of Racism mediates the relationship between color-blind racial attitudes and self-reported multicultural competence only. The authors grouped the dimension of White empathy in with White guilt to create a latent construct titled *compassionate costs of racism.* Using a structural equation model to test for mediation, Spanierman et al. found that the latent variable of compassion costs of racism mediated the relationship between scores on the CoBRAS and multicultural knowledge. This finding suggests that the empathy dimension of Psychosocial Costs of Racism might explain some of the relationship between color-blind racial attitudes and the knowledge dimension of multicultural counseling competence, although this relationship is

somewhat unclear, given the fact that empathy was paired with another dimension of Psychosocial Costs of Racism.

Providing further clarity on these relationships was the second study by Spanierman et al. (2008), who included the observer and demonstrated measures of multicultural counseling competence in analysis. The authors first conducted Pearson *r* correlations among variables, finding that White empathy was significantly associated with higher levels of overall self-reported multicultural counseling competence, demonstrated multicultural counseling competence, and supervisor ratings of multicultural counseling competence. Using hierarchical regression, the authors found that White empathy significantly predicted higher supervisor ratings of multicultural counseling competence.

To summarize, the results from the Spanierman et al. (2009) and Spanierman et al. (2008) studies suggest that the empathy one has in regards to witnessing racism or oppression has a relationship with multicultural counseling competence and color-blind racial attitudes. Furthermore, this relationship is not only present in the general population, but also with students in counseling graduate training programs.

In conclusion, the previously reviewed literature on empathy suggests that it is a central process to successful, effective therapy. Empirical research on empathy, in particularly its predictive strength of therapy process and outcome research, has found that that client-ratings of therapist empathy is the strongest predictor of processes and outcomes, followed by observer-ratings and therapist-ratings. There is also a relationship between the different ratings of empathy and both color-blind racial attitudes and multicultural counseling competence.

Hypotheses

In conclusion, therapist multicultural counseling competence is an ethical imperative for providing competent therapy to racial and ethnic minority clients. Lower levels of multicultural counseling competence can result in being less empathic toward racial and ethnic minority clients. This relationship is similar to that of empathy and color-blind racial attitudes, which has also concluded that higher color-blind racial attitudes are related to lower levels of therapist-rated empathy. To date, there has been no attempt to test the extent to which color-blind racial attitudes mediate the relationship between multicultural counseling competence and therapist-rated empathy. In addition to these gaps in the research, a review of empathy literature has concluded that empathy has not been assessed in the specific context of expressing empathy toward a racial and ethnic minority client; specifically, there has been no attempt to differentiate between whether empathy expressed toward a racial and ethnic minority client differs from global empathy.

1. Therapist-rated multicultural counseling competence will significantly predict therapist-rated empathy.
2. Therapist-rated multicultural counseling competence will significant predict therapist-rated color-blind racial attitudes
3. Therapist-rated color-blind racial attitudes will significantly predict therapist-ratings of cognitive and affective empathy.
4. Therapist-rated color-blind racial attitudes will partially mediate the relationship between therapist-rated multicultural counseling competence and therapist-rated empathy.

CHAPTER 3

METHODOLOGY

This chapter provides information on the study's research design, participants, data collection measures, procedure, data analysis, and the limitations of the proposed study.

Research Design

This quantitative study was a between-subjects, descriptive field study. Descriptive field studies do not experimentally control variables, and data is collected in a real-life setting (Heppner et al., 2016). Furthermore, in descriptive field studies, external validity is high due to the fact that participants are taken directly from a population of interest (Heppner et al., 2016). The current study has high external validity due to the sample being comprised of both licensed mental health practitioners and trainees completing supervised practica or internship placements. The study was a non-experimental research design using structural equation modeling to test for a mediation effect of one variable on the relationship between one exogenous variable and two endogenous variables. Non-experimental research designs do not manipulate the independent variable or randomly assign participants to a manipulated group. The

current study did not manipulate the independent variable of multicultural counseling competence, nor did it assign participants into groups in order to manipulate responses (Heppner et al., 2016).

The target population for this study was licensed mental health practitioners and graduate students in counseling psychology, clinical psychology, and counselor education programs currently completing practicum or internship. The study used questionnaires which have been widely used in empirical studies which have examined the constructs being studied in the current investigation and have adequate reliability and validity. Additionally, the study adapted one of the instruments to assess a secondary research question.

Participants

Participants were licensed therapists or doctoral- and masters-level students in training who were completing a supervised practicum or internship in counseling psychology, clinical psychology, or counselor education training programs at the time of responding. Research on multicultural counseling competence had samples including supervised trainees and practicing licensed therapists, and it was deemed acceptable to have a sample comprised of both students and licensed practitioners. Participants were not denied participation due to race or gender, and were18 years of age or older. Weston and Gore recommended a minimum of 200 participants in counseling psychology research using structural equation modeling. Therefore, the current sample strove to have a minimum of 240 total participants, but would have settled for a minimum of 200 participants if all other procedures for obtaining data were exhausted.

A total of 551 people began or completed the survey. Of the 551 participants, 192 (34.8%) reported having an 'other degree', 147 (26.7%) reported having an M.A., 89 (16.1%) reported having an M.S., 44 (8.1%) reported having a Psy.D., 38 (6.9%) reported having a Ph.D., 37 (6.7%) reported having an M.Ed., while 4 (0.7%) did not respond. Four hundred and ninety (88.9%) reported not being a doctoral intern, 57 (10.3%) reported being a doctoral intern, while 4 (0.7%) did not respond. Two hundred and nineteen (39.7%) reported their current degree program or highest degree program completed to be counselor education, 163 (29.6%) reported clinical psychology, 120 (21.8%) reported counseling psychology, 43 (7.8%) reported either a combined clinical and counseling psychology or a school psychology program, and 7 (1.3%) did not respond. Three hundred and thirty-four (60.6%) participants identified as cisgender, 207 (37.6%) did not respond, while ten (1.8%) identified as transgender, gender nonconforming, gender fluid, or other gender identity that was not listed. Four hundred and fourteen (75.1%) participants identified as female, while 81 (14.7%) identified as male and 56 (10.2%) did not respond. Four hundred and twenty-six (77.1%) participants identified as heterosexual, while 122 (22.1%) identified as bisexual, gay, or other sexual identity, and 3 (0.5%) did not respond.

Racial identity statistics were initially obtained by having participants select from six options, with a seventh option of not having a racial identity listed and writing in their racial identity. There were 593 initial responses for racial identity. Four hundred and four (68.1%) identified as White/Caucasian, 70 (11.8) identified as Hispanix/Latinx, 38 (6.4) identified as Black/African American, 34 (5.7%) identified as Asian/Asian American/Asian Pacific Islander, 20 (3.4%) identified as biracial/multiracial, 13 (2.1%)

identified as American Indian/Native American/Alaskan or Hawaiian Native/Indigenous, 3 (0.5%) identified as Jewish, 2 (0.3%) identified as Middle Eastern, 2 (0.3%) identified as Middle Eastern/North African, 1 (0.2%) identified as Arab American/Middle Eastern North African, 1 (0.2%) identified as Asian/European, 1 (0.2%) identified as Jewish/Ashkenazi, 1 (0.2%) identified as Puerto Rican, 1 (0.2%) identified as Turkish, and 1 (0.2%) identified as White/European American. Participants who responded both White/Caucasian and a second identity were coded to be non-White/Caucasian. Following this transformation, three hundred and seventy-seven (68.4%) participants identified as White/Caucasian, while 172 (31.2%) identified as non-White/Caucasian and 2 (0.3%) did not respond.

Table 1

Initial and final demographic statistics

Identity	*n*	%
Initial Statistics		
White/Caucasian	404	68.1%
Hispanix/Latinx	70	11.8%
Black/African American	38	6.4%
Asian/Asian American/Asian Pacific Islander	34	5.7%
Biracial/Multiracial	20	3.4%
American Indian/Native American/Alaskan or Hawaiian Native/Indigenous	13	2.1%
Jewish	3	0.5%
Middle Eastern	2	0.3%
Middle Eastern/North African	2	0.3%
Arab American/Middle Eastern North African	1	0.2%
Asian/European	1	0.2%
Jewish/Ashkenazi	1	0.2%
Puerto Rican	1	0.2%
Turkish	1	0.2%
White/European American	1	0.2%
Final Statistics		
White/Caucasian	377	68.4%
Non-White/Caucasian	172	31.2
No response	2	0.3%

Participants' age ranged from 19 to 87 years old ($M = 30.96$, $SD = 9.24$). The average number of multicultural counseling courses completed was 3.29 ($SD = 34.38$). Participants reported seeing an average of 39.56 ($SD = 157.87$) racial and ethnic minority clients in their practice, with an average of 144.40 ($SD = 627.35$) total clients seen. Participants reported completing an average of 46.76 ($SD = 264.04$) training semesters. Notably, there were 527 responses provided to the question of estimated number of training semesters. Of these 527 responses, 484 responses fell within the range of 0 to 10 semesters, which represents 91.8% of the total responses. It is possible that some respondents mistook the question for an estimated number of training hours or number of clients seen in training; therefore, the original number of estimated training semesters is likely not an accurate reflection of the average total number of training semesters among the sample.

Table 2

Descriptive statistics for age, number of multicultural counseling courses completed, number of racial and ethnic minority clients seen in practice, number of total clients seen in practice, and number of total training semesters completed

	n	Range	Min	Max	*M*	*SD*	Median	Mode
Age	547	68	19	87	30.96	9.24	28	26
MCC - Completed	546	800	0	800	3.29	34.39	1	1
REM Clients	526	3000	0	3000	39.56	157.87	10	0
Total Clients	524	10000	0	10000	144.40	627.35	30	0
Training Semesters	527	3500	0	3500	46.76	264.04	3	0

Note: MCC – Completed is number of multicultural courses completed. REM Clients is the estimated total number of racial and ethnic minority clients seen in practice, Total Clients is the estimated total number of clients seen in practice, and Training Semesters is the total number of semesters spent completing practicum and internship placements.

Procedure

Approval for the study was obtained from the Cleveland State University Institutional Review Board (IRB) in February 2019. Once IRB approval was obtained, Master's- and Ph.D.-level clinical and counseling psychology and counselor education programs were identified using APA and Council for Accreditation of Counseling and Related Educational Programs (CACREP) websites. Training directors from these programs were contacted via email and asked to forward an email solicitation to students for participation. In order to minimize skewed responding from regions of the country, all CACREP and APA training programs were contacted. Information on CACREP-accredited and APA-accredited training programs was obtained from their respective websites. According to the APA Education Directorate website for accredited programs,

as of January 2019, there were 317 counseling and clinical psychology graduate programs in the United States (APA, 2017). Furthermore, according to the CACREP directory website for accredited programs, there were 351 total graduate training programs in the United States for clinical mental health counseling and mental health counseling graduate degrees and 87 accredited programs for doctoral degrees in counselor education and supervision as of January 2019 (CACREP, 2017). In total, training directors from 385 CACREP graduate programs and 279 APA graduate programs were contacted between March 2019 and May 2019, due to some programs having one training director or coordinator for multiple programs. Professional organizations with student listservs allowing research participant solicitation were also contacted for permission to solicit participants. Participants were also solicited from state and professional organization listservs. Specifically, the Ohio Counseling Association (OCA) and the Association of Counseling Center Training Agencies (ACCTA) were contacted to solicit participants. At the time of email contact via the OCA listserv, solicitation reached 1,855 recipients.

Data was confidentially gathered using SurveyMonkey and kept confidential; participants were offered the option to submit an e-mail address for a chance to win one of three $25 Amazon.com gift cards. Phillips (2015) concluded that using a raffle system as an incentive for research is an ethical way to collect data. In order to counterbalance the measures, half of participants were administered the measures as followed: a measure of general empathy, a measure of color-evasion color-blind racial attitudes, a measure of multicultural counseling competence, a measure of desirable responding, a measure of power-evasion color-blind racial attitudes, and an adapted measure of empathy with a

vignette as the referent. The second half of the sample was administered the measures as followed: a measure of general empathy, a measure of power-evasion color-blind racial attitudes, a measure of multicultural counseling competence, a measure of desirable responding, a measure of color-evasion color-blind racial attitudes, and an adapted measure of empathy with the vignette as the referent. Individual *t*-tests were conducted for each latent variable within the structural models to determine if there were any significant differences between responses to the two different orders of measures; results are presented in Chapter 4. Data was collected using the data collection program Surveymonkey, and was transferred from Surveymonkey to Microsoft Excel, and then transferred to Stata for data analysis.

Measures

Demographic Questionnaire. Participants completed a demographic questionnaire prior to completing instruments. The demographic questionnaire asked participants to provide their age, gender, racial and ethnic identity, sexual orientation/sexual identity, practitioner/graduate student status, age, number of multicultural courses taken, and highest degree earned.

Color-Blind Racial Attitudes Scale (CoBRAS). The CoBRAS (Neville et al., 2000) is a 20-item measure assessing cognitive aspects of color-blind racial attitudes. The CoBRAS uses a 5-point likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), where higher scores reflect higher levels of color-blindness. Neville et al. produced initial items based on writings on color-blind racial attitudes by Schofield (1986) and Frankenberg (1993), producing a 26-item preliminary instrument, which was used to determine factor structure. The CoBRAS is comprised of three factors: *Racial*

Privilege, which measures respondent blindness to White privilege; *Institutional Discrimination*, which measures awareness of the implications of institutional forms of racial discrimination and exclusion; and *Blatant Racial Issues*, which measures unawareness to general, pervasive discrimination. In the current study, coefficient alpha for the total measure was found to be .97 for the entire measure. Coefficient alpha's for the three subscales were as followed: *Racial Privilege* (.90), *Institutional Discrimination* (.94), and *Blatant Racial Issues* (.97).

Neville et al. (2000) initially identified 26 items assessing color-blind racial attitudes after consulting with experts on racial attitudes as well as discussions with racially diverse university students and individuals in the community. After receiving feedback from colleagues, Neville et al. determined an initial 26-item instrument which they intended to measure both color-evasion and power-evasion color-blind racial attitudes.

After an initial 26-item instrument was administered to a sample of 302 college students, factor analysis of the CoBRAS demonstrated that the CoBRAS is an adequate measure of power-evasion color-blind racial attitudes (denial of racism by believing in equal opportunity), and a poor measure of color-evasion color-blind racial attitudes (Neville et al, 2000.). Initial factor analysis uncovered three factors: *Racial Privilege*, *Institutional Discrimination*, and *Blatant Racial Issues*. The *Racial Privilege* factor coefficient alpha was .83, the *Institutional Discrimination* factor coefficient alpha was .81, and the *Blatant Racial Issues* factor coefficient alpha was .76. Confirmatory factor analysis confirmed the initial three factor structure, finding a goodness-of-fit of .90. The authors concluded that evidence was not found that items were consistent with color-

evasion color-blind racial attitudes; therefore, the CoBRAS assesses power-evasion color-blind racial attitudes across three factors.

Examples from the CoBRAS include, "White people in the U.S. have certain advantages because of the color of their skin" (factor 1 *Racial Privilege*), "Social policies, such as affirmative action, discriminate unfairly against white people" (factor 2 *Institutional Discrimination*), and "Social problems in the U.S. are rare, isolated situations" (factor 3 *Blatant Racial Issues*; Neville et al., 2000). The CoBRAS has adequate split-half reliability (.72), obtained by splitting the test in two equal halves, and test-retest reliability (.80), obtained after administering the CoBRAS two weeks after initial test administration among a sample of undergraduate students. Using the group difference method, criterion-related validity was found to be .87 (Wilks's $\Lambda = .87$, $F[1, 1034] = 12.43$, $p < .001$) and was demonstrated by using a multivariate analysis of variance (MANOVA) to compared scores on CoBRAS factors among racial groups (White, Black, and Latino/a) in a sample of 594 college students and community members comparing scores on the CoBRAS across racial groups. Comparing scores across racial groups to determine criterion-related validity is based on the assumption made by the authors based on their literature review that racial groups will vary in the degree to which they are color-blind. Specifically, the authors, based off their literature review, hypothesized that Whites would, on average, have higher color-blindness scores compared to other racial groups. Additionally, Neville et al. found concurrent validity with a measure of racism to range from .36 to .55.

Studies using the CoBRAS to assess color-blind racial attitudes among practitioners and graduate students in psychology and counseling programs have

concluded the CoBRAS has strong reliability and validity. Neville et al. (2006) used the CoBRAS to assess the association between color-blind racial attitudes and multicultural counseling competence. Participants in the sample were 79 mental health practitioners with degrees in social work and clinical, counseling, and school psychology, and 51 graduate students in clinical, counseling, and school psychology programs; participants were grouped as either practitioners or students. Among the 79 mental health practitioners, 60 identified as White, 10 identified as Black, 2 identified as Asian American, 3 identified as Latino/a, 1 identified as Native American, and 3 did not respond. Among the 51 graduate students, 20 identified as White, 20 identified as Black, 5 identified as Asian American, 1 identified as Latino/a, 2 identified as Native American, and 3 identified as unknown/other. In their analysis, Neville et al. found coefficient alpha to be .84 for the practitioner sample and .82 in the graduate student sample.

In addition to the Neville et al. (2006), Chao (2013) used the CoBRAS to test for an interaction between multicultural training, multicultural counseling competence, and color-blind racial attitudes. Chao administered the CoBRAS to a sample of 259 school counselors, finding coefficient alpha to be .88. In Chao's sample of school counselors, 179 identified as White/European American, 31 identified as Black, 28 identified as Latino/a, 13 identified as Asian American, 1 identified as Native American, 5 identified as biracial, and 2 identified as multiracial. In sum, empirical studies using the CoBRAS in samples of mental health professionals and graduate students in mental health programs have found strong coefficient alphas, suggesting the CoBRAS has strong psychometric properties. Furthermore, these studies have utilized diverse populations of

mental health practitioners and students, which is similar to the proposed sample in the present study.

Intergroup Ideologies Measures: Color-Blindness subscale. The color-blindness subscale of the Intergroup Ideologies Measure (Rosenthal & Levy, 2012) assesses color-evasion color-blind racial attitudes. Ryan and Levy initially developed the IIM as being a measure of Polyculturalism, or the focus of how cultures interact, share ideas, and influence one another, both in the present and throughout history. The purpose of developing the IIM was to distinguish Polyculturalism as being distinct from multiculturalism and colorblindness. The IIM is comprised of three subscales: the Polyculturalism subscale, which assesses Polycultural attitudes of respondents, the Multicultural scale, which assesses a respondent's recognition of differences between racial and ethnic groups, and the Color-Blindness subscale. The Color-Blindness subscale of the IIM is a five item measure of color-blindness assessing the extent to which respondents recognize unique differences of individuals as well as recognize commonalities across groups (Rosenthal & Levy). The color-blind subscale uses a seven-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Examples of items on the color-blind subscale include, "Ethnic and cultural group categories are not very important for understanding or making decisions about people" and "At our core, all human beings are really all the same, so racial and ethnic categories do not matter" (Rosenthal & Levy). Factor analysis revealed adequate loadings (ranging from .57 to .74) for the three intended subscales of the IIM, suggesting adequate construct validity. Rosenthal and Levy reported adequate internal consistency for the color-blindness subscale in a sample of White and Asian American undergraduate

students (α = .86) and a sample of adults (α = .76). Furthermore, Rosenthal & Levy (2016) found coefficient alpha to be .85 in a sample of 329 undergraduate students. In the current study, coefficient alpha was found to be .79. The color-blind subscale was also found to have strong correlations ranging from .46 to .24 with a similar measure of color-blindness by Ryan, Casas, Kelly-Vance, Ryalls, and Nero (2010), suggesting adequate convergent validity.

Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised (MAKSS-CE-R). The MAKSS-CE-R assesses multicultural counseling competence by providing an overall score of multicultural counseling competence as well as scores on three subscales: Multicultural Awareness, Multicultural Knowledge, and Multicultural Skills (Kim et al., 2003). The MAKSS-CE-R is a 33-item revision of the original MAKSS-CE (Ponterotto et al., 1991). Critiques of the original MAKSS-CE concluded the original instrument was in need of further confirmatory factor analyses and assessments of criterion validity (e.g., Ponterotto et al., 1994; Ponterotto & Alexander, 1996; Pope-Davis & Dings, 1995). In response to the criticism, Kim et al. designed a revision using exploratory and confirmatory factor analysis to support a three factor structure.

Kim et al. (2003) administered an initial revision of the MAKSS-CE to a sample of 338 graduate students from 13 counselor education and counseling, clinical, and school psychology graduate programs across the United States. Using exploratory factor analysis, Kim et al. concluded the revised version of the MAKSS-CE fit a similar three factor model, with loadings greater than .30 and conceptually consistent with one

another. Using confirmatory factor analysis, Kim et al. found an Incremental Fix Index of .96, indicating acceptable fit.

The MAKSS-CE-R is comprised of 10 items measuring multicultural awareness (e.g., "Even in multicultural counseling situations, basic implicit concepts such as 'fairness' and 'health', are not difficult to understand), 13 items measuring multicultural knowledge (e.g., "At the present time, how would you rate your understanding of 'ethnicity'"), and 10 items measuring multicultural skills (e.g., "How would you rate your ability to effectively consult with another mental health professional concerning the mental health needs of a client whose cultural background is significantly different from your own?"). Items assessing multicultural awareness are rated from 1 (*strongly disagree*) to 4 (*strongly agree*), and items assessing multicultural knowledge and multicultural skills are rated from 1 (*very limited*) to 4 (*very good*). Additionally, two items on the multicultural knowledge subscale are rated from 1 (*very limited*) to 4 (*very aware*). Kim et al. found coefficient alphas to be .81 for the entire instrument, with coefficient alphas of .80 for the Awareness subscale, .87 for the Knowledge subscale, and .85 for the Skills subscale, suggesting adequate reliability. In the current study, coefficient alpha for the entire instrument was .85. Coefficient alpha for the Awareness subscale was .71, coefficient alpha for the Knowledge subscale was .85, and coefficient alpha for the Skills subscale was .84.

The MAKSS-CE-R has adequate construct validity with the MCI (r = .51). Kim et al. (2003) expected moderate correlations between the MAKSS-CE-R and the MCI due to the fact that each instrument was developed separately from each other. Additionally, Kim et al. established construct validity by comparing scores of participants who had

reported taking at least one multicultural counseling course with scores of participants who had not reported taking a course. Participants who had completed at least one multicultural course had significantly higher scores than participants who had not completed a course on MAKSS-CE-R total scale scores ($M = 2.81$ vs. $M = 2.70$), MAKSS-CE-R Awareness subscale scores ($M = 2.70$ vs. $M = 2.58$), and MAKSS-CE-R Knowledge subscale scores ($M = 2.94$ vs. $M = 2.82$; Kim et al.).

Empirical studies utilizing the MAKSS-CE-R to assess self-reported multicultural counseling competence among mental health practitioners and graduate students in counseling and psychology graduate programs have found adequate psychometric properties of the instrument. In a sample of 114 graduate counseling students and practicing mental health professionals, Balkin, Schlosser, and Levitt (2009) administered the MAKSS-CE-R to test for a relationship between religious identity, sexism, homophobia, and multicultural counseling competence. Ninety-four participants identified as Caucasian, 3 identified as being of Asian descent, 6 identified as African American, 1 identified as Hispanic/Latino/a, 1 identified Native American, and 2 identified as biracial/multiracial. Balkin et al. found coefficient alphas to range from .44 to .88 between the three MAKSS-CE-R subscales.

In addition to the Balkin et al. (2006) study, Robb (2014) used the MAKSS-CE-R to assess multicultural counseling competence among art therapists. The sample in Robb's study was comprised of 519 graduate students in art therapy programs; of the 519 students, 290 identified as Caucasian, 11 identified as African American, 9 identified as Hispanic/Latino/a, 7 identified as multiracial, 4 identified as Asian American, 2 identified as international, 1 identified as other, and 11 did not respond. Robb initially found

coefficient alpha scores to be .912 for the Knowledge subscale, .895 for the Skills subscales, and .553 for the Awareness subscale, which was deemed unacceptable. After reviewing alpha levels for each question on the Awareness subscale and removing three questions with low alpha scores, a revised Awareness coefficient alpha score of .643 was obtained.

The MAKSS-CE-R has been used in many other studies on multicultural counseling competence (e.g., Cartwright et al., 2008; Fuertes et al., 2006); however, these studies do not present coefficient alpha results in their instrumentation section. Nonetheless, the use of the MAKSS-CE-R in multicultural research indicates it is an acceptable measure of self-reported multicultural counseling competence. Furthermore, the MAKSS-CE-R demonstrates adequate reliability among samples which will be similar to the one in the present study.

Interpersonal Reactivity Index (IRI): Empathic Concern and Perspective-Taking subscales. The IRI (Davis, 1980) is a 28-item measure of empathy. Items are rated on Likert-type scale of 0 (*does not describe me at all*) to 4 (*describes me very well*). The IRI is comprised of four subscales: Fantasy (the tendency of the respondent to identify strong with characters in books, movies, or plays), Perspective-Taking (the tendency or ability of the respondent to adopt the perspective, or point of view, of other people), Empathic Concern (tendency for the respondent to experience feelings of warmth, compassion, and concerns for others undergoing negative experiences), and Personal Distress (extent to which a respondent experienced feelings of discomfort and anxiety when witnessing the negative experiences of others). Consistent with previous research examining therapist-rated empathy (e.g., Burkard & Knox, 2004; Constantine,

2000; Constantine, 2001b), the Empathic Concern and Perspective-Taking subscales of the IRI will be used in the present study as a measure of affective and cognitive empathy. The Empathic Concern and Perspective-Taking subscales of the IRI combined are 14 items. The Empathic Concern subscale is a measure of cognitive empathy, and the Perspective-Taking subscale is a measure of affective empathy. Example of items on the Empathic Concern subscale include, "When I see someone being taken advantage of, I feel kind of protective toward them" and "Sometimes I don't feel sorry for other people when they are having problems", while examples of the Perspective-Taking subscale include, "Before criticizing somebody, I try to imagine how I would feel if I were in their place" and "I believe that there are two sides to every question and try to look at them both" (Davis). Davis established test-retest reliability between .61-.79 and between .62-.81 across two different samples of undergraduate students enrolled in a psychology class, indicating adequate reliability.

Constantine (2001b) utilized the Perspective Taking and Empathic Concern subscales of the IRI in a study of multicultural counseling competence, empathy, and multicultural case conceptualization ability. Constantine's sample was comprised of 132 therapists, 100 of whom identified as White, 11 identified as African American, 8 identified as Asian American, 8 identified as Latino/a American, 2 identified as biracial, and 1 identified as American Indian. Constantine reported coefficient alpha to be .72 for the Empathic Concern subscale and .63 for the Perspective Taking subscale, indicating adequate reliability of this measure for use on practicing therapists. In the present study, coefficient alpha for the Perspective Taking subscale was .83, while coefficient alpha for the Empathic Concern subscale was .79.

Also using the Empathic Concern and Perspective Taking subscales of the IRI was Constantine (2000), who assessed affective and cognitive empathy as predictors of multicultural counseling competence. The sample in the Constantine study was comprised of 124 counselors who were members of the American Counseling Association. Of the 124 participants, 103 identified as White, 10 identified as Latino/a, 4 identified as African American, 3 identified as Asian American, and 1 identified as biracial. Constantine found coefficient alpha to be .70 for the Perspective Taking subscale and .77 for the Empathic Concern subscale, indicating adequate reliability when used with mental health practitioners.

As previously stated, reviews of empathy, multicultural counseling competence, and color-blind racial ideology literature concluded that empathy has not been assessed in the context of being expressed specifically toward a racial and ethnic minority-identified client. In other words, there has not been an attempt to ascertain whether empathy assessed toward a racial and ethnic minority-identified client is different from the global definition of affective and cognitive empathy. Therefore, in addition to using global empathy as the outcome variable in this analysis, the IRI was adapted so that items assess a respondent's ability to empathize with a racial and ethnic minority client.

In order to do this, participants were given a vignette used in the Burkard and Knox (2004) study on color-blind racial attitudes and empathy. Respondents in the Burkard and Knox study rated themselves as being less empathic toward both White and African American clients who were experiencing discrimination; therefore, the vignette featured an African American client who reports experiencing discrimination as a presenting concern. The researcher and dissertation chair adapted the IRI to reflect

answers toward the vignette. Items were re-worded to assess whether the respondent can empathize with the client, and an analysis was run to test for differences between globally rated empathy and empathy in the context of being expressed toward a minority client. In the present study, coefficient alpha for the adapted Perspective Taking subscale was .76, while coefficient alpha for the Empathic Concern subscale was .87.

Balanced Inventory of Desirable Responding (BIDR): Impression Management subscale. The BIDR (Paulhus, 1990) is a 40-item Likert-type scale assessing desirable responding across two scales: the tendency to self-report in an honest but positively biased way (self-deceptive positivity) and deliberate self-presentation to the audience (impression management). As previously discussed by Tracey (2016), impression management is a preferable alternative to social desirability in multicultural counseling research; therefore, the Impression Management subscale of the BIDR will be used. The Impression Management subscales of the BIDR is a total of 20 items. Example of items on the Impression Management scale include, "My first impressions of people usually turn out to be right" and "I am a completely rational person" (Paulhus). Paulhus found test-retest reliability among a sample of 433 college students to be .65 and coefficient alpha to range from .75 to .86 for the Impression Management subscale. Concurrent validity of the 40-item BIDR was demonstrated using correlations with the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), which was found to be .71, and the Social Desirability Inventory (Jacobson, Kellogg, Cauce, & Slavin, 1977), which was found to be .80.

In a sample of 259 school counselors, Chao (2013) administered the BIDR to control for desirable responding among participants, finding coefficient alpha to be .85.

Of the 259 school counselors, 179 identified as White/European American, 31 identified as Black, 28 identified as Latino/a, 13 identified as Asian American, 1 identified as Native American, 5 identified as biracial, and 2 identified as multiracial. One limitation of this measure is that coefficient alpha was for both subscales of the BIDR, and not the Impression Management subscale only; however, the coefficient alpha score does suggest the BIDR has adequate psychometric strength.

Additionally, in a sample of 221 therapist, Gushue, Walker, and Brewster (2017) administered the BIDR to a sample of 198 White psychology graduate trainees. Using both scales of the BIDR, Gushue et al. found coefficient alpha to be .70 for the Self Deceptive Enhancement subscale and .73 for the Impression Management subscale. In the current study, coefficient alpha for the BIDR Impression Management subscale was .79. In sum, the BIDR has been found to have adequate reliability for use with the target sample in the present study.

Descriptive statistics for measures. Descriptive statistics were obtained for the five measures administered, and are presented below. Results showed no concerns regarding instrument validity or reliability.

Table 3

Descriptive statistics for the CoBRAS, MAKSS-CE-R, IIM, BIDR, IRI, and adapted version of the IRI.

Instrument	*n*	Range	Min	Max	*M*	*SD*	Median	Mode
Adapted IRI	373	45	17	62	48.11	4.49	49	49
MAKSS-CE-R	402	58	60	118	92.90	9.26	92	91
IRI	462	53	17	70	57.08	8.02	58	57
CoBRAS	414	99	21	120	83.99	31.56	97.5	112
IIM	441	15	5	20	7.32	2.98	6	5
BIDR	416	103	36	139	88.75	20.04	89	106

Note: Adapted IRI is the adapted version of the Interpersonal Reactivity Index. MAKSS-CE-R is the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised, IRI is the Interpersonal Reactivity Index, CoBRAS is the Color-Blind Racial Attitudes Scale, IIM is the Intergroup Ideologies Measure, and BIDR is the Balanced Inventory of Desirable Responding.

Analyses

The present study utilized structural equation modeling (SEM) to analyze data. Structural Equation Modeling allows for the testing of plausibility for hypothesized causal structures among a set of unobserved constructs (Fassinger, 1987; Martens, 2005). Given the complexity of the final measurement model and subsequent structural model, it was determined that gender identity, racial identity, age, and sexual identity would be the covariates used in the final structural models. This decision was based on the variability between the number of training programs and degree types, as well as the variability in number of multicultural courses completed, number of training semesters completed, number of total clients seen, and number of racial and ethnic minority clients seen.

Preliminary analyses. According to Weston and Gore (2006), multicollinearity is a concern in SEM research due to the use of related measures as indicators of constructs, and the authors suggest screening for bivariate correlations between observed

variables. Weston and Gore cite Kline's (2005) recommendation of treating bivariate correlations of $r = .85$ or higher as being problematic. The current analysis will use the recommended cutoff of $r = .85$ to test for multicollinearity. Pearson r coefficients showed no issues with bivariate correlations between the final observed variables used within the two structural models.

In order to test for normality and skewness in the sample, Weston and Gore recommend examining the distribution of each observed variable; using the recommended cutoff by Bowen and Guo (2012), if kurtosis is greater than 1 or less than -1, the distribution will be considered problematic. If data was skewed and non-normal, data transformation would have been utilized, as recommended by Bowen and Guo. Tabachnik and Fidell (2007), as cited in Bowen and Guo, recommend starting with square root transformation, then attempting a log transformation. The current data did not require data transformation due to issues with distribution. Kurtosis and skewness values were obtained for each individual item serving as observed variables for the latent variables in the measurement models, and are presented below. Results showed no issues regarding skewness and kurtosis regarding individual items used as observed variables within the final measurement and structural models. Because these results showed no issues regarding skewness and kurtosis, the decision was made to use individual items from the instruments as observed variables within the latent variables.

Table 4

Number of observations, mean, standard deviation, skewness, and kurtosis values presented for each observed variable within the final measurement and structural models.

Item	Number of Observations	*M*	*SD*	Pr (Skewness)	Pr (Kurtosis)
IRI – 1	477	4.25	0.84	0.0000	0.0000
IRI – 2	479	3.72	0.99	0.0000	0.7815
IRI – 3	474	4.31	0.83	0.0000	0.0000
IRI – 4	478	4.13	0.90	0.0000	0.0000
IRI – 5	477	3.89	0.98	0.0000	0.2048
IRI – 6	475	3.94	0.88	0.0000	0.0009
IRI – 7	475	3.72	0.97	0.0000	0.5387
Adapted IRI – 1	383	4.63	0.78	0.0000	0.0000
Adapted IRI – 2	382	1.38	0.72	0.0000	0.0000
Adapted IRI – 3	383	4.68	0.69	0.0000	0.0000
Adapted IRI – 4	382	3.90	1.03	0.0000	0.8711
Adapted IRI – 5	383	2.38	1.10	0.0057	0.0000
Adapted IRI – 6	382	4.45	0.91	0.0000	0.0000
Adapted IRI – 7	381	4.39	0.83	0.0000	0.0000
CoBRAS – 1	427	4.18	1.88	0.0000	0.0000
CoBRAS – 2	427	4.18	1.83	0.0000	0.0000
CoBRAS – 3	425	4.09	2.00	0.0001	0.0000
CoBRAS – 4	425	4.18	1.76	0.0000	0.0000
CoBRAS – 5	427	4.27	2.09	0.0000	0.0000
CoBRAS – 7	426	4.25	2.17	0.0044	0.0000
CoBRAS – 8	427	4.17	1.94	0.0000	-
CoBRAS – 9	427	4.15	1.94	0.0000	0.0000
CoBRAS – 10	426	4.10	1.89	0.0000	0.0000
CoBRAS – 11	427	4.27	2.03	0.0000	0.0000
CoBRAS – 12	426	4.31	2.09	0.0000	0.0000
CoBRAS – 13	427	3.99	1.69	0.0011	0.0000
CoBRAS – 14	426	4.10	1.91	0.0001	0.0000
CoBRAS – 15	427	4.20	1.58	0.0587	0.0000
CoBRAS – 16	424	4.18	1.83	0.0000	0.0000
CoBRAS – 17	426	4.39	2.17	0.0000	0.0000
CoBRAS – 18	424	4.12	1.73	0.0002	0.0000
CoBRAS – 19	425	4.28	2.16	0.0000	0.0000
CoBRAS – 20	426	4.22	1.99	0.0000	0.0000
IIM – 2	444	1.27	0.63	0.0000	0.0000
IIM – 3	443	1.70	0.93	0.0000	0.0000
IIM – 4	444	1.35	0.66	0.0000	0.0000

IIM – 5	442	1.50	0.82	0.0000	0.0000
MAKSS – 1	436	1.85	0.62	0.3694	0.0145
MAKSS – 2	440	1.76	0.75	0.0008	0.8307
MAKSS – 9	441	1.81	0.61	0.3073	0.0136
MAKSS – 16	439	2.42	0.80	0.0466	0.0379
MAKSS – 17	440	2.32	0.85	0.0070	0.0177
MAKSS – 18	437	2.83	0.84	0.0027	0.0343
MAKSS – 19	436	2.09	0.92	0.0003	0.0000
MAKSS – 20	438	1.88	0.90	0.0000	0.0725
MAKSS – 21	430	3.23	0.61	0.0005	0.0192
MAKSS – 22	431	3.51	0.56	0.0000	0.0000
MAKSS – 23	430	2.84	0.67	0.0636	0.7149

Note: Adapted IRI is the adapted version of the Interpersonal Reactivity Index. MAKSS-CE-R is the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised, IRI is the Interpersonal Reactivity Index, CoBRAS is the Color-Blind Racial Attitudes Scale, IIM is the Intergroup Ideologies Measure, and BIDR is the Balanced Inventory of Desirable Responding.

Theoretical foundation. The theoretical SEM model for the current investigation was based on literature reviewed which identified a relationship between therapist multicultural counseling competence and color-blind racial attitudes. Specifically, there is empirical evidence that higher scores of overall multicultural counseling competence and multicultural skills, knowledge, and awareness, are correlated with lower scores of color-blind racial attitudes. Furthermore, the theoretical SEM model was based on literature reviewed which identified a relationship between therapist multicultural counseling competence and ratings of empathy. Specifically, higher scores of overall multicultural counseling competence and multicultural skills, knowledge, and awareness, are correlated with higher scores of therapist-rated empathy. Additionally, the theoretical SEM model was based on literature reviewed which identified a relationship between therapist color-blind racial attitudes and therapist-rated empathy. Specifically, lower scores of color-blind racial attitudes are correlated with higher scores of therapist-rated empathy.

Exploratory factor analysis. In order to determine the appropriate observed variables for the measurement model, an exploratory factor analysis with oblique rotations was completed. Each individual item from the MAKSS-CE-R, CoBRAS, IIM, IRI, and adapted version of the IRI were included in the factor analysis. Loadings higher than 0.2 were considered to be indicative of contributing to a factor. Seven factors were extracted from the factor analysis, which were largely consistent with the subscales of the instruments used. The MAKSS-CE-R loaded into four factors: multicultural skills, multicultural awareness, and two separate factors for multicultural knowledge. The two separate multicultural knowledge factors were both comprised of individual items from the MAKSS-CE-R Knowledge subscale. Notably, the CoBRAS, which is comprised of three subscales, loaded into one singular latent variable, which was labeled "power-evasion color-blind racial ideology". Additionally, the seven items loading into the empathy factor were the seven items from the perspective-taking subscale of the IRI; none of the items from the empathic concern subscale of the IRI loaded into a single factor. Thus, the empathy latent variable within the measurement and structural models was comprised of items examining the perspective-taking component of empathy. Additionally, four items from the IIM loaded into one factor, which was labeled "color-evasion color-blind racial ideology".

Table 5

Standardized factor loadings for exploratory factor analysis

Instrument & Number	Description	Standardized Loadings
MCC – Awareness		
MAKKS-CE-R 1	... in most counseling situations	0.7338
MAKSS-CE-R 2	… "health", are not difficult to understand	0.2220
MAKSS-CE-R 9	… measures in most counseling sessions	0.5130
MCC – Knowledge		
MAKSS-CE-R 16	"Transcultural"	0.4844
MAKSS-CE-R 17	"Pluralism"	0.5230
MAKSS-CE-R 18	"Mainstreaming"	0.2454
MAKSS-CE-R 19	"Cultural Encapsulation"	0.7215
MAKSS-CE-R 20	"Contact Hypothesis"	0.7686
MCC – Skills		
MAKSS-CE-R 21	…of different cultural backgrounds?	0.6538
MAKSS-CE-R 22	… the way you think and act?	0.5635
MAKSS-CE-R 23	… in a multicultural counseling situation?	0.4215
Empathy		
IRI 1	… I would feel if I were in their place	0.4855
IRI 2	… listening to other people's arguments	0.3165
IRI 3	… thinks look from their perspective	0.7352
IRI 4	… and try to look at both of them	0.8354
IRI 5	… from the "other guy's" point of view	0.2031
IRI 6	… disagreement before I make a decision	0.7315
IRI 7	… "put myself in his shoes" for a while	0.4477
CBRI – Color-Evasion		
IIM 2	… tell you much about who they are	0.5153
IIM 3	… categories do not matter	0.6887
IIM 4	… do not matter very much to who we are	0.8069
IIM 5	… race and ethnicity are not important	0.8439
CBRI – Power-Evasion		
CoBRAS 1	…has an equal chance to become rich	0.3759
CoBRAS 2	…type of social services people receive	0.5577
CoBRAS 3	…as American and not African American	0.5867

CoBRAS 4	…are necessary to create equality	0.6801
CoBRAS 5	… is a major problem in the US	0.9489
CoBRAS 7	…it is not an important problem today	0.9571
CoBRAS 8	... as White people in the U.S.	0.7633
CoBRAS 9	… because of the color of their skin	0.6137
CoBRAS 10	… issues causes unnecessary tension	0.6691
CoBRAS 11	… or solve society's problems	0.9401
CoBRAS 12	… because of the color of their skin	0.8848
CoBRAS 13	… adopt the values of the U.S.	0.4891
CoBRAS 14	… only official language of the U.S.	0.5474
CoBRAS 15	… than racial and ethnic minorities	0.4063
CoBRAS 16	… unfairly against White people	0.6315
CoBRAS 17	… of racial and ethnic minorities	1.0181
CoBRAS 18	… because of the color of their skin	0.5358
CoBRAS 19	… U.S. are rare, isolated situations	1.0524
CoBRAS 20	… role in who gets sent to prison	0.7863

Note: Adapted IRI is the adapted version of the Interpersonal Reactivity Index. MAKSS-CE-R is the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised, IRI is the Interpersonal Reactivity Index, CoBRAS is the Color-Blind Racial Attitudes Scale, IIM is the Intergroup Ideologies Measure, and BIDR is the Balanced Inventory of Desirable Responding.

Final model structure. In structural equation modeling, latent variables represent theoretical factors, or constructs, which represent hypothetical variables (Weston & Gore, 2006). Latent variables might be exogenous variables (independent variables) or endogenous variables (dependent variables). Latent variables in the present SEM model were the three dimensions multicultural counseling competence (skills, knowledge, and awareness), the two dimensions of color-blind racial attitudes (color-evasion and power-evasion), and one dimension of empathy (perspective taking). Indicator variables were the observed or measured variables, which differs from latent variables (Weston & Gore, 2006). The current model uses indicator variables for the latent variables that were found from the previously discussed EFA.

The SEM model had three exogenous variables, which are similar to an independent variable. The exogenous variables were the three dimensions therapist multicultural counseling competence (multicultural skills, multicultural knowledge, and

multicultural awareness). The theoretical model hypothesized that the three exogenous variables of multicultural counseling competence predicted the endogenous variable of therapist-rated empathy; the three exogenous variables of multicultural counseling competence predicted the two endogenous variables of color-blind racial attitudes (color-evasion color-blind racial attitudes and power-evasion color-blind racial attitudes); and the two endogenous variables of color-blind racial attitudes predicted the endogenous variable of therapist-rated empathy toward racial and ethnic minority clients. Furthermore, the theoretical model hypothesized that the two endogenous variables of color-blind racial attitudes partially mediated the relationship between the three exogenous variables of multicultural counseling competence and the endogenous variable of therapist-rated empathy and the endogenous variable of empathy expressed toward a racial and ethnic minority client.

In SEM, a measurement model describes relationships between observable variables and the constructs they are hypothesized to measure (Weston & Gore, 2006). The purpose of the measurement model is to evaluate how well observed variables combine to measure latent constructs. The purpose of the structural model is to specify the hypothesized relationships among latent variables (Weston & Gore, 2006). The structural model in the present study hypothesized a direct effect between the latent variable of multicultural counseling competence and therapist-rated empathy and an indirect effect between multicultural counseling competence and therapist-rated empathy through color-blind racial attitudes. Model identification is the degree to which the estimated parameters in the model are unique, meaning that a unique solution for each parameter exists (Fassinger, 1987). A model is considered identified when there are

more known variables than unknown variables. Specifically, known variables in a model are data gathered from observed variables and relationships between observed variables, while unknown variables are the measured parameters between latent variables. The present model was considered an identified model; there are a greater number of known variables than unknown variables.

It was hypothesized that higher scores on the MAKSS-CE-R significantly predicted higher scores of affective and cognitive empathy as measured by the two subscales of the IRI; conversely, it was predicted that lower scores on the MAKSS-CE-R significantly predicted lower scores of affective and cognitive empathy as measured by the two subscales of the IRI. It was also predicted that higher scores on the MAKSS-CE-R significantly predicted lower scores on the two measures of color-blind racial attitudes. Conversely, it was predicted that lower scores on the MAKSS-CE-R significantly predicted higher scores on the two measures of color-blind racial attitudes. It was predicted that higher scores on the two measures of color-blind racial attitudes significantly predicted lower scores of cognitive and affective empathy; conversely, it was predicted that lower scores on the two measures of color-blind racial attitudes significantly predicted higher scores of cognitive and affective empathy.

An additional research question was related to empathy. The literature review indicated that empathy was not assessed when specifically expressed toward a racially and ethnically-identified client. Therefore, in order to test for a difference between globally-measured empathy and empathy expressed towards a racial and ethnic minority-identified client, the adapted version of the IRI was utilized in a separate model and replaced scores of empathy as measured by the original IRI.

Gaps in Literature

This study filled a gap in the literature by examining whether color-blind racial attitudes mediated the relationship between therapist-rated multicultural counseling competence and therapist-rated empathy. Previous research determined a significant relationship between therapist multicultural counseling competence and color-blind racial attitudes, a significant relationship between therapist color-blind racial attitudes and ratings of empathy, and a significant relationship between therapist multicultural counseling competence and ratings of empathy.

CHAPTER 4

RESULTS

This chapter presents information on data cleaning and preparation, descriptive statistics, demographic data, and preliminary analyses regarding outliers and assumptions. This chapter also presents results exploring the study's hypotheses.

Preliminary Analyses

Counter balancing analysis. In order to test whether the order of the measures significantly influenced responding and subsequent data collection, independent sample *t*-tests were run to compare the two versions of the survey. *T*-tests were run for each of the six latent variables in the two measurement models. Latent factor scores were extracted and then modeled within each *T*-test. Results showed no significant differences in scores on the instruments which serve as observed variables for latent variables. Results are shown in the table below.

Table 6

T-test results for differences in scores between survey versions for latent variables

Latent Variable	*T*	Survey 1 Mean & *SD*	Survey 2 Mean & *SD*	*p*-value	Degrees of Freedom
MCC – Skills	-0.2593	Mean = -.003 *SD* = .361	Mean = .004 *SD* = .354	Pr = 0.7955	549
MCC – Knowledge	-0.3958	Mean = -.006 *SD* = .437	Mean = .009 *SD* = .471	Pr = 0.6924	549
MCC – Awareness	1.6658	Mean = .022 *SD* = .389	Mean = -.031 *SD* = .345	Pr = 0.0963	549
CBRI – Color-Evasion	0.1110	Mean = .002 *SD* = .517	Mean = -.003 *SD* = .565	Pr = 0.9116	549
CBRI – Power-Evasion	-0.3886	Mean = -.015 *SD* = 1.069	Mean = .022 *SD* = 1.164	Pr = 0.6977	549
Empathy – General	-1.6190	Mean = -.027 *SD* = .482	Mean = .037 *SD* = .422	Pr = 0.1060	549
Empathy – Adapted	-0.7570	Mean = -.013 *SD* = .503	Mean = .018 *SD* = .446	Pr = 0.4494	549

Note: MCC – Knowledge is the latent variable of the knowledge dimension of multicultural counseling competence. MCC – Awareness is the latent variable of the awareness dimension of multicultural counseling competence, MCC – Skills is the skills dimension of multicultural counseling competence, CBRI – Color-Evasion is the color-evasion dimension of color-blind racial attitudes, CBRI – Power-Evasion is the power-evasion dimension of color-blind racial attitudes, Empathy – General is the non-adapted version of the Interpersonal Reactivity Index, and Adapted – Empathy is the adapted version of the Interpersonal Reactivity Index.

Missing data analysis. Missing data was accounted for using the maximum likelihood estimation for incomplete data, specifically Full-Information Maximum Likelihood (FIML) method. The FIML approach estimates a likelihood response value for each missing response based on all the variables present in the data set. It uses information from the observed data, including the sums of squares and cross products from the covariance of two random split-halves of data, in order to estimate a sample that

has fully inclusive data (Allison, 1987, as cited by Carter, 2006). The use of partial data in the likelihood function provides a theoretical advantage for likelihood-based inference (Enders & Bandalos, 2001). The use of FIML means that all responses are included in data analysis, and that when a respondent's data is partially missing, likely responses can be estimated. This approach to missing data is preferable to other approaches to missing data, such as listwise deletion, as it does not eliminate data that can be used to otherwise inform latent variables. This means that in the current study, data from all respondents was used in data analysis. In the current study, the highest number of responses on an individual item was 479, and the lowest number of responses was 381. This means that, for a given variable, FIML was estimated a response for between 0 and 98 responses.

Model Fit and Interpretation

Assessing for overall goodness-of-fit among measurement models in structural equation modeling is a crucial step to assessing whether hypothesized relationships between latent variables exist. Hu and Bentler (1999) provided a review of recommended cutoff values for assessing fit; for the purpose of assessing goodness-of-fit in the present study, the fit statistics of $\chi 2$, Root Mean Square Error of Approximation (RMSEA), Tucker-Lewis Index (TLI), and Comparative Fit Index (CFI) were used to assess fit. The $\chi 2$ goodness-of-fit test assesses the degree of difference between the observed distribution and the expected, hypothesized distribution (Hu & Bentler, 1999). The RMSEA value assesses the degree to which a hypothesized measurement model is different from a perfect measurement model, while the TLI and CFI are two measures of fit which compare a hypothesized measurement model from a baseline model (Xia & Yang, 2019).

Hu and Bentler (1999) recommended a cutoff value of > 0.95 for TLI and CFI values and a cutoff value of > 0.06 for RMSEA values. Significant $\chi 2$ scores suggest that a model is not a good fit (Weston & Gore, 2006); however, Weston and Gore argued that significant $\chi 2$ scores may not suggest a model is a poor fit, given that it tests whether a model is an exact fit to the data, which is considered rare. Additionally, larger sample sizes tend to produce higher values of power, which often produces frequent significant $\chi 2$ values. In conclusion, goodness-of-fit values to assess whether measurement models were a good fit in the present research were the RMSEA, TLI, and CFI values, while the $\chi 2$ values were also reported, consistent with the recommendation by Weston and Gore.

Goodness-of-fit estimates for individual latent variables. Goodness-of-fit estimates were initially obtained for each latent variable (multicultural counseling competence, color-blind racial ideology, empathy, and adapted empathy) independent of one another. The observed variables for the multicultural counseling competence latent variable were the individual 33 items from the MAKSS-CE-R. Goodness-of-fit estimates for the multicultural counseling competence latent variable independent of other latent variables showed poor fit, $\chi 2 = 2519.96$, $p = 0.00$, RMSEA = 0.096, CFI = 0.546, TLI = .0516. The observed variables for the empathy latent variable were the individual items from the Perspective Taking and Empathic Concern subscales of the IRI. Goodness-of-fit estimates for the empathy latent variable independent of other latent variables showed poor fit, $\chi 2 = 454.48$, $p = 0.00$, RMSEA = 0.101, CFI = 0.820, TLI = 0.787.

The observed variables for the color-blind racial ideology latent variable were individual items from the COBRAS and individual items from the Color-Blindness subscale from the IIM. Goodness-of-fit estimates for the color-blind racial ideology

latent variable showed poor fit, $\chi 2 = 1929.49$, $p = 0.00$, RMSEA = 0.114, CFI = 0.846, TLI = 0.832. Observed variables for the adapted empathy latent variable were the 14 adapted items from the Perspective Taking and Empathic Concern subscales of the IRI. Goodness-of-fit estimates for the adapted empathy latent variable showed poor fit, $\chi 2 = 649.23$, $p = 0.00$, RMSEA = 0.139, CFI = 0.768, TLI = 0.726. In sum, goodness-of-fit estimates for each of the four latent variables independent of one another showed inadequate fit.

Goodness-of-fit estimates for multiple latent variables with all observed variables. Goodness-of-fit estimates were then obtained using measurement models with each latent variable included; one measurement model was run with multicultural counseling competence, color-blind racial ideology, and empathy as latent variables, and one model was run with multicultural counseling competence, color-blind racial ideology, and adapted empathy as latent variables. The first measurement model was comprised of the latent variables multicultural counseling competence, with individual items of the MAKSS-CE-R as observed variables, color-blind racial ideology, with individual items of the COBRAS and Color-Blindness subscale of the IIM as observed variables, and empathy, with individual items of the Perspective Taking and Empathic Concern subscales of the IRI as observed variables. Goodness-of-fit estimates showed poor model fit, $\chi 2 = 6886.14$, $p = 0.00$, RMSEA = 0.061, CFI = 0.751, TLI = 0.743. The second measurement model was comprised of the same latent variables of the first measurement model, with the latent variable of adapted empathy substituting for the empathy latent variable; the observed variables for the latent variable of adapted empathy were the adapted items of the Perspective Taking and Empathic Concern subscale of the

IRI. Goodness-of-fit estimates showed poor model fit, $\chi 2 = 7238.33$, $p = 0.00$, RMSEA = 0.064, CFI = 0.738, TLI = 0.731.

Goodness-of-fit estimates with non-significant observed variables excluded. Both measurement models with the latent variables of multicultural counseling competence, color-blind racial ideology, and either empathy or adapted empathy showed the same 8 items of the MAKSS-CE-R and one item of the Color-blindness subscale of the IIM as being non-significant. These items were removed and two measurement models were tested for goodness-of-fit. Goodness-of-fit estimates for the model with empathy as a latent variable showed poor fit, $\chi 2 = 5453.73$, $p = 0.00$, RMSEA = 0.063, CFI = 0.788, TLI = 0.781. Goodness-of-fit estimates for the model with adapted empathy as a latent variable showed poor fit, $\chi 2 = 5823.59$, $p = 0.00$, RMSEA = 0.067, CFI = 0.773, TLI = 0.765.

In sum, goodness-of-fit estimates for measurement models which included all observed variables for all latent variables, and then subsequently removing only non-significant items, each showed poor overall fit. However, goodness-of-fit estimates did improve with the removal of non-significant items. Given that the eight non-significant items within the multicultural counseling competence latent variable were all from the Awareness subscale of the MAKSS-CE-R, measurement models were then run with all items of the MAKSS-CE-R Awareness subscale excluded as observed variables for the multicultural counseling competence latent variable. Goodness-of-fit estimates for the model with empathy included as a latent variable showed poor fit, $\chi 2 = 5192.19$, $p = 0.00$, RMSEA = 0.064, CFI = 0.795, TLI = 0.0787. Goodness-of-fit estimates for the model with adapted empathy as a latent variable also showed poor fit, $\chi 2 = 4916.60$, $p = 0.00$,

RMSEA = 0.071, CFI = 0.784, TLI = 0.776. While removing the items of the MAKSS-CE-R Awareness subscale as observed variables for the latent variable of multicultural counseling competence did improve goodness-of-fit values, these values still did not represent adequate fit for both measurement models.

In sum, goodness-of-fit estimates were poor for models which included all observed variables, models excluding non-significant observed variables, and models excluding the latent variable of MCC Awareness. The next step was testing six separate measurement models for goodness-of-fit, with each of the three dimensions of multicultural counseling competence (skills, knowledge, and awareness) treated as the only latent variable measuring overall multicultural counseling competence. What follows is a review of goodness-of-fit estimates for the six separate measurement models for each of the six models.

Goodness-of-fit estimates with individual MCC latent variables. The measurement model with the knowledge dimension of multicultural counseling competence as the overall multicultural counseling competence latent variable and general empathy as the empathy latent variable showed goodness-of-fit values as follows: $\chi 2 = 3985.92$, $p = 0.00$, RMSEA = 0.067, CFI = 0.820, TLI = 0.812. The measurement model with the skills dimension of multicultural counseling competence as the overall multicultural counseling competence latent variable and general empathy as the empathy latent variable showed goodness-of-fit values as follows: $\chi 2 = 3453.54$, $p = 0.00$, RMSEA = 0.066, CFI = 0.837, TLI = 0.830. The measurement model with the awareness dimension of multicultural counseling competence as the overall multicultural counseling competence latent variable and general empathy as the empathy latent variable showed

goodness-of-fit values as follows: $\chi 2 = 3496.44$, p = 0.00, RMSEA = 0.066, CFI = 0.826, TLI = 0.818.

The measurement model with the knowledge dimension of multicultural counseling competence as the overall multicultural counseling competence latent variable and adapted empathy as the empathy latent variable showed goodness-of-fit values as follows: $\chi 2 = 4308.10$, $p = 0.00$, RMSEA = 0.072, CFI = 0.805, TLI = 0.797. The measurement model with the skills dimension of multicultural counseling competence as the overall multicultural counseling competence latent variable and adapted empathy as the empathy latent variable showed goodness-of-fit values as follows: $\chi 2 = 3782.15$, $p = 0.00$, RMSEA = 0.072, CFI = 0.821, TLI = 0.812. The measurement model with the awareness dimension of multicultural counseling competence as the overall multicultural counseling competence latent variable and adapted empathy as the empathy latent variable showed goodness-of-fit values as follows: $\chi 2 = 3745.34$, $p = 0.00$, RMSEA = 0.071, CFI = 0.814, TLI = 0.805.

In sum, separating the three dimensions of multicultural counseling competence and treating each dimension as a singular latent variable for overall multicultural counseling competence somewhat improved goodness-of-fit values. However, these values still did not meet the recommended cutoff scores by Hu and Bentler (1999); an exploratory factor analysis (EFA) was then run to assess the factor loadings of the instruments used to construct latent variables. Results of this EFA are presented in chapter 3.

Goodness-of-fit estimates using only EFA significant observed variables. A measurement model was tested using only the items from the EFA loading .02 or greater

into the latent variables of multicultural counseling competence, color-blind racial ideology, empathy, and adapted empathy. However, given that the EFA showed the knowledge dimension of multicultural counseling competence had two separate clusters of items loading together, separate measurement models were tested for goodness-of-fit. Specifically, one measurement model had a latent variable of MCC-Knowledge comprised of all items from the two clusters of factors from the EFA, one measurement model had two separate latent variables for MCC-Knowledge comprised of each cluster of items from the EFA, and two separate measurement models, each with a latent variable of MCC-Knowledge comprised of each cluster of items from the EFA. What follows is a review of goodness-of-fit values for each of these four models.

A measurement model was tested using each of the two clusters of items from the EFA to comprise one general latent variable of MCC-Knowledge; this model also used general empathy as the latent variable for empathy. Goodness-of-fit values for this model were as follows: $\chi 2 = 2646.81$, $p = 0.00$, RMSEA = 0.059, CFI = 0.879, TLI = 0.874. A second measurement model was tested, with two separate latent variables for MCC-Knowledge, as well as general empathy as the latent variable for empathy. Goodness-of-fit values for this model were as follows: $\chi 2 = 2507.91$, $p = 0.00$, RMSEA = 0.057, CFI = 0.890, TLI = 0.884. In sum, the separation of the two clusters of items for MCC-Knowledge, creating two separate latent variables of MCC-Knowledge, and including them both in the same measurement model appeared to improve goodness-of-fit values, although these values still did not represent adequate overall fit.

The next step was to run a measurement model with each of the latent variables of MCC-Skills, MCC-Awareness, CBRI, and Empathy, and one of the two MCC-

Knowledge latent variables. Goodness-of-fit values for the first model was as follows: $\chi 2 = 2019.67$, $p = 0.00$, RMSEA = 0.058, CFI = 0.905, TLI = 0.899. Goodness-of-fit values for the second model was as follows: $\chi 2 = 1922.68$, $p = 0.00$, RMSEA = 0.055, CFI = 0.908, TLI = 0.903. In sum, it appeared that the latter cluster of items provided a stronger measure of MCC-Knowledge. Additionally, this MCC-Knowledge latent variable was deemed to be a more accurate measure of current knowledge of multicultural counseling competence. A measurement model including adapted empathy as opposed to general empathy was then run to test for goodness-of-fit. Goodness-of-fit values for this model was as follows: $\chi 2 = 1997.53$, $p = 0.00$, RMSEA = 0.058, CFI = 0.903, TLI = 0.898.

Summary. In conclusion, while the goodness-of-fit values for the measurement model do not meet the standards presented by Hu & Bentler (1999), it was determined the last model tested was considered to have adequate fit values, given the complexity of the model. Despite not meeting the values recommended by Hu & Bentler (1999), Xia and Yang (2019) argue that RMSEA values of less than .06 typically show adequate model fit, and that the RMSEA, TLI, and CFI values can be used as a means for "model improvement". Given the number of re-specifications which lead to the best overall values, the current measurement models are likely a reflection of the most "improved" latent models studying the theoretical constructs of multicultural counseling competence, color-blindness, and empathy. In sum, further elimination of observed variables, after removing non-significant items, may have threatened the overall validity of the study by threatening the validity of the latent variables being studied.

Table 7

Factor loadings for general empathy measurement model

Parameter	**Unstandardized Estimate**
makss1 → mcc awareness	0.73
makss2 → mcc awareness	0.44
makss9 → mcc awareness	0.56
makss16 → mcc knowledge	0.71
makss17 → mcc knowledge	0.72
makss18 → mcc knowledge	0.60
makss19 → mcc knowledge	0.63
makss20 → mcc knowledge	0.50
makss21 → mcc skills	0.78
makss22 → mcc skills	0.60
makss23 → mcc skills	0.58
cobras1 →cbri power	0.67
cobras2 →cbri power	0.72
cobras3 →cbri power	0.80
cobras4 →cbri power	0.82
cobras5 →cbri power	0.95
cobras7 →cbri power	0.94
cobras8 →cbri power	0.86
cobras9 →cbri power	0.78
cobras10 →cbri power	0.80
cobras11 →cbri power	0.94
cobras12 →cbri power	0.93
cobras13→cbri power	0.76
cobras14 →cbri power	0.74
cobras15 →cbri power	0.64
cobras16 →cbri power	0.83
cobras17 →cbri power	0.94
cobras18→cbri power	0.76
cobras19 →cbri power	0.94
cobras20 →cbri power	0.88
iim2 → cbri color	0.63
iim3 → cbri color	0.73
iim4 → cbri color	0.80
iim5 → cbri color	0.80
iri1 → general empathy	0.64
iri2 → general empathy	0.52
iri3 → general empathy	0.73
iri4 → general empathy	0.69
iri5 → general empathy	0.44
iri6 → general empathy	0.60

iri7 → general empathy	0.59

Note: Adapted IRI is the adapted version of the Interpersonal Reactivity Index. MAKSS-CE-R is the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised, IRI is the Interpersonal Reactivity Index, CoBRAS is the Color-Blind Racial Attitudes Scale, and IIM is the Intergroup Ideologies Measure.

Table 8

Factor loadings for adapted empathy measurement model

Parameter	**Unstandardized Estimate**
makss1 → mcc awareness	0.73
makss2 → mcc awareness	0.44
makss9 → mcc awareness	0.55
makss16 → mcc knowledge	0.70
makss17 → mcc knowledge	0.72
makss18 → mcc knowledge	0.60
makss19 → mcc knowledge	0.63
makss20 → mcc knowledge	0.50
makss21 → mcc skills	0.77
makss22 → mcc skills	0.61
makss23 → mcc skills	0.58
cobras1 →cbri power	0.67
cobras2 →cbri power	0.72
cobras3 →cbri power	0.80
cobras4 →cbri power	0.82
cobras5 →cbri power	0.95
cobras7 →cbri power	0.94
cobras8 →cbri power	0.86
cobras9 →cbri power	0.78
cobras10 →cbri power	0.80
cobras11 →cbri power	0.94
cobras12 →cbri power	0.93
cobras13→cbri power	076
cobras14 →cbri power	0.74
cobras15 →cbri power	0.64
cobras16 →cbri power	0.83
cobras17 →cbri power	0.76
cobras18→cbri power	0.76
cobras19 →cbri power	0.94
cobras20 →cbri power	0.88
iim2 → cbri color	0.63
iim3 → cbri color	0.73
iim4 → cbri color	0.79
iim5 → cbri color	0.81
airi1 → general empathy	0.78

airi2 → general empathy	-0.59
airi3 → general empathy	0.91
airi4 → general empathy	0.35
airi5 → general empathy	-0.19
airi6 → general empathy	0.65
airi7 → general empathy	0.70

Note: Adapted IRI is the adapted version of the Interpersonal Reactivity Index. MAKSS-CE-R is the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised, IRI is the Interpersonal Reactivity Index, CoBRAS is the Color-Blind Racial Attitudes Scale, and IIM is the Intergroup Ideologies Measure.

Structural Model Analysis

Once measurement models with appropriate goodness-of-fit values were identified, structural models were tested to determine the extent of relationships between endogenous and exogenous variables and to test for mediation. Two models were run including the covariates of age, gender identity, sexual identity, and racial identity. Given the complexity of the model, the decision was made to eliminate degree program, degree type, number of racial and ethnic minority clients seen in therapy, number of total clients seen in therapy, and doctoral intern status as covariates. Gender identity, sexual identity, racial identity, and age were included due to past literature indicating that racial identity predicts multicultural counseling competence (e.g., Bellini, 2002; Chao et al., 2011; Hill et al., 2013; Holcomb-McCoy & Myers, 1999; Lassiter & Chang, 2006; Pope-Davis & Ottavi, 1994; Sodowsky et al., 1998;). Furthermore, given that sexual identity, gender identity, and age are three identities which may experience oppression and discrimination, which may affect one's multicultural counseling competence, color-blindness, or capacity for empathy, they were also included in the final structural models.

General empathy structural model. The exogenous variables in this model were the three dimensions of multicultural competence (skills, knowledge, and awareness). The two dimensions of color-blind racial ideology (power-evasion and

color-evasion) were endogenous variables in the model, serving as the mediator. The other endogenous variable in the model was empathy. The sexual identity covariate was coded to be heterosexual and non-heterosexual, the gender identity covariate was coded to be male and female, and racial identity was coded to be White and non-White. Paths were drawn from the four covariates to the endogenous variables of color-evasion color-blind racial ideology, power-evasion color-blind racial ideology, and empathy. Direct effects were found for the exogenous variable of multicultural awareness on the endogenous variable of color-evasion color-blind racial attitudes ($\beta = -0.155$, $p = 0.019$), while the exogenous variable of multicultural skills had a direct effect on the endogenous variable of empathy ($\beta = 0.239$, $p = 0.003$). There was also a direct effect of the covariate sexual identity on power-evasion color-blind racial ideology endogenous variable ($\beta = -0.512$, $p = 0.001$), and the covariate gender identity on the color-evasion color-blind racial ideology endogenous variable ($\beta = 0.125$, $p = 0.027$), meaning that heterosexual-identified participants had higher ratings of power-evasion color-blind racial attitudes compared to non-heterosexual identified participants. There were no indirect effects in the model. The model showed adequate fit, $\chi 2 = 2160.63$, $p = 0.00$, RMSEA = 0.050, CFI = 0.901, TLI = 0.894.

Table 9

Parameter estimate coefficients for general empathy structural model.

Parameter	**Standard Error**	***P*-value**
makss1 → mcc awareness	0.07	<0.001
makss2 → mcc awareness	0.06	<0.001
makss9 → mcc awareness	0.06	<0.001
makss16 → mcc knowledge	0.03	<0.001
makss17 → mcc knowledge	0.03	<0.001
makss18 → mcc knowledge	0.04	<0.001
makss19 → mcc knowledge	0.04	<0.001
makss20 → mcc knowledge	0.04	<0.001
makss21 → mcc skills	0.05	<0.001
makss22 → mcc skills	0.05	<0.001
makss23 → mcc skills	0.05	<0.001
cobras1 →cbri power	0.03	<0.001
cobras2 →cbri power	0.02	<0.001
cobras3 →cbri power	0.02	<0.001
cobras4 →cbri power	0.02	<0.001
cobras5 →cbri power	0.01	<0.001
cobras7 →cbri power	0.01	<0.001
cobras8 →cbri power	0.01	<0.001
cobras9 →cbri power	0.02	<0.001
cobras10 →cbri power	0.02	<0.001
cobras11 →cbri power	0.01	<0.001
cobras12 →cbri power	0.01	<0.001
cobras13→cbri power	0.02	<0.001
cobras14 →cbri power	0.02	<0.001
cobras15 →cbri power	0.03	<0.001
cobras16 →cbri power	0.02	<0.001
cobras17 →cbri power	0.01	<0.001
cobras18→cbri power	0.02	<0.001
cobras19 →cbri power	0.01	<0.001
cobras20 →cbri power	0.01	<0.001
iim2 → cbri color	0.03	<0.001
iim3 → cbri color	0.03	<0.001
iim4 → cbri color	0.03	<0.001
iim5 → cbri color	0.03	<0.001
iri1 → general empathy	0.03	<0.001
iri2 → general empathy	0.04	<0.001
iri3 → general empathy	0.03	<0.001
iri4 → general empathy	0.03	<0.001
iri5 → general empathy	0.04	<0.001
iri6 → general empathy	0.04	<0.001

iri7 → general empathy	0.04	<0.001
mcc awareness → cbri power	0.19	0.15
mcc knowledge → cbri power	0.14	0.32
mcc skills → cbri power	0.17	0.61
mcc awareness → cbri color	0.07	0.02
mcc knowledge → cbri color	0.05	0.50
mcc skills → cbri color	0.06	0.44
mcc awareness → general empathy	0.08	0.47
mcc knowledge → general empathy	0.07	0.08
mcc skills → general empathy	0.08	0.00
cbri color → general empathy	0.02	0.99
cbri power → general empathy	0.08	0.73
age → cbri power	0.01	0.48
age → cbri color	0.00	0.52
age → general empathy	0.00	0.56
racial identity → cbri power	0.13	0.18
racial identity → cbri color	0.04	0.95
racial identity → general empathy	0.06	0.82
sexual identity → cbri power	0.14	0.00
sexual identity → cbri color	0.05	0.07
sexual identity → general empathy	0.07	0.25
Gender identity → cbri power	0.17	0.09
Gender identity → cbri color	0.06	0.03
Gender identity → general empathy	0.08	0.54

Note: Adapted IRI is the adapted version of the Interpersonal Reactivity Index. MAKSS-CE-R is the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised, IRI is the Interpersonal Reactivity Index, CoBRAS is the Color-Blind Racial Attitudes Scale, and IIM is the Intergroup Ideologies Measure.

Adapted empathy structural model. The exogenous variables in this model were the three dimensions of multicultural competence (skills, knowledge, and awareness). The two dimensions of color-blind racial ideology (power-evasion and color-evasion) were endogenous variables in the model, serving as the mediator. The other endogenous variable in the model was empathy. Paths were drawn from the four covariates to the endogenous variables of color-evasion color-blind racial ideology, power-evasion color-blind racial ideology, and adapted empathy. Results from the model showed a direct effect of the multicultural awareness exogenous variable on the color-

evasion color-blind racial ideology endogenous variable (β = -0.158, p = 0.017). There was a direct effect of the endogenous variable of color-evasion color-blind racial ideology on the endogenous variable of adapted empathy (β = -0.394, p = 0.000), as well as a direct effect of multicultural skills on adapted empathy, (β = 0.216, p = 0.016). There was an indirect effect of the exogenous variable of multicultural awareness on the endogenous variable of adapted empathy (β = 0.068, p = 0.030).

Notably, in the second structural model, a direct effect was found between the covariate of sexual identity and the endogenous variable of power-evasion color-blind racial ideology (β = -0.512, p = 0.001), meaning that heterosexual-identified participants had higher scores of power-evasion color-blind racial attitudes compared to non-heterosexual identified participants The covariate gender identity had direct effects on the endogenous variable of color-evasion color-blind racial ideology (β = 0.126, p = 0.025)and the endogenous variable of adapted empathy (β = -0.200, p = 0.018), meaning that male-identified participants had higher ratings of color-evasion color-blind racial attitudes and lower ratings of empathy compared to female-identified participants. The covariate of racial identity had a direct effect on the endogenous variable of adapted empathy (β = -0.167, p = 0.015), meaning that non-White identified participants had higher ratings of empathy compared to White-identified participants. The model showed adequate fit, $\chi 2$ = 2220.88 , p = 0.00, RMSEA = 0.051, CFI = 0.897, TLI = 0.890.

Table 10

Parameter estimate coefficients for adapted empathy structural model.

Parameter	**Standard Error**	***P*-value**
makss1 → mcc awareness	0.07	<0.001
makss2 → mcc awareness	0.06	<0.001
makss9 → mcc awareness	0.06	<0.001
makss16 → mcc knowledge	0.03	<0.001
makss17 → mcc knowledge	0.03	<0.001
makss18 → mcc knowledge	0.04	<0.001
makss19 → mcc knowledge	0.04	<0.001
makss20 → mcc knowledge	0.04	<0.001
makss21 → mcc skills	0.05	<0.001
makss22 → mcc skills	0.05	<0.001
makss23 → mcc skills	0.05	<0.001
cobras1 →cbri power	0.03	<0.001
cobras2 →cbri power	0.02	<0.001
cobras3 →cbri power	0.02	<0.001
cobras4 →cbri power	0.02	<0.001
cobras5 →cbri power	0.01	<0.001
cobras7 →cbri power	0.01	<0.001
cobras8 →cbri power	0.01	<0.001
cobras9 →cbri power	0.02	<0.001
cobras10 →cbri power	0.02	<0.001
cobras11 →cbri power	0.01	<0.001
cobras12 →cbri power	0.01	<0.001
cobras13→cbri power	0.02	<0.001
cobras14 →cbri power	0.02	<0.001
cobras15 →cbri power	0.03	<0.001
cobras16 →cbri power	0.02	<0.001
cobras17 →cbri power	0.01	<0.001
cobras18→cbri power	0.02	<0.001
cobras19 →cbri power	0.01	<0.001
cobras20 →cbri power	0.01	<0.001
iim2 → cbri color	0.03	<0.001
iim3 → cbri color	0.03	<0.001
iim4 → cbri color	0.03	<0.001
iim5 → cbri color	0.03	<0.001
airi1 → adapted empathy	0.02	<0.001
airi2 → adapted empathy	0.04	<0.001
airi3 → adapted empathy	0.02	<0.001
airi4 → adapted empathy	0.05	<0.001
airi5 → adapted empathy	0.05	<0.001
airi6 → adapted empathy	0.03	<0.001

airi7 → adapted empathy	0.03	<0.001
mcc awareness → cbri power	0.19	0.14
mcc knowledge → cbri power	0.14	0.32
mcc skills → cbri power	0.17	0.59
mcc awareness → cbri color	0.07	0.02
mcc knowledge → cbri color	0.05	0.50
mcc skills → cbri color	0.06	0.45
mcc awareness → adapted empathy	0.09	0.21
mcc awareness → adapted empathy	0.03	0.03 (indirect effect)
mcc knowledge → adapted empathy	0.07	0.20
mcc skills → adapted empathy	0.09	0.01
cbri color → adapted empathy	0.10	<0.001
cbri power → adapted empathy	0.03	0.41
age → cbri power	0.01	0.48
age → cbri color	0.00	0.50
age → adapted empathy	0.00	0.41
racial identity → cbri power	0.13	0.19
racial identity → cbri color	0.04	0.99
racial identity → adapted empathy	0.07	0.02
sexual identity → cbri power	0.15	0.001
sexual identity → cbri color	0.05	0.07
sexual identity → adapted empathy	0.08	0.02
gender → cbri power	0.17	0.003
gender → cbri color	0.06	0.03
gender → adapted empathy	0.09	0.03

Note: Adapted IRI is the adapted version of the Interpersonal Reactivity Index. MAKSS-CE-R stands for the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition – Revised, IRI is the Interpersonal Reactivity Index, CoBRAS is the Color-Blind Racial Attitudes Scale, and IIM is the Intergroup Ideologies Measure.

CHAPTER 5

DISCUSSION

This chapter presents discussion of the results of the study. Future directions for research, practice, and training are also discussed. Limitations and conclusions of the study are also discussed.

Overview

The purpose of this study was to determine the extent to which color-blind racial attitudes mediate the relationship between multicultural counseling competence and empathy. A secondary aim of this study was to collect preliminary data on whether there is a difference between empathy that is expressed generally, and empathy that is expressed toward a client with a minority racial and ethnic identity. It was hypothesized that color-blindness would mediate the relationship between multicultural counseling competence and empathy.

This study added to the literature on multicultural counseling competence in that it found evidence that different dimensions of color-blind racial attitudes mediate relationships between cultural competence and empathy expressed toward clients of color, specifically African American male clients. This is the first study to examine the

extent to which color-blindness contributes to the relationship between therapist multicultural counseling competence and empathy. The results are significant in that they help to better understand how therapists can better hone their multicultural counseling competence by understanding that "seeing" color is important in the therapy room.

More broadly, this study added to the literature in that the context of empathy mattered when this mediated relationship is significant. The findings suggest that color-blind racial attitudes were salient in the relationship between multicultural counseling competence and empathy when empathy was being expressed toward a client with a racial and ethnic minority identity. Moreover, color-blind racial attitudes were not a salient factor when empathy was being rated in general, and not in a clinical setting towards a client. These findings somewhat contrast the previous research which has found relationships between multicultural counseling competence, color-blindness, and empathy (e.g., Burkard & Knox, 2004; Constantine, 2000; Fuertes & Brobst, 2002; Neville et al., 2006). There are many possible reasons for these differences; most notably, that multicultural counseling competence and color-blind racial attitudes were separated into the specific dimension of their respective theoretical construct within the measurement and structural models.

Results found partial support for all four of the hypotheses. The skills dimension of multicultural counseling competence was predictive of both general empathy and adapted empathy, while the awareness dimension of multicultural counseling competence had an indirect effect on adapted empathy. Furthermore, the knowledge domain of multicultural counseling competence was not predictive of either general empathy or adapted empathy. Regarding the second hypothesis, the awareness dimension of

multicultural counseling competence was predictive of color-evasion color-blind racial attitudes in both structural models; however, none of the three dimensions of multicultural counseling competence were predictive of power-evasion color-blindness, and the skills and knowledge dimensions of multicultural counseling competence were not predictive of color-evasion color-blindness.

Hypothesis three was partially supported. Color-evasion color-blindness was predictive of adapted empathy, but not of general empathy, while power-evasion color-blindness was not predictive of either general empathy or adapted empathy. Finally, hypothesis 4 was partially supported; there was a partial mediation of color-evasion color-blindness on the relationship between the awareness dimension of multicultural counseling competence and adapted empathy. There was no mediated effects of power-evasion color-blindness on any relationship between dimensions of multicultural counseling competence and either general or adapted empathy.

Within the structural model exploring general empathy, results showed the covariate of sexual identity had a direct effect on the endogenous variable of power-evasion color-blind racial attitudes. This finding suggests that sexual minority participants tended to report having lower power-evasion color-blind racial attitudes. Additionally, results from the general empathy structural model found that gender-identity had a direct effect on the endogenous variable of color-evasion color-blind racial attitudes; this finding suggests that female-identified participants tended to report lower color-evasion color-blind racial attitudes. Within the structural model assessing adapted empathy, the covariate of gender identity had a direct effect on the endogenous variables of color-evasion color-blind racial attitudes and empathy; this suggests that female-

identified participants tended to espouse lower color-evasion color-blind racial attitudes and were rating more empathy toward the client of color. Additionally, racial identity had a direct effect on the endogenous variable of adapted empathy; this suggests that racial/ethnic minority participants tended to be more empathic toward the African American client compared to White participants.

A possible reason for these findings is that individuals with oppressed identities may be able to better empathize with others compared to individuals with more privileged identities. It is notable that racial identity did not have a significant effect on color-blindness or empathy; one possible explanation for this finding is that empathy was being assessed globally.

Relationship between Multicultural Counseling Competence and Color-Blind Racial Ideology. Results were somewhat inconsistent with previous research regarding multicultural counseling competence and the theoretical construct of color-blind racial ideology; however, this study is unique in that it separated power-evasion and color-evasion dimensions of color-blind racial ideology, which has implications for results. Overall, these results are somewhat consistent with findings by Johnson and Williams (2015), Chao et al. (2011), and Chao (2013), who concluded a relationship between color-blindness and multicultural counseling competence. Results from both structural models showed that multicultural awareness predicted color-evasion color-blind racial ideology; specifically, that lower levels of multicultural awareness predicted higher levels of color-evasion color-blind racial attitudes. This means that the less culturally aware a participant was, the more likely they were to have color-blind racial attitudes characteristic of not "seeing" race; these findings are consistent with research by Chao et

al. and Chao. Notably, power-evasion racial-ideology was not significantly predicted by multicultural awareness.

The lack of significant relationship between both color-evasion and power-evasion color-blind racial attitudes and the skills dimension of multicultural counseling competence may be explained by the fact that the sample was largely comprised of trainees and not practitioners, as previous research has found multicultural competence are honed throughout one's training and career. It is possible there was not enough variability within the current sample to achieve a significant relationship. Additionally, the lack of relationship between multicultural awareness and power-evasion color-blind racial ideology contrasts the findings by Neville et al. (2006). Neville et al. concluded that greater color-blind racial attitudes predicted lower scores of multicultural awareness and knowledge; however, color-blindness was assessed using the CoBRAS, which, as previously mentioned, is a measure of power-evasion color-blind racial ideology, and not color-evasion.

In conclusion, these results are somewhat consistent with past research in that they show a relationship between the theory of multicultural counseling competence and the theory of color-blindness (e.g., Chao et al., 2011; Chao, 2013; Johnson & Williams, 2015). However, the lack of relationship between specific dimensions of multicultural counseling competence and color-blind racial ideology is not consistent with past research.

Relationship between Multicultural Counseling Competence and Empathy. Results were mixed regarding the relationship between therapist multicultural counseling competence and empathy, both general empathy and empathy toward a racial and ethnic

minority client. Results from the structural model testing general empathy demonstrated that the skills dimension of multicultural counseling competence significantly predicted general empathy; specifically, that the more multiculturally skilled a clinician rated themselves, the more empathic they rated themselves. Additionally, the structural model testing adapted empathy toward an African American male client found that both the skills and awareness dimensions of multicultural counseling competence significantly predicted empathy. Specifically, the higher a respondent rated themselves as multiculturally skilled or aware, the more empathic they rated themselves toward an African American client.

These results are somewhat consistent with previous research examining the relationship between multicultural counseling competence and empathy. They are consistent with findings from Constantine (2000), who found the multicultural counseling competence dimension of awareness to significantly predict therapist-rated empathy. These results are also consistent with research exploring observer-rated multicultural counseling competence and observer-rated empathy; namely, that higher client ratings of multicultural counseling competence predicted higher client ratings of empathy (e.g., Fuertes & Brobst, 2002; Fuertes & Brobst, 2006; Sarmiento, 2012; Wang & Kim, 2010;). These findings are consistent with research in other disciplines of mental health, such as rehabilitation counseling (e.g., Bellini, 2003; Matrone & Leahy, 2005). Additionally, the finding of multicultural skills predicting ratings of empathy is not surprising, given that empathy is a therapy skill.

What remains unclear is the specificity of these studies in regards to which dimensions of multicultural counseling competence best predict empathy, as well as the

role of having participants rate themselves as being capable of empathy toward a specific client. There was no relationship between general empathy and multicultural knowledge and awareness, but there was a significant relationship between empathy expressed toward an African American male client and multicultural skills and awareness. The finding that multicultural knowledge did not predict either general empathy or adapted empathy is notable. Given that multicultural knowledge is primarily concerned with knowledge of how racial and ethnic minority people are treated in the United States. Given that many racial and ethnic minority people face discrimination and oppression, it is reasonable to expect multicultural knowledge to have a direct effect on adapted empathy. This finding is significant and may be further explored to determine why this relationship did not exist in the present study.

One possible reason for this difference is due to the fact that mental health students and practitioners were participants in this study; when participants were rating their ability to empathize with an African American client, their levels of multicultural counseling competence naturally played a salient role in how well they would be rating themselves as being capable of empathy. Relatedly, the fact that the client in the vignette was a racial and ethnic minority person may play in a role in the significance of results; if the vignette client identified as Caucasian/White, it is possible there would not be a relationship between multicultural counseling competence dimensions and empathy. Further, these results may be due to the specific identities of the vignette client as well as the situation depicted in the vignette. For example, results may be different had the client depicted in the vignette identified as a transgender, Asian-American female experiencing discrimination by a roommate may have elicited different empathy scores from the

current results. The current results are generalizable in that generally-rated empathy and empathy rated toward a person of color may differ; the extent to which there are differences between different client identities and situations remains unknown.

Relationship between Color-Blind Racial Ideology and Empathy. Results showed inconsistent findings regarding color-blind racial ideology and empathy. The structural model testing general empathy showed that neither color-evasion nor power-evasion color-blind racial attitudes were predictive of general ratings of empathy. This is inconsistent with research regarding color-blindness and empathy, which has previously found that higher self-ratings color-blind racial attitudes resulted in lower ratings of empathy (Burkard & Knox, 2004). One possible explanation for this is that a type II error occurred, in that the null hypothesis failed to be rejected; given that the RMSEA values for both structural models were close to the cutoff values, which increases the possibility of a type II error occurring. However, results from the current study differ from the results in the Burkard and Knox study in that the authors assessed color-blind racial attitudes using the CoBRAS, while the current study separated out power-evasion color-blind racial attitudes from color-evasion color-blind racial attitudes.

Notably, these results are somewhat consistent with research examining related constructs of color-blind racial attitudes, such as microaggressions. Exhibiting high color-blind racial attitudes in therapy is a form of microaggression, and research has shown that these microaggressions have a negative impact on therapy processes and outcomes (e.g., Constantine, 2007; Owen et al., 2010; Owen et al., 2011a; Owen et al., 2014b). Given that empathy expressed toward a client is a type of therapy process, the

fact that a dimension of multicultural counseling competence predicted a type of therapy process is consistent with previous research.

Current results demonstrated that color-evasion color-blind racial attitudes were significantly, negatively predictive of ratings of empathy toward an African American male client. Results from the structural model testing for empathy expressed towards an African American male client showed that lower color-evasion color-blind racial attitudes were predictive of higher ratings of empathy expressed toward a racial and ethnic minority-identified client. This partially supports the hypothesis that color-blind racial attitudes will predict ratings of empathy. There are two possible reasons for the disparity of results between the structural model testing general empathy and structural model testing for empathy expressed toward a racial and ethnic minority-identified client. First, the lack of significance between color-evasion color-blind racial attitudes and general empathy may be due to the lack of race-related questions within the measure of general empathy; in other words, one may still be empathic despite having high color-evasion color-blind racial attitudes. Similarly, color-blind racial attitudes may become relevant to testing for empathy when empathy is expressed toward a client with a racial and ethnic minority identity. This would somewhat contrast results from Burkard and Knox (2004), who found that color-blind racial attitudes are predictive of a therapist's ability to empathize with a client, regardless of client race.

Results also showed no significant relationship between power-evasion color-blind racial attitudes and both general empathy and empathy expressed toward a racial and ethnic minority-identified client. The former finding of no relationship between power-evasion color-blindness and general empathy is counter to previous research,

which has found that higher ratings of color-blindness, as measured by the CoBRAS, a measure of power-evasion color-blindness, predicts lower ratings of empathy (Burkard & Knox, 2004). The current findings show no relationship between power-evasion color-blindness and ratings of empathy, or empathy expressed toward a racial and ethnic minority-identified client. There are two possible reasons for these findings. First, empathy expressed toward a racial and ethnic minority-identified client is likely to be more sensitive to color-evasion color-blindness, as color-evasion is characterized as not "seeing" color, whereas power-evasion is characterized as actively denying that racism exists. The vignette of the racial and ethnic minority-identified client, specifically the clinical situation it depicts, may simply lend itself to not "seeing" race as opposed to "denying" that racism exists. Second, the Burkard and Knox study's analogue research design differs from the current' study's, which may also explain the inconsistent results.

Relationship between Multicultural Counseling Competence, Color-Blind Racial Ideology, and Empathy. Results showed that color-evasion color-blind racial ideology partially mediated the relationship between multicultural awareness and empathy expressed toward a racial and ethnic minority client, but not with general self-ratings of empathy. This partially supports the original hypothesis that color-blindness will mediate the relationship between multicultural counseling competence and empathy. Color-evasion color-blind racial attitudes appears to contribute to the relationship between one dimension of multicultural counseling competence (awareness) and empathy, but only when empathy is being expressed toward a racial and ethnic minority client. In other words, a clinician's multicultural counseling awareness is significantly predictive of their ability to express empathy toward a client of color, and the extent to

which they hold color-evasion color-blind racial attitudes partially explains this relationship.

One possible explanation for this finding is that the construct of empathy is somewhat changed within the two separate models; in one model, respondents are simply asked to rate their empathy in a hypothetical way, while in the adapted model, respondents were asked to rate how empathic they would be towards another person. Additionally, the respondents were asked to make a clinical judgment in terms of how their therapy skills would be applied towards a client of color, which makes color-blind racial attitudes and multicultural counseling competencies more salient in their ratings of empathy. The finding that neither color-evasion nor power-evasion mediated the relationship between multicultural skills is notable, in that therapy process has been shown to be sensitive to cultural dynamics within the therapeutic relationship. One possible explanation for this finding is that both the measure of empathy, as well as the vignette and subsequent adapted empathy measure, did not require respondents to identify specific therapy skills they might utilize when working with the client in the vignette.

Taken together, these results suggest the contribution of color-blindness to the relationship between empathy and multicultural counseling competence is unique to multicultural awareness, and not skills or knowledge. This finding is reasonable in that being multiculturally aware primarily involves being aware of one's perceptions and beliefs regarding racial and ethnic identities, and being aware of potential biases and previous lived experiences which might impact perceptions and beliefs. As previously discussed, these findings appear to contradict the findings by Burkard and Knox (2004),

who had concluded no difference regarding therapist ability to empathize with clients, regarding of client race. One possible reason for these differences in due to the different research designs and data analyses in the respective studies. In conclusion, these findings provide ample opportunities for future research, exploring the differences in dimensions of color-blindness and how these differences may be related to multicultural counseling competence as well as empathy and, more broadly, therapy process.

Implications for Training

Results have many implications for training. These results are consistent with previous results concluding that better developed multicultural skills and awareness are predictive of ratings of empathy, as well as empathy expressed toward a racial and ethnic minority client. This reinforces the importance of training programs focusing attention on providing culturally competent education and training to students. Training programs should address color-blindness as negative, especially because not "seeing" color is considered a positive in broad society, and emphasize that becoming aware of biases is important to minimizing biases. Programs may emphasize and promote the growth needed for minimizing color-blind racial attitudes by integrating more experiential activities and providing opportunities for critical incidents in order to reduce color-blindness among trainees.

Given that previous research (e.g., Bellini, 2002; Lee & Khawaja, 2013; Lee et al., 2014) has found diverse caseloads, multicultural coursework, and experiential activities to all increase multicultural counseling competence, these interventions to build multicultural counseling competence should also implement discussions around color-blindness as well. The finding of multicultural awareness being positively predictive of

color-evasion color-blindness is important for training, in that it suggests that discussions focused on acknowledging racial differences and discussing bias can help to raise multicultural awareness among students. While power-evasion color-blind racial attitudes were not predictive of empathy in either model, students in training as well as professionals in the field would still benefit from honing their awareness around color-blindness as a broad construct.

Additionally, the findings reinforce previous research findings that better multicultural skills are predictive of greater empathy. It is also important to note that multicultural skills were predictive of empathy expressed toward a racial and ethnic-minority client. These findings reinforce the importance of training programs to continue to provide training on culturally adapted interventions and broader therapy processes and skills consistent with research and literature on culturally adapted treatments (e.g., Bernal, Jimenez-Chafey, & Rodriguez, 2009; Griner & Smith, 2006; Whaley & Davis, 2007) as well as the most recent multicultural guidelines for practice (American Psychological Association, 2017). Additionally, these culturally adapted interventions are likely to also assist with building awareness regarding color-blind racial attitudes among students in training.

Implications for Research

Future research should continue to build on these results by continuing to better understand the differences between different dimensions of multicultural counseling competence and color-blind racial attitudes and how these different dimensions play a role in the relationship between the theoretical constructs of cultural competence, color-blindness, and empathy. Researchers might replicate the current study's methodology

using vignettes featuring different client identities or using instruments using observer-rated multicultural counseling competence and empathy, with the goal of rating empathy expressed in actual therapy sessions. Future research should also seek to have a more diverse sample of practitioners and trainees; specifically, future research should attempt to recruit more practitioners. Future research might also explore how other interactions similar to color-blindness, such as attitudes toward religion, gender identity, or sexual identity, contribute to the relationship between multicultural counseling competence and empathy. Similarly, research may examine how these variables interact when a client in a vignette is White-identified, and the therapist is a person of color.

The constructs of White empathy toward racism, cultural humility, multicultural orientation, and racial microaggressions should be further explored within the context of this research. Given that White empathy toward racism is predictive of lower color-blind racial attitudes (Spanierman & Heppner, 2004; Spanierman et al., 2009) and greater multicultural knowledge (Spanierman et al., 2008), future research might examine the extent to which color-blindness might mediate a relationship between multicultural counseling competence and White empathy toward racism, or test for other relationships between these constructs. Similarly, because the constructs of multicultural orientation and cultural humility are related to therapy processes and outcomes (e.g., Hook et al., 2013; Owen et al., 2011c; Owen et al., 2014a), future research may explore whether color-blindness mediates a relationship between these constructs and empathy. Finally, because racial microaggressions have a relationship with therapy processes (e.g., Constantine et al., 2007; Owen et al., 2014b), future research might explore whether color-blindness mediates a relationship between racial microaggressions and empathy.

As mentioned previously, the use of the CoBRAS has been nearly universal when studying color-blind racial attitudes. However, as the CoBRAS is shown to be a good measure of power-evasion color-blind racial attitudes, and a poor measure of color-evasion racial attitudes, future research may separate color-evasion and power-evasion when studying how the effects of color-blindness on dimensions of cultural competence. Future research should consult the recommendations by Awad and Jackson (2014) in their review of the measurement of color-blind racial attitudes. Continuing to use the instruments recommended for measuring color-evasion racial attitudes should be utilized by researchers going forward. Additionally, separating power-evasion and color-evasion color-blind racial attitudes should be assessed within empathy research in order to better understand the differences these two dimensions have in regards to their relationship to multicultural counseling competence and empathy. Specifically, future research should continue to explore why certain dimensions of color-blind racial attitudes significantly influence the relationship between multicultural counseling competence and empathy, both global empathy and when empathy is expressed clinically, and qualitative research approaches to better understanding may be warranted. Given that racial identity was a salient predictor of dimensions of color-blindness in the current study, future studies may focus solely on obtaining a sample of White or non-White identified participants only, in order to better understand what other covariates (such as training program or degree type).

The findings also provide future research possibility regarding empathy research; specifically, how empathy is measured in terms of self-rated empathy and expressed to clients, more broadly to others, and more specifically toward racial and ethnic minority

clients. The current findings suggest differences in terms of how well clinicians can identify with and expressed empathy towards clients and how empathic they rate themselves. Future research may continue to explore why these differences occur, as well as the consequences of these differences clinically. Again, a qualitative research approach designed to identify themes and patterns for these differences may be warranted.

Finally, future research may focus on further exploration of why the knowledge domain of multicultural counseling competence did not have a relationship with either rated empathy or expressed empathy. As previously discussed, there are theoretical rationales for why skills and awareness have relationships with empathy; for example, expressing empathy is a clinical skill that is honed through training, supervision, and practice, while multicultural awareness is similarly honed through training, supervision, and practice. Further exploration is warranted for determining why knowledge did not have a significant relationship to both types of empathy. Additionally, the current study only examined the therapy process of empathy as the outcome variable; future research may expand on this by exploring other therapy processes such as trustworthiness or working alliance. This may be achieved by replicating the current research design and using a measure or working alliance or trustworthiness in place of empathy.

Implications for Practice

These findings suggest that practitioners should continue to prioritize culturally competent practice with racial and ethnic minority clients, in particular African American male clients. Additionally, these findings emphasize the importance of continued development of each dimension of multicultural counseling competence, and treating

development in each of the three domains of competence equally important to developing overall competence. Practitioners should continue to strive to be open to diversity and identify and process critical incidents in their practice as a means for honing their multicultural counseling competence (e.g., Tummala-Narra et al., 2012; Delsignore et al., 2010). These findings are also relevant to practice for White practitioners, as previous research has found White practitioners to identify fewer critical incidents and have a less positive attitude toward diversity and multiculturalism as opposed to non-White practitioners (e.g., Coleman, 2006; Dickson et al., 2008). In sum, practitioners should recognize that the racial and ethnic identity of the client matters in the therapy room, especially when they are showing empathy toward a client.

Results show that skills and awareness domains of multicultural counseling competence contribute to empathy in some way, with skills contributing to both general and expressed empathy, and awareness contributing to empathy expressed toward a racial and ethnic minority client. These findings reinforce the importance of clinicians being mindful of culturally adapted interventions as well as culturally competent care, as previously outlined by the aforementioned literature on cultural adapted interventions and culturally competent care (e.g., APA, 2017; Bernal et al., 2009; Griner & Smith, 2006; Whaley & Davis, 2007).

Limitations

This research is not without limitations. Cause and effect relationships between variables are not possible with non-experimental research designs, meaning the differences between multicultural counseling competence, color-blind racial attitudes, and empathy are not further explained within the research. Additionally, the exclusion of

the BIDR Impression Management subscale as a covariate means that desirable responding was not taken into account in the final analyses. While data in the current study was gathered anonymously and is considered low-stakes, there is still the possibility respondents did not respond wholly truthfully for fear of being perceived as racist or prejudice. The exclusion of other covariates, such as number of racial and ethnic minority clients seen in practice, means that current results and conclusions may not be entirely generalizable to past research on multicultural counseling competence, color-blind racial attitudes, and empathy.

A significant limitation to this study is the demographic sample being primarily White, female, cisgender, and heterosexual. Previous research has found differences in multicultural counseling competence in terms of racial identity (e.g., Bellini, 2002; Chao et al., 2011; Hill et al., 2013; Holcomb-McCoy & Myers, 1999; Lassiter & Chang, 2006; Pope-Davis & Ottavi, 1994; Sodowsky et al., 1998;). Lower multicultural counseling competence may skew the subsequent scores for empathy and color-blindness; thus, a more diverse sample may lead to different results regarding the role multicultural counseling competence has on empathy, and the role color-blindness plays in potentially mediating this relationship. Future research may focus on obtaining a more diverse sample in terms of gender, racial identity, gender identity, and sexual identity.

Another limitation of this research is the disproportionate number of trainees to practitioners. Previous research has concluded that multicultural training hones multicultural counseling competence (e.g., Cartwright et al., 2008; Estrada et al., 2002; Malott, 2010). Thus, having a sample of primarily trainees who have not completed training programs might result in lower multicultural counseling competence scores,

which ultimately may impact the subsequent scores of empathy and color-blind racial attitudes. Additionally, this sample conflated students and graduates of psychology and counselor education programs, as well as practitioners with graduate trainees. This is notable, as previous research on multicultural counseling competence, color-blind racial attitudes, and empathy (e.g., Burkard & Knox, 2004; Chao et al., 2011, Hansen et al., 2006;) have used samples comprised of only practicing psychologists or psychology graduate students. Future research may focus on obtaining a sample with only clinicians, or at minimum a sample with lesser variability between the number of participants that identity as students in training versus the number of participants identifying as clinicians. Research should also study these constructs among samples comprised of only students and graduates of counselor education or psychology graduate programs.

A final limitation of the current study is the validity of the MAKSS-CE-R. While this instrument has been used extensively in previous multicultural counseling research, the current study's EFA finding of two separate clusters of MCC-Knowledge suggests that the items assessing multicultural knowledge may need to be updated.

Conclusions

In summary, this study partially supports previously research findings regarding multicultural counseling competence, color-blind racial attitudes, and empathy. The study also provides future directions for research regarding differences of color-blind racial attitudes and how these differences affect empathy expressed toward clients. It was notable that multicultural awareness did not have a direct effect on ratings of empathy, given previous research findings. It is also notable that the only indirect effect was when empathy was expressed toward a client with a minority racial and ethnic identity. This

emphasizes the importance of clinicians honing their multicultural counseling competence, and understanding this is a career-long effort.

The mediation hypothesis was partially supported, with color-evasion color-blind racial ideology mediation the relationship between multicultural counseling competence and empathy only when empathy was being expressed toward a racial and ethnic minority client. One possible explanation for this is that respondent color-blind racial attitudes became more significant when the stimulus of a racial and ethnic minority client was introduced, and not when they were tasked with rating their general empathy.

This research has implications for research, practice, and training. Future research should continue to explore the role of color-blind racial attitudes on multicultural counseling competence and empathy, with an emphasis on differentiating between power-evasion and color-evasion color-blind racial attitudes. Practitioners should continue to be mindful of personal biases and how these effect their training and practice. Training programs should continue to integrate interventions designed to challenge trainee attitudes on race with the goal of honing multicultural counseling competence. In sum, these results provide further evidence that multicultural counseling competence is a nuanced and ever-evolving theoretical construct, and should continue to be a focus of attention within the training, practice, and research components of the mental health field.

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APPENDIX A

Survey Instruments

I. Demographic Data

1. Please identify your gender identity (select all that apply):

    1. Cisgender (gender identity matches sex assigned at birth)
    2. Transgender (gender identity does not match sex assigned at birth)
    3. Gender nonconforming/gender fluid
    4. Man
    5. Woman
    6. Other gender identity not listed (specify) _____

2. Please identify your racial identity:

    1. Black/African American
    2. Asian/Asian American/Pacific Islander
    3. Hispanic/Latinx
    4. American Indian/Native American/Alaska or Hawaiian Native/Indigenous
    5. White/Caucasian
    6. Biracial/multiracial
    7. Not listed

3. Please identify your sexual orientation/sexual identity:

    1. Heterosexual
    2. Bisexual
    3. Gay
    4. Not listed

4. Please indicate your current professional status
    1. Graduate student
    2. Practitioner

5. Please indicate your degree or current degree program
    1. Counseling psychology
    2. Clinical psychology
    3. Combined clinical/counseling psychology
    4. School psychology
    5. Counselor education/Clinical mental health counseling

6. Please indicate your highest degree completed
    1. Ph.D.
    2. Psy.D.

3. M.A.
4. M.S.
5. M.Ed.
6. Other (specify) _____

7. Please indicate your age:_____

8. Please indicate the number of multicultural counseling courses you have completed: _____

9. Please estimate the number of racial and ethnic minority clients you have seen for therapy:_____

10. Please estimate the total number of clients you have seen in your practice:_____

11. Please indicate the total number of practicum training semesters you have completed in both your master's and/or doctoral program:_____

APPENDIX B

Sample Solicitation Email

I. Sample Email to Training Directors

Dear Training Director,

My name is Brian Fitts and I am a fifth-year doctoral candidate in the counseling psychology program at Cleveland State University. I am completing my dissertation research examining multicultural counseling competence, color-blind racial attitudes, and empathy among students and practitioners. I am requesting your assistance in collecting data and would appreciate your help. If you are willing, I would appreciate you forwarding this request to your students for participation. Completion of the survey will take between 15-20 minutes, and participants completing the survey have the chance to win one of three Amazon.com gift cards. Please do not hesitate to contact me if you have any further questions.

II. Sample Email to Practitioners

Dear Practitioner,

My name is Brian Fitts and I am a fifth-year doctoral candidate in the counseling psychology program at Cleveland State University. I am completing my dissertation research examining multicultural counseling competence, color-blind racial attitudes, and empathy among practitioners. I am requesting your assistance in collecting data and would appreciate your help. If you are willing, please consider completing the following instruments. Completion of this survey will take between 15-20 minutes, and upon completion, you will have the option to enter your email for a chance to win one of three Amazon.com gift cards. Please do not hesitate to contact me if you have any further questions.

APPENDIX C

Vignette

I.

I am an African-American, male, freshman in college. I've been here about six weeks, and I'm finding it difficult to connect with people, hard to make friends in classes or in my dorm. I miss my friends at home, and also miss my family. Everything seems different here, and I don't feel like I know how to talk to people, how to make friends. My Resident Assistant has encouraged me to take part in some dorm activities, but I haven't felt like going. I find it hard to leave my room. It seems like everyone here is White. I like different kinds of music, do different things, and really don't seem to be able to connect. There were lots of White people in my hometown, but I really hung out mostly with my African-American friends and family. I lived in my hometown my whole life, so my friends are people I've known all my life. There's no one here from my hometown, and the people who are here just don't seem to want me to be involved. It's making me think that maybe I should transfer to a school closer to home.

APPENDIX D

Informed Consent

Dear Participant,

You are invited to participate in my dissertation research. I am Brian Fitts, a fifth-year student in the counseling psychology doctoral program at Cleveland State University.

Purpose

This study examines therapist ratings of color-blind racial attitudes, multicultural counseling competence, and empathy. I am studying how color-blind racial attitudes impact the relationship between multicultural counseling competence and empathy.

Procedure

You are invited to complete the following Surveymonkey instrument. You will answer questions about your attitudes toward diversity, multiculturalism, and race. You will answer demographic questions.

Risks and Discomforts

The risks from participating in this study are minimal. The risks are no more than in everyday life.

Benefits

There are no direct benefits from participating in this study. Participants have the option of entering a drawing for one of three $25 Amazon gift cards.

Time Commitment

It takes between 20 and 30 minutes to finish this survey.

Confidential Data Collection

You are not asked for your name on this survey. You have the option of entering your email address for a chance to win one of three $25 Amazon gift cards. All data will be kept for five years.

Right to Refuse or Withdraw

Participation in this study is voluntary. You may refuse at any time. You may withdraw at any time. There is no penalty for refusing to participate. There is no penalty for withdrawing.

For More Information

If you have questions about this study, please call Julia Phillips at (216) 875-9869. This project has been reviewed and approved by the Cleveland State University Institutional Research Board (approval #TBA).

If you agree to participate, please click "continue".

Best Regards,

Brian R. Fitts, M.A.
Doctoral Student

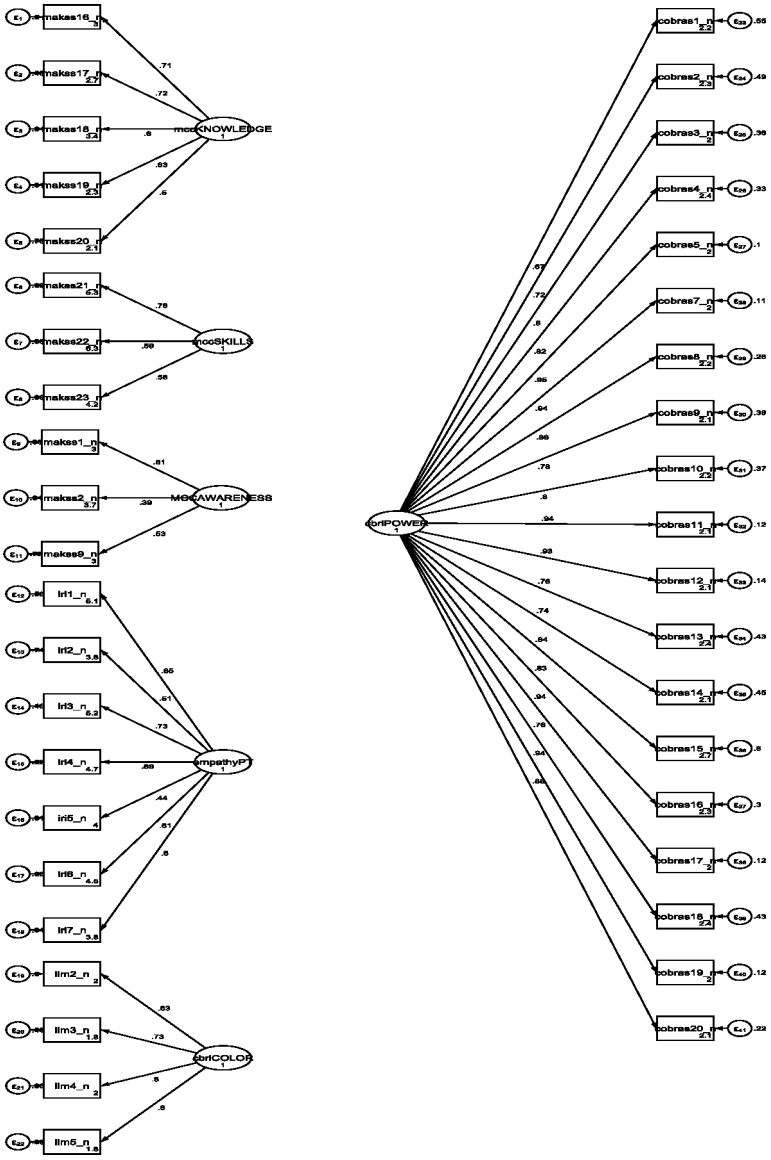
***I understand that if I have any questions about my rights as a research subject I may contact the Cleveland State University Institutional Research Board at (216) 687-3630.**

***By clicking "continue", I am indicating my voluntary agreement to participate, that I am 18 years of age or older, and that I have read the information provided and all of my questions have been answered.**

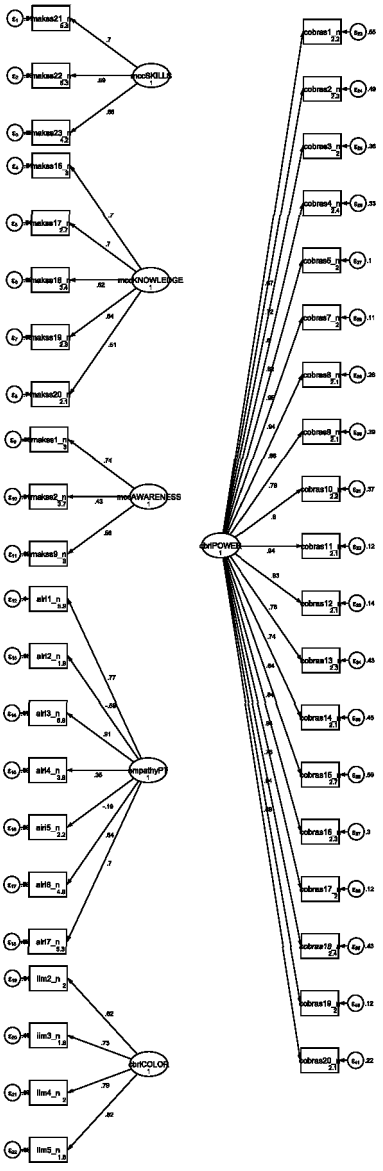
Appendix E

Measurement and Structural Model

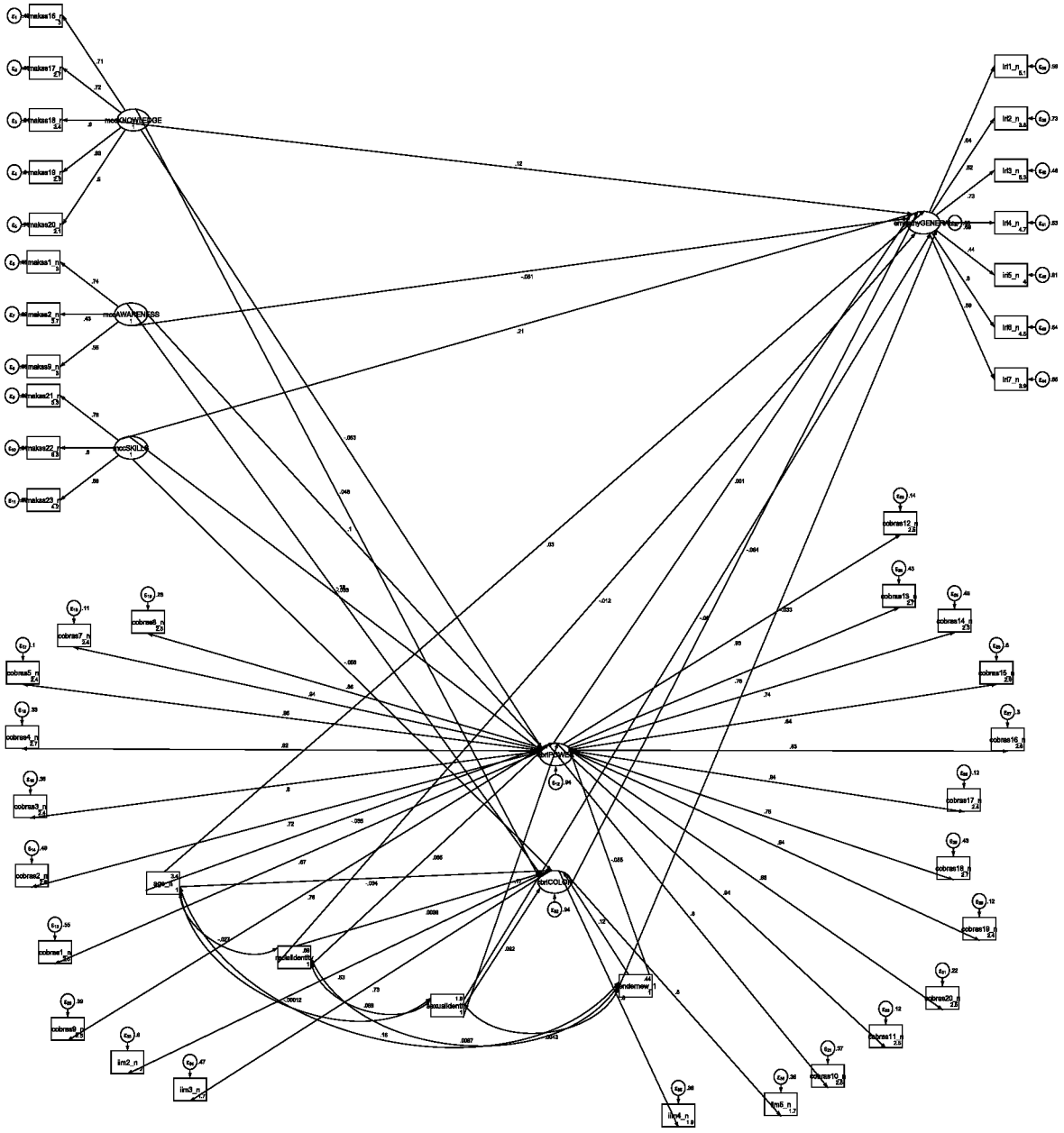
I. General Empathy Measurement Model



II. Adapted Empathy Measurement Model



III. General Empathy Structural Model



IV. Adapted Empathy Structural Model