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Development and Preliminary Validation of the Youth Therapist Observational Cultural Competence Scale

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DEVELOPMENT AND PRELIMINARY VALIDATION OF THE YOUTH THERAPIST
OBSERVATIONAL CULTURAL COMPETENCE SCALE

A dissertation defense submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at Virginia Commonwealth University.

by

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Abstract

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of
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Virginia Commonwealth University, 2014

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The increasing diversity of the United States creates a pressing public health need to

investigate methods to increase the engagement, retention, and efficacy of mental health services

for racial/ethnic minority (REM) youth. Evidence from the adult psychotherapy treatment

literature suggests that enhancing therapist cultural competence leads to increases in client

satisfaction, alliance, and retention (Constantine, 2002; Sodowsky, Kuo-Jackson, Richardson, &

Corey, 1998; Worthington, Soth-McNett, & Moreno, 2007). However, this relationship has not

been adequately explored in youth mental health services, due in part, to a lack of valid and

reliable measurement. This research project included measure development and initial validation

of the Youth Therapist Observational Cultural Competence Scale (YTOCCS) with the aim of

creating an observer-rated measure of youth therapist cultural competence. The measure was

developed from a review of the theoretical and empirical literature and integrated the surveyed

opinions of practicing child therapists, caregivers of REM children involved in the mental health

system, and experts in therapist cultural competence. The study used an extreme group design

based on child-therapist alliance selecting 32 recordings of 8 unique child-therapist dyads. Three

coders were trained using a standardized manual and independently double coded early treatment

sessions from an effectiveness trial for individual child cognitive-behavioral therapy conducted in community clinics. The measure demonstrated good reliability as measured by intraclass correlation coefficient, adequate internal consistency, and evidence supported initial validity through demonstrated significant between-group differences. Future studies are warranted to refine the measure and to explore the factor structure of the measure.

Development and Preliminary Validation of the Youth Therapist Observational Cultural Competence
Scale

The population of the United States is becoming increasingly diverse with respect to

race/ethnicity. In 2005, non-Hispanic white Americans made up 67% of the population,

contrasted with a projected 47% of the nation's population in 2050 (Taylor & Cohn, 2012). To

compare, the Latino population is expected to more than double by 2050, to 29% of the

population (Taylor & Cohn, 2012). In 2008, 43% of all children born in the US were from

ethnic/racial minority or multiethnic families, with projected 1% growth per year (K. M. Johnson

& Lichter, 2010). By 2023, non-Hispanic white children will be the minority, reflecting a

"majority minority" American youth population (Kotkin, 2010). The demographics of the

United States are changing.

There may be implications for many systems from this increase in diversity. With

increased diversity of clientele, sectors such as education (e.g., universities), medical systems,

and other customer-oriented industries have begun to employ new business methods (Ridley &

Kleiner, 2003). It remains an empirical question whether culturally diverse individuals can be

served effectively by being incorporated into existing systems, or whether modifications are

needed.

Child mental health treatment is one system where this question is particularly important

to consider. Culture may influence youth psychotherapy in a variety of ways. First, culture

impacts youth development in the ways that children perceive themselves and interact with the

world (Bronfenbrenner, 1979a). Cultural background is related to risk and resiliency factors for

psychopathology, and individuals from diverse cultures may develop and express

psychopathology in different ways (Gibbs, 2003). The mechanisms of change may be different

for these groups, then, and treatments that were created for and found to be efficacious with

majority populations may not generalize to other groups (e.g., Cardemil, Reivich, Beevers, Seligman, & James, 2007; O'Donnell, O'Donnell, Wardlaw, & Stueve, 2004; Spencer et al., 2006). If this is the case, treatments may need to be tailored for specific populations to be most effective.

Culture may also affect individuals' engagement and use of treatment. Research shows that racial/ethnic minority (REM) youth disproportionately experience barriers to access and ongoing utilization of mental health services (Gudino, Lau, Yeh, McCabe, & Hough, 2008). When minority youth do access care, they are less likely to remain in treatment. Estimates state that between 35-75% of children and families seeking mental health services terminate before the end of treatment, with higher numbers of attrition for families from minority race/ethnic backgrounds (Gonzalez, Weersing, Warnick, Scahill, & Woolston, 2011; Nock & Kazdin, 2001). Differences in mental health service utilization cannot be explained by ethnic differences in mental health disorder diagnosis, functional impairment, or disorder severity (Garland et al., 2005). Rather, these disparities in access may be the result of structural, attitudinal, and cultural barriers to treatment access and retention (Gudino et al., 2008). These results suggest that racial/ethnic minority youth frequently receive a less than adequate dose of care in the current mental health system.

Culture may impact youth psychotherapy through the process and content of therapy. Authors have stated that because all human thoughts and behaviors are culturally-based, culturally appropriate assessment, understanding, and interventions are needed to understand the context for effective therapy (Trimble, 2003). If cultural contexts are ignored, therapists may deliver content that is not validated for the client's culture, or use a therapeutic process that impairs the working relationship. Therapists have the opportunity to make appropriate

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modifications to therapy content and processes in response to recognition of the client's different cultural background. Therapists may select a culture-specific therapy, or make a cultural modification to established treatments (Bernal & Domenech-Rodríguez, 2012; Nagayama Hall, 2005). A number of processes for making systematic culture-specific treatment modifications have been recommended (e.g., Domenech Rodríguez, Baumann, & Schwartz, 2011; Hwang, 2006; Lau, 2006; Rosselló, Bernal, & Rivera-Medina, 2008). Modifications can also be made in the therapeutic process through the client-therapist interactions that mark the therapeutic relationship (Kiesler, 1973). Modifications in the therapeutic approach and relationship, seen through verbal and non-verbal behaviors indicating cultural competence, may enhance the client's ability to engage in psychotherapy (Bernal & Castro, 1994; Damashek, Bard, & Hecht, 2012).

Cultural competence has been identified as an important goal for therapists to pursue, with specific recommendations for how to modify behavior to enhance treatment efficacy across diverse client groups (Ridley, 1985; S. Sue, Zane, Nagayama Hall, & Berger, 2009; S. Sue, 1977, 1998). The Multicultural Counseling Competencies (MCC) has emerged as the dominant model of therapist cultural competence, guiding therapists to make personal, process, and content alterations in their own awareness, knowledge, and skills to intervene with clients from a variety of backgrounds (e.g., Arrendondo et al., 1996; D. W. Sue, Arredondo, & McDavis, 1992; Worthington, Soth-McNett, & Moreno, 2007). The MCCs have become increasingly complex and dynamic over time, including provisions for multiple system levels and dimensional considerations for therapist behavior. Additional authors have offered their own definitions of the MCCs (e.g., Gamst et al., 2008; Stuart, 2004; D. W. Sue, 2001; S. Sue, 2006). However, while multiple definitions of cultural competence have been offered in the literature, few are well

operationalized. This issue has led to what is referred to as the "theory-practice" gap of cultural competence: the field's inability to reach a consensus on the behavioral definition of cultural competence has slowed scientists' ability to examine it (S. Sue, 2006; Young, Marshall, & Valach, 2007). If we are to understand how cultural competence might influence treatment, we need a better definition.

A number of instruments have been developed to measure therapist cultural competence (Gamst et al., 2008). These instruments measure therapist cultural competence by therapist self-report, behavioral assessment in analogue counseling situations, written responses to vignettes, or supervisor ratings of therapist behavior in analogue situations, with therapist self-report being most common (Ruelas, 2003). Each method has limitations, described later in this paper. The majority of these measurement systems were developed in college student confederate counseling situations, and there is considerably less research into cultural competence with clinical populations (Ruelas, 2003).

Another important weakness of the past work on measuring therapist cultural competence is the exclusive focus on adult clients. Research has not investigated therapist cultural competence in an objective, process-orientated fashion with youth clinical populations (e.g., S. Sue, Zane, Nagayama Hall, & Berger, 2009; Worthington et al., 2007). Clearly, if cultural competence is an important component of treatment with youth, a measure is needed to guide research and clinical care (e.g., guide program evaluation, supervision).

This study aimed to address this gap in the literature by providing preliminary psychometric data for an observational measure of cultural competence for youth psychotherapy. The initial section of this paper provides critical background information to set the stage for the study by discussing and reviewing five distinct but related topics. First, the definitions of key constructs

used in this study including race, ethnicity, and minority are provided. Second, there is an

exploration of how culture may interact with youth psychotherapy. Third, there is a

comprehensive review of the dominant cultural competence model within psychotherapy

research, with particular emphasis on the multiple paradigms that stem from this model, and

review of models in adjacent fields. This section incorporates a synthesis of empirical support

for the dominant model, and will conclude with the definition of cultural competence used in this

study. This section was inclusive, to ensure that the measure included content reflecting the full

breadth of the target construct (Clark & Watson, 1995). Fourth, there is a review of

measurement tools and critical analysis of major issues in assessment of therapist cultural

competence. The specific aims and method follow this literature review. Immediately

following, the results are detailed. Last, the discussion places the results within the current

scientific literature.

Definitions

In this section, the definitions used in this paper for the terms *culture*, *race*, *ethnicity*, and

minority are provided. Consideration must be given because defining these terms is problematic

for several reasons. Cultural variables are dynamic rather than static (Serafica & Vargas, 2006).

Because culture is transmitted through social interactions generationally, cultural practices can

be altered within a generation or modified across generations (Bronfenbrenner, 1979).

Therefore, definitions offered within this paper must be viewed within the context of the current

time period. Further, definitions provided for the psychology context will be highlighted due to

this paper's focus on psychotherapy.

Psychologists have struggled with an inclusive or exclusive definition of culture (D. W.

Sue & Sue, 2008). According to some, culture is the product of strategies for living in a specific

habitat that evolved among a particular group of people that has been passed between generations (Gauvain & Cole, 2005). Others have emphasized the symbolic nature of culture, as it provides a language-based conceptual framework for encoding and interpreting sensory information (North, 1990). In this way, there is shared meaning between those of the same culture, with those who make similar judgments using a similar culturally-based information system (Goodenough, 1989). These descriptions share commonalities in emphasizing the interaction and social nature of culture.

Definitions are provided through lists of cultural groups in some systems. To the U.S. government, culture refers to a group organized around shared beliefs, norms, and values (United States Department of Health and Human Services, 2001). To others, culture refers to the entire way of living for a society including values, beliefs, attitudes, norms, practices, language, and religion (Davies & Cummings, 2006). As defined by the American Psychological Association (APA), and the definition used in this paper, elements of culture include age, gender, gender identity, race, ethnicity, health status, national origin, religion, sexual orientation, disability, language, or socioeconomic status (APA, 2002).

While the inclusive definition of culture is important for guiding future research on the impact of a variety of sociocultural issues in psychotherapy, race/ethnicity were selected as the primary cultural variables to examine in this study. There has been dramatic diversification of the U.S. population with respect to race/ethnicity, with projected continued change (Frazier & Tettey-Fio, 2006). There have been calls for improving mental health services for racial/ethnic minority youth in the United States (United States Department of Health and Human Services, 2000; APA Presidential Task Force on Evidence-Based Practice, 2006). The majority of empirical knowledge about culture in psychotherapy has focused on race/ethnicity as the primary

cultural variable (e.g., Griner & Smith, 2006; Huey & Polo, 2008). Generally, randomized

controlled trials have not been powered to examine the influence of intersectionality, such as the

combination of racial/ethnic group as well as socioeconomic status, or the combination of

acculturation and religious group (Safran et al., 2009). Additionally, experts have raised

concerns that existing psychosocial treatments may not work well with members of racial/ethnic

minority groups (G. Bernal & Scharron-del-Rio, 2001; Gray-Little & Kaplan, 2000; Hall, 2001;

S. Sue, 2003). For these reasons, race/ethnicity were selected as the variables to examine in the

current study.

Defining race is controversial, with some claiming a biological definition and others as a

social construction. Popular definitions of race have focused on distinctions based on biology

and genetics (Merriam-Webster, 2004). Physical characteristics have been suggested to vary

between members of different races in a number of dimensions: skin pigmentation, nasal index,

lip form, and the color and distribution of body hair (Simpson & Yinger, 1953). Other

definitions include a group of people with shared ancestry and genetic similarly, that when

combined, distinguishes individuals from another sub-group (Helms, 1990).

Definitions of race focusing exclusively on physiognomy and ancestry are problematic

for a number of reasons. First, there are overlapping physical characteristics between recognized

racial groups, and there is more shared genetic similarity than difference among individuals from

all races (Joseph G. Ponterotto, Utsey, & Pedersen, 2006). Second, attributions made to similar

genetics or ancestry fail to account for the vast within-group differences for individuals in the

same race (Sue et al., 1998). Therefore, due to the variations in culture, language, customs, and

values of individuals with shared physiognomy, some claim that this definition of race has

"completely lost its utility" (Jones, 1997, p. 345).

Instead, most researchers in the United States studying race have defined race as a sociohistorical and political construct (Smedley & Smedley, 2005). Individuals learn social constructions of race through childhood development in the United States, and these ideas frame conceptions of their racial group (Ponterotto, Utsey, & Pedersen, 2006). Therefore, even though the concept of race is biologically invalid, the social construction of race continues to be relevant (Ponterotto et al., 2006). The National Institute of Health (NIH) has agreed with this viewpoint, defining race and ethnicity as socio-political constructs, and not reflections of anthropology (NIH, 2001).

Ethnicity is a group classification of individuals who share social and cultural heritage that are passed between generations (Rose, 1964; Yinger, 1976). Distinct to ethnicity is the shared activities of the cultural group, which could include nationality, language, customs, or religion (Yinger, 1976). Individuals can hold multiple ethnic identities that express salience at different times (Brewer, 1999) .

The term ethnicity has been used interchangeably with race at times in the United States (Ponterotto et al., 2006). The boundaries of race, ethnicity, and nationality have been vague more recently in popular understanding and science (Fenton, 2010). For example, race, ethnicity, and nationality are all defined, in part, by shared heritage (Fenton, 2010). Further, race, ethnicity, and socioeconomic status can combine with other social statutes (e.g., immigration status, language, health-status) in complex ways to create patterns of interaction and intersectionality (Schultz & Mullings, 2006). However, historically, race and ethnicity have been constructed differently and therefore, authors have advocated for defining these as different constructs (Ponterotto et al., 2006).

One commonly used term in research into race/ethnicity is *minority*. This term can be defined as:

> [a] group of people who, because of physical or cultural characteristics, are
>
> singled out from others in the society in which they live for differential and
>
> unequal treatment, and who therefore regard themselves as objects for collective
>
> discrimination… [m]inority status carries with it exclusion from full participation
>
> in the life of the society. (Wirth, 1945, p. 347)

The key to this definition, and the one used in this study, is the focus on the economic, political, and social power differential between individuals in majority and minority groups (Ponterotto et al., 2006). This is a distinction from a strictly numerical representation. Ponterotto and colleagues describe, "[t]he term minority can imply 'less than' in the minds of people, and persons of color do not see themselves as less than anyone" (2006, p. 6). For this reason, some individuals are offended by this term. Minority groups are also defined, in part, by distinction from a majority group. The majority group within the United States has been defined broadly as the non-Hispanic white population (Sue, 2009). In this study, the term minority is used to reflect Wirth's (1945) distinction of groups within a power differential. There is no intention to assign inferior status to a minority group.

This study will use the NIH reporting classification of five racial groups, as measured into the following categories: (a) white, (b) black or African American, (c) American Indian or Alaska Native, (d) Asian, and (e) Native Hawaiian or Other Pacific Islander (Office of Management and Budget, 2011). The ethnic categories of Hispanic/Latino and non-Hispanic/Latino can belong to any of the aforementioned racial groups. While this classification may be regarded as simplistic and does not resolve the reviewed disagreements about

terminology, use of these categories allows for integration of past research into the current study focus. *Race/ethnicity* will be used when the researcher measured both constructs, with the term *racial/ethnic minority* (REM) used to describe individuals not represented in the non-Hispanic white group. Authors' definitions are used when reviewing the literature because participant self-identification of race/ethnicity varies with terminology (Snipp, 1986). Retaining each author's original terms will avoid viewing these concepts as interchangeable (APA, 2003). Racial/ethnic minority (REM) youth are the focus of the current study.

With preliminary definitional issues discussed, I turn next to explore how these cultural variables may influence psychotherapy.

Culture in Psychotherapy

The mental health disparity literature indicates that individuals of minority race/ethnicity are not benefitting from the current mental health system at the same rate as majority member peers (Imel et al., 2011; S. Sue & Dhindsa, 2006; U.S. Department of Health and Human Services, 1999). Given my focus on psychotherapy, I found three main ways that culture may influence the efficacy of psychotherapy: a) development of psychopathology, b) engagement in mental health services, and c) the process and content of psychotherapy. In this section, each of these factors is considered.

Development and Expression of Psychopathology

Cultural differences in language, childrearing customs, family systems, education, social standards, diet, stress, coping strategies, and opportunity may all affect the prevalence and expression of childhood disorders (Achenbach et al., 1990). The developmental-contextual perspective on child development states that individual development occurs within a set of inter-related systems composed of the individual within his social-cultural, community, and family

environments (Bronfenbrenner, 1994; Garcia Coll, Akerman, & Cicchetti, 2000; Sameroff, 2009; Spencer et al., 2006). Stated simply, development is influenced by context. This theory makes assumptions that the unique biological makeup and temperament of the individual contributes to development and experience of the world. Biological differences that influence skin color, for example, would then influence the way the child experiences the world and develops. Development does not occur within a vacuum, though, but occurs within the context of the individual's biology and past experiences, family, community, and society. Throughout this developmental process, each individual contributes to his or her own development. Finally, the developmental-contextual perspective acknowledges that culture has an ecological context, and that culture is dynamic across generations (Serafica & Vargas, 2006).

Race/ethnicity can simultaneously influence multiple ecological levels of development (Yasui & Dishion, 2007). Cultural influences permeate each contextual level in the ecology of REM youth from internal development (e.g., ethnic identity, self-regulation), primary socializing contexts and interpersonal patterns (e.g., family systems, socialization of cultural values), to their relationships with larger societal contexts (e.g., biculturalism). The influence of developmental and social-contextual factors on multiple identity development, as well as influence of intersectionality in oppression all influence development (Ecklund, 2012). The relationship with societal contexts includes experiences of discrimination, racism, and oppression, as well as the development of coping strategies to integrate these experiences (Yasui & Dishion, 2007).

Intersectionality of identity refers to the way in which an individual embodies within the self, multiple, cultural, ethnic and group identifies (Almeida, Woods, & Messineo, 1998). Intersectionality allows for the simultaneous and multiple influences of diverse cultural group values, norms, and expectations that contribute to a complex individual identity, and can be seen

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as an individual and family construct. During development, a child may possess multiple intersecting cultural identities, and the child's family may represent intersectionality of identity within the family unit (Ecklund, 2012). In this way, the child is learning about the multiple identities that he/she will inhabit during development, with only some shared by his/her family.

Differences may occur in both normal development, and maladaptive development. The ecological model proposes that racial/ethnic differences in psychopathology stem from the different risk and resilience levels of children, with self-regulation and prosocial coping styles as mechanisms that enhance resiliency (Yasui & Dishion, 2007). Differences in parenting and child-rearing strategies may also influence patterns of risk and resilience for youth.

Culture and parenting behavior have been a focus of research for decades (e.g., Barry et al., 1967; Bowie et al., 2013; Darling & Steinberg, 1993; Deater-Deckard & Dodge, 1997; Johnston & Mash, 2001; Pettit & Dodge, 2003). Barry and colleagues (1967) explored the relationship between economic survival patterns and parenting practices of over 100 global societies, and concluded that cultural values influence the parenting practices. The prevalence of different styles and practices of parenting varies among ethnic groups in America (Darling & Steinberg, 1993). Different patterns of racial socialization, or race-related messages from parent to child, have important consequences on children's self-identity development and well-being (Hughes, 2003). Hughes (2003) concluded that African American parents provide more messages to prepare their children for bias and discrimination than Hispanic parents. Messages about emotions also seem to differ by group. In multiracial families, a higher level of emotion coaching and modeling about anger by fathers is associated with lower child anxiety and depressive symptoms, whereas this relationship was not found in European American or African American groups (Bowie et al., 2013). Emotion coaching is an important behavior in the

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development of psychopathology (Cicchetti, Ackerman, & Izard, 1995). Therefore, differences in patterns of emotion coaching may interact with development of psychopathology, or youth's experience of psychopathology.

Psychologists have explored potential differences in the expression of psychopathology for individuals from different cultures. Cultural variations in psychopathology may be found in affective, behavioral, or linguistic expressions of distress or in the cognitions and sensory experiences (APA, 2000). Comprehensive reviews have focused on known differences in cross-cultural expressions of mental disorders, to be briefly visited here (Canino & Alegria, 2011; Lewis-Fernández et al., 2010).

The expression of anxiety disorders has been explored across cultures. Findings suggest that Asian and Hispanic children were far more likely to report experiences of heightened anxiety sensitivity than compared to white peers, but were less likely to experience panic attacks (Weems, Hayward, Killen, & Taylor, 2002). However, other researchers found that the assessment instrument predicted findings of differences in somatic complaints between Hispanic and European American children (Pina & Silverman, 2004). Therefore, results are equivocal about whether the expression of these disorders is different cross-culturally, or whether translation issues and interpretation of symptoms may explain these measured differences.

Some cultural groups may also have unique syndromes. Using the example of anxiety, the cross-cultural presentation of anxiety are *trung gio´* (wind-related) attacks in Vietnam (which are associated with headaches) and *ataque de nervios* (attack of nerves) among Latin Americans. However, these syndromes are more than just language translations of the same disorders. *Ataques* in Puerto Ricans and Dominicans may meet criteria for panic attacks, or be categorized as aggravated grief or anger responses (Lewis-Fernández et al., 2010). South Korean and

Japanese patients who are driven to avoid social situations out of fear that they may do something that will offend or embarrass another person are labeled as having the offensive subtype of *Taijin kyofusho* (TKS) or literally ''fear of interpersonal relations,'' in the Japanese language (Lewis-Fernández et al., 2010). Concern over one's own behavior or physical presence (e.g., smell) as being embarrassing for a second individual does not qualify for social phobia under the nosology system used in the United States (DSM-IV-TR, APA, 2000). Despite these categorical differences in nomenclature, TKS has the same prevalence rates as social phobia and responds well to similar psychopharmacology (Stein, 2009). Therefore, some have suggested that TKS and social phobia are different phenotypes of the same underlying pathology, and each express differently due to cultural values (Stein, 2009). These syndromes may have some similarities to Western conceptualizations, but impasses in understanding may restrict therapist's ability to recognize, diagnose, and effectively treat diverse clients.

Authors have urged the American Psychiatric Association to provide better integration of culturally relevant information throughout the Diagnostic and Statistical Manual of Mental Disorders (DSM) text that provides criteria for clinical diagnosis, rather than relegation to a section in the appendix (Lewis-Fernández et al., 2010). The newest version of the DSM (DSM-V; American Psychiatric Association [APA], 2013) rejects the concept of "culturally-bound" syndromes by acknowledging that all distress is bound by local context, and instead advocates for exploring cultural syndromes, cultural idioms of distress, and cultural explanations for distress (APA, 2013). These concepts reflect clusters of symptoms that occur more commonly in specific cultural groups, ways of expressing distress, and the perceived etiology of symptoms or distress, respectively. Culture-related diagnostic issues are included within the section for each disorder, such as reminding clinicians who may diagnose a child with Conduct Disorder to

consider if the undesirable behavior was near-normative in the context where it occurred (e.g., war zones or a very violent neighborhood; APA, 2013, p. 474).

Prevalence rates describe the proportion of individuals in a population who manifest a particular symptom, symptom cluster, or disorder at a given point in time (Verhulst & Koot, 1992). Differences in prevalence rates of a particular symptom or disorder in two or more population groups may reflect underlying differences between groups (Serafica & Vargas, 2006). Epidemiology and the reports of prevalence rates are a robust area of literature, and only a brief review is provided here. Reviews of epidemiological research reveal that autism rates remain remarkably consistent across Canada, England, Iceland, Japan, and Sweden (Klinger, Dawson, & Renner, 2003). Attention-deficit/hyperactivity disorder (ADHD) has been identified in multiple cultures, but the base rates have been found to fluctuate. Prevalence rates suggest that less than 2% of Japanese youth have ADHD (Kanbayashi, Nakata, Fujii, Kita, & Wada, 1994), while upwards of 29% of Indian youth have been identified with ADHD (Bhata, Nigam, Bohra, & Malik, 1991). Anxiety disorder prevalence has been suggested to range from 4% of a community sample in Italy to 19% in Israel (see Serafica & Vargas, 2006). Depressive disorders are less studied through epidemiological research (Serafica & Vargas, 2006). Differences in prevalence rates may be a function of diagnostic criteria, measurement error, and sample characteristics. However, these findings that prevalence rates for mental health disorders vary across nations raise questions about the universality of disorders across cultures.

Prevalence rates can also be examined for different race/ethnic groups within the United States. The National Health and Nutrition Examination Survey (NHANES), a collaboration between NIMH and the National Center for Health Statistics of the Centers for Disease Control and Prevention, conducted a survey from 2001 to 2004 of mental health disorder prevalence rates

in American youth between the ages of 8-15 (Merikangas et al., 2010). This survey concluded that there were very few ethnic differences among youth diagnostic rates. However, Mexican American youth had significantly higher rates of mood disorders than either European American or African American youth. In addition, Mexican American youth had a lower prevalence rate of ADHD. It should be noted that large-scale surveys of prevalence rates do not report on differences of symptom expression (e.g., whether one group expresses somatic symptoms of anxiety at a higher prevalence). However, this study supports a similar rate of psychopathology for youth in the United States is across race/ethnic groups.

This section has focused on exploring psychopathology in relation to culture. Base rate prevalence, risk and protective factors, and expressions of psychopathology for different cultural groups are important areas of research that should continue to be explored. Underlying the question of development and expression of psychopathology is whether different cultural groups have similar change mediators for intervention. Authors have lamented that the field still does not have an understanding of the change processes and mechanisms (i.e., why therapy works) for child and adolescent psychotherapy (Doss, 2004; Kazdin & Nock, 2003). Swenson and Prelow (2005) explored the direct and indirect relationships among supportive parenting, ethnic identity, self-esteem, self-efficacy, on depression symptoms and problem behavior in a group of African American and European American adolescents. Results showed that supportive parenting predicted adolescents' perceived self-efficacy, which fully mediated the relation between ethnic identity and depressive symptoms for the African American sample. In the European American sample, the relation between supportive parenting and depressive symptoms was fully mediated by self-esteem. Self-esteem, by contrast, was not a significant mediator variable in the model for African American youth. These results suggest that there may be differential developmental

pathways to adjustment and psychopathology for youth of different race/ethnicity. Further information about culture's role in moderating change mechanisms and processes is sorely needed.

Psychopathology is one possible pathway for child and adolescent psychotherapy to be influenced by client different cultural characteristics. Detection of psychopathology is related to engagement in care; symptom severity levels are higher for racial/ethnic minority youth in initial appointments in community mental health services than the symptom levels of non-Hispanic whites (Gudino et al., 2008), suggesting that REM youth present to treatment at higher levels of symptom severity or functional impairment. Thus, it is plausible that culture may influence families' initiation of and engagement in mental health services. In the next section, I review the literature related to this proposition.

Engagement in Mental Health Services

Engagement in mental health services for ethnic minorities has been low (U.S. Surgeon General, 2001) and continues to be so (Gonzalez et al., 2010). There may also be different processes at work when children and families from racial/ethnic minority groups engage in psychotherapy treatment. Behavioral, attitudinal, and structural barriers exist to mental health treatment (Gould, Beals-Erickson, & Roberts, 2011).

Treatment engagement has been defined several ways. McKay and Brannon (2004) defined it as a multi-phase process including: (a) identification that there is a problem by a parent, teacher, or other adult recognizing a child's mental health problem, (b) selection of where to get help, (c) initiation of services, and (d) continued engagement in care. Thus, there are multiple points during this process at which barriers emerge to deter families from seeking or continuing services.

Financial, behavioral, attitudinal and structural barriers to identification of mental health problems and selection of a provider pose a critical issue for many racial/ethnic minority families. The Integrated Theory on Participant Involvement incorporates multiple ecological levels of predictors for parent engagement in treatment, including parental motivation for treatment, perceived costs of treatment, appointment availability, biases about psychotherapy, level of community social support, and minority race/ethnicity status (McCurdy & Daro, 2001). Barriers can also occur at different time points before families enroll in treatment, including seeking treatment, finding treatment, and initiating treatment (Wisdom, Cavaleri, Gogel, & Nacht, 2011). Lower family income level and low or no insurance coverage have also been identified as common barriers for families to seek psychotherapy services. These barriers are exacerbated for racial/ethnic minority groups (USDHHS, 1999).

Structural barriers to selection of services and initiation in treatment include lack of availability of services, transportation, and geographic accessibility. Geographic accessibility to mental health services pose a significant challenge to many families as mental health centers are geographically not located in ethnocultural minority areas (Alegria et al., 2003). For example, in Washington, D.C. neighborhoods, the number of mental health providers is negatively correlated with the percentage of African American neighborhood residents, such that areas with greater concentrations of African American residents have fewer mental health providers (Ronzio, Guagliardo, & Persaud, 2006). In addition, neighborhoods with higher concentrations of African American residents have higher indicators of poverty, as well as increased levels of crime, home ownership turn over, violence, noise, and overcrowding (D. R. Williams & Williams-Morris, 2000). These factors may exacerbate any existing mental health conditions.

There may be disproportionate barriers to the initiation of treatment and ongoing engagement in care for racial/ethnic minority families. In a study of racial and ethnic differences in service utilization among high-risk youth who had been referred by public service sectors, authors found that non-Hispanic whites had the highest rates of service use for any mental health service and Asian American/Pacific Islanders had the lowest utilization rates (Garland et al., 2005). Researchers also measured informal service use, including self-help, peer counseling, counseling from clergy, or alternative healers. Latino Americans had the highest rate of engagement in informal services, and African Americans had the lowest rate (Garland et al., 2005). Unreliable transportation was the most endorsed barrier to attending frequently occurring health care appointments in a study of inner-city Latino parents seeking pediatric medical care (Flores, Abreu, Olivar, & Kastner, 1998). Specifically, transportation issues named included lack of car, excessive distance between home and clinic location, expense or inconvenience of public transportation. Transportation barriers exist at a higher rate for underrepresented minority families as compared to Caucasian, non-Hispanic white families (Flores et al., 1998).

Low rates of initiation of treatment and retention among racial/ethnic minorities may also be related to therapist demographics. In the United States, 74-76% of psychologists are white/European American and primarily English-speaking (APA, 2009; NSF, 2009). Only 12% of psychologists report speaking a language other than English well enough to provide services in that language, and 9% reported actually providing services in another language (APA, 2010). Meanwhile, nearly 20% of the U.S. population speaks a language other than English in the home (Shin & Kominski, 2010). Ethnic minorities represent roughly 25% of the population in the U.S. and are expected to surpass 50% between 2040 and 2050 (Ortman & Guarneri, 2009). Although neither therapist ethnicity nor non-English language fluency implies the ability to work

effectively within different cultures (L. R. Schwartz, Sable, Dannerbeck, & Campbell, 2007), the demographic mismatch between therapists and clients may present challenges to client engagement in therapy.

To address these challenges, authors have explored what factors relate to improvements in client engagement and lower attrition. Research shows that therapists who are perceived as having higher cultural competence have greater client satisfaction (Constantine, 2002; Fuertes et al., 2006), as well as clients who show more engagement in therapy delivered within community mental health centers (Wade & Bernstein, 1991). Researchers who attended to unique REM client barriers to mental health services found a higher participation rate for Latino parents of preschool children in an externalizing treatment (Mendez & Westerberg, 2012). Therefore, it may be important for therapists to possess knowledge and the skills to help REM clients navigate barriers to care.

Client engagement is also related to outcomes. Castro and colleagues have offered heuristic framework for examining the interactions of client culture, four engagement behaviors (awareness of treatment, entry into treatment, participation in treatment activities, completion of treatment), therapist cultural adaptations to evidence-based treatments, and client outcomes (Castro, Barrera, & Holleran Steiker, 2010). In a study of evidence-based treatment for child disruptive behavior disorders, caregiver and therapist ethnicity match predicted youth's retention in treatment, mutually agreed upon termination when symptoms remit, and decreases in symptoms (Halliday-Boykins, Schoenwald, & Letourneau, 2005). Client perception of therapist cultural competence was related to client satisfaction, engagement, and achievement of personalized goals as part of a child abuse treatment program (Damashek et al., 2012).

In sum, cultural competence may be an important target to enhance in order to improve

client engagement. Engagement may also impact the content and process of therapy. In the next section, an examination of differences in the content and processes for therapy for REM youth takes place.

Response to the Content and Process of Treatment

REM and majority member clients may have different responses to the content and process of therapy. In this section, the ways that client REM status interacts with therapy content will be explored by examining treatment outcome data for REM clients. Then, an introduction to how client-therapist difference in race/ethnicity may have an impact on therapy process will take place. This section focuses primarily on reviewing potential problems in applying unaltered content and processes. Recommendations for adapting content and changing processes are presented in subsequent sections of this paper.

Response to content. The content of many treatments target change mechanisms theoretically informed by models created by and tested on primarily majority-group members (G. Bernal & Scharron-del-Rio, 2001). Treatment may implicitly assume a specific treatment goal that may not fit with a specific group's cultural values or preferences. For example, it may be inappropriate to use a therapeutic component targeting nighttime separation for separation anxiety with clients from a culture that values co-sleeping (e.g., Saudi Arabia; BaHammam, Alameri, & Hersi, 2008). In this way, racial/ethnic differences in etiology or psychopathology could affect the efficacy of targeting specific change mechanisms in therapeutic content.

Psychological treatments have been created and empirically supported for a variety of youth mental health problems (Chorpita, Angeles, Daleiden, & Phillips, 2011). However, there has been limited evidence supporting treatment efficacy with racial/ethnic minority youth (G. Bernal, Bonilla, & Bellido, 1995; Huey & Polo, 2008; S. Sue, 1998). Meta-analysis results

found support for some empirically supported treatments with REM youth (Huey & Polo, 2008). While these findings are promising, there are limitations to the youth psychotherapy literature that warrant review before reaching a conclusion that treatments work universally well for all youth, regardless of culture.

The field needs better reporting and recruiting of diverse samples of youth to test treatment sufficiently. Methodological problems hinder the ability to come to definite conclusions. In reviewing over 90 studies exploring empirically supported in depth for possible inclusion in the present paper, only 46.5% provided detailed information on the race/ethnicity of their samples. In a report on the state of child psychotherapy research, Kazdin (1990) reported that 20.2% of studies report on children's race. While the field has made progress in the past two decades, there is still much room for improved reporting. A recent review of 12 randomized controlled trials examining treatments for youth depression found that only seven papers included information on race/ethnicity; three of which included more than 85% white samples (Compton et al., 2009). Similarly, in a meta-analysis of empirically supported treatment for youth, authors state in the conclusion that only 13 of the 35 included studies reported race/ethnicity, and only six included tests of moderation (Weisz, McCarty, & Valeri, 2006). Better reporting would increase understanding of the generalizability of results, improve clinical utility and translation, and allow for subsequent reviews and meta-analyses to aggregate data. When reported, sample sizes of racial/ethnic minority youth are often too small to come to decisive conclusions. Therefore, recruitment of diverse samples needs to be improved.

Some well-designed studies with diverse samples have lent support to the claim that some specific psychological treatments are effective for certain racial/ethnic minority groups. This finding appears to largely point to some universal mediators of treatment for youth.

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However, some studies that support treatment efficacy across groups used treatment modifications for specific racial/ethnic minority groups. Largely, treatments that have been culturally adapted for specific groups tend to have evidentiary support (e.g., parent management training for Hispanic/Latino parents; Martinez & Eddy, 2005). These culturally adapted interventions have not been systematically well-defined in treatment outcome literature.

While treatments largely appeared to benefit youth from a variety of backgrounds, it should be noted that large studies with diverse samples have suggested that there may be an effect size differences in efficacy for racial/ethnic groups (e.g., Arnold et al., 2003; Curry et al., 2006; Ginsburg et al., 2011). Huey and Polo's (2008) meta-analysis found that found that five out of 12 included studies found support for a moderating effect for race/ethnicity in youth treatment outcomes, while the remaining studies found no support for this effect. All studies included in the Huey and Polo meta-analysis had randomized controlled trial designs, standardized measurement of outcome variables, and experimental treatments were compared with control treatment groups. Authors of one original study that did not find a moderating effect for race/ethnicity stated that 72% therapists in the study had discussed ethnicity-related issues with REM youth when warranted by the presenting problem (Harper & Iwamasa, 2000). This anecdotal evidence suggests that therapists may be attuned to culture in their interactions with REM clients, but respond in a culturally competent fashion only when relevant to the presenting problem or when culture-relevant barriers to treatment arise. Therefore, a plausible explanation for the discrepant results for the moderating effect of race/ethnicity could be that therapists in some trials are automatically communicating in culturally competent fashions thus enhancing the treatment's effectiveness, and other therapists are not. Treatment delivery may not have been equal across all reviewed studies.

In sum, there is equivocal evidence whether treatment content created for majority member youth can be used with REM youth, and produce similar outcomes. Evidence suggests that these treatments may provide benefit from REM youth, but perhaps at different rates than for majority member peers. Limitations within the field of psychotherapy literature have hindered the ability to reach firm conclusions.

Response to therapeutic process. The processes between client and therapist of different race/ethnicity may also contribute to retention and outcome. In this section, there will be a review of how the process of psychotherapy may be affected by therapist-client differences in race/ethnicity. The focus of this section will be on possible differences in communication, relationship, and role expectations.

Intercultural communication, or communication between two members of different cultures, may impede therapeutic processes. Communication has been called the most important aspect to practice that health professionals must master and an essential requirement in any interaction (Roberts, 2007). It is important to consider both what is said (verbal behaviors) and also how it is said (non-verbal behaviors). In order to establish a positive therapeutic relationship and alliance, accurate and genuine communication is needed (Sue et al., 2007).

Intercultural communications are particularly susceptible to interpersonal misunderstandings (Shelton, Dovidio, Hebl, & Richeson, 2009). This occurs when individual members of two different groups communicate, and lose intended meaning due to obstacles in perception, verbal, and non-verbal processes (Shelton, Dovidio, Hebl, & Richeson, 2009). Social Identity Theory provides an explanation for the social categorization that involves a basic distinction between the group containing the self (the ingroup) and other groups (outgroups) (Tajfel & Turner, 1979; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987). Social Identity

Theory posits that individuals use categorization (similarities within groups and differences between groups exaggerated), social comparison, and create a self-concept reflecting a personal identity and a social identity (Tajfel & Turner, 1979). Brewer's social identity model of optimal distinctiveness states that individuals experience opposing levels of need for differentiation and inclusion with social groups, based on the size and permeability of the group's boundaries (Brewer, 1991). The salience of whether the individual is identifying with personal identity or social identity is context dependent.

Five processes have been theorized to explain change in psychotherapy: client characteristics, therapist characteristics, change processes (including specific techniques), structure of therapy, and the therapeutic relationship (Grencavage & Norcross, 1990). Some have contended that specific therapy techniques explain just 15% of the variance in treatment outcomes, leaving a large share of the variance to other factors and processes (Asay & Lambert, 1999). The second task force on Evidence Based Therapy Relationships concluded that the therapeutic relationship is at least as important as specific treatments in predicting client outcomes, and recommended that therapists consider adapting of the therapeutic relationship based on client characteristics by changing responses to resistance, client preferences, culture, and religion (Norcross & Wampold, 2011).

The therapist and client different race/ethnicity group membership can influence social perception, affect, cognition, behavior, and communication in ways that systematically create intergroup biases (Gaertner & Dovidio, 2000). The expression of biases depends on the context, motivation, and social norms of the group (Shelton et al., 2009). Racial categorization is generally automatically activated in the United States, along with related racial attitudes and stereotypes (Shelton et al., 2009). In the U.S. and societies that place emphasis on

egalitarianism, individuals tend to express indirect rather than obvious prejudice (Gaertner &
Dovidio, 2000). Communication patterns may display discrimination, and can harm the
interpersonal relationship between two individuals from different race/ethnicity.

The therapy process has been defined as the therapist-client interactions (Kiesler, 1973).
An important therapy process variable is the therapeutic relationship, with emphasis on the
therapist-client alliance (affective bond, agreement on tasks and goals), and client's view of the
therapist as credible (Asay & Lambert, 1999; Hawley & Weisz, 2005; Horvath & Symonds,
1991). The APA Presidential Task Force on Evidence-Based Practice (2006) provided a
definition of evidence-based practice in psychology as the "integration of the best available
research with clinical expertise in the context of patient characteristics, culture, and preferences"
(p. 273). However, research suggests that REM clients experience threats to the therapeutic
relationship, which prevents them from benefiting from psychotherapy at the same rate as
majority members (American Psychological Association, 2003; Vasquez, 2007).

Researchers have suggested that REM clients may experience unique difficulties
establishing the affective bond and agreement on treatment goals with racial/ethnic majority-
member therapists (Vasquez, 2007). Therapists who have difficulty establishing a warm and
understanding relationship with REM clients may impede therapy's effectiveness. For example,
fewer communications of empathy from white therapists has been associated with lower rapport
and decreases in affect from the client (Fuertes et al., 2002). Sue (1981) suggested that clients
see less culturally competent therapists as less trustworthy, and this lack of trust causes clients to
prematurely terminate from treatment. Sodowsky and colleagues' (1996) found evidence that
clients who report a less empathetic multicultural counseling relationship with their therapist are
more likely to prematurely drop out of treatment. Therefore, modifications in the therapeutic

stance and relationship based on knowledge of cultural differences may enhance the client's ability to engage in psychotherapy (Sue, 1991).

Racial/ethnic minorities may also have different interpersonal expectation for therapist/client roles and relationship. For example, Asian American clients may expect the therapist to be authoritarian, directive, and structured (S. Sue & Zane, 1987). The multicultural therapeutic relationship is inversely associated with instances of cultural misunderstandings, differences in role expectations, differences in illness myth, and failures of the therapist to adequately engage REM clients (Vasquez, 2007).

The therapeutic relationship has been the focus of many empirical investigations of the process of psychotherapy, and has been proposed as an important factor in youth psychotherapy (Shirk & Karver, 2003). However, establishing a strong relationship with youth clients may pose unique challenges to therapists, due to developmental and family systems factors (Shirk & Karver, 2003; Karver et al., 2008). For example, child clients infrequently refer themselves and may disagree that they should be in treatment. Youth clients may be more likely to engage in a series of therapy impeding behavior, including failing to complete homework, inconsistent attendance, low involvement in session activities, lack of engagement with the therapist, and premature attrition (Karver et al., 2008). However, two recent meta-analyses of the alliance in child psychotherapy show that it is associated with therapy outcomes with a small effect size (McLeod, 2011; Shirk, Karver, & Brown, 2011). The effects of race/ethnicity were not examined. Therefore, it has been suggested that establishing a strong alliance with youth clients may be more challenging but is also more critical as opposed to psychotherapy with adult clients (Webb, Auerbach, & Derubeis, 2012).

The parent-therapist alliance has also been explored because parents are often included in child and adolescent therapy, and may be the focus of some behavioral treatments (Shirk et al., 2011). The parent-therapist alliance is also associated with beneficial treatment outcomes, though not above the child-therapist alliance (McLeod, 2011). Due to the developmental process of racial/ethnic identity development, the parent-therapist alliance may be particularly important in psychotherapy between therapists and clients from different cultural backgrounds.

Cross-cultural therapeutic relationships may impede therapeutic progress if they are fraught with microaggressions, or "brief, everday exchanges that send denigrating messages about group membership" (D. W. Sue et al., 2007). Vasquez (2007) uses microaggressions in counseling as a term that conveys power dynamics in interactions in cross-cultural encounters that convey attitudes of "dominance, superiority, and denigration: that a person with privilege is better than the person of color, who is less intelligent, capable, worthy, and so forth" (p. 881). Sue and colleagues (2007) described racial microaggressions as falling into the categories of microassaults, including hostile or overt racial incidents such as racial name-calling; microinsults, or incidents that are perceived as offensive or insulting; and microinvalidations, or incidents when persons of color feel devalued, ignored, or delegitimized. Sue and colleagues described themes of the more subtle forms microinsults and microinvalidations: assumptions that a person of color is foreign born or not a true American, assumptions of lower intelligence, statements that deny the presence of race, assumptions of criminality, denial of individual racism, treatment as second class citizens, and assumptions that life chances are due solely to effort and race poses no obstacle. Descriptive research and qualitative interviews of personal experiences with college students and adults in various occupational fields support this taxonomy of microaggressions (see Torres-Harding, Andrade, & Romero Diaz, 2012).

The deleterious effects of exposure to microaggressions in everyday interpersonal relationships are extreme. Women exposed to daily sexist microaggressions have shown symptoms mimicking posttraumatic stress disorder (Berg, 2006). Franklin and Boyd-Franklin (2000) described racial microaggressions causing African Americans to feel delegitimized, disrespected, and unrewarded. Soloranzo and colleagues (2000) found that college students who reported enduring higher levels of racial microaggressions experienced more self-doubt, isolation, frustration, and feelings of rejection. Microaggressions have been associated with increases in depression and substance abuse (APA Division 44, 2000). Negative communication patterns have been explained by the presence of microaggressions in occupational, social, and patient-doctor interpersonal relationships (Berg, 2006).

As the client-therapist relationship is expected to be a warm and supportive environment, microaggressions may be particularly harmful in the therapeutic context. Microaggressions have been found to lead to the client thinking that the therapist sees him as intellectually and socially inferior, a second-class citizen, assuming criminality, assuming a universal minority experience, and assuming the superiority of white cultural values (D. W. Sue et al., 2008). Within therapeutic dyads, microaggressions have been associated with lower alliance ratings and premature termination (Owen, Imel, Tao, Wampold, Smith, & Rodolfa, 2011). Behavioral markers of therapist microaggressions include the presence of expressions of colorblindness, overidentification with cultural group, denial of personal or individual racism, minimization of racial–cultural issues, assignment of unique or special status on the basis of race or ethnicity, stereotypic assumptions about members of a racial or ethnic group, accused hypersensitivity regarding racial or cultural issues, the meritocracy myth, culturally insensitive treatment considerations or recommendations, acceptance of less than optimal behaviors on the basis of

racial–cultural group membership, idealization, and dysfunctional helping or patronization (Shelton & Delgado-Romero, 2011; D. W. Sue et al., 2007, 2008; Torres-Harding, Andrade, & Romero Diaz, 2012).

With some notable exceptions, few studies have explored children's experiences of microaggressions. One study of transracial adoption interviewed 41 Asian American children adopted into primarily families with western-European descent (Vashchenko, D'Aleo, & Pinderhughes, 2012). Authors provided examples of microaggression statements including, "You speak good English", and "Do you play a violin?" (p. 247). Results showed that parent's bicultural competence (skills, attitudes, and behaviors parents demonstrate that reflect understanding and comfort with another culture) predicted children's reporting of positive valenced public interactions. Racial diversity of the school environment nor the child's age predicted reporting of positive or negatively valenced public interactions. The study was unable to explore whether differences indicated that children remembered microaggressions more, or if they simply had different levels of microaggressive experiences. While preliminary, results indicate that adult social modeling of cultural competence may be important for children.

The research reviewing REM youth's response to the content and process of unaltered psychotherapy is inconclusive. Inconsistent demographic sample reporting hinders ability to reach firm conclusions. However, some research indicates that youth may benefit from similar content as their majority member peers. On the process side, research shows that intercultural communication can impede understanding and may lead to more difficulty establishing a therapeutic relationship. Further understanding of these important content and process level variables is needed within a youth population.

In this section, three factors were explored as problematic for REM youth receiving mental health services. First, there may be differences in the development and expression of psychopathology. These differences may impact therapist's ability to accurately assess and treat youth from different backgrounds. Next, engagement practices may need to be different with REM youth and families, as there are unique barriers to care for these groups. Last, evidence is equivocal whether REM youths respond to the content and process of treatments designed for and tested with majority-member clients. Culturally competent therapy is needed to address these three areas. In the next section, a review of cultural competence models and definitions for altering therapeutic content and processes are explored.

Cultural Competence

In this section, different models and definitions for culturally competent therapist behavior are explored. The goal of this section is to understand possible alterations in the process and content to psychotherapy based on the client's cultural background, with particular attention paid to operationalized definitions that can lead to behavioral descriptions. To meet this goal, models of therapist cultural competence are reviewed. Given the overall aim being the development of an observational measure of cultural competence, I reviewed models from psychology, business, and medical literatures to identify behavioral markers for cultural competence. I begin this review with an acknowledgement of caveats, historical trends, and the primary focus and assumptions of this literature.

The definition of cultural competence is widely debated within the literature (Whaley & Davis, 2007). Cultural competence has been seen as a process, orientation, or approach (Sue, 1998). As such, more than a technique or a set of topics to consider when working with diverse clients, it is a way of construing the helping relationship to involve the client, the helper, and

context (Sue, 2003) in a fluid process (Lakes, López, & Garro, 2006). Reaching a consensus agreement on a definition is challenging since authors focus on different parts of the therapeutic process.

One difficulty in settling on a definition of cultural competence is that authors differ in the system level they focus on. Some models of cultural competence in psychotherapy literature distinguish between four levels of analysis: provider level, treatment level, institutional level (e.g., the mental health agency), and systems level (e.g., systems of care in a community) (e.g., Brach & Fraserirector, 2000; D.W. Sue & D.Sue, 2008; S. Sue & Zane, 2009; Whaley & Davis, 2007). The purpose of this study is to focus on the first level of the provider, hereafter, the therapist.

Differences in the epistemology of cultural competence researchers represent another and inherent impasse in the psychology literature. Postpositive, constructive, and postmodern approaches to cultural competence have different conceptions of the nature of culture, ideal role of the therapist, methods of practice, definitions of measurement, and the goals or outcomes of research studies (C. C. Williams, 2006). Researchers working under one scientific orientation rarely interact with the scholarly works of others. Counseling psychologists have contributed greatly to the body of literature into process orientation cultural competence models, while clinical psychologists have provided guidelines for researchers and therapists to make content adaptations to treatments based on client culture. This study represents an attempt to bridge the gap between these two bodies of literature, by incorporating both process oriented and content specific models into a cultural competence measurement system, to be described further in a later section.

The literature also reflects a dilemma between emic (culturally specific) and etic (general) definitions of cultural competence. The field has been criticized for a lack of emic models of cultural competence (Bean, Perry, & Bedell, 2001). For example, Bean and colleagues have provided multiple models of culturally competent family therapist practices, for African Americans (Bean, Perry, & Bedell, 2002), Hispanics/Latinos (Bean et al., 2001), and Asian Americans (Kim, Bean, & Harper, 2004). These models were derived from literature reviews of influential papers on family therapy with each ethnic group, and content analyses to derive cultural competence guidelines for practice. Whaley and Davis (2007) have described emic approaches most beneficial for therapists working with one specific ethnic group, but impractical for the majority of therapists who work with diverse clientele. The current study's aims were to create one measurement system that can be used broadly to measure therapist cultural competence with a variety of youth from different backgrounds. To serve the purpose of this study's goal to produce an inclusive measurement system for cultural competence, etic and emic models are reviewed.

A preponderance of the scholarly writing on cultural competence has focused on theoretical models, with a dearth of empirical studies (Powell Sears, 2012). This issue has been referred to as the "theory-research" gap in multicultural research (Worthington et al., 2007). Authors have lamented that most cultural competence research has measured outcomes of client preferences, with few linking therapist behaviors to differences in treatment outcome (Domenech Rodríguez et al., 2011; Griner & Smith, 2006; S. Sue & Zane, 2009). Indeed, some authors have decried accrediting agencies (e.g., American Psychological Association) for adopting cultural competencies as professional standards due to the weak research basis (Thomas & Weinrach, 2004). Thomas and Weinrach argue,

"many of the activities recommended in the Competencies have never been demonstrated to relate to counseling effectiveness and, in fact, show little construct relationship to actually working with clients… we found it interesting and contradictory that professional associations that emphasize and promote scientific methodology… would adopt or endorse the Competencies prior to providing a stronger research base for them." (Thomas & Weinrach, 2004, p. 42)

In defense of cultural competence, authors have argued that establishing cultural competence professional standards helps guide future research (S. Sue, 2003). Further, the definition of what qualifies as evidence has been questioned (Sue & Zane, 2006). Cultural competence researchers argue that authors who state that only efficacy methodology and randomized controlled trial data will support the validity of cultural competence are biased (S. Sue, 2003). Stanley Sue advocated for establishment of policies for cultural competence standards on the basis of ethical-moral issues, due to the overwhelming evidence of persistent racial and ethnic mental health disparities (e.g., USDHHS, 2001). Further, he stated that there are systemic reasons why empirical studies of cultural competence have not occurred: difficulty recruiting and retaining REM participants, difficulty conducting culturally sensitive research, lack of consensus over operationalization of cultural competence, and the field's overemphasis of internal validity within research studies (Sue & Zane, 2009). Last, Sue suggested that policy formations and professional standards should be created first, in order to guide funding of research into cultural competencies.

In the next section, I review models of cultural competence. The goals of this section were to provide a comprehensive, but not exhaustive, cross-sectional review of definitions to provide a review of the most influential categories of cultural competence. A detailed analysis of

the psychotherapy literature reveals two themes (see Table 1) with regards to cultural

competence: a) Multicultural Counseling Competencies (MCC, Sue, Arrendondo, & McDavis,

1982, 1992), which discusses the development of competencies for therapists to reach, and

author's definitions of this model, and b) systematic cultural adaptations to psychotherapy

content. Regarding the MCC model, fifteen definitions are reviewed. The MCC literature

provides guidance from conceptual and theoretical standpoints. With regards to adaptations,

Domenech-Rodríguez and Bernal (2011) described that the field is filled with different processes

for making cultural adaptations through frameworks, models, and guidelines. Therefore,

adaptation models were examined for a convergence of themes, and for their ability to provide

behavioral recommendations for improving practice for therapists with racial/ethnic different

clients. Because of this focus, some well known cultural adaptation models designed to direct

research attention were not included (e.g., Selective and Directive Treatment Adaptation

Framework, Lau, 2006; Hybrid Prevention Program Model, Castro, Barrera, & Martinez, 2004;

see Domenech-Rodriguez & Bernal, 2006 for a review). For both the MCC and adaptation

review, empirical support for these models and definitions will be reviewed when available. The

focus of this section intends to identify a wide breadth of behavioral markers of cultural

competence, and therefore models from adjacent fields (business and medical healthcare) are

also reviewed for further direction and to ensure saturation of the cultural competence definition.

Multicultural Counseling Competencies

The Multicultural Competencies Model is the most widely-recognized model of cultural

competence (Ponterotto, Fuertes, & Chen, 2000; Wendt & Gone, 2012). The first paper (D. W.

Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vasquez-Nuttall, 1982) laid the ground work

by providing recommendations for therapists to acknowledge their own value positions

(*attitudes*), gather information about minority groups (*knowledge*), and develop strategies to modify the effects of political, social, and economic forces on minority groups (*skills*). The three-factor model provided by Sue and colleagues (1982, 1992, 1998) has been revised and expanded over time. The majority of research into cultural competence models was formed as either reactions to, or modifications of, this original model (Sue, 1998). All of the models included can be classified into three categories: awareness, knowledge, and skills (see Table 1). The American Psychological Association (APA) adopted this three-factor model of multicultural competence defining cultural competence as therapist's knowledge, awareness, and skill (APA, 2003). This definition was also incorporated into professional ethical guidelines to emphasize the need for culturally sensitive interventions and treatment APA, 2002).

The following sections are organized by the three factors of the Multicultural Counseling Competency model: awareness, skills, and knowledge. In each section, the MCC definition is provided, followed by each of the remaining definitions. A review of the empirical evidence concludes each section.

Awareness. Awareness focuses on the therapist's self-awareness of the stimulus value of his group membership on his client. This also reflects the therapist's awareness of his/her own beliefs, and how they may impact the client (D. W. Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vazquez-Nutall, 1982). The first behavior that demonstrates competence in this area is a movement away from ethnoculturalism. Therapists can be observed demonstrating this competence when they respect differences, and communicate a view of other cultures as equally valuable and legitimate as their own (D. W. Sue, Arrendondo, & McDavis, 1992). Second, culturally competent therapists have awareness of their cultural beliefs and values, and how these may affect the client. Competence in this area can be demonstrated through avoiding prejudice,

stereotyping, and microaggressions. Third, therapists will show comfort with differences due to race or belief systems, seen by understanding differences and not denying them. The authors provide a scathing review of a colorblind attitude, wherein a therapist views all clients as human only and does not acknowledge racial differences. Sue et al. (1982) state that this viewpoint was initially intended to remove bias, but has the unintended effect of denying the experiences of many clients of color due to their membership in different racial groups. Last, to demonstrate competence in the awareness domain, therapists should know the limitations of their awareness, and refer clients to therapists who share their own race/culture when warranted (D.W. Sue et al., 1982).

The original multicultural competencies model (Sue, Arrendondo, and McDavis's 1982, 1992) was expanded with dimensions in a later iteration (Arredondo et al., 1996). This model included the three domains of skills, knowledge, and awareness across three dimensions representing attitudes and beliefs toward one's own culture, worldview, and intervention strategies. Therapist behavior that conveys awareness of their own attitudes and beliefs about their own culture includes identifying social and cultural pressures that have influenced their own development and information processing (Arredondo et al., 1996). Further, Arredondo and colleagues recommend that therapists recognize the limits of their own competence, and refer multicultural clients to other professionals when deemed appropriate.

Derald Wing Sue and his collaborators continued to provide definitions of the MCC model over the years. For example, the Dimensional Multicultural Counseling Competencies definition expanded awareness to span across two dimensions: domains of one's own culture, worldview, and intervention strategies; and dimensions representing the immutable characteristics that individuals are born with (e.g., race, attractiveness, A

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Table 1.

Categories and Factors of Therapist Cultural Competence Definitions

Identifying Information	Field	Cultural Competence Factors			
		MCC Tripartite Factors			
		Awareness	Knowledge	Skills	Other
Multicultural Counseling Competencies (D.W. Sue, Arrendondo, McDavis, 1982, 1992)	Psychology	X	X	X	
Cross-Cultural Counseling Competencies (D.W. Sue, 1990)	Psychology		X (knowledge of culture-bound communication styles and sociopolitical facets of non-verbal communication)	X (counseling is a communication style)	
Dimensional Multicultural Counseling Competencies (Arrendondo et al., 1996)	Psychology	X (awareness of own and the client's culture, worldview, and intervention strategies)	X (therapist's knowledge of their own and the client's culture, worldview, and intervention strategies)	X (therapist's skill to tailor treatment to client's culture, worldview, through intervention strategies)	
Multidimensional Multicultural Counseling Competencies (D.W. Sue et al., 2001)	Psychology	X	X	X	X (dimensions of specific cultures)
APA Multicultural Guidelines for Psychologists (APA, 2002)	Psychology	X (commitment to cultural awareness)	X (commitment to knowledge of self and others)	X (psychologists strive to apply culturally-appropriate skills in clinical practices e.g., assessment, client-in-context, interventions)	X (provides guidelines for education and organizational change as well as practice)

Identifying Information	Field	Cultural Competence Factors			
		MCC Tripartite Factors			
		Awareness	Knowledge	Skills	Other
Integrative Multidimensional Model of Cross-Cultural Counseling (Leong, 1996)	Psychology		X (universal, group, and individual levels)		
Flexible and Dynamic Cultural Competence (Lopez, 1997)	Psychology	X (recognizes his/her own culture-bound framework)	X (recognizes client's worldview)	X (moves between worldviews fluidly)	
Culturally Specific Universal Healing Conditions (Fischer, Jome, & Atkinson, 1998)	Psychology		X (provides appropriate ritual or treatment)	X (meets client's expectations, shares worldview)	X (therapeutic relationship, client expectations)
Common Factors Cultural Counseling (Constantine & Ladany, 2001)	Psychology	X (therapist self-awareness)	X (knowledge of multicultural issues; understanding of unique client variables)	X (multicultural counseling skills)	X (ability to establish positive alliance, self-efficacy to use cultural knowledge)
Cultural Hypothesis Testing (S. Sue, 1998, 2006)	Psychology		X (culture-specific knowledge; scientific-mindedness)	X (dynamic sizing)	X (credibility and gift-giving, understand resistance, client's perspective, client's perception of services, consult)
Multicultural Counseling Relationship (Sodowsky et al., 1994; 1996, 1998)	Psychology	X	X	X	X (multicultural counseling relationship)

Identifying Information	Field	Cultural Competence Factors			
		MCC Tripartite Factors			
		Awareness	Knowledge	Skills	Other
Proximal Process Model (S. Sue & Zane, 2009)	Psychology	X (awareness of client's culture)	X (knowledge of culture)	X (culturally-congruent goals and treatment in culturally-congruent way)	
Psychotherapy Adaptation Modification Framework (Hwang, 2006)	Psychology	X (dynamic issues and cultural complexities)	X (cultural differences in distress expression; beliefs about mental illness causes and treatment address cultural issues specific to the client's population)	X (improving the client-therapist relationship)	X (orient client to treatment, increase mental health awareness)
Ecological Validity Framework (Bernal, Bonilla, & Bellido, 1995)	Psychology				X (language, persons, metaphors, content, concepts, goals, methods, context)
Multidimensional Framework for Culturally Responsive Therapy (Koss-Chionio & Vargas, 1992)	Psychology		X (knowledge of poverty, racism and discrimination, acculturation, normative behavior)	X (skills that work for one group may not apply for others)	
Commonwealth Cultural Competence (Commonwealth Fund, 2003)	Medicine		X (aware of impact of cultural factors on health and behavior; cultural knowledge)	X (skills to manage cultural factors appropriately)	

Identifying Information	Field	Cultural Competence Factors			
		MCC Tripartite Factors			
		Awareness	Knowledge	Skills	Other
The Integrative Model of Doctor-Patient Communication (Ashton et al., 2003)	Medicine			X (elicit patient's explanatory model, negotiate with communication skills)	
Patient-Centered Cultural Competence (Betancourt, 2004)	Medicine	X (ability to identify when patients are distrustful of medical)	X (develop skills for negotiation)	X (elicit patient's explanatory model, perceptions of medicine and use of complementary treatment, assess decision-making)	
Multisystemic Cultural Intelligence (Johnson, Lenartowicz, & Apud, 2006)	Business		X (cultural knowledge)	X (personal skills)	X (personal attributes)
Cultural Intelligence (Earley & Ang, 2003)	Business		X (cognitive)	X (physical alterations)	X (motivation)
Intercultural Communication (Gertsen, 1990)	Business		X (cognitive)	X (communication)	X (affective)

dimension), the major historical, political and social legacies (C dimension), and the shared experiences between individuals with different A dimension characteristics (B dimension) (Arrendondo et al., 1996). Therefore, the culturally competent therapist following this definition needs to show awareness of the intersection of each of these dimensions. Arrendondo and colleagues provide operationalized exemplars for each dimension. Therapist behaviors that show high awareness include the therapist's ability to identify the culture that he/she belongs to, significance of their group membership, and relationship of their group members to members of other groups (Arrendondo et al., 1996).

D. W. Sue's (2001) tripartite dimensional model of cultural competence integrates five race- and ethnic groups who merit such competence (African Americans, Asian Americans, Latino Americans, Native Americans, and European Americans); 31 specific competencies divided into three domains (beliefs/attitudes, knowledge, and skills); and four levels of analysis to which cultural competence should apply (individual, professional, organizational, and societal). Although this model of cultural competence is inclusive in scope, the concrete implications for daily clinical applications are most clear in the second dimension (i.e., specific competencies). These competencies, adapted from Sue's earlier work (D. W. Sue et al., 1992), focus on personal attributes of the therapist. Example competencies in the awareness domain are categorized into "beliefs/attitudes" including that the therapist is ''comfortable with differences that exist between themselves and others," "aware of stereotypes and preconceived notions", and "values bilingualism." (D. W. Sue, 2001, p.799).

Several other definitions vary to which they focus on therapist self-awareness, awareness of the client's culture, or a combination. Sodowsky and colleagues' definition includes an awareness dimension including proactive multicultural sensitivity and responsiveness, extensive

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multicultural interactions and life experiences, broad-based cultural understanding, advocacy, and enjoyment of multiculturalism (Sodowsky et al., 1998; Sodowsky, Taffe, Gutkin, & Wise, 1994). López's (1997) Flexible and Dynamic Cultural Competence definition focuses on therapist and supervisor processes showing cultural competence in psychotherapy and supervision. The main point of López's definition is that culturally competent therapists can differentiate their own culturally bound frameworks or perspectives from those of the client's, and then move between these perspectives skillfully. Constantine and Ladany (2001) proposed six domains in their definition, here called Common Factors Cultural Counseling. One of their domains states that the therapist has the necessary self-awareness of their own values and biases to intervene appropriately with the client (Constantine & Ladany, 2001). The Proximal Process Model states that a culturally competent therapist possesses awareness of the client's culture (S. Sue & Zane, 2009). The Culturally Specific Universal Health Conditions definition states that the therapist should be aware of his/her own worldview, and the client's worldview, and attempt to align the two (Fischer, Jome, & Atkinson, 1998).

The American Psychological Association's multicultural guidelines indicate that culturally competent therapists display a commitment to cultural awareness (APA, 2003). This includes awareness of their impact on others, influence of their personal and professional roles in society, and that all interactions are cross-cultural as each individual has a variety of multicultural identities (APA, 2003). While the guidelines include discussion of skills, knowledge, and awareness, it states that increasing awareness is the most critical strategy that therapists can use to build cultural competence (APA, 2003, p. 24). Recommended strategies to build awareness include self-reflection, interviewing family members and same-cultural group members, and creating a personal autobiography (APA, 2003).

Research supports the importance of the awareness domain in two ways. Factor analyses validating multiple measurement tools for therapist cultural competence support an awareness factor. Validation studies of the Multicultural Counseling Inventory (Sodowsky et al., 1994) show support for the reliability and validity of the awareness subscale (Pope-Davis & Dingus, 1995). The sociopolitical awareness subscale on the Cross-Cultural Counseling Inventory – Revised has demonstrated good content, construct, and criterion-related validity (LaFromboise et al., 1991). The studies examining the reliability and validity of both scales were focused on factor analyses with counseling trainees, or analogue of therapy sessions. In a study examining the predictors of self-reported multicultural awareness, the Awareness subscale of the Multicultural Counseling Knowledge, Awareness, and Skills (Ponterotto et al., 1999) was the only subscale significantly negatively related to social desirability (Constantine & Ladany, 2000).

Empirical evidence also connects therapist behavior demonstrating awareness, client behavior, and some client outcomes. In one of the only studies of cultural competence process with clients, content reflecting the therapist's awareness of his/her differences from the client was one of the eight major themes that was derived from a cluster analysis of transcripts from psychotherapy with seven African American adult females (Jones, 1978). Further, when third party raters observed therapists as avoidant or unaware of race, clients were shown to explore problems less (Thompson & Jenal, 1994). In family therapy, support has been found for therapists addressing concerns about working with a culturally dissimilar therapist to increase client satisfaction (Bean et al., 2002). A relationship between therapist's use of statements demonstrating their awareness of the client's culture and treatment satisfaction was demonstrated in a study of therapists providing services in 63 sessions with 21 clients (Chang & Thomas,

2012). In this way, evidence supports the inclusion of cultural awareness in a definition of therapist cultural competence.

To conclude, awareness is a factor that has multiple foci: self-awareness of cultural heritage, awareness of the client's culture, and awareness of how these factors may impact treatment. There is some preliminary empirical support for awareness from factor analyses of cultural competence scales and studies examining client's satisfaction with counseling. Next, I turn to the second domain of the MCCs, skills.

Skills. The second domain of the Multicultural Counseling Competencies model is *skills.* This competency was created in reaction to research that individuals from different races define mental health problems differently, and respond differently to therapy. *Skills* states that therapists should demonstrate the ability to both send and receive accurate and appropriate verbal and nonverbal information. This domain states that competent therapists should practice and deliver a wide variety of verbal and nonverbal responses (D.W. Sue et al., 1982, 1992). The authors highlight the importance of the therapist's ability to both recognize and transmit communication in this reciprocal process, and describe the subtlety of applying culture-specific knowledge in appropriate fashions. Culturally competent skills might be observed when the therapist varies the level of directedness as dictated by the client. In later iterations of this model, skills was expanded to include the therapist's ability to communicate effectively, to anticipate the impact of his/her helping styles on the client, and recognize the limitations of his/her abilities with specific populations (D.W. Sue, 1990; D.W. Sue et al., 1992; D.W. Sue et al., 1998).

Derald Wing Sue's extension of the original MCC definitions in the Multidimensional Multicultural Counseling definition included eleven behaviors that demonstrate culturally

competent skills. Many behaviors focus on career development that would not be observable in an individual therapy session (e.g., therapists should seek out educational multicultural experiences) (D.W. Sue, 2001). Within sessions, therapists could be seen engaging in a variety of verbal and nonverbal helping styles, taking responsibility to provide linguistic competence for clients, showing expertise in cultural aspects of assessment, educating clients in the nature of the therapist's psychotherapy practice, and applying culture-specific knowledge (D.W. Sue, 2001).

López's definition includes four processes where therapists can show culturally competent skills: engagement, assessment, theory, and methods. This definition states that the basic skill set of a culturally competent therapist is for the therapist to move fluidly between the therapist and client's worldview. To do this, therapists first engage clients in treatment by establishing a warm working alliance (López, 1997). Engaging clients in this way allows them to share their beliefs about the presenting problem and facilitates collaborative goal setting. Second, therapists use both formal and informal assessment procedures, and employ the norms of the client's culture (López, 1997). Third, the therapist recognizes that the client may have a different theory of the etiology of the emotional disturbance, as well as different theories for how therapy may help. López states that a skilled therapist respects different etiology of illness theories, but also can distinguish between culturally bound differences in illness myth and dysfunctional thinking based on psychopathology. The last domain, methods, refers to the strategies that the therapist employs to facilitate change. The culturally competent therapist will individualize treatment to use interventions that are culturally compatible with the client's beliefs (López, 1997). While some of these behaviors are similar to the original MCC definition, specific therapist behaviors of eliciting and resolving the illness myth are added by Lopez's (1997) definition of cultural competence.

Two definitions included in this paper focus primarily on the similarities between cultural competence and general therapist competence. Constantine and Ladany (2001) proposed a cultural competence definition, here called the Common Factors Cultural Counseling model, with six dimensions reflecting therapist self-awareness, knowledge about multicultural issues, multicultural counseling self-efficacy, understanding of unique client variables, ability to establish a positive alliance, and multicultural counseling skills (Constantine & Ladany, 2001). These six dimensions contain some overlap; for example, multicultural relationship is defined as the therapist's skillful ability to address multicultural issues within the context of the working alliance. Multicultural counseling skills refers to the therapist's ability to communicate their general, cultural, and individual-specific knowledge effectively, which serves to increase the client's perception of the therapist as credible (Constantine & Ladany, 2001). Related, the Culturally Specific Universal Healing Conditions definition states that the therapist skillfully meets the client's role and process expectations (Fischer et al., 1998).

Stanley Sue describes *dynamic sizing* as an important feature of a culturally competent therapist in his cultural hypothesis testing definition (S. Sue, 1998, 2006). Dynamic sizing means that the therapist skillfully knows when to generalize and be inclusive, and when to individualize and be exclusive. In this way, dynamic sizing refers to a specific set of skills that culturally competent therapists must have. A culturally competent therapist will know how to avoid stereotypes, and still appreciate culture. Further, the therapist can place the client in context, and acknowledges whether he has characteristics of his cultural group, or individual differences (Sue, 1998). A therapist demonstrating high competence with dynamic sizing would apply culture-specific knowledge after testing the salience and relevance of that information (Sue, 1998, 2006).

First defined by Sue, dynamic sizing appears within the cultural competence literature as an important theme (Hall, 2001; Hwang, 2011). Dynamic sizing makes the point that cultural competence is not stereotyping. The therapist should react to the multidimensional conceptualization of the intersections of multiple client identities. Cultural knowledge provides a context in which to understand the client and to determine how similar a client may be to other members of their cultural group.

The Proximal Process definition describes therapists skills in achieving credibility with REM clients by conceptualizing the presenting problem in a manner that is congruent with the client's culture, encouraging culturally congruent goals, and culturally acceptable means to achieving goals (S. Sue & Zane, 2009). Sue and Zane (2009) describe another domain they called "giving" that corresponds to the importance of therapists to give rationale for their treatment model, and provide hope for improvement. They emphasize the importance of delivering something to instill hope early in treatment, whether this is early symptom remission, discussion of expected benefits of treatment, or the benefits that others have experienced from treatment.

The APA's guidelines on multicultural practice state that culturally competent therapists possess the skills to applying the awareness and knowledge relevant to their client (APA, 2003). The guidelines state that therapists should not develop a new set of culturally responsive skills, but rather should realize that there are situations when culture-centered adaptations in intervention and practice may be effective. However, they do not give specific behavioral recommendations for how to skillfully implement cultural knowledge and awareness.

Empirical support for the skills domain is in two areas. First, validation studies of existing measures of cultural competence have consistently found support for subscales

measuring culturally competent skills in the Multicultural Awareness Knowledge Skills Scale, Multicultural Counseling Inventory, and Cross-Cultural Counseling Inventory-Revised (Mollen, Ridley, & Hill, 2003; Ruelas, 2003; Sodowsky et al., 1994; Ponterotto & Alexander, 1996). Second, there is some modest evidence of improved therapy outcomes with increased therapist cultural competence skill. Atkinson and colleagues have produced a series of studies that demonstrates client's improved outcomes based on therapist's verbalizations using cultural referents rather than verbalizations emphasizing the universal human experience (Atkinson, Casas, & Abreu, 1992; Thompson, Worthington, & Atkinson, 1994). Worthington and colleagues (2000) found that therapists who used more frequent spontaneous verbalizations including racial or cultural referents were rated higher on MCCs by trained observers. Kim, Li, and Liang (2002) found that Asian American clients assigned to therapists who emphasized immediate resolution of problems (described as a culturally competent practice) tended to rate the working alliance higher than clients who worked with therapists who emphasized the attainment of insight.

In sum, skills may include the communication patterns between clients and therapists. Some authors have expanded the skills definition to include therapist self-efficacy to perform culturally competent treatment, and establish a multicultural therapeutic relationship. There is some preliminary evidence supporting culturally competent skills in therapy. In the next section, I review the knowledge factor as the last of the MCC definition domains.

Knowledge. The knowledge domain can be divided into two separate areas: general knowledge and similar processes, and group-specific knowledge. In this section, I first describe the original MCC definition of similar knowledge and processes that therapists should use with a variety of REM clients, and contrast this with other author's definitions. The MCC definition of

culturally competent knowledge includes instructions for therapists to apply specific-group knowledge about the client. Therefore, I then review the research regarding specific-group knowledge. Empirical evidence for the knowledge domain is integrated throughout these sections.

The original Multicultural Counseling Competency definition (D.W. Sue et al., 1992) includes five behaviors in the knowledge domain. First, the therapist will demonstrate knowledge of systems of oppression, including the role of cultural racism in identity development. Second, the therapist must possess some culture-specific knowledge for the group he/she is working with, demonstrated by awareness of a group's history, experiences, cultural values, and lifestyles. Third, the therapist will have knowledge of the inherent bias in some theoretical practices of psychotherapy. Behaviors demonstrating competence in this area would include providing appropriate language and culture materials for the client, and selection of an appropriate treatment plan. Last, the therapist shows awareness of common barriers minority clients face when pursuing mental health service. This competency is observed when the therapist changes institutional features to be more compatible for the client. For example, a therapist may change the times of day when they offer appointments, make adaptations to office décor, or change the location of the mental health agency to be most accessible to minority populations (D.W. Sue et al., 1982).

Leong (1996) proposed a multidimensional view of multicultural knowledge in the Integrative Multidimensional Model of Cross-Cultural Counseling based on the tripartite theory of personality (Kluckhorn & Murray, 1950). In this model, the client's personality and behavior are understood to be made up of an individual dimension (how that individual is unique), a group dimension (how that individual is like some others), and a universal dimension (how that

individual is like all other individuals). Leong states that therapists most frequently ignore the group dimension, and recommended therapists to attend to cultural schemas and relationship dynamics that may occur when the therapist and client are operating from different levels.

Culture-specific knowledge is one of Stanley's Sue's three factors making up culturally competent practice. Within Stanley Sue's model, culture-specific knowledge includes the therapist's knowledge of his/her own culture, as well as the client's group (S. Sue, 1998, 2006). Therapists demonstrating culture-specific knowledge would use information about the client's cultural group including the sociopolitical influences, tailor intervention strategies to use meaningful metaphors and interventions, or appropriate assessment techniques.

Sue also stated that culturally competent therapists demonstrate *scientific-mindedness* (S. Sue, 2006). A *scientific-minded* therapist forms hypotheses based on their knowledge of the client's cultural background, develops ways to creatively test hypotheses, and makes decisions based on their acquired data. Use of scientific-mindedness guards against applying concepts based in the therapist's own culture onto their client (S. Sue, 1998, 2006). This principle challenges therapists and researchers to develop relevant ways to test their hypotheses, and integrate findings from these measurements into daily practice. For example, a therapist demonstrating scientific mindedness might be uncertain of the cultural meaning of a symptom and could engage in hypothesis testing. If the symptom is a sign of a psychotic episode, then other symptoms of psychosis should be present, other individuals within the client's culture should be unfamiliar with his/her symptoms, and experts in the culture of the client should acknowledge that his/her behavior is unusual in that culture (S. Sue, 1998). The therapist can test each of these hypotheses to arrive at an accurate and culturally appropriate diagnosis and treatment plan.

Stanley Sue later expanded his recommendations for concrete behavioral markers of therapists demonstrating cultural competence, to include: self-awareness of stimulus value, assessment of client (including cultural variables, such as immigration status, experiences of oppression, acculturative status), pre-therapy interventions, hypothesizing and testing hypotheses, attending to credibility and giving, understanding the nature of discomfort and resistance, understanding client's perspective, strategy or plan for intervention, assessment of session, and willingness to consult.

Stanley Sue and Zane (2009) have described that cultural competence and a general common factors competence are related constructs on a continuum representing the distance between emphasis and goal of treatment. That is, knowledge of culture is a distal factor, which leads to the use of appropriate tactics (alterations in structure, directness, or authority). These tactics lead to changes in the process (increases in therapist credibility), and this process leads to eventual change in the target behavior.

Specific-group knowledge definitions. Specific-culture recommendations for culturally competent practice are presented next. Categories of ethnic similarities have been suggested. For example, Nagayama Hall (2001) proposed that interdependence, spirituality, and discrimination are common constructs that differentiate ethnic minority groups from majority groups in the United States. Therefore, a general knowledge of the systems of oppression and discrimination for REM in the United States, as well as specific-groups knowledge is considered necessary for culturally competent practice.

Some legitimate criticisms are levied at providing recommendations for using relational, process, or content changes in counseling minority clients. First, this approach may unintentionally imply that multicultural counseling is defined by application of techniques

without a conceptual framework (D. W. Sue, 1990). Second, therapists may be limited in their

ability to skillfully apply specific-culture knowledge, and emphasizing changes in specific

techniques may be distal to the goal of offering effective therapy (S. Sue & Zane, 1987). Last,

and most importantly, stereotyping may occur when describing characteristics of each

racial/ethnic group and making recommendations for shifts in relational, process, and content of

psychotherapy (Sue, 1990). Therefore, this section should be read with a degree of caution with

emphasis that these descriptions are of general group mean differences, and may be moderated

by factors including age, gender, acculturation, stage of racial identity development,

socioeconomic status, education, and other characteristics (D.W. Sue, 1990). Further, more

variability occurs within racial/ethnic groups than between them (D.W. Sue & Sue, 2008). Yet,

to detect when therapists are using appropriate culture-specific knowledge, it is necessary to first

identify this knowledge.

It is beyond the scope of this paper to provide an exhaustive review the entire diversity of

people from different cultures. Therefore, issues most relevant to youth psychotherapy were

selected to review: (a) brief overview of cultural group, (b) the role of family, (c) expectations

for the helping relationship, and (d) communication style. Groups representing the proposed

sample for this study will be reviewed; in particular, African Americans, Asian Americans, and

Latino/Hispanic Americans.

African Americans. The U.S. Census defines black as a term that references individuals

who can trace their racial origins to Africa, including African American, African, Latino/a of

African descent, and Caribbean (U.S. Census, 2008). Blacks make up 13.5% of the United

States population (U.S. Census, 2008). However, this group is overrepresented with poverty

rates and unemployment rates for African Americans twice as high than for white Americans (Sue, & Sue, 2008).

African Americans are less likely than white counterparts to seek mental health services, and are more likely to prematurely terminate when they do engage in services (Constantine, Redington, & Graham, 2008). Only 16% of African Americans with a diagnosable mood disorder seek mental health services (Kessler, 1994). Further, African Americans seeking mental health services are more likely to receive diagnoses overestimating psychopathology, even when there is no difference between their presenting symptoms and those of a white person's symptoms (Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983). African Americans' participation in psychological treatment may begin with some misgivings. Review articles suggest that African Americans may have a general suspicion of white people, stemming from the history of oppression in America, which can negatively impact their working relationship with white therapists (Fyffe, 2000).

Many of the cultural values prevalent in African American communities originated in West Africa (Holloway, 1990). As is the case with many nonwestern peoples, some dominant American cultural values and African American values are often at odds. For instance, American cultural worldview promotes individualism, competition, material accumulation, nuclear families, religion as distinct from other parts of culture, and mastery over nature (D.W. Sue & D. Sue, 2003). In marked contrast, many African Americans, particularly those with traditional worldviews, embrace values such as the significance of the collective over the individual, kinship and affiliation, extended families, spirituality, connectedness, harmony with nature, and holistic thinking (Asante & Gudykunst, 1989; Nobles, 1991). Middle-class African Americans

are often likely to adopt value orientations that encompass elements from both African American and mainstream American cultural perspectives (D.W. Sue & D. Sue, 2003).

A number of African-centered psychological instruments have been developed to assess constructs related to the psychological, behavioral, and spiritual experiences of African Americans (Utsey, Belvet, & Fischer, 2008). For example, the Africentrism Scale (Grills & Longshore, 1996) measures the degree that African Americans adhere to the Africentric principles of *Nguzo Saba* (e.g., collective work, self-determination, unity, and responsibility). The Africultural Cultural Systems Inventory measures Africentric coping styles used by African Americans in time of stress and includes domains measuring cognitive/emotional debriefing, spiritual-centered coping, collective coping, and ritual-centered coping (Utsey et al., 2000).

There has been a decline in the past two decades in two-parent African American families, with 48% of African American children currently living in single mother households (Fields, 2003). African American children are more likely to live in a home with multiple generations as compared to white children. These extended family members can provide emotional and economic support for children (D.W. Sue & D. Sue, 2008). African American families frequently have strong kinship bonds, high educational and achievement attainment, and adaptability of family roles (D.W. Sue & D. Sue, 2008). Therapists working with these families should ask questions to understand who lives in the home, who shares responsibility for child rearing, and aim to strengthen the existing family structure (D.W. Sue & D. Sue, 2008).

Cunningham and colleagues (2010) identified culturally competent therapist behaviors in implementing evidence-based family therapy with African American clients. This study used an existing process measure of therapist behavior for multisystemic therapy (MST-Treatment Interaction Process System, Foster, Cunningham, Warner, & Henggeler, 2004) and conducted

interviews with African American and Caucasian therapists and supervisors with 2-10 years of experience delivering MST. Participants were asked to identify which therapist behaviors contributed to outcome success with African American families. Three clinical psychologists used qualitative methods to review transcripts of interviews and group responses into therapists behaviors believed to be helpful, unhelpful, and neutral with African American families. Results showed that a number of behaviors believed to be important for therapists working with African American families (e.g., accepting gifts, content relating to spirituality or cultural context, therapists making generalizations about race or socioeconomic status) almost never occurred. Many of the damaging therapist behaviors did not occur with enough frequency to be reliably rated. However, four therapist behaviors (strength focus, reinforcing parent behavior, instrumental support, take responsibility) were associated with increases in within-session caregiver engagement for African American and Caucasian caregivers. Storytelling was the only behavior that produced unique improvements in engagement for African American caregivers, with no significant improvements for Caucasian caregivers. Storytelling was defined as the therapist's use of a story or example to make a topic appropriate to therapeutic problem areas. While the study linked therapist behavior to improvements in within-session engagement, they did not provide information about how therapist behavior may be related to overall treatment outcomes. This study was also limited in its use of existing process measure, without flexibility to incorporate items specifically designed to measure cultural competence.

Research has also focused on the therapeutic processes that are most beneficial for African American adolescents in psychotherapy contexts (Liddle et al., 2006). Liddle and colleagues used culturally competent intervention strategies in a study of African American adolescents with disruptive behavior disorders, including incorporating accurate cultural

knowledge into treatment and attending to cultural factors in client's lives. Authors

recommended using multiple systems and theoretical frameworks for conceptualizing

problematic behavior, as well as focusing on risk and protective factors for African Americans

including institutional, cultural, and individual racism. Further, to address the mistrust that

African Americans often feel toward mental health services, authors recommend that therapists

take a highly collaborative stance when forming therapeutic goals to facilitate the development

of trust in the therapeutic alliance. It was recommended to use cultural themes to encourage

client engagement, as well as encouraging clients to connect to mentors within their own

community to incorporate the value of communalism. Last, authors recommend that therapists

should acknowledge the systematic barriers faced by many African American adolescent clients,

and incorporate skill building for negotiating the system in beneficial ways. Other authors have

used intervention adaptations for African American youth including principles of spirituality,

harmony, collective responsibility, oral tradition, holistic approach, experiences with prejudice

and discrimination, racial socialization, and interpersonal/communal orientation (Belgrave,

Chase-Vaughn, Gray, Dixon-Addison, & Cherry, 2000; Belgrave, 2002; Cherry et al. 1998,

Harvey & Hill, 2004, Jackson-Gilfort et al. 2001).

     Styles of communication may impact psychotherapy process with African American

youth. Code switching refers to a practice in which individuals alter their behavioral patterns to

conform to the current environment (Celious & Oyserman, 2001). Code switching may cause a

considerable amount of stress for African American youth. For example, an adolescent may

speak and behave in the black English vernacular when interacting with African American peers,

yet change speech and behavioral patterns to meet the norms and expectations valued in more

integrated settings. These changes in self-presentation can lead to increased stress (Celious &
Oyserman, 2001).

Latinos. In this section, Latino and Hispanic refer to individuals living in the United
States with ancestry from Mexico, Puerto Rico, Cuba, El Salvador, the Dominican Republic and
other Latin American countries (D. W. Sue & D. Sue, 2008). The term *Hispanic* is a term that
refers to the shared Spanish language, while *Latino* is more frequently used to refer to anyone of
Latin American origin or ancestry, including Brazilians (Gibbs & Nahme Huang, 2003). The
U.S. Census recognizes Hispanic as an ethnic group, and Hispanics can be members of any racial
group. There are about 35 million Latinos in the United States, 65% of Mexican ancestry, 8.6%
Puerto Rican, 3.7% Cuban-American, and the remaining 22% represent Central and South
America (U.S. Census, 2004). Latinos make up the largest minority group in the United States
(D. W. Sue & D. Sue, 2008). There are wide variations in this group with regard to acculturation
and immigration status (D.W. Sue & D. Sue, 2008). Over 30% of Latino children live beneath
the poverty line, as compared to 17% of all children in the United States (U.S. Census Bureau,
2003).

Despite the heterogeneity of the Latino group, most Latinos share a history of
colonization by Spain (language, culture, religion, and worldview), experiences of immigration,
and exposure to oppression (Comas-Diaz, 2006). Latinos psychotherapy needs may include
issues relating to ethnic identity, immigration, acculturation, and discrimination (Comas-Diaz,
1989). Approximately one in every 10 Latino children in the United States lives in a home
where he/she is a citizen, but at least one parent is not a citizen (Rios-Ellis et al., 2005). Further,
while individuals who have immigrated to the United States often display resilience and view
challenges as temporary, this resilience does not carry on to their children (S. J. Schwartz, Unger,

Zamboanga, & Szapocznik, 2010). Children of immigrants tend to view discrimination against them as permanent and institutionalized (Valencia, 2006). In this way, Latino children may experience unique stress in navigating the cultural bridge between their country of ancestry and the United States (Comas-Diaz, 2006).

The values of Latino families may differ from those of other cultures. Family tradition is an important aspect of life for Latino Americans. Family unity (*familismo*), respect for family members, loyalty, and cooperation are valued. Latino children may live within a broad network of family and friends. Interpersonal relationships are especially important to Latino families (Dingfelder, 2005). The family may extend beyond relatives to include neighbors, godparents, and close family friends. Latinos may be reluctant to seek outside help unit until all family resources are exhausted (D. W. Sue & D. Sue, 2008). Family roles are frequently delineated across sex lines; within the family the father often assumes the role of the primary authority figure (Lopez-Baez, 2006). Similarly, adolescent male children may be given more independence, while female adolescent children are more restricted.

Spirituality may also be important to Latino families. Many Latino families are Catholic (Gibbs & Nahme Huang, 2003). The therapist's understanding of the importance of events like baptism, first Holy Communion, and funerals will facilitate the client's feelings of being understood (Organista, 2003). Sue and Sue (2008) recommend assessing the influence of religious or spiritual beliefs when establishing the therapeutic relationship with Latinos. For example, some clients may express a feeling of *fatalism,* or a belief that the misfortunes in life are inevitable and be resigned to their fate. Latino families may seek the services of a *curandera* (folk healer) or seek out their priest before they consult a mental health professional (Dobkin de

Rios, 2001). Therefore, it is important for therapists to work with other helpers within the family's system.

Interventions targeting Latino families have explored the cultural competence factors that predict higher attendance in therapy. For Latino parents, offering materials and treatment in Spanish and English, and promoting family discussions about culture predicted higher retention in treatment (Mendez & Westerberg, 2012). Similarly, some treatment may be inherently consistent with one's cultural orientation. For example, in a study of depressed Puerto Rican adolescents comparing the efficacy of cognitive behavioral therapy (CBT), interpersonal therapy, and a wait-list control, researchers concluded that both CBT and interpersonal therapy led to symptom remission, but only interpersonal therapy increased youth's self-concept (Rosselló & Bernal, 1999). Authors stated that interpersonal therapy was more compatible with Puerto Rican values of *personalismo* (the preference for personal contacts in social situation) and *familismo* (the tendency to place interest of the family over the individual).

There are some specific recommendations for therapist behavior when working with Latino families. Therapists should engage in a respectful and warm manner, describe the roles of each individual, fully describe confidentiality, and elicit the client's explanation for the problematic symptoms (D.W. Sue & D. Sue, 2008). In addition, therapists should assess acculturative level, consider the impact of cultural and societal aspects on the problem, use a translator if necessary, and assess the resources available to the family within their community. Some authors have recommended that therapists engage in *platica*, or small talk during the beginning of a session (Organista, 2003). However, others point out that the individual's comfort with this may depend on their acculturative status (D.W. Sue & D. Sue, 2008). As the client gains trust in the therapist, they will likely form a close, personal bond and may perceive

the therapist as a family member (D.W. Sue & D. Sue, 2008). Therefore, invitations to family

events or gift-giving should not be interpreted as dependency or a lack of appropriate boundaries

(D.W. Sue & D. Sue, 2008).

Asian Americans and Pacific Islanders. The Asian American population in the United

States is currently over 12 million (Council of National Psychological Associations for the

Advancement of Ethnic Minority Interests, 2009). Approximately 66% of this group immigrated

to the United States, and 40% speak limited English (U.S. Census Bureau, 2005). The term

Asian American encompasses more than 43 distinct groups including Chinese, Filipino, Korean,

Asian Indians, Japanese, Vietnamese, Laotians, and Cambodians (Council of National

Psychological Associations for the Advancement of Ethnic Minority Interests, 2009). Native

Hawaiians, Guamanian, and Samoans are considered the Pacific Islander group (D.W. Sue & D.

Sue, 2008). Approximately 76% of this group have immigrated within the past 20 years

(Council of National Psychological Associations for the Advancement of Ethnic Minority

Interests, 2009).

Generalizations are difficult to make due to the large differences both between groups

and within this vast group category of Asian Americans (Uba, 1994). Individuals within the

Asian American and Pacific Islander group vary considerably on levels of acculturation, English

fluency, amount of education, and religious beliefs (D.W. Sue & D. Sue, 2008). Within the

Asian American population, some ethnic groups (e.g., Southeast Asian, Korean) appear to have

greater mental health needs than others (e.g., Chinese, Japanese; Kuo, 1984; Uehara, Takeuchi,

& Smukler, 1994; Ying & Hu, 1994).

Asian Americans have been misunderstood through the "model minority" myth; that is,

that they have overcome racial discrimination, now enjoy educational and economic success and

are no longer at risk for psychological or social challenges (Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2009). However, Asian Americans access mental health services and engage in treatment at much lower rates than their Caucasian counterparts. According to reports, only 17% of Asian Americans with a psychological problem seek help, and only 6% seek help from mental health professionals (U.S. Surgeon General, 2001). Authors have stated that clients' adherence to traditional Asian cultural values, including hierarchical relationships, collectivism, and achievement orientation, could have an important role in the therapist's ability to engage an Asian American in the counseling process (D.W. Sue & D. Sue, 2008).

Asian American children from immigrant communities encounter unique developmental challenges not shared by majority group youths. They are faced with stressors associated with minority and immigrant status, such as racism, discrimination, and cultural rifts within their own families (Lau, Jernewall, Zane, & Myers, 2002). Stressful conditions associated with an acculturation to the majority culture include discrimination, feelings of alienation, and identity confusion.

There may be a stronger relationship between intergenerational conflict and child distress for Asian American youths than for white youths (Lau et al., 2002). Family values include respect for elders, devotion, obedience, and maintenance of family traditions. These tenets discourage or prohibit open conflict between children and their parents. In the interest of maintaining harmony, individuals are expected to avoid confrontation, and give "face" or respect to others (Chan, 1992). Asian American parents tend to be authoritarian and directive in parenting practices, and child problem behavior is often interpreted as caused by a lack of discipline (Jose et al., 2000).

Traditional Asian cultural values include a collectivistic orientation (Chan, 1992).

Therefore, Asian families may present to therapy with a goal of improving family or group

orientation (D.W. Sue & D. Sue, 2008). Japanese American parents rated children behaving well

as the most important social competence, whereas European American parents chose "being self-

directed" as the most important behavior (O'Reilly, Tokuno, & Ebata, 1986). Further, Asian

American parents are less likely to elicit their child's perspective on family matters (D.W. Sue &

D. Sue, 2008). Therefore, authors have recommended that therapists assess goals and treatment

approaches by seeing the individual as part of a family system (D.W. Sue & D. Sue, 2008). For

example, symptoms can be assessed by asking, "How does your family see the problem?" and a

discussion of goals introduced with, "How important are considerations of your family in

deciding how to deal with your problem?" (D.W. Sue & D. Sue, 2008, p. 363). Issues relating to

the value of a holistic view on mind and body, academic goals, and experiences of racism and

prejudice may also arise in therapy with Asian American clients (D.W. Sue & D. Sue, 2008).

Evidence suggests that skillful use of cultural knowledge is connected to improved

communication between REM clients and their therapists. In a study of attrition rates for REM

clients, Wade and Bernstein (1991) found that therapists who had taken a cultural sensitivity and

knowledge training course had clients who returned for more sessions, as compared to therapists

who had not taken this course. Worthington (2000) found that therapists who used more

spontaneous statements referring to race or culture were evaluated as more culturally competent

by third party observers. Holcomb-McCoy (2002) found support for a knowledge factor in a

survey of the multicultural competencies of over 50,000 practicing therapists, and found that

self-perceptions of low cultural knowledge most correlated with low ratings of multicultural

competence skillfulness. Cross-cultural training courses and intensive training programs are

found to increase self-rated cultural knowledge and skill (Yutrzenka, 1995). Therapist's statements demonstrating their knowledge of the client's culture were associated with reduced symptoms and improvements in functioning for a treatment seeking adult population (Chang & Thomas, 2012). This evidence supports the inclusion of skillful use of cultural knowledge in measures of cultural competence.

Culture specific knowledge definitions of cultural competence have strength in providing very specific behavioral recommendations for therapists in treatment with minority clients. Authors of these definitions frequently recommend application of this knowledge within a sensitive and tailored way for the individual. However, culture-specific cultural competence models have been criticized by some as implying that cultural competence is a set of techniques that therapists can use without engaging in personal awareness exercises (D.W. Sue et al., 2001). Further, there is some danger that uninformed therapists will apply culture-specific recommendations without the necessary dynamic sizing (S. Sue, 1998). Therefore, the culture-specific knowledge reviewed in this section is useful, as long as applied within a culturally competent fashion.

Conclusion to MCC Definitions

Empirical evidence for the Multicultural Counseling Competencies is equivocal. Worthington and colleagues (2007) conducted a 20-year content analysis of leading journals in counseling and clinical psychology, and concluded that the empirical evidence linking multicultural counseling competencies and favorable treatment outcomes is not robust. However, evidence supports therapist cultural competence improving client satisfaction, attendance, and engagement. Ponterotto et al. (2000) discussed support for the model as falling into three categories: (a) prevalent professional support among training programs and

professional organizations, (b) research on culturally responsive therapist behavior, and (c) self-report measurement research. Worthington and colleagues (2007) concluded that future research needs to create instruments that apply broadly and specifically to measuring therapist cultural competence, and to use dependent process and outcome variables in statistical models.

The information provided in the Multicultural Counseling Competency model provides some ability to extract behavioral definitions. The broad definitions of the awareness, skills, and knowledge domains are both strengths and weaknesses of this definition. Any behavior where the therapist applies either general racial/ethnic minority, or specific group knowledge fits into this domain. Further, changes in the environment or structure of therapy reflect therapist's competence in the knowledge domain. However, the breadth of this definition may make it difficult to conclude that the therapist's behavior was changed due to his/her knowledge about the client's culture. For example, can a cultural competence behavior be concluded when a client thanks his therapist for meeting him at a later appointment time than usual? Or was this therapist operating in a flexible fashion without any knowledge about how appointment availability may interact with client engagement in treatment for a particular cultural group? This definition requires some inference or understanding of the therapist's motives for behavior change.

Cultural Adaptations

The next section focuses on three models that guide therapists in making adaptations to treatment content based on the client's culture. The Ecological Validity Framework, The Multidimensional Framework for Culturally Responsive Therapy, and Psychotherapy Adaptation Modification Frameworks are reviewed below. Despite these models' focus on therapy content,

there are similarities between the recommended behavior in each and the MCC recommendations (see Table 1).

  Ecological Validity Framework. The first known framework for systematic adaptations made to psychotherapy based off of cultural factors proposed in the literature was the Ecological Validity Framework (EVF; Bernal, Bonilla, & Bellido, 1995). Cultural treatment adaptation is defined as the systematic modification of an intervention to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). These systemic alterations of intervention protocols are designed to enhance the cultural consideration and contexts to align with client's values, contexts, and worldviews (Benish, Quintana, & Wampold, 2011).

  The EVF was originally created to adapt evidence-based treatments for Latino populations. The framework guides researchers and therapists to adapt treatment for specific minority groups along one of eight dimensions: language, persons, metaphors, content, concepts, goals, methods, and context. Language applies to oral and written communication, as well as jargon (regionalisms, slang). The persons dimension refers to the client-therapist dyad as well as structural considerations including the client's expectation for the therapist (Bernal, Bonilla, & Bellido, 1995). Metaphors can reflect cultural responsiveness in both verbal forms (folk sayings) as well as visual forms, inside of the intervention as well as outside (e.g., culturally relevant artwork in the waiting room). Adaptations on the content dimension include changes in light of the client group's values, customs, and traditions. Treatment goals and methods are adapted to work within the cultural context, and the context dimension refers to appropriate consideration of the sociopolitical and historical climate (Bernal, Bonilla, & Bellido, 1995).

Rosselló and Bernal (1999, Rosselló et al., 2008) used the EVF to adapt cognitive behavioral therapy (CBT) and interpersonal therapy for adolescences (IPT-A) depression for Puerto Rican youth with depression. In both treatments, the content was adapted so that therapists included focus on extended family ties and hierarchical relationships. Further, the methods were altered such that parent participation was encouraged, and family themes of balancing interdependence, dependence, and independence were included in treatment. The first study showed that culturally adapted IPT-A and CBT were associated with symptom remission, as compared to a wait list control condition (Rosselló & Bernal, 1999). The second study showed that individual and group adaptations of both active and adapted treatments led to symptom remission (Rosselló et al., 2008).

Domenech Rodríguez and colleagues culturally adapted a parent management training using an ecological validity cultural adaptation process model for Mexican American families with children who exhibit behavioral problems (2011). Using data from focus groups with Mexican American families, she adapted treatment across the eight dimensions of the ecological validity model. Researchers made content adaptations by using explicitly stated cultural values to frame goals (e.g., *respeto*). A list of metaphors, or *dichos*, was produced in manualized intervention and constantly updated for interventionists to use during teaching. For example, a metaphor that one has now fallen into the trap (*caer en la trampa*) was used frequently when therapists were guiding parents through role-plays (p. 180). Findings show increased retention and better child outcomes for the parents in the culturally adapted treatment as compared to the control group.

The EVF provides eight specific areas to focus adaptations on to enhance cultural competence. This model has demonstrated empirical support for improving efficacy for cultural

populations. Further, the eight adaptation areas lend themselves to behavioral recommendations

for improving cultural competence. For example, the use of cultural metaphors could be counted

within a session. In this way, the EVF adds much to the existing cultural competency literature.

Multidimensional Framework for Culturally Responsive Therapy. Vargas and Koss-

Chionio developed a framework to understand the different areas where cultural adaptations can

take place in psychotherapy (1992). It was developed with the assumption that cultural

responsiveness is a necessary condition in all therapy, and to provide a description of areas

where adaptations may be possible. The framework states that psychotherapy is located along

dimensions of structure and culture (Koss-Chionio & Vargas, 1992). The structure dimension

contains two categories measuring process and form. The process is the change that occurs

because of psychotherapy, and the form is the style of executing therapy according to guidelines

about modality or method (Koss-Chionio & Vargas, 1992). The cultural dimension includes two

categories of context and content. The context refers to the interpersonal interactions between

the client and therapist and how the expectations of each individual impact the therapy process

and progression. The cultural content is defined as the meaning that social experiences that

serves as the lens for the client's understanding and displays of individual behavior, interpersonal

interactions, and emotions (Koss-Chionio & Vargas, 1992).

Authors of this framework advocate for each therapist to make their own modifications in

the structure of treatment implementation, based on the cultural dimension (Koss-Chionio &

Vargas, 1992). While authors encourage therapists to make adaptations, they caution that these

adaptations should be made with considerable thought and intentionality. Authors advocate for a

culturally responsive rather than culturally sensitive approach to therapy, differentiating the two

terms by stating that culturally responsive assumes more of an active approach orientation for the

therapist. Last, they state that the skills with which an adaptation is used for one client cannot be assumed to work for another client (Koss-Chionio & Vargas, 1992). Authors recommend four content domains for therapists to consider when working with culturally diverse clients: poverty, racism or discrimination, acculturation, and normative behavior.

This framework provides an organizational structure for viewing models and definitions of cultural adaptation. It provides high therapist flexibility, with few specific behavioral guidelines. Authors using this framework have suggested behavioral guidelines in the form and process of therapy, including that the therapist should ask questions, invite clients to tell their stories in their own words, and listen effectively (Webb, 2010). Therefore, while this framework provides organization, it does not contribute specific behavioral recommendations for alterations of form or process based on the client's cultural content.

Psychotherapy Adaptation and Modification Framework. Hwang (2006) proposed a psychotherapy and adaptation modification framework specifically for Asian Americans immigrants that could be expanded to work with other ethnic groups. The Psychotherapy Adaptation Modification Framework (PAMF, Hwang, 2006) incorporates six therapeutic domains to adapt for different cultures: dynamic issues and cultural complexities, orienting clients to psychotherapy, understanding cultural beliefs about mental illness, improving the client-therapist relationship, understanding cultural expressions of distress, addressing cultural issues specific to the population. The PAMF is considered a top-down adaptation of an existing evidence-based treatment for specific cultural groups. The PAMF provides a description of 25 therapeutic principles across the six domains. For example, within the domain of improving the client-therapist relationship, PAMF recommends that therapists should address the client-therapist roles and expectations for therapy. The domain of dynamic issues and cultural

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complexities contains two principles (e.g., be aware of dynamic sizing, and be aware and address a client's multiple identities).

While the PAMF is framed as a cultural adaptation, investigation into the model shows that it includes principles targeting therapist self-awareness, knowledge, and skills (Bernal, 2006). As a companion, Hwang (2009) has also provided a formative method of adapting psychotherapy (FMAP) as a bottom-up approach to cultural adaptation that uses five phases to stimulate collaboration with community participants. Hwang (2006, 2009) has provided a comprehensive model for compatible adaptations to both therapist behavior and therapy content to improve treatment for diverse clients. Two published case study reports support the use of PAMF to guide therapist's cultural adaptations in psychotherapy (Hwang, Wood, Lin, & Cheung, 2006; Hwang & Wood, 2007).

PAMF contributes to the literature by attempting to fill the awareness-action gap. In constructing the PAMF, Hwang (2006) writes that much of the cultural competence literature has focused on therapist's increased self-awareness and increasing their own knowledge. He criticized these models for leaving cultural considerations as an academic and descriptive exercise, but that specific behaviors had not been defined for therapists. This model contributes specific behavioral recommendations to improve cultural competence.

In sum, content adaptation models vary in their ability to provide guidance for specific behavioral adaptations for culturally competent behavior. The Ecological Validity Framework has led to interventions that improve participant retention and outcome in randomized controlled trials. However, it should be noted that authors did not test this framework against another method of cultural adaptations. Therefore, results support the use of cultural adaptations for models but may not provide discrete support for this framework. Overall, the content adaptation

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models provide information about specific behaviors that indicate cultural competence.

Medical Health Care Models and Definitions

Medical health care scholars and providers have invested efforts into establishing cultural competence guidelines. The Institute of Medicine has suggested that a culturally sensitive approach to medical care that avoids bias, prejudice, and stereotyping may help reduce health care disparities (Smedley, Smith, & Nelson, 2002). Multiple frameworks have been proposed to improve cultural competence among health care providers (Betancourt et al., 2003; Crenshaw et al., 2011). Cultural competence training has focused on different topics and is shown to improve provider knowledge, attitudes, and skills, although patient outcomes are not frequently assessed (Betancourt & Green, 2010; Crenshaw et al., 2011). Three major models will be reviewed in the following section for medical provider cultural competence with patients: (a) Commonwealth Cultural Competence, (b) Integrative Model, and (c) the Patient-Centered Cultural Competence model.

Commonwealth Cultural Competence. The Commonwealth Fund created a report on cultural competent medical practices (2003), defining cultural competence as including the levels of organizational (e.g., hiring and promoting minorities in the health care workforce), systemic (e.g., providing on-site interpreters), and clinical dimensions (e.g., cross-cultural training for providers). This section will focus exclusively on the clinical aspect, because of this papers's aim to explore provider (i.e. therapist) levels of cultural competence.

The clinical aspect provides a definition for doctor-patient interactions. Clinical cultural competence was defined as including three components reflecting that the practitioner: (1) is aware of the impact of social and cultural factors on health beliefs and behaviors, (2) is equipped with the tools and skills to manage cultural factors appropriately through training and education,

and (3) has the necessary knowledge to deliver quality care to all patients. Poor cross-cultural provider-patient communication increases the rates of patient dissatisfaction, poor adherence to medications and health promotion, and poorer health outcomes (Commonwealth Fund, 2003). Achievement of cultural competence would eliminate the one-size fits all approach and replace it with a more responsive approach to the needs of diverse groups.

Integrative Model. The Integrative Model of patient-doctor communication describes how patient-doctor communication patterns influence patients' health outcomes, including the prevalence of racial and ethnic bias that can occur without knowing or detection (Ashton et al., 2003). This model states that when the patients and doctors are of different cultural origin, religion, gender, or national origin, each part of the pair is using a different explanatory model for the interaction and the patient's illness. Therefore, information must be communicated to understand each person's perspectives, and come to a collaborative consensus for treatment (Ashton et al., 2003). This collaborative communication and ultimate arrival at a consensus goal is what Ashton et al. refer to as "effective communication." Cultural competence facilitates this process.

The Integrative Model contains four stages of communication for the patient-doctor dyad. First, each participant has his/her own communication style, made up of verbal and non-verbal behaviors. Communication styles are influenced by both stable factors (individual's age, education, linguistic skill, and ethnicity), as well as an adaptive factor (cognitive-affective factors including goals of the interaction, perception of partner, perception of relationship, communication strategies, and current emotional state). Importantly, communication is seen as an interaction between a dyad, with empirical evidence supporting the influence of patient's communication behaviors on doctors. Four key patient behaviors influence doctors behavior,

including providing a health narrative, asking questions, expressing concerns, and being assertive (Street, 1991; Street, 1995). Doctors can also influence these interactions, by using specific questions to elicit the patient's explanatory model (e.g., the cause, symptom onset, control and meaning, pathophysiology, prognosis, and treatment; Ashton et al., 2003). The ultimate focus of the Integrative Model is for the doctor to use culturally competent communication strategies to elicit the patient's explanatory model for the disease and then negotiate to a shared explanatory model. Cultural competence behaviors include inviting patient participation and using questions to elicit patients' explanatory model (Ashton et al., 2003).

Patient-Centered Cultural Competence. Joseph Betancourt and his colleagues have focused the past two decades of research efforts on improving medical student and physician cultural competence through the Patient-Centered Cultural Competence model (Betancourt & Green, 2010; Bolton et al., 2007; Green et al., 2008; Greer, Park, Green, Betancourt, & Weissman, 2007; Rodriguez, Cohen, Betancourt, & Green, 2011). Betancourt defines cultural competence as the ability of health care professionals to communicate with and effectively provide high-quality care to patients from diverse sociocultural backgrounds. To achieve these ends, Betancourt has proposed a framework approach for providers to develop patient-centered care, implementing the exploration, empathy, and responsiveness to patient's needs, values, and preferences (2004). Betancourt (2010) describes this framework approach as superior to categorical approaches to cultural competence, which focuses exclusively on training practitioners in with the knowledge and skills to approach one specific cultural group. This definition also includes the needed skills to negotiate between two cultural perspectives.

Specific skill sets are recommended for medical training programs through the Patient-Centered Cultural Competence model (Betancourt, 2004, 2010). First, physicians are trained in

the necessary methods to work with diverse patients. Specific behaviors that are measured in this domain include the practitioner's ability to elicit the patient's explanatory model of the illness and symptoms, assess the patient's perceptions of medicine and use of complementary, folk, or alternative medicines, assess the decision-making preferences for the patient and the role of family, elicit the patient's perception of medicine and use of complementary or alternative medicines, develop skills for negotiating, and become aware of the issues of mistrust and prejudice on clinical decision making (Betancourt & Green, 2010; Betancourt, 2004). Betancourt concludes his definition by making recommendations for medical schools to measure the relation between student's cultural competence training and patient outcome, using quality improvement methodology (Betancourt & Green, 2010).

To date, a full test of Betancourt's proposed definition has not taken place. However, his team has explored associated concepts as they relate to medical students' cultural competence. Training students to work effectively with interpreters and increasing student diversity were two methods identified as significant predictors of medical student's proficiency with patients with limited English proficiency (Rodriguez et al., 2011). Training with cross-cultural opportunities most predicted medical student perceptions of themselves as prepared to work with pediatric patients and families from different cultural backgrounds than their own (Green et al., 2008). Specific behaviors measured as part of *skills* included: (1) determining how a patient wants to be addressed or interacted with, (2) taking a social history, (3) assessing the patient's understanding of the cause of the illness, (4) identifying whether the patient is distrustful of the health care system or physician, (5) negotiating with the patient about aspects of the treatment, (6) identifying religious beliefs and cultural customs that may affect clinical care, (7) identifying how a patient makes decisions within a family system, and (8) working effectively with a

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medical interpreter (Green et al., 2008). Medical residents who had access to more cross-cultural

treatment training experiences scored themselves higher on each skill set (Green et al., 2008).

Ratings of medical trainees preparedness and skillfulness to use culturally competent care was

associated with their experience in training with diverse client populations (Greer et al., 2007).

Review of the medical field's definitions and evidence for cultural competence provides

some guidelines for evaluating cultural competence. First, the principle of preparedness (ability

to practice culturally competent medical care) is related to medical residents who had more

experience treating culturally diverse clientele. Therefore, a preparedness, or prior knowledge,

component may be important for measuring cultural competence. Definitions of cultural

competence within the medical literature focused primarily on providing practitioners and

trainees with appropriate knowledge and skills to implement culturally competent care. Authors

have proposed behavioral assessment methods for measuring the use of knowledge and skills;

however, these have not been tested to date in patient populations. While some of the definitions

used in the medical literature used the term 'awareness' (e.g., "physicians are aware of impact of

social and cultural factors on health and behavior", Commonwealth Fund, 2003), careful

inspection of these terms show that awareness is being used synonymously with possessing

knowledge.

In comparison to the MCC model (D.W. Sue et al., 1992), the medical models reviewed

here did not include a component emphasizing the personal awareness of the providers's own

cultural heritage, values, or bias. The difference in focus on the therapist between psychotherapy

researchers and medical research may have it's roots in psychology's focus on the interpersonal

relationship of psychotherapy, and may be explained by the different expectations for intimacy

that patients have for medical doctors versus therapists. However, evidence has not connected

therapist appropriate use of MCC principles, client processes, and symptom outcomes in clinical populations. Therefore, it is also possible that therapist self-awareness is not a critical part of cultural competence. However, medical practitioners likely need to a certain base level of awareness in order to recognize when to implement appropriate and skillful application of knowledge, there may be a process of doctor self-awareness that is assumed in some models that is not explicit. Medical models may benefit from including a self-awareness component to their definitions and training models.

Business Industry Models and Definitions

The increasingly global business market has led business leaders to seek international markets to expand markets for their products, find new sources of materials, and cost-effective manufacturing. Not all international business ventures succeed. Authors of a conceptual review concluded that international business failure is explained by two general themes: a) expatriate failure, and b) the inability of managers to appreciate the cultural challenges of doing business internationally (J.P. Johnson, Lenartowicz, & Apud, 2006).

Authors of a review revealed a lack of consensus over the definitions and contents of cultural competence in the business setting (J. P. Johnson, Lenartowicz, & Apud, 2006). The most frequently cited definitions were selected for this review if they focused on intercultural interactions and provided specific recommendations for improving efficacy. Three definitions will be reviewed: (a) intercultural communication (Gertsen, 1990), (b) cultural intelligence (Earley & Ang, 2003), and (c) a multisystemic approach to cultural intelligence (Johnson et al., 2006). Some definitions converge with psychology principles to cultural competence; therefore, more emphasis will be given to those definitions that differ.

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Intercultural communication. Gertsen (1990) defined intercultural competence as the ability to function effectively in a different culture. Gertsen's definition includes three interdependent dimensions: attitudes, cognitive, and communicative/behavioral. Within the attitudes domain, individuals who have higher intercultural competence are posited to be empathetic to others world experiences, open, and flexible to adjustments to other cultural contexts (Gertsen, 1990). By contrast, attitudes of prejudice, stereotype, and ethnocentrism are found to negatively correlate with intercultural competence. Moderate support was found for the relation between attitudes and efficacy in business interactions in foreign cultures (Gertsen, 1990). Research shows that those with high cultural empathy or openness may not always express these as culturally appropriate behavior in business situations. The second domain of intercultural competence in business settings is the knowledge approach. This domain is similar to a knowledge domain in many psychology definitions, and includes the individual's understanding of specific culture's acceptable and unacceptable behavior.

Gertsen's (1990) last domain is the communicative behavioral approach. Gertsen concludes that the intercultural competence must be observed through the expression of appropriate behaviors. To this end, he finds research support for three levels of communication: 1) language fluency, 2) verbal expression, and 3) non-verbal expressions. Language fluency allows business managers to converse directly with clients. However, even if individuals rely on translators, appropriate understanding of verbal expressions including expression of respect, empathy, role flexibility, and a willingness to listen to others are critical. Last, non-verbal behavior including body language, eye movements, and use of touch are seen as important. Gertsen recommends that companies use behavioral assessments in role-play situations when hiring consultants who are expected to function in cross-cultural situations (Gertsen, 1990).

Cultural intelligence. Business researchers have also searched for a cultural intelligence factor that informs cultural competence. Earley has focused his career on defining and creating conceptual models for management training with regards to cross-cultural efficacy in work teams, and in international business (e.g., Earley & Singh, 1995; Earley & Ang, 2003; Earley & Mosakowski, 2004; Earley, 2006). Cultural intelligence is defined as an "outsider's seemingly natural ability to interpret someone's unfamiliar and ambiguous gestures the way that person's compatriots would" (Earley & Mosakowski, 2004, p. 140). Cultural intelligence also involves the ability to adapt flexibly to new environmental contexts.   In this way, cultural intelligence does not presuppose prior cultural knowledge, but implies adaptability to new cultural situations.

Earley defines cultural intelligence as having three components: cognitive, physical, and emotional/motivational (or head, body, and heart in popular press, Earley & Ang, 2003; Earley & Mosakowski, 2004). The cognitive (or head) component includes two knowledge domains. First, the outsider must have a certain level of rote knowledge about the cultural context that he/she is entering. This is necessary but not sufficient, as the individual must also possess the ability to devise new learning strategies in different environmental contexts. Within the managerial context, this means hypothesis-testing from observed patterns of behavior among individuals from the same cross-cultural context (Earley & Mosakowski, 2004).

 The physical (or body) component of cultural intelligence refers to the ability to use effective non-verbal communication. Authors recommend that, as a first step, individuals looking to increase their cultural intelligence should have an open stance toward other cultural norms with regard to non-verbal communication differences, and expressions of physical affection. For example, an American who has a difficult time hiding discomfort for a French business client's customary greeting with a hug and kiss on both cheeks reflects a low level of

cultural intelligence for the physical component. Authors reviewed research showing that managers bidding for client business who physically mirrored their different culture business clients actions were more likely to be made an offer (Earley & Mosakowski, 2004). Specific physical alterations are recommended in: personal space proximity, appearance (e.g., attire), posture, mirroring, greetings, and eye contact (Earley & Mosakowski, 2004).

The last component to the cultural intelligence model is affective (or heart). This component refers to the individual's self-efficacy and motivation to work within cross-cultural contexts. Authors suggest that individuals who are the most successful at this domain can draw on past experiences to raise their confidence. For example, a business leader who has difficulty managing an intercultural group in a foreign country may either experience low confidence or high confidence to continue to engage in this line of work. Authors suggest that individuals who have had past success, whether or not in the specific domain of intercultural groups, are more likely to have higher motivation to continue to try to manage the group (Earley & Ang, 2003; Earley & Mosakowski, 2004). Authors suggest that if business managers can be trained in analogue settings approximating the physical and cognitive adaptations of a new cultural setting, if managers do not have this confidence from past experiences (Earley & Mosakowski, 2004).

Authors state that all three domains of cultural intelligence must interact together, and that failure in any one part can lead to inefficiency or loss of business (Earley & Ang, 2003). In order to improve cultural intelligence, authors set out a six-step process. First, individuals should conduct an assessment of their current levels of cultural intelligence, using their own impressions as well as feedback from higher and lower level personnel. This can take the form of formal assessment, informal assessments of past business successes, or as a simulation. For example, authors describe a staged a cocktail party to observe a consultant's skilled application

of South Korean social etiquette (Earley & Mosakowski, 2004, p. 146). The second step is that the individual selects training experiences that focus on his/her cultural intelligence weaknesses, step three is to carry out this training, and step four is to re-allocate work load to allow for increased focus on cultural training. In step five, the individual enters the cultural situation they have been training for, and specifically use their self-assessed strengths to guide early interactions. In this way, if the individual has been found to have strong mirroring skills, he/she is instructed to mirror as much as possible in the early minutes of an interaction to increase the chances of smooth intercultural communication (Earley & Mosakowski, 2004, p. 146). The final step is to evaluate how the interaction went, using self-assessment and feedback from all involved parties. This evaluation may lead to further training, as deemed necessary.

Cross-Cultural Competence in International Business. The Cross-Cultural Competence in International Business (CCCIB) definition and model extend the work by Gertsen, Earley and colleagues (Johnson et al., 2006). First, authors of the CCCIB reviewed relevant definitions of cultural competence, and describe a 'knowing' and 'doing' gap. They explain that research has focused on the antecedents to cultural competence (knowing) but do not provide an explanation of the behavioral manifestations of these antecedents (doing). This gap is similar to the awareness-action gap that psychological researchers have identified in cultural competence research (e.g., D.W. Sue & D. Sue, 2008). Academics across different specializations are simultaneously trying to bridge these gaps.

The CCCIB concludes that cultural competence is made up of three individual components: personal attributes (values, beliefs, norms, personality traits), personal skills (abilities and aptitudes), and cultural knowledge (general, as well as specific to the target culture) (J. P. Johnson et al., 2006). Cultural competence draws upon these components to work

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successfully with people from different national cultural backgrounds. This ability to effect

change is moderated by the organization's institutional ethnocentrism and cultural distance from

the target culture. Authors explain that an individual's adaptive behavior for a specific cultural

context may be buffered if the organization is culturally distant. For example, an American

company may have a policy that individuals on the sales teams may not accept gifts from clients.

The American salesman working in a culturally distant culture where provision of gifts is

common, then, may behave in less culturally competent ways due to organizational rules. In this

way, the individual is limited by organizational contexts.

Several pieces from business definitions of cultural competence are relevant to the

present study. First, business researchers have had a similar difficulty with reaching a consensus

definition of cultural competence, and in providing behavioral assessments of this in practice. At

the individual level, definitions of cultural competence largely fall into three domains measuring

attributes, knowledge, and communication skills. Two of these domains (knowledge and skills)

converge with the factors suggested by the prevailing psychology definition of awareness,

knowledge, and skills (e.g., Sue, Arrendondo, & McDavis, 1982, 1992).

Business definitions add components of an individual's motivation to interact

interculturally, and their personal attributes and biases that lead to communication styles. None

of the three definitions reviewed here made explicit the need for an individual's awareness of

his/her own personal biases or values. However, each discussed that the individual may need to

alter his/her personal interaction styles, which assumes a degree of awareness into their natural

interactional patterns. Building on these definitions, business researchers have identified specific

behaviors that have been connected to improved intercultural communication. In this way, the

literature from organizational behavior and international business can help bridge the awareness-

action gap in the psychology literature. Researchers of management and business training have guided business leaders to change their physicality, as well as knowledge and flexible application of learning styles (Earley, 2006). This body of literature contributes to the understanding of cultural competence as a flexible application of confidence to apply cross-cultural techniques, knowledge, and alterations of non-verbal communication styles.

Conclusion of Cultural Competence Definitions

Major themes emerge from the review of models and definitions of cultural competence written in the psychology, medical, and business fields. First, authors in all fields seem to agree that cultural competence is a behavior worth researching and achieving, yet discuss their concern that their fields have not reached a consensus definition. Further, conceptual articles and training recommendations are written frequently from a rational and ethical basis, without consistently demonstrated empirical support. Despite these limitations, some conclusions can be reached.

The Multicultural Counseling Competency model of *awareness, skill,* and *knowledge* serves as an adequate explanatory model for the majority of the cultural competence definitions explored across fields. Each of the 21 reviewed models and definitions included a factor for culture-specific knowledge. Several authors discuss that skills in dynamic sizing is important when applying culture-specific knowledge. While empirical support exists for awareness within the psychotherapy literature, this factor was largely absent in the medical and business fields. However, close examination indicated that awareness was assumed in these definitions. Last, empirical support has been found for cultural adaptations in a number of process and content domains (e.g., language, metaphors, content). While many definitions indicated the presence of a relationship factor, it was unclear how distinct this multicultural relationship factor was from a more general positive alliance experience, or from other aspects of the three-factor MCC model.

Therefore, cultural competence is defined in this study as the therapist's awareness, skill, knowledge, and adaptation of the content and process of therapy to work effectively with a client of a different cultural background. Examples gathered from the psychotherapy, medical, and business models were used to provide behavioral demonstrations of these four factors. Use of scientific mindedness and dynamic sizing in applying culture-specific knowledge emerged from several psychotherapy studies. Psychotherapy researchers and medical field colleagues agreed on several factors: (1) elicit the client's explanatory model for mental illness, (2) identify family dynamics and decision-makers, (3) negotiate goals, and (4) orient client to provider's treatment model. Cultural adaptation researchers discuss changing language, persons, metaphors, content, concepts, goals, methods, and contexts. Business models discussed that an individual's engagement in culturally competent behavior is partially predicted by their levels of motivation to be culturally competent, while psychology definitions focus on a related construct of therapist self-efficacy to perform culturally competent care. Therefore, therapists may have differing levels of self-efficacy to demonstrate skillful culturally competent behaviors.

This definition of cultural competence is comprehensive. In order to determine whether evidence can support this definition, a system to measure this cultural competence definition is needed. In the next section, there is a review of existing measurement systems and problems within the literature of measuring cultural competence.

Measurement of Cultural Competence

Having now reviewed cultural competence definitions, this section reviews efforts to measure cultural competence. Many instruments have been proposed to quantify therapist cultural competence (Stuart, 2004; S. Sue, 2006; Wang & Kim, 2010) and these can be organized into therapist self-report, vignettes, and observer reported (see Table 2).

Self-Report

The first category of measurement discussed is therapist self-reports. Self-report measures involve the therapist reporting on his/her own behavior. Differences of opinion exist regarding how direct and objective self-report assessment is as a general method (cf. Cone, 1978; Witt, Cavell, Heffer, Carey & Martens, 1988). In this section, five self-report measures are reviewed: (1) Multicultural Counseling Inventory, (2) Multicultural Counseling Awareness, Knowledge, and Skills Survey, (3) Multicultural Counseling Awareness Scale-Form B, (4) Multicultural Counseling Knowledge and Awareness Scale, and (5) California Brief Multicultural Competency Scale. Following a description of each scale, the validity of self-report measures of cultural competence is discussed.

The Multicultural Counseling Inventory (MCI; Sodowsky et al, 1994) contains 40 self-report items designed to assess behaviors and attitudes related to four factor analytically derived subscales. Authors found adequate fit for a four-factor model measuring multicultural counseling skills, multicultural awareness, multicultural counseling knowledge, and multicultural counseling relationship. The MCI includes a relationship subscale that measures aspects of therapists' interpersonal processes with racial and ethnic minority clients (Sodowsky et al., 1994). The relationship subscale demonstrates adequate reliability (Ponterotto and Alexander, 1996) and content validity (Sodowsky et al., 1994). Research findings demonstrating that students with multicultural training or more professional experience working with culturally diverse clients score higher on the MCI provide support for the criterion-related validity of the scale. The four-factor model was derived from both exploratory and confirmatory factor analyses that provided moderate support for the construct validity of the scale (Sodowsky et al., 1994).

The Multicultural Counseling Awareness, Knowledge, and Skills Survey (MAKSS) is a

60-item self-report for therapists to report on their multicultural awareness, knowledge, and skills

(D'Andrea, Daniels, & Heck, 1991). The MAKKS uses Sue, Arrendondo, and McDavis's

(1982) original Multicultural Counseling Competencies model as a guiding principle. The

measure is divided into three subscales measuring awareness, knowledge, and

skills. Participants who complete the survey instrument respond to item prompts such as "In

general, how would you rate your skill level in terms of being able to provide appropriate

counseling services to culturally diverse clients?" with a 1-4 response range indicating degree of

knowledge or agreement with item prompt. The awareness subscale measures therapist's

awareness of personal attitudes towards racial/ethnic minority members or persons of color, the

knowledge subscale measures knowledge about persons of color, and the skills subscale

measures ability to provide cross-cultural counseling (D'Andrea et al., 1991). Items on the

MAKSS are highly face valid.

The Multicultural Counseling Awareness Scale-Form B (MCAS-B; Ponterotto, Rieger,

Barrett, & Sparks, 1994) is a 45-item therapist self-rating scale. The MCAS-B uses a seven

point Likert-type scale to measure multicultural knowledge, skills, and awareness. The MCAS-

B is a revised version of the 70-item original Multicultural Counseling Awareness Scale (MCAS,

Ponterotto, Sanchez, & Magids, 1991). It is based on Sue and colleagues' (1982) competency

report, with three factors measuring cultural competence including knowledge, skills, and

awareness. Initial validity was supported by expert judge's ability to classify items into

subscales, and a factor analysis supporting a two-factor fit (knowledge/skills, awareness).

The Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto et al.

2002) is a 32-item, self-report measure of therapist perceived multicultural counseling

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knowledge and awareness. Twenty items assess knowledge (e.g., "I check up on my minority/cultural counseling skills by monitoring my functioning – via consultation, supervision, and continuing education"); and 12 items assess awareness (e.g., "I am aware that being born a minority in this society brings with it certain challenges that white people do not have to face"). Items are rated on a 7-point scale from 1 (*not at all true*) to 7 (*totally true*), with higher scores indicating greater perceived knowledge and awareness of multicultural counseling issues. The intercorrelation between the Knowledge and Awareness subscales is .04 (Ponterotto et al. 2002). The MCKAS possesses a moderate to high degree of reliability, and adequate temporal stability and internal consistency (Ponterotto & Potere, 2003).

The California Brief Multicultural Competence Scale (CBMCS; Gamst et al., 2008) was designed to create a single, brief instrument for items in several other multicultural counseling competence measures, to increase the efficiency of measurement in community mental health clinics. The self-report measure was created with 1,244 mental health service providers in Southern California. Scale development began by aggregating items from a variety of existing self-report measures. Authors used confirmatory factor analysis to test a one-factor solution, three correlated factor solution, and four factor correlated solution on two separate samples of therapists, and found the most support for the four-factor solution. The four factors were labeled knowledge, awareness, sensitivity, and nonethnic ability. Three of these competencies correlated with the three competencies described in the Multicultural Counseling Competencies model (Sue, Arrendondo, McDavis, 1992). Nonethnic ability measured issues related to people with disabilities, low socioeconomic status, lesbians and gay men, and seniors. The development study supported initial reliability and construct validity, but additional tests are needed.

Table 2.

Measures of Therapist Cultural Competence

Measure and authors	*Measurement*	*Factors*	*Population*	*Psychometric Evaluations*
Multicultural Counseling Inventory (Sodowsky et al., 1994)	Therapist self-report	1- Awareness 2- Knowledge 3- Skills 4- Relationship	Adult	Constantine & Ladany (2001); Kocarek et al. (2001)
Multicultural Counseling Awareness, Knowledge, and Skills Survey (D'Andrea et al., 1991)	Therapist self-report	1- Awareness 2- Knowledge 3- Skills	Adult	Constantine & Ladany (2001); Ponterotto & Alexander, 1996
Multicultural Counseling Awareness Scale-Form B (MCAS-B; Ponterotto, Sanchez, & Magids, 1991)	Therapist self-report	1 – Awareness 2 – Knowledge 3 – Skills	Adult	Ponterotto, Sanchez, & Magids, 1991
Multicultural Counseling Knowledge and Awareness Scale (Ponterotto et al., 1996; Ponterotto, Gretchen, et al., 2002)	Therapist self-report	1- Awareness 2- Knowledge	Adult	Ponterotto & Potere (2003) Constantine, Gloria, & Ladany (2002)
California Brief Multicultural Competency Scale (Gamst et al., 2004)	Therapist self-report	1- Nonethnic ability 2- Knowledge 3- Awareness 4- Sensitivity	Adult	Gamst et al., 2004
Cross-Cultural-Counseling Inventory-Revised (LaFromboise et al., 1991)	Observer rated (by supervisor)	Unidimensional measuring cultural competence	Adult	Ponterotto & Alexander, 1996

One chief criticism of these measurement tools is that scales reflect different conceptualizations of multicultural competence. In a study examining two self-report scales (MCI and the MCAS-B), Pope-Davis and Dings (1994) concluded that although these instruments' subscales were positively correlated, they seemed to measure fundamentally different constructs. Further, despite the fact that many scales are based from the Multicultural Counseling Competencies (D.W. Sue, Arrendondo, McDavis, 1982, 1992) model, these tools tend to differ in the factors that contribute to the variance of the overall multicultural counseling competence construct. For example, D'Andrea et al. (1991) reported a three-factor model (i.e., awareness, knowledge, and skills) of multicultural competence, Sodowsky et al. (1994) described both a four-factor model (i.e., awareness, knowledge, skills, and relationship) and a unifactor model (i.e., general multicultural competence) of multicultural counseling competence; and Ponterotto et al. (1999) proposed a two-factor model (i.e., knowledge and awareness) of multicultural counseling competence. Therefore, despite similar goals to measure perceived multicultural counseling competence, there may be some lack of clarity about what is actually measured by existing competence instruments.

Several investigations have questioned the validity of self-report questionnaires for cultural competence. Multiple studies have demonstrated that there is little association between therapist self-reported cultural competence and observer-rated cultural competence (Constantine, 2001; Worthington et al., 2000) or performance on multicultural case conceptualization tasks (Ladany, Inman, Constantine, Hofheinz, 1997). Self-report measures correlate highly with social desirability scores (Worthington et al., 2000). Awareness also appears to affect therapist's abilities to accurately rate their skill; trainees rate themselves as higher in cultural competence

prior to taking a multicultural counseling course, and significantly lower after the course (LaFromboise et al., 2004).

Authors have discussed a developmental stage model of therapist cultural competence with early stages including the therapist's "halo of naiveté" in believing that his/her skills are adequate to counsel individuals from other groups, followed by denial of differences between groups and colorblind attitudes, and ultimately culminating in acceptance of self-identity and self-directed seeking of additional multicultural knowledge (Carney & Kahn, 1984). Self-report measures could be invalid based on the therapist's own perceptions of his/her skill, and developmental level. White psychology graduate students have reported high levels of anxiety, helplessness, and fear of being misunderstood or negative evaluation when confronting racial dialogues in training (D.W. Sue, Rivera, Capodilupo, Lin, & Torino, 2010). Therefore, avoidance of these topics and adoption of a colorblind attitude may be motivated by avoiding anxiety (Sue et al., 2010). Additionally, self-reported measures of cultural competence have been shown to be associated with social desirability (Worthington et al., 2007). Social desirably attitudes correlate significantly and positively with most self-report multicultural counseling competence instruments (*r* ranging from 0.18-0.30, *p* < .05; Constantine & Ladany, 2000).

Self-report cultural competency inventories are likely to measure anticipated rather than actual multicultural counseling competence. In other words, these instruments are tapping a sense of self-efficacy in the future execution of cultural competence (Constantine & Ladany, 2000; Pope-Davis & Dings, 1995). Little relation exists between perceptions of cultural competency and observed or demonstrated culturally competent behavior (Constantine & Ladany, 2000). In sum, there is inadequate support for the validity of a self-report measure of therapist cultural competence.

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Performance Tests

Performance tests, sometimes called vignettes, are stories that provide concrete examples of people and their behaviors in certain situations (Lapatin et al., 2012). These tests have emerged as a popular method for examining predictors of mental health disparities and therapist behavior because they allow researchers to vary characteristics of interest (e.g., client race, gender, socioeconomic status) while holding others constant (e.g., symptom profile; Shulman et al., 1999; Martinez and Guarnaccia, 2007). This research design can be faster than use of real participants, as there are no requirements for recruitment, consent procedures, or internal board review human subjects documentation (Lapatain et al., 2012). Performance tests can take on multiple methods including writing, role plays with or without scripts, or analogues of psychotherapy with non-treatment seeking healthy participants.

Constantine and Ladany (2001) developed a behavior-based method of assessment that objectively evaluates trainees' case conceptualization ability in terms of the incorporation of clients' cultural variables. Studies using this method have assessed to what degree respondents actually integrate and differentiate multicultural information into the etiology and treatment conceptualizations associated with clients' presenting concerns (Constantine & Ladany, 2000, 2001; Ladany, Inman, Constantine, and Hofheinz, 1997).

Performance tests are unable to measure the gap between projected behavior, and actual behavior (Hughes, 1998; Barter & Reynold, 1999, 2000). The prompts for these tests describe a single client who is treatment seeking for symptom relief. Bromely (2004) reported on six studies using performance test methodology to assess multicultural competencies. Only one of the six studies included both a minority-member test prompt and a majority-member test prompt, allowing for examination of differences between therapist behavior based on client

characteristics. All failed to assess whether therapists account for the impact of race for European American clients. However, there was no statistically significant relationship between therapist social desirability and performance on multicultural competency performance test examinations. Bromley also found no correlation between rates of competency as measured by performance tests and those measured by self-report. Overall, these results indicate that performance tests may provide information about therapist's cultural competence.

The validity of performance test methods has been questioned, as each prompt represents a new measurement tool, and scenarios are rarely replicated or standardized. Further, vignette case conceptualizations have not been statistically related to observer rated culturally competent behavior (Constantine & Ladany, 2001). Therefore, despite the feasibility advantages to vignette research, there is wide variation in the validity of this methodology.

Observational Measurement

Observer-rated measurement has been called the 'gold standard' of therapy process research (Hill, 1991). Observer-rated cultural competency has demonstrated associations with criterion-based evidence of cultural competence, including multicultural verbal content (Worthington et al., 2000). There is one known observer-rated tools to measure cultural competence created for adult non-clinical samples, and validated on college student analogues of therapy sessions.

The Cross-Cultural Counseling Inventory – Revised (CCCI-R, LaFromboise, Coleman, & Hernandez, 1991) is a 20-item observational system measuring therapist's behavior on three subscales: cross-cultural counseling skill, sociopolitical awareness, and cultural sensitivity. Items are rated on a six-point scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*), with higher scale scores indicating higher levels of cultural competence in session. Reliability of the

CCCI-R was established by four independent judges on 13 videotapes of two practicum students (a white/Anglo-American male and white/Anglo-American female) provide either cognitive-triad training or cross-cultural role plays with a Mexican American confederate in a scripted role play (LaFromboise, Coleman, & Hernandez, 1991). A validation study explored the factor structure when 86 undergraduate coders used the CCCI-R to rate one 7-minute videotaped interview between a white/Anglo-American practicum student and a confederate with a predetermined script. The vignette consisted of the female therapist interviewing an African American male client whose presenting problem involved difficulties adjusting to a predominantly white university and urban environment. In this study, the 20-item scale yielded an internal consistency (coefficient alpha) reliability of 0.95, and a factor analysis identified three factors.

The developers of the CCCI-R used strong methodological rigor with observational methods, factor analysis, and reliability demonstrated through 86 independent raters. However, since the measure was validated on only one 7-minute vignette, the external validity of this measure's use in novel therapy situations is unknown. Further, all measure development took place with analogue procedures and with college student populations, further limiting the external validity. Therefore, while the CCCI-R provides measurement advances in several areas, there is still a need for an observational measure targeting a treatment seeking population in a variety of clinical contexts. Last, no measures exist exclusively targeting measurement of these behaviors in youth psychotherapists.

Developers of the CCCI-R measured therapist cultural competence on a continuum. To explore this further, two continuum models of therapist cultural competence are reviewed. These measurement systems lend themselves to dimensional ratings of therapist behavior.

Cross and colleagues developed a six-stage model of cultural competence (Cross, Bazron, Dennis, & Isaacs, 1989). While the model was originally developed for organizations, it has been adapted for individual therapists. In this model, stage one represents cultural destructiveness, when the therapist assumes a cultural superiority over the client. Stage two is cultural incapacity. In this stage, the therapist may support a system of separate-but-equal in society, and has lower expectations for minority clients. Stage three involves the therapist behaving in a cultural blindness, such that only individuals in the majority-member culture benefit from the ethnocentric universal systems in place. Stage four is a place of precompetence; here, the therapist begins to address issues of culture through experiences like cultural sensitivity trainings. Stage five is when the therapist reaches a basic level of cultural 'competence', or an ability to work adequately with individuals from different cultural backgrounds. Stage six is an advanced cultural competency position, wherein the therapist works at an organizational-level to effect changes in hiring, research direction, and advocates on behalf of diversity issues (Cross et al., 1989).

Castro (1998) developed a similar model of a continuum representing cultural competence. His continuum includes six stages, ranging from -3 (cultural destructiveness) to +3 (cultural proficiency). Therapists working at a -3 level have an attitude of superiority about their own culture, and view culturally dissimilar clients as inferior. The next level (-2) represents cultural incapacity, or an attitude that separate but equal services is adequate. Cultural blindness (level -1) follows, with a worldview that all cultures and individuals are the same and equal. The three lower levels of this model indicate cultural incompetence. In the positive direction, culturally sensitivity or openness makes up the first level of cultural competence (level 1). This level is also characterized by therapists understanding the vast within-group differences in

cultural groups. Level 2 is called cultural competence, and is achieved when therapists can work

with complicated issues and can understand cultural distinctions. The last level (Cultural

Proficiency, level 3) is assigned to professionals who demonstrate proficiency in the design and

implementation of interventions. Castro (1998) indicates that therapists can demonstrate cultural

proficiency (level 3) with one group, but may be at a lower level with other groups. Castro's

model uniquely describes cultural competence on a continuum, with gradations of competence

gained through demonstrations of specific therapeutic processes. This model also indicates that

therapist cultural behavior may be orthogonal to itself, such that a therapist may be proficient

(level 3) with one group, but in a stage of colorblindness (level -1) with another group.

Measurement Summary

Multiple methods were reviewed for measuring therapist cultural competence behaviors,

including therapist-self reports, analogues, and observational methods. Each methodology

provides unique information and has strengths and weaknesses (Kazdin, 2003). Observational

coding has been referred to as the gold standard for therapy process research (Hill, 1991).

Observational research methods allow researchers to view the behavior of interest without

depending on the potential bias of self-report measures methods that can occur with self-report

measurements (Moncher & Prinz, 1991).

Observational coding methods also have limitations. Therapy process measures have

different levels of required inference for coders to provide ratings (McLeod, Islam, & Wheat,

2013). Noninferential measures ask coders to focus on overt behaviors, while inferential

measures ask coders to understand therapist's intentions (Mcleod, Islam, & Wheat, 2013). It

may be difficult for coders to discern the true meaning of the intention behind therapist's overt

behaviors, as well as the emotional impact of behaviors. The perspectives of each participant in

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treatment cannot be reliably measured through observational methods.   Despite these

limitations, process research that is conducted without observational methods may be missing

important information. Therapy process research measuring the perspectives of the client and

therapist in addition to observational coding systems provide the greatest degree of information.

The study's aim was to develop an observational coding system tool that can measure a

frequently omitted variable alongside other measures of the therapeutic process.

While some work in measurement has begun, it has been concluded that the collective

group of instrumentation is still "only in it's infancy" (Ponterotto, Fuertes, et al., 2000, p. 646).

Further, the majority of cultural competence measurement has been theoretically derived, and not

empirically based. Continuum based ratings of therapist cultural competence behavior might be

particularly relevant. Table 2 summarizes the efforts to operationalize and measure therapist

cultural competence, and shows that a variety of factors have been concluded. Last, no existing

measures have focused on youth therapist cultural competence.

Developmental Considerations in Cultural Competence Measurement

Much of the work reviewed in this paper has focused on adult and college student

populations, with a few notable exceptions (cf. Bean, Perry, & Bedell, 2001). The models

reviewed are not specific to youth populations. This is problematic, as the tasks of childhood

and adolescence are unique with respect to race/ethnicity (Chang & Downey, 2012; Phinney,

1990). Further, therapist behavior may need to be different with youth clients versus adult

clients. For example, authors have proposed that children are much less likely to be self-referred

than adults, which necessitates different magnitudes in the therapist's engagement strategies

when confronted with initial resistance (Karver et al., 2008). Therefore, any downward

adaptations of existing cultural competence measures must incorporate the unique factors of

youth psychotherapy. Issues relating to acculturation, racial/ethnic salience, and racial/ethnic identity development may interact with a youth's interaction in psychotherapy. However, research in this area is limited because these constructs are not routinely measured or reported in youth psychotherapy outcome studies.

Acculturation is defined as changes that take place as the result of contact with a culturally different group and is most commonly studied when people are residing out of the region of origin (Schwartz et al., 2010). Further, this construct includes individual's orientations toward heritage and the receipt of cultural contexts for individuals living outside of their region of origin (Schwartz et al., 2010). Higher acculturative stress over conflicts around ethnic identity is correlated with increased youth behavior problems and depression (Hovey & King, 1996). Intergenerational acculturation conflict may disrupt the family system as children acculturate and learn English fluency faster than their parents, and often function as cultural brokers or translators (Chung, 2001).

Development of a positive racial/ethnic identity for youth is associated with resiliency factors, but the salience of racial/ethnic identity varies for each person (French & Chavez, 2010; Yoon, 2011). Racial socialization consists of the mechanisms through which sources (i.e., parents, teachers, community members) transmit information, values, and perspectives about race and ethnicity to their children (Hughes et al., 2006). Racial socialization is considered to part of the process of developing racial identity (Bennett, 2006).

Racial identity development models progress from obliviousness of the importance of race to the awareness of racism and appreciation for diversity. Cross stated that racial identity begins in a stage characterized by the internalization of negative stereotypes, and culminates when the individual is anchored in a positive sense of racial identity and can perceive and

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transcend race proactively (Cross, 1971, 1978, 1991). However, Phinney (1989) found empirical support for three stages: diffusion/foreclosure (little interest in race/ethnicity or relying on the opinions of others about one's own race), moratorium (exploration of one's own race/ethnicity), and achieved (confident sense of self as a minority group member). Notably, Phinney's work focused specifically on adolescents, and he found that about 50% were in the diffusion/foreclosure stage, with 25% each in the following two stages.

Research has examined the interaction of chronological age and race/ethnicity identification, and development. Children ages 3-5 show racial awareness and identification of their own racial group (Fox & Jordan, 1983). Authors suggest that ethnic awareness develops later, due in part to the required attention to complex cues including behavior, customs, beliefs, and values (Bernal, Knight, Garza, Ocampo, & Cota, 1990). A cognitive developmental framework was created to investigate the steps of ethnic identity acquisition in pre-school and elementary school age children (Bernal, Knight, Garza, Ocampo, & Cota, 1990). This framework stated that as children's cognitive abilities develop, they move from correct ethnic labeling to ethnic constancy.

A therapist's culturally competent behavior is important even with young child clients who have yet to understand their own race/ethnicity. Children may identify with cultural metaphors and objects in psychotherapy even if they cannot explain their relevance. For example, Mexican children ages 6–11 displayed increased verbal engagement after discovering Mexican toys during the intake psychotherapy session (Garza & Bratton, 2005). Bernal and colleagues describe that children indicate their preference for cultural food and music before they can identify themselves with that culture (1990). Therefore, providing a culturally competent

environment and relationship may increase even a very young child's comfort and trust within psychotherapy.

School counselors have adopted models of cultural competence for their work with children and adolescents. The American School Counselor Association (ASCA) has adopted a position that school counseling professionals must integrate cultural knowledge, sensitivity, and awareness into existing school counseling programs (Lewis & Hayes, 1991). In order to gain competence, specific recommendations have been given to engage in multicultural counseling, multicultural consultation, understanding racism and student resistance, multicultural assessment, understanding racial identity development, multicultural family counseling, social advocacy, developing school-family-community partnerships, and understanding cross-cultural interaction partners (Holcomb-McCoy, 2004). Differences in cross-cultural interaction patterns can include verbalizations such as posing questions, giving directives, and commenting on behavior or appearance (Holcomb-McCoy, 2004). For counselors and teachers, the actual words used to communicate to individual students as well as the voice tone and volume are indicators to students about the overall atmosphere of the school environment. In addition to verbal communication, nonverbal communication including facial expressions, hand signals, gestures, body movements, and physical appearance play a part in counselor-to-student interpersonal interaction. Therefore, school counselors have been advised to gain awareness and skill in altering these behaviors in order to raise cultural competency with youth students (Holcomb-McCoy, 2004).

Additional challenges occur in measuring process level variables in youth psychotherapy. Some have suggested that cultural competence incorporates aspects of the therapeutic relationship (Sodowsky et al., 1994). Therapeutic relationship variables, such as alliance, may

be more complex in youth psychotherapy due to the requirement to align with both the parent and the youth client (Shirk & Karver, 2003). Alliance also predicts satisfaction in youth psychotherapy (Garland, Saltzman, & Aarons, 2000; Kendall & Southam-Gerow, 1996). In a study of the relation between parent-therapist and child-therapist alliance on retention, satisfaction, and outcome, only parent-therapist alliance was significantly related to measures of therapy retention (i.e., family participation, frequency of cancellations, premature termination; Hawley & Weisz, 2005). Youth-therapist alliance and parent-therapist alliance both significantly predicted parent satisfaction with services. However, parent satisfaction with services was not related to youth satisfaction with services. These studies demonstrate the complex nature of measuring therapeutic relationship process variables in youth psychotherapy, and the importance of including both parent-level and youth-level variables in models.

In sum, the psychotherapy process with youth of racial/ethnic minority backgrounds is an important dimension that merits further attention. Client variables including age, racial/ethnic identity development, race/ethnicity salience, and acculturation may moderate the impact of culturally competent behavior on satisfaction and outcomes. However, these variables are rarely measured. Models examining the psychotherapy process should measure the therapist's demonstration of culturally competent behavior with the child client, as well with the parent/caregiver and other members of the child client's ecological system (e.g., teachers, church leaders).

Cultural Competence Model

Competency has been defined as the degree to which therapists have the knowledge and skill required to deliver treatment to the standard needed for it to achieve expected effects (Fairburn & Cooper, 2011). Competent therapists are expected to possess numerous competent

behaviors, including a theoretical orientation to guide interactions, skillful use of interventions to produce the conditions necessary for change in their client, and an awareness of when to apply these techniques (Constantine & Ladany, 2001, Shaw & Dobson, 1988, Yeaton & Sechrest, 1981). Within cultural competence, a preponderance of the literature has focused on defining cultural competence as using awareness in working with clients from diverse backgrounds, knowledge about specific cultural groups, and skillfulness application of this knowledge. However, the literature has yet to describe how the psychotherapeutic process between client and therapist may manifest the therapist's cultural competence. There is little consensus or consistent measurement of these three therapist characteristics.

There is a paucity of research into youth psychotherapy process relating to therapist cultural competence. However, there is support for content adaptations relating to alterations in the language, persons, metaphors, content, concepts, goals, methods, and contexts (Bernal et al., 1995). Content alterations necessitate the therapist's awareness and knowledge to alter treatment, and skillful ability to make consistent changes to any one of these areas. The adult literature has provided some limited support for MCCs, as well as adaptations to treatment content.

The Youth Therapist Observational Cultural Competence Scale (YTOCCS) was designed to measure each of the cultural competence factors discussed above: awareness, knowledge, skills, and adaptation. In this study, the term *Understanding* includes the therapist's awareness of his/her own cultural background, awareness of the client's background, openness to discussions of differences, awareness of potential differences between client and therapist's backgrounds, and the therapist's awareness of a potential stimulus value that he/she may have on the client. The term *Knowledge* includes group-specific knowledge of the client's culture,

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cultural expectations for children, cultural beliefs about health and etiology of distress, as well as an understanding of the client's cultural context and the current sociopolitical climate. By contrast, *Communication* includes the therapist's skillfulness in the using of a variety of verbal and non-verbal interventions, negotiating differences in therapy expectations, providing suggestions for systems-level interventions, and changes in the language, persons, metaphors, content, concepts, goals, methods, structure, roles (i.e., degrees of autonomy, expert), or process of treatment.

Specific Aims

This study had three specific aims with related hypotheses. The first aim was to develop an observational measure of cultural competence for youth psychotherapists, the Youth Therapist Observational Cultural Competence Scale (YTOCCS), based on prior literature on cultural competence and cultural adaptation, with collaboration from experts, therapists, and parents of youth within the mental health service sector. The second aim was to examine the reliability of the YTOCCS using estimates of interrater reliability. It was hypothesized that the YTOCCS would demonstrate adequate reliability through acceptable intra-class correlations (ICC > 0.60, Cicchetti, 1994) and internal consistency ($\alpha > 0.80$; Clark & Watson, 1985). The last aim was to explore the preliminary validity supporting the YTOCCS. Construct validity, through expected associations with theoretically similar constructs, was explored at this stage. It was hypothesized that there would be significant differences between alliance groups on YTOCCS item scores (Tabachnick & Fidell, 2007).

General Method

Overview

The validity of any measurement system relies on the extent to which the evidence supports inferences made from the scores (Clark & Watson, 1995). A single study cannot conclude whether a measure is valid or not. Authors have recommended a series of studies using different methods and samples to reach firm recommendations for reliability and validity (Clark & Watson, 1995; DeVellis, 2012; Kazdin, 2003). These steps progress as follows: (a) define the theoretical and empirical domain of the measure's content, (b) examine the internal characteristics of the measure, (c) examine the relationships between the measure and other measures within and outside of the nomological net (e.g., provide construct validity).

Two studies were conducted to develop and test the initial validity of the YTOCCS. The methods and results from the development study informed the psychometric study. Following this, a summary of findings and concluding discussion will synthesize the results with the current literature and discuss future research.

Procedures

The present project included an item development study and a psychometric study designed to begin to establish initial reliability and validity of an observational coding system to measure therapist cultural competence with youth, the YTOCCS, with the intention of informing future psychometric studies. The first study involved scale definition and item development to provide initial support for the content validity of the YTOCCS. During the psychometric study phase, the YTOCCS was used to code youth psychotherapy recordings sampled using an extreme groups design for child-therapist alliance ratings. The reliability was examined using interrater reliability, and evidence supporting construct validity explored through examining the ability of

the scale to accurately could classify recordings as high or low alliance. This study was

approved by Virginia Commonwealth University's Institutional Review Board.

Study 1: Item Development

Method

Scale definition.   DeVellis (2012) recommends beginning any measure development

with a clear definition, to allow all content to reflect the scale definition. Further, content validity

can only be established when the domain is well-defined. The scale definition establishes the

boundaries of construct measured.

The definition of the constructs measured by the YTOCCS was derived from the

previously discussed literature review (APA, 2003; D. W. Sue, Arredondo, & McDavis, 1992; S.

Sue, 2006; Constantine & Ladany, 2000, 2001). Therapists could demonstrate cultural

competence by showing either verbal or non-verbal signs of awareness, knowledge, skill, and

adaptation of treatment process or content for the client's cultural background. Measure

development followed Hill's (1992) process measure recommendations for a pantheoretical scale

that can be applied to all forms of counseling and therapy.

Item development. Pope-Davis and colleagues (2001) emphasized the importance of

incorporating consumer perspectives on multicultural competency skills. An initial item pool

was created using three methods: culling items from existing measures of cultural competence,

deriving items from a literature review, and conducting surveys with therapists, experts, and

caregivers of racial/ethnic minority children who have experience with receiving mental health

care.

The first major contribution to the item pool came from literature review and gathering

items from existing cultural competence scales. Items were also culled from existing cultural

competence measurement systems (see Table 2, California Brief Multicultural Competence Scale, CBMCS, Gamst et al., 2008; Cross-Cultural Counseling Inventory-Revised, CCCI-R, LaFromboise et al., 1991; Multicultural Awareness, Knowledge, Skills Survey, MAKSS, D'Andrea et al., 1991; Multicultural Counseling Awareness Scale-Form B, MCAS-B, Ponterotto & Alexander, 1996; Multicultural Counseling Knowledge and Awareness Scale, MCKAS, Ponterotto, Gretchen, Utsey, Rieger & Austin, 2002, Multicultural Counseling Inventory, MCI, Sodowsky et al., 1994). This initial review resulted in a large subset of items ($n = 181$).

The second major set of contributors to the item pool came from surveys. Surveys of caregivers, therapists, and experts in the field on therapist cultural competence were conducted. Methods for each are described next.

Caregiver survey. Caregivers were recruited from Internet parenting groups. Recruitment emails were sent to list coordinators and posted on online community boards with links to the online survey, hosted through secure Internet survey software provided by the institution (REDCap). Items generated from the caregiver survey were added to items culled from the literature and existing measures. The following groups were targeted for recruitment: Mocha Moms, Parents of ADHD Children, OCD Support for Parents, Circle of Moms, Babble, Mom365, and Mommy Matters. Within the website Depression Forums, recruitment materials were posted in three rooms: Parents and Children's Depression Central, Depressed and Bipolar Children, and Mental Health: Families and Caregivers (see Appendix A for survey form). All participants provided informed consent to be included in the study.

Caregivers responded to fifteen open-ended questions designed to elicit descriptions of therapist behavior that demonstrates cultural competence when working with youth clients (e.g., "How would you know that your child's therapist was incorporating your (or your child's) values

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and beliefs into therapy?"). Questions were derived from a cultural competence literature search, and were both positively and negatively worded to provide examples of excellent as well as poor competence. Caregivers were also asked their opinions of how therapists should approach children from different age groups within the caregivers cultural background, their opinions on how the physical environment of the therapist's office impacts their feelings of someone from their culture being welcomed, and a broad question that asked caregivers to provide any other characteristics or behaviors of a culturally sensitive child/adolescent therapist. Respondents were also asked to rate the importance of different therapist behaviors using a Likert-type scale.

Two advanced psychology graduate students with training in cultural competence coded the survey responses to consensus. Guided by thematic analysis, each student separately read all the responses to become familiar with the data, separately generated codes, created an initial list of themes, reviewed themes, and named themes (Braun & Clark, 2006). The two students met to discuss their coding, and reached consensus on primary themes and identified therapist behaviors. Themes and items created were reviewed and approved by a faculty advisor.

Therapist Survey. Therapists representing the wide range of individuals with training backgrounds providing child and adolescent treatment were specifically sought for participation. Recruitment emails were sent to the American Psychological Association (APA) Division 12-Society of Clinical Psychology, APA Division 16 -School Psychology, APA Division 17-Counseling Psychology, APA Division 29- Psychotherapy, APA Division 37-Society for Child and Family Policy and Practice, APA Division 42- Psychologists in independent practice, APA Division 43-Society for Family Psychology, APA Division 45-Society for the study of Ethnic Minority Issues, APA Division 53-Society of Clinical Child and Adolescent Psychology, APA Division 54 –Society of Pediatric Psychology, American Counseling Association, and the

National Association of Social Workers.

Expert Survey. The following creators of multicultural competence counseling scales and models were contacted: Teresa LaFromboise, Hardin Coleman, Alexis Hernandez, Derald Wing Sue, David Sue, Stanley Sue, Joseph Ponterotto, Cheryl Holcomb-McCoy, Madonna Constantine, Gargi Roysircar Sodowsky, Richard Taffe, Terry Gutkin, Steven Wise, Nathan Zane, and Roy Bean. Experts were emailed a total of three times over four weeks with an invitation to respond. They were provided with the scale definition and refined item list (44 items), and invited to provide feedback.

Results and Discussion

Caregiver survey results. In total, 15 caregivers responded to recruitment efforts. Thirteen caregivers completed the survey, and 12 were included yielding 195 statements (1 excluded because the caregiver indicated that the family had no experience with the mental health system). From the included sample, 11 were female. A majority ($n = 10$) of the respondents were biological parents of the treatment-seeking child, 1 respondent was a foster parent, and 1 indicated she was a step-parent.

Participants were asked to select all racial/ethnic categories that fit. Caregivers self-identified their race and ethnicity as follows: White ($n = 7$), Black ($n = 5$), Asian ($n = 3$), and multiracial ($n = 3$). Six caregivers identified as Latino/a. Seven indicated that they spoke another language in addition to English: Spanish ($n = 5$), Mandarin ($n = 1$), and Vietnamese ($n = 1$). None stated they exclusively spoke a language other than English at home, one reported having used interpreter language services in health care appointments. Family income varied, with 17% ($n = 2$) reporting an annual family income of less than $20,000, 17% ($n = 2$) reporting

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$20,000-35,000, 25% (*n* = 3) earning $35,000-50,000; 25% (*n* = 3) earning $50,000-75,000; and 17% (*n* = 2) reporting greater than $75,000 per year.

The caregivers reported on experiences seeking mental health services for 15 children. Seven caregivers reported using multiple mental health services for their children (e.g., psychiatrist, in-home counseling, family therapy, individual therapy). No caregivers exclusively used the child's pediatrician for mental health services. Children received 4-20+ sessions, with the modal category being 20+ sessions.

The primary broad themes that emerged were that caregivers valued therapists who understand the importance of family (including involving family members, acknowledging family who are not biologically related), show respect for cultural background and view it as a strength, demonstrate understanding of religion, and understand the realities of their family life (i.e., family roles, values). Caregivers also converged on the importance of therapists avoiding stereotyping children (i.e., "my son isn't every black child you've seen on tv"), as well as avoiding assumptions that their child is just like children from majority-groups. Caregivers also stated that a therapist who ignores or avoids asking questions about culture may indicate the therapist's own discomfort with the topic, and would make them feel less comfortable bringing up problems that have a cultural bend. Caregivers agreed that involving parents in therapy sessions, and eliciting their opinions on treatment decisions, was a good way to incorporate cultural values/beliefs.

The value of therapists who possess knowledge about the family's cultural group also emerged as a theme. Respondents discussed different specifics of knowledge as important, including: holidays, traditions, language, religions, family relations, and cultural expectations. One respondent reflected that while it is important for therapists to know cultural touchstones,

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therapists should not instruct the child in his/her own culture because "my husband and I can teach our children about our culture and do not need the therapists to do this." Therapists who make explicit statements about openness, interest in other cultures, and acceptance of differences help to convey an open and aware attitude.

Caregivers agreed that many behaviors should be avoided if the therapist is trying to be sensitive to the client's family's culture. Therapists should not stereotype, neither through statements making assumptions about the child based on group-based knowledge, ignorance, nor in actions that demonstrate these thoughts. Similarly, therapists should not act in overly familiar stereotypical ways. For example, one caregiver stated, "I don't want anyone trying to bond [by] using Ebonics or fist bumping my child or I."

Respondents agreed that the most common demonstration of low cultural competence is when culture is ignored. One respondent reflected on an experience with a school counselor writing, "I am pretty sure the counselor has eyes and saw he was the only black kid in his class oh but she doesn't see race lol too bad we see it. [sic]" Many caregivers expressed approval of therapists asking cultural questions, even if they are uncertain of specific cultural knowledge, because the client's family is aware that the therapist might be uncertain. Stated simply by one respondent, "[h]onesty is the best policy so just come out and say there are some things you know and some you don't. We know it anyway." Further, caregivers agreed that therapists should ask questions about culture to the family. Questions about the family's perspective of cultural strengths, as well as questions about any possibly negatives and discriminatory experiences were each listed as important.

Two questions asked about age-specific recommendations for youth from the caregiver's cultural background. Caregivers agreed that for younger children (ages 3-11), more inclusion of

family is better, speaking the child's first language, and supporting children within expected boundaries. For example, two respondents relayed some dissatisfaction with therapists who they felt coached their children to be disrespectful by going against parental wishes. Respondents diverged about other therapist behaviors; for example, some requested that therapists play with children and be warm, while others thought that younger children need more firm directives from a therapist. There was no systematic demographical difference in these two responses. For older children and adolescents, caregivers agreed that therapists need to be trustworthy allies for children yet tell caregivers immediately of any big concerns. Therapists working with older children may also encourage identity development by encouraging exploration and providing role modeling to younger children.

Caregivers answered questions about systems-level interventions that may facilitate culturally competent care. Nine of the respondents, including all of those who indicated that they speak a language other than English at home, agreed that bilingual staff and support materials are appreciated. Two of the respondents felt strongly that culturally competent care would be most likely given by a therapist who is of the same cultural background as their child. For example, one caregiver stated, "I'd like him to have a role model, someone like him, with a lot of education."

Caregivers also provided ranked and ordered lists of their priorities when seeking treatment for their children. Respondents were asked how important it was for their child's therapist to be aware, knowledgeable, and skillful in incorporating cultural background into treatment from 1 (*not at all important*) to 5 (*very important*). Caregivers agreed that it was important, with none stating that it was unimportant ($M = 4.25$, $SD = 0.62$; range 3-5). Caregiver responses to open-ended questions led to the creation of three new items.

At the end of the caregiver survey, fourteen new items were added into the item pool. Items referring to the need for therapists to approach cultural topics, dynamic sizing, microaggressions, collaborative goal setting, involvement of other family members and relevant persons, eliciting the illness myth, and alterations in the therapy environment were written.

Therapist survey results. Fifty-one therapists completed part of the survey, with 29 completing all parts. Therapist participants were 27.5% male. Participants were asked to check all racial categories that applied to themselves with 82.7% identifying with one group and 15.4% identifying with two groups. Therapist participants were 69.2% Caucasian, 34.6% African American, 7.7% Asian, and 1% Native Hawaiian or Other Pacific Islander; 38.5% identified their ethnicity as Hispanic/Latino. Their self-reported professional specialties were Social Work (51.9%), Psychology (42.3%), and other (3.8%, 1 psychiatric nurse, 1 mental health professional). The highest degree completed by participants were 63.9% Master's in Social Work, Counseling, Marriage and Family Therapy, or a related field, and 22.1% PhD or PsyD. The majority identified themselves as primarily a child/adolescent therapist (81.5%). All reported at least some experience treating racial/ethnic minority youth, with a range of 4-100% of their child experience comprised from with REM youth ($M = 66.48\%$, $SD = 28.13$).

Therapists were provided with the refined item list (at this stage 44 items; see below) and scale definition, and asked to rate how well the item measures youth therapist cultural competence on a Likert-type scale with 1 (*poor fit*) to 5 (*excellent fit*). At the end of the survey, there was one open-ended question inviting therapist participants to provide suggestions for other behaviors representing culturally competent practice with youth that were not represented on the survey. There was a large range of average ratings from therapists (range = 0.67-5.00, $M = 2.45$, $SD = 0.85$). Therapist responses to open ended questions resulted in one additional item.

Expert Survey Results. Three experts completed the survey. Expert participants were 66.7% male. Experts self-identified their own racial/ethnic categories, with 66.7% (2 participants) identifying with more than one racial category. Expert participants were 66.7% Caucasian, 33.3% African American, 33.3% Asian; 33.3% identified ethnicity as Hispanic/Latino. Their self-reported professional specialties were Psychology (100%).

Experts were provided with the scale definition and items, and asked to rate how well the item measures youth therapist cultural competence on a Likert-type scale with 1 (*poor fit*) to 5 (*excellent fit*). At the end of the survey, there was one open-ended question inviting experts to provide suggestions for other behaviors representing culturally competent practice with youth that were not represented on the survey. The average ratings from the three experts of all of the items was 2.67-5.00, with only one item dipping below a quality rating of 3. The experts' responses to the open-ended questions resulted in the addition of one item.

Summary of Item Development Study

There were 181 items after accruing all of the items from other MCC scales and the caregiver survey. One hundred and thirty-seven were eliminated or combined, due to redundancy with other selections in the item pool. The remaining 44 items were included in a therapist and expert survey. The responses from the survey were aggregated. Items had a mean response of 2.54 (*SD* = 1.50). Nineteen items had an average rating higher than 3.5, which represented items in the good fit range. An additional two items were created from responses to open ended questions. Following the survey portion of the study, the item pool contained 21 items.

The 21 highest-rated items were organized into four theoretical domains of scale conception: understanding, knowledge, communication, and omission. This reflects the three multicultural competence domains (awareness, skill, knowledge) as well as a presence/omission

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domain that was created based on results from the caregiver survey that therapist's approaching cultural topics is imperative. During this phase of the project, coding manual preparation began and further combination occurred of overlapping items to reduce coder burden. Items were reduced due to redundancy ($n = 5$), or combined due to highly overlapping behaviors ($n = 3$). In this way, the final 13 items on the YTOCCS measure are derived from theoretical and empirical literature review, caregiver, clinician, and expert surveys.

Study 2: Initial Psychometric Exploration

Study 1 demonstrates initial evidence to support the content validity for the initial YTOCCS items. The following section details the method that followed to develop and test the YTOCCS. The study design, research setting and materials, training of coders, and recording selection are described in this section.

Method

Study design. Researchers recommend an extreme-group comparison study design when providing preliminary data exploring the relation between two psychological constructs (Feldt, 1961; Pelham & Blanton, 2013). Pelham and Blanton (2013) recommend using extreme groups designs to test potential relationships, in order to maximize the chance of detecting an effect. By contrast, these authors state that if an effect cannot be detected using extreme groups, then it is usually unlikely that an effect will be found using a full distribution of scores. Quasi-experimental designs frequently create extreme groups from pre-test inclusion data using well-validated measures, creating two groups of individuals who are more similar to each other and qualitatively different from the other group (Pelham & Blanton, 2013).

Researchers have used extreme group designs when investigating central microanalytic processes. For example, Diamond and Liddle (1996), in an effort to better understand conflict

resolution in multidimensional family therapy, selected five recordings each of families who resolved or did not resolve a conflict in the course of family therapy, and analyzed observers' ratings for association with youth cooperation. Similarly, Gottman, Coan, Carrere, and Swanson (1998) created two criterion groups of 20 couples each from 130 originally recruited to represent low and high marital satisfaction, to explore using more labor intensive behavioral observation. In a follow up paper, Gottman and colleagues (2000) defended their extreme group research design stating that well-constructed criterion groups that represent extremes of the construct of interest allow for maintaining uniform power across the range of the construct of interest. Further, the authors state that this design allows for more focused and intensive study of the construct of interest.

In the definition of optimal extreme groups, the criterion used is the power of the final statistical test. Feldt (1961) provides recommendations for creating the optimal cut-points for the size of two extreme-groups, based on balancing the needs of the experiment with regards to expected variability and magnitude of true differences between the groups and proportion of subjects available for each group. To illustrate, the large expected differences expected in an outcome variable is clearly an advantage of a sampling perspective that divides a population into the top 10% and lowest 10%; however, this also increases the standard error of the difference and may restrict the number of subjects available. Therefore, Feldt (1961) recommends dividing symmetrical upper and lower percentiles which results in a combination of increasing the chance of observing a true difference in scores, optimizes group size, and within-group variance to yield the most powerful between-group tests. Authors recommend using 25th and 75th percentiles as starting points for creating extreme groups (Pelham & Blanton, 2013).

Feldt's (1961) recommendations were followed to create two extreme groups using observer-rated client-therapist alliance on the Therapy Process Observational Coding System-Alliance (TPOCS-A, McLeod & Weisz, 2005). Evidence from the adult psychotherapy treatment literature suggests that enhancing therapist cultural competence leads to increases in alliance and retention in services (Constantine, 2002; Sodowsky et al., 1998; Worthington et al., 2007). Though to our knowledge this relationship has not been explored in youth psychotherapy process research, it is expected that therapist cultural competence will also increase client alliance in youth samples. Therefore, the sample of psychotherapy recordings for this observational measurement design study was created through two extreme groups of child-therapist alliance (i.e., low and high).

A power analysis was conducted using the software program G*Power 3 to determine the minimum recording sample size needed to achieve a power of 0.80 and alpha of 0.05 (Faul, Erdfelder, Lang, & Buchner, 2007). Prior research has shown a large effect size for the relationship between cultural competence and alliance (Constantine, 2001). Therefore, the power for a strong correlation ($r > 0.40$) was calculated. A minimum sample size of 32 double-coded recordings for explorations of initial validity was determined.

Research materials. Data used in this study was collected as part of a large clinical effectiveness trial: the UCLA Youth Anxiety and Depression Study (YADS; Primary Investigator: John Weisz, Ph.D.). The anxiety arm of the study compared individual cognitive-behavioral therapy for anxious youth, Coping Cat (ICBT; Kendall, 1994) with a usual care condition. The depression arm compared individual cognitive-behavioral therapy for depression youth, Primary and Secondary Control Enhancement Training (PASCET; Weisz, 1997) with a usual care condition.

All selected recordings were videotapes on DVD format and all were rated at Virginia Commonwealth University in laboratory space provided by Dr. Michael Southam-Gerow and Dr. Bryce McLeod. This space consisted of a private office with a locked door, equipped with computers with enhanced security to protect session materials. Each station included headphones to protect the confidentiality of participants.

Treatment. The individual CBT condition included an anxiety and depression arm. The anxiety CBT arm used the Coping Cat manual. The Coping Cat program is an empirically supported treatment for youth anxiety that includes psychoeducation of anxiety, skill building, and graded exposures to feared stimuli (Kendall, 2000). Role-playing and *in vivo* exposures during sessions are complemented by out of session homework assignments requiring skill rehearsal.

Primary and Secondary Control Enhancement Training (PASCET, Weisz, Thurber, Sweeney, Proffitt, & LeGagnoux, 1997) is an empirically supported cognitive behavioral treatment for youth depression. PASCET follows the two-process model of control to enhance rewards or reduce punishment: *primary control* involves conforming objective conditions to one's wishes, while *secondary control* involves changing oneself to reduce the punishment from objective conditions (Weisz, Rothbaum, & Blackburn, 1984). Treatment includes activity selection, graded goal attainment, cognitive restructuring, and relaxation training.

Recording selection. Assumptions based on empirical literature guided the sampling plan for recordings. The priorities for sampling were to create conditions for cultural competence to most likely occur. Non-matched dyads (i.e., clients from a different racial/ethnic background than therapist), phase of treatment, content of treatment, presenting problem, and client age were

considered, in that priority order, when selecting the sample. See Figure 1 for an overview of the recordings selected. Each priority is detailed further below.

The racial/ethnic diversity of the sample was prioritized. All clients were identified by their caretakers as racial/ethnic minorities (see Youth Participants section below for detailed accounting). Therapist-client dyads were from different self-reported racial/ethnic backgrounds.

Cultural competence is conceptualized as a therapist behavior capable of enhancing client engagement. In youth psychotherapy, cultural competence may be most important during the engagement phase of treatment during assessment to avoid over-pathologizing or minimizing (Gushue, Constantine, & Sciarra, 2008) to produce family buy-in (Lyon, Lau, McCauley, Vander Stoep, & Chorpita, 2014) and build initial alliance (Yasui & Dishion, 2007). During initial treatment sessions, therapists are more likely to view clients as members of their group ('my new client is Latino') before learning enough information to individualize them ('My new client is a shy boy with a wicked sense of humor in conflict with his parents about reluctance to attend school because he has difficulty reading'). Research indicates that therapist-client alliance changes from early, middle, and late sessions (Patterson & Chamberlain, 1994). Because of these assumptions, sessions were selected from the first four available sessions for each client to target the early and beginning of the middle portions of therapy. Only clients who had at least four sessions of recordings were used.

The primary aim of this study was to develop a measure of cultural competence; therefore, recordings were sampled with the aim of including a wide range of therapist behavior to ensure adequate variance. Results from the parent study showed that the majority of therapists were adherent to their manualized treatment assignments (98.9% anxiety arm, 98% depression arm; Southam-Gerow et al., 2010; Weisz et al., 2009). It is unknown if therapist adherence to

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manualized treatment affects their cultural competence. However, due to the high levels of adherence in the manualized treatment condition, it is likely that the usual care (UC) condition demonstrated a wider range of therapist behaviors. For this reason, UC was oversampled in comparison to the manualized treatment conditions with $n = 6$ ($n = 3$ depression condition) participants in usual care.

Client age was an important variable to consider when selecting a sample. Children enrolled in the parent trial were aged 8-15 ($M_{age} = 11.24$, $SD = 2.16$). Adolescence contains the most developmental changes since infancy (Holmbeck, 2000), resulting in vast biological, social, and psychological changes. Older children and adolescents are embedded within multiple contexts with each impacting racial/ethnic identity that can become particularly salient during this time in development (Cauce & Gonzalez, 1993; Cauce et al., 1996). These changes have led authors to recommend different alliance building strategies for older children and adolescents (Chu, Suveg, Creed, & Kendall, 2010). Therapists may be more verbal, making cultural competence strategies like exploring differences and eliciting the client's perspective, easier to observe. Therefore, therapist's cultural competence may be more observable with older children. For these reasons, older children and adolescents were oversampled ($M_{age} = 12.40$, $SD = 2.08$).

Sampling plan. Two independent coders rated video taped sessions of 8 clients from CBT and usual care treatment for child anxiety and depression drawn from a pool. Each coder was randomly assigned 6 participants to code. The recordings from the first four sessions for selected participants were assigned to coders. In the event that a particular session was not available, the next session was selected. For 5 of the 8 participants, sessions 1-4 were available for coding. Each participant had at least an initial session (i.e., Session 1) available, and no

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sessions were sampled above session 7. Within the recordings that were sampled, no coder ratings were missing.

The TPOCS-A was used to create two extreme groups of alliance: low and high. See Figure 1 for an overview of the sampling plan. The TPOCS-A score at session 1 and session 4 were used to create these groups. The TPOCS-A score from the first session available ($M = 1.96$, $SD = 0.81$), as well as the fourth session ($M = 1.89$, $SD = 0.99$) was used from the 32 participants with different racial/ethnic backgrounds than their therapists and did not meet exclusion criteria. The first step was to create groups of participants who started off with low and high alliance with their therapists. To accomplish this, the TPOCS-A score from the first session available was used to divide the sample into thirds at the 33rd (TPOCS-A Score ≤ 1.56) and 67th (TPOCS-A ≥ 2.33) percentiles, respectively. Then, TPOCS-A scores from the fourth or mid session were used to identify which participants had an increasing or decreasing alliance. The mean change in alliance from session 1 to session 4 was -1.50 ($SD = 0.56$). Participants who experienced more than 1 standard deviation of change were tallied. Finally, these results were combined to identify participants who began with higher alliances and experienced an increase in an alliance ($n = 7$) as well as those who had a lower initial alliance which steadily decrease ($n = 11$). Children over the age of 10 were then selected, leaving 7 participants in the high group and 7 in the low group. Usual care sessions were oversampled in a 2:1 ratio with CBT sessions, and participants were selected for equal matching of presenting problem (see Figure 1).

Youth Participants. The parent trial, Youth Anxiety and Depression Study (YADS), enrolled 105 youth ranging in age from 8-15 ($M_{age} = 11.31$, $SD = 2.15$). Parents reported their children were 33.3% Caucasian, 21.0% African American, 27.6% Latino/Hispanic, 9.5% Multiracial, and 7.7% Other or did not report. Annual family income was under $15,000 for

32.0% of families, $15,000-$30,000 for 32.2%, $30,000-$45,000 for 10.8%, $45,000-$60,000

for 7.8%, and more than $60,000 for 10.0% (7.2% did not report income). Primary diagnoses

were determined using the Diagnostic Interview Schedule for Children Version 4.0, combined

parent and youth report; (Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone, 2000) using DSM-IV

criteria (American Psychiatric Association, 1994). Youth had primary diagnoses of: 30.5%

Major Depressive Disorder, 17.1% Minor Depressive Disorder, 17.1% Separation Anxiety

Disorder, 12.4% Social Phobia, 10.5% Specific Phobia, 6.7% Dysthymic Disorder, and 5.7%

Generalized Anxiety Disorder. Youth had an average of 2.96 diagnoses.

A subset of 8 youth was selected for the present study. Clients were 50% male. Client

participant age ranged from 10-15 (M_{age} = 12.40, SD = 2.08) were 50% male, 12.5% black,

62.5% Latino/Latina, and 25% multiethnic. The participants were equally divided between those

who enrolled in treatment to target anxiety (50%) and those who enrolled for depression (50%).

 The majority of the selected participants (75%) were in the usual care arm of the parent trial.

The client participants' primary diagnostic targets were 37.5% major depressive disorder, 25%

specific phobia, 12.5% separation anxiety disorder, 12.5% social phobia, and 12.5% minor

depressive disorder (American Psychiatric Association, 1994). Annual family income was only

available for 5 of the youth participants, showing an average of $26,889 ($SD$ = $27,804.58).

There were an average of 15 sessions per client, and each client had an average of 2.65

psychological diagnoses.

Therapist participants. Therapists were randomly assigned to either the CBT or UC

conditions. Therapists attended 1 day of CBT training. Following this training, these therapists

received weekly supervision on cases by doctoral level psychologists with expertise in CBT for

youth depression and/or anxiety. Treatment took place in community clinics in Los Angeles
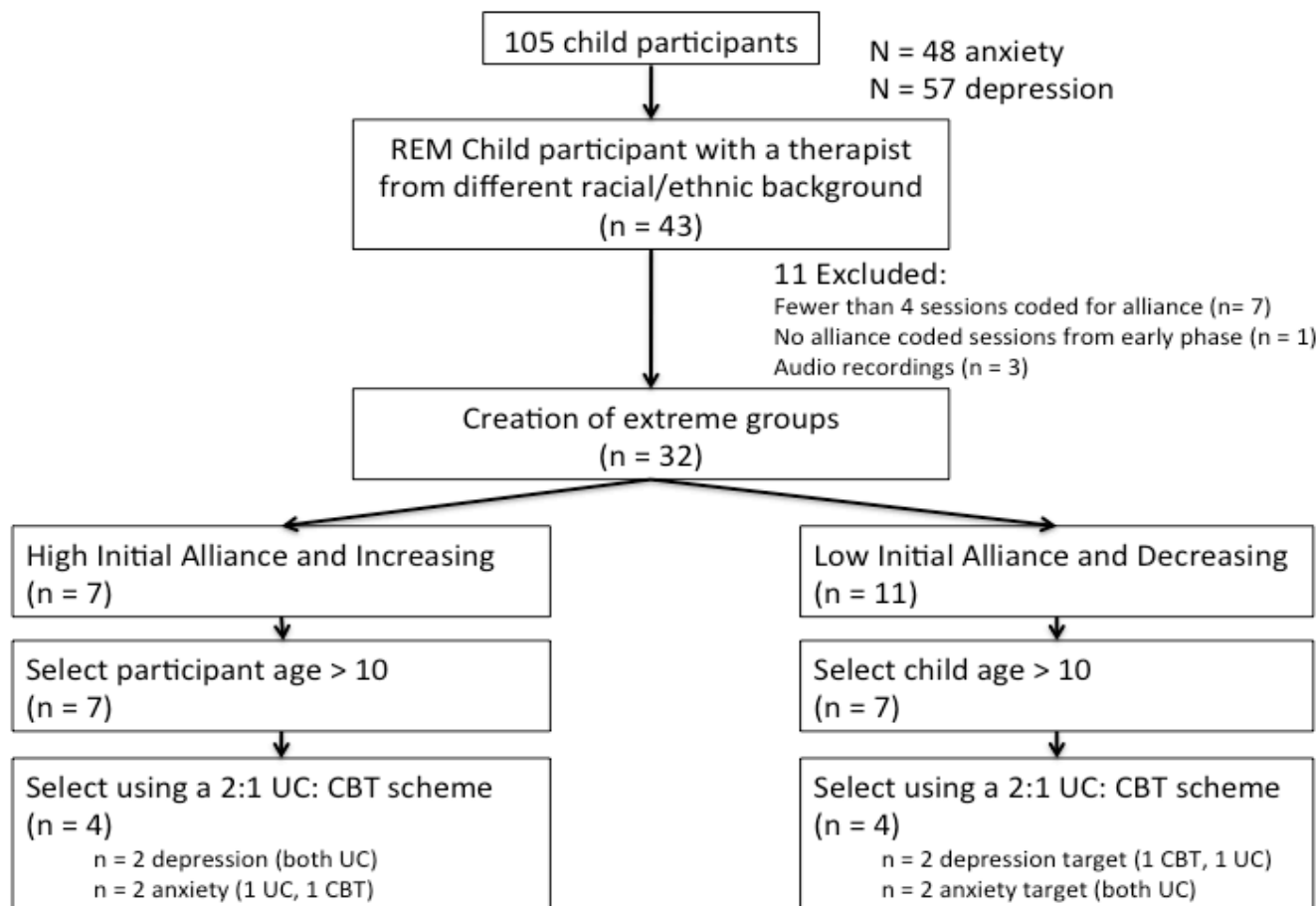
Figure 1. Sampling Plan for Participants Selected for Study

County, California.

Participating clients in YADS were recruited from naturally-occurring referrals; therapists were recruited from among current clinic employees; and the agencies were selected from among large public community mental health clinics in Los Angeles County (CA). Therapists were randomly assigned to treatment condition. Therapist mean age was 32.79 ($SD = $ 7.75). The majority of the sample was female (77.50%), 50.4% were white, 7.8 % were Asian American, 3.1% were African American, and 11.60% self-identified as multiracial or "other", and 24.0% identified as Hispanic/Latino. With regards to professional status, 11.6% were state licensed, 27.1% were social workers, 58.1% had a professional specialty in psychology (e.g., psychologists, doctoral students in psychology), 2.3% specialized in psychiatry, and 10.9% were classified as other (e.g., registered art therapist). This sample was selected to provide a heterogeneous sample top optimize the chances of observing the full range of cultural competence scores for data analysis.

Eight therapists were selected for this study. Each therapist in this subsection of the trial had just one child participant enrolled; thus, each client-therapist dyad is unique. Therapist average age was 34.88 ($SD = 9.92$), and 50% ($n = 4$) were White, 25% ($n = 2$) Hispanic/Latino, 12.5% ($n = 1$) Asian and 12.5% ($n = 1$) multiracial or other. The majority of the sample was female (75.0%), 75% had a professional specialty in social work, with 25% specializing in psychology. None were state licensed at the time of the trial.

Client outcomes from parent trial. Weisz and colleagues (2009) and Southam-Gerow and colleagues (2010) compared the effectiveness of individual CBT for youth for depression and anxiety, respectively, against usual care. Diagnostic and symptom outcomes were determined using the Diagnostic Interview Schedule for Children Version 4.0 (Shaffer et al.,

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2000), as well as symptom and behavioral self- and parent-report measures for each problem type (see Weisz et al., 2009, and Southam-Gerow et al., 2010 for full details). Therapists and participants were randomized to CBT or UC, and treatment continued until normal termination. Therapists in the CBT condition were more likely to use CBT interventions and demonstrated a high proportion of the required elements present in each session (anxiety arm = 98.9%, depression arm = 98%), while therapists in the UC condition used more family-systems and psychodynamic practices.   More than 66% of youth no longer met diagnostic criteria for their initial presenting problem at the end of treatment, and there were no statistically significant differences in remission rates for the participants in CBT or UC. However, a significantly larger proportion of youth in the UC condition for both anxiety and depression used additional mental health services simultaneously during the trial, such as seeking services from a school mental health counselor, and there were indications that CBT produced remission in fewer sessions. Authors concluded that while UC and CBT both led to symptom remission, CBT showed some practical advantages over UC.

Measures. The Therapy Process Observational Coding System for Child Psychotherapy-Alliance Scale (TPOCS-A; McLeod & Weisz, 2005 is an 9-item observer rated measure of the therapeutic alliance. It includes six items that measure the affective bond between the client and therapist and three items that measure collaborative involvement in treatment tasks. The TPOCS-A is scored on a 6-point scale ranging from 0 (*not at all*) to 5 (*a great deal*). Two independent coders rated the TPOCS-A. Items from the bond and task subscales were combined to form a total TPOCS-A score. Previous studies on the TPOCS-A have demonstrated adequate psychometric properties (Chiu, McLeod, Har, & Wood, 2009; McLeod & Weisz, 2005). Using

all of the available sessions from the selected participants, the TPOCS-A demonstrated good reliability in this subsample ($M = 2.94$, $SD = .79$, ICC = 0.91, $\alpha = .86$).

   Coding manual development. A coding manual is critical to achieve reliable ratings of observable behavior (Hill, 1992). The YTOCCS coding manual development was informed by prior observational coding systems (e.g., Hill, 1992; Alexander et al., 1995; Diamond, Liddle, Hogue, & Dakof, 1999; Markman et al., 1995; McLeod, 2011). The first step was creation of the scale to guide coder training and coding. To prepare for this step, scale items were reworded to reflect only observable therapist behavior (Alexander, Newell, Robbins, & Turner, 1995). The methods used in this study included: (a) coding the entire session to ensure capturing therapist behavior that may have a low base rate, (b) coding both micro-analytic (e.g., behavior in small units of time) and macro-analytic (e.g., overall ratings at the session level) systems, (c) use of a detailed manual including item distinctions and exemplars, and (d) directions to guard against biased coding.

   There were two systems used to capture therapist behavior: frequency counts and quality ratings. This system was derived from recommendations from the clinician, caregiver, and expert survey, who discussed the importance of therapists not omitting cultural content from sessions when it is relevant. Coders were instructed to count the number of times they saw therapists using behaviors described in the cultural competence coding manual. Each time a coder observed a behavior, they rated the item as a frequency count of 1 and gave a quality rating in the measure's item. For example, if a therapist was asking questions about the family's expectations for treatment, coders would make a tally mark for "Present", and provide a quality rating for the item "Negotiate." Similarly, coders were given instructions for rating therapist omissions, which were defined as occasions when raters judged that a culturally appropriate

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response was needed but not given. The sample for this study included intake and early treatment sessions for all of the youth participants. Coders were instructed to rate the omission item if culture was never explored in the first session between a client and therapist. Coders tallied number of omissions, and provided lower quality ratings for the appropriate item. An example from the study can be used to illustrate this point. In an intake, a participant's mother discussed her concerns that her son's teacher made assumptions that he was a gang member due to his race. The therapist did not ask questions or explore this, so coders rated this incident as one "omission", and provided a lower quality rating (e.g., 2) for "Awareness."

Coders were instructed to rate behavior that they observed the therapist display on a rating scale from 1 (*culturally biased*), 2 (*poor - omission*), 3 (*acceptable*), 4 (*adequate*), 5 (*good*), 6 (*very good*), to 7 (*excellent - culturally proficient*). The rating scale was selected to reflect Cross's (1988) stages of cultural proficiency. A 5-point Likert-type scale was piloted by the first author on 20 randomly selected video recordings and rejected due to not reflecting the full variability in therapist performance. Raters assigned a 0 to any behavior that did not occur during the session.

Coders viewed the entire session to maximize chance of measuring behaviors that have a low base rate (Hogue et al., 1996). Further, the coding manual instructed raters to pause the videotaped recording every five minutes to record ratings for each behavioral item (microanalytic), and to record an overall code for each item at the end of the session (macroanalytic). In this way, the coding strategy involves microanalytic ratings of therapist behaviors. Microanalytic coding strategies have been recommended when psychotherapy process research used to understand details about interactions for specific groups, and are

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suggested to be less subject to cultural biases of coders and developers of observational coding

systems (Markman, Leber, Cordova, & St. Peters, 1995).

The manual cautioned against 'halo effects' and 'horn effects', which could result in

coders forming global impressions based on a small sample of behavior. The manual provided

exemplars to guide accurate coding (Hogue et al., 1996). The YTOCCS coding manual was

prepared by the first author, edited by two VCU clinical psychology faculty members and six

VCU psychology graduate students ($n = 2$ Counseling Psychology doctoral students, $n = 4$

Clinical Psychology doctoral students specializing in Child/Adolescent populations). During

coder training, coders provided feedback and the manual was further refined.

Each item was described in the manual. Items were defined, and exemplars of therapist

behavior reflecting items included. Examples of therapist behavior demonstrating both low

competence and high competence on each item were provided. The coding manual was provided

in hard copy, as well as electronic copy, to each coder.

Coding procedures. The coding manual provided specific instructions for rater behavior

during coding sessions. Coders were instructed to have the coding manual accessible at all times

during coding, and review each code when assigning it. Raters were instructed to code the

therapist's behavior in sessions based off of their own knowledge from any previous session

from this child-therapist dyad. Coders were instructed to avoid distractions (e.g., reading email,

using social media) during coding sessions. Codesheets provided space for coders to record their

thoughts, questions, and comments about the sessions and the coding system. Online coding

journals were kept to detail issues that occurred to guide measure refinement for future studies.

Coder selection. The selection of coders is an important consideration in observational

process research. Most studies of therapist behavior involve two coders (Barber, Fotz, et al.,

2004). Researchers who developed the only other observational therapist cultural competence used graduate students in Counseling of Educational psychology doctoral programs as raters (CCCI-R; LaFromboise, Coleman, & Hernandez, 1991). Authors have recommended using judges with higher degrees of training when inferences are required in observational coding of therapy process research (Mcleod et al., 2013). While it is unknown whether rater demographics influence reliability of observational cultural competence measurement, prior researchers in this area prioritize having raters that are representative of the client demographics (Worthington et al., 2000). Each of these factors were considered when recruiting raters.

Three doctoral-level graduate students in applied psychology ($n = 2$ clinical psychology, $n = 1$ counseling psychology) were recruited to code the YTOCCS. Coders were all female, with one identifying as Latina, one identifying as African American, and one identifying as White. All coders had master's degrees in psychology and had completed required coursework in their respective programs in multicultural counseling (≥ 1 graduate level course). Each had completed clinical training both in the departmental training clinic and in community placements with children and adolescents. All coders self-identified research interests in working with diverse populations in research and clinical work, adapting psychotherapy for diverse populations, and cultural competence. Two coders specialized in child/adolescent clinical psychology, and one coder specializes in counseling psychology with particular training experience and interest in adolescent and college student populations. Two coders identified their primary theoretical orientation as cognitive-behavioral, and one coder identified her primary theoretical orientation as relational-cultural. All coders had clinical and applied research experience working with African American and Latino youth.

Coder training began with readings and discussion of the specific aims of the project. Each rater read three papers on multicultural counseling competence prior to the first training session, as well as the introduction of this dissertation regarding specific-group knowledge and developmental factors impacting cultural competence (i.e., D.W. Sue et al., 1992; S. Sue, 2006; Constantine & Ladany, 2001) and given the opportunity to discuss the readings and ask questions in a group training session.

Next, coders read the YTOCCS coding manual and reviewed the coding sheet. Coders provided written and verbal feedback through a series of meetings. All feedback was incorporated into the coding manual through item descriptions and distinctions, intended to clarify the boundaries between two codes. One coder provided additional readings which were incorporated into the coding materials (e.g., Jordan, 2000).

Coders then practiced coding sessions. The first four sessions from two clients were selected for coder training. For the first client (i.e., the 4 first sessions from the same client-therapist pair), raters consensus coded each tape in meetings together. Recordings were paused every five minutes to discuss whether coders thought culturally relevant material was present or absent, guided by the coding manual. At the end of the recording, each coder was asked to assign a rating using the Likert-type scale. Coders discussed ratings to come to consensus.

Coders watched the next participant's four sessions and provided independently rated therapist behavior on the Likert-type scale described above. Weekly meetings were held between coders and the primary author to refine the coding manual and coding procedures further. Feedback and recommendations from pilot coding were incorporated into the coding manual at this stage, following recommendations of other psychotherapy process researchers

(McLeod & Weisz, 2005; Slade et al., 2008). At this stage, the last edits of the coding manual were incorporated. No further edits to the manual occurred during the active coding stage.

Coding. Coders were each assigned 24 recordings, representing the first four available psychotherapy sessions from six different client-therapist dyads. Clients were randomly assigned to each coder, and the order of client coding was randomly assigned to each coder. Coders completed an average of 2-4 ($M = 2.67$) recordings per week, culminating in 12 weeks of active coding. Coders used an online tracking system to receive their coding assignments for the week. They logged questions about the coding system as well as any problems with the recordings into an online tracking system.

Weekly meetings took place between coders and the primary author to guard against coder drift aided by questions from the online tracking system. The coding manual guided discussions. Expert consultants on psychotherapy process research consulted with the primary author biweekly throughout the study.

Data Analysis Plan

Analyses progressed through two stages. First, descriptive analyses of the YTOCCS scale were explored. Following this, initial explorations of reliability and validity took place.

First, descriptive statistics demonstrating frequency, range, mean, and standard deviations for each item were calculated. Available research does not provide detailed information regarding the base rate frequency of culturally competent therapist behaviors in youth psychotherapy. Normality and linearity of score distributions were explored.

Intra-class correlations was calculated across all raters for each of the items to examine inter-rater reliability (ICC; Shrout & Fleiss, 1979). The ICC is commonly used to examine inter-rater reliability and has been used in most studies measuring competence (e.g. Barber et al.,

1996; Carroll et al., 2000; Vallis et al., 1986). The ICC provides an estimate of the ratio of the true score variance to total variance. The reliability coefficients represent the model ICC (1, 3) based on a one way random effects model, and is analogous to Cronbach's alpha. ICCs values below .40 reflect "poor" agreement, ICCs from .40 to .59 reflect "fair" agreement, ICCs from .60 to .74 reflect "good" agreement and ICCs .75 and higher reflect "excellent" agreement (Cicchetti & Sparrow, 1981). This study aimed to produce ICCs in the good to excellent range, with expected lower values for items that require higher degrees of inference (e.g., items measuring therapist's awareness).

Cronbach's alpha was examined as a measure of internal consistency with a target alpha between 0.80 and 0.95 (Clark & Watson, 1995). Inter-item correlations were also examined. An item analysis was completed to determine whether removal of any items would lead to improvements in alpha.

This study aimed to gather evidence supporting the content and construct validity of the YTOCCS. Expert and stakeholder consensus on items on the measure provided initial support for the content validity of the scale. All sessions were double coded and after exploring reliability the average between the two coders represents the YTOCCS score used in subsequent analyses. This helped to ensure that the scores are not simply based on one coder's interpretation of a session or therapist-child interaction.

The association of the YTOCCS with the TPOCS-A was examined for evidence supporting construct validity. One aspect of construct validity includes the degree that a measure operates within a set of theoretical constructs and their respective measures, or fits into the nomological network (Nunnally & Bernstein, 1994). Between-group comparisons are commonly used in psychotherapy process research to establish preliminary validity (e.g., Diamond, Liddle,

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Hogue, & Dakof, 1999). In this way, t-tests were performed to explore the differences of YTOCCS scores between the high and low alliance (as measured by TPOCS-A) groups.

Results and Discussion

The results for the psychometric study are presented in two sections. First, the descriptive statistics on the YTOCCS and its internal structure follows. Following this, the results of the reliability and validity studies are provided.

Descriptive statistics of the YTOCCS. Means and standard deviations of YTOCCS item scores are presented in Table 3. Frequencies were summed and reported as numerical counts out of the 64 sessions observed (i.e., 32 sessions coded by 2 coders). Coders observed the presence of some cultural competence behavior in a majority of the sessions (i.e., 45 out of the 64 opportunities). The most frequently reported item was Omissions, with at least one omission rated in 57 out of the 64 opportunities. Only two sessions contained no scores on any items. The item History was never observed by any coder, and the items Adaptation and Variety were observed fewer than 10 times each. Most often, means fell in the center point of the scale (i.e., 3-4 on the 7-point scale). Only Values/Norms used the full 7-point range, with most items demonstrating a restricted range.

Subscales were created by eliminating zeros and taking the mean of theoretically-derived similar items: Understanding (Awareness and Openness), Knowledge (History, Values/Norms, Health, Development, Adaptation), Communication (Variety, Negotiate, Advocacy, and Trust), as well as creating an overall scale score. The subscale Opportunities was created by subtracting the frequency counts of Omission from Presence.

The Shapiro-Wilk test of normality was positive for small samples ($p < .01$) for Awareness, Development, Trust, Presence, and Omission and the total YTOCCS score indicating

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that scales were positively skewed (i.e., more scores in lower range of competence; Tabachnick & Fidell, 2007). Visual inspection of histograms and Normal Q-Q Plots confirmed the positive skew of these variables. Transformations were completed to prepare the variables for correlational equations. A constant (i.e., 1) was added to each item and subscale. The YTOCCS total scale score, Knowledge and Opportunities subscales were linear following a square root transformation. A log transformation was performed on the items Awareness, Development, Trust, Presence, and the Communication subscale. Last, a natural log transformation was performed on the Understanding subscale. Two items had positive kurtosis (Development and Presence), however, following aforementioned transformations, each demonstrated normality and linearity.

Reliability and Preliminary Validity. The reliability of the YTOCCS items and subscales was assessed using the full sample of double coded sessions. Inter-rater reliability was calculated using the model ICC (1, k) based on a one-way random effects model (Shrout & Fleiss, 1979). Using this model, raters are treated as random effects because a different random sample of coders rated each recording. The ICC is then interpreted as the percentage of total variance accounted for by items variance. This model will produce an estimate of rater agreement for the average rating of all raters. Values were categorized according to Cicchetti's (1994) criteria (e.g., below .40 = poor agreement; .40-.59 = fair agreement; .60-.74 = good agreement; .75 and above = excellent agreement). Interrater reliability was in the good to excellent range for all of the items (average ICC = 0.71), except Trust and Omissions. Additionally, the item History was never coded by raters. The items with lower reliability were further explored.

The low frequency of the History item was explored through coder meetings and by examining coder method journals. Coders reported that the item never occurred in the sample. When discussing the possibility of coding an omission of history, coders stated that discussion of an ethnic group's history or major figures may seem unnatural in early psychotherapy sessions. One coder stated an opinion that this item may be less representative of competence in youth psychotherapy, because it may be less likely for youth clients to be familiar with their group's collective history. Coders agreed that a therapist demonstrating knowledge of a cultural group's history would demonstrate cultural competence, if it occurs.

A difference in Trust score between coders was calculated and examined for patterns. One coder rated the item Trust present in 13 out of 24 assigned tapes, while the remaining two coders made up only 6 ratings, combined. This suggests possible coder effects on this item, with one coder endorsing this item at a higher frequency than other raters. The item Omission was coded simultaneously as the quality item where the coder judged that a culturally competent behavior was needed. To provide additional reliability information, omissions were examined quality level variable for each case (e.g., Omission of Awareness, Omission of Openness, etc.). Interrater reliability was in the poor range for the items Openness Omissions (ICC = 0.28, M = 2.09, SD = 0.32), Awareness Omissions (ICC = 0.35, M = 2.15, SD = 0.12), Variety Omissions (ICC = 0.19, M = 2.12, SD = 0.16), Adaptation Omissions (ICC = 0.13, M = 2.01, SD = 0.09) and Trust Omissions (ICC = 0.12, M = 2.02, SD = 0.10). The first two items make up the Understanding subscale, and the last three are items from the Communication subscale, indicating some clustering of reliability discrepancies. The Knowledge Omission subscale and items all performed in the good range.

Table 3.

YTOCCS Item Interrater Reliability and Means

Item	Frequency	Range	Mean (SD)	ICC
Awareness	18	1-5	2.72 (1.23)	0.61
Openness	33	2-7	3.94 (1.41)	0.75
History	0	0	N/A	N/A
Values/Norms	36	1-7	3.47 (1.42)	0.74
Health	5	2-7	4.20 (2.59)	0.92
Development	11	2-5	2.55 (1.04)	0.77
Adaptation	4	3-6	4.75 (1.50)	0.99
Variety	5	2-5	4.20 (1.30)	0.65
Negotiate	11	2-5	3.64 (0.92)	0.68
Advocacy	11	2-7	4.00 (1.84)	0.75
Trust	21	1-6	4.14 (1.28)	0.42
Presence	45	1-13	3.51 (2.81)	0.70
Omissions	57	1-10	1.74 (1.56)	0.58

Note. 1- Frequency refers to the number of times this code was rated higher than a 0, out of 64 opportunities (i.e., 32 sessions observed by 2 raters). 2- Range, mean, and standard deviation calculated from sessions where the code was rated above a 0.

Table 4.

YTOCCS Scale Interrater Reliability and Means

Scale	Range	Mean (SD)	ICC	Cronbach's Alpha
Understanding	0-6.00	2.80 (0.56)	0.72	0.92
Knowledge	0-6.50	3.02 (1.21)	0.68	0.78
Communication	0-7.00	3.34 (1.02)	0.63	0.58
Opportunities	-5.50-12.00	0.98 (2.88)	0.64	0.89
Total Score	0-6.85	3.23 (1.89)	0.66	0.77

Internal Consistency for YTOCCS. Two methods for examining internal consistency were performed: inter-item correlations, and the coefficient alpha. The internal consistency of the YTOCCS was assessed using the full sample of sessions. Inter-item correlation for items was examined (Table 5). Authors have suggested that developers should work toward a target mean inter-item correlation rather than try to produce a certain level of coefficient alpha, because inter-item correlations are a more straightforward measure of internal consistency (Clark & Watson, 1995). The inter-item correlations were analyzed using Clark and Watson's (1995) suggested targets for inter-item correlation in the range of $r = .15$—$.50$ (see also Briggs & Cheek, 1986). Lower correlations indicate an item with a lack of expected association with other items, while correlations higher than $r = 0.50$ suggest possible item redundancy. Because the items Presence and Omission were coded as frequencies simultaneously with their quality items, some degree of overlap was expected. Presence correlated highly with Openness, while Omission was negatively associated in a moderate degree with Awareness, Development, Advocacy, and Presence. The item Health demonstrated a high correlation ($r > .60$) with Awareness, Values/Norms, and Advocacy, suggesting some redundancy between these items.

Cronbach's alpha was calculated for each scale of the YTOCCS as a measure of internal consistency (Table 4). Cronbach's alpha ranged from .58 (Communication) to .92 (Understanding) for each subscale. Total YTOCCS subscale scores were used as variables to calculate internal consistency for a total YTOCCS score. The alpha for the total YTOCCS score was 0.77. These results indicate consistency among the items within the scale.

The internal consistency was explored without certain items that had low performance. Variety and Adaptation both occurred infrequently in the sample (i.e., five and four times, respectively) and had few significant correlations with other items. If Variety and Adaptation

are removed from the scale, the full-scale alpha would be 0.89, and the Communication subscale alpha raises to 0.71. Further, if Health is removed, the full-scale alpha raises to 0.91, and the Knowledge subscale alpha raises to 0.81.

Relation of Cultural Competence to Alliance. Construct validity was explored by examining the relation between alliance scores using the TPOCS-A and the YTOCCS. It was hypothesized that therapist cultural competence could predict whether the therapist-client dyad was in the high or low alliance group. A series of T-tests were performed to the mean YTOCCS scores for the high and low alliance groups. The average scale YTOCCS scores from the first two sessions were averaged to create an early treatment therapist cultural competence score for each case ($M = 2.89$, $SD = .67$). The average scale TPOCS-A scores from the last session sampled for this study from each case was used as the low and high alliance group dependent variable ($M_{high} = 3.45$, $SD = 0.56$; $M_{low} = 1.05$, $SD = 0.84$). Results indicate significant differences for all YTOCCS codes between high and low alliance groups for eight child-therapist dyads (see Table 6).

Summary and Concluding Discussion

This study sought to provide preliminary evidence concerning an observational measure of cultural competence in youth psychotherapy. The first specific aim was to develop a measurement system for youth therapist cultural competence based on theoretical and empirical literature with cooperation from therapists, experts, and parents of racial/ethnic minority youth. The second aim was to explore the initial validity and reliability of the measure. Two studies were completed to pursue these aims. In the first study, the measure was first defined and initial

Table 5.

YTOCCS Inter-Item Correlations

Item	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Awareness	1												
2. Openness	0.347**	1											
3. History	.	.	.										
4.Values/Norms	.238*	.629*	.	1									
5. Health	.635**	.292	.	.651**	1								
6. Development	.050*	.383**	.	.245**	.250*	1							
7. Adaptation	.160	.109	.	.352	.266*	.116	1						
8. Variety	.156	.203	.	.243	.068	-.138	.369*	1					
9. Negotiate	.118	.385*	.	.220	.095	.219**	-.107	.170	1				
10. Advocacy	.482**	.315	.	-.178	.800**	.342	-.073	.08*	-.422	1			
11. Trust	.082	.028	.	-.199	.419*	.237	.081	.465	.264*	.374**	1		
12. Presence	.215	.609**	.	.382*	.409*	.300*	.642	.043	.038**	.408*	.349	1	
13. Omission	-.115**	-.302*	.	-.191	-.067	-.424*	.077	-.140	.142	-.397*	.144	-.693*	1

Note. *p < .05, **p < .001

Table 6.

Between-Groups Comparison of YTOCCS Scores

YTOCCS Item	High Alliance Group Mean	Low Alliance Group Mean
Awareness	5.56 (0.89)	2.03 (0.79)**
Openness	5.87 (0.75)	3.09 (0.89)*
History	N/A	N/A
Values/Norms	4.03 (0.76)	3.25 (0.89)**
Health	3.89 (1.20)	1.03 (1.01)**
Development	5.10 (0.76)	3.67 (0.89)*
Adaptation	4.95 (0.67)	2.98 (0.45)**
Variety	4.86 (0.84)	2.99 (0.58)*
Negotiate	5.57 (0.71)	2.09 (0.34)**
Advocacy	4.65 (0.97)	2.89 (1.09)**
Trust	5.47 (0.84)	1.06 (0.76)**
Presence	6.03 (2.93)	3.29 (2.45)**
Omission	2.09 (1.50)	4.19 (2.12)**

* $p < .01$
** $p < .001$

items were created from surveys of therapists, experts, and parents of racial/ethnic minority children. Following this, a coding manual was created, coders trained, and recordings were double coded from two extreme groups of child-therapist alliance participants. The second study represented a psychometric evaluation of the measure, exploring initial reliability and validity. As a general conclusion, I developed a 13-item measure that demonstrated adequate reliability and initial validity by predicting extreme group alliance membership.

My initial aim was to identify a set of items deemed relevant by a variety of stakeholders that could be used to observationally code culturally competent behavior in therapists. The first phase accumulated opinions from practicing therapists, experts, and parents of racial/ethnic minority youth who had experience with the mental health system. Results indicated that behaviors demonstrating cultural awareness, knowledge, and ability to communicate in a variety of ways were defined as culturally competent. These recommendations created the initial content of the measure. Caregivers and experts converged on recommendations that therapists should not avoid cultural topics, and that omitting cultural factors from treatment could be detrimental to a therapeutic relationship. The Presence and Omission items on the YTOCCS resulted from this consensus.

Once I had developed an item set and created a coding manual, I used a dataset of therapy recordings to engage in a preliminary psychometric study, focused on reliability and validity. One of the aims of this study was to report on the base rate of culturally competent behavior in child therapy. Items were rated on the YTOCCS for the majority of sessions, indicating that cultural material was present in the sample. This reflects both culturally competent behavior (either low or high quality), as well as times when coders determined that a culturally competent

response was warranted yet not provided. Only two sessions were rated as appropriately devoid of cultural material. These findings converge with findings from school counseling, foster care systems, pediatric primary care, family therapy, and prevention research indicating that cultural material is present in child psychotherapy, warranting further study about the unique behaviors required for providers in each of these settings (Bean et al., 2001; Cunningham, Foster, & Henggeler, 2002; Cunningham, Foster, & Warner, 2010; Damashek et al., 2012; Godoy & Carter, 2013; Kim et al., 2004; Yasui & Dishion, 2007).

There were differences in the means and frequencies on the YTOCCS and the other measure of observer rated cultural competence, the CCCI-R. LaFromboise et al. (1991) found highest means for items measuring the therapist's awareness, and lowest interrater reliability for items measuring the therapist's cultural knowledge. These findings are divergent from the current study, which found lower means for items measuring awareness and higher agreement for items measuring knowledge. However, LaFromboise et al. (1991) developed and tested the CCCI-R in an analogue experiment with a counselor specifically selected because of cross-cultural counseling proficiency. By contrast, the sample in the present study used psychotherapy sessions from actual counseling sessions, and the therapist's cultural competency was not manipulated but samples selected that might represent high and low cultural competence. In this way, the lower quality mean scores on the YTOCCS may indicate a broader range of competence than the sample used in the CCCI-R development study.

The third aim of the study was to examine the reliability and validity of the YTOCCS. The interrater reliability of the YTOCCS was examined using intraclass correlations to determine how trained graduate students can independently view a youth psychotherapy sessions and produce similar scores. The results provide a reliability estimate of the mean scores of all coders

considered as a whole to allow for generalizability to other samples conducted with similar procedures.

For a majority of the items and subscales, interrater reliability was in the "good" range (mean item ICC = 0.66). This is consistent with the interrater reliability for the only other known observer-rated cultural competence measure, the CCCI-R (LaFromboise et al., 1991), whose authors described a generalized kappa of 0.58, $p < .001$ when aggregating their raters, but stated that the reliability would be 0.63 for a single rater using the CCCI-R to evaluate and compare several therapists. There are differences in how the YTOCCS and the CCCI-R coding manuals instruct coders to rate sessions: LaFromboise et al. (1991) instructed raters to imagine that they were in the shoes of the client in the observed analogue situations, while the YTOCCS instructs coders to rate behavior of the therapist without this assumption.

The internal consistency of the YTOCCS was lower than studies ($\alpha = 0.77$) of the CCCI-R, which ranged between 0.88-0.92 in psychometric studies. When the YTOCCS scale internal consistency was explored without three items, it was raised to 0.91. Alpha is influenced by the correlations among items, as well as scale length. In this way, a high alpha can indicate a unidimensional scale or a multidimensional, but long, scale (Furr, 2011). The lower alpha for the YTOCCS may indicate multidimensionality, which is consistent with the factor analyses published for other therapist cultural competence measures (LaFromboise et al., 1991; Roysircar et al., 2005; Sodowsky et al., 1994). Factor analysis studies are needed with larger sample sizes to explore dimensionality of the scale.

Evidence supported the initial content and construct validity of the YTOCCS. Items were derived from the theoretical and empirical literature on cultural competence, with items nominated by caregivers who have experience with the mental health system, and input from

clinicians and experts. By contrast, the items on many other measures of therapist cultural competence are exclusively theory-based (e.g., LaFromboise et al., 1991), or have developed from analogue counseling situations (e.g., Roysicar et al., 2005).

Adult psychotherapy literature suggest a moderate to strong relationship between therapist cultural competence and alliance (Mayorga, 2008; Vasquez, 2007). The findings in this study confirm that this relationship is similar in youth psychotherapy. There were significant differences in YTOCCS scores between alliance groups. In this way, the YTOCCS performed in the expected way and these findings lend support to the preliminary construct validity of the measure.

Strengths and Limitations

There were considerable strengths to this study: incorporation of stakeholder perspectives in measure development; inclusion of expert opinions; the use of well-validated observer-rated alliance ratings for the same recordings to allow for comparisons between constructs; dimensional view of cultural competence; independent highly trained coders; use of therapists and clients from an effectiveness trial. Despite these strengths, there were also limitations.

The study used a small sample of 8 child and therapist participants, resulting in 32 recordings total. The primary aims of this study were to develop the measure and demonstrate some initial reliability and validity; therefore, the sample size was selected to serve this purpose. Future studies should include more recordings of a wider variety of client-therapist alliance with the goal of exploring the normality of the YTOCCS.

Demographic data for the participants and therapists were collected as part of the parent trial, with existing limitations of exclusively measuring race/ethnicity in one variable. The demographics of the small selected sample included Black, Latino, and multiethnic children

only. The validity of the measure needs to be tested on youth samples from different

racial/ethnic backgrounds before any conclusions can be reached regarding any etic external

validity applications (e.g., Nagayama Hall, 2005).   It is recommended to test the measure in

samples that include multi-method measurement of race/ethnicity and cultural variables.

Collecting information on immigration background, acculturation, language preference, and the

ability of participants to select multiple racial/ethnic backgrounds is prioritized.

The number and training of coders limits the ability to generalize the reliability of the

scale to other potential raters. Each coder was an advanced graduate student with experience

providing psychological services to children/adolescents, and a self-identified interest in cultural

factors affecting psychotherapy process and efficacy. The coders contributed different

perspectives to the YTOCCS development with the goal of creating an atheoretical scale with

regards to psychotherapy modality (e.g., psychodynamic, cognitive-behavioral). It is also

possible that these different theoretical orientations led to inherent differences in how specific

items were viewed between coders. Despite the multiple procedures used to protect against

coder drift (e.g., selecting advanced graduate students, coding with a manual, standardized

training including consensus coding, weekly meetings), there was some indication of coder bias

affecting reliability estimates. One coder who identified as practicing from a relational-cultural

perspective (i.e., stemming from psychodynamic theory) stated in her methods journal that she

coded the item Trust quite frequently in part because she finds this element to be so important in

her own work as a therapist. This indicates that coders were, at times, likely coding from

experience rather than from the definitions provided in the manual. Future code manual

revisions should include instructions in the coder manual to base ratings off of the manual only,

and revisit these instructions in regular meetings.

Another limitation to this study is the lack of a strong validity comparison measure. It was not possible to correlate the results from the YTOCCS with any other criterion measure of youth therapist cultural competence. In the absence, association with alliance measurement was used to support construct validity. Future studies should use multiple methods (e.g., therapist self-report, parent report, YTOCCS) to further explore validity.

Future Directions

These findings suggest a few next steps: (a) the YTOCCS scale and coding manual need revision with the goal of improved reliability and validity and, (b) future studies are needed with larger sample size with the power necessary to examine sources of systematic variation at different levels of nesting. Each of these steps is discussed in turn.

Scale and coding manual revision. Scale revisions and item reduction must be guided by balancing the needs of reliability and validity (DeVellis, 2012). While the internal consistency is improved by eliminating three items (Variety, Adaptation, and Health), the validity may be compromised. The items on the YTOCCS were created from a literature review and iterative study of the preferences and opinions from practicing clinicians, parents of racial/ethnic minority children in the mental health system, and experts on cultural competence. In this study, coders viewed unique client-therapist dyads in sequence. Therefore, therapists were only seen with one child in one therapy condition in this sample. The Variety item was partially defined as the therapist's changes in communication to best suit the child's cultural background, while Adaptation involves the therapist's changes to the therapy content to fit the child's cultural context. The critical term in each definition is *changing*. These two items may have been lower performing in this sample because coders had difficulty judging whether therapists were *changing* their approach for any one child, with nothing else to compare to the

therapist's behavior. In this way, a study with a different sampling plan (e.g., small number of therapists with multiple clients each) may produce higher frequencies for these items, and provide greater opportunity to reach reliability.

In a similar way, the item Health demonstrated some potential redundancy with other items. The item Health includes assessment, and knowledge about the variety of ways that mental health issues may present for individuals from different cultural groups. This item may have been limited by the solely outpatient counseling setting represented in this sample. Items in this definition may be more likely to be present in different practice settings, including inpatient, school-based, or pediatric hospital settings.

Two other hypotheses should be considered. Clinicians, parents, and experts may have identified the variables Variety and Adaptation as important systems-level competencies rather than individual therapist level competencies. It is also possible that these competencies cannot be observed, and require different methods of measurement. Exploration of these hypotheses was beyond the scope for in this initial study. Therefore, I plan to retain these items to explore these possibilities further in future larger, multi-level samples with multiple settings.

Future psychometric studies. Further exploration of the structure of the measure is needed. Due to the small sample size, internal consistency was only examined using Cronbach's alpha for subscales and total score. A larger sample is needed for factor analytic methods (Clark & Watson, 1995). Information about the factors of the YTOCCS could help move toward an operationalized definition of cultural competence that can provide guidelines for child/adolescent therapists (Arrendondo & Perez, 2006; Fuertes et al., 2006).

The lack of available well-validated measures of observer-rated therapist cultural competence limits the ability to establish criterion-related validity. However, the YTOCCS

could be used as a measure of a part of cultural competence training, following the other authors of multicultural counseling competence scales (Ponterotto et al., 1994). Criterion-related validity would be supported if the YTOCCS could accurately categorize students as either receiving or not receiving cultural competence training. A second possibility would be rating therapy recordings from a therapist nominated as highly culturally competent. Last, it would demonstrate further validity if the YTOCCS could reliably distinguish between low and high therapist cultural competence an experimental scripted analogue study (Ponterotto et al., 1994).

There was insufficient power to explore systematic differences in reliability due to the nesting of data in this study. There were efforts to balance the high and low alliance groups on treatment provided (CBT or UC) and problem type, but the sample sizes were too small to examine variance in outcomes based on these factors. It is possible that culturally competent behaviors would vary based on the type of treatment delivered; CBT might involve cultural adaptations to treatment manuals, while interpersonal therapies may be adapted to include more members of the child's family, for example (Sue, 2009). Coder effects can also cause systematic bias. While power was insufficient to fully test for coder effects in the present study, there was some evidence that coder effects caused low reliability on at least one item. Two recommendations for future research are merited: (a) complete a follow up study with large sample size of clients with a variety of presenting problems nested within therapists practicing from a variety of tracked theoretical orientations, and conduct a variance components analysis to explore any systematic differences at different levels of nesting; and (b) recruit coders from a variety of cultural and training backgrounds to explore variations in reliability based on personal experiences. These studies could also address the dearth of empirical information about how coder characteristics influence psychotherapy process research (Hill & Lambert, 2004).

This study aimed to develop an observational measurement system for youth therapist cultural competence, to meet the larger aim of improving the mental health care for underserved children. Though a measure was developed and some initial reliability and validity evidence accrued, this study represents just the first step in a larger program of research needed to develop a reliable and valid measure of youth therapist cultural competence. Further exploration is needed in different samples, methods, and procedures. Once more evidence supports the validity of the YTOCCS, it may be used to explore the relation between cultural competence and symptom outcome, and converted into a training tool to increase cultural competence behaviors.

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CAREGIVER QUESTIONNAIRE

Age:	**Gender:** Male Female	**Race: (check all that apply)** __ American Indian or Alaska Native __ Asian __ Black or African American __ Native Hawaiian or Other Pacific Islander __ White	**Ethnicity:** __ Hispanic/Latino __ Not Hispanic/Latino

What languages do you speak at home? (Write in all that apply) **Have you sought medical or mental health services for your children in any language other than English?** __ **Yes** __ **No**	**What is your family's annual income? (check only one)** __ Less than $20,000 __ $20,000-$35,000 __ $35,000-$50,000 __ $50,000-$75,000 __ $75,000-$100,000 __ $100,000-$500,000 __ More than $500,000

1. **How many children do you have? (please include any children for whom you make medical decisions)**

   __ O (I have no children)   __ 5
   __ 1   __ 6
   __ 2   __ 7
   __ 3   __ 8
   __ 4   __ 9 or more

2. **What is your relationship to your children?** (check all that apply)

   __ Biological parent   __ Step-parent
   __ Adoptive parent   __ Non-custodial parent
   __ Foster parent   __ Sibling
   __ Grandparent   __ Friend
   __ Other family member   __ Court-appointed guardian

3. **Have any of your children ever used mental health services (including counseling, therapy, family therapy, school counseling, or a doctor who prescribes medicine to help with mental health?)**
   Yes___   No ___

    If you answered, "Yes", how many of your children have sought mental health services? _____

4. **What type of mental health services has your family used in the past for one of your children?** (check all that apply)

   ___ Child individual therapy/counseling   ___ Family therapy/counseling
   ___ Pediatrician/Primary Care physician   ___ School counselor/Guidance counselor
   ___ Child/Adolescent Psychiatrist   ___ Psychiatric inpatient hospital
   ___ In-home counselors   ___ Crisis Intervention
   ___ Other   ___ Not applicable – our family has not

5. Overall, what was your satisfaction with the mental health services that your child(ren) used in the past?

__ Very dissatisfied   ___ Not applicable
__ Dissatisfied
__ Neither satisfied nor dissatisfied
__ Satisfied
__ Very satisfied

used mental health services.

6. Please rank how important these factors were when looking for a mental health provider to work with your child (1 = most important; 6 = least important)

___ Cost / Insurance or Medicaid reimbursement

___ The sense that someone of my child's culture is welcome

___ Treatment specialty/provider training

___ Accessibility (parking, near bus lines, neighborhoods, appointment times)

___ Reputation

___ The sense that the provider can help my child

          ___ Not applicable

1. Please provide some information about the first child (*Child #1*) in your care who sought mental health services. (Check here if not applicable ___)

What is Child #1's race?: (check all that apply) __ American Indian or Alaska Native __ Asian __ Black or African American __ Native Hawaiian or Other Pacific Islander __ White	What is Child #1's ethnicity: __ Hispanic/Latino __ Not Hispanic/Latino	How old was Child #1 when he/she sought mental health services? (Check all that apply) ____ 5 or younger ____ 6-12 ____ 13-17 ____ 18 or older	How many times did Child #1 meet with his/her provider? (if your child is still enrolled, check box closest to where he/she is in treatment currently) __ Less than 1 __ 1-2 __ 2-4 __4-20 __ 20+

2. Please provide some information about the first child (**Child #2**) in your care who sought mental health services. (Check here if not applicable ___)

What is Child #2's race?: (check all that apply) __ American Indian or Alaska Native __ Asian __ Black or African American __ Native Hawaiian or Other Pacific Islander __ White	What is Child #2's ethnicity: __ Hispanic/Latino __ Not Hispanic/Latino	How old was Child #2 when he/she sought mental health services? (Check all that apply) ____ 5 or younger ____ 6-12 ____ 13-17 ____ 18 or older	How many times did Child #2 meet with his/her provider? (if your child is still enrolled, check box closest to where he/she is in treatment currently) __ Less than 1 __ 1-2 __ 2-4 __4-20 __ 20+

3. Please provide some information about the first child (**Child #3**) in your care who sought mental health services. (Check here if not applicable ___)

What is Child #3's race?: (check all that apply) __ American Indian or Alaska Native __ Asian __ Black or African American __ Native Hawaiian or Other Pacific Islander __ White	What is Child 32's ethnicity: __ Hispanic/Latino __ Not Hispanic/Latino	How old was Child #3 when he/she sought mental health services? (Check all that apply) ____ 5 or younger ____ 6-12 ____ 13-17 ____ 18 or older	How many times did Child #3 meet with his/her provider? (if your child is still enrolled, check box closest to where he/she is in treatment currently) __ Less than 1 __ 1-2 __ 2-4 __4-20 __ 20+

4. Please provide some information about the first child (**Child #4**) in your care who sought mental health services. (Check here if not applicable ___)

What is Child #4's race?: (check all that apply)	What is Child #4's ethnicity:	How old was Child #4 when he/she sought mental health services? (Check all that apply)	How many times did Child #4 meet with his/her provider? (if your child is still enrolled, check box closest to where he/she is in treatment currently)
__ American Indian or Alaska Native __ Asian __ Black or African American __ Native Hawaiian or Other Pacific Islander __ White	__ Hispanic/Latino __ Not Hispanic/Latino	____ 5 or younger ____ 6-12 ____ 13-17 ____ 18 or older	__ Less than 1 __ 1-2 __ 2-4 __ 4-20 __ 20+

1. How important is it to you that your child's therapist shows awareness, knowledge, and skill in incorporating your cultural background into treatment with your child?

   1 – not important at all
   2 – not very important
   3 - unsure/neutral
   4 - pretty important
   5 – very important

2. How would your child's therapist's attitudes and knowledge about your (or your child's) culture affect therapy? (write in answer)

3. What qualities do you think are important for therapists who are working with children and adolescents from your cultural background to have? (write in answer)

4. How would you know that your child's therapist was aware of your (or your child's) cultural background? (write in answer)

5. How would you know that your child's therapist was aware of his/her different cultural background, and how that may impact treatment? (write in answer)

6. How would you know that your child's therapist was unaware of your (or your child's) cultural background? (write in answer)

7. How would you know that your child's therapist had an open attitude toward you (or your child's) cultural background? (write in answer)

8. How would you know that your child's therapist had a closed attitude toward you (or your child's) cultural background? (write in answer)

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9. How would you know that your child's therapist has knowledge of your (or your child's) cultural background? (write in answer)

10. How would you know that your child's therapist lacked knowledge of your (or your child's) cultural background? (write in answer)

11. How would you know that your child's therapist was incorporating your (or your child's) values and beliefs into therapy? (write in answer)

12. How would you know that your child's therapist was not incorporating your (or your child's) values and beliefs into therapy? (write in answer)

13. What kinds of things would a therapist do differently for children of different ages from you culture? For children (ages 3-11)? (write in answer)

14. What kinds of things would a therapist do differently for children of different ages from you culture? For adolescents (ages 12-17)? (write in answer)

15. What kind of physical environment in your child's therapist's office makes you feel that someone of your (or your child's) cultural is welcome? Examples may include things like art on the walls, images of youth in posters, brochures available in multiple languages, etc. (write in answer)

16. Below, please tell us any other important characteristics or behaviors of a culturally sensitive child/adolescent therapist? In other words, what other kinds of things would a therapist do or say that would make you feel that he/she was culturally aware? (write in answer)

VITA

Carrie Elizabeth Bair Tully was born on December 16, 1983 in Syracuse, NY. She received her Bachelor's of Arts degree from Boston University in 2006, and her Master's in Science degree in 2011 from Virginia Commonwealth University (VCU). Her research interests include pediatric health psychology, cultural competence and adaptations to treatment, and dissemination and implementation of empirically supported treatments.

Biographical Information

Date of Birth: December 16, 1983
Place of Birth: Syracuse, NY
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Academic Training

Undergraduate: Boston University
                       B.A., May 2006
                       Major: Psychology and Political Science

Masters: Virginia Commonwealth University
                       M.S., May 2011
                       Major: Psychology

Thesis Topic: *Relations Among Media, Eating Pathology, and Body Dissatisfaction*
                       in College Women

Thesis Advisor: Suzanne E. Mazzeo, Ph.D.

Doctoral: Virginia Commonwealth University
                       Ph.D. Expected August 2015
                       Major: Clinical Psychology, Child-Adolescent

Dissertation Topic: *Development and Validation of the Youth Therapist Observational*
                       Cultural Competence Scale

Doctoral Advisor: Michael A. Southam-Gerow, Ph.D.

Awards and Honors

Deborah Braffman Schroeder Endowed Research Scholarship   2014

Dean's List, VCU   2009 – 2014

Psychology Department Travel Award, VCU   2011 – 2013

Society for the Advancement of Psychology Travel Award, VCU   2010 – 2012

Publications

Bean, M.K., Jeffers, A.M., **Tully, C.B.,** Thornton, L.M. and Mazzeo, S.E. (2014). Motivational interviewing with parents of overweight children: Study design and methods for the NOURISH+MI study. *Contemporary Clinical Trials, 37*(2), 312-321. Doi: 10.1016/j.cct.2014.02.001

Serdar, K.L., Kelly, N.R., Palmberg, A.A., Thornton, L.M., **Tully, C.B**., and Mazzeo, S.E. (2014). Comparing the efficacy of online and face-to-face dissonance-based eating disorder prevention. *Eating Behaviors*, *22*(3), 244-260.

Lydecker, J.A., Hubbard, R.R., **Tully, C.B.,** Utsey, S.O. and Mazzeo, S.E. (2014). White Public Regard: Associations among eating disorder symptomatology, guilt, and White guilt in young adult women. *Eating Behaviors, 15*, 76-82. Doi:10.1016/j.eatbeh.2013.10.007.

Tully, C.B. (2014). Review of the International Depression Literacy Survey. (2014). *Association of American Medical College MedEdPORTAL Directory and Repository of Educational Assessment Measures*: https://www.mededportal.org/publication/9501.

Evans, R.K., **Tully, C.B.**, & Wijesooriya, N.R. (2013). Encouraging families to be more active: Application of the 5-As model in pediatric primary care. *Virginia Pediatrics,* Fall 2013. http://www.virginiapediatrics.org/publications.

McLeod, B.D., Southam-Gerow, M.A., **Tully, C.B.,** Rodriguez, A., and Smith, M.M. (2013). Making a case for treatment integrity as a psychological treatment quality indicator. *Clinical Psychology Science and Practice*, *20*(1), 14-32. Doi: 10.1111/cpsp.12020.

Southam-Gerow, M.A., Arnold, C.C., **Bair, C.E.**, and Cox, J.R. (2013). Dissemination of evidence-based treatments. In: C.A. Alfano & D.C. Beidel (Eds.), *Comprehensive evidence-based interventions for school-aged children and adolescents*. Hoboken, NJ: Wiley.

Bair, C.E., Kelly, N.R., Serdar, K.L., and Mazzeo, S.E. (2012). Does the Internet function like magazines? An exploration of image-focused media, eating pathology, and body dissatisfaction. *Eating Behaviors, 13*(4), 398-401. Doi: 10/1037/a0026457.

Kelly, N.R., Mitchell, K.S., Gow, R.W., Trace, S.E., Lydecker, J.A., **Bair, C.E.,** and Mazzeo, S.E. (2011). An evaluation of the reliability and construct validity of eating disorder measures in White and Black women. *Psychological Assessment*, *24*(3), 608-617. Doi: 10.1037/a0026457.

Professional Activities

Reviewer

Journal of Clinical Child and Adolescent Psychology   2014

Clinical Psychology Review	2014
Eating Behaviors	2011 – 2014
Journal of Pediatric Psychology	2012 – 2013
Journal of Behavioral Medicine	2012
Journal of Consulting and Clinical Psychology	2012

Professional Memberships

American Psychological Association

Association for Behavioral and Cognitive Therapies

Society for the Advancement of Psychology

Program Development

| Adolescent Bariatric Surgery Program | 2012 – 2013 |
| Department of Pediatrics, VCU Health System, Richmond, VA | |

TEENS (Teaching, Encouragement, Exercise, Nutrition,	2011 – 2012
and Support) Pediatric Weight Management Program	
Department of Pediatrics, VCU Health System, Richmond, VA	

Clinical Activities

Pre-Doctoral Internship	2014 – 2015
Pediatric Psychology/Child Psychology Track	
Baylor College of Medicine/Texas Children's Hospital, Houston, TX	

Psychology Resident	2012 – 2014
Department of Endocrinology, Diabetes, and Metabolism	
Department of Pediatrics, VCU Health System, Richmond, VA	

| Assessment Extern | 2012 – 2014 |
| ChildSavers, Richmond, VA | |

Behavior Specialist	2010 – 2014
TEENS (Teaching, Encouragement, Exercise, Nutrition	
and Support) Pediatric Weight Management Program	
Department of Pediatrics, VCU Health System, Richmond, VA	

| Graduate Student Therapist | 2010 – 2013 |
| Center for Psychological Services and Development, Richmond, VA | |