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Self-Reported and Observed Cultural Competence and Therapeutic Alliance in Family Therapy

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UNIVERSITY OF MIAMI

SELF-REPORTED AND OBSERVED CULTURAL COMPETENCE AND
THERAPEUTIC ALLIANCE IN FAMILY THERAPY

By

Carla C. Mayorga

A DISSERTATION

Submitted to the Faculty
of the University of Miami
in partial fulfillment of the requirements for
the degree of Doctor of Philosophy

Coral Gables, Florida

December 2008

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Self-Reported and Observed Cultural Competence
and Therapeutic Alliance in Family Therapy

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Because of its political and philosophical launching ground (Arredondo & Perez, 2006), cultural competence did not begin as an empirical research program, and as a result, there remains disagreement about how to define and measure cultural competence. Although the application of cultural competence remains unclear to some psychologists (Fuentes et al., 2006), it is now common knowledge that the therapeutic alliance is a statistically and clinically significant contributor to effective therapy. This pilot study merges two prominent bodies of literature, cultural competence and therapeutic alliance, with the underlying assumption that a culturally competent counselor will be able to provide effective service through the therapeutic relationship (Pope-Davis et al., 2002). This pilot study was designed to provide information about the relationship between therapists' self-reports and their observed behaviors regarding cultural competence (CC), examine how therapists' CC facilitates the formation of working alliances, and examine the role of CC in predicting parent-child discrepancy in alliance. Participants were family therapists and family members involved in a multi-site clinical trial study (Parent Study) evaluating Brief Strategic Family Therapy (BSFTTM; Szapocznik, Hervis, & Schwartz, 2003). A total of 14 therapists from 8 community treatment programs from across the country were included in the rating portion of the study. The Parent Study included

African American and Hispanic families with adolescents ages 12-17, mostly referred from the juvenile justice system. Scores from Roysircar's *Multicultural Counseling Inventory (MCI; 1994)* and *Cultural Diversity Observer Rating Scale (CDORS; 2005)* were compared. Observed therapeutic alliance was evaluated using the *Vanderbilt Therapeutic Alliance Scale-Revised*. The associations were evaluated with 3 multilevel univariate linear models using HLM software. Since 6 of 14 therapists (43%) completed the MCI, the pilot study was completed without self-reported competence as a predictor of therapeutic alliance (only CDORS was used). The results of this study failed to provide support for the hypothesized relationships between cultural competence and therapeutic alliance. These results are discussed in light of the methodological limitations of this study and suggestions are made to improve future investigations in this area.

DEDICATION

This dissertation is dedicated my parents, Lydia and Oscar, my brothers, Oscar, Luis and George, my sister Sarah, the Fabulous Four including Erin, Nikki and Susana, my husband-to-be Roger, my wonderful friend Liz and great friends from CMTP.

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Chapter 1

Introduction

Over the past two decades, the field of psychotherapy has witnessed tremendous growth in the development and investigation of culturally competent training and practice. This growth is a result of a movement initiated by psychologists concerned that our field was excluding and not providing adequate services to people of color and other historically underserved populations. This political movement also has inherent ethical underpinnings. Fowers and Davidov (2006) describe multiculturalism as a social, intellectual and moral movement that is strengthened by its aims of inclusion, social justice, and mutual respect. “It is easy to see how such attractive goals have inspired arduous and heartfelt efforts in reforming psychology and society, particularly if one contrasts these goals with their opposites (prejudice, discrimination, oppression, and injustice)” (p. 584). Because of this political and philosophical launching ground (Arredondo & Perez, 2006), cultural competence did not begin as an empirical research program, and as a result, there remains disagreement about how to define and measure cultural competence.

In their meta-analytic review of culturally adapted mental health interventions, Griner and Smith (2006) found evidence of statistically significant client improvement across a variety of conditions and outcome measures when interventions were conducted in clients’ preferred language and when interventions explicitly included cultural values and concepts into treatments targeted to specific racial and ethnic groups. However, the authors reported that few studies evaluated the level of cultural competence of the therapists and suggested that measures of cultural competence be included in future

studies (Griner & Smith, 2006). In contrast to the application of cultural competence remaining unclear to some psychologists (Fuertes et al., 2006), it is now common knowledge that the therapeutic alliance is a statistically and clinically significant contributor to effective therapy. One of the most important ways that cultural competence can influence therapeutic process and outcome is through the therapeutic alliance (Friedlander, Escudero, & Heatherington, 2006).

Cultural Competence Theory

The most well recognized and influential conceptual framework of cultural competence was originally developed by D.W. Sue, Arredondo, and McDavis' (1992) *Multicultural Counseling Competencies and Standards*. This framework became the foundation for the American Psychological Association's *Multicultural Guidelines* (2003) and includes a complex, multidimensional perspective on cultural competency that encompasses cultural awareness and beliefs, cultural knowledge, and cultural skills.

D.W. Sue et al. (1992) define the three dimensions as follows:

The first deals with counselors' attitudes and beliefs about racial and ethnic minorities, the need to check biases and stereotypes, development of a positive orientation toward multiculturalism, and the way counselors' values and biases may hinder effective cross-cultural counseling. The second recognizes that the culturally skilled counselor has good knowledge and understanding of his or her own worldview, has specific knowledge of the cultural groups he or she works with, and understands sociopolitical influences. The last deals with specific skills (intervention techniques and strategies) needed in working with minority groups (it includes both individual and institutional competencies). (p. 481)

D.W. Sue and D. Sue (1990) reviewed the literature evaluating characteristics of the culturally competent counselor, and they organized these characteristics along three dimensions described below in D.W. Sue et al.'s (1992) seminal article:

First, a culturally skilled counselor is one who is actively in the process of becoming aware of his or her own assumptions about human behavior, values,

biases, preconceived notions, personal limitations, and so forth... Second, a culturally skilled counselor is one who actively attempts to understand the worldview of his or her culturally different client without negative judgments... Third, a culturally skilled counselor is one who is in the process of actively developing and practicing appropriate, relevant, and sensitive intervention strategies and skills in working with his or her culturally different clients. (p. 481)

The authors emphasized the fact that becoming culturally skilled is an active process that is ongoing, never reaching an end point. Furthermore, the conceptual framework as summarized by D.W. Sue et al. (1992) states,

Given the aforementioned discussion of cross-cultural counseling competencies, it is possible to develop a 3 (Characteristics) \times 3 (Dimensions) matrix in which most of the cross-cultural skills can either be organized or developed. For example, the characteristics (a) counselor awareness of own assumptions, values, and biases; (b) understanding the worldview of the culturally different client; and (c) developing appropriate intervention strategies and techniques would each be described as having three dimensions: (a) beliefs and attitudes, (b) knowledge, and (c) skills. Thus, a total of nine competency areas are identified. (p. 481)

D.W. Sue and D. Sue (2003) expand our understanding of cultural competence by adding a third facet, foci of therapeutic interventions. "Culturally competent helping professionals must not confine their perspectives to just individual treatment, but must be able to intervene effectively at the professional, organizational, and societal levels as well" (p. 26). Specifically, the first of four foci of intervention and development, an individual focus, calls for working through one's own biases, prejudices, and misinformation/lack of information regarding culturally diverse groups in our society. The second, professional, focus calls for an acknowledgement of the influences of Western European perspectives on how we define psychology. The third, organizational, focus calls for a realization that institutional practices, policies, programs and structures may be oppressive to certain groups, especially if the institutions are monocultural. The fourth, societal, focus, calls for psychologists to target systemic causes of mental and

physical health problems, such as social policies (e.g., racial profiling) that are detrimental to the mental and physical health of historically marginalized people.

Multicultural Domains: From Theory to Practice

Although the literature on cultural competence has expanded, the articulation of awareness, knowledge, and skills as three dimensions of cultural competence (D.W. Sue et al., 1982; 1992) has primarily been philosophical and theoretical. S. Sue (2006) and Arredondo et al. (1996) are two of the few researchers who offer specific operationalizations of how these dimensions may be manifested in specific behaviors that occur in treatment and in training. Arredondo et al. (1996) published a revised Multicultural Counseling Competencies and accompanying explanatory statements to further clarify and define the three domains of awareness, knowledge, and skills. Giving life to the competencies, the explanatory statements include examples and anecdotes. Using language that describes the means of demonstrating operationalized competencies, the new format provided by Arredondo and her colleagues goes beyond the original Multicultural Counseling Competencies document (D.W. Sue et al., 1992). The new format facilitates both the practitioner and the educator to apply multicultural perspectives with all interpersonal counseling and counselor education.

Operationalizations such as those S. Sue (2006) and Arredondo et al. (1996) present are essential to the development of independent observation measures of cultural competence in therapy sessions. In particular, S. Sue differentiates between process and content of cultural competency and frames cultural competence as a multidimensional phenomenon. He describes three orthogonal processes which include scientific mindedness, dynamic sizing, and culture-specific expertise. First, scientific mindedness is

used to form hypotheses about clients rather than make assumptions, develop creative ways to test these hypotheses, and then act on acquired data. Second, dynamic sizing is described as knowing when to generalize and be inclusive and knowing when to individualize and be exclusive. Hence, appreciating the importance of culture without stereotyping is crucial. Third, having culture-specific knowledge and skills is essential to understanding and correctly evaluating client characteristics. These processes are difficult to operationalize and measure because one person can practice one or more of these processes, and each to varying degrees.

Despite these difficulties, S. Sue identified content of cultural competence by offering ten concrete strategies to enhance cultural competence in treatment (see Table 1.1; S. Sue, 2006, p. 240). Although S. Sue's strategies offer more concrete and clear applications of cultural competence, these operationalizations have yet to be directly measured. Consequently, more research on the development of behavioral measures is still warranted. Using research-based behavioral measures of cultural competence would help both practitioners and clinical supervisors to better understand the applications of cultural competence in therapeutic interventions. Receiving accurate and relevant feedback from a supervisor who used an observational measure to evaluate the practitioner will help both the practitioner and supervisor identify areas of strength and weakness and then formulate goals toward further developing cultural competence.

Table 1.1: Concrete Steps to Take in Improving Cultural Competency in Treatment

Self-awareness and stimulus value
Assessment of client
Pretherapy intervention
Hypothesizing and testing hypotheses
Attending to credibility and giving
Understanding the nature of discomfort and resistance
Understanding clients' perspective
Strategy or plan for intervention
Assessment of session
Willingness to consult

Cultural Competence in the Family Therapy Arena

Gender, race, class, religion, nationality, and even generational cohort all contribute to cultural identities. In the family therapy arena, numerous authors have confirmed the importance of race, ethnicity, and culture as influences on the interactions within families and between families and larger systems (Gushue, Greenan, & Brazitis, 2005; McGoldrick, Giordano, & Pearce, 1996; D.W. Sue & D. Sue, 2003). This research can be grouped into three general trends: between-group cultural differences, within-group cultural differences, and how culture affects the interactions between the therapist and the family. McGoldrick et al.'s (1996) *Ethnicity and Family Therapy* may be the best known source in the family therapy field for describing between-group cultural differences. They describe the family interactional patterns of approximately 40 racial, ethnic, and religious groups. To understand the cultural context of families, certain domains have been highlighted including understanding a family's cultural values and, as such, what is "normal" in a given family. Even the definition of "family" may vary from nuclear families of parents and children to extended families of those related by kinship bonds. To understand a family's cultural context, the therapist should also consider how sociopolitical systems affect the family's patterns. For example, how do the "normal"

family patterns of an immigrant family change when parents depend on their children's English proficiency to navigate school systems? Furthermore, therapists are required to evaluate what makes for a culturally appropriate intervention: Is open conflict tolerated; can the therapist communicate directly to children; what is the accepted level of emotional expression?

Researchers also suggest that there are significant differences among families of the same culture. To control for the danger of stereotyping via delineating culture-based differences in families, researchers have provided four systematic ways of thinking about within-group cultural differences among families (Gushue et al., 2005). The first is to be aware of national differences within broad categories used to communicate culture. For example, there are more than 32 distinct cultural groups under the heading, "Asian and Pacific American" in the United States (D.W. Sue & D. Sue, 2003); and there are significant differences between a Japanese American family and a Malaysian American family, for instance. A second within-group moderator is socioeconomic status. Researchers explore the influence of social class on depression in families (Falicov, 2003) and on family functioning (Minuchin, Lee, & Simon, 1996; Ross, 1995). The third and fourth systematic ways of thinking about within-group cultural differences among families are differences in acculturation and in racial-cultural identity within families. For example, immigrant children typically acculturate more rapidly than their parents, creating the potential for cultural conflict between traditional parents and their "Americanized" children (Santisteban & Mitrani, 2003). Therefore, a therapist needs to be aware of the cultural differences that exist within the same family. The racial-cultural identity paradigm (Helms, 1995) suggests that family members may have different

experiences of and responses to racism and the sociopolitical context of the U.S. which lead to varying orientations to race and culture. These differences may contribute to synergy or conflict within the family and between family members and the therapist.

Cultural Competence Primarily Measured as Self-Report

Most of the research conducted on cultural competence has primarily relied on therapist self-reports (Constantine & Ladany, 2000). The four primarily used self-report measures include the Multicultural Awareness-Knowledge-Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991), the Cross-Cultural Competency Inventory—Revised (CCCI—R; LaFromboise, Coleman, & Hernandez, 1991), the Multicultural Counseling Awareness Scale-Form B (MCAS-Form B; Ponterotto, Sanchez, & Magids, 1991), and the Multicultural Counseling Inventory (MCI; Sadowsky, Taffe, Gutkin, & Wise, 1994). Only one measure, LaFromboise et al.'s (1991) CCCI—R, has been used as an observational measure by clinical supervisors and culturally different clients to provide behavioral feedback to therapist trainees. Researchers of the CCCI-R responded first to the call to develop behavioral measures of cultural competence. This 20-item six point Likert-type scale evaluates three areas: 1) cross-cultural counseling skill, 2) sociopolitical awareness and 3) cultural sensitivity. A noteworthy difference between the CCCI-R and the MCI by Roysircar Sadowsky and colleagues is MCI's fourth subscale, Multicultural Counseling Relationship, which makes the MCI most relevant to this study. Additionally, an observational measure of cross-cultural competence is being developed by Roysircar and colleagues, the *Cultural Diversity Observer Rating Scale* (CDORS). Not a unifactor instrument like the CCCI-R, the CDORS has a stable three factor structure resulting from the exploratory factor analyses including *Counselor Helping Behaviors* (15 items),

Counselor Awareness of Client Contexts (7 items), and *Counselor's Perceived Barriers and Frustrations* (7 items; Roysircar, Pimpinella, Spanakis, & Vincent, 2007). Concisely, *Counselor Helping Behaviors* addresses counselor actions that aim to support clients, share with them, listen to their stories, and include their contexts and status in conceptualization and interventions. *Counselor Awareness of Client Contexts* addresses the counselor's self-examination in an effort to understand one's own biases and socialization in addition to an examination of the client's cultural upbringing and worldview. *Counselor's Perceived Barriers and Frustrations* addresses the counselor's self-doubts, disconnection from the client, and overemphasis on the differences between counselor and client, and overall emotional negativity (Roysircar et al., 2007).

Ponterotto, Rieger, Barrett, and Sparks (1994) thoroughly reviewed the prominent measures in the field at the time. The Cross-Cultural Inventory-Revised (CCCI-R), developed by LaFramboise, Coleman and Hernandez (1991), consists of 20 items and is completed by an evaluator. Respondents rate the extent to which the CCCI-R items describe the counselor using a 6-point Likert-type format. Sample items include: "Counselor is aware of how own values might affect the client" (awareness item), "Counselor demonstrates knowledge about the client's culture" (knowledge item), and "Counselor is willing to suggest referral when cultural differences are extensive" (skills item). Psychometric properties include adequate internal consistency with coefficient alpha of .95 and interrater reliability of .78 (Ponterotto et al., 1994). Criterion and content validity have been established. The CCCI-R is efficient to complete and score and was the first instrument of its kind. However, the factor structure is still in question since support has been found for both a unidimensional construct (one clear factor) and a

multidimensional construct (three factors). Instrument developers recommend the scale be scored as a unidimensional construct.

The Multicultural Counseling Awareness Scale—Form B: Revised Self Assessment (MCAS:B), developed by Ponterotto, Sanchez, and Magids (1991), is a 45-item counselor self-rating scale. Measuring multicultural knowledge/skills and awareness using a 7-point Likert-type format, the MCAS:B includes a demographic questionnaire and requires 15-25 minutes to complete. Sample items include: “I feel all the recent attention directed toward multicultural issues in counseling is overdone and not really warranted” (awareness item), “I am knowledgeable of acculturation models for various ethnic minority groups” (knowledge/skills item), and “At this point in my professional development, I feel I could benefit little from clinical supervision of my multicultural client caseload” (social desirability item). Psychometric properties include a full-scale coefficient alpha of .93 and a low to moderate correlation (.37) between Factor 1 (knowledge/skills) and Factor 2 (awareness), supporting further investigation of the MCAS:B as bidimensional. An efficient instrument, the MCAS:B requires only 20 minutes to complete. Limitations include the need for concurrent validity studies, for studies testing the bidimensional structure of the instrument, and for studies evaluating the utility and validity of the three items measuring social desirability.

The Multicultural Counseling Inventory (MCI), developed by Sadowsky et al. (1994), consists of 40 items measuring multicultural competence and can be completed in 15-25 minutes. Indicating the degree to which the scale items describe their own work, counselors, psychologists or trainees use a 4-point scale format ranging from “very inaccurate” (1) to “very accurate” (4). The MCI has 4 subscales: Multicultural

Counseling Skills (11 items), Multicultural Awareness (10 items), Multicultural Counseling Knowledge (11 items) and Multicultural Counseling Relationship (8 items). The Skills, Awareness, and Knowledge subscales measure content similar to that described for the CCCI-R and MCAS:B. The fourth subscale, Multicultural Counseling Relationship, is a unique feature of the MCI and the reason for its use in this study evaluating therapeutic alliance. This unique subscale refers to the counselor's stereotypes of, and comfort level with, minority clients. Sample items are prefaced with "When working with minority clients..." and include: "I form effective working relationships with the clients" (skills item), "I have experience at solving problems in unfamiliar settings" (awareness item), "I use innovative concepts and treatment methods" (knowledge item), and "I perceive that my race causes the clients to mistrust me" (relationship item). As reported by instrument developers, psychometric properties include a Cronbach's alpha of .87 for the full MCI scale (Roysircar Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998), and subscale alphas ranging from .68 for Multicultural Counseling Relationship (8 items) to .80 for Multicultural Counseling Skills (11 items; Roysircar Sodowsky et al., 1998). The factor matrix indicated moderate correlations among the factors, with correlations ranging from .16 to .31 (Sodowsky et al., 1994). Criterion and construct validity have been demonstrated, and it is the only instrument with a relationship subscale. However, concurrent and convergent validity studies are needed to assess the relationship of MCI to theoretically similar and dissimilar constructs.

The Multicultural Awareness-Knowledge-and-Skills Survey (MAKSS), designed by D'Andrea, Daniels, and Heck (1991), consists of 8 demographic and 60 survey items

that are self-administered and require about 20-25 minutes to complete. Using two different 4-point scales, the MAKSS assesses the effects of instructional strategies on students' multicultural counseling development. Sample items include: "In general, how would you rate your level of awareness regarding different cultural institutions and systems" (1 = "very limited" to 4 = "very aware"), and "Psychological problems vary with the culture of the client" (1 = "strongly disagree" to 4 = "strongly agree"). The 60 items of the MAKSS are divided equally into three subscales measuring multicultural awareness, knowledge and skills. Psychometric properties include coefficient alphas for internal consistency at .75 for the Awareness subscale, .90 for the Knowledge subscale and .96 for the Skill subscale. The coefficient alpha for the total scale was not reported in D'Andrea et al. (1991). The Knowledge and Skills subscales are best interpreted as single factors and the Awareness subscale seems tridimensional. Measured before and after training, subscale intercorrelations produced low values, suggesting some independence between the subscales. The MAKSS has satisfactory internal consistency and can discriminate between groups who have received training in multicultural counseling issues and those who have not. Factor analytic studies are required to test the three-dimensional construct of the total scale. Concurrent validity checks with related yet more established instruments are also required.

One major criticism of the self-report measures is that they tend to capture *anticipated* rather than *actual* behavior and attitudes related to cultural competence. It has been argued that self-report measures, which are typically used for research on attitudes and values (i.e., intrapsychic processes), are appropriate for capturing the awareness dimension of cultural competence (Roysircar et al., 2007). However, Constantine, Gloria

and Ladany's (2002) study submitted the subscales of three self-report cultural competence measures (the MAKSS, the MCI and the MCKAS) to confirmatory factor analyses to confirm the measures' underlying factor structures (multicultural attitudes/beliefs, knowledge and skills). Additionally, Constantine and colleagues explained that self-reported multicultural instruments may be measuring self-efficacy as opposed to actual abilities to counsel diverse clients (Constantine, 2001; Constantine & Ladany, 2000). Constantine and Ladany (2000) argue that because most cultural competence measures are self-reports, their relationship to demonstrated cultural competence has yet to be established. These authors addressed this concern by comparing self-report scores to multicultural case conceptualization ability (their operationalization of demonstrated cultural competence). Constantine and Ladany found that, after controlling for social desirability, the four multicultural competence self-report measures that were evaluated had no statistically significant relationship with multicultural conceptualization ability. Consequently, self-report measures apparently do not assess this particular operationalization of demonstrated ability of cultural competence.

Similarly, Fuertes et al. (2006) evaluated the role of therapist multicultural competence in the work of fifty-one therapy dyads (intern and extern therapists and college student clients). Clients and therapists completed ratings after the third session of treatment at one of three university therapy centers in northeastern United States that participated in this study. The CCCI-R was used to measure perceptions of therapist multicultural competency. Among their statistically significant findings, therapists' self-ratings were higher on multicultural competence than their clients' ratings. Additional studies (Ladany, Inman, Constantine, & Hofheinz, 1997) found no correlation between

self-reported multicultural competence and case conceptualization (demonstrated multicultural competence). Worthington, Mobley, Franks and Tan (2000) found limited support for their hypothesis that self-reported multicultural counseling competencies (measured by the MCI) would be positively associated with observer-rated competencies (in this study, observer-rated transcripts of audiotaped analog sessions measured by CCCI-R).

Additional Correlates of Cultural Competence

Based on a qualitative analysis, Constantine, Melincoff, Barakett, Torino, and Warren (2004) explored the experiences and perceptions of 12 multicultural counseling scholars with regard to the field of multicultural counseling. Participants described multicultural counseling competence (hereafter called cultural competence) to include being open minded and flexible, being committed to or passionate about one's vision of multicultural counseling competence, and being an active listener. Participants typically believed that possessing cultural competence included having knowledge and awareness of the impact of demographic and cultural variables in people's lives and general knowledge and awareness about cultural issues and historical variables. Participants also described cultural competence as having skills including "the ability to make culturally sensitive therapeutic interventions..., the ability to integrate counselor and client cultural identities into the therapy process and relationship..., and the ability to integrate diagnostic and cultural factors into multicultural case conceptualizations" (p. 381, Constantine et al., 2004). Other descriptions of cultural competence included having a commitment to social justice; being aware of biases, stereotypes, judgments and limitations; and being aware of one's cultural identities.

Self-reported cultural competence has been examined in relation to demographic, educational, and training variables (Ottavi, Pope-Davis, & Dings, 1994; Pope-Davis, Reynolds, Dings & Nielson, 1995; Pope-Davis, Reynolds, Dings & Ottavi, 1994; Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998). Examining predictors of observer ratings in cultural competence, Constantine (2001) looked at the roles of counselor and client race or ethnicity, counselor-client racial or ethnic match, previous academic training in multicultural counseling, and self-reported cultural competence. Results include counselor race or ethnicity contributing significant variance to observed cultural competence. In this study, observed cultural competence was measured using CCCI-R ratings of trainees completing an intake session with clients in a community counseling training clinic. After accounting for counselor and client race or ethnicity, racial or ethnic matching did not contribute significant variance to CCCI-R ratings. After accounting for these two variables, results revealed that the number of formal multicultural counseling courses taken contributed significant positive variance to CCCI-R ratings. Finally, after accounting for all three of these variables, results supported no relationship between self-reported cultural competence (MCI full-scale score) and observer ratings of cultural competence (CCCI-R ratings). Constantine (2001) suggests that self-reported and observed cultural competence may be “two theoretically divergent constructs” (p. 460).

Addressing training variables, Sodowsky, Kuo-Jackson, Richardson, and Corey (1998) hypothesized, “after the significant contributions of multicultural social desirability and race were taken into account, counselor attitudes of feelings of social inadequacy and locus of control racial ideology overall and individually made significant contributions to self-reported MCCs [multicultural counseling competencies]; and

multicultural training variables overall, and number of ethnic minority and international clients, number of multicultural research projects, and number of multicultural courses individually made significant contributions to self-reported MCCs” (261). The current study did not assess social desirability because independently-observed data (CDORS) is being collected along with self-reported cultural competence (MCI), as advised by Gargi Roysircar (personal communication, July 24, 2007).

Prior multicultural training was significantly correlated with higher levels of self-reported cultural competence (Pope-Davis, Reynolds, Dings & Nielson, 1995; Pope-Davis, Reynolds, Dings & Ottavi, 1994). D’Andrea, Daniels, & Heck (1991) and Neville et al. (1996) have found that coursework in multicultural counseling contributed to changes in counselor’s self-reported competence in working with culturally diverse clients. Constantine (2001) investigated the roles of prior multicultural counseling training, counselor theoretical orientation, and cognitive and affective empathy in predicting aspects of multicultural case conceptualization ability in professional counselors. First, supporting prior findings (D’Andrea et al., 1991; Neville et al., 1996), Constantine (2001) found that prior academic training may promote multicultural case conceptualization, which may be parallel to or contribute to cultural competence. Second, Constantine (2001) found that counselors with an eclectic/integrative (e.g., indicated more than one primary theoretical approach to counseling) theoretical orientation were rated with higher *etiology* multicultural case conceptualization skills than were counselors with a psychodynamic or cognitive-behavioral orientation. Additionally, counselors with an eclectic/integrative theoretical orientation were rated with higher *treatment* multicultural case conceptualization skills than were counselors with a

psychodynamic theoretical orientation. Third, “affective empathy attitudes contributed significant positive variance to both etiology and treatment ratings of multicultural case conceptualization ability, while cognitive empathy attitudes contributed unique positive variance only to the treatment ratings” (p. 368).

Constantine (2001) makes the argument described below that counselor’s multicultural case conceptualization ability is a viable operationalization of their actual multicultural counseling competence. Ladany et al. (1997) explain that one aspect of cultural competence may be the ability to conceptualize clients’ concerns by differentiating and integrating multicultural knowledge pertaining to clients’ problems. In 2000, Constantine and Ladany delineated that multicultural case conceptualization requires counselors to be aware of and “integrate the impact of various cultural factors on clients’ presenting issues, and [be] able to articulate an appropriate treatment plan for working with clients based on this knowledge” (p. 358).

Client conceptualizations become more complex as counselors make associations between and among hypothesized etiologies of presenting issues and, subsequently, integrate these data into their treatment plans. Hence, counselors’ multicultural case conceptualization ability (i.e., the inclusion of cultural data within conceptualizations of clients’ presenting concerns) may represent an appropriate manifestation of their actual multicultural counseling competence. (p. 358)

Pope-Davis et al.’s (2002) important study examined the role of client variables as they influence clients’ perceptions of multicultural counseling. Among the findings,

Clients who defined themselves and their presenting problem using cultural constructs seemed to prefer racially or gender-similar counselors. Clients who did not believe that culture influenced their interpersonal relationships tended to place less importance on cultural competence of the counselor. (p. 384)

Pope-Davis et al. (2002) suggest that their findings propose complexities that may not have been addressed in previous research on racial identity and preference for racially

similar counselors. Similarly, the results provide information that is useful in interpreting research that explored clients' perceptions of expertness, trustworthiness, and attractiveness, levels of mistrust, perceptions of credibility and competence, and the impact of counselors' behaviors on clients' perceptions of helpfulness. Although useful, much of the previous research on client characteristics is somewhat limited without a context.

Limitations of the Research on Cultural Competence

Limitations on the findings from Constantine et al.'s (2004) qualitative study reviewed earlier include data lacking testimonial validity, and generalizability of the findings to other multicultural counseling scholars possibly being limited. It has been recommended that other researchers replicate and extend their study (Constantine et al., 2004). Other limitations included an analog study design which does not translate directly to clinical practice (Constantine, 2001). Also, multicultural case conceptualization ability was based on one vignette at one point in time. Responding to multiple case conceptualization exercises across time might have resulted in different findings. Similarly, when evaluating the relationship between racial identity attitude stages and self-reported cultural competence, Ottavi et al.'s (1994) study limitations include the assessment of racial identity at only one time point and using only self-report measures. Recommendations for future studies include assessing racial identity pre- and post-cultural competence training.

Sodowsky, Kuo-Jackson, Richardson, and Corey (1998) made recommendations for future research that are pivotal in this study. The authors believe that the interpersonal processes of frustration and connection in cross-racial and ethnic counselor dyads are

missing from the literature. The formation of a multicultural counseling relationship that fosters ethnotherapeutic empathy, which is “integrating cultural knowledge with a dynamic experience of the client's subjective culture,” needs to be examined (p. 262). Sadowsky et al. (1998) call for an evaluation of clinician’s (e.g., trainee’s) relational process with minority clients. “A study on multicultural training that monitors trainees' ongoing multicultural relationship process in treatment and its link to outcome (e.g., Sadowsky et al., 1998) could provide information on important process-outcome issues in MCCs [multicultural counseling competencies]. This would advance the construct of MCCs, which, to date, has been studied only through retrospective reporting, surveys, and investigations into discrete correlates (e.g., the number of minority clients or demographics), which limitations also characterize this study” (p. 262). The current study proposes to evaluate cultural competence and therapeutic alliance. As Sadowsky et al. (1998) suggest, this study will help to clarify the construct of cultural competence by providing process information on the role it has in predicting therapeutic alliance.

Both Ottavi et al. (1994) and Pope-Davis et al. (1995) recommend that future studies examine cultural competency using observational methods and self-report, and evaluate the relationship between these two approaches. Constantine (2001) suggested that future studies use behaviorally-based methods of assessing cultural competence rather than relying on self-report measures alone. Constantine explained that self-reported multicultural instruments may be measuring self-efficacy as opposed to actual abilities to counsel diverse clients (Constantine, 2001; Constantine & Ladany, 2000). There is a call in the literature for “the use of more valid procedures for evaluating demonstrated multicultural competence...to more precisely determine trainees’ and counselors’ ability

to work effectively with culturally diverse clients” (Constantine, 2001, p. 461). Constantine, Gloria and Ladany (2002) wrote, “It is important that these [self-report] measures are not used as tools in assessing clinicians’ demonstrated competence in working with culturally diverse clients. Relying solely on self-report multicultural instruments for data about clinicians’ competence in this vein may fail to yield accurate information about their true ability” (p. 342). They argue that future studies need to test the function of cultural competencies in real-life situations, which this study addresses by evaluating cultural competence as a predictor of therapeutic alliance. Consequently, this study includes measures of therapists’ self-reported cultural competence and independent observers’ ratings of therapists’ culturally competent behaviors that occur in family therapy sessions. Also, this study will examine if independent observations of therapist cultural competency predict the formation of alliances with family members.

Therapeutic Alliance

“In the past two decades, psychotherapy researchers and practitioners have postulated that the therapeutic alliance—defined broadly as the collaborative and affective bond between therapist and patient—is an essential element of the therapeutic process” (Martin, Garske, & Davis, 2000, p. 438) and a consistent predictor of outcome (Bordin, 1979; Gaston, 1990; Horvath & Luborsky, 1993; Lambert & Hill, 1994). Martin et al. (2000) proposed two reasons for the increased interest in alliance in the past 20 years: the recurrent finding that the quality of alliance is related to subsequent therapeutic outcome and the inability of researchers to find a consistent difference in the effectiveness of psychotherapy across orientations. This has led to researchers making the argument that the quality of the alliance is more important than the type of treatment in

predicting positive therapeutic outcomes (Horvath & Symonds, 1991). Research on individual psychotherapy indicates that alliance has a direct therapeutic effect in long-term and short-term therapies from many therapeutic orientations (Eaton, Abeles, & Gutfreund, 1988; Henry & Strupp, 1994; Krupnik et al., 1996; Muran & Gorman, 1995). Two meta-analyses of the alliance literature have been conducted (Horvath & Symonds, 1991; Martin et al., 2000). Most theoretical definitions of the alliance have three themes in common: (a) the collaborative nature of the relationship, (b) the affective bond between patient and therapist, and (c) the patient's and therapist's ability to agree on treatment goals and tasks (Martin et al., 2000). Using various techniques, Martin et al.'s review of the alliance literature indicated that alliance is moderately related to outcome ($r = .22$), which is within the range of many other effect sizes that are associated with psychotherapy outcome (Matt & Navarro, 1997). What is evident from this review is that the strength of the alliance is predictive of outcome, although researchers are still investigating the processes underlying the relation. Safran and Muran (1996) have dedicated years of research to creating and testing models of the patterns of patient-therapist transactional sequences associated with improvements in the therapeutic alliance (Safran, Crocker, McMain, & Murray, 1990; Safran, Muran, & Samstag, 1994). They are working toward informing clinicians of empirically tested nuances of the clinical process. Examining these processes, this study evaluates whether culturally competent interactions predict therapeutic alliance in family therapy.

Fuertes et al.'s (2006) study examines the relationship between cultural competence and therapeutic alliance with ratings completed by both the therapist and the client in therapeutic dyads. Fuertes and colleagues found a statistically significant

positive relationship between client and therapist ratings of therapist multicultural competence and of client and therapist ratings of working alliance. Fuertes and colleagues anticipated a positive relationship between these constructs since a previous study (Li & Kim, 2004) found a significant relationship between measures of therapist cultural competence and working alliance with a sample of Asian American college students who volunteered for career-focused counseling. Fuertes and colleagues admit to limitations in generalizability because therapists were externs and interns with relatively limited clinical experience and clients were college students. The current study addresses Fuertes et al.'s suggestions to extend the findings of this study by including participants from different regions of the United States, therapists with varying levels of experience, and more diverse clients (not college students).

Common Factors in Therapy

Frank and Frank (1998) state that “the aim of psychotherapy is ultimately to improve patients’ morale, self-esteem, optimism, and the like, through a trusting relationship with a culturally salient figure. Psychotherapy helps patients reinterpret their distressing experiences in a more positive light. In addition to a relationship, each psychotherapy embodies a rationale that both the therapist and patient believe may be helpful. It is, in other words, a form of healing ritual” (p. 590), which they initially outlined in Frank and Frank (1991). Fischer, Jerome, and Atkinson’s (1998) major contribution encourages counseling psychologists to consider the use of a common factors framework to bridge the gap between etic and emic approaches to multicultural counseling. Etic approaches to counseling are assumed to be culturally generalizable or universal, whereas emic approaches are designed to be culturally specific. In their article,

Fischer et al. (1998) provide an overview and synthesis of major common (e.g., nonspecific) factors approaches: (a) the therapeutic relationship, (b) a shared worldview between the client and counselor, (c) client expectations for positive change, and (d) interventions believed by both client and counselor to be a means of healing.

First, the therapeutic relationship factor “represents the positive, trusting, and healing relationship between client and counselor. The therapist’s personal qualities appear to be an integral part of the development of the relationship” (p. 534). Second, “a shared worldview provides a common framework from which both client and counselor think about their work together. The more the counseling participants share an understanding of each other’s worlds, the easier it may be to form a therapeutic relationship” (p.534). Third, “Client expectations can be conceptualized as hope or faith in the counseling process,” that is hope for a positive benefit from therapy (p. 537). Fourth, “It is important to note how the three previous common factors set the stage for the counseling interventions or treatment to be accepted by the client as capable of reducing distress. Once a therapeutic relationship has developed in which client and counselor share aspects of a worldview, and the client’s expectations for symptom relief has been increased, then the counselor can join with the client in conducting interventions to heal the client’s pain” (p. 538).

The authors propose that a common factors perspective provides a framework with which to organize and understand the diverse body of multicultural literature and research. This perspective offers a “process by which they [counselors] can integrate an understanding of universal aspects of healing (the skeleton of common factors) with the unique cultural experiences and affiliations of their clients (the flesh of cultural

knowledge)” (p. 543). Implications of the common factors perspective for practice include providing a “guiding schema for counselors in that they can continually ask themselves throughout the therapy process, ‘How can I continue building relationships with my clients, understanding my clients’ worldviews and perceptions of distress, raising my clients’ expectations, and implementing culturally relevant interventions?’” (p. 569). In regards to implications for research, Fischer et al. (1998) found that “most of the research to date bearing on the multicultural therapeutic relationship has used preference for counselor ethnicity or perceived counselor credibility as dependent variables. Other measures of the therapeutic relationship need to be used in multicultural research to move beyond mere preferences and credibility ratings. For example it would be important to determine if some factors suggested above have an effect on measures of the working alliance” (p. 573).

Therapeutic Alliance in Family Therapy

Within the family therapy arena, Pinsof and Catherall (1986) initiated the line of research evaluating therapeutic alliance not only at the individual level with each family member, but also at the systemic level with the family as a unit. Realizing balanced relationships within the family has been shown to predict positive outcomes in family therapy. For example, Robbins and colleagues have shown that in-session alliances predict retention/dropout from family therapy with drug using adolescents (Robbins, Turner, Alexander, & Perez, 2003; Robbins et al., 2006, 2008). In particular, Robbins et al. (2003) found that dropout cases had statistically significant higher unbalanced alliances (parent minus adolescent) than did completer cases. Furthermore, results from a later study (Robbins et al., 2006) indicated that adolescents and mothers in the dropout

group demonstrated statistically significant lower alliance scores in Session 2 than adolescents and parents in the completer group. Lastly, the most recent study results (Robbins et al., 2008) demonstrated that completer cases had statistically significant higher levels of alliance across all family members than dropout cases, and dropout cases had statistically significant higher unbalanced alliances than completer cases. With respect to longer term outcomes, Hogue, Dauber, Stambaugh, Cecero, and Liddle (2006) demonstrated that alliances predicted reductions in adolescent drug use. In their latest contribution, Robbins and colleagues (2008) call for more process research evaluating what contributes to the formation of therapeutic alliances in family therapy. This study will examine how therapists' cultural competence affects levels of therapeutic alliance with both parent and adolescent, and whether unbalanced therapeutic alliances with parents and adolescents may be a function of cultural competence. This expands on Fuertes et al.'s (2006) research on therapist-client dyads by examining the therapists' working alliance with family members in treatment and how therapist observed cultural competence affect these alliances.

Fuertes et al. (2006) suggest that the multicultural therapy literature holds an unstated assumption that therapist multicultural competence is most relevant to European American therapists who work with minority or immigrant populations. I see merit in Fuertes et al.'s argument that cultural competence seems to be important in all therapy services and interactions regardless of matching or non-matching cultural backgrounds. Since we are products of socialization of all kinds (for example, racial, cultural, class, gender), "we all prescribe [sic] consciously or unconsciously to worldviews and ideologies that shape every day perceptions of self, others, the world, and what is

consider [sic] ‘normal’ or appropriate behavior” (Fuentes et al., 2006, p. 483).

Furthermore, I anticipate that cross-cultural issues will be relevant even in therapeutic interactions in which clinician and client are of the same race and ethnicity because class, education, gender, religious and age differences come into play. In the unlikely case that all these additional factors were matched, the cultures of family of origin would likely vary. It follows that respectful unknowing is necessary in all therapeutic interactions.

Friedlander et al. (2006) suggest that multicultural issues affect the therapeutic interactions between the therapist and the family. To highlight the influences of culture on therapeutic alliance, I will provide specific ways that race, ethnicity, acculturation, social class and religion affect therapeutic alliance. Race and ethnicity shape how family therapists build therapeutic alliances with family members in therapy. Szapocznik and colleagues’ long standing research program (Szapocznik & Kurtines, 1989; Szapocznik & Williams, 2000) has addressed engagement with Latino and recently with African American families with adolescents committing delinquencies. Traditionally, these families are difficult to engage in therapy. Successful retention of these families is attributed to the manifestation of Latino and African American community values in the interventions. Distinct levels of acculturation within a family also affect the process of building therapeutic alliance (Muir, Schwartz, & Szapocznik, 2004; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). For instance, it may be easier for therapists acculturated to the U.S. and trained in the U.S. to connect with children, who tend to be more acculturated to the U.S. than their parents.

Social class is confounded with race and ethnicity, and it also affects the creation and maintenance of therapeutic alliance. Lack of awareness of one’s position of power as

an educated therapist will most likely contribute to difficulties connecting and working with low income families. Additionally, knowing how religious beliefs and spirituality shape client families' lives and understanding of problems and solutions will enhance the therapeutic relationship. Hall (2001) suggests that spirituality may be very important especially to minority families, and problems may arise from incongruent views of spirituality and religion between therapist and family members. Family members may incorporate spirituality in their daily lives, and incorporating spirituality in therapy may be necessary to build therapeutic alliance and for treatment to be effective.

Cultural competence encompasses understanding how cultural identities impact clinical work, in particular the work of building and maintaining therapeutic alliances with family members. It follows that empirical research is needed to further examine the relationship between culturally competent behavior and building therapeutic alliances in family therapy. Also, attention to the cultural context is consistent with systemic views of the family in that attention must be given to the context in which interactions occur (Robbins, Mayorga, & Szapocznik, 2003).

Robbins et al. (2003) report that while most research on alliance has examined process and outcome relationships in individual psychotherapy, minimal research has explored this process with youth in family therapy (Digiuseppe, Linscott, & Jilton, 1996; Florsheim, Shotorbani, Guest-Warnick, Barratt, & Hwang, 2000). Even less research has examined the alliance with parents in family therapy (Kroll & Green, 1997; Robbins et al., 2003, 2006, 2008). It cannot be assumed that findings on the role of alliance in the context of individual therapy can be translated to the context of family therapy. To address this need in the literature, this study focuses on alliance between adolescent and

therapist and between parent and therapist, and their relationship to therapist cultural competence.

This study merges two prominent bodies of literature, cultural competence and therapeutic alliance, with the underscored underlying assumption delineated by Pope-Davis and colleagues:

Today, many would argue that a competent counselor must be culturally competent to function effectively. The need to develop proficient and effective counselors has resulted in a focus on the development of a counselor's cultural competence (Ottavi, Pope-Davis, & Dings, 1994; Ponterotto et al., 1995; Pope-Davis et al., 1995; D.W. Sue, Ivey, & Pedersen, 1996). *The underlying assumption has been that if a counselor is culturally competent, the counselor will be able to provide the most effective service through the establishment of rapport [italics added], appropriate interventions, and culturally appropriate treatment.* (p. 356)

This study will contribute to the extant clinical research literature on cultural competence by 1) providing information about the relationship between therapist's self-reports and their observed behaviors regarding cultural competence, 2) examining how therapists' cultural competence facilitates the formation of working alliances with family members in the treatment context, and 3) examining the role of cultural competence in predicting discrepancy in therapeutic alliance with parent and with adolescent.

This study will be conducted using videotaped family therapy sessions collected during a national clinical trial investigating Brief Strategic Family Therapy (BSFT), henceforth called the Parent Study. The availability of these videotapes provides a unique opportunity for the observational assessment of cultural competence and therapeutic alliance in family therapy. One of the limitations is that there are only 23 therapists available. Given this potential sample size, this investigation will be considered a pilot study. The timeliness and importance of investigating the effects of cultural competence

on alliance makes this pilot data extremely helpful in evaluating preliminary hypothesis and forming new ones.

Hypotheses

On the basis of the literature documenting that self-reported cultural competence does not correlate with observed cultural competence, and for the purpose of confirming this non-relationship in this sample before subsequent analyses, this study replicated the following hypothesis:

Hypothesis A: Therapists' self-reported cultural competence scores will not be statistically significantly correlated with independently observed ratings of therapists' cultural competence.

On the basis of the findings of Fuertes et al. (2006) that observed cultural competence has a statistically significant positive relationship to alliance, this study examined the following hypothesis:

Hypothesis B: Cultural competency (observer ratings) will predict therapeutic alliance with parent and with adolescent.

On the basis of the clinical and research literature documenting the importance of therapeutic alliances in psychotherapy research and the clinical finding that unbalanced alliances predict dropout from treatment (Robbins et al. 2003, 2006, 2008), this study examined the following hypothesis:

Hypothesis C: Cultural competency (observer ratings) will predict discrepancy between ratings of therapeutic alliance with parent and with adolescent.

It is of note that this study's HLM analyses to evaluate cultural competence as a predictor of therapeutic alliance originally included both self-reported cultural competence (MCI scores) and observed cultural competence (CDORS scores) as predictors. Unfortunately, only six therapists completed the self-report measure (MCI), and, as a result, the HLM analyses could not include the MCI scores as a predictor. The primary purpose of Hypothesis A was to ascertain that these predictors were not correlated.

Chapter 2

Method

Participants

Participants in this study were therapists and family members that participated in a multi-site clinical trial study currently approved by UM IRB, hereafter referred to as the Parent Study. All therapists signed consent forms that included an option stating their willingness to be approached about participating in future research studies. Only those therapists who agreed to be approached for future research studies on this consent form were contacted in the current study.

Family members in the Parent Study also signed informed consent or assent forms that included an option to agree or disagree with using videotapes of family therapy sessions for future research studies. Only videotapes of those families in which all participants agreed to have their tapes used for future research studies were included in the current study.

The participant pool included 23 family therapists who signed consent to participate in the Parent Study. Therapists in the Parent Study are 14 female and 9 male drug abuse counselors from 8 community treatment programs (CTP) from across the country including Puerto Rico. The therapist sample includes 5 Black (African American or Caribbean), 5 White-Hispanic, and 13 White non-Hispanic therapists. Of 23 family therapists, 14 therapists both consented to be approached for future studies and treated at least five families who consented to the use of their videotaped family therapy sessions. Of these 14 family therapists, 6 therapists also agreed to complete the self-reported measure. After reviewing Parent Study records and consulting with directors of the

community treatment programs (CTPs) that participated in the Parent Study, I obtained contact information for 20 therapists, some of whom were no longer employees of the CTPs. There was no contact information for three therapists who left the CTP that participated in the Parent Study. Four of the therapists for whom we had contact information did not consent to the use of their videotaped family therapy sessions in future studies, leaving us with a total of 16 therapists. Two of these 16 therapists did not treat at least 5 families who consented to the use of their videotaped family therapy sessions for future studies. A total of 14 therapists were included in the rating portion of the study; these 14 therapists were contacted and introduced to this study, as procedures indicate. As a result, response rate for the MCI ($n = 6$) was 43%. Therapists in the current study are 7 female and 7 male therapists ranging in age from 29 to 58 years-old ($M = 43.57$, $SD = 8.92$). This therapist sample includes 7 White non-Hispanic, 3 African-American, 3 White-Hispanic, and 1 Black Islander (West Indian) therapists.

Four-hundred-eighty families were randomized into one of two treatment conditions of the Parent Study from 551 screens. The current study is evaluating the Brief Strategic Family Therapy (BSFTTM; Szapocznik, Hervis, & Schwartz, 2003) condition only—the condition with videotaped family therapy sessions. The Parent Study randomized 107 African American family participants and 193 Hispanic family participants. Referrals from the juvenile justice system make up 72% of randomized participants and 75% have a history of prior arrests. In the Parent Study, adolescent participants were included if they were ages 12 to 17 inclusive and had used illicit drugs, other than alcohol or tobacco, in the 30-day period preceding the baseline assessment. Adolescents referred from an institution (e.g., detention, residential treatment, court, etc.)

were included even if they did not report drug use in the 30-day period preceding the baseline assessment). Adolescents in the study currently lived with or were expected to live with formal or informal “family.” Family was defined as any individual(s) who serve in the legal or traditional role of family members. However, placements in foster care settings were excluded from the study. After randomization, adolescents resided in the same geographical area of a community treatment program (CTP), within an “area” designated by each CTP. Each CTP was allowed to set its own radius of operation because BSFT involved regular home therapy sessions. Adolescents were excluded if they were expected to be released to a halfway house, institution, independent or assisted living facility, foster care, or to a location outside of the designated geographical area. This was done to maximize the likelihood that adolescents would remain available for treatment, and that charges that occurred prior to entry into the study would not affect availability for follow-up assessments. Videotapes of the families who approved and consented to the use of their videotaped family therapy sessions for future studies only were seen.

Measures

Multicultural Counseling Inventory

The Multicultural Counseling Inventory (MCI), a self-report instrument developed by Sadowsky et al. (1994), consists of 40 items measuring multicultural competence and can be completed in 15-25 minutes. Indicating the degree to which the scale items describe their own work, counselors, psychologists or trainees use a 4-point scale format ranging from “very inaccurate” (1) to “very accurate” (4). The MCI has 4 subscales: Multicultural Counseling Skills (11 items), Multicultural Awareness (10

items), Multicultural Counseling Knowledge (11 items) and Multicultural Counseling Relationship (8 items). The Skills, Awareness, and Knowledge subscales measure content similar to that described for the CCCI-R and MCAS:B. The fourth subscale, Multicultural Counseling Relationship, is a unique feature of the MCI and the reason for its use in this study evaluating therapeutic alliance. This unique subscale refers to the counselor's stereotypes of, and comfort level with, minority clients. Sample items are prefaced with "When working with minority clients..." and include: "I form effective working relationships with the clients" (skills item), "I have experience at solving problems in unfamiliar settings" (awareness item), "I use innovative concepts and treatment methods" (knowledge item), and "I perceive that my race causes the clients to mistrust me" (relationship item). As reported by instrument developers, psychometric properties include a Cronbach's alpha of .87 for the full MCI scale (Roysircar Sodowsky, Kuo-Jackson, Richardson, & Corey, 1998), and subscale alphas ranging from .68 for Multicultural Counseling Relationship (8 items) to .80 for Multicultural Counseling Skills (11 items; Roysircar Sodowsky et al., 1998). The factor matrix indicated moderate correlations among the factors, with correlations ranging from .16 to .31 (Sodowsky et al., 1994). Criterion and construct validity have been demonstrated, and it is the only instrument with a relationship subscale. However, concurrent and convergent validity studies are needed to assess the relationship of MCI to theoretically similar and dissimilar constructs.

The items on Sodowsky's *Multicultural Counseling Inventory (MCI)*, (1994) include "When working with minority clients...I perceive that my race causes the clients to mistrust me, ...I am confident that my conceptualization of client problems does not

consist of stereotypes and value-oriented biases, and ...I examine my own cultural biases.” Therapists will rate all 40 items using a four-point Likert scale from 1 = “very inaccurate” to 4 = “very accurate.” Scores of 4 indicate high multicultural competence and scores of 1 indicate poor multicultural competence with some reverse item scores.

Ratings of Therapy Sessions

Cultural Diversity Observer Rating Scale

The *Cultural Diversity Observer Rating Scale (CDORS)*; Roysircar et al., 2005) is a 29 item observer rating scale designed to measure therapists’ culturally responsive behaviors with clients. Roysircar et al. (2007) reported a stable three factor structure resulting from the exploratory factor analyses including *Counselor Helping Behaviors* (15 items), *Counselor Awareness of Client Contexts* (7 items), and *Counselor’s Perceived Barriers and Frustrations* (7 items). Coefficients of factor congruence for structures of middle session (sessions 4 and 5) and late session (sessions 9 and 10) were .85, .82, and .78 for factors 1, 2, and 3, respectively (Roysircar, Spanakis, Pimpinella, & Vincent, 2006). Concisely, *Counselor Helping Behaviors* addresses counselor actions that aim to support clients, share with them, listen to their stories, and include their contexts and status in conceptualization and interventions. *Counselor Awareness of Client Contexts* addresses the counselor’s self-examination in an effort to understand one’s own biases and socialization in addition to an examination of the client’s cultural upbringing and worldview. *Counselor’s Perceived Barriers and Frustrations* addresses the counselor’s self-doubts, disconnection from the client, and overemphasis on the differences between counselor and client, and overall emotional negativity (Roysircar et al., 2007).

Two steps are followed for two subscales, 1) Counselor Awareness of Client Contexts and 2) Counselor Barriers and Frustrations. First, the rater records the frequency of a counselor's behavior and the number of client responses elicited by that particular behavior. Twelve categories of behaviors (referred to as themes) are listed for the rater to look for and tally. To identify themes, the raters use a codebook of cultural awareness and intervention themes that Roysircar and her colleagues developed that accompanies the instrument (Roysircar et al., 2007). Second, after tallying for the counselor and the client, the rater uses the appropriate scale rating of 0 to 5 for each counselor behavior. Step one and two use a Likert scale from 0 = behavior not present to 5 = four or more counselor behaviors with one or more client responses. The third subscale is scored using a Likert scale from 0 = Not Present to 5 = Very Strong to rate counselors on 17 items measuring Counselor Helping Behaviors (Roysircar et al., 2005).

As expected by the authors, Roysircar et al. (2007) found that *Counselor Helping Behaviors* and *Counselor Awareness of Client Contexts* were moderately correlated with trainee self-reported Perspective Taking and Empathic Concern (subscales from the Interpersonal Reactivity Index, IRI, Davis, 1980), State Hope Scale (Snyder et al., 1996), and Adapted Racial Ideology Scale (adapted from the Multidimensional Internal-External Control Scale, Gurin, Gurin, Lao, & Beattie, 1969), with Pearson r correlations ranging from .45 to .71. These correlations demonstrated convergent validity. Providing evidence of discriminant validity, *Counselor's Perceived Barriers and Frustrations* had low, statistically nonsignificant correlations with Perspective Taking and Empathic Concern subscales of the IRI, State Hope Scale, Adapted Racial Ideology Scale, and CDORS factors 1 and 2. Furthermore, the correlation between *Counselor Helping Behaviors* and

Counselor Awareness of Client Contexts was moderate, $r = .32$, $p < .05$, suggesting relative factor independence.

Therefore, Roysircar et al. (2006) report that the CDORS appears to be psychometrically sound with acceptable convergent and discriminant validity. Roysircar et al. (2007) also reported that the CDORS showed high interrater reliability (Cohen's Kappa of .95) and moderately high internal consistency (Factor 1 $\alpha = .81$; Factor 2 $\alpha = .75$ and Factor 3 $\alpha = .72$). In Roysircar et al.'s (2006) study, each case of 10 process notes was coded by two raters. The process notes were part of Roysircar's Multicultural Interactions Project, an experiential component of a doctoral level course. Trainees are asked to participate in ten meetings with an individual in the local community who is culturally different from them. Weekly process notes focusing on dyadic interactions and trainee intrapersonal reactions during these meetings were submitted. After a pair of coders rated each case, the pair met to discuss their identification of themes and Likert ratings of the identified themes, and "often through debate reached consensus" on previously dissimilar identification of themes and ratings (p. 4). Eighteen coders rated 110 cases; each coder rated an average of 6 cases (60 process notes). The average interrater reliability across the 18 raters (9 pairs) was Cohen's Kappa .95.

Vanderbilt Therapeutic Alliance Scale-Revised

The *Vanderbilt Therapeutic Alliance Scale-Revised* (VTAS-R; Diamond, Liddle, Hogue, & Dakof, 1999) measures aspects of the working relationship between individual family members and the therapist in the context of family sessions. Ratings are based on observations of family members' behaviors and therapist family member interactions as they occur in the sessions. Twenty-six items are rated on a Likert-type scale ranging from

0 (not at all) to 5 (a great deal). VTAS-R consists of three factors: positive working relationship, negative relationship, and superficial/ boring session interactions (Robbins et al., 2003). The current study used items from the positive working relationship factor also used in Robbins et al. (2003, 2006). This six-item factor is a good indicator of the revised scale since it explains 37% of the variance, and its use is consistent with this study's focus on examining positive working alliances. Since Robbins et al. (2003), researchers on therapeutic alliance and treatment outcome in family therapy for adolescents with behavior problems have used the VTAS-R (Hogue et al, 2006; Robbins et al., 2006; 2007; Shelef, Diamond, Diamond, & Liddle, 2005). This study also used the VTAS-R to continue this line of research on therapeutic alliance in family therapy with drug-using adolescents while extending the scholarship with gained understanding in cultural competence. In continuing this line of research using the VTAS-R, it is noteworthy that the VTAS-R measures alliance-related behavior in family therapy at the individual and not at the system level. This measure meets the needs of the current study because it provides data on balanced or split alliances by rating the strength of the alliance between individual family members and the therapist. The analyses used in this study focus on the therapist as the organizing unit (Level-two unit, see Design and Analyses), so the VTAS-R meets the needs of this study.

Selection and Training of Raters

Raters were three undergraduate level raters and one master's level rater. Raters included three women and one man, ranging in age from 21-30 years. Two undergraduate raters were selected from a pool of students who responded to an announcement for a research assistant position. The other two raters were already employed by the Center for

Family Studies. The ratings of one undergraduate level rater were not used in this study because the rater failed to establish interrater reliability with other raters, including me. Throughout the data collection period, many attempts were made to increase the dropped rater's study protocol adherence.

Raters were required to become versed with the definitions and decision rules provided in the *Vanderbilt Therapeutic Alliance Scale-Revised Rating Manual* and in the procedures described in CDORS research. During training, raters attended weekly meetings and completed rating assignments (e.g., rating sessions, constructing examples, etc.). Raters were required to achieve a minimum acceptable interrater agreement of .70 (compared to the gold standard) before conducting study ratings. For this type of data, an ICC of .60 is considered adequate, .70 is robust, and .80 is excellent (Robbins et al., 2006). Intraclass correlations (ICC) on five consecutive ratings were used to determine if raters meet this minimum criterion. Training to criterion took place using sessions from videotapes of therapy sessions that were part of a large sample of cases that were not selected to be included in this study.

Intraclass Correlations

Shrout and Fleiss (1979) discussed six forms of the intraclass correlation and provided guidelines for choosing an appropriate form. Choices depend on whether the ANOVA design should be one-way or two-way, whether raters are considered random or fixed effects, and whether the unit of analysis is a single rater or the mean of several raters. Applying Shrout and Fleiss' guidelines to this study's continuous rating scales, it is appropriate to use the ICC formula shown below.

$$ICC(3,1) = \frac{BMS - EMS}{BMS + (k - 1)EMS}$$

In this two-way mixed model for Shrout and Fleiss' Case 3, the same k judges rate all n targets, and the component representing the i^{th} judge's effect may be estimated.

Reliability is calculated from a single measurement. The two-way ANOVA yields a between-targets mean square (*BMS*) and a residual mean square (*EMS*). It is appropriate to use this ICC formula to evaluate the consistency of the judges' ratings, thus treating the judges as fixed effects (Shrout & Fleiss, 1979).

Once trained, raters were required to complete at least 1 videotape/session per week and attend a weekly training meeting. At least one session was rated by all raters per week. Initially, phone meetings involved raters reviewing the appropriate rating manual to ensure that the raters use the same decision rules when completing ratings. During training, the lead author met with raters individually whenever necessary to adjust for discrepancies and to retrain raters to meet the minimum acceptable criterion.

Coders of cultural competence received brief training in multicultural counseling theory. Raters were exposed to the process and content of cultural competence by reviewing the three domains of cultural competence and the APA Multicultural Guidelines (2003). Specifically, we also focused on S. Sue's (2006) article describing cultural competence as a multidimensional phenomenon and delineating operationalizations (10 strategies) of cultural competence. Raters were shown examples of each CDORS item from the videotaped BSFT sessions collected during the Parent Study. Only sessions not included in the study were shown. Raters were considered to have gained accurate understanding of rating procedures for the CDORS when they met ICC criterion described above.

Rating therapeutic alliance (VTAS-R) involved viewing the entire family therapy session in 20-minute segments, stopping the videotape, and completing ratings for adolescents and parent figures. Therapists that are active in session will show more alliance. Given that the VTAS-R is sensitive to frequency of therapists' behaviors and activity, the time unit needs to be consistent. For this reason, ratings are conducted in 20 minute segments. Raters were required to keep extensive notes of adolescent, parent, and therapist behaviors that occurred during the segment. If necessary, raters stopped the videotape during a segment to replay a portion of the tape that they could not understand or hear. If raters could not decipher what was said after the second viewing, they were instructed to continue watching the segment and to ignore the information they could not understand when they complete their ratings for the segment. Up to three ratings were generated for each segment, one for the target adolescent and two for the parent figures. Raters followed the same instructions for each subsequent segment. Raters were instructed to base ratings only on what occurred in the segment being rated. The entire family session was rated in approximately three segments (\approx 60 minute session).

The data collection team of three raters was divided into two groups; each group used only one measure, either the CDORS or VTAS-R. Using stratified sampling, each rater within the VTAS-R group rated up to three family sessions (e.g., one session per family client) per therapist. For example, VTAS-R Rater A rated videotaped sessions of Families 1, 2, and 3 whereas VTAS-R Rater B rated videotaped sessions of Families 4, 5, and 6, all working with Therapist N). At least 20 percent of all sessions were double rated to evaluate interrater reliability. Family clients of each therapist were randomly selected from those families who consented to the use of their videotaped family therapy sessions

in future research. Raters were instructed to rate the third session of family therapy treatment. If the third session of treatment was not available, session 2, then session 4, or then session 1 was rated. It is preferred to use the third session as a point for data collection because it was determined that by session 3, enough time had passed for therapists and clients to begin forming a therapeutic relationship. Also, the third session was early enough in treatment to provide ratings from families who might otherwise discontinue treatment. Fuertes et al. (2006) used session three as a point for data collection for their study which included evaluating cultural competence and therapeutic alliance. Unlike VTAS-R ratings, CDORS ratings were completed by a single rater who established interrater reliability with me as the lead investigator, given the absence of a gold standard for this measure.

Interrater reliability

The two VTAS-R raters double rated 12 sessions for the purpose of evaluating interrater reliability. Raters achieved a mean ICC (3,1) of .75 for the total scale. Raters demonstrated exact agreement on 25% of the comparisons and were discrepant by only 1 point in the Likert scale on 50% of the comparisons. Thus, raters were quite consistent in 75% of the comparisons. The CDORS rater and I rated 8 sessions for the purpose of evaluating interrater reliability. The CDORS rater and I achieved a mean ICC (3,1) of .93 for the total scale. There was exact agreement on 79% of the comparisons.

Therapist Demographic Form

Therapist participants of the Parent Study completed the *Therapist Demographic Form (TDF)* as part of the Parent Study protocol. This clinical research form was created for the Parent Study. The data collected from this form includes therapists' self-reported

sex, ethnicity, age, education, and years of clinical experience. No new demographic data was collected.

Design and Analyses

Hypothesis A

To test Hypothesis A, a simple correlation was conducted between MCI (self-reported cultural competence) scores and CDORS (independently-observed cultural competence) scores. For this analysis, CDORS scores were aggregated for each therapist because the ICC indicated very good consistency in CDORS scores.

Hypothesis B

To test Hypothesis B, two sets of multilevel univariate linear models were analyzed using HLM software (HLM 6; Raudenbush, Bryk, Cheong, & Congdon, 2004). HLM was the most appropriate analysis for this hypothesis because the data is nested: families are nested within therapists. That is, six videotapes of six different family participants were rated for each therapist.

The Parent Therapeutic Alliance Models (Proposed Models $B_{\text{par}1}$ and $B_{\text{par}2}$) have family client alliance scores as the level-one unit and therapists as the level-two unit. The dependent variable is Parent Therapeutic Alliance (VTAS-R Parent Score). Although therapeutic alliance scores were calculated for each parent/caregiver present during the family therapy session, calculating a single Parent score addresses several scenarios (e.g., one parent present, two biological parents present, mother and stepfather present, father and stepmother present, etc.). If there were two or more parents/caregivers, an average Parent score was calculated. In these models, the level-two predictor is independently-observed cultural competence (CDORS). The models are delineated below.

Model B_{par}1: One-Way ANOVA (Unconditional) Model with Random Effects

L1 Model: $Y_{ij} = \beta_{0j} + r_{ij}$

L2 Model: $\beta_{0j} = \gamma_{00} + u_{0j}$

β_{0j} = mean parent alliance of each therapist

γ_{00} = grand mean parent alliance across therapists

r_{ij} = unique effect of the i^{th} parent therapeutic alliance score on mean parental alliance for the j^{th} therapist

u_{0j} = unique effect of the j^{th} therapist on grand mean parent alliance

σ^2 = unconditional within-therapist variance in parent therapeutic alliance scores

τ_{00} = unconditional between-therapists level variance around grand mean parent alliance

The ICC is the proportion of the total variance in parent therapeutic alliance that is due to differences between therapists. In the unconditional model (above), the variance is decomposed into between-therapist variance and within-therapist variance. ICC ranges from 0 to 1 (or 0% to 100%), with higher values representing stronger clustering effects.

Model B_{par}2: Regression with Means as Outcomes Model (RwMO)

L1 Model: $Y_{ij} = \beta_{0j} + r_{ij}$

L2 Model: $\beta_{0j} = \gamma_{00} + \gamma_{01}(CDORS_j - \overline{CDORS.}) + u_{0j}$

β_{0j} : average parent therapeutic alliance for the j^{th} therapist.

γ_{00} : grand mean parent therapeutic alliance for therapists with an average independently observed cultural competence.

γ_{01} : the average change in mean parent therapeutic alliance given a one-unit increase in independently-observed cultural competence across therapists.

r_{ij} : unique effect of the i^{th} parent therapeutic alliance score on mean parental alliance for the j^{th} therapist.

u_{0j} : residual of mean parent therapeutic alliance for the j^{th} therapist, after controlling for independently observed cultural competence.

σ^2 : unconditional within therapist variance in parent therapeutic alliance.

τ_{00} : conditional between-therapist variance in mean parent therapeutic alliance after controlling for the effects of independently observed cultural competence.

Note that Models $B_{\text{adol}1}$ and $B_{\text{adol}2}$ are the same as Models $B_{\text{par}1}$ and $B_{\text{par}2}$ above with the exception that Adolescent Therapeutic Alliance will replace Parent Therapeutic Alliance as the Dependent Variable.

Hypothesis C

To test Hypothesis C, a third set of multilevel univariate linear model was analyzed using HLM software (HLM 6; Raudenbush, Bryk, Cheong, & Congdon, 2004). HLM was the most appropriate analysis for this hypothesis because the data is nested: families are nested within therapists. That is, six videotapes of six different family participants were rated for each therapist.

The Magnitude of Discrepancy between Parent and Adolescent Therapeutic Alliance Models (Proposed Models C1 and C2) have family client as the level-one unit and therapists as the level-two unit. The dependent variable is Magnitude (absolute value) of Discrepancy between Parent and Adolescent Therapeutic Alliance, $| \text{VTAS-R Parent}$

Score – VTAS-R Adolescent Score | . The level-two predictor is independently-observed cultural competence (CDORS). The models are delineated below.

Model C1: One-Way ANOVA (Unconditional) Model with Random Effects

$$\text{L1 Model: } Y_{ij} = \beta_{0j} + r_{ij}$$

$$\text{L2 Model: } \beta_{0j} = \gamma_{00} + u_{0j}$$

β_{0j} = mean discrepancy in therapeutic alliance of each therapist

γ_{00} = grand mean discrepancy in therapeutic alliance across therapists

r_{ij} = unique effect of the i^{th} discrepancy in therapeutic alliance score on mean discrepancy in therapeutic alliance for the j^{th} therapist

u_{0j} = unique effect of the j^{th} therapist on grand mean discrepancy in therapeutic alliance

σ^2 = unconditional within-therapist variance in discrepancy in therapeutic alliance

τ_{00} = unconditional between-therapist level variance around grand mean discrepancy in therapeutic alliance

The ICC is the proportion of the total variance around grand mean discrepancy in alliance that is due to differences between therapists. In the unconditional model (e.g., B_{par1}, B_{adol1} and C1) the variance is decomposed into between-therapist variance and within-therapist variance. ICC ranges from 0 to 1 (or 0% to 100%), with higher values representing stronger clustering effects.

Model C2: Regression with Means as Outcomes Model (RwMO)

$$\text{L1 Model: } Y_{ij} = \beta_{0j} + r_{ij}$$

$$\text{L2 Model: } \beta_{0j} = \gamma_{00} + \gamma_{01}(\overline{CDORS}_j - \overline{CDORS}) + u_{0j}$$

β_{0j} : average discrepancy in therapeutic alliance for the j^{th} therapist.

γ_{00} : grand mean discrepancy in therapeutic alliance for therapists with an average independently observed cultural competence.

γ_{01} : the average change in mean discrepancy in therapeutic alliance given a one-unit increase in independently-observed cultural competence.

r_{ij} : unique effect of the i^{th} discrepancy in therapeutic alliance score on mean discrepancy in therapeutic alliance for the j^{th} therapist.

u_{0j} : residual of mean discrepancy in alliance for the j^{th} therapist, after controlling for independently observed cultural competence.

σ^2 : unconditional within-therapist variance in discrepancy in therapeutic alliance

τ_{00} : conditional between-therapist variance in mean discrepancy in therapeutic alliance after controlling for the effects of independently observed cultural competence.

For all three sets of models, the conditional residual variance between therapists, τ_{00} , was compared to the unconditional variance estimated in the context of the original one-way ANOVA model with random effects. By comparing the τ_{00} estimates across the two models (e.g., C1 and C2), we developed an index of the proportion reduction in variance, or variance explained, at level-two.

$$\text{Proportion of variance explained in } \beta_{0j} = \frac{\hat{\tau}_{00}(\text{randomANOVA}) - \hat{\tau}_{00}(\text{RwMO})}{\hat{\tau}_{00}(\text{randomANOVA})}$$

Procedures

Therapists who agreed to be approached for participating in future research studies on the Parent Study consent form were contacted to determine if they are interested in participating in the current research study. Therapists were provided with a Therapist Consent Form that specifically describes the current study. I spoke to each

therapist to explain the purpose of the study and their rights as research participants.

After they asked any questions they had about the current study and verbalized that they understood their rights as a research participant, they were asked to sign the consent form and return it in a pre-stamped envelope to the research team in Miami.

The second research procedure is the completion of the multicultural competency self-report questionnaire. After I explained the purpose of the study and their rights as research participants, therapists completed the *Multicultural Counseling Inventory (MCI*, Sadowsky et al., 1994) if they chose to participate in the study. Therapists were also presented with three written questions about their experience with clients of different ethnicities/races as an addendum to the MCI. Therapists were asked to return the original questionnaire to the Miami research team via mail (using a pre-stamped envelope).

The third research procedure was to complete ratings of therapist multicultural competency and family alliance using videotapes selected from the archives of the Parent Study. This recoding of existing data was completed in the same location as the Parent Study. All ratings were done by research staff that must follow guidelines for good research practice.

Chapter 3

Results

The first hypothesis that therapists' self-reported cultural competence scores will not be statistically significantly correlated with independently observed ratings of therapists' cultural competence was tested with a Pearson correlation between MCI (self-reported cultural competence) scores and CDORS (independently-observed cultural competence) scores. Mean and standard deviation values for MCI and CDORS scores are provided in Table 3.1. Results show that in this sample there is no statistically significant relationship between self-reported and independently-observed cultural competence ($r = .33, p = .529$).

Table 3.1: Mean and SD for MCI and CDORS

	Mean	Standard Deviation	N
MCI	3.13	.39	6
CDORS	1.69	.89	6

Before proceeding to results of analyses testing Hypotheses B and C, below are Tables 3.2 and 3.3 which present descriptive statistics and a correlation matrix of therapeutic alliance and observed cultural competence variables, respectively.

Table 3.2: Mean and SD of Alliance Variables and CDORS

	Mean	Standard Deviation	N
Parent Alliance	3.44	.42	82
Adolescent Alliance	2.60	.80	80
Discrepancy in Alliances	.97	.60	79
Composite CDORS score	1.72	.09	83

Table 3.3: Correlation Matrix of Alliance Variables and CDORS

		Parent Alliance	Adolescent Alliance	Discrepancy in Alliances	Composite CDORS score
Parent Alliance	Pearson Correlation	1	.413**	.096	.010
	Sig. (2-tailed)		.000	.398	.932
	N	82	79	79	82
Adolescent Alliance	Pearson Correlation	.413**	1	-.782**	-.090
	Sig. (2-tailed)	.000		.000	.428
	N	79	80	79	80
Discrepancy in Alliances	Pearson Correlation	.096	-.782**	1	.167
	Sig. (2-tailed)	.398	.000		.142
	N	79	79	79	79
Composite CDORS score	Pearson Correlation	.010	-.090	.167	1
	Sig. (2-tailed)	.932	.428	.142	
	N	82	80	79	83

The second hypothesis that cultural competency (observer ratings) will predict therapeutic alliance with parent and with adolescent was tested with two sets of multilevel univariate linear models analyzed using HLM software. The Parent Therapeutic Alliance Models (Proposed Models $B_{\text{par}1}$ and $B_{\text{par}2}$) have family client alliance scores as the level-one unit and therapists as the level-two unit. The dependent variable is Parent Therapeutic Alliance (VTAS-R Parent Score). As noted previously, if there were two or more parents/caregivers, an average Parent Score was calculated. A composite score was then calculated by taking the average of all ratings (per 20 minute

segment) completed per session. In these models, the level-two predictor is independently-observed cultural competence (CDORS).

For Models $B_{\text{par}1}$ and $B_{\text{par}2}$, the Parent Therapeutic Alliance Models, independently-observed cultural competence does not predict mean parent therapeutic alliance, $\gamma_{01} = .04$, $t = .08$, $p = .937$, see Table 3.4.

Table 3.4: Results from the One-Way ANOVA Model $B_{\text{par}1}$

<i>Fixed Effect</i>	<i>Coefficient</i>	<i>Se</i>		
Average parent alliance, γ_{00}	3.44	.05		
<i>Random Effect</i>	<i>Variance Component</i>	<i>Df</i>	<i>X²</i>	<i>p Value</i>
Therapist mean, u_{oj}	.00003	13	10.03	> .500
Level-1 effect, r_{ij}	.17			

The residual variance between therapists, $\tau_{00} = .00003$, was estimated in the context of the random ANOVA model (Table 3.4). The ICC is the proportion of the total variance in parent therapeutic alliance that is due to differences between therapists. For Model $B_{\text{par}1}$, ICC was calculated using, $\rho = \tau_{00} / \tau_{00} + \sigma^2$. In this model, the ICC is equal to $.00003 / (.00003 + .17)$, or .0002. Subsequently, analysis of Model $B_{\text{par}2}$ required dropping the unique effect of therapist j on mean alliance, u_{oj} . The null hypothesis that $\tau_{00} = 0$, was not rejected: $\chi^2(13) = 10.03$, $p > .500$ (see Table 3.5).

Table 3.5: Results from Means-as-Outcomes Model $B_{\text{par}2}$

<i>Fixed Effect</i>	<i>Coefficient</i>	<i>Se</i>	<i>t Ratio</i>
Model for therapist means			
INTERCEPT, γ_{00}	3.44	.05	74.66
MEAN CDORS, γ_{01}	.04	.51	.08

For Models $B_{\text{adol}1}$ and $B_{\text{adol}2}$, the Adolescent Therapeutic Alliance Models, independently-observed cultural competence does not predict mean adolescent therapeutic alliance, $\gamma_{01} = -.81$, $t = 1.01$, $p = .43$, see Table 3.6.

Table 3.6: Results from the One-Way ANOVA Model B_{adol1}

<i>Fixed Effect</i>	<i>Coefficient</i>	<i>se</i>		
Average adolescent alliance, γ_{00}	2.60	.09		
<i>Random Effect</i>	<i>Variance Component</i>	<i>Df</i>	χ^2	<i>p Value</i>
Therapist mean, u_{oj}	.00023	13	10.03	> .500
Level-1 effect, r_{ij}	.64			

In this sample, there was no demonstrated relationship between independently-observed cultural competence and adolescent therapeutic alliance. The residual variance between therapists, $\tau_{00} = .00023$, was estimated in the context of the random ANOVA model (Table 3.6). The ICC is the proportion of the total variance in parent therapeutic alliance that is due to differences between therapists. For Model B_{adol1} , ICC was calculated using, $\rho = \tau_{00} / \tau_{00} + \sigma^2$. In this model, the ICC is equal to $.00023 / .00023 + .64$, or $.00036$. Subsequently, analysis of Model B_{adol2} required dropping the unique effect of therapist j on mean alliance, u_{oj} . The null hypothesis that $\tau_{00} = 0$, was not rejected: $\chi^2(13) = 10.03, p > .500$ (see Table 3.7).

Table 3.7: Results from Means-as-Outcomes Model B_{adol2}

<i>Fixed Effect</i>	<i>Coefficient</i>	<i>Se</i>	<i>t Ratio</i>
Model for therapist means			
INTERCEPT, γ_{00}	2.60	.09	29.03
MEAN CDORS, γ_{01}	-.81	1.01	-.80

The third hypothesis that cultural competency (observer ratings) will predict discrepancy between ratings of therapeutic alliance with parent and with adolescent was tested with a third set of multilevel univariate linear models analyzed using HLM software. The Magnitude of Discrepancy between Parent and Adolescent Therapeutic Alliance Models (Proposed Models C1 and C2) have family client as the level-one unit and therapists as the level-two unit. The dependent variable is Magnitude (absolute value) of Discrepancy between Parent and Adolescent Therapeutic Alliance, |VTAS-R Parent

Score – VTAS-R Adolescent Score | . In these models, the level-two predictor is independently-observed cultural competence (CDORS).

For Models C1 and C2, the Magnitude of Discrepancy between Parent and Adolescent Therapeutic Alliance Models, independently-observed cultural competence does not predict magnitude (absolute value) of discrepancy between parent and adolescent therapeutic alliance, $\gamma_{01} = 1.12$, $t = 1.49$, $p = .14$, see Table 3.8.

Table 3.8: Results from the One-Way ANOVA Model C1

<i>Fixed Effect</i>	<i>Coefficient</i>	<i>Se</i>		
Average discrepancy in alliance, γ_{00}	.97	.08		
<i>Random Effect</i>	<i>Variance Component</i>	<i>Df</i>	χ^2	<i>p Value</i>
Therapist mean, u_{oj}	.03	13	18.77	0.13
Level-1 effect, r_{ij}	.34			

In this sample, there was no demonstrated relationship between independently-observed cultural competence and discrepancy between parent and adolescent therapeutic alliance. The residual variance between therapists, $\tau_{00} = .028$, was estimated in the context of the random ANOVA model (Table 3.8). The ICC is the proportion of the total variance in parent therapeutic alliance that is due to differences between therapists. For Model C1, ICC was calculated using, $\rho = \tau_{00} / \tau_{00} + \sigma^2$. In this model, the ICC is equal to $.028 / (.028 + .34)$, or .076. Subsequently, analysis of Model C2 required dropping the unique effect of therapist j on mean alliance, u_{oj} . The null hypothesis that $\tau_{00} = 0$, was not rejected: $\chi^2(13) = 18.77$, $p = .13$ (see Table 3.9).

Table 3.9: Results from Means-as-Outcomes Model C2

<i>Fixed Effect</i>	<i>Coefficient</i>	<i>se</i>	<i>t Ratio</i>
Model for therapist means			
INTERCEPT, γ_{00}	.93	.07	14.26
MEAN CDORS, γ_{01}	1.12	.75	1.49

Chapter 4

Discussion

Because of its political and philosophical launching ground (Arredondo & Perez, 2006), cultural competence did not begin as an empirical research program, and as a result, there remains disagreement about how to define and measure cultural competence. Although the application of cultural competence remains unclear to some psychologists (Fuentes et al., 2006), it is now common knowledge that the therapeutic alliance is a statistically and clinically significant contributor to effective therapy. This pilot study merges two prominent bodies of literature, cultural competence and therapeutic alliance, with the underlying assumption that a culturally competent counselor will be able to provide effective service through the therapeutic relationship (Pope-Davis et al., 2002).

This pilot study was designed to examine how therapists' observed cultural competence facilitates the formation of working alliances with family members in the treatment context, and examine the role of cultural competence in predicting discrepancy in therapeutic alliance with parent and with adolescent. It was hypothesized that a) therapists' self-reported cultural competence scores would not be statistically significantly correlated with independently observed ratings of therapists' cultural competence, b) cultural competency (observer ratings) would predict therapeutic alliance with parent and with adolescent, and c) cultural competency (observer ratings) would predict discrepancy between ratings of therapeutic alliance with parent and with adolescent. The research yielded no statistically significant relationship between self-reported and independently-observed cultural competence. Also, observed cultural competence did not predict parent therapeutic alliance or adolescent therapeutic alliance,

and observed cultural competence did not predict magnitude of discrepancy between parent and adolescent therapeutic alliance.

One possible explanation for a lack of relationship between self-reported and observed cultural competence is that the self-report (MCI) and observed (CDORS) measures of cultural competence are not capturing the same constructs (Constantine & Ladany, 2000; Worthington, Mobley, Franks & Tan, 2000). Self-report measures might be capturing self-efficacy rather than actual abilities to counsel diverse clients (Constantine, 2001; Constantine & Ladany, 2000). Additionally, the self-report measure might be capturing only one dimension of cultural competence (e.g., awareness) and the observed measure might be capturing another dimension altogether (e.g., skills). As such, one would only expect a modest correlation at best. Given that the construct of cultural competence is difficult to define and operationalize and that the CDORS is a developing measure, future research should continue to evaluate the relationship between different measures and methods for capturing cultural competence.

The evaluation of the second hypothesis of this study raises questions about our understanding of the relationship between cultural competence and therapeutic alliance in family therapy for adolescents with behavior problems. If this result is representative of a general population of therapists, cultural competence may not be directly predictive of the therapeutic alliance either with parents or adolescents. It is possible that the global measure of cultural competence used in this study, CDORS, may not capture specific aspects of cultural competence that are predictive of therapeutic alliance in family therapy. Such aspects might include how a therapist facilitates agreement on therapeutic goals and tasks when family members differ in levels of acculturation or racial identity

development, or how a therapist manages to connect with multiple family members that are in open conflict with one another. These types of interventions require considerable skill and sensitivity to both the parents' and adolescents' unique world view and experience, and may not be easily captured using a system as general as the CDORS.

In this study, cultural competence did not predict discrepancy between ratings of therapeutic alliance with parent and with adolescent. This study's results might be explained by the sample including a mix of families who both completed and dropped out of treatment. The analyses of this study did not account for this variable (dropout versus completer family). It is possible that this study's sample might include only families who completed treatment and had minimal discrepancy in therapeutic alliance. In future studies, it will be important to sample both families who completed treatment and families who dropped out of treatment to more clearly evaluate the role of cultural competence in predicting unbalanced alliances. For example, with a larger sample, we can examine how cultural competence predicts highest and lowest levels of unbalanced alliances and how that predicts completion of treatment or early termination. In this study, not accounting for whether a family completed treatment or terminated early would account for the inconsistency with Robbins et al.'s findings that unbalanced alliances lead to early termination of treatment.

Surprising results also included the negligible ICCs calculated for the preliminary models (Bpar1, Badol1 and C1). In this sample, therapeutic alliance did not vary by therapist. It is likely that therapists in this sample were highly skilled in building alliance, and there is not enough variation in alliance scores in this sample. BSFT is a manualized treatment for which significant training focuses on engagement and retention of families

for which this is typically difficult. It will be important to evaluate whether this result generalizes to therapists not trained in BSFT.

Study Implications

The results of this study imply that there is no relationship between self-reported and observed cultural competence in this sample. Results also show that observed cultural competence does not predict therapeutic alliance with family members nor does it predict balanced alliances with parent and adolescent in this sample. The small sample size invites caution in evaluating these results. Another study conducted with a considerably larger sample of therapists is needed to better test the guiding hypotheses of this investigation. This study attempted to build on current literature by using a sample from the community, both therapists and family clients, rather than sampling trainee clinicians and college student clients (Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001). Also, this study attempted to expand the current literature by using independently observed ratings of actual family therapy sessions whereas other studies have used case conceptualization ability or client ratings (Pope-Davis et al., 2001). This is the first study of its kind to evaluate cultural competence and therapeutic alliance in family therapy. I speculate that this creates a need that has yet to be addressed in the literature, an observational measure of cultural competence that captures the particulars of how a family therapist works with differences in acculturation and in racial-cultural identity among family members. This measure does not capture how the therapist works with family members who differ in acculturation levels (Santisteban & Mitrani, 2003) and in racial-cultural identity development (Helms, 1995), which are important components to consider when conducting culturally competent family therapy. The CDORS, which was

developed exclusively to measure independent observations of cultural competence, appears to have been designed to evaluate global cultural competence processes in non-conjoint therapy sessions. Studies like this one might benefit from evaluating specific aspects of cultural competence that are directly related to therapeutic alliance. An addendum to the CDORS that takes into account the particulars of cultural competence in conjoint sessions, including couple, family and group therapy might also be useful.

Limitations

With 23 possible therapist participants and 14 actual participants, this study is framed as an initial investigation, a pilot study. I did not have contact information for 3 of 23 therapists (13%) and 26% of therapists (6 of 23) did not consent to the use of their videotaped family therapy sessions in future studies or treated less than 5 families who provided this consent. In regards to calculating an average Parent Therapeutic Alliance score if there were two or more parents/caregivers, not including ratings from each individual parent might have affected the data if parents had very different alliance ratings in the session. Considering the cultural competence ratings, the CDORS is a developing instrument. The data collected using this measure of observed cultural competence is preliminary. Also, during data collection, only one of two CDORS raters met criteria for interrater reliability with the author, so a single rater completed all CDORS ratings. In addition, undergraduate level raters completed CDORS ratings, which contrasts the protocol in the cultural competence literature. “Other” ratings are typically completed by supervisors, those with expertise in cultural competence, or by clients themselves, none of which describes the undergraduate level CDORS raters.

Another limitation in this study is its ex-post facto design, which prevented me from assessing the client families' perceptions of their therapist's cultural competence to increase internal validity of the study (Pope-Davis et al., 2001). Including this additional perspective would allow the researcher to expand beyond therapist self-report and independent observation of cultural competence. Although therapists' racial identity development and levels of acculturation may affect cultural competence, this study did not evaluate these variables to examine the correlations with cultural competence. Another limitation is that observations were made in the beginning stages of treatment (e.g., session 3, 2, 4 or 1) and not at various points in treatment. As Fuertes et al. (2006) explained, the relationships among study variables may change at a latter point in treatment (e.g., session 6 or 12). Additionally, there was a time lag between tapings of the family therapy sessions and the administration of self-report measures (MCI). I do not know if therapists completed training in cultural competence or experienced personal growth in the time between the taped therapy session and the self-report measure. The potential effects of this variable remain unknown. Considering these limitations, this study has merit in its attempt to understand the effects of independently-observed cultural competence on therapeutic alliance, a well-known predictor of effective outcomes in family therapy.

Future Directions

This study attempted to evaluate if cultural competence predicts therapeutic alliance with family members. Future research with a larger sample is needed to better evaluate this relationship. For reasons addressed in the limitations section, it would be important to assess therapists' racial identity and levels of acculturation and to assess the

client families' perspective of their therapist's cultural competence. If possible, measures should be collected at various points of treatment, not just at the initial stages. To confirm and readily generalize results, more data on the cultural competence and therapeutic alliance of therapists with varying degrees and years of work experience is necessary. This study's result that therapists' self-reports of in-session processes and observed measures may be capturing different constructs calls for the use of observational measures in future process and outcome research, supporting previous findings (Constantine, 2001; Constantine & Ladany, 2000). If collecting data on family therapy, couple or group therapy, it would be important to find a way to capture the cultural competence components in conjoint therapy not fully captured in existing global measures. Studies like this one would benefit from using a measure that evaluates the particular processes of therapists' work with family members who differ in racial identity development and acculturation levels. Lastly, it would be important to sample both families who completed treatment and families who dropped out of treatment to more clearly evaluate the role of cultural competence in predicting unbalanced alliances, which has been shown to be related to dropout in prior research.

In conclusion, although the results of this pilot investigation failed to provide evidence of a significant relationship between cultural competence and therapeutic alliance, I believe that the guiding questions of this study and its rationale are sufficiently strong to warrant the design and implementation of a similar study with a larger community sample of therapists and clients. Literature that contributes to the understanding of observed cultural competence is growing, so examining this within the context of family therapy makes this a potentially important step. Also expanding the

literature on what processes contribute to building therapeutic alliance, extending this study would facilitate understanding how therapists' cultural competence levels affect levels of therapeutic alliance with both parent and adolescent, and whether unbalanced therapeutic alliances with parents and adolescents may be a function of cultural competence.

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