

FACTORS RELATING TO MULTICULTURAL COMPETENCE IN BEGINNING
PSYCHOLOGY INTERNS

BY

Christian Vargas, M.S.

University of Kansas

Submitted to the Department of Psychology and Research in Education and the Faculty
of the Graduate School of the University of Kansas

In partial fulfillment of the requirement for the degree of

Doctor of Philosophy.

Committee:

Chairperson* _____

Karen D. Multon, Ph.D.

Committee Members _____

Barbara Kerr, Ph.D.

Thomas Krieshok, Ph.D.

Kristen Hensley, Ph.D.

Angela Lumpkin, Ph.D.

Date defended: July 21, 2010

The Dissertation Committee for Christian Vargas, M.S. certifies
that this is the approved version of the following dissertation:

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ACKNOWLEDGEMENTS

I would like to thank those who have provided support and encouragement throughout my academic career. First, thank you to my advisor and dissertation chair, Dr. Karen Multon for your guidance. I would also like to thank Dr. Thomas Krieshok who along with Dr. Multon encouraged me to apply for the doctoral program and helped me to believe that I could reach this goal. Thank you to my committee members, Dr. Barbara Kerr, Dr. Thomas Krieshok, Dr. Angela Lumpkin, and Dr. Kristen Hensley, for your guidance and smiling faces.

To everyone at my internship site, UMKC Counseling Center, thank you so much for all of your support in this last year. I didn't realize how much fun I could have during such a stressful time. I would like to especially thank Dr. Allison Roodman, Dr. Arnold Abels, Dr. Heather Noble, Dr. Lynette Sparkman-Barnes, Dr. Rachel Pierce, and Dr. Sherri Theoharidis for your encouragement and uplifting words. To my intern cohort, forever friends, and soon to be psychologists, Mike Hines and Brian Licuanan, I would not have gotten through this last year without you. You have made the ending to this journey a truly special one and I feel blessed to have gone through this with you by my side and to be able to call you my friends. Thank you to all of my friends who have provided lots of laughs and fun times throughout the years. My life is better for having you in it.

And last, to my family. My parents Gwen, Debbie, and John, my brothers Jonathan and Justin, and sister Meagan, what would I do without you. Thank you for always being there for me! To my husband Matt and son Mason, I could never thank you

enough. Your undying love, support, and encouragement are what keep me going. Coming home to you is what gets me through the day. I love you both beyond words. When I doubted myself you encouraged me, when I fell you picked me up, when I cried you wiped my tears, and when I laughed you laughed with me. You two are the biggest blessing I have ever received and I am eternally grateful for your presence in my life. I am a better person because I have you. I love you!

ABSTRACT

There is a paucity of research on the multicultural competence of the psychology intern population. Therefore, the purpose of this study is to examine counseling and clinical psychology interns' multicultural training experience and competence prior to beginning internship. Examining psychology interns' pre-internship multicultural experience, childhood, adolescent, and adult multicultural experience, their universal-diverse orientation, their graduate program multicultural emphasis, their choice of internship site, and their individual characteristics provided insight into the current readiness of graduate students to work with different populations while on internship. Beginning interns from clinical and counseling doctoral psychology programs were administered surveys to assess for multicultural personality, universal-diverse orientation, multicultural social desirability, multicultural competence, and various individual factors. Results displayed support for the contention that multicultural life experiences have significant predictive value for the multicultural competence of beginning interns. Results also confirmed that there is a positive relationship between multicultural personality and multicultural competence as well as between multicultural personality and universal-diverse orientation.

TABLE OF CONTENTS

Acknowledgements.....	iii
Abstract.....	v
Table of Contents.....	vi
List of Tables.....	ix
Chapter I- Introduction.....	10
Hypothesis.....	19
Summary.....	20
Chapter II- Literature Review.....	21
History of Multicultural Counseling.....	21
Culture.....	23
Emic and Etic Perspectives.....	25
Definition of Multiculturalism.....	26
Worldview.....	27
Definition of Multicultural Counseling.....	28
Emic Research and Theories.....	29
Etic Definition, Research, and Theories.....	33
Multicultural Education.....	40
Qualitative and Quantitative Research on Education.....	40
The Multiculturally Competent Counselor.....	43
Summary.....	48
Chapter III- Methods.....	50
Participants.....	51

Measures.....	53
Demographic Questionnaire.....	53
The Multicultural Competence Inventory.....	53
Multicultural Social Desirability Scale.....	55
The Multicultural Personality Questionnaire.....	55
The Miville-Guzman Universality-Diversity Scale Short.....	57
Procedure.....	58
Chapter IV- Results.....	60
Data Transformation.....	60
Hypothesis 1.....	61
Hypothesis 2.....	63
Hypothesis 3.....	64
Hypothesis 4.....	65
Hypothesis 5.....	66
Hypothesis 6.....	69
Hypothesis 7.....	70
Hypothesis 8.....	71
Chapter V- Discussion.....	72
Summary of Findings.....	72
Explanation of Findings.....	75
Conclusions and Implications.....	83
Limitations of the Study.....	86

Future Research Directions.....	88
References.....	90
Appendix A: Demographic Questionnaire.....	100
Appendix B: Miville-Guzman Universality-Diversity Scale Short.....	103
Appendix C: Consent Form.....	105
Appendix D: Tables.....	107

LIST OF TABLES

Table 1. Demographic Information.....	107
Table 2. Means Scores and Standard Deviations for Measures.....	111
Table 3. Intercorrelations among Multicultural Competence (MCI), Multicultural Social Desirability (MCSD), Multicultural Personality (MPQ), Universal-Diverse Orientation (M-GUDS-S), client hours, and multicultural life experience.....	113
Table 4. Regression Analysis Summary for Multicultural Experiences Variables Predicting Multicultural Competence, Adjusting for Social Desirability.....	114
Table 5. Means and Standard Deviations of High, Medium, and Low Infusion Groups on the Multicultural Competence Inventory.....	115
Table 6. Means and Standard Deviations of Internship Sites on the Multicultural Competence Inventory.....	116
Table 7. Means and Standard Deviations of Counseling and Clinical Psychology Beginning Interns on the Multicultural Competence Inventory.....	117

CHAPTER I

Introduction

In the last three decades there has been a major shift in psychology to focus on becoming competent in providing services to culturally diverse populations. In 1973 Korman stated that “the provision of professional services to persons of culturally diverse backgrounds by persons not competent in understanding and providing professional services to such groups shall be considered unethical” (p. 105). Because the United States and the population served by psychologists in the U.S. has become more culturally diverse and is projected to continue in that direction, it is an ethical responsibility for the profession of psychology to adapt to this change and provide appropriate services. In order for professionals to meet this ethical obligation educational programs must incorporate multicultural training but before multicultural competence can be assessed or trained, it must be defined.

The Surgeon General’s Report on Mental Health (1999) showed that although there are effective treatments available for most mental health issues, nearly half of all Americans who suffer from severe mental illness do not seek treatment. Historically, mind and body have been thought of as separate but this report made the connection between mental and physical health and emphasizes the importance of mental health to overall health and well-being (U.S. Department of Health and Human Services [DHHS], 1999). This report also stated that one in five Americans experience some form of mental illness in any given year. And failure to seek treatment for these problems can have severe and sometimes fatal consequences.

According to recent estimates, people who identify their race as anything other than European American comprise approximately 37% of the U.S. population (U.S. Census, 2000). Over the next 50 years the diversification of the United States will continue to rapidly increase as the percentage of individuals who identify as White alone is expected to decrease by 10%, while the percentages of those who identify as Latino, Black, and Asian are expected to increase to nearly 25%, 15%, and 8% respectively (U.S. Census, 2000). Also the percentage of individuals who identify as multiracial, Native American, Pacific Islander, or Native Hawaiian is expected to double by 2050 (U.S. Census, 2000). In the United States alone, the overall annual prevalence of mental disorders is about 21 percent of adults and children (DHHS, 1999). This study found that this percentage was similar for both minorities and European Americans in the United States. This finding applied to minorities in the community but did not address “high-need subgroups” such as persons who are homeless, incarcerated, or institutionalized. Also there are some minority groups where mental health is not openly studied therefore this information cannot be provided, such as American Indians, Alaska Natives, Asian Americans, and Pacific Islanders (DHHS, 1999). DHHS identified these groups as having a higher need for mental health care but less than adequate services available.

The DHHS study also showed that minority groups have less access to, and availability of, mental health services and are less likely to receive needed mental health services. When they do receive services it is often of poorer quality and they are underrepresented in research (DHHS, 1999). Although there are reasons for the lack of assessing mental health services that pertain to all groups such as cost, fragmentation of services, lack of availability of services, and societal stigma, there are additional barriers

many minority groups face. Such barriers include mistrust and fear of treatment, racism and discrimination, and differences in language and communication. This report posits that mental health disparities may also stem from minorities' historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status (DHHS, 1999). The combination the minority groups in the United States face of having a higher rate of mental illness due to societal stressors such as racism, poverty, and inequality of income and economic possibilities and not receiving adequate services for their illnesses makes these groups experience a greater disability burden in terms of lost workdays and limitations in daily activities (DHHS, 1999).

There has obviously been a need to address providing adequate and appropriate services for underrepresented groups in counseling. Psychology has termed the ability to provide these services multicultural competence. In 1982 Sue, Bernier, Curran, Feinberg, Pedersen, and Smith developed three fundamental multicultural competency areas which are used in most models of multicultural competency and that relate to mental health practitioners' cultural beliefs/attitudes, knowledge, and skills. Sue, Arrendondo, and McDavis (1992) defined multiculturally competent counselors as those professionals who possess the necessary skills to work effectively with clients from various cultural/ethnic backgrounds. At that time, the literature on multicultural competence focused on three areas 1) the awareness of one's own personal worldviews and how one is the product of cultural conditioning 2) knowledge of the worldviews of culturally different clients and 3) the skills necessary for working with culturally different clients (Corvin & Wiggins, 1989; D'Andrea, Daniels, & Heck, 1992; Sue et al., 1992). These three areas were used

by the Association for Multicultural Counseling and Development (AMCD) Professional Standards Committee as the basis for developing a set of Multicultural Counseling Competencies. Their definition of multicultural counseling is counseling when the participants differ as a result of their varying racial and ethnic backgrounds (Holcomb-McCoy & Myers, 1999).

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) which accredits graduate counseling programs requires the integration of multiculturalism into core subject areas, and they also require that the counselor education programs have diverse faculty and student representation along with practicum placements that provide clinical experiences with culturally different clients (Holcomb-McCoy & Myers, 1999). Most psychology programs with any kind of accreditation have to meet some standard of multicultural curriculum. Hill and Strozier (1992) surveyed 61 American Psychological Association (APA)-accredited counseling psychology programs and found that 87% offered at least one course on multicultural issues. There are several differences between CACREP and APA accreditation that do not allow for one program to have both types of accreditation. CACREP accredits both Master's and Doctoral programs, where-as APA only accredits doctoral programs. They each require a different amount of coursework hours to be completed and also have differing core areas for the coursework. CACREP standards are more competency based than APA standards, which allow the program to define their desired outcome for students. Also APA accredits counseling training programs where as CACREP accredits specialty areas (Evans and Gladding, 2010).

Although a set of standards for training including multicultural competence has been established, research has found differences in multicultural competence scores between counseling psychology students and clinical psychology students. Hung (2000) found that students in clinical programs rated themselves as significantly less multiculturally competent than did counseling psychology students. She also reported that students with more multicultural training and ethnic minority students had significantly higher competency scores. Additionally, she found that interns had significantly higher competency scores than pre-internship students which she attributed to additional multicultural training. A requirement of both counseling and clinical psychology doctoral programs is to complete a year-long internship. The internship can be at various different types of sites such as university counseling centers, state hospitals, veteran affairs facilities, and community mental health centers. During internship, the goal is for the intern to complete a certain number of hours of individual therapy with clients. Other aspects of internship include training through presentations and seminars. Internships accredited by the American Psychological Association have a requirement to provide some experience and training in multicultural issues. Therefore, interns receive additional multicultural education while on internship.

Although there has definitely been a push towards multicultural education in graduate programs in counseling psychology, there is still question as to what training leads to multicultural competency. A study done by Allison and Echemendia (1996) focused on the multicultural competence of graduates found that counseling psychologists reported lower levels of competence when providing services to ethnic minority clients of certain groups, meaning they felt less able to provide effective

services than others. They surveyed 266 recent graduates of clinical and counseling psychology doctoral programs and found in 12 percent of ratings, service providers indicated that they were not competent to provide services to diverse clients, indicating that they felt like they were unable to provide effective services at all for this population. Eight percent of these providers continued to provide services to clients whom they identified that they were not competent to treat (Allison et al.). However more than 50 percent reported strong feelings of competence in providing services to European Americans, women, and economically disadvantaged individuals.

The literature suggests that factors such as gender, educational level, and age have been found to be related to multicultural competence (Holcomb-McCoy & Myers, 1999). Contact with culturally different persons has been shown to be positively correlated with higher levels of self-reported multicultural competence (Sodowsky, Taffe, & Gutkin, 1991). Some of these factors cannot be changed by training such as gender and age but others can like educational level and contact with culturally different persons can.

A national survey conducted by Holcomb-McCoy and Myers (1999) found five factors of multicultural competence which include knowledge, awareness, definitions, racial identity development, and skills. The participants in this study were 151 professional counselors who were also members of the American Counseling Association. The authors oversampled ethnic minorities and members who joined after 1992 to establish an adequate sample for comparisons on the variables of ethnicity and recent graduation. The participants perceived themselves to be most competent on the definitions and awareness factors and least competent on the racial identity and knowledge factors. Participants' scores were moderately competent on the skills factor.

All of the respondents believed they had adequate to more than adequate training in multicultural issues. They also found a significant mean difference of .14 between the CACREP and non-CACREP graduates' perception of training on the knowledge factor. Concerning demographic characteristics, ethnicity was the only variable that was found to influence the knowledge, awareness, racial identity, and skill factors. For these participants, ethnicity was the only variable that was statistically significant and influenced knowledge, awareness, racial identity, and skill factors of multicultural competence (Holcolmb-McCoy & Myers, 1999). They also found that participants who had taken a multicultural counseling course had significantly higher levels of self-perceived multicultural competence on the knowledge and racial identity factors. These researchers suggest that more research needs to be done to assess the multicultural competence of counselors and to uncover what training has been most beneficial in preparing them to work with diverse populations (Holcolmb-McCoy & Myers).

One area of research looks beyond the multicultural competence of counselors to the general ability to accept and understand differences. This is referred to as a multicultural personality disposition. In the last decade the construct of a multicultural personality has been developed. Brummet considers a multicultural personality to describe a person whom is able to show sensitivity and competence while working with different cultures. One specific component of the multicultural personality theory is the universal-diverse orientation identified by Ponteretto, Utsey, and Pedersen (2006).

Millville, Gelso, Pannu, Liu, Touradji, Holloway, and Fuertes (1999) states:

“Universal-diverse orientation is thus defined as an attitude toward all other persons that is inclusive yet differentiating in that similarities and

differences are both recognized and accepted: the shared experience of being human results in a sense of connectedness with people and is associated with a plurality of diversity of interactions with others” (p. 292).

Brummet, Wade, Ponteretto, Thomas, and Lewis (2007) found that multicultural personality disposition predicted self esteem, psychological hardiness, interpersonal functioning, and overall psychological well-being. A multiculturally competent counselor is likely to have a multicultural personality disposition. Miville (1999) goes on to state that individuals who place themselves in diverse situations do so because they appreciate differences and similarities and therefore have enhanced emotional connections which reinforce their universal disposition orientation. Therefore, this study suggests these beginning interns will be more likely to have a multicultural personality and the desire to be multiculturally competent.

Education has been identified as a means to gain multicultural competence in the field of psychology. Having a multicultural personality disposition is likely to have a part in a person’s ability to be multiculturally competent. Therefore, educating psychologists to have a multicultural personality could increase their multicultural competence.

Rameriz (1999) suggests that a multicultural personality can be enhanced “through seeking interaction with diverse individuals and new cultural environments, taking on leadership roles in culturally diverse contexts that foster creative problem-solving, and being proactive in terms of social justice for oppressed groups” (Rameriz, 1999, p. 26).

Some have proposed that appreciating and accepting differences and similarities begins in childhood. Schools and early childhood programs have begun to examine the

importance of adding multicultural education to their classroom environment. Ponterotto, Mendelowitz, Collabolletta, and Ernest (2008) related multicultural personality to the Strength-Based School Counseling Model. They assert that any school counseling model should help prepare students for interacting in and adapting to an increasingly diverse world. This increases the schools counselor's role to involve facilitating students'

“(a) understanding of themselves, their own worldviews, and concomitant cultural biases; (b) knowledge of a multicultural history and of culturally diverse groups that they will likely encounter; and (c) skill development regarding interacting with culturally diverse individuals in new environments” (Galassi & Akos, p.66)

Similarly to the education of a beginning intern, they provide culturally based interventions that they believe could help to increase the multicultural personality of school-aged students (Ponterotto et al., 2008). In Australia all educational settings are required to implement multicultural education due to the ethnically heterogeneous society (Vuckovic, 2008). Vuckovic states that the aim of multicultural education is for the individual to accept his or her own and other's ethnicity. This brings up the question of how much childhood and adolescent experiences, such as a multicultural education, lead to a multicultural personality disposition as an adult, and multicultural competence as a counselor later in life.

There is a paucity of research on the multicultural competence of the beginning intern population. Therefore, the purpose of this study is to examine counseling and clinical psychology interns' multicultural training experience and competence prior to beginning internship. Examining psychology intern's pre-internship multicultural

experience, childhood and adolescent multicultural experience, their universal-diverse orientation, their graduate program multicultural emphasis, their choice of internship site, and their individual characteristics will provide insight into the current readiness of graduate students to work with different populations while on internship. This study will provide information to applied psychology regarding our current multicultural training and readiness for internship in terms of multicultural competence. The following are the hypotheses used to guide this study.

Hypotheses

Hypothesis 1: Interns from graduate programs that had one multicultural course will have significantly lower self-perceived multicultural competence scores, when controlling for social desirability, than those who had a graduate curriculum that integrated multicultural training throughout the curriculum.

Hypothesis 2: Interns with more experience with clients who are culturally different will have significantly higher self-perceived multicultural competence scores when adjusting for social desirability.

Hypothesis 3: There is no significant difference in self-perceived multicultural competence scores of interns who chose internship sites with more multicultural training at the site and internship sites with less focus on multicultural training at the site when controlling for social desirability.

Hypothesis 4: There are no differences between the multicultural competency scores of interns from counseling psychology programs and those from clinical psychology programs when controlling for social desirability.

Hypothesis 5: Individuals with more multicultural life experiences will have higher self-perceived multicultural competence scores when adjusting for social desirability.

Hypothesis 6: Individuals with more multicultural life experiences will have higher multicultural personality scores.

Hypothesis 7: Individuals with higher multicultural personality scores will have higher self-perceived multicultural competence scores when controlling for social desirability.

Hypothesis 8: Universal-disposition orientation scores will correlate positively with multicultural personality scores.

Summary

Sue, Ivey, and Pedersen's (1996) metatheory of multicultural counseling posits that a culturally competent counselor will have self awareness of their own cultural background and how that has influenced their thoughts, beliefs, and actions. The clinician will also have an understanding and acceptance that people with different cultural backgrounds have different worldviews. Therefore, a graduate student entering an internship who has had various multicultural life and training experiences will have a multicultural personality and thus be more likely to be multiculturally competent when working with clients of diverse backgrounds.

CHAPTER II

Literature Review

The United States has become a melting pot of different cultures and ethnicities. The acknowledgement of multiculturalism in our society has coincided with the growth of the profession of psychology and the need to offer services to a wider variety of clients. This growth has made it necessary for professional psychologists to be able to provide services at a competent level to clients of varying backgrounds. Therefore, in the 1960's and 1970's the literature began to focus on multicultural issues, and this theme has continued in the research. Counseling psychology in particular has provided the most research and education on multicultural counseling. Korman (1973) stated that "the provision of professional services to persons of culturally diverse backgrounds by persons not competent in understanding and providing professional services to such groups shall be considered unethical"(p. 105). In order to better understand what is currently taking place in research regarding multicultural competency training it is best to first look at the history of multicultural counseling.

History of Multicultural Counseling

Ponterotto (2008) describes the history of multicultural counseling in five distinct periods he refers to as moments. First is Pre-1960 which he refers to as Benign Neglect. During this period there was little research regarding cultural issues or different cultures. Jackson (1995) conducted a review of literature which revealed that besides African Americans, there was very little focus on other American minority groups. The literature addressed minority groups on the topics of educational achievement, testing, and career

development only (Ponterotto, 2008). The second moment took place in the 1960's and 1970's which Ponterotto calls the Birth of a Movement. The Civil Rights Movement took place during this time and combined with the Civil Rights Act of 1964 these events influenced the field of psychology to make a commitment to address mental health issues for minority groups. Atkinson and Thompson (1992) uncovered three major trends in multicultural research in the 1970s. These trends were (1) the underutilization of voluntary mental health services by ethnic and racial minority clients; (2) African American clients preferred an African American therapist over a European American therapist; (3) and ethnic and racial minority professionals were underrepresented in all areas of psychology.

Ponterotto (2008) called the third moment Gaining Momentum and Establishing a Specialty which took place in the 1980's. This era had the biggest growth in attention on multicultural issues. Research shifted from focusing on between-group to within-group differences. There was also the development of racial identity development and acculturation theories. The 1990s began the fourth moment Maturation and Expansion of a Specialty. There was a large increase in multiculturally focused literature in this period. Racial identity, acculturation, and worldview constructs were the major focus of counseling research. There was also an increase in attention on other minority groups such as gay and lesbian populations, the elderly, and the disabled. This was also the beginning of psychology promoting and examining multicultural competence. During the 1990s multicultural counseling became an established specialty in the field of psychology (Ponterotto, 2008). The fifth moment began in 2000 and is what the field of psychology is currently experiencing, Beyond Borders and Disciplines. This period is

marked by research and theories expanding beyond the North American population, the joining of multicultural counseling with other specialties such as positive psychology, and the increase of scientific methods to enhance the study of multicultural counseling, including measure of competency. Following is a more specific discussion of the research that been conducted on multicultural counseling and training and definitions of the terms used in this research.

Culture

Culture is broadly defined as a common heritage or set of beliefs, norms, and values (DHHS, 1999). Culture is important because it influences what all people bring to the clinical setting, clients and clinicians alike. It can account for how clients describe their symptoms and what they define as symptoms that should be reported. Culture also affects whether people seek services in the first place, what types of services they seek, what coping styles and social supports they have, and what stigma they attach to mental illness (DHHS, 1999). There are culture-bound disorders as well as cultural resiliencies; meaning there are both disorders and strengths that exist in only specific cultures or that certain behaviors or practices may determined to be a disorder in one culture while being famed as a strength in another. An example of this is the idea of a shaman in Native American culture. The shaman is believed to have the ability to communicate with the spirit world, getting and giving information from and to plants and animals. In this culture the shaman is believed to have this power and to be a healer. If this same person, the shaman, were to seek counseling services in Western society today, admitting that they communicate with plants and animals without considering his or her cultural

background could be interpreted as having delusions which could lead the professional to a diagnosis like schizophrenia.

There is also a culture among mental health professionals identified in the jargon used, textbooks studied, and their own worldviews. Most professionals share a worldview about the interconnectedness of the mind, body, and environment. This also means that professionals may view symptoms differently than their clients. This may be magnified when the clinician and the client are from different cultural backgrounds. Mental health systems have in large part been ill-equipped to deal with minority groups and have displayed bias in their delivery of care (DHHS, 1999). Although culture is not the only influence on mental health issues, it is an important one that has historically been underestimated but has more recently gained more attention. It is apparent that everyone has at least one if not many cultures but how are these cultures examined.

One proposed way of examining a person's culture is to look at their personal identity. Sue (2001) identified a tripartite framework to assist in exploring and understanding the formation of personal identity. The model has three levels of personal identity development: 1) individual level; 2) group level; and 3) universal level. The individual level speaks to the uniqueness of each individual person. This uniqueness comes from each individual having differences in genetics and experiences which contribute to individual uniqueness. The group level refers to similarities within groups. Each person is born into a culture with shared beliefs, values, rules, and social practices (Sue, Ivey, & Pedersen, 1996). Some of these differences or similarities are stable such as race, and some are fluid, such as socioeconomic status. The universal level refers to the fact that we all belong to the human race which has similarities. These similarities

include biological and physical similarities, common life experiences, self-awareness, and the ability to use language to communicate. Traditionally the group level has been overlooked in psychology. This may be for several reasons. The individual level is celebrated in Euro-American culture with messages such as “be independent” being taught to youth and portrayed in the media. The universal level is where psychology has traditionally studied human behavior and the human experience in general. The group level has also been ignored because people find issues of race, religion, and disability uncomfortable to discuss due to the emotions they trigger. All three levels must be examined for a holistic approach to examining human behavior and the client’s culture (Sue & Sue, 2008).

This framework is relevant to multicultural training because in order to structure the education for competency it is necessary to define culture and show how multicultural counseling is distinct from other types of counseling. This concept may also be understood as it relates to the broad concepts of emic and etic which represent one of the fundamental distinctions in approach to multiculturalism in the counseling psychology literature (Fukuyama, 1990). Following is a discussion of the distinction of these terms and a review of literature relevant to them.

Emic and Etic Perspectives

These terms were first used to describe differences in cultural patterns between groups and have been borrowed from ethnographic research. They are descriptive of the perspectives taken by the researcher. Wehrly and Watson-Gegeo (1987) described the distinction between the concepts as such:

“Emic interpretations are presented in the language (that is, concepts and categories) and from the point of view of a cultural insider—that is, a member of the social group under investigation...since there are ultimately as many emic perspectives in a group as there are group members, attention to differences and variation is crucial for arriving at a genuine understanding of a group’s culture. Etic interpretations are based on or use concepts and categories from the analytic language of the social sciences, especially anthropology, and therefore allow for cross-cultural comparisons. An etic interpretation is always from an outsider’s point of view, even when the research is a cultural insider.” (p.67).

Counseling psychology has adopted the use of the terms in a somewhat different manner. Although it can continue to refer to the different perspectives of the researcher it also refers to the different perspectives of practitioners of counseling between broad culture characterizations (etic) and culture-specific perspectives (emic) (Essandoh, 1996). This creates an important distinction of the practitioners’ focus. Their work may be influenced either by theories that account for differences among culture groups (emic), or on the characteristics of counseling that apply universally to different groups (etic) (Fukuyama, 1990). This also parallels the debate regarding using an inclusive versus and exclusive definition of multiculturalism. These differences are important in examining the education received by beginning interns. Multicultural counseling cannot take place if the client’s culture is not first examined. A counselor who is multiculturally competent must be attuned to what the client’s culture is and his/her particular needs. Multicultural counseling is by definition including the client’s culture into the conceptualization,

diagnosis, and treatment interventions. Therefore, multiculturalism will be further discussed.

Definition of Multiculturalism

There are differing opinions on the definition of multiculturalism. Sue and Sue (2003) believe this debate refers to whether culture should be used in the context of race and ethnicity; which is the exclusive definition; or if culture refers to any group with common experiences, such as a sport team or members of the same fraternity, the inclusive definition. Sue and Sue also acknowledge that some scholars are concerned that the expanded definition of multiculturalism beyond race and ethnicity could possibly dilute the meaningfulness of the term. Another debate regarding multiculturalism is whether theories and concepts should be applied universally or specifically. MacPhee, Kreutzer, and Fritz (1994) suggested that most research conducted in North America is based on the assumption of universality which treats European Americans as the reference group. The problem with this is that all theories and concepts may not be generalizable to every culture; therefore they argue that research must also emphasize specificity when necessary. For example, different theories of identity development have been developed for different cultures such as Asian Americans and African Americans (Sue & Sue). For the purpose of this study Sue and Sue's broader definition will be used because most practicum students and interns use race and ethnicity, among other terms to describe and track their clients.

Worldview

Central to any debate about multicultural counseling is the concept of worldview. Worldview is essential to the emic perspective because it is one of the most important

aspects of cultural distinction between people as representatives of different groups (Ibrahim, Roysircar-Sodowsky & Ohnishi, 2001). Worldview has been defined in various ways. Ho (1995) defines worldviews as a set of presuppositions underlying our views about the world and our place in it. Worldview can be generally understood to refer to the “philosophy of life” of an individual (Ibrahim, 1985) or “our basic perceptions and understandings of the world” (Trevino, 1996a, p.198). Sue and Sue (1990) describe worldview as “not only composed of our attitudes, values, opinions, and concepts, but also they may affect how we think, make decisions, behave, and define events” (p.137). Worldview is typically thought to be reflective of a shared cultural experiences as well as varying among individuals even from the same culture due to unique experiences (Myers, Speight, Highlen, Cox, Reynolds, Adams, & Hanley 1991). When examining multicultural issues practitioners are encouraged to access both their client’s and their own worldview and how the differences in this may impact and influence the therapy. Therefore, the understanding of the importance of a worldview is essential to the following discussion regarding multicultural counseling.

Definition of Multicultural Counseling

The definition of multicultural counseling has been widely accepted as: “Multicultural counseling and therapy can be defined as both a helping role and process that uses modalities and defines goals consistent with the life experiences and cultural values of clients, recognizes client identities to include individual, group, and universal dimensions, advocates the use of universal and cultural specific strategies and roles in the healing process, and balances the importance of individualism and collectivism in

the assessment, diagnosis, and treatment of client and client systems” (Sue & Torino, 2005).

This definition has several implications for counseling practice. The multicultural counselor not only uses traditional therapy skills and has an objective stance but also serves as a teacher, consultant, and advocate when appropriate and necessary. While advice and suggestions may be effectively used for some populations, whatever the counselor does in terms of treatment and defining goals should be consistent with the client’s background (Sue & Torino, 2005). All approaches to therapy must also recognize all three levels of the client’s identity including individual, group, and universal. The multicultural therapist must be willing to use interventions that are culturally specific if it would be helpful for a certain client based on their background. This includes consulting with healers and helpers from the client’s background when necessary. Multicultural counseling also honors both individualism and collectivism by recognizing the importance of the individual as well as acknowledges the groups to which they belong. Within multicultural counseling there may also be the need to not only address the client but also the client systems which may be sources of prejudice or discrimination (Sue & Torino, 2005). There are many theories of multicultural counseling from both the emic and etic perspectives. The following is a review of some of the most relevant theories.

Emic Research and Theories

Gonzalez, Biever, and Gardner (1994) developed the Social Constructionist Approach to multicultural counseling. Social constructionism is described as a mechanism for considering cultural factors when providing appropriate psychological

services (Gonzalez et al.). Social constructivism posits that meaning is derived from social interaction. According to this view, there are multiple truths which are all valid. There is no universal truth. It is based on the social consciousness of multiple belief systems and perspectives. Three assumptions of this theory are: 1) perceptions of the world are culturally learned and mediated; 2) people from different cultures perceive the world differently; 3) and counseling requires an understanding of the client's perspective of the world around them or world view (Ibrahim, 1991; Pedersen, 1991). Social constructivism asserts that meaning is fluid and can change based on the different groups the client belongs to, such as religious groups, cultural background, and family. This theory emphasizes the importance of language since social interactions tend to take place through conversation and dialogue. In social constructivism, psychological theory is an agreed upon understanding which has proven to be useful in several contexts. Therefore, theory is not "right" in itself; we chose to make it right because it has proven to work in several situations. When questioning the usefulness of a theory, the question is not if, but how and when. There is no need to determine if a theory is correct or incorrect but how and when it could be useful. When beginning to work with a client, the therapist works to understand the client's theory on the problem that brought them to therapy instead of fitting the client into the therapist's theory. This is referred to as the multicultural perspective (Gonzalez et al., 1994). This also affects diagnoses and assessment. Currently diagnoses from the Diagnostic and Statistical Manual of Mental Disorders IV-TR are based on a norm, but that norm may not apply to a client who is not from the majority culture. Social constructivism posits that the therapist should work to understand client behaviors from the social context in which they occur. Much like the

current trend in social psychology, this theory states that situationalism rather than dispositionalism influences people's behavior. The social constructivist takes a "not-knowing stance," defined by Anderson (1991) as

"a general attitude and belief that the therapist does not have access to privileged information, that the therapist can never fully understand another person, and that there is always a need to know more about what has been said or what is not known" (p. 3).

The therapist should ascertain how the client sees himself or herself as both similar to and unique to his or her own culture. The therapist is seen as a learner not an expert. The therapist is to maintain a strong sense of curiosity in regards to the client's perspective of his/her problem. He/she must be open to all ideas the client has about the source of the problem. The therapeutic relationship is seen as collaborative with the client and therapist both searching for solutions. What the client states is the problem, is the problem. The therapist does not look for something beyond the client's stated problem to be the real issue. The therapist's way of understanding is more of a hypothesis and is not to be assumed to be correct. The therapist and client should find multiple possibilities. The social constructivist therapist emphasizes opportunities instead of barriers when listening to the client's story and always makes space for the client to tell his or her story (Anderson, 1991). This theory encourages the clinician to be open and nonjudgmental, which is also a component of having a multicultural personality. A criticism of this theory is that it assumes all clients will be articulate and self-aware in a way that will allow them to have a theory about their problems and be able to share these with the therapist which is not always the case. It also assumes that

providing a different theory or worldview is not useful which many theories would refute and have used as an intervention in itself such as cognitive-behavioral therapy.

One of the most popular multicultural counseling theories comes from Sue, Ivey, and Pedersen (1996) and is a metatheory. It is a broad and culture-based conceptualization of counseling involving six propositions. The first is that each Western and non-Western theory represents a different worldview. The second proposition posits that the totality and interrelationships of client-counselor experiences and contexts must be the focus of treatment. The third states that a counselor or client's racial/cultural identity will influence how problems are defined and dictate or define appropriate counseling goals or processes. The fourth is that the ultimate goal of a culture-centered approach is to expand the repertoire of helping responses available to counselors. Conventional roles of counseling are only some of many alternative helping roles available from other cultural contexts, which is the fifth proposition. And the final proposition states that there is an emphasis on the importance of expanding personal, family, group, and organizational consciousness in a contextual or relation-to-self-orientation (Sue, Ivey, & Pedersen).

This theory provokes psychologists to see culture as deeply imbedded in the consciousness of all human beings and central in all psychological functioning. Culture is important for the counselor, client, and the therapeutic relationship. Sue, Ivey, and Pedersen (1996) consider how cultural influences the processes and goals of counseling and call on the profession of psychology to change the way multicultural counseling is thought about by encouraging all counseling to consider cultural influences (Sue, Ivey, &

Pedersen). With so many theories, established and emerging about multicultural counseling, it is apparent that it is highly regarded in the profession of psychology.

Another hallmark of multicultural counseling theories from the emic perspective is the many theories of identity development. The concept of racial or ethnic identity has been examined in psychology literature as a social construction and “refers to a sense of group or collective identity based on one’s perception that he or she shares a common heritage with a particular group” (Helms, 1993, p.3). There are identity development models for several different racial groups including African Americans, Asian Americans, and European Americans. One criticism of the focus on group identity development and other emic perspective theories is that it treats these groups as homogenous and promotes stereotyping. This study will focus more on theories from the etic perspective. The following is a review of these theories.

Etic Definition, Research, and Theories

Models of multicultural counseling from an etic perspective look at differences in general instead of specific to a group. One such model is Steenbarger’s (1993) three-stage multicontextual counseling model. Steenbarger recognized that there are two trends in counseling that continue to hold true, brevity and diversity. Brevity refers to the field of psychology focusing on providing brief therapy, where time is considered in treatment planning. Another focus has been multicultural counseling which embraces diversity and calls on the practitioner to be competent to treat clients that differ from the clinician. Steenbarger posits that although both brief therapy and multicultural counseling are strong forces, they have contrasting developmental assumptions. The first assumption is the locus of the client problem. Brief therapy approaches tend to view problems as

internal to clients, resulting from the learning of maladaptive behaviors and cognitions and the disowning of important facets of self. Multicultural counseling assumes a client's problems are a function of poor person-environment fit (Steenbarger). Problems result from a tension between the demands and resources of the environment and the needs of the individual. These approaches also differ in their assumptions in their criteria for client inclusion.

Brief therapies tend to target higher functioning clients who have acute onset complaints and can quickly form a therapeutic alliance. On the other hand, multicultural approaches recognize that forming a therapeutic alliance may be more challenging due to cultural differences. Other ways these two approaches differ is in their therapeutic methods and therapeutic aims. Brief therapy tends to be more confrontational and expects rapid change. This type of therapy has a goal of challenging the client's views, cognitions and interactional patterns, and helping him/her to generate more adaptive patterns of action and understanding. In contrast, multicultural therapy stresses a matching of the counselor and client communications as a primary intervention strategy and seeks to validate client worldviews. Empowerment and identity development are the main goals (Steenbarger, 1993).

Steenbarger's (1993) model is an integration of both brief therapy and multicultural counseling. One of the goals of this model is to have both system and individual change. His mutlicontextual model conceptualizes the dimension of time (brief to long term) as interacting with those of change target (individuals to groups and systems) and scope (educational and supportive through reconstructive). The interaction of the individual with his or her physical, social, and cultural contexts is captured at the

intersection of these dimensions. Therefore there are brief, system-change strategies which are preventative including consultation and workshops; and short-term person-change strategies which are educational and include skill building activities and theme groups. For long-term treatment there are long-term, system-change strategies which are reconstructive and include ecological strategies and social advocacy and long-term person-change strategies which are remedial and include support groups and individual therapy (Steenbarger). The framework of this model states that helping others occurs at the client-context interface.

With this model there are three stages of counseling. The first is engagement which involves an assessment of the strengths and weaknesses of the client and an assessment of fit between these characteristics and the client's environment. This is an open-minded inquiry that leads to a collaborative plan for client treatment. The second stage is discrepancy. This refers to the realignment of the person-context interface through education and consciousness raising and is ecological and consultative. The third stage, consolidation, is characterized by practice, feedback, and the establishment of fit and appropriate social structures. Steenbarger (1993) believes that the strength of this model is that it seeks to empower clients by treating them as co-counselors collaborating in the process of system change. This goal can be reached in brief or long-term therapy (Steenbarger). One strength of this model is its attempt to capture the complexity of multicultural counseling. One criticism of this model is that it does not seem to support or prepare the client for setbacks including bureaucracy and racism that they will likely encounter in their lives.

Another major multicultural counseling theory is Ho's (1995) perspective on internalized culture. This theory supports the idea that multicultural training should be infused throughout the curriculum in training programs. Understanding and transcending internalized culture are central components to this theory. Internalized culture guides an individual through social actions, like a map. This shapes personality formation and psychological functioning through the individual's cultural influences (Ho). Ho suggests that internalized culture influences the formation of worldviews. He defines worldviews as a set of presuppositions underlying our views about the world and our place in it (Ho). Ho asserts that the basic mechanism for effective multicultural counseling is the idea of counselors transcending their own cultures. He suggests that the therapist must examine his or her own internalized culture in order to be sensitive against overgeneralization and stereotyping. Cultural identification and cultural orientation are used to help the counselor better understand the client. Cultural identification refers to acknowledging that individuals may differ widely in the extent to which they identify with the cultural heritage of their group. Cultural orientation reaffirms a measure of autonomy in individual preference for various cultural patterns. Both of these concepts are tools in development of self identities and worldviews and both must be considered in order to understand the client (Ho).

Ho (1995) emphasizes the importance of educational programs to produce multiculturally competent counselors by not just relying on one diversity course but that diversity should be a theme throughout all coursework. He also suggests that self-understanding should be a primary goal in education. Ho's basic assumptions are that all counseling necessarily entails cultural awareness; both the counselor's and client's

worldview and cultural identities must be assessed. He adds that the unique life experiences of the client must be considered and appropriate adjustments must be made. Becoming apologetic and timid with minority clients does a disservice to them and counselors must have an in-depth knowledge of the culture of clients different from their own (Ho). Therefore, Ho's theory would suggest that interns from training programs that integrate multiculturalism throughout their coursework will be more multiculturally competent than interns from programs that have one multicultural course, which this study will attempt to examine.

Two etic, or "culturally neutral," models that are currently a major focus in multicultural research and of this study are universal-diverse orientation and multicultural personality. The construct of universal-diverse orientation (UDO) was developed by Millville, Gelso, Pannu, Liu, Touradji, Holloway, and Fuentes (1999). UDO is defined as

"an attitude towards all other persons that is inclusive yet differentiating in that similarities and differences are both recognized and accepted; the shared experience of being human results in a sense of connectedness with people and is associated with a plurality of diversity of interactions with others." (p. 292).

UDO is a component of a multicultural personality disposition, which is a theory that looks beyond the multicultural competence of counselors to the general ability to accept and understand differences. In the last decade the construct of a multicultural personality has been developed. Brummet (2006) considers a multicultural personality to describe a person whom is able to show sensitivity and competence while working with people from different cultures. Brummet, Wade, Ponteretto, Thomas, and Lewis (2007)

found that multicultural personality disposition predicts self esteem, psychological hardiness, interpersonal functioning, and overall psychological well-being. A multiculturally competent counselor is likely to have a multicultural personality disposition. Millville (1999) goes on to state that individuals who place themselves in diverse situations do so because they appreciate differences and similarities and therefore have enhanced emotional connections which reinforce their universal diverse orientation.

Education has been identified as a means to gain multicultural competence in the field of psychology. And having a multicultural personality disposition is likely to have a part in a person's ability to be multiculturally competent. Therefore, educating psychologist to have a multicultural personality could increase his or her multicultural competence. Rameriz (1999, p. 26) suggests that a multicultural personality can be enhanced "through seeking interaction with diverse individuals and new cultural environments, taking on leadership roles in culturally diverse contexts that foster creative problem-solving, and being proactive in terms of social justice for oppressed groups."

Some have proposed that appreciating and accepting differences and similarities begins in childhood. Schools and early childhood programs have begun to examine the importance of adding multicultural education to their environment. Pederson, Mendelowitz, Collabolletta, and Ernest (2008) related multicultural personality to the Strength-Based School Counseling Model. They assert that any school counseling model should help prepare students for interacting in and adapting to an increasingly diverse environment. This increases the school counselors' role to involve facilitating students'

"(a) understanding of themselves, their own worldviews, and concomitant cultural biases; (b) knowledge of a multicultural history and of culturally

diverse groups that they will likely encounter; and (c) skill development regarding interacting with culturally diverse individuals in new environments” (Galassi & Akos, p 115.; Ponterotto, Utsey, & Pedersen, 2006).

They provide culturally based interventions that they believe could help to increase the multicultural personality of school-aged students (Ponterotto et al., 2008). In Australia all educational settings are required to implement multicultural education due to the ethnically heterogeneous society (Vuckovic, 2008). Vuckovic states that the aim of multicultural education is for the individual to accept his/her own and other’s ethnicity. There has not been much research on how multicultural experiences or exposure during childhood or adolescence impacts having a multicultural personality as an adult or its’ influence on multicultural competence. This study will attempt to measure this.

Another recent model of multicultural counseling which calls for change in training future clinicians is Heeson Jun’s (2010) theory of social justice and multicultural counseling. She suggests that students can learn to view others from a holistic perspective by transcending inappropriate dichotomous, linear, and hierarchical thinking. She asserts that multicultural issues should be learned through transformative learning, which facilitates compassion, resilience, collaboration, and understanding, and implementing social justice for self and others. This theory calls for the practitioner to shift both thinking and learning styles in a way that allows him/her to better work with individuals with complex demographic identities and dynamic and complex sociocultural contexts. Jun prefers the etic approach, stating that having a model for each type of diversity can perpetuate stereotyping and leaves out people who fit several categories such as biracial

individuals. She asserts that racial categorization is never really accurate due to within group variability and also promotes stereotyping. The challenge for the practitioner is to obtain and accurately apply knowledge about the client's particular cultural group without minimizing or missing differences within that individual. The hallmark of this theory is the conceptualization of the identity of a person from a holistic approach by examining simultaneously multiple identities and how they intersect. Jun suggests the use of experiential learning activities and emotion in multicultural training to promote a new and different way of thinking. A strength of theories from the etic perspective is that these theories seem to emphasize the importance of multicultural training, some theories even insisting that there should be infusion of multicultural information throughout graduate training for psychologist. The following is a discussion of multicultural training and a review of research on its effectiveness.

Multicultural Education

Having discussed culture and theories of multicultural counseling it is now important to review the effects of multicultural counseling education. The following is a review of theories of counselor training as well as both qualitative and quantitative research related to multicultural counselor competence.

Qualitative and Quantitative Research on Education

Research on multicultural counseling competence has generally shown to be improved by education. The specific effectiveness of this education has also been examined. Salvadore (1998) evaluated doctoral students enrolled in a multicultural training course using the Multicultural Counseling Inventory (MCI) (Sodowsky, Taffe, Gutkin & Wise, 1994) and found significant pre to post-class differences for the

multicultural knowledge subscale, but not subscales measuring awareness, skill, or relationship. Neville, Heppner, Louie, Thompson, Brooks and Baker (1996) found that a multicultural counseling course significantly increased the level of multicultural therapy competencies of participants. And Berg (2000) found a significant increase of the level of multicultural awareness for men who took a multicultural counseling course at the Master's level. For Berg's study, neither race nor delivery style of instructor had a significant effect on the course impact of multicultural awareness of participants. These two studies utilized the Multicultural Awareness, Knowledge, and Skill Survey (MAKSS; D'Andrea, Daniels, Heck, 1991).

Several studies have also looked at the factors that have contributed to counselors who self-report higher levels of multicultural competency. Carlson, Brack. Laygo, Cogen, and Kirkscey (1998) reported that self-perceived multicultural competency and general perceptions of counselor competence reflected greater exposure to multicultural training and activities. Sadowsky, Kuo, Richardson and Corey (1998) conducted a multiple regression analysis to explore factors related to higher levels of multicultural competencies as measured by the Multicultural Counseling Inventory (MCI). They found that multicultural counseling courses were one of several variables that made important contributions to higher levels of multicultural competence. Other variables included number of minority and international clients and participation in multicultural research projects. These studies support the assumption that training is indicative of increased multicultural counseling competence. More recently research has focused on what aspects of training are most salient to increased competence.

Qualitative studies have been conducted recently to examine the impact of multicultural training, specifically attempting to provide information regarding what aspects of the course were most salient for counselor trainees, and what contributed to course efficacy. Langman (2000) interviewed 17 graduate students about their experiences in courses that focused on multicultural issues in education and human services. He reported important variables for students regarding courses that included course goals, content, class size, makeup of class small groups, length of course, course requirements, nature of interactions of students with course instructor, and other students. Students in this study expressed a preference for a comprehensive curriculum that integrated various cultures and interventions. They also preferred that cultures not be presented as homogenous. Similarly, Kanitz (1998) interviewed European American counseling students and found six themes regarding their multicultural training experience which indicated a need for this type of education. These themes were resistance to self-exploration, showing relatively little self-awareness regarding racial issues, being fearful of negative evaluation, and ambivalence about articulating racial information regarding clients as well as discussing racial issues in general.

There has been a paucity of research on the infusion of multicultural education throughout the graduate psychology curriculum. Very few programs have integrated multicultural education throughout their curricula. Some of the programs that have tried this include University of Wisconsin-Milwaukee, Arizona State University, Teachers College-Columbia University, Boston College, and University of Georgia. Although some programs have started to apply this method of teaching multicultural counseling competency it is still not the standard for most education programs. This study will

attempt to examine if there is a difference in competency between students from such programs and those from programs that have one multicultural course. The following is a discussion of multicultural counseling competency as the goal of multicultural education is to train multiculturally competent counselors.

The Multiculturally Competent Counselor

All of the theories reviewed here assert that a practitioner must continuously strive for multicultural competency. Some have proposed guidelines to measure this competency. Sue and Sue (1999) propose useful guidelines that may help bridge the gap between contemporary forms of therapy and traditional non-Western indigenous healing when working with a culturally different client who believes mental health disorders are of a spiritual nature. First they encourage the clinician to avoid invalidating the client's cultural belief system. Although the clinician may not have the same beliefs around what is causing the client's mental disorder and could help, invalidating the client's beliefs could damage the working relationship. It is important that the therapist is open and able to entertain alternative worldviews and understand that such beliefs reflect the realities of a different culture. Avoiding being judgmental allows the client to more readily share his or her story and feel validated and to encourage the building of mutual respect and trust (Sue & Sue). The second guideline involves gaining knowledge about the culturally different client's beliefs and healing practices. Sue and Sue offer that for desensitization and normalization to occur, the clinician must become knowledgeable about the assumptions and practices of the client's culture. The third guideline states that learning through experience is essential. Sue and Sue recommend attending culturally different

activities so that the clinician can view these cultural differences among the people of that culture. This allows the clinician to personalize their understanding of the culture.

The fourth guideline is to avoid overpathologizing and underpathologizing a culturally different client's problem. Sue and Sue (1999) stress that difference does not equal deviance. There must be a balance. While it is important to understand the client's cultural context, have knowledge of culture-bound syndromes, and be aware of cultural relativism being oversensitive to these factors may predispose the therapist to minimize problems. The fifth guideline encourages the therapist to be willing to seek the advice of and/or utilize the services of traditional healers in the client's culture. There are several advantages to this including gaining additional insight into client populations, enhancement of the cultural credibility of the therapist, and the opportunity for multidisciplinary work with clients. The sixth guideline states that spirituality must be seen as an intimate aspect of the human condition and a legitimate aspect of mental health work. Since spirituality is such a large part of several different cultural worldviews it can be essential for the therapist to be willing to integrate it into his or her practice to work effectively with such clients. The final guideline calls for the clinician to be involved with and take a helping role in the community (Sue & Sue). According to Sue and Sue, following these guidelines will increase a clinician's multicultural competence. These steps can be applied by an individual but there is also the need for competence at the systems level.

To accomplish this Sue and Sue (1999) call for the systems to change including mental health care delivery systems, businesses, and schools. They suggest this change should involve developing multicultural organization competence. If the therapist must

be multiculturally competent, so must the organization. To meet the unmet needs of minority populations, organizations must not only employ individuals with multicultural therapy skills, but the agency itself needs to have a multicultural culture. There are some theories that propose how an agency can accomplish this. Cross and colleagues (1989) developed a detailed six-stage developmental continuum of cultural competence for caregiving organizations such as mental health agencies. The stages are as follows; 1) cultural destructiveness, 2) cultural incapacity, 3) cultural blindness, 4) cultural pre-competence, 5) cultural competence, and 6) cultural proficiency.

The first stage, cultural destructiveness, refers to programs that have participated in culture/race-based oppression, forced assimilation, or even genocide. These include such devastating events in history such as the Tuskegee experiment which involved deliberately withholding treatment from Black men with syphilis. Stage two, cultural incapacity, is represented by programs that lack the capacity to help minority clients. This could be due to discriminatory hiring, subtle unwelcoming messages to minority clients, and lower expectations of minority clients based on unchallenged stereotypical beliefs. The third state in Cross and colleague's model is cultural blindness, which refers to agencies that provide services that are governed by the philosophy that all people are the same and all helping interventions are universally applicable. This blindness treats all clients as if they are the same, therefore ignoring cultural differences. Cross and colleague's fourth stage, cultural pre-competence, includes agencies that recognize their inability to effectively provide treatment to minority clients and begin discussing and making changes to become a more multiculturally competent agency. Cultural competence is the fifth stage on the continuum.

“Agencies at this stage show continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptation to service models in order to better meet the needs of culturally diverse populations” (Cross et al., 1989, p. 17).

The final stage, cultural proficiency, suggests that both the agency and the individuals within the agency are acting at the highest level of multicultural competence. This would involve the agency consistently conducting evaluations of its multicultural competence, conducting research, and adding new therapeutic approaches to benefit the culturally different client. Cross and colleagues (1989) recognize that few agencies will reach this stage in the continuum. An agency should continuously monitor its own competence to provide effective service to clients of various backgrounds. An organization that strives for multicultural competence is more likely to encourage and hopefully require its professionals to be multiculturally competent. This study will focus on competence at the individual level. Internships with APA accreditation are assumed to be working towards providing competent services.

For competence to occur at either the individual or organizational level both must first discuss the issue of providing services for varying types of individuals. Some may argue that good counseling is good counseling, but ignoring differences can lead to more harm than good. In the helping professions, insensitive counseling and therapy can result in cultural oppression rather than liberation (Constantine, 2007).

In order to perform multicultural counseling, one must work towards becoming a culturally competent healer (Sue et al., 1998). A culturally competent psychologist

works towards several primary goals. First, they must become aware of their own assumptions and biases about human behavior, values, preconceived notions, and personal limitations. This is known as awareness. A culturally competent psychologist has moved from being culturally unaware to being aware and sensitive to his/her own cultural heritage and to valuing and respecting differences. This includes being aware of his or her own detrimental attitudes, beliefs, and feelings. He/she is aware of his or her own biases and values and how these may affect clients while also being comfortable with differences that exist between the psychologist and client. A culturally competent psychologist is also sensitive to circumstances that might call for them to refer the client to a different therapist that may be appropriate for the client such as if personal biases exist (Sue et al., 1998).

Second, the culturally competent psychologist must acquire knowledge by attempting to understand the clients' assumptions, biases, and worldview. He or she must be knowledgeable and informed on a number of culturally diverse groups, as well as the sociopolitical systems treatment of marginalized groups. He or she must also possess specific knowledge and understanding of the generic characteristics of counseling and therapy as well as institutional barriers that prevent some diverse clients from using mental health services (Sue et al., 1998). Lastly, the psychologist must actively work to gain knowledge and experience in appropriate interventions for his or her client by increasing his or her skills. The psychologist must be able to generate a wide variety of verbal and nonverbal helping responses as well as communicate accurately and appropriately. Also, the culturally competent psychologist is able to exercise institutional intervention skills on behalf of the client when appropriate. He or she can anticipate the

impact of the helping styles and limitations he or she possesses on culturally diverse clients. And he or she is able to play helping roles characterized by a focus on the client's system, not just the conventional counselor mode of operation (Sue et al, 1982; Sue, Arrendondo, & McDavis, 1992; Sue et al., 1998). For a beginning intern to be multiculturally competent they would have to meet all of these criteria. These three criteria of awareness, knowledge, and skills are widely accepted in the field of psychology as the necessary components to being a multiculturally competent clinician.

Models such as this prompted the field of psychology to seek to measure multicultural competency. Out of this, assessment of competency was born. Many measures have been developed in order to assess multicultural competence and some have been discussed throughout this review. For the purposes of this study the Multicultural Counseling Inventory (MCI) will be used to assess beginning interns self perceived multicultural competency because it is the most widely used measure of competency.

Summary

Since the 1960's psychology has begun to recognize the importance of addressing culture in therapy brought on by the insurgence of minority clients seeking therapy services. Psychology, particularly counseling psychology, has since provided research in to what is effective therapy for different cultures as well as an examination of the education students receive to learn to work with a diverse clientele. Part of this examination has looked at whether practicing psychologist are competent to provide services to diverse clients. In the last decade, research has examined universal diverse orientation and multicultural personality. It seems that that having a multicultural

personality would lend to being a multiculturally competent counselor. This study seeks to examine this as well as others factors contributing to the multicultural competence of beginning interns. It was hypothesized that the level of integration of multicultural information in the graduate program would increase self-perceived multicultural competence when adjusting for social desirability. This study also predicted that interns with experience with more culturally diverse client experience would have higher self-perceived multicultural competence scores when controlling for social desirability. Additionally, it was hypothesized that there would be no difference between internship site choice and multicultural competence. And it was predicted that there would be no difference in competency scores for clinical and counseling psychology beginning interns. This study also hypothesized that more multicultural life experiences would increase multicultural competence scores and multicultural personality scores. And finally, it was predicted that higher multicultural personality scores would correlate with multicultural competence scores and universal-diverse orientation would correlate with multicultural personality.

CHAPTER III

Method

Beginning interns were asked to complete several questionnaires to examine their multicultural experiences, multicultural personality, and multicultural competence, as well as their multicultural social desirability. It was hypothesized that the level of integration of multicultural information in the graduate program would increase self-perceived multicultural competence when adjusting for social desirability. This study also predicted that interns with experience with more culturally diverse client experience would have higher self-perceived multicultural competence scores when controlling for social desirability. Additionally, it was hypothesized that there would be no difference between internship site choice and multicultural competence. And it was predicted that there would be no difference in competency scores for clinical and counseling psychology beginning interns. This study also hypothesized that more multicultural life experiences would increase multicultural competence scores and multicultural personality scores. And finally, it was predicted that higher multicultural personality scores would correlate with multicultural competence scores and universal-diverse orientation would correlate with multicultural personality.

Multicultural experiences during childhood, adolescence, and adulthood, as well as information about the intern's practicum placement, internship site, client contact hours, and gender were gathered through a demographics questionnaire. The interns multicultural competencies were measured by the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, and Wise, 1994) and these scores were adjusted for by

using the Multicultural Social Desirability Scale (MCSD; Sodowsky, Kuo-Jackson, Richardson, and Corey, 1998) to better assess the usefulness of self-reported multicultural competence. Universal-diverse orientation was measured by the Miville-Guzman Universality-Diversity Scale Short (M-GUDS-S; Miville, Holloway, Gelso, Pannu, Liu, Touradji, and Fuertes, 2000). And, multicultural personality was measured by the Multicultural Personality Questionnaire (MPQ; Van der Zee and Van Oudenhoven, 2000). This chapter includes a description of the participants for this study, a description of the measures used, and the procedure.

Participants

Data were collected from 78 participants; however data for 4 participants were deleted due to missing data. It appeared that these 4 participants began to complete the survey but did not finish it. More than half of the survey was not completed for two participants. The other two participants who were removed had not completed questions for one entire measure. Therefore, a total of 74 participants were included in this study. Participants were from clinical psychology doctoral programs ($n = 43$, 58.1%) and counseling psychology doctoral programs ($n = 31$, 40.5%). Most participants' doctoral programs were accredited by the American Psychological Association (APA) ($n = 71$, 95.9%). Two programs (2.7%) were accredited by CACREP and 1 participant (1.4%) reported attending a program that had no accreditation. Participants included 15 males (20.3%) and 59 females (79.7%). The participants' ages ranged from 22 to 61 with a mean age of 29.63 ($SD=6.51$). Fifty-eight participants identified as European American or White (78.40%), 9 identified as African American or Black (12.20%), 2 identified as Asian or other Pacific Islander (2.70%), 8 identified as Spanish/Hispanic/Latino

(10.80%), and 2 identified as American Indian (2.70%). Fifty-nine (79.7%) participants reported getting internships accredited by APA.

Participants were asked to identify at what type of sites they had completed practicum training. 41 (55.4%) are attending internship at a university counseling center, 10 (13.5%) at a private general hospital, 38 (51.4%) at a community mental health center, 9 (12.2%) at a medical school, 18 (24.3%) at a prison or correctional facility, 27 (36.5) at a private outpatient clinic, 12 (16.2%) at a private psychiatric hospital, 23 (31.1%) at a psychology department, 15 (20.3%) at a school district, 13 (17.6%) at a state/county/other public hospital 14 (18.9%) at a veterans affairs medical center, and 7 (9.5) marked other which included athletic departments. Participants were also asked where they would be attending internship. 25 (33.8%) are attending internship at a university counseling center, 6 (8.1%) at a private general hospital, 9 (12.2%) at a community mental health center, 1 (1.4%) at an armed forces medical center, 5 (6.8%) at a consortium, 8(10.8%) at a medical school, 4 (5.4%) at a prison or correctional facility, 6 (8.1%) at a private outpatient clinic, 5 (6.8%) at a private psychiatric hospital, 1 (1.4%) at a psychology department, 1 (1.4%) at a school district, 6 (8.1%) at a state/county/other public hospital 7 (9.5%) at a veterans affairs medical center, and 3 (4.1) marked other which included athletic departments.

Two participants reported having zero client contact hours despite having practica experience; therefore the mean number of client contact hours for all participants was used for these two participants. The mean number of client contact hours accrued ranged from 150 to 3400, with an average of 958.69 hours ($SD = 529.82$). The percentage of non-White clients the interns had provided service for ranged from 0% to 100%, with an

average of 28.86% ($SD = 24.04$). Interns estimated the percentage of friends, schoolmates, and neighbors that were different/diverse from them as a child (ages 0-12), adolescent (ages 13-17), and as an adult (age 18+). During childhood, interns percentage of multicultural life experiences ranged from 0 to 100 with an average of 26.29%. During adolescence the percentages ranged from 0 to 100 with an average of 26.12%. And as an adult the percentages ranged from 1 to 100 with an average of 34.3% (See Table 1 for descriptive statistics by type of program).

Measures

Demographic Questionnaire

The demographic questionnaire (See Appendix A) was developed for this study. Participants were asked to indicate their gender, age, ethnicity, current degree program and its' accreditation. They were also asked how their program infused multicultural information into the curriculum, the type of site in which they completed practica and were matched for internship, and if their internship site is accredited. Participants were asked to indicate the number of client contact hours they had accrued and to estimate the percentage of non-European American clients they had seen. They were also asked what percentage of their family and friends were culturally different than them as a child (0-12), adolescent (13-17), and adult (18+).

The Multicultural Counseling Inventory (MCI)

The MCI was developed by Sadowsky, Taffe, Gutkin, and Wise (1994). The MCI is a self-report instrument designed to measure multicultural counseling competencies. This instrument has four factors: a) Multicultural Counseling Skills, b) Multicultural Awareness, c) Multicultural Relationship, and d) Multicultural Counseling

Knowledge. It is one of the most widely used self-report measures of multicultural competence. There are 40-items answered by a 4-point Likert scale ranging from 4 = very accurate to 1 = very inaccurate, with 4 indicating high multicultural competence and 1 indicating low multicultural competence (Sodowsky et al). The Awareness subscale consists of items that assess “proactive multicultural sensitivity and responsiveness, extensive multicultural interactions and life experiences, broad-based cultural understanding, advocacy within institutions, enjoyment of multiculturalism, and an increase in minority caseload” (Sodowsky et al., p. 142). The Knowledge subscale is composed of items that measure “culturally relevant case conceptualization and treatment strategies, cultural information, and multicultural counseling research” (Sodowsky et al., p. 142). The Skills subscale is composed of items assessing “success with retention of minority clients, recognition of and recovery from cultural mistakes, use of nontraditional methods of assessment, counselor self-monitoring, and tailoring structured versus unstructured therapy to the needs of minority clients” (Sodowsky et al., p. 141). The Relationship subscale includes items measuring “counselor trustworthiness, comfort level, stereotypes of minority clients, and worldview” (Sodowsky et al., p. 142).

The four factors of this instrument showed moderate to moderately high internal consistency reliabilities of .83 Awareness, .79 Knowledge, .83 Skills, and .65 Relationship. Interfactor correlations ranged from .18 to .41; which validates that the four subscales measure different constructs (Sodowsky et al., 1994). In a study of multicultural counseling competence scales relation to social desirability attitudes and case conceptualization abilities, Constantine and Ladany (2000) found Cronbach’s alphas of .91 for the total scale, .82 for the Awareness subscale, .84 for the Knowledge subscale,

.81 for the Skills subscale, and .71 for the Relationship subscale in a sample of Master's and doctoral level counseling and clinical psychology students.

Multicultural Social Desirability Scale (MCSD)

The MSDS, developed by Sodowsky, Kuo-Jackson, Richardson, and Corey (1998), is a 26 item scale in a true-false format. It is used to assess multicultural social desirability and is most often used with the MCI per recommendation of the authors as well as Constantine and Ladany (2000) to better assess the usefulness of self-reported multicultural competence. A high score (i.e., 25-26) indicates that one is claiming favorable attitudes towards minorities all the time versus a low score (i.e., 5-6) indicating that one is not concerned about appearing unsympathetic towards minorities. Sodowsky and colleagues through several studies determined that a mean score of 16 is considered realistic intergroup attitudes and indicates balance between the two perspectives.

Cronbach's alpha for the MCSD is reported to be .80 (Sodowsky et al., 1998). Both the MCI and MCSD were obtained for this study by contacting the measures developer, Dr. Gargi Roysircar, by phone and email. The measures were both mailed and faxed along with supporting literature after this author filled out the application form and paid the fees.

The Multicultural Personality Questionnaire (MPQ)

Van der Zee and Van Oudenhoven (2000) developed the Multicultural Personality Questionnaire based on the Costa and McCrae (1992) Big Five factors; however, they specifically focused on traits relevant to multicultural success. It was designed to measure multicultural effectiveness (Van der Zee & Van Oudenhoven). It is a 78 item questionnaire with a five-point scale ranging from (1) not at all applicable to (5) totally

applicable. The MPQ measures five scales of multicultural effectiveness. These scales include: a) Cultural Empathy, b) Open-Mindedness, c) Emotional Stability, d) Social Initiative, and e) Flexibility. The Cultural Empathy scale measures the ability to empathize with the feelings, thoughts, and behaviors of members from different cultural groups. Statements from this scale include “Notices when someone is in trouble; “ “Understands other people’s feelings.” High scorers on the Cultural Empathy scale have been found to have an interest in other people and are sensitive to their feelings and beliefs (Rushton & Irwing, 2008). The Open-Mindedness scale looks at an open and unprejudiced attitude towards out-group members and towards different cultural norms and values. Example statements include, “Gets involved in other cultures” and “Finds other religions interesting.” High scorers on this scale have an absence of prejudice (Rushton & Irwing, 2008). The third scale, Social Initiative, examines a tendency to actively approach social situations and to take the initiative rather than to wait and see. Example items include, “Is inclined to speak out.” High scorers tend to actively approach social situations and take the initiative (Rushton & Irwing). The Emotional Stability scale measures a tendency to remain calm in stressful situations versus a tendency to show strong emotional reactions under stressful circumstances. An example item is, “Can put setbacks in perspective.” High scorers have been found to remain calm in stressful situations (Rushton & Irwing). The final scale, Flexibility, measures the ability to switch easily from one strategy to another. A tendency to feel attracted to new and unknown situations, experiencing them as a challenge rather than as a threat. Example items include, “Avoids adventure” and “Starts a new life easily.” High scorers tend to easily adapt to new situations (Rushton & Irwing).

A study of personality and individual differences by Leone, Van der Zee, van Oudenhoven, Perugini, and Ercolani (2005) examined the generalizability of the MPQ with a sample of Italian participants and found satisfactory internal consistencies for each scale with an alpha coefficient of .85 for Cultural Empathy, .83 for Open-mindedness, .86 for Social Initiative, and .85 for Emotional Stability. Flexibility had an alpha coefficient of .65. It was also conducted with a sample Dutch participants and found an alpha of .82 for Cultural Empathy, .83 for Open-mindedness, .89 for Social Initiative, .88 for Emotional Stability, and .74 for Flexibility. Validity was examined for the MPQ in relation to the Big Five factors. Van der Zee and Van Oudenhoven (2000) found strong relationships among the scales which were later replicated by Leone et al. with Open-mindedness (.50), Social Initiative (.76) and Emotional Stability (-.73) being strongly related to Openness to Experience, Extraversion and Neuroticism. Cultural Empathy was most strongly related to Openness to Experience (.39). Flexibility was strongly negatively related to Conscientiousness (-.46; Leone et al.). The MPQ was obtained for this study by contacting the authors by email. The measure was sent as an email attachment.

The Miville-Guzman Universality-Diversity Scale Short (M-GUDS-S)

The Miville-Guzman Universality-Diversity Scale (M-GUDS) was developed by Miville, Holloway, Gelso, Pannu, Liu, Touradji, and Fuertes (1999) to measure the construct of universal-diverse orientation, which “reflects an attitude of awareness and acceptance of both similarities and differences among people” (p. 291). It is a 45-item scale that uses a Likert format with responses ranging from 1 (strongly disagree) to 6 (strongly agree). It has shown strong internal consistency across several samples (Miville

et al.). Yeh and Arora (2003) obtained a Cronbach's alpha of .93 when investigating 159 school counselors' multicultural training and self-construal as predictors of universal-diverse orientation. Their sample was 79.2% White, 13.8% African American, 1.9% Hispanic, 1.3% Asian American, .6% Native American, and 3.1% identified as multiracial (Yeh & Arora).

The Miville-Guzman Universality-Diversity Scale Short (M-GUDS-S; 2000, See Appendix B) was developed from factor-analytic studies of the original M-GUDS. The M-GUDS-S is also a 6-point Likert scale self-report instrument that measure universal-diverse orientation (Fuertes, Miville, Mohr, Sedlacek, & Gretchen). Examples of items include, "I am only at ease with people of my race" and "Persons with disabilities can teach me things I could not learn elsewhere." Higher total scores indicate higher levels of universal-diverse orientation. Fuertes et al. reported a Cronbach's alpha of .79 for the M-GUDS-S. A study by Brummet (2007) using the M-GUDS-S total score to measure well-being and multicultural personality disposition found a Cronbach's alpha of .75. This measure was obtained for this study by printing it from the author's website.

Procedure

A power analysis was conducted using the G Power computer program (Faul, Erdfelder, Lang & Buchner, 2007) in order to establish the number of participants needed to find a significant effect at the .05 alpha level. The results of the power analysis indicated 78 participants for the MCI, 44 participants for the MPQ, and 26 for the M-GUDS-S. Thus, in order to answer the proposed research questions, the minimum number of participants was set at 78.

The survey was created and distributed using Qualtrics survey software. The consent statement (Appendix C) and survey link was emailed to training directors at all APA accredited counseling ($n = 70$) and clinical ($n = 162$) doctoral psychology training programs. The email requested that the training directors forward the consent and survey link to their students who would be beginning internship in the summer or fall. Reminder emails were sent at one week and two weeks after the initial request. The surveys were presented in the following order: a) demographics questionnaire, b) M-GUDS-S, c) MPQ, d) MCI, and e) MCSD. Participant data were collected using Qualtrics survey software and then transferred to the Statistical Package for Social Sciences (SPSS) for analysis. One way analysis of covariance and regression analyses were used to examine the data.

CHAPTER IV

Results

This chapter will report the results of the following hypotheses utilizing both general linear models and regression analyses.

Data Transformation

The data were examined before completing the main analysis. The intention was to identify any missing data or violations of the assumption of normality. Levene's test and visual inspection of both the predicted value and residual scatterplot and the spread versus level plot graph were conducted. This examination showed that the variables exhibited normal properties. Two cases were missing more than half of the data and two other cases were missing entire measures or subscales; these cases were removed from the analysis. Examination of the data revealed that data appeared to be missing randomly for the MCI. Missing data on this scale were dealt with by performing a missing values analysis and imputing estimated means due to the fact that a reasonably low percentage of respondents (less than 5%) were missing data on any individual question. The first question of the MPQ "likes low-comfort holidays" was not answered by half of the participants. As recommended by the authors, the item mean was computed and used for the missing values.

A total of 74 cases were identified for this data analysis. Table 1 displays the descriptive properties of this data set.

Means and standard deviations for all measures by type of program and for the total sample are provided in Table 2. Intercorrelations among the measures and variables are displayed in Table 3 (Appendix D).

One- way analysis of covariance (ANCOVA) were performed on the global scale and on each of the four subscales of the MCI to detect mean differences between counseling and clinical psychology beginning interns. These ANCOVA's were performed in order to test the hypotheses that had the MCI as the dependent variable while controlling for social desirability. The global scale and the four subscales of the MCI were the dependent variables. The MCSD scale was the covariate. Significance was indicated by $p \leq .05$. Regression analyses were also used to determine the relationship between variables for several hypotheses. A separate listwise regression analysis and partial correlation were run for each hypothesis requiring this type of analysis. For these analyses the MCSD was entered as the control variable as recommended by the authors, then the predictor variable was entered. Also, a hierarchical regression analysis was conducted to examine the effect of the predictor variables on the MCI (See Table 4).

The MCSD was used as a control variable for all hypotheses that examined the MCI scores as recommended by the authors and previous literature. A regression analysis showed that the MCSD did predict MCI scores, $r = .34$, $r^2 = .12$ $t(1, 73) = 3.03$, $p = .00$. This finding supports controlling for social desirability when measuring multicultural competence because it accounts for 12% of the variance (See Table 4).

Hypothesis 1

It was predicted that interns from programs that infused multicultural information throughout the curriculum would have higher self-perceived multicultural competence

than those with less infusion. One-way analyses of covariance were performed to examine the relationship between the level of infusion of multicultural information in the intern's graduate program and multicultural competence when controlling for multicultural social desirability. The participants were put into three groups to compare. The high infusion group ($n = 42$) indicated that multicultural information was infused in almost every course in their education. The low infusion group ($n = 16$) indicated that one course focused on multicultural information. The medium infusion group ($n = 15$) indicated that more than one course infused multicultural information. The no infusion group was not included in the analysis because only one person identified as being in this group, which is not enough to compare to the other three groups. Means and standard deviations for each group (i.e., low, medium and high infusion) are provided in Table 5. To check the assumption of linearity the spread versus level plot graph was visually inspected. There appeared to be a linear relationship and the error terms did not seem to overlap. The assumption of homogeneity of variance was assessed by the Levene's test, $F(2, 70) = .36, p = .70$; this indicated no significant violation of the equal variance assumption. The assumption of homogeneity of variance was assessed by the Levene's test for the subscales as well, Skills $F(2,70) = 1.48, p = .23$, Awareness $F(2,70) = .22, p = .80$, Relationship $F(2,70) = .38, p = .69$, and Knowledge $F(2,70) = 1.15, p = .32$; this indicated no significant violation of the equal variance assumption.

There was not a significant difference between the three groups based on level of infusion of multicultural information on their global self-perceived multicultural competence score, when controlling for multicultural social desirability, $F(2,69) = 1.31, p = .28$. Also, no significant differences were found for three of the MCI subscales (Skills

$F(2,69) = .07, p = .94$, Relationship $F(2,69) = .03, p = .98$, and Knowledge $F(2,69) = 1.26, p = .29$). There was a significant difference on the level of infusion and the MCI Awareness subscale when controlling for multicultural social desirability $F(2,69) = 3.39, p = .03$. However, post hoc analysis (Bonferonni) showed no significant mean differences between groups on this subscale. Therefore, Hypothesis 1 was rejected as the results indicated no relationship between infusion of multicultural information in the graduate curriculum and self-perceived multicultural competence.

Hypothesis 2

It was hypothesized that interns with more experience with clients who were culturally different than them would have significantly higher self-perceived multicultural competence scores when adjusting for social desirability. A regression analysis was used to examine this relationship. The analysis determined whether client experience accounted for significant variance in predicting multicultural competence. To check the assumption of linearity the predicted value and residual scatterplot was visually inspected. The vast majority of scores appeared to be between -2 and 2, meaning this assumption was not violated. The correlation between MCI scores when controlling for social desirability and the percentage of culturally different clients was positive and statistically significant, $r(70) = .26, p = .03$. The r^2 was .06; thus, about 6.5% of the variance in MCI scores could be predicted from the percentage of culturally different clients seen after controlling for MCSD. The correlation between MCI Awareness subscale scores when controlling for social desirability and percentage of culturally different clients was also positive and statistically significant, Awareness $r(70) = .36, p = .01$. The r^2 was .10, indicating that approximately 10% of the variance in MCI

Awareness scores could be predicted from the percentage of culturally different clients. However, the other three subscales did not show a statistically significant relationship: Skills $r(70) = .13, p = .27$; Relationship $r(70) = .21, p = .08$; Knowledge $r(70) = .13, p = .27$. Therefore, Hypothesis 2 was supported as interns with more experience with culturally different clients had higher self-perceived multicultural competence scores on the global scale. However, when examining the subscales it seems that only the Awareness subscale showed a relationship between experience with culturally different clients and self-perceived multicultural competence.

Hypothesis 3

It was predicted that there would be no difference in multicultural competence scores of interns who chose internship sites with more multicultural training at the site and internship sites with less focus on multicultural training at the site when controlling for social desirability. One-way analyses of covariance were performed to determine if there was a relationship between multicultural competence scores and internship site choice. There were four groups: group 1 included university counseling centers ($n = 24$), group 2 included hospitals and veterans affairs centers ($n = 21$), group 3 included outpatient community mental health counseling centers ($n = 10$), and group 4 included other internship sites such as schools and athletic departments ($n = 19$). Means and standard deviations for each group are provided in Table 6. To check the assumption of linearity the spread versus level plot graph was visually inspected. There appeared to be a linear relationship and the error terms did not seem to overlap. The assumption of homogeneity of variance was assessed by the Levene's test, $F(3, 70) = .37, p = .77$; this indicated no significant violation of the equal variance assumption. The assumption of

homogeneity of variance was assessed by the Levene's test for the subscales as well, Skills $F(3,70) = 1.53, p = .21$; Awareness $F(3,70) = .07, p = .97$; Relationship $F(3,70) = .36, p = .78$; and Knowledge $F(3,70) = .78, p = .51$, this indicated no significant violation of the equal variance assumption.

There was not a significant difference between any of the groups and multicultural competence scores, when controlling for multicultural social desirability, $F(3,69) = 1.05, p = .38$. No significant differences were found for the MCI subscales either (Skills $F(3,69) = .88, p = .45$, Relationship $F(3,69) = .45, p = .72$, Knowledge $F(3,69) = .44, p = .73$, and Awareness $F(3,69) = 1.28, p = .29$). Therefore, Hypothesis 3 was supported as there did not appear to be a relationship between internship site type and self-perceived multicultural competence.

Hypothesis 4

This study predicted that there would be no difference between the multicultural competency scores of interns from counseling psychology programs and those from clinical psychology programs. One-way analyses of covariance were performed to examine this hypothesis. There were 43 clinical psychology intern participants and 31 counseling psychology intern participants. See Table 7 for means and standard deviations. To check the assumption of linearity the spread versus level plot graph was visually inspected. There appeared to be a linear relationship and the error terms did not seem to overlap. The assumption of homogeneity of variance was assessed by the Levene's test, $F(1, 71) = 1.34, p = .25$, this indicated no significant violation of the equal variance assumption. The assumption of homogeneity of variance was assessed by the Levene's test for the subscales as well, Skills $F(1,71) = 1.89, p = .17$; Awareness $F(1,71)$

= .77, $p = .38$; Relationship $F(1,71) = 2.03$, $p = .159$; and Knowledge $F(1,71) = .12$, $p = .73$; this indicated no significant violation of the equal variance assumption.

There was not a significant difference between the clinical and counseling psychology interns on multicultural competence scores, when controlling for multicultural social desirability, $F(1,70) = 2.68$, $p = .11$. Also, no significant differences were found for three of the MCI subscales (Skills $F(1,70) = 2.18$, $p = .14$; Relationship $F(1,70) = 1.37$, $p = .25$; and Knowledge $F(1,70) = 1.05$, $p = .31$). There was a significant difference between counseling and clinical psychology interns on the MCI awareness subscale when controlling for multicultural social desirability $F(1,70) = 8.32$, $p = .01$, with counseling interns having higher scores than clinical interns. Therefore, Hypothesis 4 was partially supported. There does appear to be a difference between counseling and clinical psychology students self-perceived multicultural competence, specifically in awareness of multicultural issues.

Hypothesis 5

This study predicted that interns with more multicultural experiences would have higher self-perceived multicultural competence scores when controlling for social desirability. Partial correlations were used to examine the relationship between self-perceived multicultural competency and experiences in childhood, adolescence, and adulthood. First, a partial correlation was used to examine childhood experiences (ages 0-12) and self-perceived multicultural competence scores when controlling for social desirability. To check the assumption of linearity the predicted value and residual scatter plot was visually inspected for the global scores and the subscales. The vast majority of scores appeared to be between -2 and 2, meaning this assumption was not violated. The

correlation between MCI scores ($M = 124, SD = 14.58$), when controlling for MCSD ($M = 17.67, SD = 3.76$) and the percentage of culturally different people in the interns life during their childhood ($M = 26.29, SD = 34.08$), was positive and statistically significant, $r(70) = .44, p = .00$. And r^2 was .20, thus 20% of the variance in MCI scores when controlling for MCSD could be predicted from the percentage of culturally different people in the intern's life during childhood. This finding held true when examining the relationship on each subscale as well: Skills $r(70) = .26, p = .03, r^2 = .07$, 6.8% of the variance explained; Awareness $r(70) = .45, p = .00, r^2 = .20$, 20% of variance explained; Relationship $r(70) = .27, p = .02, r^2 = .08$, 8% of variance explained; and Knowledge $r(70) = .36, p = .00, r^2 = .13$, 12% of variance explained.

Second, the relationship between the percentage of culturally different people in the intern's life as an adolescent (ages 13-17) and MCI scores when controlling for MCSD was examined. To check the assumption of linearity the predicted value and residual scatter plot was visually inspected for the global scores and the subscales. The vast majority of scores appeared to be between -2 and 2, meaning this assumption was not violated. This correlation also was positive and statistically significant, $r(70) = .41, p = .00, r^2 = .17$, 17% of variance explained. And the relationship between the percentage of multicultural experiences in adolescence ($M = 26.12, SD = 33.04$) and each of the MCI subscales when controlling for MCSD were also positive and statistically significant: Skills $r(70) = .27, p = .02, r^2 = .08$, 8% of variance explained; Awareness $r(70) = .40, p = .00, r^2 = .16$, 16% of variance explained; Relationship $r(70) = .33, p = .00, r^2 = .11$, 11% of variance explained, Knowledge $r(70) = .28, p = .02, r^2 = .08$, 8% of variance explained.

Finally, the relationship between the percentage of culturally different people in the interns life since age 18 to the present and MCI scores when controlling for MCSD was examined using a partial correlation. To check the assumption of linearity the predicted value and residual scatter plot was visually inspected for the global scores and the subscales. The vast majority of scores appeared to be between -2 and 2, meaning this assumption was not violated. The correlation was positive and statistically significant, $r(70) = .43, p = .00, r^2 = .19$, 19% of variance explained. The relationship between the percentage of multicultural experiences as an adult ($M = 34.30, SD = 30.04$) and each of the MCI subscales was also examined. There was no statistically significant relationship between multicultural experiences as an adult and the MCI Relationship scale when adjusting for MCSD, $r(70) = .21, p = .07$. However there was a statistically significant and positive relationship between multicultural experiences as an adult and the other three subscales; Skills $r(70) = .29, p = .01, r^2 = .09$, 9% of variance explained; Awareness $r(70) = .45, p = .00, r^2 = .20$, 20% of variance explained; and Knowledge $r(70) = .33, p = .00, r^2 = .11$, 11% of variance explained. Therefore, Hypothesis 5 was partially supported because multicultural experience in childhood, adolescence, and adulthood predicted increased self-perceived multicultural competence scores. However, in adulthood the relationship between multicultural experience and multicultural competence in relationships was not significant.

Hypothesis 5 was also investigated by conducting a multiple regression using all three levels of multicultural experience in life (percent of non-White clients, childhood, adolescence, and adult multicultural experience) and the percentage of non-White clients seen. When examined together it seemed that none of the multicultural experiences

predicted multicultural competence, when adjusting for social desirability. Percent of non-White clients, $t(5, 69) = -.03, p = .98$; childhood experience, $t(5, 69) = 1.56, p = .12$; adolescent experience, $t(5, 69) = .37, p = .71$; and adult experience, $t(5, 69) = 1.53, p = .13$. This finding seems to conflict with the results when each type of multicultural experience is examined independently as stated previously (See Table 4).

Hypothesis 6

It was hypothesized that interns with more multicultural life experiences would have higher multicultural personality scores. A Pearson correlation was used to examine the relationship between multicultural experiences in childhood (0-12) and multicultural personality scores (MPQ). There was no statistically significant relationship found between multicultural childhood experiences and MPQ on the full scale or any of the subscales: Full scale $r(71) = .22, p = .07$; MPQ Cultural Empathy $r(71) = -.03, p = .79$; MPQ Open-mindedness $r(71) = .33, p = .00$; MPQ Social Initiative $r(71) = .07, p = .58$; MPQ Emotional Stability $r(71) = .17, p = .15$; MPQ Flexibility $r(71) = .20, p = .09$.

Second, a Pearson correlation was used to examine the relationship between multicultural experiences in adolescence (13-17) and multicultural personality scores (MPQ). There was a positive statistically significant relationship found between multicultural adolescent experiences and MPQ on the full scale, $r(71) = .28, p = .02, r^2 = .08$, 8% of variance explained. There was also a positive statistically significant relationship found between multicultural adolescent experiences ($M = 26.12, SD = 33.04$) and the MPQ Open-mindedness subscale, $r(71) = .31, p = .01, r^2 = .09$, 9% of variance explained. However, there was no significant relationship between multicultural adolescent experiences and the MPQ Cultural Empathy subscale, $r(71) = .06, p = .61$, the

MPQ Social Initiative subscale, $r(71) = .15, p = .20$, the MPQ Emotional Stability subscale, $r(71) = .21, p = .07$, and the MPQ Flexibility subscale, $r(71) = .24, p = .05$.

Finally, a Pearson correlation was used to examine the relationship between multicultural experiences as an adult (18+) and multicultural personality scores (MPQ). There was a positive statistically significant relationship found between multicultural adult experiences and MPQ on the full scale, $r(71) = .24, p = .04, r^2 = .06$, 6% of variance explained. There was also a positive and statistically significant relationship found between multicultural adult experiences ($M = 34.30, SD = 30.04$) and the MPQ Open-mindedness subscale, $r(71) = .30, p = .01, r^2 = .09$, 9% of variance explained. However, there was no significant relationship between multicultural adult experiences and the MPQ Cultural Empathy subscale, $r(71) = .17, p = .14$; the MPQ Social Initiative subscale, $r(71) = .18, p = .12$; the MPQ Emotional Stability subscale, $r(71) = .04, p = .73$; and the MPQ Flexibility subscale, $r(71) = .18, p = .14$. Therefore, Hypothesis 6 was partially supported as the analysis found a significant positive relationship between multicultural experience in childhood, adolescence, and adulthood and self-perceived multicultural competence scores globally. During adolescence and adulthood, this relationship was positive and significant on the Open-Mindedness subscale only.

Hypothesis 7

It was predicted that interns with higher multicultural personality scores would have higher self-perceived multicultural competence scores when controlling for social desirability. A regression analysis was used to examine if multicultural personality scores (MPQ) would predict self-perceived multicultural competence scores (MCI) when adjusting for social desirability (MCSD) for beginning interns. To check the assumption

of linearity, the predicted value and residual scatterplot was visually inspected. The vast majority of scores appeared to be between -2 and 2, meaning this assumption was not violated. There was a positive statistically significant relationship between MPQ and the MCI when controlling for MCSD, $r(71) = .57, p = .00. r^2 = .32$; therefore 32% of the variance in MCI scores when adjusting for MCSD can be predicted by MPQ scores. Hypothesis seven was therefore supported.

Hypothesis 8

This study hypothesized that universal-diverse orientation scores would correlate positively with multicultural personality scores. A Pearson correlation was performed to examine the relationship between universal-diverse orientation (MGUDS-S) and multicultural personality scores (MPQ). There was a positive statistically significant relationship between the two, $r(71) = .48, p = .00$. The r^2 was .23; therefore 23% of the variance in MPQ scores could be explained by universal-diverse orientation. Hypothesis 8 was supported.

CHAPTER 5

Discussion

This chapter includes a summary of the results for each of the proposed hypotheses, as well as an interpretation of those findings both in context of the current study and the multicultural competence literature as a whole. Also included is a discussion of what these findings may mean for the field of psychology. Limitations to the present study are included and the future directions for research are examined.

Summary of Findings

Hypothesis 1 stated that interns from graduate programs that had one multicultural course would have significantly lower self-perceived multicultural competence scores than those who had a graduate curriculum that integrated multicultural training throughout the curriculum. This hypothesis was rejected. The participants were placed into three groups based on the level of infusion in their program; the high infusion group, the medium infusion group, and the low infusion group. There was not a significant difference in the results between the groups based on level of infusion of multicultural information for the global and three of the subscales on the multicultural competence inventory when controlling for social desirability. There appeared to be a significant difference between the three groups on the MCI Awareness subscale, however when further examining this, there was not a significant mean difference between the three groups.

The second hypothesis, predicting that interns with more experience with clients who were culturally different would have significantly higher self-perceived multicultural

competence scores, was partially supported by this sample. Interns self-perceived multicultural competence scores on the global scale and the awareness subscale, when adjusting for social desirability, increased positively based on having a higher percentage of clients who were culturally different than the intern. However, there was not a significant relationship between percentage of clients who were culturally different and multicultural competence on the relationship, skills, and knowledge subscales. Therefore, the percentage of culturally different clients predicted increased self-perceived multicultural competence globally and on multicultural Awareness, but it was not a predictor of a multicultural Relationship, Knowledge, or Skills.

It was predicted in Hypothesis 3 that there would not be a significant difference in self-perceived multicultural competence scores of interns who chose internship sites with more multicultural training at the site and internship sites with less focus on multicultural training at the site. This hypothesis was not supported in the results. There were four groups based on the type of internship site the intern would attend; 1) university counseling centers, 2) hospitals and VAs, 3) outpatient community mental health centers, and 4) other internship sites including schools and athletic departments. There was no significant difference found between the groups in this sample indicating that the internship site choice did not predict self-perceived multicultural competence.

Hypothesis 4, that there would be no differences between multicultural competence scores when controlling for social desirability for interns from counseling psychology programs and those from clinical psychology program, was partially supported by this sample. There was no significant difference between the two groups of interns on the global scale, Skills subscale, Knowledge subscale, and Relationship subscale of the

Multicultural Competence Inventory. However, there was a significant difference between counseling and clinical psychology interns on the Awareness subscale of the Multicultural Competence Inventory. This sample's results suggested that there is a difference between interns educated in clinical psychology programs and those whose graduate program was in counseling psychology on their awareness of multicultural issues, with counseling interns having a higher score.

It was predicted in Hypothesis 5 that interns with more multicultural experiences would have higher self-perceived multicultural competence scores. This prediction was partially supported by the results of this study. Multicultural experience was examined by the percentage of family and friends that were culturally different than the intern in different stages of their life including childhood, adolescence, and adulthood. Multicultural experience did predict multicultural competence globally and on the subscales for interns during childhood and adolescence. However, in adulthood, multicultural experience predicted the global multicultural competence scores as well as the Skills, Knowledge, and Awareness subscales but did not predict the Relationship subscale score. When all variables of multicultural experience were examined together they did not seem to predict multicultural competence. Although this finding differs from the examination of the variables individually, it is interesting to note.

Hypothesis 6 stated that interns with more multicultural experiences would have higher multicultural personality scores, when adjusted for social desirability, which was partially supported with this sample. The results found that multicultural experience as a child did not predict multicultural personality globally or on any of the subscales. However, multicultural experience as an adolescent and as an adult did predict

multicultural personality globally and on the Open-Mindedness subscale. But it did not predict multicultural personality on the Cultural Empathy, Social Initiative, Emotional Stability, or Flexibility subscales.

This study hypothesized that interns with higher multicultural personality scores would have higher self-perceived multicultural competence scores, when adjusting for social desirability in Hypothesis 7. This prediction was supported by this sample. There was a positive and significant relationship between multicultural personality scores and multicultural competence scores for interns.

Hypothesis 8 predicted that universal-diverse orientation, as measured by the MGUDS-S, would positively correlate with multicultural personality scores, which was supported in this study. The results indicated a positive and significant correlation between multicultural personality scores and universal-diverse orientation scores.

Explanation of Findings

Some theories of multicultural competence have suggested that infusion of multicultural information throughout the graduate education would produce more culturally competent psychologist. Ho (1995) emphasized the importance of training programs to produce multiculturally competent counselors by not just relying on one diversity course but that diversity should be a theme throughout all coursework. Past research has also indicated the importance of infusion of multicultural information throughout the curriculum. Holcolmb-McCoy and Myers (1999) found that participants who had taken a multicultural counseling course had significantly higher levels of self-perceived multicultural competence on the knowledge and racial identity factors. Salvadore (1998) evaluated doctoral students enrolled in a multicultural training course

using the Multicultural Counseling Inventory (MCI) and found that those with more multicultural training throughout their education had high self-perceived multicultural competence scores.

Neville, Heppner, Louie, Thompson, Brooks and Baker (1996) found that a multicultural counseling course significantly increased the level of multicultural therapy competencies of participants. Sodowsky, Kuo, Richardson and Corey (1998) conducted a multiple regression analysis to explore factors related to higher levels of multicultural competencies as measured by the Multicultural Counseling Inventory (MCI). They found that multicultural counseling courses were one of several variables that made important contributions to higher levels of multicultural competence. It is apparent that multicultural training influences self-perceived multicultural competence.

These studies show that a multicultural education is an important component of multicultural competence therefore it has been suggested that that more education on multicultural issues should increase multicultural competence. The results from the current study tentatively, do not support the literatures' suggestion. This study did not show a significant difference on multicultural competence scores between three levels of infusion of multicultural information. There has not been much research on infusion throughout the curriculum as previous research has focused on having a multicultural course in general. Also, very few programs have adopted this model of training. However, the results of this study cautiously may not support the literature because it may not include students from programs that use an infusion model. The participants were asked to identify the level of infusion of multicultural information in their doctoral program, therefore it is possible that their response could be inaccurate compared to what

the program itself might conclude. It is possible that if the doctoral program was identified the comparisons could have produced different results.

Although the current study does not support infusion of multicultural information in the graduate education to increase multicultural competence, the results from this study do tentatively provide additional confirming evidence that more experience with clients who are culturally different, increases self-perceived multicultural competence. This supports previous literature that has also indicated that working with more culturally different clients increases competency. Sodowsky, Taffe, and Gutkin (1991) found that contact with culturally different persons has been shown to be positively correlated with higher level of self-reported multicultural competence. Sodowsky, Kuo, Richardson, and Corey (1998) conducted a multiple regression analysis to explore factors related to higher levels of multicultural competencies and found that variables included number of minority and international clients and participation in multicultural research projects. The coupling of past findings with the current results of this sample tentatively shows additional support for increasing beginning interns experience with culturally different clients to increase competence, implying that doing therapy with diverse clients helps the intern to feel more competent to continue to work with diverse clients.

There is a paucity of research on choice of internship site, however, this study sought to investigate if self-perceived multicultural competence was related to the type of internship site the beginning intern would be attending. Research has indicated that individuals who consider themselves multiculturally competent and seek to increase multicultural competence tend to seek out multicultural opportunities. Carlson, Brack, Laygo, Cohen, and Kirkscey (1998) reported that self-perceived multicultural

competency and general perceptions of counselor competence reflected greater exposure to multicultural training and activities. This study cautiously did not support this suggestion. Although, university counseling centers have been known to focus on multicultural competence there has not been much examination of differences of multicultural training at different internship sites (Magyar-Moe et al., 2005). The majority of internship sites offer some type of multicultural training and/or experience, especially those with APA-accreditation as this is a requirement (APA, 2010). It may be that the results of this study are true for the population in that there is no relationship between self-perceived multicultural competence and internship site type choice.

Previous research has found a difference in counseling and clinical psychology students' self-perceived multicultural competence. Hung (2000) found that students in clinical programs rated themselves as significantly less multiculturally competent than counseling psychology students ratings. Hung suggests that this difference is due to counseling programs having a greater focus on multicultural education than clinical doctoral programs. The results of this study partially support the literature in that there was not a significant difference on global, Skills, Knowledge, or Relationship multicultural competence scores; however, there was a difference between counseling psychology doctoral students and clinical psychology doctoral beginning interns on the Awareness subscale. Beginning interns from counseling psychology had higher scores on the awareness subscale which measures "proactive multicultural sensitivity and responsiveness, extensive multicultural interactions and life experiences, broad-based cultural understanding, advocacy within institutions, enjoyment of multiculturalism, and an increase in minority caseload" (Sodowsky et al., 1994, p.142). This tentatively

suggests that there may be some difference in clinical and counseling programs education that increases multicultural awareness or possibly a difference in the type of person that pursues a clinical versus a counseling program, however; the difference may have decreased in the last decade due to heightened sensitivity for the need for multicultural training.

This study sought not only to investigate the effects of specific multicultural education in graduate programs but also the effect of multicultural life experiences on multicultural competence as a beginning intern. More recent research has focused on the influence of multicultural life experiences in childhood, adolescence, and adulthood on multicultural competence as well as on having a multicultural personality and a universal-diverse orientation. Contact with culturally different persons has been shown to be positively correlated with higher level of self-reported multicultural competence (Sodowsky, Taffe, & Gutkin, 1991). Millville (1999) stated that individuals who place themselves in diverse situations do so because they appreciate differences and similarities and therefore have enhanced emotional connections which reinforces their universal disposition orientation. These studies have suggested that having more multicultural experiences leads to a multicultural personality which would increase competence. When examining the variables of multicultural experience separately, this sample supported the literature. However, when these variables were examined together they did not appear to predict multicultural competence. The analysis that found a significant relationship was grounded in theory and supported by the literature while the results of the combined analysis was based purely on the numbers of this sample. Therefore, it is more likely that the finding that supports the literature is valid. Rameriz (1999) suggests that a

multicultural personality can be enhanced “through seeking interaction with diverse individuals and new cultural environments, taking on leadership roles in culturally diverse contexts that foster creative problem-solving, and being proactive in terms of social justice for oppressed groups” (p.26). Therefore, multicultural personality should be enhanced by an education that encourages culturally diverse interactions. Pederson, Mendelwitz, Collaboletta, and Ernst (2008) proposed that appreciating and accepting differences and similarities begins in childhood, where having a multicultural personality can begin.

Brummet (2007) considered a multicultural personality to describe a person whom is able to show sensitivity and competence while working with people from different cultures. A multiculturally competent counselor is likely to have a multicultural personality disposition. The sample in this study tentatively partially supported the previous research. The results of this study showed that more multicultural experiences during childhood predicted higher self-perceived multicultural competence scores but did not predict higher multicultural personality scores. For this sample of beginning interns, multicultural experience in adolescence predicted higher self-perceived multicultural competence scores, adjusting for social desirability. It also predicted a higher multicultural personality global scale score and Open-Mindedness score but was not a predictor of the other subscales: Cultural Empathy, Social Initiative, Emotional Stability, and Flexibility.

For this sample, multicultural experience in adulthood predicted increased multicultural competence on the global scale and the subscales except the Relationship subscale. This suggests that having more multicultural experiences as an adult does not

influence “counselor trustworthiness, comfort level, stereotypes of minority clients, and worldview” (Sodowsky et al., 1994, p. 142). Multicultural experience as an adult was also found to predict higher multicultural personality scores on the global scale and Open-Mindedness subscale. The Open-Mindedness subscale measures having an open and unprejudiced attitude towards out-group members and towards different cultural norms and values. Although research has suggested a relationship between multicultural personality and multicultural competence this study found that multicultural life experiences at various life stages have a different relationship with each of these constructs. And that Open-Mindedness is more affected by life experiences as an adolescent and as an adult than the other areas of multicultural personality. Previous research has not specifically focused on these distinct stages of life and their impact on multicultural personality or multicultural competence factors. These differences may be due to the differences in multicultural personality and multicultural competence as separate constructs. This study did find that multicultural personality accounted for 32% of the variance in multicultural competence scores when controlling for social desirability, which makes it a significant predictor. However, even though multicultural personality is a predictor of multicultural competence they are different constructs and there are other variables that contribute to multicultural competence as well.

Recent research (i.e., Brummet, 2007) has suggested that universal-diverse orientation is a component of multicultural personality. Universal-diverse orientation is a component of a multicultural personality disposition, which is a theory that looks beyond the multicultural competence of counselors to the general ability to accept and understand differences (Brummet, 2007). The results of this study cautiously supported the

prediction that interns with a higher multicultural personality score would have higher self-perceived multicultural competence. The results also supported the hypothesis that interns with a higher universal-diverse orientation scores correlated positively with multicultural personality scores. This supports the literature's suggestion that universal-diverse orientation is a component of multicultural personality. It also reinforces that multicultural personality correlates with multicultural competence.

The results for this study tentatively reinforce the importance of the awareness component of multicultural competence. Several predictions that were partially supported found a significant difference on variables in relation to the Awareness subscale which measures "proactive multicultural sensitivity and responsiveness, extensive multicultural interactions and life experiences, broad-based cultural understanding, advocacy within institutions, enjoyment of multiculturalism, and an increase in minority caseload" (Sodowsky et al., 1994, p. 142). Previous theories and research also address the importance of self and social awareness on being a multiculturally competent counselor.

Ho (1995) also suggests that self-understanding should be a primary goal in training. Ho's basic assumptions are that all counseling necessarily entails cultural awareness; both the counselor's and client's worldview and cultural identities must be assessed. Holcomb-McCoy and Myers (1999) found that recent doctoral program graduates perceived themselves to be most competent on the definitions and awareness factors. Kanitz (1998) interviewed European American counseling students and found six themes regarding their multicultural training experience which indicated a need for self-awareness training. These themes were resistance to self-exploration, showing relatively

little self-awareness regarding racial issues, being fearful of negative evaluation, ambivalence about articulating racial information regarding clients as well as discussing racial issues in general. This further supports the focus on the beginning intern's self awareness in education towards competency. The following is a discussion of the implications of these findings.

Conclusions and Implications

The United States has become a melting pot of different cultures and ethnicities. The ability to relate to, work with, understand, and accept people who are different has become increasingly necessary to navigate through society. The acknowledgement of multiculturalism in society has coincided with the growth of the profession of psychology and the need to offer services to a wider variety of clients. This growth has made it necessary for professional psychologists to be able to provide services at a competent level to clients of varying backgrounds. In the last three decades there has been a major shift in psychology to focus on becoming competent in providing services to culturally diverse populations.

Korman (1973) stated that “the provision of professional services to persons of culturally diverse backgrounds by persons not competent in understanding and providing professional services to such groups shall be considered unethical” (p. 105). It is an ethical responsibility for the profession of psychology to adapt to the increase in minority populations seeking services and to provide appropriate services. In order for professionals to meet this ethical obligation educational programs must incorporate multicultural training.

Since the 1960's psychology has begun to recognize the importance of addressing culture in therapy brought on by the insurgence of minority clients seeking therapy services. Psychology, particularly counseling psychology, has since provided research in to what is effective therapy for different cultures as well as an examination of the education students receive to learn to work with a diverse clientele. Part of this examination has looked at whether practicing psychologists are competent to provide services to diverse clients. In the last decade, research has sought to expand on multicultural competence by examining universal diverse orientation and multicultural personality. The results of this sample showed that multicultural personality can be influenced as early as adolescence and that multicultural experiences in adolescence and adulthood are essential to the formation of a multicultural personality. Having a multicultural personality also can increase the clinician's multicultural competence.

There is a paucity of research on the multicultural competence of the intern population. Therefore, this study examined counseling and clinical psychology interns' multicultural training experience and competence prior to beginning internship. Examining psychology intern's pre-internship multicultural experience, childhood, adolescent, and adult multicultural experiences, their universal-diverse orientation, their graduate program multicultural emphasis, their choice of internship site, and their individual characteristics provided insight into the preparedness of graduate students to work with different populations while on internship.

Sue, Ivey, and Pedersen's (1996) metatheory of multicultural counseling posits that a culturally-competent counselor will have self awareness of their own cultural background and know how that has influenced his/her thoughts, beliefs, and actions. The

clinician will also have an understanding and acceptance that people with different cultural backgrounds have different worldviews. Therefore, a graduate student entering an internship who has had various multicultural life and training experiences will have a multicultural personality and therefore be more likely to be multiculturally competent when working with clients of diverse backgrounds. The results of this study support this assumption.

Multicultural competence continues to be an essential component of educating and training future psychologists. It undoubtedly will continue to be a focus of both graduate training programs and internship sites. The findings of this study offer information pertaining to the education of both clinical and counseling psychology graduate students preparing for internship. The results suggest that multicultural experiences, specifically in adolescence and adulthood, can impact self-perceived multicultural competence, as well as working with diverse clients. Therefore, to increase the multicultural competence of interns, graduate programs should emphasize and facilitate more multicultural experiences throughout educational programs including in practica and classrooms. This will lead to an increase in multicultural personality and multicultural competence. Because the formation of a multicultural personality can begin at a young age and having this type of personality can increase self-perceived multicultural competence, it seems appropriate to assess these constructs as the student enters a doctoral level program. This could be beneficial in determining what education is needed to increase students' multicultural personality and competence.

Graduate programs should continue to focus on awareness of multicultural issues but may also benefit from adding education around the other components of multicultural

personality and competency, such as cultural empathy, skills, knowledge, flexibility, relationship, emotional stability, and social initiative, to increase these constructs overall.

Limitations of the Study

There were several possible limitations to this study. First there were twice as many female participants as males; however this seems to reflect the actual ratio of females to males in psychology. In the 70's women made up twenty percent of doctoral - level psychologist, however in 2005 nearly 72 percent of doctoral-level psychologists were female (Cynkar, 2007). Also there were a very high number of European American participants in comparison to the number of minority participants. This also seems to be a reflection of the ratio of European Americans to minorities in the field of psychology. In 2004, the APA Commission on Ethnic Minority Recruitment, Retention and Training in Psychology Task Force reported 5.8% of their members were ethnic minorities which was a 17.8 percent increase from 1997 (CEMRRAT, 2004).

The overall number of participants is another limitation of this study. Although there were significant findings, the power analysis based off of previous literature suggested the need for at least four more participants to show an effect. The limited number of respondents to the study could be because the survey and consent were sent out in May 2010, which is the end of the spring semester for the majority of doctoral programs. At this point, many beginning interns are preparing for internship including possibly moving. If the survey were sent earlier in the semester there could have been a higher response rate.

This study relied on training directors at graduate programs to distribute the study survey link to beginning interns in the program, therefore random selection cannot be

guaranteed. Also, some training directors declined to participate stating that their own institution's human subjects committee also needed to approve the study. Two training directors stated that they felt like their students had recently been inundated with survey requests and for that reason they were choosing to not send them the link to participate. However, this was the best procedure to use in terms of gathering a sample of beginning interns as doctoral program training directors are usually the points of contact for internship. Therefore, it was assumed that training directors would be most likely to know how many interns would be beginning internship, who they were, and could get them the survey the quickest.

This sample was also self-selected. It is likely that interns who chose to participate may have some interest in multicultural counseling. Another limitation is that this study used self report measures, which was necessary to examine a national sample. The MCSD was used to adjust for social desirability on the MCI as suggested by Sodowsky (1996) in an attempt to account for using a self-report measure, however future research should study multicultural competence by both observational and self-report methods and examine the relationship between the two as suggested by Pope-Davis et al. (1995). Interns also identified the level of infusion of their educational program and its accreditation, which could have been incorrect. There was also no true control group or random selection due to interns already having completed their program of choice except for internship and possibly dissertation. Another possible limitation is that the interns were asked to report the percentage of non-White clients with whom they had worked. Asking for the percentage in this way (ie., "non-white"), instead of using the term "diversity", excluded other types of diversity such as age, ability, and sexuality.

The Association of Psychology Postdoctoral and Internship Centers (APPIC) reported that 2,823 doctoral graduate students matched with an internship site for the 2010-2011 internship year (APPIC, 2010). This sample had a total of 74 participants indicating that only 2.6% of the beginning intern population was examined in this study. This limits the study's generalizability as only a small percentage of the total population participated in this study and with more participants the results may have been different.

Future Directions for Research and Education

The field of psychology has included multicultural competency as an essential part of being a competent psychologist overall. This implies that education that increases this competency will also continue to be a focus. The need to access and evaluate this training for effectiveness continues to be present. It is necessary for research to continue to examine the characteristics of students and training that will lead to competency. Future research could replicate this study and conduct similar studies that might address the limitations of this study and strengthen the findings. Such changes might be increasing the sample size, examining beginning interns conducting therapy as well as gathering data through self-report measures, and correctly identifying the infusion of multicultural information in the graduate programs. There is also the opportunity to further investigate the possible difference in graduate programs infusion of multicultural information. It would be interesting to continue to examine multicultural life experiences at various stages of life and what that impacts in terms of personality and competency.

Future research could also further examine other demographic variables impact on multicultural personality and competence that were not addressed in this study. Some of these variables might be region of the country the intern was raised in or the region where

they attended their graduate program, the possible differences in interns' diversity (i.e. sexuality, ethnicity, ability), and biracial and multiracial interns. It would also be interesting to examine students at different levels of training (i.e., after the first practicum). Multicultural personality and competence could be assessed at the beginning of a doctoral program and the student's education could be tailored to increase their particular growth edges. Also, studies may find it unnecessary to use both the MPQ and M-GUDS-S, as they both appear to measure the same construct. MPQ; therefore using both measures may be redundant. Future studies might use other self-report measures of multicultural competence as well. It is this author's hope that applied psychology research and doctoral training programs will continue to find ways to improve psychologists' ability to provide effective and appropriate services to underrepresented populations and that future psychologists will continue to desire to increase their multicultural competence.

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APPENDIX A:

Demographic Questionnaire

Please complete the following questionnaire. If there is a question you do not feel comfortable answering, please skip that question and go to the next question.

Basic Demographics

1. What is your gender?
 Male Female

2. What is your age? _____

3. What is your race? (Mark an X in the appropriate box/es.)
 White
 American Indian or Alaskan Native
 Spanish/Hispanic/Latino
 Asian race or other Pacific Islander
 Other race, Specify other _____
 Black or African American
 Asian Indian

4. What type of degree program are you currently enrolled in?
 Clinical
 Counseling

5. What type of accreditation does your program have?
 APA
 CACREP
 None

6. How did your program present multicultural information? (Check all that apply.)
 little or no multicultural information presented in any course
 one course focused on multicultural information
 more than one course focused on multicultural information
 multicultural information infused in almost every core course in my program

7. Where are you beginning internship this year? (Mark an X in the appropriate box/es.)

- University Counseling Center
- Private General Hospital
- Community Mental Health Center
- Armed Forces Medical Center
- Consortium
- Medical School
- Prison or other Correctional Facility
- Private Outpatient Clinic
- Private Psychiatric Hospital
- Psychology Department
- School District
- State/County/Other Public Hospital
- Veterans Affairs Medical Center
- Other please specify _____

8. Is your internship APA accredited?

- Yes
- No

9. What type of practicum placements have you completed? (Check all that apply.)

- University Counseling Center
- Private General Hospital
- Community Mental Health Center
- Armed Forces Medical Center
- School District
- State/County/Other Public Hospital
- Veterans Affairs Medical Center
- Consortium
- Medical School
- Prison or other Correctional Facility
- Private Outpatient Clinic
- Private Psychiatric Hospital
- Psychology Department
- Other please specify _____

10. How many client contact hours you have accrued? _____

11. Please estimate the percentage of non-White clients you have seen.

_____ percent

Questions 12-14: Different or Diverse refers to someone being different from you in any aspect such as race/ethnicity, ability, sexual orientation, national origin, culture, religion, etc.

12. Please estimate how many of your friends, schoolmates, and neighbors were different/diverse from you as a child (ages 0-12) _____ percent
13. Please estimate how many of your friends, schoolmates, and neighbors were different/diverse from you as an adolescent (ages 13-17) _____percent
14. Please estimate how many of your friends, schoolmates or co-workers, and neighbors are different/diverse from you as an adult (18- present) _____percent

Appendix B

MIVILLE-GUZMAN UNIVERSALITY-DIVERSITY SCALE – SHORT FORM, (M-GUDS-S)

The following items are statements using several terms that are defined below for you. Please refer to these definitions throughout the rest of the questionnaire.

Culture refers to the beliefs, values, traditions, ways of behaving, and language of any social group. A social group may be racial, ethnic, religious, etc.

Race or racial background refers to a sub-group of people possessing common physical or genetic characteristics. Examples include White, Black, American Indian, etc.

Ethnicity or ethnic group refers to a specific social group sharing a unique cultural heritage (e.g., customs, beliefs, language, etc.). Two people can be of the same race (i.e., White), but from different ethnic groups (e.g., Irish-American, Italian-American, etc.).

Country refers to groups that have been politically defined; people from these groups belong to the same government (e.g., France, Ethiopia, United States). People of different races (White, Black, Asian) or ethnicities (Italian, Japanese) can be from the same country (United States).

Instructions: Please indicate how descriptive each statement is of you by circling the number corresponding to your response. This is not a test, so there are neither right nor wrong, good nor bad answers. All responses are anonymous and confidential.

Indicate how descriptive each statement is of you by circling the number corresponding to your response.	Strongly Disagree	Disagree	Disagree a Little Bit	Agree a Little Bit	Agree	Strongly Agree
1. I would like to join an organization that emphasizes getting to know people from different countries.	1	2	3	4	5	6
2. Persons with disabilities can teach me things I could not learn elsewhere.	1	2	3	4	5	6
3. Getting to know someone of another race is generally an uncomfortable experience for me.	1	2	3	4	5	6
4. I would like to go to dances that feature music from other countries.	1	2	3	4	5	6
5. I can best understand someone after I get to know how he/she is both similar to and different from me.	1	2	3	4	5	6
6. I am only at ease with people of my race.	1	2	3	4	5	6
7. I often listen to music of other cultures.	1	2	3	4	5	6
8. Knowing how a person differs from me greatly enhances our friendship.	1	2	3	4	5	6
9. It's really hard for me to feel close to a person from another race.	1	2	3	4	5	6
10. I am interested in learning about the many cultures that have existed in this world.	1	2	3	4	5	6
11. In getting to know someone, I like knowing both how he/she differs from me and is similar to me.	1	2	3	4	5	6
12. It is very important that a friend agrees with me on most issues.	1	2	3	4	5	6

Indicate how descriptive each statement is of you by circling the number corresponding to your response.	Strongly Disagree	Disagree	Disagree a Little Bit	Agree a Little Bit	Agree	Strongly Agree
13. I attend events where I might get to know people from different racial backgrounds.	1	2	3	4	5	6
14. Knowing about the different experiences of other people helps me understand my own problems better.	1	2	3	4	5	6
15. I often feel irritated by persons of a different race.	1	2	3	4	5	6

Appendix C

Consent Form and Survey Link

Dear Training Director:

I am collecting data for my dissertation and would greatly appreciate it if you would forward this message to your graduate students who will be beginning internship for the 2010-2011 year.

I am recruiting volunteer beginning interns to participate in my web-based dissertation research. The study involves the trainees' perceptions of their multicultural competence and multicultural personality. This research has been approved by the University of Kansas HCSL.

Dear Beginning Interns:

Below you can find a link to a brief questionnaire that will take approximately 15-20 minutes to complete. The questions are non-intrusive and focus primarily on your personality and self-perceived multicultural competence. You can save your responses and return to the survey if you need to. Participation in this study is voluntary, and you may withdraw from participation at any time. Moreover, under no circumstances will individual data be released. Only group data will be reported. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response.

By accessing the link below, you are acknowledging your informed consent for participation in this study.

http://kansasedu.qualtrics.com/SE?SID=SV_5sXa0u7WRCIBMR6&SVID=

If you have any questions about this research please contact Christian Vargas, M.S. at krisi12@ku.edu or Karen Multon, Ph.D. at kmulton@ku.edu. Completion of the survey indicates your willingness to participate in this project and that you are at least age eighteen. If you have any additional questions about your rights as a research participant, you may call (785) 864-7429, write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, or email mdenning@ku.edu.

Thank you in advance for your participation!

Christian Vargas, M.S.
Doctoral Candidate
Dept. of Psychology & Research in Education
University of Kansas
krisi12@ku.edu

Karen Multon, Ph.D.
Professor and Chair
Dept. of Psychology & Research in Education
University of Kansas
kmulton@ku.edu

Appendix D

Table 1

Demographic Information

	Counseling		Clinical		Total	
	(n = 31)		(n = 43)		(n = 74)	
Variable	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
Gender						
Male	9.00	26.70	7.00	16.30	15.00	20.30
Female	22.00	73.30	36.00	83.70	59.00	79.70
Race^a						
European American	18.00	66.70	35.00	88.40	53.00	78.40
American Indian/Alaskan Native	1.00	3.30	1.00	2.30	2.00	2.70
Spanish/Hispanic/Pacific Islander	6.00	20.00	2.00	4.70	8.00	10.80
Asian/Other Pacific Islander	1.00	2.30	1.00	3.30	2.00	2.70
Black/African American	5.00	16.70	4.00	9.30	9.00	12.20
Program Accreditation^b						
APA	28.00	90.00	43.00	100.00	71.00	95.90
CACREP	2.00	6.70	0.00	0.00	2.00	2.70
None	1.00	3.30	0.00	0.00	1.00	1.40
Internship Accreditation						
Yes	26.00	80.00	34.00	79.10	60.00	79.70

Table 1

Demographic Information cont'd.

	Counseling (n = 31)		Clinical (n = 43)		Total (n = 74)	
Variable	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
No	5.00	16.70	9.00	20.90	14.00	18.90
Multicultural Infusion^c						
Little or No	0.00	0.00	1.00	2.30	1.00	1.40
One Course	7.00	30.00	12.00	30.20	20.00	30.10
More than One Course	4.00	13.30	11.00	27.90	14.00	21.90
Almost Every Course	20.00	70.00	19.00	48.00	39.00	57.50
Internship Site^d						
Counseling Center	22.00	70.00	3.00	7.00	24.00	32.90
Hospitals	0.00	0.00	21.00	48.40	21.00	28.80
Outpatient	5.00	16.70	5.00	11.60	10.00	13.70
Other	4.00	13.30	14.00	32.60	19.00	25.70
Practicum Sites						
Counseling Center	26.00	86.70	14.00	32.60	40.00	54.80
Private General Hospital	2.00	6.70	8.00	18.60	10.00	13.70
Community Mental Health	15.00	50.00	22.00	51.20	37.00	50.70

Table 1

Demographic Information cont'd.

	Counseling (n = 31)		Clinical (n = 43)		Total (n = 74)	
Variable	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>	<u>n</u>	<u>%</u>
Medical School	3.00	10.00	5.00	11.60	8.00	11.00
Prison/Correctional Facility	7.00	23.30	1.00	25.60	18.00	24.70
Private Outpatient Clinic	6.00	20.00	20.00	46.50	26.00	35.60
Private Psychiatric Hospital	0.00	0.00	12.00	27.90	12.00	16.40
Psychology Department	6.00	20.00	16.00	37.20	22.00	30.00
School District	2.00	6.70	12.00	27.90	14.00	19.20
State/County/Other Public Hospital	4.00	13.30	9.00	20.90	13.00	17.80
Veterans Affairs Medical Center	8.00	26.70	6.00	14.00	14.00	19.20
Other	3.00	10.00	4.00	9.30	7.00	9.60
	<u>M (SD)</u>		<u>M (SD)</u>		<u>M (SD)</u>	
Age	31.90	(9.36)	28.12	(2.90)	29.64	(6.60)
# of Client Hours	694.63	(411.95)	1091.95	(595.29)	924.07	(558.46)
% of Non-White Clients	24.90	(26.29)	29.90	(19.83)	27.85	(22.64)
% Diversity in Childhood	23.13	(31.84)	27.38	(35.44)	25.61	(33.82)

Table 1

Demographic Information cont'd.

	<u>M (SD)</u>	<u>M (SD)</u>	<u>M (SD)</u>
% Diversity in Adolescence	25.23 (32.64)	25.00 (23.07)	25.10 (32.08)
% Diversity in Adulthood	41.27 (33.40)	28.95 (26.92)	34.08 (30.19)

Note. ^a The ethnicity/race category of Asian Indian was not added to the table due to no participants identify this race; ^b APA = American Psychological Association, CACREP = Council for Accreditation of Counseling & Related Educational Programs; ^c Little or No = little or no multicultural information presented in any course , One Course = one course focused on multicultural information, More than One Course = more than one course focused on multicultural information, Almost Every Course = multicultural information infused in almost every core course in my program; ^d Descriptives are provided for internship sites based on the groupings used for analysis.

Table 2

Means and Standard Deviations of Measures

	Counseling (n = 31)	Clinical (n = 43)	Total (n = 74)
Measure	<u>M (SD)</u>	<u>M (SD)</u>	<u>M (SD)</u>
MCI ^a	126.63 (16.24)	122.23 (13.29)	124.03 (14.62)
MCI Skills	37.54 (4.48)	36.27 (3.90)	36.80 (4.17)
MCI Awareness	29.46 (5.90)	26.20 (4.90)	27.54 (5.54)
MCI Relationship	24.20 (3.62)	25.28 (3.03)	24.83 (3.03)
MCI Knowledge	35.43 (5.75)	34.47 (4.78)	34.87 (5.18)
MCSD ^b	17.27 (3.59)	17.95 (3.90)	17.67 (3.76)
MPQ ^c	3.51 (.25)	3.53 (.35)	3.53 (.31)
MPQ Cultural Empathy	4.21 (.38)	4.08 (.34)	4.13 (.36)
MPQ Open-mindedness	3.58 (.43)	3.64 (.42)	3.62 (.42)
MPQ Social Initiative	3.61 (.39)	3.53 (.54)	3.56 (.48)
MPQ Emotional Stability	3.04 (.41)	3.20 (.49)	3.14 (.46)
MPQ Flexibility	3.17 (.38)	3.25 (.50)	3.22 (.45)
M-GUDS-S ^d	4.73 (.53)	4.75 (.46)	4.74 (.49)
M-GUDS-S Diversity of Contact	4.61 (.64)	4.43 (.80)	4.50 (.74)
M-GUDS-S Relativistic Appreciation	4.76 (.60)	4.76 (.60)	4.76 (.60)

Table 2

Means and Standard Deviations of Measures cont'd.

	Counseling (n = 31)	Clinical (n = 43)	Total (n = 74)
Measure	<u>M (SD)</u>	<u>M (SD)</u>	<u>M (SD)</u>
M-GUDS-S Comfort w Differences	4.81 (.82)	5.07 (.59)	4.96 (.70)

Note. Means and Standard Deviations of measures are before adding a covariate. ^aMCI = Multicultural Competence Inventory; ^bMCSD = Multicultural Social Desirability Scale
^cMPQ = Multicultural Personality Questionnaire; ^dM-GUDS-S = Miville-Guzman
 Universality-Diversity Scale Short

Table 3

Intercorrelations among Multicultural Competence (MCI), Multicultural Social Desirability (MCSD), Multicultural Personality (MPQ), Universal-Diverse Orientation (M-GUDS-S), client hours, and multicultural life experience. (n = 74).

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
1. MCI	--																				
2. MCI S	.83**	--																			
3. MCI A	.85**	.60**	--																		
4. MCI R	.59**	.37**	.36**	--																	
5. MCI K	.86**	.67**	.63**	.36**	--																
6. MCSD	.35	.24	.27	.39	.27	--															
7. MPQ	.61**	.61**	.45**	.33**	.53**	.28**	--														
8. MPQ C	.46**	.49**	.27*	.31**	.40**	.21	.53**	--													
9. MPQ O	.68**	.58**	.55**	.37**	.64**	.28*	.71**	.53**	--												
10. MPQ S	.45**	.50**	.37**	.04	.45**	.22	.82**	.30**	.50**	--											
11. MPQ E	.29*	.32**	.20	.22	.20	.09	.74**	.13	.24	.55	--										
12. MPQ F	.33**	.32**	.24*	.25*	.25*	.22	.73**	.08	.34**	.51**	.56**	--									
13. MGUDSS	.66**	.50**	.62**	.34**	.58**	.43**	.48**	.33**	.68**	.35**	.08	.31**	--								
14. MGUDSSD	.65**	.40**	.74**	.28*	.56**	.27*	.39**	.24*	.60**	.35**	.01	.19	.78**	--							
15. MGUDSR	.25*	.34**	.16	-.20	.33**	.19	.19	.19	.43**	.17	-.12	.07	.65**	.33**	--						
16. MGUDSSC	.46**	.32**	.37**	.49**	.35**	.44**	.41**	.27*	.35**	.22	.26*	.37**	.70**	.29*	.16	--					
17. # Client Hours	.13	.19	-.02	.18	.12	.03	.19	.10	.27*	.05	.01	.27*	.19	.07	.18	.16	--				
18. % NWClients	.28*	.16	.34**	.24*	.16	.13	.24*	.03	.22	.14	.17	.26*	.13	.16	-.09	.18	.12	--			
19. % DChildhood	.38**	.24*	.41**	.21	.32**	-.10	.22	-.03	.33**	.07	.17	.20	.32**	.33**	.15	.19	.25*	.47	--		
20. % DAdolescence	.38**	.27*	.39**	.30**	.26*	-.00	.28*	.06	.31**	.15	.21	.24*	.25*	.29*	.02	.19	.15	.57**	.77**	--	
21. % DAdulthood	.44	.30	.46**	.23*	.35*	.10	.24*	.18	.30**	.18	.04	.18	.34**	.36**	.22	.14	.06	.44**	.64**	.71**	--

Note. **p < .01, *p < .05. MCI = Multicultural Competence Inventory, MCI S = Skills Subscale, MCI A = Awareness Subscale, MCI R = Relationship Subscale, MCI K = Knowledge Subscale, MCSD = Multicultural Social Desirability Scale, MPQ = Multicultural Personality Questionnaire, MPQ C = Cultural Empathy Subscale, MPQ O = Open-mindedness Subscale, MPQ S = Social Initiative Subscale, MPQ E = Emotional Stability Subscale, MPQ F = Flexibility Subscale, MGUDSS = Miville-Guzman Universality-Diversity Scale Short, MGUDSSD = Diversity of Contact Subscale, MGUDSSR = Relativistic Appreciation Subscale, MGUDSSC = Comfort with Differences Subscale, # Client Hours = Number of Client Contact Hours, %NWClients = Percentage of non-White Clients, % DChildhood = Percentage of Diversity in Childhood, %DAdolescence = Percentage of Diversity in Adolescence, %DAdulthood = Percentage of Diversity in Adulthood.

Table 4

Regression Analysis Summary for Multicultural Experiences Variables Predicting Multicultural Competence, Adjusting for Social Desirability. (n = 74)

Predictor Variable <i>P</i>	<i>B</i>	<i>SE B</i>	β	<i>t</i>
MCSD .001	1.38	.41	.35	3.36
% NWClients .98	-.00	.77	-.00	-.03
% DChildhood .12	.11	.07	.25	1.56
% DAdolescence .71	.03	.08	.07	.37
% DAdulthood .132	.11	.07	.22	1.53

Note. %NWClients = Percentage of non-White Clients, % DChildhood = Percentage of Diversity in Childhood, %DAdolescence = Percentage of Diversity in Adolescence, %DAdulthood = Percentage of Diversity in Adulthood. $r^2 = .34$, $\Delta r^2 = .22$, $F\Delta(4, 68) = 5.54$, $p = .001$

Table 5

Means and Standard Deviations of High, Medium, and Low Infusion Groups on the Multicultural Competence Inventory (MCI).

	High Infusion (n = 42)	Medium Infusion (n = 15)	Low Infusion (n = 16)
	<u>M (SD)</u>	<u>M (SD)</u>	<u>M (SD)</u>
MCI	124.97 (14.37)	126.64 (10.93)	120.22 (18.17)
MCI Skills	36.71 (4.23)	37.22 (4.05)	36.81 (4.34)
MCI Awareness	28.23 (5.26)	28.89 (4.30)	24.88 (6.74)
MCI Relationship	24.71 (3.26)	25.07 (3.08)	25.13 (3.83)
MCI Knowledge	35.31 (5.30)	35.47 (3.11)	33.40 (6.32)

Note. Means and Standard Deviations of measures are before adding a covariate.

Table 6

*Means and Standard Deviations of Internship Sites on the Multicultural Competence**Inventory (MCI).*

	Counseling Centers (n = 24)	Hospitals (n = 21)	Outpatient (n = 10)	Other (n = 19)
	<u>M (SD)</u>	<u>M (SD)</u>	<u>M (SD)</u>	<u>M (SD)</u>
MCI	122.48 (15.72)	120.82 (13.53)	127.82 (13.44)	128.15 (14.52)
MCI Skills	36.63 (4.14)	35.81 (3.53)	37.40 (5.29)	37.84 (4.15)
MCI Awareness	27.60 (5.56)	25.89 (5.29)	28.92 (5.23)	28.83 (5.83)
MCI Relationship	24.20 (3.72)	24.76 (3.13)	25.10 (3.13)	35.68 (3.43)
MCI Knowledge	34.04 (6.05)	34.36 (5.44)	36.40 (4.50)	35.79 (3.82)

Note. Means and Standard Deviations provided are before adding a covariate. Means and Standard Deviations are provided for internship sites based on the groupings used for analysis.

Table 7

Means and Standard Deviations of Counseling and Clinical Psychology Beginning

Interns on the Multicultural Competence Inventory (MCI).

	Counseling (n = 42)	Clinical (n = 15)
	<u>M (SD)</u>	<u>M (SD)</u>
MCI	126.63 (16.24)	122.23 (13.27)
MCI Skills	37.54 (4.48)	36.28 (3.90)
MCI Awareness	29.45 (5.90)	26.20 (4.90)
MCI Relationship	24.20 (3.62)	25.28 (3.03)
MCI Knowledge	35.43 (5.75)	34.47 (4.77)

Note. Means and Standard Deviations of measures are before adding a covariate.