The Effects of Cultural Competence and Racial Identity Development on the Working Alliance in African-American and Caucasian Counseling Dyads: A Preliminary Analysis

Peter J. Scoma
Philadelphia College of Osteopathic Medicine, pscoma@gmail.com

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THE EFFECTS OF CULTURAL COMPETENCE AND RACIAL IDENTITY
DEVELOPMENT ON THE WORKING ALLIANCE IN AFRICAN-AMERICAN AND
CAUCASIAN COUNSELING DYADS: A PRELIMINARY ANALYSIS

By Peter J. Scoma

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Department of Psychology

Dissertation Approval

This is to certify that the thesis presented to us by ___Peter J. Scoma_____

on the ___30th___ day of ___May, 2012___, in partial fulfillment of the requirements for the
degree of Doctor of Psychology, has been examined and is acceptable in both scholarship
and literary quality.

Committee Members' Signatures:

Takako Suzuki, PhD, Chairperson

Ange Puig, PhD

Robert A DiTomasso, PhD, ABPP

Robert A DiTomasso, PhD, ABPP, Chair, Department of Psychology
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Abstract

Multicultural considerations in behavioral healthcare rightfully remain a point of interest for practitioners, administrators and educators alike. Attention to culturally sensitive practice as a core competency for mental health practitioners has become rooted in academic curriculum and clinical trainings (Bussema & Nemec, 2006; Schottler et al., 2004). Despite this increased awareness of culturally competent practice, the results of these efforts are unclear as minority utilization of behavioral healthcare services continues to decline (Flaskerud, 2007). Racial biases and prejudice are still apparent in administrative and institutional settings that aspire to integrate cultural competencies into their organizations (Sue & Sue, 2007). Literature investigating the translation of training to practice is minimal and inconclusive (Flaskerud, 2007). This study examined how a Caucasian practitioner’s degree of cultural competence related to the formation of the therapeutic alliance as well as how each individual’s respective stage of racial identity development influenced their relationship. Results observed a significant correlation between a clinician’s degree of cultural competence and strength of the therapeutic alliance. Small sample size and lack of differentiation among key variables did not allow for several hypotheses to be tested, however, an exploratory analysis found the subscales of the Working Alliance Inventory (WAI) to be highly predictive of one another between two administrations. A strong negative correlation was observed between the Skills and Awareness subscales of the Multicultural Counseling Inventory (MCI). Outcomes from this investigation were promising and provide future direction for further research in this area.
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Chapter one: Introduction

Statement of the Problem

It has long been realized that the therapeutic alliance between patient and practitioner is the single greatest predictor of positive therapeutic outcomes (Summers & Barber, 2003; Wampold, 2001; Luborsky. L., Diguer, L., Seligman, D.A., Rosenthal, R., Krause, E.D., Johnson, S., et al., 1999). With a steady increase of diverse populations assimilating into the United States, issues of cultural competence in the field of mental health service providers rightfully remain at the forefront of interest. Despite the emphasis on training culturally competent practitioners at both the academic and continuing education level, the effects of these teachings are rarely assessed from the client’s point of view. Disparities in the utilization of behavioral healthcare among minority group members highlight the minimal progress made in terms of adapting behavioral health services to accommodate diverse populations (Flaskerud, 2007; Carpenter-Song, E.A., Schwallie, M.N., & Longhofer, J., 2007). Although many academic curricula now incorporate training directed at increasing a clinician’s ability to counsel diverse populations, often it is only assumed that this education translates into practice when counseling cross-cultural populations. In addition, issues of cultural identity development are rarely addressed despite its correlation with a practitioner’s ability to benefit from multicultural training (Sue, et al., 1998; Parker et al., 2008).

Multiculturalism has been referred to as the “fourth force in counseling,” a paradigm that transcends theoretical orientation and is universally applicable to all helping relationships in psychotherapy (Kang, 2006; Pedersen, 1991). Despite acknowledging the need for culturally competent clinicians and subsequent incorporation
of training in said competencies across academic curriculum, outcome data demonstrate a further decline in minority utilization of behavioral healthcare services (Flaskerud, 2007; Carpenter et al., 2007; Smedley, B.E., Stith, A.Y., Nelson, A.R., 2003). Although awareness of cultural issues in treatment continues to increase among healthcare professionals, the discrepancy between these two factors deserves further investigation if the intention to assist minority populations to the best of our ability is genuine.

Research suggests that although the field has responded to the call for integration of cultural competencies in academic curriculum, attempts have been made through the filter of an ethnocentric monocultural perspective that pervades society (Sue, D.W., Carter, R.T., Casas, M.J., Fouad, N.A., Ivey, A.E., Jensen, M., et al, 1998; Sue & Sue, 2008). Sue contends that educational institutions are not exempt from cultural conditioning and often harbor biases and attitudes, which are evident in the conception and implementation of multicultural training curriculum.

Culturally competent practitioners engage in serving diverse patients with a conscious awareness of their own attitudes, biases and value judgments, which enable them to understand and appreciate the cultural perspectives of their diverse patients (Sue et al., 1998; Sue & Sue, 2007). Together with specific knowledge and information about the particular group with which he or she is working, the therapist is able to form a more accurate conceptualization of the patient’s problem, which results in approaches to treatment and service delivery methods that are of optimal benefit to the patient (Summers & Barber, 2003; Messer & Wampold, 2002).

Racial identity development refers to the degree to which cultural identity is a salient factor of an individual’s life (Hardiman, 1982). To study or assess cultural
CULTURAL COMPETENCE

competence, one must take into account the moderating effect of racial identity development. Research supports the contention that in order for a clinician to become culturally competent, that individual must demonstrate a certain degree of development with regard to his or her own cultural identity (Sue & Sue, 2007). Simply stated, it is unlikely that a clinician whose own racial identity is poorly developed will be able to genuinely understand and empathize with another individual whose cultural identity is a salient feature of their life. The implications of this idea suggests that clinician's receiving instruction in culturally competent practices will only be receptive to such teachings if their own racial identity is adequately developed (Sue & Sue, 2007).

Bordin (1979) defined the therapeutic alliance as, “the vehicle through which psychotherapies are effective.” The alliance between patient and therapist has been shown to have a marked effect on treatment outcomes and compliance, even more so than the particular psychotherapeutic modality utilized or length of treatment (Elvins & Green, 2008; Wampold, 2001; Luborsky et al., 1999). The therapeutic alliance is further defined to include three major tenets: 1) mutual recognition of shared goals; 2) agreement of patient and therapist roles or tasks in the therapeutic process; 3) attachment bond (Bordin, 1979). An accurate and culturally sensitize conceptualization of the patient’s problems strongly influence mutual goals for treatment as well as the steps each individual must take to work towards a positive outcome. The bond is reinforced by ensuring the patient feels genuinely understood by the therapist who is able to empathize with the patient’s own experience of adversity through a racial lens (Summers & Barber, 2003).
Purpose of the Study

The purpose of this investigation was to further understand the relationships between a clinician’s degree of cultural competence, the racial identity of both the client and the clinician and how each relates to the formation of the working alliance in psychotherapy. The process of this investigation was two-fold: First, this study examined the relationship between cultural competence and its relation to the therapeutic alliance in counseling dyads consisting of Caucasian student therapists and African-American clients. Second, taking into account the effect of racial identity development, this investigation endeavored to examine the relationship between both the client and therapist’s stage of racial identity development as it relates to the formation of the working alliance.

The implications for achieving a better understanding of the relationships between the aforementioned constructs are widespread. To this point, the relationship between cultural competence and more efficacious mental health care of minority clients in cross cultural dyads has been conceptualized in a positive, linear fashion, without adequate regard for moderating elements such as racial identity development. The outcome of this investigation will serve to highlight additional factors such as racial identity development that have the potential to greatly influence the impact of mental health services on African American clientele.
Chapter Two: Literature Review

Defining Cultural Competence

Multicultural competence can be defined in a variety of ways most aptly categorized by Sue and colleagues (1998) as,

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 culture 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. (p.84)

Culturally competent practitioners work toward specific goals including a conscious awareness of their own assumptions, values and biases, understanding the worldview of culturally diverse clients and utilizing appropriate intervention strategies and techniques (Sue & Sue, 2008). The ability to work with diverse clientele requires not only acquisition of knowledge and therapeutic skills relative to the patient, but also includes a thorough awareness of one’s own cultural identity and attitudes toward diverse populations. Traditional views of cultural competence defined the term as “cultural literacy” (p.21), which directed practitioners to focus on in-depth, culture specific knowledge and skill acquisition in order to be able to practice in a culturally competent fashion (Sue et al, 1982). It was assumed that culturally competent practice was attained by having vast knowledge of a specific culture which in turn enabled the practitioner to understand the perspective of the client and to tailor interventions appropriately to provide assistance in the most effective and efficient manner possible (Dean, 2001;
Goldberg, 2000). Although, this particular skill set is an important tenet of culturally competent practice, over time it has become only one aspect of competent practice with diverse populations.

To arrive at a thorough understanding of cultural competence, it is important to consider its theoretical development. While cultural competence was first defined as a degree of cultural literacy, the post-modern view of multicultural practice asks whether or not an individual can actually become competent in understanding the worldview of individuals from varying ethnic backgrounds (Dean, 2001; Goldberg, 2000; Laird, 1998). This post-modern perspective focuses more so on the practitioner’s own degree of cultural identity and identification with their own cultural background rather than specific knowledge and skills acquisition (Laird, 1998). Perhaps the most accurate definition of multicultural competence can be derived from combining traditional and post-modern perspectives that emphasize the need for cultural literacy, cross-cultural knowledge and skill in direct practice in additional to an awareness of one’s own cultural identity and the degree to which ethnicity is a salient aspect of the practitioners life (Sue & Sue, 2008).

**Awareness of Assumptions, Values and Biases.** Culturally competent practice requires a continuous pursuit to attain conscious awareness of preconceived values, biases and assumptions regarding minority group members (Sue & Sue, 2008). Of equal importance is the pursuit of understanding one’s own cultural background and the factors that have contributed to the formation of schema regarding racial identity. Acquiring this awareness requires the practitioner to acknowledge that cultural conditioning takes place on all levels including institutional values that influence their training in the helping profession (Sue et al., 1998). This awareness not only occurs on an introspective level but
also causes the practitioner to consider how cultural schema influence their conceptualization and treatment of diverse clients.

**Understanding the Worldview of the Culturally Different Client.** In addition to the aforementioned acknowledgement of personal biases and attitudes, culturally competent practitioners are able to understand and appreciate worldviews that may contrast their own (Sue & Sue, 2008). Although a clinician may not share their client’s perspective, culturally competent practice requires that the therapist attempt to understand the client’s belief system and use that information when forming a case conceptualization or devising treatment plans and interventions. This process is aided by the clinician gaining knowledge regarding various ethnic backgrounds as well as an understanding of how a particular culture or ethnicity may influence personality formation, vocational choices, psychopathology, or help-seeking behavior (Sue et al., 1998). Working toward this dimension of cultural competence requires research and awareness regarding prevalence rates of various mental disorders in particular populations. Additionally, skills can also be acquired by interacting with diverse populations in a non-clinical manner. Interacting with individuals outside of the helping role can aid in further understanding various cultures without having to maintain treatment boundaries.

**Developing Appropriate Intervention Strategies and Techniques.** Research has shown that treatment efficacy improves when practitioners define goals and utilize treatment modalities consistent with the life experiences and cultural values of their clients (Summers & Barber, 2003; Martin et al., 2000). Practitioners must realize that therapeutic techniques and approaches may be culture-bound for some individuals and
need to be flexible in choosing interventions. The culturally competent practitioner must also have a rudimentary understanding of various models of cultural identity development and be able to roughly assess where their client falls in regards to the salience of culture in their lives (Bussema & Nemec, 2006). Culturally sensitive clinicians do not apply a cookie-cutter approach to members of a certain ethnic background but are careful to attend to individual differences and tailor their approach to treatment accordingly (Sue & Sue, 2008).

**Therapeutic Alliance**

Despite a multitude of psychotherapy models, theories and techniques, the therapeutic alliance transcends perhaps every other aspect of treatment as the primary predictor of positive therapeutic outcomes (Elvins & Green, 2008; Wampold, 2001; Luborsky et al., 1999; Summers & Barber, 2003; Gaston, 1990). Furthermore, the alliance in treatment between client and practitioner is a clearly measurable phenomenon, whose effects are empirically validated and maintains educational value in that it can be broken down into skills and taught accordingly (Luborsky et al., 1999). Although the importance of the therapeutic alliance was first recognized in psychoanalytic writings, its recognition has endured several paradigm shifts in the field. Carl Rogers (1965) defined the empathic bond between patient and therapist as, “the essential therapeutic agent in treatment. (p. 56)” Aaron Beck (1979) emphasized the relationship as, “an important first step in treatment. (p. 23)” Research supports the impact of the therapeutic alliance across diverse orientations, with variability resulting only from use of different measures (Summers & Barber, 2003; Elvins & Green, 2008; Wampold, 2001).
Given its importance in the therapeutic process, the therapeutic alliance also referred to as the working alliance or helping alliance, has received a great deal of attention in the literature. Surveys show that the majority of Western practitioners prescribe to an "eclectic" approach to practicing psychotherapy that borrows from a variety of theoretical orientations (Williams, 2006). It is believed that the working alliance is the one factor whose importance remains static across varying approaches to treatment. Even still, literature pertaining to the therapeutic alliance varies in the manner in which the construct is defined (Horvath & Greenberg, 1989; Luborsky et al., 1983; Luborsky et al., 1996). Most agree that it is a conglomerate of numerous factors, however, for the purposes of this investigation, we will survey the available definitions to arrive at a universal concept measurable by the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989).

A comprehensive definition of the therapeutic alliance requires a brief review of its origin and historical background. Sigmund Freud was the first to consider the importance of the attachment between therapist and client as a collaboration between the two with the intent of solving the client’s problem (Freud, 1912). He believed the relationship to be the primary vehicle through which the patient’s problems could be understood and treated. The term ego alliance was used by Sterba (1934) to describe the healthy part of the client’s ego that joined with the analyst to achieve the goals of treatment. Greenson (1965, 1967) was the first to draw a distinction between the working alliance and the therapeutic alliance, the former being the client’s ability to align with the tasks of the analyst and the latter defining the bond formed between therapist and client.
In the 1970’s the concept of the therapeutic alliance moved away from its foundation in psychodynamic theory and was defined by Luborsky (1976) to encompass the relational elements of all helping relationships. He suggested that the alliance was comprised of two phases, the first being the Type I alliance by which the client comes to view the therapist as a source of assistance. The therapist reciprocates by fostering a warm, caring and supportive relationship with the client. The second phase of the alliance formation, the Type II alliance, involves a commitment from the client to the therapeutic process itself along with a willingness to invest him or herself in the treatment. Luborsky was also the first to define the therapeutic alliance as a measurable construct and attempt to measure it by reviewing session transcripts and counting events indicative of Type I and II alliance formation.

Bordin (1979, 1989, 1994) expanded on Luborsky’s work and moved further away from conceptualizations of the therapeutic alliance grounded in analytical theory. He saw the alliance in treatment as a “collaborative entity” defined by an integration of three essential components: mutual agreement of the therapeutic goals, consensus regarding the tasks of both therapist and client, as well as the bond formed between the two during the therapeutic process (Bordin, 1975). He phrased this idea as the “Working alliance.” Bordin (1994) believed that patient and therapist must begin treatment with parallel views of an acceptable outcome as well as mutual agreement regarding the roles each would take in working toward treatment goals. The attachment bond was used to define the degree to which the patient felt “understood” by and thus connected with the therapist on a relational level. It is this tenet of the alliance that will likely have the greatest impact on this investigation as it is hypothesized that cultural competence greatly
affects the practitioner’s ability to “understand” patients in cross-cultural counseling scenarios. Kurcias (2007) found that the patient ratings of the therapeutic alliance were correlated with psychology student trainees who demonstrated complexity and focus in their conceptualization of their patients and their presenting problems. It is in this area that culturally competent practitioners will likely excel in their ability to connect with patients of opposing cultural backgrounds.

Bordin (1994) hypothesized that while the working alliance is a fundamental factor in any helping relationship, different therapeutic approaches will place varying demands on the relationship. He predicted that the profile of the working alliance would change depending on the orientation of the clinician and that fluctuation in the strength of the alliance will no doubt result. He stressed that the repair of ruptures to the alliance constitutes a main task of therapy if a positive outcome is to be achieved.

**Measuring the working alliance.** The Working Alliance Inventory (WAI) (Horvath, 1981, 1986) measures the alliance between client and therapist, providing feedback that parallel’s Bordin’s triadic definition of the working alliance. The WAI provides a global measure of the working alliance along with 3 subscale scores that can be used to further examine Bordin’s three components of the working alliance. For the purpose of this investigation, the brief, client rated version will be utilized.

**Timing the assessment of the working alliance.** Research shows that the modal number of psychotherapy sessions attended is one (Zuroff et al., 2005). The timing in which the therapeutic alliance is assessed is critical in order to avoid surveying a biased sample. Studies have demonstrated that assessing the therapeutic alliance between the third and fifth session is the most reliable predictor of whether or not the client will
remain in therapy as well as the likelihood of a positive outcome (Barber et al., 1999; Hersoug et al., 2000). Additionally, client report of the alliance following the intake session or after the first therapy session has shown to be a valid predictor of premature termination (Barber et al., 1999; Tyron & Kane, 1993). However, some studies have also found that clients reporting a strong alliance following the initial intake session may terminate therapy prematurely or not achieve a positive outcome throughout the course of treatment (Hilliard et al., 2000; Eames & Roth, 2000). It is speculated that such individuals may enter treatment with unrealistic expectations or may be persuaded by the clinician to believe that unrealistic goals will be met within a very limited amount of time.

Some studies have suggested that in therapeutic encounters resulting in a positive outcome, the alliance follows a “U” shaped trajectory, due to the initial formation of a strong bond with the client that slowly deteriorates as the therapist focuses on the relational schema underlying the presenting problem (Gelso & Carter, 2004). Over the course of treatment, symptoms may resolve resulting in restoration of the alliance between client and clinician. It is of note that support of the “high-low-high” theory is mixed and is said to vary based on the type of treatment being used. Kivlighan & Shaughnessy (1995, 2000) found that support of the “U” shaped pattern of alliance was not found in short-term therapy, but rather a steadily increasing measure of alliance were most commonly correlated with positive outcomes in brief dynamic therapy.

Taking into account the variability between findings in regards to alliance and premature termination, this investigation will assess client perceptions of the therapeutic alliance following the first and third therapeutic encounter. By doing so, it is likely that
we will survey a relatively unbiased sample that will include clients who may terminate therapy prematurely. Although the assessment of the therapeutic alliance performed at the conclusion of the initial encounter may be less accurate than at the assessment made at the conclusion of the third session, having this measure will allow the sample to include individuals who will terminate treatment prematurely.

Studies have shown that clients who enter treatment with a severe level of impairment follow a non-traditional trajectory in the alliance with their clinician (Kivlighan & Shaughnessy, 2000). Furthermore, the diagnosis of the client can often have an effect on the formation and maintenance of the alliance. A prime example would be the attachment style of a client diagnosed with Borderline personality disorder, or other illness marked by similar patterns of relational instability.

**Racial Identity Development**

Generalizations and stereotyping of ethnic minorities remains a social concern, even amongst practitioners dedicated to culturally competent practice. Learning and understanding characteristics of a certain ethnic group is an important tenet of culturally competent practice but can lead to a monolithic perspective (Sue et al., 1998). Many individuals come to view all African-Americans, Asians or American Indians as having the same belief systems without regard to individual differences within these minority groups. Frequently overlooked is the fact that there exists a great degree of variance regarding the salience of culture and the role that one’s own sense of racial identity factors into an individual's belief system and behaviors (Sue & Sue, 2008).

Clinical implications of not attending to within-group differences pose a serious threat to the formation of the working alliance as well as the outcome of treatment
The clinician who utilizes a static approach with all individuals of a certain ethnic group without regard for personal beliefs and attitudes is vulnerable to arriving at a biased interpretation of the client’s presenting issues and delivering service in a manner that is incongruent with the client’s particular worldview. It is of note that many clinicians fall into such patterns with good intentions of practicing in a culturally competent fashion, yet fail to recognize individual differences (Sue et al., 1998).

**African-American Racial Identity Development.** As minority issues in therapeutic practice first gained recognition in the 1970’s, African-Americans were the first group to receive attention in the literature (Cross, 1971; Jackson, 1975; Thomas, 1971). During the civil rights movement, Cross formulated a model of psychological Nigrescense, which he described as the developmental process through which African-Americans in the United States transitioned from a White frame of reference to a positive Black frame of reference (Cross 1971, 1991, 1995). Cross believed that Nigrescense occurs through a five-stage process whereby individuals start out with White ideals and beliefs which transforms into a positive black frame of reference (Hall et al., 1972). The stages delineated by Cross (1971) are as follows: preencounter, encounter, immersion-emersion, internalization, and internalization-commitment.

Individuals in the preencounter stage of Black racial identity development value White beliefs and ideals while either consciously or unconsciously devaluing their own identity as an African-American (Cross, 1995). Common amongst individuals in the preencounter stage is low self-esteem, self-hatred toward one’s own cultural background and a desire to integrate into White society. Research has correlated poor mental health with African-Americans in the preencounter stage of development (Vandiver, 2001).
The encounter stage is believed to occur in a two-step process, the first being an encounter with a profound crisis or life event that creates dissonance with the previously held worldview (Cross, 1971, 1991, 1995). Second, the individual forms an alternative perspective, resulting in a shift from previously held beliefs and behaviors. The individual comes to feel both angry and guilty at being brainwashed by White Society, which leads into the next stage of immersion-emersion. In this stage, an interest in African-American heritage is awakened and the person becomes immersed within it. A sense of Black Pride begins to form, yet internalization of positive attitudes is limited. In the emersion phase of development, feelings of anger are replaced with an increasing sense of pride.

As the individual enters the internalization stage, dissonance between past and newly developed worldviews begins to subside. Negative attitudes toward Whites diminish as the person becomes more tolerant and flexible in understanding the beliefs of other cultures. The final stage, internalization-commitment demonstrates not only the acquisition of a multicultural belief system, but a profound desire for social change as the individual engages in behaviors aimed toward social justice (Cross, 1971, 1991, 1995).

Although Cross’ (1971) original theory of Black racial identity development has remained largely intact as well as prominent in the field of racial identity, there have been several revisions over the past thirty-five years. Vandiver (2001) criticizes Cross’s work for making the assumption that to progress from the preencounter to internalization-commitment stages of development parallels the transition from psychological dysfunction to psychological health. Cross (1995) has responded to criticism by maintaining the general structure of his original model, while adding subtypes to certain
stages. An assumption of Cross’s original model was that Black racial identity
development occurred in a linear fashion, not allowing one to co-exist at two stages
simultaneously. Cross revised his earlier model to include “race salience” defined as, “the
degree to which race is an important and integral part of a person’s approach to life.”

**White Racial Identity Development.** Although White Culture predominates in
the United States, the average individual of Euro-American descent likely thinks of
“race” or “ethnicity” only in reference to persons of minority ethnic groups. Katz (1985)
points out that,

> “Because white culture is the dominant cultural norm in the United States, it acts
as an invisible veil that limits many people from seeing it as a cultural system. . . .
Often, it is easier for many Whites to identify and acknowledge the different
cultures of minorities than to accept their own racial identity. . . . The difficulty of
accepting such a view is that White culture is omnipresent. It is so interwoven in
the fabric of everyday living that Whites cannot step outside and see their
belief’s, values, and behaviors as creating a distinct racial group.” (p 89)

Katz’s observations are particularly relevant in identifying the disconnect between
training clinicians in culturally competent practice and the translation of education to
practice. Sue and colleagues (1998) make reference to identifying and ameliorating
previously held belief’s and biases of varying ethnic groups in order to move toward
culturally competent practice, however, limited attention has been given to how these
misattributions are formed in the first place. Also, there is little information to suggest
how one should go about transforming these beliefs to increase counseling effectiveness.
Ridley and colleagues (1994) believe that counselors possess a perceptual schema that
affects how information from the environment is processed. It is believed that through these perceptual filters, information expressed by the client and received by the clinician may be interpreted and processed in a manner that distorts the meaning of the information. Ridley believes that the majority of practitioner biases are a result of cultural conditioning that limits his or her ability to practice in a culturally sensitive manner, defined by Ridley as, “the ability of counselors to acquire, develop, and actively use an accurate cultural perceptual schema in the course of multicultural counseling.”

Increasing awareness of biases and attitudes requires that racial identity development receive further attention, particularly in regard to White Euro-Americans. In recent years, researchers have begun to focus more on identifying stages of White racial identity development and developing assessment tools to measure developmental processes (Rowe et al., 1994; Helms, 2001). The benefits of doing so include identifying appropriate training foci in multicultural competencies that attend to the development of the student as studies have shown that the degree of racial identity development often determines the ability of the student to benefit from training (Bussem & Nemec, 2006; Goh, 2005). In addition, identifying the racial identity development of both clinician and client may allow for better pairing of therapeutic dyads that will increase the likelihood of a positive treatment outcome.

Cross (1971) was the first to formally define the concept of racial identity development as it pertained to African-Americans. Several attempts have since been made to conceptualize a linear stage model of racial identity development that is applicable to individuals of all ethnic backgrounds. Phinney and Rotherman (1987) make reference to the universal application of racial identity as it necessitates an integrative
comparison of various racial groups, versus comparison of minority groups against the Euro-American “norm.” Despite this approach, White racial identity development models that have received increased attention over the past fifteen years pertain solely to Caucasian individuals.

**Helm’s White racial identity model.** Janet Helm’s (1984, 1990, 1994, 1995) has come to be known as one of the primary theorists of White racial identity development. She draws her theory based on the assumption that White Americans inherently harbor racist attitudes towards minority groups. Helm’s developmental approach conceptualizes racial identity development as occurring in a two-stage process, the first being abandonment of racism followed by the defining of a non-racist identity (Helms, 1994; 1995). Helms believes that individuals transition through these two phases while progressing through a six-stage developmental process consisting of Contact, Disintegration, Reintegration, Pseudo-Independence, Immersion/Emersion, and Autonomy which are thoroughly explained below:

i) **Contact:** Individuals in this stage are likely to have minimal exposure to member of minority groups and are likely unaware of racism and prejudice as social concerns. Societal influences projecting a dichotomy of White equals “good” and African American equals “bad” are unnoticed but perceived on an unconscious level. The concept of racial diversity is not considered to be applicable to these individuals who perceive themselves as members of the larger, more dominant majority group.

ii) **Disintegration:** In this stage, dissonance results from the holding of two dichotomous perspectives. Sue (1996) uses the example of one believing
they are nonracist, yet not wanting their son or daughter to marry a
member of a minority ethnic group. The resulting conflict is maintained by
trying to balance an unbiased perspective with own-group loyalty.

iii) **Reintegration:** Dissonance resulting from the previous stage is resolved as
a regression to the dominant ideology of one’s own sociocultural group is
strengthened. In this stage, tolerance for minority groups is weakened as
feelings of White superiority become more prevalent. Minority group
issues are seen as a result of “their” own actions, downplaying the role of
Caucasians in minority group oppression.

iv) **Pseudo-Independence:** Individuals typically enter this stage following an
insightful experience that has a profound effect on previously held belief’s
regarding minority group members. Although people in this stage are
categorized as attempting to amend past beliefs and values, the change is
only superficial and limited to intellectual conceptualization versus
internalization. They may begin to seek out minority group members but
are careful to select those with whom there exists some common ground.
Issues of White privilege, discrimination, and prejudice first begin to enter
the consciousness of the individual, however, they are only superficially
comprehended.

v) **Immersion/Emersion:** At times, the insight gained in the pseudo-
independence stage motivates the individual to pursue a more thorough
understanding of his or her own experience as a White American. Helm’s
believes it is during this stage that a personal meaning of racism is derived
and insight into the repercussions of White privilege are realized. Confrontation of previously held beliefs are challenged in experiential and affective domains versus the superficial exploration performed in previous stages. This stage is also marked by attempts to combat racism and prejudice by encouraging others to examine their own biases.

vi) Autonomy: The final stage of Helm’s model entails the formation of a new identity, knowledgeable of cultural differences, and willing to abandon White entitlement. Guilt resulting from White Privilege has resolved with the acceptance of one’s role in perpetuating racist ideology.

Helms (1995) defined information-processing strategies as, “defense mechanisms utilized by White people to avoid or assuage anxiety and discomfort around the issue of race.” Each stage of Helm’s theory of White racial identity development correlates with a particular information-processing strategy. She believed that the Contact stage was indicative of obliviousness or denial while Disintegration demonstrated suppression and ambivalence. Reintegration aligned with selective perception and “out-group” distortion while Pseudo-independence involved the individual manipulating reality by viewing cultural diversity with a narrowed perspective. Immersion/emersion involved reshaping one’s perceptions while Autonomy focused on complex thought and flexibility. Helm’s insight into the cognitive processes underlying each developmental stage provides us with information regarding where to focus multicultural training and furthers our understanding of the barriers that need to be overcome to successfully develop into a culturally sensitive practitioners (Helms, 1984; 1995).
Despite the wide acceptance and popularity of Helm’s model, several critics have pointed out discrepancies in her theoretical formulation while others express fundamental disagreement with her approach to conceptualizing White racial identity development (Rowe et al., 1994). Rowe and colleagues (1994) criticize Helm’s model for focusing solely on the development of White attitudes toward minority groups versus gaining an awareness of themselves as a culturally diverse group. Rowe (1996) takes issue with Helm’s theory of White racial identity development occurring in a linear, step-wise fashion, making the assumption that to progress throughout the various stages symbolizes a transition from “poor” to “good” psychological health.

Rowe, Bennett, and Atkinson’s White Racial Consciousness Model. Rowe and colleagues (1994) disagreement with Helm’s conceptualization of White racial identity led to the development of their own model that perhaps better reflects their position that White racial identity does not necessarily occur in stages but can be better understood by grouping individuals in various stages of development into “types” that reflect their degree of racial consciousness. Their model proposes that the majority of individuals fall into two distinct groups from which seven different “types” emerge.

Unachieved individuals are seen as belonging to one of the following “types” or “statuses”:

i) Avoidant types are unaware of minority issues and concerns and lack insight into their own racial identity. They are known to minimize or avoid racial issues.

ii) Dependent types often model their own racial attitudes and belief’s after significant others in their lives. They have likely had limited experience
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with individuals outside of their own ethnic group from which to draw a personal perspective.

iii) Dissonant types are often in a transitional period of development after having insightful experiences that clash with previously held beliefs.

Achieved individuals are seen as belonging to one of the following “types” or “statuses”:

i) Dominant types hold strong beliefs of White superiority and minority inferiority.

ii) Conflictive types believe that racism in society has been largely ameliorated and see current efforts to oppose racist ideology as reverse racism. While they oppose overt discrimination they are not willing to advocate for or taken action to alter the status quo.

iii) Reactive types demonstrate an awareness of racism in society but are unaware of their role in perpetuating prejudice and discrimination.

iv) Integrative types are able to relate to a variety of racial and ethnic issues. There is an increased awareness of one’s own racial identity as well as a morally driven motivation to advocate for racial/ethnic minorities.

Rowe and colleagues (1994) believe that transition from type to type involve one’s own personal experiences and the degree of dissonance created as a result encountering situations or circumstances that cause conflict with their internal belief system. Individuals often move from type to type throughout the course of their life with the exception of Unachieved- Avoidant and Dependent types who lack the internalized attitudes and motivation to challenge their beliefs.
The Hardiman Model of White Racial Identity Development. Hardiman (1982) provided one of the first integrative attempts to conceptualize white racial identity development by studying a group of White antiracist activists. Considering such individuals to be at the utmost level of racial awareness, she proposed a five-stage model of White racial identity development which included the following stages: 1) Naiveté, 2) Acceptance, 3) Resistance, 4) Redefinition, and 5) Internalization.

i) Naiveté: Hardiman likens the Naiveté stage to early childhood, a period during which time the individual is unaware of racism and prejudice. Individuals in this stage do not harbor racist beliefs and experience little to no discomfort with racial issues. Societal influences from media sources as well as parents, friends, and peers begin to instill a particular belief system that transforms the individual and moves them along to the next stage of Hardiman’s model.

ii) Acceptance: This stage is characterized by a more conscious awareness of race and culture and the formation of appropriate values and belief’s. However, there is a focus on White supremacy and superiority along with the belief that minorities are inferior to Whites and solely responsible for any shortcomings or hardships. The idea of oppression is denied and rationalizations are made to make sense of the individual’s skewed worldview.

iii) Resistance: Transiting into the resistance stage begins when the realities of prejudice and discrimination can no longer be denied and are often challenged by personal experiences. This stage represents a major change
in the belief system of the individual who abandons all previously held values and adopts an opposing perspective. For the first time, the individual becomes more conscious of being White and is aware of their inherent racist attitudes. They can clearly see the existence and marked effect of oppression on minority groups, which may bring about negative feelings of anger and hatred toward Whites in general. There is now a desire to interact cross-culturally, however, there is often concern for making racist comments accidentally and a desire to atone for previously held beliefs. Minorities are often looked up to and idealized during this stage, which is an introspective experience for many as they struggle to be more in touch with their own cultural background while wishing to reject it in the same moment.

iv) *Internalization:* This stage is characterized by a lack of all prejudice beliefs and racist behavior. It is a new identity for the individual that requires continual maintenance as oppressive, societal influences are ever-present.

As with all other models of White racial identity development, critics have noted several limitations of Hardiman's model. Sue and colleagues (1998) question the generalizability of Hardiman's theory, as the general theory was derived from the autobiographies of Anti-racist White Americans nearly thirty years prior. In addition, it has been argued that the Naiveté stage, borrowed from pre-existing social identity development theory can only truly exist in young children between the ages of four and five. Finally, Hardiman's theory lacks any empirical research in support of the five
stages, however, her early work served to bring the concept of White racial identity development to the consciousness of many during a time in which racial identity focused solely on minority groups.

Research suggests that a minority group member’s early reaction to treatment, which is to include, the therapeutic process and the actual clinician is strongly influenced by one’s degree of racial identity development in addition to their minority status (Sue & Sue, 2008). Examining the interactions and alliance formation in cross cultural counseling dyads relies heavily on the degree to which both individuals identify with their own ethnic background as disparities between both individuals, in particular the clinician, determines his ability to practice in a culturally competent fashion. For example, utilizing a cognitive behavioral approach with a depressed African-American teenager would vary greatly in its implementation depending on the individual’s degree of racial identity development. Characteristic feelings of isolation and alienation would likely relate directly to the patient’s sense of self in the greater realm of their minority status. The source of poor self-esteem stemming from a stereotypic “White is good” perspective in the Naiveté individual would contrast sharply with the same symptom in an African-American who is said to have reached an Integrative awareness degree of development, frustrated by their efforts to combat an oppressive society.

The clinician’s conscious awareness of his patient’s stage of racial identity development is beneficial to enable the client to move toward an integrative awareness stage (Sue & Sue, 2008). By being able to accurately assess the client’s status, the clinician can anticipate the course of his racial identity development, fully aware of the potential pitfalls that may threaten the therapeutic alliance and possibly derail the course
of treatment. The clinician's awareness allows treatment to facilitate the client's racial identity development and collaboratively work toward a well-defined treatment goal.

Earlier in the chapter, Cross's (1995) five-stage model of Nigrescence was outlined and each individual stage delineated. I will again refer to this model; however, I will focus solely on the clinical implications encountered when counseling patients at each respective stage. Helm's six-stage model of White racial identity development will also be utilized to mark varying degrees of racial identity development on behalf of the White clinicians for the purpose of making accurate comparisons between the two groups.

The preencounter stage is characterized by identification of White belief's and ideals while devaluing one's own African-American identity (Cross, 1995). Patients at this stage will often prefer and identify with a White clinician whom they will hold in very high regard, introducing the possibility that the client may become dependent on the therapist who is viewed with great power and capability (Sue & Sue, 2008). The patient may also attempt to please the clinician, providing information he believes will lead the therapist to hold him in high regard. The client's tendency to seek approval from the clinician can seriously interfere with the course of treatment, leading to inaccurate self-report and feedback. The preencounter patient may present with resistance to an African-American or minority member clinician, beginning the therapeutic process with negativity, hostility and often non-compliance, while some may request and only work with a White clinician (Sue & Sue, 2008). Interventions aimed at exploring cultural belief's may result in the client feeling threatened by the clinician as doing so will likely uncover feelings of self-loathing, poor self-esteem and negative feelings. Preencounter
patients prefer an approach to treatment that remains solution-focused and directive, not requiring self-exploration of any sort.

The conclusions drawn above make the assumption that the White therapist him/herself is in a positive degree of racial identity development (e.g. Immersion/emersion or autonomy) that allows him/her to identify the status of the patient and respond accordingly. By utilizing particular interventions, the patient’s development can be supported in treatment via education from the clinician who will appropriately model a non-judgmental stance and a positive attitude toward minority groups along with validation of the client’s experience (Sue et al., 1998; Sue & Sue, 2008). As a result, dyads consisting of a White therapist in positive stages of racial identity development will likely form a strong alliance with African-American client’s in Cross’s Preencounter stage of development, as the clinicians conceptualization of the client’s issues is likely to include cultural factors that will also be considered in the content and service delivery style of the practitioner.

White clinicians in the negative stages of racial identity development (e.g. contact, disintegration, reintegration, or pseudo-independence) may fail to consider racial identity as a treatment factor and/or unknowingly thwart the client’s development by reinforcing their negative belief system. In this situation, negative self-schema in regards to cultural identity are overlooked by the clinician. Regardless of this omission, practitioners in negative stages of racial identity development are still likely to achieve and maintain a strong therapeutic alliance. The clinician remains highly revered by the client and does not attempt to address negative attitudes and ideals that are likely to be painful for the client to discuss (Sue & Sue, 2008).
Cross (1995) describes the internalization stage of African-American racial identity development as a resolution of the dissonance between past and present worldviews. Negative attitudes and prejudice toward Whites diminish as the individual becomes more flexible in considering and attempting to understand the worldview of other cultures, thus integrating a multicultural perspective. Although, societal oppression continues to affect them, they possess greater psychological resources to manage these issues. With regard to clinical implications, the internalized person is likely to choose and form a strong alliance with a practitioner whom they feel can accurately conceptualize their worldview. Race is secondary to this factor in terms of therapist preference which is focused more so on similar attitudes and perspectives (Sue et al., 1998; Sue & Sue, 2008).

The internalized person requires a therapist with a proportionately developed sense of racial identity and a high degree of self-awareness who is able to identify the client’s degree of racial identity and integrate this information in his conceptualization and approaches to treatment. If these conditions are met, there is a high likelihood of a strong alliance formation between client and practitioner.
Chapter Three: Hypotheses

This investigation examined the relationship between Caucasian clinician’s self-reported cultural competence and the working alliance as reported by African-American clients. The relationship of racial identity development for both the clinician and client was assessed in order to examine client-clinician pairings likely to form a strong therapeutic alliance.

Hypothesis 1

Culturally competent Caucasian clinicians will be in positive stages of racial identity development.

The clinician’s cultural competence was assessed by the Multicultural Counseling Inventory (Sadowsky et al., 1994). The clinician’s racial identity was assessed by the White Racial Identity Attitude Scale (Helms & Carter, 1990) to determine whether the individual’s belief’s correlate to either positive or negative stages of racial identity development.

It is a widely accepted concept that a clinician’s degree of racial identity positively correlates with their ability to learn and benefit from training in cultural competence (Sue & Sue, 2007). The rationale that underlies this concept contends that an individual with an underdeveloped racial identity will struggle to understand the perspective of an individual with a well-developed racial identity. Research supports the notion that clinicians with an underdeveloped racial identity are unlikely to benefit from training in multicultural competence and subsequently treat diverse populations in a culturally sensitive manner (Sue & Sue, 2007).
Hypothesis 2

Caucasian clinicians who adhere to culturally competent practice will form a positive therapeutic relationship with African American clients in all stages of racial identity development except for clients in the immersion stage.

The clinician’s degree of culturally competent practice was assessed by their completion of the Multicultural Counseling Inventory (MCI) (Sadowsky et al., 1994). The therapeutic relationship was assessed by the client completing a Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989).

Culturally competent practitioners possess the ability to conceptualize issues in treatment through the eyes of the client, taking into account the worldviews and belief systems that often vary from their own (Sue et al., 1998). This enables the practitioner to have a more thorough understanding of the client’s problems as well as an accurate and effective approach to treatment. Whether or not the client feels the clinician understands his or her presenting circumstances contributes greatly to the attachment bond in the therapeutic relationship (Horvath & Symonds, 1991). Subsequently, the patient’s compliance with treatment toward mutually agreed upon goals increases as a result of the firm attachment bond.

African American clients in the immersion stage of racial identity development are likely to harbor feelings of anger toward Caucasians as a whole as an awareness of White privilege and history of oppression by this group begins to form (Cross, 1971). Caucasian clinician practicing in a culturally competent fashion may be able to better identify African American clients in this stage of racial identity development; however, it remains highly unlikely that the two will be able to form a positive working alliance.
Hypothesis 3

Caucasian clinicians in positive stages of racial identity development will score higher on the WAI with African American clients in all stages of racial identity development except for clients in the immersion stage.

To assess this hypothesis, the clinician’s racial identity development was measured by the WRIAS (Helms & Carter, 1990) and the client’s racial identity will be assessed using the RIAS-B (Helms & Parham, 1985).

As previously discussed, therapists who are sensitive to cultural issues in therapy are able to form a better understanding of their client’s circumstances and are able to conceptualize the client’s problems more accurately leading to more effective, culturally appropriate interventions and service delivery style. Clients in the pre-encounter stage of development may or may not attend to cultural beliefs in their own life. If so, they likely harbor anti-Black perspectives and align with White values and ways of living. In this pairing, the therapist is able to identify the client as being in a pre-encounter stage of development and be able to address the client’s belief system in the context of treatment.

The pairing of a Caucasian therapist in the positive stages of racial identity development with an African-American client in the internalization and internalization-commitment stages of development is likely to result in a strong therapeutic alliance, particularly in regards to the bond attachment (Sue, 2007). In this clinical scenario, both individuals strongly identify with their cultural background and are able to understand one another’s worldview. The therapist will be sensitive to cultural factors of the client, which will enhance his or her ability to form an accurate conceptualization and select an approach to treatment that will be of optimal benefit to the client.
African American clients in the immersion stage of racial identity development are in the process of developing pride in their cultural background along with experiencing feelings of anger toward the white majority who is seen at this point as an oppressive force (Cross, 1971). Although a Caucasian clinician with a well-developed racial identity may be better able to understand African American clients in this stage of development, they will likely find themselves unable to form a positive therapeutic relationship with these individuals as they simply do not have an interest in engaging with a White therapist.

**Hypothesis 4**

Caucasian therapists in negative stages of racial identity development will only be able to form a working alliance with African-American clients in pre-encounter and encounter stages of racial identity development.

To assess this hypothesis, the clinician’s stage of White racial identity development was measured by the WRIAS (Helms & Carter, 1990) while the client’s stage of racial development was assessed by the RIAS-B (Helms and Parham, 1985). The therapeutic relationship was measured by the WAI (Horvath & Greenberg, 1989). Additionally, Caucasian clinicians whose scores on the WRIAS correlate with the negative stages of racial identity development will form a strong working alliance (as indicated by their score on the WAI) with African American client’s whose scores on the RIAS-B correlate with Cross’s pre-encounter and encounter stages of racial identity development.

Clients whose scores on the RIAS-B correlate with Cross’s internalization and internalization commitment stage of racial identity demonstrate a fully developed sense of racial identity and a keen awareness of how racial issues influence society and
relationships. Their knowledge of and often dedication toward changing societal norms is a major facet of their identity. A clinician with a poorly developed sense of racial identity will not acknowledge or be aware of their client’s development. In turn, the clinician’s lack of racial identity development will be observed by the client, leaving him feeling as though this clinician will never truly understand his perspective or presenting issues.

African-American clients in the pre-encounter stage of racial identity development either consciously or unconsciously devalue their own “Blackness.” Their beliefs often align with those of White society and may demonstrate a great deal of self-hate and low self-esteem (Cross, 1971, 1991, 1995). Additionally, research shows that mental health is generally very poor in this population (Sue & Sue, 2008). When these two individuals are paired in a therapeutic relationship, cultural factors will often remain unacknowledged. The African-American client may idealize his White therapist and not attend to the subtle racism evident in the relationship. Conversely, if racism is detected by the client, he may identify with these beliefs that align with his own self-hatred toward his African-American identity. As a result, such individuals are likely to foster a positive alliance in therapy.

Hypothesis 5

Culturally competent Caucasian clinicians in positive stages of racial identity development will score higher on the WAI with African American clients in all stages of racial identity development except for clients in the immersion stage.

To test this hypothesis, the clinician’s cultural competence was assessed using the MCI (Sadowsky, et al., 1994) while their stage of racial identity development was assessed using the WRIAS (Helms & Carter, 1990). Additionally, the client’s stage of
racial identity development was assessed by the RIAS-B (Helms & Parham, 1985) while the strength of the working alliance was measured by the client, using the WAI (Horvath & Greenberg, 1989).

The fifth hypothesis, a summation of hypotheses one and two demonstrates the interconnectedness of the constructs being investigated. As previously stated, most clinicians who are culturally competent also demonstrate a well-developed racial identity. While we contend that these clinician’s will form a working alliance with African American clients in all stages of racial identity development, there remains one exception. African American clients whose beliefs align with Cross’s immersion stage of racial identity development are unlikely to form a working alliance with any Caucasian therapist regardless of their respective stage of racial identity development.
Chapter Four: Methodology

Overview

This investigation examined the relationship between Caucasian clinician’s self-reported cultural competence and the working alliance as reported by African-American clients. The relationship of racial identity development for both the clinician and client was also assessed in order to determine client-clinician pairings likely to form a strong therapeutic alliance. Participants for this investigation came from two main sources. Caucasian clinicians were recruited from doctoral and Master’s level students who were completing their clinical training at various PCOM training sites including the Lancaster, Roxborough, and Cambria Healthcare Centers as well as The Center for Brief Therapy and Family Medicine on-site clinics at PCOM. African American clients were recruited from patient populations at the aforementioned training sites. The clinicians completed the White Racial Identity Attitude Scale (WRIAS) and the Multicultural Competence Inventory (MCI) at the start of the investigation. The clients were asked to complete the Black Racial Identity Attitude Scale (RIAS-B) and Working Alliance Inventory (WAI) at the end of the session in which they were solicited. Two sessions later, the clients were asked to complete a second WAI. Data gathered were then used to determine the validity of the stated hypotheses.

Design and Design Justification. All data were analyzed using several Pearson Correlations to determine support for the hypotheses stated in the previous section. The Results chapter will describe in detail the changes in statistical analysis that were made due to the poor response rate.
**Participants.** All of the clinicians who participated in this investigation were student therapists recruited from cohorts of Master's students and doctoral candidates seeking either a Master’s degree in Clinical and Counseling Health Psychology or a Doctoral degree in Clinical Psychology from the Philadelphia College of Osteopathic Medicine. Participation was voluntary and student therapists reserved the right to withdraw from the study at any time without explanation or consequence. In addition, student therapists received compensation from the student investigator in the form of two $10.00 VISA gift cards for each complete set of data they were able to obtain from one client.

Clients participating in this investigation were recruited from various PCOM training sites including the Lancaster, Roxborough, and Cambria Healthcare Centers as well as The Center for Brief Therapy and Family Medicine on-site clinics at PCOM. Clients were solicited for their participation in this investigation by the student therapists at their respective training site.

**Inclusion and Exclusion Criteria.** Student therapists participating in this investigation were Caucasian men and women between 18 and 88 years of age. All participants were active graduate students pursuing a Master’s degree or Doctoral degree through the psychology program at the Philadelphia College of Osteopathic Medicine. Non-Caucasian students were excluded from this investigation due to the nature of the constructs being studied. Criteria were determined based upon information provided to the investigator through a basic demographic questionnaire form presented to the student therapist after being formally solicited by the principal investigator.
Clients participating in this investigation were African-American men and women between 18 and 88 years of age seeking psychological treatment. Clients younger than 18 or older than 88 were excluded from this investigation. Additionally excluded were participants who met diagnostic criteria for traumatic brain injury, mental retardation, pervasive developmental disorders, delirium, dementia, schizophrenia and other psychotic disorders or are actively suicidal or homicidal. Evaluation for the above disorders was made by the clinician prior to their soliciting the client to participate.

Recruitment. The principal investigator presented the study and related procedures to all psychology students training at PCOM during a weekly staff meeting. Students were informed of the inclusion/exclusion criteria and asked to respond to an email sent out by the principal investigator following the staff meeting. Student therapists who were interested and met inclusion criteria were asked to reply to the email in order to receive the study materials which include a demographics form which formally qualified or disqualified them from participating in the investigation.

Clients who fit the inclusion and exclusion criteria listed above were solicited from various PCOM training sites including the Lancaster, Roxborough, and Cambria Healthcare Centers as well as The Center for Brief Therapy and Family Medicine on-site clinics at PCOM. Once the student therapist had determined that a particular client met both inclusion criteria, he solicited the client’s participation in the investigation by following protocol detailed in Appendix C.

Measures

Test materials consisted of the Multicultural Counseling Inventory (Sodowsky et al., 1994), Working Alliance Inventory- Short versions of the client form and clinician

**Multicultural Counseling Inventory.** The MCI (Sodowsky et al., 1994) is a 40-item self-report scale with an estimated administration time of approximately 10-15 minutes. The MCI endeavors to assess four factors of multicultural competence including (a) multicultural awareness, (b) multicultural relationships, (c) knowledge, and (d) counseling skill (Green et al., 2005). Test items are phrased as statements to which the test taker provides a reply based on a 4-point Likert scale (4=very accurate, 3=somewhat accurate, 2=somewhat inaccurate, 1=very inaccurate). All items are worded to indicate that a response of 1 indicates a low degree of cultural competence and a response of 4 equates to a high degree of cultural competence. Inclusive ranges of scores are as follows: Skills and knowledge 11 to 44; awareness 10 to 40; and relationship 8 to 32. Full scale scores may range from 40 to 160 respectively. For the purposes of this investigation, a mean score of 100 was utilized as the cutoff to determine whether a clinician is culturally competent or is not.

The MCI is preferable to other measures of cultural competence for a multitude of reasons. Other widely used measures of multicultural competence such as the Cross-Cultural Counseling Inventory-Revised (CCCI-R), Multicultural Counseling Awareness Scale- Form B (MCAS-B) and Multicultural Awareness-Knowledge-and Skills Survey (MCKAS) focus solely on assessment of three domains identified by the APA: awareness, skills and knowledge (Stanhope et al., 2005). The MCI includes assessment in the area of relationship formation, a competency correlated with increased positive
outcomes in treatment (Kocarek et al., 2001). In addition, the MCI provides a measure of cultural competence that parallels both traditional as well as post-modern perspectives that stress the need for self-awareness of cultural attitudes in addition to cultural literacy (Green et al., 2005).

Research has concluded that the psychometric properties of the MCI are stronger than those of the CCCI-R, MCAS-B, and MCKAS (Boyle & Springer, 2001). Studies suggest that the MCI likely has considerable potential for bridging the gap between competence practice and empirical validation (Green et al., 2005). Research supports positive pre- to post-changes on awareness and skills subscales in regard to improvements made during multicultural training in a distance-learning social work program (McFadden, Dumbrill & Maiter, 2000). In a larger investigation of 442 Masters students training in counseling psychology, researchers reported consistent evidence of the MCI’s reliability and validity with a range of alpha reliability coefficients for each of the four subscales ranging from .65 to .84 (Walters & Wheeler, 2000). In addition, Walters and Wheeler (2000) also reported strong outcomes related to criterion-related validity in that students with previous training in multicultural competencies remonstrated higher scores on both skills and self-awareness subscales in comparison to students without previous training. As with all currently available measures of cultural competence, the MCI is limited by the fact that information is gathered through self-report. Additionally, it is of note that the MCI is intended for assessing the cultural competence of social workers, however, the various domains of assessment expand its utility to other mental health service providers.
**Working Alliance Inventory- Client Version.** The short form versions of the WAI (Horvath & Greenberg, 1989) are 12-item measures designed to assess the strength of the working alliance from either the client’s or clinician’s perspective. Replies are provided based on a 7-point Likert scale and requires approximately 3 minutes to administer. Items load on 3 subscales that dovetail with Bordin’s tripartite conceptualization of the working alliance that includes agreement on therapeutic tasks and goals as well as patient-therapist bond (Summers & Barber, 2003). The three subscales of the WAI have been found to be highly intercorrelated and have demonstrated a high degree of interrater reliability (Horvath & Greenberg, 1989; Tichenor & Hill, 1989; Fenton et al., 2001). In addition, the WAI is highly correlated with other measures that assess working alliance including the Penn Helping Alliance Scale and the California Psychotherapy Alliance Scale (Tichenor & Hill, 1989; Marmar et al., 1989).

**Black Racial Identity Attitude Scale.** The RIAS-B (Helms & Parham, 1985,1996, Parham & Helms, 1981) is a 50-item self-report questionnaire (long form) that assesses the stages of Black racial identity development proposed by Cross (1971) which include (a) pre-encounter, (b) encounter, (c) immersion/emersion, and (d) internalization (See Appendix G). Test takers are asked to respond to statements with a rating on a 5-point Likert scale that ranges from 1= strongly disagree to 5= strongly agree. When scored, the respondent is provided with a scaled score for each of the four types of racial identity attitudes with higher scores representing an increased association with the respective attitude toward racial identity. The RIAS-B takes approximately 15
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minutes to administer and requires the responder to be at or above an eighth grade reading level.

There exists ample support for the reliability and validity of the RIAS-B (Helms & Parham, 1996; Lemon & Waehler, 1996). Helms and Parham (1996) report alpha estimates of .76, .51, .69, and .80 for Preencounter, Encounter, Immersion-Emersion and Internalization subscales respectively. Fisher, Tokar and Serna’s (1998) analysis of the RIAS-B demonstrated support for convergent and discriminant validity in three of the four subscales finding limited internal consistency in the Encounter subscale. The authors conclude that despite this limitation, the RIAS-B demonstrates a high degree of construct validity, particularly in comparison to other measures of Black racial identity development.

**White Racial Identity Attitude Scale.** The WRIAS (Helms & Carter, 1990) is a 50-item self-report questionnaire designed to measure the five stages of white racial identity development proposed by Helms (1984). Approximate administration time is estimated to be between 10-15 minutes. Test takers are required to respond to statements using a 5-point Likert scale that ranges from 1 (strongly disagree) to 5 (strongly agree). Summed scores may range from 10 to 50 and are intended to correlate with Helms’ (1984) five stages of white racial identity development (contact, disintegration, reintegration, pseudo-independent, and autonomy).

The WRIAS has received significant attention in the research community as many have called the measures psychometric properties into question (Behrens, 1997; Pope-Davis, Vandiver, & Stone, 1999; Rowe, Behrens & Leach, 1995; Swanson, Tokar, & Davis, 1994). Given the lack of alternative measures currently available, the WRIAS is
commonly used in studies investigating white racial identity development despite its limitations (Mercer & Cunningham, 2003). However, in order to maintain the internal validity of this investigation, the WRIAS was scored using four different factors that dovetail with Helms’ model of white racial identity development, on which test items have been empirically supported to load (Mercer & Cunningham, 2003).

The WRIAS has several limitations, most notably low internal consistency and reliability as high correlations between factor analyses suggest that items have the potential to load on two or more scales (Behrens, 1997). Exploratory factor analysis suggests that rather than providing an outcome measure that correlates positively with Helms’ five-factor model of development, the WRIAS primarily measures white racial identity development as a single construct (Swanson et al., 1994; Rowe et al., 1995). An investigation of 308 White university students concluded that the largest factor had factor loadings from 32 of the test items from all five scales (Tokar & Swanson, 1991). In addition, the factor was highly correlated with negative attitudes held toward African Americans or culture in a dichotomous pattern of loading (Rowe et al., 1995).

Helms’ (1984) original model of white racial identity development conceptualized the process as occurring in a linear fashion whereby White individuals would progress through the five stages in a sequential manner. She later revised the model to incorporate a multidimensional element that allowed for the individual to simultaneously exist in two stages at the same time as they progressed in a hierarchical fashion (Helms, 1997). Helm’s revisions were again met with criticism by researcher’s who found that the WRIAS did not correlate with the five-stage model but rather with entirely different constructs.
including Degree of Racial Discomfort and Attitudes of Racial Curiosity (Pope-Davis et al., 1999).

In response to these criticisms, Mercer and Cunningham (2003) conducted a principal components analysis of the WRIAS with a sample of 430 college students consisting of 150 men and 280 women in a Southern urban city. A coefficient alpha reliability analysis was first used to assess the psychometric properties of the WRIAS in addition to a principle component analysis that was compared to the original five scales. Coefficient reliability analyses of the original scales demonstrated low to moderate reliability estimates (Contact = .45; Disintegration = .76; Reintegration = .76; Pseudo-Independent = .60; Autonomy = .53) as well as high positive and negative intercorrelations between the five scales (Mercer & Cunningham, 2003).

Analyses concluded that each of Helms’ original five-factor stages of White racial identity development loaded on several individual test questions. However, loading on particular test items was correlated with elements of positive and negative white racial identity development (Mercer & Cunningham, 2003). Internal consistency reliability analyses yielded sufficient reliability estimates for four scales including (White Superiority/Segregationist Ideology = .87; Perceived Cross-Racial Competence and Comfort = .81; Interest in Racial Diversity = .75; Reactive Racial Dissonance = .63) Intercorrelations of the proposed scales demonstrated significant correlations between White Superiority/Segregationalist Ideology and Perceived Cross Racial Competence and Comfort (r= -.42, p < .001), Interest in Racial Diversity (r= -.13, p < .05), and Reactive Racial Dissonance (r= .27, p < .001). In addition, Perceived Cross Racial Competence was significantly correlated with Reactive Racial Dissonance (r= -.13, p < .05).
Findings indicated that Cunningham and Mercer’s (2003) derived scales did not correlate with Helms’ original five-factor model in regard to the magnitude of intercorrelations or theoretical perspective. For example, White Superiority/Segregationalist Ideology and Reactive Racial Dissonance were correlated positively with negative identity development while Interest in Cross-Racial Competence and Comfort were correlated with Interest in Racial Diversity as dimensions of positive racial identity development. In an attempt to make use of the WRIAS to measure White racial identity development of students therapists in this investigation while maintaining a high degree of internal validity, Cunningham and Mercer’s factors will be utilized.

**Personal Health Questionnaire.** The Personal Health Questionnaire (PHQ-9) (Kroenke, Spitzer, & Williams, 2001) is a 9-item, paper and pencil assessment tool used to detect the presence and severity of depressive symptoms over a two week period. Persons surveyed are required to respond to each item with a number on a 4-point Likert scale between 0 (not at all) and 3 (nearly every day). The PHQ-9 requires an 8th grade reading level yet remains reliable when read aloud to an individual who then provides verbal responses.

**Procedure**

Participation in this investigation was voluntary for all subjects who retained the right to withdraw at any time without explanation or forfeiture of their compensation. Student therapists were solicited based on the aforementioned inclusion/exclusion criteria from Master’s and Doctoral level psychology cohorts completing practicum and pre-doctoral internships at various PCOM sponsored Healthcare Centers and Mental Health Clinics in Philadelphia. The student therapists training at these sites were solicited by the
student investigator at a weekly meeting during which time the nature of the investigation was explained as well as the procedure for collecting data. Those student therapists who showed interest in participating were asked to respond to an email sent out by the student investigator to inform him of their interest in participating in the study.

Student therapists who agreed to participate were given an envelope, which contained one copy of the “Letter to Therapist,” one copy of the WRIAS, one copy of the MCI, and one copy of a demographics form. The envelope had a single digit number in the upper right hand corner, which matched all of the forms contained in the envelope for organizational purposes. The “Letter to Therapist” provided instructions for completing study materials, which required each subject to complete all forms and return them to the mailbox in the Center for Brief Therapy marked “Scoma-Research Materials.” Once the demographics form had been received by the student investigator and the student therapist was determined to be eligible to participate, they received 14 manila envelopes, (seven “A” envelopes and seven “B” envelopes) of client study materials. Because no identifying information was gathered, all forms as well as the manila envelope had two, single digit numbers separated by a hyphen in the upper right hand corner. The first number correlated to a particular student therapist and the second number correlated to the particular client. For example, the first student therapist who participated in this investigation received the number one. The first, second, and third client solicited by the student therapist to participate in the study received envelopes respectively numbered, “1-1,” “1-2,” “1-3.” The envelopes marked with the letter “A” contained one copy of the “Letter to Client,” one copy of the WAI, one copy of the RIAS-B and a $10.00 VISA gift
card for compensation. The envelope marked “B” contained one copy of the WAI and was given to the client two sessions after envelope “A” was distributed.

If a client was new to the student therapist and appeared to meet inclusion criteria, the student therapist included a brief demographics form with the Personal Health Questionnaire (PHQ) at the time of intake (see Appendix A). If the client’s responses to the demographics questionnaire qualified them for participation in the study, the student therapist then formally solicited them by reading a supplied script (see Appendix C). If the client agreed to participate, they were given an envelope "A" at the close of the first session with directions to deposit study materials in a wire bin marked "RESEARCH MATERIALS" found at the front desk of each training site.

If a client had already been in treatment prior to the start of data collection, the clinician was likely to know whether or not they meet inclusion criteria. If they did not, the student therapist presented the demographics form to the client and asked them to complete it. If the client met inclusion criteria to participate in the study, the student therapist read the supplied script (see Appendix C) to solicit their participation in the study. If the client agreed, they were given an envelope "A" at the close of that session and asked to complete the materials in a common area of the training site. When completed, study materials were placed in the provided manila envelope, sealed, and deposited in the wire bin at the front desk marked "RESEARCH MATERIALS."

Two sessions after envelope "A" was distributed (e.g. 1 & 3, 8 & 10) the student therapist provided the client with an envelope "B" at the close of the session. The client was again directed to complete the enclosed materials in a common area of the training site before placing them back in the manila envelope, sealing it, and placing the envelope
in the wire bin at the front desk marked "RESEARCH MATERIALS." The student therapist then collected the envelopes from the bin and placed it in the mailbox of the student investigator in the Center for Brief Therapy. If the client was someone whom the student had been treating before data collection began, the student noted the session numbers on envelopes "A" and "B" before returning them to the student investigator. This was not necessary for new clients. Student therapists were asked to deposit all study materials in a mailbox in the Center for Brief Therapy (CBT) marked "Scoma- Research Materials." The student investigator checked the mailbox on a weekly basis and deposited a $10.00 VISA gift card in the respective student’s mailbox for all envelopes he was able to gather that week. Student therapists had the opportunity to earn a total of $20.00 in VISA gift cards as compensation for a complete data set and could gather up to eight sets of data.

If a client completed the "A" envelope and then did not return to treatment, the student therapist returned the incomplete materials to the mailbox in the CBT marked "Scoma- Research Materials." The student therapist did not receive any monetary compensation for envelopes containing incomplete materials.

**Analysis of Risk/Benefit Ratio**

**Potential risk to participants.** Given the nature of this investigation, there were some potential risks to clients who chose to participate. There was the possibility that the client may have felt pressured into participating to please their clinician. If the client had been in treatment with the student therapist for a period of time, they may have felt as though their compliance with the study was necessary for them to continue to work effectively with their respective therapist. Although the WAI and RIAS-B do not
demonstrate any evidence of harm to those assessed, racial matters may have been uncomfortable for some individuals to reflect upon which had the potential to strain the alliance between clinician and client who may have terminated treatment prematurely as a result. As previously stated, African-Americans who do not identify their ethnicity as a salient feature of their life, may have been adversely affected by a premature reflection of their racial development. In conclusion, there was an additional possibility that a client may have found the nature of this investigation suspicious or unorthodox in such an early stage of treatment, which may have caused them to drop out of treatment prematurely.

**Potential Benefit to Participants.** There was potential for this investigation to highlight and raise awareness of cultural differences in the dyads being studied. Whereas some clinicians may be hesitant to discuss cultural differences with their clients openly, this nature of this investigation was likely to produce a discussion between client and therapist that may have otherwise not occurred. Because of this discussion it is possible that the therapeutic relationship was strengthened as a result.

**Potential Benefit to Others.** The potential impact of this investigation was promising. Although the study was plagued by a very small sample size and low power, it does provide future researchers with information on how such constructs can best be studied and feedback for those who may choose to replicate a similar investigation in the future.

**Procedures for Maintaining Confidentiality.** All data gathered from participants in this investigation were anonymous and only accessible by the student investigator. All materials were stored in a locked cabinet for the duration of the investigation and were destroyed once the investigation was completed. All of the
participants in this investigation were given a demographics form with an assigned number. Neither their name nor any other identifying information was collected for the purposes of this investigation. Additionally, the MCI, WRIAS, RIAS-B and WAI were also assigned the same number and stored alongside the demographics form in a manila envelope with the number of the data set written on the upper right-hand corner of the envelope.
Chapter 5: Results

In order for this investigation to be adequately powered at the .05 level of significance for a medium effect size at .80 power, a minimum of 64 participants were required to test the stated hypotheses; i.e., eight therapists and eight clients for each therapist. At the end of data collection, however, six student therapists had successfully solicited only 14 clients for participation in this investigation. Of those 14 clients, four had failed to return to treatment to complete the second set of measures and two had completed the measures incorrectly (One client did not complete the backside of the RIAS-B form and one client provided written responses to each item in lieu of circling numbers on the Likert scale as directed). The remaining data sets were poorly differentiated with little to no variability in certain constructs essential for computing the statistical analyses. Although underpowered, sufficient data were gathered to test only one of the five stated hypotheses.

Demographic characteristics

The student therapists solicited for this investigation included six men and women between the ages of 24 and 53 who self-identified as Caucasian. Both Master's and Doctoral students were represented in the sample at a ratio of 2 to 4 (see Table 1.)

<table>
<thead>
<tr>
<th>Table 1. Demographics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student Therapist</strong></td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
</tbody>
</table>
The eight clients who participated in this study self-identified as African American and were between the ages of 19 and 67. Of the eight clients surveyed, four fell into the Emersion stage of RID while RIAS-B scores placed three in the Pre-encounter stage and one in the Encounter stage (see Table 2).

Table 2. Client RID

<table>
<thead>
<tr>
<th>Client</th>
<th>Age</th>
<th>Ethnicity (Self-identified)</th>
<th>Stage of RID</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>60</td>
<td>African-American</td>
<td>Emersion</td>
</tr>
<tr>
<td>2</td>
<td>19</td>
<td>African-American</td>
<td>Emersion</td>
</tr>
<tr>
<td>3</td>
<td>47</td>
<td>African-American</td>
<td>Pre-encounter</td>
</tr>
<tr>
<td>4</td>
<td>51</td>
<td>African-American</td>
<td>Emersion</td>
</tr>
<tr>
<td>5</td>
<td>37</td>
<td>African-American</td>
<td>Pre-encounter</td>
</tr>
<tr>
<td>6</td>
<td>42</td>
<td>African-American</td>
<td>Encounter</td>
</tr>
<tr>
<td>7</td>
<td>67</td>
<td>African-American</td>
<td>Emersion</td>
</tr>
<tr>
<td>8</td>
<td>59</td>
<td>African-American</td>
<td>Pre-encounter</td>
</tr>
</tbody>
</table>

Descriptive statistics

The Multicultural Counseling Inventory (MCI) positively correlates abilities in the realms of skills, awareness, formation of relationships and general knowledge of common clinical issues related to various cultural backgrounds. Scores are continuous and do not correlate with a developmental model or stages of cultural competence. Total scores range from 40 to 160. All student therapists scored within a very narrow range (120-125) and demonstrated poorly differentiated subscale scores as well (see Tables 3a. & 3b.).
Table 3a. MCI: Descriptive Statistics

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCI Skills</td>
<td>6</td>
<td>36</td>
<td>37</td>
<td>36.25</td>
<td>.463</td>
</tr>
<tr>
<td>MCI Awareness</td>
<td>6</td>
<td>27</td>
<td>29</td>
<td>28.38</td>
<td>.916</td>
</tr>
<tr>
<td>MCI Relationship</td>
<td>6</td>
<td>25</td>
<td>28</td>
<td>27.38</td>
<td>1.061</td>
</tr>
<tr>
<td>MCI Knowledge</td>
<td>6</td>
<td>32</td>
<td>41</td>
<td>34.75</td>
<td>2.659</td>
</tr>
<tr>
<td>MCI Total</td>
<td>6</td>
<td>120</td>
<td>125</td>
<td>123.63</td>
<td>2.264</td>
</tr>
</tbody>
</table>

Table 3b. MCI: Therapist Scores

<table>
<thead>
<tr>
<th>Therapist</th>
<th>MCI: Total</th>
<th>MCI: Skills</th>
<th>MCI: Knowledge</th>
<th>MCI: Awareness</th>
<th>MCI: Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>120</td>
<td>37</td>
<td>41</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>2</td>
<td>125</td>
<td>36</td>
<td>34</td>
<td>29</td>
<td>28</td>
</tr>
<tr>
<td>3</td>
<td>124</td>
<td>36</td>
<td>35</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>4</td>
<td>120</td>
<td>36</td>
<td>35</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>5</td>
<td>121</td>
<td>40</td>
<td>33</td>
<td>29</td>
<td>26</td>
</tr>
<tr>
<td>6</td>
<td>120</td>
<td>37</td>
<td>32</td>
<td>27</td>
<td>27</td>
</tr>
</tbody>
</table>

**Hypothesis one.** Culturally competent Caucasian clinicians will be in positive stages of racial identity development.

Of the six student therapists surveyed, all WRIAS scores placed the therapists in positive stages of racial identity development (RID) (see Table 3.). Additionally, items endorsed on each measure were associated with an “Interest in racial diversity,” a stage of White racial identity development revised from Janet Helm’s (1998) six stage developmental model, by Mercer and Cunningham (2003) (see Table 4.).
Table 4. WRIAS: Descriptive Statistics

<table>
<thead>
<tr>
<th>Positive RID Stage: Interest in RD</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Data gathered are in support of the first hypothesis, as Caucasian clinicians were found to be exclusively in positive stages of White racial identity development. Although not directly evaluated in this study, it is important to note that clinicians with a well-developed sense of racial identity typically demonstrate higher degrees of cultural competence.

**Hypothesis two.** Caucasian clinicians who adhere to culturally competent practice will form a positive therapeutic relationship with African American clients in all stages of racial identity development except for the immersion stage.

Because of the poor differentiation with regard to clients and their respective stage of racial identity development, it was not possible to analyze the data and determine support of the stated hypothesis.

**Hypothesis three.** Caucasian clinicians in positive stages of racial identity development will score higher on the WAI with African American clients in all stages of racial identity development except for clients in the immersion stage.

As with the previous hypothesis, the lack of variability in the areas of Caucasian and Black RID do not allow a comparison to be made.
**Hypothesis four.** Caucasian therapists in negative stages of racial identity development will only be able to form a working alliance with African-American clients in pre-encounter and encounter stages of racial identity development.

As demonstrated in Table 4., the Caucasian student therapists WRIAS scores showed no variability whatsoever as all students were in positive stages of RID. Additionally, all scores fell in the exact same stage, "Interest in racial diversity." The absence of Caucasian clinicians in negative stages of RID precluded this hypothesis from being tested.

**Hypothesis five.** Culturally competent Caucasian clinicians in positive stages of racial identity development will score higher on the WAI with African American clients in all stages of racial identity development except for clients in the immersion stage.

As with hypotheses 2, 3, & 4, lack of variability in the areas of RID for both the clients and student therapists do not allow this hypothesis to be formally evaluated.

**Exploratory Analysis**

In response to the limited number of participants and poorly differentiated outcomes for several key variables, the investigator decided to conduct an exploratory analysis to determine if there were any correlations between variables not formally considered in the aforementioned hypotheses. In order to do so, the MCI as well as the first and second WAI’s were scored with more detail to determine individual subscale scores and the correlation coefficients were computed.

**First and second WAI total scores.** The relationship between the first and second set of WAI scores were analyzed by using a Pearson Correlation and found to be positively correlated ($r=.84, p=.005$) (See Figure 1) Outcomes support that scores on the
first WAI can be used to predict the sores on the second WAI and that WAI Total scores across the time frame were stable.

**Figure 1.**

![Graph showing WAI scores](image)

**First and second WAI subscale scores.** WAI individual subscale (task, goals, and bond) scores were also shown to be positively correlated between the first and second administration of the measure. A Pearson Correlation analysis was used to analyze the WAI Task subscale scores on the first and second administration and found a positive correlation between the two variables \( r = .79, p = .005 \) (see Figure 2)

**Figure 2.**

![Graph showing WAI Task scores](image)

Similarly, a Pearson Correlation was also used to analyze the WAI Goals subscale scores on the first and second administration and found a positive correlation between the two variables \( r = .89, p = .005 \) (see Figure 3) A Person Correlation
comparing WAI Bond subscale scores between the first and second administration found a similar relationship between both variables as they were also positively correlated \((r = .58, p = .005)\) (see Figure 4).

Figure 3.

![Graph showing relationship between WAI Goals First and WAI Goals Second.](image)

Figure 4.

![Graph showing relationship between WAI Bond First and WAI Bond Second.](image)

**Relationship between MCI skills and awareness subscales.** One rather unexpected outcome was revealed with a Pearson Correlation between MCI subscales (skills, awareness, knowledge and relationship) with one another. A significant negative correlation \((r = -.926, p = .005)\) was found between the MCI Awareness subscale and MCI Skills subscale (see Table 3).
Table 5. MCI Skills subscale and Awareness subscale correlation

<table>
<thead>
<tr>
<th>MCI Skills Subscale</th>
<th>MCI Awareness Subscale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Correlation</td>
<td>-.926**</td>
</tr>
<tr>
<td>Sig. (1-tailed)</td>
<td>.000</td>
</tr>
<tr>
<td>N</td>
<td>6</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.05 level (1-tailed).

In summation, the lack of differentiation among key variables greatly limited the ability to test the majority of stated hypotheses. In addition, the small sample size and resulting low power did not allow for results to be adequately tested. However, we were able to extract a significant correlation between the first and second WAI measures which demonstrated test-retest reliability of the measure itself. The same effect was also observed in the individual WAI subscales (goals, task, and bond) from one administration to the next. An exploratory analysis found a significant negative correlation (r = -.926) between MCI Skills and Awareness subscales.
White Racial Identity Development

One aspect of the data collected that made it not possible to test hypotheses 2, 3, 4, and 5 was the lack of differentiation among Caucasian student therapists with regard to their degree of racial identity development. All student therapists’ scores on the WRIAS placed them not only in positive stages of RID but also placed them exclusively in the same stage (Interest in racial diversity).

There are numerous reasons behind the poorly differentiated scores. All student therapists were enrolled in the same academic department whose own mission includes a dedication to preparing practitioner-scholars with a sensitivity to cultural, ethnic, gender diversity and the underserved and also identifies multiculturalism as a core competency. In line with their mission, student therapists training at the Center for Brief Therapy received diversity trainings in addition to their required diversity courses. There is a clear expectation of how students should present with regard to their thoughts and feelings toward diverse clientele. Because the WRIAS is quite transparent, it would not be difficult for a student to present himself in a desired way that may be counter to his own internal belief system. There is also the possibility that students believed the principal investigator, who interacted regularly with them as part of their clinical training at that time, would see their responses to the WRIAS. In this instance, there may have been an element of social desirability whereby student therapists may have felt pressured to present themselves in a “positive” light.
**Black racial identity development**

Although more variability was observed in terms of racial identity in the African American client sample, most clients were polarized between emersion and pre-encounter stages of RID. The only outlier was one client whose score on the RIAS-B was in the encounter stage of RID. Because of the low power, there was not an adequate test of this hypothesis. As initially thought, African American clients in the Immersion stage of RID were not represented at all in the client sample. Cross (1991) describes the immersion stage as often resulting from a racial encounter whereby the individual identifies with all aspects and characteristics of their race to the exclusion of people outside their racial group. His or her belief system during this stage of development would make seeking help from anyone who is not an African American unlikely. It is possible that these clients may have been represented by those who did not return to treatment following the initial meeting or did not choose to participate in the study at all.

The absence of individuals in the internalization/internalization commitment stage of RID can only be due to the limited sample size and the relatively short data collection period. African Americans whose racial identity has fully evolved to the point where they experience comfort around individuals of all races and often take action towards social justice are said to be in the Internalization or Internalization commitment stage of RID. Had the sample of student therapists contained students in negative stages of RID, there may have been grounds to explain the absence of African Americans in this stage of RID, however, there were not.
Inability to Test all Hypotheses

Poor variability was not only limited to the racial identity development of the Caucasian students but also affected the scores on the MCI. Although some variability did exist, scores on the MCI (which can range from 60-140) demonstrated a range of 5 points, between 120 and 125. The reasons why little differentiation existed here are similar to the WRIAS as the non-random sample of graduate students selected for this investigation were likely to have an interest in presenting themselves in a positive way. It is, however, also quite possible that these students sought careers in a helping profession (or were interested in treating diverse clientele) and possess qualities consistent with racially evolved individuals. There is also the possibility that the sample of student therapists were influenced by the training they had received in cultural competence, some of which is aimed at furthering an individual’s RID. Research has substantiated the correlation between high degrees of racial identity development and cultural competence (Sue & Sue, 1991).

The lack of differentiation among key variables was also due to the very poor response rate and resulting small sample size. As previously mentioned, the investigators were seeking to gather data from seven student therapists and 64 clients but fell short with only 14 clients solicited which ultimately yielded eight usable sets of data. Student therapist participation was much higher as six students agreed to participate in the study. The inclusion criteria were adjusted halfway through the data collection process in an attempt to gather more client data. The initial dissertation proposal required all clients to be starting treatment with the student therapist at the start of data collection. The protocol required that data be collected on the first and third session and clients already in
treatment with a student therapist were excluded from participating in the investigation. Shortly after data collection began, the student investigator started to receive feedback that many students currently had full caseloads and were not taking on new clients. They added that save for the time they have been in treatment, many student therapists had clients on their caseload that otherwise met criteria to participate in the investigation. Following the submission of a revised proposal, the final four weeks of data collection were open to clients who had been in treatment for any length of time who met remaining inclusion criteria. It is of note however, that all eight sets of complete data were collected from clients at the first and third session. Student therapists did report successfully soliciting some clients who has already been in treatment for a period of time, however, none provided a complete data set by the end of data collection, which ran for a total of 16 weeks.

There are several factors likely responsible for the low response rate. Initially it seemed as though student therapists were not very proactive in seeking out potential clients. However, discussions with several student therapists early on in the data collection process revealed that many had attempted to solicit multiple clients but were not well received. They reported that some clients appeared suspicious of the process as evidenced by their questions or anxious affect. Common questions included whether or not more would be required of them if they agreed to participate. The general presumption from clients who did not want to participate was that they would somehow owe someone for the monetary compensation despite the fact that requirements were clearly stated. Some clients simply stated that they were not interested. Although the legitimacy of the student therapists accounts is not in question, it is important to consider
that some of the students may not have attempted to solicit every client who met inclusion criteria for other reasons such as the somewhat bulky data-collection procedures of general disinterest in the constructs being assessed. One must also consider the fact that some clients may have had difficulty or were not have been able to read the study materials. Although the study was limited to clients who were able to complete the intake paperwork on their own without significant assistance, there remains the possibility that some clients may have been intimidated by the reading requirements of the study materials, enough so to override their desire for monetary compensation.

Client mistrust of the student therapists may have also been a significant factor in the observed small sample size of clients in this investigation. American history is replete with examples of Caucasian individuals exercising their White privilege in malevolent ways against minority groups, African Americans in particular. Although the most egregious of these events occurred many years ago, archetypes have passed down notions of the need for hyper vigilance against the Caucasian majority in modern day life. African Americans may very well be sensitive and appropriately guarded against the idea of being "studied" by their White counterparts. As mentioned previously, student therapists collecting data spoke anecdotally of low participation due to clients being presented with study data and refusing to participate and not the lack of clients who met inclusion criteria. Because there were no data gathered to specifically study this phenomenon, we are limited in our ability to draw a formal hypothesis. However, student therapist reports did indicate a trend that suggests client mistrust may have been a significant factor in the ultimately low number of client participation.
The PCOM healthcare centers generally treat a lower socioeconomic stratum of society. Studies support the correlation between low socioeconomic status and likelihood of having endured a traumatic experience at one or several points across the lifespan. Symptoms of anxiety such as hypervigilance, avoidant behavior and re-experiencing, secondary to a diagnosis of acute stress disorder or post-traumatic stress disorder are overrepresented in these populations. For many of these individuals, the experience of participating in a "study" organized by the Caucasian majority may have triggered a perception of vulnerability and resulting avoidance of the request. This dynamic might have been further complicated by the relationship between the client and referring physician along with the implicit, skewed power differential between the two. Simply stated, many PCOM HCC patients may have felt pressured to follow the referral of their physician for mental health services even if they were privately opposed or disinterested in engaging in treatment.

The bulk of the data collection process on the side of the student therapists may also have played a role in gathering limited data sets. The procedure required of the student therapist to collect data from their clients was quite extensive and time consuming and may have not fit into the flow of a busy outpatient healthcare center. As a result, it is likely that some student therapists may simply have not wanted to participate in the process. There is also the likelihood that some students did not want to discuss race and culture so early on in treatment or at all. They may have decided that a discussion regarding the discrepancy between their ethnic backgrounds was not indicated. There is also the possibility that the students did not want to have their performance evaluated.
(despite the fact that it was done so anonymously), particularly if they perceived the principal investigator as having access to their responses.

Because the data collection procedure was extensive and required a significant amount on time on behalf of both student therapist and client, the investigator decided to provide considerable monetary compensation in the form of VISA gift cards ($10.00 per client and $20.00 for each clinician for a complete data set). The poor response rate may suggest that the financial compensation was not a great motivator for the clients. With regard to the student therapists, it is possible that compensation was a motivating factor for them as evidenced by their report of trying to solicit all clients who were appropriate.

By the end of the 16-week data collection period, data were gathered from only 14 clients. Of the 14 clients, 8 complete data sets were obtained as 4 had not returned to complete the second WAI and 2 had completed the surveys incorrectly (One client did not answer the questions on the backside of the RIAS-B while the other provided written responses to each item in lieu of circling numbers on the Likert scale as directed). Additionally, one client who provided a complete set of data seemed to endorse items randomly, often indicating contradictory ideas (e.g. Client circled 5 which indicates “Strongly agree” to items stating, “I feel comfortable around Black people” and “I don’t feel comfortable when Black people are around.”), which made the data unreliable and not usable.

As aforementioned, it is likely that social desirability may have influenced some clients decisions to participate in mental health treatment. As nearly all of the mental health referrals at PCOM HCC's come from primary care physicians and students, client's participating in this investigation may have felt compelled to follow through with these
referrals even while being privately opposed to treatment. Use of a measure such as the Marlowe-Crown Social Desirability Scale (Crowne & Marlowe, 1960) would have allowed us to assess this dimension and more accurately account for the poorly differentiated data gathered.

**Exploratory Analysis**

**Prediction of WAI scores.** In response to the inability to test hypotheses 2, 3, 4, and 5, investigators decided to conduct an exploratory analysis to determine if any relationships existed that had not been formally considered in the initial hypotheses. A Pearson correlation analyzing the first and second WAI total scores found them to be significantly associated across time. The strong correlation between measures can possibly be interpreted as a measure of reliability as little fluctuation was observed from one measure to the next. However, the initial hypothesis expected the strength of the working alliance to follow a “U shaped” trajectory that decreased slightly from the first to third session. The measurement taken from the third session was hypothesized to provide a reliable indicator as to the likelihood of the client remaining in treatment and achieving a positive outcome prior to termination. The data gathered did not support this trend but rather demonstrated a general degree of stability along with a slight increase in the strength of therapeutic alliance over three sessions.

**Prediction of WAI subscale scores.** Analysis of WAI subscale scores demonstrated a similar relationship to the total scores outlined above, as all subscales were highly correlated with one another from the administration of the first assessment to the second assessment. Again, this does demonstrate a degree of reliability for the WAI;
however the scores did not follow the expected “U” shaped trajectory often observed from session to session.

**Predication of WAI subscales.** A Pearson correlation was conducted to look at the relationships between WAI subscales within the same survey administration. The Goals and Task subscales were found to be highly associated and predictive of one another (r = .951, p = .005). Lack of additional research in this area leaves the relationship between these two subscales open to interpretation. It seems plausible that the goals in treatment often define the tasks of both client and therapist, tasks that are required of each to achieve mutually agreed upon treatment goals. It is important to consider that because all student therapists were providing cognitive behavioral therapy to their clients, they might have been oriented toward collaborative goal setting and clearly defining client/therapist tasks in the therapeutic process which may very well account for the relationship observed between these two variables.

**Analysis of MCI subscales.** One of the most interesting observations in this study resulted from a Pearson correlation that analyzed the relationship of the four subscales of the MCI with one another. The majority of subscales were positively correlated with one another as expected, however, there was a particularly strong negative correlation between the MCI Skills and MCI Awareness subscales. Initially, there was concern that the measures might have been incorrectly scored (e.g. missed reverse-score items), however, a third round of scoring confirmed that the data analyzed were indeed accurate. Although this investigation has several limitations we can try and speculate on why this phenomenon was observed in this particular group.
First, consider the student therapist who practices with a keen awareness of cultural issues but lacks the skill necessary to integrate that awareness into the conceptualization and treatment of diverse clientele. This could be a result of inexperience and/or a lack of understanding about how to provide culturally sensitive treatment. Given the attention cultural competence receives in the academic curriculum at PCOM, it is likely that a student’s awareness of cultural issues develops before their skills in treating diverse populations.

**Limitations of the study**

Despite taking various measures to reduce threats to the validity and reliability of this investigation, there remained several threats, which could have confounded outcome data. The uniqueness of this study alone provides some insight into the difficulty many researchers have had in trying to quantify and measure more abstract constructs such as cultural competence and racial identity development. Clinicians who demonstrate a commitment toward becoming more culturally competent often possess a very genuine personal desire to engage in self-exploration that will raise awareness of personal beliefs and biases toward minority groups. Such pursuits often range outside the academic setting and include purposefully engaging in life experiences aimed at further understanding the plight of the minority individual as much as a majority group member is able to do. Some of the measures available to assess cultural competence do consider these factors, however, to date, a truly accurate measure of cultural competence without limitations has yet to be created. The four measures chosen for use in this investigation were selected because they represent the most reliable and valid instruments in their
respective class. Limitations of each measure are detailed *Measures* section of Chapter Four.

Allowing one student therapist to collect data from eight of their clients had its advantages and disadvantages. By soliciting students from PCOM’s healthcare centers, we were able to control for theoretical orientation and exposure to training in cultural competence. However, we also had one student therapist who collected 67% of the data that was obviously overly represented in the statistical analyses. It should be noted that this particular student therapist was very well received by his clients as evidenced by strong scores on both administrations of the WAI. It is interesting however, that this clinician was a 24 year old, 2nd year Master’s student and probably had the least exposure to training in cultural competence in comparison to the other five students. Moreover, this statistic also supports the lack of a correlation between therapists experience and ability to form a positive therapeutic relationship (Bordin, 1994).

PCOM sponsored healthcare centers generally cater to serving the underserved, lower SES, and disenfranchised minority clientele. These clients often lack private insurance and are limited in their options for seeking treatment. While collecting data from this population is certainly practical due to the constructs being measured, it does not allow for random sampling.

In conclusion, the small sample size of this investigation increases the possibility that an potential effect could not be detected in the statistical analysis. Another issue is that the sample itself was biased and precluded generalization. As stated, the practicality of obtaining a larger sample size for this investigation would have been extremely difficult given the constraints in which this research was conducted.
Future directions

Because this investigation was significantly underpowered and exploratory in nature, further investigation into the stated hypotheses is clearly indicated. If this study were to be replicated in the future, it may be beneficial to break the investigation down into multiple, more manageable studies. An example might be assessing the RID of Caucasian clinicians in isolation. By doing so, the procedure would be more streamlined which may result in better compliance and a larger sample group. An additional recommendation would involve a much longer data collection period. Although data collection was quite slow, there was a consistent trickle of surveys coming in. It seems a reasonable assumption that if the study were conducted over a 12-18 month period, we may have gathered a more substantial sample of clients..

Retrospectively, the use of a pilot group prior to data collection would have served well to provide us with insight as to how both the study materials and data collection procedure were perceived. As previously mentioned, many student therapists commented that a large number of potential subjects met criteria to participate in the investigation, yet declined for an unknown reason. Although, we have strong speculations as to why this occurred, a pilot group would have provided feedback and allowed us to alter the structure of the study accordingly.

Summary

The lack of research in this area hints to the inherent difficulty often faced when studying matters of race and culture. While the statistical analyses did support some relationships between multiple variables, the investigation as a whole was plagued with severe threats to internal and external validity. It is the hope of the investigator that this
project serves to provide direction to future researchers dedicated to gaining a better understanding of the cross cultural therapeutic dyad.
References


Appendix A

Personal Health Questionnaire (PHQ) Cover Sheet
(Demographic Information)

1) Date of Birth: ______

2) Ethnicity:
   - ☐ African-American
   - ☐ Hispanic
   - ☐ Non-Hispanic White
   - ☐ Other ________________
Appendix B

Therapist Demographics Questionnaire

1) Date of Birth: ________

2) Ethnicity:

☐ Hispanic
☐ Non-Hispanic White
☐ African-American
☐ Other ________________
Appendix C

Letter to Clinicians

Takako Suzuki Ph.D.
Philadelphia College of Osteopathic Medicine
Department of Psychology
Takakosu@pcom.edu
215-871-6435

Peter Scoma, MS
Petersc@pcom.edu
215-510-0628

Dear participant,

The purpose of this investigation is to examine factors that influence the working alliance in cross-cultural therapeutic relationships consisting of Caucasian clinicians and African-American clients. We will be gathering the following information from both yourself and your clients. Student therapists interested in participating in the study will receive the following materials:

- 1 manila envelope including:
  - 1 Therapist Demographics Form
  - 1 “Letter to Therapist”
  - 1 Multicultural Counseling Inventory (MCI)
  - 1 White Racial Identity Attitude Scale (WRIAS)

- 8 manila envelopes, marked “A” which include the following items:
  - 1 “Letter to Client”
  - 1 Black Racial Identity Attitude Scale (RIAS-B)
  - 1 Working Alliance Inventories- Short Form, Client Version
  - 1 Personal Health Questionnaire Cover Sheet
  - 1 $10.00 VISA giftcard

- 8 manila envelopes, marked “B” which includes the following item:
  - 1 Working Alliance Inventory- Short Form, Client Version

When you receive the first single packet please complete the Therapist Demographics Form, Multicultural Competence Inventory and White Racial Identity Attitude Scale and seal them in the manila envelope with the same identification number in the upper right hand corner. We ask that you place all the materials in the envelope that we have provided and return them to Peter Scoma’s mailbox in the Center for Brief Therapy marked “Research Materials – P. Scoma”.

The clients that we are seeking for this investigation are African-American men and women between the ages of 18 and 88 who are presenting for treatment of a medical or
psychiatric condition at your respective training site. Clients can participate at any point in treatment so long as the second packet is distributed 2 sessions after the first packet is distributed (e.g. Session 1 and 3, session 11 & 13, etc.). Demographic information such as age and ethnicity will be gathered by the supplied cover sheet of the PHQ and will be used to qualify or disqualify a subject from participating in the study. This sheet is included in the client’s envelope, and needs to be administered with the PHQ for clients being solicited at intake, or later on for clients who are already in treatment. If a client meets the inclusion criteria to participate, the student therapist will read the supplied script posted below to orient the client to the study and ask them to consider participating. At the end of the session, once the client has had an opportunity to consider whether or not they want to participate, the student therapist will read a second script to the client, which explains the study in more detail. At this point, the student therapist will determine whether or not the client wishes to participate and if so dispense study materials and directions for completion.

Exclusion criteria:

Participants who meet criteria for mental retardation, pervasive developmental disorders, delirium, dementia, active psychosis, and/or active suicidal or homicidal ideation will not be allowed to participate in this investigation. Clients who are not able to complete the PHQ, or need extensive support from yourself will also be excluded from the study as it will be assumed that they are not able to read at an 8th grade level.

The Procedure:

Clinicians:

- Complete the following forms upon receipt:
  - Demographics form
  - Multicultural Counseling Inventory (MCI)
  - White Racial Identity Attitude Scale (WRIAS)

Client:

- In the beginning of the session, the client will complete the PHQ cover sheet (Demographic data), and PHQ.
- At the end of the session the client will need to complete contents of envelope “A” which includes the following:
  - Black Racial Identity Attitude Scale (RIAS-B)
  - Working Alliance Inventory- Short Form, Client Version
- Two sessions later, the client will need to complete the contents of envelope “B” which includes the following:
  - Working Alliance Inventory- Short Form, Client Version

The procedure for this investigation involves the clinician handing out the envelope “A” at the end of the first data collection session, which includes a Black Racial
Identity Attitude Scale, Working Alliance Inventory and $10.00 VISA giftcard. Please put the completed cover sheet of the PHQ (demographic data) back in the client’s envelope before you hand it to the client. Should the client not return for treatment, the clinician will return the completed “A” envelope and incomplete “B” envelope to the responsible investigators mailbox in the Center for Brief Therapy marked “Research Materials – P. Scoma”. While no identifying information will be collected at any point throughout the investigation, the two measures and manila envelopes will be marked with numbers in the upper right hand corner and grouped together accordingly when you receive them. When returning completed packets, please ensure that the numbers on the surveys correspond with the number on the manila envelope before placing them in the mailbox in the Center for Brief Therapy (CBT) labeled “Research Materials – P. Scoma. Additionally, please write the session number on the upper right hand corner of both “A” and “B” manila envelopes (e.g. 1 for the first meeting, 8 for the eighth meeting, etc.). When the responsible investigator receives the envelopes of data from you, he will place your compensation in your mailbox at the CBT. You will receive a $10.00 VISA gift card for envelope “A” (WAI and RIAS-B) and a second $10.00 VISA gift card for envelope “B” (WAI administered following the third session). If a client does not return to treatment after completing envelope “A”, you will only be compensated for the “A” envelope. If a client drops out of the study either formally by speaking with you or informally by simply not returning study materials after the first session, please send an email to the responsible investigator informing him that a client has dropped out. You will receive a $10.00 VISA giftcard as compensation for clients who have decided to withdraw from the study for any reason.

You may read the following passage to the client once their responses to the PHQ cover sheet have formally qualified them for the investigation.

“Here at the PCOM healthcare center we are always looking for ways to improve patient care. From time to time we conduct research studies to help us figure out how we can best serve our clients. We are currently doing a research study on culture and ethnicity to determine how we can provide the best service to African-American clients. We are asking clients to fill out some surveys about their opinions and attitudes toward culture as well as how satisfied they are with the service they are receiving from the PCOM’s healthcare center. It will take about 15 minutes of your time and you will receive a $10.00 VISA gift card today for your participation. Take some time to think about it and we can discuss it more when we are finished today.”

At the close of the meeting, you can remind the client about the study, and ask if they are interested in participating. You can provide them additional information by reading them the passage below.

“The purpose of this research study is to look at the relationships between clients and therapists of different ethnic backgrounds, in this case, African-American and Caucasian, to figure out what characteristics determine the type of relationships they will form with one another. Your participation in this study is completely voluntary. It is completely up to you whether you choose to participate or not and your decision will not effect your
treatment whatsoever. If you decide that you want to participate, I will ask you to complete three brief forms. Two forms will need to be completed at the end of today’s meeting and take most people about 12 minutes to complete. The first form asks questions about your feelings toward your ethnicity and determines how important cultural factors are in your everyday life. The second form will ask you questions about the services you have received from your clinician. As previously mentioned, you will fill out one of these surveys today and then another one after our next meeting. Please remember to not skip items and complete all of the questions in the surveys even if you are not completely sure about an answer. As a participant in this study your time will be compensated with a $10.00 VISA gift card, which will be given to you at the end of today’s meeting. Other than completing these three forms, there is nothing else that will be asked of you. Additionally, your name and/or any personal information will not be collected at any point during this study and your answers will not be shared with anyone besides the 2 people conducting the study, whose names are on the "Letter to Client" in the envelope. If you decide to participate today and change your mind later on, you can stop at any time and you will still receive the $10.00 VISA gift card.”

In conclusion, the following is a step-by-step breakdown of the data collection procedure.

1) Client completes PHQ cover sheet, which is in the client’s envelope. Please take the sheet from the envelope and ask them to fill it out if they appear to be a potential participant. If they mark the box “African-American,” are between the ages of 18-88 and meet the inclusion criteria stated above, you will read the first script to them after completing your intake paperwork, before the clinical assessment. If the client is already in treatment, you may begin the session by introducing the study and reading the first script. Please remember that individuals with mixed ethnic backgrounds are not eligible to participate as the measures we are using apply only who identify themselves as African-Americans.

2) At the end of the meeting, please read the second script to confirm whether or not a client chooses to participate in the study.

3) If a client does want to participate, please hand them envelope A. Please be sure to put the cover sheet of the PHQ back to the envelope before you hand it to the client.

4) Instruct the client to complete all materials in the waiting room of the HCC, seal the envelope when done, and deposit the materials in the bins at the front desk marked “Research Materials.”

5) Collect the envelope from the “Research Materials” bin and drop it off in the mailbox at the Center for Brief Therapy marked “Research Materials – P. Scoma”. Please remember to record the session number in the upper right hand corner of both manila envelopes. Your compensation will be placed in your mailbox in the CBT.
6) Two sessions after envelope “A” has been completed (e.g. 1 & 3, 4 & 7, etc.), administer envelope “B” (Working Alliance Inventory) and provide the same instructions for completion as listed above.

7) Collect the envelope from the “Research Materials” bin and drop it off in the mailbox labeled “Research Materials – P. Scoma” at the Center for Brief Therapy to receive your compensation.

If you have any questions, please direct them to either Dr. Takako Suzuki or Peter Scoma using the contact information listed above.

Thank you very much for your assistance in this research project,

Sincerely,

Takako Suzuki, Ph.D.
Principal Investigator

Peter Scoma, M.S.
Responsible Investigator
Appendix D

Letter to Client

Takako Suzuki Ph.D.
Principal Investigator
Philadelphia College of Osteopathic Medicine
Department of Psychology
Takakosu@pcom.edu
215-871-6435

Peter Scoma, MS
Responsible Investigator
Petersc@pcom.edu
215-510-0628

Dear Participant,

The purpose of this research study is to look at the relationship between therapists and clients of different ethnic or racial backgrounds. The results from this study will help figure out how we can best serve African-American clients who come to the healthcare center for treatment. Providing the very best care to all of our clients is very important to us. Your participation in this study will help us learn specifically how we can best serve our African-American clients.

Your participation in this study will require you to fill out two different types of surveys. One survey will ask how you feel about your race and culture. This will take about 12 minutes to complete and you only have to do it once. The other survey will ask about the services you have received from your therapist. This will take about 2 to 3 minutes to complete. You will be asked to fill this survey out twice - once at the end of today's session and again after two sessions. We ask that you not skip any questions and complete all surveys to the best of your ability. You do not have to put your name or any personal information on any of the surveys. Your answers will not be seen by anyone except the two investigators whose contact information is listed above. Additionally, your therapist will not have access to the surveys you fill out.

If you decide to participate in this research study your therapist will give you a $10.00 VISA gift card for your participation along with an envelope that contains the surveys we are asking you to complete. Participation in this research study is completely voluntary. If you decide today that you do want to participate and then change your mind later on, you are free to drop out of the research study at any time and may keep your $10.00 VISA gift card.

Thank you so very much for your participation in this study.
CULTURAL COMPETENCE

Sincerely,

Takako Suzuki, Ph.D.
Principal Investigator

Peter Scoma, MS
Responsible Investigator