To the Graduate Council:

I am submitting herewith a dissertation written by Dwight David Tolliver entitled "The Counselor Color Consciousness Scale: Evidence for Relevance, Reliability, and Validity." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Psychology.

Jacob Levy, Major Professor

We have read this dissertation
and recommend its acceptance:

Dawn Szymanski_____

John Lounsbury_____

Suzanne Molnar_____

J. Roger Parsons_____

Accepted for the Council:

Carolyn R. Hodges,_____
Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

The Counselor Color Consciousness Scale (CCCS): Evidence for Relevance, Reliability, and Validity

A Dissertation
Presented for the
Doctor of Philosophy
Degree
The University of Tennessee, Knoxville

Dwight David Tolliver
August 2008

DEDICATION

This dissertation is dedicated in loving memory of my father, Thurman Tolliver, and sister, Kristie Tolliver.

ACKNOWLEDGEMENTS

Completing a dissertation, though rewarding in many ways, is a very challenging endeavor. To do so, I needed to overcome many obstacles that I did not imagine I would face. The support, love, and encouragement of so many people were, therefore, vital to its completion. First, I would like to express my most sincere gratitude to my advisor, Dr. Jacob Levy whose support, professional guidance, commitment, and interest in multicultural research were essential to the completion of this project. Special and sincere thanks are also extended to my committee members, Drs. Dawn Szymanski, John Lounsbury, Suzanne Molnar, and Roger Parsons for their support and helpful suggestions through the conceptualization, implementation, and writing of this research project. A special thank you goes to my dear friend and psychology internship peer, Hisham Abu Raiya, whose statistical help assisted greatly in the completion of this dissertation project.

Further, this study could not have been completed without the deep love, respect, support, and consistency of my beloved wife, Shannon Tolliver. Truly, she is a fantastic life partner, mother, and person with whom I wish to share the rest of my life. Additionally, I want to extend my love and acknowledgement to my three children, who serve as inspirations to me on a daily basis. They are Julianne Kristi, Mallory Rose, and Nathan Thurman Tolliver. Furthermore, I want to express my deepest love, acknowledgment, and appreciation to my mother, Bertha Ward, who always believed in my ability to succeed academically even though I am a first generation college student. I also want to express my deep gratitude to the participants in this study; this educational and professional milestone could not have been completed without the support of each of you.

ABSTRACT

The purpose of the current investigation was to develop the Counselor Color Consciousness Scale (CCCS) that was constructed based on Ridley's (1995, 2005) theoretical conceptions of this construct. This study aimed to assess the relevance, reliability, and validity of the CCCS as a scientific tool measuring racial attitudes of white therapists and their work with clients of color. The sample consisted of 73 white therapists in Study 1, and 118 white therapists in Study 2. Both studies used a web survey format.

Overall, the results were noteworthy in several respects. First, the CCCS showed high internal consistency in both studies. Second, the CCCS demonstrated discriminant and convergent validity. More specifically, the CCCS was significantly correlated, in the hypothesized directions, with multicultural knowledge, confidence in the counseling relationship, an avoidant racial attitude, a dissonant racial attitude, and color blind racial attitudes (and each of its subscales). Finally, the CCCS demonstrated concurrent validity by being correlated, in the hypothesized direction, with the constructs of public and private self-consciousness, affective empathy, and self-monitoring. .

These findings highlight the fact that the CCCS can be a new variable to be used in multicultural research. Other implications of these findings for theory, practice, and research, the limitations of the study, and directions for future research are discussed.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I
INTRODUCTION AND GENERAL INFORMATION

In the 1990's, multiculturalism emerged, arguably, as the fourth force in psychology (Pedersen, 1999), complementing the earlier forces of psychodynamic, behavioral, and humanistic explanations of human behavior (Gelso & Fretz, 2001). Gelso and Fretz asserted that multiculturalism has shifted from, at the minimum, an ancillary area or topic of interest among counseling psychologists to an area that requires the attention of all psychologists. However, there are many counseling psychologists who believe that there is more progress needed in order to have a true multicultural profession (Gelso & Fretz). Two factors that have been salient to the emergence of a multicultural focus in psychology are the changing demographics in our society and social changes that have impacted psychological practice (Gelso & Fretz).

Concerning the changing demographics, the United States (US) Census Bureau (2006) reported that minority populations are growing 12 times faster than the White, non-Hispanic population. In the 1990's, growth for minority populations was 13.2 percent higher than during the previous two decades, and this rate is reportedly higher during the 2000's (US Census Bureau, 2006). Specifically, the minority population grew from approximately 70 million individuals in 1990, to approximately 85 million in 2000, and to approximately 100 million in 2006 (US Census Bureau, 2006). Concerning the effects of the changing demographics on the practice of psychology, Gelso and Fretz (2001) asserted that ethnically diverse and minority populations rival only the aging population with respect to the fastest growing clientele for practicing psychologists and mental health counselors in the twenty first century.

With respect to social changes, the social movements of the 1950's and 1960's brought a significant number of racial/ethnic minorities into contact with psychologists and mental health

practitioners (Gelso & Fretz, 2001). This included desegregation of schools and universities, the creation of mental health community centers, and civil rights laws. Suddenly, researchers and practitioners were forced to perform accurate psychological testing, make accurate diagnoses, provide effective counseling, and conduct quality research for racial/ethnic minority clients. However, data accumulated and indicated that researchers and practitioners were ineffective in performing these roles as they related to a culturally diverse clientele (Essandoh, 1996).

Research findings have suggested that minority clients are not treated as well or competently as their white counterparts (Gelso & Fretz, 2001). Specifically, research has suggested that racial and ethnic clients' level of psychopathology is overestimated (Gynther, 1979); their prognosis is often underestimated (Butcher, Braswell, & Raney, 1983); they are engaged in shorter periods of treatment (Sue, Fujino, Hu, Takeuchi, & Zane, 1991); they are referred to more restrictive forms of treatment (Gynther, 1979); they underutilize traditional outpatient mental health services (Leong, 1994; Cheung & Snowden, 1990); and they have higher termination rates from treatment (Terrell & Terrell, 1984).

This study aims to enhance the multicultural psychological literature by developing and providing evidence for the relevance, reliability, and validity of a color consciousness scale. By developing and validating a new scale that measures a counselor defense mechanism that has potentially negative effects on the therapeutic process, this investigation could be opening new doors for multicultural research in the broad field of psychology. There are decades of research suggesting that mental health professionals do not work as effectively with clients of color. It would be nice to see this trend reversed. Thus, all research devoted to a greater understanding of the process that perpetuates this trend can be a tremendous asset to our field, which is the aim of this dissertation project.

CHAPTER II
A REVIEW OF THE LITERATURE

Counselor Color/Culture Consciousness

Ridley (1995, 2005) conceptualized color consciousness as another illusion that many counselors face in the therapeutic relationship. In theory, color consciousness is the opposite of color blindness. Ridley asserted that a color conscious viewpoint implies that a minority client's concerns stem from his/her minority status. Additionally, Ridley theorized that a color conscious counselor, while making the client's race/ethnicity of vital importance diagnostically, would overlook the client's contribution to the presenting problem.

Gelso and Fretz (2001) discussed multicultural counseling competencies and the need for therapists to have knowledge and understanding of multicultural issues such as within group differences and beliefs about healing processes. However, as Gelso and Fretz pointed out; therapists and researchers also need to focus their attention on what counselors do with the cultural knowledge. In other words, the message seems clear that being multiculturally competent entails developing the ability to appropriately integrate and incorporate cultural information (Ridley, Li, & Hill, 1998). Thus, color consciousness may be viewed as an inappropriate and excessive focus on general cultural knowledge and information as well as a counselor placing too much weight on a client's specific race/ethnicity for diagnostic and therapeutic purposes (Gelso & Fretz, 2001; Ridley, 1995, 2005).

Ridley (1995, 2005) theorized that color consciousness is a defense mechanism employed by therapists that is unintentional in nature. Ridley viewed white guilt as a major contributor to color consciousness and asserted that this defense mechanism has some merit since minority

groups have been subjected to oppression and discrimination. In Ridley's theory, the white guilt is built upon the idea that white therapists harbor strong and painful feelings about the mistreatment of minority groups even though they may not be overtly racist. In other terms, the defense mechanism manifests itself in the form of color consciousness because white counselors may bear the burden of guilt for all white people even though they may never have been directly responsible for the injustices that minority groups have faced (Ridley, 1995, 2005). Thus, the guilt and being color conscious is generalized to all minority group individuals and clients of color regardless of client factors and client contributions that are unique to his/her presenting problem.

Ridley (1995, 2005) further asserted that the consequence of color consciousness is misdiagnosis in that the misdiagnosis, in theory, would be an under-diagnosis of psychopathology in minority clients. Due to the feelings of guilt and display of color consciousness, Ridley suggested that therapists may fail to identify the severity of psychopathology because they place emphasis on color/cultural information such as racism and discrimination, thus, unintentionally minimizing a minority client's potential psychopathology. Casas (1984) theorized that under-diagnosis can occur when counselors' assume that clients' problems are a natural part of their culture. If this occurs, the therapist may believe that the client cannot be treated by usual therapeutic practice.

Currently, color consciousness is a theoretical construct. This investigation aims to shed light on this intriguing and potentially important variable that can be used in multicultural research by validating a scale that measures this theoretical construct. This investigation views color consciousness as a counselor defense mechanism and assumes that the measurement of this

construct should focus on the internal processes of white therapists as they work with clients of color, such as how they internally experience white guilt. Thus, the relevance for color-consciousness lies partly in its ability to capture the manner in which color-consciousness is manifested in counseling relationships. Ridley (1995, 2005) provided the relevance for color consciousness as a theoretical construct, and this investigation aims to provide evidence for the relevance of color consciousness as a scientific measurement tool to be used in multicultural research.

The remainder of the literature review focuses on summarizing the existing literature with respect to the particular skills, concepts, constructs, and/or criteria (i.e., multicultural counseling skills, multicultural knowledge, color-blindness, white racial identity attitude types, self-consciousness, empathy, self-monitoring) that should be related to color-consciousness. However, since color-consciousness is a theoretical concept that has not been measured; it has not been directly linked to any of the skills, concepts, and/or constructs upon which this literature review focuses. Thus, another aim of the literature review is to hypothesize, given the existing research with that particular skill, concept, and/or construct, the relationship between it and color consciousness.

Multicultural Counseling Competencies

In 1980, the Division of Counseling Psychology of the American Psychological Association (APA) outlined 11 characteristics of a culturally skilled counselor (D.W. Sue et al., 1982). These characteristics included competencies related to counselor awareness of his or her attitudes and beliefs, knowledge, and skills. This publication served as the impetus for other

major works on cross-cultural and multicultural issues and concerns. On a larger scale, it finally created a place for cross-cultural and multicultural psychology in APA.

Sue, Arredondo, and McDavis (1992) expanded the original 11 characteristics and developed a set of 31 specific multicultural counseling competencies and standards. They asserted that three primary levels of awareness are needed in order to be considered a culturally competent counselor. First, a culturally competent counselor is active in the process of becoming aware of her or his own cultural values and biases. Second, a culturally competent counselor is one who is active in the process of understanding the worldview of a culturally different client. Third, a culturally competent counselor develops and practices appropriate intervention strategies with her/his culturally different client.

Sue and Sue (1999) summarized the three levels by stating that only an enlightened, nondefensive, open, and skilled mental health professionals has the ability to implement an understanding of minority group experiences. Additionally, the conception of counselors' being aware of their own cultural values implies that counselors are respectful of differences, sensitive to own cultural heritage, aware of own values and biases, comfortable with differences, and acknowledge own racist attitudes, beliefs, and feelings (Sue & Sue, 1999).

Subsequent to 1992, Sue et al. (1998) expanded the 31 specific competencies to 34, although the basic organization of the expanded standards follows the Sue, Arredondo, and McDavis (1992) format. In sum, the development of this cross-cultural counseling competency model is the longest standing model of multicultural counseling (Ponterotto, Fuertes, & Chen, 2000). Multicultural scholars have been working within this framework for over two decades and have been able to operationalize the competencies with detailed behavioral descriptions that are widely believed to be valid among multicultural experts (Ponterotto, Fuertes, & Chen).

Since the conceptualization and content validity of multicultural counseling competencies and standards has been established, the focus turns towards reviewing the literature on the extent to which multicultural counseling competencies affect the counseling process and, more distally, counseling outcomes. Wade and Bernstein (1991) compared counselors who received multicultural training to counselors who had not received multicultural training. The results indicated that the multiculturally trained counselors were rated higher on scales of counselor credibility and relationship measures by the participants in the study. Additionally, the Black female clients returned for more follow-up sessions and expressed more satisfaction with the counseling experience.

Thompson and Jenal (1994) investigated the effect of race avoidant counselors, and the results indicated that clients conformed to the universality of the treatment, race issues disappeared from the content discussed during counseling sessions, and the counselors found it difficult to build rapport with their clients. Sodowsky (1996) investigated the effects of culturally consistent counselors and culturally discrepant counselors. In this investigation, Sodowsky (1996) exposed counseling students to one of two videotapes depicting either a counselor who is culturally consistent in their description of the client (e.g., issues of external kinship, respect for elders) or a counselor who is culturally inconsistent in their description (e.g., individual assertiveness, personal responsibility). The results indicated that culturally consistent counselors were rated as more culturally competent and expert.

Constantine (2002) conducted a quantitative study that used mediation to show causality. The study examined clients' attitudes towards seeking counseling, multicultural counseling competencies perceived by the clients, general counseling competencies perceived by the client, and client satisfaction with the counseling experience. The results indicated that the client's

attitudes towards seeking counseling, perceived multicultural counseling competencies, and perceived general counseling competencies were all significant predictors of client satisfaction. Additionally, multicultural counseling competencies mediated the relationship between client's attitudes towards seeking counseling and their satisfaction with counseling, and there was a strong correlation between the client's perception of multicultural counseling competencies and general counseling competencies. In short, this investigation displayed the positive results that accompany a culturally skilled counselor.

In a qualitative study by Pope-Davis et al. (2002) that examined racial/ethnic minority clients' perspectives on multicultural counseling competencies in their own experience of being in therapy, counselors who demonstrated interest in the client's culture were perceived as more competent. Data also emerged that suggested that multicultural counseling competencies were more important and therapeutically pivotal for some clients while other clients seemed less concerned about multicultural counseling competencies. This finding implied the need to understand the client in his/her context by having a deep understanding of within group differences and possessing the ability to integrate and incorporate cultural information thoughtfully when working with clients of color. The results of these aforementioned studies provided strong evidence for cultural responsiveness as a counseling strategy that builds credibility with racial/ethnic minority clients and as a counseling strategy that leads to greater client satisfaction.

Concerning the relationship between color-consciousness and multicultural counseling competencies, the research suggests that being somewhat color-conscious as opposed to avoiding issues of race/ethnicity has been correlated with better and more effective services with clients of color. However, the conception of color-consciousness that is proposed in this investigation

recognizes potential pitfalls for therapists in being overly color-conscious. Thus, given the strong and concentrated focus on multiculturalism in psychology over the past 20-30 years (Sue & Sue, 1999); it is the hypothesis of this investigator that color-consciousness will be positively associated with multicultural knowledge but negatively correlated with the counselor's confidence in building a strong relationship with clients of color.

Additionally, given that the conception of color consciousness as having some negative effects on the therapeutic relationship (Ridley, 1995, 2005) along with the research suggesting that attending to race/ethnicity as opposed to avoiding issues of race/ethnicity may lead to more positive outcomes (Atkinson, Casas, & Abreu, 1992), this investigator hypothesizes that there will not be a significant relationship in either direction between high scores on the multicultural counseling competency subscale and color consciousness, as being overly sensitive to race/ethnicity may be viewed as a lack of integrating multicultural skills into the counseling process

.

Counselor Color-Blind Racial Attitudes

Color-blind racial attitudes have been defined as "the belief that race should not and does not matter" (Neville et al., 2000, p.60). Furthermore, Ridley's (1995, 2005) theoretical conceptions of color-blindness implied that minority clients are similar to non-minority clients. Ridley viewed color blind counselors as individuals who believe that people are similar and, thus, ignore the minority status of clients. In other terms, they relate to minority clients as though race is unimportant. The minority client is viewed as just another client, and a color-blind counselor may use phrases such as "We're all the same", and "I don't see you as being a minority, just another human" (Ridley, 2005, p. 67).

Ridley (1995, 2005) postulated several factors that contribute to color-blindness. First, a therapist's fear that he/she is unconsciously racist may result in a need to appear impartial. Second, some counselors may feel uncomfortable discussing race due to unresolved personal issues or insecurities about race. Third, a counselor may feel incompetent and fear that his/her ignorance will be exposed. Finally, some counselors may not want to hurt clients' feelings, and they may feel that a discussion about race will be harmful to clients. These therapists would be considered overprotective by Ridley's conception, and it would result in a color-blind approach to therapy.

Neville et al. (2000) maintained that a color-blind racial attitude has three dimensions. These include the denial of white privilege, the denial of institutional racism, and the denial of the existence of racial discrimination. This is not an overt expression or manifestation of racism, prejudice, or discrimination; however, it is a failure to recognize that examples of potential discrimination may display evidence of societal racism. Neville et al. also observed that color-blind attitudes do not endorse an explicit belief in racial superiority. Ridley (1995, 2005) supported this notion by asserting that unintentional racists are unaware of the harmful consequences of their behavior. However, since they have no wish to do harm; it is difficult for them to see themselves as racists. Consequently, they are "more likely to deny their racism" (Ridley, 2005, p. 38).

This color-blind attitude is contradicted by various population statistics that suggest that racially and ethnically diverse groups are neither socially nor economically equal to whites in the United States. For example, the U.S. Department of Commerce (1998) noted that unemployment rates among African-Americans are consistently twice as high as European Americans

unemployment rates and annual incomes of people of color remain disproportionately lower than those of European Americans.

Before the impact of a color-blind therapist attitude on the counseling process is discussed, it seems important to clarify the different conceptions of racism. Earlier conceptions of racism were viewed as overt attitudes and behaviors used to limit the rights and freedoms of African Americans (McConahay, 1986). Recent conceptions of racism include less overt forms of prejudice. Sue and Sue (1999) asserted that unintentional forms of racism or bias are more dangerous because they are more pervasive.

In Sue and Sue's (1999) view, the therapist with unintentional forms of racism could be a well-intentioned individual who views her/himself as moral, just, and decent. Gaertner and Divido (1986) asserted that individuals may have contradictory feelings towards racial/ethnic minority groups that result in expressed attitudes of equality along with contradictory behaviors that demonstrate racial bias. Burkard and Knox (2004) further asserted that this contradiction may be reconciled by these individuals by denying that racial issues matter. In other words, the individual develops a color-blind attitude.

From a counseling perspective, research has suggested that racial and ethnic minority clients' level of psychopathology is overestimated (Gynther, 1979); their prognosis is often underestimated (Butcher, Braswell, & Raney, 1983); they are engaged in shorter periods of treatment (Sue, Fujino, Hu, Takeuchi, & Zane, 1991); they are referred to more restrictive forms of treatment (Gynther, 1979); they underutilize traditional outpatient mental health services (Leong, 1994; Cheung & Snowden, 1990); and they have higher termination rates from treatment (Terrell & Terrell, 1984). Racial and ethnic minorities do not display a lesser need for services as evidenced by the U.S. Surgeon General report that stated that Asian Americans

underutilize and prematurely terminate counseling services even though their need for these services are no less than that of other racial or ethnic groups (Gelso & Fretz, 2001).

As Ridley (1995, 2005) suggested, therapists may unwittingly perpetuate prejudice and racism in the counseling process because they may be unaware of their own racism and privilege afforded to them. This could manifest itself in the therapy process when counselors ignore or minimize clients' reports of racism or prejudice experienced at work or in school. If these counselors continually deny the existence of societal racism, they may be unlikely to address racism in the counseling process (Burkard & Knox, 2004).

Some prior investigations linking cross-cultural competencies to the counseling process have focused on clients' perceptions of counselors' cultural responsiveness after cultural sensitivity training for the counselor. These investigations suggested that counselors who were culturally responsive were rated as more credible and culturally competent (Atkinson, Casas, & Abreu, 1992), reported lower attrition rates from counseling (Wade & Bernstein, 1991), and had clients who self-disclosed more intimately (Thompson, Worthington, & Atkinson, 1994). The limitations from these investigations are that there is not a direct link between cultural unresponsiveness and color-blind racial/ethnic attitudes, and racial identity development measures are not included in the analysis.

The measurement of therapists' color-blind attitudes while responding to vignettes that controlled for client race has also been investigated. Constantine (2002) investigated the link between multicultural competence and racial attitudes and concluded that therapists who rated themselves low in multicultural competence also rated themselves high in negative racial attitudes. This research found a correlational relationship between racial attitudes and multicultural competence; however, it did not show any direct effects on the counseling process.

Thompson and Jenal (1994) found that when counselors avoided racial topics with Black clients, the clients responded to the avoidance through acquiescence, avoidance, or hostility.

Want, Parham, Baker, and Sherman (2004) indicated that a white counselor high in racial consciousness was rated as highly as a Black counselor low in racial consciousness by participants who responded to a vignette. They further asserted that this finding testified to the importance of the counselor's level of racial consciousness for Black and white counselors when serving Black clients. However, it also suggested that Black clients overall prefer Black counselors, and Black clients may show the highest level of resistance towards white counselors. In other research, therapists' response to vignettes suggested that therapists' level of color-blindness is directly related to their capacity for empathy (Burkard & Knox, 2004) with clients of color.

It should be noted that the existing measurement for color-blindness is measured by assessing racial attitudes pertaining to the denial of white privilege, the denial of institutional racism, and the denial of the existence of racial discrimination (Neville, et al., 2000). Additionally, the measure was normed on undergraduate college students. Thus, it does not necessarily measure the conscious and unconscious counseling processes being manifested by white therapists during the counseling process. Obviously, this investigator expects color-consciousness to be inversely related to color-blindness; however, it should be noted that the measurement of color-consciousness focuses on white therapists working with clients of color and will be normed on a population of white therapists as opposed to the color-blind measurement that focuses on measuring color-blindness in college students.

White Racial Consciousness / Identity

As is evident from the multicultural competencies and standards, counselor self-understanding is one of the three primary levels of awareness needed in order to be considered a culturally competent counselor (Sue, Arredondo, & McDavis, 1992; Gelso & Fretz, 2001). In fact, Thompson, Worthington, and Atkinson (1994) and Enns (1993) found that simply possessing and obtaining knowledge of other cultures has only yielded limited gains in counselor effectiveness when working with diverse clients. Thus, Gelso and Fretz asserted that a counselor's understanding of his/her own culture is just as important as understanding a client's culture, and the argument could be made that this is the most essential ingredient for providing culturally effective therapeutic services.

In this light, one of the primary issues related to a white counselor's self-understanding is racism (Gelso & Fretz, 2001). Helms (1984) and Rowe, Bennett, and Atkinson (1994) developed white racial identity / consciousness models to help white therapists increase their awareness about their own culture, to become aware of their own racist behaviors, and to change their own racist behaviors. Thus, this implies that white therapists are diverse in their own attitudes, beliefs, and behaviors with respects to their culture. In other terms, within group differences also applies to white, majority individuals in the same manner that it applies to persons of another race/ethnicity.

As Gelso and Fretz (2001) and Sue and Sue (1999) pointed out, controversy surrounds the precise and differential meanings of various terms used in describing and conceptualizing white racial identity / consciousness. Helms' (1984) original theory was based on the effects of race in counseling. The theory built upon the Nigrescence theory of Cross (1971), which dealt

with black racial identity development. Thus, Helms (1984) developed her own theory of white racial identity development in addition to expanding Cross' (1971) theory and model of black racial identity development. Her white racial identity development theory has undergone revisions and elaborations since she first introduced her theory; however, the most notable refinement was changing the term racial identity "stage" to "ego status". This was done in order to capture the fluidity and dynamic nature of an individual's attitudes, behaviors, and emotions as they relate to white racial identity as opposed to the more static conception of stage theories.

Even though Helms' (1984) model is the most cited, researched, and applied white racial identity development model (Sue & Sue, 1999), the model that will be used for the purposes of this investigation is the white racial consciousness model that was developed by Rowe, Bennett, and Atkinson (1994) and refined by Rowe, Behrens, and Leach (1995). The white racial consciousness model addresses some of the limitations of Helms' model. First, Helms' model, arguably, seems to be based on racial/ethnic minority identity development models and since these models occur in the face of oppression and discrimination, they may not be applicable to white identity (Rowe, Atkinson, & Bennett). Second, Helms' model has been criticized for placing too much emphasis on the development of white attitudes towards minorities instead of focusing on white attitudes towards their own identity (Rowe, Atkinson, & Bennett).

Third, Helms' White Racial Identity Attitudes Scale (WRIAS; Helms, 1990) has been criticized for poor psychometric properties. For instance, Tokar and Swanson (1991) found that the factor structure of the WRIAS does not support the five hypothetical constructs found in Helms' (1984) model. Additionally, Behrens (1997) conducted a meta-analysis of the WRIAS and found that the scale displayed poor reliability and lacked construct validity. Thus, due to the

limitations noted, especially with respect to the psychometric limitations of the WRIAS, this investigation will proceed by discussing the white racial consciousness model developed by Rowe, Bennett, and Atkinson (1994).

Theoretically, white racial consciousness is defined as "the characteristic attitudes held by a person regarding the significance of being white and what that implies in relation to those who do not share white group membership" (Bennett, Atkinson, & Rowe, 1993, p.3). Choney and Behrens (1996) asserted that the attitudes white individuals have regarding racial/ethnic minorities tend to cluster into certain attitudes that can be described and labeled. Rowe, Bennett, and Atkinson (1994) adapted their theory based on Phinney's (1989) stages of ethnic identity where categories of ethnic identity could be defined based on the presence, absence, or consideration of how one explores his/her ethnicity and how committed individuals are to their ethnic group. By using Phinney's (1989) model as a guide, Rowe, Bennett, and Atkinson (1994) defined white racial consciousness as comprising two major groupings and seven specific types of attitudes that characterize white racial consciousness. The unachieved statuses represent attitudes that are not securely integrated into one's belief structure, and the achieved statuses refer to attitudes that display some level of exploration or commitment to racial/ethnic related ideas (Choney & Behrens).

Rowe, Bennett, and Atkinson (1994) labeled the two groupings as unachieved and achieved statuses. The unachieved statuses are avoidant, dependent, and dissonant attitude types. Avoidant attitudes are conceptualized as consisting of individuals who ignore, avoid, deny, or minimize racial issues, and these individuals may not consider their own racial identity or be aware of minority issues (Sue & Sue, 1999). Dependent attitudes are individuals characterized

by being dependent on others and following their lead, and who have developed minimal racial attitudes through their own personal experience or consideration (Rowe, Bennett, & Atkinson). Dissonant attitudes refer to individuals who feel conflicted between their belief system and contradictory experiences, which is conceptualized as a transitory status for a person in that he/she may be able to break free from these attitudes depending on factors such as support, environment, and intensity of beliefs (Rowe, Bennett, & Atkinson).

The achieved statuses are dominative, conflictive, reactive, and integrative types (Rowe, Bennett, & Atkinson, 1994). Dominative attitudes are ethnocentric in nature and may characterize an individual who believes in white superiority and minority inferiority (Rowe, Bennett, & Atkinson). Conflictive types oppose direct discrimination and may believe that discrimination has been eliminated, but these individuals may be unwilling to change the status quo (Rowe, Bennett, & Atkinson). Reactive attitudes characterize those who are aware that racism and discrimination exist, may be unaware of their responsibility in perpetuating it, and may over-identify with minorities (Rowe, Bennett, & Atkinson). Finally, integrative types "have integrated their sense of whiteness with a regard for racial/ethnic minorities … [and] integrate rational analysis, on the one hand, and moral principles, on the other, as they relate to a variety of racial/ethnic issues." (Rowe, Bennett, & Atkinson, p. 141).

Despite this theorized conception and importance of counselors' awareness of their own cultural values with respects to developing multicultural counseling competence, there is little research that directly examines white counselors' racial attitudes, and the direct effect this has on counseling processes and, more distally, on counseling outcomes (Burkhard & Knox, 2004). Additionally, the literature that does exist on white racial attitudes primarily consists of using the

WRIAS to explore the relationship between white racial identity and counselor perceptions of working alliance and white racial identity and self-reported multicultural counseling competencies (Ponterotto, Fuertes, & Chen, 2000). For instance, Burkard, Ponterotto, Reynolds, and Alfonso (1999) explored the effect of white racial identity attitudes of counselors and their perceptions of working alliance, yielding results that indicated that more advanced white racial identity attitudes resulted in stronger perceptions of being able to form working alliance with clients of color.

The dearth of literature linking white racial attitudes to the therapeutic relationship seems more perplexing when one considers the reason Helms (1984) originally developed her white racial identity model. Specifically, Helms proposed an interactional model of cross-racial counseling, which asserted that a counselor's racial identity development and a client's racial identity development interact to affect the counseling process. Helms (1984) hypothesized that a therapeutic relationship with a counselor who has a more advanced racial identity status than the client would be most promising with respects to counseling outcomes while the reverse relationship would result in poor counseling outcomes. Essentially, Helms speculated that race/ethnicity is much more than a categorical variable when investigating cross-cultural counseling dyads and linked racial identity status to the counseling process. As such, Richardson and Helms (1994) found support for her hypothesis through black students' reactions to videotaped counseling sessions, yet it remains unclear how this dynamic plays out in a naturally occurring counseling relationship.

Concerning the relationship between the achieved and unachieved attitude statuses conceptualized by Rowe, Bennett, and Atkinson (1994) and color-consciousness, this investigator views color-consciousness as possessing aspects of both achieved and unachieved

statuses. Specifically, the hypothesis is that color-consciousness will be positively correlated with a reactive and dissonant attitude type, and a negative association with an avoidant attitude status. Thus, being overly color conscious may be conceptualized as over-identifying with clients of color, having conflicted feelings between his/her belief systems and experiences of growing up in a racist society, but consciously or unconsciously trying to confront and work through issues of race/ethnicity, racism, own biases, etc.

Self-Consciousness

Duval and Wicklund (1972) conceptualized self-consciousness as a consistent tendency to either direct attention inward or outward, and Fenigstein, Scheier, and Buss (1975) built on this theory of objective self-awareness by developing a scale to measure the construct of self-consciousness. In Duval and Wicklund's (1972) conceptions of self-consciousness, they speculated that it has two separate aspects. Specifically, they suggested that one aspect of self-consciousness is a private, cognitive, and ruminating orientation toward the internal world of an individual. As an example, Fenigstein, Scheier, and Buss (1975) likened this private self-consciousness to the Jungian conception of introversion insofar as the introvert is generally oriented toward the internal world of ideas and concepts, and a privately self-conscious individual is oriented toward thoughts and reflections of the internal world that deal solely with the self.

Concerning the other aspect to self-consciousness, Duval and Wicklund (1972) leaned on Mead's (1934) original conceptions of self-consciousness and referred to it as public self-consciousness. Mead (1934) asserted that self-consciousness is present when an individual becomes aware of another's perspective. Fenigstein, Scheier, and Buss (1975) argued that as one

becomes aware of another's perspective, he/she may then view him/herself as a social object. Thus, the essence of public self-consciousness is the idea that one views him/herself as a social object insofar as an individual is focused on the reactions of others to him/herself (Fenigstein, Scheier, & Buss, 1975).

Hull et al. (1988) theorized and found empirical support for a model of self-consciousness that concluded that high self-conscious individuals perceive most stimuli as self-relevant and also more readily attempt to integrate and internalize this information when compared with less self-conscious individuals. Furthermore, they argued that the process of integration is a self-perception process that has direct affective and behavioral consequences. For instance, there is empirical support with respects to how priming affects one's behaviors, such as being primed with hostility and then perceiving an ambiguous target as more hostile (Bargh & Pietromonaco, 1982) and white subjects being exposed to an African American prime and subsequently responding with greater hostility (Chen & Bargh, 1997).

Most psychologists in the scientific community agree that priming affects behavior and internal states; however, they differ on explanations such as the extent to which these processes affect behaviors and internal states, the extent to which these processes are automatic, and individual differences that play a role in the effects on behaviors and internal processes (Hull et al., 2002). Contrary to many social psychologists, Hull et al. (2002) argued that self-consciousness is associated with a tendency to encode information as self-relevant. Furthermore, they asserted that highly self-conscious individuals want to understand how the information being encoded is self-relevant. Thus, Hull et al. (2002) concluded that highly self-conscious individuals are more likely to be affected by priming manipulations. Additionally, highly self-conscious individuals have shown greater responsivity to angry cues (Scheier & Carver, 1977)

and shown greater proclivity to increase pro-social behaviors when primed with being generous (Batson et al., 1999).

In sum, Hull et al. (2002) emphasized that highly self-conscious individuals are more susceptible to self-relevant primes, detailing some of the emotional and behavioral consequences of the priming (e.g., activating emotions, increasing pro-social behaviors). In this light, this investigator hypothesizes that highly self-conscious therapists will also have tendencies to be color-conscious in their approach to their work with clients of color. More specifically, it seems reasonable to hypothesize that there will be a strong relationship between the white guilt dimension of color consciousness and both the private and public self-consciousness dimensions of self-consciousness and that clients of color serve as cues that activate the internal state of self-consciousness. Additionally, the hypothesis further asserts that white therapists will then become aware of their clients' perspective and will ultimately view themselves as social objects, thus, activating the public self-consciousness dimension of self-consciousness.

Empathy

Empathy has been defined as an affective trait insofar as it has been conceptualized as the capacity and/or ability to experience the emotions and experiences of another (Bryant, 1982). It has also been viewed as a cognitive ability in regards to having the capacity to comprehend the emotions of another (Hogan, 1969). Day and Chambers (1991) conceptualized the affective component of empathy as the ability to respond to another individual's emotions with the same emotion while cognitive empathy is to intellectually assume and/or understand the perspective of another individual.

No matter the exact conception of empathy, empathy is a foundational disposition in counseling (Bohart, et al., 2002). Additionally, Ho (1992) and Ridley and Lingle (1996) argued that empathy is essential in cross-cultural counseling. More specifically, Fischer, Jorne, and Atkinson (1998) asserted that therapists' expression of empathy in a culturally responsive manner is a determining factor in clients' of color perceptions of therapists' cultural sensitivity. Thus, empathy has been conceptualized as an important factor in cross-cultural counseling (Constantine, 2002).

Additional research has suggested that empathy should be considered one of the main predictors of individual differences in prejudice, as Backstrom and Bjorklund (2007) found that empathy mediated the relationship between social dominance and generalized prejudice (i.e., the relationship between empathy and generalized prejudice was strongly inverse). Burkhard and Knox (2004) found a significant, inverse relationship between color-blind racial attitudes and empathy. Basil, Ridgway, and Basil (2008) found that higher levels of empathy resulted in more donation giving, which was viewed by them as a prosocial behavior. In context to this study, Basil, Ridgway, and Basil (2008) found, through structural equation modeling, that empathy led to an increase in anticipated guilt, which then served to increase donation intention (Basil, Ridgway, & Basil, 2008)

Concerning this investigation, the expectations are that color consciousness and the white guilt dimension will be strongly and positively associated with empathy. There is no expectation that the overlooking clients' contributions to the presenting problem dimension of color consciousness will be associated with empathy, as it is primarily concerned with the type of information that white therapists focus on in therapy and how they diagnose/interpret symptoms of clients of color. It should be noted that there is a dearth of literature that examines the

differentiating aspects of affective and cognitive empathy (Jolliffe & Farrington, 2006). However, most researchers consider them separate processes where both involve reactions to the emotions of another and that affective empathy leads to cognitive empathy (Jolliffe & Farrington, 2006). Thus, the expectations for this analysis are that affective and cognitive empathy will have a strong, positive relationship with color-consciousness and the white guilt dimension of color consciousness.

Self-Monitoring

Snyder (1974) introduced the concept of self-monitoring, hypothesizing that it reflects the degree to which individuals observe and control their expressive behaviors and self presentations to act in accordance with social cues (Snyder, 1974). Lennox and Wolfe (1984) asserted that the concept of self-monitoring involves two key characteristics, thus, adding structure to Snyder's (1974) conceptions of self-monitoring without changing his conceptions of self-monitoring.

Lennox and Wolfe (1984) argued that one aspect of self-monitoring is that it reflects the degree to which an individual is sensitive to the expressive behavior of others, and the second aspect refers to one's ability to modify self-presentations. Snyder (1974) hypothesized that high self-monitors are sensitive and alert to social cues that trigger socially desirable and/or appropriate behaviors as well as using these cues to modify their self-presentation or behavior. Additionally, Snyder (1974) argued that high self-monitors emphasize the public self. As expected, Snyder (1974) speculated that low self-monitors are less alert and sensitive to social cues and tend to maintain a consistent self-presentation across different situations.

Leone and Hawkins (2006) argued that the construct of self-monitoring "is one designed to capture individual differences in characteristic orientations to close relationships" (p. 740).

They found that high self-monitors preferred the structure of their social relationships to be segmented (e.g., engage in different activities with a variety of partners); they chose friends based on activities (e.g., the activity of interests is more important than the person); and they had an uncommitted orientation towards romantic partners (e.g., more prone to dissolution). Low self-monitors were found to prefer social relationships that are integrated; friends were chosen based on the person; and they had a committed orientation towards romantic partners (Leone & Hawkins, 2006).

Leone and Hawkins (2006) argued that low self-monitors attend more closely to their inner psychological states when compared to high self-monitors. Leone (2006) further explained that research has supported the view that low self-monitors view themselves as principled individuals whose identity is determined largely by dispositional factors and enduring attributes. DeMarree, Wheeler, and Petty (2006) found that low self-monitors were more likely to change their behavior and self-conceptions when they were primed with self-relevant, dispositional information about the self while high self-monitors were more likely to change behaviors and/or self-conceptions when the priming manipulation was perceived to convey social information.

Haferkamp (1989) found support for this and focused his investigation on counselors-in-training. The investigation found that low self-monitors were perceived as more genuine and congruent when compared to high self-monitors while also being viewed as more dogmatic, rigid, and nonconforming in their clinical work with clients. High self-monitors were found to be more manipulative, directive, adaptive, and less tolerant of ambiguity. Additionally, Mill (1984) found that high self-monitors were better at interpreting the vocal expressions of others, which gives validity to Snyder's (1974) original conception of self-monitoring and being attentive to the expressive behavior of others. Additionally, Mill (1984) found that high self-

monitors were rated lower with respects to attributes such as displaying empathy and being genuine.

Given the above research, the construct of self-monitoring was selected in this investigation, as it seems reasonable to assume that the construct of self-monitoring should be related to the construct of color consciousness. More specifically, the expectation of this investigation is that low self monitors will be more color conscious than high self-monitors. As previously discussed, color consciousness is conceptualized as having a strong relationship with being more self-conscious and having a greater capacity to display empathy. Thus, these traits are more associated with low self-monitors, and this investigation expects that a strong, inverse relationship will exist for color-consciousness and high self-monitoring.

Hypotheses

Based on the review of the literature just presented (i.e., rationale for the expected results is discussed in the literature review), the expectations were to find the following relationships between counselor color-consciousness, along with the separate hypotheses for the white guilt and overlooking clients' contributions to the presenting problem dimensions of color consciousness, and the other constructs being measured in this dissertation study:

1. Higher scores on the counselor color-consciousness scale would be associated with higher scores on multicultural knowledge, a reactive racial attitude type, a dissonant racial attitude type, affective and cognitive empathy, and public and private self-consciousness. The expectations for the white guilt dimension are the same as the expectations for the full color-consciousness scale; however, the expectations for the overlooking clients' contributions to the presenting problem dimension would be that it

would not be significantly associated with the self-consciousness measures or the affective and cognitive empathy measure.

2. Higher scores on the counselor color-consciousness scale would be linked to lower scores on counselor's confidence in the counseling relationship, an avoidant racial attitude type, each of the scales measuring color-blind racial attitudes, and the self-monitoring scales. The expectations for the white guilt dimension and the overlooking clients' contributions to the presenting problem dimension are the same as the expectations for the full color-consciousness scale.
3. Equally as important as the significant positive or negative correlations, there are also constructs, concepts, and/or skills where a significant relationship would not be expected based on theory and research. Specifically, color consciousness as a full scale and each of the two dimensions of the full scale are not expected to be significantly related to multicultural awareness (see the methods section in order to see how this is measured as a multicultural concept), multicultural counseling skills, an integrative racial attitude type, conflictive racial attitude type, dependent racial attitude type, social anxiety, or cognitive empathy.

CHAPTER III
METHOD

The proposed study comprised two primary investigations aimed at validating a new scale-- the Counselor Color Consciousness Scale (CCCS). The first study focused on providing initial validation of the CCCS by investigating the reliability estimates of the CCCS. The second study provided validation of the CCCS, and, more specifically, the second study provided construct validity, criterion-related validity, and incremental validity of the CCCS.

Study 1:

Data Source

Concerning the first step for the initial validation of a color/culture consciousness scale, the primary investigators composed a set of 26 items attempting to measure color/culture consciousness in therapists. Ridley's (2005) theoretical conceptions of color consciousness and the primary investigators interpretations of this theoretical construct served as the guide in establishing a core set of items that made up the CCCS.

The second step consisted of providing content validity of the initial set of items. The primary investigator and his academic advisor disseminated the items to colleagues and peers who are experts in the broad field of multicultural psychology. These experts analyzed the set of items in order to ensure that the content of the items has the potential to measure the construct of color/culture consciousness. Once the colleagues investigated the set of items, their feedback was incorporated into the measure.

This process resulted in the aforementioned 26 items (see Appendix D), and theoretically comprised two subscales. The first subscale measured the concept of white guilt, and the second subscale measured the notion that color/culture consciousness may result in counselors

overlooking a client of color's contributions to the presenting problems due to being overly sensitive to the client's race and/or culture (e.g., overly focused on issues of racism).

Participants/Sample

The third step entailed establishing reliability estimates of the CCCS. The sample comprised 73 self-identified white mental health professionals who completed a web survey. Table 1 provides background demographic information on the sample (it should be noted that all tables are located in the Appendix). Of the 73 participants, 51 identified as female (69.9%), and the mean age of the participants was 34.19. Concerning highest degree earned, 38 participants reported that they had earned a master's degree (52.1%), 27 indicated that they had earned a doctorate's degree (37.0%), and 8 reported that a bachelor's degree was their highest degree earned (11.0%). Concerning their mental health specialization, 40 participants reported that they identify as a Counseling Psychologist (52.1%), 24 as Clinical Psychologists (32.9%), 5 as Counselors (6.8%), and 4 as Social Workers (5.5%).

Procedure

After the CCCS was constructed and IRB approval was granted, the CCCS was posted as a web survey through the MrInterview software used by the University of Tennessee's Information Technology office. The web survey was then sent to two listserves. See Appendix H for a copy of the message that was sent to the two listserves requesting participation in this dissertation study, which served as the recruitment letter for this web survey. More specifically, the message requesting participation in this research study was posted to the Association of Counseling Center Training Agencies (ACCTA) and the Council of Counseling Psychology Training Programs (CCPTP) listserves. It should be noted that the reliability estimates will be reported in the Study 1 Results section along with the reliability analysis and correlation analysis

between the WG and OC subscales. It should also be mentioned that online surveys are being increasingly used as a research tool in the social sciences (Granello & Wheaton, 2004; Glover, 2005).

Study 2:

Construct Validation Variable Measures

Multicultural Counseling Inventory (MCI, Appendix A; Sodowsky, Taffe, Gutkin, & Wise, 1994). This 40-item self-report inventory was developed to assess behaviors and attitudes related to multicultural counseling competencies. The items are measured on a 4-point Likert scale, ranging from 1 (*very inaccurate*) to 4 (*very accurate*). The total scale comprises four subscales. The first subscale consists of 10 items measuring awareness of multicultural issues and multicultural sensitivity (e.g., "*I am involved in advocacy efforts against institutional barriers in mental health services for minority clients*", and "*in order to be able to work with minority clients, I frequently seek consultation with multicultural experts and attend multicultural workshops or training sessions*"), and high scores on this subscale is indicative of the presence of awareness of multicultural issues and multicultural sensitivity.

The second subscale includes 11 items and measures knowledge of minority cultures and incorporating this knowledge into practitioner activities such as treatment planning and case conceptualization (e.g., "*when working with minority clients, I include the facts of age, gender roles, and socioeconomic status in my understanding of different minority cultures*", and "*when working with minority clients, I apply the sociopolitical history of the clients' respective minority groups to understand them better*"), and high scores represents more multicultural knowledge.

The third subscale measures general counseling and specific multicultural counseling skills and includes 11 items (e.g., "*when working with minority clients, I am able to quickly*

recognize and recover from cultural mistakes or misunderstandings", and "*when working with all clients, I am able to distinguish between those who need brief, problem-solving, structured therapy and those who need long-term, process-oriented, unstructured therapy*") with high scores representing the greater presence of multicultural counseling skills. The fourth subscale measures the counselor's relationship and interaction process with the minority client and includes eight items (e.g., "*when working with minority individuals, I am confident that my conceptualization of client problems do not consist of stereotypes and biases*", and "*when working with minority clients, I perceive that my race causes clients to mistrust me*"). Again, high scores refer to greater competence with respects to attending to the relationship and interaction process with minority clients.

Sodowsky, Taffe, Gutkin, and Wise (1994) used factor analysis to develop this measure, yielding the four factors/subscales and reported internal consistency reliabilities (i.e., Cronbach's alphas) as .81 for the Multicultural Counseling Skills (MCS) subscale, .80 for the Multicultural Awareness (MA) subscale, .67 for the Multicultural Counseling Relationship (MCR) subscale, .80 for the Multicultural Counseling Knowledge (MCK) subscale, and .86 for the full scale. A recent additional study by Middleton et al. (2005) reported .73, .79, .52, and .76 for the respective subscales and .79 for the full scale.

For this study, Chronbach's alpha reliability estimates were .62, .78, .75, and .76 for the MCR, MCK, MCS, and MA subscales, respectively, and .87 for the full scale. These reliability estimates are slightly lower than the reliabilities reported by Sodowsky, Taffe, Gutkin, and Wise (1994). Moderate intercorrelations, ranging from .21 to .61, were found among the four subscales and closely approximate the MCC subscale correlations found by Sodowsky, Taffe, Gutkin, and Wise (1994). See Table 12 for intercorrelations.

Color-Blind Racial Attitude Scale (CoBRAS, Appendix B; Neville et al., 2000). The CoBRAS comprises 20-items that measures the extent to which an individual may deny racism and the effect of race on people's lives in the United States. CoBRAS items range from *1 (not at all appropriate or clear*) to 5 (*very appropriate or clear*). The total scale comprises three subscales. The first subscale measures unawareness of White racial privilege and included seven items (e.g*., "white people in the U.S. are discriminated against because of the color of their skin*"). The second subscale measures unawareness of institutional racism and included seven items (e.g*., "race is very important in determining who is successful and who is not*"). The third subscale comprises six items and measures unawareness of blatant racial issues items (e.g*., "racial problems in the U.S. are rare, isolated situations*"). Higher scores are indicative of greater unawareness of White racial privilege, institutional racism, and blatant racial issue. Concerning the full scale, item scores are added to obtain subscale scores and a total score, which ranges from 20-120 with higher scores indicating higher levels of color-blindness in respondents.

Neville et al. (2000) reported concurrent validity scores with two measures of racial discrimination (i.e., Modern Racism Scale; McConahay, 1986; Quick Discrimination Index; Ponterotto et al., 1995). Neville et al. (2000) reported coefficient alphas of .86-.91 for the total score across three initial development studies for the CoBRAS, and a two-week test-retest reliability coefficient of .68. An initial exploratory factor analysis and a confirmatory factor analysis provided evidence of construct validity.

For this study, Chronbach's alpha reliability estimates were .80, .78, and .61 for the White Racial Privilege (WRP), Institutional Racism (IR), and Blatant Racial Issues (BRI) subscales, respectively, and .88 for the full scale. These reliability estimates are slightly lower

than the coefficients reported by Neville et al. (2000). Moderate to high intercorrelations, ranging from .59 to .68, were found among the three subscales. See Table 12 for intercorrelations.

Oklahoma Racial Attitudes Scale (ORAS, Appendix C; LaFleur, Leach, & Rowe, 2003). The ORAS was developed to assess a model of White racial consciousness, as conceptualized and proposed by Rowe, Bennett, and Atkinson (1994). The ORAS is a self-report measure comprising 34 items, 24 of which represent achieved status attitudes (i.e., conflictive, reactive, and dominative-integrative type) and 10 representing unachieved status attitudes (i.e., avoidant, dependent, dissonant), thus, resulting in six scales. ORAS items range from *1 (strongly disagree*) to 5 (*strongly agree*).

Concerning the achieved status attitudes, the dominative-integrative scale measures racial acceptance. In the Oklahoma Racial Attitudes Scale- Preliminary Form (ORAS-P; Choney & Behrens, 1996), the dominative and integrative types comprised two separate scales; however, these two attitude types have been combined in the ORAS because LaFleur, Leach, and Rowe (2003) have conceptualized them as a bi-polar dimension where the lower score represents the dominative attitude type and a high score represents an integrative attitude type. This scale includes 10 items (e.g., *Whites usually have higher goals than minorities*). The conflictive scale measures a White individual's conflicting attitudes towards discrimination, includes seven items, and high scores are indicative of conflicting attitudes towards discrimination (e.g., *Minorities deserve to be treated fairly, but they demand too much*). The reactive scale measures a White individual's over-identification with minority groups, includes seven items, and a high score represents over-identification with minorities (e.g., *being White gives us a responsibility toward minorities*).

Concerning the unachieved status attitudes, the avoidant scale measures a White individuals lack of interest or concern in racial/ethnic issues, includes three items, and high scores refer to avoidant attitudes (e.g., *I don't really want to think about minority concerns*). The dependent scale measures a White individual's reliance on others for his/her opinions about racial/ethnic issues, includes three items, and a high score represents dependent attitudes (e.g., *my attitudes toward minorities are really based on what others have told me*). The dissonant scale measures a White individuals uncertainty with respects to his/her opinions about racial/ethnic issues or concerns, includes four items, and high scores are indicative of dissonant attitudes (e.g., *I am really having to change my thinking about minorities*).

Psychometrically, the ORAS built upon the ORAS-P (Choney and Behrens, 1996) by using classical test theory analysis, a structural equation analysis, and a cross-validation analysis with archival data gathered during administrations of the ORAS-P in order to arrive at the ORAS (LaFleur, Leach, & Rowe, 2003). The analyses yielded the following Chronbach's alphas for the six scales: .84 for Dominative-Integrative Attitudes (DI), .72 for Reactive Attitudes (R), .83 for Conflictive Attitudes (C), .60 for Avoidant Attitudes (Av), .78 for Dependent Attitudes (De), and .73 for Dissonant Attitudes (Dis) (LaFleur, Leach, & Rowe, 2003). There were two intercorrelations that exceeded .4, which were between the DI and C types (i.e., .57), and the Dis and De types (i.e., .45; LaFleur, Leach, & Rowe, 2003). The structural equation analysis resulted in a less than adequate fit of the model (i.e., AGFI = .86; LaFleur, Leach, & Rowe, 2003), and the cross-validation with the archival data displayed a less than adequate fit as well (AGFI = .80; LaFleur, Leach, & Rowe, 2003).

For this study, Chronbach's alpha reliability estimates were .46, .85, .73, .54, .85, and .54, respectively, for the DI, C, R, Av, De, and Dis subscales of the ORAS. Thus, except for the

DI and Dis subscales, the reliability estimates closely approximate the coefficients reported by LaFleur, Leach, and Rowe (2003). Concerning the inter-correlations between the subscales, low to moderate inter-correlations, ranging from .09 to .61, were found. Dissimilar to the results found by LaFleur, Leach, and Rowe (2003) concerning inter-correlations, there were three correlations that exceeded .4. Specifically, the correlations greater than .4 were between the DI and Av types ($\underline{r}$ = -.41), the Av and C types ($\underline{r}$ = .49), and the DI and Dis types ($\underline{r}$ = -.42). See Table 12 for the inter-correlations.

Criterion-Related Validation Variable Measures

Self-Consciousness Scale (SCS, Appendix E; Fenigstein, Scheier, & Buss, 1975). This 23 item self-report inventory was developed to identify behaviors and attitudes that constitute the domain of self-consciousness. The items were measured on a 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The total scale comprised three subscales. The first subscale consists of 10 items measuring the private process of self-focused attention and attention to one's inner thoughts and feelings (e.g., "*I'm alert to changes in my mood*", and "*I never scrutinize myself*"), thus it is called the private self-consciousness subscale (PrSC), and high scores are indicative of being privately self-conscious. The second subscale includes seven items and measures one's general awareness of the self as a social object that has an effect on others (e.g., "*I'm concerned about my way of doing things*", and "*I'm usually aware of my appearance*"), thus it is called the public self-consciousness subscale (PuSC), and high scores represent being aware of one's public self. The third subscale measures social anxiety or a discomfort in the presence of others and includes six items (e.g., "*I get embarrassed very easily*"), thus it is referred to as the social anxiety self-consciousness subscale (SaSC).

Fenigstein, Scheier, and Buss (1975) used factor analysis to develop this measure, yielding the three factors/subscales and reported test-retest reliabilities as .79 for the PrSC subscale, .84 for the PuSC subscale, and .79 for the SaSC subscale, and .80 for the full scale. For this study, Chronbach's alphas reliability estimates were .74, .80, and .81, respectively, for the PrSC, PuSC, and SaSC subscale, and .83 for the full scale. Concerning the intercorrelations between the subscales, low to moderate intercorrelations, ranging from .08 to .44, were found. See Table 12 for the intercorrelations.

Revised Self-Monitoring Scale (RSM, Appendix F; Lennox & Wolfe, 1984). This 12 item self-report inventory was developed to measure the construct of self-monitoring, as originally conceptualized and measured by Snyder (1974). Thus, Lennox and Wolfe sought to more accurately measure the construct of self-consciousness and revised Snyder's (1974) 30 item, True/False measure to the current scale. The items were measured on a 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The total scale comprised two subscales. The first subscale consists of six items measuring an individual's ability to modify his/her self-presentation (e.g., "*In social situations, I have the ability to alter my behavior if I feel that something else is called for"*), and high scores are indicative of having more ability to modify self-presentation. The second subscale includes six items and measures one's sensitivity to expressive behavior (e.g., "*I am often able to read people's true emotions correctly through their eyes*"), and high scores are indicative of being more sensitive to expressive behaviors.

Lennox and Wolfe (1983) used factor analysis to revise this measure, yielding the two factors/subscales and reported Chronbach's reliability estimates as .77 for the Ability to Modify Self-Presentation subscale (SMA), .70 for the Sensitivity to Expressive Behavior subscale (SMS), and .75 for the full scale. Additionally, O'Cass (2000) reported Chronbach's alpha as .86

for the SMA, .80 for the SMS, and .85 for the full scale, and O'Cass (2000) also found the identical factor structure and high factor loadings that were found by Lennox and Wolfe (1983).

For this study, Chronbach's alphas reliability estimates were .85 and .77, respectively, for the SMA and SMS, and .84 for the full scale. Thus, these reliability estimates closely approximate O'Cass' (2000) findings. Concerning the inter-correlation between the subscales, a moderate inter-correlation of .38 was found. See Table 12 for the intercorrelations.

Basic Empathy Scale (ES, Appendix G; Jolliffe and Farrington, 2006). This 20 item self-report inventory was developed to measure empathy. The items were measured on a 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), and the full scale comprised two subscales. The first subscale consists of 11 items measuring the affective empathy (e.g., "*After being with a friend who is sad about something, I usually feel sad)*, and high scores are indicative of having more affective empathy. The second subscale includes nine items and measures one's cognitive empathy (e.g., "*When someone is feeling 'down', I can usually understand how they feel*"), and high scores represent the presence of more cognitive empathy.

Jolliffe and Farrington (2006) used factor analysis to develop this measure, yielding the two factors/subscales and reported Chronbach's alpha reliability estimates as .82 for the Affective Empathy subscale (EAS), .78 for the Cognitive Empathy subscale (ECS) subscale, and .81 for the full scale. For this study, Chronbach's alphas reliability estimates were .79 and .79, for the EAS and ECS subscales, and .81 for the full scale. Thus, it closely approximates the findings from Jolliffe and Farrington (2006). Concerning the inter-correlation between the subscales, a moderate inter-correlation of .26 was found. See Table 12 for the intercorrelations.

Sample

The sample comprised 118 self-identified white mental health professionals who completed an online survey. Table 7 provided the demographic information of the sample. Of the 118 participants, 83 identified as female (70.3%), and the mean age of the participants was 36.22. Concerning highest degree earned, 57 participants reported that they had earned a master's degree (48.3%), 41 indicated that they had earned a doctorate's degree (34.7%), and 20 reported that a bachelor's degree was their highest degree earned (16.9%). Concerning their mental health specialization, 56 participants reported that they identify as a Counseling Psychologist (47.5%), 35 as Clinical Psychologists (29.7%), 20 as Counselors (16.9%), and 7 as Social Workers (5.9%).

Procedure

A survey comprising the construct validity and criterion-related validity measures outlined in this Methods section was constructed. Then, a web space for the purpose of the study was created, and the survey was posted online. It should be noted that the web survey used the same software and procedures as outlined in Study 1 with respects to constructing the web survey. There were two distinct methods used to recruit participants to participate in the study. The first method was a "snowballing" technique, and the second method was more systematic.

Concerning the "snowballing" method, a recruitment e-mail was sent to colleagues and peers of the primary investigator. This e-mail reached approximately 60 peers and colleagues, about half of whom would self-identify as white. See Appendix I for a copy of the recruitment letter sent to these individuals. The recruitment letter contained a direct request to all self-identified white mental health professionals to complete the web survey. However, it also contained an indirect request for each individual to forward the message to peers and colleagues

who would be interested in completing the survey. This also meant that the primary investigator had many informal discussions with these individuals, requesting their assistance in disseminating the web survey. This is where the snowball effect occurred as it seems as though many peers and colleagues reported that they were able to disseminate the web survey to peers and colleagues with success.

The more systematic method used to recruit participants was to post the web survey to listserves, similar as the strategy used in Study 1. Specifically, the web survey was posted to the following two listserves: 1) ACCTA (same as in Study 1) and 2) Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues of Division 44 of the American Psychological Association. It appears that these two listserves were fruitful in attracting participants to this study. It should also be noted that data is still being collected in hopes of attracting between 200 and 300 total participants in the study. This would allow this study to factor analyze the CCCS. The number of participants ceased at 118 for the purposes of the dissertation study; however, there are approximately 150 completed web surveys at this time. The plan is to continue data collection and post the web survey to more listserves after the defense of this dissertation (e.g., CCPTP).

CHAPTER IV
RESULTS

Study 1:

The purpose of Study 1 was to provide initial reliability estimates for the CCCS. Table 1 summarizes the demographic information for the 73 participants in Study 1. The results indicated that the 26 item CCCS scale and two 13 item subscales showed solid reliability estimates. Specifically, the full scale's Chronbach's alpha estimate was .84. The White Guilt (WG) subscale estimate was .78, and the Overlooking of Client's Contribution to the Presenting Problem (OC) subscale estimate was .72. Thus, the CCCS scale as well as the WG and OC subscales showed high reliability when all of the 26 items were included in the reliability estimates.

The next step was to investigate the reliability estimates of the WG and OC subscales when each item was excluded from the analysis. Tables 2.1 and 2.2 show the results of the Chronbach's alpha reliability estimates if items are hypothetically deleted from the subscales. For instance, if a subscale has an alpha of .80 and the deletion of one item would increase the alpha to .81; then that item should be scrutinized for whether it should remain an item or whether it needs to be reworded to more accurately and clearly represent the scale or subscale. Additionally, Tables 2.1 and 2.2 show the specific wording of each item, how each item affects the Chronbach's alpha reliability estimate, and the mean, standard deviation, and range of each item on the scale.

The results of this analysis indicated that the deletion of four items would increase the Chronbach's alpha reliability estimates for the CCCS total scale and WG and OC subscales. Specifically, two items from the WG subscale and two items from the OC subscale should be

considered for deletion. Concerning the WG subscale, the deletion of items WG1R and WG8 would increase Chronbach's alpha. More specifically, the WG subscale would increase to .83 if these two items were removed from the scale, which is an increase of .5 (i.e., from .78 to .83). With respects to the OC subscale, the deletion of items OC1 and OC3 would increase alpha. More specifically, the OC subscale would increase to .74 if these two items were removed from the scale, which is an increase of .2 (i.e., from .72 to .74). With regards to the total CCCS, the Chronbach's alpha reliability estimate would increase to .87 if these items were removed, which is an increase of .2 for the reliability estimate.

Nunnally (1983) also suggested that another way to investigate the manner in which each item affects the reliability estimate is to study the inter-item correlations. The purpose of the inter-item correlations is to garner an idea about how well the items relate to one another (Nunnally, 1983). Nunnally (1983) stressed that it is essential to examine the inter-item correlations to ensure that all or nearly all of the correlations are positive, suggesting that negative correlations, if any, should be very low and widely scattered in the matrix. If any item has a consistent negative correlation with all or most of the other items, then clearly that item, as scored, is not measuring the same thing as the other items. Indeed, it may be measuring exactly the opposite of what the others are measuring. Thus, an inter-item correlation matrix was run for the two subscales.

Tables 3.1 and 3.2 summarize the results of the inter-item correlations for the WG and OC subscales, respectively. From the WG subscale, the only items that have negative inter-item correlations are items WG1R and WG8, which were the items removed from the WG subscale. However, the OC subscale identified three additional items that are negatively correlated with other items. More specifically, OC2R, OC11, and OC13 are the only other items on the OC

subscale besides OC1 and OC3 that are negatively correlated with other items. Thus, these items were considered for deletion but will be included in Study 2 in order to be further examined statistically.

In addition to the reliability analysis, one-way ANOVA's were run along with a correlational analysis for age, investigating if there were differences among the participants across the across the various demographic categories for the CCCS total scale and WG and OC subscales. The results are presented in Table 4. Please note that Table 4 also contains the means and standard deviations for the CCCS total scale and WG and OC subscales along with the means and standard deviations of the scales across the various demographic categories (i.e., gender, age, degree, and specialization). There was only one statistically significant difference when the participants were analyzed across demographic information. Specifically, females scored significantly higher ($M = 41.69$, $SD = 6.09$) on the WG subscale than males ($M = 37.64$, $SD = 9.61$), $t(72) = 4.72$, $p = .03$.

***Study 2**:*

The purpose of Study 2 was to validate the CCCS. In light of this purpose, a reliability analysis was performed along with attempting to provide construct validity, criterion-related validity, and incremental validity for the CCCS.

Reliability

A similar reliability analysis that was used in Study 1 was used in the reliability analysis of Study 2. Table 6 summarized the demographic information for the 118 participants in Study 2. The results indicated that the 22 item CCCS scale and two 11 item subscales showed solid reliability estimates. Specifically, the total scale's Chronbach's alpha estimate was .83. The WG

subscale estimate was .77, and the OC subscale estimate was .76. Thus, the CCCS scale as well as the WG and OC subscales showed high reliability for these 22 items. From Study 1, four items were eliminated. When these four items were eliminated from Study 1, the Chronbach's alpha reliability estimates were .87, .83, and .74 for the CCCS, WG, and OC, respectively. Thus, for Study 2; the OC subscale's reliability estimate increased slightly while the WG subscale and CCCS total scale's reliability estimates decreased slightly.

The next step was to investigate the reliability estimates of the WG and OC subscales when each item was excluded from the analysis. Tables 7.1 and 7.2 show the results of the Chronbach's alpha reliability estimates if items are hypothetically deleted from the subscales. For instance, if a subscale has an alpha of .80 and the deletion of one item would increase the alpha to .81; then that item should be scrutinized for whether it should remain an item or whether it needs to be reworded to more accurately and clearly represent the scale or subscale. Additionally, Tables 7.1 and 7.2 show the specific wording of each item, how each item affects the Chronbach's alpha reliability estimate, and the mean, standard deviation, and range of each item on the scale.

The results of this analysis indicated that the deletion of two items would increase the Chronbach's alpha reliability estimates for the CCCS full scale and WG and OC subscales. Specifically, one item from the WG subscale and one item from the OC subscale may be considered for deletion for future research purposes related to the CCCS. However, for the validation of the CCCS in Study 2; the items will remain. Concerning the WG subscale, the deletion of item WG3R would increase Chronbach's alpha. More specifically, the WG subscale would increase slightly to .78. With respects to the OC subscale, the deletion of item OC2R would increase alpha. More specifically, the OC subscale would increase slightly to .77. With

regards to the total CCCS, the Chronbach's alpha reliability estimate would increase slightly to .84.

It should be noted that an inter-item correlation matrix was run, similar to the analysis run in Study 1 based on Nunnally's (1983) conception of how to further investigate reliability; however, a table was not included for this in Study 2 because the results indicated that the only items that had a negative correlation with the other items were WG3R and OC2R, and these items have already been discussed in this reliability analysis. Thus, it seems redundant to include the table at this point.

Validity

In order to assess the validity of the CCCS and the WG and OC subscales, the following analyses were performed: 1) One-way ANOVA's (and correlational analysis for age) between the demographic variables and the CCCS, WG, and OC 2) Correlational analyses among the CCCS, WG, OC and the other total scales and subscales included in the study to provide construct validity because modest inter-correlations could provide support for both discriminant and convergent validity of the CCCS and WG and OC subscales 3) Correlations between the CCCS, WG, and OC and the criterion-related variables used in the study in order to investigate concurrent validity and 4) Hierarchical regression analyses to determine whether the CCCS subscales have incremental validity.

ANOVA's between Demographic Variables and CCCS, WG, and OC

Table 8 summarized the results of the one-way ANOVA's for each of the demographic variables and correlational analysis for age as they relate to the CCCS, WG, and OC scales. It should also be noted that Table 8 includes these same analyses for each of the total scales and subscales used in the study. The results of a one-way ANOVA indicated that there were

significant differences between the mental health specialization groups in their scores on the CCCS {F (3, 114) = 5.92, $p < .01$} and WG {F (3, 114) = 3.30, $p < .05$} and OC {F (5, 318) = 6.93, $p < .01$} subscales.

Concerning the specific results just mentioned, Bonferroni's post-hoc method of statistically comparing the means of the different mental health specialization groups was run. On the CCCS, the Counseling Psychology participants (M = 69.80, SD = 10.61, $p < .01$) scored significantly higher than Counselor (M = 60.80, SD = 9.64, $p < .01$) and Clinical Psychology participants (M = 62.46, SD = 9.94, $p < .01$). With respects to the WG subscale, the Counseling Psychology participants (M = 34.70, SD = 6.54, $p < .01$) scored significantly higher than the Clinical Psychology participants (M = 30.60, SD = 30.60, $p < .01$). With regards to the OC subscale, the Counseling Psychology participants (M = 35.11, SD = 5.68) scored significantly higher ($p < .01$) than Counselor (M = 29.15, SD = 29.15) and Clinical Psychology participants (M = 31.86, SD = 31.86).

Correlational Analyses: Construct Validity

The correlations between the CCCS and WG and OC subscales with each of the total scales and subscales used in the study are presented in Table 9. Additionally, Table 5 displayed the correlations among the CCCS and WG and OC subscales from Study 1 subsequent to the deletion of the four items (i.e., WG1R, WG8R, OC1, OC3). Beginning with the correlation between the two subscales on the CCCS (i.e., WG, OC), the results from Study 1 demonstrated that the subscales were significantly and positively correlated (r = .61, $p < .01$) and, from Study 2, WG and OC yielded a significant and positive correlation (r = .51, $p < .01$) as well.

Concerning the remaining scales and subscales used to demonstrate construct validity, the CCCS was significantly correlated with many of these scales and subscales. Specifically, higher

scores on the CCCS were associated with higher scores on the R ($r = .60$, $p < .01$) and Dis ($r = .26$, $p < .01$) subscales of the ORAS and MCK ($r = .29$, $p < .01$) of the MCI while displaying significant and negative correlations with the MCR ($r = -.29$, $p < .01$) subscale of the MCI, the CoBRAS full scale ($r = -.53$, $p < .01$) and each of its subscales, IR ($r = -.52$, $p < .01$), WRP ($r = -.48$, $p < .01$), and BRI ($r = -.33$, $p < .01$), and the Av ($r = -.32$, $p < .01$) subscale of the ORAS.

With respects to the WG subscale, there were significant and positive correlations with the R ($r = .58$, $p < .01$) and Dis ($r = .21$, $p < .01$) subscales of the ORAS and MCK ($r = .30$, $p < .01$) of the MCI while higher scores on the WG subscale were linked with lower scores on the MCR ($r = -.24$, $p < .01$) subscale of the MCI, the CoBRAS full scale ($r = -.45$, $p < .01$) and each of its subscales, IR ($r = -.44$, $p < .01$), WRP ($r = -.40$, $p < .01$), and BRI ($r = -.29$, $p < .01$), and the Av ($r = -.29$, $p < .01$) subscale of the ORAS.

Concerning the OC subscale, there were significant and positive correlations with the R ($r = .45$, $p < .01$) and Dis ($r = .24$, $p < .01$) subscales of the ORAS and MCK ($r = .20$, $p < .05$) of the MCI while displaying significant and negative correlations with the MCR ($r = -.26$, $p < .01$) subscale of the MCI, the CoBRAS full scale ($r = -.47$, $p < .01$) and each of its subscales, IR ($r = -.47$, $p < .01$), WRP ($r = -.45$, $p < .01$), and BRI ($r = -.27$, $p < .01$), and the Av ($r = -.25$, $p < .01$) and DI ($r = -.22$, $p < .05$) subscales of the ORAS. There was also a significant, inverse relationship between OC and the DI subscale of the ORAS ($r = -.22$, $p < .05$), which was not an expected relationship.

As an additional analysis to ensure that the CCCS full scale and WG and OC subscales discriminated between the scales and subscales used in the study where there were statistically significant correlations detected, the study investigated a discriminant validity coefficient based on Campbell and Fiske's (1959) work. More specifically, Campbell and Fiske (1959) argued

that the following equation can be used to ensure that two scales discriminate between one another (i.e., the two scales are different and measure different constructs): $r_{xy} / \sqrt{(r_{xx} * r_{yy})}$, where r_{xy} represents the statistically significant correlation between the two scales and r_{xx} and r_{yy} represent the respective reliabilities of the two scales involved in the correlation. Campbell and Fiske (1959) argued that a validity coefficient between -.85 and .85 informs us that discriminant validity exists between the two scales. The results of the discriminant validity analysis are presented in Table 10. Each of the validity coefficients was between -.85 and .85, thus, providing evidence that the CCCS, WG, and OC scales are measuring different constructs.

Correlation Analyses: Criterion-Related Validity

Table 9 also contains the results of the correlations that will be discussed below. Concerning the scales and subscales used to demonstrate criterion-related validity, the CCCS was significantly correlated with many of these scales and subscales. Specifically, higher scores on the CCCS were significantly correlated with higher scores on the SCS ($r = .18$, $p < .05$) and ES ($r = .22$, $p < .05$) total scales and the PuSC ($r = .20$, $p < .05$) and EAS ($r = .29$, $p < .01$) subscales while displaying significant and negative correlations with the SMA ($r = -.23$, $p < .05$) subscale of the RSM full scale.

With respects to the WG subscale, there were significant and positive correlations with the SCS ($r = .25$, $p < .01$) and ES ($r = .27$, $p < .01$) full scales and the PuSC ($r = .26$, $p < .01$) and EAS ($r = .33$, $p < .01$) subscales. Contrary to expectations in regards to the WG subscale, WG did not have a strong, inverse relationship with SMA ($r = -.17$, $p = .07$) or SMS ($r = .09$, $p = .32$) subscales, or the RSM ($r = -.05$, $p = .58$) full scale, or positive relationship with the ECS ($r = .02$,

p = .81) subscale. In fact and as can be discerned from the correlation, the relationship between WG and SMS was positive, which is not the hypothesized direction.

Concerning the OC subscale, higher scores on the OC were associated with significantly lower scores on the SMA (r = -.24, p < .01) subscale and RSM (r = -.24, p < .01) full scale. Additionally, it should be noted that the expectations were for the OC subscale to have a significant, inverse relationship with the SMS scale, yet the results indicated that this relationship was not statistically significant (r = -.16, p = .08).

Hierarchical Regression Analyses

In order to determine the demographic variables that needed to be controlled for in the regression analyses, correlational analyses between the demographic variables and the outcome measures (i.e., scales and subscales used to establish criterion-related validity) were calculated and are presented in Table 8. These analyses showed that there were some significant correlations between the demographic variables and the outcome measures. More specifically, greater age was significantly correlated with lower scores on the SCS (r = -.26, p < .01) full scale, and the PuSC (r = -.29, p < .01), PrSC (r = -.21, p < .05), and EAS (r = -.22, p < .05) subscales.

A one-way ANOVA analysis revealed that there were differences between male and female participants on the EAS subscale, suggesting that females (M = 41.22, SD = 5.52) scored statistically higher (t (117), p < .05) than males (M = 38.57, SD = 6.24) on this subscale. Concerning the demographic variable of highest degree earned, doctorate participants scored significantly lower (M = 21.68, 16.24; SD = 5.68, 5.18) on the PuSC and SaSC subscales (F (2, 115), p < .05), respectively, than bachelor's level participants (M = 25.45, 19.25; SD = 4.36, 4.31). With respects to the demographic variable of mental health specialization, the results

indicated that Counseling Psychology participants (M = 43.09, 21.43; SD = 5.29, 3.24) reported significantly lower scores (F (3, 114), $p < .05$) on the RSM full scale and SMS subscale, respectively, than Counselor participants (M = 48.15, 24.05; SD = 6.77, 3.97).

The next phase involved running hierarchical regression analyses in order to control for the demographic variables. In other terms, the goal of this analysis was to investigate the effect of the demographic variables on the outcome or criterion-related variables in order to provide incremental validity for the correlations found between the criterion variables and the CCCS total scale and WG and OC subscales. Table 11.1 through 11.6 summarized the results of the hierarchical regression analyses.

In the first step of the hierarchical regression analyses, the demographic variables were entered in the first block. In the second step, the CCCS total scale, WG, and/or OC subscales were entered in the second block, and the significance of the change in R^2 was tested by examining the statistical significance of the beta weights associated with each of the independent variables (i.e., demographic variables, CCCS, WG, OC). This process was repeated for each criterion or outcome measure.

The results revealed that after controlling for the demographic variables, the CCCS total scale and WG subscale maintained statistical significance with each of the dependent variables under investigation, which strengthens the criterion-related validity of the outcome variables (i.e., SCS, PuSC, PrSC, EAS). Specifically, higher scores on the CCCS were associated with higher scores on the SCS ($\beta = .18$, $p < .05$), PuSC ($\beta = .17$, $p < .01$ for demographic variable age & $\beta = .26$, $p < .05$ for demographic variable degree), and ESA ($\beta = .26$, $p < .01$ for demographic variable age & $\beta = .28$, $p < .01$ for demographic variable gender). Concerning the WG subscale, the results indicated that higher scores on the WG subscale were associated higher scores on the

SCS (β = .21, $p < .05$), PuSC (β = .22, $p < .01$ for demographic variable age & β = .23, $p < .01$ for demographic variable degree), PrSC (β = .19, $p < .05$), and ESA (β = .30, $p < .01$ for demographic variable age & β = .33, $p < .01$ for demographic variable gender). However, the OC subscale's significant negative correlation with the RSM full scale (β = .16, $p = .11$) and SMS subscale (β = -.08, $p = .42$) were not significant after controlling for the demographic variable of mental health specialization.

CHAPTER V
DISCUSSION

The purpose of the current investigation was to develop the Counselor Color Consciousness Scale (CCCS) and to assess its reliability and validity as a scientific tool that can be used to enhance the study of the counseling process between white therapists and clients of color. In this section, the notable findings of the study are presented. More specifically, the results that show the evidence for the relevance, reliability, and validity of the CCCS and its subscales are presented. Additionally, interpretations of the key findings are offered, and then a discussion regarding the implications of the findings for psychological research, theory, and practice follows. Finally, potential limitations of the study and recommended directions for future research are covered.

Notable Findings

Overall, the results of this study demonstrated the relevance of the construct of color-consciousness. The CCCS is a unique instrument that measures attitudes, behaviors, and unconscious motives/intentions of white therapists in their work with clients of color. Ridley's (1995, 2005) theoretical conceptions provided the theoretical relevance of this construct, and the results of this analysis indicated that the construct of color-consciousness can be an exciting, new variable to be used in research devoted to multicultural counseling. Its relevance to multicultural psychology was evidenced by the relationships (i.e., modest correlations) with existing instruments that have been used extensively in multicultural research.

More specifically, the analyses provided support for the validity of the CCCS along with the WG and OC subscales. First, the findings generated evidence for the discriminant validity of

the subscales. Discriminant validity refers to the principle that measures of different constructs should not be so highly correlated as to lead one to conclude that they measure the same construct (Fiske, 1982), which was tested mathematically based on Campbell and Fiske's (1959) mathematical conceptions of discriminant validity. Despite the fact that each of the full scales and subscales that were hypothesized to be significantly related to each other showed a statistically significant relationship, these correlations were modest.

Second, the modest correlations among the full scale and subscales aimed at providing construct validity pointed to their convergent validity. Convergent validity refers to the principle that different measures of a given construct should be at least moderately correlated among themselves (Fiske, 1982). More specifically, multicultural knowledge (positive relationship), a counselor's confidence in the counseling relationship (negative relationship), a reactive white racial attitude type (positive), a dissonant white racial attitude type (positive), an avoidant white racial attitude type (negative) and all color-blind racial attitudes (negative) that were expected to show modest relationships with the CCCS and its subscales did so in this analysis, providing solid evidence and support for the construct validity of the CCCS and its subscales.

Third, the CCCS full scale and WG and OC subscales demonstrated concurrent validity. Specifically, the WG subscale showed the expected correlational results with the criterion-related variables of self-consciousness and empathy. The expectations were that WG would show a strong, positive relationship with public self-consciousness, private self-consciousness, and affective empathy, which were discovered in the results. Additionally, the CCCS full scale demonstrated concurrent validity for the most part. It showed the expected relationship with self-consciousness and affective empathy. With respects to the OC subscale, it showed a strong,

inverse relationship with the ability to change behaviors dimension of the self-monitoring scale and self-monitoring full scale.

However, there were also unexpected results related to the CCCS, WG, and OC scales and the criterion-related variables. Specifically, the OC and WG subscales did not correlate significantly with the sensitivity to expressive behavior of others dimension of the self-monitoring scale, and the WG subscale did not have the expected strong, inverse relationship with the ability to modify behaviors dimension of the self-monitoring construct. In fact, the WG subscale showed a positive, non-significant relationship with the sensitivity to expressive behavior of others subscale. Additionally, the significant relationships between the self-monitoring scales and OC subscale were nullified when we controlled for demographic variables. Thus, some of the results associated with the self-monitoring scales and CCCS scales were not expected or hypothesized. The relationships found are tenuous since the significant results were not significant after controlling for demographic variables, and future research will need to investigate these relationships more fully. One additional finding worth noting is that WG did not show a strong, significant relationship with cognitive empathy.

Finally, the CCCS full scale and WG subscale demonstrated evidence of incremental validity. Except for the null results related to OC and the construct of self-monitoring, significant relationships among the CCCS, WG, an OC and the criterion-related measures were maintained after controlling for the effects of the demographic variables. Thus, the links between color-consciousness (and white guilt) and the outcome measures could not be explained by these potentially confounding explanatory variables.

In sum, this study yielded substantial evidence for the relevance and reliability of the CCCS full scale and WG and OC subscales while showing strong support for the validity of the

CCCS full scale and the WG and OC subscales. The unexpected results related to the OC subscale and its criterion-related validity tempered the validity results slightly. Overall, the CCCS full scale and the WG and OC subscales demonstrated promise as measures of color consciousness in white therapists working with clients of color with potentially significant implications for multicultural research.

Implications for Psychological Theory, Practice, and Research

The findings of this study have several implications for psychological theory, practice, and research. First, this study was able to develop a measure of color-consciousness that showed solid reliability and validity. Ridley (2005) conceptualized the theoretical construct of color-consciousness as a counselor defense mechanism that white therapists face when they perform therapeutic services to clients of color. Due to the unconscious nature of this construct, being able to measure the construct of color-consciousness seemed daunting at first. Thus, being able to develop a measure that captures the construct of color-consciousness is a promising first step in being able to use this as a variable in multicultural psychology.

This investigation found solid evidence to support the construct of color-consciousness (e.g., relationship with multicultural knowledge, color-blindness). Additionally, this study found evidence to support Ridley's (1995, 2005) hypothesis that color consciousness is a counselor defense mechanism that has potential negative effects on the therapeutic process. The evidence for this was found in the inverse relationship between a counselor's confidence in providing therapy services to clients of color and the CCCS as well as the positive relationships with the reactive and dissonant white racial attitude types and the CCCS. The reactive attitude is an over-identification with minority clients while the dissonant is an unachieved attitude type of feeling

conflicted and/or confused about minority individuals. In fact, one hypothesis is that dissonant attitudes are strongly linked to white therapists who are struggling to emerge from being made aware of the prevalence of racism in our society and being confronted with how to change/modify their attitudes/behaviors.

The results of this analysis from this study and this sample suggest that color-conscious white therapists are empathetic, publicly and privately self-conscious, and do not modify behaviors to fit others and situations. However, there were some findings that were contrary to the expectations of this investigator. More specifically, white guilt was not related to cognitive empathy, nor was it was related to the construct of self-monitoring.

Concerning cognitive empathy, there is a dearth of research devoted to differentiating affective and cognitive empathy. Even though the measures of affective and cognitive empathy showed modest correlations ($r = .26$, $p < .01$), these two dimensions of empathy also were significantly correlated with different constructs used in this study (see Table 12). More specifically, cognitive empathy showed significant relationships with most of the dimensions of the multicultural counseling inventory, while affective empathy showed significant relationships with the color-blind (i.e., inverse) and color-conscious constructs. Thus, more research is needed to understand and differentiate the processes of cognitive and affective empathy.

Concerning the construct of self-monitoring, and, more specifically, the being sensitive to the expressive behavior of others dimension of this construct, it appears that there may be an aspect to white guilt that may be related to being sensitive to the expressive behavior of others. This relationship was insignificant statistically, but it was a positive relationship. This is especially confusing since this dimension of self-monitoring was positively and significantly correlated with each of the color-blind subscales and full scale. More research is also needed in

this area as well as this investigator cannot think of a logical reason for this result based on prior research and the other findings in this study.

Second, this measurement of color-consciousness focused on normalizing the instrument on white therapists and developing a measure that was geared towards white therapists and their work with clients of color. One criticism this investigator has about the CoBRAS instrument is that it was normed on a general college population and measures general conceptions of racism and unintentional racism and not how color-blindness may look in a therapeutic encounter. This is especially important given that it does appear that the pendulum has swung from white therapists being color-blind to their being more color conscious. Evidence for this that was not covered in the results section is simply that the average score for each CCCS item was a 3.0, and the average score for each CoBRAS item was a 1.8. Additionally, the evidence suggesting that the CCCS and CoBRAS showed a strong, inverse relationship and also being able to find evidence that the two instruments measured different constructs (i.e, discriminant validity) was vital to validating the CCCS.

Third, the CCCS can be used as a variable to examine the effect of color consciousness on the therapeutic alliance and on counseling outcomes. Past research has suggested that counselors who are willing and open to focusing on race, issues of oppression, etc. are more effective than counselors not open to this process. However, with the pendulum swinging towards more color consciousness; white therapists need to be cognizant of the costs of color consciousness, which deals with the ability and developing the skills to integrate contextual (e.g., the effects of racism) information into the therapeutic process (Ridley, Li, & Hill, 1998). Thus, the CCCS can be used as a multicultural counseling variable that allows researchers to gain more insight into how to effectively integrate cultural information into the therapeutic process.

Fourth, the CCCS, and especially the WG subscale, was strongly and positively correlated with affective empathy, self-consciousness, and self-awareness, and past research has linked these traits to the emotion of guilt. Thus, future research may be able to conduct a path analysis study that investigates and integrates the aforementioned constructs into a useful interactional model between white therapists and clients of color. For instance, the research suggests that individual who are more self-conscious are also more affected by emotional stimuli. A path analysis may be able to investigate the stimulus value of a client of color and how this relates to the emotion of guilt in white therapists with the concepts of empathy, self-consciousness, and self-awareness as mediating variables.

Fifth, this investigator hypothesizes that the reason that the construct of color-consciousness could be measured in this study is because of the multicultural education being infused into psychology over the past 20-30 years. In other terms, the unconscious process of white guilt is not as unconscious as it once was. The awareness of white privilege, and the strong efforts by educators, researchers, and practitioners to acknowledge, discuss, and process the idea of white privilege may have resulted in white therapists in this sample responding more openly and candidly to the color-conscious items. The finding that the CCCS was strongly and positively correlated with the MCK (i.e., multicultural knowledge) also suggests that educators, researchers, and practitioners are raising the awareness on white guilt.

Finally, in psychological practice; these findings seem to imply and reinforce the need for experience with respect to white therapists working with clients of color. More specifically, the findings partially suggest this notion insofar as CCCS scores were inversely, even though insignificantly, related to age. Additionally, older white therapists also had significantly higher scores on the multicultural skills, concepts, and constructs, especially the multicultural awareness

subscale that measures multicultural awareness with clients of color that is based on direct experiences with them in clinical practice. Thus, the idea is that direct experiences with clients of color will lessen white guilt over time and assist therapists in integrating cultural/racial information. This implies the need for multicultural training programs and courses to infuse direct experiences into their programs and curricula, respectively.

Limitations and Future Directions

The findings should be considered in light of the following limitations. First, the two subscales of the CCCS are theoretical in nature. As such, the items on the CCCS related to the WG and OC subscales are theoretical and have not been supported statistically through factor analysis. Thus, interpreting the results of the correlations between the CCCS subscales and the other scales and subscales used in the investigation should be done with some caution, even though there were strong reliability and validity results to support the two subscales.

Second, a small limitation of the study is that it did not ask participants for years of counseling experience. In hindsight, this would have been a good demographic variable to include in the analysis because years of experience may be more important than chronological age. Third, the data is correlational in nature, thus, by this design its internal validity is not as high as its external validity. Fourth, reliability estimates for scores on three subscales of the Oklahoma Racial Attitudes Scale were weak. Finally, the study utilized a survey format, and its findings were based on self-report data. Future studies that utilize different research methods (e.g., observer reports, direct observation) could provide further support for the construct and measurement of color consciousness.

Despite these limitations, the findings of the study point to several directions for future research. First, the CCCS should be factor analyzed in order to test the theoretical nature of the two theoretical dimensions of the construct of color-consciousness. Hopefully, this will enhance the reliability and validity of the CCCS. Second, it is still an empirical or qualitative question as to the extent to which racial and cultural information should be discussed, processed, etc. in the therapeutic relationship. In other terms, research is needed to investigate the extent to which color consciousness impacts the therapeutic process and outcomes (e.g., working alliance between client and counselor, under-diagnosing).

Third, future investigations could study the link between the CCCS and other variables related to therapist personality variables, therapist theoretical orientation, client personality variables, clients' diagnoses, differences in clients of color based on type of setting, etc. Fourth, structural equation modeling and/or path analysis could be used to investigate the relationships between the interactions between counselors and clients.

Finally, the broad field of multicultural counseling/psychology can move towards a greater understanding of determining what works best with whom and under what circumstances with clients of color. With race and cultural serving as the catalyst for this type of research, multicultural psychology can move towards a greater understanding of how white therapists can be more effective with clients of color. There are decades of research suggesting that mental health professionals do not work as effectively with clients of color as they do with white clients. It would be nice to see this reversed. Thus, all research devoted to a greater understanding of the process that perpetuates this result are tremendous assets to our field. By developing a measure that assists in this endeavor and that can be used in future research to also assist in this undertaking, this investigator hopes that he has not only contributed to multicultural research and

knowledge in the short-term but also believes that the idea of color consciousness can lead to future research that helps in improving services to clients of color.

LIST OF REFERENCES

LIST OF REFERENCES

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders, fourth edition, text revision*. Washington, DC: American Psychiatric Association.

Backstrom, M., & Bjorklund, F. (2007). Structural modeling of generalized prejudice: The role of social dominance, authoritarianism, and empathy. *Journal of Individual Differences, 28*(1), 10-17.

Bargh, J.A., & Pietromonaco, P. (1982). Automatic information processing and social perception: The influence of trait information presented outside conscious awareness on impression management. *Journal of Personality and Social Psychology, 43*, 437-449.

Basil, D.Z., Ridgway, N.M., & Basil, M.D. (2008). Guilt and giving: A process model of empathy and efficacy. *Psychology and Marketing, 25*(1), 1-23.

Batson, C.D., Thompson, E.R., Seuferling, G., Whitney, H., & Strongman, J.A. (1999). Moral hypocrisy: Appealing moral to oneself without being so. *Journal of Personality and Social Psychology, 77*, 525-537.

Basil, D.Z., Ridgway, N.M., & Basil, M.D. (2008). Guilt and giving: A process model of empathy and efficacy. *Psychology & Marketing, 25*(1), 1-23.

Behrens, J.T. (1997). Does the White Racial Identity Attitude Scale measure racial identity? *Journal of Counseling Psychology, 44*, 3-12.

Bennett, S.K., Atkinson, D.R., & Rowe, W. (1993, August). *White racial identity: An alternative perspective*. Paper presented at the meeting of the American Psychological Association, Toronto, Canada.

Bohart, A.C., Elliot, R., Greenberg, L.S., & Watson, J.C. (2002). In J.C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 89-108). London: Oxford University Press.

Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance, *Psychotherapy: Theory, Research, and Practice, 16*, 252-260.

Bryant, B.K. (1982). An index of empathy for children and adolescents. *Child Development, 53*, 413-425.

Burkard, A.W., & Knox, S. (2004). Effect of therapist color-blindness on empathy and attributions in cross-cultural counseling. *Journal of Counseling Psychology, 51*(4), 387-397.

Burkhard, A.W., Ponterotto, J.G., Reynolds, A.L., & Alfonso, V.C. (1999). White counselor trainees' racial identity and working alliance perceptions, *Journal of Counseling & Development, 77*, 324-329.

Busseri, M.A., & Tyler, J.D. (2003). Interchangeability of the working alliance inventory and working alliance inventory, short form, *Psychological Assessment, 15*(2), 193-197.

Butcher, J.N., Braswell, L., & Raney, D. (1983). A cross-cultural comparison of American Indian, Black, and White inpatients of the MMPI and presenting symptoms. *Journal of Consulting and Clinical Psychology*, 51, 587-594.

Campbell, D.T., & Fiske, D.W. (1959). Convergent and *discriminant validation by the multitrait-multimethod matrix. Psychological* Bulletin, 56, 81-105.

Casas, M. (1984). Policy, training, and research in counseling psychology: The racial/ethnic perspective. In S. Brown and R. Lent (Eds.), *Handbook of counseling psychology* (pp. 785-831). New York: John Wiley & Sons.

Chen, M. & Bargh, J.A. (1997). Nonconscious behavioral confirmation processes: The self-fulfilling nature of automatically activated stereotypes. *Journal of Experimental Social Psychology, 33*, 541-560.

Cheung, F.K., & Snowden, L.R. (1990). Community mental health and ethnic minority populations, *Community Mental Health Journal, 26*, 277-291.

Choney, S.K., & Behrens, J.T. (1996). Development of the Oklahoma Racial Attitudes Scale preliminary form (ORAS-P). In G.R. Sodowsky & J.C. Impara (Eds.), *Multicultural assessment in counseling and clinical psychology* (pp. 225-240). University of Nebraska-Lincoln: Buros Institute of Mental Measurements.

Constantine, M.G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes towards counseling and ratings of their counselors' general and multicultural competence. *Journal of Counseling Psychology, 49*, 255-263.

Cross, W. E. (1971). The Negro to black conversion experience, *Black World, 20*, 13-17.

Day, H.I., & Chambers, J. (1991). Empathy and burnout in rehabilitation counselors. *Canadian Journal of Rehabilitation, 5*, 33-44.

DeMarree, K.G., Wheeler, S.C., Petty, R.E. (2005). Priming a new identity: Self-monitoring moderates the effects of nonself primes on self-judgments and behavior. *Journal of Personality and Social Psychology, 89*(5), 657-671.

Duval, S. & Wicklund, R.A. (1972). *A theory of objective self-awareness*. New York: Academic Press.

Enns, C.Z. (1993). Twenty years of feminist counseling and therapy, *The Counseling Psychologist, 21*, 3-87.

Essandoh, P.K. (1986). Multicultural counseling as the "fourth force": A call to arms, *The Counseling Psychologist, 24*, 126-137.

Fenigstein, A., Scheier, M.F., and Buss, A.H. (1975). Public and private self-consciousness: Assessment and theory. *Journal of Consulting and Clinical Psychology, 43*(4), 522-527.

Fischer, A.R., Jorne, L.M., & Atkinson, D.R. (1998). Reconceptualizing multicultural counseling: University healing conditions in a culturally specific context. *The Counseling Psychologist, 26*, 525-588.

Fiske, D. W. (1982). Convergent-discriminant validation in measurements and research strategies. *New Directions of Methodology of Social & Behavioral Science, 12*, June 1982, 77-92.

Gaertner, S.L., & Dovidio, J.F. (1986). The aversive form of racism. In J.F. Dovidio & S.L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 91-125). New York: Academic Press.

Gelso, C.J. & Fretz, B.R. (2001). *Counseling Psychology* (2nd Ed.). Orlando, FL: Hardcourt Publishers.

Glover, D. B. (2005). The online e-survey: A research approach for the ICT age. *International Journal of Research & Method in Education, 28,* 135-146.

Granello, D. H., & Wheaton, J. E. (2004). Online data collection: Strategies for Research. *Journal of Counseling & Development, 82,* 387-393.

Gynther, M.D. (1979). Ethnicity and personality: An update. In J.N. Butcher (Ed.), *New developments in the use of the MMPI* (pp. 113-140). Minneapolis: University of Minnesota Press.

Haferkamp, C.J. (1989). Implications of self-monitoring theory for counseling supervision. *Counselor Education and Supervision, 28*, 290-297.

Helmes, E. (1993). A modern instrument for evaluating psychopathology: The Personality Assessment Inventory professional manual, *Journal of Personality Assessment, 61*, 414-417.

Helms, J.E. (1984). Toward a theoretical explanation of the effects of race on counseling: A black and white model, *The Counseling Psychologist, 12*(4), 153-165.

Helms, J.E. (Ed.) (1990). *Black and White racial identity: Theory, research, and practice*. Westport, CT: Greenwood Press.

Ho, M.K. (1992). *Minority children and adolescents in therapy*. Newbury Park, CA: Sage.

Hogan, R. (1969). Development of an empathy scale. *Journal of Consulting and Clinical Psychology, 33*, 307-316.

Horvath, A.O. (1994). Empirical validation of Bordin's pantheoretical model of the alliance: The Working Alliance Inventory perspective. In A.O. Horvath & L.S. Greenberg (Eds.), *The Working Alliance: Theory, Research, and Practice* (pp. 108-128). New York: Wiley.

Horvath, A. O., & Greenberg, L. S. (1986). Development and validation of the Working Alliance Inventory. In L.S. Greenberg and W. Pinsof (Eds.), *The psychotherapeutic process: A resource handbook* (pp. 529-556). New York: Guilford Press.

Hull, J.G., Slone, L.B., Meteyer, K.B., Matthews, A.R. (2002). The nonconsciousness of self-consciousness. *Journal of Personality and Social Psychology, 83*(2), 406-424.

Hull, J.G., Van Treuren, R.R., Ashford, S.J., Propsom, P., & Andrus, B.W. (1988). Self-consciousness and the processing of self-relevant information. *Journal of Personality and Social Psychology. 37*, 756-768.

LaFleur, K.N., Leach, M.M., & Rowe, W. (2003, June). Oklahoma Racial Attitudes Scale manual, unpublished.

Lennox, R.D., & Wolfe, R.N. (1984). Revision of the self-monitoring scale. *Journal of Personality and Social Psychology, 46*, 1349-1364.

Leone, C. (2006). Self-monitoring: Individual differences in orientations to the social world. *Journal of Personality, 74*(3), 633-657.

Leone, C., & Hawkins, L.B. (2006). Self-monitoring and close relationships. *Journal of Personality, 74*(3), 739-778.

Leong, F.T.L. (1994). Asian Americans' differential patterns of utilization of inpatient and outpatient public mental health services in Hawaii, *Journal of Community Psychology, 22*, 82-96.

McConahay, J.B. (1986). Modern racism, ambivalence, and the Modern Racism Scale. In J.F. Dovidio & S.L. Gaertner (Eds.). *Prejudice, discrimination, and racism* (pp. 91-125). New York: Academic Press.

Mead, G.H. (1934). *Mind, self, and society*. Chicago: University of Chicago Press.

Middleton, R.A., Stadler, H.A., Simpson, C., Guo, Y-J., Brown, M.J., Crow, G., Schuck, K., Alemu, Y., & Lazarte, A.A. (2005). Mental health practitioners: The relationship between white racial identity attitudes and self-reported multicultural competencies, *Journal of Counseling and Development, 83*, 444-456.

Mill, J. (1984). High and low self-monitoring individuals: Their decoding skills and empathic expression. *Journal of Personality, 52*(4), 372-388.

Morey, L.C. (1991). *The Personality Assessment Inventory professional manual*. Odessa, FL: Psychological Assessment Resources.

Morey, L.C. (2003). *Essentials of PAI assessment*. Hoboken, NJ: John Wiley & Sons.

Neville, H.A., Lilly, R.L., Duran, G., Lee, R., & Browne, L. (2000). Construction and initial validation of the Color-Blind Racial Attitudes Scales (CoBRAS*). Journal of Counseling Psychology, 47*, 59-70.

Nunnally, J.C. (1983). *Psychometric theory*. New York: McGraw-Hill.

O'Cass, A. (2000). A Psychometric evaluation of a revised version of the Lennox and Wolfe revised self-monitoring scale. *Psychology and Marketing, 17*(5), 397-419.

Pedersen, P. (Ed.). (1999). *Multiculturalism as a fourth force*. Philadelphia: Brunner/Mazel.

Phinney, J.S. (1989). Stages of ethnic identity in minority adolescents, *Journal of Early Adolescence, 9*, 34-49.

Ponterotto, J.G., Burkard, A.W., Rieger, B.P., Grieger, I., D'Onofrio, A., Dubuisson, A., et al. (1995). Development and initial validation of the Quick Discrimination Index (QDI). *Educational and Psychological Measurement, 55*, 1016-1031.

Ponterotto, J.G., Fuertes, J.N., & Chen, E.C. (2000). Models of multicultural counseling. In S.D. Brown & R.W. Lent (Ed.), *Handbook of counseling psychology* (pp. 639-669). New York, NY: John Wiley & Sons.

Pope-Davis, D.B., Toporek, R.L., Ortega-Villalobos, L., Ligiero, D.P., Brittan-Powell, C.S., Liu, W.M., et al. (2002). Client perspectives of multicultural counseling competence: A qualitative examination, *The Counseling Psychologist, 30*(3), 355-393.

Richardson, T.Q., & Helms, J.E. (1994). The relation of the racial identity attitudes of black men to perceptions of parallel counseling dyads, *Journal of Counseling and Development, 73*, 172-177.

Ridley, C.R. (1995). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention.* Thousand Oaks, CA, US: Sage Publications, Inc.

Ridley, C.R. (2005). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention, 2nd Ed*. Thousand Oaks, CA: Sage.

Ridley, C.R., Li, L.C., Hill, C.L. (1998). Multicultural assessment: Reexamination, reconceptualization, and integration, *The Counseling Psychologist, 26*, 827-910.

Ridley, C.R., & Lingle, D.W. (1996). Cultural empathy in multicultural counseling: A multidimensional process model. In P.B. Pedersen, J.G. Draguns, W.J. Lonner, & J.E. Trimble (Eds.), *Counseling across cultures* (4th Ed., pp. 21-46). Thousand Oaks, CA: Sage.

Rowe, W., Bennett, S., & Atkinson, D.R. (1994). White racial identity models: A critique and alternative proposal, *The Counseling Psychologist, 22*, 120-146.

Rowe, W., Behrens, J.T., & Leach, M.M. (1995). Racial/ethnic identity and racial consciousness: Looking back and looking forward. In J.G. Ponterotto, J.M. Casas, L.A. Suzuki, and C.M. Alexander (Eds.), Handbook of multicultural counseling (pp. 218-236). Thousand Oaks, CA: Sage Publications.

Scheier, M.F., & Carver, C.S. (1977). Self-focused attention and the experience of emotion: Attraction, repulsion, elation, and depression. *Journal of Personality and Social Psychology, 35*, 625-636.

Snyder, M. (1974). Self-monitoring of expressive behavior. *Journal of Personality and Social Psychology, 30*(4), 526-537.

Sodowsky, G.R. (1996). The Multicultural Counseling Inventory: Validity and applications in multicultural training. In G.R. Sodowsky & J.C. Impara (Eds.), *Multicultural assessment in*

counseling and clinical psychology (pp. 283-324). Lincoln, NE: Buros Institute of Mental Measurements.

Sodowsky, G.R., Taffe, R., Gutkin, T.B., & Wise, S. (1994). Development of the multicultural counseling inventory: A self-report measure of multicultural counseling competencies, *Journal of Counseling Psychology, 41*, 137-148.

Sue, D.W., Arrendo, P., & McDavis, R.J. (1992). Multicultural competencies/standards: A Call to the Profession. *Journal of Counseling and Development, 70*(4), 477-486.

Sue, D.W., Bernier, J.B., Durran, M., Feinberg, L., Pedersen, P., Smith, E., & Vasquez-Nuttall, E. (1982). Position Paper: Cross-Cultural counseling competencies. *The Counseling Psychologist, 10*, 45-52.

Sue, D.W., Carter, R.T., Casas, J.M., Fouad, N.A., Ivey, A.E., Jensen, M., LaFromboise, T., Manese, J.E., Ponterotto, J.G., & Vazquez-Nutall, E. (1998). *Multicultural counseling competencies: Individual and organizational development*. Thousand Oaks, CA: Sage.

Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York: Wiley.

Sue, S., Fujino, D.C., Hu, L., Takeuchi, D.T., & Zane, N.W.S. (1991). Community mental health services of ethnic minority groups: A test of the cultural responsiveness hypothesis, *Journal of Consulting and Clinical Psychology, 59*, 533-540.

Terrel, F., & Terrell, S. (1984). Race of counselor, client, sex, cultural mistrust level, and premature termination from counseling among Black clients. *Journal of Counseling Psychology, 31*, 371-375.

Thompson, C.E, & Jenal, S.T. (1994). Interracial and intraracial quasi-counseling interactions when counselors avoid discussing race. *Journal of Counseling Psychology,41*, 484-491.

Thompson, C.E., Worthington, R., & Atkinson, D.R. (1994). Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures. *Journal of Counseling Psychology, 41*, 155-161.

Tokar, D.M., & Swanson, J.L. (1991). An investigation of the validity of Helm's (1984) model of White racial identity. *Journal of Counseling Psychology, 38*, 296-301.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1,* 207-210.

U.S. Census Bureau (2006). www.census.gov/

U.S. Department of Commerce, (1998*). Census Bureau current population reports* (Series P-60, Selected issues). Washington, DC: U.S. Government Printing Office.

Wade, P. & Bernstein, B.L. (1991). Culture sensitivity training and counselor's race: Effects on Black female clients' perceptions and attrition. *Journal of Counseling Psychology, 38*, 9-15.

Want, V., Parham, T.A., Baker, R.C., & Sherman, M. (2004). African American students' ratings of Caucasian and African American counselors varying in racial consciousness. *Cultural Diversity and Ethnic Minority Psychology, 10*(2), 123-136.

APPENDICES

Table 1

Demographic Information of the Sample for Study 1 (CCCS, n = 73)

Age:	
M	34.19
sd	9.57
> 20 < 30	30 (41.1%)
> 30 < 40	26 (35.6%)
> 40	17 (23.3%)
Gender:	
Female	51 (69.9%)
Male	22 (31.1%)
Highest Degree Earned:	
Bachelor's	8 (11.0%)
Master's	38 (52.1%)
Doctoral	27 (37.0%)
Specialization:	
Clinical Psychology	24 (32.9%)
Counseling Psychology	40 (54.8%)
Counselor	5 (6.8%)
Social Work	4 (5.5%)

Table 2.1
Item Level Descriptive Statistics for the "White Guilt" (WG) subscale (n = 73)

Variable	*M (SD)*	Range	Chronbach's Alpha If Item Deleted
White Guilt:[1]			
I don't openly discuss issues of race and culture with my client. (**WG1R**)	4.04 (1.21)	1-5	.803*
I feel pressure to be a positive White role model when working with clients of color. (**WG2**)	2.78 (1.24)	1-5	.762
Being accountable to clients of color as a positive White role model is not an aim for me when I deliver therapeutic services. (**WG3R**)	3.22 (1.30)	1-5	.770
Because clients of color continue to be victims of racism and oppression, it is impossible to accurately assess their psychopathology. (**WG4**)	2.04 (1.03)	1-5	.763
I worry about clients of color perceiving me as a racist. (**WG5**)	2.75 (1.20)	1-5	.762
Because minorities have been treated so Poorly in our society, I feel personally responsible to provide services that don't disadvantage clients of color. (**WG6**)	3.67 (1.20)	1-5	.755
I don't feel burdened by the mistreatment of minority populations in our society. (**WG7R**)	3.85 (1.05)	1-5	.765
It is important for me that my clients of color know I am not racist. (**WG8**)	3.60 (.91)	1-5	.805*
There are times when I feel personally burdened for society's wrongs concerning the treatment of people of color. (**WG9**)	3.41 (1.05)	1-5	.757
I harbor strong and painful feelings about the mistreatment of minorities in our society. (**WG10**)	3.59 (1.03)	1-5	.760

Table 2.1- Con.

Item Level Descriptive Statistics for the "White Guilt" (WG) subscale (n = 73)

Variable	*M (sd)*	Range	Chronbach's Alpha If Item Deleted
I am able to provide therapeutic services with a client of color without feeling any personal responsibility for racism/discrimination/oppression. (**WG11R**)	2.92 (1.06)	1-5	.748
I am afraid to provide a severe diagnosis to clients of color, because I don't want to be perceived as a racist. (**WG12**)	1.49 (.69)	1-4	.776
I feel guilty about the mistreatment of people of color in our society (**WG13**)	3.10 (1.15)	1-5	.740

Note. [1]Participants responded to all items in this subscale on a 5-point scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). The numbers for the reverse scored items represent the score after being reversed. *Item has been deleted from the CCCS

Table 2.2
Item Level Descriptive Statistics for the "Overlooking Clients' Contributions o the Presenting Problem" (OC) subscale (n = 73)

Variable	*M (sd)*	Range	Chronbach's Alpha if Item Deleted
OC:[1]			
The effect of racism/discrimination is the most important variable to understand when assessing clients of color. (**OC1**)	2.55 (.88)	1-4	.734*
A client's race/ethnicity is not of concern when attempting to assess their psychopathology. (**OC2R**)	4.56 (.87)	1-5	.714
Clients of color typically have some presence of "cultural paranoia" because of the effect of racism in our society. (**OC3**)	3.11 (.92)	1-5	.724*
In clients of color, many clinical symptoms are the result of experiences with racism/ discrimination/oppression. (**OC4**)	3.53 (.88)	1-5	.686
Clients of color manifest clinical symptoms differently than White clients. (**OC5**)	3.53 (.73)	2-5	.705
Clinical symptoms and diagnoses exist in all client populations, regardless of client race/ethnicity. (**OC6R**)	2.11 (1.24)	1-5	.707
Because of the effects of racism, I see the need to offer different diagnoses for clients of color (compared to White clients) even if the symptoms are similar. (**OC7**)	2.42 (1.00)	1-5	.685
I tend to see client symptomatology instead of race/ethnicity/culture. (**OC8R**)	3.25 (1.14)	1-5	.673
When I work with clients of color, it is important for me to appear impartial concerning race/ethnicity. (**OC9R**)	3.23 (1.15)	1-5	.685
I strictly adhere to DSM-IV criteria when diagnosing a client of color. (**OC10R**)	3.37 (1.02)	1-5	.683

Table 2.2- Con.

Item Level Descriptive Statistics for the "White Guilt" (WG) subscale (n = 73)

Variable	*M (sd)*	Range	Chronbach's Alpha If Item Deleted
It is possible that I have minimized clients' of color contributions to psychopathology because I have placed too much weight on the effects of racism. (**OC11**)	2.58 (1.08)	1-4	.715
Racism is often the primary cause of minority clients' clinical problems. (**OC12**)	2.55 (.97)	1-4	.693
Minority clients' concerns stem from their minority status. (**OC13**)	2.53 (.87)	1-4	.716

Note. [1]Participants responded to all items in this subscale on a 5-point scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). The numbers for the reverse scored items represent the score after being reversed. *****Item has been deleted from the scale

Table 3.1

Inter-item Correlation Matrix of the WG subscale of the CCCS (n = 73)

	WG1R	WG2	WG3R	WG4	WG5	WG6	WG7R	WG8	WG9	WG10	WG11R	WG12	WG13
WG1R	1.0	-.02	.14	-.04	-.04	-.03	-.06	.06	.02	.08	.24	-.03	.04
WG2		1.0	.56	.25	.34	.27	.16	-.10	.25	.23	.37	.16	.37
WG3R			1.0	.05	.35	.29	.10	.03	.16	.15	.22	.03	.30
WG4				1.0	.36	.31	.11	-.04	.32	.32	.51	.42	.43
WG5					1.0	.27	.21	.15	.32	.04	.28	.42	.31
WG6						1.0	.48	-.15	.41	.44	.42	.13	.44
WG7R							1.0	-.18	.46	.52	.36	.16	.48
WG8								1.0	-.03	-.07	-.26	.12	-.12
WG9									1.0	.33	.34	.06	.58
WG10										1.0	.49	.17	.43
WG11R											1.0	.15	.60
WG12												1.0	.29
WG13													1.0

Table 3.2

Inter-item Correlation Matrix of the OC subscale of the CCCS (n = 73)

	OC1	OC2R	OC3	OC4	OC5	OC6R	OC7	OC8R	OC9R	OC10R	OC11	OC12	OC13
OC1	1.0	-.19	.05	.05	-.22	-.08	.13	-.08	.06	.03	.00	.26	.27
OC2R		1.0	-.06	.09	.31	.27	-.01	.27	.30	.34	-.04	.08	-.02
OC3			1.0	.23	.06	.00	-.02	.24	.05	.06	.37	-.16	.08
OC4				1.0	.20	.21	.23	.59	.19	.24	.24	.30	.11
OC5					1.0	.29	.28	.17	.21	.18	-.03	.19	.27
OC6R						1.0	.33	.28	.14	.11	.00	.27	.09
OC7							1.0	.33	.35	.36	.14	.33	.17
OC8R								1.0	.33	.41	.23	.27	.09
OC9R									1.0	.41	.19	.20	.19
OC10R										1.0	.23	.27	-.07
OC11											1.0	.11	-.04
OC12												1.0	.26
OC13													1.0

Table 4

One Way ANOVA's for CCCS total scale and WG & OC subscales, respectively, for Demographic Variables (n = 73)

Demographic Variable	*n*	*M*	*sd*		p-value
CCCS:	**73**	**79.79**	**12.37**		
Gender					
Male	22	76.23	14.56		
Female	51	81.33	11.10	*F(1,71)*	*p* = .106
Highest Degree Earned					
Bachelor's	8	78.50	15.53		
Master's	38	79.97	12.73		
Doctorate	27	79.92	11.30	*F(2,70)*	*p* = .953
Specialization					
Clinical Psychology	24	76.58	11.09		
Counseling Psychology	40	81.58	12.23		
Counseling	5	79.20	18.51		
Social Work	4	82.00	13.88	*F(3,69)*	*p* = .468
Age	118	36.22	12.33		*r* = -.03
WG:	**73**	**40.47**	**7.50**		
Gender					
Male	22	37.64	9.61		
Female	51	41.69	6.09	*F(1,71)*	*p* = .033*
Highest Degree Earned					
Bachelor's	8	39.63	10.88		
Master's	38	41.24	7.45		
Doctorate	27	39.63	6.56	*F(2,70)*	*p* = .664
Specialization					
Clinical Psychology	24	39.21	6.68		
Counseling Psychology	40	41.18	7.73		
Counseling	5	39.80	10.62		
Social Work	4	41.75	7.54	*F(3,69)*	*p* = .763
Age	118	36.22	12.33		*r* = -.10

Table 4- Con.

One Way ANOVA's for CCCS total scale and WG & OC subscales, respectively, for Demographic Variables (n = 73)

Demographic Variable	*n*	*M*	*sd*		p-value
OC:	**73**	**39.33**	**6.16**		
Gender					
Male	22	38.59	5.66		
Female	51	39.65	6.39	*F(1,71)*	*p* = .505
Highest Degree Earned					
Bachelor's	8	38.88	5.96		
Master's	38	38.74	6.49		
Doctorate		40.30	5.82	*F(2,70)*	*p* = .595
Specialization					
Clinical Psychology	24	37.38	6.13		
Counseling Psychology	40	40.40	5.68		
Counseling	5	39.40	8.29		
Social Work	4	40.25	7.93	*F(3,69)*	*p* = .298
Age	118	36.22	12.33		*r* = .05

Note. * $p < .05$

Groups that do not share a subscript have means that are different, using Bonferroni's method of comparing means and using alpha level of .05.

Table 5

Correlations of all subscales and scales in Relation to the CCCS total scale and WG and OC subscales (n = 73)

	CCCS	WG	OC
CCCS	**-----**		
WG	.92**	**-----**	
OC	.87**	.61**	**-----**

Note. ** p < .01

Table 6

Demographic Information of the Sample for Study 2 (CCCS, n = 118)

Age:	
M	36.22
sd	12.33
> 20 < 30	50 (42.4%)
> 30 < 40	31 (26.3%)
> 40	37 (31.4%)
Gender:	
Female	83 (70.3%)
Male	35 (29.7%)
Highest Degree Earned:	
Bachelor's	20 (16.9%)
Master's	57 (48.3%)
Doctoral	41 (34.7%)
Specialization:	
Clinical Psychology	35 (29.7%)
Counseling Psychology	56 (47.5%)
Counselor	20 (16.9%)
Social Work	7 (5.9%)

Table 7.1
Item Level Descriptive Statistics for the "White Guilt" (WG) subscale (n = 73)

Variable	*M (sd)*	Range	Chronbach's Alpha If Item Deleted
White Guilt:[1]			
I feel pressure to be a positive White role model when working with clients of color. (**WG2**)	2.94 (1.26)	1-5	.754
Being accountable to clients of color as a positive White role model is not an aim for me when I deliver therapeutic services. (**WG3R**)	3.27 (1.17)	1-5	.776*
Because clients of color continue to be victims of racism and oppression, it is impossible to accurately assess their psychopathology. (**WG4**)	1.92 (1.05)	1-5	.758
I worry about clients of color perceiving me as a racist. (**WG5**)	2.84 (1.20)	1-5	.748
Because minorities have been treated so Poorly in our society, I feel personally responsible to provide services that don't disadvantage clients of color. (**WG6**)	3.92 (1.05)	1-5	.743
I don't feel burdened by the mistreatment of minority populations in our society. (**WG7R**)	3.84 (.98)	1-5	.743
There are times when I feel personally burdened for society's wrongs concerning the treatment of people of color. (**WG9**)	3.23 (1.21)	1-5	.718
I harbor strong and painful feelings about the mistreatment of minorities in our society. (**WG10**)	3.46 (1.11)	1-5	.734
I am able to provide therapeutic services with a client of color without feeling any personal responsibility for racism/discrimination/oppression. (**WG11R**)	2.64 (1.09)	1-5	.747

Table 7.1- Con.

Item Level Descriptive Statistics for the "White Guilt" (WG) subscale (n = 73)

Variable	*M (sd)*	Range	Chronbach's Alpha If Item Deleted
I am afraid to provide a severe diagnosis to clients of color, because I don't want to be perceived as a racist. (**WG12**)	1.54 (.75)	1-4	.761
I feel guilty about the mistreatment of people of color in our society (**WG13**)	3.31 (1.06)	1-5	.720

Note. [1]Participants responded to all items in this subscale on a 5-point scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). The numbers for the reverse scored items represent the score after being reversed. *Item considered for deletion

Table 7.2
Item Level Descriptive Statistics for the "Overlooking Clients' Contributions o the Presenting Problem" (OC) subscale (n = 73)

Variable	*M (sd)*	Range	Chronbach's Alpha If Item Deleted
OC:[1]			
A client's race/ethnicity is not of concern when attempting to assess their psychopathology. (**OC2R**)	4.61 (.67)	1-5	.762*
In clients of color, many clinical symptoms are the result of experiences with racism/ discrimination/oppression. (**OC4**)	3.39 (.94)	1-5	.716
Clients of color manifest clinical symptoms differently than White clients. (**OC5**)	3.59 (.88)	1-5	.729
Clinical symptoms and diagnoses exist in all client populations, regardless of client race/ethnicity. (**OC6R**)	2.09 (1.18)	1-5	.757
Because of the effects of racism, I see the need to offer different diagnoses for clients of color (compared to White clients) even if the symptoms are similar. (**OC7**)	2.41 (1.03)	1-5	.717
I tend to see client symptomatology instead of race/ethnicity/culture. (**OC8R**)	3.10 (1.11)	1-5	.700
When I work with clients of color, it is important for me to appear impartial concerning race/ethnicity. (**OC9R**)	3.07 (1.10)	1-5	.738
I strictly adhere to DSM-IV criteria when diagnosing a client of color. (**OC10R**)	3.38 (1.00)	1-5	.714

Table 7.2- Con.

Item Level Descriptive Statistics for the "Overlooking Clients' Contributions to the Presenting Problem" (OC) subscale (n = 73)

Variable	*M (sd)*	Range	Chronbach's Alpha If Item Deleted
It is possible that I have minimized clients' of color contributions to psychopathology because I have placed too much weight on the effects of racism. (**OC11**)	2.50 (.97)	1-5	.749
Racism is often the primary cause of minority clients' clinical problems. (**OC12**)	2.40 (.90)	1-5	.707
Minority clients' concerns stem from their minority status. (**OC13**)	2.53 (.89)	1-5	.740

Note. [1]Participants responded to all items in this subscale on a 5-point scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). The numbers for the reverse scored items represent the score after being reversed. *Item considered for deletion

Table 8

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
CCCS:	**118**	**65.97**	**10.72**		
Gender					
Male	35	65.74	12.92		
Female	83	66.07	9.73	*F(1,116)*	*p* = .88
Highest Degree Earned					
Bachelor's	20	66.20	8.90		
Master's	57	66.47	10.38		
Doctorate	41	65.17	12.10	*F(2,115)*	*p* = .84
Specialization					
Social Work $_{a,c}$	7	67.71	7.18		
Counseling $_{b,c}$	20	60.80	9.64		
Counseling Psychology $_{a}$	56	69.80	10.61		
Clinical Psychology $_{b,c}$	35	62.46	9.94	*F(3,114)*	*p* = .00**
Age	118	36.22	12.33		*r* = -.13
WG:	**118**	**32.91**	**6.56**		
Gender					
Male	35	33.03	7.85		
Female	83	32.86	5.98	*F(1,116)*	*p* = .90
Highest Degree Earned					
Bachelor's	20	35.10	5.42		
Master's	57	32.72	6.34		
Doctorate	41	32.10	7.24	*F(2,115)*	*p* = .24
Specialization					
Social Work $_{a,b}$	7	33.71	6.29		
Counseling $_{a,b}$	20	31.65	5.47		
Counseling Psychology $_{a}$	56	34.70	6.54		
Clinical Psychology $_{b}$	35	30.60	6.57	*F(3,114)*	*p* = .02**
Age	118	36.22	12.33		*r* = -.16

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
OC:	**118**	**33.07**	**5.75**		
Gender					
Male	35	32.71	6.69		
Female	83	33.22	5.35	*F(1,116)*	*p* = .67
Highest Degree Earned					
Bachelor's	20	31.10	5.07		
Master's	57	33.75	5.71		
Doctorate	41	33.07	6.03	*F(2,115)*	*p* = .21
Specialization					
Social Work $_{a,c}$	7	34.00	2.31		
Counseling $_{b,c}$	20	29.15	5.56		
Counseling Psychology $_{a}$	56	35.11	5.68		
Clinical Psychology $_{b,c}$	35	31.86	5.10	*F(3,114)*	*p* = .00**
Age	118	36.22	12.33		*r* = -.06
MCI:	**118**	**129.21**	**11.38**		
Gender					
Male	35	129.06	11.18		
Female	83	129.28	11.52	*F(1,116)*	*p* = .92
Highest Degree Earned					
Bachelor's	20	127.90	9.11		
Master's	57	128.26	13.16		
Doctorate	41	131.17	9.52	*F(2,115)*	*p* = .39
Specialization					
Social Work	7	137.29	11.04		
Counseling	20	128.85	8.73		
Counseling Psychology	56	128.73	12.27		
Clinical Psychology	35	128.57	11.11	*F(3,114)*	*p* = .29
Age	118	36.22	12.33		*r* = .24**

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
MCR:	**118**	**24.53**	**3.08**		
Gender					
Male	35	24.34	3.27		
Female	83	24.60	3.02	*F(1,116)*	*p* = .68
Highest Degree Earned					
Bachelor's	20	24.95	3.02		
Master's	57	24.46	3.38		
Doctorate	41	24.41	2.73	*F(2,115)*	*p* = .80
Specialization					
Social Work	7	26.43	1.62		
Counseling	20	24.50	3.17		
Counseling Psychology	56	23.88	3.14		
Clinical Psychology	35	25.20	2.98	*F(3,114)*	*p* = .08
Age	118	36.22	12.33		*r* = .00
MCK:	**118**	**36.90**	**3.69**		
Gender					
Male	35	36.43	4.76		
Female	83	37.10	3.15	*F(1,116)*	*p* = .37
Highest Degree Earned					
Bachelor's	20	36.95	2.52		
Master's	57	36.58	3.62		
Doctorate	41	37.32	4.26	*F(2,115)*	*p* = .62
Specialization					
Social Work	7	38.43	2.23		
Counseling	20	36.35	3.84		
Counseling Psychology	56	37.43	3.24		
Clinical Psychology	35	36.06	4.35	*F(3,114)*	*p* = .20
Age	118	36.22	12.33		*r* = .18

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
MA:	**118**	**37.97**	**3.53**		
Gender					
Male	35	38.23	3.35		
Female	83	37.86	3.61	*F(1,116)*	*p* = .60
Highest Degree Earned					
Bachelor's	20	37.10	3.14		
Master's	57	37.56	3.82		
Doctorate	41	38.95	3.11	*F(2,115)*	*p* = .08
Specialization					
Social Work	7	39.71	3.77		
Counseling	20	38.20	2.97		
Counseling Psychology	56	37.75	3.77		
Clinical Psychology	35	37.83	3.41	*F(3,114)*	*p* = .56
Age	118	36.22	12.33		*r* = .29**
MCS:	**118**	**29.82**	**4.70**		
Gender					
Male	35	30.06	4.35		
Female	83	29.73	4.86	*F(1,116)*	*p* = .73
Highest Degree Earned					
Bachelor's	20	28.90	4.42		
Master's	57	29.67	5.32		
Doctorate	41	30.49	3.84	*F(2,115)*	*p* = .44
Specialization					
Social Work	7	32.71	5.96		
Counseling	20	29.80	3.29		
Counseling Psychology	56	29.68	5.10		
Clinical Psychology	35	29.49	4.43	*F(3,114)*	*p* = .41
Age	118	36.22	12.33		*r* = .23*

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
CoBRAS:	**118**	**37.32**	**11.17**		
Gender					
Male	35	38.37	11.61		
Female	83	36.88	11.02	*F(1,116)*	*p* = .51
Highest Degree Earned					
Bachelor's	20	38.05	9.39		
Master's	57	38.49	12.40		
Doctorate	41	35.34	10.07	*F(2,115)*	*p* = .37
Specialization					
Social Work $_{a,b}$	7	36.43	7.81		
Counseling $_{a}$	20	46.70	11.07		
Counseling Psychology $_{b}$	56	34.41	10.75		
Clinical Psychology $_{b}$	35	36.80	9.85	*F(3,114)*	*p* = .00**
Age	118	36.22	12.33		*r* = -.06
IR:	**118**	**13.65**	**4.84**		
Gender					
Male	35	13.20	4.28		
Female	83	13.84	4.58	*F(1,116)*	*p* = .48
Highest Degree Earned					
Bachelor's $_{a}$	20	14.90	3.63		
Master's $_{a}$	57	14.21	5.02		
Doctorate $_{b}$	41	12.27	3.76	*F(2,115)*	*p* = .04*
Specialization					
Social Work $_{a,b}$	7	13.57	3.10		
Counseling $_{a}$	20	17.50	4.81		
Counseling Psychology $_{b}$	56	12.55	4.28		
Clinical Psychology $_{b}$	35	13.23	3.76	*F(3,114)*	*p* = .00**
Age	118	36.22	12.33		*r* = -.14

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
WRP:	**118**	**14.80**	**5.35**		
Gender					
Male	35	16.03	6.07		
Female	83	14.28	4.97	*F(1,116)*	*p* = .11
Highest Degree Earned					
Bachelor's	20	14.30	4.85		
Master's	57	14.98	5.68		
Doctorate	41	14.78	5.22	*F(2,115)*	*p* = .89
Specialization					
Social Work	7	14.86	4.30		
Counseling	20	17.35	5.43		
Counseling Psychology	56	13.73	5.48		
Clinical Psychology	35	15.03	4.94	*F(3,114)*	*p* = .08
Age	118	36.22	12.33		*r* = .02
BRI:	**118**	**8.87**	**2.99**		
Gender					
Male	35	9.14	2.92		
Female	83	8.76	3.03	*F(1,116)*	*p* = .53
Highest Degree Earned					
Bachelor's	20	8.85	2.56		
Master's	57	9.30	3.34		
Doctorate	41	8.29	2.62	*F(2,115)*	*p* = .26
Specialization					
Social Work $_a$	7	8.00	1.91		
Counseling $_b$	20	11.85	3.62		
Counseling Psychology $_a$	56	8.13	2.46		
Clinical Psychology $_a$	35	8.54	2.57	*F(3,114)*	*p* = .00**
Age	118	36.22	12.33		*r* = -.05

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
R:	**118**	**24.53**	**4.63**		
Gender					
Male	35	24.51	4.62		
Female	83	24.53	4.66	*F(1,116)*	*p* = .99
Highest Degree Earned					
Bachelor's	20	24.60	3.76		
Master's	57	24.33	4.98		
Doctorate	41	24.76	4.60	*F(2,115)*	*p* = .90
Specialization					
Social Work	7	22.71	3.30		
Counseling	20	22.75	4.83		
Counseling Psychology	56	25.55	4.81		
Clinical Psychology	35	24.26	4.14	*F(3,114)*	*p* = .08
Age	118	36.22	12.33		*r* = -.05
DI:	**118**	**44.77**	**3.20**		
Gender					
Male	35	43.91	3.54		
Female	83	45.13	2.99	*F(1,116)*	*p* = .06
Highest Degree Earned					
Bachelor's	20	45.55	2.54		
Master's	57	44.91	3.12		
Doctorate	41	44.20	3.54	*F(2,115)*	*p* = .27
Specialization					
Social Work	7	44.00	3.27		
Counseling	20	45.60	2.37		
Counseling Psychology	56	44.45	3.58		
Clinical Psychology	35	44.97	2.95	*F(3,114)*	*p* = .49
Age	118	36.22	12.33		*r* = -.18

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
Av:	**118**	**10.85**	**4.24**		
Gender					
Male	35	12.57	4.98		
Female	83	10.12	3.69	*F(1,116)*	*p* = .00**
Highest Degree Earned					
Bachelor's	20	10.20	3.35		
Master's	57	11.33	4.69		
Doctorate	41	10.49	3.99	*F(2,115)*	*p* = .48
Specialization					
Social Work	7	9.86	3.48		
Counseling	20	13.05	5.35		
Counseling Psychology	56	10.61	4.19		
Clinical Psychology	35	10.17	3.45	*F(3,114)*	*p* = .08
Age	118	36.22	12.33		*r* = .04
C:	**118**	**4.26**	**1.52**		
Gender					
Male	35	4.69	1.73		
Female	83	4.08	1.40	*F(1,116)*	*p* = .049*
Highest Degree Earned					
Bachelor's	20	4.50	1.19		
Master's	57	4.37	1.78		
Doctorate	41	4.00	1.25	*F(2,115)*	*p* = .37
Specialization					
Social Work	7	4.00	1.15		
Counseling	20	4.50	1.76		
Counseling Psychology	56	4.25	1.34		
Clinical Psychology	35	4.20	1.75	*F(3,114)*	*p* = .86
Age	118	36.22	12.33		*r* = -.05

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
De:	**118**	**4.82**	**2.09**		
Gender					
Male	35	5.31	2.23		
Female	83	4.61	2.01	*F(1,116)*	*p* = .098
Highest Degree Earned					
Bachelor's	20	5.40	2.52		
Master's	57	4.61	2.12		
Doctorate	41	4.83	1.82	*F(2,115)*	*p* = .36
Specialization					
Social Work	7	4.14	2.19		
Counseling	20	4.55	1.76		
Counseling Psychology	56	4.89	1.34		
Clinical Psychology	35	5.00	1.75	*F(3,114)*	*p* = .71
Age	118	36.22	12.33		*r* = -.10
Dis:	**118**	**8.50**	**2.50**		
Gender					
Male	35	9.09	3.15		
Female	83	8.25	2.63	*F(1,116)*	*p* = .14
Highest Degree Earned					
Bachelor's	20	8.10	2.69		
Master's	57	8.79	3.01		
Doctorate	41	8.29	2.57	*F(2,115)*	*p* = .54
Specialization					
Social Work	7	9.00	2.08		
Counseling	20	7.85	2.60		
Counseling Psychology	56	9.05	2.80		
Clinical Psychology	35	7.89	2.94	*F(3,114)*	*p* = .16
Age	118	36.22	12.33		*r* = .06

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
SCS:	**118**	**77.99**	**11.12**		
Gender					
Male	35	78.80	11.17		
Female	83	77.65	11.15	*F(1,116)*	*p* = .61
Highest Degree Earned					
Bachelor's	20	82.25	8.63		
Master's	57	78.42	11.02		
Doctorate	41	75.32	11.82	*F(2,115)*	*p* = .07
Specialization					
Social Work	7	78.86	6.74		
Counseling	20	76.85	10.05		
Counseling Psychology	56	78.48	11.09		
Clinical Psychology	35	77.69	12.67	*F(3,114)*	*p* = .94
Age	118	36.22	12.33		*r* = -.26**
PrSC:	**118**	**38.21**	**4.73**		
Gender					
Male	35	38.37	4.58		
Female	83	38.15	4.82	*F(1,116)*	*p* = .81
Highest Degree Earned					
Bachelor's	20	37.55	5.29		
Master's	57	39.04	4.39		
Doctorate	41	37.39	4.83	*F(2,115)*	*p* = .19
Specialization					
Social Work	7	39.71	3.73		
Counseling	20	38.30	4.76		
Counseling Psychology	56	37.98	4.77		
Clinical Psychology	35	38.23	4.95	*F(3,114)*	*p* = .84
Age	118	36.22	12.33		*r* = -.21*

Table 8- Con.

One Way ANOVA's (and correlation for Age) for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
PuSC:	**118**	**23.14**	**5.43**		
Gender					
Male	35	23.26	5.61		
Female	83	23.10	5.39	*F(1,116)*	*p* = .88
Highest Degree Earned					
Bachelor's$_{a}$	20	25.45	4.36		
Master's $_{a,b}$	57	23.39	5.35		
Doctorate$_{b}$	41	21.68	5.68	*F(2,115)*	*p* = .03*
Specialization					
Social Work	7	22.29	5.22		
Counseling	20	23.05	4.67		
Counseling Psychology	56	23.57	5.61		
Clinical Psychology	35	22.69	5.73	*F(3,114)*	*p* = .86
Age	118	36.22	12.33		*r* = -.29**
SaSC:	**118**	**16.64**	**5.29**		
Gender					
Male	35	17.17	5.58		
Female	83	16.41	5.18	*F(1,116)*	*p* = .48
Highest Degree Earned					
Bachelor's $_{a}$	20	19.25	4.31		
Master's $_{a,b}$	57	16.00	5.47		
Doctorate $_{b}$	41	16.24	5.18	*F(2,115)*	*p* = .05*
Specialization					
Social Work	7	16.86	2.54		
Counseling	20	15.50	3.83		
Counseling Psychology	56	16.93	5.81		
Clinical Psychology	35	16.77	5.58	*F(3,114)*	*p* = .77
Age	118	36.22	12.33		*r* = -.06

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
RSM:	**118**	**44.50**	**6.00**		
Gender					
Male	35	45.31	6.93		
Female	83	44.16	5.58	*F(1,116)*	*p* = .34
Highest Degree Earned					
Bachelor's	20	45.65	6.56		
Master's	57	44.91	6.40		
Doctorate	41	43.37	5.05	*F(2,115)*	*p* = .29
Specialization					
Social Work $_{a,b}$	7	45.57	6.60		
Counseling $_{a}$	20	48.15	6.77		
Counseling Psychology $_{b}$	56	43.09	5.29		
Clinical Psychology $_{a,b}$	35	44.46	5.84	*F(3,114)*	*p* = .01**
Age	118	36.22	12.33		*r* = -.04
SMA:	**118**	**22.40**	**3.75**		
Gender					
Male	35	22.69	4.23		
Female	83	22.28	3.56	*F(1,116)*	*p* = .59
Highest Degree Earned					
Bachelor's	20	22.60	4.06		
Master's	57	22.81	3.77		
Doctorate	41	21.73	3.58	*F(2,115)*	*p* = .37
Specialization					
Social Work	7	23.00	4.47		
Counseling	20	24.10	3.54		
Counseling Psychology	56	21.66	3.62		
Clinical Psychology	35	22.49	3.75	*F(3,114)*	*p* = .09
Age	118	36.22	12.33		*r* = .02

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
SMS:	**118**	**22.10**	**3.47**		
Gender					
Male	35	22.63	3.80		
Female	83	21.88	3.33	*F(1,116)*	*p* = .29
Highest Degree Earned					
Bachelor's	20	23.05	3.66		
Master's	57	22.11	3.82		
Doctorate	41	21.63	2.81	*F(2,115)*	*p* = .33
Specialization					
Social Work $_{a,b}$	7	22.57	3.21		
Counseling $_{a}$	20	24.05	3.97		
Counseling Psychology $_{b}$	56	21.43	3.24		
Clinical Psychology $_{a,b}$	35	21.97	3.31	*F(3,114)*	*p* = .03*
Age	118	36.22	12.33		*r* = -.10
ES:	**118**	**80.44**	**7.48**		
Gender					
Male	35	78.54	8.01		
Female	83	81.24	7.15	*F(1,116)*	*p* = .07
Highest Degree Earned					
Bachelor's	20	81.75	6.10		
Master's	57	80.23	9.07		
Doctorate	41	80.10	5.46	*F(2,115)*	*p* = .69
Specialization					
Social Work	7	82.29	7.83		
Counseling	20	76.80	7.33		
Counseling Psychology	56	81.14	7.54		
Clinical Psychology	35	81.02	7.08	*F(3,114)*	*p* = .12
Age	118	36.22	12.33		*r* = -.18

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
EAS:	**118**	**40.43**	**5.84**		
Gender					
Male	35	38.57	6.24		
Female	83	41.22	5.52	*F(1,116)*	*p* = .02*
Highest Degree Earned					
Bachelor's	20	42.15	3.82		
Master's	57	40.25	7.30		
Doctorate	41	39.85	4.06	*F(2,115)*	*p* = .34
Specialization					
Social Work	7	42.43	5.88		
Counseling	20	37.60	6.48		
Counseling Psychology	56	41.16	5.73		
Clinical Psychology	35	40.49	5.33	*F(3,114)*	*p* = .09
Age	118	36.22	12.33		*r* = -.22*
ECS:	**118**	**40.00**	**3.38**		
Gender					
Male	35	39.97	3.70		
Female	83	40.02	3.26	*F(1,116)*	*p* = .94
Highest Degree Earned					
Bachelor's	20	39.60	15.53		
Master's	57	39.98	12.73		
Doctorate	41	40.24	11.30	*F(2,115)*	*p* = .78

Table 8- Con.

One Way ANOVA's for all subscales and total scales in the CCCS validation study for the Demographic Variables (n = 118)

Demographic Variable	*n*	*M*	*sd*		p-value
Specialization					
Social Work	7	39.86	2.91		
Counseling	20	39.20	3.62		
Counseling Psychology	56	39.98	3.33		
Clinical Psychology	35	40.54	3.46	*F(3,114)*	*p* = .57
Age	118	36.22	12.33		*r* = -.02

Note. ** p < .01

* p < .05

Groups that do not share a subscript have means that are different, using Bonferroni's method of comparing means and using alpha level of .05.

Table 9

Correlations of all subscales and scales in Relation to the CCCS total scale and WG and OC subscales (n = 118)

	CCCS	WG	OC
CCCS	**-----**		
WG	.89**	**-----**	
OC	.85**	.51**	**-----**
MCI	.04	.09	-.03
MCR	-.29**	-.24**	-.26**
MCK	.29**	.30**	.20*
MA	-.10	-.05	-.13
MCS	.12	.17	.04
CoBRAS	-.53**	-.45**	-.47**
IR	-.52**	-.44**	-.47**
WRP	-.48**	-.40**	-.45**
BRI	-.33**	-.29**	-.27**
R	.60**	.58**	.45**
DI	-.15	-.05	-.22*
Av	-.32**	-.29**	-.25**
C	-.12	-.11	-.11
De	.14	.16	.07
Dis	.26**	.21**	.24**

Table 9- Con.

Correlations of all subscales and scales in Relation to the CCCS total scale and WG and OC subscales (n = 118)

	CCCS	WG	OC
SCS	.18*	.25**	.06
PrSC	.14	.22*	.01
PuSC	.20*	.26**	.08
SaSC	.06	.06	.04
RSM	-.16	-.05	-.24**
SMA	-.23*	-.17	-.24**
SMS	-.03	.09	-.16
ES	.22*	.27**	.11
EAS	.29**	.33**	.16
ECS	-.01	.02	-.04

Note. ** $p < .01$
* $p < .05$

Table 10

Discriminant Validity Computation for Statistically Significant Correlations between CCCS full scale and subscales and other Scales and Subdscales used in the Study (n = 118)

Variables	r_{xy}	r_{xx}	r_{yy}	validity coefficient
CCCS & MCR	-.29	.83	.62	-.40
CCCS & MCK	.29	.83	.78	.36
CCCS & CoBRAS	-.53	.83	.88	-.62
CCCS & IR	-.52	.83	.78	-.65
CCCS & WRP	-.48	.83	.80	-.59
CCCS & BRI	-.33	.83	.61	-.46
CCCS & R	.60	.83	.73	.77
CCCS & Av	-.32	.83	.54	-.48
CCCS & Dis	.26	.83	.54	.39
WG & OC (Study 1)	.61	.83	.74	.78
WG & OC (Study 2)	.51	.77	.76	.67
WG & MCR	-.24	.77	.62	-.35
WG & MCK	.30	.77	.78	.39
WG & CoBRAS	-.45	.77	.88	-.55
WG & IR	-.44	.77	.78	-.57

Table 10- Con.

Discriminant Validity Computation for Statistically Significant Correlations on all Scales and Subdscales used in the Study (n = 118)

Variables	r_{xy}	r_{xx}	r_{yy}	validity coefficient
WG & WRP	-.40	.77	.80	-.51
WG & BRI	-.29	.77	.61	-.42
WG & R	.58	.77	.73	.47
WG & Av	-.29	.77	.54	-.45
WG & Dis	.21	.77	.54	.33
OC & MCR	-.26	.76	.62	-.38
OC & MCK	.20	.76	.78	.26
OC & CoBRAS	-.47	.76	.88	-.57
OC & IR	-.47	.76	.78	-.61
OC & WRP	-.45	.76	.80	-.58
OC & BRI	-.27	.76	.61	-.40
OC & R	.45	.76	.73	.60
OC & Av	-.25	.76	.54	-.39
OC & Dis	.24	.76	.54	.37
OC & DI	-.22	.76	.46	-.37

Note. The following formula was used to arrive at the validity coefficient $r_{xy} / \sqrt{(r_{xx} * r_{yy})}$, where r_{xy} refers to the correlation between the two particular variables in question and r_{xx} refers to the reliability coefficient of the first variable and r_{yy} refers to the reliability coefficient of the second variable.

Table 11.1
Summary of Hierarchical Regression Analyses for Variables Predicting SCS (n = 118)

Variable	R	R^2	R^2 Change	*B*	*SE B*	β
Step 1						
Age	.26	.07	.07	-.23	.08	-.26*
Step 2						
CCCS	.30	.10	.03	.25	.11	.18*
Step 1						
Age	.26	.07	.07	-.23	.08	-.26**
Step 2						
WG	.33	.11	.04	.36	.15	.21*

Note. * $p < .05$ ** $p < .01$

Table 11.2
Summary of Hierarchical Regression Analyses for Variables Predicting PuSC (n = 118)

Variable	R	R^2	R^2 Change	*B*	*SE B*	β
Step 1						
Age	.29	.08	.08	-.13	.04	-.29*
Step 2						
CCCS	.33	.11	.03	.09	.05	.17**
Step 1						
Age	.29	.08	.08	-.13	.04	-.29**
Step 2						
WG	.36	.13	.05	.18	.07	.22*
Step 1						
Degree	.24	.06	.06	.36	.29	-.01*
Step 2						
CCCS	.31	.09	.03	.05	.19	.26*
Step 1						
Degree	.24	.06	.06	.36	.29	-.01*
Step 2						
WG	.33	.11	.05	.19	.07	.23**

Note. * $p < .05$ ** $p < .01$

Table 11.3

Summary of Hierarchical Regression Analyses for Variables Predicting PrSC (n = 118)

Variable	R	R^2	R^2 Change	*B*	*SE B*	β
Step 1						
Age	.21	.04	.04	-.08	.04	-.21*
Step 2						
WG	.28	.08	.04	.14	.07	.19*

Note. * $p < .05$

Table 11.4
Summary of Hierarchical Regression Analyses for Variables Predicting EAS (n = 118)

Variable	R	R^2	R^2 Change	*B*	*SE B*	β
Step 1						
Age	.22	.05	.05	-.10	.04	-.22*
Step 2						
CCCS	.34	.12	.07	.14	.05	.26**
Step 1						
Age	.22	.05	.05	-.10	.04	-.22*
Step 2						
WG	.37	.14	.09	.27	.08	.30**
Step 1						
Gender	.21	.04	.04	-2.65	1.16	-.21*
Step 2						
CCCS	.35	.12	.08	.16	.05	.28**
Step 1						
Gender	.21	.04	.04	-2.65	1.16	-.21*
Step 2						
WG	.39	.15	.11	.30	.08	.33**

Note. * $p < .05$ ** $p < .01$

Table 11.5

Summary of Hierarchical Regression Analyses for Variables Predicting RSM (n = 118)

Variable	R	R^2	R^2 Change	*B*	*SE B*	β
Step 1						
Specialization	.30	.09	.09	8.90	6.07	.52*
Step 2						
OC	.34	.11	.02	-.16	.17	.16[1]

Note. * $p < .05$ [1] $p = .11$

Table 11.6

Summary of Hierarchical Regression Analyses for Variables Predicting SMS (n = 118)

Variable	R	R^2	R^2 Change	*B*	*SE B*	β
Step 1						
Specialization	.27	.07	.07	4.30	2.97	.43*
Step 2						
OC	.28	.08	.01	-.05	.06	-.08[1]

Note. * $p < .05$ [1] $p = .42$

Table 12

Bivariate Correlations of all subscales and scales used in the study except for the CCCS, WG, and OC scale and subscales (n = 118)

	MCI	MCR	MCK	MA	MCS	CoBRAS	IR	WRP	BRI	R	DI	Av	C
MCI	----												
MCR	.57**	----											
MCK	.77**	.21**	----										
MA	.78**	.37**	.46**	-----									
MCS	.85**	.28**	.61**	.54**	-----								
CoBRAS	-.25**	.04	-.41**	-.15	-.19*	-----							
IR	-.20*	.10	-.34**	-.14	-.18*	.88**	-----						
WRP	-.18	.04	-.35**	-.09	-.11	.91**	.68**	-----					
BRI	-.30**	-.07	-.38**	-.19*	-.23*	.79**	.59**	.59**	-----				
R	.15	-.11	.35**	.03	.13	-.73*	-.69**	-.69**	-.46**	----			
DI	.32**	.36**	.19*	.36**	.11	-.10	-.01	-.24*	-.18	-.09	----		
Av	-.26**	-.13	-.36**	-.21**	-.10	.77**	.62**	.78**	.56**	-.61**	-.41**	----	
C	-.35**	-.09	-.37**	-.27**	-.29**	.50**	.40**	.42**	.50**	-.27**	-.26**	.49**	-----
De	-.34**	-.30**	-.27**	-.24**	-.23**	.00	-.09	.06	.02	.08	-.30**	.14	.25*
Dis	-.24**	-.35**	-.08	-.31**	-.06	.11	.05	.14	.07	-.05	-.42**	.27**	.32**
SCS	-.18	-.15	-.01	-.21*	-.17	.07	.09	.11	-.07	-.01	-.10	.04	.08
PrSC	.15	.07	.19*	.10	.08	-.03	-.03	.03	-.13	.08	.13	.00	-.12
PuSC	-.20*	-.16	-.03	-.27**	-.15	.11	.11	.11	.05	.02	-.03	.07	.09
SaSC	-.31**	-.22*	-.16	-.26**	-.28**	.06	.09	.09	-.08	-.13	-.29**	.02	.18*
RSM	.10	.17	-.09	.16	.09	.34**	.34**	.31**	.22*	-.18	.03	.25**	-.07
SMA	.06	.16	-.11	.07	.08	.28**	.26**	.26**	.22*	-.18	.07	.18	-.06
SMS	.10	.12	-.04	.19*	.06	.28**	.30**	.26**	.15	-.11	-.03	.24**	-.07
ES	.09	-.05	.09	.11	.09	-.27**	-.27**	-.21*	-.24**	.24**	.19*	-.20*	-.15
EAS	-.09	-.21*	.03	-.12	-.01	-.25**	-.26**	-.19*	-.21*	.28**	.07	-.18	-.07
ECS	.34**	.25**	.15	.44**	.22**	-.17	-.15	-.13	-.17	.04	.29**	-.13	-.22*

Note. ** $p < .01$
* $p < .05$

Table 12- Con.

Bivariate Correlations of all subscales and scales used in the study except for the CCCS, WG, and OC scale and subscales (n = 118)

	De	Dis	SCS	PrSC	PuSC	SaSC	RSM	SMA	SMS	ES	EAS	ECS
De	----											
Dis	.22*	----										
SCS	.09	.15	-----									
PrSC	-.06	.02	.68**	----								
PuSC	.04	.18	.82**	.44**	----							
SaSC	.21*	.11	.66**	.30**	.30**	----						
RSM	-.02	-.02	.19*	.29**	.18*	-.06	----					
SMA	-.01	-.02	10	.18	.15	.10	.85**	----				
SMS	-.02	-.02	.21*	.32**	.16	.00	.82**	.38**	----			
ES	-.16	-.16	.13	.23*	.10	-.04	.13	.00	.23*	----		
EAS	-.07	-.07	.14	.13	.15	.03	.01	-.07	.10	.90**	----	
ECS	-.22*	-.22*	.04	.29**	-.03	-.15	.27**	.11	.34**	.66**	.26**	----

Note. ** $p < .01$
* $p < .05$

Appendix A: Multicultural Counseling Inventory (MCI)

The scale ranges from 1 (very inaccurate) to 4 (very accurate). The scale indicates the following:

1- very inaccurate
2- somewhat inaccurate
3- somewhat accurate
4- very accurate

When working with minority clients, …

1.	(MCR1R) I perceive that my race causes the clients to mistrust me.*	1	2	3	4
2.	(MCR2R) I have feelings of overcompensation, oversolicitation, and guilt that I do not have when working with majority clients.*	1	2	3	4
3.	(MCR3) I am confident that my conceptualization of client problems does not consist of stereotypes and value-oriented biases	1	2	3	4
4.	(MCR4R) I find that differences between my worldviews and those of the clients impede the counseling process.*	1	2	3	4
5.	(MCR5R) I have difficulties communicating with clients who use a perceptual, reasoning, or decision-making style that is different from mine.*	1	2	3	4
6.	(MCK1) I include the facts of age, gender roles, and socioeconomic status in my understanding of different minority cultures.	1	2	3	4
7.	(MCK2) I use innovative concepts and treatment methods.	1	2	3	4
8.	(MCK3) I manifest and outlook on life that is best described as "world-minded" or pluralistic.	1	2	3	4
9.	(MCK4) I examine my own cultural biases.	1	2	3	4
10.	(MCR6R) I tend to compare client behaviors with those of majority majority group members.*	1	2	3	4
11.	(MCK5) I keep in mind research findings about minority clients' preferences in counseling.	1	2	3	4
12.	(MCK6) I know what are the changing practices, views, and interests of people at the present time.	1	2	3	4
13.	(MCK7) I consider the range of behaviors, values, and individual differences within a minority group.	1	2	3	4

14. (MCK8) I make referrals or seek consultations based on the clients' minority identity development. 1 2 3 4

15. (MCR7R) I feel my confidence is shaken by the self-examination of my personal limitations.* 1 2 3 4

16. (MCK9) I monitor and correct my defensiveness (e.g., anxiety, denial, anger, fear, minimizing, overconfidence). 1 2 3 4

17. (MCK10) I apply the sociopolitical history of the clients' respective minority groups to understand them better. 1 2 3 4

18. (MCS1) I am successful at seeing 50% of the clients more than once, not including intake. 1 2 3 4

19. (MCR8R) I experience discomfort because of the clients' different physical appearance, color, dress, or socioeconomic status.* 1 2 3 4

20. (MCS2) I am able to quickly recognize and recover from cultural mistakes or misunderstandings. 1 2 3 4

21. (MCS3) I use several methods of assessment (including free response questions, observations, and varied sources of information, excluding standardized tests). 1 2 3 4

22. (MA1) I have experience at solving problems in unfamiliar settings. 1 2 3 4

23. (MCK11) I learn about clients' different ways of acculturation to the dominant Society to understand the clients better. 1 2 3 4

24. (MCS4) I understand my own philosophical preferences. 1 2 3 4

25. (MA2) I have a working understanding of certain cultures (including African-American, Native American, Hispanic, Asian American, new Third World immigrants, and international students). 1 2 3 4

26. (MCS5) I am able to distinguish between those who need brief, problem-solving, structured therapy, and those who need long-term, process-oriented, unstructured therapy. 1 2 3 4

27. (MA3) When working with international students or immigrants, I understand the importance of the legalities of visa, passport, green card, and naturalization. 1 2 3 4

Evaluate the degree to which the following multicultural statements can be applied to you.

28. (MA4) My professional or collegial interactions with minority individuals are extensive. 1 2 3 4

29. (MA5) In the past year, I have had a 50% increase in my multicultural case load. 1 2 3 4

30. (MA6) I enjoy multicultural interactions as much as interactions with people of my own culture. 1 2 3 4

31. (MA7) I am involved in advocacy efforts against institutional barriers in mental health services for minority clients (e.g., lack of bilingual staff, multiculturally skilled counselors, racial and ethnic minority counselors, minority professional leadership, and outpatient counseling facilities). 1 2 3 4

32. (MA8) I am familiar with nonstandard English. 1 2 3 4

33. (MA9) My life experiences with minority individuals are extensive (e.g., via ethnically integrated neighborhoods, marriage, and friendship). 1 2 3 4

34. (MA10) In order to be able to work with minority clients, I frequently seek consultation with multicultural experts and attend multicultural workshops or training sessions. 1 2 3 4

When working with all clients, …

35. (MCS6) I am effective at crisis interventions (e.g., suicide attempt, tragedy, broken relationships). 1 2 3 4

36. (MCS7) I use varied counseling techniques and skills. 1 2 3 4

37. (MCS8) I am able to be concise and to the point when reflecting, clarifying, and probing. 1 2 3 4

38. (MCS9) I am comfortable with exploring sexual issues. 1 2 3 4

39. (MCS10) I am skilled at getting a client to be specific in defining and clarifying problems. 1 2 3 4

40. (MCS11) I make my nonverbal and verbal responses congruent. 1 2 3 4

Appendix B: Color Blind Racial Attitudes Scale (CoBRAS)

The scale ranges from 1 (not at all appropriate or clear) to 6 (very appropriate or clear).

The scale indicates the following:

1- Strongly disagree
2- Somewhat disagree
3- Neither disagree, nor agree
4- Somewhat agree
5- Strongly agree

1. (IR1) Everyone who works hard, no matter what race they are, has an equal chance to become rich. 1 2 3 4 5
2. (IR2R) Race plays a major role in the type of social services (such as type of health care or day care) that people receive in the US.* 1 2 3 4 5
3. (WRP1) It is important that people begin to think of themselves as American And not African American, Mexican American, or Italian American. 1 2 3 4 5
4. (WRP2R) Due to racial discrimination, programs such as affirmative action are necessary to help create equality.* 1 2 3 4 5
5. (BRI1R) Racism is a major problem in the US. 1 2 3 4 5
6. (IR3R) Race is very important in determining who is successful and who is not.* 1 2 3 4 5
7. (BRI2) Racism may have been a problem in the past, it is not an important problem today. 1 2 3 4 5
8. (IR4R) Racial and ethnic minorities do not have the same opportunities as white people in the US.* 1 2 3 4 5
9. (WRP3) White people in the US are discriminated against because of the color of their skin. 1 2 3 4 5
10. (BRI3) Talking about racial issues causes unnecessary tension. 1 2 3 4 5

11. (BRI4R) It is important for political leaders to talk about racism to help work through or solve society's problems.* 1 2 3 4 5

12. (IR5R) White people in the US have certain advantages because of the color of their skin.* 1 2 3 4 5

13. (WRP4) Immigrants should try to fit into the culture and values of the US. 1 2 3 4 5

14. (WRP5) English should be the only language in the US. 1 2 3 4 5

15. (IR6R) White people are more to blame for racial discrimination than racial and ethnic minorities.* 1 2 3 4 5

16. (WRP6) Social policies, such as affirmative action, discriminate unfairly against white people. 1 2 3 4 5

17. (BRI5R) It is important for public schools to teach about the history and contributions of racial and ethnic minorities.* 1 2 3 4 5

18. (WRP7) Racial and ethnic minorities in the US have certain advantages because of the color of their skin. 1 2 3 4 5

19. (BRI6) Racial problems in the US are rare, isolated situations. 1 2 3 4 5

20. (IR7R) Race plays a huge role in who gets sent to prison.* 1 2 3 4 5

Appendix C: Oklahoma Racial Attitudes Scale (ORAS)

The scale ranges from 1 (strongly disagree) to 5 (strongly agree).

The scale indicates the following:

1- Strongly disagree
2- Somewhat disagree
3- Neither disagree, nor agree
4- Somewhat agree
5- Strongly agree

1. (Q1) I can accept minorities intellectually, yet emotionally I'm not really sure.	1	2	3	4	5
2. (R1) Minorities deserve special help in education.	1	2	3	4	5
3. (DI1R) Minority cultures are pretty backward when you compare them to White cultures.*	1	2	3	4	5
4. (C1) Welfare programs are used too much by minorities.	1	2	3	4	5
5. (DI2) In selecting my friends, race and culture are just not important.	1	2	3	4	5
6. (Av1) I avoid discussions that have to do with racial issues.	1	2	3	4	5
7. (R2) Being White gives us a responsibility toward minorities.	1	2	3	4	5
8. (DI3R) I don't want to deal much with minorities because they are different in ways that I don't like.*	1	2	3	4	5
9. (C2) Minorities have more influence on government programs than they should have.	1	2	3	4	5
10. (DI4) I don't mind being one of the few Whites in a group of minority people.	1	2	3	4	5
11. (De1) Other people's opinions have largely determined how I feel about minorities.	1	2	3	4	5
12. (R3) Sometimes I feel guilty about being White when I think about all the bad things Whites have done to minorities.	1	2	3	4	5
13. (DI5R) I believe that minority people are probably not as smart as Whites.*	1	2	3	4	5
14. (C3) Previous ethnic groups, such as the Irish or Italians, adapted to American culture without massive government aid programs, and that is what minorities today should do.	1	2	3	4	5

15. (DI6) I am comfortable with my non-racist attitude toward minorities. 1 2 3 4 5

16. (Dis1) Because I'm really not sure about how I feel, I'm looking for answers to questions I have about minority issues. 1 2 3 4 5

17. (R4) Whites have an unfair advantage over minorities. 1 2 3 4 5

18. (DI7R) I would not like it if a friend had an intimate relationship with a minority person.* 1 2 3 4 5

19. (C4) Minorities deserve to be treated fairly, but they demand too much. 1 2 3 4 5

20. (DI8R) Whites are commonly less emotional or impulsive than minorities.* 1 2 3 4 5

21. (Av2) Racial issues may be important, but I don't want to think about them. 1 2 3 4 5

22. (R5) I believe that it is society's responsibility to help minority people whether they want it or not. 1 2 3 4 5

23. (DI9R) Whites usually have higher goals than minorities.* 1 2 3 4 5

24. (C5) Over the past few years the government has paid more attention to minority concerns than they deserve. 1 2 3 4 5

25. (DI10R) If a minority family with about the same income and education as I have moved next door, I would not like it at all.* 1 2 3 4 5

26. (Dis2) I'm really not sure about how I feel about minorities. 1 2 3 4 5

27. (R6) It's impossible to get a fair deal if you are a minority person. 1 2 3 4 5

28. (De2) My attitudes toward minorities are really based on what others have told me. 1 2 3 4 5

29. (C6) Minorities get more media attention than is necessary. 1 2 3 4 5

30. (Av3) I don't really want to think about minority concerns. 1 2 3 4 5

31. (R7) The advantages that Whites get are taken for granted. 1 2 3 4 5

32. (Dis3) I am really having to change my thinking about minorities. 1 2 3 4 5

33. (C7) About all that is necessary to achieve racial equality in the U.S. has been done. 1 2 3 4 5

34. (De3) What I think about minorities is pretty much based on what I've heard others say. 1 2 3 4 5

35. (Dis4) My feelings about minorities are mixed compared to what I used to think. 1 2 3 4 5

Appendix D: Counselor Color Consciousness Scale (CCCS)

The scale ranges from 1 (strongly disagree) to 5 (strongly agree).

The scale indicates the following:

1- Strongly disagree
2- Somewhat disagree
3- Neither disagree, nor agree
4- Somewhat agree
5- Strongly agree

White Guilt:

1. (WG1R) I don't openly discuss issues of race and culture with my client.* 1 2 3 4 5

2. (WG2) I feel pressure to be a positive White role model when working with clients of color. 1 2 3 4 5

3. (WG3R) Being accountable to clients of color as a positive White role model is not an aim for me when I deliver therapeutic services.* 1 2 3 4 5

4. (WG4) The effect of racism/discrimination is the most important variable to understand when assessing clients of color. 1 2 3 4 5

5. (OC1) Because clients of color continue to be victims of racism and oppression, it is impossible to accurately assess their psychopathology. 1 2 3 4 5

6. (OC2R) A client's race/ethnicity is not of concern when attempting to assess their psychopathology.* 1 2 3 4 5

7. (OC3) Clients of color typically have some presence of "cultural paranoia" because of the effect of racism in our society. 1 2 3 4 5

8. (OC4) In clients of color, many clinical symptoms are the result of experiences with racism/discrimination/oppression. 1 2 3 4 5

9. (OC5) Clients of color manifest clinical symptoms differently than White clients. 1 2 3 4 5

10. (WG5) I worry about clients of color perceiving me as a racist. 1 2 3 4 5

11. (WG6) Because minorities have been treated so poorly in our society, I feel personally responsible to provide services that don't disadvantage clients of color. 1 2 3 4 5

12. (OC6R) Clinical symptoms and diagnoses exist in all client populations, regardless of client race/ethnicity.* 1 2 3 4 5

13. (OC7) Because of the effects of racism, I see the need to offer different diagnoses for clients of color (compared to White clients) even if the symptoms are similar. 1 2 3 4 5

14. (OC8R) I tend to see client symptomatology instead of race/ethnicity/culture.* 1 2 3 4 5

15. (OC9R) When I work with clients of color, it is important for me to appear impartial concerning race/ethnicity.* 1 2 3 4 5

16. (OC10R) I strictly adhere to DSM-IV criteria when diagnosing a client of color.* 1 2 3 4 5

17. (OC11) It is possible that I have minimized clients' of color contributions to psychopathology because I have placed too much weight on the effects of racism. 1 2 3 4 5

18. (WG7R) I don't feel burdened by the mistreatment of minority populations in our society.* 1 2 3 4 5

19. (WG8) It is important for me that my clients of color know I am not racist. 1 2 3 4 5

20. (WG9) There are times when I feel personally burdened for society's wrongs concerning the treatment of people of color. 1 2 3 4 5

21. (WG10) I harbor strong and painful feelings about the mistreatment of minorities in our society. 1 2 3 4 5

22. (WG11R) I am able to provide therapeutic services with a client of color without feeling any personal responsibility for racism/discrimination/oppression.* 1 2 3 4 5

23. (WG12) I am afraid to provide a severe diagnosis to clients of color, because I don't want to be perceived as a racist. 1 2 3 4 5

24. (WG13) I feel guilty about the mistreatment of people of color in our society. 1 2 3 4 5

25. (OC12) Racism is often the primary cause of minority clients' clinical problems. 1 2 3 4 5

26. (OC13) Minority clients' concerns stem from their minority status. 1 2 3 4 5

Appendix E: Self-Consciousness Scale (SCS)

The scale ranges from 1 (strongly disagree) to 5 (strongly agree).

The scale indicates the following:

1- Strongly disagree
2- Somewhat disagree
3- Neither disagree, nor agree
4- Somewhat agree
5- Strongly agree

1. (PrSC1) I'm always trying to figure myself out. 1 2 3 4 5

2. (PuSC1) I'm concerned about my style of doing things. 1 2 3 4 5
3. (PrSC2R) Generally, I'm not very aware of myself.* 1 2 3 4 5

4. (SaSC1) It takes me time to overcome my shyness in new situations. 1 2 3 4 5

5. (PrSC3) I reflect about myself a lot. 1 2 3 4 5
6. (PuSC2) I'm concerned about the way I present myself. 1 2 3 4 5

7. (PrSC4) I'm often the subject of my own fantasies. 1 2 3 4 5

8. (SaSC2) I have trouble working when someone is watching me. 1 2 3 4 5

9. (PrSC5R) I never scrutinize myself.* 1 2 3 4 5
10. (SaSC3) I get embarrassed very easily. 1 2 3 4 5
11. (PuSC3) I'm self-conscious about the way I look. 1 2 3 4 5

12. (SaSC4R) I don't find it hard to talk to strangers.* 1 2 3 4 5
13. (PrSC6) I'm generally attentive to my inner feelings. 1 2 3 4 5

14. (PuSC4) I usually worry about making a good impression. 1 2 3 4 5

15. (PrSC7) I'm constantly examining my motives. 1 2 3 4 5

16. (SaSC5) I feel anxious when I speak in front of a group. 1 2 3 4 5

17. (PuSC5) One of the last things I do before I leave my house is look in the mirror. 1 2 3 4 5

18. (PrSC8) I sometimes have the feeling that I'm off

somewhere watching myself. 1 2 3 4 5

19. (PuSC6) I'm concerned about what other people think of me. 1 2 3 4 5

20. (PrSC9) I'm alert to changes in my mood. 1 2 3 4 5

21. (PuSC7) I'm usually aware of my appearance. 1 2 3 4 5

22. (PrSC10) I'm aware of the way my mind works when I work through a problem. 1 2 3 4 5

23. (SaSC6) Large groups make me nervous. 1 2 3 4 5

Appendix F: Revised Self-Monitoring Scale (RSM)

The scale ranges from 1 (strongly disagree) to 5 (strongly agree).

The scale indicates the following:

1- Strongly disagree
2- Somewhat disagree
3- Neither disagree, nor agree
4- Somewhat agree
5- Strongly agree

1. (SMA1) In social situations, I have the ability to alter my behavior if I feel that something else is called for. 1 2 3 4 5

2. (SMA2) I have the ability to control the way I come across to people, depending on the impression I wish to give them. 1 2 3 4 5

3. (SMA3) When I feel that the image I am portraying isn't working, I can readily change it to something that does. 1 2 3 4 5

4. (SMA4R) I have trouble changing my behavior to suit different people and different situations.* 1 2 3 4 5

5. (SMA5) I have found that I can adjust my behavior to meet the requirements of any situation in which I find myself. 1 2 3 4 5

6. (SMA6) Once I know what a situation calls for, it's easy for me to regulate my actions accordingly. 1 2 3 4 5

7. (SMS1) I am often able to read people's true emotions correctly (through their eyes). 1 2 3 4 5

8. (SMS2) In conversations, I am sensitive to even the slightest change in the facial expression of the person with whom I am conversing. 1 2 3 4 5

9. (SMS3) My powers of intuition are quite good when it comes to understanding the emotions and motives of others. 1 2 3 4 5

10. (SMS4) I can usually tell when others consider a joke to be in bad taste, even though they may laugh convincingly. 1 2 3 4 5

11. (SMS5) I can usually tell when I've said something inappropriate by reading it in the listener's eyes. 1 2 3 4 5

12. (SMS6) If someone is lying to me, I usually know it at once from that person's manner of expression. 1 2 3 4 5

Appendix G: Basic Empathy Scale (ES)

The scale indicates the following:

1- Strongly disagree
2- Somewhat disagree
3- Neither disagree, nor agree
4- Somewhat agree
5- Strongly agree

1. (ESA1R) My friend's emotions don't affect me much.*	1 2 3 4 5
2. (ESA2) After being with a friend who is sad about something, I usually feel sad.*	1 2 3 4 5
3. (ESC1) I can understand my friends' happiness when they do well at something.	1 2 3 4 5
4. (ESA3) I get frightened when I watch characters in a good scary movie.	1 2 3 4 5
5. (ESA4) I get caught up in other people's feelings easily.	1 2 3 4 5
6. (ESC2R) I find it hard to know when my friends are frightened.*	1 2 3 4 5
7. (ESA5R) I don't become sad when I see other people crying.*	1 2 3 4 5
8. (ESA6R) Other people's feelings don't bother me at all.*	1 2 3 4 5
9. (ESC3) When someone is feeling 'down' I can usually understand how they feel.	1 2 3 4 5
10. (ESC4) I can usually figure it out when my friends are scared.	1 2 3 4 5
11. (ESA7) I often become sad when watching sad things on TV or in films.	1 2 3 4 5
12. (ESC5) I can often understand how people are feeling even before they tell me.	1 2 3 4 5
13. (ESA8R) Seeing a person who has been angered has no effect on my feelings.*	1 2 3 4 5
14. (ESC6) I can usually figure out when people are cheerful.	1 2 3 4 5
15. (ESA9) I tend to feel scared when I am with friends who are afraid.	1 2 3 4 5
16. (ESC7) I can usually realize quickly when a friend is angry.	1 2 3 4 5
17. (ESA10) I often get swept up in my friend's feelings.	1 2 3 4 5

18. (ESA11R) My friend's unhappiness doesn't make me feel anything.* 1 2 3 4 5
19. (ESC8R) I am not usually aware of my friend's feelings.* 1 2 3 4 5

20. (ESC9R) I have trouble figuring out when my friends are happy.* 1 2 3 4 5

Appendix H: Recruitment Letter for Study 1

Research Request

Hi xxxx,

I need your help in order to complete my dissertation. If you self-identify as a white therapist; please complete this web survey. Below you can learn more about the study. Thank you for your time.

Warmly,

Dwight Tolliver, M.S., N.C.C. University
of Tennessee- Knoxville Doctoral Candidate in
Counseling Psychology

Purpose:

The purpose of this culturally informed and directed research study is to provide initial reliability estimates to a new scale that measures racial attitudes of white mental health helping professionals and white mental health helping professionals-in-training. This dissertation project has been approved for human subjects use by the Institutional Review Board (IRB) at the University of Tennessee.

Targeted Population for the Websurvey:

Self-identified white, non-Hispanic, mental health helping professionals and mental health helping professionals-in-training. The survey is anonymous and solicits only non-identifying demographic information (e.g., age, gender, degree earned, professional identity).

Time:

The websurvey comprises 25 items and will take approximately **5-10** minutes to complete.

Where to go:

http://survey.utk.edu/mrIWeb/mrIWeb.dll?I.Project=CCCS

Contact Information:

If you have questions at any time about the study or the procedures, you may contact the primary investigator, Dwight Tolliver, at dtolliv1@utk.edu, or his academic advisor, Jacob J. Levy, Ph.D., at 215G Austin Peay Building, Knoxville, TN 37996, phone: (865) 974-4866, email: jlevy4@utk.edu. Additionally, you may contact the University of Tennessee's Compliance Office at (865) 974-3466 or at the following address: Research Compliance Services, Office of Research, 1534 White Avenue, Knoxville, TN, 37996.

Appendix I: Recruitment Letter for Study 2

Research Request

Hi xxxx,

I need your help in order to complete my dissertation. So, I have two requests. **First**, if you self-identify as a white therapist; please complete this web survey. There will be **six $50 cash awards** awarded for those who participate and enter a valid email address. **Second**, I would greatly appreciate any efforts from each of you to send this to therapists you personally know (e.g., in the community, from your specific graduate programs, etc.). Below you can learn more about the study. Thank you for your time.

Warmly,

Dwight Tolliver, M.S., N.C.C. University
of Tennessee- Knoxville Doctoral Candidate in
Counseling Psychology

Purpose:

The purpose of this culturally informed and directed research study is to validate a new scale that measures racial attitudes of white mental health helping professionals and white mental health helping professionals-in-training. This dissertation project has been approved for human subjects use by the Institutional Review Board (IRB) at the University of Tennessee.

Targeted Population for the Websurvey:

Self-identified white, non-Hispanic, mental health helping professionals and mental health helping professionals-in-training. The survey is anonymous and solicits only non-identifying demographic information (e.g., age, gender, degree earned, professional identity).

Time:

The websurvey comprises ~150 items and will approximately **25-30** minutes to complete.

Where to go:

http://survey.utk.edu/mrIWeb/mrIWeb.dll?I.Project=CCCSVAL

Contact Information:

If you have questions at any time about the study or the procedures, you may contact the primary investigator, Dwight Tolliver, at dtolliv1@utk.edu, or his academic advisor, Jacob J. Levy, Ph.D., at 215G Austin Peay Building, Knoxville, TN 37996, phone: (865) 974-4866, email: jlevy4@utk.edu. Additionally, you may contact the University of Tennessee's Compliance Office at (865) 974-3466 or at the following address: Research Compliance Services, Office of Research, 1534 White Avenue, Knoxville, TN, 37996.

Vita

Dwight Tolliver was born in Circleville, Ohio on January 24th, 1974. He was raised in Circleville and went to elementary school, junior high school, and high school in Circleville. He graduated from Circleville Central High School in 1992. From there, he went to Wittenberg University in Springfield, Ohio and received a B.A. in Business Administration in 1996. While at Wittenberg, Dwight also played baseball as a three year starter. He then matriculated at the University of Tennessee to pursue his master's degree in business administration in 1998 after working in public accounting for PricewaterhouseCoopers for two years. However, while at the University of Tennessee; Dwight switched his educational and career focus and earned his M.S. in Counseling in 2001. Subsequent to his M.S., Dwight worked at Lenoir City High School as a school counselor for two years and with Youth Villages as a crisis counselor for one year before returning to the University of Tennessee to pursue his doctorate in psychology in 2004.

Currently, Dwight is completing his doctorate in Counseling Psychology with a cognate in Statistics at the University of Tennessee. Additionally, he is completing the degree requirements by interning at The Ohio State University's Counseling Center in Columbus, Ohio. His degree will be conferred in the Summer of 2008.