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Clients' Perceptions of Their Psychotherapists' Multicultural Orientation

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The current retrospective study examined whether clients' ($N = 176$) perceptions of their psychotherapists' multicultural orientation (MCO) were associated with their psychological functioning, working alliance, and real relationship scores. Moreover, we tested whether clients' perceptions of the working alliance and the real relationship mediated the relationship between clients' perceptions of their psychotherapists' MCO and psychological functioning. The results showed that clients' perceptions of their psychotherapists' MCO were positively related to working alliance, real relationship, and psychological functioning. Only clients' ratings of the working alliance mediated the relationship between clients' perceptions of their psychotherapists' MCO and psychological functioning. Thus, because clients perceive their psychotherapists as being more oriented toward cultural issues, they may view the therapist as being more credible and may gain a sense of comfort in the therapeutic process. In turn, clients' strong alliance facilitates improvement in psychological well-being.

Keywords: multicultural competence, psychotherapy outcomes, working alliance, real relationship, multiple mediation

As the demography of the United States continues to diversify, there is growing interest and need to understand how cultural factors influence the therapeutic environment (Worthington, Soth-McNett, & Moreno, 2007). This need is underscored by the American Psychological Association's (APA; APA, 2003) guidelines for psychotherapy, which include a widely accepted model of multicultural competence, focusing on the awareness, knowledge, and skills needed by psychotherapists to negotiate cultural complexities during psychotherapy (Sue, Arredondo, & McDavis, 1992). Moreover, several scholars assert that adherence to the multicultural guidelines should be an ethical and a professional mandate because it is believed that it has a direct influence on clients (Arredondo & Toporek, 2004; Mintz et al., 2009). However, McCutcheon and Imel (2009) provided the following conclusion for their research: "although we intuitively accept that these (multicultural) processes are fundamental competencies for psychologists, we should also be mindful that we lack evidence as to whether and how they are related to actual improvements in culturally competent care" (pp. 766–767). As such, in this study, we will investigate whether clients' perceptions of their psychotherapists' multicultural orientation (MCO) are associated with clients' psychological functioning, and then explore whether therapeutic relational processes might facilitate this relationship.

Multicultural Competencies or MCO: A Clarification of Terms

A critical question is how researchers distinguish between the ways in which psychotherapists conduct therapy and their ability to effectively deliver an intervention (Barber, 2009). For instance, a psychotherapist may consider himself or herself to be a cognitive behaviorist (orientation), but may not be very skilled in this approach (competence). Thus, if competence is defined as the ability to effectively implement a given psychotherapy approach, this therapist would most likely be rated poorly on a cognitive-behavioral therapy competence measure. Given this delineation between competence and orientation, it is possible that previous studies examining psychotherapists' multicultural competencies (Constantine, 2002; Fuertes et al., 2006; Owen, Leach, Wampold, & Rodolfa, 2011a) were in fact assessing MCO. As such, we contend that the term "multicultural orientation" more accurately captures clients' ratings on cross-cultural counseling inventories, as compared with competency. Specifically, orientation, as defined by Merriam-Webster's dictionary (Orientation, 2010), is "a usually general or lasting direction of thought, inclination, or interest." Given this definition, MCO can be considered a "way of being" with the client, guided primarily by therapists' philosophy or values about the salience of cultural factors (e.g., racial/ethnic identity, client's cultural background) in the lives of therapists as well as clients. Conversely, multicultural competencies can be viewed as "ways of doing" or perhaps how well a therapist

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engages in and implements her or his multicultural awareness and knowledge while conducting therapy. The implication of such a difference between competencies and orientation is not trivial. For instance, is it sufficient that psychotherapists are mindful of cultural issues in therapy and implement culturally salient skills? Or rather, is there a level of cultural knowledge, skills, and awareness that a psychotherapist must attain to qualify as competent? If so, do clients recognize their psychotherapists' level of competency and does it matter?

MCO, Working Alliance, and the Real Relationship

Psychotherapists' MCO is thought to largely influence the therapeutic relationship with clients, which in turn can affect clients' psychological well-being (Paniagua, 2005; Sue, 2003). Although the therapeutic relationship includes many facets, Gelso (2009) concluded that central to this relationship are the working alliance, the real relationship, and transference/countertransference. We focus on the former two in this study. The working alliance, a robust predictor of psychotherapy outcomes, has been commonly defined as the agreement on the goals for therapy and the methods to reach those goals, as well as the emotional bond between the client and psychotherapist (Bordin, 1979; Horvath, Del Re, & Flückiger, in press). Essentially, the working alliance describes "the degree to which the therapy dyad is engaged in collaborative, purposeful work" in which therapeutic activities and attitudes can affect this process (Hatcher & Barends, 2006, p. 293).

Accordingly, psychotherapists' MCO may enhance the alliance by providing culturally relevant explanations for clients' psychological distress or use culturally sensitive interventions (Wampold, 2007). Moreover, the client may gain a sense of trust and safety with the psychotherapist who is able to attend to salient cultural factors (e.g., identity, religion), which may enable the psychotherapy dyad to deepen exploration of core concerns. Consequently, as the alliance is strengthened, the effect on clients' psychological well-being may be enhanced. Indeed, these theoretical positions have empirical support. For example, clients' perceptions of their psychotherapists' MCO have been associated with client ratings of working alliance and psychotherapist empathy (Constantine, 2007; Fuertes et al., 2006; Li & Kim, 2004). A missing link, however, is whether clients' perceptions of working alliance serve as a facilitating process between their perceptions of psychotherapists' MCO and client psychological well-being.

Although the concept of alliance has been ubiquitously applied to describe the relationship between client and therapist, Gelso (2009) asserted that other relational processes also have an impact on the psychotherapy process. Specifically, the *real relationship* is a dynamic present in all dyads and is described as the personal connection between the client and psychotherapist. It involves two elements, realism and genuineness. Realism describes clients' realistic perceptions of the psychotherapist, without relational factors such as transference (Gelso, 2009). Genuineness is the authentic representation of oneself in a manner that is open and honest (Gelso & Hayes, 1998; Greenson, 1967). The real relationship is rooted in the belief that clients can perceive the psychotherapist as a person with imperfections, likes, and dislikes (Gelso, 2009; Knox, Hess, Petersen, & Hill, 1997). That is, clients may view their psychotherapist in terms of a personal relationship, one where self-disclosures or discussions are not exclusively related to the work in psychotherapy (e.g., conversations about the weather, sports, or current affairs). Although clients' perceptions of the real relationship are related to working alliance (Kelley, Gelso, Fuertes, Marmarosh, & Lanier, 2010), there is also evidence that it can uniquely contribute to the prediction of psychotherapy outcomes (Fuertes et al., 2007; Marmarosh, Gelso, Markin, & Majors, 2009).

Cultural issues brought up in therapy are not always the focus of therapy, but may still impact clients' perceptions of a psychotherapist's MCO and potentially affect the real relationship. For instance, Chang and Berk (2009) found that some racial/ethnic minority (REM) clients reported that cultural issues were not central in their psychotherapy process. Further, Maxie et al. (2006) found that psychotherapists are most likely to attend to cultural issues when these topics are raised by clients or when they are associated with clients' presenting issues. However, it can be argued that being culturally sensitive is important in therapy regardless of whether a cultural issue is the presenting problem. That is, it is likely that when clients perceive their psychotherapist as being unaware of cultural topics, they may feel less connected or invested in the psychotherapist, and possibly psychotherapy. To date, there are no known studies examining the relationship between clients' perceptions of the real relationship and psychotherapists' MCO. Moreover, by using two possible mediators (i.e., alliance and real relationship) to explain the relationship between clients' perceptions of their psychotherapists' MCO and clients' psychological well-being, we will be able to ascertain how clients' perceptions of their psychotherapists' MCO operate in psychotherapy.

Previous Studies on Clients' Perceptions of Their Psychotherapists' MCO

Psychotherapy studies have found that clients' perceptions of their psychotherapists' MCO are positively associated with clients' ratings of working alliance, session quality, psychotherapists' empathy, and general competence (Constantine, 2002, 2007; Fuertes & Brobst, 2002; Fuertes et al., 2006; Kim et al., 2002; Li & Kim, 2004). The primary criterion variable in several studies has been clients' satisfaction with services, which has also been positively related to clients' perceptions of their psychotherapists' MCO (Constantine, 2002, 2007; Fuertes & Brobst, 2002; Fuertes et al., 2006). Although satisfaction with services is an important variable, research has shown small correlations between satisfaction and indicators of psychotherapy outcome, such as level of psychological distress (Blais et al., 2002; Lambert, Salzer, & Bickman, 1998; Owen, Rhoades, Fincham, & Stanley, in press). Currently, there are no known studies that have established a relationship between clients' perceptions of their psychotherapists' MCO and symptom-based outcomes.

Given the sociopolitical environment in the United States and continued presence of racial and ethnic discrimination (Constantine, 2007; Sue et al., 2007), it is important to consider the effects of cross and similar racial/ethnic psychotherapy dyads (i.e., White client–White psychotherapist, White client–REM psychotherapist, REM client–White psychotherapist, REM client–REM psychotherapist). Although many multicultural scholars have emphasized REM clients' experiences with White psychotherapists, we argue that *all* clients bring with them a racial/ethnic background that can possibly impact the psychotherapy relationship (Fuertes et al.,

2006; Phinney, 1992). For instance, racial/ethnic cultural norms influence personal identities, world views, and perceptions of social interactions (e.g., the therapeutic process). Although the content of clients' cultural norms may vary, we contend clients' perceptions of their psychotherapists' MCO will affect the therapeutic relationship consistently among cross and similar racial/ethnic dyads. For instance, an Italian American client may perceive his or her African American psychotherapist as being more oriented toward cultural issues by asking questions exploring his family values. In a similar manner, a Japanese American client may perceive her Japanese American psychotherapist who utilizes a more directed psychotherapy approach as having a strong MCO (Atkinson & Matsushita, 1991).

Generally, the effects of client–psychotherapist racial/ethnic matching on psychotherapy outcomes have ranged from small to null (Clarkin & Levy, 2004; Maramba & Hall, 2002). These studies, however, have not examined how clients perceive their psychotherapists' MCO in cross and similar racial/ethnic psychotherapy dyads. For instance, some studies have focused exclusively on REM clients with White therapists (Constantine, 2002, 2007; Li & Kim, 2004), whereas others have included White and REM clients who were treated by primarily White therapists (Fuertes & Brobst, 2002). Recently, Fuertes et al. (2006) found that cross and similar racial/ethnic dyads reported similar perceptions of their psychotherapists' MCO. However, the degree to which cross and similar racial/ethnic dyads may moderate the relationship among MCO, alliance, the real relationship, and psychological functioning is still unknown. Related to this issue, Fuertes and Brobst (2002) found that REM clients' ratings of their psychotherapists' MCO accounted for nearly 16% of the variance in clients' ratings of satisfaction with psychotherapy services, as compared with 2% for White clients. However, they conducted separate analyses for White and REM clients and did not formally test whether there were differences between REM and White clients. Thus, we will examine whether our mediation model is consistent for similar and cross racial/ethnic dyads.

Hypotheses

We posited that clients' perceptions of their psychotherapists' MCO would be positively related to client psychological well-being (hypothesis 1), working alliance scores (hypothesis 2), and the real relationship (hypothesis 3). Next, we hypothesized that the relationship between clients' perceptions of their psychotherapists' MCO and psychological well-being would be mediated by clients' ratings of working alliance (hypothesis 4) and the real relationship (hypothesis 5). Finally, we expected that these meditation effects would be consistent for cross and similar racial/ethnic psychotherapy dyads (hypothesis 6).

Method

Participants

Clients. The sample included 176 clients from a university counseling center, of which 136 were women, 38 were men, and two were transsexual-men, with a median age of 25 years (range = 18–41). Of these 176 clients, 71 were graduate students, 40 seniors, 26 juniors, 21 sophomores, 7 freshman, 7 nonstudents, and 4 did not indicate an educational level. Additionally, 95 clients identified as White/Euro American, 30 as Asian American (including Middle Eastern clients), 22 as Hispanic/Latino(a), 22 as multiracial/ethnic, six as African American, and one client identified as Native American. Given the low representation of clients in some racial/ethnic groups and the lack of differences in clients' perceptions of their psychotherapists' MCO in previous studies (Constantine, 2001), we decided to dichotomize racial/ethnic status into White ($n = 95$) and REM ($n = 81$).

Psychotherapists. Thirty-three psychotherapists treated the 176 clients in this study. The average number of clients reporting for each psychotherapist was 5.33. The psychotherapists were predoctoral interns, postdoctoral fellows, staff psychologists, and staff psychotherapists from a large university counseling center located in the Western United States. Nine of the psychotherapists self-identified as REM and 24 self-identified as White. Psychotherapists were not directly assessed as a part of this study, which limited our ability to gather detailed information about their therapeutic approach. However, typically this counseling center offers brief psychotherapy (6–10 sessions) for clients, and the median number of sessions in this sample was five. Additionally, it is common practice at this counseling center for the psychotherapist who conducted the intake to continue to see the client for psychotherapy. There is no prescribed therapeutic approach for psychotherapists.

Measures

Cross-Cultural Counseling Inventory—Revised (CCCI-R). The CCCI-R (LaFromboise, Coleman, & Hernandez, 1991) was used to assess clients' perceptions of their psychotherapists' MCO. The CCCI-R is composed of 20 items that are rated on a 6-point scale, ranging from 1 (*strongly disagree*) to 6 (*strongly agree*), with higher scores indicating more perceived MCO. The CCCI-R is an observer-based rating scale, and for this study, we followed the procedure used by Constantine (2002, 2007) and Fuertes et al. (2006) and made minor changes to the wording of the items. For instance, we modified the item, "Counselor is aware of his or her own cultural heritage" to, "My counselor is aware of his or her own cultural heritage." The CCCI-R assesses various aspects of multicultural processes such as cross-cultural counseling skill, sociopolitical awareness, and cultural sensitivity. LaFromboise et al. (1991) found that the CCCI-R is best represented by a one-factor structure. The content validity for the CCCI-R has been supported because the items reflect cross-cultural competencies defined by APA Division 17. In psychotherapy studies, clients' perceptions of their psychotherapists' MCO have been related to working alliance, general psychotherapy competence, and satisfaction with psychotherapy services (Constantine, 2002, 2007; Fuertes & Brobst, 2002). In the current study, the Cronbach's alpha was .96.

Schwartz Outcome Scale-10 (SOS-10). The SOS-10 (Blais et al., 1999) was the outcome measure in the current study. This 10-item scale assessed clients' current psychological well-being (over the past week). The items were rated on a 7-point scale ranging from 1 (*never*) to 7 (*all the time or nearly all the time*). Example items include "I am generally satisfied with my psychological health," "I feel hopeful about my future," and "I have peace of mind" (Blais et al., 1999). Across studies, the SOS-10 has

exhibited reliability estimates above .85 (e.g., 1-week test/retest, $r = .87$; Cronbach's alpha = .91; Blais et al., 1999; Hilsenroth, Ackerman, & Blagys, 2001; Young, Waehler, Laux, McDaniel, & Hilsenroth, 2003). Further, convergent and discriminant validity has been supported in previous studies, with correlations in the predicted direction with a variety of clinical and psychological well-being scales, and reliably discriminated between clinical and nonclinical samples (Owen & Imel, 2010 for a review). The Cronbach's alpha coefficient for this sample was .94.

Perceptions of pre-psychotherapy distress. Clients rated their perceptions of their pre-psychotherapy emotional and interpersonal state based on three questions. The first question was based on previous work from the Consumers Report (1994): "How were you feeling when you started counseling?", which was rated on a 5-point scale ranging from 1 (very good [life was much the way I liked it to be]) to 5 (very poor [I barely managed to deal with things]; Seligman, 1995). The next two questions were added to provide a broader assessment of clients' perception of their pre-psychotherapy distress. The second question was "When you started counseling, how were your relationships with friends, family, or romantic partner?", which was rated on a 5-point scale ranging from 1 (*very good*) to 5 (*very poor*). This item was adapted from the SOS-10 (Blais et al., 1999). The last question was "When you started counseling, how often did you feel hopeful about your future?", which was rated on a 4-point scale ranging from 1 (*most of the time*) to 4 (*rarely or none of the time*). This item was adapted from the Center for Epidemological Studies—Depression Scale (Radloff, 1977). The Cronbach's alpha for these three items in this sample was .70.

Previous studies have relied on the first question as a proxy of pre-psychotherapy distress (Nielsen et al., 2004; Owen, Tao, & Rodolfa, 2010; Owen, Wong, & Rodolfa, 2009; Seligman, 1995). To provide support for this item, Nielsen et al. (2004) compared clients' recall of distress at intake with the Outcome Questionnaire-45 (Lambert et al., 1996), which was completed before every session. The results showed that clients' Outcome Questionnaire-45 scores at intake were correlated with clients' recall of their initial distress after 55 weeks ($r = .57$; Nielsen et al., 2004), suggesting that clients' recall of their pre-psychotherapy distress was fairly accurate. Because the measures were different and the time between the two assessments was pronounced, it would be expected that the correlation would be much lower, but this was not the case. In fact, Nielsen et al. (2004) concluded that the relationship was "of sufficient magnitude to fall within the range of validity indexes generally accepted for measures of psychotherapy outcome" (p. 33). Clients' recall of their pre-psychotherapy distress has been shown to be consistent, regardless of the length of time between when they started psychotherapy and when they completed the retrospective assessment (Nielsen et al., 2004; Owen et al., 2010). However, 1-item measures are limited in their breadth of assessment. Thus, we determined that adding two items would strengthen this assessment method.

Working Alliance Inventory—Short Form Revised (WAI-SR). The WAI-SR (Hatcher & Gillaspy, 2006) is a client-rated measure of working alliance that consists of 12 items that assess goals and tasks for psychotherapy as well as the relational bond between the client and the psychotherapist. Example items include: "We agree on what is important for me to work on," "I believe the way we are working with my problem is correct," and "I believe [therapist] likes me." These items were rated on a scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*), with higher scores indicating a better working alliance. The WAI-SR and the other variations of the instrument are commonly used measures of working alliance, and the reliability and validity has been demonstrated in numerous studies by comparing it with other working alliance and psychotherapy outcome scales (Hatcher & Gillaspy, 2006; Horvath et al. in press for a review). For purposes of this study, the total scale score was used, which yielded a Cronbach's alpha of .96.

The Real Relationship Inventory—Client Version (RRI-C). The RRI-C (Kelley et al., 2010) is a 24-item client-rated measure that describes clients' perceptions of their attitudes and feelings of the real relationship with the therapist. The items are rated on a 5-point scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*). The RRI-C has two subscales, Genuineness and Realism (each consisting of 12 items). In the current study, we used total scale score because the two subscales were highly correlated ($r = .92$). Example items include "I was able to see myself realistically in therapy" and "My therapist seemed genuinely connected to me." The internal consistency for the RRI-C has been supported because Cronbach's alpha scores and 2- to 3-week test–retest estimates were more than .84 (Kelley et al., 2010). The RRI-C subscale has been significantly correlated with other client- and therapist-rated measures of the real relationship ($rs > .60$). In the current study, the Cronbach's alpha for the RRI-C was .95.

Procedures

Participants were recruited from a large West Coast university counseling center. Clients were asked on their intake card(s) whether they would be willing to receive a survey about their psychotherapy experience. Those who agreed were sent an E-mail at the end of the academic quarter and were able to access the anonymous survey instruments online. One hundred ninety-four individuals responded to the electronic survey (21% response rate) and 176 clients had services appropriate for this study (i.e., received individual psychotherapy and completed all measures). If clients endorsed multiple individual psychotherapists (or no psychotherapist), they were excluded from the analyses. Clients initially completed an informed consent, and then the outcome and process measures. For purposes of this study, clients were specifically directed to rate their psychotherapist on the WAI-SR, the RRI-C, and CCCI-R measures. For clients who were no longer in therapy, the items were adjusted to reflect the past tense. The survey responses were collected anonymously (the participants' E-mail addresses were not linked to their responses) and all procedures were approved through the university Institutional Review Board committee.

Results

Preliminary Analyses

Initially, we tested whether clients' perceptions of their psychotherapists' MCO would vary based on the race/ethnic status of the client and therapist. We conducted a 2 (client race/ethnicity) $\times$ 2 (therapist race/ethnicity) multivariate analysis of variance with CCCI-R, WAI, and RRI-C as the dependent variables and race/ethnic status as the independent variable. The results demonstrated that the therapist race/ethnicity, client race/ethnicity, or the inter-

action between client and therapist race/ethnicity were statistically significant on these three measures, Fs(1,172) < 2.50, ps $> .14$, partial η^2 ranged from .001 to .01. The means for each group are reported in Table 1. Given that some clients were currently in therapy while others had completed therapy, we also tested whether their scores on the measures differed (i.e., WAI, RRI-C, CCCI-R, and SOS-10). We conducted a multivariate analysis of variance to examine whether clients' scores on the WAI, RRI-C, and CCCI-R differed as a function of currently being in therapy or not. The results demonstrated that there were no significant differences on any of the measures, Fs(1, 172) < 2.0, ps $> .18$, partial η^2 was .001 for CCCI-R, .005 for WAI, and .01 for RRI-C. Further, we conducted an analysis of covariance to examine whether SOS-10 scores differed for clients who were currently in therapy versus those who had completed therapy, controlling for clients' perceptions of their pretherapy distress. Again, the results were not statistically significant, $F(1, 172) = 2.61$, $p > .10$, partial $\eta^2 = .02$.

In order to quantify the variability introduced by the psychotherapist in their clients' CCCI-R, WAI, RRI-C, and SOS-10 scores, we conducted four multilevel baseline models that allowed for a calculation of the intraclass correlation (ICC). The ICC is the proportion of total variance in the variables that is attributable to therapists. The psychotherapists' ICCs for the CCCI-R, WAI, RRI-C, and psychotherapy outcomes were .001, .001, .03, and .03, respectively (ps $> .05$). Thus, psychotherapists accounted for a small amount of variance in these measures (<1% – 3% of the variance in these variables, suggesting that psychotherapists did not differ in terms of how clients scored on the CCCI-R, WAI, the RRI-C, or SOS-10; see Owen, Leach, Wampold, & Rodolfa, 2011, for a discussion of ICCs in cultural psychotherapy research). As such, we decided to use traditional regression analyses and not multilevel modeling in our primary analyses.

Primary Analyses

Table 2 provides an overview for the bivariate correlations among the variables. Clients' perceptions of their psychotherapists' MCO were positively associated with working alliance (supporting hypothesis 1) and the real relationship (supporting hypothesis 2). Additionally, we conducted a regression analysis to ascertain whether clients' perceptions of their psychotherapists' MCO would be significantly related to client psychological well-being, after controlling for clients' perceptions of their pretherapy distress. The results were significant, suggesting that clients who rated their psychotherapist higher on the CCCI-R (i.e., MCO) also had higher SOS-10 scores (i.e., psychological well-being), after controlling for their perceptions of their pretherapy distress (Figure 1, path c). This result supports hypothesis 3.

Table 2
Bivariate Correlations for SOS-10, Perceptions of Pre-Psychotherapy Distress, CCCI-R, RRI-C, and WAI-SR

Variables	1	2	3	4	5
1. Psychological well-being (SOS-10)	—				
2. Pre-psychotherapy distress	−.39*	—			
3. MCO (CCCI-R)	.30*	−.01	—		
4. Alliance (WAI-SR)	.34*	−.01	.73*	—	
5. Real relationship (RRI-C)	.27*	.05	.65*	.72*	—

Note. $N = 276$. Multicultural orientation (MCO) was measured by the CCCI-R (Cross-cultural Competencies Inventory—Revised), psychological well-being was measured by the SOS-10 (Schwartz Outcome Scale-10), alliance was measured by the WAI-SR (Working Alliance Inventory—Short Form Revised), and real relationship was measured by the Real Relationship Inventory—Client Version.
* $p < .001$.

Next, we examined whether the relationship between clients' perceptions of their psychotherapists' MCO and psychological well-being would be mediated by clients' perceptions of the working alliance (hypothesis 4) and the real relationship (hypothesis 5; Figure 1). The use of a multiple meditational model allows for more than one mediator to be tested simultaneously, which is a multivariate extension mediation model (Preacher & Hayes, 2008). Specifically, Preacher and Hayes (2008) suggested examining multiple mediation with a product-of-coefficient approach, as compared with the causal steps approach (Baron & Kenny, 1986), as well as using bootstrapping methods to estimate the indirect effects. We conducted our multiple mediation analysis with bootstrapping methods (10,000 subsamples) using a script provided by Preacher and Hayes (2008). The results from the multiple mediation analysis demonstrated that clients' perceptions of their psychotherapist's MCO were significantly mediated by working alliance, $B = .33$, 95% confidence interval: .02–.61. Additionally, the relationship between clients' perceptions of their psychotherapists' MCO and SOS-10 scores was reduced and no longer statistically significant when the mediators were included in the model (Figure 1, patch c'). However, the real relationship was not a statistically significant mediator in this model, $B = .09$, 95% confidence interval: −.11–.32. The total variance accounted for in the model was 28% ($R^2 = .28$, $F(6, 169) = 11.16$, $p < .001$). Thus, our results support hypothesis 4 but

Table 1
Descriptive Information for Measures

Client-Therapist Dyads	CCCI-R	WAI-SR	RRI-C	SOS-10	Pre-Tx Distress	*N*
Client White–therapist REM	5.20 (.63)	5.32 (1.57)	3.82 (.80)	5.22 (.81)	3.18 (.80)	20
Client White–therapist White	5.09 (.68)	5.55 (1.22)	3.80 (.60)	4.95 (1.25)	2.88 (.77)	75
Client REM–therapist REM	5.18 (.72)	5.45 (1.24)	3.87 (.63)	5.12 (1.32)	3.03 (.81)	36
Client REM–therapist White	5.11 (.64)	5.81 (.82)	4.00 (.58)	5.16 (1.15)	2.96 (.64)	45
Total sample	5.12 (.67)	5.57 (1.18)	3.87 (.63)	5.07 (1.19)	2.96 (.75)	176

Note. Mean, with Standard Deviation in parentheses. CCCI-R = Cross-cultural Competencies Inventory—Revised (range: 1–7); WAI-SR = Working Alliance Inventory—Short Form Revised (range: 1–7); RRI-C = Real Relationship Inventory—Client Version (range: 1–5); SOS-10 = Schwartz Outcome Scale-10 (range: 1–7); Pre-Tx distress = perceptions of pre-psychotherapy distress (range: 1–4.67).

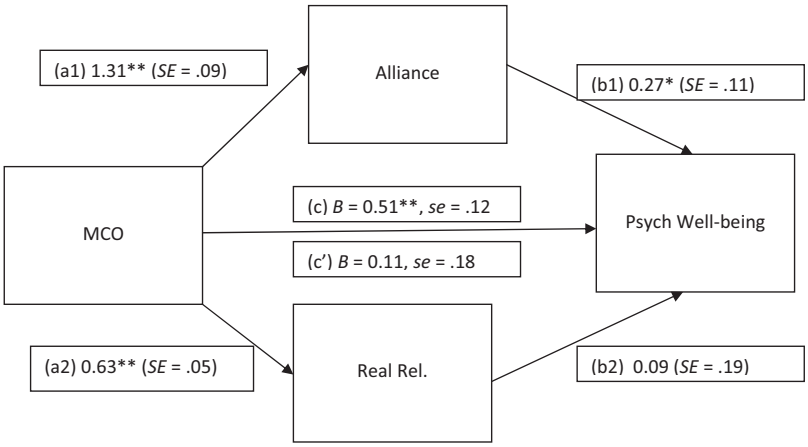

Figure 1. Multiple mediation model. $^{*}p < .01$, $^{**}p < .001$. The numbers in the figure reflect the unstandardized regression coefficients based on the bootstrap multiple mediation procedure. In this model, we also controlled for client and psychotherapist race/ethnicity and clients' perceptions of their pre-psychotherapy distress (these effects are not shown, for parsimony). Only clients' perceptions of their pre-psychotherapy distress were significant, $B = -.64$, $SE = .10$, $p < .001$.

not hypothesis 5 (the multiple mediation model was consistent for clients who were currently in and out of therapy).

Finally, we posited the multiple mediation model would be consistent for cross and similar client–psychotherapist dyads (i.e., White client–White therapist, White client–REM therapist, REM client–White therapist, and REM client–REM therapist; hypothesis 6). Because the sample sizes of some groups were small, it may be appropriate to view the results tentatively. On the basis of power analyses for mediation effects (at .80 power), we had sufficient power to detect a medium-sized indirect effect for the White client and White psychotherapist group, but only had the power to detect a large-sized indirect for the White client and REM psychotherapist group (Fritz & MacKinnon, 2007). To test whether the multiple mediation model would be a good fit across client–psychotherapist dyads, we conducted a multigroup multiple mediation model with bootstrapping procedures. This analysis was conducted using AMOS 18 (Arbuckle, 2009). Specifically, we replicated our aforementioned multiple mediation model and then compared the fit of the model when the paths in model were constrained to be equal across all groups, and then allowed to vary across groups.

The results demonstrated that the unconstrained model was a better fit to the data, as compared with the constrained model, $\chi^2 = 40.58$, $df = 18$, $p < .01$. These results suggest that the multiple mediation effects were not consistent for cross and similar racial/ethnic psychotherapy dyads. As seen in Table 3, working alliance was only a statistically significant mediator for the relationship

Table 3
Multiple Group Multiple Mediation Model: Direct and Indirect Effects for Alliance and the Real Relationship

	Therapist white		Therapist REM	
	Client white	Client REM	Client white	Client REM
Estimated Paths	($n = 75$)	($n = 45$)	($n = 20$)	($n = 36$)
Direct effects *B* (*SE*)				
a1 MCO–WAI	1.48** (.12)	.65** (.17)	2.06** (.32)	1.34** (.18)
b1 WAI–SOS-10	.38* (.19)	.23 (.20)	.32 (.27)	.57* (.25)
a2 MCO–RRI	.62** (.08)	.60** (.10)	.99** (.18)	.52** (.12)
b2 RRI–SOS-10	.10 (.30)	.30 (.33)	.49 (.46)	.18 (.39)
Indirect effects *B* (95% confidence intervals)				
a1 × b1	.56* (.01, 1.13)	.15† (−.10, .44)	.66 (−.42, 1.82)	.76* (.11, 1.49)
a2 × b2	.06 (−.30, .43)	.18 (−.20, .59)	.49 (−.39, 1.45)	.09 (−.30, .51)

Note. a1 = the association between MCO and WAI; b1= the association between alliance and psychological well-being; a2 = the association between MCO and RRI; b2 = the association between RRI and SOS-10; a1 × b1 = the indirect effect of WAI for the relationship between MCO and SOS-10; a2 × b2 = the indirect effect of RRI for the relationship between MCO and SOS-10. Confidence intervals that do not include zero in the range are statistically significant. Multicultural orientation (MCO) was measured by the CCCI-R (Cross-cultural Competencies Inventory—Revised), psychological well-being was measured by the SOS-10 (Schwartz Outcome Scale-10), alliance was measured by the WAI-SR (Working Alliance Inventory—Short Form Revised), and real relationship was measured by the Real Relationship Inventory—Client Version.

† The specific indirect effect for this group was lower than the other three groups.

$^{*}p < .05$. $^{**}p < .001$.

between clients' perceptions of their psychotherapists' MCO and psychological well-being with White client–White psychotherapist and REM client–REM psychotherapist dyads ($ps < .05$). Working alliance was not a significant mediator for the other two groups. Given these findings, we explored whether the differences in the specific indirect effect for working alliance were statistically significant among the four cross and similar racial/ethnic psychotherapy groups. We conducted multiple group comparisons by constraining the paths for three of the four groups and then repeated this process such that all groups would be unconstrained for comparison. We found the specific indirect effects for working alliance were not statistically different among the groups, with the exception of the REM clients–White psychotherapists group having a smaller indirect effect for alliance as compared with the other groups ($ps < .05$). Although the specific indirect effect for alliance in the White clients–REM psychotherapists group was not statistically significant, this specific indirect effect did not significantly vary from the other groups. This may be because of a lower sample size ($n = 20$) for this therapeutic dyad (Fritz & MacKinnon, 2007). Collectively, these results do not support hypothesis 6.

Discussion

The dearth of research examining the influence of MCO on clinical psychotherapy outcomes provided impetus for the current study. Indeed, we found that White and REM clients' perceptions of their psychotherapists' MCO were positively associated with their psychological well-being, even after controlling for clients' perceptions of their pre-psychotherapy distress. This finding expands on previous studies examining the relationship between clients' ratings of their psychotherapists' MCO and satisfaction with psychotherapy (Constantine, 2002, 2007; Fuertes & Brobst, 2002; Fuertes et al., 2006) by providing more evidence that multicultural processes in therapy are associated with clients' psychological health and well-being. More research is needed to understand the directionality of these findings, because clients who are feeling better might be apt to rate their psychotherapist more positively on therapeutic processes (Barber, 2009). However, at present, we contend that these findings correspond with theoretical positions calling for psychotherapists to attend to their MCO in treatment (Paniagua, 2005; Sue, 2003; Wampold, 2007).

We were also interested in potential therapeutic relationship factors (i.e., alliance and the real relationship) that might serve as mediators for the association between clients' perceptions of their psychotherapists' MCO and psychological well-being. Consistent with our theoretical assertions, we found that clients' perceptions of their psychotherapists' MCO were positively related to the working alliance and that the alliance significantly mediated the relationship between clients' perceptions of their psychotherapists' MCO and client psychological well-being. Although our data did not allow us to draw firm conclusions about the directionality of effects, clients' perceptions of their psychotherapists' MCO may assist in the work of psychotherapy, as seen in the positive relationship with working alliance. Central to the alliance is the ability to form a "confident collaboration" with clients that is marked by engagement in purposeful therapeutic work (Hatcher & Barends, 1996, 2006). Thus, as clients perceive their psychotherapists being more oriented toward focusing on cultural issues, they may view the therapist as more credible and feel more comfortable in the therapeutic process. In turn, clients' strong alliance facilitates improvement in psychological well-being. Said simply, the formation of a strong alliance creates a relational base for clients and psychotherapists to effectively manage cultural issues, which in turn can assist clients' therapeutic outcomes. These findings are comparable with previous research, which showed that clients' perceptions of their psychotherapists' MCO are associated with ratings of psychotherapists' credibility and trustworthiness, general competence, and empathy (Constantine, 2002; Fuertes et al., 2006).

Although clients' perceptions of the real relationship was not a significant mediator for the association between clients' ratings of their psychotherapists' MCO and psychological well-being, we found a strong and positive association between clients' perceptions of their psychotherapists' MCO and the real relationship. The findings here suggest that an orientation toward cultural issues in psychotherapy is interlinked with what it means to be authentically connected with clients. For instance, when psychotherapists appropriately reveal their own cultural values and acknowledge their client's cultural background, clients may perceive them as being empathic and thus are more likely to be themselves in therapy. Because this is the first known study exploring the relationship between clients' perceptions of their psychotherapists' MCO and the real relationship, further empirical investigations are warranted to better understand these associations.

We expected that our mediation model would be consistent across cross and similar racial/ethnic psychotherapy dyads (i.e., White clients–White psychotherapists, White clients–REM psychotherapists, REM clients–White psychotherapists, and REM clients–REM psychotherapists), but this was not the case. For White clients who were treated by White psychotherapists and for REM clients who were treated by REM psychotherapists, we found that alliance was a significant mediator. However, alliance did not mediate the relationship between REM clients' perceptions of their White psychotherapists' MCO and psychological well-being. This finding runs counter to nearly all theoretical assertions of how clients' perceptions of their psychotherapists' MCO influences the psychotherapy process. One interpretation is that other relational factors, such as transference, are influencing how clients' perceptions of their psychotherapists' MCO affect client well-being. That is, the power dynamics within the White psychotherapist—REM client relationship could lend itself to recapitulation of previous negative experiences for REM clients with White individuals. Thus, a corrective emotional experience with the psychotherapist may facilitate the relationship between REM clients' perceptions of their White psychotherapists' MCO and client well-being. At this point, we encourage future research to understand how REM clients' perceptions of their White psychotherapists' MCO influences clients' psychological well-being.

This study provides preliminary, yet noteworthy, evidence of the need for psychotherapists to consider their multicultural awareness and knowledge in their work with clients as they relate to psychological well-being. It is clear that a psychotherapist's acumen toward cultural factors in psychotherapy and a client's belief that his or her psychotherapist is attuned and willing to focus on multicultural issues are related to developing a positive working alliance and a real relationship, two cornerstones of the therapeutic relationship. As such, psychotherapists may need to recognize that clients' psychological

well-being is related to creating an environment where clients are comfortable raising cultural issues and believe their therapist is culturally self-aware and open to discussing these topics. This is not to suggest that an initial and perfunctory discussion (e.g., during intake) is sufficient to build collaboration on the goals for therapy, such as asking if there are any "cultural issues" to bring up, or disclosing to a client that she is comfortable discussing any cultural differences. Rather, psychotherapists may want to integrate culturally salient factors in their conceptualization of clients' problems, work collaboratively to modify interventions in a way that is culturally sensitive, and convey a genuine interest in the cultural heritage of their clients.

Because there are so few empirical studies assessing the relationship of MCO and therapeutic outcomes, the area is replete with research opportunities. First, there are no known prospective studies that have examined clients' perceptions of their psychotherapists' MCO. Prospective studies would be valuable to disentangle the directionality of the effects. Second, although nearly all MCO studies have relied on the CCCI-R, new process-oriented measures could increase our understanding of how specific cultural processes influence the course of treatment. Third, future researchers could incorporate other psychosocial variables that have been included in other culturally focused research literatures. For example, level of cultural mistrust, personality traits, or ethnic identity could easily be included to determine the role of these factors and their interactions with psychotherapists' MCO. For example, delineating the intersection between level of mistrust and level of competence could help account for dropout rate differences or the degree to which psychotherapy was considered effective.

Limitations

The results from this study should be interpreted within the scope of its methodological strengths and limitations. First, a primary limitation, similar to the majority of the studies examining clients' perceptions of their psychotherapists' MCO, is that our study used a retrospective cross-sectional design. In particular, the retrospective nature of this study coupled with the electronic survey methodology raises several concerns. All the measures were completed at the same time, which makes clients' perceptions of their pretherapy functioning score a process of memory recall. There is some support for the method of retrospective assessment (Nielsen et al., 2004; Owen et al., 2009; Seligman, 1995). As our findings are correlational, the directionality of the effects in this study cannot be definitively determined. Second, the response rate (21%) was low; however, it is similar to other electronic surveys (Northey, 2005). Third, we did not assess the degree to which cultural issues were salient in clients' presenting problem or therapy process. Thus, there could be differences in our results for clients who present with specific culturally based issues (e.g., discrimination). Finally, clients' perceptions of their psychotherapists' MCO, working alliance, and the real relationship are conceptually distinct; however, our results revealed that these concepts were highly interrelated. These high correlations are also consistent in previous studies where the relationship between clients' perceptions of their psychotherapists' MCO and working alliance were high (Constantine, 2007; Fuertes et al., 2006). Thus, it may be important to examine how these concepts are interrelated and distinct.

Overall, this study was one of the first to examine the relationship between MCO and psychological well-being. The study offers some promising, yet challenging results. Although perceived MCO was positively associated with alliance and alliance mediated the relationship between clients' perceptions of their psychotherapists' MCO and psychological well-being, our findings were not consistent across similar and crossed racial/ethnic dyads, specifically REM clients who were treated by White psychotherapists. It is clear that psychotherapists and training programs need to continue to focus on MCO in order to increase positive psychotherapeutic outcomes. This study offers some hope that the past 20 years of research and training have yielded some tangible results in the area of MCO.

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