A Meta-Analysis of Multicultural Competencies and Psychotherapy Process and Outcome

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For decades, psychologists have emphasized the provision of multiculturally competent psychotherapy to reduce racial and ethnic disparities in mental health treatment. However, the relationship between multicultural competencies (MC) and other measures of clinical process and treatment outcome has shown heterogeneity in effect sizes. This meta-analysis tested the association of client ratings of therapist MC with measures of therapeutic processes and outcome, including: (a) working alliance, (b) client satisfaction, (c) general counseling competence, (d) session impact, and (e) symptom improvement. Among 18 studies (20 independent samples) included in the analysis, the correlation between therapist MC and outcome ($r = .29$) was much smaller than the association with process measures ($r = .75$), but there were no significant differences in correlations across different types of MC or clinical process measures. Providing some evidence of publication bias, effect sizes from published studies ($r = .67$) were larger than those from unpublished dissertations ($r = .28$). Moderator analyses indicated that client age, gender, the representation of racial–ethnic minority (R–EM) clients, and clinical setting were not associated with effect size variability. Based on these findings, we discuss implications and recommendations for future research that might lead to a better understanding of the effects of therapist MC on treatment process and outcome. Primary needs in future research include the development and evaluation of observer ratings of therapist MC and the implementation of longitudinal research designs.

Keywords: multicultural competence, psychotherapy, meta-analysis, process and outcome

Cultural factors are crucial to diagnosis, treatment, and care. They shape health-related beliefs, behaviors, and values. But the large claims about the value of cultural competence for the art of professional care-giving around the world are simply not supported by robust evaluation research showing that systematic attention to culture really improves clinical services. (Kleinman & Benson, 2006, p. 1673)

There are clear racial and ethnic disparities in access to and quality of mental health services (Alegria et al., 2008; Fortuna, Alegria, & Gao, 2010; Lee, Martins, Keyes & Lee, 2011; Smedley, Stith, & Nelson, 2002). Similarly, there is evidence that some therapists achieve poorer outcomes with racial–ethnic minority (R–EM) clients relative to White clients on their caseload (Hayes, Owen, & Bieschke, 2014; Imel et al., 2011; Owen, Imel, Adelson, & Rodolfa, 2012). To address these inequalities and more effectively serve a rapidly diversifying U.S. population, the field of psychology has emphasized increasing the number of multiculturally competent providers (Korman, 1974; Pederson, Carter, & Ponterotto, 1996; Whaley & Davis, 2007). Multicultural competence has generally been defined as having both the ability to work effectively across diverse cultural groups and the specific expertise to treat clients from certain culturally diverse groups as well as minority and underrepresented groups (Sue, Arredondo, & Mc- Davis, 1992; Sue, Zane, Nagayama Hall, & Berger, 2009). Since 1973, the American Psychological Association (APA) has maintained that the provision of multiculturally competent mental health services is an ethical imperative (Korman, 1974; Ridley, 1985). In 2008, the APA Task Force on the Implementation of the Multicultural Guidelines detailed recommendations for integrating multicultural competencies (MC) into all psychology-related activities, including education, practice, research, and policy (American Psychological Association, 2008). The expectation is that efforts to train more multiculturally competent providers will result in a more effective mental health workforce and ultimately reduce treatment disparities. However, whether different levels of therapist MC actually correspond to better psychotherapy outcomes for R–EM clients remains unclear. In the current study, we provide an empirical analysis of the current literature assessing the relationship between measures of MC and treatment process and outcome. We begin with a brief description of the MC construct and various ways it has been measured, followed by a review of studies that have tested the relationship between MC and critical
measures of psychotherapy process and outcome. We also note potential factors that may influence observed associations, consistency across effects, and reasons for variability.

**Defining Therapist Multicultural Competencies**

The dominant model of therapist MC is Sue et al.’s (1992) tripartite model, which outlines a specific set of knowledge, skills, beliefs, and attitudes intended to describe the culturally competent provider. These providers are those who continuously work toward (a) expanding their knowledge of their clients’ cultural background and worldview; (b) developing and utilizing culturally relevant interventions and treatment strategies that are appropriate to clients; and (c) gaining awareness of one’s own assumptions, beliefs, and values and how they can impact interactions with a client or perceptions of the presenting issue. This understanding of therapist MC was later expanded to include a provider’s ability to recognize how the confluence of heritage or personal backgrounds influence his or her own and clients’ behavior (Sue, 1998; Whaley & Davis, 2007). This definition has led to several distinctions in how therapist MC is operationalized, including direct measures that focus on assessing specific MC models or indirect measures that examine conceptual correlates to therapist MC.

Direct measures include those that focus on therapist skills or interventions (Sue, 2001; Sue & Sue, 2012), individual counselor characteristics (Pope-Davis & Ottavi, 1994; Worthington, Mobley, Franks, & Tan, 2000), or assess in-session processes (López, 1997; Toporek & Reza, 2001; see discussions in Huey, Tilley, Jones, & Smith, 2014 and Sue et al., 2009). Commonly used direct self-report measures of therapist MC include the Multicultural Awareness/Knowledge/Skills Survey (MAKSS; D’Andrea, Daniels, & Heck, 1991), the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS; Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002), and the Cross-Cultural Counseling Inventory—Revised (CCCI–R; LaFromboise, Coleman, & Hernandez, 1991).

Indirect therapist MC measures assess attributes or indicators related to MC, including those that are conceptually antithetical (e.g., microaggressions) or parallel (e.g., feminist orientation, cultural humility). For example, the perpetration of racial microaggressions (whether conscious or not) has been discussed as a specific manifestation of culturally incompetent behavior. Theoretically, therapists who commit microaggressions more frequently are less likely than therapists with higher levels of MC to be aware of biases and stereotypes, as well as less knowledgeable about the potential harm microaggressions may have on historically marginalized clients (e.g., Constantine, 2007; Owen, Imel, et al., 2011; Owen, Tao, & Rodolfa, 2010). Indirect measures include microaggression scales—for example, the Racial Microaggressions in Counseling Scale (RMCS; Constantine, 2007), the revised RMCS (Owen, Tao, Imel, Wampold, & Rodolfa, 2014), and the Microaggressions Against Women Scale (MAWS; Owen et al., 2010), as well as measures of therapist cultural humility (Cultural Humility Scale; Hook, Davis, Owen, Worthington, & Utsey, 2013) and scales assessing counseling competencies in working with women (Counseling Women Competencies Scale; Ancis, Szymanski, & Ladany, 2008; Owen et al., 2010).

**Relationship of Therapist MC to Psychotherapy Process and Outcome**

Despite differences in underlying theoretical perspectives, each of the conceptions of therapist MC broadly hold that there is variability in how well specific cultural processes are navigated by therapists. Current research also suggests that higher ratings on therapist MC are associated with more positive ratings on treatment processes and outcomes. Research focused on the relationship of MC with psychotherapy process and outcome typically includes a client rating of therapist MC, which is then correlated with another client-reported outcome (e.g., measures of working alliance or treatment outcome). Findings from MC studies have generally revealed that higher client ratings of therapists’ MC are positively related to important therapeutic processes, including working alliance, client satisfaction, general counseling competence, and session impact. However, it is also possible that associations vary across measures of treatment process and outcome (e.g., alliance vs. psychological well-being) or different types of MC measures (direct vs. indirect measures of MC). We provide a brief review of current findings below.

**Therapist MC and working alliance.** Working alliance refers to the collaboration between the therapist and the client, as well as the contribution of both individuals in directing the process of therapy (Bordin, 1979; Horvath & Greenberg, 1989; Horvath & Symonds, 1991). Overall, correlations between client-rated alliance and MC have ranged from moderate to large, indicating that higher ratings of therapist MC are positively related to ratings of the alliance. For example, a study with African American clients (n = 40) treated by White therapists demonstrated a strong positive relationship between client-rated working alliance and therapist MC (r = .70) and a negative relationship with client-perceived racial microaggressions (r = -.40; Constantine, 2007). In another study, researchers found a similar pattern, wherein clients’ ratings (n = 51) of working alliance were strongly correlated with perceived MC (r = .73; Fuertes et al., 2006). Furthermore, in a study of university counseling center clients (n = 232), there was a negative relationship between working alliance and microaggressions (r = -.29; Owen et al., 2012).

Much smaller effects were found in two unpublished dissertations. For example, in a study with racial and ethnic minority clients from a community mental health setting (n = 15), the relationship between clients’ ratings of working alliance and perceptions of therapist MC was very small and not statistically significant (r = .04; Ward, 2002). Similarly, in a study with 19 therapy dyads (African American clients and White therapists), the relationship between client-rated provider level of color blindness, a form of racial microaggression, and working alliance was also close to zero and not statistically significant (r = -.01; Morton, 2011).

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1 See Ridley and Shaw-Ridley (2011) for conceptual and semantic distinctions between multicultural competence and multicultural competencies.

2 We were unable to locate studies that utilized observer ratings to test the relationship between MC and clinical processes or outcomes. Accordingly, in our analysis, references to therapists’ MC and results correlating therapists’ MC to other clinical processes or treatment outcomes are based entirely on client ratings.
Therapist MC and client satisfaction. Client satisfaction pertains to clients’ sense of fulfillment and whether their expectations were met by services received in therapy sessions (Druss, Rosenheck, & Sotlar, 1999). Overall, studies indicate a strong relationship between client satisfaction and client perceptions of their therapists’ MC. For example, two studies with racial minority participants (n = 112, 40; Constantine, 2002, 2007) found that client ratings of their therapists’ MC, using the CCCI–R (LaFromboise et al., 1991) and Client Satisfaction Questionnaire–8 (CSQ–8; Larsen, Attkisson, Hargreaves, & Nguyen, 1979), were positively associated with satisfaction with therapy (rs = .59, .64). In a study examining similar processes, Fuertes et al. (2006) measured 51 clients’ perceptions of their counselors’ MC using the CCCI–R and found that they were strongly related to client satisfaction scores (r = .83) on the Counselor Evaluation Inventory (CEI) satisfaction subscale (Linden, Stone, & Shertzer, 1965). In another study with racial minority clients (n = 61; Kim, Ng, & Ahn, 2009), researchers utilized the CCCI–R and two satisfaction items: (a) “If a person you knew wanted to see a counselor, how likely would you be to recommend your counselor?” and (b) “How likely are you to return for your next session?” Results indicated a moderate to large positive association between client perceptions of therapist MC and these satisfaction items (rs = .61 and .43, respectively).

Therapist MC and general counseling competence. General counseling competence (GCC) refers to therapist expertise (e.g., skills and knowledge), trustworthiness (e.g., openness, genuineness), and attractiveness (e.g., admiration toward, liking; Atkinson & Wampold, 1982; Barak & LaCrosse, 1975; Strong, 1968). A primary question in multicultural counseling research has been to determine if GCCs are distinct from MC (Coleman, 1998; Drinane, Owen, Adelson, & Rodolfa, 2014; Sue et al., 2009). In one study, both MC and GCC measures were administered to R–EM clients (n = 112) to determine predictors of satisfaction with therapy. Results indicated that MC and GCC were highly correlated (r = .78). This was corroborated in a study with a similar population (Fuertes & Brobst, 2002), which demonstrated a strong correlation between clients’ (n = 85) perceptions of therapist GCCs and MC (r = .72). In three studies with Asian American clients (Kim, Li, & Liang, 2002; Kim et al., 2009; Li & Kim, 2004), the relationship between GCC and MC was also quite large (n = 78, 61, and 52; rs = .62, .65, and .68, respectively). However, these large correlations were not verified in another study where the relationship between clients’ (n = 51) ratings of their therapists’ MC and GCC were relatively small and not statistically significant (r = .23; Fuertes et al., 2006). Overall, the variability in correlations—from small to large—across these five studies raises questions as to the actual association between MC and GCC.

Therapist MC and session impact. Session impact refers to clients’ evaluations of a psychotherapy session, including immediate effects and post-session mood (Stiles & Snow, 1984), and has been linked to working alliance and treatment outcomes (Horvath & Greenberg, 1994; Owen, Hilsenroth, & Rodolfa, 2013; Stiles, Shapiro, & Firth-Cozens, 1988; Watson, Schein, & McMullen, 2010). A component of session impact is depth, broadly defined as the extent to which a therapy session was considered powerful or valuable to the client (Stiles & Snow, 1984). An empirical examination of session depth and its association to perceptions of therapist MC indicates a moderate to strong correlation. For example, the relationship between session depth and client-rated MC with Asian American clients (ns = 78, 52) resulted in both moderate (r = .39; Li & Kim, 2004) and strong relationships (r = .69; Kim et al., 2002).

Therapist MC and treatment outcomes. Whereas the relationship between therapist MC and clinical processes is important to clarify, two decades of reviews on MC research (Constantine, Gloria, & Ladany, 2002; Dunn, Smith, & Montoya, 2006; Ponterotto & Alexander, 1996; Ponterotto, Rieber, Barrett, & Sparks, 1994; Pope-Davis & Dins, 1995; Worthington, Soth-McNett, & Moreno, 2007) have identified one critical gap—the dearth of studies that actually assess the impact of therapist MC on client psychotherapeutic or treatment outcomes. Treatment outcomes have commonly been assessed via client ratings of psychological symptoms (e.g., depression and anxiety), well-being (e.g., the Schwartz Outcome Scale [SOS–10]; Blais et al., 1999), or retrospective reports of clients’ perception of change due to therapy (e.g., patient estimate of improvement [PEI]; Hatcher & Barends, 1996). Overall, there has been scant evidence that therapists who are rated as having greater MC demonstrate better treatment outcomes (Sue et al., 2009).

Several studies have begun to address the relationship between client ratings of their providers’ MC (e.g., CCCI–R; LaFromboise et al., 1991) and client ratings of treatment outcome (e.g., symptoms or distress; PEI; SOS–10). Effect sizes from these studies vary widely from small to large. For example, there was a small but significant correlation between client perceptions of racial microaggressions in therapy and client-reported symptom reduction (n = 232; r = −.18; Owen, Imel, et al., 2011). An unpublished dissertation with minority clients (n = 80) reported small and nonsignificant correlations between MC and depression and anxiety symptoms (rs = .03 and .12, respectively; Sarmiento, 2012). However, another study indicated a moderate correlation between perceptions of therapist MC and clients’ reports on psychological outcomes measured by the SOS–10 (n = 143; r = .31; Owen, Leach, Wampold, & Rodolfa, 2011). Finally, in a study conducted with African American clients (n = 120), there was a large positive (r = .59) relationship between ratings of MC and psychological symptoms, as well as social and personal improvement (Hook et al., 2013). While the results of this final study provide promising evidence for the effect of MC on client mental health improvement, the inconsistency in these studies raises questions about the actual relationship between MC and treatment outcome.

Summary and Potential Sources of Variability

The above review examines the association between therapist MC and clinical processes and outcomes over the past two decades. Based on the extant literature, it appears that MC is linked to variables such as client satisfaction and session impact (e.g., depth), although the latter has been less frequently studied. Several discrepancies do emerge, however. The first involves MC and working alliance, in which study effects range from small to large. In an inspection of dissertations, we found some evidence for smaller effects, which may serve to inflate the observed effects in the literature. Similarly, some studies indicate strong connections between GCC and MC such that it appears that measures may be assessing a similar underlying construct (e.g., overall competence),
but recent studies have demonstrated smaller associations. The association between MC and treatment outcome appears to be generally smaller than associations with process measures and also appears to be inconsistent across studies.

Different effects within and across types of process and outcome association (MC and alliance vs. MC and outcome) might suggest actual variability in these relationships or simply may be a result of sampling error—for example, we would expect a certain amount of variability in correlations across studies by chance even if the true correlation were large and stable. Alternatively, different patterns of association across measures may provide important information regarding the nature and impact of MC. Meta-analysis allows a test of whether variability in effects between studies is larger than what would expect by chance and also allows for the examination of moderators that might explain observed variability. For example, if the correlation of MC with client satisfaction is higher than the alliance, this may suggest that MC provides more general information about a client’s feelings about counseling rather than more specific information about a client’s relationship with a therapist. It may also be that correlations with process and outcome are stronger in measures explicitly designed to measure therapist MC (e.g., direct MC measures like the CCCI–R) as compared to indirect measures that are thought to capture some aspect of MC from a client rating of therapist behavior (e.g., RMCS).

In addition to the variability in effects due to the type of MC measure or outcome, there are other study-level variables that may moderate the relationship between MC and psychotherapeutic processes and outcomes, including demographics (e.g., client R–EM status, age, and gender) and setting (e.g., university vs. community). As a primary example, it has been claimed that MC is of most importance when working with racial and ethnic minority clients as compared to White clients (Sue et al., 1982, 1992; Sue & Sue, 2012). For example, clients’ R–EM status has been shown to influence the relationship between their perceptions of their therapists’ MC and client satisfaction ratings (Constantine, 2002). This stance is held in contrast to others who argue that MC is important for all clients and should be considered regardless of clients’ racial and/or ethnic background. For example, clients are likely to have intersections of and multiple cultural identities, which may all be significant to their lives (Collins, Arthur, & Wong-Wylie, 2010; Owen, Tao, Leach, & Rodolfa, 2011; Pedersen, 2007; Vontress & Jackson, 2004). A relationship between the representation of R–EM clients (i.e., percentage of R–EM clients) in a study and the correlation of MC with other outcomes would provide a test of whether the importance of MC is specific to R–EM clients. It is possible that for White clients, ratings of MC are less connected to other process ratings. Therefore, in studies with a greater percentage of White clients, associations may be attenuated. Alternatively, if therapist MC is important for all clients, we do not expect to see differences in the strength of association with other clinical processes or outcomes.

In terms of other demographic variables, age is associated with the endorsement of mental health symptoms among racial and ethnic minorities (Vega & Rumbaut, 1991; Yeh, 2003). Moreover, a tendency for younger clients to defer to a therapist could potentially impact perceptions of MC (also known as credibility; Sue & Zane, 1987) and increase associations of MC with other ratings of the provider (e.g., GCC). Gender differences have also been a focus of psychotherapy outcome and process research for several decades (Ogrodniczuk, 2006; Owen, Wong, & Rodolfa, 2009), but few studies have examined the potential variation in effects of MC for men and women (see Griner & Smith, 2006). Thus, a closer examination of the role gender may play in MC is warranted.

In addition to client demographic factors, we also consider where psychotherapy was being provided. MC training is highly emphasized within the field of counseling psychology (Bieschke & Mintz, 2012; Council of Counseling Psychology Training Programs [CCPTP], 2009), and many counseling psychologists have been frequently employed by university counseling centers (CCPTP, 2009); Illfelder-Kaye, Lese-Fowler, Bursley, Reyes, & Bieschke, 2009). However, community mental health centers (CMHCs) have historically served a more diverse clientele as well as employed multidisciplinary mental health professionals, which has led to the development of service and training models that address therapist MC and provision of multiculturally competent counseling (Chu et al., 2012; Park-Taylor et al., 2009). As such, we tested whether clinical setting (e.g., university counseling center vs. CMHC) would moderate the association between MC and clinical processes and/or treatment outcomes.

Current Study

The purpose of this meta-analysis was to determine the relationship of MC to relevant clinical processes and outcomes in psychotherapy. Although individual MC studies have provided critical knowledge about this relationship, the current study presents a comprehensive summary of empirical findings to date. We also explored the heterogeneity of associations between therapist MC and clinical process and treatment outcomes, including publication status, and tested other potential sources of variability through a series of moderator analyses that include: (a) type of outcome measure (e.g., alliance vs. satisfaction vs. treatment outcome), (b) type of MC measure (e.g., CCCI–R or Cultural Humility Scale [CHS]), (c) demographics (i.e., mean age, gender percentage, R–EM percentage), and (d) clinical setting. Our first hypothesis was that higher therapist MC would generally be associated with measures of positive psychotherapy process. In particular, we expected (Hypotheses 1a–d) that MC would be strongly positively associated with (1a) working alliance, (1b) client satisfaction, (1c) GCC, and (1d) session impact. We predicted a smaller but still positive association between MC and treatment outcome (Hypothesis 2). We predicted no evidence of different associations across process outcomes (Hypothesis 3), but did predict that the association of MC with clinical outcome would be significantly smaller than the association with treatment process (Hypothesis 4). However, based on the extant literature, other moderator analyses for MC measure type (i.e., direct vs. indirect), as well as demographics, setting, and publication status, were considered exploratory, and therefore no formal hypotheses were stated.

Method

Literature Search

A doctoral student and the first author conducted an electronic search of relevant published and unpublished studies in the following databases: Academic Search Premier, CINAHL, Dissertation Abstracts, ERIC, Family and Society Studies Worldwide,
Health Source: Nursing/Academic Edition, MEDLINE, PsycArticles, PsycINFO, PubMed, and Social Services Abstract. The search terms used were (cultural competence or culturally competent or multicultural competence or multiculturally competent) and (counselor or counseling or therapist or psychotherapist or psychotherapy). We also conducted an iterative search in reference sections of reviews of counselor cultural competence and primary references of the published and unpublished primary studies of cultural competence. We also sought information (e.g., other papers in press) from authors with two or more publications identified in the search.

Initially, we identified approximately 43,000 peer-reviewed articles using the search terms listed above, including duplicates. We examined the titles of these articles and subsequently retrieved 130 potential journal articles or dissertations. The doctoral student and primary investigator reviewed these studies independently by reading abstracts and method sections to decide whether to include them for further analysis. Decisions regarding which studies to include involved ascertaining if studies were actual psychotherapy or counseling studies (vs. analogue), if the procedures included some type of MC measure or assessment, and if clinical processes or outcomes were correlated with the MC measures. We did not consider qualitative, analogue, or case studies. This process yielded 39 studies of which the reference sections were also checked to ensure that all potential studies were located.

Final inclusion criteria for analysis were (a) the study included a client rating of therapist MC or a highly related construct; (b) the research was based on ratings from actual psychotherapy/counseling sessions—thus, analogue studies from a lab setting (e.g., client ratings of therapist videotapes) or those evaluating case management services (e.g., rehabilitation, vocational) were excluded; and (c) the study presented values or allowed for a calculation of a correlation coefficient (r) between MC and therapy processes or outcomes. Twenty-one studies were excluded, as they did not meet all inclusion criteria. The inclusion criteria did not restrict studies to specific years; however, all of the summarized studies were conducted between 2002 and 2014. Of the 18 included studies (20 independent samples), 13 were published studies in peer-reviewed journals and five were unpublished dissertations (see Figure 1; for more detailed information about the excluded studies, see the Appendix).

Coding Procedures

The coding team consisted of two members, in which one coder, a doctoral student in counseling psychology (the third author), determined characteristics from each study, followed by the second coder (the first author), who checked for accuracy. The following descriptive information was coded: (a) sample size and participant characteristics, including age, gender, and race or ethnicity; (b) average number of psychotherapy sessions that clients received; (c) the types and names of measures used to assess MC; and (d) the types and names of measures used to assess clinical processes and treatment outcomes. Information from all of the included studies was extracted directly from the published articles or dissertations.

MC measures included inventories or self-report tools used to assess client perceptions of therapist multicultural awareness, skills, and knowledge (e.g., sociopolitical awareness, cultural sensitivity); cultural processes or interactions within therapy (e.g., racial microaggressions, cultural humility); or perceived approaches or stances related to cultural identity variables (e.g., gender). MC measures were categorized into two types—MC direct and MC indirect. An MC direct measure included inventories like the CCCI–R or MCI in which items explicitly ask participants to rate a therapist’s MC. An MC indirect measure is one that assesses clients’ perceptions of more nuanced and implicit MC congruent behavior (e.g., nonsexist language) or MC antithetical behavior (e.g., racial microaggression, color blindness; see Table 1).

Clinical process measures were categorized as those intended to examine aspects of the psychotherapeutic relationship or what transpires during the course of therapy and through the client–therapist interaction (Orlinsky & Howard, 1986). These included the alliance, session impact, satisfaction, and general competence. Outcome measures were defined as those designed to assess symptoms or complaints related to a specific presenting issue (e.g., depression) or broader psychological functioning (e.g., general life satisfaction, social interactions, ability to enjoy activities).

Statistical Analyses

For each measure (i.e., clinical process or treatment outcome) within each study, the primary effect size of interest was the Pearson product–moment correlation (r). To correct for nonnormality of the correlation effect size and stabilize variance estimation, rs were converted to z scores for the meta-analysis and then back-transformed to rs for interpretation (Fisher, 1924). Variability in effect sizes across studies was examined

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3 Only studies that included client ratings of their therapists were selected. While observer ratings of MC are clearly important, there were not a sufficient number of studies. We address limitations of client ratings of MC in the Discussion section.

4 Race and/or ethnicity were coded as the percentage of racial and ethnic minority clients included in the study. Gender was coded as the percentage of men and women included in the study.
using the $I^2$ statistic, which quantifies the amount of “true” between-study heterogeneity in effect sizes not due to chance (Huedo-Medina, Sánchez-Meca, Marín-Martínez, & Botella, 2006).

We conducted several specific meta-analyses. First, we provided an overall estimate of client perceptions of their therapists’ MC to all psychotherapy process and outcome measures. To account for dependencies between multiple observed correlations within a single study, we aggregated associations within the study such that there was one observed correlation between MC and the outcome within a study. Second, we conducted separate meta-analyses, each associating the correlation of MC with a different process or outcome measure. When there were multiple observations of the same type of correlation within a study (e.g., a study reported two correlations between MC and satisfaction), these correlations were aggregated. However, when different types of associations were reported within a study (e.g., MC with treatment outcome vs. MC with alliance), effects were not aggregated in order to allow for different patterns of association across outcomes. Specific moderators (e.g., measure type, percentage of R–EM clients) were tested via meta-regression. We restricted moderator analyses regarding demographics and setting to the total set of studies (i.e., we did not explore moderators within specific types of process measures). This was for two reasons: (a) the number of studies within each specific clinical process or outcome was relatively small and thus underpowered and (b) we did not have a specific rationale for why the effect of specific moderators (e.g., the percentage of R–EM clients) would be different across outcomes. Moderator results are reported in terms of $d(r)$ or the predicted difference ($d$) in the correlation coefficient ($r$) across levels or values of the moderator.

For each meta-analysis, we utilized a random effects model, which assumes that the studies in our database were drawn from a population of studies and therefore allows estimation of study-level heterogeneity as well as generalizing to the population of studies examining the association of MC and psychotherapy process and outcome (Cooper, Hedges, & Valentine, 2009). All analyses were conducted in R (R Core Development Team, 2011) with the meta-analysis package “metafor” (Viechtbauer, 2014). Effect size aggregation within a study was conducted using formulas outlined by Hunter and Schmidt (2004), utilizing the package “MAc” in R (Del Re & Hoyt, 2010), assuming a correlation of .50 between different outcomes within a study (Wampold et al., 1997).

### Table 1

<table>
<thead>
<tr>
<th>MC measure</th>
<th>Type</th>
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<td>Color-Blind Racial Attitudes Scale (CoBRAS)</td>
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<tr>
<td>Cross-Cultural Counseling Inventory—Revised (CCCI–R)</td>
<td>Direct</td>
</tr>
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<td>Cultural Humility Scale (CHS)</td>
<td>Indirect</td>
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<tr>
<td>Feminist-oriented approach (FOA)</td>
<td>Indirect</td>
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<td>Multicultural Counseling Inventory (MCI)</td>
<td>Direct</td>
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<td>Racial Microaggressions in Counseling Scale (RMCS)</td>
<td>Indirect</td>
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### Results

#### Descriptive Characteristics and Publication Bias

Eighteen studies (20 independent samples, 53 effects) met the inclusion criteria of measuring clients’ perceptions of their therapists’ MC and treatment process and outcome (see Table 2). Of these 53 effects, 25 (47%) examined the relationship between MC and therapeutic alliance, nine (17%) the relationship between MC and treatment outcomes, eight (15%) the relationship between MC and client satisfaction, eight (15%) the relationship between MC and general competencies, and three (8%) the relationship between MC and session depth. Across all studies, the mean number of sessions was eleven (median = 5.7), ranging from one to 58 sessions. The mean number of participants across studies was 93 (median = 78; range = 15–472). Across studies, the majority of clients were women (68%; range = 26–100%). Men represented 32% of clients (range = 0–74%), and 1.3% of clients identified as Other (range = 1–2%). Across studies, an average of 80% of clients reported race–ethnic minority group membership (range = 30–100%). The mean age of clients was 24 years old (median = 22 years old; range = 19–48 years old; note that one study did not report age).

We tested for the presence of publication bias in several ways. First, we examined the difference in effect sizes between published and unpublished studies. There was a significant difference, with dissertations providing weaker associations across all outcomes as compared to published articles, $d(r) = -.39$, 95% confidence interval (CI) $[-.65, -.05]$. However, the rank correlation test (Begg & Mazumdar, 1994) did not reveal a significant relationship between observed correlations and sampling variance, $r = .11, p > .50$, indicating that there was no clear relationship between the sample size and the observed correlation. Notably, there was still no relationship even when dissertations were included in the meta-analysis, $r = -.04, p > .50$. This pattern held when publication tests were restricted to associations with process variables as well as clinical outcomes.

#### Client Perceptions of Their Therapists’ MC and Therapy Process

The effect sizes for the various outcomes are listed in Figure 2. Supporting Hypotheses 1a–d, the associations between perceptions of MC across four specific clinical processes were large, but heterogeneity in effect sizes was moderate to large for each outcome: (a) therapeutic alliance, $r = .61, k = 16, 95\%$ CI $[.50, .71]$; $I^2 = 90.35\%$, $Q(15) = 155.48, p < .001$; (b) client satisfaction, $r = .72, k = 5, 95\%$ CI $[.63, .80]$; $I^2 = 63.82\%$, $Q(4) = 11.05, p = .03$; (c) general counseling competencies, $r = .62, k = 7, 95\%$ CI $[.49, .73]$; $I^2 = 79.51\%$, $Q(6) = 29.29, p < .001$; and (d) session depth, $r = .58, k = 3, 95\%$ CI $[.37, .73]$; $I^2 = 70.74\%$, $Q(2) = 6.83, p = .033$. These findings suggest that client ratings of their therapists’ MC account for approximately 37% of the variance in working alliance, 52% of the variance in client satisfaction, 38% of the variance in GCC, and 34% of the variance in session depth.

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5 One study (Hook, Davis, Owen, Worthington, & Utsey, 2013) involved three independent samples and corresponding analyses that fit the criteria for inclusion in our meta-analysis.
<table>
<thead>
<tr>
<th>Source</th>
<th>N</th>
<th>Age</th>
<th>Percentage of racial–ethnic minority (R–EM) clients</th>
<th>Gender percentage</th>
<th>Clinical context</th>
<th>Multicultural competencies (MC) measure</th>
<th>Outcome or process measure</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constantine (2002)</td>
<td>112</td>
<td>21.0</td>
<td>100%</td>
<td>70% women 30% men</td>
<td>University students</td>
<td>CCCI–R</td>
<td>CRF–S</td>
<td>0.78</td>
</tr>
<tr>
<td>Constantine (2007)</td>
<td>40</td>
<td>19.7</td>
<td>100%</td>
<td>65% women 35% men</td>
<td>University students</td>
<td>RMCS</td>
<td>CSQ</td>
<td>0.64</td>
</tr>
<tr>
<td>Fuertes &amp; Brobst (2002)</td>
<td>85</td>
<td>30</td>
<td>42%</td>
<td>80% women 20% men</td>
<td>Graduate students</td>
<td>CCCI–R</td>
<td>CSQ WAI–SR</td>
<td>−0.40</td>
</tr>
<tr>
<td>Fuertes et al. (2006)</td>
<td>51</td>
<td>26.5</td>
<td>76%</td>
<td>53% women 47% men</td>
<td>University students</td>
<td>CCCI–R</td>
<td>CRF–S</td>
<td>0.72</td>
</tr>
<tr>
<td>Hook, Davis, Owen, Worthington, &amp; Utsey (2013)</td>
<td>472</td>
<td>21</td>
<td>40%</td>
<td>68% women 32% men</td>
<td>University students</td>
<td>CHS</td>
<td>WAI–SR</td>
<td>0.70</td>
</tr>
<tr>
<td></td>
<td>134</td>
<td>26.4</td>
<td>30%</td>
<td>68% women 32% men</td>
<td>Online survey</td>
<td>CCCI–R</td>
<td>CSQ WAI–SR</td>
<td>0.59</td>
</tr>
<tr>
<td>Kim, Li, &amp; Liang (2002)</td>
<td>78</td>
<td>20.1</td>
<td>100%</td>
<td>63% women 37% men</td>
<td>University students</td>
<td>CCCI–R</td>
<td>PEI</td>
<td>0.59</td>
</tr>
<tr>
<td>Kim, Ng, &amp; Ahn (2009)</td>
<td>61</td>
<td>21.0</td>
<td>100%</td>
<td>66% women 34% men</td>
<td>UCC</td>
<td>CCCI–R</td>
<td>SIS–Depth</td>
<td>0.68</td>
</tr>
<tr>
<td>Li &amp; Kim (2004)</td>
<td>52</td>
<td>18.9</td>
<td>100%</td>
<td>69% women 31% men</td>
<td>University students</td>
<td>CCCI–R</td>
<td>EUS</td>
<td>0.62</td>
</tr>
<tr>
<td>McCann (2006)</td>
<td>115</td>
<td>NR</td>
<td>100%</td>
<td>68% women 32% men</td>
<td>Churches, university students</td>
<td>CCCI–R</td>
<td>WAI–SR</td>
<td>0.50</td>
</tr>
<tr>
<td>Morton (2011)</td>
<td>19</td>
<td>47.7</td>
<td>100%</td>
<td>26% women 74% men</td>
<td>VA, UCC, and CMH</td>
<td>CoBRAS</td>
<td>WAI–SR</td>
<td>−0.01</td>
</tr>
<tr>
<td>Owen, Tao, &amp; Rodolfa (2010)</td>
<td>232</td>
<td>22</td>
<td>48%</td>
<td>70% women 30% men</td>
<td>UCC</td>
<td>RMCS</td>
<td>SOS–10</td>
<td>−0.39</td>
</tr>
<tr>
<td>Owen et al. (2014)</td>
<td>45</td>
<td>24</td>
<td>76%</td>
<td>60% women 40% men</td>
<td>University students</td>
<td>RMCS</td>
<td>WAI–SR</td>
<td>−0.18</td>
</tr>
<tr>
<td>Owen, Leach, Wampold, &amp; Rodolfa (2011)</td>
<td>143</td>
<td>25.0</td>
<td>45%</td>
<td>72% women 26% men</td>
<td>UCC</td>
<td>CCCI–R</td>
<td>PEI</td>
<td>−0.29</td>
</tr>
<tr>
<td>Owen, Tao, Leach, &amp; Rodolfa (2011)</td>
<td>176</td>
<td>25.0</td>
<td>46%</td>
<td>77% women 22% men</td>
<td>UCC</td>
<td>CCCI–R</td>
<td>SOS–10</td>
<td>0.33</td>
</tr>
<tr>
<td>Owen, Tao, &amp; Rodolfa (2010)</td>
<td>121</td>
<td>23.0</td>
<td>40%</td>
<td>100% women</td>
<td>UCC</td>
<td>MAWS</td>
<td>SOS–10</td>
<td>−0.33</td>
</tr>
<tr>
<td>Rasheed (2011)</td>
<td>40</td>
<td>29.1</td>
<td>100%</td>
<td>100% women</td>
<td>Online survey</td>
<td>CCCI–R</td>
<td>WAI–SR</td>
<td>0.35</td>
</tr>
<tr>
<td>Sarmiento (2012)</td>
<td>80</td>
<td>21.4</td>
<td>100%</td>
<td>78% women 22% men</td>
<td>UCC</td>
<td>CCCI–R</td>
<td>CES–D</td>
<td>0.03</td>
</tr>
<tr>
<td>Ward (2002)</td>
<td>15</td>
<td>34.7</td>
<td>100%</td>
<td>85% women 15% men</td>
<td>CMH</td>
<td>MCI</td>
<td>WAI–SR</td>
<td>0.04</td>
</tr>
</tbody>
</table>

Note.  
CCCI–R = Cross-Cultural Counseling Inventory—Revised; CEI = Counselor Evaluation Inventory; CERS = Counselor Effectiveness Rating Scale; CES–D = Center for Epidemiologic Studies Depression Scale; CHS = Cultural Humility Scale; CMH = community mental health; CoBRAS = Color-Blind Racial Attitudes Scale; CRF–S = Client Rating Form–Short; CSQ = Client Satisfaction Questionnaire; EUS = Empathic Understanding Subscale; FOA = Feminist-Oriented Approach; GAD–7 = Generalized Anxiety Disorder–7; MAWS = Microaggressions Against Women Scale; MCI = Multicultural Counseling Inventory; NR = not reported; PEI = Patient Estimate of Improvement; RMCS = Racial Microaggressions in Counseling Scale; RRI–C = Real Relationship Inventory–Client; SIS–Depth = Session Impact Scale–Depth; SOS–10 = Schwartz Outcome Scale–10; UCC = university counseling center; VA = Veterans Administration Hospital; WAI–SR = Working Alliance Inventory—Short Form Revised.
The correlation between perceptions of MC and treatment outcomes was moderate in size with large heterogeneity in effect sizes, $r = .29, k = 7, 95\% \text{ CI} [.16, .41]; F = 76.12\%, Q(6) = 25.13, p < .001$, which supports Hypothesis 2. This finding suggests that client perceptions of their therapists’ MC account for over 8% of the variance in therapy outcomes.

**Moderator Analyses**

The heterogeneity observed above suggests that the relationship between MC and clinical processes and treatment outcomes varied quite substantially across studies. To examine potential explanations for heterogeneity across studies, we conducted separate moderator analyses in three areas: (a) type of measures, (b) participant demographics, and (c) setting.

There was no significant difference in the correlation of MC across the four different measures of treatment processes, $Q(3) = 2.11, p > .50$ (Hypothesis 2). However, there was a significant difference between the correlation of MC with process measures (i.e., alliance, satisfaction, depth, GCC) and clinical outcome, $r(d) = 0.45, 95\% \text{ CI} [0.24, 0.64]; Q(1) = 14.39, p < .001$, where the correlation between MC and process variables in aggregate ($r = .75$) was more than twice as large as the correlation with treatment outcomes ($r = .29$; Hypothesis 3).

The type of MC measure (direct vs. indirect) did not have a significant influence on the strength of the relationship between MC and outcomes, $r(d) = -.18, 95\% \text{ CI} [-.45, .11]; Q(1) = 1.53, p = .22$. In addition, there was no significant effect of average client age, $r(d) = -.01, 95\% \text{ CI} [-.05, .01]; Q(1) = 1.58, p = .21$, the percentage of R–EM clients within a study, $r(d) = .0002, 95\% \text{ CI} [-.006, .006]; Q(1) = 0.005, p > .50$, or the percentage of women in a study, $r(d) = -.006, 95\% \text{ CI} [-.02, .004]; Q(1) = 1.41, p = .24$. Finally, the effect size difference between clinical settings (i.e., university [$r = .73$] vs. community setting [$r = .46$]) was notable but not significant, $r(d) = .27, 95\% \text{ CI} [-.09, .57]; Q(1) = 2.16, p = .14$. Notably, there were only five effects from community settings in the entire meta-analysis, and one of these effects was near zero and from an unpublished dissertation with a small sample ($r = .03, n = 15$; Ward, 2002).

**Discussion**

This is the first known meta-analysis to summarize the relationship between client perceptions of therapist MC and psychotherapeutic processes and outcomes. Beyond summarizing the effects of clients’ perceptions of therapist MC in psychotherapy, we addressed Kleinman and Benson’s (2006) call for evidence that “culture really improves clinical services” (p. 1673). To this end, our analysis of 20 independent samples and 53 effects demonstrated strong and positive effects of client perceptions of therapist MC on four important clinical processes ($rs$ ranged from .38 to .72 across measures) and a moderate relationship between MC and treatment outcomes ($r = .29$). In other words, client perceptions of therapist MC account for approximately 8.4% of the variance in therapy outcomes, and therapist MC is closely linked to other core clinical processes. Our analysis also showed that the associations between client-rated MC and therapy outcomes were consistent with other correlational estimates cited in the literature on empirically supported therapeutic variables, such as working alliance, empathy, genuineness, goal census and collaboration, and alliance–rupture repair (e.g., Elliott, Bohart, Watson, & Greenberg, 2011; Horvath, Del Re, Flückiger, & Symonds, 2011; Kolden, Klein, Wang, & Austin, 2011; Norcross & Lambert, 2011; Safran, Muran, & Eubanks-Carter, 2011; Tryon & Winograd, 2011). Accordingly, therapist MC should be considered an important empirically supported therapeutic relational factor, similar to those listed above.

The moderate to large heterogeneity in effect sizes for all of the clinical process and treatment outcome variables warranted moderator analyses, which offer potentially important explanations for the variability. Accordingly, we discuss interpretations of moderation results found after testing the strengths of association of MC with publication status, the type of psychotherapy outcome measure, client demographics, and clinical setting.

**Interpretation of Moderator Analyses**

**Process versus treatment outcome measures.** The association between MC and clinical processes was twice as large as the relationship with clinical processes ($r = .75$ vs. $r = .29$). To start, the correlation between client-rated MC and clinical process variables was fairly large ($rs$ ranged from .58 to .72). These large correlations indicate that these processes may occur concurrently, such that a strong working alliance is more likely to exist when the therapist exhibits more multicultural competencies (and vice versa). Alternatively, these high correlations could indicate that cultural processes and other clinical processes, such as alliance or session depth, are fused. It may be tempting to conclude that high correlations suggest that therapist MC is not unique or distinct from these other clinical processes (see Coleman, 1998). However, it will be important to examine the construct validity of such tightly interrelated variables. For example, a factor analysis exam-
ining the correlation between the CCCI–R–7, a modified version of the CCCI–R, and the WAI-SR (Hatcher & Gillaspy, 2006) found evidence for treating MC and alliance as separate constructs (vs. a model in which items from both scales were loaded onto one global factor; Drinane et al., 2014). Thus, the high correlations demonstrated in our analysis might simply suggest that therapist MC works in concert with other clinical processes to produce therapeutic change (see, e.g., Owen, Tao, et al., 2011).

A moderate association between MC and clinical treatment outcomes was found in several studies, albeit not consistently so. The lack of longitudinal studies limits our understanding of the association between client perceptions of their therapists’ MC and therapy outcomes. To our knowledge, a classic process study design wherein changes in clients’ psychological functioning from pre- to posttreatment are correlated with their perceptions of therapist MC early in treatment has yet to be done. While moderate associations between therapist MC and therapy outcomes may be evident in such designs (see commonalities in associations between retrospective and longitudinal designs; Moore & Owen, 2014), this research remains a critical gap in the MC literature.

**Client demographics and clinical setting.** Our results indicated that the clinical setting (i.e., UCC vs. CMHC) and client demographics, including age, gender, and percentage of R–EM clients in the study, did not affect the relationship between MC and either clinical processes or treatment outcomes. Whereas the percentage of R–EM clients in each study was not a significant moderator, this result warrants some attention. Specifically, this “no-difference” finding contributes to an ongoing discussion regarding whether therapist MC is most important for R–EM clients or perhaps (and corresponding to our findings) a critical factor for clients regardless of their R–EM status. Simultaneously, our results highlight a need for MC research that is sensitive to client differences, including consideration of client-defined group membership and intersections of identities. This is in contrast to limiting clients to a set of predefined identity statuses based on researcher-determined categorical indicators. For example, studies on client and therapist racial–ethnic match may be overlooking the importance of intersectionality or other cultural identity variables (e.g., sexual orientation, religion, etc.; see Ibaraki & Hall, 2014).

**Publication status.** There were mixed results for tests of publication bias. Dissertations provided smaller effects on average as compared to published studies, suggesting that there is some tendency for unpublished studies to have lower overall effects. However, there was no clear relationship between study sample size and effect size (both when dissertations were and were not included in analyses). While these analyses are somewhat limited by the low number of effects (k = 20), these results suggest that both small and large effects have been published regardless of sample size.

Our results also contribute to a growing corpus of meta-analyses examining the role of cultural factors in psychotherapy, including the effect of culturally adapted treatments on clinical outcomes (e.g., Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Smith, Rodriguez, & Bernal, 2011). For example, Benish et al. (2011) conducted a meta-analysis comparing culturally adapted versus unadapted bona fide therapies. Whereas the summary of studies found that culturally adapted treatments were more efficacious than unadapted bona fide treatments, the researchers found that the efficacy of these culturally adapted treatments was moderated solely by the incorporation of the clients’ beliefs about the meaning behind their presenting issues (also known as the illness myth). In other words, therapists’ integration of clients’ cultural narratives into the intervention significantly accounted for differences in client improvement (see also Huey et al., 2014). Consistent with this finding, our study indicates that client perceptions of how a therapist navigates cultural factors in treatment are correlated with outcome. Despite this contribution, there are important limitations to consider, which we describe next.

**Limitations and Directions for Further Research**

The first limitation of our study was the reliance on clients to assess therapist MC. Although client perspectives are certainly critical (Constantine, Kindaichi, Arorash, Donnelly, & Jung, 2002), it is not clear that clients can conduct nuanced assessments of therapist behaviors (e.g., how well a client can assess the provider’s ability to recognize the impact of their personal heritage; see Ridley & Shaw-Ridley, 2011, for a full discussion). For example, 13 out of the 20 independent samples included in our analysis utilized an adapted version of the CCCI–R, a measure originally intended for use by trained observers (see Drinane et al., 2014 for a critique). Additionally, we must note that a comparison between types of MC direct measures was not possible, as the only other measure in the set of studies was the MCI (and it was only used once). Accordingly, correlations between self-, observer-, and therapist-rated measures need to be addressed (Hoyt, Warbasse, & Chu, 2006).

With respect to therapist-reported measures, we excluded two studies that examined therapists’ own ratings of their MC that were associated with changes in their client outcomes (Larrison, Schoppelrey, Hack-Rizio, & Korr, 2011; Menapace, 1997). Larrison et al. (2011) found that therapists who rated themselves higher on one subscale of the MCI (Sadowsky et al., 1994) with R–EM clients had better treatment outcomes (e.g., client-reported symptom reduction). Menapace (1997) found that therapists who rated their MC higher also rated their outcomes with Black clients as being more favorable. Although these studies are consistent with the findings of our meta-analysis, the validity of therapist self-ratings have been considerably questioned (Hoyt et al., 2006; Owen, Imel, et al., 2011; Worthington & Dillon, 2011).

Our meta-analysis also highlights the lack of behavioral detail in client-reported MC measures. What exactly are providers doing in sessions? For MC psychotherapy research to progress, a greater willingness to wade into the raw data of actual counselor–client interactions is required. At present, there is not a single study correlating an observer rating of therapist MC with treatment outcome. Similarly, there are no studies that have examined the correlation of observer ratings of MC with other measures of treatment process. Developing useful observer ratings will be complicated, as initial work suggests that observer, therapist, and client ratings do not agree (Hoyt et al., 2006). For example, in two MC studies (ns = 52, 55), the correlation between observer ratings and therapists’ self-reports of MC was not significant (rs = .03, .09; Constantine, 2001; Worthington et al., 2000). Additionally, clients of the same therapist tend to disagree on their therapist’s MC (e.g., intraclass correlation [ICC] < .01, as measured by the CCCI–R; Owen, Leach, et al., 2011). However, there appears to be
more agreement among clients of the same therapist in their perceptions of some indirect MC measures, such as the cultural humility scale (ICC = .20; Owen et al., 2014). The next wave of MC research will have to consider these discrepancies, which could result from measurement issues or from the need to increase use of other approaches to determine MC (e.g., observing the behavior of providers with known levels of treatment outcomes with racial–ethnic minority patients). Accordingly, there was a notable shortage of outcome measures included in our analysis intended to assess improvement for specific diagnoses or type of treatment provided. Whereas the SOS–10 and PEI are helpful in determining clients’ overall psychological well-being, only one study (i.e., Sarmiento, 2012) utilized scales that assess reduction (or increase) in depression or anxiety (i.e., CES–D; GAD–7). Moreover, this particular study revealed a nonsignificant relationship between MC and these measures. Future MC therapist psychotherapy studies would benefit from including measures to determine whether treatment outcome measures or specific diagnoses moderate effect size (e.g., Lambert, 2007; Wampold et al., 1997).

Finally, a major limitation of the current state of MC research is the overrepresentation of retrospective studies and the absence of longitudinal studies. A major disadvantage of the former is the potential difficulty for clients to recall specific and more nuanced aspects of their therapy experience. Similarly, only the most recent events (Rubin & Baddeley, 1989) and/or incidents that are more personally relevant (Beckett, Da Vanzo, Sastry, Panis, & Peterson, 2001) are likely to be recalled. These reporting biases restrict a fuller understanding of the influence of MC across all clients. Also, the need for repeated observations in studies of therapist MC is clear. It is critical that future research utilize approaches that assess influence of MC on clients over time and the potential cause-and-effect relationship between MC and clinical outcomes. It is important to note, however, that retrospective analyses allow for clients to reflect on the totality of their psychotherapy sessions, which may account for perception changes and responses that are more attuned to the gestalt experience (e.g., Moore & Owen, 2014). Moreover, retrospective analyses offer more representative explanations regarding utilization, including data from both clients who remain in therapy and those who drop out.

Whereas there is a dearth of studies that correlate treatment outcome with ratings of therapist MC (only nine were found and included in this analysis), we have provided meta-analytic evidence that therapist MC is tightly related to other important clinical processes at the intervention level. This provides convincing evidence for continued examination of therapist MC. However, the approaches researchers should take to move the literature forward remain a major question. We have identified several areas to consider, including longitudinal studies that examine MC in psychotherapy, which aim to discriminate between those therapists who demonstrate relatively better or poorer outcomes with R-EM clients (Hayes et al., 2014; Imel et al., 2011; Larrison et al., 2011). Another recommendation is to improve and develop observer-rated measures that directly assess provider behaviors as well as address the lack of an established correlation between observer-, self-, and therapist-reported MC ratings (Hoyt et al., 2006). Ultimately, the goal of providing all clients with multiculturally competent care will require the field of psychology to identify and rigorously test the specific cultural processes that can effect change in psychotherapy. We hope that this meta-analysis will reinforce the importance of therapist MC and provide an “empirical compass” to explore new approaches to understanding the effects of MC as well as galvanizing the importance of MC as a critical psychotherapeutic factor.

References

References marked with an asterisk indicate studies included in the meta-analysis.


Toporek, R. L., & Reza, J. V. (2001). Context as a critical dimension of multicultural counseling: Articulating personal, professional, and insti-
Appendix

Excluded Studies

Of the excluded studies, 12 focused on providers’ MC but did not include an MC-related measure or specifically examine the relationship of MC to treatment processes or outcomes (Barratt, 2007; Bellini, 2003; Constantine, 2001; Godley, Hedges, & Hunter, 2011; Hayes et al., 2014; Imel et al., 2011; Lie, Lee-Rey, Gomez, Bereknyei, & Braddock, 2011; Matrone & Leahy, 2005; Owen et al., 2012; Schwan, 2007; Woidneck, Pratt, Gundy, Nelson, & Twohig, 2012; Worthington et al., 2000), three utilized analytic approaches that did not allow for calculation of the correlation between MC and clinical processes or outcomes (Grantham, 1973; Guerrero & Andrews, 2011; Jones, 1978), two addressed organizational MC (Costantino, Malgady, & Primavera, 2009; Hamada, 2006), two utilized therapist report of MC versus client report (Larrison et al., 2011; Menapace, 1997), one assessed case-management-type services rather than psychotherapy (Damashek, Bard, & Hecht, 2012), and one assessed the MC of physicians (not psychiatrists; Fuertes, Boylan, & Fontanella, 2009).