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Therapist Multicultural Competence, Asian American Participants' Cultural Values, and Counseling Process

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Abstract

Asian Americans drop out of mental health treatment at a high rate. This problem could be addressed by enhancing therapists' multicultural competence and by examining clients' cultural attitudes that may affect the counseling process. In the present study, we used a video analogue design with a sample of 113 Asian American college students to examine these possibilities. The result from a *t* test showed that the session containing therapist multicultural competencies received higher ratings than the session without therapist multicultural competence. In addition, correlational analyses showed that participant values acculturation was positively associated with participant ratings of counseling process, while the value of emotional self-control was negatively correlated. The results of a hierarchical multiple regression analysis did not support any interaction effects among the independent variables on counseling process. All of these findings could contribute to the field of multicultural competence research and have implications for therapist practices and training.

Keywords

multicultural counseling competence; acculturation; enculturation; cultural values; Asian Americans

A recent U.S. Surgeon General's report indicated that only 17% of Asian Americans with a psychological problem sought professional help and less than 6% sought this help from a mental health treatment provider (U.S. Department of Health and Human Services, 2001). One approach to addressing this problem is for Asian American clients to be served by ethnically and linguistically matched mental health professionals. However, pragmatically speaking, ethnically and linguistically matched health delivery is rare and not available in all geographic locations. Moreover, the vast majority of mental health providers are European American. For example, according to a recent study, 87.5% of psychologists who are service providers are European American, whereas 3.6% are Hispanic, 2.7% are Black, 1.7% are Asian/Pacific Islander, and less than 1.0% are Native American (American Psychological Association Center for Workforce Studies, 2009). In addition, even among Asian Americans seeking services at an ethnicity-specific agency, approximately 33% of clients miss a

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scheduled intake appointment (Akutsu & Chu, 2006) and 10% to 22% of clients drop out of treatment after the intake (Akutsu, Tsuru, & Chu, 2004).

Therefore, another approach to addressing the pattern of under-utilization of psychological services by Asian Americans is to examine ways in which non–Asian American counselors, especially European American counselors, can provide more culturally relevant and sensitive services to clients with an Asian American background. As a matter of fact, an expanding body of theoretical literature highlights the importance of multicultural counseling competence in producing positive counseling process and outcome (e.g., Ponterotto, Casas, Suzuki, & Alexander, 2010; Pope-Davis, Coleman, Liu, & Toporek, 2003).

The increasing visibility of multicultural counseling competence as a topic of interest in research, practice, and training has led to a greater understanding of the potential components of multicultural competence that counselors can acquire in order to provide effective services to clients who are culturally different from themselves. Originally developed by Sue et al. (1982); revised by Sue, Arredondo, and McDavis (1992); and further operationalized by Arredondo et al. (1996), multicultural counseling competencies have been proposed to represent three characteristics: (a) being aware of assumptions, values and biases; (b) understanding the worldview of the culturally different client; and (c) developing appropriate intervention strategies and techniques. Each of these characteristics comprises three domains (attitudes/beliefs, knowledge, and skills), and there are 31 competencies across these domains.

However, the literature on multicultural counseling competencies has been consistently criticized for lacking empirical support and validation (Atkinson & Israel, 2003). Research literature has been scant in terms of examining whether these competencies lead to increased effectiveness in cross-cultural counseling process and outcome. Atkinson and Israel (2003) concluded that the successful policy changes resulting from the multicultural counseling competence movement actually took place without strong empirical evidence. Thus, to address this significant limitation, one could begin to study the multicultural counseling competencies in the context of a counseling session. Specifically, we focused our attention on the seven competencies under the skills domain of intervention strategies and techniques. These competencies span from verbal and nonverbal communication skills to language, consultation, testing, psychoeducation, and client advocacy skills. In the present study, we compared a session that used these competencies with a session that lacked these competencies.

The third approach to addressing early termination or limited usage of mental health services by Asian Americans is to consider client characteristics that may come into play during the process of counseling, such as client cultural beliefs or attitudes. Ting and Hwang (2009) suggested identifying both environmental and population factors as determinants of mental health services utilization; for Asian Americans, cultural variables may include level of acculturation (i.e., the degree to which individuals adhere to the cultural norms of the dominant society). Asian American individuals vary with regard to the extent of their acculturation to dominant European American cultural norms of the United States, such as individuality and independence (Wolfe, Yang, Wong, & Atkinson, 2001). Researchers have examined Asian and Asian American acculturation and utilization of psychological services. Frey and Roysircar (2006) found that in a study on Asian international students, the more acculturated South Asian students reported greater utilization of help resources.

In addition to acculturation, writers have pointed out that enculturation (i.e., the degree to which persons retain the norms of their culture of origin) may influence client factors that

play out in counseling, such as emotional expressiveness, attitude toward seeking psychological help, and beliefs regarding relationships (e.g., Sue & Sue, 2003; U.S. Department of Health and Human Services, 2001). These authors have posited that one's adherence to traditional Asian cultural values, which include hierarchical relationships, collectivism, and achievement orientation, could have an important role in the counseling process with Asian American clients.

It is interesting, however, that studies examining clients' enculturation and the effect on counseling process have had mixed results. On the one hand, some investigations found that less enculturated Asian Americans compared with more enculturated Asian Americans rated their counselors as more empathic (Kim & Atkinson, 2002). On the other hand, some studies found that more enculturated Asian American clients compared with less enculturated clients gave higher counselor ratings (Kim, Li, & Liang, 2002; Kim, Ng, & Ahn, 2005). Furthermore, other studies found no relationship between client's degree of enculturation and session outcome (Kim et al., 2003; Li & Kim, 2004). Although there are many possible reasons for these inconsistent findings, one possibility is that the various dimensions within Asian cultural values (e.g., emotional self-control vs. humility) may have different effects on mental health service delivery, depending on which values were salient during the counseling process. For example, the value of emotional self-control has been identified as a potential negative predictor of successful counseling process. Asian Americans with high adherence to emotional self-control may feel less comfortable discussing personal issues than do their counterparts who do not firmly endorse emotional self-control; subsequently, this values conflict would negatively affect clients' perception of the therapist's empathy and of agreed-on counseling goals and tasks.

Despite the literature on Asian American acculturation and enculturation and mental health services, there are gaps that need to be filled. First, measurement of acculturation and enculturation can be problematic. For example, using proxy variables (e.g., assessing English versus Asian language as the client's language of choice; Akutsu et al., 2004) is not ideal, nor is conceptualizing acculturation and enculturation as being mostly based on behaviors instead of values (e.g. Zhang & Dixon, 2001). Furthermore, acculturation and enculturation are often conceptualized as two ends of the same bidirectional construct (e.g. Ting & Hwang, 2009) rather than being seen as independent, as the concept of biculturalism would suggest (Berry, 1980). Also, because many of these studies on Asian cultural values simply examined client attitudes toward seeking counseling services, we aimed to study cultural values in the context of a therapeutic interaction. Furthermore, we were interested in operationalizing and examining multicultural competence as manifested in therapist interventions. Investigations along these lines could clarify the role of culture and cultural competence in Asian American clients' immediate experiences of therapy, and, in doing so, perhaps help explain Asian American utilization rates of psychological services.

Thus, we created an analogue design study to focus centrally on therapist multicultural counseling skills and participant cultural values. According to the principles of research design, the artificiality of an analogue experimental design is suitable for an area of research with little previous empirical knowledge (Heppner, Kivlighan, & Wampold, 2008). The experimental variable in our study was session type: either supportive counseling with multicultural competencies or supportive counseling alone. The other independent variables were participant adherence to the Asian cultural value dimension of emotional self-control and adherence to European American cultural values.

In terms of the dependent variables, we chose perceived counselor empathy and client–counselor working alliance to garner participant perceptions of counseling process. These variables were chosen because they are considered good indicators of effective counseling

process and outcome (Heppner et al., 2008). For example, a meta-analysis found that 54% (72% when measured by client perceptions) of studies showed a positive relationship between empathy and outcome (Orlinsky, Grawe, & Parks, 1994). Similarly, we measured working alliance, one of the common factors of psychotherapy that is necessary for change (e.g. Wampold, 2001). It can be reasoned that working alliance plays an important role in increasing the rates of Asian Americans who remain in counseling and therapy services.

In the present study, we hypothesized that the supportive counseling condition containing the seven multicultural counseling skills competencies will be rated higher on session outcome (i.e., working alliance and counselor empathy) than the supportive counseling condition that does not contain the competencies (Hypothesis 1). Regarding the possible relations between participant enculturation and acculturation on counseling process, we hypothesized that there would be an inverse relation between adherence to emotional self-control and session outcome (Hypothesis 2) and a positive relation between adherence to European American values and session outcome (Hypothesis 3). In addition, we examined the potential moderating roles of participant adherence to emotional self-control and adherence to European American values on the relation between type of counseling (presence or absence of the skills competencies) and session outcome. Given the dearth of empirical research on this issue, we could not generate hypotheses in any particular direction regarding these interaction effects.

Method

Participants

Participants were 113 (43 men, 70 women) Asian American college students at a large West Coast university. Participants' ages ranged from 18 to 32 years with a mean of 19.45 years (*SD* = 1.73). The participants' grade levels were as follows: 50 (44.2%) first-year students, 33 (29.2%) sophomores, 20 (17.7%) juniors, and 10 (8.8%) seniors. Participants' generation since immigration ranged from first to fifth generation, with the majority (53.6%) being second generation. Participants' ethnic backgrounds included Asian Indian, Asian multiethnic, Chinese, Filipino, Japanese, Korean, Taiwanese, and Vietnamese, with Chinese (25.7%) and Korean (13.3%) being most common. Seventeen (15.2%) participants had previously participated in counseling. The students were recruited from an Asian American studies course and were given course credit for their participation.

Measures

The *Emotional Self-Control subscale of the Asian American Values Scale—Multidimensional* (Emotional Self-Control; Kim, Li, & Ng, 2005) was administered to measure participant adherence to the value of emotional self-control. Emotional Self-Control has eight items and uses a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*). A previous study found a coefficient alpha between .80 and .89 (Kim, Li, & Ng, 2005); an alpha of .73 was found in the present study.

The *European American Values Scale for Asian Americans—Revised* (EAVS–AA–R; Hong, Kim, & Wolfe, 2005) was used to measure participant adherence to European American cultural values. The EAVS–AA–R contains 25 items reflecting European American values such as individualism and importance of leadership. The EAVS–AA–R uses a 4-point scale (1 = *strongly disagree*, 4 = *strongly agree*) and was based on the 18-item European American Values Scale for Asian Americans (Wolfe et al., 2001). Hong et al. (2005) reported that the instrument had a unidimensional factor structure and a person-separation reliability of .78; a coefficient alpha of .63 was found in the present study.

To measure client perception of the therapeutic working alliance, we used the 12-item *Working Alliance Inventory—Short Form* (WAI–SF; Tracey & Kokotovic, 1989). The WAI–SF was developed from a factor analysis of the four highest loading items from each subscale (task, goal, bond) of the original 36-item Working Alliance Inventory (Horvath & Greenberg, 1989). Tracey and Kokotovic (1989) recommended the use of the general alliance scores and reported a coefficient alpha of .98; the present study yielded a coefficient alpha of .82. Participants rated each item on a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*).

The 16 items of the *Empathic Understanding Subscale of the Relationship Inventory* (EUS; Barrett-Lennard, 1962) represent the empathy construct of person-centered therapy and are rated on a 7-point scale (−3 = *I strongly feel that it is not true*, 3 = *I strongly feel that it is true*). The published version of the EUS is worded for a male therapist and from a client's perspective. In our study, the male pronoun was replaced with a gender-neutral subject. Past studies have reported coefficient alphas ranging from .88 to .89 (Horvath & Greenberg, 1989), whereas the present study's data yielded a coefficient alpha of .86. Because participants were in a video analogue study, we instructed them to complete the inventory "as if they were the client in the video."

To conduct a manipulation check of whether the two versions of the therapy session segment were differentiated on the experimental condition (supportive counseling with multicultural competencies or supportive counseling only), we developed a seven-item scale (rated on a scale of 1 = *strongly disagree* to 6 = *strongly agree*) to measure participant observations of the presence of culturally competent skills in the two counseling conditions. For example, one of the items read, "In the session I viewed, the counselor helped the client determine whether the 'problem' stemmed from racism or people's biases so that she wouldn't blame herself too much and offered to intervene with the restaurant on the client's behalf." The current data yielded a coefficient alpha of .84.

Procedure

Recruitment of participants—Asian American students were recruited from an Asian American studies course. On the basis of their availability, students signed up for one of two time slots corresponding to the two conditions. Fifty-five participants viewed the competency condition and 58 participants viewed the supportive condition. Students were informed that the purpose of the study was to investigate their thoughts and feelings about a video segment of a counseling session that had already begun between an Asian American college student and a European American counselor.

Previdео questionnaire administration—Before viewing the video analogue counseling session, students signed the informed consent form. Then, the students were asked to complete the Emotional Self-Control, EAVS–AA–R, and a demographic questionnaire.

Video analogue counseling session—We created two approximately 15-min video segments, depicting a female European American counselor and a female Asian American client, portrayed by a European American graduate student therapist in a counseling, clinical, and school psychology program and an East Asian American undergraduate research assistant, respectively. In the counseling session, the client tells her counselor about negative interactions she and her family experienced at a restaurant and a hotel. The two video clips showed the counselor implementing either supportive counseling with the additional presence of multicultural skills competencies or supportive counseling without the competencies. For the competencies, we operationalized the seven skills of culturally

appropriate intervention strategies into therapist verbal statements. Examples of these skills include discussing experiences of racism or bias from the vantage of "healthy paranoia," attending to instances of discrimination and being mindful of sociopolitical contexts, and taking responsibility for educating clients on the process of psychological intervention (Arredondo et al., 1996).

In operationalizing the seven competencies, we recognized the limitations of incorporating an abundance of skills into a 15-min session vignette. We also acknowledge that some of these skills are better represented by direct therapist demonstration than others, but all were referred to in the video, even if indirectly. For example, the skill of *interacting in the language requested by the client* was represented by the therapist saying, "People sometimes access emotions more easily in another language in which they are fluent. If words in another language fit what you are feeling, I encourage you to use those when the mood strikes."

The following is an excerpt from the vignette, which illustrates the skill of recognizing that a client's problem may originate from racism or biases in others so that the client does not inappropriately blame herself or himself for the problem. The client's responses in both conditions were identical, as was the therapist's speech, except for the statements representing multicultural skills, which are shown in italics:

> *Client:* Well, we went out to dinner Saturday night. We went to this popular restaurant located right next to the mall. It was kind of crowded, but we stayed, because we were hungry and had already bought tickets to see a movie at that mall after dinner. But, after we were seated, our waiter took a really long time to get our drinks. I mean a really long time! Then, it took some time for him to return for our food order, and even longer to serve us [Client hesitates]. We ate pretty fast and took half of it to eat later, just so that we could make the movie.
>
> *Counselor:* I hear some frustration in your voice.
>
> *Client:* Yeah, I was so frustrated. It seemed that people around us were getting served quickly and they were enjoying their meal. I don't know why the service was so very different for us…. You know, we were acting the same as any of the other people eating there [Client hesitates] Yeah, and I have a small suspicion that it was because we were Asian Americans…. But, I don't want to blow things out of proportion. It wasn't, like, an obvious instance of discrimination [Client hesitates]. It's not like they didn't give us any service or told us to sit somewhere else away from other people, and the waiter didn't say anything to us that was insulting. It was just the way he acted toward us and the way he, you know, treated us.
>
> *Counselor:* So, it sounds like you're not certain what to make of this situation. *You know, as I'm listening to you describe it, it seems like you really suspect that you and your family were mistreated because of your Asian ethnic background. I wonder if it would be helpful to further explore this possibility.*
>
> *Client:* Yeah, it reminded me of another incident a year ago, when we were on vacation, and the hotel we went to said they lost our reservation, and they said they had no vacancies. We had to wait a long time for them to look up the system and see if they could put us somewhere. But I also saw that many people were checking out at the same time. So, I thought there would have been a room available pretty quickly. I was just pretty annoyed about the whole thing, especially because they didn't apologize or anything. But, you know, my parents didn't get mad, they just told us that we would have to wait a while in the lobby to figure things out. They

basically told us that there was nothing we could do but be nice to the hotel workers.

Counselor: So, it sounds like maybe you were confused by your parents' calm reaction and the fact that they gave the hotel a lot of the benefit of the doubt.

Client: Yeah, well, I'm not confused, because I know them, and they don't like to make a big deal out of things. They never raise their voice and would never ask to see the manager or anything.

Counselor: It seems to me that you and your parents may have different reactions to the same situation. *You know, this is making me wonder if perhaps your parents, and you said that they were pretty traditional, might have been trying to maintain harmony between them and the hotel and refraining from expressing any negative feelings about the situation. I've read that these are important values in traditional Asian culture. I mean, I'm not saying I agree or disagree with how your parents reacted, but the values system followed by traditional Asian Americans could help us to better understand your parents.* What do you think?

Client: Hmmm, yeah, it's interesting that the way they were brought up may have something to do with how they respond to stuff like this.

Counselor: How do you feel about having a different view-point than your parents on these types of social interactions, *which, in my opinion, I think are possible acts of racism?*

Two psychology doctoral students with training and experience in psychotherapy and multicultural issues reviewed the counseling scripts, and improvements to the scripts were made on the basis of their feedback before creating the videotapes. The entire script can be obtained from Bryan S. K. Kim.

Postvideo questionnaire administration—After watching the counseling vignette of either culturally skilled supportive counseling or supportive counseling only, participants were instructed to complete a postvideo survey "as if they were the client in the video"; that is, to rate the counselor they viewed using the WAI–SF, the EUS, and the manipulation check.

Results

Preliminary Analyses

Means, standard deviations, and intercorrelations of all continuous independent and dependent variables are shown in Table 1. A *t* test showed no significant difference in age between participants assigned to the two session conditions. Similarly, Pearson chi-square tests showed no significant relationships between the session condition and sex, academic level, generation status, and previous counseling experience. Also, *t* tests revealed that the manipulation of the session conditions was successful in that there was a significant difference in the expected direction between supportive counseling that included multicultural competencies ($M = 4.49$, $SD = 0.841$) and supportive counseling alone ($M = 3.66$, $SD = 0.997$), $t(110) = 4.734$, $p = .000$, Cohen's $d = 0.90$.

Main Analyses

To examine the first hypothesis regarding the comparison between supportive counseling with multicultural competencies and supportive counseling only, we conducted an independent samples *t* test. Because the correlation (.80, $p < .001$) between WAI–SF and EUS was very high, we created an overall process effectiveness score by conducting a

principal components analysis with all of the items from these two scales; the 7-point scale of the EUS scores was renumbered to match that of the WAI–SF scores. To ensure an internally consistent score, we retained those items that had loadings greater than .40. This analysis led to the retention of 25 items with a coefficient alpha of 0.94. Using this combined WAI–SF and EUS score for our dependent variable, the *t* test revealed a significant difference between the two conditions, $t(110) = 1.82$, $p = .035$, Cohen's $d = 0.34$, with supportive counseling with multicultural competencies ($M = 4.47$, $SD = 0.98$) receiving a higher score than supportive counseling only ($M = 4.12$, $SD = 1.09$). Hence, Hypothesis 1 was supported according to this result.

As for the possible relationships between Emotional Self-Control and WAI–SF and EUS, the results of the correlational analysis as shown in Table 1 yielded inverse significance, with $r = -0.24$, $p < .01$, and $r = -0.23$, $p < .01$, respectively. A similar result was found for the relation between Emotional Self-Control and the combined WAI–SF and EUS score, $r = -0.24$, $p < .01$. Hence, Hypothesis 2 was supported according to this result.

As for the possible relations between EAVS–AA–R and WAI–SF and EUS, the results of the correlational analyses as shown in Table 1 yielded positive significance, with $r = .20$, $p < .05$, and $r = .17$, $p < .05$, respectively. A similar result was found for the relation between EAVS–AA–R and the combined WAI-SF and EUS scores, $r = .19$, $p < .05$. Hence, Hypothesis 3 also was supported according to this result.

To examine the possible moderating roles of Emotional Self-Control and EAVS–AA–R scores on the relation between session type and overall counseling process effectiveness, we conducted a two-step hierarchical multiple regression analysis. In Step 1, the predictor variables were session type (dummy coded: 1 = supportive counseling only, 2 = supportive counseling with multicultural competencies), Emotional Self-Control, and EAVS–AA–R. In Step 2, the predictor variables were the interaction between session type and Emotional Self-Control and the interaction between session type and EAVS–AA–R. The criterion variable was the overall process effectiveness score that was created in the testing of Hypothesis 1. The scores on the main variables were centered before the interaction terms were created. As shown in Table 2, the additional variance accounted for in Step 2 was not statistically significant. Hence, the results did not indicate the presence of moderating roles of the two value dimensions on the relation between type of counseling and process effectiveness.

It is interesting that in contrast to the results of the *t* test and correlational analyses described above, the results of the regression analysis revealed that session type, Emotional Self-Control, and EAVS–AA–R were not significant predictors. This inconsistency could be explained by the fact that both the *t* test and the correlational analyses were based on a one-tailed test whereas the regression was based on a two-tailed test, hence causing the regression analysis to have less statistical power. Also, specific to the correlational analysis, the inconsistent results between it and the regression also could be due to the correlation indexing the total variance, which contains both unique and shared variance, and the regression analysis indexing only the unique variance associated with each of the relationships.

Discussion

The present study used a video analogue design to test the potential effects of multicultural counseling competency and client values on Asian Americans' evaluation of counseling process. The *t* test results yielded support for considering multiculturally competent interventions as a useful strategy in counseling process. This finding reinforces previous findings that multiculturally skilled therapy interventions positively influence ratings of

general competence. For example, Zhang and Dixon (2001) found that Asian international student clients rated culturally responsive counselors higher than culturally neutral counselors in expertness, attractiveness, and trustworthiness; cultural responsiveness was operationalized as including diverse Asian crafts and pictures as décor, greeting the clients in their native language, and inquiring about behavioral differences between the United States and countries of origin. Also, the current results extend the findings of Fuertes et al. (2006), who surveyed cross-cultural therapy dyads at university counseling centers and discovered positive relationships between perception of therapist multicultural competence and perceptions of therapist empathy, working alliance, and satisfaction with counseling. Although Zhang and Dixon did not examine multicultural counseling competencies per se and Fuertes et al. did not manipulate their competency variable, the existing literature, combined with our findings, offers helpful information on the importance of incorporating multicultural competencies when working with Asian American clients.

The results also showed that the participant adherence to emotional self-control was inversely related to the counseling process. However, this result should be considered tentative, because although the total shared variance was significant according to the correlational analysis, the unique shared variance when considered alone was not significant as shown by the regression analysis. Notwithstanding this important limitation, the observed inverse association supports the importance of studying specific Asian value orientations in therapy process and outcome research as suggested by Kim, Li, and Ng (2005). Our study puts forth the importance of considering client cultural values in establishing a strong therapeutic relationship. In other words, when working with Asian American clients who value emotional self-control, it would be important for practitioners to be sensitive to clients' potential discomfort or inexperience with sharing personal problems with a professional counselor and to perhaps discuss clients' views about attending therapy early on in the therapeutic process. It might also be helpful for practitioners to recognize the challenge of discussing sensitive cultural issues such as racism and discrimination and, subsequently, activating distressful feelings in both the client and the counselor, thereby further contributing to a negative appraisal of therapy.

In terms of the observed positive relation between acculturation to European American values and counseling process, this result also should be considered tentative because, like the result regarding participant adherence to emotional self-control, the significant relation was only observed with total shared variance and not with unique shared variance alone. Notwithstanding this important limitation, this finding is consistent with previous research (e.g., Tata & Leong, 1994). The current results echo the findings of Kim, Ng, and Ahn (2005), who found that Asian American participants' adherence to European American values was positively associated with ratings of working alliance and session depth. Moreover, these associations can be explained by the findings of Mallinckrodt, Shigeoka, and Suzuki (2005), who found a positive correlation between client acculturation and counselor etiology beliefs, suggesting that acculturation may cultivate positive counseling process because of greater degree of match between client and counselor mental health worldviews and an agreed-on explanation of presenting problems.

As in all research, there are important limitations to the present study. First, given that the results were not robust in that the multiple regression analysis failed to replicate the findings from the *t* test and correlational analyses, the present study may have lacked adequate statistical power. Consistent with this idea, the observed effect sizes for the *t* test and correlations were small according to Cohen's definitions. Therefore, we recommend that future studies ensure that there is adequate power. One avenue to ensuring adequate power is to enlarge the effect size by increasing the length of the therapy segment and to include more statements of multicultural competence. In addition, modifying how the session type

variable is operationalized would be important because some of the theorized interventions of multicultural competence also may be perceived as a part of supportive counseling (e.g., appropriate eye contact, psychoeducation regarding therapy process). As for the cultural values variables, it would be important to include participants that similarly reflect the entire range of enculturation and acculturation variables (note that the majority of our sample comprised second-generation individuals). Furthermore, the use of larger sample sizes also would increase the statistical power for both the session type and the cultural values variables.

As for other limitations, the client depicted in the counseling vignette was visibly East Asian, although the Asian population, including the sample used for the present study, is quite heterogeneous. We also acknowledge that completing the manipulation check from a third-party perspective may have lessened the potency of the ratings and was discrepant with completing the other instruments as if the respondent was the client of the video. Also, the relatively low internal reliability for the EAVS–AA–R score may pose a threat to statistical conclusion validity. Finally, the use of a nonclient, West Coast college student sample limits the study's generalizability; more research needs to be done to assess the applicability of these findings to real therapy clients and to a more diverse population in terms of age and geographic location.

The present results also raise a question regarding the essence of multicultural competencies. The significant relationship between multicultural competence and client-perceived working alliance and empathy suggests the possibility that a component of multicultural competence may be deeper alliance and empathy. Thus, in future studies, researchers could study multicultural competencies compared with alliance- and empathy-focused interventions or therapist alliance and empathy as mediating variables of multicultural therapeutic alliance and therapist characteristics. Future research could also use Asian Americans participants in a control group study, or Asian Americans could be surveyed on their experiences and evaluation of therapy.

In terms of practice implications, the present findings provide tentative support for incorporating multicultural skills in therapy, such as having sensitivity to issues of oppression, and providing psychoeducation regarding the psychotherapy process. Also, our results reinforce the importance of considering client characteristics in building and maintaining an effective counseling process. With Asian American clients in particular, it would be helpful for therapists to be aware of the potential effects of clients valuing emotional self-control and of clients acculturating to European American values salient to so many Asian Americans. In terms of training, these findings promote the teaching of multiculturally competent skills in introductory counseling skills. Finally, our conclusions underscore the importance of learning how to build the working alliance and empathy quickly. Furthermore, they remind counselors that within the same racial or ethnic group affiliation, clients bring their unique and multidimensional cultural identities to the process of mental health services engagement.

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Table 1

Means, Standard Deviations, and Intercorrelations Among the Independent and Dependent Variables

Variable	*M*	*SD*	1	2	3	4
1. Emotional Self-Control	3.41	0.85				
2. EAVS–AA–R	2.82	0.29	−0.48***			
3. WAI–SF	4.54	1.22	−0.24**	0.20*		
4. EUS	0.98	1.02	−0.23**	0.17*	0.80***	
Combined WAI–SF and EUS	4.29	1.05	−0.24**	0.19*	0.95***	0.95***
Manipulation check	4.06	1.01				

Note. Emotional Self-Control = Emotional Self-Control subscale of the Asian American Values Scale—Multidimensional; EAVS–AA–R = European American Values Scale for Asian Americans—Revised; WAI–SF = Working Alliance Inventory—Short Form; EUS = Empathic Understanding subscale of the Relationship Inventory.

* $p < .05$.

** $p < .01$.

*** $p < .001$.

Table 2

Results of Hierarchical Multiple Regression Analyses on Overall Process Effectiveness

Independent variable	β	*t*	*p*	ΔR^2	*F*	*p*
Step 1						
Session type (A)	.17	1.86	.065	.10	3.80[a]	.012
Emotional Self-Control (B)	−.18	−1.74	.085			
EAVS–AA–R (C)	.12	1.10	.257			
Step 2						
A	.17	1.90	.060	.05	2.92[b]	.058
B	−.21	−2.03	.045			
C	.11	1.06	.292			
A × B	−.20	−1.89	.061			
A × C	.04	0.41	.685			

Note. Session type = supportive counseling only, dummy coded 1, or supportive counseling with multicultural competencies, dummy coded 2; Emotional Self-Control = Emotional Self-Control subscale of the Asian American Values Scale—Multidimensional; EAVS–AA–R = European American Values Scale for Asian Americans—Revised.

[a] $df = 3, 108$.

[b] $df = 2, 106$.