The Effects of Ethnic Matching on Abusive/Neglectful Minority Clients' Counseling Satisfaction, Engagement, Pre-mature Termination, and Outcome

by

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A dissertation submitted to the Graduate Faculty in Educational Psychology in partial fulfillment
of the requirements for the degree of Doctor of Philosophy,
The City University of New York

2010

This manuscript has been read and accepted for the Graduate Faculty in Educational Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

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Abstract

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Advisor: Georgiana Shick Tryon, Ph.D.

This dissertation explored the relationship of ethnic matching between abusive and/or neglectful ethnic minority parents and minority counselors. Specifically, it examined these clients' satisfaction with and engagement in counseling as well as type of termination (unilateral or continuing) and outcome (client adjustment, meeting of agency goals, and re-abuse). This study also looked at the relationships of ethnic identity and acculturation discrepancies of clients who abused their children and their counselors, who were either ethnically matched or not matched, to client satisfaction, client engagement, client termination type, and client outcome.

This dissertation sought to answer the following questions: (a) Are child-abusing clients who are ethnically matched with their counselors more satisfied with the intake counseling session than those who are not ethnically matched? (b) Are child-abusing clients who are ethnically matched with counselors more likely to become engaged in counseling than their non-matched counterparts? (c) Are child-abusing clients who are ethnically matched with their counselors less likely to terminate early than those who are not ethnically matched? (d) Do child-abusing clients who are ethnically matched with their counselors have better outcomes than

those who are not ethnically matched? (e) How do client-counselor differences in ethnic identity and acculturation relate to client satisfaction, engagement, termination, and outcome?

I confirmed that abusive/neglectful clients who were ethnically matched with their counselors were significantly less likely to terminate prematurely after engagement than ethnically unmatched clients. Ethnic matching was not related to engagement, client satisfaction, or counseling outcome. Overall, results of this study suggested that ethnic matching per se may have little to do with client satisfaction, engagement, and outcome. Results also suggested that in contrast to ethnic matching, client-counselor ethnic identity discrepancy is important in client engagement, early-termination, and counseling outcome regardless of whether or not clients are ethnically matched. Although acculturation discrepancy was related to re-abuse, it had little relationship with the other variables in this study.

Acknowledgements

I wish to thank Dr. Georgiana Tryon for her extraordinary patience and support through the arduous task of completing this dissertation. She was my counselor when I was discouraged and my professor when I needed academic support. Without her guidance, extensive knowledge, and selflessness this process would have been absolutely impossible. I would also like to thank Dr. Carol Kehr Tittle, Dr. Mary Kopala, and Dr. Joseph LiPuma for their time and recommendations, which proved to be invaluable. Thanks to Dr. Leveque who has been my mentor for the past three years. She has made my transmission from social work to school psychology a smooth one.

I would also like to thank my family. My children, Keron, Keister, and Keeya were always understanding when dinner was late or nonexistent. My mother-in-Law, Beulah Barrow, provided priceless babysitting services without which I would not have made it this far. Finally, my husband, Dr. Ovid Barrow, has been my biggest cheerleader. He listened to the reading of numerous drafts and provided helpful criticisms, suggestions, and encouragement. He often arrived at work absolutely exhausted after staying up with me late into the night…I love you. Last but not least, a great big thank you goes out to my mother, Mabel Hendricks, who did not live to see this day.

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CHAPTER I

Dissertation Overview

Child abuse/ neglect is one of the nation's most serious concerns (U.S. Department of Health and Human Services: Administration for Children & Families, 2008). These reports indicate that during the 2006 Fiscal Year, State Child Protective agencies throughout the United States received more than 3 million reports of child abuse or neglect. As a result of these reports, state agencies investigated caretakers of approximately 6 million children and determined that over 900,000 children were victims of abuse or neglect. The U.S. Department of Health and Human Services further noted the high rate of child fatalities due to abuse and/or neglect. According to this agency, more than 1,500 children died as a result of abuse or neglect and about 75% of these fatalities resulted from parental action or lack thereof.

During this same period, Fiscal Year 2006, African Americans, American Indians, and interracial children experienced high rates of abuse and neglect, with the rate for African Americans almost double that of Caucasian Americans. Additionally, African Americans and Hispanic children accounted for almost half of all child fatalities resulting from abuse and/or neglect (US Department of Health and Human Services, 2008). The report further suggested that approximately 80% of the perpetrators were the victims' parents (i.e., biological, adoptive, and step parents). To address their abusive behaviors, child welfare agencies frequently refer these parents to counseling. However, an estimated 10% to 15% of referred parents resist counseling (Reece, 2005) and terminate early (Harris, 1998). One of the factors associated with early termination is clients' minority status (Barrett et al., 2008).

There are disparities in mental health care for racial and ethnic minorities who frequently experience less access to or provision of optimal treatments as well as problematic diagnostic practices (Snowden, 2003). In addition, members of ethnic minorities frequently have counselors who are not of the same race or ethnicity. Some investigators have argued that this ethnic disparity between client and counselor is responsible for ethnic minorities' dissatisfaction with counseling (Constantine, 2002), underutilization of mental health services (Jerrell, 1998; Maramba & Hall, 2002), high drop-out rate from counseling after one session (Maramba & Hall, 2002; Sue, 1997), which Tryon (1985) termed non-engagement, and poor treatment outcomes at the termination of counseling sessions (Erdur, Rude, & Baron, 2003).

To further complicate matters, the past several years have shown an increase in the number of immigrants entering the Unites States. As of 2007, the immigrant population in the United States reached an estimated 37.9 million, which equates to about one eighth of the residents in this country, and of this amount, 2, 918,000 immigrants reside in New York City (Camarota, 2007). Although these individuals come from different cultures, they experience mental health problems similar to those of Caucasian Americans (Shin, Chow, Camacho-Gonsalves et al., 2005). However, immigrant families pose unique challenges to mental health professionals (Earner, 2007). Differences in parenting styles (Jambunathan, Burts, & Pierce, 2000) and use of physical punishment (Wissow, 2000) are two of the issues that cause problems for some of these families. As a result, school personnel and social service agencies consistently refer immigrant families, many of whom are members of racial and ethnic minorities, for counseling to address these issues, and often this is the first instance during which these families come into contact with government and/or community agencies (Earner, 2007).

A large population of immigrant minority families is currently involved with the child welfare system. For example, the Committee for Hispanic Children and Family, Inc. (2002, as cited in Johnson, 2007) stated that as the rate of the immigration population increases in the United States, so does the number of minority children placed in the foster care system as a result of parental abuse or neglect. Many of these parents need counseling to address the problems they have raising their children. McGuigan, Katzev, and Pratt (2002) suggested, however, that these immigrant families' distrust of the child welfare system and their desire to maintain privacy may account for early termination from or resistance (i.e., non-engagement) to services, including counseling services.

Definitional Problems in Studies of Early Termination/Drop-Out

The literature on early termination/drop-out rate has shown mixed results due to the inconsistency in defining this variable (Barrett et al., 2008). Barrett and colleagues pointed out that although every study defines early dropout as termination of services before a defined number of sessions, the actual numbers of sessions vary substantially among studies. Their review of the client attrition literature indicated that definitions of early termination/drop-out included "the point at which two consecutive sessions were missed …, failure to attend the last scheduled session…., termination of therapy anytime within the first 9 months…., and failure to return after an intake session" (p. 248). Hatchett and Park (2003) compared four operational definitions of dropout: therapist judgment, "failure to attend the last scheduled appointment, median-split procedure, and failure to return to therapy after the intake session" (p. 226). According to Hatchett and Park, investigators should not use the median-split (or a duration based criterion in the study of early termination), but rather they should employ this definition when examining therapy duration. Wierzbicki and Pekarik (1993) recommended that

investigators should use either therapist judgment or missed last appointment when defining early termination/drop-out.

In addition, Hatchett and Park (2003) indicated that using “failure to return after the intake appointment” (p. 229) as the definition for premature termination/early termination/dropout is “of questionable validity” (p. 229). Also, Garfield (1994, as cited in Hatchett & Park, 2003) contended that those clients who fail to return after the intake session cannot terminate early as they have not really began counseling. This argument is supported by Tryon (1985). Tryon refers to clients’ failure to return after the intake session as non-engagement.

Evidence supplied by Tryon and others (Kokotovic & Tracey, 1987; Tryon, 1989, 1990; Tryon & Tryon, 1986) indicates that clients who fail to return to counseling after the first session have not really become involved, or engaged, in the counseling process, and, therefore, cannot terminate a process that they have not begun. As results of the aforementioned studies support the distinct difference between client leave taking after the intake session and dropout after later sessions, this dissertation uses Tryon’s (1985) definition of engagement (i.e., client failure to return after the initial counseling session) in the study of counseling of minority clients who abuse or neglect their children.

Definitional Problems Hindering Studies with Ethnic Minority Participants

To address issues of non-engagement in and early termination from counseling, some authors have recommended that ethnic minority clients be matched with ethnically similar counselors (Jerrell, 1998; Vetter, 2004) in the belief that immigrant and minority clients may be more likely to stay in counseling with counselors who are similar ethnically to themselves. Sue (1998) defined ethnic minorities as groups such as African Americans, Latinos, Asian

Americans, and American Indians. In his article, Sue recommended that ethnic matching is beneficial to ethnic minorities and suggested that therapists should be actively recruited and trained to service ethnically similar clients. Sue further suggested that there should be ethnic variety among services providers as this would afford clients the opportunity to choose providers of similar ethnicity.

Results of several studies (Erdur et al., 2003; Maramba & Hall, 2002; Sue, 1998) have supported the benefits of ethnic matching between client and counselor. Results suggested that matching increases client satisfaction (Gamble, 2001; Rubin, 1999), decreases dropout rate (Jerrell, 1998; Sue et al., 1991; Yeh, Eastman, & Cheung, 1994), and improves treatment outcome (Gamst et al., 2001; Russell et al., 1996; Russell, Fujino, Sue, Cheung, & Snowden, 1996). Others, however, have found that client-counselor ethnic match did not predict client utilization of mental health services (Marmaba & Hall, 2002), satisfaction with counseling (Gamble, 2001), involvement in the counseling process (Bhagavsthula, 2004), or outcome (Diaz-Vivar, 2003; Erdur, Rude, & Baron, 2003; Fujino, Okazaki, & Young, 1994; Jones, 1978).

Ethnicity. Some of the failure to clarify the client-counselor ethnic matching issue may stem from the fact that the authors of all of these studies used the terms race and ethnicity interchangeably. Though a relationship exists between race and ethnicity, the terms are not identical. Because investigators often use ethnicity as a euphemism for race (Cokley, 2007), most studies actually examined the impact of client-counselor race instead of ethnicity. Cokley (2007) defined race as a group of people who share physical characteristics and other hereditary traits. However, Cokely acknowledged that defining ethnicity has proven to be problematic.

Phinney (1996) proposed that ethnicity has several components, which include cultural characteristics and values, a subjective sense of belonging, and experiences related to minority

status, all of which have psychological implications for minority individuals. Phinney also indicated that ethnicity is not a dichotomous variable but rather it varies in strength from individual to individual within the same ethnic group. According to Phinney, ethnic identity is a multifaceted group of factors that determines the degree and type of involvement one is willing to have with one's ethnic group. Two individuals from the same ethnic group may differ substantially in their involvement with and commitment to that group. For example, an individual who socializes only with similar group members and is immersed in her or his ethnic group activities may feel a stronger commitment to that group than an individual who socializes with other groups. This dissertation determined the ethnic identities of client and counselor participants.

Acculturation. Individuals' level of acculturation may also impact clients' engagement, satisfaction, termination, and counseling outcome. As they have with ethnicity and race, investigators have had problems defining acculturation. Trimble (2002) indicated that examiners originally viewed acculturation as a change that occurred in the members of one group as they interacted with members of another group, but more recently, there has been a shift in this definition to the notion that change occurs in both groups as they interact with each other.

Berry (2003) postulated two levels of change resulting from acculturation: cultural and psychological. At the cultural level, both dominant and minority group members experience change as they come into continuous contact with each other, while individuals of both groups also undergo change on a psychological and behavioral level. Rudmin (2003) indicated that acculturation involves the adaptation of new cultural practices. One has only to purchase a Regge-Rap CD, listen to the Black Entertainment Television (BET), or tune into one of the popular New York City Radio Stations (107.5 WBLS) to notice the cultural change evident in

music. Hip Hop (African American) and Reggae (Jamaican) mixed songs currently play on most popular radio stations, BET, and are available in record stores. The psychological/behavioral level of acculturation refers to individuals' preference and attitudes toward adaptation of the new culture (language use, mode of dress, social attitudes, music, and food) and retention of their own culture (Matsudaira (2006)).

However, according to Berry (2003), not all individuals acculturate at the same rate. Individuals must determine whether or not they will maintain their culture of origin or adopt the dominant culture. Phinney (2003) indicated that there is a close relationship between acculturation and ethnic identity, suggesting that ethnic identity is fluid and can conceptualized as one part of the acculturation process. Identity has to do with belonging and one's sense of individuality (Solomos & Goldberg, 2002). According to Solomos and Goldberg, identity is not "simply imposed" (p. 6) upon an individual, but rather the individual chooses it and utilizes it within certain contexts. Therefore, when examining acculturation, investigators should also focus on ethnic identity.

Also, most authors do not consider acculturation in studies of client-counselor matching. As counseling is particularly important for minority and immigrant parents who abuse and neglect their children, client-counselor ethnic matching may contribute to greater client engagement and satisfaction for these clients, and the acculturation of client and counselor may also relate to engagement and satisfaction. Thus, this dissertation also examined clients' and counselors' level of acculturation.

The Dissertation Study

In New York City there is a large population of diverse minority groups involved with Child Protective Services and receiving services to reduce the recurrence of child abuse or

neglect. According to the U.S. Department of Health and Human Services (2008), African American children had the highest victimization rate of 19.8% followed by American Indians at 15.9 percent, children of multiple races at 15.4 percent, and White and Hispanic children at 10.7 and 10.8%, respectively. However, results of studies conducted by Fluke et al. (2005) have revealed extremely high rates of recidivism of child abuse and/or neglect irrespective of services received. The report indicated that among child abuse victims, approximately 17% were revictimized within a 5-year period and most of the subsequent victimization occurs within the first few months following the initial abuse and/or maltreatment. DePanfilis and Zuravin (1999) found an overall abuse and/or neglect recurrence rate of 43%. As of December 2007, the New York City Administration for Children's Services investigated over 63,000 allegations of abuse and/or neglect for the year and referred approximately 99% of these cases for services (e.g., parenting classes, individual and family counseling, substance abuse treatment, anger management treatment, and sex abuse treatment).

Prior to October of 2006, the author of this dissertation was employed by the NYC Administration for Children Services, in the capacity of Director of Field Operations. One aspect of her responsibilities was to ensure the referral of clients for the appropriate services to address their abusive and/or neglectful behaviors. However, her experience corroborated reports in the literature that irrespective of the services to which she referred clients, there was a high rate of recidivism of abuse and/or neglect, and parents often failed to comply with services. Thus, they did not receive the help they needed. It is possible that these clients' resistance and lack of compliance could have been due in part to ethnic mismatches with their counselors.

This dissertation explored the relationship of ethnic matching between abusive and/or neglectful ethnic minority parents and minority counselors and clients' satisfaction with and

engagement in counseling as well as type of termination (unilateral or continuing) and outcome (client adjustment, re-abuse). This study also looked at the relationship of ethnic identity and acculturation of clients and counselors who were either ethnically matched or not matched to client satisfaction, client engagement, client termination, and client outcome.

This dissertation also sought to answer the following questions: (a) Are child-abusing clients who are ethnically matched with their counselors more satisfied with the intake counseling session than those who are not ethnically matched? (b) Are child-abusing clients who are ethnically matched with counselors more likely to become engaged in counseling than their non-matched counterparts? (c) Are child-abusing clients who are ethnically matched with their counselors less likely to terminate early than those who are not ethnically matched? (d) Do child-abusing clients who are ethnically matched with their counselors have better outcomes than those who are not ethnically matched? (e) How do client-counselor differences in ethnic identity and acculturation impact satisfaction, engagement, termination, and outcome? Answers to these questions could facilitate counseling service provision to minority clients who abuse or neglect their children.

Of the 10 hypotheses, only 1 was confirmed, 2 were partially confirmed, and 2 produced opposite results. Specifically, I confirmed that abusive/neglectful clients who were ethnically matched with their counselors were significantly less likely to terminate prematurely after engagement than ethnically unmatched clients. Ethnic matching was not related to engagement, client satisfaction, or counseling outcome. Overall, results of this study suggested that ethnic matching per se may have little to do with client satisfaction, engagement, and outcome, although clients who were ethnically matched with their counselors were less likely to terminate prematurely from counseling. Results also suggested that, in contrast to ethnic matching, client-

counselor ethnic identity discrepancy is important in engagement, early-termination, and counseling outcome regardless of whether or not clients are ethnically matched or not. Although acculturation discrepancy was related to re-abuse, it had little relationship the other variables in this study.

CHAPTER II

Literature Review

This chapter provides a review of the literature concerning several concepts that are integral parts of this dissertation. It begins with an overview of child abuse and neglect in the United States concentrating on minority and immigrant populations. Since this dissertation focused on providing counseling to parents who are members of minority populations and who abuse or neglect their children, the chapter provides a review and critique of counseling process and outcome studies that examine client-counselor ethnic match and includes definitions and discussions of the concepts of ethnicity, race, and acculturation and their potential impact on counseling with ethnic minority clients. A presentation of studies documenting the magnitude of recurrence of child abuse and neglect to emphasize the need for counseling of abusers along with results of the few counseling studies with parents/guardians who abuse their children sets the stage for the dissertation rationale and hypotheses.

Child Abuse and/or Neglect

Child abuse and/or neglect are among the nation's most serious problems, with an estimated 905,000 children being victims of abuse or neglect in 2006 (U.S. Department of Health and Human Services, 2008). The U.S. Department of Health and Human Services cites the definition of child abuse and neglect specified in the Federal Child Abuse Prevention and Treatment Act (CAPTA), (42U.S.C.A, 5106g) amended by the Keeping Children and Family Safe Act of 2003:

> A recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation: or an act or failure to act which presents an imminent risk of serious harm. (p xiii)

For the 2006 fiscal year, Child Protective Service (CPS) agencies within the United States received approximately 3.3 million reports of abuse and/or neglect, which involved approximately 6 million children (U.S. Department of Health & Human Services, Administration for Children & Families, Administration for Children, Youth, & Families: Child Maltreatment, 2006). According to this report, CPS agencies investigated approximately 3.6 million of these 6 million children, and determined that at least one child was abused or neglected in about 30% of these investigations. In New York State, using corporal punishment is not necessarily considered abuse/ neglect. However, if the punishment harms the child (causes pain, leaves a mark, etc) it could be considered excessive corporal punishment, which is neglect (Parent's Guide to New York State Child Neglect and Abuse Laws, 2008).

During the 2006 Fiscal Year, African Americans, American Indians, and Interracial children had the highest rates of abuse or neglect, with the rate of African American children nearly doubling that of Caucasian children (19.8 and 10.7 per 100 children of the same race, respectively). Also, in 2006, approximately 1,530 children died as a result of abuse or neglect, and there has been an increasing trend in the number of child fatalities. For the year 2001, the rate of child fatalities was reported as 1.96 per 100,000; however, child fatalities increased to 2.04 per 100,000 over the next five years, and although Caucasian children account for an estimated 43% of child fatalities, African American and Hispanic children accounted for approximately 47% (U.S. Department of Health & Human Services, 2008). In addition, parents committed approximately 75% of child fatalities resulting from abuse or neglect, with 27% caused by mothers who acted alone.

Although no data currently exist that provide an actual count of the number of immigrant/minority families involved with the child welfare system (Earner, 2007), surveys of

local community agencies suggest that members of this population have been increasingly brought to the attention of child welfare agencies (Impact 2003, as cited in Earner, 2007). There is some evidence that as the rate of the immigrant children in the general population has increased, so has the number of ethnic minority children in Foster Care (Committee for Hispanic Children & Families, Inc., 2002, as cited in Johnson, 2007).

Johnson (2007) proposed that immigrant families settling in the United States invariably come into contact with different cultural groups, which may include the dominant group, other ethnic minority groups, and second and third generation immigrants who may have already integrated into the dominant group. Like their parents, immigrant children experience the dominant culture through schools and other means (Johnson, 2007). However, unlike their parents, these children, because of association with peers, may subsequently engage in activities that go against the values and beliefs of their parents and this rebellion might lead to child maltreatment (Smith-Hefner, 1998).

To address parents' abusive behavior, CPS workers frequently refer them to counseling. Preventive agencies provide services to prevent abuse and neglect. These services include family and individual counseling, substance abuse treatment, and parenting classes, and are designed to reduce the likelihood of recurrence of abuse and/or neglect. According to the U.S. Department of Health and Human Services, caretakers of approximately 3.8 million children received Preventive Services during the 2006 Fiscal year, which represented an increase of about 1.8 million children from the previous year. Additionally, caretakers of minority child victims (African Americans and Hispanics) were 38% more likely than those of Caucasian child victims to receive Preventive Services.

However, even though they are referred for help, many of these parents resist taking part in Preventive Services (Reece, 2005). Reece estimated that between 10% and 15% of abusive/neglectful parents and caretakers resist treatment and pointed out four characteristics of resistant clients: they are dangerous, they fail to respond to interventions, they do not become actively involved in the treatment process, and they fail to engage in treatment within the appropriate time frame.

Other studies pertaining to child abuse intervention programs have highlighted several factors that influence early termination of treatment by parents and caretakers, and have produced conflicting results. For example, Olds and Kitzman (1993) found that younger mothers were less likely to dropout of parenting programs, however, Josten, Mullett, Savik, Campbell, and Vincent (1995) found that this same population was more likely to terminate counseling early. Another study by Hersog et al. (1986) found that clients' ethnicity was unrelated to early termination of Prevention Services. McGuigan, Katzev, and Pratt (2002) examined the determinants of retention in a child abuse prevention program in an effort to find, among other variables, the maternal attributes that influenced program retention. These authors concluded that maternal distrust and desire to maintain privacy might lead to termination of contact with outsiders.

According to Harris (1998), investigators need to determine the factors that relate to treatment termination to inform implementation of client retention strategies. Parents' resistance to services may eventually lead to non-engagement in or early termination from counseling to prevent recurrence of child abuse and/or neglect. Since minority and immigrant parents represent large percentages of individuals who commit child abuse or neglect, counseling studies with these populations should inform efforts to serve them.

Ethnic Matching in Counseling

Multicultural issues are necessary ingredients for the provision of effective mental health services, given the ever-changing nature of the American society. Also, with the increase in the number of immigrants to this country (U.S. Census Bureau, 2001), mental health professionals have become cognizant of the several cultural factors inherent in working with immigrant families (Constantine, 2002) including the pivotal role played by culture in mental health, mental illness, and mental health service provision (Department of Health & Human Services, 2005). According to the Surgeon General's Executive Summary (2005), in order to deliver services that are responsive to ethnic minorities, practitioners must have an understanding of the role of culture. Overall, health and productivity directly relate to good mental health, and good mental health also contributes to healthy family functioning (Department of Health & Human Services, 2007).

One in five Americans experience poor mental health that if left untreated will have a substantial negative impact on all aspects of life (Department of Health & Human Services, 2007). For example, one study (Fendrich, Warner, & Weissman, 1990) examined the association between maternal depression and children's psychological health. The authors studied children of depressed and nondepressed mothers and found that children of depressed parents were more susceptible to psychopathology than their counterparts. Children of depressed parents are also at high risk of developing anxiety and externalizing disorders (Warner et al., 1995).

It is well known that individuals' worldviews and general beliefs about mental health affect their utilization of mental health services (Gamble, 2001). Sue (1981) suggested that the worldviews held by many minority individuals are very different from those held by members of the dominant culture. He defined worldview as the way one "perceives his/her relationship to the

world (nature, institutions, other people, things, etc)" (p. 73). For example, some cultures do not subscribe to the idea of counseling and suppress mental health issues and problematic behaviors or handle these difficulties within the family (Sue & Sue, 1972 as cited in Sue, 1981). On the other hand, the mainstream dominant culture embraces the idea of counseling. Thus, Sue (1981) suggested, "counseling is a white middle class activity that holds values and characteristics different from those of third world groups" (p. 28). Based on the aforementioned articles, one can contend that this argument not only applies to clients but also to the providers of mental health services, as their views of the world may impede their ability to provide appropriate services to individuals from the minority cultures.

The difference in worldviews among individuals from different cultures is evident in the findings of Sue, Wagner, Margullis, and Lew (1976). According to Sue and his colleagues, individuals from the Asian culture subscribe to the belief that strong-willed people and those who abstain from morbid thoughts enjoy good mental health. On the other hand, Caucasian individuals are less likely to subscribe to this belief (Sue et al., 1976). Similarly, Smith (1981) suggested that minorities, specifically African Americans, believe that one's environment determines one's mental health status. According to Gamble (2001), cultural views influence how one sees the world and, as such, there is much debate (Maramba & Hall, 2002; Shin et al., 2005; Sue et al., 1991) over whether or not clients would benefit from having a counselor who shares the same cultural background (i.e., client-counselor ethnic matching).

Sue (1981) pointed out that the typical counseling model involves the verbal interaction between counselor and client, with the counselor encouraging the client to divulge personal information and feelings. In order to facilitate this process and obtain any degree of satisfactory outcome, the counselor must be able to read the client's non-verbal cues and correctly interpret

those provided verbally. Sue indicated that the exchange, both verbal and nonverbal, must be accurately sent and received. Serious problems may arise, which can be detrimental to the counseling relationship, should either counselor or client read the wrong message in the other's verbal or nonverbal responses. Following Sue's argument one might conclude that miscommunication might lead to client lack of counseling engagement, early termination, dissatisfaction, and/or lack of positive outcome. In cultures that dissuade individuals from showing emotions or expressing feelings, counseling might not achieve the aspired goals.

Sue (1981) further pointed out that counseling holds different values for the White middle-class population than it does for minority groups. In addition, Tryon and DeVito (1981) found that the White counselors in their study preferred clients who are young, attractive, verbal, intelligent, and successful. Clearly, some ethnic minority clients of low socioeconomic status (SES) and/or illegal immigrants do not possess these characteristics and, therefore, counselors may discriminate against them, albeit not intentionally. Sue et al. (1991) also indicated that culture and ethnicity are related, as ethnically similar individuals most likely share the same cultural background.

Client nonengagement in counseling (i.e., failure to continue counseling post initial appointment; Tryon, 1985) and later client attrition or termination of treatment prior to completion of services (i.e., premature termination/dropout) have dire consequences for individuals (Harris, 1998) as clients who do not engage in the counseling process or terminate treatment early suffer more than those who complete treatment (DeLeon, 1991; Pekarik, 1992). However, the disparity in mental health care may lead to ethnic minorities' underutilization of mental health services (Marbarama & Hall, 2002) and dissatisfaction with treatment (Constantine, 2002).

Earner (2007) conducted an immigrant parent focus group and found that cultural misunderstanding was the central issue among participants. Members of this focus group cited the lack of mutual cultural understanding as one of the three barriers they faced when working with staff at a large urban welfare agency. Cultural misunderstanding may lead to non-engagement or early termination from counseling for these clients. Other factors associated with early termination include minority status and expectations regarding counseling (Harris, 1998).

The idea that minorities' underutilization of mental health services is due to the lack of ethnically similar counselors is based on the supposition that minorities view ethnically similar counselors as being more credible than Caucasian counselors (Atkinson & Matsushita, 1991). Gamist et al. (2001) indicated that an ethnic match occurs when the client and counselor are of the same general ethnicity (i.e., African American client and African American counselor). Similarly, Matthews et al. (2002) indicated that matching clients and counselors ethnically may be necessary for the enhancement of communication and trust, as their study suggested that ethically matched clients were more likely to accept referrals to post-discharge treatment. Sue (1977) indicated that all ethnic minority groups, but particularly African Americans, tend to drop out of treatment rather quickly, and about half of those whom he studied terminated after only one session (i.e., did not becoming engaged in counseling). He found that ethnicity was a significant predictor of premature termination.

Sue (1998) suggests that ethnic dissimilarity with counselors may be one of the most important reasons that African Americans avoid seeking mental health assistance. He believes that ethnically dissimilar counselors are less likely to understand and be responsive to the values, lifestyles, and cultural biases of their clients' belief system than are ethnically similar counselors. Adams (2000) suggested that African Americans often do not trust White counselors enough to

divulge their personal, emotional issues to them. Adams suggested that trust is the central initial issue of the White counselor/African American client counseling dyad. Sue and Zane (1987) suggested that those counselors who are racially/ethnically similar to their clients acquire greater credibility during the early stages of treatment. Erdur, Rude, and Baron (2003) indicated that racial-ethnic dissimilarity between counselors and clients causes misunderstanding, miscommunication, and cultural biases within counseling services. Nickerson, Helms, and Terrell (1994) suggested that cultural mistrust might be one reason that some ethnic minorities underutilize mental health facilities.

Numerous studies (reviewed below) have explored the effects of client-counselor ethnic matching on various aspects of counseling process and outcome. Readers should note that the authors of these studies used the term ethnic matching, but this often means that clients and counselors were matched according to race, not ethnicity. This literature review discusses the importance of a race-ethnic distinction in a later section.

Client satisfaction. One construct associated with treatment outcome, or at least the client's perception of outcome, is client satisfaction (Lebow, 1983). In addition, studies have linked client satisfaction to client non-engagement in counseling (Kokotovic & Tracey, 1987) and non-adherence to medical recommendations (Sherbourne, Hays, Ordway, DiMatteo, & Kravitz, 1992). According to Pascoe (1983), satisfaction refers to "the recipient's reaction to the context, process, and results of his service experience" (p. 189). While developing a measure to assess parent satisfaction with foster care, Kapp and Vela (2004) conducted a literature review about levels of satisfaction of parents involved in the child welfare system. Although these authors did not report how satisfied parents were with the child welfare system, they indicated

that the literature review revealed that counselors labeled many of these clients as untreatable, unresponsive, hard-to-reach, and being members of minority groups.

Some researchers have examined minority satisfaction with mental health services (Constantine, 2002; Gamble, 2001; Gamst et al., 2003; Rubin, 1999; Vetter, 2004) and obtained varying results. Rubin (1999) examined parental satisfaction with mental health case management services and parents' perceptions of the cultural competence of their children's case managers. Cultural competence refers to the ability of professionals to not only recognize and appreciate people from different cultures but to be able to work effectively with the members of other cultural groups (Sue, 1998). Participants were 146 families in receipt of case management services. Treated children were in need of extensive mental health services and therefore were referred for both intensive and traditional case management. Rubin used several self-reported measures to measure satisfaction with case management and client-rated counselor cultural competence. Client/counselor dyads were naturally occurring. Results of this study indicated that client-rated counselors' cultural competence was positively correlated with parental satisfaction, and racial match between client and counselor was associated with counselor cultural competence.

Gamble (2001) studied client-therapist ethnic match, ethnic identity, and satisfaction with mental health treatment. The sample consisted of 24 Portuguese-Americans between the ages of 23 to 58 who were currently in counseling. Similar to Rubin (1999), Gamble administered clients' questionnaires that measured client satisfaction and ethnic identity. The results of this study indicated that client satisfaction did not differentiate between the ethnically matched and unmatched client-counselor dyads. However, for the ethnically matched dyads, client satisfaction was significantly correlated with clients' ethnic identity. Clients who scored high on ethnic

identity reported more satisfaction than those who scored low on this measure when matched with counselors of the same ethnicity.

Constantine (2002) examined predictors of counseling satisfaction of racial and ethnic minorities. Constantine examined two hypotheses: (a) Racial and ethnic minority clients' ratings of their counselors' general multicultural competence, and clients' attitudes about counseling will have significant influence on these clients' satisfaction; (b) racial and ethnic minority clients' ratings of their counselors' multicultural competence will contribute significant variance to counseling satisfaction rating beyond the variance accounted for by their attitudes toward counseling and ratings of their counselors' general counseling competence.

In Constantine's (2002) study, clients were 112 ethnic minority college and graduate students who identified themselves as Black Americans, Latino(a) Americans, Asian Americans, American Indians, or biracial Americans. They attended five mid-to- large-sized predominantly White colleges and universities located in the northeastern part of the United States. Their 37 counselors held either doctoral or masters degrees in either counseling or clinical psychology. Counselors self-identified as White Americans, Black Americans, Asian Americans, Latino(a) Americans, or biracial Americans. Clients completed the following measures: a Client Demographic Questionnaire, the Attitudes Towards Seeking Professional Psychological Help Scale-Short Form (ATTSPPHS-S; Fischer & Farina, 1995), the Counselor Rating Form-Short version (CRF-S; Corrigan & Schmidt, 1983), the Cross-Cultural Counseling Inventory-Revised (CCCI-R; LaFromboise, Coleman, Hernandez, 1991), and the Client Satisfaction Questionnaire-8 (CSQ-8; Larsen et al., 1979).

Constantine (2002) found that clients' attitudes towards counseling accounted for significant variance in their counseling satisfaction. After accounting for their attitude toward

counseling, she found that clients' rating of their counselors' general competence added increased significant variance to client satisfaction. After accounting for the two previously mentioned variables, she found that clients' ratings of their counselors' multicultural competence added increased significant variance to client satisfaction. Thus, the results of this study confirmed both hypotheses.

Gamst et al. (2003) also examined the effects of client-counselor racial match on 96 Asian-American mental health consumers' satisfaction, and their results suggested that this population would benefit from racial matching. Sixty-six participants were adult clients, while the remaining 30 were parents or caregivers of child consumers. As was the case with the previous studies, the authors measured client satisfaction and treatment outcome by self-administered questionnaires. The results indicated that consumer satisfaction was higher for racially matched consumers, and outcome, as measured by the Global Assessment of Functioning (GAF) posttest, was higher for matched caregivers of child consumers than for caregivers who were unmatched with their counselors.

More recently, Vetter (2004) examined the effects of ethnicity and client-counselor ethnic match on adult clients' satisfaction with community mental health centers. Participants consisted of 1,022 consumers of community mental health services who were African Americans, White Americans, Latino Americans, and Asian Americans. Vetter measured client satisfaction with service via a survey instrument. Results indicated that satisfaction was related to ethnic match only for some minority clients but showed no significant relationship for others. Asian-American clients reported more satisfaction when they were ethically matched with their counselors, while Latino-Americans clients reported less satisfaction when matched. For African Americans and White Americans, ethnic matching had no significant effect on client satisfaction.

The results of the above studies provide no definitive argument for ethnic matching of client and counselor as it relates to client satisfaction. Some hypotheses were clearly supported, some were partially supported, and still others were not supported. The discrepancy in results may be attributed to the fact that the ethnic groups were often collapsed into racial groups (i.e., African Americans, Latino Americans, and White Americans). Helms (2007) indicated that ethnicity refers to the cultural practices of a group of individuals; however, individuals of a given ethnic group may be from different racial groups. Cultural practices include customs, language, dialect, and values. Although many of these individuals in the studies reviewed were racially similar to their counselors, because the studies failed to differentiate between race and ethnicity, some clients may have been racially similar but ethnically different from their counselors.

In addition, there are other specific limitations inherent in the above studies. First, the findings from Constantine (2002) may not generalize to populations other than counseling center clients from the northeast region of the United States. Also, she used only clients diagnosed with some type of DSM-IV (American Psychiatric Association, 1994) adjustment disorder, therefore, her findings may not generalize to populations with other diagnoses. Similarly, the Gamble (2001) and Gamst et al. (2003) studies utilized only Portuguese-American and Asian-American clients, respectively, and therefore, the results of these studies are limited to only these populations.

Premature termination (dropout) and non-engagement. In addition to client satisfaction, authors have examined premature termination or dropout rate in order to determine the possible benefits of ethnic matching in the client/counselor dyad. Sue et al. (1991) operationalized premature termination as the failure to return to therapy following the first session in testing the cultural responsiveness hypothesis that ethnic and/or linguistic matches between therapists and

clients would result in fewer premature dropouts, increased client participation (number of sessions attended), and better treatment outcome than would ethnic mismatches. Tryon (1985), however, calls client failure to return for a second counseling session non-engagement. She (1985) and others (Hilsenroth & Cromer, 2007; Kokotovic & Tracey, 1987; Tryon & Tryon, 1986) provided evidence that clients who leave counseling after the first session have not become involved (i.e., engaged) in the counseling process, and, therefore, cannot terminate a process that they have not begun (Kokotovic & Tracey, 1987; Tryon, 1989). Thus, this dissertation used the term non-engagement for client failure to return following the first session and employed the term premature termination for client post-engagement nonreturn for scheduled counseling sessions (Tryon, 1989).

Sue and his colleagues (1991) utilized 15 years of client engagement data from the Automated Information System (AIS). The Los Angeles County Department of Mental Health maintains this system. The AIS contained information on 600,000 clients during the years 1973-1988 who were African Americans, Asian Americans, White Americans, and Mexican Americans. However, the authors included only data on clients who received treatment during the most recent five-year period. The authors excluded American Indians and non-Mexican American Latinos from the study due to their small group size. They also excluded clients who were admitted only for assessment or for non-psychiatric illness from the study, as well as clients who were referred elsewhere for continued treatment. According to Sue et al., all clients were adults who had completed or terminated treatment after being admitted for treatment of a particular psychiatric disorder as diagnosed per the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (DSM-III; American Psychiatric Association, 1980). Sue et al. defined ethnic match as when the client and therapist were of the same ethnicity (e.g., African American

Client/African American Therapist). They indicated language match if the therapist was proficient in the client's language.

The results of this study indicated that client-counselor ethnic match resulted in lower odds of non-engagement for clients of all minority groups, except African Americans (Sue et al., 1991). Overall, this study suggested that ethnic match is a very important consideration for Asian Americans, Mexican Americans, and White clients in predicting engagement in counseling. For all client groups, ethnic match also related to greater number of sessions attended, but ethnic match was only related to treatment outcome for Mexican Americans. For the other groups, ethnic match failed to predict treatment outcome.

Similarly, Jerrell (1998) found that younger clients stayed in treatment longer when they were treated by ethnically similar counselors. Like Sue and his colleagues (1991), Jerrell utilized one year's worth of data from agencies funded by a Californian public health authority. The purpose of Jerrell's study was to explore further the concept of cultural responsiveness in the mental health system. Jerrell (1998) referred to cultural responsiveness as providing ethnic youths with mental health services from a facility staffed by personnel who were ethnically and culturally similar to these clients. The study examined the following questions: (a) Do clients with ethnically matched providers stay in outpatient care longer? (b) Do clients need more intensive care if they have a matched counselor? (c) What are the effects of using more outpatient service and less intensive service?

Three social-behavioral models that explain the use of medical care services (Aday, Fleming, & Anderson 1984; Andersen, 1968; Andersen, Kravist, & Andersen 1976 as cited in Jerrell, 1998) guided the analysis. According to these models, there are three categorical variables that explain the use of medical care services: (a) predisposing variables, (b) enabling

variables, and (c) need factors. Predisposing variables included age, educational level, race, gender. Enabling variables included means to access health service (income, health insurance). Need factors referred to health status or symptoms.

Jerrell (1998) analyzed one year's worth of data (1992-1993) from a California system-wide management and billing information system using a series of multiple linear regression analyses to isolate the predisposing, enabling, and need factor variables. Participants were 4,656 children and adolescents who received a broad array of services from agencies funded by a county public health authority in California. Participants were admitted to special inpatient units, residential programs, and day treatment programs. Others received services from clinics and school-based outpatient centers, crisis centers, and case-management centers. Ethnic specific agencies provided some of the services and ethnic staff in mainstream agencies provided other services. Of the 4,656 children and adolescents, 48% were ethnic youths and staff members of the same ethnic group provided outpatient services for 32% of these children and adolescents. The youths were Black, Asian, and Hispanic.

Jerrell (1998) found that those clients who received services from ethnically similar service providers stayed in treatment longer than those who received services from non-matched service providers. There were no statistically significant differences in the use of outpatient service among the ethnic youth studied. Females and adolescent clients used significantly less outpatient service than did younger or male clients. In this sample only two predisposing variables, being female or adolescent, related negatively to outpatient service use. One enabling variable, ethnic match between client and service provider, related significantly to outpatient service use.

Maramba and Hall (2002) conducted a meta-analysis of seven studies of ethnic match and engagement in counseling. Although they obtained only small effect sizes, the results supported the argument that ethnic match is related to counseling utilization and engagement for members of ethnic minorities. Using PsycINFO and the Social Science Citation Index, the authors selected seven studies, published between the years 1977 and 1999, for inclusion in the meta-analysis. The studies had nonoverlapping samples. All studied non-engagement (i.e., client failure to return after the first session). Authors operationalized utilization as number of sessions attended or GAS score. Maramba and Hall conducted separate meta-analyses for each criterion variable, non-engagement, utilization, and GAS score, with the Advanced Basic Meta-Analysis program, Version 1.10 (Mullen, 1988, as cited in Maramba & Hall, 2002). Clients matched with counselors of the same ethnicity were more likely to become engaged in counseling than clients not matched with counselors of the same ethnicity. However, the overall effect size for ethnic matching was very small, $r = .03$. Clients who were ethnically matched with counselors attended more sessions than those who were not matched, $r = .04$. Ethnic match was not related to GAS score, $r = .01$.

In another meta-analysis, Shin et al. (2005) analyzed results from 10 articles in an attempt to determine the effect of ethnic match on African American retention (a term that included both unilateral termination and missed sessions) rate. The 10 studies each used African American clients and Caucasian American counselors. Studies included findings published in peer-reviewed journals as well as unpublished dissertations. Shin et al. coded all 10 studies using an instrument developed specifically for the review (Lipsey & Wilson, 2001). They subjected the coding instrument to independent verification to ensure the reliability of the meta-analysis. The authors used a random effects meta-analysis to analyze the data. There were no overall

significant effects of client-counselor racial matching for African American clients and Caucasian American counselors and counseling retention. The results of this analysis did not support an argument for racial-ethnic matching.

As is evident from these findings, there is no definitive answer as to whether or not ethnic matching decreases the possibility of non-engagement or client unilateral termination from counseling. Jerrell (1998) and Sue et al. (1991) utilized data from public clinics. However, both of these studies had limitations. Both studies were retrospective studies of public health facilities in a specific geographical location, namely California. As indicated by Jerrell (1998), retrospective studies are susceptible to miscoding of information. Since there was no independent evaluation of diagnostic accuracy, diagnoses could have been incorrectly coded.

There were also major limitations evident in the two meta-analyses discussed previously. One analysis included only 7 studies, while the other analyzed 10 studies. Of the seven studies that Mambara and Hall (2002) analyzed, two utilized participants from the same geographical location and this may have significantly influenced the outcome of the meta-analysis. In addition, two of the seven studies accounted for 75% of the participants and the same research group conducted these two studies.

The studies examined by Shin et al. (2005) failed to describe the procedures used to assign clients to therapist. These authors utilized 10 studies; however, the data provided by 7 of these studies were from the same data set. This clearly compromised the findings, as these studies had the same results. In addition, 3 of the studies failed to describe the type of counseling intervention provided to the participants and the causes for which they sought treatment.

Counseling outcome. Another dependent measure that various authors have examined with regard to ethnic matching of client and counselor is counseling outcome. Outcome refers to

the Global Assessment of Functioning (GAF) according to the Axis V rating (Gamist et al., 2004) of the *Diagnostic and Statistical Manual of Mental Disorders*, *4th edition* (DSM-IV; American Psychiatric Association, 1994). Jones (1978) examined client-counselor racial match and counseling processes and outcome with 14 female clients of either African American or Caucasian counselors. Both clients and counselors completed questionnaires that measured their impressions of counseling outcome after 10 sessions. Results indicated that racial match did not predict outcome.

Lee (2004) found mixed results in a sample of Latino and African American children and adolescents with regard to ethnic match with their counselors and counseling outcome. In this study, Lee examined 4,603 children receiving community mental health services. Unmatched Latino and African American client participants experienced more positive clinical outcomes than their matched counterparts. Similarly, Diaz-Vivar's (2003) study of archival data found no support for the argument that ethnic match improved clinical outcome for children and adolescents.

Erdur, Rude, and Baron (2003) examined the relationship between symptom improvement and client-counselor ethnic matching with college student clients. This study attempted to determine the effect, if any, of ethnic similarity between client and counselor on course and outcome of treatment. The Research Consortium of Counseling Psychological Services collected the data. In an effort to obtain a representative sample of college students, the researchers used schools from the major athletic conferences as categories for selections. However, realizing the constraints of this selection process, the authors also made an effort to include additional small, medium, and large colleges and universities. The sample consisted of 973 college student clients ranging in age from 16 to 57. Clients had 194 counselors of which

172 were Caucasian, 11 were Hispanic, and 11 were African American. Counselors' education level ranged from Bachelor's degrees to Ph.D.s. Erdur and his colleagues utilized *The Outcome Questionnaire-45* (OQ-45; Lambert, Lunnen, Umphress, Hensen, & Burlingame, 1994) as a measure of clients' level of distress. They administered the OQ-45 at intake and immediately prior to each counseling session. Erdur et al. defined ethnicity on the basis of clients' and therapists' self-identification. The dependent variable was the difference between scores on the OQ-45 at intake and at the last session. This study found that client improvement of symptoms, or treatment outcome, was not significantly related to client-counselor ethnic match; however, there was a trend for clients from ethnically dissimilar dyads to show a greater degree of improvement.

Like Erdur et al. (2003), Gamst et al. (2004) also examined counseling outcome as a function of ethnic matching. These authors' goal was to extend previous research conducted in this area and to determine if results of previous studies could generalize across age groups by studying children and adolescent clients. They tested the following hypotheses: (a) clients who are ethnically matched would have more positive clinical outcome than their unmatched counterparts, (b) the effect of matching would be more pronounced with middle adolescents, because they have incorporated their ethnic identification in their self-schema, than with younger clients, and (c) when there is client and counselor ethnic match, mental health center visits should decrease. Visits or visitations referred to the frequency of visits to a mental health center.

Clients were children and adolescents between the ages of 6 and 18 who utilized a large mental health outpatient center in California (Gamst et al., 2004). Client (n = 1,946) and counselor (n = 147) ethnicity was based on their self-report. Counselors' educational level ranged from high school diploma to Ph.D. Clients received a large variety of treatments (e.g.,

individual therapy, family therapy, case management, crisis intervention, and medication support). For each client, counselors completed the GAF Axis V rating of the *Diagnostic and Statistical Manual of Mental Disorders*, 4th *edition* (DSM-IV; American Psychiatric Association, 1994) at intake and at termination or at annual review. Researchers calculated a GAF pre-post counseling difference score for each client. Gamst et al. (2004) evaluated client visitation by counting the total number of counseling visits each client made to the center. The results indicated that ethnic match between client and counselor did not significantly influence child and adolescent clients' clinical outcome as measured by GAF difference scores. In addition, African American children who were ethnically matched with counselors had need for fewer mental health center visits.

However, another study by Gamst et al. (2001) found opposite results. The authors examined archival data of a sample of 253 Asian-American adults and children who were patients at a large community mental health agency in California during a 4-year period. Results of this study indicated that clients who were ethnically matched with their counselors had higher GAF scores at termination and more clinical visits than their unmatched counterparts. Even after adjusting for several covariates, ethnically matched clients still experienced higher levels of visitation. However, one limitation of this study was that there was no way to achieve precise ethnic match as the classification of Asian American included clients from several ethnic groups (i.e., Asian-Pacific, Southeast Asian, and Filipino; Gamist et al., 2001).

Results of Russell et al. (1996) support Gamist et al.'s (2001) findings. They found that ethnically matched African-American, Asian-American, and Mexican-American clients had higher GAF scores at termination. Similarly, Halliday-Boykins, Schoenwald, and Latourneau's

(2005) findings also suggested that when caregiver and counselor had similar ethnicity, clinical outcomes and utilization of service were enhanced for youths experiencing behavioral problems.

As is evident, there are mixed findings regarding the relationship between client/counselor ethnic match and counseling outcome. As a result there is no definitive answer to the question of whether or not ethnic matching improves counseling outcome.

Other variables relative to client-counselor ethnic matching. Others have examined the effects of ethnic matching of clients and counselors on other variables in addition to non-engagement, early termination, treatment outcome, and client satisfaction. Bhagavathula (2004) examined the effects of client and counselor ethnicity on topic intimacy and self-disclosure. Client participants were 50 South Asian women between the ages of 18 to 30, recruited from several colleges within the United States. Counselors were both South Asian and European American women. Results indicated that when ethnically matched with counselors, South Asian women revealed less than when interviewed by ethnically dissimilar counselors. This study's results refuted the argument for ethnic matching.

In another study, Marquez (2006) examined the effects of ethnic and worldview match between client and counselor on counselors' ability to understand the clients, counselors' expertise, and how likely clients were to choose counselors of the same ethnicity or worldview. Results indicated that matched counselors received higher ratings of their ability to understand clients, counselors' expertise, and client choice based on same ethnicity or worldview.

Campbell and Campbell (2007) examined effects of gender and ethnic match on the outcome of mentoring at-risk college students. Participants consisted of 339 undergraduate students enrolled in a mentoring program. Although the study found no advantage for gender match, students matched ethnically with mentors evidenced higher cumulative Grade Point

Averages (GPAs), graduated at a higher rate, and had a higher rate of graduate school admissions.

Summary. Clearly there is no definitive answer as to whether or not client-counselor ethnic match is beneficial to clients from minority groups. Depending on outcome measures and samples studied, different studies yielded varying results. Some results supported the argument for ethnic match while others refuted the argument. Most studies examined a minority/Caucasian dyad, with the counselor being Caucasian and the client being a minority group member. None of the studies examined other mismatches within racial groups (e.g., Latino client/African American counselor, West Indian client/African American client). Additionally, all of the studies used the terms race and ethnicity interchangeably. Studies utilized data from outpatient treatment centers, inpatient treatment centers, and college campuses. Only one study (Rubin, 1999) examined clients receiving services from a case management agency, and none examined the relationship between ethnic match and client satisfaction and engagement using a sample consisting of abusive and/or neglectful parents.

Client Preference for Counselor Ethnicity

It is possible that some clients may prefer counselors who are not ethnically similar to them and that other clients may have no preference for counselors' ethnicity. Some researchers, therefore, have studied client preference for ethnically matched counselors. Atkinson, Poston, Furlong, and Mercado (1989) examined counselor gender and ethnic group preferences of 339 Mexican, Asian, and Caucasian American university students. Their results suggested that clients' preference for ethnically similar counselors was not as important as their preference for counselors of the same sex. In addition, when given a choice, clients preferred a counselor with a higher educational degree than they had. Also, Asian American and Caucasian American

participants preferred counselors with similar socioeconomic status over counselors who were ethnically similar.

Another study (Proctor & Rosen, 1981) asked African American and Caucasian American clients to provide their preference for counselors' ethnicity. These authors studied 34 male clients (24 Caucasians and 8 African Americans) who were referred to the Veterans Administration outpatient mental health clinic. Approximately half of the Caucasian and half of the African American clients indicated no preference for the ethnicity of their counselors. However, the authors indicated that social desirability may have influenced the results as the interviewer in this study was Caucasian. Ponterotto, Alexander, and Hinkston (1988) also studied African-American preference for counselor characteristics. Participants were African-American students from a mid-western university. Results indicated that clients preferred a counselor with similar attitudes and values. Because ethnically similar individuals tend to hold similar attitudes and values, one might theorize that this sample of participants would have preferred ethnically similar counselors.

Taken together, the results of these studies indicate that clients may not always have a preference for counselors of similar ethnicity. Clients may prefer other counselor characteristics (i.e., education, gender) more than ethnicity. However, college students comprised the bulk of the clients for these studies, and their preferences for counselors may not be similar to preferences of other types of clients.

What Variables Define Ethnic Matching?

It is evident from the studies reviewed that investigators often use the term ethnicity as a euphemism for race (Cokley, 2007). Cokley acknowledged that defining, conceptualizing, and

measuring the construct of ethnicity has proven to be challenging for investigators. As a result, studies do not define ethnicity in a consistent way, limiting the generalizability of findings.

Ethnicity. Cokley (2007) pointed out that, over the years, the definition of ethnicity has undergone many changes. According to Cokley, ethnicity refers to a "characterization of a group of people who see themselves and are seen by others as having a common ancestry, shared history, shared traditions, and shared cultural traits such as language, beliefs, values, music, dress, and food" (p. 226).

Quintana (2007) noted that over time there has been a shift from a narrow definition of ethnicity that related to demographics to a more broad socially-constructed definition. In addition, he contended that, despite a large body of research, this construct (i.e., ethnicity) continues to lack a "clear objective, agreed upon, scientific definition" (p. 224). Nevertheless, investigators have attempted to clarify the inconsistencies in the way they use race and ethnicity in research (Quintana, 2007).

According to Cokley (2007), different investigators have adopted either a broad, intermediate, or narrow definition of ethnicity. The broad definition includes both cultural characteristics and biophysical traits. Cokley indicated that authors often use the broad definition of ethnicity interchangeably with race. The intermediate definition of ethnicity includes shared cultural characteristics and national origin, while the narrow definition includes only cultural characteristics. Smeadly (1999) argued against the use of the broad definition because although individuals may share similar physical characteristics, they may identify with different cultural groups. Similarly, Greeley (1974) suggested that ethnicity, when used broadly, refers to individuals being differentiated from others based on nationality, race, religion, or language. A more narrow definition of ethnicity, proposed by Schermmerhorn (1969), is a collection of

individuals within a dominant society with ancestral ties, either real or perceived, shared historical past, and a symbolic cultural focus.

Sollors (2002) indicated that, over the past 400-year period, the meaning of ethnicity has evolved substantially. From 1772, when the word ethnicity first appeared in the dictionary to the present, various individuals have defined this word differently from one another. Sollors further pointed out that the original definition of this construct was synonymous with being archaic and or uncommon. However, the use of the term ethnicity remained dormant for a substantial number of years until World War II, when Sollors indicated that an unnamed sociologist revived the term and defined it more or less as a social category. Gordon (1988) suggested that although the word race may be subsumed by that of ethnicity, the converse is not necessarily the case. He believed that ethnicity is a very broad concept, which includes race, culture, and other concepts.

Burkey (1978) contended that the word “ethnicity” has both psychological and social components. This author further argued that culture is made up of norms, values, beliefs, and technology. Based on this definition, ethnicity is, therefore, a combination of several constructs. Like Burkey, Abizadeh (2001) also pointed out that ethnicity is a difficult concept to define. This author contended that ethnicity is a socially-constructed belief and is, therefore, very difficult to define. He believed that genealogy alone is not sufficient to determine ethnicity, but rather one must also consider other constructs, such as looks, language, and place of origin. Alvidrez, Azocar, and Miranda (1996) suggested that investigators have used different definitions when referring to ethnicity. These authors contended that broad categories such as African American, Latino(a), Asian American, and Native American are appropriate but only for the initial categorization of an ethnic group. They recommended that investigators should use additional description due to the heterogeneous nature of these groups. Investigators should take factors

such as country of origin and geographic residence into consideration when determining ethnicity.

Burkey (1978) utilized the broad definition in his conceptualization of ethnicity. According to Burkey, three factors influence ethnicity within the individual's environment. These include language, culture, and physical appearance. Speaking one's language/dialect correctly, whether verbally or nonverbally, is a necessary tool in counseling of ethnic minority members (Sue, 1981). In Burkey's (1978) model, culture plays a role in ethnicity as it is defined as the "shared symbolic meanings of specific social units or social collectivity" (p. 7). Physical type, in this model, may be the only means by which one may distinguish members of different groups, as prolonged, extensive contact between group members often results in "cultural overlap" (p. 8) and language sharing (Burkey, 1978).

Unlike Burkey (1978), Phinney (1996) utilized the intermediate definition of ethnicity. This author proposed that cultural values, subjective sense of belonging, and experiences related to minority status all have psychological importance. Phinney's (1996) model of ethnicity proposed that one must identify the specific cultural characteristics related to an ethnic group in order to comprehend the psychological implication of ethnicity (i.e., mental health). This author proposed that cultural norms and values alone, although important components of ethnicity, cannot adequately explain psychological outcomes as they relate to ethnicity. The next part of Phinney's (1996) model considered ethnicity as it relates to subjective sense of belonging. This aspect of the model proposed that identification with a particular ethnic group varies in strength from one individual to another. Phinney (1996) contended that:

> Ethnic identity is not a categorical variable that one has or does not have.

> Rather it is a complex, multidimensional construct that ……varies across members of a group. Ethnicity is a meaningful psychological variable to the extent that it has salience …for the individual involved. (p. 922)

The final aspect of Phinney's model is that of minority status. Phinney (1996) contended that minority status, or one's situation and experiences within the dominant society, is important to ethnicity. This author believed that factors influencing psychological outcomes include an individual's personal experience with prejudice, his response to discrimination, and his ethnic group's present and historical status within the dominant society.

Helms (2007) utilized the more narrow definition of ethnicity. She believed that ethnicity refers to one's commitment to a specific ethnic group and one's engagement in the cultural practices of that group irrespective of race. This dissertation combined Phinney's (1996) and Helms' (2007) definitions of ethnicity. According to Phinney, ethnicity takes into consideration cultural values, subjective sense of belonging, and experiences related to minority status. Helms contended that race should not be considered in the assessment of ethnicity. Since this dissertation argued that ethnicity does not equate to race, ethnicity is defined as a person's subjective sense of belonging to and participation in cultural practices of a specific ethnic group, regardless of race.

Race. Cokley (2007) defined race as "a characterization of a group of people believed to share the physical characteristics such as skin color, facial features, and other hereditary traits" (p. 226). A distinction between race and ethnicity would prompt the examination of ethnic differences within race (Orin & Winant, 1986), such as differences between Blacks (e.g., West Indians, African Americans, African, Dominican). According to the Department of Health and Human Services (2007), there are four most recognized racial and ethnic minority groups in the

United States. According to federal classification, African American (blacks), American Indian and Alaska Natives, Asian American and Pacific Islanders, and White Americans (whites) are all races, while Hispanic Americans (Latino) are members of an ethnicity and may be of any race (Department of Health & Human Services, 2007).

One can clearly see that ethnicity is not a dichotomous term that one can easily determine by phenotypical features (race). For example, what would be the ethnicity of a third generation Caribbean person of Chinese ancestry? As an individual from the Caribbean, the author of this dissertation is aware of numerous individuals scattered all over the Caribbean/West Indies, who are 3rd and 4th generation Caribbean/West Indians but whose foreparents originated from such places as India, China, and Africa. As a result of where they now reside, these individuals have adopted the West Indian/Caribbean culture and norms. They speak the dialect (Guyanese, Jamaican, and Bajan), have the same superstitions (e.g., do not put umbrellas on the bed, do not sweep after sunset, after midnight enter a building facing backward), eat the same foods, and embrace the same child-rearing practices (e.g., corporal punishment is the most effective form of discipline). With which ethnic group would such individuals identify? Therefore, investigators who group all African Americans, Asians, and Caucasians according to physical appearance are in essence conducting a study of race and not one of ethnicity.

There are several races in the United States (Department of Health & Human Services, 2007), but within each of these racial categories are subgroups based on ethnicity and national origin. While an individual may claim multiple ethnicities, one can claim only one race, and one has no control over one's race, as each individual is born into her race (Cheng, 2003). Cheng provided an excellent example of an individual whose race and ethnicity substantially contrasted. He described a young woman of Chinese ancestry, who was adopted by an Italian couple. Others

perceived this young woman as Chinese (i.e., race), but she perceived herself as Italian (i.e., ethnicity), as she was immersed in the Italian culture (spoke the language, knew the history, observed the customs) and knew nothing of the Chinese culture. In this particular case, the woman was of the Chinese race but of Italian ethnicity. Many researchers claiming to study ethnicity would have lumped this young woman into the "Chinese" group. Alvidrez, Azocar, and Miranda (1996) cautioned that race should "not be used as an explanatory variable in psychotherapy research" (p. 904).

Acculturation. Like ethnicity and race, investigators also have had difficulty defining acculturation. Between 1936 and 1954 authors shifted the definition of acculturation from viewing it as one group's change as a result of continuous first hand contact with another group to viewing it as changes that occur in two or more autonomous cultural systems (Trimble, 2002). Trimble indicated that the key part of the earlier definition was "continuous first hand contact (with the dominant culture) with continuous being the key word" (p. 6), while the key words in the newer definition of acculturation are "change and adaptation" (p. 6). In other words, investigators currently consider individuals' level of acculturation to be dependent on how much they have adapted to the dominant culture by changing their behaviors and beliefs. However, Berry (2003) defined acculturation as the change in culture that occurs when two groups have continuous interaction with each other. According to Berry, this change occurs at both the group level and individual levels.

Acculturation is a concept with roots in the social and behavioral sciences (Trimble, 2002). Like ethnic identity, the concept of acculturation underwent change in its meaning and usage. Initially, investigators conceptualized acculturation as bipolar (Stephenson, 2000) or a unidirectional process of cultural change, which leads eventually to full assimilation (Suarz-

Orozco, 2001). Chia and Costigan (2006) indicated that the bipolar model postulates that the extent of one's loss of his/her original ethnic culture was an indicator of the level of acculturation into the dominant society. However, this view has since shifted to the current model that conceptualizes acculturation as a multidimensional process (Stephensen, 2000).

According to Hollowell (1945, as cited in Berry, 2003), investigators initially became interested in the concept of acculturation as a means of examining the effect of European dominance of indigenous people. Later, they used the term acculturation to understand changes that immigrants undergo as a result of entering and residing within the dominant culture (Beiser, 2000). More recently, the focus of acculturation studies has been on understanding how ethnic minority groups relate to each other and what changes ethnic minority members undergo as a result of their interaction with members of the dominant culture (Padilla, 1980a).

In addition, Johnson (2007) discussed acculturation and its implications for child welfare services with children of immigrants. According to Johnson, their experiences with the acculturation process shape immigrant children's cognitions, which often lead to the enrichment of both these children and their parents. However, this is not always the case, especially for families who are vulnerable, as these children's process of adjustment sometimes results in their families' involvement with child protective agencies. According to Johnson, several factors influence the "acculturative orientation of immigrant children and their parents" (p. 1429). These factors occur at the macro, exo, and micro level of the family system. Johnson outlined these systems in her model.

At the macro level, public policies, which include immigration policies and societal attitudes towards immigrant groups, influence the acculturation process. On the exo level, health care and social services and social networks influence the acculturation process. According to

Johnson (2007), at the micro level, parental factors such as "congruence of parental cultural beliefs and parenting style with host culture" (p. 1430) and factors associated with parent-child relationships such as "harmony/dissonance between parental and child's acculturation" (p. 1430) influence the process and have implications for child maltreatment. Typically, counseling usually addresses these "intergenerational-intercultural conflicts" between immigrant parents and their children.

Berry (2003) indicated that there are currently two schools of thought regarding the definition and process of acculturation and postulated two levels of acculturation: cultural and psychological. According to Matsudaira (2006), "at the cultural level, acculturation refers to collective changes in social structure, social climate, economic base, and political organization" (p. 462). Alterations occur in the economic, linguistic, political, religious, and social institutions, and they are replaced by other institutions. Psychological acculturation refers to changes within the individual as a result of coming into continuous and prolonged contact with the dominant culture. Both the changing culture of an individual's origin and the more dominant culture influence psychological acculturation (Berry, 2003). The distinction between these two concepts (psychological and cultural acculturation) is necessary because despite being exposed to the same external culture not all members of an ethnic group change at the same pace or in the same way (Berry, 1980).

Berry (1980) proposed a model of acculturation, which has been widely used, cited (Stephensen, 2000), and studied (Ryder, Alden, & Paulhus, 2000). Berry's model postulates that any small group within a dominant society must respond to two questions: Will members maintain their culture? or will they adopt the dominant culture (Leong, 1994)? Responses to these two questions can lead to four distinct acculturation statuses: integration, assimilation,

separation, or marginalization (Berry, 1980). According to Leong (1994), Integrationists are those individuals who choose to maintain their original cultural values, while adopting those of the host country. Assimulationists reject the values and beliefs of their ethnic culture and strongly adopt those of the dominant culture. Seperationists reject the host culture and maintain the traditional cultural values, and Marginalists choose to reject both the dominant and traditional cultures.

Berry (2003) suggested a general framework for the conceptualization of acculturation. At the group level, one culture comes into continuous contact with another, which invariably leads to a change in both groups. Berry cautioned that practitioners working with immigrants or studying the acculturation process must consider and understand three things: the key features of both groups, the nature of the groups' relationships, and the resulting cultural changes. On the psychological/individual level, members of both groups undergo psychological changes and behavioral shifts (changes in speech, dress, and foods) that eventually lead to adaptation. On the psychological level, Berry (2003) suggested that one must take into account psychological changes that occur in the individuals from both groups and the effect of the adaptation to the new situation when working with immigrants or studying their acculturation. According to this model, adaptations can either be soicocultural or psychological. Therefore, one can define psychological acculturation as the degree to which an individual learns and adopts the values, behaviors, lifestyles, and language of the dominant culture (Zane & Mak, 2003).

Both groups and individuals engage in the process of acculturation differently (Berry, 2003), and these differences have been associated with one's willingness to use mental health services (Zane & Mak, 2003). Burkey (1978) suggested that acculturation can either be voluntary or involuntary and the latter may result from coercion. This author proposed that "borrowed

traits” (p. 120) may become additions to the groups’ culture, however more often than not they replace the existing culture. Berry (1980) did not agree with Burkey (1978). According to Berry (1980), one’s involvement in the dominant culture does not necessarily equate to a decrease in involvement in the original culture.

Ryder, Alden, and Paulhus (2000) questioned whether or not the acculturation process is unidimensional or bidimensional. From the unidimensional perspective, individuals assimilate into the mainstream culture while simultaneously losing their original groups’ values and beliefs (Ryder et al., 2000). On the other hand, the bidimensional perspective, proposed by some authors (Berry, 1980; Sanchez & Fernandez, 1993), suggests that both the original and dominant cultural values and beliefs vary.

Ryder et al. (2000) conducted three studies to examine the validity and utility of the bidirectional model. The first study’s goal was to compare the two models (bidirectional and unidirectional) and determine the validity and utility of the bidirectional model. The authors hypothesized that a strong negative correlation between the heritage (original) culture and the mainstream (dominant) culture would provide support for the unidirectional model of acculturation. In the first study, Ryder and his colleagues studied 164 undergraduate students (109 females and 55 males). Students’ ages ranged from 17 to 23 years old, and all self-identified as having Chinese ancestry. Participants completed three questionnaires: an instrument measuring unidirectional acculturation, one measuring bidirectional acculturation, and the other measuring personal factors. The results of this study supported the bidirectional approach to acculturation, as the two dimensions did not indicate polar opposites of a single dimension.

The goals of the second study were to solidify a new bidimensional measure developed by the authors, strengthen the findings of the first study, which indicated that the two subscales

were not polar opposites, and compare the two models to cross-cultural self-identity (Ryder et al., 2000). The results of the second study again supported the bidirectional model of acculturation, as the two dimensions were shown to be distinct and independent. The third study aimed to replicate Study 2 findings across another population of individuals and to incorporate other aspects of acculturation (i.e., namely interpersonal aspects). Participants included those with Chinese, non-Chinese East Asian, and non-English speaking ancestry. The non-English speaking sample consisted of no Chinese or East Asian descendants. Participants completed several instruments that measured aspects of self-identity, interpersonal problems, social avoidance, shyness, and social anxiety. As was the case with both Study 1 and 2, the results of Study 3 supported the bidirectional model of acculturation.

Tarn et al. (2005) examined the effects of acculturation, ethnic match, autonomy, and religiosity on trust in one's physician. Participants consisted of 467 English-speaking Japanese Americans, 315 Japanese-speaking Japanese Americans, and 175 Japanese residing in Japan. Tarn and colleagues administered participants a questionnaire that consisted of several validated scales and elicited demographic and religious information. Scales included a Health Survey that measured quality-of-life related to health and the Autonomy Preference Index. Japanese Americans also completed a 6-item acculturation scale. Participants also responded to the questions that measured trust in one's physician. Results indicated that Japanese Americans, whether English speaking or Japanese speaking, reported more trust in their physicians than did Japanese residing in Japan, and ethnic match was positively related to trust in one's physician. In addition, higher acculturation was associated with greater trust.

Definitions this study utilized. According to Cokley (2007) the broad definition of ethnicity includes, among other variables, a common ancestry and biophysical traits. As a result,

investigators often use the broad definition interchangeably with race, as is evident in the studies previously discussed. The intermediate definition includes shared cultural characteristics and national origin, while the narrow definition only includes cultural characteristics. In addition, Smedly (1999) also argued against the use of the broad definition of ethnicity. Since the narrow definition excludes national origin and this variable is important to distinguish among African Americans from the United States, from Africa, and from the West Indies/Caribbean, this dissertation did not utilize the narrow definition. So, in an effort to distinguish between race, which is defined as a group of individuals with shared physical characteristics, and ethnicity, this dissertation utilized the intermediate definition of ethnicity (i.e., include both participants' national origin and their culture).

Zane and Mak (2003) defined psychological/individual acculturation as the degree to which an individual adopts the values, behaviors, life styles, and language of the dominant culture. This dissertation used Zane and Mak's definition; however, it did not include adaptation of language, as the study did not look at participants' language. The reason for choosing this definition was because the broad definition includes common ancestry and biophysical traits, which are often used interchangeably with race. The narrow definition includes only cultural characteristics and omits country of origin. The omission of country of origin will not take into account West Indian, Hispanics, or other ethnic groups from different countries. From experience, the author of this dissertation is aware that although West Indian/Caribbean individuals share similar culture, there are some differences depending on the country of origin. For example, some of the foods are specific to a particular island, some phrases have slightly different meanings, and attitudes towards certain practices are sometimes different. In addition, the dissertation used the racial categories as indicated by the Department of Health and Human

Services (2007) to assess participants' race, with each participant indicating that he or she belonged to one of four categories. The four most recognized racial groups in the United States are African American (blacks), American Indian and Alaska Natives, Asian American and Pacific Islanders, and White Americans.

Counseling Those Who Abuse/Neglect Children

The studies reviewed above indicate that the ethnic match of client and counselor may influence whether clients become engaged in, satisfied with, complete, and improve in counseling. These studies' results should, therefore, inform counseling of minority clients, including those referred by the child welfare system for abusing and neglecting their children.

Serving those who abuse and neglect in New York City and across the U.S. In New York City, there is a large population of different minority groups that receives services to reduce the recurrence of child abuse and/or neglect. A large New York City Social Service Agency is charged with the responsibility of investigating allegations of child abuse and/or neglect received from the State Central Registry abuse hotline. Upon receipt of a report of abuse or neglect by the State Central registry, the case is either accepted and referred to the relevant child welfare agency for investigation or closed due to lack of evidence (Drake, Johnson-Reid, & Sapokaite, 2006). During the investigation, caseworkers determine whether or not parents may benefit from counseling, parenting skills classes, domestic violence counseling, or other services. After an assessment is completed, a referral is made to a Purchase Preventive Service Agency (PPRS) that assumes the responsibility of providing the necessary services to address the parents' abusive behavior. Due to the number of abusive/neglectful clients requiring counseling and other services necessary to prevent reabuse, Administration for Children Services contracts out these services to PPRS agencies. In other words, ACS purchases preventive services for their clients.

As the studies below will show, however, many of the parents referred are resistant to services. The rate of recidivism of child abuse and/or neglect cases is extremely high for this population irrespective of the services being received. Based on the experience of the author of this dissertation, many of these parents voice dissatisfaction with their service providers, which subsequently may contribute to their failure to comply. As a result they do not become engaged in or terminate counseling early (i.e., dropout), and often the State Central Registry receives new allegations of child abuse and/or neglect with these same parents being named as the alleged perpetrators.

One study (U.S. Department of Health & Human Services, Office of the Assistant Secretary for Planning & Evaluation, 2005) utilized data from the National Child Abuse and Neglect Data System (NCANDS) and tracked children over a 5-year period. Results indicated that approximately one third of children who were subjects of abuse and or neglect were likely to be re-reported within a 5-year period. In addition, those who received services were also likely to be re-reported. According to the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (2005), if a child was deemed to be the victim of abuse/neglect, after the initial investigation, then this child was more likely to be re-victimized. In addition, the implementation of services following an investigation increased the likelihood of recurrence regardless of whether or not this was an initial investigation. It is the opinion of the author of this dissertation that families receiving services are under more scrutiny than those not receiving services. So it is possible that they are more likely to be re-reported for abuse than families who are not in the service system.

Two studies (Fluke, Shusterman, Hollinshead, & Ying-Ying, 2005; Fluke, Ying-Ying, & Edwards, 1999) obtained similar results when they examined data from 10 states, over a 1-year

period. These authors reported that abuse recurrence was associated with services provision at the conclusion of the investigation. DePanfilis and Zuravin (1999) found that approximately 43% of the families included in their 5-year study had at least one report of child abuse and or neglect, about 12% experienced three re-reports, and an estimated 11% experienced four or more re-reports. In addition, these authors found that the overall rate of recurrence, over the 5-year period studied was approximately 43%. Also, the time between recurrences decreased as recurrence increased. Levy et al. (1995) also examined 304 children over a 5-year period in an effort to determine the rate of recurrence of child abuse. Levy and his colleagues found that approximately 17% of the participants experienced reabuse, with the greatest risk occurring within the initial 2-year period following the first occurrence.

One would intuitively believe that previously unfounded cases would be less likely to experience re-reporting, however this was not the case in a study conducted by Way, Chung, Johnson-Reid, and Drake (2001). These authors found that unfounded cases, or cases in which there was not enough evidence to substantiate the allegations, also had a high risk of re-reporting, and high recurrence was evident for cases in which "Lack of Supervision" was the allegation (Johnson-Reid, Drake, Chung, & Way, 2003).

As of December 2007, the Administration for Children Services, New York City, reported that a total of 63,434 allegations of abuse and or neglect. This represented a 4% decrease from the previous year. Of this amount, 99.2% of these cases were referred for General Preventive Services and 31,565 cases were being actively serviced by a PPRS agency, compared to 30,078 for the previous year (NYCACS, Administration for Children's Services, Flash, December 2007, 2008).

Ethnic diversity of PPRS providers and their clients. As a former employee of the Administration of Children's Services in one particular area of Brooklyn, New York, this dissertation author experienced first hand that a high concentration of Latino Americans and African Americans who abused/neglected their children were serviced by ethnically dissimilar service providers. These service providers varied substantially with regard to culture/ethnicity. Service providers originated from the Caribbean, Nigeria, South America, and the United States, while the clients consisted of individuals from The West Indies, Puerto Rico, Mexico, Santo Domingo, and the Dominican Republic. Although this dissertation author could not find specific data on the demographic make up of this particular community, the demographic make up of Brooklyn as a whole is as follows: Whites make up approximately 41% of the population, Black or African Americans (this includes Black people from all national origins) 36%, American Indian and Alaska Natives 0.4%, Asians 7.5%, Native Hawaiian and other Pacific Islanders 0.1%, some other race 10%, two or more races 4%, and Hispanics or Latinos (of any race) 20%. (U.S. Census Bureau, 2000).

Could ethnic mismatches with their providers relate to low satisfaction/high dropout rates of parents who abuse/neglect their children? Would ethnic matching between abusive/neglectful parents and their service providers increase satisfaction and/or reduce dropout rate thereby possibly reducing the risk of them further abusing/neglecting their children?

Green, Power, Steinbool, and Gaines (1981) suggested that several factors impact successful and unsuccessful intervention with parents who abuse their children. These authors found that those parents who perceived the need for involvement in service achieved more favorable outcomes, while involuntary (i.e., mandatory) entrance into the program predicted less positive outcomes.

Earner (2007) studied two immigrant focus groups in an effort to determine the barriers they faced when working with a large urban child welfare agency. His study identified lack of "mutual cultural understanding" (p. 77) as one of three barriers to an appropriate public welfare system. According to Johnson (2007), immigrant children straddle many cultures including that of their parents, the subculture of their schools, and that of the dominant culture. According to Johnson, although this experience may be positive for some families, it may result in an acculturation gap between immigrant children and their parents (Birman & Taylor-Ritzler, 2007). This gap, along with the adjustment process to the new culture, could result in the family becoming involved with the child welfare system (Johnson, 2007) as differences in beliefs and values may lead to child maltreatment (Smith-Hefner, 1998).

Thus far, no published studies have examined client-counselor ethnic match using parent clients who abuse or neglect their children, but results of a pilot study for this dissertation (Barrow & Tryon, 2008) suggested that ethnic matching could be important for this client population. Twenty-five counselors and their clients from a large urban social service agency completed the *Stephenson Multigroup Acculturation Scale* (SMAS; Stephenson, 2000) and the *Multigroup Ethnic Identity Measure* (MEIM; Phinney, 1992) before intake. After intake, clients completed *Client Satisfaction Questionnaire-8* (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). All participants (i.e., both clients and counselors) were minority group members, but 11 of the counseling dyads (44%) were ethnically matched according to their MEIM self-reported ethnicities and 14 dyads were unmatched ethnically. For ethnically matched dyads only, as the difference between counselors' and clients' acculturation increased, with counselors being more acculturated, client satisfaction with counseling increased. Perhaps these clients looked to their ethnically similar but more acculturated counselors (who had been in the U.S. longer than they

had) as having important things to teach them about child-rearing and what is acceptable in this culture. Ethnic matching did not relate to engagement, however, as all clients were required to return for a second appointment and they all did.

Rationale for Study

Prior to October 30, 2006, the dissertation author was an employee of the Administration for Children's Service (ACS). As part of her responsibility she was required to refer ACS clients to Purchase Preventive Service Agencies (PPRS), which provided such services as individual and family counseling, parenting skills classes, drug treatment counseling, anger management and sex abuse treatment. Thus, the author has first-hand knowledge of the service provider agencies for ACS.

The reason she chose to study parents who abuse or neglect their children is because there is high recidivism for abuse/neglect cases received by ACS as the above literature indicates. In the author's experience in many of these cases, the parents who abuse and neglect have been referred to the PPRSs for counseling, but are resistant, have never become engaged, or have dropped out of counseling shortly after engagement. For instance, on several occasions these PPRS agencies were forced to close the cases due to non-compliance of clients. Thus, these clients did not receive the help that they need, which, according to the author's experience and the literature reviewed above, often is associated with recurrence of allegations of abuse and/or neglect. It is possible that some of these parents' resistance and lack of compliance could relate to ethnic mismatches with their counselors.

While numerous studies reviewed above have investigated ethnic matching using clients from minority groups and their Caucasian counselors, the results are equivocal concerning whether or not ethnic match facilitates client engagement, satisfaction, continuation, and

outcome. One reason for this is that authors tend to confuse race and ethnicity (Cokley, 2007) and often do not take acculturation into account (Phinney, 1996). In addition, none of the studies used clients who abused/neglected their children. So, while it is possible that ethnic matching of these clients with their counselors could facilitate service provision, the current literature provides no evidence for this assertion. Thus, this dissertation was done to determine how ethnic matching between minority clients who abused/neglected their children related to client satisfaction with the initial interview, engagement, satisfaction with intake, continuation in counseling, and early outcome. The study also examined how acculturation differences between clients and their counselors related to client satisfaction, engagement, continuation, and outcome. The results of the study have practical implications for the referral process of a large New York City Social Service Agency.

Hypotheses

Results of studies by Erdur et al.(2003), Maramba and Hall (2002), and Sue (1998) have supported the benefits of ethnic matching between client and counselor. Results suggested that matching increases client satisfaction (Rubin, 1999; Gamble, 2001), decreases dropout rate (Sue et al., 1991; Jerrell, 1998), and improves treatment outcome (Russell et al., 1996). However, results of other studies did not support ethnic match for client satisfaction (Vetter 2004), engagement/early termination (Shine et al., 2005), and outcome (Marbmba & Hall, 2002). Readers should note, however, that none of these studies used clients who abused or neglected their children. Based on the ethnic matching literature, the author of this dissertation examined the following hypotheses:

HO 1: Clients who have abused/neglected their children and are ethnically matched with their counselors (determined by client and counselor self-identification) will be

significantly more likely to be engaged in counseling (defined as client return for post-intake counseling sessions; Tryon, 1985) than ethnically unmatched clients.

HO 2: Clients who have abused/neglected their children and are ethnically matched with their counselors will be significantly less likely to terminate prematurely post-engagement (defined as client failure to return after the second counseling session) than ethnically unmatched clients.

HO 3: Clients in ethnically matched counseling dyads will have significantly higher scores on the post-intake Counseling Satisfaction Questionnaire than will clients who are not ethnically matched with their counselors.

HO 4: Clients who are ethnically matched with their counselors will have significantly greater improvement on the Global Assessment Scale and the Client Behavior Rating Scale and significantly fewer incidents of re-abuse than will clients who are not ethnically matched with their counselors.

Gamble (2001) found that clients who scored higher on ethnic identity reported more satisfaction than those who scored lower on this measure when matched with counselors of the same ethnicity. For counseling dyads that were not ethnically matched, Barrow and Tryon (2008) found a medium effect for a negative relationship of client-counselor ethnic identity difference and client satisfaction. Thus, the author advanced the following hypotheses:

HO 5: In ethnically unmatched dyads, client-counselor ethnic identity discrepancies (assessed by the Multicultural Ethnic Identity Measure) will be negatively correlated with client satisfaction with intake and Global Assessment Scale and Client Behavior Rating Scale improvement scores, and positively correlated with re-abuse.

HO 6: For ethnically unmatched dyads, there will be lower client-counselor ethnic identity discrepancies for engaged than non-engaged clients and for continuing clients than premature terminating clients.

HO 7: For ethnically matched dyads, there will be a positive relationship between client-counselor acculturation discrepancy (assessed by the Stevenson Multigroup Acculturation Scale) and client satisfaction, improvement in Global Assessment Scale scores, and improvement in Client Behavior Rating Scale, and a negative relationship with re-abuse.

Barrow and Tryon (2008) found that client-counselor acculturation differences related differently to client satisfaction ratings in ethnically matched and unmatched counseling dyads. When dyads were ethnically matched, larger client-counselor acculturation differences (with the counselor being more acculturated) were associated with greater client satisfaction with intake. For unmatched dyads, however, larger client-counselor acculturation differences were negatively associated with client satisfaction. Thus, the author advanced the following hypotheses:

HO 8: For ethnically matched dyads, engaged and continuing clients will have larger client-counselor acculturation discrepancy scores than non-engaged and premature terminating clients.

HO 9: For ethnically unmatched dyads, there will be a negative relationship between client-counselor acculturation discrepancy (assessed by the Stevenson Multigroup Acculturation Scale) and client satisfaction and improvement in Global Assessment Scale and Client Behavior Rating Scale scores, and a negative relationship with re-abuse.

HO 10: For ethnically unmatched dyads, engaged and continuing clients will have smaller client-counselor discrepancy scores than non-engaged and premature terminating clients.

CHAPTER III

Method

This chapter describes the agency where the study was conducted, including its clientele and counselors, and the method by which the investigator selected and solicited participants for the study. The chapter also describes the instruments that the investigator utilized to determine ethnicity, ethnic identity, and acculturation of clients and counselors, as well as instruments and methods used to assess engagement, satisfaction, termination type, and early outcome. The chapter closes with a description of the study's design and data analyses procedures.

Setting

The author of this dissertation study was the principal investigator (PI), and she conducted the study in the outpatient department at one of the Purchase Preventive Service Agencies (PPRS; agencies contracted by the Administration for Children's Services to monitor and provide counseling services to abusive/neglectful parent clients). This agency is located in Brooklyn, New York. According to agency administration, 90% of its clientele are individuals referred by the Administration for Children Services (ACS). At the time of the study (7-9-2009 to 12-28-2009), there were approximately 135 clients, with 90% of them being women and 10% men. Additionally, this agency services approximately 123 children: those currently in foster care, those recently discharged from foster care, and those at risk of being placed into foster care.

Adult clients are biological parents of children who are currently in foster care or are at risk of being placed into foster care. At the time of the study, a small amount, approximately 15% of the adult clients, were biological parents whose children had recently been released from foster care. Clients ranged in age from 24 to 57 and came from various racial and ethnic

backgrounds. Approximately 95 of the clients were African Americans. Within this racial group are ethnic groups such as British West Indians/Caribbean (Jamaica, Trinidad, and Barbados).

Although Guyana is geographically located on the South American Continent, Guyanese have adopted the West Indian culture and are often considered to be culturally a part of the British West Indian/Caribbean. For instance, many Guyanese cricketers are members of the West Indian Cricket Team, and Guyana is a member of the Caribbean Community. Additionally, Guyana is the only former British Colony on the continent of South America. Guyana became a member of the Caribbean Community (CARICOM) in 1973. As a result, Guyanese clients were considered to be of British West Indian/Caribbean ethnicity.

Within the African American racial group are clients from Africa, the United States, West Indian/Caribbean, and Dominican Republic. At the time of the study, approximately 15% of the clients were Hispanics (non-black) with origins from Puerto Rico, and the remaining 10% of clients were from various other ethnic backgrounds such as Caucasian (non religious Jewish), Asian (China and India). Additionally, there was a small group of individuals of Asian descent (race), but British West Indian/Caribbean ethnicity.

The majority, approximately 80%, were unemployed and receiving government assistance. The other 20% were employed as Certified Nursing Assistants (CNA), Nurses' Aides, and Transit Workers.

There were 13 counselors from varying ethnic and racial backgrounds at the agency at the time of the study. Eight were African Americans (British West Indian, African, Puerto Rican (Latina(o), and Black American) and 5 were Caucasian (European, American, Latina(o)). There were 11 female and 2 male counselors. With regard to their education, 5 counselors held Masters

Degrees in Social Work (MSW), 4 were currently in MSW programs, and the remaining 4 held Bachelor Degrees in Social Work. The counselors ranged in age from 32 to 49.

This agency provides both in-home counseling service and outpatient services. Clients can receive both individual and family counseling as well as parenting classes and couples counseling. Individual counseling for biological parents (the treatment focus of this dissertation), is tailored to address their specific needs and includes a treatment plan that identifies social, psychological, and behavioral goals. Treatment goals are aimed at reducing parental anger and use of force as method of discipline, promoting non-aggressive alternative methods of discipline, minimizing risks for additional abusive/neglectful incidents, and encouraging prosocial problem-solving and communication in the family. Counselors encourage clients to achieve these goals by identifying, understanding, and managing the source of stress associated with abuse/neglect, by training in effective discipline strategies, and by examining child development expectations that might promote coercive interactions. The achievement of treatment goals relates to the use of more effective discipline methods, decreased parental reports of overall psychological distress, lower risk of child abuse/neglect, and lower rate of abuse/neglect recidivism.

The agency also provides case management service. The Case Manager works with the client to secure and complete any necessary applications. While in the office, the Case Manager makes telephone calls, faxes resumes, make referrals to public assistance/social security, and conducts internet searches. All of this is done with clients' consent and in their presence. Counselors also assist in locating any additional resources that would positively impact the clients' ability to manage their lives. The agency has been in existence for the past 15 years and accepts all insurance plans, including Medicaid and Medicare.

Participants

Participants were volunteers from naturally occurring client/counselor dyads. All counselors at the agency were potential participants. The PI solicited counselors and then solicited clients of counselors who consented to participate in the study. After attending an already scheduled staff meeting (see Appendix G), the PI met with individual counselors and invited them to participate in the study (see Appendix L) by signing a consent form (see Appendix H). The procedure section below provides a very detailed description of participant solicitation.

Nine of the 13 counselors (69%) at the agency agreed to participate in the study. Seven counselors (77.8%) were female and two (22.2%) were male. Most counselors (n = 4) either had MSW degrees, or were MSW interns (n = 4), and one had a BSW degree. Counselors had worked with this client population for less than a year on average (M = .85, SD = .71, range = .08 – 3.00 years). All but 2 of the counselors were immigrants.

Tables 1 and 2 provide counselors' self-descriptions of their race and ethnicity from their answers to questions on the *Multi Group Ethnic Identity Measure* (MEIM; see instruments below). Counselors were almost equally divided between Black and White, with the largest plurality describing themselves as either African American or Latina (33% for each).

Table 1

Frequencies and Percents for Counselors' Race

Race	Frequency	Percent
Black	5	55.6
White	4	44.4
Total	9	100.0

Table 2

Frequencies and Percents for Counselors' Ethnicity

Ethnicity	Frequency	Percent
African American	3	33.3
Latina	3	33.3
European	1	11.1
West Indian	2	22.2
Total	9	100.0

Both client and counselor questionnaires (see instruments section) included questions on age, salary, marital status, level of education, counseling experience, theoretical orientation, and annual income. Counselors did not want to participate if they were required to provide information on income, marital status, and age. Additionally, each indicated that they did not have a particular theoretical orientation and therefore did not respond to this question. So, in order to carry out the study, the PI indicated to potential counselors that they did not have to answer demographic questions with which they were uncomfortable. Only then did 9 of the 13 counselors consent to participate.

A similar problem was encountered with the client participants. On the Client Demographic Questionnaire, clients were required to respond to demographic questions such as age, education level, individual/household income, marital status, and number of indicated cases. Clients readily provided information regarding level of education, number of indicated cases, and years with ACS. However, since only 17 clients provided information regarding age, and 29 gave their marital status, these two variables were not included in data analysis.

Sixty-three clients of the 9 therapist participants gave permission to participate in the study. Of the client participants, 7 (11.1%) were male and 56 (89.9%) were female. A total of 178 clients were solicited, with 81 (46%) of them agreeing to participate in the study. However, only 63 (35.4%) of them fit the criteria necessary for participation in the study. See Procedure section for study criteria. Tables 3 and 4 provide clients' self-described race and ethnicity. Although the agency keeps no actual records regarding clients' immigration status, the agency director indicted that approximately 65% of clients are immigrants, while many more are children of immigrants. Appendix O presents self-described race and ethnicity for the 18 clients who did not meet criteria.

Table 3

Frequencies and Percents for Clients' Race

Race	Frequency	Percent
Black	48	76.2
Hispanic	7	11.1
East Indian	1	1.6
White	7	11.1
Total	63	100.0

Table 4

Frequencies and Percents for Clients' Ethnicity

Ethnicity	Frequency	Percent
African American	23	36.5
African	3	4.8
American	4	6.3
British	1	1.6
East Indian	1	1.6
Latino(a)	8	12.7
Spanish	1	1.6
West Indian	22	34.9
Total	63	100.0

The vast majority of clients (n = 48, 76.2%) described their race as Black. A similar percentage of participants described their ethnicity as either African American or West Indian (n = 45, 71.4%). Table 5 gives client participants' education. Two-thirds of clients had a high school or GED degree.

Table 5

Frequencies and Percents for Clients' Education

Education	Frequency	Percent
Some High School	8	12.8
High School or GED	42	66.7
Some College	1	1.6
College Degree	10	15.8
Master's Degree	2	3.2
Total	63	100.0

Clients were not equally distributed among counselors, with the number of clients per counselor ranging from 2 to 17 (M = 7.00, SD = 12.81). Below are the frequency and percent of the number of clients each counselor contributed to the study. Table 6 presents the breakdown of number of clients for each counselor. Because counselors 5 and 7 were the most senior experienced of all counselors, they carried a higher case load. Combined, they contributed a total of 27 clients to the study.

Table 6

Frequency and Percents for Number of Clients Contributed by Each Counselor

Counselor	Frequency	Percent
Counselor 1	7	11
Counselor 2	3	5
Counselor 3	4	6
Counselor 4	8	13
Counselor 5	10	16
Counselor 6	7	11
Counselor 7	17	27
Counselor 8	5	8
Counselor 9	2	3
Total	63	100

Clients had been involved with the Administration for Children's Services from 8 months to 3 years (M = .85, SD = .71). All clients were abusive/neglectful parents assigned to receive individual counseling services who had at least one indicated case of abuse and/or neglect of their child(ren). In fact, the number of ACS indicated cases that clients had ranged from 1 to 5 cases (M = 1.54, SD = .91). The term "indicated case" refers to an investigation in which the ACS caseworker found some credible evidence that supported allegations of child abuse and/or neglect. Although ACS referred these clients for counseling, counseling attendance was not be mandated by the Courts. Thus, the clients were free to continue or leave counseling as they wished. In the author's experience, parents under Court mandate are less likely to prematurely terminate services, but it is not possible to determine whether their staying in counseling is a

result of a good match with their counselor or because of the Court mandate. Thus, the study used clients NOT mandated for counseling.

All clients referred for abuse/neglect meeting the criteria according to the paragraphs above (i.e., biological parent clients of participating counselors who were referred, but not mandated, for individual counseling) were eligible for participation in the study. Clients were excluded from participation if they requested specific counselors, as this may have influenced engagement and satisfaction ratings. Clients were also excluded from the study if they received other mental health services (i.e., group counseling, addiction counseling, family counseling) in addition to individual counseling, as this too may have influenced results. To determine eligibility, the PI used client information provided on the demographic questionnaire (see *Instruments* section). In the participating agency, clients are assigned counselors based strictly on mutual availability.

Instruments

The Multi Group Ethnic Identity Measure (MEIM; Phinney, 1992). This study utilized the MEIM (see Appendix A), a popular measure in studies of ethnic identity (Gomez, 2004;Walker, Wingate, Obasi, & Joiner, 2008), that assesses the three aspects of ethnic identity conceptualized by Phinney (1996): affirmation (or the sense of belonging to a specific ethnic group), achievement (or the resolution of the ethnic identity issue), and behavior or attitudes towards other ethnic groups. Phinney (1996) also proposed that the way one perceives other groups also influences ethnic identity and labeled this aspect Other Group Orientation. Phinney (2006) indicated that ethnic identity is a progress that is ongoing, which may continue throughout one's life depending on one's personal experience.

Unlike authors of other measures that are specific to either a particular race or ethnic group (i.e., African Americans (Parhan & Hemls, 1981), Chinese Americans (Ting-Toomey, 1981), Greek Americans (Constantinou & Harvey, 1985), Jewish Americans (Zak, 1973), and Mexican Americans (Garcia, 1982)), Phinney (1992) developed the MEIM to use across ethnic groups (Ponterotto, Gretchen, Utsey, Stracuzzi, & Saya, Jr., 2007). Cokley (2007) identified the MEIM as the dominant measure of ethnic identity in the literature. Ponterotto and Park-Taylor (2007) found 234 studies and 158 dissertations that used the MEIM to measure ethnic identity.

Respondents answer the 23 MEIM statements using a 4-point Likert scale ranging from 1 = Strongly disagree to 4 = Strongly agree. According to Phinney (1992), scores are “derived from reversing negatively worded items, summing across items, and obtaining the mean. In the case where subjects have missing items, means are calculated on nonmissing items” (p. 104). Fourteen (items 1, 2, 3, 5, 6, 8R, 10R, 11, 12, 13, 14, 16, 18, and 20) of the MEIM’s 23 items assess the three components of ethnic identity in Phinney’s (1996) model (i.e., 5 items assess Affirmation and Belonging, 7 items assess Ethnic Identity Achievement, and 2 items assess Ethnic Behaviors). These 14 items comprise the Total Ethnic Identity score for which scores can range from 1 to 4 with higher scores indicating greater ethnic identity. The MEIM also includes 6 additional items that assess another aspect of ethnic identity, Other Group Orientation, which according to Phinney and her colleague (Phinney & Ong, 2007) is a construct that is separate from ethnic identity but that moderates one’s Identity (Ponterotto, 2007). Other-Group Orientation scores can range from 6 to 24. The present study did not use the 6-item Other Group Orientation subscale as this subscale has shown low internal consistency with some populations (Ponterotto et al., 2003), and it measures a construct that is separate from ethnic identity (Phinney & Ong, 2007). Three additional MEIM items are not included in the scoring and refer

to the respondent's ethnicity, ethnicity of the respondent's father, and that of the respondent's mother.

In Phinney's (1992) study, participants were 417 high school students, 235 females and 182 males. All participants attended an urban high school, and the sample consisted of Asian Americans (*n* = 134), African American (*n* = 131), Hispanics (*n* = 89), students from mix backgrounds (*n* = 41), Whites (*n* = 12), and others (*n* = 10). Participants came from diverse socioeconomic backgrounds, including professional, white collar or skilled, and unskilled. Phinney collected data from an additional sample of 136 college students, 47 males and 89 females. The college sample included Hispanics (*n* = 58), Asian (*n* = 23), Whites (*n* = 23), Blacks (*n* = 11), mixed background (*n* = 8), and American Indian (*n* = 1).

In addition to completing the MEIM, participants also completed a *Self-Esteem Inventory* and responded to questions about their age, grade point average, parental occupation, and gender (Phinney, 1992). Cronbach alphas for each sample indicated that overall reliability of the Ethnic Identity Scale was .81 for high school participants and .90 for college participants. For the Affirmation and Belonging subscale reliability was .75 for high school participants and .86 for college sample. For the Ethnic Identity Achievement subscale reliabilities were .69 and .80 for high school and college participants, respectively. However, for the Other Group Orientation subscale, reliabilities were only .71 and .74 for the two groups.

Factor analysis of the high school sample, revealed three factors; however, since two of them were highly intercorrelated, Phinney combined them yielding two factors. The first included, "all items designed to assess Ethnic Identity and accounted for 20% of the variance explained"(Phinney, 1992, p. 165), while items assessing the second factor, Other Group Orientation, account for 9.1% of the explained variance. For the college sample, there were five

factors; however, since three were highly intercorrelated, Phinney combined them into one factor and the other two factors seemed to be subfactors of one factor. This resulted in the emergence of two factors for the college group: Ethnic Identity Items and Other Group Orientation Items. The first factor accounted for 30.8% of the variance and the second explained 11.4%.

Ponterotto, Gretchen, Utsey, Stracuzzi, and Saya (2003) examined the psychometric properties of the MEIM using a sample of junior and senior high school students consisting of 114 females and 105 males. Sample make-up was as follows: 85% Whites, 6% Pacific Islanders, 5% Hispanics, 1% Native Americans, and 3% other/biracial. Participants' socioeconomic status ranged from upper to lower class. All participants completed a four-page questionnaire, which included the MEIM and a demographic questionnaire. The authors conducted Confirmatory Factor Analysis, using the AMOS 4.5 statistical program for structural equating modeling. "The purpose of conducting the CFA was to test the goodness of fit of Phinney's (1992) proposed two-factor model and compare this model to a global factor model" (p. 509). Results of this study indicated that the MEIM two-factor model "represents a better fit than a global model" (p. 512). However, as was the case with the Phinney (1992) study, the OGO scale showed "weaker OGO items with this particular sample" (p. 512). However, Ponterotto et al. indicated that one large limitation of their study was the restricted and homogeneous nature of their sample, which had primarily White (85%) participants.

Calculation of client-counselor ethnic match and ethnic identity discrepancies from MEIM responses. In the dissertation study, the PI used the clients' and counselors' answers to the open-ended ethnicity self-identification question on the MEIM to determine client-counselor Ethnic Match. According to Phinney (1992) "self identification refers to the ethnic label that one uses for oneself" (p. 158). Several studies (Fujino et al., 1994; Gamst et al., 2000, 2001; Russell

et al., 1996; Yeh et al., 1994) have used client-counselor self-identification to determine client-counselor ethnic match. Following their procedures, this study considered Ethnic Match to be achieved when counselor and client were of the same general ethnicity, as per self-identification (i.e., Black American client-Black American counselor, West Indian/Caribbean client-West Indian/Caribbean counselor).

While individuals may label themselves as being from the same ethnic group, they “vary widely in their sense of belonging to their group, their attitudes toward the group, their ethnic behavior, and their understanding of the meaning of their ethnicity” (Phinney, 1992, p. 159). These latter beliefs and behaviors define individuals’ Ethnic Identity. Thus, this dissertation examined client-counselor Ethnic Identity discrepancies using their MEIM Total Ethnic Identity scores.

The client’s Total Ethnic Identity score was subtracted from the counselor’s Total Ethnic Identity score. The absolute value was used to determine Ethnic Identity Discrepancy. The smaller the difference between these participants’ Ethnic Identity scores, the stronger Ethnic Identity match; the greater the absolute difference between client and counselor scores, the weaker the Ethnic Identity match. For example, a difference score of 1 was a closer match than a difference score of 3. A difference of zero, indicated a perfect Ethnic Identity match between client and counselor.

*The Stephenson Multigroup Acculturation Scale (*SMAS; Stephenson, 2000*).* The process of acculturation is important to understanding differences within ethnic groups (Stephensen, 2000), and as is the case with ethnic identity, there are numerous acculturation measures. However, many of these measures assess specific ethnic groups. For instance Ansersen et al. (1993) developed the Acculturation Scale for South Asians; Landrine and Klonoff (1994)

developed the *African American Acculturation Scale*; Marin, Sabogal, VanOss-Marin, Otero-Sabogal, and Perez-Stable (1987) developed the Short Acculturation Scale for Hispanics; and Ramirez, Cousins, Santos, and Supik (1986) developed the Media-Based Acculturation Scale for Mexican Americans. In addition, Matsudaira (2006) indicated there are several measures that assess Berry's (1980) four modes of acculturation, one of which is the *Stephenson Multigroup Acculturation Scale* (SMAS; Stephenson, 2000).

The SMAS (see Appendix B) assesses the two central issues postulated by Berry (1980) that result in the four modes of acculturation (integration, assimilation, separation, and marginalization) Berry's first central issue addresses the immersion of individuals in their ethnic culture, while the other addresses individuals' immersion in the culture of the dominant culture. In addition, the SMAS is capable of assessing acculturation in multiple ethnic groups (Stephenson, 2000). Due to funding agencies' mandates that researchers include a representative sample in studies and the recognized need to assess acculturation across ethnic groups, Stephensen (2000) developed the SMAS.

The SMAS (Stephenson, 2000) consists of 32 items assessing behavioral and attitudinal aspects of acculturation that can be applied across ethnic groups. Individuals respond to each item on a 4-point Likert response format including: 1 = True, 2 = Partly true, 3 = Partly false, and 4 = False. The SMAS is scored according to two subscales: ethnic group immersion (EGIS = 17 items) and dominant group immersion (DGIS = 15 items). Scores range from 1 to 4 and are determined by calculating mean item responses. High scores on the EGIS indicate lower levels of acculturation, while high scores on the DGIS indicate greater acculturation.

Stephenson (2000) conducted three studies in the development and evaluation of the SMAS. The purpose of the first study was to describe the development of the instrument and

develop an initial pool of items for the SMAS. The intent of the second study was to examine the instrument's factor structure, internal consistency, and validity. The third study was conducted in order to determine whether or not the factor structure obtained from the second study provide a god fit with an independent sample, using both exploratory and confirmatory factor analysis. The third study also assessed convergent and discriminant validity of the instrument.

Following a review of the acculturation literature, Stephenson (2000) recruited a team of researchers, consisting of ethnically diverse individuals. Team members (n = 10) were professionals from the community along with consultants. Team members were charged with generating an initial item pool, which consisted of 195 items. However, after reviewing the initial items for relevance, representativeness, clarity, wording, and ambiguity, team members reduced the initial item pool to 145 items.

Stephenson (2000) conducted the initial study in 2 phases. In the first phase, participants consisted of African Americans (n = 6), African American descendants (n = 18), Asian Americans (n = 4), European Americans (n = 14), and Hispanic American (n = 12). In the second phase of the study, participants included African Americans (n = 4), African descendants (n = 18), Asian Americans (n = 4), European Americans (n = 14), and Hispanic American (n = 10). A snowball sampling method, (that is the author relied on referrals from initial subjects to generate additional subjects) was used and participants were recruited from New York City, Boston, and Massachusetts. The SMAS was individually administered in English to each participant. Following the administration of the questionnaire, participants were debriefed and asked to comment on each item. Based on participants' responses and recommendations, problematic items were eliminated from the scale, resulting in a 115-item questionnaire. However, more items were eliminated following a final review by the research team, resulting in a 95-item

questionnaire that reflected Berry's (1980) two dimensions of acculturation: dominant society immersion (SDI) and ethnic society immersion (ESI). These two domains consisted of 47 and 48 items, respectively.

Participants for the second phase of the study (Stephenson, 2000) were recruited from the same three geographical areas and a large northeastern university. Participants' ages ranged from 18 to 73 and consisted of 30% men and 70% women. The sample consisted of African Americans (n = 35), Asian American (n = 33), European Americans (n = 125), Hispanic Americans (n = 85), and participants of African descent (n = 158). Additionally, the sample consisted of 206 first or immigrant generation, 83 second generation, 56 third generation, and 89 fourth or more generation. All participants were administered the 95-item SMAS. Participants were also administered to SCL-90-R Derogatis (1994) that is a standardized problem checklist widely used to evaluate construct validity.

Following data analysis, Stephenson (2000) retained a total of 32 items that accounted for more that 50% of the variance. Factor 1 (ESI) accounted for about 27%, while Factor 2 (DSI) accounted for approximately 23%, with a very large number of language items being loaded on Factor 1. Stephenson reported coefficient alphas of .86 for the full scale, .97 for Factor I (ESI) and .90 for Factor 2 (DSI). For Factor 1, item-to-total correlations range from .51 to .87 and from .57 to .83 for Factor 2. Stephenson conducted two one-way between-groups analyses of variance, which revealed the mean difference between generations was significant for DSI, $F(3, 432)$ =73.64, $p <. 001$ and for the ESI, $F(3, 432) = 31.48$, $p < .001$. Tukey post hoc test results indicated that all pairwise comparisons, except third and fourth generations on both the DSI and ESI, were significant at $p < .05$ level.

Stephenson (2000) conducted a third study, in an effort to determine whether or not the results obtained in the second study, with regard to factor structure, were robust across samples and provided a good fit with a new sample. Additionally, this third study evaluated both the convergent and discriminant validity of the scale when compared to two other instruments used to assess acculturation. The sample included 208 undergraduate students, ranging in age from 18 to 60 years old. African American (n = 4), Asian Americans (n = 15), European Americans (n = 151), Hispanic Americans (n = 31), and participants of African descent (n = 7) completed the SMAS, The Acculturation Rating Scale for Mexican Americans (ARSMA-II; Cuellar & Maldanado, 1995), The Bidimensional Acculturation Scale for Hispanics (BAS; Marin & Gamba, 1996). The ARSMA-II has two subscales: the Mexican Orientation Scale (MOS) and the Anglo Orientation Scale (AOS). Stephenson used these two instruments since there were no other published acculturation rating scales consistent with the most popular conceptualization of acculturation. According to Stephenson, a new conceptualization of acculturation no longer considered individuals as being either acculturated or not acculturated. Rather, the most popular conceptualization is that acculturation is a multidimensional and complex process of learning. Involvement in one society does not equate to the absence or diminished involvement in another. As a result of this new conceptualization, individuals can take any of four positions of acculturation. As a result, Stephenson modified these two instruments for use with diverse ethnic populations.

Results indicated coefficient factors of .94 for Factor 1 and .75 for Factor 2 (Stephenson, 2000). Additionally, the ESI subscale of the SMAS was positively correlated with MOS of the ARSMA-II ($r = .87$, $p < .01$) but negatively correlated with the AOS of the ARSMA-II ($r = -.28$, $p < .01$). The ESI of the SMAS was also positively correlated with the Hispanic domain of the

BAS ($r = .83$, $p < .01$) but negatively correlated with the non-Hispanic domain of the BAS ($r = -.25$, $p < .01$). With regard to the DSI of the SMAS, this subscale was positively correlated with the AOS ($r = .49$, $p < .01$) and negatively correlated with the MOS ($r = -.15$, p = ns). The DSI was also positively correlated with the non-Hispanic subscale of the BAS ($r = .48$, $p < .01$) and negatively correlated with the Hispanic subscale scale ($r = -.17$, p = ns). The ESI was significantly correlated with both the DAS and ARSMA. The DSI was also correlated with the DAS and ARSMA.

Calculation of client-counselor acculturation discrepancies from SMAS responses. In this study, the PI used the SMAS scores to determine client and counselor acculturation discrepancies (Stephenson, 2000) in the following way. Clients and counselors completed the SMAS, and the PI tallied both their EGIS and DGIS scores. Match was determined by examining both the EGIS (the immersion of individuals in their ethnic culture) and DGIS (individuals' immersion in the culture of the dominant culture). Thus, the PI calculated two client-counselor acculturation discrepancy scores. One was the EGIS discrepancy score. The EGIS assesses the immersion of individuals in their ethnic culture. The client's EGIS score was subtracted from the counselor's EGIS score and the absolute value of this difference was used to indicate acculturation discrepancy for EGIS. The same was done for the client and counselor DGIS scores that assessed the immersion of individuals in the dominant culture. For both EGIS and DGIS, the smaller the absolute difference between client and counselor, the stronger the acculturation match was; the greater the absolute difference between client and counselor, the weaker the acculturation match.

Client Satisfaction Questionnarie-8 (CSQ-8; Larsen et al., 1979). Several authors have developed measures to assess client satisfaction (Britner & Phillips, 1995; Wilson & Conroy, 1999; Winefield & Barlow, 1995). However, probably the most widely employed measure is the

8-item Client Satisfaction Questionnaire (CSQ-8; Larsen, Attkisson, Hargreaves, & Nguyen, 1979; see Appendix C) that is used extensively in the assessment of client satisfaction as it relates to primary medical care, mental health treatment, and many other human services (Attkisson & Greenfield, 2004).

The CSQ-8's items assess client satisfaction with mental health treatment and the context in which it takes place (Sabourin et al., 1989). The aspects of client satisfaction measured are general satisfaction, kind or type of service, treatment staff, quality of service, and outcome of service. Clients respond to each of the items on the CSQ-8 on a scale from 1 to 4, with 4 being the highest. Scores range from 8-32, with higher scores indicating greater satisfaction. According to Atkinson and Greenfield (1999), the CSQ-8 is a valid and reliable measure of client satisfaction.

The CSQ has high internal consistency, with coefficient alphas ranging from .85 to .93 (Sabourin et al., 1989). This measure has good concurrent validity (Attkisson & Zwick, 1982; Larsen et al., 1979). In addition the CSQ-8 is highly correlated with client dropout rates (Sabourin et al., 1989), and Tryon (1990) found that clients who did not become engaged scored lower than engaged clients on the CSQ.

DeWilde and Hendricks (2005) investigated the psychometric properties of the CSQ-8 in a Dutch Population. They translated the CSQ-8 into Dutch and mailed it to clients of a large substance abuse clinic. Prospective participants were also mailed the Mental Health Therometer-MHT-16 (which is the standard Dutch satisfaction assessment tool), and the mailing was part of an annual satisfaction survey carried out by the facility. The sample pool consisted of 927 clients; however, only 28.3% responded. Results indicated high internal consistency with a Cronbach alpha of .92. According to DeWilde and Hendricks this is consistent with internal

consistencies from other studies. Additionally, "reliability as calculated by Cronbach's α is based on variability of items in a scale. In our sample, items show little variance and Cronbach's α can be expected to be high because of this." (p. 161).

Additionally, these authors (DeWilde & Hendricks, 2005) found one factor that accounted for more than 65% of the variance. Also, when compared to scores on the MHT-16, they obtained a rank order correlation of $r = .66$ ($p < .001$). The CSQ-8 also evidenced significant correlations with the subscale of the MHT-16, with a low of .40 and a high of .71. The subscales of the MHT are Satisfaction With Information Provided, Satisfaction With Participation In Treatment Plan, Satisfaction With Counselor, and Satisfaction With The End Results. According to DeWilde and Hendricks, "the CSQ-8 is a good instrument to assess general satisfaction" (p. 161).

In an effort to determine whether or not the CSQ-8 is a suitable instrument to use with Hispanics, Roberts, Attkisson, and Stegner (1983) examined 3,628 clients from 76 facilities consisting of community mental health centers and public health centers. Of these facilities 11 were residential, 20 were partial care, 41 were inpatient clinics, and 4 were psychiatric inpatient clinics. Existing clients completed the questionnaire prior to their session, while new clients completed the CSQ-8 following their intake session. Participants consisted of Mexican Americans ($n = 42$), Other Hispanics ($n = 96$), Blacks ($n = 36$), and Anglos ($n = 2,605$). Results indicated item-to-total correlations of .44 to .77 for Mexican Americans, .64 to .80 for Other Hispanics, .52 to .66 for Blacks, and .55 to .69 for Anglos. Additionally, Roberts et al. found the reliability of the CSQ-8, to be high for all groups (Cronbach alphas ranged from .86 to .91). Roberts and colleagues concluded that the CSQ-8 is a suitable measure of clients' satisfaction for Hispanics. Also, they stated that the CSQ-8 "seem(s) to operate about the same, whether

administered to Anglos, Blacks, persons of Mexican descent, or persons of other Hispanic descent" (p. 471).

In this dissertation study, the PI used the CSQ-8 to determine client satisfaction with the initial session.

Client Demographic Questionnaire. Appendix D presents a demographic questionnaire for clients to complete that the PI constructed. Questions include number of Indicated cases clients has had and whether or not mental health services were mandated by the courts. A question about age was also included as Jerrell (1998) found that younger clients stayed in treatment longer when they were treated by ethnically similar counselors. Questions regarding gender, educational level (Constantine, 2002), whether or not clients have a preferences for a particular counselor, if they specifically requested a particular counselor, and whether or not The Administration for Children's Services referred them. This information was necessary to determine clients' eligibility for participation in the study and to provide client descriptive information. Additionally, questionnaire completion was necessary in order to maximize clients' privacy by avoiding a review of the clients' records.

Counselor Demographic Questionnaire. Appendix E presents a demographic questionnaire for counselors to complete that the investigator constructed. It consists of demographic questions including, income, marital status, theoretical orientation, age, educational background, gender, and counseling experience that Tryon (1989) found to be associated with client non-engagement and post-engagement client dropout.

Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss & Cohen, 1976*).* Following the procedure of Gamist, Dana, Aghop, and Terry (2000, 2004), this study used a *Global Assessment of Functioning* (GAF; Appendix M), which is an Axis V rating of the DSM-IV (American

Psychiatric Association, 1994) as an outcome measure. Endicott et al. (1976) developed the GAS for clinicians to assess clients' GAFs. It is a single rating scale with scores ranging from 1-100 with higher scores indicating better global functioning. Ten equal intervals divide the scale and the scale lists the defining characteristics of each 10-point interval. Thus, a rating in the 91-100 interval indicates that the client has "no symptoms, superior functioning in a wide range of activities…" (Endicott et al., 1976, p. 768), while a rating in the 1-10 interval indicates that the client "needs constant supervision for several days…" (p. 768).

Endicott et al. (1976) reported interrater reliabilities ranging from .61 to .91. They also found that GAS scores correlated highly with scores from other instruments assessing mental status and family functioning. GAS scores also predicted readmissions to hospital. More recently, Jones, Thornicroft, Coffey, and Dunn (1995) found the GAS score to be a valid and reliable measure of GAF. A literature review (D'Andrea & Heckman, 2008) found wide usage of the GAS as an outcome measure in multicultural counseling research.

The counselors completed the GAS for each client at intake and at the end of each counseling session (Erdur et al., 2003). Following Erdur et al's procedure, the PI obtained a difference score by subtracting GAS score at intake (GAS-1) from the last session GAS score (GAS-2). A positive difference score indicated improvement in global functioning, while negative scores suggested the opposite.

In order to match GAS score to each client, the counselor wrote client's name at the top right hand corner of the GAS. After each counseling session, the counselor placed the GAS in a plain white envelope and gave it the receptionist. The investigator collected envelopes on a daily basis.

Client Behavior Rating Scale (CBRS). Appendix N presents a rating scale designed to assess clients' progress towards their treatment goals, as determined by their counselors. The investigator constructed this scale, which consists of seven items. The PI constructed this because it directly reflects targeted agency goals that counselors are to work toward with their clients. Thus, on the CBRS counselors rate clients' ability to manage anger, likelihood using non-aggressive or forceful discipline methods, and client problem-solving skills. Other items include, child abuse/neglect risk reduction and improvement in family communication. Questions are scored on a 4-point Likert scale ranging from 1 = Strongly disagree to 4 = Strongly agree. Total scores range from 4 to 28, with a coefficient alpha from this study of .70. Higher scores depict greater progress.

The counselors completed the CBRS for each client at the end of each counseling session. The investigator obtained a difference score by subtracting CBRS score after the first session (CBRS-1) from the last session CBRS score (e.g., CBRS-2). A positive difference score indicated progress toward goals. Higher difference scores indicated greater progress (i.e., a difference score of 10 suggested greater progress toward treatment goal than a difference score of 3).

In order to match CBRS score to each client, the counselor wrote the client's name at the top right hand corner of the CBRS. After each counseling session, the counselor placed the CBRS in the same plain white envelope, containing the GAS. This envelop was given to the receptionist. The investigator collected envelopes on a daily basis.

Procedure

The Primary Investigator (PI) made an initial telephone contact with the agency director and requested a face-to-face meeting. At the time of the telephone call, the PI outlined the

purpose and design of the research study and requested the director's permission for agency participation in the study (see Appendix F). During the meeting, the PI discussed the study with the director in depth and presented her with the script introducing the research at the staff meeting (see Appendix G). Once the director agreed to allow agency participation, the PI requested to be invited to the next counselors' staff meeting to personally introduce herself and briefly describe the study to potential counselor participants using the script.

The PI attended an already-scheduled staff meeting for counselors, and the agency receptionist also attended the meeting. At the meeting, the director introduced the PI, who briefly described the reason for her presence and requested an individual meeting with each counselor. During the individual meetings, the PI invited the counselor to participate in the study (see Appendix L). Once the counselor agreed to participate, the PI reviewed the Participant Information Statement and Consent Form - Counselor Version (see Appendix H) and obtained the counselor's signature. Counselors then completed the Counselor Demographic Questionnaire, the SMAS, and the MEIM. The PI also met individually with the receptionist and outlined her role in the study (see Appendix I).

Prior to intake, the receptionist introduced the PI to clients of participating counselors. The receptionist advised each client that the study was not part of the intake process nor would it impact the client's participation at the agency. The PI then requested a few minutes of the client's time to describe the study. If the client agreed to participate, the PI escorted the client to a vacant office. The PI then reviewed the Participant Information and Consent Form - Client Version (Appendix J). She told the client that the study was to determine how well counselors work with different clients.

The PI then advised the client that she was not an employee or representative of the agency, but rather a doctoral graduate student carrying out a study as part of the requirement for graduation. To prove her status as a graduate student, the PI showed clients her validated student identification card. The PI reiterated that failure to participate in the study had absolutely no impact on the client's relationship with the agency and that the client was not obligated to participate. The PI also reiterated that if she/he decided to participate, the client was free to withdraw consent and to discontinue participation at any time during the study without prejudice.

The PI further indicated that the questionnaires that she gave the client were not part of the agency intake process but were necessary for the study being conducted by PI. The PI also explained that the agency had a standard set of forms that each client *must* complete in order to receive counseling services from the agency. However, the questionnaires being distributed by the PI were different from the agency forms and had no impact on service provision, as they were only used for the study and only the PI had access to the completed questionnaires. The PI also advised clients that counselors had no access to their questionnaire information. The PI told clients that their counselors would perform a client assessment at the end of each counseling session, and provide the results to the PI. Additionally, the PI informed clients that the PI would be notified should client receive any new reports of abuse or neglect.

Once a client agreed to participate in the study and signed the consent form, the PI walked the client to the receptionist desk and notified the receptionist of the client's decision to participate. The agency receptionist then gave the client an envelope containing the Client Demographic Questionnaire, the MEIM, and the SMAS to complete. The receptionist directed the client to place completed questionnaires in the envelope, seal it, and return it to her. The receptionist then hand delivered the sealed envelope, containing questionnaires, to the PI. At the

time the receptionist delivered the envelope to the PI, she advised the PI of the counselor to whom the client was assigned. The PI then contacted the assigned counselor (via internal phone call) and advised her/him to complete the GAS and CBRS for the client after each session. At this time the PI encoded on the envelope a number, the date, and the initials of the counselor. She later transferred this letter-number sequence to the top right hand corner of each of the client's questionnaire. This allowed the PI, at the time of data analysis, to match each client with the appropriate counselor. While the client was in the intake session, the PI reviewed the Client Demographic Questionnaire to determine the client's eligibility for participation.

Logistically, all new clients of participating counselors completed the three required participant questionnaires, but the PI used in the data analysis responses from only those clients who met the outlined criteria. In this way, clients completed these questionnaires on only one occasion rather than two (i.e., completion of one questionnaire to determine eligibility and completion of the other two after eligibility determination). Responses from those not meeting the required criteria (n = 18), although they had completed the required questionnaires, were excluded from the analysis.

After their intake sessions, the agency receptionist asked each participating client to complete the CSQ-8 and return it to her in a sealed envelope. The same procedure was followed as with the completion of the MEIM, SMAS, and Client Demographic Questionnaire, with the client sealing the CSQ-8 in an envelope, returning it to the receptionist, the receptionist returning the envelope to the PI, and the PI inscribing the appropriate number-letter sequence on the envelope, which was later transcribed to the top left hand corner of the client's completed questionnaire.

After completion of the CSQ-8, the receptionist asked the client to wait for a few minutes as the PI wished to speak with them. The PI then advised the client that she would be notified of the results of the study once it had been completed. The PI told the client, “Thanks for your participation in this study. Results will be available in approximately 6 months. Results will be made available to the counseling agency and you may obtain a copy of same by requesting it from the receptionist. You may also request a copy to be directly mailed to you by providing me with your mailing address.” For those clients who do not meet the criteria for participation, the PI advised them accordingly by stating the exact reason for non acceptance in the study (i.e., “you do not have an indicated case”; “you were mandated by court order to attend counseling”; “you requested a specific counselor”).

After each session with participating clients, including the intake session, counselors assessed client’s overall functioning and provided the receptionist with a GAS score. Counselors wrote the clients’ name on the top right hand corner of the score sheet, which was placed in a plain, white, sealed envelope and hand delivered to the receptionist. Counselor also completed the CBRS at the end of each session. The name of client was written on the top right hand corner of the CBRS, which was placed in the same plain white envelope as the GAS score. The PI collected envelopes on a daily basis. Additionally, counselors notified the PI of any new allegations of abuse or neglect that any participating client received. The ACS Child Protective Specialist usually informs the PPRS counselors whether or not a client with whom the counselor is working has had new reports of abuse or neglect. A client is considered to have reabused if the ACS Child Protective Specialist found evidence to substantiate the new allegations. On the GAS score sheet, the counselor indicated whether or not a participating client received new allegations of abuse or neglect. This information was written on the bottom left hand corner of the GAS

score sheet. Information regarding new allegations was written on every GAS score sheet (i.e., if no new allegations counselor indicated “no new allegations” if new allegations were received counselor indicated “new report of abuse or neglect received”). This was necessary to ascertain that counselor did not forget to inform PI of new allegations.

In order to match scores on the SMAS, MEIM, and CSQ-8, all client instruments (i.e., each SMAS, MEIM, CSQ-8, and demographic questionnaire) were number/letter coded (e.g., 1, date, and initials of the therapist). Final sequence was 1:6-10-09-AB, which indicated the first intake client seen on 6-10-09, by counselor with initials AB. Since each therapist had no more than two intake appointments daily, keeping track of each new patient by this method was relatively simple. Once the clients completed the CSQ-8 and it was returned to the PI, she matched it with the other instruments based on number/letter code. Counselors’ instruments were coded only with their initials as counselors completed demographic questionnaire, SMAS, and MEIM at the same time. As indicated above, at the time PI received the clients’ questionnaires in the sealed envelopes from the receptionist, the PI inscribed number, date, and initials, of assigned counselors on envelope. Later, this letter/number sequence was transferred to each client questionnaires. This allowed PI, at the time of data analysis, to accurately match client with counselor.

Additionally, PI constructed a list of the clients participating in the study. Next to each name was the corresponding number-letter sequence. This list was kept separated from the questionnaires. This list was necessary to verify clients’ attendance status and to appropriately code clients as continuing or terminating.

Engagement and premature termination. In accord with Tryon’s (1985) definition, the client was considered engaged if she returned for her second session (i.e., first session

immediately following the intake session). A client who failed to return for three consecutive sessions following her second counseling session (the session after the intake session) was considered to have terminated prematurely. Thus, engagement was client return for a second session, and premature termination occurred sometime after the client had attended a second session. To determine client engagement and termination status, the PI contacted the receptionist on a weekly basis and ascertained all clients' attendance status.

Data collection extended over a five-and-one-half--month period. The completion of the questionnaires took participants approximately 30 minutes and there were no identifiable risks to the participants other than those experienced in everyday life. The PI kept the questionnaire data in a locked file cabinet in her office to which only she had access and she did not share any individual data with agency officials or counselors.

Design and Data Analysis

The current study utilized a quasi-experimental, two-group design (i.e., engaged *vs.* non-engaged clients, continuing *vs.* premature terminating clients, ethnically matched *vs.* ethnically unmatched counseling dyads) (Crano & Brewer, 2002). Clients and counselors were naturally occurring counseling dyads (i.e., there was no random assignment).

The PI used chi-square tests to determine the relationship between ethnic match of client and counselor and engagement and premature termination statuses (hypotheses 1 and 2). *T* tests were used to compare client-counselor MEIM Ethnic Identity and SMAS acculturation difference scores for engaged and non-engaged clients and satisfaction (CSQ-8) and outcome (GAS and CBRS) scores of clients in ethnically matched and unmatched dyads (hypotheses 3, 4, 6, 7, 9, and 11). The PI also used Pearson Product Moment correlations to test hypotheses 5, 8, and 10, correlating client-counselor ethnic identity and acculturation difference scores for

ethnically matched and unmatched dyads with satisfaction and outcome scores. To obtain significance at the $p < .05$ level for a large effect, the PI needed to obtain at least 26 clients in each of the comparison groups (Cohen, 1992).

In addition to hypothesis testing, the PI summarized client and counselor descriptive data, providing frequencies, means, and standard deviations for their responses to demographic questionnaires.

CHAPTER IV

Results

This chapter discusses the results of this study. It begins by presenting client-counselor matches according to race, ethnicity, ethnic identity, and acculturation. Then the chapter presents results of hypotheses testing.

Client-Counselor Matches

In order to test the hypotheses, the PI had to first calculate the various racial, ethnic, and acculturation matches/discrepancies between participants. In this study, the PI determined ethnic match based on clients' and counselors' response to the open-ended ethnicity self- identification question on Phinney's (1992) Multi-Group Ethnic Identity Measure (MEIM). Ethnic Match was considered achieved when counselor and client were of the same general ethnicity as per self-identification (i.e., Black American client-Black American counselor, West Indian/Caribbean client-West Indian/Caribbean counselor). This procedure yielded 27 client-counselor ethnic matches and 36 non-matches. Table 7 provides frequency and percent of matches for specific ethnic groups.

Table 7

Frequency and Percent of Client-Counselor Matches for Specific Ethnic Groups

Ethnicity	Matched Frequency	Percent	Unmatched Frequency	Percent
African American	9	14.29	14	22.22
African	0	0	3	4.76
American	0	0	4	6.35
British	0	0	1	1.6
East Indian	0	0	1	1.6
Latino(a)	6	9.52	2	3.2
Spanish	0	0	1	1.6
West Indian	12	19	10	15.87
Total	27	42.78	36	57.2

Next, using the MEIM Total Ethnic Identity scores, the PI determined client-counselor ethnic identity discrepancy, because individuals can vary in their sense of belonging to their ethnic group even when they are of the same ethnicity. The client-counselor identity discrepancy was the absolute difference of their MEIM scores. In this sample, the average MEIM Total Ethnic Identity scores for all clients was 1.99 (SD = .60), indicating that overall clients scored at the mean of the range of possible scores that is 1 to 4. Unlike their clients, counselors scored higher overall in terms of ethnic identity (M = 2.79; SD = .79) than the possible mean of 2. While this suggests that overall, on average clients were less ethnically identified than their counselors, client and counselor scores did not differ significantly on this measure, $t(61) = .65, p = .74$). In

this sample, client-counselor ethnic identity discrepancy scores ranged from .70 to 2.80 (M = 1.65, SD = .61), with the smallest possible discrepancy being 0 and the largest possible discrepancy being 3. As was previously indicated the smaller the Ethnic Identity Discrepancy score, the smaller the difference between participants' Ethnic Identity and the stronger the ethnic identity match. In this case, the mean score of 1.65 suggests that overall clients and counselors had ethnic identity matches that were neither very strong nor very weak, but were about midway between these two extremes. In other words, compared to an average possible discrepancy score of 2, overall clients and counselors had about average ethnic identity matches.

In this sample, the average EGIS score for all clients was 1.37 (SD = .87) suggesting that overall clients were not very immersed in their ethnic culture (possible mean of 2), however, overall these clients were very much immersed in the dominant culture, as indicated by their DGIS mean score of 2.57 (SD = .1.01). Counselors, on average were somewhat immersed in their ethnic culture as indicated by their EGIS mean of 1.85 (SD = 1.12), however, they were more immersed in the dominant culture as suggested by their DGIS mean score of 2.27 (SD = .63). This suggests that overall clients and counselors were similarly immersed in the dominant culture; but overall clients appeared to be less immersed in their ethnic culture than were their counselors. Examination of client and counselor scores showed that they did not differ significantly for EGIS ($t(61) = 0.83$, $p = .58$) or DGIS ($t(61) = 0.96$, $p = .79$).

Using scores on the *Stephenson Multigroup Acculturation Scale* (SMAS; Stephenson, 2000), the PI calculated client-counselor acculturation discrepancies using the absolute difference of their scores for both ethnic group immersion (EGIS) and dominant group immersion (DGIS). The EGIS discrepancy scores ranged from 0 to 3.35 (M = .63, SD = 1.41), with the possible discrepancy range being between 0 and 4. The EGIS mean score of .63

suggests that, overall clients and counselor had a relatively strong EGIS match (i.e., were similarly immersed in their ethnic group). DGIS discrepancy scores ranged from .95 to 3.75 (M = 2.87, SD = .94), with the possible discrepancy range being between 0 and 4. The mean score of 2.87 suggests that, compared to an average possible discrepancy score of 2, overall clients and counselor had a weaker DGIS match (i.e., one member of the dyad was more immersed in the dominant culture than the other member). In 37 (59%) client-counselor dyads, counselors were more immersed in dominant culture than were clients. Conversely, 26 (41%) of the clients were more immersed in the dominant culture than were their counselors. Thus, in the majority of dyads, counselors tended to be more immersed in the dominant culture than were their clients. Two counselors (one an East Indian and the other, Spanish) in the unmatched dyads obtained extremely high DGIS scores (3.74 and 3.59, respectfully), which accounted for the high overall average of this group. Although these counselors only contributed one client each to the study, their scores impacted the overall DGIS for the unmatched dyads.

Gender Differences

Although not hypothesized, the PI conducted a chi-square analysis to examined gender differences as they relate to engagement and early termination. The results of the chi-square were not significant, χ^2 (1) = 0.449, p = 0.503 suggesting male clients were no more likely to be engaged than their female counterparts. Similarly, the results of the chi-square analysis was not significant for early termination from counseling, χ^2 (1) = 0.137, p = 0.711 suggesting that male clients were no more likely to terminate early than female clients. The PI also examined the relationship between gender differences and treatment outcome and client satisfaction. Results of a chi-square analysis, χ^2 (1) = 0.321, p = 0.571, suggests no significance between male and female clients as it relates to reabuse. Also, male and female clients did not differ significantly

on either the CBRS, GAS, or CSQ-8. Table 8 presents mean and standard deviations for male and female clients.

Table 8

Independent Sample t test of Male and Female clients by Client Behavior Rating Scale Improvement, Global Assessment Scale Improvement, and Client Satisfaction.

Variable				Male			Female		
	t	*df*	Sig.	*N*	*M*	*SD*	*N*	*M*	*SD*
Client Behavior Rating Scale Improvement	1.01	61	.372	7	12.37	7.86	56	11.48	8.26
Global Assessment Scale Improvement	0.766	61	.598	7	12.14	21.19	56	14.28	17.24
Client Satisfaction	0.99	61	.324	7	16.17	6.78	56	19.38	6.62

Client-Counselor Ethnic Match Hypotheses

The first series of hypotheses (Hypotheses 1-4) examined the importance of client-counselor ethnic matching. These hypotheses predicted that clients who were ethnically matched with their counselors would have superior engagement, less premature termination, and better outcomes than clients who were not ethnically matched with their counselors.

Engagement. A client was considered to be engaged in counseling if he/she returned for post-intake counseling sessions (Tryon, 1985). There were 43 engaged clients and 20 non-engaged clients in this sample. Hypothesis 1 indicated that clients who abused/neglected their children and are ethnically matched (n = 27) with their counselors would be significantly more likely to become engage in counseling than ethnically unmatched clients (n = 36). Table 9 presents cross tabbed data for ethnically matched and unmatched clients and engagement. To test hypotheses 1, the PI conducted a chi-square analysis. The result of the chi-square was not

significant, χ^2 (1) = 0.10, *p* = .755, suggesting that participants matched ethnically with their counselors were not more likely to become engaged in counseling compared to unmatched clients. Hypothesis 1 was not supported.

Table 9

Cross Tabs for Client-Counselor Ethnic Match and Engagement in Counseling

Ethnically Matched	Engaged	
	No	Yes
No	12	24
Yes	8	19

Note. χ^2 (1) = 0.10, *p* = .755.

Premature termination/dropout. Since this study extended over a 5 ½ month period, data were only available for this period of time. A client who failed to return for three consecutive sessions following his/her second counseling session (the session after the intake session) was considered to have terminated prematurely (*n* = 40), while clients who were still in counseling at the conclusion of the study were considered to be continuing or non-terminating clients (*n* = 23). Clients began premature termination as early as 2 weeks after the engagement session, and premature termination extended to 3.5 months following the engagement session. For example, the last premature terminating client did so 3.5 months after engagement. Premature terminating clients spent an average of 6.77 weeks (*SD* = 3.69) in counseling. According to the agency director, continuing clients averaged 8 months in counseling, but the PI was not able to verify this figure.

Hypothesis 2 predicted that clients who had abused/neglected their children and were ethnically matched with their counselors would be significantly less likely to terminate prematurely post-engagement than ethnically unmatched clients. Table 10 presents cross tabs of ethnic matching and termination type. To test Hypothesis 2, the PI conducted a chi-square analysis. The result of the chi-square was significant, χ^2 (1) = 4.80, p = .03, suggesting that client participants who were not ethnically matched with their counselors tended to terminate unilaterally during the course of the study more frequently than did clients who were ethnically matched with counselors. Hypothesis 2 was supported.

Table 10

Cross Tabs between Client-Counselor Ethnic Match and Client Premature Termination

Ethnic Match	Premature Termination	
	No	Yes
No	9	27
Yes	14	13

Note. χ^2 (1) = 4.80, p = .028.

Counseling satisfaction and client-counselor ethnic match. After intake, clients completed the Client Satisfaction Questionnaire (CSQ) to determine how satisfied they were with the intake interview. Clients' scores covered almost the entire range (8-32) of possible scores on the CSQ (sample range = 8-31) and yielded a mean of 18.56 (SD = 6.78). Hypothesis 3 predicted that clients who were ethnically matched with their counselors (n = 27) would be more satisfied with the intake interview than those who were not matched (n = 36).

To test this hypothesis, the PI conducted an independent sample *t* test. Table 11 presents the CSQ means and standard deviations for ethnically matched and unmatched clients. The results of the *t* test were not significant, *t* (61) = 0.64, *p* = .528, suggesting that match clients were no more satisfied with their intake session than unmatched clients. Hypothesis 3 was not supported.

Table 11

Means, Standard Deviations, and Independent Sample t Test of Post-Intake Counseling Satisfaction Questionnaire Scores of Ethnically Matched and Unmatched Counseling Dyads

Variable	Matched			Unmatched					
	N	*M*	*SD*	*N*	*M*	*SD*	*t*	*df*	*Sig*
Client CSQ score	27	17.93	6.64	36	19.03	6.93	0.64	61	.528

Although matched clients were no more satisfied with intake than unmatched clients, the PI believed that it was possible that client satisfaction may have been more related to engagement than to client-counselor ethnic matching. Previous studies had shown that clients were more satisfied with engagement than non-engagement interviews (Kokotovic & Tracey, 1987; Tryon, 1990). Table 12 presents the CSQ means and standard deviations for engaged and unengaged clients and the results of the *t* test. The results of the *t* test were not significant, *t* (61) = 0.63, *p* = .530, suggesting that engaged clients were no more satisfied with their intake session than unengaged clients.

Table 12

Means, Standard Deviations, and Independent Sample t Test of Post-Intake Counseling Satisfaction Questionnaire Scores of Engaged and Unengaged Dyads

Variable	Unengaged			Engaged					
	N	*M*	*SD*	*N*	*M*	*SD*	*t*	*df*	*Sig*
Client CSQ score	20	19.35	7.03	43	18.19	6.71	0.63	61	.530

Counseling outcome. Hypotheses 4 examined the relationship between ethnic matching and counseling outcome. There were three outcome measures that assessed improvement in clients' global adjustment (difference in GAF scores from first to last session), improvement in meeting agency goals (difference in CBRS scores from first to last session), and reports of client re-abuse. Table 13 presents the mean amount of improvement in ethnically matched and unmatched clients' GAF and CBRS scores. Clients who were ethnically matched with their counselors began counseling with average GAF scores of 65.00 (*SD* = 11.97). As the table indicates, ethnically matched clients improved their global functioning from first to last session by 4.56 points. Clients who were not ethnically matched with their counselors began counseling with an average GAF scores of 69.00 (*SD* = 9.84). These clients improved their global functioning by an average of 6.64 points. As Table 12 indicates, while clients in both groups (ethnically matched and ethnically unmatched) showed GAF improvement, there was no significant difference between them. Thus, this part of Hypothesis 4 was not supported.

Clients who were ethnically matched with their counselors entered counseling with average CBRS scores of 10.30 (*SD* = 3.59). Table 12 shows that these clients improved their meeting of agency goals by 12.51 points. Clients who were not ethnically matched with counselors entered counseling with average CBRS score of 9.70 (*SD* = 6.90) and improved their scores by 15.17 at the last session. Thus, both ethnically matched and unmatched clients increased their scores on the CBRS that assessed agency goals, and Table 12 shows that they did not differ from each other in a statistically significant manner on the CBRS at the last session. So, this part of Hypothesis 4 was not supported.

Table 13

Independent Sample t Tests on Improvement Scores from the Client Behavior Rating Scale and the Global Assessment Scale by Matched and Unmatched Counseling Dyads

Variable				Matched			Unmatched		
	t	*df*	Sig.	*N*	*M*	*SD*	*N*	*M*	*SD*
Client Behavior Rating Scale Improvement	0.64	61	.526	27	12.51	17.85	36	15.17	19.10
Global Assessment Scale Improvement	1.11	61	.273	27	4.56	7.97	36	6.64	6.95

A client was considered to have re-abused if new allegations of abuse/neglect were received while she was in counseling. A third of all clients (*n* = 21) re-abused their children while in counseling. Of the 27 ethnically matched clients, 9 (33%) received new allegations of abuse/neglect, while 12 (33%) of the 36 ethnically unmatched clients received new reports alleging abuse/neglect. Hypothesis 4 predicted that ethnically matched clients would have fewer

re-abuse incidents than clients who were not ethnically matched with their counselors. In fact, however, one third of both ethnically matched and ethnically unmatched clients re-abused their children, and thus, the result of the chi-square test to examine this aspect of Hypothesis 4 was not significant, χ^2 (1) = 0.01, p = .935. Because ethnically matched and ethnically unmatched clients did not differ significantly on any outcome measure, Hypothesis 4 was not supported.

Summary. Results supported only one of the four hypotheses for ethnic matching. Clients who were ethnically matched with their counselors were less likely to terminate prematurely than were clients who were not ethnically matched. Client-counselor ethnic matching was not associated with engagement, satisfaction with intake, or counseling outcome.

Effects of Client-Counselor Ethnic Identity Discrepancy in Ethnically Un-matched Dyads

Results of the pilot study for this dissertation (Barrow & Tryon, 2008) showed that ethnic identity discrepancy between ethnically un-matched clients and counselors was negatively associated with client satisfaction with intake. However, there was no significant association between ethnic identity discrepancy and satisfaction in ethnically matched dyads.

Intake satisfaction and counseling outcome. Therefore, Hypothesis 5 predicted that client-counselor ethnic identity discrepancy (the absolute value of the difference between the client's and counselor's MEIM Total Ethnic Identity scores) for ethnically unmatched dyads would be negatively related to client satisfaction with intake (CSQ), improvement in global adjustment (last session GAF – first session GAF), improvement in meeting agency goal score (last session CBRS – first session CBRS), and positively related to child re-abuse. The average ethnic identity discrepancy score for the 36 unmatched client-counselor dyads was 1.55 (*SD* = 0.59) . Table 14 presents the means and standard deviations of unmatched clients' CSQ scores,

GAF improvement scores, CBRS improvement scores, and incidents of re-abuse as well as the correlation of these scores with client-counselor ethnic identity discrepancy scores.

Table 14

Means and Standard Deviations of Client Satisfaction Scores, Global Assessment Scale Improvement Scores, and Client Behavior Rating Scale Improvement Scores as well as Re-Abuse and Their Correlations with Un-Matched Dyads' Ethnic Identity Discrepancies

Variable	*M*	*SD*	Correlation with MEIM Ethnic Identity Discrepancy	*p* =
CSQ	19.03	6.93	0.01	.966
GAF Improvement	15.17	19.10	0.36	.032
CBRS Improvement	6.64	6.95	0.35	.036
Re-Abuse	0.26	0.45	-0.24	.270

Note. $n = 36$

Contrary to prediction, neither satisfaction with intake nor re-abuse were significantly related to client-counselor ethnic identity discrepancy for clients in ethnically unmatched dyads. Also, contrary to prediction, unmatched clients improvement scores on the GAF and the CBRS were positively associated with client-counselor ethnic identity discrepancy. Thus, when clients were not ethnically matched with their counselors, larger ethnic identity discrepancies (with clients being less ethnically identified) between them and their counselors were associated with greater improvements in global adjustment and in reaching agency goals. Hypothesis 5 was not supported.

Hypotheses 6 also addressed ethnic identity discrepancy in ethnically unmatched client-counselor dyads. It predicted that, in ethnically unmatched dyads ($n = 36$), there would be lower

client-counselor ethnic identity discrepancies for engaged (n = 24) than non-engaged clients (n = 12) and for continuing clients (n = 9) than premature terminating clients (n = 27). To examine hypothesis 6, two independent t tests were conducted. Tables 15 and 16 present the results of these t tests. Both were significant. Contrary to prediction, however, engaged clients who were not ethnically matched with counselors had larger ethnic identity discrepancies (clients were less ethnically identified than their counselor) with their counselors than did unmatched, non-engaged clients (see Table 15). On the other hand, in support of Hypothesis 6, ethnically unmatched continuing clients had smaller ethnic identity discrepancies with their counselors (clients were less ethnically identified than their counselors) than did unmatched non-continuing clients (see Table 16). Thus, Hypothesis 6 was only partially supported.

Table 15

Independent Sample t tests for Unmatched Dyads on Client-Counselor Ethnic Identity Discrepancy by Engaged and Non-Engaged

Variable				Engaged		Non-Engaged	
	t	*df*	Sig.	*M*	*SD*	*M*	*SD*
MEIM Discrepancy	2.14	34	.01	0.76	0.50	0.20	0.22

Table 16

Independent Sample t test for Unmatched Dyads on Client-Counselor Ethnic Identity Discrepancy by Continuing and Non-Continuing

Variable				Continuing		Non-Continuing	
	t	*df*	Sig.	*M*	*SD*	*M*	*SD*
MEIM Discrepancy	2.18	34	.04	0.42	0.43	0.79	0.51

Ethnically matched dyads. Although there was no hypothesis for ethnically matched dyads, the PI examined correlations between ethnic identity discrepancy score and CSQ, GAF, and CBRS scores for clients who were ethnically matched with their counselors as a secondary analysis. The average ethnic identity discrepancy score for the 27 matched client-counselor dyads was 1.02 (SD = 0.63), indicating that these clients and counselors had similar ethnic identities (i.e., less than the possible mean of 2). Table 17 presents the means and standard deviations of matched clients' CSQ scores, GAF improvement scores, CBRS improvement scores, and incidents of re-abuse as well as the correlation of these scores with client-counselor ethnic identity discrepancy scores. Although matched clients' re-abuse was not related to ethnic identity discrepancy, there were positive associations between their GAF, CBRS, and CSQ scores and ethnic identity. This indicates that when clients were ethnically matched with their counselors larger ethnic identity discrepancy scores were associated with greater satisfaction,

global adjustment, and achieving agency goals. However, there was no relationship between re-abuse and ethnic discrepancy for clients who were ethnically matched with their counselors.

Table 17

Means and Standard Deviations of Client Satisfaction Scores, Global Assessment Scale Improvement Scores, and Client Behavior Rating Scale Improvement Scores as well as Re-Abuse and Their Correlations with -Matched Dyads' Ethnic Identity Discrepancies

Variable	*M*	*SD*	Correlation with MEIM Ethnic Identity Discrepancy	*p*
CSQ	18.31	6.64	0.42	.047
GAF Improvement	17.52	11.53	0.31	.035
CBRS Improvement	8.41	4.0	0.42	.039
Re-Abuse	0.31	0.29	0.31	.42

Although not hypothesized, independent *t* tests were conducted to examine the relationship between ethnic identity discrepancy and engaged (n = 19) *vs* non-engaged (n = 8) and continuing (n = 14) *vs* non-continuing (n = 12) for ethnically matched counseling dyads (n = 27). Tables 18 and 19 present the results of these *t* tests. For clients who were ethnically matched with counselors there was no relationship between ethnic identity discrepancy and engaged *vs* non-engaged. On the other hand, clients ethnically matched with their counselors and who did not terminate early, had smaller ethnic identity discrepancies.

Table 18

Independent Sample t tests for Matched Dyads on Client-Counselor Ethnic Identity Discrepancy by Engaged and Non-Engaged

Variable				Engaged		Non-Engaged	
	t	*df*	Sig.	*M*	*SD*	*M*	*SD*
MEIM Discrepancy	1.82	25	.08	0.61	0.41	0.28	0.29

Table 19

Independent Sample t test for Matched Dyads on Client-Counselor Ethnic Identity Discrepancy by Continuing and Non-Continuing

Variable				Continuing		Non-Continuing	
	t	*df*	Sig.	*M*	*SD*	*M*	*SD*
MEIM Discrepancy	2.23	25	.035	0.35	0..22	0.70	0.49

Summary. The series of hypotheses that dealt with client-counselor ethnic identity discrepancies in ethnically un-matched dyads produced partial support for one hypothesis (i.e., in ethnically unmatched dyads, there would be lower client-counselor ethnic identity discrepancies for continuing clients than premature terminating clients). Thus, unmatched clients with similarly held ethnic identities to their counselors were more likely to stay in counseling. Contrary to

prediction, however, larger client-counselor ethnic identity discrepancies were related to some better client outcomes for ethnically unmatched clients. The findings for clients who were ethnically matched with their counselors were similar to those for ethnically unmatched clients and their counselors. Thus, clients who were ethnically matched and had similar ethnic identities to their counselors tended to remain in counseling longer than matched clients with larger client-counselor ethnic identity discrepancy. Larger client-counselor ethnic identity discrepancies for matched clients were also related to greater client satisfaction with intake, and similar to un-matched clients, better global adjustment and goal outcomes.

Taken together, these results suggest that client-counselor ethnic identity discrepancies play important roles in counseling outcomes, engagement, and continuation regardless of whether clients and counselors are ethnically matched. Thus, from these results, it appears that clients with larger ethnic identity discrepancies with their counselors tended to become engaged and to improve and to just leave counseling (i.e., dropout) without formally terminating, while clients who were similar to their counselors in terms of ethnic identity tended to show less improvement and continued in counseling.

Effects of Client-Counselor Acculturation Discrepancies

The pilot for this dissertation (Barrow & Tryon, 2008) found that when dyads were ethnically matched, larger client-counselor acculturation differences were associated with greater client satisfaction with intake. For unmatched dyads, however, larger client-counselor acculturation differences were negatively associated with client satisfaction. These findings formed the bases of Hypotheses 7 through 10. There are two types of acculturation scores that the Stephenson Multi-Group Acculturation Scale (SMAS; Stephenson, 2000) provides: Ethnic Group Immersion scores (EGIS) and Dominant Group Immersion scores (DGIS). To obtain

client-counselor acculturation discrepancy scores for both EGIS and DCIS, the PI subtracted clients' and counselors' scores on each and took the absolute value of the differences to test the hypotheses.

Ethnically matched clients. For clients who were ethnically matched (n = 27) with their counselors, Hypothesis 7 predicted that there would be positive relationships between client-counselor acculturation difference scores (both EGIS and DGIS) and client satisfaction scores (CSQ), improvement in global adjustment (last session GAF – first session GAF), and improvement in meeting agency goal score (last session CBRS – first session CBRS), and negatively related to child re-abuse. Table 20 presents means and standard deviations for these scores as well as their correlations with both client and counselor acculturation discrepancy scores.

Table 20

Means and Standard Deviations and Relationships of Client Satisfaction Scores, Global Assessment Scale Change Scores, and Client Behavior Rating Scale Change Scores as well as Re-Abuse with Matched Dyads' EGIS and DGIS Discrepancies

Variable	*M*	*SD*	Correlation with EGIS (*p* =)	Correlation with DGIS (*p* =)
CSQ	18.56	6.78	-.04	.30
			(.84)	(.13)
GAF improvement	13.87	18.49	-.13	.21
			(.53)	(.30)
CBRS improvement	5.57	7.41	-.16	.32
			(.41)	(.11)
Re-Abuse	.25	.44	.60	-.41
			(.01)	(.07)
EGIS	.63	1.41	—	—
DGIS	2.87	.94	—	—

$n = 27$

The correlations between client-counselor acculturation discrepancies and client satisfaction with intake and those between acculturation discrepancies and global adjustment and agency goal improvement were not significant, and thus, this part of Hypothesis 7 was not supported. The correlations of acculturation discrepancy and re-abuse, however, indicate that

acculturation discrepancy was related to client re-abuse of children. As predicted, in ethnically matched dyads, client-counselor discrepancies of ethnic group immersion (EGIS) were significantly, positively associated with client re-abuse. The larger the difference between client and counselor immersion in the ethnic group (with clients being more immersed than counselors), the more likely the client was to re-abuse. In these same dyads, client-counselor acculturation discrepancies for immersion in the dominant group tended to be negatively related to client re-abuse ($p < .07$). Thus, the larger the difference between client and counselor immersion in the dominant culture (with clients being more immersed than counselor), the less likely the client was to re-abuse. This latter finding approached, but did not achieve significance at the customary $p < .05$ level, but represented a medium effect size (Cohen, 1992). Hypothesis 7 received only partial support.

Based on the findings by Barrow and Tryon (2008), Hypothesis 8 predicted that for ethnically matched dyads ($n = 27$), engaged ($n = 8$) and continuing clients ($n = 14$) would have larger client-counselor acculturation discrepancy scores (both EGIS and DGIS) than non-engaged ($n = 19$) and premature terminating clients ($n = 13$). Tables 21 and 22 present means and standard deviations for these clients and show that the *t* tests were not significant. Thus, client-counselor acculturation discrepancies did not differentiate engaged and non-engaged and continuing and non-continuing clients who were ethnically matched with their counselors, and Hypothesis 8 was not supported.

Table 21

Independent Sample t Test for Matched Dyads on EGIS and DGIS by Engaged and Non-Engaged

Variable				Engaged		Non-Engaged	
	t	*df*	Sig.	*M*	*SD*	*M*	*SD*
EGIS	0.68	25	.503	2.69	1.18	3.06	1.52
DGIS	0.96	25	.346	2.73	0.81	3.05	0.70

Table 22

Independent Sample t Test for Matched Dyads on EGIS and DGIS by Continuing and Non-Continuing

Variable				Continuing		Non-Continuing	
	t	*df*	Sig.	*M*	*SD*	*M*	*SD*
EGIS	0.26	25	0.79	1.51	0.78	1.6	1.00
DGIS	0.64	25	0.52	0.69	0.47	0.84	0.75

Ethnically unmatched clients. Hypothesis 9 indicated that for the 36 clients who were not ethnically matched with their counselors, there would be negative relationships between client-counselor acculturation difference scores (both EGIS and DGIS) and client satisfaction scores

(CSQ), improvement in global adjustment (last session GAF – first session GAF), improvement in meeting agency goal score (last session CBRS – first session CBRS), and a positive relationship with child re-abuse. Table 23 presents means and standard deviations for these scores as well as their correlations with both client and counselor acculturation discrepancy scores.

Table 23

Means and Standard Deviations and Relationships of Client Satisfaction Scores, Global Assessment Scale Change Scores, and Client Behavior Rating Scale Change Scores as well as Re-Abuse with Un-Matched Dyads' Acculturation Discrepancies

Variable	*M*	*SD*	Correlation with EGIS (*p* =)	Correlation with DGIS (*p* =)
CSQ	19.03	6.93	-.14 (.43)	.04 (.83)
GAF improvement	15.17	19.10	.13 (.47)	-.27 (.11)
CBRS improvement	6.64	6.95	.24 (.16)	-.24 (.17)
Re-Abuse	.26	.45	-.10 (.64)	-.09 (.68)
EGIS	.38	1.28	—	—
DGIS	-.15	1.37	—	—

n = 36

None of the correlations was significant. Hypothesis 9 was not supported.

Hypothesis 10 stated that for ethnically unmatched dyads (*n* = 36), engaged (*n* = 24) and continuing clients (*n* = 9) will have smaller client-counselor acculturation discrepancy scores (both EGIS and DGIS) than non-engaged (*n* = 12) and premature terminating clients (*n* = 27). To examine hypothesis 10, the PI conducted four independent sample *t* tests.

Table 24 shows that the *t* test on client-counselor EGIS (ethnic group immersion) acculturation discrepancy scores by engagement was not significant suggesting that no difference exists for engaged clients compared to non engaged clients. Table also shows that the *t* test on client-counselor DGIS (dominant group immersion) acculturation discrepancy scores by engagement was not significant, suggesting that no difference exists for engaged clients compared to non-engaged clients.

Table 24

Independent Sample t Test for Unmatched Dyads on Client-Counselor Acculturation Discrepancies by Engaged and Non-Engaged

Variable				Engaged		Non-Engaged	
	t	*df*	Sig.	*M*	*SD*	*M*	*SD*
DGIS	0.62	34	.540	1.03	0.86	1.21	0.79
EGIS	0.70	34	.485	0.95	0.67	1.00	0.91

Table 25 shows that the *t* test on client-counselor EGIS discrepancy scores by continuing clients showed a trend toward but was not significant, suggesting that no difference exists for continuing clients compared to non continuing clients. The *t* test on client-counselor DGIS discrepancy scores by continuing clients was not significant, suggesting that no difference exists

for continuing clients compared to non continuing clients. Thus, Hypothesis 10 was not supported.

Table 25

Independent Sample t Test for Unmatched Dyads on Client-Counselor Acculturation Discrepancies by Continuing and Non-Continuing

Variable				Continuing		Non-Continuing	
	t	*df*	Sig.	*M*	*SD*	*M*	*SD*
EGIS	1.92	34	.063	0.57	0.95	0.06	0.60
DGIS	1.57	34	.125	0.81	0.87	1.33	0.85

Summary. None of the hypotheses relating to client-counselor acculturation discrepancies was entirely confirmed. Hypotheses 7-10 generated 24 comparisons, with only 1 of these being significant. These results suggest that for both clients who were ethnically matched with their counselors and those who were not, client-counselor acculturation differences had little relationship to satisfaction with intake, engagement, continuation in counseling, or outcome.

Summary of Results

Table 26 summarizes the results of hypothesis testing. There was confirmation for only 1 of the 10 hypotheses, 2 others were partially confirmed, and 2 yielded results opposite prediction.

Table 26

Outcomes of Hypothesis Testing

Hypothesis	Outcome
Clients who have abused/neglected their children and are ethnically matched with their counselors will be significantly more likely to be engaged in counseling than ethnically unmatched clients.	Not Confirmed
Clients who have abused/neglected their children and are ethnically matched with their counselors will be significantly less likely to terminate prematurely post-engagement than ethnically unmatched clients.	Confirmed
Clients in ethnically matched counseling dyads will have significantly higher scores on the post-intake Counseling Satisfaction Questionnaire than will clients who are not ethnically matched with their counselors.	Not Confirmed
Clients who are ethnically matched with their counselors will have significantly greater improvement on the Global Assessment Scale and the Client Behavior Rating Scale and significantly fewer incidents of re-abuse than will clients who are not ethnically matched with their counselors.	Not Confirmed
In ethnically unmatched dyads, client-counselor ethnic identity discrepancies will be negatively correlated with client satisfaction with intake and Global Assessment Scale and Client Behavior Rating Scale improvement scores, and positively correlated with re-abuse.	Not Confirmed. Some results opposite prediction.

Table 26 continued

Hypothesis	Outcome
For ethnically unmatched dyads, there will be lower client-counselor ethnic identity discrepancies for engaged than non-engaged clients and for continuing clients than premature terminating clients.	Partially Confirmed One result opposite of prediction.
For ethnically matched dyads, there will be a positive relationship between client-counselor acculturation discrepancy and client satisfaction, improvement in Global Assessment Scale scores, and improvement in Client Behavior Rating Scale, and a negative relationship with re-abuse.	Partially Confirmed
For ethnically matched dyads, engaged and continuing clients will have larger client-counselor acculturation discrepancy scores than non-engaged and premature terminating clients.	Not Confirmed
For ethnically unmatched dyads, there will be a negative relationship between client-counselor acculturation discrepancy and client satisfaction and improvement in Global Assessment Scale and Client Behavior Rating Scale scores, and a negative relationship with re-abuse.	Not Confirmed
For ethnically unmatched dyads, engaged and continuing clients will have smaller client-counselor discrepancy scores than non-engaged and premature terminating clients.	Not Confirmed

While clients who were ethnically matched with their counselors were more likely to continue counseling post-engagement than were clients who were not ethnically matched, ethnic matching did not relate to engagement, satisfaction with intake, or outcome. Ethnic identity discrepancy between client and counselor yielded the most significant results, however. In this sample of child-abusing parents, larger client-counselor ethnic identity discrepancies were associated with more positive outcomes regardless of whether or not client and counselor shared the same ethnicity.

CHAPTER V

Discussion

This chapter summarizes and discusses study results in terms of how client-counselor ethnic match, ethnic identity discrepancy, and acculturation discrepancies related to clients' who abused and/or neglected their children satisfaction with intake, engagement, early termination (dropout), and counseling outcome.

Results of the Study

The purpose of this study was to explore the relationship between ethnic matching and its effect on clients' counseling satisfaction, engagement, early termination, and counseling outcome. Since extremely high recidivism rates are evident in child abuse and neglect cases (US Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, 2005) and since minority and immigrant parents represent a large percentage of individuals who commit child abuse and neglect (US Department of Health & Human Services, 2008), counseling studies with this population can inform efforts to serve them. Although other studies have examined the effects of ethnic matching on client satisfaction (Gamble, 2001; Gamst et al., 2003), engagement (Sue et al., 1991; Jerrell, 1998; Maramba & Hall, 2002), premature termination (Shine et al. 2005), and outcome (Erdur, Rude, & Baron, 2003; Gamist et al., 2004; Lee, 2004), researchers need to distinguish between race and ethnicity when conducting studies related to the concept of ethnicity. However, due to the many changes the definition of ethnicity has undergone over the past years, different researchers have utilized varying definitions for this concept. To further complicate matters, studies (Constantine, 2002; Sue et al, 1991; Sine et al., 2005) claiming to examine ethnicity actually studied race instead. Thus, this study represented an improvement over others in providing a distinction between race

and ethnicity and in examining client-counselor ethnic matching and acculturation discrepancies as they related to client satisfaction, engagement, dropout, and outcome.

Of the 10 hypotheses, only 1 was confirmed, 2 were partially confirmed, and 2 produced opposite results. Specifically, I confirmed that abusive/neglectful clients who were ethnically matched with their counselors were significantly less likely to terminate prematurely after engagement than ethnically unmatched clients. Ethnic matching was not related to engagement, client satisfaction, or counseling outcome.

Satisfaction with initial interview. This study revealed that clients who abused or neglected their children and who were ethnically matched with their counselors were no more satisfied with their intake session than their unmatched counterparts. These findings are similar to those of other studies (Vetta, 2004; Gamble, 2001). Gamble reported no difference between matched and unmatched clients related to client satisfaction, and Vetta found that satisfaction was related to ethnic match only for some minority clients but not for others. According to Vetta, Asian-American clients reported more satisfaction when they were ethnically matched with their counselors, however, Latino-Americans reported less satisfaction, while for African Americans and White Americans ethnic matching had no significant effect on counseling satisfaction. In the current study, there were no Asian Americans and the majority of clients were African American (36.5%) or West Indian (34.9%). Similar to ethnic matching, this study found no difference between male and female clients and satisfaction with their initial interview.

Results of other studies (Constantine, 2002; Rubin, 1999) suggested that ethnic matching between client and counselor may be less important for client satisfaction than counselors' cultural competence (i.e., the ability of professionals to not only recognize and appreciate people from different cultures but to be able to work effectively with the members of other cultural

groups (Sue, 1998)). This study did not assess counselor cultural competence, so it is not possible to know if this variable would have been related to client satisfaction in the present study.

Ethnic identity discrepancy between client and counselor did, however, relate to client satisfaction with intake, but not in the manner predicted. There was virtually no relationship between client-counselor ethnic identity discrepancy and satisfaction in ethnically un-matched dyads. The study's results indicated, however, that when client and counselor were of the same general ethnicity and had dissimilar ethnic identities (i.e., larger ethnic identity discrepancies), clients were more likely to be satisfied with the intake counseling session. Thus, dissimilar client-counselor ethnic identities may be important for client satisfaction when counselor and client are of the same ethnicity.

This dissertation failed to support the pilot study (Barrow & Tryon, 2008) findings of significant associations for client-counselor acculturation discrepancies and client satisfaction with intake. Thus, for client-counselor participants in this study ethnic matching, ethnic identity discrepancy, and acculturation discrepancies generally were not related to client satisfaction with intake. It may be that client satisfaction has more to do with other issues that this study did not assess. For example, Constantine (2002) found that ethnic minority clients rated general counselor competence as important in their counseling satisfaction regardless of the ethnicity of their counselor.

Engagement and premature termination (counseling continuation/dropout). Participants who were ethnically matched with their counselors were no more likely to become engaged in counseling than were unmatched clients. This result contrasted with that of Maramba and Hall (2002) who found that clients matched with counselors of the same ethnicity were more likely to

become engaged in counseling than those not ethnically matched. It should be noted, however, that the correlation between engagement and ethnic match in Maramba and Hall's study, although significant, was very small ($r = .03$). Sue et al. (1991) indicated that ethnic match resulted in lower odds of non-engagement for all minority groups except African Americans. Overall Sue et al. suggested that ethnic match was important for Asian Americans, Mexican Americans, and White clients in predicting engagement. The discrepancy in results between my study and that of Sue et al. may be due to the fact that a large minority of my client participants self- identified as African Americans and there were no Asian American clients.

On the other hand, ethnically matched client participants tended to continue in counseling post-engagement (i.e., not drop out) more frequently than did clients who were not ethnically matched with their counselors. These results were not supported by Shin et al. (2005) who found ethnic match was not related to pre-mature termination from counseling.

Comparable to some findings concerning client satisfaction, ethnic identity discrepancy played a role in both engagement and premature termination. For clients who were not ethnically matched with their counselors, larger client-counselor ethnic identity discrepancies were associated with engagement and smaller ethnic identity discrepancies were associated with continuing in counseling. Similarly, for clients who were ethnically matched with their counselors, smaller ethnic identity discrepancies were associated with counseling continuation.

Acculturation discrepancies between client and counselor did not relate to either engagement or counseling drop out for either ethnically matched or un-matched dyads. For un-matched dyads, however, acculturation discrepancies approached significance for counseling continuation, suggesting that a larger sample might have resulted in significant findings. However, there was no relationship between gender and counseling continuation/dropout.

Counseling outcome. Treatment outcome was assessed in three areas: global adjustment, improvement in meeting agency goals, and reports of client re-abuse. This study found no relationship between gender and any of the counseling outcomes measures. Although both ethnically matched and unmatched clients improved their global adjustment and achievement of agency goals, there was no statistical significance between the two groups for these outcomes. Additionally, one third of both ethnically matched and unmatched clients received reports of re-abuse. This finding is comparable to results of a national, 5-year study (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2005) that found that approximately one third of children who were subjects of abuse and or neglect were likely to be re-reported within a 5-year period. This reabuse could be related to the fact that many clients do not distinguish between abuse and discipline, especially those of West Indian descent. As a result it might be necessary for counselors to educate their clients about the differences between these two concepts. Overall, counseling outcome was not related to ethnic matching. The results contrast with some findings by others. For example, Lee (2004) found that unmatched Latino and African American client participants experienced more positive clinical outcome than their matched counterpart, while Erdur, Rude, and Baron (2003) found that client improvement of symptom or treatment outcome was not statistically related to client-counselor ethnic match. However, these authors indicated that there was a trend for clients from ethnically dissimilar dyads to show a greater degree of improvement.

As it did with engagement and dropout, client-counselor ethnic identity discrepancy played a role in the counseling outcomes of this sample. For both clients in ethnically matched dyads and those in ethnically unmatched dyads, larger client-counselor identity discrepancies

were associated with greater improvements in global adjustment and meeting of agency goals. In the case of unmatched dyads, these results were contrary to predictions. There was, however, no significant relationship between client-counselor ethnic identity discrepancy and client re-abuse of his/ her children.

Client-counselor acculturation discrepancies, however, did relate significantly to client re-abuse, but only for dyads where clients were ethnically matched with their counselors. In these dyads, greater client-counselor discrepancy for ethnic group immersion (with clients being more immersed in their ethnic group) was related to more re-abuse. Thus, ethnically matched clients who were more strongly immersed in their native culture than were their counselors tended to re-abuse their children. Since there is no literature on this topic, I can only speculate on this finding based on my experience working for ACS. Clients' cultures of origin often endorse corporal punishment as the main method of discipline. When these clients are assigned to counselors of the same ethnicity, they may believe that counselors will be more understanding of re-abuse than would counselors of other ethnicities when in fact, their counselors are not as ethnically identified with their culture of origin and do not endorse corporal punishment. On the other hand, larger client-counselor dominant group immersion discrepancy (with the client being more immersed in the dominant group) was related to less re-abuse by clients. While acculturation reflects the changes that occur as a result of continuous contact between two cultures, an individual's level of acculturation is dependent on the extent to which he/she adapts to the dominant culture by changing her behaviors and beliefs (Berry, 2003). This includes adaptation to the dominant culture's parenting styles. Maybe abusive/neglectful minority parents, who are more immersed in the dominant culture are more willing to take the advice of their counselor, with regard to disciplining methods, regardless of the counselor's ethnicity.

Summary. Sue (1988) indicated that ethnicity alone reveals very little about individuals' attitudes, values, behaviors, and experiences. As a result ethnic mismatch can result in cultural match, and therapist and clients from different ethnic groups might share similar cultural values. Others (Tyler, Sussewell, & Williams-McCoy, 1985) have questioned whether a counseling ethnic mismatch is detrimental. Sue postulated that therapist and clients who match ethnically may share experiences and thus relate well with each other. However, mismatch has the advantage of allowing client and counselor to learn about cultural diversity and confront any values that might be conflicting.

Overall, results of this study suggest that for clients who have abused their children ethnic matching per se may have little to do with client satisfaction, engagement, and outcome, although when clients were ethnically matched with their counselors were less likely to terminate prematurely from counseling. Results also suggested that, in contrast to ethnic matching, client-counselor ethnic identity discrepancy is important in engagement, early-termination, and counseling outcome regardless of whether or not clients are ethnically matched. Although acculturation discrepancy was related to re-abuse, it had little relationship the other variables in this study.

As noted above, ethnic identity more than ethnic match was important in engagement, early-termination, and counseling outcome for clients in both matched and unmatched dyads. Clients, regardless of whether they were ethnically matched with their counselor or not, who had larger ethnic identity discrepancies with their counselors tended to become engaged (although this finding only approached significance for matched clients), to improve in symptoms and meeting agency goals, and to just leave counseling (i.e., dropout) without formally terminating,

while clients who were similar to their counselors in terms of ethnic identity tended to show less improvement and continued in counseling.

Implications of the Study for Practice

This study has implication for the referral practice of the New York City Administration for Children's Services (ACS). It is currently the custom of this agency to refer clients for counseling services based on the availability of counselors, irrespective of the clients' ethnicity or cultural background. For instance, a Latino or an African client may be referred to an agency that is serviced predominantly by Caribbean/West Indian providers. Such disparity in ethnicity between client and counselor may be associated with client post-engagement dropout. So, agency personnel should consider ethnically matching clients and counselors to facilitate counseling continuation.

ACS should also consider having all clients and counselors complete the MEIM. This would not only facilitate ethnic matching, but would provide ethnic identity data to allow calculation of client-counselor ethnic identity discrepancies that this study indicated may be important predictors of outcome. Finally, ACS should assess and attend to clients' cultural immersion. My results suggest that clients who are immersed in the ethnic culture appear to be at risk for re-abuse of their children, perhaps because differences in ethnic cultural beliefs and values from those of the dominant culture may lead to child maltreatment (Johnson, 2007; Smith-Hefner, 1998). The New York City Administration for Children Services should therefore become more cognizant of the referral process and ways that they can intervene to better serve their clients. Additionally, results of this study may be helpful to receptionists or other individuals who accept the intake referral. Results may assist these individuals when they pair clients with counselors.

Results of this study can guide the recruitment process of PPRS agencies. Agencies would be able to determine if their counselor recruitment process is adequate for the clients they service. For instance, an agency located in the East Flatbush section of Brooklyn NY (predominantly populated by Caribbean immigrants) may seek to recruit counselors of Caribbean heritage. Additionally, incidents of reabuse can be greatly diminished if agencies screen both counselors and clients to determine the extent to which these individuals are immersed in either their ethnic or dominant cultures. This information can guide the assignment of clients to counselors, which would then have an effect on clients' reabuse.

Limitations

There are several limitations of this study that may have influenced the results. Future research in this area should note these limitations and work towards eliminating them. First, many counselors failed to provide demographic information related to age, marital status, and income. Clients were also reluctant to provide information regarding age and marital status. These factors might have related to the results of this study. Ogrodniczuk et al. (2005) suggested that minority individuals who are economically disadvantaged, young, and have less than a high school education are at a high risk of dropping out of treatment. Jerrell (1998) found that young clients stayed in treatment longer when treated by ethnically similar counselors, while Tryon and DeVito (1981) found that counselors preferred clients who were young, attractive, verbal, intelligent, and successful. Additionally, some ethnic minority clients prefer counselors of similar socioeconomic status (Atkinson, Poston, Furlong, & Mercado, 1989). Since much of this demographic information was not included in the study, it was impossible to determine their effects on the dependent variables.

A second limitation of this study relates to the lack of experience of the counselors working with this population. Of the 9 counselors, 4 held Masters Degree in Social Work, 1 held a Bachelors Degree in Social Work, and 4 were Social Worker Interns. Additionally, counselors had worked with this client population for less than a year on average. Cohn (1979) suggested that the level of training of service providers was related to the recurrence of child re-abuse. Tryon (1989) found that good therapeutic skill as practiced by experienced counselors was related to higher engagement. Additionally engagement was positively related to therapist experience. Tryon also found that engaging therapist trainees were older and had better verbal and diagnostic skills than non-engaging trainees. Future studies should employ more experienced, better trained counselors with this population, or at least include counselors with broader ranges of experience and training.

Third, the sample size of the current study was very small. Although the recommended minimum of 26 per group (Cohen, 1992) for the overall sample of engaged *vs.* non-engaged clients was obtained, the overall size of each group (particularly for analyses of only matched or only un-matched clients) was much smaller, and even the larger sample did not sample nearly enough of the larger population of abusive/neglectful clients located in New York City. As of December 2007, The New York City Administration for Children's Services investigated 63,000 allegations of abuse and neglect for the year and referred 99% of these cases to for services. Additionally, this study obtained data from a single programmatic source, which limits its generalizability.

With such a small sample size and the fact that African Americans and Latina(o) clients accounted for almost 50% of my sample, this study focused only on a small number of ethnic

groups and therefore ignored differences that might be evident in other groups (Murphy, Faulker, & Behrens, 2004).

A fourth limitation was the reliability of the re-abusing information. Prior to October 2006, the Principal Investigator was employed by the Administration for Children's Services and is aware that communication between Child Protective Specialist and PPRS Providers are often limited. In most instances CPS and PPRS service providers fail to communicate prior to the date of a court hearing, which often occurs every 4 to 8 weeks. Since a court report is due at each hearing, CPS and PPRS providers update each other on the client's progress. As a result it was difficult to determine if every re-abuse occurrence was reported to the counselors.

A fifth limitation to this study was that all client participants were referred by the Administration for Children Services and although not court mandated to attend counseling, there might have been a need to appear favorable to their Child Protective Specialists. As a result this could have heavily influenced some clients' tendency to terminate early or to become engaged as noncompliance with services might be a negative reflection on the client and might influence the status of her case closing. Based on experience, the PI is aware that lack of compliance with ACS services often results in an investigation remaining open with ACS or the CPS petitioning the Family Court for court-mandated services. Lack of cooperation can also result in removal of children from the home.

A sixth limitation of this study is the fact that the church has historically played a significant role in the lives of African Americans. The church has served as the foundation for counseling, among other purposes, for those in need in the Black community. This fact could have had an impact on the outcome of this study, since the majority of the participants of this study self-identified as Black.

Future Research

In addition to addressing the limitations above, future research should replicate this study in other geographical areas to either confirm or refute the findings. For example, future studies might examine abusive/neglectful parents in multiple PPRS agencies and throughout the five Boroughs of New York City (e.g., The Bronx, Queens, Staten Island, and Manhattan). This would allow findings to be more generalizable to the abusive and neglectful parents in the city of New York.

Second, information should be gathered in such a way that counselors' demographic information is obtained in order to determine if these variables influence abusive neglectful clients' satisfaction, engagement, and treatment outcome.

Third, future research should include a wider variety of ethnic minorities in an effort to truly understand the effects of ethnic matching.

Fourth, all aspects of ethnic identity should be studied to determine whether it relates to the dependent variables. The MEIM assesses three aspects of Ethnic Identity conceptualized by Phinney (1996): affirmation (or the sense of belonging to a specific ethnic group), achievement (or the resolution of the ethnic identity issue), and behaviors or attitudes towards other ethnic groups. The current study utilized the total ethnic identity score and did not differentiate between the three aspects of one's ethnic identity.

Finally, the SMAS assesses two central issues Berry (1980) postulated, which results in four modes of acculturation: integration, assimilation, separation, and marginalization. While this study addressed the two central acculturation issues (immersion of individuals in their ethnic culture and immersion in the dominant culture), the four modes of acculturation were not addressed. Future studies might need to examine the integrationist, assimilationists,

separationists, and marginalists to determine whether client-counselor ethnic match is an important factor in counseling for these individuals.

Appendix A

The Multi-Group Ethnic Identity Measure

Please answer each question as carefully as possible by circling *one* of the numbers to the right of each question to indicate your degree of agreement or disagreement.

1 Strongly Agree	2 Somewhat Agree	3 Somewhat disagree	4 Strongly Disagree

#	Item				
1.	I have spent time trying to find out more about my own ethnic group, such as its history, traditions, and customs	1	2	3	4
2.	I am active in organizations or social groups that include mostly members of my own ethnic group.	1	2	3	4
3.	I have a clear sense of my ethnic background and what it means to me.	1	2	3	4
4.	I like meeting and getting to know people from ethnic groups other than my Own.	1	2	3	4
5.	I think a lot about how my life were affected by my ethnic group membership	1	2	3	4
6.	I am happy that I am a member of the group I belong to	1	2	3	4
7.	I sometimes feel it would be better if ethnic groups did not try to mix together	1	2	3	4
8.	I am not very clear about the role of my ethnicity in my life	1	2	3	4
9.	I often spend time with people from ethnic groups other than my own	1	2	3	4
10.	I really have not spent much time trying to learn more about the culture and history of my ethnic group	1	2	3	4
11.	I have a strong sense of belonging to my own ethnic group	1	2	3	4

The Multi-Group Ethnic Identity Measure

Use the numbers given below to indicate how much you agree or disagree with each statement:

1	2	3	4
Strongly Agree	Somewhat Agree	Somewhat disagree	Strongly Agree

12. I understand pretty well what my ethnic group membership means to me, in terms of how to relate to my own group and other groups 1 2 3 4
13. In order to learn more about my ethnic background, I have often talked to other people about my ethnic group
14. I have a lot of pride in my ethnic group and its accomplishments 1 2 3 4
15. I don't try to become friends with people from other ethnic groups 1 2 3 4
16. I participate in cultural practices of my own group, such as special foods, music, or customs 1 2 3 4
17. I am involved in activities with people from other ethnic groups 1 2 3 4
18. I feel a strong attachment towards my own ethnic group 1 2 3 4
19. I enjoy being around people from ethnic groups other than my own 1 2 3 4
20. I feel good about my cultural and ethnic background 1 2 3 4
21. My father's ethnic group is ____________________
22. My mother's ethnic group is ____________________

Appendix B

Stephenson Multigroup Acculturation Scale

Please answer each question as carefully as possible by checking *one* of the numbers to the right of each question to indicate your degree of agreement or disagreement.

1 Strongly Disagree	1 Disagree	1 Agree	1 Strongly Agree

Item	Rating
I know how to speak my native language/dialect.	1 2 3 4
I like to speak my native language/ dialect.	1 2 3 4
I speak my native language/dialect with my friends and acquaintances from my country of origin.	1 2 3 4
I know how to read and write in my native language/ dialect.	1 2 3 4
I fell comfortable speaking my native language/ dialect.	1 2 3 4
I speak my native language/dialect at home.	1 2 3 4
I like to listen to music of my ethnic group.	1 2 3 4
I speak my native language/dialect with my spouse.	1 2 3 4
When I pray I use my native language/dialect.	1 2 3 4
I have never learned to speak the language/dialect of my native country.	1 2 3 4
I am informed about current affairs in my native country.	1 2 3 4
I attend social functions with people from my native country.	1 2 3 4

Appendix B

Stephenson Multigroup Acculturation Scale

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree

Item	Rating
I am familiar with the history of my native country.	1 2 3 4
I think in my native language/dialect.	1 2 3 4
I stay in close contact with family members and relatives in my native country.	1 2 3 4
I regularly read magazines of my ethnic group.	1 2 3 4
I eat traditional food from my native culture.	1 2 3 4
I attend social functions with people from my native country.	
I have many (Anglo) American acquaintances.	1 2 3 4
I speak English at home.	1 2 3 4
I know how to prepare (Anglo) American foods.	1 2 3 4
I am familiar with the history of my native country.	1 2 3 4
I think in English.	1 2 3 4
I speak English to my spouse or partner.	1 2 3 4
I feel totally comfortable with (Anglo) American people.	1 2 3 4
I attend social functioning with (Anglo) American people.	1 2 3 4
I am familiar with important people in American history.	1 2 3 4

Appendix B

Stephenson Multigroup Acculturation Scale

1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree

Item				
I understand English, but I'm not fluent in English.	1	2	3	4
I am informed in current affairs in the United States.	1	2	3	4
I like to eat American foods.	1	2	3	4
I regularly read an American newspaper.	1	2	3	4
I feel comfortable speaking English.	1	2	3	4
I feel at home in the United States.	1	2	3	4
I feel appreciated by (Anglo) Americans.	1	2	3	4

Appendix C

Client Satisfaction Questionnaire (CSQ-8)

Please answer all of the questions below, by circling the one that best reflects your feeling. I am interested in your honest opinion, whether they are positive or negative. Thank you very much, I really appreciate your help.

How would you rate the quality of service you have received?

Excellent	Good	Fair	Poor

To what extent has our program met your needs?

Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs

If a friend were in need of similar help, would you recommend our program him or her?

No, definitely	No, I don't think so	Yes, I think so	Yes, definitely

How satisfied are you with the amount of help you have received?

Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

Have the services you received helped you to deal more effectively with your problems?

Yes, definitely	Yes, I think so	No, I don't think so	No, definitely not

In an overall general sense, how satisfied are you with the service you have received.

Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

If you were to seek help again, would you come back to our program

No, definitely	No, I don't think so	Yes, I think so	Yes, definitely

Appendix C

Client Satisfaction Questionnaire (CSQ-8)

Did you get the kind of service you wanted?

No definitely | No, not really | Yes, generally | Yes, definitely

Appendix D

CLIENT DEMOGRAPHIC QUESTIONNAIRE

Please respond to the following question by either writing in your answer or circling the one that best reflects your response for each item.

What was your age at your last birth day? ______

What is the highest level of education you have completed?

Less then 12th grade	High School/GED
Some College	Associates Degree
BA/BS Degree	Masters Degree
PhD/MD/JD	

What is your yearly income?

Less than 20, 000	60, 000 to 79,999
20,000 to 39,999	80,000 to 99,999
40,000 to 59,999	Over 100,000

What is your total household yearly income ?

Less than 20, 000	60, 000 to 79,999
20,000 to 39,999	80,000 to 99,999
40,000 to 59,999	Over 100,000

What is your current marital status?

Single/Never Married	Divorce/Separated
Married	Widowed

Appendix D

CLIENT DEMOGRAPHIC QUESTIONNAIRE

How long have you been involved with ACS?

Less than 1 year 1 to 2 years

2 to 3 years 3 to 4 years

4 to 5 years More than 5 years

Have any of your cases been Indicated ? Yes No

If yes, how many of your cases have been indicated ______

Apart from those provided by this agency, are you currently receiving any other mental health services?

Yes No

Were you mandated by the Judge to receive mental health services?

Yes No

Would you prefer a counselor of your ethnicity?

Yes No No preference

Have you requested a specific counselor with which to work at this agency?

Yes No

Who is your current counselor? ___________________________

What was the date of your intake appointment? _________________

Appendix D

CLIENT DEMOGRAPHIC QUESTIONNAIRE

What is your race?

Circle the one that best describes your race

Black White

Indian/Alaska Natives Asian American/Pacific Islander

Mixed: parents are from two different
racial groups

Other (write in):___________

My father's race is…..

Circle the one that best describes your father's race

Black White

Indian/Alaska Natives Asian American/Pacific Islander

Mixed: parents are from two different
racial groups

Other (write in):___________

My mother's race is …..

Circle the one that best described your mother's race

Black White

Indian/Alaska Natives Asian American/Pacific Islander

Mixed: parents are from two different
racial groups

Other (write in):___________

Appendix E

COUNSELOR DEOMGRAPHIC
QUESTIONNAIRE

Please respond to the following questions by either writing in your answer or circling the one that best reflects your response for each item.

What is your gender ? Male Female

What was your age at your last birth day? _____

What is the highest level of education you have completed?

Less than 12th grade High School/GED

Some College Associates Degree

BA/BS Degree Masters Degree

PhD/MD/JD

What is your race? ________

Check the response that best answer to the question

Black White

Indian/Alaska Natives Asian American/Pacific Islander

Mixed: parents are from two different
racial groups

Other (write in):___________

Appendix E

COUNSELOR DEOMGRAPHIC
QUESTIONNAIRE

What is your father's race?

Check the one that gives the best answer to the question

Black White

Indian/Alaska Natives Asian American/Pacific Islander

Mixed: parents are from two different
racial groups

Other (write in):___________

What is your mother's race?

Circle the one that gives the best answer to the question

Black White

Indian/Alaska Natives Asian American/Pacific Islander

Mixed: parents are from two different
racial groups

Other (write in):___________

What is your current marital status?

Single/Never Married Divorce/Separated

Married Widowed

How long have you been a counselor?_____

Appendix E

COUNSELOR DEOMGRAPHIC
QUESTIONNAIRE

How long have you worked with this particular population of clients (abusive/neglectful clients)?

____

What is your theoretical orientation ? __________

What is your yearly income?

Less than 20, 000 60, 000 to 79,999

20,000 to 39,999 80,000 to 99,999

40,000 to 59,999 Over 100,000I

If you hold a college degree, what is your major? _____________

Appendix F

Script of Telephone Conversation with Agency Director

Hello Ms……… My name is my name is Arlene Barrow, and I am a doctoral student in the Ph.D. Program in Educational Psychology at the Graduate School and University Center of the City University of New York (CUNY). I am conducting a study to see whether or not matching clients with counselors/therapists of similar cultures will have an effect on clients' attendance at and satisfaction with counseling. I hope the results of my study will improve counseling services to clients referred for services by the Administration for Children's Services. I am contacting you since your agency's clientele matches the population that this study targets. This includes individuals who were referred by the Administration for Children's Services and have at least one Indicated case of child abuse and/or neglect.

The results of this study may give insight into your clients' engagement, dropout, and satisfaction, which could have a substantial impact on service delivery.

I am requesting a face-to-face meeting with you in order to better describe the study and meet with your staff members.

Appendix G

Script Introducing My Research at the Staff Meeting

Good morning (afternoon) ladies and gentlemen. As you are aware, my name is Arlene Barrow, and I am a doctoral student in the Ph.D. Program in Educational Psychology at the Graduate School and University Center of the City University of New York (CUNY). I am conducting a study to see whether or not matching clients with counselors/therapists of similar cultures will have an effect on clients' attendance at and satisfaction with counseling. I hope the results of my study will improve counseling services to clients referred for services by the Administration for Children's Services. Your agency was selected as a possible participant in this study because your clientele matches the population that this study targets. This includes individuals who were referred by the Administration for Children's Services and have at least one Indicated case of child abuse and/or neglect.

Both you and your clients are given the option to participate. The clients who agree will be given four questionnaires to complete. The first three questionnaires ask about their demographic information, native language, their ethnic group, their native country, their native foods, etc. The last questionnaire asks them about the service they receive from the agency. Once they agree to participate in the study, they will be asked to complete the first three questionnaires. After their counseling session they will be asked to complete the last questionnaire. This procedure will commence at the beginning of their first counseling session and will end at the conclusion of the session. Due to the need to complete these questionnaires their stay at the agency will be approximately 30

minutes longer than usual, as this is the estimated time it will take to complete all three questionnaires. The counselors who agree to participate will be asked to complete questionnaires similar to the first three completed by the clients. Participating counselors will be requested to complete these questionnaires at the time they agree to participate in the study. The estimated time to complete these three questionnaires is 15 to 20 minutes. Participating counselors will also be asked to complete assessments of their clients at the end of each counseling session.

In addition, both participating counselors and their clients will be asked to complete consent forms. The consent forms also make provision for counselors and clients to revoke consent, should they decide to do so after giving permission.

There are no risks involved in this study other than that encountered in everyday life. The participation of your agency in this study will not affect either counselor or their clients, or the service provided. The information provided on the questionnaires would be confidential. I would be the only one to see it and I will not share it with anyone. I will combine all information that I receive from all clients and counselors to complete my study. Should the study be published, information would be provided in such a way that counselors, clients, or the agency cannot be identified.

Should participants desire a summary of the research findings, they should ask me and provide the address to which the correspondence should be mailed.

If any counselor decides to participate, they are free to withdraw their consent and to discontinue participation at any time with no consequences.

Appendix H

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

(Counselor)

My name is Arlene Barrow, and I am a doctoral student in the Ph.D. Program in Educational Psychology at the Graduate School and University Center of the City University of New York (CUNY). I invite you to participate in a study to see whether or not matching clients with counselors/therapists of similar cultures will have an effect on clients' attendance at and satisfaction with counseling. I hope the results of my study will improve counseling services to clients referred for abuse or neglect. You were selected as a possible participant in this study because you are currently a counselor of the agency being studied; your clients were referred by the Administration for Children's Services and each have at least one Indicated case of child abuse and/or neglect.

If you decide to participate, you will be requested to complete three questionnaires. The first two questionnaires will ask about your native language, your ethnic group, your native country, your native foods etc. The estimated time required to complete both questionnaires will be 15 to 20 minutes. The third questionnaire asks demographic questions i.e. marital status, age, theoretical orientation, etc. Additionally, you will be requested to perform a client assessment, at the beginning of each counseling session, and provide me with a GAS score upon conclusion of the session. You will be requested to write the client's name on the top right hand corner of the score.

You will also be requested to assess clients' progress towards their treatment goal. This will be accomplished via the Client Behavior Rating Scale. Like the GAS, you will be requested to write the client's name on the top right hand corner of the CBRS, which

will be placed in the same plain white envelope as the GAS. The envelope should be sealed and placed in the locked box provided. Finally, you will be requested to notify me of any new allegations of abuse or neglect a participating client receives. This information should be indicated at the bottom of the CBRS. Any participating client for whom I do not receive a CBRS or GAS, for a specific week, I will contact you to determine her attendance status. Finally, you will be requested to notify me of any new allegations of abuse or neglect a participating client receives.

There are no risks involved in this study other than those encountered in everyday life. Your participation in this study will not affect employment at the agency. The information that you tell me on the questionnaires will be kept confidential. I will be the only one to see it and I will not share it with anyone. I will combine your information with information that I receive from other counselors to complete my study. Should the study be published, information would be provided in such a way that you cannot be identified. You will not be identified in any publication or presentation of the study findings. When presenting the findings of this study only group scores will be reported.

Should you desire a summary of the research findings, please check the box at the bottom of the Multi-Group Ethnic Identity Measure and provide the address to which you want the correspondence mailed.

Your decision whether or not to participate will not prejudice your future relations with your clients or the agency you are now employed. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time with no consequences.

If you have questions about this research, you may contact me at 718-467-3741 or abarow@gc.cuny.edu., or my advisor Georgiana Tryon at 212-817-8285 or Gtryon@gc.cuny.edu. If you have questions about your rights as a participant in this study, you can contact Kay Powell, IRB Administrator, The Graduate Center/City University of New York, (212) 817-7525, kpowell@gc.cuny.edu.

You will be given a copy of this form to keep.

You are making a decision whether or not to participate. Your signature indicates that, having read the information provided above, you have decided to participate.

…………………………………….	………………..………………
Signature of Research Participant	Signature of Investigator
………………………………	……………………………..
(Please PRINT name)	Please Print Name

……………………………………………………………

Date

Appendix I

Script of Conversation with Receptionist

Good morning (afternoon) Ms…… As you are aware, my name is Arlene Barrow, and I am a doctoral student in the Ph.D. Program in Educational Psychology at the Graduate School and University Center of the City University of New York (CUNY). I am conducting a study at this agency and am requesting your assistance in collecting the data. After intake, I would like you to introduce me to the client. You will advise each client that the study will not be part of the intake process and will not impact his/her participation at the agency. Once a client agrees to participate in the study, you will give him/her three forms to complete: Client Demographic Questionnaire, The Miltigroup Ethnic Identity Measure (MEIM), and Stephenson Multigroup Acculturation Scale (SMAS). You will provide the clients with copies of the questionnaires in an envelope that they can seal to keep their results confidential. You will then direct them to place the completed questionnaires in the envelope and seal it. You will then hand deliver the sealed envelope, containing the questionnaires, to me. After their counseling session, you will ask them to complete another form: the CSQ-8 and return it to me in a sealed envelope.. The same procedure would be followed as with the completion of the other forms, with the client sealing the CSQ in an envelope, returning it to you, and you returning the envelope to me.

Appendix J

Informed Consent

CITY UNIVERSITY OF NEW YORK, GRADUATE CENTER

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

(Client)

My name is Arlene Barrow, and I am a doctoral student in the Ph.D. Program in Educational Psychology at the Graduate School and University Center of the City University of New York (CUNY). I invite you to participate in a study to see whether or not matching clients with counselors/therapists of similar cultures will have an effect on clients' attendance at and satisfaction with counseling. I hope the results of my study will improve counseling services to clients referred for abuse or neglect. You were selected as a possible participant in this study because you are currently a client of the agency being studied, you were referred by the Administration for Children's Services and you have at least one Indicated case of child abuse and/or neglect.

If you decide to participate, you will be requested to complete four questionnaires. Two questionnaires will ask about your native language, your ethnic group, your native country, your native foods, etc. The third questionnaire will ask you to provide demographic information, your age, your gender, your level of education, etc. The last questionnaire will ask you about the service you receive from the agency you currently attend. Once you agree to participate in the study, you will be requested to complete the first three questionnaires, prior to your intake session. After completion of the first three questionnaires, you will be requested to return them to me. Upon receipt of the completed questionnaires, I will inscribe the initials of your counselor on the envelope, which will later be transferred to the top right hand corner of each questionnaire.

After your counseling session you will requested to complete the last questionnaire. This procedure will commence at the beginning of your first counseling session and will end at the conclusion of the session. Due to the need to complete these questionnaires, your stay at the agency will be approximately 30 minutes longer than usual, as this is the estimated time it will take to complete all three questionnaires. However, not everyone that completes the questionnaires will be included in the study, since after review of the demographic questionnaire, some of you may not qualify. Qualification is dependent on some specific criteria, i.e., has at least one indicated case, receiving individual counseling, not court mandated, referred by Administration for Children's Services, not receiving counseling from another agency, etc. Additionally, your counselor will be requested to perform a client assessment, at the beginning of each counseling session, and provide the results to me. Also your counselor will notify me of any new allegations of abuse or neglect you receive.

There are no risks involved in this study other than those encountered in everyday life. Your participation in this study will not affect your services at the agency. The information that you tell me on the questionnaires will be confidential. I will be the only one to see it and I will not share it with anyone. I will combine your information with information that I receive from other clients to complete my study. Should the study be published, information would be provided in such a way that you cannot be identified. You will not be identified in any publication or presentation of the study findings. When presenting the findings of this study only group scores will be reported.

Should you desire a summary of the research findings, please check the box at the bottom of the Client Satisfaction Questionnaire and provide the address to which you want the correspondence mailed.

Your decision whether or not to participate will have no effect on your future relations with your counselor or the agency you now attend. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time with no consequences.

If you have questions about this research, you may contact me at 718-467-3741 or abarow@gc.cuny.edu., or my advisor Georgiana Tryon at 212-817-8285 or Gtryon@gc.cuny.edu. If you have questions about your rights as a participant in this study, you can contact Kay Powell, IRB Administrator, The Graduate Center/City University of New York, (212) 817-7525, kpowell@gc.cuny.edu.

You were given a copy of this form to keep.

You are making a decision whether or not to participate. Your signature indicates that, having read the information provided above, you have decided to participate.

…………………………………..　　　　　　　　…………………………….

Signature of Research Participant　　　　　　　　Signature of Investigator

……………………………………..　　　　　　　　…………………………...

(Please PRINT name)　　　　　　　　Print Name

………………………………..

Date

Appendix K

Script of Conversation with Clients

Hello,

My name is Arlene Barrow. I am not an employee or representative of the agency, but rather a graduate doctoral student carrying out a study as part of the requirement for graduation. To prove my status as a graduate student, here is a copy of my validated student identification card. Please be advised that your failure to participate in the study will have absolutely no impact on your relationship with the agency and you are not obligated to participate. If you decide to participate, then you are free to withdraw your consent and to discontinue participation at any time without prejudice. Additional forms (questionnaires) are not required as part of the intake process but are necessary for the study I am conducting. Additionally, the Agency has a standard set of forms that each client *must* complete in order to receive counseling services from the agency. However, the questionnaires being distributed by me are different from the agency forms and have no impact on service provision, as they will only be used for the study and only I would have access to the completed questionnaires. No agency staff, not even the director, would have access to any of the forms you complete.

Appendix L

Script of Conversation with Counselor

As you are aware, my name is Arlene Barrow, and I am a doctoral student in the Ph.D. Program in Educational Psychology at the Graduate School and University Center of the City University of New York (CUNY). I am inviting you to participate in a study to see whether or not matching clients with counselors/therapists of similar cultures will have an effect on clients' attendance at and satisfaction with counseling. I hope the results of my study will improve counseling services to clients referred for abuse or neglect. I am soliciting you as possible participant in this study because some of your clients fit the criteria of those I am studying.

If you decide to participate, the agency receptionist will give you two questionnaires to complete. The questionnaires will ask about your native language, your ethnic group, your native country, your native foods etc. The estimated time required to complete both questionnaires is 15 to 20 minutes. Additionally, you will be required to perform a client assessment, at the beginning of each counseling session, and provide me with a GAF score upon conclusion of the session. You must write the client's name on the top right hand corner of the paper on which you write the score, place it a sealed envelope and give it to the receptionist immediately following the conclusion of the session.

There are no risks involved in this study other than those encountered in everyday life. Your participation in this study will not affect employment at the agency. The information that you tell me on the questionnaires will be confidential. I will be the only one to see it and I will not share it with anyone. I will combine your information with

information that I receive from other counselors to complete my study. Should the study be published, information would be provided in such a way that you cannot be identified. You will not be identified in any publication or presentation of the study findings. When presenting the findings of this study only group scores will be reported.

Should you desire a summary of the research findings, please check the box at the bottom of the Multi-Group Ethnic Identity Measure and provide the address to which you want the correspondence mailed.

Your decision whether or not to participate will not prejudice your future relations with your clients or the agency where you are now employed. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

If you have questions about this research, you may contact me at 718-467-3741 or abarow@gc.cuny.edu., or my advisor Georgiana Tryon at 212-817-8285 or Gtryon@gc.cuny.edu. If you have questions about your rights as a participant in this study, you can contact Kay Powell, IRB Administrator, The Graduate Center/City University of New York, (212) 817-7525, kpowell@gc.cuny.edu.

You will be given a copy of this form to keep.

Appendix M
Global Assessment Scale

Please rate your client's level of functioning in the last week by selecting a number, within the range, that described her functioning on a hypothetical continuum of mental health issues. For example, a client whose "behavior is considerably influenced by delusions" (range 21-30) should be given a number within that range (eg. 25). Rate actual functioning independent of whether or not client is receiving and may be helped by other forms of treatment. Please indicate rating in box below:

Range	Description
100–91	No symptoms, superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his warmth and integrity.
90–81	Transient symptoms may occur, but good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, "everyday" worries that only occasionally get out of hand.
80–71	Minimal symptoms may be present but no more than slight impairment in functioning, varying degrees of "everyday" worries and problems that sometimes get out of hand.
70–61	Some mild symptoms (eg, depressive mood and mild insomnia) OR some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him "sick."
60–51	Moderate symptoms OR generally functioning with some difficulty (eg, few friends and flat affect, depressed mood, and pathological self-doubt, euphoric mood and pressure of speech, moderately severe antisocial behavior).
50–41	Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (eg, suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious antisocial behavior, compulsive drinking).
40–31	Major impairment in several areas, such as work, family relations, judgment, thinking, or mood (eg, depressed woman avoids friends, neglects family, unable to do housework), OR some impairment in reality testing or communication (eg, speech is at times obscure, illogical, or irrelevant), OR single serious suicide attempt.
30–21	Unable to function in almost all areas (eg, stays in bed all day), OR behavior is considerably influenced by either delusions or hallucinations, OR serious impairment in communication (eg, sometimes incoherent or unresponsive) or judgment (eg, acts grossly inappropriately).
20–11	Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (eg, repeated suicide attempts, frequently violent, manic excitement, smears feces), OR gross impairment in communication (eg, largely incoherent or mute).
10–1	Needs constant supervision for several days to prevent hurting self or others, or makes no attempt to maintain minimal personal hygiene.

Appendix N

Client Behavior Rating Scale

This questionnaire assesses clients' progress toward their treatment goals. Please use the numbers below to indicate your agreement or disagreement with each statement. Check the circle next to each item that best reflects your assessment of the client's progress.

Client's Name: _______________

	4 Strongly Agree	3 Somewhat Agree	2 Somewhat Disagree	1 Strongly Disagree
Client is better able to manage her/his anger	4	3	2	1
Client is aware of non-aggressive alternative methods of discipline	4	3	2	1
Client is likely to use non-aggressive alternative methods of discipline	4	3	2	1
Client is less likely to use force as a method of discipline	4	3	2	1
There is reduced risk of abuse/neglect incidents	4	3	2	1
There has been improvement in client's prosocial problem solving skills	4	3	2	1
There has been improvement in communication between client and other household members	4	3	2	1

Did this client receive any new allegations of abuse or neglect?

Yes **No**

Appendix O

Frequencies and Percents for Clients' Ethnicity for Clients Who Volunteered But Did n=Not Meet Criteria for Participation.

Ethnicity	Frequency	Percent
African American	4	0.22
African	0	0.0
American	1	0.06
British	0	0.0
East Indian	0	0.0
Latino(a)	4	0.22
Spanish	0	0.0
West Indian	9	.50
Total	18	100

Appendix O

Frequencies and Percents for Clients' Race of Those who Volunteered But Did Not Meet Criteria for Participation in the Study

Race	Frequency	Percent
Black	12	0.67
Hispanic	5	0.27
East Indian	0	0.0
White	1	0.06
Total	18	100.0

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