

**FLORIDA INTERNATIONAL UNIVERSITY**

**Miami, Florida**

**DEVELOPMENT OF A MULTICULTURAL COMPETENCE  
DIAGNOSTIC TOOL FOR NUTRITION PROFESSIONALS:  
ASSESSING TRAINING NEEDS**

**A thesis submitted in partial satisfaction of the**

**requirements for the degree of**

**MASTER OF SCIENCE**

**IN**

**DIETETICS AND NUTRITION**

**by**

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**1996**

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I dedicate this thesis to my parents, Francesco and Yoko, my husband, Gil, and my brother, Vincenzo, for all their love, support, and understanding. Without them, the completion of this work would not have been possible.

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## **ABSTRACT OF THE THESIS**

### **DEVELOPMENT OF A MULTICULTURAL COMPETENCE DIAGNOSTIC TOOL FOR NUTRITION PROFESSIONALS: ASSESSING TRAINING NEEDS**

by

**Anna Delfina Giannella**

**Florida International University, 1996**

**Professor Katharine Curry, Major Professor**

Multicultural competence assessment among nutrition professionals has become essential in delivering effective nutrition counseling services to people who come from a variety of ethno-racial and cultural backgrounds. The purpose of the present research was to develop and test the reliability and validity of an instrument to measure multicultural counseling awareness, knowledge, and skills among nutrition professionals. A 52-item survey with a demographics section of 11 questions was developed and administered to 71 participants (n=71). Respondents included students from the Approved Preprofessional Practice Program (n=7) and Coordinated Undergraduate Program (n=22), and dietitians from the dietetic associations of Dade County (n=22), Broward County (n=7), and West Palm Beach County (n=9). Results indicated higher multicultural awareness than multicultural skills and knowledge among participants. Students' scores were compared to dietitians' scores and no significant differences were found. Overall, the proposed tool was proven to be reliable and valid in assessing multicultural competence among nutrition professionals.

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# CHAPTER I

## INTRODUCTION

The purpose of the present study was to develop and test the reliability and validity of an instrument to measure multicultural competence/sensitivity among nutrition professionals. A 52-item survey was developed and divided into three subscales that provide measures of multicultural counseling awareness, knowledge and skills. This survey is a diagnostic instrument to assess multicultural training needs as an aid in educational program development.

Cultural competence and cultural sensitivity are often used interchangeably in the literature and have been variously defined by authors. Cultural competence can be defined as a set of academic and interpersonal skills that allows individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups (1). Cultural sensitivity can be defined as the recognition that cultural differences as well as similarities exist, that both are valued, and that there is no right or wrong cultural difference; they are just different (2). For the purposes of the present research, these terms will appear as synonymous as they often appear in the multicultural literature.

According to Sue, the changing demographics of the United States presents many new challenges to counselors-educators. These challenges are rooted in a growing awareness that the United States is rapidly becoming transformed as a country in which the majority of its citizens come from a variety of minority groups (3). By year 2000, US

population trends indicate a shift toward an older and more culturally diverse population (4). Projections show that by the year 2000, more than one third of the population will be racial and ethnic minorities. By the year 2010, racial and ethnic minorities will become a numerical majority, with White Americans constituting approximately 48% of the population (5).

The United States population trend towards diversification certainly adds to the rationale and need for not only a multicultural perspective, but also the actual need to measure cultural competence/sensitivity among counseling professionals. It is becoming obvious that the awareness and understanding of different cultures is an invaluable aspect of any profession that involves dealing with people.

According to Gim et al and McWhirter, cultural sensitivity facilitates therapy and results in better outcomes for diverse clientele, while cultural insensitivity reduces therapy effectiveness (6, 7). Therefore, culturally sensitive therapists are the ones who will thrive and succeed within a society where cultural diversity has become a major trend.

In order to better understand other people's cultures, the first step is to become aware of our pattern of thinking, feeling and behaving, which determines our own cultural framework, from which everything stems in our lives. Oftentimes, we think of people being different from ourselves, inferior or superior, just by the way they appear, behave, think or speak. Rarely do we think and begin to understand that they might be coming from a different cultural background, and that for this reason might have been exposed to a different native environment.

According to Barer-Stein , food is only one aspect of ethnocultural traditions, yet it is one of the most persistent (8). Food plays an inextricable role in our daily lives. Without food we cannot survive. But food is much more than a tool of survival. Food is a source of pleasure, comfort, security. Food is also a symbol of hospitality, social status, and has ritual significance. What we select to eat, how we prepare it, serve it, and even how we eat it, are all factors deeply touched by our individual cultural inheritance (8).

As mentioned previously, food is only one facet of culture. However, its relationship to the well being and health, both physical and psychological cannot be denied. Food, in the context of social group, is used to reinforce cultural values and enhance social unity. Beliefs about food have also been incorporated into many religious practices (8 ).

Food means different things to different people. The food habits and patterns are developed, learned and shared by members of a group. Food patterns are more varied in the South than in any other region of the United States because of the great ethnic diversity of the South, particularly in Florida (9).

According to the US Census of 1980, the highest percent of foreign born population is found in Miami (35.3%), followed by Los Angeles (22.3%), New York (21.3%), San Francisco (15.7%), San Diego (12.7%) and Chicago (10.5%) (10). The diverse ethnic mix in Miami includes Americans from many descents, African Americans, Cubans, Haitians, Bahamians, Jamaicans, South and Central Americans, Asians, Europeans, among others.

## **Research Questions**

The uniqueness of South Florida's ethnic mix along with US population trends and the importance of food as one facet of culture, have brought up the importance of dealing with multicultural issues. Therefore, the following research questions were formulated for the present study:

- 1- The 52-item survey proposed in this study will be found to be a reliable tool in assessing multicultural competence/sensitivity among nutrition professionals.
- 2- The 52-item survey proposed in this study will be found to be a valid tool in assessing multicultural competence/sensitivity among nutrition professionals.
- 3- The degree of multicultural competence/sensitivity among nutrition professionals will be found to increase with years of dietetic practice.

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **Conceptualizations of culture**

In order to understand multicultural counseling and development, it is important to define the concept of culture. In the current literature many definitions of culture can be found. According to one of the many definitions, culture can be defined as the learned patterns of thinking, feeling and behaving that make life meaningful for a particular group of human beings (11). These learned patterns are determined primarily by the surrounding environment to which a certain group of people is exposed. Therefore, there is simply no best culture. Every culture is valid, because it serves a purpose of making life meaningful for a particular group of people (11). Cultural heritage offers not only a sense of collective identity, but a sense of pride and dignity, purpose and stability, to everyday life (11).

Myers defined culture as a way of life of a people. He indicated that such a definition is indestructible because as long as there are people, they will have a way of life (12). Elliot defined the culture of an individual as being dependent on the culture of a group or class, and the culture of that group or class being dependent on the society to which that group belongs (13).

Many culture experts have distinguished between objective and subjective culture. According to Hines and Pedersen, there is a distinction between objective and subjective

culture. Objective culture refers to the observable behavioral expressions that are culturally learned or derived (e.g. dress, food, music, language). Subjective culture refers to the internalized feelings, attitudes, opinions, and assumptions members of a culture hold (14).

Triandis defines subjective culture as a cultural group's characteristic way of perceiving the man-made part of the environment. The perception of rules and the group's norms, roles, and values are aspects of subjective culture... People who live next to one another, speak the same dialect, and engage in similar activities are likely to share the same subjective culture (15). Yet, according to Brislin "culture refers to the widely shared ideas, values, formations and uses of categories, assumptions about life, and goal-directed activities that become unconsciously or subconsciously accepted as 'right' or 'correct' by people who identify themselves as members of a society... A society is sometimes a country (e.g. Japan), sometimes a more delimited segment of society (e.g. the middle class in the US), and sometimes an ethnic group within a large country (e.g. Polish-Americans, or Palestinian Arabs living in Israel)" (16).

### **Definition of multicultural/cross-cultural counseling**

According to Sue et al., cross-cultural counseling has been defined as "any counseling relationship in which two or more of the participants differ in cultural background, values, and lifestyle" (17). Yet, according to Fukuyama, the use of the term cross-cultural implies a comparison between two groups (i.e., the "standard group" and the "culturally different group"). Therefore, in order to adopt a broader and inclusive

view, the term multicultural seems to be more effectively used to define this broad view that cross-cultural counseling encompasses (18).

According to Pedersen, every counseling encounter is multicultural in some aspect because all humans differ in terms of cultural background, values or life styles (19).

Atkinson et al identified multicultural counseling as any counseling relationship in which the participants represent differing ethnic or minority groups or in which “the counselor and client(s) are racially and ethnically similar but belong to different cultural groups because of other variables such as sex, sexual orientation, socioeconomic factors, and age”(20).

Vontress defines cross-cultural counseling from the perception of cultural differences and similarities: “... if the counselor and the client perceive mutual cultural similarity, even though in reality they are culturally different, the interaction should not be labeled cross-cultural counseling”. Likewise, a culturally similar counselor and client may actually perceive themselves as different from each other, which would constitute a cross-cultural interaction (21).

### **Multicultural/cross-cultural counseling competencies**

The need for developing minimal cross-cultural counseling competencies were first published by the American Psychological Association (APA) Division 17 position paper in 1982 by Sue et al. Specific cross-cultural counseling competencies were identified and recommended to be incorporated into training programs. They were divided up into three dimensions: beliefs and attitudes, knowledge, and skills (17).

According to Pedersen, three components have been identified as important in achieving multicultural counselor competence: awareness, knowledge, and skill development. The first stage involves awareness of culturally learned assumptions, opinions, and attitudes, i.e., the counselor's recognition of the contrasts and conflicts between cultures and the need to develop more accurate and appropriate attitudes, opinions, and assumptions about culture in counseling. The second stage deals with knowledge about relevant facts and information about the culture in question. Knowledge may also include gathering information about the particular social and political history of a group. Thus, providing understanding of the sociopolitical experiences of a racial-ethnic and cultural group. Skill entails developing the ability to interact with persons from another culture (19). This three stage multicultural development process is in accordance to the American Psychological Association (APA) Division 17 position paper previously mentioned (17).

### **Awareness component**

The awareness stage emphasizes assumptions of differences and similarities of behavior, attitudes, and values. Our basic assumptions determine how we see the world. Each person's assumptions are unique. They constitute culture within the person and are not external. The purpose of the multicultural counseling awareness is to identify assumptions of cultural bias that were not consciously recognized before (19). Oftentimes, behaviors and attitudes manifested by the counselor at a level of unawareness may promote, unknowingly, underlying and implicit assumptions that have profound effects upon others (22).

Pedersen identified the ten most frequently encountered examples of cultural bias among counselors about multicultural counseling and development. The first assumption is that people all share a common measure of “normal” behavior, which is more or less universal across social, cultural, and economic or political background. However, normal behavior will change according to the situation, the cultural background of a person or persons being judged, and the time during which a behavior is being displayed or observed (22).

The second assumption places a strong emphasis on individualism, yet the importance of the group, family, organization, or society that the individual belongs to is often taken for granted. Many counselors in the United States use the criteria of self-awareness, self-discovery, and self-fulfillment as measures of success in most counseling situations. Pedersen stated that it is important for counselors to work comfortably and skillfully both in cultures that primarily emphasize the welfare of the individual and in cultures that emphasize the value of the unit (22).

The third frequent assumption is the definition of problems from a framework limited by academic discipline boundaries, i.e., the tendency that counselors have to face the client’s problems from his own discipline perspective only. Oftentimes, the multidisciplinary approach that sees the individual as a whole is forgotten (22).

The fourth assumption is based on Western cultures’ dependence on abstract words and the assumption of counselors in the United States that others will understand these abstractions in the same way as they are intended (22). Concepts such as “good” or

“bad” have little meaning without putting the concept in a contextual setting for many, if not most, of the world’s population (19).

The fifth assumption relates to overemphasis on independence. Independence is valuable and dependence is undesirable. It is often presumed that individuals should not depend on others; nor should the individual allow others to be dependent on them. However, there are many cultures in which dependencies are described as not only healthy but absolutely necessary (22).

The sixth assumption places significant higher importance on formal counseling than on natural support systems, i.e., immediate friends and family. Therefore, a counselor needs to include consideration of a client’s natural support system in an effective treatment plan for counseling (22).

The seventh assumption is based on linear thinking dependence, where each cause has an effect and each effect is tied to a cause. It does not take into consideration that some cultures may just see cause and effect as both being part of the same undifferentiated reality (22).

The eighth assumption focuses on changing the individual to fit the system, instead of trying to change the system to fit the individual. Frequently, the counselor assumes that is much more easier to help the individual adapt to conditions than to make an effort to transform the social institutions (22).

The ninth assumption does not recognize the importance of history in helping solve current problems. Counselors are more likely to focus on immediate events that might have caused the problem (22). It is important to acknowledge that in some cultures

the understanding of past events plays an essential role in understanding present crisis (19).

The tenth assumption is that counselors already know all of their assumptions, which causes a closed mindness and cultural encapsulation. It is necessary that counselors come together and start out recognizing their own assumptions and bring them up to discussion. If counselors choose not to challenge their own cultural biases, they will be less likely to communicate effectively with persons from other cultures (22).

According to Pedersen, the importance of examining culturally learned assumptions must become a more important part of the curriculum in the development of counselors for a world that includes many cultures (22).

### **Knowledge component**

After the culturally biased assumptions are brought up to awareness, the next stage in multicultural development is to acquire cultural knowledge. Pedersen stated that “knowledge, based on awareness of underlying assumptions, is the beginning of understanding” (19). According to Mio, the counselee’s credibility towards the counselor can be significantly increased if counselor’s specific cultural knowledge is improved (23).

According to Arredondo et al and Sue et al, culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions of and biases about normality/abnormality and the process of counseling. They possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally and in their work. They are knowledgeable about the particular group with which they work, and communication

style differences. Moreover, they are knowledgeable about sociopolitical influences on ethnic minorities and are aware of institutional barriers that prevent them from using services (24, 25).

### **Skill component**

The third component of multicultural development is the acquisition of appropriate skills to bring about change. Several training models were developed to increase counselors' multicultural skills. The Triad Model developed by Pedersen, consists of simulated cross-cultural microcounseling interviews. The role-plays consist of a counselor, a client, and a pro-counselor (supportive ally) or an anti-counselor (an antagonistic operator). The pro and the anti-counselors act as internal dialogues of the counselor and the client to highlight salient issues that may affect the interaction between the two (19).

Parker, Valley, and Geary support the importance of all three components of multicultural counseling. They developed the multifaceted approach, which is a combination of assessment of cultural knowledge, review of ethnic literature, personal involvement, and development of small-group projects (26).

According to Sue, Arredondo & McDavis, culturally skilled counselors seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally different populations. They are able to engage in a variety of verbal and nonverbal helping responses. They make appropriate referrals when their linguistic skills do not match the language of the client (25).

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## **Multicultural competence and nutrition professionals**

According to Farkas, in order to enhance the efficacy of nutrition education counseling, practitioners need to understand the culture with which they work. It is emphasized that if the nutrition counselor and the client belong to distinct cultural backgrounds and there is no adjustment of communication patterns, nutrition education interaction can be influenced. The two ethnic groups considered in this study were Native Canadian clients who were members of the Ojibwa and Cree tribes, and nutrition educators who were non-Native Euro-Canadians. Although both client and nutrition educator spoke English, for many Native Canadians English was a second language. It was concluded that ethno-specific communication patterns of the sender (nutrition educator) may enhance or hinder mutual understanding during a cross-cultural interaction (27).

DeGariné, Hertzler et al., Nichter and Nichter, and Wilson pointed out that nutrition educators must go beyond the culture's food habits and eating practices when cross-cultural counseling is concerned. They must understand the symbolic meaning of food within the culture (28, 29, 30).

Jackson and Broussard stated that health care providers need to recognize and respect clients' cultural backgrounds and adjust counseling, education, and treatment programs accordingly (31). Story and Harris also emphasized the importance of developing sound ethnic nutrition education materials, so that informed decisions can be made (32).

Kittler and Sucher listed four steps for successful cross-cultural counseling: self-evaluation, pre interview research, in-depth interview, and unbiased data analysis. The first step identifies the culturally biased assumptions made within a determined culture. One example of dietary cultural bias involves classifying foods according to which are considered edible and which are not. Health professionals should become familiar with how they personally categorize foods, and what is considered a normal meal pattern for themselves. By doing this, they can avoid imposing their own bias and assumptions into the counseling setting. The second step focuses on cultural background. The health practitioner searches for basic knowledge of country of origin, religious food practices, and health beliefs. The third step is the in-depth interview. It should be used to establish the client's cultural background, adaptations made in the US, personal preferences, socioeconomic status. The last step will be the unbiased assessment of the information obtained. Practitioners should avoid ethnocentric assumptions and make an informed decision about the therapy to be implemented (33). The best counseling outcomes are achieved when the counselor is aware of his personal cultural assumptions, is knowledgeable about the cultural heritage of a client, and conducts the session within accepted communication patterns determined by the client's cultural background.

### **Multicultural competency instruments**

#### **The multicultural awareness - knowledge - and skills survey (MAKSS)**

The MAKKS is a self-administered written test developed by D'Andrea, Daniels, and Heck. The MAKSS consists of a total of 60 items that are equally divided into three sub-scales. The questions on the survey are represented in a multiple-choice format, with

8 additional items covering demographic information. Besides addressing participants' demographic characteristics, the other 60 items are designed to obtain a measure of participants' perceptions of their level of multicultural counseling awareness, knowledge, and skills (34).

### **The multicultural counseling inventory (MCI)**

The MCI is a self-report measure of multicultural competence. Three factors of the MCI - Multicultural Counseling Skills, Multicultural Awareness, and Multicultural Counseling Knowledge - are comparable to the three broad competencies defined by Sue et al (17). However, Multicultural Counseling Relationship was identified as an additional factor. The MCI authors agree that the instrument needs to be further validated and suggest that the MCI could be jointly administered with other multicultural competence instruments (35).

### **Cross-cultural competency inventory (CCCI) and cross-cultural competency inventory-revised (CCCI-R)**

The CCCI developed by Hernandez and LaFramboise (36) and the CCCI-R developed by LaFramboise et al (37) are considered rating scales of multicultural counseling competency measures.

### **Multicultural counseling awareness scale - Form B (MCAS-Form B)**

The MCAS - Form B is a 45-item self-report tool and builds upon and extends the work of the CCCI-R (38).

## **CHAPTER III**

### **METHODOLOGY**

As mentioned earlier, a 52-item survey in addition to a demographics section of 11 questions was developed. This multicultural competence diagnostic tool for nutrition professionals was designed to measure an individual's multicultural counseling awareness, knowledge and skills. It was divided into three subscales. Items #1-18 provided a measure of multicultural counseling awareness; items #19-39 provided a measure of multicultural counseling knowledge; items #40-52 provided a measure of multicultural counseling skills. The instrument is in accordance to the American Psychological Association Division 17 position paper on cross-cultural counseling competencies (17). The multicultural competence/sensitivity survey for nutrition professionals was developed based on the MAKSS created by D'Andrea et al (34). Survey results are to be used in assessing multicultural training needs and development of educational programs.

#### **Subjects and data collection**

Prospective subjects included Senior dietetic students (n=22), Approved Preprofessional Practice Program students - AP4 (n=7), Miami Dietetic Association nutrition professionals (n=22), Broward County Dietetic Association nutrition professionals (n=7), West Palm Beach Dietetic Association nutrition professionals (n=9), and subjects unidentified as to County specific Dietetic Association affiliation (n=4). A total of 71

participants answered the Multicultural Competence/Sensitivity Survey for nutrition professionals.

The multicultural competence/sensitivity survey was administered at a monthly dietetic association meeting for Dade County and at a joint dietetic association meeting for Broward and West Palm Beach counties. Respondents had a choice to mail their responses in a self-addressed envelope or return it at the end of the meeting. Senior students and AP4 students completed the survey at the end of the graduating semester.

### **Instrument and statistical analysis**

Permission to utilize the MAKSS by D'Andrea et al was obtained and the items number 1, 3, 8, 12, 21, 22, 25, 26, 27, 32, 38, 41 were used verbatim in the present study (30). The awareness subscale (items 1 through 19) of the present study was drawn upon the ten most frequent assumptions of cultural bias according to Pedersen (22). The knowledge subscale (items 20 through 39) had two sections. The first section (items 19 - 31) was created based on the eating patterns of the South Florida ethnic mix (9). The second section (items 32 to 39) were utilized verbatim from the MAKSS by D'Andrea et al. The skills subscale (items 40 through 52) was based on Bartley's book (39) and questions 45, 46, 50 and 51 were utilized verbatim from MAKSS by D'Andrea et al (34).

In order to develop a reliable and valid instrument, the questionnaire was reviewed by a chosen panel of experts composed of 9 professionals involved with counseling and multicultural issues. Realistic evaluations and insightful impressions were provided. The panel identified questions that were hard to read as written or that were hard for respondents to understand. Inappropriate sequencing of questions was also identified and corrected.

The measuring device was a self-administered survey through the use of a questionnaire. The self-administered questionnaire was self-explanatory and restricted to closed answers. Circling the answers was the only task required. The questionnaire was designed to be clear and uncluttered.

Subjects who completed the survey were provided two or four options in responding to items. The two-option items allowed respondents to circle T (true) or F (false), and the four-option items were ranked on a Likert-type scale from 1 to 4.

Scoring instructions for the present instrument were based on the MAKSS by D'Andrea et al (34). A score of 1 indicated "very limited" or "strongly disagree", a score of 2 indicated "limited" or "disagree", a score of 3 indicated "good" or "agree", and a score of 4 indicated "very good" or "strongly agree". As to the true and false items, a score of 1 indicated desirable answer (right answer), and a score of 2 indicated undesirable answer (wrong answer). Answers that were left blank received a score of zero. Reversed scoring procedures applied to items number 6, 15, 44, 45, 46, and 47.

In order to calculate the total subscale scores, individual item scores comprising each subscale were summed (Items # 1-18 = awareness, items # 32- 39 = knowledge, items # 40-52 = skills) and the sum was divided by the number of items in each subscale to generate three mean subscale scores. For the true and false items, percentage of right and wrong answers were calculated.

To determine reliability of items on the subscales, Cronbach's alpha coefficient (a measure of internal consistency) was calculated for the three subscales. A calculation of .70

was a generally accepted level of reliability for the subscales, according to the scoring instructions for the MAKSS (34).

In order to test whether each subscale is distinct, correlation coefficients between the scales were determined by using Pearson r coefficient. Lower correlation between the subscales suggested that they were distinct measures of multicultural counseling awareness, knowledge, and skills and supports construct validity. This followed the scoring procedures used for the MAKSS (34).

Frequencies and percentages were calculated for the demographics section. T-tests were used to compare mean differences between professionals and students. All statistical analyses were performed using SPSS computer software.

### **Limitations of the Study**

This study is limited by the utilization of non-probability sampling. Small sample sizes were obtained from diverse groups, and only from respondents that were available and volunteered at the time. Therefore, results cannot be extrapolated or representative of nutrition professionals in southeastern Florida, the state of Florida or the United States. The sample may also have been influenced by the fact that great number of the respondents reside in a county with a very culturally diverse population.

## CHAPTER IV

### RESULTS

#### Characteristics of Respondents

The group of respondents was comprised of Florida International University Approved Pre Professional Practice Program students - AP4 students (10.4%), Coordinated Undergraduate Program Students - CUP students (32.8%), Miami Dietetic Association - MDA (32.8%), Broward Dietetic Association - BCDA (10.4%), and West Palm Beach Dietetic Association (13.4%). There were 4 subjects who did not identify themselves as to county dietetic association affiliation. Therefore, they were not included in the summary of frequencies and percentages that appear in Table 1. Seventy one questionnaires were used for data analysis.

**Table 1**

#### Affiliations of respondents

<i>Category</i>	<i>Frequency</i>	<i>Percent (%)</i>
AP4 Students	7	10.4
CUP Students	22	32.8
MDA Dietitians	22	32.8
BCDA Dietitians	7	10.4
WPBC Dietitians	9	13.4
<b>Total</b>	<b>67</b>	<b>100</b>

The Majority of respondents were female (95.8%). Most of them held a Bachelor's degree (50.7%), 17.4% held an Associate degree, 24.6% held a Master's degree, and 7.2% reported having a Post Graduate degree. Respondents' frequencies and percents according to educational levels are summarized in Table 2. There were 2 missing responses for this category. Therefore, they were not included in the percentages.

**Table 2**

**Educational levels of respondents**

<i>Educational Level</i>	<i>Frequency</i>	<i>Percent(%)</i>
Associate Degree	12	17.4
Bachelor's	35	50.7
Master's	17	24.6
Post Graduate	5	7.2
<b>Total</b>	69	100

Age of participants were divided into three ranges with respective frequencies and percentages depicted in Table 3. All participants answered this question.

**Table 3**

**Age range of respondents**

<i>Age</i>	<i>Frequency</i>	<i>Percent(%)</i>
< 25 years	17	23.9
26 - 40 years	26	36.6
> 41 years	28	39.4
<b>Total</b>	71	100

Respondents were also classified according to professional status. The categories included were as follows: registered dietitian, licensed dietitian, nutritionist, registered dietitian eligible, diet technician registered and other ( in training, AP4, CUP, MS student). Respondents had a choice to mark one answer. Therefore, the answers reflected respondents' perceptions of professional status. Respective frequencies and percentages appear in Table 4 and there were no missing answers to this question.

**Table 4****Professional status of respondents**

<i>Professional Status</i>	<i>Frequency</i>	<i>Percent(%)</i>
R.D.	35	49.3
L.D.	3	4.2
Nutritionist	1	1.4
R.D.E.	1	1.4
D.T.R.	8	11.3
AP4/CUP/Students	23	32.4
<b>Total</b>	71	100

Years of dietetic practice were also compiled. A total of 8.5% answered that they were not currently practicing, 38% have been practicing for less than 3 years, 16.9% have been practicing for 4 to 10 years, and 36.6% have been practicing for more than 11 years. Results are summarized in Table 5. There were no missing answers to this question.

**Table 5****Years of practice**

<i>Years of Practice</i>	<i>Frequency</i>	<i>Percent(%)</i>
Not practicing	6	8.5
< 3 years	27	38
4 - 10 years	12	16.9
> 11 years	26	36.6
<b>Total</b>	71	100

Work status results are shown in Table 6. There were no missing answers. A total of 38% of respondents worked on a full-time basis and 38% worked on a part-time basis. It was found that 23.9% of respondents worked other than on a full-time or part-time basis. Results are shown in Table 6.

**Table 6****Employment status**

<i>Work status</i>	<i>Frequency</i>	<i>Percent (%)</i>
Part-time	27	38
Full-time	27	38
Other	17	23.9
<b>Total</b>	71	100

According to place of employment, it was found that 38% of respondents worked in hospitals, 5.6% worked in private practice, 5.6% worked in public health, 9.9% worked in education, and 28.2% were AP4 students, CUP students, and other students. A total of 12.7% worked in occupations other than dietetics practice. Frequencies and percentages are summarized in Table 7 and there were no missing responses for this question.

**Table 7**

**Place of employment**

<i>Facility</i>	<i>Frequency</i>	<i>Percent (%)</i>
Hospital	27	38
Private practice	4	5.6
Public health	4	5.6
Education	7	9.9
Student	20	28.2
Other	9	12.7
<b>Total</b>	71	100

Information on respondents' annual incomes was compiled. It was found that over 57.8% of respondents had an income of less than \$30,000 dollars per year. Details on annual income brackets can be found in Table 8. There were 11 missing answers to this question.

**Table 8**

**Annual income**

<i>Annual income</i>	<i>Frequency</i>	<i>Percent</i>
0 - 10,000	9	12.7
10,001 - 20,000	12	16.9
20,001 - 30,000	20	28.2
30,001 - 40,000	11	15.5
40,001 - 50,000	5	7.0
> 50,001	3	4.2
<b>Total</b>	60	100

Respondents were grouped according to citizenship. A total of 88.7% were American citizens and 8.5% were not American citizens. There were two missing answers for this question. In addition, information on number of years respondents have been living in South Florida was collected. It was found that the majority (76.1%) have been living in South Florida for over 6 years. Results are summarized in the table 9. There were 2 missing answers for this question.

**Table 9**

**Years in South Florida**

<i>Years in South FL</i>	<i>Frequency</i>	<i>Percent (%)</i>
0 - 2 years	5	7
2.1 - 5.0 years	8	11.3
5.1 - 6 years	2	2.8
> 6 years	54	76.1
<b>Total</b>	69	100

**Non-statistical results - Ethnicity and cultural background**

Thirty two categories were generated by the answers provided by the respondents in the demographics section. Respondents perceived themselves in unique ways. The description of the cultural background was not limited to nationality. Their answers were mostly generated based on country of origin and ethno-racial inheritance. Some respondents included religion as well. These 32 categories are shown in Table 10. There were 7 missing responses.

**Table 10****Ethnicity**

<i>Ethnicity</i>	<i>Frequency</i>	<i>Percent (%)</i>
WASP	5	7.8
American	10	15.6
Jamaican	3	4.7
Hispanic	4	6.25
French American	1	1.6
Portuguese	1	1.56
Cuban American	1	1.56
Caucasian/European decent	4	6.25
White Hispanic	4	6.25
Hispanic Nicaraguan	1	1.56
Anglo	2	3.13
Black Jamaican	1	1.56
White Non-Hispanic	2	3.13
African American	2	3.13
Jewish	1	1.56
Irish American Catholic	1	1.56
Trinidadian Mixed	1	1.56
Russian German	1	1.56
White Irish German	1	1.56
White	2	3.13
White American	5	7.8
German American	1	1.56
White Cuban	1	1.56
Hillbilly	1	1.56
Slovenian American	1	1.56
American Jewish	1	1.56
Greek American	1	1.56
Brazilian Caucasian	1	1.56
Jewish/Russian/English	1	1.56
Anglo Saxon Czech	1	1.56
Middle Eastern	1	1.56
Anglo White/American Indian	1	1.56
<b>Totals</b>	<b>64</b>	<b>100</b>

## **Awareness Subscale**

Means and standard deviations for the multicultural awareness subscale were calculated for items 1 through 18 (see Table 11). All questions for the proposed tool are found in Appendix A.

Item 1 stated that culture is not external, but is within the person. The mean score was  $2.84 \pm .86$  and 67 responses were obtained for that question. A total of 65.7% of respondents either agreed or strongly agreed with the statement and 34.4% either disagreed or strongly disagreed.

Item 2 had respondents evaluate awareness of their own cultural values and biases and how they affected the way they think and behave. The mean score was  $3.35 \pm .51$  and 68 responses were obtained for that question. A total of 98.6% of respondents either agreed or strongly agreed with the statement. Only one respondent disagreed with the statement.

Item 3 had respondents evaluate if they consider themselves culturally sensitive. The mean score was  $3.30 \pm .69$  and 69 responses were obtained for that question. A total of 92.8% of respondents either agreed or strongly agreed with the statement. A total of 7.2% disagreed or strongly disagreed.

Item 4 had respondents evaluate their ability to compare different cultural perspectives including their own culture. The mean score was  $3.37 \pm .64$  and 70 responses were obtained. A total of 97.2% of respondents agreed or strongly agreed and 2.9% strongly disagreed.

Item 5 stated that people from different cultures behave differently about food. The mean score was  $3.64 \pm .51$  and 70 responses were obtained. A total of 98.6% of respondents agreed or strongly agreed and one respondent disagreed.

Item 6 had the scoring reversed. It stated that the important measures of success in most counseling situations are client self-awareness, self-fulfillment, and self-discovery. The mean score was  $1.5 \pm .61$  and 70 responses were obtained. The majority agreed or strongly agreed (97.2%), and two respondents disagreed or strongly disagreed.

Item 7 had respondents evaluate their awareness of the changing demographics of the United States. The mean score was  $3.39 \pm .67$  and 70 responses were obtained. A total of 92.8% respondents agreed or strongly agreed and 7.1% disagreed or strongly disagreed.

Item 8 stated that multicultural counseling skills are relevant to the dietetics and nutrition practitioner. The mean score was  $3.76 \pm .43$  and 70 responses were obtained. A total of 75.7% respondents strongly agreed and 24.3% agreed. There was no disagreement to that statement.

Item 9 stated that food is used to reinforce cultural values and enhance social unity. The mean score was  $3.61 \pm .57$  and 69 responses were obtained. A total of 95.6% respondents agreed or strongly agreed and 4.3% disagreed.

Item 10 stated that nutrition counseling can be influenced by client's religious beliefs. The mean score was  $3.68 \pm .47$  and 69 responses were obtained. All respondents either agreed or strongly agreed.

Item 11 had respondents evaluate their willingness to experiment with foods and flavors that are different from those of their cultural background. The mean score was 3.43

$\pm .73$  and 70 responses were obtained. A total of 91.4 % of respondents agreed or strongly agreed and 8.6% disagreed or strongly disagreed.

Item 12 stated that dietetics and nutrition practitioners should know about ethnic cuisines. The mean score was  $3.79 \pm .41$  and 70 responses were obtained for . All respondents agreed or strongly agreed with the statement.

Item 13 question stated that the US Dietary Guidelines and the Food Guide Pyramid can be adapted to the nutritional needs of any ethnic group. The mean score was  $3.24 \pm .60$  and 70 responses were obtained. A total of 8.6% of respondents disagreed and 91.6% agreed or strongly agreed.

Item 14 question had respondents evaluate their familiarity with the health problems of minorities. The mean score was  $3.06 \pm .59$  and 70 responses were obtained. A total of 88.6% agreed or strongly agreed and 11.4% disagreed or strongly disagreed.

Item 15 had the scoring reversed. It stated that assertiveness is a desirable characteristic regardless of cultural background. The mean score was  $1.87 \pm .77$  and 68 responses were obtained. A total of 17.6% disagreed or strongly disagreed and 82.3% agreed or strongly agreed.

Item 16 had respondents evaluate if they make judgments before trying new foods. The mean score was  $2.93 \pm .73$  and 70 responses were obtained. A total of 72.8% agreed or strongly agreed and 57.1% disagreed or strongly disagreed.

Item 17 stated that multicultural training should be part of dietetics and nutrition education programs. The mean score was  $3.64 \pm .48$  and 70 responses were obtained. All respondents agreed or strongly agreed to the statement.

Item 18 stated that the acquisition of ethnic knowledge helps dietetics professionals attain positive counseling outcomes with different ethnic groups. The mean score was  $3.67 \pm .47$  and 70 responses were obtained. All participants agreed or strongly agreed with the statement.

Results on the awareness subscale are summarized in Table 11 as follows:

**Table 11**

**Awareness Scale**

<i>Item #</i>	<i>Mean ± SD</i>	<i>n</i>	<i>Minimum</i>	<i>Maximum</i>
1	2.84 ± .86	67	1	4
2	3.35 ± .51	68	2	4
3	3.30 ± .69	69	1	4
4	3.37 ± .64	70	1	4
5	3.64 ± .51	70	2	4
6*	1.50 ± .61	70	1	4
7	3.39 ± .67	70	1	4
8	3.76 ± .43	70	3	4
9	3.61 ± .57	69	2	4
10	3.68 ± .47	69	3	4
11	3.43 ± .73	70	1	4
12	3.79 ± .41	70	3	4
13	3.24 ± .60	70	1	3
14	3.06 ± .59	70	1	4
15*	1.87 ± .77	68	1	4
16	2.93 ± .73	70	1	4
17	3.64 ± .48	70	3	4
18	3.67 ± .47	70	3	4
<b>Overall</b>	3.15 ± .23	70	2.67	3.65

Note: n indicates total number of responses to that question.

SD indicates standard deviation.

\* indicates reversed scored questions.

## **Knowledge subscale**

The multicultural knowledge subscale had two sections. Items 19 through 31 were true or false questions. Items 32 through 39 were rated according to respondents' perceptions of their understanding of cultural terms.

Item 19 stated that dietary adequacy generally varies with ethnic group. That statement is false and 33.3% of respondents answered it correctly.

Item 20 stated that green vegetables constitute a major part of the Seminole Indian diet. That statement is false and 79.4% of respondents answered it correctly.

Item 21 stated that heredity is the major cause of diabetes and overweight among Seminole Indians. That statement is false and 55.6% of respondents answered it correctly.

Item 22 stated that the best recommendation to reduce salt content of Kosher meats would be to rinse and drain the meat thoroughly. That statement is true and 70.1% of respondents answered it correctly.

Item 23 stated that according to Jewish dietary laws, meat and dairy products should not be eaten together. That statement is true and 98.6% of respondents answered it correctly.

Item 24 stated that the hot-cold system of beliefs and practices concerning food and health is practiced largely among Asians. That statement is false and 21% of respondents answered it correctly.

Item 25 stated that black beans are widely consumed by Cubans. That statement is true and 98.6% answered it correctly.

Item 26 stated that Haitians often believe that milk is for children only. That statement is true and 78.5% of respondents answered it correctly.

Item 27 stated that intolerance to milk is prevalent among American Indians. That statement is false and 20.9% of respondents answered it correctly.

Item 28 stated that tofu and green leafy vegetables can be good alternatives as sources of calcium in Oriental diets. That statement is true and 92.6% of respondents answered it correctly.

Item 29 stated that corn, chili, and beans constitute a traditional Mexican diet. That statement is true and 92.8% of respondents answered it correctly.

Item 30 stated that traditional soul food is usually salty and high in fat and cholesterol. That statement is true and 92.5% of respondents answered it correctly.

Item 31 stated that pork products have been a staple of the African American diet for several centuries. That statement is true and 76.2% of respondents answered it correctly.

Items 32 through 39 had respondents rate their understanding of cultural terms on a 4-point Likert scale that ranged from very limited to very good. Means and standard deviations were calculated, and missing responses were not included in the valid percent.

Item 32 had respondents rate their understanding of cultural encapsulation. The mean score was  $1.74 \pm .82$  and 69 responses were obtained. A total of 79.7% of respondents answered having limited or very limited understanding and 20.2% answered having good or very good understanding.

Item 33 had respondents evaluate their understanding of multicultural counseling. The mean score was  $3.00 \pm .89$  and 69 responses were obtained. A total of 27.5% of respondents answered having limited or very limited understanding and 72.4% answered having good or very good understanding.

Item 34 had respondents evaluate their understanding of culture. The mean was  $3.16 \pm .78$  and 69 responses were obtained. A total of 20.2% of respondents answered having limited or very limited understanding and 79.7% answered having good or very good understanding.

Item 35 had respondents evaluate their understanding of ethnicity. The mean was  $3.14 \pm .80$  and 70 responses were obtained. A total of 17.2% of respondents answered having limited or very limited understanding and 82.8% answered having good or very good understanding.

Item 36 had respondents evaluate their understanding of prejudice. The mean was  $3.49 \pm .63$  and 69 responses were obtained. A total of 92.7% answered having good or very good understanding and 7.2% answered having limited understanding.

Item 37 had respondents evaluate their understanding of ethnocentrism. The mean was  $2.84 \pm .96$  and 69 responses were obtained. A total of 68.1% answered having good or very good understanding and 31.9% answered having limited or very limited understanding.

Item 38 had respondents evaluate their understanding of stereotyping. The mean was  $3.36 \pm .73$  and 69 responses were obtained. A total of 88.4% answered having good

or very good understanding and 11.5% answered having limited or very limited understanding.

Item 39 had respondents evaluate their understanding of Xenophobia. The mean was  $2.03 \pm 1.01$  and 66 responses were obtained. A total of 72.1% of respondents answered having limited or very limited understanding and 28% answered having good or very good understanding.

Results are summarized in Table 12 as follows:

**Table 12**  
**Understanding of cultural terms**

Items #	Mean $\pm$ SD	n	Minimum	Maximum
32	$1.74 \pm .82$	69	1	4
33	$3.00 \pm .89$	69	1	4
34	$3.16 \pm .78$	69	1	4
35	$3.14 \pm .80$	70	1	4
36	$3.49 \pm .63$	69	2	4
37	$2.84 \pm .96$	69	1	4
38	$3.36 \pm .73$	69	1	4
39	$2.03 \pm 1.01$	68	1	4
<b>Overall</b>	$2.85 \pm .59$	70	1.5	3.75

Note: n indicates total number of responses to that question.  
SD indicated standard deviation.

### **Skills subscale**

Means and standard deviations for the multicultural skills subscale were calculated for items 40 through 52. All questions for the proposed tool are found in Appendix A. These questions were provided as counseling options and had respondents rate themselves according to their perceptions about the statements.

Item 40 stated that more time needs to be devoted to clients who speak English as a second language. The mean was  $2.86 \pm .78$  and 66 responses were obtained. A total of

71.2% of respondents agreed or strongly agreed and 28.7% disagreed or strongly disagreed.

Item 41 stated that it is important to make language accommodations and find out about the client's cultural background. The mean was  $3.58 \pm .50$  and 69 responses were obtained. All respondents agreed or strongly agreed with the statement.

Item 42 stated that it is important to ask questions about food taboos, restrictions, and health beliefs of clientele. The mean was  $3.59 \pm .52$  and 69 responses were obtained. A total of 98.6% of respondents agreed or strongly agreed and 1.4% disagreed.

Item 43 stated that it is important to learn about the cultural groups that make up the population served. The mean was  $3.65 \pm .48$  and 68 responses were obtained. All respondents agreed or strongly agreed with the statement.

Item 44 had the scoring reversed. It stated that it is important to provide the same treatment to different ethnic groups. The mean was  $2.38 \pm 1.15$  and 68 responses were obtained. Half of respondents agreed or strongly agreed and half of them disagreed or strongly disagreed.

Item 45 also had the scoring reversed. It stated that it is important to focus on helping a client fit the system. The mean was  $2.52 \pm 1.05$  and 69 responses were obtained. A total of 56.5% of respondents agree or strongly agreed and 43.5% disagreed or strongly disagreed.

Item 46 also had the scoring reversed. It stated that it is important to focus on immediate events that might have caused the present situation. The mean was  $2.10 \pm .78$

and 68 responses were obtained. A total of 29.4% of respondents agreed or strongly agreed and 70.6% disagreed or strongly disagreed.

Item 47 also had the scoring reversed. It stated that it is important to classify clients into ethnic groups by their appearance. The mean was  $3.57 \pm .70$  and 69 responses were obtained. A total of 94.2% of respondents disagreed or strongly disagreed and 5.8% agreed or strongly agreed.

Item 48 stated that it is important to use ethnic nutrition education resources. The mean was  $3.58 \pm .53$  and 69 responses were obtained. A total of 98.5% of respondents agreed or strongly agreed and 1.4% disagreed.

Item 49 had respondents rate their skills in identifying various ethnic communication patterns. The mean was  $2.74 \pm .76$  and 69 responses were obtained. A total of 63.8% of respondents answered having good or very good skills and 36.2% answered having limited or very limited skills.

Item 50 had respondents rate their ability to conduct an effective counseling interview with a person from a different ethnic background. The mean was  $2.86 \pm .67$  and 69 responses were obtained. A total of 69.5% answered having good or very good ability and 30.4% answered having limited ability.

Item 51 had respondents rate their ability to determine the needs of clients whose cultural backgrounds differed from theirs. The mean was  $2.88 \pm .76$  and 69 responses were obtained. A total of 71% answered having good or very good ability and 29% answered having limited or very limited ability.

Item 52 had respondents rate their level of multicultural counseling experience. The mean was  $2.67 \pm .92$  and 69 responses were obtained. A total of 59.4% of respondents answered having good or very good levels and 40.6% answered having limited or very limited levels. Results are summarized in Table 13 as follows:

**Table 13**

**Cultural Skills**

<i>Question #</i>	<i>Mean ± SD</i>	<i>n</i>	<i>Minimum</i>	<i>Maximum</i>
40	2.86 ± .78	66	1	4
41	3.58 ± .50	69	3	4
42	3.59 ± .52	69	2	4
43	3.65 ± .48	68	3	4
44*	2.38 ± 1.15	68	1	4
45*	2.52 ± 1.05	69	1	4
46*	2.10 ± .78	68	1	4
47*	3.57 ± .70	69	1	4
48	3.58 ± .53	69	2	4
49	2.74 ± .76	69	1	4
50	2.86 ± .67	69	2	4
51	2.88 ± .76	69	1	4
52	2.67 ± .92	69	1	4
<b>Overall</b>	<b>3.00 ± .33</b>	<b>69</b>	<b>2.23</b>	<b>3.85</b>

Note: n indicates total of responses to that question

SD indicates standard deviation

\* indicates reversed scoring

**Description of subpopulations**

As mentioned previously, the surveyed population was comprised by AP4 students, CUP students, MDA dietitians, WPBC dietitians, and BCDA dietitians. Tables 14, 15, 16, and 17 represent scores of multicultural awareness, knowledge, and skills for each subpopulation. Means, standard deviations, and total number of responses for each group was calculated.

**Table 14**  
**Summaries of multicultural awareness scores by subpopulation levels**

<i>Group</i>	<i>Mean ± SD</i>	<i>n</i>
AP4 students	3.2353 ± .3160	7
CUP students	3.1616 ± .1961	22
MDA dietitians	3.1552 ± .2179	22
WPBC dietitians	2.9823 ± .2190	9
BCDA dietitians	3.1429 ± .2681	7
<b>Overall</b>	<b>3.1412 ± .2310</b>	<b>67</b>

Note: n indicates total of responses to that question.  
SD indicates standard deviation.

**Table 15**  
**Summaries of multicultural knowledge scores by subpopulation levels**

<i>Group</i>	<i>Mean ± SD</i>	<i>n</i>
AP4 students	8.0000 ± 1.8257	7
CUP students	9.0000 ± 1.2344	22
MDA dietitians	8.5909 ± 1.5325	22
WPBC dietitians	8.3333 ± 2.4495	9
BCDA dietitians	9.0000 ± 2.1602	7
<b>Overall</b>	<b>8.6716 ± 1.6732</b>	<b>67</b>

Note: n indicates total of responses tot that question  
SD indicates standard deviation  
The maximum score for this subscale is 13.

**Table 16**  
**Summary of multicultural knowledge (understanding) scores by subpopulation**

<i>Group</i>	<i>Mean ± SD</i>	<i>n</i>
AP4 students	3.0357 ± .4605	7
CUP students	2.9602 ± .5309	22
MDA dietitians	2.9773 ± .5743	22
WPBC dietitians	2.3472 ± .6336	9
BCDA dietitians	2.6250 ± .6997	7
<b>Overall</b>	<b>2.8563 ± .6000</b>	<b>67</b>

Note: n indicates total of responses to that question.  
SD indicates standard deviation.

**Table 17**  
**Summary of multicultural skills scores by subpopulation**

<i>Group</i>	<i>Mean ± SD</i>	<i>n</i>
AP4 students	3.0504 ± .3490	7
CUP students	2.9895 ± .2231	22
MDA dietitians	3.0982 ± .3919	22
WPBC dietitians	2.8632 ± .4348	9
BCDA dietitians	2.8791 ± .1529	7
<b>Overall</b>	<b>3.0031 ± .3293</b>	<b>67</b>

Note: n indicates total of responses to that question.  
SD indicates standard deviation.

### **Differences between professionals and students**

T-tests were used to compare mean differences between professionals and students regarding scores on the subscales of multicultural awareness, knowledge, and skills. For the purpose of the present research, the group of professionals included 4 categories: registered dietitians, licensed dietitians, nutritionists, and registered dietitian eligible (n=40). The group of students included preprofessional practice program students and coordinated undergraduate program students (n=29). These two groups were determined based on respondents' perceptions of their professional status. Refer to Table 4 for further details. Diet technicians were not included in this grouping. Overall, statistical analysis did not show significant differences between the two groups ( $p \leq .05$ ). However, when questions were individually analyzed, significant differences between professional and students ( $p \leq .05$ ) were found for questions number 8 and 42. Overall results are summarized in Table 18.

**Table 18****T-tests comparing overall scores for professionals and students**

<i>Subscale</i>	<i>Mean ± SD (P)</i>	<i>Mean ± SD (S)</i>	<i>t</i>	<i>p-value</i>
Awareness	3.1342 ± .222	3.1947 ± .233	-1.01	.317
Knowledge	8.5250 ± 1.908	8.3913 ± 2.190	.25	.801
Understanding	2.8313 ± .607	3.0000 ± .550	-1.08	.284
Skills	3.0215 ± .368	3.0370 ± .249	-.18	.861

SD indicates standard deviation

P indicates professionals

S indicates students

p ≤ .05

**Reliability analysis**

Overall and subscale internal consistencies were calculated and are presented in Table 19. The minimal acceptable level for reliability was set at .70 using Cronbach's alpha. This level is currently the acceptable level found in the literature (34). Overall reliability was at .7852.

**Table 19****Subscale and overall reliabilities**

Subscale	Alpha
Awareness	.6453
Understanding	.8808*
Skills	.6461
<b>Overall</b>	<b>.7852*</b>

\* signifies coefficient in desired range of .70 and above

### Overall subscales correlations

A Pearson correlation analysis was done to determine if there was any relationship among subscales. Correlation coefficient results are shown in Table 20, and significant correlations were indicated by p values  $\leq .05$ . Results indicated that higher awareness scores were associated with higher knowledge, higher understanding, and higher skills. In addition, understanding and skills were positively correlated. However, knowledge is not significantly correlated with understanding and skills.

**Table 20**

#### Subscales correlations, Pearson r coefficients and p-values

<i>Subscale</i>	<i>Pearson coefficient(r)</i>	<i>p-value</i>
Awareness w/ Knowledge	r = .2846	p = .017*
Awareness w/ Understanding	r = .2501	p = .037*
Awareness w/ Skills	r = .4042	p = .001*
Knowledge w/ Understanding	r = .1943	p = .107
Knowledge w/ Skills	r = .2358	p = .051
Understanding w/ Skills	r = .4672	p = .001*

\* p  $\leq$  .05

## CHAPTER V

### DISCUSSION

The US population trends towards cultural diversity have certainly created the need for culturally competent counselors. This is no exception when it comes to the Dietetics and Nutrition profession. The purpose of this research was to develop a valid and reliable tool to assess nutrition professionals' levels of multicultural awareness, knowledge, and skills. Thus, assessing training needs and providing a basis for developing Dietetics and Nutrition programs.

A total of 71 respondents answered the 52-item survey, plus the 11-item demographics section. Respondents included AP4 students, CUP students, MDA members, BCDA members, and WPBDA members.

#### **Research questions**

##### **1- The 52-item survey proposed in this study will be found to be reliable .**

According to previous work done by D'Andrea et al, a Cronbach alpha coefficient of .70 is a generally accepted level of reliability. Overall tool reliability was calculated and found to be at .7852. Therefore, the proposed tool was proven to be reliable in assessing multicultural competence/sensitivity among nutrition professionals.

##### **2- The 52-item survey proposed in this study will be found to be valid.**

Construct validity was assessed to test if subscales were distinct. Pearson r coefficients were determined, and results indicated that subscales were distinct measures of multicultural awareness, knowledge, and skills.

### **3- The degree of multicultural competence/sensitivity among nutrition professionals will be found to increase with years of dietetic practice.**

T-tests were used to compare mean differences between professionals and students. No significant differences in multicultural competence/sensitivity were found between the groups. Therefore, years of dietetic practice did not seem to be correlated to higher multicultural competence/sensitivity among nutrition professionals.

#### **Respondents characteristics**

The majority of respondents were female (95.8%) and most of them held a Bachelor's degree. Seventy six percent of them were 26 years and older. About 49.3% were registered dietitians and 32.4% were students. Other professional categories included licensed dietitians, nutritionists, registered dietitian eligible, and diet technicians (14.1%).

Thirty seven percent of all respondents were in practice for over 11 years . Equal proportions of respondents worked on a part-time and full-time basis. In addition, most of the practicing individuals reported working in hospitals (38%).

Information on annual income was also compiled. It was found that 58% of respondents made an average of \$30,000 dollars per year.

According to citizenship, 88.7% of respondents were Americans. However, when asked about their cultural backgrounds, 32 categories were identified (Table 10). It becomes complex when individuals try to define themselves as to ethno-racial and cultural

background. Findings show that respondents defined their cultural background according to country of birth and ethno-racial inheritance. The uniqueness of responses showed the cultural diversity of South Florida nutrition professionals.

### **Awareness subscale**

Overall, the group of respondents perceived themselves as being culturally aware. The mean score was 3.15. However, the questions that evaluated respondents' awareness of cultural bias and assumptions had the lowest scores (item 6 and item 15). These results confirmed previous work by Pedersen about the ten most frequent assumptions of cultural bias in counseling (22). According to item 6, the important measures of success in most counseling situations are client self-awareness, self-fulfillment, and self-discovery. Item 15 stated that assertiveness is a desirable characteristic regardless of cultural background. According to Pedersen, many counselors in the United States presume that counseling is primarily directed toward the development of individuals rather than units (e.g. family) (22). Results showed that nutrition professionals are no exception to the rule.

Respondents were aware of the changing demographics of the United States, and that multicultural counseling skills were relevant to the dietetics and nutrition practitioner. They agreed unanimously that practitioners should know about ethnic cuisines. In addition, it was a consensus that multicultural training and acquisition of ethnic knowledge should be part of dietetics and nutrition programs.

### **Knowledge subscale**

The knowledge subscale was divided up into two sections. Items 19 through 31 were true or false, and questions 32 through 39 were rated on a 4-point Likert type scale.

Results indicated that the average percentage of right answers was 67% for the true and false questions (questions # 19 to #31), and the overall score for the understanding of cultural terms was 2.85 (questions #32 to 39). These results showed that respondents had higher multicultural awareness (3.15) than multicultural knowledge (2.85).

### **Skills subscale**

The overall score for the skills subscale was 3.00. Questions # 44 to 46 had reversed scores and addressed the cultural bias and assumptions in counseling. These questions received the lower scores, which again concurs with previous work done by Pedersen (22).

Respondents unanimously agreed that it is important to make language accommodations and find out about the client's cultural background

The lower scores obtained on the skills subscale indicated that educational programs need to target the acquisition and improvement of multicultural counseling skills among nutrition professionals.

### **Comparison of mean differences between professionals and students**

Overall, no significant differences were found between these two main groups as previously discussed ( $p \leq 0.05$ ). The only exceptions were questions # 8 and # 42, where students scored higher than professionals. Students showed higher awareness in rating the relevance of multicultural counseling skills and the importance of asking clients about their food taboos, restrictions and health beliefs. Those differences could be explained by the amount of training received by current students as opposed to professionals. According to years of dietetic practice, most of the professionals have been practicing for over 11 years, and perhaps did not receive the same training in nutrition counseling.

### **Tool reliability**

Overall reliability was within pre-determined level according to previous work done by D'Andrea (34). The overall score was .7852 (Table 19). However, true and false items on the knowledge subscale should be administered separately, because they are not a series of attitudinal questions that can be rated on a Likert type scale.

Results indicated that higher reliability scores on the awareness and skills subscales would be obtained if items 6 and 45 were deleted. Item 6 stated that the important measures of success in most counseling situations were client self-awareness, self-fulfillment, and self-discovery. Item 45 had respondents rate the importance of focusing on helping a client fit the system. These two items evaluated respondents' awareness of cultural bias and assumptions according to Pedersen (22), and were previously validated in the MAKSS (34). However, nutrition professionals did not seem to answer them in the same fashion as counseling students and psychologists. The difference in responses could be explained by differences between academic disciplines and respective levels of multicultural competence/sensitivity. Perhaps respondents did not answer the way they were expected to, because there is less multicultural awareness, knowledge, and skills among nutrition professionals than among counseling psychologists. Despite perceiving themselves as culturally competent, results indicate that nutrition professionals would benefit from further training.

### **Subscales correlation**

Pearson r coefficients were calculated, and results indicated that subscales were distinct measures of multicultural counseling awareness, knowledge, and skills. Therefore,

construct validity was supported. Higher awareness scores were associated with higher knowledge, understanding, and skills. Understanding and skills were positively correlated. Knowledge was not significantly correlated with understanding (see Table 20).

### **Summary and Conclusions**

Interesting results were obtained regarding ethno-racial and cultural backgrounds of respondents. The complexity of this matter became evident by the uniqueness of responses and the number of categories generated.

Findings indicated that respondents perceived themselves as being culturally competent/sensitive. Multicultural awareness scores were highest among respondents, followed by skills and knowledge.

Respondents recognized the changing demographics of the United States and the need for educational programs that target the acquisition and improvement of multicultural counseling knowledge and skills among nutrition professionals.

The Multicultural Competence Diagnostic Tool was found to be reliable and valid in measuring multicultural competence/sensitivity among nutrition professionals. Results indicated that the nutrition professionals are no exception to the rule when it comes to master the understanding and avoidance of the ten most frequent assumptions of cultural bias in counseling. Improvements in the tool could be achieved by eliminating or changing items geared toward professionals other than nutrition professionals.

Overall, no differences were found on the levels of multicultural competence/sensitivity between professionals and students. In addition, years of practice did not seem to have an effect in increasing multicultural competence/sensitivity among

nutrition professionals. Results indicated that in some instances, students showed higher multicultural awareness when rating the relevance of multicultural skills (item 8) and the importance of asking clients about their food taboos, restrictions, and health beliefs (item 42).

### **Recommendations**

Nutrition professionals perceive multicultural training to be beneficial regardless of their cultural background. In a changing world, where cultural diversity has become common place, efforts should focus in increasing multicultural competence among nutrition professionals. Learning to understand and appreciate cultural differences provides the nutrition professional with skills to conduct effective nutrition counseling. It is suggested that multicultural training be an integral part of not only undergraduate programs, but also graduate and continuing education programs.

The Multicultural Competence Diagnostic Tool for Nutrition Professionals is a new research instrument. Therefore, further testing of its reliability and validity is warranted. Since results from the present research cannot be generalized and extrapolated to the US population due to sample size limitations, respondents' characteristics, and research design, it is suggested that it be used in different US geographic regions. Additionally, it is suggested the it be used in the assessment of multicultural training needs among nutrition professionals, and as a pre and post-test instrument in the evaluation of program effectiveness.

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## APPENDIX

## MULTICULTURAL FACTORS: SURVEY FOR NUTRITION PROFESSIONALS

My name is Anna Giannella and I am a registered dietitian. In order to partially fulfill the requirements for the degree of Master of Science in Dietetics and Nutrition I am developing a survey.

This is a survey, not a test. There are no right or wrong answers. Confidentiality is guaranteed and only group data will be published. Please complete both the survey and the demographic items below. Thank you for your cooperation!

1- Are you:

- male
- female

2- How old are you?

- less than 25 years old
- 26 - 40 years old
- more than 41 years old

3- Professional status - Please indicate one answer:

- R.D., L.D.
- L.D.
- Nutritionist
- R.D.E.
- D.T.R.
- Other (specify)\_\_\_\_\_

4- For how many years have you been practicing?

- less than 3 years
- 4 - 10 years
- more than 11 years

5- Do you work:

- part-time
- full-time
- other (specify)\_\_\_\_\_

6- What type of facility do you work in?

- hospital
- private practice
- public health
- education
- other (specify)\_\_\_\_\_

7- What is your annual income?

- \$10,000 - \$ 20,000
- \$ 20,001 - \$ 30,000
- \$ 30,001 - \$ 40,000
- \$ 40,001 - \$ 50,000
- more than \$50,001

8- How would you describe your ethnic/cultural background?

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9- Are you an American citizen?

- yes
- no

10- What is the highest educational level you have attained?

- associate degree
- bachelor's
- master's
- post-graduate

11- For how many years have you lived in South Florida?

- 0 - 2 years
- 2.1 - 5 years
- 5.1 - 6 years
- more than 6 years

I - For each of the following statements, indicate if you strongly disagree (SD), disagree (D), agree (A), or strongly agree (SA):

- 1- Culture is not external, but is within the person.  
SD    D    A    SA
- 2- I am aware of my cultural values and biases and how they affect the way I think and behave.  
SD    D    A    SA
- 3- I consider myself culturally sensitive.  
SD    D    A    SA
- 4- I am able to compare different cultural perspectives including my own.  
SD    D    A    SA
- 5- People from different cultures behave differently about food.  
SD    D    A    SA
- 6- The important measures of success in most counseling situations are client self-awareness, self-fulfillment, and self-discovery.  
SD    D    A    SA
- 7- I am aware of the changing demographics of the United States.  
SD    D    A    SA
- 8- Multicultural counseling skills are relevant to the dietetics and nutrition practitioner.  
SD    D    A    SA
- 9- Food is used to reinforce cultural values and enhance social unity.  
SD    D    A    SA
- 10- Nutrition counseling can be influenced by client's religious beliefs.  
SD    D    A    SA
- 11- I like to experiment with foods and flavors that are different from those of my cultural background.  
SD    D    A    SA
- 12- Dietetics and nutrition practitioners should know about ethnic cuisines.  
SD    D    A    SA
- 13- The US Dietary Guidelines and the Food Guide Pyramid can be adapted to fit the nutritional need of any ethnic group.  
SD    D    A    SA
- 14- I am familiar with the health problems of minorities.  
SD    D    A    SA
- 15- Assertiveness is a desirable characteristic regardless of cultural background.  
SD    D    A    SA
- 16- I do not make judgments before trying new foods.  
SD    D    A    SA
- 17- Multicultural training should be a part of dietetics and nutrition education programs.  
SD    D    A    SA
- 18- The acquisition of ethnic knowledge helps nutrition professionals attain positive counseling outcomes with different ethnic groups.  
SD    D    A    SA

II- For each of the following statements, indicate whether you think is true (T) or false (F):

- 19- Dietary adequacy generally varies with ethnic group.  
T      F
- 20- Green vegetables constitute a major part of the Seminole Indian diet.  
T      F
- 21- Heredity is the major cause of diabetes and overweight among Seminole Indians.  
T      F
- 22- The best recommendation to reduce salt content of kosher meats would be to rinse and drain the meat thoroughly.  
T      F
- 23- According to Jewish dietary laws, meat and dairy products should not be eaten together.  
T      F
- 24- The “hot-cold” system of beliefs and practices concerning food and health is practiced largely among Asians.  
T      F
- 25- Black beans are widely consumed by Cubans.  
T      F
- 26- Haitians often believe that milk is made for children.  
T      F
- 27- Intolerance to milk is prevalent among American Indians.  
T      F
- 28- Tofu and green vegetables can be good alternatives as sources of calcium in oriental diets.  
T      F
- 29- Corn, chilis, and beans constitute a traditional Mexican diet.  
T      F
- 30- Traditional “Soul Food” is usually salty and high in fat and cholesterol.  
T      F
- 31- Pork products have been a staple of the African American diet for several centuries.  
T      F

How do you rate your understanding of the following terms? Indicate very limited (VL), limited (L), good (G), or very good (VG):

- 32- Cultural encapsulation  
VL L G VG
- 33- Multicultural counseling  
VL L G VG
- 34- Culture  
VL L G VG
- 35- Ethnicity  
VL L G VG
- 36- Prejudice  
VL L G VG
- 37- Ethnocentrism  
VL L G VG
- 38- Stereotyping  
VL L G VG
- 39- Xenophobia  
VL L G VG

III- The following is a series of counseling options. Please indicate if you strongly disagree (SD), disagree (D), agree (A), or strongly agree (SA). For effective MULTICULTURAL counseling, it is important to:

- 40- Devote more time to a client who speaks English as a second language.  
SD D A SA
- 41- Make language accommodations and find out about the client's cultural background.  
SD D A SA
- 42- Ask questions about food taboos, restrictions, and health beliefs.  
SD D A SA
- 43- Learn about the cultural groups that make up the population served.  
SD D A SA
- 44- Provide the same treatment to different ethnic groups.  
SD D A SA
- 45- Focus on helping a client fit the system.  
SD D A SA
- 46- Focus on immediate events that might have caused the present situation.  
SD D A SA
- 47- Classify clients into ethnic groups by their appearance.  
SD D A SA
- 48- Use ethnic nutrition resources.  
SD D A SA

For the items below, indicate very limited (VL), limited (L), good (G), or very good (VG):

49- How would you rate your skills in identifying various ethnic communication patterns?

VL L G VG

50- How would you rate your ability to conduct an effective counseling interview with a person from a different ethnic background?

VL L G VG

51- How would you rate your ability to determine the needs of clients whose cultural backgrounds differ from yours?

VL L G VG

52- How would rate your level of multicultural counseling experience?

VL L G VG

**THANK YOU!**