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Multicultural Group Screening Form (MGSF): Development of a Pre-Group Screening Form for Use with Diverse Groups at University Counseling Centers

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MULTICULTURAL GROUP SCREENING FORM (MGSF): DEVELOPMENT OF A PRE-GROUP SCREENING FORM FOR USE WITH DIVERSE GROUPS AT UNIVERSITY COUNSELING CENTERS

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TARONISH H. IRANI, M.A.

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I HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER MY SUPERVISION BY **TARONISH HOMI IRANI** ENTITLED **MULTICULTURAL GROUP SCREENING FORM (MGSF): DEVELOPMENT OF A PRE-GROUP SCREENING FORM FOR USE WITH DIVERSE GROUPS AT UNIVERSITY COUNSELING CENTERS** BE ACCEPTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PSYCHOLOGY.

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Abstract

To date, no instrument has been developed that specifically assesses multicultural issues within the context of group work. Rather, such issues are based to a large extent on clinician's judgment (Corey & Corey 1992; Jennings & Anderson, 1997; Riva, Lippert, & Tackett, 2000). The purpose of this study was to develop an instrument (i.e., the Multicultural Group Screening Form, MGSF) designed to address this void in the literature. Such a tool provides a basis for future studies on the multicultural factors that could impact the group process and outcome. Among the group literature reviewed, DeLucia-Waack's and Donigian's (2004) discussion on diversity variables citing various key researches that might impact successful engagement in group therapy, and the Multigroup Ethnic Identity Measure (MEIM) by Phinney (1992) are key among the various sources used in the development of this instrument. Therefore, 71 items and six primary scales were designed based on expert's opinion and extant review of existing theory. A total of 153 undergraduate students at Wright State University (WSU), completed the measures, and then initial reliability estimates were examined. Internal consistency analyses were conducted on the 71 items that comprised a proposed six primary scales. Based on these analyses, results showed that 35 items were retained representing five primary scales. The five primary scales are Ethnic Identity (α =.78), Racial Attitude (α -=.71), Group Leader Preferences (α = .70), Stigma (α = .73), and Verbal Participation/Self –Disclosure (α =.71). The scale that was deleted due to low reliability scores was Value Orientation scale (α = .55). Furthermore, the construction of this measure suggests categories and areas for item refinement that can be built upon in further iterations of this instrument.

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I can no other answer make, but, thanks, and thanks. ~William Shakespeare

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Dedication

This dissertation is dedicated to all college students, specifically students of color in providing their perspective to help me in the process of developing the screening form. I also dedicate this to my training in diversity, and group psychotherapy that has made this a product of my passion for giving the community.

Chapter I

The uniqueness of group process begins by understanding the selection and formation of groups. In group psychotherapy, group selection and composition are two important initial phases of decision making process (Unger, 1989). Selection of groups involves focusing attention on screening criteria (Unger, 1989). Therefore, pre-group screening is an essential step in the selection and formation of groups. According to DeLucia- Waack (1997), Pre group screening helps to clarify important characteristics that are most indicative of success in group work. Further, group leaders are ethically responsible to select potential group members that are likely to benefit from the experience (Hines, & Fields, 2002). The screening criteria discussed in the group literature are expected to provide more specificity and stability in the process of selecting potential group members who are likely to benefit from this decision (Frances, Clarkin & Marachi, 1980). Moreover, Chen and Hahn (2001) emphasized the importance of pre-group screening and described it as the key to resolving questions of negative therapeutic outcomes. Similarly, Piper and McCallum (1994) believed that as more suitable candidates for group therapy are identified, chances for premature termination are reduced. In fact, Weirzbicki & Perkarik (1993) conducted a meta-analysis of 125 studies on psychotherapy dropout. The meta-analysis determined that psychotherapy was significantly related to minority racial status, low education, and low socio-economic status. Dropout rates were higher among members identifying as African American and other minority, low level of education, and low socio economic status. Furthermore,

client demographic characteristic have been one of the variables most often researched in relation to dropout (Mennicke, Robert, & Burgoyne, 1988). Based on reviewing dropout and premature studies, Yalom (2005) indicated that one such variable that determines the reasons for premature termination is lack of cultural sensitivity.

Culturally sensitive practice is crucial in understanding the delivery of group treatment (Johnson, Torres, Coleman, & Cecil Smith, 1995). With regard to group psychotherapy, there has been a growing demand for attending to the multicultural competency of the group leaders in order for them to be effective with different ethnic groups and races during the group process (Greeley, Garcia, Kessler, & Gilchrest, 1992; Bemak & Chung, 2004; De Lucia-Waack & Donigian, 2004). Several authors (DeLucia-Waack, Coleman, & Jensen-Scott, 1992; DeLucia Waack, 1996; Hayley-Banez & Walden, 1999; Bemak & Chung, 2004; DeLucia Waack & Donigian, 2004) have highlighted the dearth of research addressing the impact of culturally diverse group members on the process and dynamics of group work. However, research has paid very little attention to pre-assessment of potential group members (Johnson et al. 1995). Given the rise in diversity of the United States national population, group members will bring values, beliefs and attitudes to the group that can influence the assumptions of the group work and it becomes necessary to give attention to these variables before the group is formed (Johnson et al., 1995). The inability to address and assess cultural issues can result in underuse and premature termination of mental health services by the culturally diverse (Sue & Sue, 1990; Leong, 1992). It has been noted by many authors that group therapist still typically rely on clinical judgment rather formal assessment measures when screening group therapy clients (Riva et al. 2000). However, recent attempts have been

made to increase the scientific rigor connected with the screening process. The CORE-R battery includes instruments by Burlingame (i.e. The Group Selection Questionnaire; GSQ) and MacNair-Semands (i.e. The Group Therapy Questionnaire; GTQ) that aim to promote more accurate screening of clients, based on the literature (Burlingame et al., 2006). However, neither instrument attempts to capture multicultural variables that might impact premature dropout or failure to attend group.

Purpose of the Study

To date, no instrument has been developed that specifically assesses multicultural issues within the context of group work. Rather, such issues are based solely on clinician's judgment (Corey & Corey 1992; Jennings & Anderson, 1997; Riva et al., 2000). The purpose of this study was to develop an instrument (i.e., the Multicultural Group Screening Form) designed to begin addressing this void in the literature. The tool would provide an empirical evaluation of the multicultural factors and group work. Such an instrument would suggest categories that might be germane to potential group failure based on multicultural concerns. Unlike previous instruments, that assessed selection criteria that did not relate to multicultural concerns, this measure will acknowledge potential cultural variables that could impact the selection process. The assessment measure can be used by researchers to assess pre-impact of multicultural variables on group participation and referral success. Furthermore, the information obtained by this measure would be a quick, cost effective way of screening for cultural values, beliefs of potential group members and subsequently provide useful information to group leaders about assessing whether they would be a good fit for group psychotherapy or not.

The MGSF instrument will be based on two main literature among sources relevant to multicultural issues in group therapy: Delucia-Waack's and Donigian's (2004) extensive discussion on research pertaining to diversity variables that might impact successful engagement in group therapy, and the Multigroup Ethnic Identity Measure (MEIM) by Phinney (1992). The measure will incorporate key assumptions that are common among ethnic groups, and is posited to affect the group outcome (DeLucia-Waack & Donigian, 2004). Thus, it will serve as an extra means to gather information in conjunction with other screening measures such as, the GTQ and GSQ. Furthermore, the focus will be to develop this instrument for the University Counseling Centers (UCC) since group treatment is widely used in this setting (Golden, Corazzini, & Grady, 1993). In addition, this study also focuses to increase the awareness and importance of multicultural issues and pre-group screening process in the field of group work. Development of this instrument is intended as the first step in researching the potential impact of multicultural variables on group access and failure.

Chapter II

Review of Current Literature

College Students, Counseling Centers, and Group experiences

College students and group psychotherapy.

Developmentally, college students are dealing with issues related to forming identities, becoming more independent, experiencing role transitions, and deciding on lifestyles, while simultaneously adjusting to college life, and choosing their careers (Chickering & Reisser, 1993; Kincade & Kalodner, 2004). Additionally, returning students face challenges when they go through a developmental process that introduces them to new ideas and ways of thinking about themselves (Chickering & Reisser, 1993; Kincade & Kalodner, 2004). Therefore, group therapy is believed to provide a platform for students to learn skills that may be beneficial in their relational, social, career, and educational domains (Kincade & Kalodner, 2004). Equally important, among the college student population, minority and nontraditional students are likely to have more demands and challenges while adjusting to higher education institutions (Bishop, 1990). Thus, counseling centers were encouraged to prepare and deal with the various challenges faced by this special student population (Bishop, 1990).

Among the racial and cultural minorities, client factors that are related to premature termination among counseling centers include socioeconomic status, race, culture, sex, education, ability, personality, and various attitudinal and expectancy

variables(Mennicke et al.,1988). Similarly, among racial and cultural minorities, African American (Terrell & Terrell, 1981; Brown, Lipford-Sanders, & Shaw, 1995; Rollock, Westman, & Johnson, 1992), Asian Americans (Sue, Fujino, Hu, Takeuchi, & Zane 1991; Chang, Yeh, & Krumboltz, 2001; Liu, Tsong, & Hayashino, 2007), and Hispanic/ Mexican Americans underutilize mental health services (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Furthermore, Black students on predominantly white campuses underuse psychological services (Winer, Pasca, Dinello, & Weingarten, 1974), as well as, Mussenden & Bingham (1985) illustrates that language barriers, cultural differences, discrimination, academic underachievement, and high dropout rates are all problems that Hispanic students confront. Furthermore, counseling centers are underused by Hispanic, Mexican Americans, and other ethnic minority group members (Museenden & Bingham, 1985; Sanchez & King, 1986; Bishop, 1990). International students are another population that is likely to face adjustment issues compared to American students (Bishop, 1990). Therefore, university counseling centers continue to face challenges in having trained professionals, and staff to address and face the need for expanding service delivery systems especially group work to accommodate the need of minority and nontraditional students (Bishop, 1990).

Group and counseling centers.

With increased student enrollment, changes in diversity and mental health demographics on university campuses, funding issues and budgetary cuts, university college counseling centers have to reformat their services, specifically introducing more psychotherapy groups, to cater to a larger and more diverse student population. Group therapy services was considered to be the treatment of choice because it cost-effective is

an intervention that meets the students' needs in a college environment (Bishop, 1990; Kincade & Kalodner, 2004). Groups tend to target a large number of student clients with diverse mental health issues in a time effective manner (Bishop, 1990). The growing popularity of group therapy is evident in the literature. Group therapy has been affirmed as one of the key treatment modalities offered by university counseling centers (Berman, Messersmith & Mullens, 1972; Golden, Corazzini, & Grady, 1993; Kincade & Kalodner, 2004). For instance, in a meta-analytic study on sites for group work, Burlingame, Fuhriman, and Mosier (2003) found that more than half of the group participants were from university counseling centers (52 %), followed by correctional facilities (20 %) and outpatient mental health (12%) centers. In sum, group work that gradually emerged during the 1960's-1990's period continues to gather momentum in college counseling centers till into the present (Kincade & Kalodner, 2004).

The following section discusses some of the current issues relevant to university counseling centers, such as trends seen among college counseling centers using group psychotherapy, challenges and key elements involved in running effective groups at university counseling centers and key foundations involved in running effective groups at university counseling centers.

Trends seen among college counseling centers using group psychotherapy.

In 1970s, Conyne, Lamb, and Strand (1975) found a dearth of research on the practice of group psychotherapy in university counseling centers and attempted to gather information about the use of therapy groups on colleges. In their study, they surveyed 129 counseling centers; 94% were public institutions and 23% were private institutions. The mean number of groups offered was 3.6 in public institutions and 2.5 in private

institutions. A total of 514 groups were offered by the counseling centers with a mean number of 4 groups per counseling center. In a follow-up study, Golden et al. (1993) attempted to research current practices of group psychotherapy at university counseling centers. The results of their study indicated that 92% of the universities offered at least one group per semester. Furthermore, groups consisted of 5-8 members, and were co-led for 1.5 hours on a weekly basis. The most frequently offered type of group was the time-limited structured theme group (66%); over one-third university counseling centers offered time-limited process-oriented theme groups (35%) and 59 % offered process-oriented psychotherapy groups.

A relationship between the size of the university and their likelihood of offering groups at the counseling center was also noted (Golden et al., 1993). In other words, the larger the counseling center, the greater the number of groups offered; the number ranged from as high as 15 groups to a low of 4 groups per university. Similarly, university affiliation influenced group offerings; public institutions offered more groups than private institutions (Golden et al, 1993). Overall, Golden et al.'s (1993) data suggested an improvement in the visibility and proliferations of group therapy compared to Conyne et al. (1975) results.

Challenges faced in running effective groups in counseling centers.

Even though, group psychotherapy is a key treatment modality offered in university counseling centers, college students' presenting concerns pose several complications, and make group facilitation a complex task (Kincade & Kalodner, 2004; Johnson, 2009). Some of the complications related to running effective groups include: underutilization of group services by college; lack of awareness of multicultural variables

during different phases of group work; clients' resistance and participation; staff's unwillingness to suggest group as a preferred treatment modality; ineffective group formatting (e.g., scheduling of groups to coincide with students' course schedule), and insufficient marketing of groups on campus (Kincade & Kalodner,2004).

First, the major challenging area in group therapy work in university counseling centers, as identified by Kincade & Kalodner (2004) was addressing multicultural variables in group. For instance, Uba (1994) identified cultural factors that form barriers to accessing mental health services for Asian Americans. Some of the reasons for barriers are cultural restrictions about seeking services when shame and stigma were attached to use of mental health services, and inability to identify mental health issues. Additionally, other barriers could be lack of knowledge about existing services, being geographically limited, having limited financial resources, language barriers, and shortage of cultural sensitivity from the staff (Root, 1985; Uba, 1994; Morrissey, 1997, Chang et al., 2001)

With regard to client resistance and participation, Parcover, Dunton, Gehlert, and Mitchell (2006) pointed out that client resistance can be either cognitive or emotional. On a cognitive level, client's resistance is identified as being due to insufficient or inaccurate information about group treatment. Thus, authors proposed that basic education about group work would clarify some of the myths and expectations students have about being a group member, reduce their fears, and generate an interest in group work. On an emotional level, client resistance could be as a result of fears and anxieties of sharing personal information with others. For instance, anxieties and fears about cultural restrictions on seeking services may result Asian Americans delay participation and result in higher dropout rates. Given that Asian Americans are likely to postpone their contact

for mental health service, have higher dropout rates, and engage in brief therapy, the needs for culturally specific services is important to consider (Liu et al., 2007). Furthermore, Akutsu (1997) pointed out that, Asian American are likely to utilize mental health services more often as other group when the services are culturally sensitive to their needs. Therefore, addressing concerns that result in client resistance and participation prior to beginning group work would be crucial in assisting group members to join group treatment (Parcover et al., 2006). In sum, screening group members and discussing their fears and misperceptions which may be more cultural specific for various ethnic groups would be crucial to address prior to including them in group treatment.

In terms of staff attitudes, Parcover et al. (2006) believed that staff attitude could play a critical role in the success of a group program since staff members play a key role in the referral process. Professional staff members at counseling centers may be reluctant or not refer their clients to groups. Quintana, Yesenosky, Kilmartin, & Macias (1991) studied referral decisions made by professional staff and doctoral level trainees at university counseling centers for 170 students. Among students presenting for treatment, 106 were referred to individual counseling, 56 were referred for group treatment. Some of the reasons for a high referral rate to individual versus group referrals included logistics such as long waiting lists (for group) or no group openings, and financial consideration. Sometimes, availability of an outside referral led counselors to refer clients to individual rather than group counseling. Additionally, more severely disturbed clients were referred to individual more often than group. Therefore, the nature of the referral as well as environmental constraints dictated services recommended by professional staff for student clients. Interestingly, the study also found that staff who had expertise in

group work referred more individuals to groups indicating that therapist competence played a role in services recommended at the end of the referral process. Additionally, Jennings and Anderson (1997) found that the more counselors trained specifically in group work, the more likely that the center's group program was successful. Clearly, creating a staff culture that supports group work is crucial to increase group work at university counseling centers (Quintana et al., 1991; Kincade & Kalodner, 2004; Parcover et al., 2006).

Key foundations involved in running effective groups in counseling centers. In order to develop effective groups in college counseling centers, Kincade & Kalodner (2004) supported the idea of honing processes related to recruitment, screening of group members, and group preparation. Pre-group screening is a pivotal part of group work; it contributes to the success of groups even before commencing the group process (Unger, 1989, DeLucia-Waack, 1997, Yalom 2005, Kinacde & Kalodner, 2004). The next section will address literature related to the importance of pre-group screening in the field of group psychotherapy.

Pre-Group Screening

Within the field of group psychotherapy, pre-group screening is recognized as an important first step in the implementation of group work (Hines & Fields, 2002). According to Yalom (2005), effective group therapy begins with a careful selection of group members who are likely to benefit from group. The process of pre-group screening involves selecting group members who would benefit if they were included in groups (Piper, & McCallum, 1994; Yalom, 2005). Furthermore, effective group screening has important implications (Roback & Smith, 1987; Riva et al., 2000). First, if group

members are assigned inappropriately, it could lead to negative outcomes (Yalom, 2005). Thus, screening potential group members for certain inclusion and exclusion factors during the initial stages can provide higher chances of group completion and reduce chances of premature terminations/dropouts from group. Second, good selection of group members can result in positive treatment outcomes. As a result, researchers constantly feel the need to identify factors and avoid member-group mismatch (Roback & Smith, 1987; Riva et al., 2000). Therefore, it is important for contemporary group researchers to continue to examine effective ways of matching clients to the group therapy according to their specific characteristics and/or concerns (Yalom, 2005, Burlingame et al., 2006).

Selection criteria.

There is literature on selection criteria for including potential members in groups (Friedman, 1976; Yalom, 1966, 1985, 2005; Unger, 1989; Piper, & McCallum, 1994; DeLucia-Waack, 1997, 2006). Although there is no exhaustive and exclusive list of screening criteria, the selection criteria currently cited are believed to minimize selection errors and improve the screening process (Piper, & McCallum, 1994). This section reviews group selection guidelines and measures used to evaluate a candidate for potential group membership.

Group selection guidelines provide information about factors to be considered prior to referring potential group members for group therapy. The implications are based on research findings from premature termination and outcome studies, as well as qualitative research discussing clinical experiences.

Group selection guidelines

Yalom (2005) stated that "All members will fit in some group, an exclusion from one group will be a feature for inclusion in another group." Group leaders need to engage potential group members in an extended interview in order to select or deselect them based on inclusion or exclusion criteria (Corazzini & Heppner, 1982; Yalom, 2005). Additionally, during the interview, group leaders should assess an individual's ability to self-disclose, give and receive feedback, and capacity or willingness to examine one's own interpersonal behavior, as these are considered to be key characteristics for participation (Freidman, 1976; Unger, 1989; Yalom, 2005)

Exclusion factors are criteria used to deselect group members who will not benefit from group (Yalom, 2005). For instance, there is considerable research to suggest that candidates who are brain damaged, paranoid, extremely narcissistic, hypochondriachal, addicted to drugs or alcohol, acutely psychotic, or sociopathic are not suited for a heterogeneous therapy groups (Wood & Melnick, 1979; Power, 1985; Yalom, 2005; DeLucia-Waack, 2006). Furthermore, individuals who are experiencing acute situational crises are also not considered good candidates for group therapy (Wood & Melnick, 1979; Power, 1985; Yalom, 2005; Delucia-Waack, 2006). In addition, DeLucia-Waack (2006), posited that some of the reasons to deselect members from a group include incongruence between member and group goals; individuals who are overtly hostile, angry or aggressive, extremely hyperactive, extremely sensitive to criticism, and those with particular disorders or problems as mentioned above. In addition, differences in coping skills in dealing with different situations, stages of dealing with the problem, values regarding the situation, disclosure levels, emotional response to the situation,

cultural heritage, socioeconomic levels, levels of resiliency, mixed gender, family situations, and birth order are also some important factors to be considered during the group screening process.

Another factor that group leaders need to screen for is group members' ability to maintain good group attendance because it is necessary for developing a cohesive group (Yalom, 2005). MacNair-Semands (2002) stated that inconsistent membership is one of the leading problems in groups.

Premature termination/ dropout

Individuals who dropout from group are considered to be unsuccessful clients for group therapy(Yalom, 2005).Dropping out is defined as either dropping out before the first group session, or after the intake session, or after many sessions (April & Nichols, 1997). Premature termination is defined differently from dropout; it is defined as a failure to return to therapy after the intake appointment (Hatchett & Park, 2003). Therefore, for this study the term premature termination is used interchangeably with dropping out.

According to Yalom (1966), patients who prematurely terminate from group therapy gain little, if any, benefit from their therapeutic experience and hinder group progress. In fact, it demoralizes or causes disintegration of the group cohesion. Therefore, the question often asked is whether dropout rates were reduced by determining which clients will remain in group therapy to benefit both the individual and the group (MacNair & Corazzini, 1994). Also, research related to factors that may result in dropping out during the initial stages of group therapy is discussed in the current dissertation. Yalom's study (1966) investigated dropout rates of nine therapy groups in a university hospital outpatient clinic. Results of the study provided information on group

selection procedures and group therapeutic techniques. One of the main conclusions of the study was that premature termination from group therapy is considered bad for the client and group. When the dropouts were studied individually, the reasons for the premature termination were organized into one or more of the major categories discussed below (Yalom, 1966, 2005). Some of these categories stem more from difficulties that the patient brings with them in the group, whereas, others are problems generated within the group. They are as follows:

(a) *External Factors:* includes factors related to premature termination due to external events that hinders involvement in group work. For instance, some group members drop out as a result of physical limitations such as, moving out of the geographical area and conflicts in scheduling which are considered logistic reasons for termination (Yalom, 1966, 2005). Similarly, external stress from life events like marital conflict, impending divorce, career or academic failure, bereavement, severe physical illness and disruptive relationships with parents could interfere with member involvement. External stress is often secondary to some internal force, and thus, contributes to, but is not the sole force behind premature termination.

(b) *Group Deviants:* refers those group members who segregate themselves from the group's progress. Some group deviants are considered to lack psychological sophistication, interpersonal sensitivity, and personal psychological insight possibly manifested in denial behavior. Additionally, factors such as low socio-economic status, lower educational, and a lower range of cultural interests can also result in group deviancy. Furthermore, individuals who are categorized as

group deviants tend to remain at the symptom-describing, advice-giving -and–seeking, or judgmental levels. They avoid sharing their immediate feelings, and here- and- now interactions. Deviant group members seem less attracted to the group and are often motivated to terminate membership (Yalom, 1966; 2005).

(c) *Problems of intimacy:* include schizoid withdrawal, maladaptive self-disclosure, and unrealistic demands for "instant intimacy". Schizoid withdrawal patients generally find it difficult to relate and communicate with others. They are generally described as "silent members", "filler-in nonentity", "withdrawn-the group child." (Yalom, 1966; 2005). Maladaptive self-disclosure involves constant fear of having to reveal themselves in group (Yalom, 1966; 2005).

(d) *Emotional Contagion:* refers to member dropout as a result of being affected by listening to the problems of other group members (Yalom, 1966; 2005).

(e) *Inability to share the doctor:* some individuals may drop out of group because they prefer receiving personalized attention needed from the therapist, and cannot tolerate sharing the therapist with other group members during the group treatment session (Yalom, 1966; Bernard & Drob, 1989).

(f) *Complications of concurrent individual and group psychotherapy:* individuals are likely to dropout if they find it difficult to engage in group treatment because it causes complexities in individual treatment in which one is involved (Yalom, 1966; Bernard & Drob, 1989).

(g) *Early provocateurs:* refers to individuals who have a short lifespan in group. Moreover, they are individuals who storm furiously into groups activate members before disappearing. They play the roles of "active investigators", "silence filler",

"blunt" and "a harsh judge". The group and the therapist would consider such individuals as "hostile interpreter", "provocateur", "catalyst", "target", and "scapegoat". They are likely to express hostility and confront the therapist in their follow-up interviews (Yalom, 1966; 2005).

(h) *Problems with orientation to group therapy:* Dropout can also result from erroneous expectations and misconceptions about group therapy (Yalom 1966; 2005).

(i) *Complications arising from sub grouping:* Complications arising from sub grouping also played a role in premature dropout (Yalom, 1966). Sub grouping is likely make one feel excluded and unable to be a part of the group (Yalom, 1966; Bernard & Drob, 1989).

Other researchers focus on other possible problems that could suggest premature termination (Bernard & Drob, 1989; Weirzbicki & Perkarik, 1993). In Bernard & Drob's (1989) study, the reasons for premature termination identified included perception of therapist's motivation, failure to set treatment goals, unexpressed negative feelings about individual therapist and/or the group therapist, group membership as narcissistic injury, experienced imbalance between giving and receiving, intragroup conflicts, and inadequate preparation. Weirzbicki & Perkarik (1993) conducted a meta-analysis of 125 studies on psychotherapy dropout. Mean dropout rate was 46.86%. There were significant differences observed for three client demographic variables: racial status, education, and income. Dropout rates were higher among members identifying as African American, lower levels of education, and low socio economic status. In addition, dropout rates increased, although not significantly, for female, young and married clients. Other

client characteristics that could result in dropout are problems with somatic complaints (Yalom, 1966, 2005; Weirzbicki & Perkarik, 1993; MacNair & Corazzini, 1994), being a scapegoat (Roback & Smith, 1987), and abuse of substances, previous therapy experience, interpersonal problems and clients in crisis (Yalom, 1966, 2005; Roback & Smith, 1987; Yalom, 2005). Similarly, research on group dropout has focused on level of motivation (Keijsers, Kampman & Hoogduin, 2001; Yalom, 2005), low level of education (Keijsers et al. , 2001; Weirzbicki & Perkarik, 1993; Yalom, 2005) greater anger and hostility (Riva et al., 2000; DeLucia-Waack, 2006), expectations of the group, patient-therapist relationship (Roback & Smith, 1987), lack of cultural sensitivity (Yalom, 2005) and interpersonal functioning, difficulties such as trusting and relating to others(Blouin et al.,1994).

Other characteristics such as reduced capacity to think about emotions without action, being more reactive than reflective, less positive emotion, great denial, lower intelligence, expectation of cultural insensitivity, and being less liked by the group could result in premature termination (Yalom, 2005). For the most part, group members may drop out because of several factors and not one individual factor. Some factors may be related to external conditions, while others may be due to individual character traits. Overall, the selection process plays a crucial role in reducing premature termination. Although, it is likely that some premature dropouts will occur in group therapy, the above criteria could help avert premature dropouts.

Among the inclusion factors, motivation and preparation are cited as the most important criteria for successful group participation (Woods & Melnick, 1979; Unger, 1989; Yalom, 2005). Furthermore, favorable expectations about group therapy and ability

to interpersonally engage with other group members are correlated with therapeutically favorable behavior in group (Yalom, 2005). In fact, some desired characteristics for group inclusion included commitment to change, willingness to become susceptible to influence of the group and report subjective experiences that would benefit the group, and willingness to be of help to others (Friedman, 1976). Additionally, other inclusion criteria are: taking into account the presenting problem, potential group members viewing group as an agent to meet needs, and the extent to which the group will facilitate resolving the client's issues or conflicts (Corazzini & Heppner, 1982). Furthermore, Riva et al. (2000), also suggested a moderate amount of social ability and ability to tolerate frustration as beneficial inclusion criteria. Assessing for a certain amount of frustration tolerance and how one would articulate their feelings is an essential component of the screening process. Other potential selection criteria for inclusion would be level of psychological mindedness (McCallum, Piper, & Joyce, 1992; Yalom, 2005).

A review of group screening measures.

It has been noted by many authors that group therapist still typically rely on clinical judgment rather formal assessment measures when screening group therapy clients (Riva et al., 2000). For example, Riva et al. (2000) surveyed the selection method used by group leaders. The results suggested that the most commonly used method for screening by group leaders was individual interview format. The authors recommended that future research focus more on developing cost effective screening instruments that could aid group leaders in matching clients to the groups that were most useful. Moreover, although future implications necessitate the need for screening measures, they are currently limited in number. Several screening instruments have been discussed that

may be useful in selecting members for group psychotherapy (DeLucia-Waack, 1997; 2006). Furthermore, there is not much group literature reflecting whether the measures that will be discussed below are relevant to multicultural group work, and seem to lack cultural sensitivity.

The measures are as follows:

(I) *Group Therapy Survey (GTS; Slocum, 1987):* The GTS measures group members' misconceptions and expectations prior to beginning group therapy (DeLucia-Waack, 1997; 2006). It has 25 items on a 4-point scale from strongly agree to strongly disagree. The categories are based on unfavorable expectations about group therapy such as: *It is unpredictable, it is not as effective as individual therapy and it can be detrimental*. Internal consistency of the GTS was reported as 0.59 using a sample of 96 students with a mean age of 20.2 years (range 16-50 years). The three major factors that emerged were "Positive Attitudes," "Misconceptions," and "Self Disclosure fears". Only positive attitudes showed adequate reliability (0.79). In addition, the sample size was small (n=96).

Later, in Carter, Mitchell, Karutheim (2001) study revised the GTS by replacing the words "group therapy" with "group counseling," re- wording a few items, and using a 5-point scale from *strongly agree* to *strongly disagree*; high scores indicate more positive attitudes toward counseling. Furthermore, the GTS is one of the few group measures that have been examined with regard to cultural and ethnic influences. Leong,Wagner, and Kim (1995) found that attitudes toward group counseling were related to the level of acculturation for Asian American students. The revised version of the GTS is particularly useful with adolescents, mainly those who might have a negative

perception of groups and/or counseling. Furthermore, this measure may help to identify misperceptions about group, which can be discussed with potential group members. A factor analysis of the Group Therapy Survey-Revised (GTS-R) conducted with a sample of 212 students with a mean age of 20 years (range from 17 to 50 years) indicated the same three subscales. The internal consistency of the overall GTS-R was .88 (Cronbach's alpha). For the individual subscales, it was as follows: .78 for Efficacy, .77 for Myths, and .75 for Vulnerability. The 2-week test-retest reliability coefficient for the overall GTS-R was .79 for a different sample of 93 college students with a mean age of 23 years.

(II) *Expectations about Counseling (EAC) (Tinsley, Workman, & Kass, 1980):* measures expectation about counseling behavior. It consists of 17 scales on a 7-point scale from *definitely do not expect this to be true* to *definitely expect this to be true*. The five categories that it assesses are client attitudes and behavior; counselor attitudes and behavior; counselor characteristics; characteristics of process; and quality of outcome. Internal consistency coefficients range from 0.70 to 0.85. It is useful in identifying negative attitudes toward counseling and/ or groups in adolescents (DeLucia- Waack, 1997).

(III) *Group Assessment Form (GAF; Lynn, 1994):* The GAF is designed for children and adolescents. It measures social competence of developmentally disabled adolescents referred for group therapy. The instrument is a symptom rating scale and includes frequency ratings on specific problematic social behaviors. It also allows for a qualitative comparison of reports provided by parent and patient. The GAF is best viewed as a structured interview but lacks reliability and validity. It is used with children, college

students, and adults as potential members for therapy groups. (Lynn, 1994; DeLucia-Waack, 1997).

(IV) *Elements (Es; Schultz, 1992):* Elements is a revised and expanded version of the traditional Fundamental Interpersonal Orientation (FIRO-B; FIRO-F) scale. It assesses self-concept and interpersonal behavior. Element B is *Behavior* that measures the dimension of interpersonal behaviors; Element F assesses feelings; Element S measures Self-concept. Not much research has been done on the psychometric properties of this instrument. However, it could be useful in screening potential group members for dimensions of interpersonal behavior and self concept (DeLucia-Waack, 1997).

(IV) *Hill Interaction Matrix- B (Hill, 1965):* Hill Interaction Matrix assesses the interactional style of prospective members. It is a 64-item self-report instrument based on the Hill Interaction Matrix consisting of statements that describe Content/Style and Work/Style interactions. Content Style assesses group members' preferred topic with a group while Work Style assesses group members' preferred level of work. It can be used to gauge group members' willingness to engage in therapeutic work, as well as their favored level of interaction. It is used to assess readiness for counseling and therapy groups and to predict dropouts (DeLucia-Waack, 1997).

Currently, the last two measures are the "gold standards," and most widely used instruments in group selection. Information is derived from the CORE-R Battery (Burlingame et al., 2006). The CORE-R Battery is designed to assist group practitioners in monitoring group process and outcome. The CORE-R provides group therapists with a tool kit of measures for assessing the effectiveness of their groups and includes three classes of measures: selection, process, and outcome.

(I) *Group Therapy Questionnaire (GTQ; MacNair & Corazzini, 1994)*: The GTQ is a self report instrument that assesses client's interpersonal behaviors, goals, motivation, and typical group roles. It was developed using 155 group clients aged 17-48 years. The clients were assigned to an open-ended interpersonal process group and were classified as either dropouts or continuers. It includes 44 items across 10 content areas, a 34-item interpersonal checklist, and a brief projective of the family constellation (Krogel, Beecher, Persnell, Burlingame, & Simonsen, 2009). Test retest reliabilities for the categories are as follows: Alcohol/Drug issues, 0.93; Expectations about group, 0.77; Interpersonal problem scale (sum of factor subscale), 0.89; Somatic concerns, 0.60. The scale was originally designed to examine the ability of GTQ to predict group member dropout (MacNair & Corazzini, 1994). One limitation of GTQ was that it required 45 minutes to complete. The GTQ has been used in combination with a thorough clinical interview (Krogel et al., 2009).

(II) *Group Selection Measure (GSQ; Davies & Burlingame*): The GSQ is a 19-item self-report instrument designed to assess the probability that clients will contribute and benefit from group therapy. The instrument can be used as a screening tool and identify clients who may not contribute to group processes or are at risk for poor outcomes. It measures 3 constructs: expectancy, ability to participate, and social skills. High values indicate poor prognosis for group therapy. In Krogel et al.'s (2009) study, group members with low scores on the GSQ expected groups to be beneficial, felt they were a part of groups, and found it easy to share their feelings and opinions. High scorers on the GSQ reported being private, passive, and were less likely to discuss their feelings. The studies of the GSQ have been to date based on either adolescent Bosnian trauma

victims or college counseling center client in a time-limited, process group. Furthermore, the findings suggest that client with great expectancy scores are likely to be more cohesive, have greater catharsis during the beginning phases of group, and remain in group for a longer time (Krogel et al., 2009). Also, studies cited in Krogel et al. (2009) suggest that individuals with a domineering style before treatment are likely to have poor symptomatic change in the beginning phases of group work, but, the effect may disappear by the middle phases of group work.

Even though the GTQ and GSQ are successful in predicting referrals to group (Krogel et al., 2009), formal screening measures continue to be unsuccessful in predicting appropriate referrals for group therapy. Additionally, scarce literature on group member selection criteria and selection measures, information is lacking on assessing multicultural variables in group work. The next section addresses the impact of multicultural variables on the process of pre-group screening.

Multicultural Group Work

Demographics in the United States (U.S.) are changing rapidly (Bemak & Chung, 2004) and results from the most recent census confirmed this conclusion (U.S. Bureau of Census, 2010). The change in national population by race in United States between 2000-2010 has seen an increase of 5.7% in the White alone category, 12.3% increase in the Black or African American alone category, 18.4% increase in American Indian and Alaska Native alone, 43.3% increase in the Asian alone category, 35.4% increase in the Native Hawaiian and Other Pacific Islander alone category, 24.4% in the some other race category, and 32.0% increase in two or more races. Further, a 43 % increase is seen in the Hispanic or Latino population compared to 4.9% increased in the non Hispanic or Latino

population. Bemak and Chung (2004) cited the census from 2000, and concluded based on the percentage of demographic population that the two fastest growing ethnic groups was Latino/a Americans and Asian Americans. It was also predicted that by 2050 the Latino/a American population will comprise 62 million or approximately 24% of the U.S population, African Americans 15.7%, and Asian Americans 8.7% of the total U.S. populations (Bemak & Chung, 2004).

With the rise in diversity of the population, multicultural work continues to gain importance in the field of psychology (Bemak & Chung, 2004). With regard to group psychotherapy, there has been a growing demand for attending to the multicultural competency of group leaders to increase effectiveness with different ethnic groups and races during the group process (Greeley, Garcia, Kessler, & Gilchrest, 1992; Bemak & Chung, 2004; De Lucia-Waack & Donigian, 2004). With those intentions, The Association for Specialists in Group Work (ASGW) has formally incorporated multicultural competencies into their principles. The practice guidelines developed by American Group Psychological Association (AGPA, 2007), have been a major step in the field of group work, emphasizing the principle for diversity-competent group workers. The principles clearly stress three main areas: attitudes and beliefs, knowledge, and skills for both group leaders and group members (Banez, Brown, & Molina, 1998; Bemak & Chung, 2004).

Researchers have paid very little attention to addressing multicultural issues in group work across the research, practice, and training domains (Bemak & Chung, 2004). Specifically, several authors (DeLucia-Waack, Coleman, & Jensen-Scott, 1992; DeLucia Waack, 1996; Hayley-Banez & Walden, 1999; Bemak & Chung, 2004; DeLucia Waack

& Donigian, 2004) have highlighted the dearth of research addressing the impact of culturally diverse group members on the process and dynamics of group work. Furthermore, DeLucia-Waack, Coleman, and Jensen-Scott (1992) indicated the need to focus research on addressing cultural diversity within a process-oriented counseling group especially, integrating multicultural work such as, cultural beliefs and behaviors, and developing theory to facilitate change and growth.

Multicultural group work is important for a many reasons; it helps to understand the complex interplay of various multicultural variables during the group process, how cultural differences, especially group members' beliefs, values, and experiences, influence member participation in group. Additionally, it also helps to understand how cultural differences with regard to expectations, goals, and assumptions that group members may have about the content and process of the group (DeLucia-Waack, Coleman, & Jensen-Scott, 1992; DeLucia-Waack, 1996). Inability to recognize the cultural differences or similarities can have some adverse effects leading to negative outcomes (Fenster, 1996). In order to avoid this, group leaders need to cultivate an in-depth understanding of group dynamics, especially when it involves members of diverse groups.

Recommendations for multicultural group work.

Several authors have put forth recommendations to enhance multicultural group work (Tsui & Schultz, 1988; DeLucia-Waack & Donigian, 2004; Bemak & Chung, 2004). Some of the recommendations discussed will be incorporated in the next two sections (i.e. the implication on pre-group screening, and multicultural consideration for group work) and have been important in the development of this measure. First, the

authors recommend a need for group leaders to be aware of their own beliefs, biases, attitude, knowledge and skills. Second, it is important for group leaders to adapt group theory and techniques such that the interventions are sensitive with the values, practices of different cultures (Tsui & Schultz, 1988; Fenster 1996; DeLucia-Waack & Donigian, 2004; Bemak & Chung, 2004). Third, knowledge of Yalom's model (2005) and its impact on diverse cultural groups will facilitate an open communication between group leaders and members if it arises during the group process (DeLucia-Waack & Donigian, 2004; Bemak & Chung, 2004). Fourth, understanding the ways in which group leaders and group members' ethnic/racial identity would converge or diverge. Fifth, there is a need to explore and understand the relevance of group work in the cultural context. Specifically, explore, recognize and integrate ways to respond to cultures that foster values different from western-oriented cultures (DeLucia-Waack & Donigian, 2004; Bemak & Chung, 2004). Sixth, group leaders need to be aware of the effect discrimination, racism, and oppression can have on individuals who belong to culturally diverse groups (Tsui & Schultz, 1988; Johnson et al., 1995; Fenster, 1996; DeLucia-Waack & Donigian, 2004; Bemak & Chung, 2004). Seventh, group leaders need to be aware of the different ways in which members belonging to different cultural groups may perceive them (for example, are they perceived as someone in a position of authority or as a peer, or an expert). Eight, group leaders need to be aware and understand ways to work with group members whose primary language is not English, and when the representation of their concerns arise due to this cultural differences (Bemak & Chung,2004). Lastly, group leaders need to model behaviors such as risk-taking and discussing sensitive issues in group (Yalom, 2005; DeLucia-Waack & Donigian, 2004).

Implications for pre-group screening

Addressing some of the key questions related to group membership can familiarize group leaders with factors that may exclude someone from joining the group or fully benefiting from the group (Liu et al., 2007). In addition, a pre-group screening assessment can help group leaders decide on how to screen for a fit between individuals and the group (Liu et al., 2007). Again, an inability to address and assess cultural issues can result in underuse and premature termination of mental health services by the different cultures (Sue & Sue, 1990; Leong, 1992). While research on dropout in the group literature is weak (McCallum, Piper, Orgodniczuk, Joyce, 2002; Whittingham & Capriotti, 2009), the research on multicultural variables in relation to dropout has been insubstantial. Furthermore, Merchant and Butler (2002), outlined questions that aid facilitators in a pre-group screening to determine what cultural factors need to be considered prior to placing ethnic minority residents in a psycho-educational group on a predominantly White adolescent residential treatment center. The questions were as follows: "Can you tell us about your cultural/racial heritage? How would a group like this be helpful to you? Would you feel comfortable sharing in a group like this? What is you experience of being a person of color at this residential treatment center?" Even though, these questions are specific to the treatment setting, it still questions the need for a comprehensive assessment that could help in screening cultural variables during the group selection phase (Whittingham & Capriotti, 2009). For this purpose, Chen and Hahn (2001) emphasized the importance of pre-group screening and described it as the key to resolving questions of negative therapeutic outcomes. Thus, group screening needs to take into account the biases, values, beliefs, and multiple identities that a group member

might feel excluded or unsafe due to the cultural or other diversity-related variables (Whittingham & Capriotti, 2009).

With regard to pre-group screening, Whittingham and Capriotti (2009) included several other recommendations in addition to the above said recommendations by group leaders. Specifically, they illustrated the need to consider differing notions of confidentiality (in relation to family), ideas and values around self-disclosure, differing interpersonal styles, conflicting cultural styles of expression(conflict avoidant vs. confrontational), differing values of group leaders/members with respect to issues of expression such as autonomy, individualism vs. collectivism, and other differences related to one's belief system.

Multicultural consideration for group work.

The current section presents a discussion of the key assumptions that often affect how the group functions. DeLucia-Waack and Donigian (2004) have elaborated on these assumptions which are common concerns to a wide range of ethnic/cultural groups. The assumptions of group psychotherapy are based on the Eurocentric approach to group work (DeLucia-Waack, 1996; Eason, 2009). The assumptions derived from a Eurocentric notion can differ from certain cultural beliefs and values of members from diverse groups making group membership potentially challenging for these members, leading to early termination (Rollock, Westman, & Johnson, 1992; DeLucia-Waack, 1996). Some of the key assumptions are categorized based on the information found in DeLucia-Waack's and Donigian's (2004) book titled *"The practice of multicultural group work."* The book elaborates on key research relevant to multicultural group work. Additionally, other

researchers have also proposed important variables that need to be assessed prior to beginning the group process. Most of the research obtained on the other variables have been derived from recommendations provided by other researchers' and their discussion on the key variable to be considered prior to pre-group screening process or in relation to working with various ethnic groups. Additionally, amongst the group literature, Whittingham and Capriotti (2009) also included several other recommendations in addition to the above mentioned recommendations. These recommendations were in relation to pre group screening phase. Specifically, they illustrated the need to consider differing notions of confidentiality (in relation to family), ideas and values around self-disclosure, differing interpersonal styles, conflicting cultural styles of expression(conflict avoidant vs. confrontational), and differing values of group leaders and members with respect to issues of expression such as autonomy, individualism vs. collectivism, and other differences related to belief system.

In this next section, the information discussed has largely focused on group work with Asian/ Asian Americans(Kaneshige, 1973; Sue & Sue, 1977;Shen, Sanchez, & Huang, 1984;Tsui, & Schultz, 1988; Matsushita, & Atkinson, 1991; Sue et al., 1991; Greeley et al.,1992;Leong, 1992; Yu and Gregg, 1993; Fujino, Okazaki, and Young's,1994; Chen, 1995; Leong et al.,1995; Fenster, 1996; Conyne, Wilson, Tang, & Shi, 1999;Chen & Han, 2001; Chung, 2004; Bemak & Chung, 2004), Black/African Americans (Terrell & Terrell,1981; Nickerson, Helms & Terrell, 1994; Williams, Frame, & Green, 1999; Pack-Brown and Fleming, 2004), Native Americans/ American Indians (Dufrene, & Coleman, 1992; Garrett, 2004), Hispanics(Delgado, 1983, Torres-Rivera,

2004; Torres-Rivera, Wilbur, Roberts-Wilbur, & Phan, 1999), and Muslim/Islam (Banawi and Stockton ,1993).

The group literatures is reviewed and categorized based on the following said categories:

1. *Group Leaders Role:* addresses assumptions about the role of the group leader as a facilitator. It is based on assessing gender or ethnicity of group leader; expectation of relationship with group leader*;* expectation of behaviors of group leader during the group process (Delgado, 1983; Tsui, & Schultz, 1988; Leong, 1992;Sue et al., 1991; Dufrene, & Coleman, 1992; Greeley et al, 1992; Banawi & Stockton, 1993,Yu & Gregg, 1993; Fujino et al, 1994; Leong et al., 1995;Fenster, 1996; Conyne et al.,1999;Torres-Rivera et al.1999;Chen & Han, 2001; Devan, 2001; Chung, 2004;Yalom 2005).
2. *Verbalization and Self Disclosure.* This category addresses the importance of verbalization and self-disclosure during the group process (Kaneshige, 1973; Shen, et al, 1984; Dufrene & Coleman, 1992; Fukuyama & Coleman, 1992; Greeley et al., 1992; Leong, 1992; Banawi and Stockton, 1993; Yu & Gregg, 1993; Chen, 1995; Leong et al. 1995; Fenster, 1996;Conyne, 1998; Conyne et al., 1999; Chen & Hahn, 2001; Bemak & Chung 2004; DeLucia-Waack & Donigian, 2004; Garrett,2004; Yalom,2005,Debiak, 2007).
3. *Ethnic Identity*: DeLucia-Waack and Donigian (2004) discussed the need to asses for and the importance of understanding constructs such as ethnic/racial identity development, acculturation, and biculturalism as it relates to the group process. (i.e. understanding ethnic identity), and its impact on the group process

(Smith,1991; Greeley et al. 1992; Phinney & Alipuria, 1990; Phinney, 1992, 1993; Fukuyama & Coleman, 1992; Leong, 1992; Yu & Gregg, 1993; Haley-Banez & Walden, 1999;Chen & Han, 2001;Bemak & Chung, 2004, DeLucia-Waack & Donigian, 2004).

4. *Racism and Prejudice:* Group member bring with them values, beliefs, unconscious racial attitudes and prejudices which is apparent during the forming stages of group process is reviewed in this section(Tsui & Schultz, 1988; Dufrene & Coleman, 1992; Fukuyama & Coleman, 1992; Gainor, 1992; Leong, 1992; Johnson et al. 1995; Leong et al. 1995; Fenster, 1996; Abernethy, 1998; DeLucia-Waack & Donigian, 2004; Marbley, 2004; Anderson, 2007; & Eason, 2007).
5. *Stigma:* The general notion of underutilization of mental health services by minority groups because of mental health stigma is considered in this section (Kaneshige, 1973; Terrell & Terrell, 1981; Tsui & Schultz, 1988; Sue et al. 1991; Leong, 1992; Banawi & Stockton, 1993; Nickerson et al., 1994; Uba, 1994; Phelps, Taylor, Gerard, 2001).
6. *Other Cultural Values :* such as, importance of taking risk and trying out new behavior (Banawi & Stockton, 1993; DeLucia-Waack & Donigian, 2004; Yalom,2005); interpersonal and cultural styles of expression (Kaneshige, 1973; Sue & Sue, 1977; Tsui & Schultz, 1988; Dufrene & Coleman,1992; Gainor, 1992; Leong, 1992; Fukuyama & Coleman, 1992; Banawi & Stockton, 1993; Leong et al. 1995; Yu & Gregg, 1993; Conyne et al.,1999; Chen & Han, 2001; Bemak & Chung, 2004; DeLucia-Waack & Donigian, 2004; Garrett, 2004; Whittingham & Capriotti, 2009); values of thoughts over feelings(Kaniseshige, 1973;Leong,

1986; Greeley et al., 1992; Banawi & Stockton, 1993; Chen, 1995; DeLucia-Waack & Donigian,2004; Pack-Brown & Felming,2004; Shechtman and Halevi, 2006); importance of unstructured interaction between members (Matsushita, & Atkinson, 1991;Greeley et al., 1992; Leong, 1992; Yu & Gregg, 1993; Chen & Han, 2001, Bemak & Chung, 2004; DeLucia-Waack & Donigian,2004); group as a treatment modality(Kaniseshige, 1973;Leong, 1992; Banawi & Stockton, 1993; DeLucia-Waack & Donigian, 2004), and individual versus group therapy as the focus of treatment (Leong, 1992; Williams, Frame, & Green, 1999; Pack-Brown & Fleming, 2003; Chung, 2004; DeLucia-Waack & Donigian, 2004).

Group leaders role.

According to Greeley et al. (1992), the effectiveness of group work is contingent to some degree on the way the group leader facilitates and influences the group process. Group leaders play a major role in creating a safe and harmonious environment to share personal information, assist in managing conflicts, provide feedback to members, and facilitate the feedback process between members. In addition, group leaders are expected to act as role models and be effective in conducting group work, which involves sharing their knowledge of group process and techniques to deal with the needs of the group members (Yalom, 2005).

According to Yalom (2005), group leaders fulfill numerous responsibilities such as focusing on the group format, providing interpretations/feedback to group members in the here and now, and helping members integrate affect, thinking, and behavior, whilst communicating empathy to the group. Additionally, they strive to create an atmosphere of equality between members and leader. However, as leaders endeavor to accomplish

these goals, they need to be aware that relationships between group leaders and members are perceived differently in different cultures (Greeley, et al. 1992). For instance, cultural groups (e.g. Asians, Latinos, Muslims and Native Americans) bestow great respect to leaders and attribute knowledge and wisdom to persons in authority. In addition, people from such cultures are more likely to view group leaders as authority figures (Tsui, & Schultz, 1988; Leong, 1992; Dufrene & Coleman, 1992; Banawi & Stockton, 1993; Yu and Gregg, 1993; Leong et al., 1995; Fenster, 1996; Torres-Rivera et al.; Chen & Han, 2001; Chung, 2004; Torres-Rivera, 2004).

As cited in Leong (1992), the Eurocentric approaches to relationships are characterized by informal and collateral relations (among equals). In contrast, interpersonal relations in most Asian cultures tend to be hierarchical with a strong respect and loyalty to authority. Hence, Asian group members are more likely to view group leaders as authority figures, defer to their judgment and expect them to have special expertise on topics and power to direct the group process (Leong, 1992; Chung, 2004). Furthermore, counselors who try to act as equal may be viewed by Asian group members as incompetent and lacking expertise because hierarchically their position is higher than that of their clients (Conyne et al., 1999). Thus, the relationship follows a hierarchical structure (Yu& Gregg, 2003; Devan, 2001). Similarly, members from Asian cultures are likely to expect group leaders to have a one-way communication with them. The group leader is considered an adviser, a teacher, an information giver, and a problem solver. They are expected to provide suggestions and initiate alternatives (Chen, 1995, Chung, 2004). Therefore, members from such cultures may not participate in group unless specifically addressed by the leader. In such cultures, authority is not challenged directly.

For example, Yu and Gregg (1993) shared how Asian clients are more likely to not disagree with authority; if they expressed their differences of opinion openly it can be perceived as a sign of disrespect. With reference to Native Americans (Dufrene & Coleman, 1992), the role of the group leader is compared to an elder, a tribe leader, a medicine person, or a clan elder who leads the group, and is seen as an authority figure and respected. Therefore, Native Americans consider authority figures to be experts on all areas, and are expected to direct the process and content of group sessions, and provide solutions to their group members (DeLucia-Waack & Donigian, 2004). However, it is also important to note that sometimes members from other cultures may also view the suggestions made by a group leader as intrusive because they are made by someone outside the family, and can also view authority figures with suspiciousness and lack of trust (Greeley et al. 1992).

In the same way, Banawi & Stockton (1993) informed that Muslims' respect for authority figures may at times interfere with group members sharing their view on issues and feeling towards group leaders. Making direct disagreements towards the leader's perspective is considered disrespectful. Thus, Muslims would limit their remarks to positive and respectful feelings and attitudes. As such, individuals from different cultures may be viewed by other dominant group members to be shy or passive (Banawi & Stockton, 1993; Chung, 2004; DeLucia-Waack & Donigian, 2004).

Different cultural groups have different perceptions about leadership. For instance, Latinos see leadership as an egalitarian relationship where it is important to respond to people equally and with respect (Torres-Rivera's et al., 1999). If a group leader does not acknowledge this difference, he/she is considered to be imposing their

values onto the members, and may lead to negative outcomes. Further, group leaders are considered to be in control and have the answers for all problems (Torres-Rivera, 2004). Leaders are viewed as the process expert, someone who takes the initiative and responsibility for the group process. Latino clients also expect group leaders to focus more on the present aspect of time than on the past or future concerns (Torres-Rivera et al., 1999; DeLucia & Donigian, 2004).

With reference to the gender or ethnicity of the leader, certain cultural groups may have problems with mixed gender groups, or having a co-leader who is of the opposite sex. Sue et al. (1991) investigated the services received, length of treatment, and outcomes of Asian-American, African-American, Mexican-American, and White clients in an outpatient setting. Sue et al. (1991) hypothesized that therapist-client matches in ethnicity and language would be beneficial to clients. Results indicated that ethnic match between therapists and clients were related to length of treatment involvement for all groups. Among clients who did not speak English as their primary language, ethnic and language match was a predictor of length and outcome of treatment. Similarly, gender match was associated with lower dropout rates for Asian Americans and Whites and with more sessions for Mexican Americans and Whites. Likewise, Fujino et al. (1994) study suggested that ethnic and gender match between Asian American women and their therapists reduces premature termination and increases duration of treatment. Therefore, these results indicate that ethnically identified group leaders can serve as important role models for group members. Additionally, Leong et al. (1995) emphasized the need to have ethnically identified leaders with similar cultural backgrounds to group members.

Therefore, affirming the fact that gender or ethnicity of the leader for certain cultural groups is important to consider during the pre-group screening phase.

With regard to the gender of the group leader, Chung (2004) pointed out that in some traditional Asian cultures, men and women are bound by traditional gender roles where men are expected to do most of the talking, while women do not speak unless given permission by men. Therefore, in order to promote participation, Asian men and women are likely to benefit if they engage in separate groups. Moreover, Muslim men differ in their interaction with women as opposed to men. For instance, men are generally polite, and not confrontative towards women, and women may feel uncomfortable in the presence of a male leader (Banawi & Stockton, 1993). As a result, Banawi and Stockton (1993) recommend having co-leaders of both sexes, and checking-in with) group members about their interactions with co-leaders of same and opposite sexes.

Lastly, with regard to expectation of group leader behavior during the group process, different cultural beliefs and expectations may clash with group leader behaviors based on theoretical orientations. Yalom (2005) mentioned that traditional group work requires leaders to self-disclose with regard to the here and now moment, as opposed to personal experiences and events. The preference is for group leaders to share very little information about their personal lives, and be more formal in their approach. Some cultures require group leaders to act as role model, disclose personal information and openly discuss their reactions during the group process. For example, Delgado (1983) illustrated that in the Latino culture, group leaders are expected to be flexible, and act out a variety of roles. They are expected to be authority figures, but are also expected to share

a great deal of themselves in the group process. Similarly, Yu and Gregg (1993) noted that Asian group members are formal and may find it difficult to talk in public. Emotional expression may not be easy and they may hold back their feelings. When faced with such a situation, group leaders may appropriately disclose personal information to model and facilitate openness and help Asian members in feeling more comfortable. It is also possible that personal sharing by the group leader would encourage Asian members to gain confidence and trust in the group leader. Further, it is also necessary for the group leader to be authentic in their self disclosure in order to avoid premature termination (as cited in Chung, 2004). However, group leaders need to be cognizant of how self-disclosure may be perceived differently by different cultural groups. Some cultural groups that may have not received personal information from group leaders may perceive the group leader as one who has exercised power when the leaders self-disclose. On the other hand, group leader's self-disclosure may foster member connection for members belonging to certain cultural groups (De-Lucia & Donigian, 2004).

Verbalization and self-disclosure.

Group psychotherapy relies mostly on verbal participation from the group members. Greater verbal participation contributes to a sense of involvement in the group (Shen, Sanchez, & Huang, 1984). However, cultural group differences exist on the quality and quantity of verbal participation or self-disclosure (Conyne, 1998; DeLucia-Waack & Donigian, 2004). Yalom's (2005) therapeutic factors for group treatment require some amount of leader self-disclosure. For example, attempts are made to engage individuals through requests for personal disclosure during catharsis, or requests for corrective feedback that are assumed from traditional group work. As such, group

members from different cultural backgrounds may view such requests as rude and intrusive.

In addition, many cultures forbid disclosing personal information, especially, when it believed to bring shame or disgrace to the family, and community (Kaneshige, 1973; Fukuyama & Coleman, 1992; Leong, 1992; Banawi & Stockton, 1993; Leong et al. 1995, Fenster, 1996; DeLucia- Waack & Donigian, 2004; Debiak, 2007). Among Asian cultural groups, group members may appear frequently confused by the traditional group therapy emphasis on verbal participation and self-disclosure. When Asian group members may be pressed for revealing personal information, it may cause distress and go against their traditional values that emphasize not disclosing family or personal matters to outsiders (Fenster, 1996; Bemak & Chung 2004). Particularly, in Japanese culture, family problems and conflicts are generally resolved within the family circle, and the only image that is displayed publicly is a socially acceptable one. Japanese individuals believe that individual problems are of minimal importance in contrast to the importance of the family (Leong, Wagner, & Kim 1995; Bemak & Chung 2004). Therefore, public exposure of family conflicts during resolving one's own individual conflicts is considered an act of being selfish and having an exaggerated sense of self- importance (Kaneshige, 1973). Hence, it is likely that Japanese group members would not want to disclose information that may bring shame or "loss of face" for the individual and his/her family (Conyne, et al., 1999). Thus, generalizing to most Asian cultures, self-disclosure behaviors are viewed as signs of thoughtlessness, disloyalty to family, immaturity, or viewed as bragging (Leong, 1992; Yu & Gregg, 1993). Given these facts, conflicts arises when group members may avoid self-disclosure by being polite or smiling or attempt to

talk about superficial issues as a way of participating, or wait to be drawn by the group leader to avoid defying cultural norms. Sometimes, members may remain quite or silent as a defense against boundary intrusion which may be perceived by others in the group as withdrawn (Fenster, 1996). As such, verbal participation is likely to be low among Asian clients' as they value silence and listening to gain wisdom (Yu & Gregg, 2003).

Sometimes, Asians are also likely not to voice their concerns because they fear being negatively judged by other group members (Yu & Gregg, 1993). Hence, one way group members could learn sharing personal feelings and experiences is through the group leaders' modeling and teaching. Group leaders who model authentic participation and share personal experiences with the groups can assist group members to open up. On the other hand, Eurocentric approach to group counseling emphasizes importance of verbal participation and self-disclosure for effective group work. As a result, problems arise when group members and the leader assume and misunderstand or misinterpret culturally different group members' lack of effort to participate or self disclose, causing increased guardedness among other members (Kaneshige, 1973). Similar to the Asian culture, Native Americans prefer not to disclose personal or family matters with outsiders (Dufrene & Coleman, 1992). Moreover, group discussions are held in a circle and each person is given an opportunity to participate. To avoid group conflicts, they are reluctant to share personal problems, and have outsiders involved in their problems. Additionally, Garrett (2004) concurred that Native American clients are reluctant with self-disclosure and have a tendency to use noninterference with their fellow group members to avoid disclosure. As a result, if group members who are culturally different feel pressured to share family or personal stories, anxiety can arise, and result in withdrawal from group,

and later, discontinuation of group (Chen, 1995). However, African Americans may engage in emotional verbal dialogue and tend to distrust members who do not verbalize their thoughts (Greeley et al. 1992).

Similarly, with regard to verbal participation and self disclosure, it is equally important to understand the role of the way silence is communicated by group members from different cultural backgrounds. This position is also reflected among the work of various authors with regard to Asian culture (Greeley et al., 1992; Leong, 1992, Yu & Gregg, 1993; De-Lucia-Waack & Donigian, 2004). For instance, Kaneshige (1973) included an explanation of how silence was viewed in the Japanese culture, as compared to Eurocentric viewpoint. Silence indicates a preference for being quiet than rambling on and saying nothing or saying something that is not well thought out; the talkative person is considered to be someone who does not think very much because he/she is busy talking; and talkative people are viewed as attention seekers. Furthermore, Sue and Sue (1977) illustrated that in some instances silence is traditionally regarded as a sign of respect for elders and politeness. On the other hand, under the Eurocentric viewpoint, silence does not accomplish anything, and is interpreted as resistance; and a person who is silent has no ideas or is not bright. Thus, the Eurocentric viewpoint is to exercise idea and responsibility by talking (Kaneshige, 1973; Greeley et al., 1992; DeLucia-Waack & Donigian, 2004). In short, cultural differences in values regarding verbal participation or self-disclosure could make group members of different cultural backgrounds uncomfortable. They may avoid taking interpersonal risks and refrain from direct types of communication by being silent, not asking direct questions, and may evade

confrontations, interruptions, and challenges to other group members (Conyne et al., 1999;Chen & Hahn, 2001).

Ethnic identity.

As discussed earlier, one of the recommendations suggested by Bemak and Chung (2004) was to understand the intersection between racial/ethnic identity development of group members and group leaders. Fukuyama and Coleman (1992) suggested that ethnic identity is considered an important variable when considering a referral for group therapy. In fact, DeLucia-Waack and Donigian (2004) suggested that biculturalism, acculturation and ethnic identity are like to affect group members' self esteem, interpersonal behavior, and their participation in groups. For instance, Phinney and Alipuria, (1990) study examined ethnic identity and commitment, the importance of ethnicity as an identity issue and relationship of ethnic identity to self-esteem among college students. The results indicated that ethnicity is an important area for minorities. Specifically, in the study they found that ethnic identity was consistently rated by minorities as more important than other domains such as political, and above or close to religious domains. Furthermore, Blacks and Mexican-Americans students showed greater need to find out about their ethnic background and its role in their lives. Furthermore, self esteem was also found to be strongly related to ethnic identity commitment for the minority students. Especially, it was related to the extent the students had thought about and resolved issues involving their ethnicity.

According to Smith (1991), ethnic identity development is useful for members for both minority and majority ethnic groups. Smith(1991) defined an ethnic group as "a

reference group where people who share common history and culture, may be identifiable because they share similar physical feature and values and who, through the process of interacting with each other and establishing boundaries with others, identify themselves as being a member of that group." Therefore, it involves the importance of identifying ethnic labels for oneself and the subjectivity of others in ethnic group membership.

Further, Smith (1991) defined *Ethnic group membership* as involving "consideration of one's family structure, family roles men and women assume, one's values and the belief systems, the language, ethnic signs and symptoms and reference group perspective one shares with others." In sum, ethnic identity is a sum total of group member's feelings about their values, beliefs, and common histories that identify them as a distinct group. Ethnic identity development also provides sense of belongingness and sense of past link for an individual. Erikson (1950), as cited in Smith's(1991) article shared that ethnic identity is a process located both in the core of the individual and in his or her communal culture. Phinney (1992) suggested that ethnic identity was well documented for diverse ethnic groups including African Americans, Hispanics, Asians, and various White ethnic groups.

Furthermore, Chen & Han (2001) study placed importance of understanding ethnic identity development will help to understand the member's readiness for group. During college years, students are developing a sense of self and identity, which often relates to their meaning of being a member of an ethnic group, especially when they are on a predominantly white campus. For example, Asian students' ethnic identity development influences their perception of cross-cultural situations and people, which

can affect all aspects of therapeutic outcome. As a result, it is important to consider the ethnic identity development level in cross-cultural groups (Chen and Han, 2001). Failing to do so, may likely lead to premature termination (Greeley et al. 1992; Haley-Banez & Walden, 1999; Leong, 1992; Yu & Gregg, 1993). Chen and Han (2001) also drew a distinction between acculturation and ethnic identity development. For instance, in acculturation, Asians self-incorporate values and beliefs of the dominant culture to survive and belong (Smith 1991). On the other hand, in ethnic identity development, Asians attach or reject their own culture into their identity. Therefore, Chen and Han (2001) believed problems could be resolved by assessing client's ethnic identity development. Scales such as Multi Ethnic Identity Measure Scale (MEIM) are available for assessment during the pre-group screening process. The information derived from this measure can be used to match clients in different ethnic identity development phases with different types of groups.

Phinney (1992, 1993) developed a three-stage model of ethnic identity development based on research with minority adolescents combined with other ego identity and ethnic identity models that relates to the four components studied in the MEIM measure. The development of Phinney's three-stage progression model is based on the major works by Erik Erikson and empirical works by Marcia (Phinney, 1990). As cited in Phinney's (1990, 1993) article, Marcia's (1966) ego identity development model recommended that ego identity status is based on the presence or absence of exploration of one's ethnic identity. Accordingly, people who have not explored or committed are said to correspond to *diffuse* status; people who have made a premature commitment without exploration, generally as a result of opinions and attitudes of others, are said to

correspond to the *foreclosure* status; people who are in the process of exploration, but have not made a commitment are said to correspond to the *moratorium* status; and people who have made a firm commitment/ decision followed by exploration are said to correspond to the *ethnic achievement* (Phinney, 1990, 1993). The ethnic identity formation can take place over time, as people explore and make decisions about the importance of ethnicity in their lives (Phinney, 1990). Accordingly, Phinney's (1990,1993) the three-stage progression model focuses on the process by which people come to understand the importance of their ethnic identity and making decisions about its function in their lives, irrespective of their ethnic involvement (Phinney, 1993). In the three progression model, adolescents and adults progress from an unexamined ethnic identity through a period of exploration, and then to a committed ethnic identity (Phinney, 1990). In *unexamined ethnic identity,* adolescents or adults have not been exposed to ethnic identity issues. In this stage, people in the two stages of *diffusion and foreclosure* were considered, as they could not be reliably distinguished from each other (Phinney, 1990, 1993). During this stage, minorities may show preference for the dominant culture, have negative views of their own group held by the majority *(foreclosed),* or *(diffusion),* or may not give it a thought or be least interested in ethnicity (Phinney, 1990). The second stage is *ethnic identity search/moratorium* where exploration begins that may take place due to significant life experiences that compel one to explore ethnicity. During this stage, individuals make attempts to immerse in their culture through learning and engaging in wide variety of activities like reading about one's cultural history, or asking people, or participating in cultural events. The third stage, *the ethnic identity achievement,* involves individuals gaining a deeper sense of their

own ethnicity (Phinney, 1990, 1993). In relation to the three stages, Phinney (1990) identified four major components of ethnic identity. These are ethnic self-identification, as affirmation and sense of belonging to the group, ethnic behavior and practices, and ethnic involvement. These four components form the basis of the MEIM developed by Phinney (1992). In the MEIM, the four general aspects of ethnic identity are assessed, including: positive ethnic attitudes and sense of belonging; ethnic achievement; ethnic behaviors or practices; and other-group orientation, and allows for it to be used across different ethnic groups. Ethnic identity is conceptualized as a continuous variable.

Self identification is defined as the ethnic label used to identify oneself in relation to a particular ethnic group. Thus, individuals will choose one's own ethnic group from the given list in the measure (Phinney, 1992). It is different from one's ethnicity which is the objective group membership determined by parents' ethnicity. *Affirmation/Belonging* involves feelings of belonging and attitudes toward one's ethnic group. *Ethnic behaviors and practices* assess one's participation through various activities in cultural traditions. Positive attitudes are reflected in statements indicating feelings of pride, happiness, and Negative attitudes involve disconnecting from one's own culture, and wanting to stay away or hide one's identity. *Ethnic Identity Achievement is* defined as "a continuous variable, ranging from the lack of exploration and commitment (low interest and awareness and little clarity concerning one's ethnicity) to evidence for both exploration and commitment, and is reflected in efforts to learn more about one's background and a clear understanding of the role of ethnicity for oneself." On the MEIM, a low score is indicative of ethnic identity diffusion; a high score, of ethnic identity achievement. Lastly, *Attitude towards other groups* is an added category to the measure as part of

assessing ethnic identity. It is considered an important factor as it provides an understanding of one's orientation towards the dominant society. However, it is difficult to assess attitudes towards the majority group because for majority group members, dominant culture ethnic attitudes and attitudes tend to overlap. Thus, this measure includes assessment of attitudes towards, and interactions with, ethnic groups other than one's own (Phinney, 1992).

Racism and prejudice.

Prejudice, racism, and discrimination commonly seen in U.S. society may manifest itself in group work (Marbley, 2004; Anderson, 2007). Racism and discrimination are historical and contemporary aspects of the U.S. society. Group leaders need to be aware, recognize, and understand that diverse group members may bring their experiences with racism and discrimination to the group sessions (Fenster, 1996). Mostly, members from ethnic and racial groups and other minorities are underrepresented in most therapy groups. As a result, groups become a microcosm of the larger society; groups mirror the values, beliefs, prejudices, biases, and stereotypes seen in society. Moreover, power relationships among group members are re-enacted dynamically within group (Tsui & Schultz, 1988; Johnson et al., 1995; Fenster, 1996). Even though, members may show little overt racism there will be some underlying unconscious racial attitudes exhibited by statements (Johnson et al., 1995). It is likely that racial tension may become evident in racially mixed groups, with the danger of disintegrating the group. For this reason, group leaders need to be knowledgeable about racial and ethnic identity theory, and understand how it may impact the group process (Fenster, 1996). Especially,

knowing the pervasiveness of racism in our society, it would be unwise to minimize the psychological damage that racism can create in the group setting.

DeLucia-Waack & Donigian (2004) and Eason (2007) emphasized the need for group leaders to have an understanding of group dynamics reflecting dominant-minority group relations and the subtle and covert nature of racism. For example, Gainor (1992) reviewed overt and covert forms of internalized oppression such as finding fault, attacking, having unrealistic expectations of leaders criticizing, and invalidating one another when coming together in a group to address an important problem. Additionally, Abernethy (1998) suggested other common racial themes which include feelings of guilt for being White, internalized racism, a sense of feeling different or unique due to race, and a sense of entitlement for anger or privilege. Further, the meanings of each themes was said to differ from person to person, and change with time/context.

Group members have concerns about racial discrimination in groups which include fears that the leader and/or other members will be judgmental, and concerned about the ability of the group leader to maintain safety in the group where members are willing to take risks of self-disclosing racial aspect of their experiences (Abernethy, 1998). However, sometimes group members may develop defensive/resistant patterns of fear, mistrust, withdrawal, and isolation from others in response to being hurt by them (DeLucia-Waack & Donigian, 2004; Eason, 2007). **S**ometimes group members may also feel ashamed of one's fear of other group members (DeLucia-Waack & Donigian, 2004; Eason, 2007). Therefore, group leaders can assist group members to explore their fears

and concerns regarding each other and move towards building group alliance and cohesiveness (DeLucia-Waack & Donigian, 2004; Eason, 2007).

Likewise, an understanding of the power and structure dynamics in the development of a group is important. For instance, if a majority of group members are White or have been raised in a Eurocentric cultural setting, the structure is highly susceptible to recapitulation of dominant-minority relations (Eason, 2007). Once again, the emphasis is on being aware of the manifestation of oppression and victimization that is likely to occur while managing a diverse group. For example, Asian clients may perceive requests for self-disclosure, and requests for feedback as impolite, and as attempts at domination. Thus, Asian clients may not disclose due to one's set cultural norms. However, a group member from a dominant culture may interpret behavior and intentions of minority group member as unacceptable, and be distrustful or guard their boundaries even more closely. As a result, a feedback loop may result in which the Asian group members feel misunderstood, unheard, angry, and frustrated. (Eason, 2007; Leong, 1992; Leong et al. 1995). Chan and Hen (2001) indicated that such value conflicts may cause Asian group members to withdraw into silence, intellectualization, or anger displacement, resulting in a negative group experience or an early termination. It should be noted that these feelings may even be multigenerational in nature. Thus, Asian clients may harbor feelings of negative transference toward dominant-culture group members based on their own or otherwise experiences with racism and discrimination (Leong, 1992; Leong et al. 1995).

Anderson (2007) also illustrates the importance of understanding the presenting concerns from a cultural perspective. Dufrene & Coleman (1992) suggested that lack of information, adherence to racial and ethnic stereotypes and beliefs, and unfamiliarity with the historical, psychological, and sociological experiences of Native Americans may be some of the hurdles to the group counseling process. Therefore, Marbley (2004) recommends that effective counseling with multiracial and multiethnic group members requires an awareness and knowledge of one's own as well as client's culture, values and norms. Setting guidelines for group members may help them communicate with each other in the least offensive, hurtful, and oppressive manner, such as insisting that the group member's response first acknowledge and validate a member's feelings and experiences. Group facilitators need to utilize self-disclosure as a tool to model how to discuss racial issues. Thus, group leaders need to proceed carefully, sensitively, and cautiously when dealing with clients who have experienced racism, discrimination or oppression. Also, groups with specific group intervention objectives are more likely to succeed when members are included on the basis of a careful pre-group screening.

Stigma.

As cited by Leong et al. (1995), most of the literature on individual therapy has found significant and reliable influence of race-ethnicity variables on treatment, including issues of utilization rates, dropout rates, outcome and process. One reason for under utilization of mental health services is the level of cultural mistrust which influences the individuals' help seeking attitudes (Kaneshige (1973; Sue et al. 1991, Leong, 1992; Nickerson et al. 1994; Leong et al., 1995; Phelps et al., 2001). Cultural mistrust research has focused on the effects of counseling process (help seeking attitudes), counseling

outcomes (premature termination) and behavioral expectations on seeking mental health services (Phelps et al., 2001). For instance, Nickerson et al. (1994) suggested that cultural mistrust can foster negative attitudes in Blacks about entering therapy with White counselors, and prospective Black clients might therefore be less willing to visit mental health clinics. Furthermore, negative attitudes fueled by a desire to avoid stigmatization might delay attempts of some to seek help (Nickerson, et al., 1994). Similarly, Leong (1992) revealed that Asian Americans' attitudes and beliefs concerning mental illness and counseling interventions are important dimensions to keep in mind. These attitudes influence not only whether or not they will seek help from mental health professionals but also how long they will stay in counseling and what types of interventions will be experienced as alienating or culturally inappropriate. Mostly, Leong et al. (1995) suggested that Asian Americans tend to underutilize group counseling services. Uba (1994) identified barriers to access mental health services for Asian Americans. One of the important barriers is the cultural norms about seeking services, specifically the stigma attached to mental health problems, bring shame to the family, and the inability to identify one's own mental health issues (Tsui & Schultz, 1988, Uba, 1994). Additional barriers include the lack of financial resources, geographical inaccessibility, the lack of knowledge of available services, and a shortage of culturally sensitive and bilingual staff. For example, Kaneshige (1973) indicated that one of the conflicts Japanese American students face is accepting they have problems that they cannot adequately overcome by themselves. Japanese-American culture views personal problems and shortcomings as being due to a lack of shortcomings and a lack of resolve and determination in the individual. Thus, Japanese-Americans' only hope is to try hard enough to resolve the

problem. If the problem persists, they bear the burden and often somatize many emotional problems. If they seek help in counseling centers, it is only after considerable time and pain. Therefore, they are likely to delay initial contact for counseling services, have higher attrition rates, and a shorter duration of therapy (Uba, 1994).

According to Sue, et al. (1991), past investigators have found problems or deficiencies in delivery of mental health services to number of ethnic minority groups, such as American Indians, Asian Americans, African Americans, and Latinos. These deficiencies could be due to a number of factors, including underutilization of services by ethnic groups and premature termination due to ineffectiveness of traditional mental health services for ethnic minority clients. Ethnic minority groups tend to drop out of treatment after one session compared to 30% drop out rates of Whites. Ethnicity was a major predictor of premature termination even after the client demographic variables and treatment variables were controlled. Terrell and Terrell's (1981) idea of cultural mistrust explains why African Americans underutilize some mental health facilities. Terrell and Terrell (1981) argued that because African Americans, as a group, have historically had race-related mistreatment by Whites, African Americans may have developed a generalized suspicion or mistrust of Whites. Specifically, cultural mistrust might cultivate negative attitudes in Blacks about entering therapy with White counselors, and prospective Black clients might therefore be less willing to enter therapy. Therefore, it is important to investigate African Americans' opinions about mental illness, help-seeking attitudes and behaviors, with focus on the examination of additional group related influences.

Other cultural values.

Due to the varying differences in all the things that people have learned to do, different values, ideals, beliefs, skills, tools, customs, and institutions, it is crucial to pay attention to the cultural differences (Sue & Sue, 1977). When working with groups, group leaders may implement traditional group interventions such as encouraging, verbal expression of feelings, and using confrontation for conflict management (Greeley et al., 1992; Leong 1992). Working with such interventions, many group leaders may overlook how the traditional group interventions could conflict with values held by various racial and ethnic minority groups (Leong, 1992; Fukuyama & Coleman, 1992). Such experiences, if not discussed early in the group process, can most likely result in premature termination from group psychotherapy among members belonging to racial and ethnic minority groups (Leong, 1992; Greeley et al., 1992; Yu & Gregg, 1992). Thus, in this section, some of the values of other cultural groups are discussed because they could play a role in facilitating or impeding the group process. Some of the conditions that will be addressed in this section are: importance of taking risk and trying out new behavior (DeLucia-Waack & Donigian, 2004); interpersonal and cultural style of expression (DeLucia-Waack & Donigian, 2004; Whittingham & Capriotti, 2009); values of thoughts over feelings(DeLucia-Waack & Donigian,2004); importance of unstructured interaction between members (DeLucia-Waack & Donigian,2004); group as a treatment modality(DeLucia-Waack & Donigian, 2004), and individual versus group therapy as the focus of treatment (DeLucia-Waack & Donigian, 2004).

With reference to the *importance of taking risks and trying out new behaviors*, group work involves promoting group members to try new behaviors and develop

relationship skills in the group setting, imitative behavior, interpersonal learning, and corrective recapitulation of the primary family group therapeutic factors (Yalom, 2005; DeLucia-Waack & Donigian, 2004). For this purpose, learning to take interpersonal risks, experimenting with new behaviors such as expressing feelings, learning to be assertive, giving feedback, and asking for help are assumed to be intrinsic elements of group work. One such task included in group work is experimenting with role-playing which involves practicing new behaviors. Group members are encouraged to role play in group which represents a safe and confidential environment. Role play in a group setting allows the players and other members an opportunity to give and receive feedback. Mostly, the group is expected to be a venue where members may feel comfortable making mistakes. However, such behaviors in certain cultures may be viewed differently. For instance, making mistakes in some cultures, and attempting to try new behaviors when others are watching would be seen as difficult (De-Lucia & Donigian, 2004). Culturally, individuals will feel like they may "lose face" if they do not meet group member's expectations. On another note, they may bring shame to their family for openly practicing and involving others in a role-play situation (De-Lucia Waack & Donigian, 2004). Therefore, experimenting with new behaviors may be viewed as violating a cultural norm (DeLucia-Waack & Donigian, 2004). On the other hand, some beliefs held in Islam (Banawi & Stockton, 1993; De-Lucia Waack & Donigian, 2004) emphasize receiving and providing support, advice, and corrective feedback to others. On the whole, expectations about experimenting with new behaviors, and taking interpersonal risks would likely lead group members to withdraw from the group.

With reference to *interpersonal styles of expression*, many cultures' interpersonal communication counteracts the preferred way of communicating in group (Kaneshige, 1973; Dufrene, Coleman & Gainor, 1992; Leong, 1992; Fukuyama and Coleman, 1992; Leong et al. 1995; Yu & Gregg, 1993; Chen & Han, 2001; DeLucia-Waack & Donigian, 2004; Garrett, 2004). For instance, Asian clients are uncomfortable with direct types of communication, especially those that involve challenges, confrontation, interruptions, and assertiveness (Leong et al., 1995). The cultural norm emphasizes verbal non-assertiveness, reluctance of emotional expression, confrontation of internal and interpersonal conflict, and avoidance of self disclosure (Tsui & Schultz, 1988; Conyne, Wilson, Tang, & Shi, 1999). Some of the cultural norms that may interfere with assertiveness include perception of authority, interpersonal harmony, modesty, and avoidance of public shame (Leong et al., 1995). Misunderstandings about these cultural variations in communication may lead to member alienation and/or an inability to develop trust and rapport with the group and leaders, and lead to early termination (Sue & Sue, 1977).

With regard to *cultural styles of expression* such as confrontation, and assertiveness, Asians tend to encourage verbal nonassertivness (Fukuyama & Coleman, 1992; Chen & Han, 2001). Therefore, when placed in a traditional group setting that emphasizes being assertive verbally and confronting others as a conflict resolutions strategy, Asian group members may become uncomfortable doing so and may be unwilling to confront (Chen & Han2001). They may view such groups as being impolite by putting group members on the spot (Leong, 1992; Kaniseshige, 1973; Chen & Han, 2001). Furthermore, individuals value humility in social interactions (Kaniseshige, 1973;

Leong et al. 1995). Politeness and not drawing excessive attention to oneself and one's personal concerns is valued in Asian cultures. (Kaneshige, 1973; Leong et al. 1995). Based on these cultural values, Asians view confrontation as a negative behavior and will avoid it at all cost (Chung, & Hahn, 2011). One reason they avoid confrontation is because Asians may perceive invitations for providing feedback, or confronting other group members as forms of domination (Yu & Gregg, 1993). On the other hand, sometimes they are likely to avoid confrontation in order to prevent being criticized. Thus, they may gesture by nodding, smiling or laughing to cope with other uncomfortable feelings, and avoid losing face (Chung, & Hahn, 2001). Although they can generously give positive feedback to others, they discount positive feedback given to them (Fukuyama & Coleman, 1992).

For Native Americans, direct confrontation must be avoided because it disrupts harmony and balance (Garrett, 2004). In contrast, Islam values the traditional group counseling that encourage group members to express their personal views and feelings and to extend help and exchange feedback among themselves (Banawi & Stockton, 1993). Therefore, Islam encourages confrontation rather than denial of feelings. However, historically and culturally, Muslims have avoided confrontations because they have been conditioned by political pressures not to confront authority. On a personal level, Muslims may avoid confrontation out of fear of rejection (Banawi & Stockton, 1993). Furthermore, sometimes they avoid confrontation with group leaders but also among group members (Banawi & Stockton, 1993). It is also important to note that avoiding confrontation may likely also cause frustration and likely to be wrongfully

interpreted by dominant culture group members, causing misunderstanding and increased guardedness among the group.

Another area of concern involves nonverbal communication (Chen & Hahn, 2001). Nonverbal communication is more culturally specific than verbal communication (Chen & Han, 2001). For instance, silence is seen as form of resistance from the Eurocentric perspective. In Asian cultures silence is regarded as a sign of respect for elders and authority figures, not disagreeing with the group, whereas, talking too much and interrupting others is regarded as being impolite (Kaneshige, 1973; Chen & Han, 2001). Another important aspect of nonverbal communication is the meaning credited to eye contact (gaze holding and directness) (Sue & Sue, 1977). Direct eye contact is regarded as impolite in Asian culture (Kaneshige, 1973; Chen & Han, 2001). Likewise, Native Americans may tend to avert their eyes as a sign of respect. Looking into someone's eyes consistently shows a level of entitlement or aggressiveness (Garrett, 2004). Communication among Native American cultures emphasizes nonverbal communication, with moderation in speech and tone especially when communicating with elders or authority figures (Garrett, 2004; DeLucia-Waack & Donigian, 2004). Similarly, Mexican-Americans and the Japanese view avoidance of eye contact as a sign of respect (Sue & Sue, 1977). However, the Eurocentric view emphasizes giving suggestions, sharing common experiences, and challenging, and all these tasks are done verbally. These expectations may not hold true for other cultures (DeLucia-Waack & Donigian, 2004).

With reference to *values of thoughts over feelings*, traditional Eurocentric views focus on sharing thoughts, feelings, and behaviors in the group setting. However, other cultural groups focus on a person's thoughts, rather than feelings. To illustrate, Leong (1986) noted that Asian clients have generally lower levels of verbal and emotional expressiveness when compared with clients raised in Western cultures. Asians are verbally and emotionally reserved (Yu & Gregg 1993). There are few studies that have indicated that Asians focus on thinking and doing rather than feelings. In Asian cultures, feelings are considered private and rarely revealed to outsiders as it is considered a sign of vulnerability or immaturity (Kaniseshige, 1973; Chen, 1995; DeLucia-Waack & Donigian, 2004; Shechtman and Halevi, 2006). Likewise, Leong et al. (1995) suggested that Asian Americans do not prefer openly expressing feelings and drawing attention to themselves. However, if they share their emotions, it is expected to be in an unspoken manner rather that in an open verbal way. Given these cultural beliefs/views Asian members may experience a lot of inhibition in expressing their feelings, even in the later stages of group process. Therefore, the group climate of open and free self-expression may be experienced by Asian Americans as uncomfortable. Conversely, Asian group members may openly talk about their thoughts more easily as opposed to feelings. For example, in Chinese culture, people attempt to reflect on a situation by gaining a logical or rational explanation. Once they achieve an understanding, they attempt to find appropriate solutions and take action. Further, Banawi and Stockton (1993) indicated that Islam encourages honest expression of feelings. However Muslims culturally vary in the ways they express emotions. For example, Muslims often value caution with the direct expressions of emotion, especially among strangers. In contrast, Pack-Brown and

Fleming (2004) noted that African Americans value emotional expressions of feeling. Greeley et al. (1992) cited that African-Americans emotionally engage themselves in verbal dialogue and may tend to distrust group members who do not verbalize their thoughts.

With regard to *importance of unstructured interaction between members*, some ethnic and racial groups give substantial importance to the structure of group (Greeley et al., 1992). For instance, in Asian cultures, individuals generally prefer counseling that is characterized by formal, structured, and direct approaches that de-emphasize a focus on the personal and/or emotional concerns and interpersonal relations, and tend to be hierarchical with a strong respect and loyalty to authority figures. (Yu & Gregg, 1993; Leong, 1992; Chen & Han, 2001; Bemak & Chung, 2004). As such, the group leader is viewed as an expert who is likely expected to adopt a structured, problem-focused (i.e. practical solutions), task-oriented approach (i.e. advice giving, suggestions) when leading groups versus an approach that is ambiguous or reflective (Matsushita, & Atkinson, 1991; Leong, 1992; Yu and Gregg, 1993; Chen & Han, 2001). Chen and Han (2001) shared that lack of structure may intensify Asians members' anxiety. Overall, cultural norms with regards to order or structure to participate can sometimes interfere with the group process. In contrast, in the Caucasian American value system (as stated in Leong, 1992); most interpersonal relationships are characterized by informal and collateral relations (among equals). Given these facts, cultural norms need to be identified and discussed in order to facilitate accurate perceptions of a group member's behavior in group (DeLucia-Waack & Donigian, 2004).

Another important issue in group work is the sense of time; some collectivistic cultures have a different perspective about timeliness. As a result, exploring different cultural perceptions of timeliness or tardiness may be essential to explore in group (Bemak & Chung, 2004).

With reference to *group as a treatment modality* (DeLucia-Waack & Donigian, 2004), there are cultures where various practices occur in a group setting. For example, daily prayers, religious festivities occur in group settings (Banawi & Stockton, 1993). Thus, with this view of the inherent group orientation in Islam, group therapy can be seen as an optimal setting, and a way for Muslims to experience personal growth. Although Islam may promote a positive perception of group settings, there are certain restrictions. Muslims may be group oriented; however, their choice of groups is usually based on family, tribe, or religious affiliation. Such groups provide emotional support, as well as a variety of convenient services, including financial assistance. In some cases, the most appropriate intervention would be family rather than group counseling. It is important to note that loyalty to the family means that Muslims will find it difficult to reveal secrets or important information outside their extended family. Obviously, such exclusive loyalty can create obstacles in group counseling, where Muslim members may not engage in group services. Similarly, Japanese feel that family problems and conflicts are to be resolved within the family circle. Therefore, being part of a group, and displaying personal inadequacy among a group of strangers is a sign of familial defect and this brings shame to the family (Kaneshige, 1973). Hence, how the treatment modality is experienced as culturally inappropriate can lead to negative outcomes (Leong, 1992).

The *individual as the focus of treatment in group therapy* is based on the Eurocentric approach to group counseling and may lead individuals coming from a collectivistic society to terminate prematurely (Leong, 1992). According to Leong (1992), ethnocentrism is the phenomenon underlying much of the insensitivity towards culturally different clients. It is based on a hierarchical view of values and assumes that one's value system is best or better than others. For example, many dominant group members may believe that emotional openness is better than emotional inhibition (which is really maintaining harmony and avoiding loss of face among Asian Americans). Individualistic cultures also focus on independence, competitiveness, emphasis on personal goals over group goals, feelings of distinction from the group members, and acceptance of confrontation when it arises in group. They define one independently from others (Chung, 2004; DeLucia-Waack & Donigian, 2004) whereas; some cultures emphasize family, community, and interdependent relationships. Priority is given to collective goals than personal goals, and thus, is in harmony with the group treatment modality. They also believe that independence and self-sufficiency are signs of maturity, whereas interdependence and group loyalty are highly valued in collectivistic cultures (Leong, 1992; Chung, 2004; DeLucia-Waack & Donigian, 2004). Likewise, African American cultures view groups with a profound sense of communalism, that is, collective identity that manifests in strong connection that often reaches beyond one's family to an extended network of relatives and community members. (William et al., 1999; Pack-Brown & Fleming, 2003).

Chapter III

Methodology

Participants

Undergraduate students at Wright State University (WSU), a mid-sized, public university in the Midwest region of the United States, were recruited for this study. After obtaining approval from the human subjects committees from Wright State University (WSU), Asian American, Caucasian, African American, Biracial, Hispanic, Native American, Multi-racial and Other group participants were recruited from the Psychology Department and Various Student Organizations on campus of the university. For example, some undergraduate students agreed to participate for a course credit in an introductory psychology course; other students agreed to participate on request of the investigator who approached classes held in the psychology department at Wright State University. Additionally, some students were recruited to participate from various student organizations affiliated with Bolinga Black Cultural Resource Center and Asian, Hispanic, Native American Center (AHNA) Center on Wright State University campus.

Out of the 161 undergraduate students, 8 participants did not complete the entire form. Some left a few items unanswered; other did not complete the entire demographic information section. All the missing information led the principal investigator to discard

the data of 8 college students, resulting in a final sample of N=153. The sample of 153 college students consisted of 55 males (35.95%), and 98 females (64.05%).

In the sample, 66(43.14%) individuals identified their ethnicity as White, Caucasian, European, not Hispanic; 48(31.37%) as Black or African American; 11(7.19%) as Asian, Asian American; 3(1.96%) as Hispanic or Latino; 1 (0.65%) as Native American /American Indian; 6(3.92%) as Biracial: Mixed: Parents from two different groups; 8(5.23%) as Multi-racial; and 10(6.54%) as Other Racial/Ethnicity. The ages of participants range from 18-60+ with a mean of 23 years. 88(57.52%) individuals identified their sexual orientation as Heterosexual; 2(1.31%) identified as Gay; 2(1.31%) identified as Bisexual; and 61(39.87%) chose not to answer the item as it was optional to do so. Moreover, 8(5.23 %) identified as having a disability, 145 (94.77%) identified not having a disability. In the sample, 71(46.41%) of individuals identified their father/ step-father/ guardian ethnicity as White, Caucasian, European, not Hispanic; 52(33.99%) as Black or African American; 10(6.54%) Asian, Asian American; 3(1.96%) as Hispanic or Latino; 2(1.31%) as American Indian; 5(3.27%) as Multi-racial; and 10(6.54) as Other Racial/Ethnicity.72(47.06%) identified their mother/ step-mother/guardian ethnicity as White, Caucasian, European, not Hispanic; 47(30.72%) as Black or African American; 12(7.84%) as Asian, Asian American; 4(2.61%) as Hispanic or Latino; 1(0.65%) as American Indian and Biracial: Mixed: Parents from two different groups; 5(3.27%) as Multi-racial; and 11(7.19%) as Other Racial/Ethnicity. The investigator treated participants in agreement with Wright State University's Human Subjects Policies & Procedures.

Instrumentation

To date, no instrument has been developed that specifically assesses multicultural issues within the context of group work. Rather, such issues are based solely on clinicians' judgment (Corey & Corey 1992; Jennings & Anderson, 1997; Riva et al., 2000). The purpose of this study was to develop an instrument (i.e., the Multicultural Group Screening Form) designed to begin to address this void in the literature. Such a tool would provide an empirical evaluation of the multicultural factors and group work. Among the group literature reviewed, DeLucia-Waack's and Donigian's (2004) discussion on diversity variables citing various key research that might impact successful engagement in group therapy, and the Multigroup Ethnic Identity Measure (MEIM) by Phinney (1992) are key sources in the development of this instrument.

The method to generate items for the Multicultural Group Screening form (MGSF) began by reviewing literature on Multicultural group work. A general search included reviewing research in books and searching databases such as PSYINFO, Pubmedline, EBSCOT, and ERIC. Further, specific searches were done in leading scholarly publications on group work: *Journal of Specialists in Group Work*, *International Journal of Group Psychotherapy*, *Group*, and *Group Dynamics: Theory, Research, & Practices*. The constructs were derived from a comprehensive qualitative and quantitative group literature search, group leaders' perspective on multicultural issues in the field of group therapy, group members' inclusion or exclusion criteria, and already existing reliable and valid screening instruments utilized in the pre- group screening process. Based on the literature, the test items were developed and arranged to fit the construct to be measured. The constructs are not only affiliated to a particular

theoretical direction, but also developed from the empirical literature regarding factors discussed to be important in the multicultural group work.

Based on the literature, a pool of 71 items were generated and sorted into the following categories: *Ethnic Identity* (Self Identification, Affirmation/Belonging, Ethnic Identity Achievement, Ethnic Behavior or Practices, and Other Group Orientation), *Racial Attitudes* (Negative biases held by group members, Expectations of being negatively evaluated by others, Possible discontinuation in group therapy, and Positive view held by group members), *Group Leader Preferences* (Gender/Ethnicity of group leader, Expectation of relationship with Group Leader, Expectation of behaviors of group leader during the group process), *Verbal Participation/Self Disclosure* (Verbal Participation/Self-Disclosure, Communication Patterns/Interactional patterns during participation, and Trying out risky/new behaviors), *Value Orientation* (Structure of the group, Values of thoughts over feelings, Expression of feelings verbally or nonverbally, Confrontation/Assertiveness), *and Stigma* (General view of mental health, Views about group versus individual, and Help seeking attitude). For each of these categories, 12-15 items were generated, except the Ethnic Identity category, which had pre-existing categories, with known reliability and validity scores. Some of the items for the categories were negatively worded.

With regard to the Ethnic Identity category, items were included from the Multigroup Ethnic Identity Measure (MEIM, Phinney, 1992). The MEIM is a 23-item scale that assesses elements of ethnic identity that are common across ethnic groups. For this study, the statements were reworded and designed to assess similar categories

assigned in MEIM. The MEIM consists of two parts, the first part, which is designed to assess ethnic identity, consists of three subscales—the Affirmation/ Belonging subscale (five items), the Ethnic Identity Achievement subscale (seven items), and the Ethnic Behaviors subscale (two items). The second part is designed to assess Other Group Orientation (five items) which measures attitudes towards other ethnic groups. Internal consistency coefficients for a college sample of Hispanic, Asians, American Indians, White, Black, and mixed-race students were .86, .80, and .90 for the Affirmation/Belonging subscale, the Ethnic Identity Achievement subscale, and the overall scale, respectively (Phinney,1992). No coefficient was given for the two-item Ethnic Behaviors subscale. The reliability of Other Group Orientation was lower than the Ethnic Identity Scale (.74) for college students. Phinney (1992) also conducted a principal-axis factor analysis, which yielded two factors. The first factor corresponded to the ethnic identity part of the MEIM, and the second factor corresponded to the other-group orientation part. The two factors accounted for 30.8 % and 11.4% of the variance explained, respectively. Phinney's (1992) study, as predicted, suggest that college students scored significantly higher on the Ethnic Identity Achievement subscale than did high school students, thus providing some construct validity for it. Furthermore, for the Multicultural Group Screening form, items were written using a 5 point Likert-type scale from 1 (Strongly disagree) to 5 (Strongly Agree) for ethnic identity category, and for other categories. Items were constructed without regard to create equal numbers of items for each dimension.

Procedure

Group experts.

The pool of 71 items was developed and based on extensive literature review and having extensive discussions with group experts. The item and the scales were first presented to three of the five group experts for the purposes of content analysis. Among the three Ph.D. level experts, one psychologist's main expertise was specific to group psychotherapy work, the second psychologist's expertise was specific to developing culturally sensitive assessment measures for a university counseling centers, and the third psychologist provided feedback on developing items for the scales to be assessed for reliability analyses.

Moreover, all the group experts were presented with the initial pool of items that included approximately 12-15 items for each category. The three group experts provided feedback on the classification of items, assisting and suggesting rewording of certain items, breaking down one item into less complex and easier items, adding and deleting items, and assessing the face validity of items. The feedback was incorporated and the item pool was revised. Later on, while seeking approval from various centers to conduct the study, the investigator presented the assessment measure and received feedback about the wording and content of the items from Dana Patterson, Ph.D., the Director of Bolinga Black Cultural Resource Center, and Mai Nguyen, M.S, the director of Asian, Hispanic, Native American Center (AHNA) Center on Wright State University campus. Additionally, the principal investigator also presented the measure to the presidents of various student government organizations. Specifically, the Asian Student Organization, Hispanic/Latino Student Organization, Black Student Union and Native American

Student Organizations. Each of the presidents played an important role in providing verbal feedback about the fit of the items to capture some of the culturally specific differences one may encounter in group work. Furthermore, the feedback was incorporated, and it resulted in refining the tool. Approximately 10-12 items per category were finalized.

College participants.

A pilot study was conducted on a total of 153 students. The participants were given a brief description of the study, and asked to make a decision as to whether they wished to participate (for consent cover letter see Appendix B). The consent cover letter consisted of an introduction of the researcher, purpose of the research, and the importance of the participants as it related to obtaining accurate information regarding their own experiences. The written consent letter was approved by the Wright State University's Institution Review Board (WSU IRB). The consent also informed that there was no penalty involved for withdrawing participation at any time during the procedure. Participants were given contact information for the primary investigator, should they have any questions or concerns regarding their participation in the study, and contact information for WSU's IRB, in agreement with human subject's research policies. Prior to participants completing the Multicultural Group Screening Form (MGSF) (see Appendix C), investigator read out the introductory script (for introductory script see Appendix A), which informed them that the form was divided into two parts, First, participants had to follow instructions, and rate statements accordingly for ethnicity. Second, participants were asked to imagine considering entering a therapy group, and to rate statements from what that might be like. The investigator also emphasized that there

were no right or wrong answers, and asked participants' to answer truthfully. Individual participation time was estimated to be 15-20 minutes. Participants received pens or course credit as remuneration. The pre-group screening form is intended for a heterogeneous process group, which is based on Yalom's interpersonal theoretical model (Yalom, 2005).

Experimental procedures.

The next procedure involved assessing the test for reliability. Assessment of reliability would involve seeing if the measurements of the particular categories are repeatable under the same conditions. (Anastasi & Urbina, 2002). The data obtained was coded (see coding sheet in Appendix D), and entered into SPSS software. The statistical procedures were run to assess internal consistency reliability of the MGSF. Internal consistency was used to see if the items were consistent with one another when measuring the same scale or category (Salkind, 2011). Specifically, Cronbach's alpha (or α) was assessed to see if the individual item scores vary with the total sore on each construct or category being measured. It was posited that higher the value the more confidence one can have that the constructs are internally consistent and measure one thing (Salkind, 2011).

Chapter IV

Results

After careful review of group literature, feedback from group experts, feedback from the two directors, as well as students of various organization on the university campus. The items generated, refined and revised were grouped into the following categories:

1. *Group Leader Preferences*: addresses assumptions about the role of the group leader as a facilitator. Items are based on assessing gender or ethnicity of the group leaders; expectation of relationship with group leader*;* expectation of behaviors of group leader during the group process (Delgado, 1983; Tsui, & Schultz, 1988; Leong, 1992;Sue et al., 1991; Dufrene, & Coleman, 1992; Greeley et al, 1992; Banawi & Stockton, 1993,Yu and Gregg, 1993; Fujino et al, 1994; Leong et al., 1995;Fenster, 1996; Conyne et al.,1999;Torres-Rivera et al.1999;Chen & Han, 2001; Devan, 2001 Chung, 2004;Yalom 2005).
2. *Verbal Participation/Self Disclosure.* This category addresses the importance of verbal participation and self-disclosure during the group process (Kaneshige, 1973; Shen, et al, 1984; Dufrene & Coleman, 1992; Fukuyama & Coleman, 1992; Greeley et al., 1992; Leong, 1992; Banawi and Stockton, 1993; Yu & Gregg, 1993; Chen, 1995; Leong et al. 1995; Fenster, 1996;Conyne, 1998; Conyne et al.,

1999; Chen & Hahn, 2001; Bemak & Chung 2004; De-Lucia & Donigian, 2004; Garrett,2004; Yalom,2005,Debiak, 2007). Specifically, it looks at research discussing differences in verbal participation/self-disclosure, communication patterns/interactional patterns during group, and trying out risky/new behaviors.

3. *Value Orientations*. This category addresses values and beliefs about certain behaviors or communication styles held by members of diverse groups (Kaniseshige, 1973; Sue & Sue, 1977, Leong 1986; Tsui & Schultz, 1988; Matsushita, & Atkinson, 1991; Greeley et al., 1992; Leong, 1992; Fukuyama & Coleman, 1992; Banawi & Stockton ,1993; Yu and Gregg, 1993; Chen, 1995; Leong et al.,1995; DeLucia-Waack, 1996; Conyne et al.. 1999; Chen & Han, 2001; Bemak & Chung, 2004; DeLucia-Waack & Donigian, 2004; Garrett, 2004; Pack-Brown & Fleming,2004; Shechtman &Halevi,2006). Items are based on structure of the group, values of thoughts versus feelings, expressing feelings verbally or nonverbally, and understanding views about confrontation/ assertiveness.
4. *Racial Attitudes* (Tsui & Schultz, 1988; Dufrene & Coleman,1992;Fukuyama & Coleman, 1992;Gainor, 1992; Leong, 1992; Johnson et al., 1995; Leong et al. 1995; Fenster, 1996; Abernethy, 1998; DeLucia-Waack & Donigian, 2004; Marbley, 2004; Anderson, 2007; & Eason, 2007). Items in this category are based on understanding negative biases held by group members, expectations of being negatively evaluated by others, possible discontinuation in group therapy, and positive views held by group members.

5. *Stigma*. This category addresses assumptions about group as a treatment modality, and individual versus group therapy as the focus of treatment (Kaneshige, 1973; Terrell & Terrell,1981;Tsui & Schultz, 1988;Sue et al. 1991; Leong, 1992;Banawi & Stockton, 1993; Nickerson et al., 1994; Uba, 1994; Williams et al.,1999; Phelps et al., 2001;Chung, 2004; DeLucia-Waack & Donigian, 2004; Pack-Brown & Fleming, 2004; Garrett 2004). The general notion of underutilization of mental health services by minority groups because of mental health stigma is also considered in this measure (DeLucia-Waack & Donigian, 2004).
6. *Ethnic Identity*. DeLucia-Waack and Donigian (2004) discussed the need to asses for and the importance of understanding constructs such as ethnic/racial identity development, acculturation, and biculturalism as it relates to the group process. However, one major limitation of their study was that the formation of this category focused on only one construct (i.e. understanding ethnic identity), and its impact on the group process (Smith ,1991; Greeley et al. 1992; Phinney & Alipuria,1990;Phinney, 1992, 1993; Fukuyama & Coleman, 1992; Leong, 1992; Yu & Gregg, 1993; Haley-Banez & Walden, 1999;Chen & Han, 2001;Bemak & Chung, 2004, DeLucia-Waack & Donigian, 2004).

Furthermore, an initial reliability estimates for the MGSF was obtained. The 71 items that comprised a proposed six primary scales was subject to internal consistency analyses with the purpose to provide an initial reliability estimate. Based on these analyses, 35 items were retained, representing five primary scales (with one scale being comprised of three reliable sub-scales).

The first scale assesses the 18 items designed to measure ethnic identity in a similar manner as the MEIM. Internal consistency analysis revealed the 18-item scale produced a Cronbach's α of .78. After examining inter-item correlations, three items were identified that had negative correlations with other items. After deleting those three items, the resulting 15 item scale yielded improved internal consistencies (α = .82). Three reliable subscales also resulted from analysis of the Ethnic Identity scale: Affirmation/Belonging (5 items; α = .82); Ethnic Identity Achievement (5 items α = .70); and Other Group Orientation (3 items; α = .76). The two items designed to measure Ethnic Behaviors and Practices did not result in a reliable independent subscale (α = .25), but did contribute to the full 15-item scale (See Appendix E, Table E1 for list of items by scale).

Next, the 10 items designed to asses Racial Attitudes were analyzed. After examining the inter-item correlations, three items were identified that had negative correlations with the other items. The resulting 7-item scale (see Appendix E, Table E2) resulted in an acceptable reliability coefficient (α = .70).

The scale designed to measure Group Leader Preference did not reliably measure a unitary construct. Three items designed to measure Expectations of Relationship with Group Leader (Hierarch/Authority v. Egalitarian) did result in a reliable scale (α = .70). The other six items (see Appendix E, Table E3) were deleted from the current MGSF.

Ten items were designed to assess participants' Verbalization/Self-Disclosure. Five of the original 10 items (see Appendix E, Table E4) did provide acceptable internal

consistency (α = .71). The remaining five items did not work well together to produce a separate sub-scale, and were thus deleted from the MGSF.

The next proposed scale analyzed was the 14 items designed to assess Values Orientations of participants. Analyses revealed that no reliable scale could be comprised by this set of items. The best Cronbach's α was achieved by a combination of six items (α = .55). Thus, all items on this proposed scale were deleted from the current MGSF.

Finally, 10 items were analyzed to assess Stigma. Internal consistency analysis revealed the most reliable scale was produced by a combination of 5 items (see Appendix E, Table E5) from the scale. The remaining 5 items were deleted from the current MGSF.

Chapter V

Discussion

The aim of the present study was to develop a culturally sensitive, reliable measure for assessing the impact of multicultural variables on group process and outcome. For this study, the initial reliability estimates for the MGSF were obtained. The Multicultural Group Screening Form (i.e. MGSF) included 71 items across six primary scales. Each primary scale was comprised of sub-scales. Out of the 71 items, 35 items were retained from the original scale and represented five primary scales. The primary scales retained in the current instrument were Ethnic Identity, General Racial Attitudes, Group Leader Preferences, Verbal Participation/Self-Disclosure, and Stigma. The Value Orientation scale was not retained because it did not have significant reliability.

Ethnic identity scale.

With reference to each primary scale in the current instrument, 15 of 18 items were retained for the *Ethnic Identity* scale and included items assessing *Affirmation/Belonging* (5 items), *Ethnic Identity Achievement* (5 items), and *Other Group Orientation* (3 items). Reliabilities for Affirmation/Belonging, Ethnic Identity Achievement, and Other group orientation were similar to the reliability coefficient obtained from the college sample when the MEIM measure was administered (Phinney, 1993). The *Ethnic Behavior and Practices* (2 items) accounted for the overall reliability and was retained.

Racial attitudes scale.

Items in the *Racial Attitudes* scale were based on three subscales: *Negative Biases held by group members* (2 items), *Expectations of being Negative Evaluated by others* (3 items), *and Possible discontinuation in Group therapy* (2 items). These items confirmed previous research that talks about the way potential group members tend to be concerned about racial attitudes such as fears that the group leader and/or other members will be judgmental towards them (Abernethy, 1998). Furthermore, they may develop defensive/resistant patterns of fear, mistrust, withdrawal, and isolation from other in response to being hurt by them (DeLucia-Waack & Donigian, 2004; Eason, 2007). Therefore, it would be crucial for group leaders to address and explore group members' fears and concerns prior to beginning group.

Group leader preference scale.

The *Group Leader Preference* scale does not reliably measure a unitary construct. Three items designed to measure Expectations of Relationship with Group Leader (Hierarch/Authority versus Egalitarian) did result in a reliable scale. Therefore, suggesting that the relationship with group leader is an important factor; however, questions about the cultural variances in how individuals perceived the group leader were raised.

Verbal participation/self disclosure scale.

For the Verbal Participation/ Self Disclosure scale, items were retained on *verbal participation/self disclosure* (2 items), *communication pattern* (1 item), and *trying out risky/new behaviors* (2 items). Items for this scale were developed based on literature about cultural differences in verbal participation or self-disclosure in groups (Conyne,

1998; De-Lucia & Donigian, 2004). Thus, it is necessary to understand ethnic group differences on these variables for an effective group outcome. Even so, this scale does not reflect true ethnic group differences in verbal participation/self disclosure do interfere with group process.

Stigma scale.

For the Stigma scale, items retained were for the following subscales: *General view of mental health* (1 item), *Group versus Individual* (1item), and *Help seeking attitude* (2 items). Once again, some of the items were not retained from the original scale because the items were worded to reflect certain cultural differences related to mental health services.

Value orientation scale.

With regard to the sixth primary scale, *the Value orientation scale*, analysis revealed that no reliable scale could comprise this set of items. Thus, all items on this proposed scale were deleted from the current MGSF. There are several possible reasons for which the *Value orientation scale* was not reliable. First, the wording of the items may need to be revisited to make sure that they truly capture the sub-scales being assessed. Second, most of the items generated were based on extensive work done on group work with Asian clients, as opposed to other ethnic groups. Therefore, the assessment of values and beliefs requires the use of content that differs across groups, and there is a lack of consensus on what values and beliefs should be included in the scale. Even when there is an agreement, such measures can be used only with particular groups and cannot be used for comparison across groups (Phinney & Ong, 2003). Therefore, assessing values and beliefs as a construct would be a much more complex

task. Given these facts, one implication for future studies is to study value construct as a single construct or create a separate assessment measure. Second, the assessment of the relations between attitudes towards seeking help, and level of conformity to a specific value system would be determined by one's level of acculturation, or generation status. For instance, Kim and Omizo (2003) found that Asian Americans who were less acculturated, adhered more to Asian values, and had less positive attitudes toward psychological help seeking behavior. Similarly, as cited in Omizo, Bryan, & Nicholas' (2008) study, Atkinson(2004) theorized that fifth generation Asian American adolescents were likely to conform more to European American values than recent immigrants to the United States. As a result, it is posited that the participants may not have been a representation of various generations, or may have differed in their level of acculturation. Thus, level of acculturation, and generation status could have influenced the extent ethnic groups adhere to one particular value system.

Strengths of this study.

Although, the field identifies pre-group screening as an important step in forming groups, there is very little research on developing effective screening instruments. Furthermore, the two most widely used selection measures such as the Group Therapy Questionnaire (GTQ) and Group Selection Questionnaire (GSQ) do not address multicultural variables, and existing screening instruments do not fully address multicultural variables. Therefore, the current instrument was developed to fill the gap in current group literature. The current instrument will help group leaders and future researchers to explore the impact of ethnic identity and other multicultural variables during pre-group screening. In doing so, it may reduce chances of premature member

termination from group, and contribute towards making groups a more effective treatment modality.

Additionally, this measure is not restricted to be used only in university counseling centers. Even though, the normative group was college students, and the measure was developed keeping in mind the potentials of group work in university counseling centers, the measure can also be used to study its effectiveness across other settings.

Limitations of this Study.

Several limitations of this study are worth mentioning: First, the sample consisted of undergraduate psychology students, which limits generalization of the results due to minimal representation of ethnic minority students in the sample. Furthermore, dividing various cultural groups to conduct a reliability analyses was questionable because it would impact the overall reliability of this measure. Thus, the small sample size made it difficult to conduct a reliability analyses comparing cross-cultural difference. However, the study brings a promising start in terms of beginning to address, and understand potential group members' cultural variables in conjunction with appropriate referral to group psychotherapy.

Second, there are several important variables that were not taken into account for this study. For example, group leader's racial/ethnic identity development (Garcia, Kessler, & Gilchrest, 1992; Greeley et al. 1992; DeLucia- Waack & Donigian, 2004; Marbley, 2004; Debiak, 2007), influence of interpersonal styles, acculturation level, concept of biculturalism, socioeconomic status, sexual orientation status, disability status,

role of gender among different ethnic groups, and so forth. No items addressing these areas were included in the current instrument.

Third, the generalization of items to a particular cultural group is questionable because of within group differences. For instance, this study does not address the complexity of heterogeneity within different cultural groups. For instance, the Asian American cultural group includes individuals who identify as Chinese, Japanese, Filipino, Vietnamese, Pakistani, and so forth (Tsui & Schultz, 1988). Even though there are common characteristics among the subgroups in the Asian cultural group, this study does not take into account the group's diverse cultural characteristics.

Fourth, the study focuses on assessing the ethnic identity development of group members (Phinney, 1992). Even though this screening measures ethnic group differences, it does not account for all dimensions of identity. The ethnic identity development model is one out of many that are discussed in the literature. For instance, racial identity development model, sexual identity development, disability identity development models are just a few to name. Fifth, even though this measure considers cultural factors that could interfere with the group process, the group leader must realize that not all individuals will benefit from this particular pre-group screening measure as it was looking at culturally specific variables. Sixth, in terms of the MGSF, the five scales are not mutually exclusive. Specifically, the items designed for constructs other than value orientation do reflect cultural differences. To illustrate, self disclosure is important prerequisite for group work (Yalom 2005), many of the items on this scale reflect how self-disclosure is viewed by different cultures. Lastly, group is not static, but dynamic with discrete states suggesting inherent challenges (Chen and Han, 2001). Thus, this

study focuses on difficulties arising during the pre-group screening. However, it is important to note that difficulties can arise at any stage in the group process, and the study does not control for those variables.

Chapter VI

Future Directions and Recommendations

Further research is needed in several key areas. First, a "match" between members' levels of ethnic identity and group processes should be clarified. Although this study implicitly attempted to link members' ethnic characteristics and group processes, this area needs further exploration. Second, like the Multigroup Ethnic identity measure, the ethnic identity scale assess key components, and it may be particularly important to study how each of the four components would be related with the stages of ethnic identity development (Chen & Han, 2001). Therefore, further exploration on incorporating stages specific to ethnic identity development would be helpful.

Third, future research needs to explore ways to refine the methods approach. For instance, one approach could involve recruiting a large number of participants from specific ethnic group organizations on campus, conducting a focus group, or re-evaluating assessing the reliability of this measure by getting a better sample size.

Fourth, future studies can also focus on scanning, rewording, and re-categorizing the deleted and existing items to better fit the scale being measured. Especially, the value orientation items generated were based predominantly on understanding group work with Asian clients. Future researchers could either study value orientation as a separate construct, or retain the specific scale of this measure and revisit the items. Future efforts could also reword items to better reflect group specific behaviors that would be posited to

interfere with the progress of group members from various ethnic groups. For example, one way of retaining these items would be working them in a neutral ways, and understanding how different cultural groups rate themselves on a group specific behavior. For instance, instead of wording sentences as "*In the culture that I identify with, talking about thoughts is more acceptable than talking about feelings,"* rewording the item as *"I am more comfortable thinking through things than becoming aware of my feelings in the group."* Fifth, it is also important to further explore ways in which other identity development models that were not considered in this study could be included. For instance, the sexual identity development model, disability identity development model, racial identity development model and so forth should be considered. Sixth, this screening measure does not account for other inclusion/exclusion criteria that are assessed by other measures. For instance, during the screening process, it is important to discuss the goal of group therapy as measured by the Group Therapy Questionnaire. Therefore, further exploration of ways to integrate the information obtained from this measure with already existing pre-group screening process to make it cost-effective and time effective is needed. Specifically, attempts should be made at combining this form with already existing measures such as the Group Therapy Questionnaire, or Group Selection Questionnaire. Lastly, the validity of this developed measure needs assessment.

APPENDIX A

Introductory Script

My name is Taronish Irani, and I am a doctoral student in clinical psychology at Wright State University's School of Professional Psychology. I am interested in gaining an understanding of how people/ students think and feel about group therapy. Filling out this assessment tool will be a step in furthering the field's understanding of how to better serve students from different backgrounds.

The survey is in two parts. First, you will be asked about your ethnicity. Please answer truthfully and know that there are no wrong answers. Second, you will be asked to imagine you are considering entering a therapy group. Please take a moment before answering these questions to imagine what that might be like. There is no right or wrong answers.

Information about your ratings will be kept confidential and will not be used by anyone. You should not write your name on any form you fill out. You may choose not to participate in this study or to withdraw at any time. Your decision to participate or not participate will not affect you in any way.

Here is a cover letter for you to review which says most of what I have just said to you. Let's read it over together, and after we are done, I can answer any questions that you may have at that time.

APPENDIX B

I am Taronish Irani, M.A., a doctoral student in the School of Professional Psychology, Wright State University, is conducting a research study for my dissertation, to learn more about the experiences of individuals who have been referred for group therapy. You are being asked to participate in this one time study. You will be asked to fill out two forms. One form will ask you questions about yourself (such as gender, age). The other form will ask questions about your ethnicity, and your general perceptions of considering entering a therapy group. The total time to complete the study will be approximately 15-20 minutes. Furthermore, you will not be penalized if you choose not to participate in this study.

The information obtained from this study will be kept strictly confidential and you will not be identified in the dissertation or any future publications. Please be aware that your anonymity will be maintained, and that there will be no identifying information on the assessment. The information will be kept in a sealed envelope, in a secure place and destroyed 5 years after the study. Information will be collected from you and approximately 70 people and the results will be reported as group data. Some people may experience discomfort while answering the questions. Therefore, if you do experience any discomfort while answering the questions, you can stop responding to the items (administered as a pen and pencil assessment) at any time, and your wishes will be respected. With reference to benefits, this study will not directly benefit you; however, it may ultimately benefit future leaders lead groups more effectively by enhancing their understanding of cultural variables and bring greater understanding to the process of group counseling. You will also receive a token (i.e. pen) upon completion of the assessment. Your help is greatly appreciated. The only costs to you should be the time you give up to help with this study.

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study, either contact my faculty advisor, **Martyn Whittingham, Ph.D.** or me, **Taronish Irani,** at the following address:

053 Student Union / 117 Health Sciences Building
School of Professional Psychology
Wright State University
Dayton, Oh 45435
937-775-3407

Once again, your participation in this study is voluntary; you may refuse to participate without penalty. If you decided to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

If you feel you have not been treated according to the description in the form, or you have general questions about giving consent, your rights as a participant in this research have violated during the course of this project, you may contact Robyn Wilks at Wright State University's Institutional Review Board (IRB) at (937) 775-4462.

_____

Taronish Irani, M.A. Date

_____

Martyn Whittingham, Ph.D. Date

APPENDIX C

MULTICULTURAL GROUP SCREENING FORM

Demographic Information

Age:

Sex:

Sexual Orientation (Optional):

Do you have a disability? Yes or No

In this country, people come from different cultures and there are different words to describe ethnic groups. For instances: we have ethnic group such as Mexican-American, African Americans, Asian American, American Indian, Native Americans, White, and many more. We are all born into one, two or sometimes more than two ethnic groups, but people differ on how important their ethnicity is to them, how they feel about it and how much one's behavior is affected by their ethnic group. The following questions are about your ethnicity or your ethnic group and how you feel about it, or react to it.

I consider my ethnicity to be (circle one or more):

a. Asian, Asian American
b. Black or African American
c. Hispanic or Latino
d. White, Caucasian, European, not Hispanic
e American Indian
d. Biracial: Mixed: Parents from two different groups
g. Other (Please Specify): _____

My father/step father/ guardian's ethnicity is (use letter above)_____

My mother/step mother/guardian's ethnicity is (use letter above)_____

Enclosed are statements, beliefs, opinions, and attitudes about other races or ethnicities. Read each statement carefully and fill in the circle your ratings about the beliefs and attitudes expressed.

1= Strongly disagree 2=Somewhat disagree 3=Neutral 4=Somewhat Agree 5=Strongly Agree

		1	**2**	**3**	**4**	**5**
1.	I am glad to be a member of the ethnic group that I belong to	○	○	○	○	○
2.	I often wonder and am unclear about the impact of ethnicity on my life	○	○	○	○	○
3.	I am proud of my ethnic group and its accomplishments	○	○	○	○	○
4.	I spend a great deal of time trying to find out more about my own ethnic group (i.e. its history, tradition, and customs)	○	○	○	○	○
5.	I learn more about my ethnic background by talking to other people about my ethnic group	○	○	○	○	○
6.	I have a clear understanding of what my ethnicity means to me	○	○	○	○	○
7.	I feel a strong sense of attachment to my own ethnic group	○	○	○	○	○
8.	I have a good understanding of what it means to be a member of my ethnic group and also to relate to other groups	○	○	○	○	○
9.	I do not invest a lot of time trying to learn more about the culture and history of my ethnic group	○	○	○	○	○
10.	I take part in cultural practices such as enjoying special food, music or customs as being part of my ethnic group	○	○	○	○	○
11.	I like getting together and knowing people whose ethnicity is different that my own	○	○	○	○	○
12.	I choose not to actively participate in social groups or					

	organizations that have mostly members of my ethnic group	○	○	○	○	○
13.	I do not have a strong sense of belonging to my ethnic group	○	○	○	○	○
14.	I spend a considerable amount of time with people who are members of different ethnic groups	○	○	○	○	○
15.	I do not like making friends with people who are members of different ethnic groups	○	○	○	○	○
16.	I like being around people who are members of different ethnic backgrounds	○	○	○	○	○
17.	I feel great about my ethnic or cultural background	○	○	○	○	○
18.	I sometimes prefer that people of different ethnic backgrounds should not mix with one another	○	○	○	○	○

For the next section, Please imagine you are considering becoming a member of a therapy group comprised of university students. Read each statement carefully and fill in the circle your ratings about the beliefs and attitudes expressed.

1= Strongly disagree 2=Somewhat disagree 3=Neutral 4=Somewhat Agree 5=Strongly Agree

		1	**2**	**3**	**4**	**5**
19.	I often view people from different ethnic groups negatively, which influences my interaction with them	○	○	○	○	○
20.	I would be more cautious about what I say in a group, as I am afraid it might be used against me	○	○	○	○	○
21.	I worry about being treated with resentment or being insulted by others in the group, solely because I am of a different ethnicity/race	○	○	○	○	○
22.	I would be suspicious of the advice given by someone of another race/ or ethnicity in a therapy group	○	○	○	○	○
23.	I would likely discontinue group therapy if group members or the group leader do not ask about my cultural beliefs	○	○	○	○	○
24.	Because I do not have many friends from different ethnic groups, it is really hard for me to understand or feel close to people from another ethnic group/race/country	○	○	○	○	○
25.	I am likely to leave the group, if I am the only member that represents my ethnic group	○	○	○	○	○
26.	I am comfortable getting to know group members from different countries, races or ethnicities	○	○	○	○	○
27.	I feel a sense of belonging with persons from different ethnic groups	○	○	○	○	○
28.	I would likely discontinue group therapy if I felt group members or the group leader were biased against me due to	○	○	○	○	○
29.	I would prefer the group leader to be of the same gender as me	○	○	○	○	○

1= Strongly disagree 2=Somewhat disagree 3=Neutral 4=Somewhat Agree 5=Strongly Agree

		1	2	3	4	5
30.	I am comfortable working with a group leader who is of the opposite gender than me	○	○	○	○	○
31.	I would expect the group leader to provide direct advice, suggestions, and solutions for my problems	○	○	○	○	○
32.	I view the group leader as someone who is in authority, and would expect him/her to have special expertise and power during the group process	○	○	○	○	○
33.	I would be more uncomfortable sharing information if the group leader was from my own ethnic group	○	○	○	○	○
34.	I would expect a group leader to act like my equal	○	○	○	○	○
35.	I would prefer a group leader who focuses on helping me problem solve	○	○	○	○	○
36.	I would not expect my group leader to share personal information about themselves	○	○	○	○	○
37.	I would not speak up in group until I am directly addressed by the leader	○	○	○	○	○
38.	When in a group, my silence would indicate that I am respectful and listening to others express their thoughts, and feelings	○	○	○	○	○
39.	I view a talkative person as an attention seeker or someone who is showing off	○	○	○	○	○
40.	I enjoy “talking things out” by speaking to others about things that bother me	○	○	○	○	○
41.	In group, I would rather be silent than say something that is not well thought out	○	○	○	○	○
42.	When I communicate, I generally communicate my emotions and / or thoughts by expressing them nonverbally (e.g., use of eye contact, facial expression etc.)	○	○	○	○	○

1= Strongly disagree 2=Somewhat disagree 3=Neutral 4=Somewhat Agree 5=Strongly Agree

		1	2	3	4	5
43.	When in a group, my silence indicates I am not happy with other people or the advice provided to me	○	○	○	○	○
44.	I am comfortable disclosing personal information with other group members	○	○	○	○	○
45.	I worry that if I do not share / disclose things about myself in group, other group members may think badly of me	○	○	○	○	○
46.	If I share my personal problems with group members, I will bring shame upon my family	○	○	○	○	○
47.	I would be ashamed if I am unable to achieve what I am expected to do in the group. For instance, If I am unable to succeed with others in terms of role-playing of new behaviors	○	○	○	○	○
48.	I am likely to leave group if the focus of group treatment involves talking about my family	○	○	○	○	○
49.	I would bring shame to my family or friends by involving myself in role-play situation and disclosing personal information about my family members	○	○	○	○	○
50.	I would not be comfortable disclosing personal information with other group members	○	○	○	○	○
51.	I would not want to discuss my feelings or emotions with group members	○	○	○	○	○
52.	In the culture that I identify with, talking about thoughts is more acceptable than talking about feelings	○	○	○	○	○
53.	Being confrontational in a group is frowned upon/considered unacceptable by people from the cultural group I identify with	○	○	○	○	○
54.	I would start/end at the exact time as it is scheduled	○	○	○	○	○
55.	Interrupting others is considered rude by the culture I identify with	○	○	○	○	○

1= Strongly disagree 2=Somewhat disagree 3=Neutral 4=Somewhat Agree 5=Strongly Agree

		1	**2**	**3**	**4**	**5**
56.	I believe it is disrespectful to directly assert your own needs and wishes in a group	○	○	○	○	○
57.	Putting someone "on the spot" is considered impolite by the culture I identify with	○	○	○	○	○
58.	People from the cultural groups I most identify with have negative views about group therapy	○	○	○	○	○
59.	I prefer seeking help from my family, and community than solely seeking help from members of a therapy group	○	○	○	○	○
60.	It is a sign of personal weakness to share my interpersonal or emotional problems with other group members	○	○	○	○	○
61.	Asking for help from other group members would make me feel like there was something wrong with me	○	○	○	○	○
62.	Seeking help for my personal problems does not mean that my family has failed in some way to help me	○	○	○	○	○
63.	Mental health treatment is negatively viewed by the culture I identify with	○	○	○	○	○
64.	I would prefer individual therapy/treatment rather than group therapy/ treatment	○	○	○	○	○
65.	I see group therapy as more helpful than working with an individual therapist	○	○	○	○	○

1= Strongly disagree 2=Somewhat disagree 3=Neutral 4=Somewhat Agree 5=Strongly Agree

		1	**2**	**3**	**4**	**5**
66.	Confronting people is important in my culture since it shows that you care enough to tell someone the truth	◯	◯	◯	◯	◯
67.	Going to a mental health provider cannot solve my problems, the only hope is to try harder to solve my problems	◯	◯	◯	◯	◯
68.	Sharing my problems with group members dishonors my family	◯	◯	◯	◯	◯
69	I would not want the group harmony to be disrupted by conflict	◯	◯	◯	◯	◯
70.	I would like the group to be structured, and provide group embers with a direction	◯	◯	◯	◯	◯
71.	I expect and prefer the group to be more unstructured, involving little direct teaching or planned activities	◯	◯	◯	◯	◯

APPENDIX D

MULTICULTURAL GROUP SCREENING FORM

Demographic Information	Sexual Orientation :
Age:	UK= Unknown
Sex :	Heterosexual =1
Male = 1; Female =2	Homosexual=2
Do you have a disability ?	Bisexual=3
Yes=1 and No=2	Transgender=4

Self Identification
1 = Asian, Asian American
2 = Black or African American
3 = Hispanic or Latino
4 = White, Caucasian, European, not Hispanic
5 = American Indian
6 = Biracial: Mixed: Parents from two different groups
7 = Other (Please Specify): _____
8 = Multiracial/ More than two ethnicities checked (Specify)

Father/ Stepfather/ Guardian ethnicity
11 = Asian, Asian American
21= Black or African American
31 = Hispanic or Latino
41 = White, Caucasian, European, not Hispanic
51 = American Indian
61= Biracial: Mixed: Parents from two different groups
71= Other (Please Specify): _____
81 = Multiracial/ More than two ethnicities checked (Specify)

Mother/Stepmother/ Guardian ethnicity
12 = Asian, Asian American
22= Black or African American
32 = Hispanic or Latino
42 = White, Caucasian, European, not Hispanic
52 = American Indian
62= Biracial: Mixed: Parents from two different groups
72= Other (Please Specify): _____
82 = Multiracial/ More than two ethnicities checked (Specify)

Items 1-18 reworded and based on categories depicted in MEIM measure

® = Reverse items

1= Strongly Disagree
2= Somewhat Disagree
3= Neutral
4= Somewhat Agree
5= Strongly Agree

Reverse Items
5= Strongly Disagree
4= Somewhat Disagree
3= Neutral
2= Somewhat Agree
1= Strongly Agree

AFFIRMATION / BELONGING

1.	I am glad to be a member of the ethnic group that I belong to
3.	I am proud of my ethnic group and its accomplishments
7.	I feel a strong sense of attachment to my own ethnic group
13.	I do not have a strong sense of belonging to my ethnic group ®
17.	I feel great about my ethnic or cultural background

ETHNIC IDENTITY ACHIEVEMENT

2.	I often wonder and am unclear about the impact of ethnicity on my life
4.	I spend a great deal of time trying to find out more about my own ethnic group (i.e. its history, tradition, and customs)
5.	I learn more about my ethnic background by talking to other people about my ethnic group

6.	I have a clear understanding of what my ethnicity means to me
8.	I have a good understanding of what it means to be a member of my ethnic group and also to relate to other groups
9.	I do not invest a lot of time trying to learn more about the culture and history of my ethnic group ®

ETHNIC BEHAVIORS AND PRACTICES

10.	I take part in cultural practices such as enjoying special food, music or customs as being part of my ethnic group
12.	I choose not to actively participate in social groups or organizations that have mostly members of my ethnic group ®

OTHER GROUP ORIENTATION

11.	I like getting together and knowing people whose ethnicity is different that my own
14.	I spend a considerable amount of time with people who are members of different ethnic groups
15.	I do not like making friends with people who are members of different ethnic groups ®
16.	I like being around people who are members of different ethnic backgrounds
18.	I sometimes prefer that people of different ethnic backgrounds should not mix with one another ®

RACIAL ATTITUDES

Negative Biases held by group members

19.	I often view people from different ethnic groups negatively, which influences my interaction with them
24.	Because I do not have many friends from different ethnic groups, it is really hard for me to understand or feel close to people from another ethnic group/race/country

Expectations of being Negative Evaluated by others

20.	I would be more cautious about what I say in a group, as I am afraid it might be used against me
21.	I worry about being treated with resentment or being insulted by others in the group, solely because I am of a different ethnicity/race
22.	I would be suspicious of the advice given by someone of another race/ or ethnicity in a therapy group

Possible discontinuation in Group therapy

23.	I would likely discontinue group therapy if group members or the group leader do not ask about my cultural beliefs
25.	I am likely to leave the group, if I am the only member that represents my ethnic group
28.	I would likely discontinue group therapy if I felt group members or the group leader were biased against me due to my ethnicity

Positive view held by group members

26.	I am comfortable getting to know group members from different countries, races or ethnicities
27.	I feel a sense of belonging with persons from different ethnic groups

GROUP LEADER PREFERENCES

Gender/Ethnicity of Group Leader

29.	I would prefer the group leader to be of the same gender as me
30.	I am comfortable working with a group leader who is of the opposite gender than me
33.	I would be more uncomfortable sharing information if the group leader was from my own ethnic group ®

Expectation of relationship with Group Leader (Hierarchy/Authority v/s Egalitarian)

31.	I would expect the group leader to provide direct advice, suggestions, and solutions for my problems
32.	I view the group leader as someone who is in authority, and would expect him/her to have special expertise and power during the group process
34.	I would expect a group leader to act like my equal
35.	I would prefer a group leader who focuses on helping me problem solve

Expectation of behaviors of group leader during the group process

36.	I would not expect my group leader to share personal information about themselves ®
37.	I would not speak up in group until I am directly addressed by the leader ®

VERBAL PARTICIPATION /SELF DISCLOSURE

Verbal Participation/Self-Disclosure

44.	I am comfortable disclosing personal information with other group members
45.	I worry that if I do not share / disclose things about myself in group, other group members may think badly of me
46.	If I share my personal problems with group members, I will bring shame upon my family
50.	I would not be comfortable disclosing personal information with other group members ®

Communication patter/Interactional patterns during Participation

38.	When in a group, my silence would indicate that I am respectful and listening to others express their thoughts, and feelings
39.	I view a talkative person as an attention seeker or someone who is showing off
41.	In group, I would rather be silent than say something that is not well thought out
43.	When in a group, my silence indicates I am not happy with other people or the advice provided to me

Trying out risky/ new behaviors

47.	I would be ashamed if I am unable to achieve what I am expected to do in the group. For instance, If I am unable to succeed with others in terms of role-playing of new behaviors
49.	I would bring shame to my family or friends by involving myself in role-play situation and disclosing personal information about my family members

VALUE ORIENTATIONS

Structure of the group

54.	I would start/end at the exact time as it is scheduled
70.	I would like the group to be structured, and provide group embers with a direction
71.	I expect and prefer the group to be more unstructured, involving little direct teaching or planned activities
48.	I am likely to leave group if the focus of group treatment involves talking about my family

Values of thoughts over feelings

51.	I would not want to discuss my feelings or emotions with group members ®
52.	In the culture that I identify with, talking about thoughts is more acceptable than talking about feelings

Expression of feelings verbally or nonverbally

40.	I enjoy "talking things out" by speaking to others about things that bother me
42.	When I communicate, I generally communicate my emotions and / or thoughts by expressing them nonverbally (e.g., use of eye contact, facial expression etc.)

Confrontation/ Assertiveness

53.	Being confrontational in a group is frowned upon/considered unacceptable by people from the cultural group I identify with
55.	Interrupting others is considered rude by the culture I identify with

56.	I believe it is disrespectful to directly assert your own needs and wishes in a group
57.	Putting someone “on the spot” is considered impolite by the culture I identify with
66.	Confronting people is important in my culture since it shows that you care enough to tell someone the truth
69	I would not want the group harmony to be disrupted by conflict ®

STIGMA

General View of mental health

63.	Mental health treatment is negatively viewed by the culture I identify with
67.	Going to a mental health provider cannot solve my problems, the only hope is to try harder to solve my problems

Group versus Individual

58.	People from the cultural groups I most identify with have negative views about group therapy
59.	I prefer seeking help from my family, and community than solely seeking help from members of a therapy group
64.	I would prefer individual therapy/treatment rather than group therapy/ treatment
65.	I see group therapy as more helpful than working with an individual therapist

Help seeking attitude

60.	It is a sign of personal weakness to share my interpersonal or emotional problems with other group members
61.	Asking for help from other group members would make me feel like there was something wrong with me
62.	Seeking help for my personal problems does not mean that my family has failed in some way to help me
68.	Sharing my problems with group members dishonors my family

APPENDIX E

Tables

Table E1

Scales and Item from Ethnic Identity scale on Multicultural Group Screening Form

Ethnic Identity (15 items; α = .82)
*Affirmation /Belonging (*α = .82)
I am glad to be a member of the ethnic group I belong to
I am proud of my ethnic group and its accomplishments
I feel a strong sense of attachment to my own ethnic group.
I do not have a strong sense of belonging to my ethnic group®.
I feel great about my ethnic or cultural background.
*Ethnic Identity and Achievement (*α = .70)
I spend a great deal of time trying to find out more about my own ethnic group (i.e., history, tradition, and customs).
I learn more about my ethnic background by talking to other people about my ethnic group.
I have a clear understanding of what my ethnicity means to me.
I have a good understanding of what it means to be a member of my ethnic group and also to relate to other groups.
I do not invest a lot of time trying to learn more about the culture and history of my ethnic group®.
*Other Group Orientations (*α = .76)
I like getting together and knowing people whose ethnicity is different than my own.
I do not like making friends with people who are members of different ethnic groups®.
I like being around people who are members of different ethnic background.
Additional items on total scale (Ethnic Behavior and Practices)
I take part in cultural practices such as enjoying special food, music, or customs as being part of my ethnic group.
I choose not to actively participate in social groups or organizations that have mostly members of my ethnic group®.

Note: ® indicates items reversed scored

Table E2

Scales and Item from Racial Attitudes scale on Multicultural Group Screening Form

Racial Attitudes (7 items; α = .70)
I often view people from different ethnic groups negatively, which influences my interaction with them.
Because I do not have many friends from different ethnic groups, it is really hard for me to understand or feel close to people from another ethnic group/race/country.
I would be more cautious about what I say in a group, as I am afraid it might be used against me.
I worry about being treated with resentment or being insulted by others in group, solely because I am of a difference ethnicity/race.
I would be suspicious of the advice given by someone of another race/or ethnicity in a therapy group.
I would likely discontinue group therapy if group members or the group leader do not ask about my cultural beliefs.
I am likely to leave a group, if I am the only member that represents my ethnic group.

Note: ® indicates items reversed scored

Table E3

Scales and Item from Group Leader Preferences scale on MGSF

Group Leader Preferences (3 items; α = .70)
I would expect the group leader to provide direct advice, suggestions, and solutions for my problems.
I view the group leader as someone who is in authority, and would expect him/her to have special expertise and power during the group process.
I would prefer a group leader who focuses on helping me problem solve.

Note: ® indicates items reversed scored

Table E4

Scales and Item from Verbal Participation/Self Disclosure scale on MGSF

Verbal Participation/Self-Disclosure (5 items; α = .71)
I worry that if I do not share/disclose things about myself in group, other group members may think badly of me.
If I share my personal problems with group members, I will bring shame upon my family.
I view a talkative person as an attention seeker or someone who is showing off.
I would be ashamed if I am unable to achieve what I am expected to do in the group. For instance, if I am unable to succeed with others in terms of role-playing of new behaviors.
I would bring shame to my family or friends by involving myself in role-playing situation and disclosing personal information about my family members.

Note: ® indicates items reversed scored

Table E5

Scales and Item from Stigma scale on MGSF

Stigma (5 items; $\alpha = .73$)
Going to a mental health provider cannot solve my problems; the only hope is to try harder to solve my problems.
People from the cultural group I most identify with have negative views about group therapy.
It is a sign of personal weakness to share my interpersonal or emotional problems with other group members.
Asking for help from other group members would make me feel like there was something wrong with me.

Note: ® indicates items reversed scored

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